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ISCCM News Headlines

- Please take active part in election.
- Election window will remain open from 1st to 7th August 2011 for voting.
- Keep an eye on your mobile (sms) and email id (authorized in ISCCM).

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Your Attention Please

- Please take active part in election.
- Election window will remain open from 1st to 7th August 2011 for voting.
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Changing Paradigm of ISCCM

The society is into a new paradigm and this brings in new challenges and opportunities. Election online through electronic voting is one such challenge and opportunity. Can we do it, we have to do it and we will do it. But this cannot be achieved without cooperation of members of the society who constitute the voters list of the society. I have the privilege of being both the election commission and the editor of the bulletin. Therefore, I take this opportunity to call upon all the members to participate actively in the election process, which has been made so easy by some hard work done during last 2 years to ensure that we can do elections online without much hassles. To the best of our knowledge, ISCCM will be the first professional society of doctors in India to do this. I wish to acknowledge the leadership of Dr Rajesh Chawla – the President who made sure that we will not fail in our objective of achieving this feet right this year. The previous executive led by Dr J Divatia endorsed the idea and supported it. This paved way for constitutional amendment through approval at last AGM. Online elections could not have been possible without hard work of Mr Nilay Jani (M/S Prometheus Solutions) and his team during last one year and later joined by MCA’s team of Hari and Sai. Contributions of Dr Pravin Amin, Dr C K Jani have also gone a long way in selection of the poll masters. The office staff of the society has been very active indeed to make it a success. Thanks to one and all who have helped and contributed in this endeavor. Success of this massive exercise will be gauged by your overwhelming participation in the election process which has remained subdued all these years with rare sparks. Election is an opportunity for the members to send the best people to the parliament of ISCCM that is national executive committee.

New opportunities will come in form of conducting our programmes online electronically and exploit the technology to its best advantage. It may be in form of conducting more meeting, examinations, conferencing and updating our membership data base. Research may get a significant boost with help of technology.

The important task that remains undone is activating the society’s branches. They form the legs and backbone of the society. They must become active and strong. Regular elections for the office bearers, local meetings and conferences should be organized. They must feel like an indispensable arm of ISCCM. This will give the society a shot in arm and it will grow still faster and become strong. This will also stimulate wider and uniform representation of different parts of the country in ISCCM executive.

Let us vote and motivate other members to vote.

Thanks.

Life has no pause buttons, Dreams have no expiry date, Time have no holiday, so, don’t waste a single moment in your life like it, live it, love and enjoy it.
Dear All,

I hope you are all aware that the elections this year would be by web based online voting system. I am happy to inform you that ISCCM is the first Indian Society to adopt the E-election system. This idea came to my mind in 2009 when I received a mail from the Society of Critical Care Medicine, USA for online voting for office bearers. I immediately called Mr Nilay Jani, CEO – Prometheus Solutions, which looks after our official website, and asked him whether we could adopt a web based voting system. After some time he informed me that it was very much possible and gave the approximate expense. I then discussed this issue with the then President Dr J Divatia and he liked the idea. Thereafter I presented the E-Election project and its probable expense in the Executive Committee of ISCCM. After its approval, I requested Mr Nilay Jani to prepare the software which took about three months to do. The software was demonstrated in the Executive Committee meeting of ISCCM for the first time in 2010. The next step was to get an approval from the General Body and thereafter make necessary amendments in the constitution. This idea and the process was presented in the AGM at Vigyan Bhawan in New Delhi and it was approved unanimously and now it is part of constitution of ISCCM.

Simultaneously, we started requesting members to update their database through the database form. For reasons of authenticity, we do not allow members to change their database without a signed database form. However getting this done has been a very difficult task. We have announced this repeatedly in the news bulletin, website, in posters during conferences and Journals for the last one and a half years. We have also sent a written request by post with a self addressed envelope to all the members. Many of you have indeed co-operated and sent us the filled data base form while others have not. For election purposes the last date for updating database was 2nd July. Remember, the election starts from 1st August. This process otherwise will continue. I request members who have not filled the form to please download it from the website and send it to us.

The election software was prepared by Mr. Nilay Jani. A question of security of the election process was raised by some members. The Executive Committee asked Dr Pravin Amin, the Past President to find a person who can do the security testing on the electronic software. He narrowed down on Ms. MCA Management Consultant Ltd. Let me assure you all that we are fortunate to work with this firm as there officials are very meticulous, systematic and non-compromising. All the glitches/ issues raised during security testing have been addressed by Mr. Nilay Jani. The E-election will also be conducted by MCA consultants. Dr N Rungta (Chief Election Officer for this year) and I have had a number of discussions through telecon and emails with them. We also visited Mumbai on many occasions to meet all concerned to make it an impartial election. Now all the testing is complete.

The profiles of all the candidates are on the website. The election days as per the constitution are between 1st August and 7th August, 5:00pm. Elections results will be announced in the Executive Committee meeting on the same day and will be put up on the website. I thank Dr Rungta for supervising the whole process very efficiently. I am sure we will succeed in this endeavour.

Friends, we must progress as a society and break old barriers and adopt new methods. This is not possible without your support. I can assure you that the election this year shall be totally impartial. This being the first time, there may be some unintentional glitches/issues. We will try to address them to the best of our capabilities. I will request you to bear with us. Please vote for your favourite candidate through this process and make it a great success. This historical change is not possible without your support. Let us do it.

On behalf on India Society of Critical Care Medicine, it gives me great pleasure to invite you to the inauguration of our new office at Dadar on Sunday 7th August 2011 between 11:00am to 1:00pm. I would like to thank Dr C K Jani, and all the members of Building Committee who worked very hard to make it possible. This new office will have a Society Manager and a person dealing with Education, Research, Membership, accounts respectively. We have already appointed Mr. Vimal Merchant as the Manager.
### ISCCM Election 2012-2013

#### President Elect - Number of Post - 1

**Dr. Shivakumar Iyer**  
(MD DNB Medicine, EDIC)  
Candidate for President Elect

I started my intensive care career with Dr. Shirish Prayag and also became ISCCM member in 1994. From 1998 to 2003, I was West Zone member and then member of the ISCCM executive. I worked along with Dr. Farhad Kapadia for the ISCCM educational courses and was nominated as Course Coordinator from 2004 to 2008. I am currently Vice-President ISCCM and Chairperson ISCCM Pune.

**List of Achievements**
- Speaker at almost every ISCCM national conference
- Workshop coordinator Fourth National ISCCM conference
- Contributor to ISCCM guidelines
- Member ColloBrace project ESMC
- Helped create IFCCM and adopt ColloBrace competencies in ISCCM
- Member, workshop on patient safety (joint ESMC and WHO project)
- Introduced Intensive Care Review Course ISCCM Pune
- International speaker at Pan Arab Society and Asian Intensive Care Conference
- Member BASIC steering group
- BASIC course coordinator for ISCCM
- Honorary Adjunct Assistant Professor Chinese University of Hong Kong
- Organizing Secretary PENSIA Nutrition Conference 2003
- Editor ICU section API textbook 2008
- Member editorial board of JICCM
- Member Editorial board JAPI
- Co-editor “Safety Practices in Critical Care” Criticare 2010 (ELSEVIER)
- Contributed several articles and chapters to ICU and Nutrition texts
- Honorary Fellow of the ISCCM

**Dr. C.K. Jani**  
Candidate for President Elect

Dr Jani C.K. is intensivist & critical Care Physician at Saifee Hospital Mumbai. She has more than 20 years of experience of critical care. Her basic qualification is M.D. medicine.

- She is very actively involved with “Indian Society of critical Care Medicine”
- She is Vice President - Indian Society of Critical Care Medicine, Chair Person-Mumbai branch, & teacher of diploma and fellow of critical care course conducted by ISCCM.
- During her tenure in various executive positions in ISCCM, Dr. Jani has been responsible for setting up
- Centralized ISCCM operations. She has also been instrumental in setting up ISCCM’s active online presence i.e. re-development of website.
- She has participated in all national annual conference as faculty and has given various presentation
- Chaired session for ISCCM Annual conference every year;
- Articles in updates-Gut Ischemia in Critical illness,
- Goal Directed Therapy in Surgical Patients
- Participated in workshop in API conference
- At Cochlin - Non Invasive Ventilator
- At Jaipur - ABG Work shop
- At Ahmedabad - Critical illness polymyopathy

**Dr Praveen Khilnani**  
MD FAAP FCCM (USA)  
Candidate for President Elect

Senior Consultant Pediatric Critical Care, Max and BLK Hospitals, Delhi.  
Chairman ISCCM Delhi and NCR  
Organizing Chairman: Criticare 2011, Delhi

Graduated from Maulana Azad Medical College, Delhi in 1978. Anesthesiology(PD) from All India Institute Of Medical Sciences (AIIMS) in 1983. Fellowship in Pediatric critical care Harvard university at Massachusetts General Hospital, Boston USA. Pediatric cardiac intensive care training at Boston childrens hospital. He has numerous publications and books to his credit, and he is on the editorial board of IJCCM, Pediatric critical care journal(SCCM), Intensive care medicine (ESICM). He is American board certified in pediatric critical care medicine and fellow American college of Critical Care medicine (FCCM) and ISCCM. Founder of Pediatric section of ISCCM year 2000. Pioneer in developing the field of pediatric critical care in India.

**Activities in ISCCM:**
- Actively associated with ISCCM in since 1996.
- Founder Chairman: Pediatric section of Indian Society of Critical Care Medicine 2000-2002
- Executive secretary: Indian Society of Critical Care Medicine(Delhi) 1999-2001
- Executive Member (North) ISCCM 2002-2004
- Vice president : Indian Society of Critical Care Medicine (Delhi) 2001-2003
- Chairman : Pediatric section ISCCM 2004-2006
- Vice President: ISCCM central 2006-2007
- Chairman JAPI (intensive care chapter) 2007-2008
- Chairman ISCCM Delhi and NCR 2009-2011

#### Vice President - Number of Posts - 2

**Dr. Rajan Barokar**  
Candidate for Vice President

**Qualification - M.D. (Internal Medicine), GMC, Nagpur 1994**

European Diploma in Intensive Care (EDIC) - 2006.  
Director & Chief Consultant: “Aditya Critical Care & Emergency Centre”, Nagpur a 28 bedded Hospital with 15 bed ICU (Surgical, Medical and Obstetric).

**Personal Information:**
- Fellow : Pulmonary & Critical Care, Loyola University Medical Centre, Chicago, USA; Intensive Care Medicine, Erasme University Hospital, Brussels, Belgium;
- Instructor - Basic & Advanced Cardiac Life Support (AHAA Recognized).
- Instructor - Fundamental Critical Care Support (FCCS) Course, Member - Indian Society of Critical Care Medicine
- European Society of Intensive Care Medicine
- Indian Medical Association.
- Academy of Medical Sciences, Nagpur.
- Association of Physicians of India.

**Past Chairman - ISCCM, Nagpur branch**

President Elect - Academy of Medical Sciences (AMS), Nagpur.

Executive member - API, Vidarbha Chapter.

Past National Executive - ISCCM.

Past Chairmain ISCCM, Nagpur Chapter  
Recognised Teacher - Certificate Course in Critical Care by ISCCM.

National Faculty - National Critical Care, Medicine, Anaesthesia Conferences and Workshops since last 12 years.

Organising secretary - First Asian Conference on Shock and Sepsis.

**Special Interests -**
- Neuro Critical Care.
- Hepatitis and Gastrointestinal Critical Care.
- Obstetric Critical Care.

**Transport of Critically Ill.**

**Dr. Deepak Govil**  
Candidate for Vice President

I have been working in the field of critical care medicine for the past 16 years. Initially starting as Consultant, at Meerut, finally progressing to a senior consultant in the institute of Critical Care & Anesthesia, Medanta- The Medicity, Gurgaon. I am looking after the 22 bedded Gastroenterology and Liver Transplant Unit.

My base speciality is Anaesthesiology. I subsequently completed the European Diploma in Intensive Care Medicine. I am an Examiner and teacher for ISCCM and I undertake inspection of various hospitals for their accreditation for running this course. I am serving in National executive of ISCCM for past five years in various capacities, also a member of the Education Committee of ISCCM for the past three years besides this, am also representing ISCCM on the Asian Board of WINFOCUS.

I am a Certified Instructor for FCCS (SCCM USA), Advanced Cardiac Life Support (AHAA USA) and Advanced Trauma Life Support Course (ATS USA).

Since the beginning of my career, I have actively strived to promote and propagate the field of critical care medicine and have been organizing numerous critical care meetings including the recently concluded 17th Critical Care Congress, the annual meeting of the ISCCM.

**Candidate for President Elect**

**Candidate for Vice President**

**Candidate for President Elect**

**Candidate for Vice President**

**Candidate for President Elect**

**Candidate for Vice President**

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**Candidate for Vice President**

**Candidate for President Elect**

**Candidate for Vice President**
Dr. Babu K. Abraham

Candidate for Executive Committee Members

MD, MRCP (UK)

Dr. Babu K Abraham completed his MBBS in 1988 and MD in General Medicine in 1992. He moved to the UK in 1996 and completed his MRCP (UK) in 1999. After his initial training in the UK, he moved to St.Michael's Hospital, Toronto, Canada to do a fellowship in Critical Medicine. He returned to India in 2003. He is now a senior consultant at Apollo Hospitals, Chennai and is also the Director of Critical Care Consultants Group Pvt Ltd, a company that provides complete solutions to establishment and administration of ICU's. He also is the Director of TACT Academy for Clinical Training Pvt Ltd, the first simulator based training centre in India. He is a recognised teacher for ISCCM since 2005 and has been an examiner for IDCCM and DM Critical Medicine at Ramachandra University. He also served as the secretary for ISCCM, Chennai branch from 2007 to 2009. He is passionate about acute care medicine training, especially simulator based, and his special interest lies in hemodynamic monitoring and antibiotic policy. He is a senior mentor for critical care trainees at Apollo hospital and has many publication in his name.

Dr. Shabbar H. K. Joad

Candidate for Executive Committee Members

MD (Medicine)

Indian Diploma in Critical Care Medicine (ISCCM, IDCC)

ISCCM Recognised Teacher for IDCC Course

AQLS Instructor

FCCS Instructor (SCCM, Florida, USA)

BASIC Instructor

Dr. Shabbar H. K. Joad holds a Diploma in Critical Care Medicine from J.N. Medical College, Aligarh University in 1989. He then joined Batra Hospital, the first tertiary care multi-speciality hospital in New Delhi. He was awarded the American Association for Respiratory Care International Fellowship, San Diego, 1996. He also holds a Diploma in Interventional Pulmonology, Barcelona, Spain 2002 and was the Organising Secretary of the Annual Conference of the Indian Association of Bronchology, "Broncocon 2005", New Delhi He underwent advanced training in Sleep Medicine, Melbourne, Australia 2002. He is currently the Joint Secretary, ISCCM (2010-2012) and the Secretary of the Delhi and NCR Chapter, ISCCM, (2009-2012). He was also the Organising Secretary of "Criticare 2011",Vigyan Bhawan, New Delhi. He is currently working as a WHO expert on "Global Safety and Transfusion Practices in the World". He has delivered lectures in State, National and International Conferences including USA and Malaysia.

Dr. Suninder S. Arora

Candidate for Executive Committee Members

MD

Dr Suninder S Arora is Director and Unit Head, Department of Medicine and Critical Care, Batra Hospital, New Delhi. Dr S S Arora obtained his postgraduate degree in Internal Medicine from J.N. Medical College, Aligarh University in 1989. He then joined Batra Hospital, the first tertiary care multi-speciality hospital in New Delhi. He has delivered lectures in State, National and International Conferences including USA and Malaysia.

Dr. Diptimala Agarwal

Candidate for Executive Committee Members

MBBS B R Ambedkar Medical College, Bangalore

MD, A, Christian Medical College & Hospital, Ludhiana.

FCCS-Fellowship in Critical Care

PGDHA Coimbatore

Professional Experience

Worked as resident in MGM Hospital, Mumbai & SMDH Jaipur.

Core team member of Oxim Anesthesia & Critical Care Associates.

Senior Consultant department of Anaesthesia & Critical Care, Pushpajali Hospital,Agra from 2000 till date.

Visiting Consultant RamRagh Hospital, Metro Upadhyay Hospital & Various other hospital of Agra from 2000 till date.

Academic Achievements

One of the pioneers in the field of Critical Care medicine in the city.

National Faculty in Trauma & Critical Care Conference.

Post Graduate Teacher &Trainer for DNB students: Anesthesiology.

Scientific Secretary of 9th National Conference of ITC2006.

Scientific Secretary 14th National Conference of ISCCM 2009.

Presently Secretary ISCCM Agra Chapter.

FCCS & CTLS Instructor.

Running BTC3 Course (Basic Trauma & Critical Care Course) for Nurses .

Running FA.R. (First Aid Resuscitation Course) for general public since 2005.

Scientific Secretary of Forthcoming 2nd Annual Conference of U.P.ISCCM to be held on 2nd to 4th September 2011 at Agra.

Dr. Sandhya Talekar

Candidate for Vice-President

Senior consultant in Critical Care, Shree Medical Foundation Pragya Hospital, Pune


2. Secretary of the Pune Branch of ISCCM from 1998 to 2000.


6. Chief Organizing Secretary for an Exclusive Workshop on Mechanical Ventilation, organized by Pune branch of ISCCM, for 14 years.


10. Elected as Vice President of ISCCM from Jan 2003 to Dec 2004.


13. Participated as faculty in many ISCCM National Conferences / Workshops/ updates in Critical Care.

Hospital and Research Center, Mumbai; Santokhi Durbabhji Memorial Hospital, Jaipur; Ruby Hall Clinic, Pune, India

Member
1. Executive member of ISCCM Jaipur Chapter
2. Association of Physicians of India
3. Indian Society of Critical Care Medicine
4. Indian Society for Emergency Medicine
5. Indian Society for Parenteral and Enteral Nutrition
6. European Society of Intensive Care Medicine
7. Society of Intensive Care Medicine (USA)

Dr. Mohan Mathew
National Posts
Organizing Chairman - ISCCM National Conference 2007 South Zone representative ISCCM-2008-2010
Bio Data
A Pioneer of critical care in Kerala.
A three day old child with "neonatal tetanus" was Ambu bagged in 1976 by Dr. Mohan Mathew for 27 days and today he is a leading dentist in Kerala. Advanced Critical Care Training from 1988-1996 wish Dr. MD/FDwood, an intensivist trained at Middlesex University Hospital under Dr. Jack Tinker God father of "Intensive Care" in the U.K.

New Director of Critical Care at Lakeshore Hospital at Kochi, Kerala, India. Honorary Fellow-Shock Trauma Centre, Baltimore, USA. Pioneer in Liver Transplantation in Critical Care in Kerala. Trained at the John Hopkins Hospital, Maryland. Baltimore in 1999. 

CCT under Dr. Bill Sibbald at the Sunny Brook hospital Toronto, and Neuro critical care from the Royal Victoria Hospital McGill, Montreal.

Founder President- Indian Trauma Life support Society 2001 and ISCCM- Cochin City Branch in 2006.

National Secretary- "International Trauma Care “ ITC from 2006 onwards.

WHO observer in International Trauma Care.

Comprehensive Trauma life support Instructor.

Teacher Diploma in Critical Care and National Board of Anaesthesiology. Member of SCCM and ESMCC and has attended Annual Conferences in US and Europe since 2006.

Speaker at International Forums for Critical Care at Hanoi, Seoul, Singapore, and Dubai.

Dr. Dr. Yatin Mehta
Chairman - ISCCM National Conference 2007 South Zone representative ISCCM-2008-2010
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Teacher Diploma in Critical Care and National Board of Anaesthesiology. Member of SCCM and ESMCC and has attended Annual Conferences in US and Europe since 2006.

Speaker at International Forums for Critical Care at Hanoi, Seoul, Singapore, and Dubai.
He is currently the Joint Secretary, ISCCM (2010-2012) and the Secretary of the Delhi and NCR Chapter, ISCCM, (2009-2012). He was also the Organizing Secretary of “Criticare 2011”, Vijyan Bhawan, New Delhi. He is currently working on a WHO expert on “Global Safety and Transfusion Practices in the World”. He has delivered lectures in State, National and International Conferences in USA and Malaysia.

Field of Interest
Traumatic Brain Injury

Zonal Member - Central Zone
Number of Post - 1

Dr. Shabar H. K. Joad
Candidate for Zonal Member - Central Zone

Qualification
- National Board of Examination’s DNB (Fellow Critical Care Medicine), « MD (Medicine)
- Indian Diploma in Critical Care (ISCCM’s IDCC)
- ISCCM Recognised Teacher for IDCC Course
- ACLS Instructor
- FCCS Instructor (SCCM, Florida, USA)
- BASIC Instructor

Work Experience: Fortis Escorts Hospital, Jaipur; India, (present), P.D. Hinduja Hospital and Research Center, Mumbai, Santokba Durlabhji Memorial Hospital, Jaipur, Ruby Hall Clinic, Pune, India

Member
1. Executive member of ISCCM Jaipur Chapter
2. Association of Physicians of India
3. Indian Society for Critical Care Medicine
4. Indian Society for Emergency Medicine
5. Indian Society for Parenteral and Enteral Nutrition
6. European Society of Intensive Care Medicine
7. Society of Intensive Care Medicine (USA)

Present Position
- Senior Consultant department of Anaesthesia & Critical Care Associates
- Core team member of Osim Anesthesia & Critical Care Associates

Academic Achievements
- One of the pioneers in the field of Critical Care medicine in the city.
- National Faculty in Trauma & Critical Care Conference.
- Post Graduate Teacher & Trainer for DNB students; Anesthesiology.
- Organizing Secretary of 9th National Conference of ITC2006.
- Co-organising Secretary 14th National Conference of ISCCM held at Agra in Feb. 2009.
- Presently Treasurer ISCCM Agra Chapter.
- Running BTC3 Course (Basic Trauma & Critical Care Course) for Nurses.
- Running F.A.R. (First Aid Resuscitation Course) for general public since 2005.
- Organizing Secretary of Forthcoming 2nd Annual Conference of U.P. & UK.

Senior Consultant Intensivist : Dayanand Medical College and Hospital, Ludhiana which is a 1100 Bedded Tertiary Care Teaching Hospital with 100 bedded ICU Complex.

Academic and Research Activity
- Guest Faculty at various International (Korean Society of Critical Care Medicine) and National Critical Care conferences and delivered Lectures and conducted workshops on varied Topics like Arterial Blood Gas Interpretation, Intra Abdominal Hypertension, Basic and Advanced Cardiac and Trauma life support, Poisonings, Airway Management, etc.
- Shared Sessions on various Critical Care and Pulmonary Conferences.
- Paper presentation at International (ATS) and National Conferences and various symposia.
- Have >11 years Experience in Critical Care Medicine and Involved in teaching Medical Students Residents and nurse on various topics in Critical Care.
Dr. Krishan Chugh is presently the Director of Institute of Child Health, Sir Ganga Ram Hospital, New Delhi. After his graduation and post-graduation in Pediatrics from premier institutions of Delhi, he acquired the skills of Pediatric Critical Care and Bronchoscopy in USA. Dr. Chugh was the founding Chairman/Convener of Critical Care Chapter of Indian Academy of Pediatrics. He has contributed to the field of critical care immensely by training 12 to 15 young pediatricians every year at his institution through the very popular "Advanced Course in Pediatric Intensive Care" for the past 16 years. The 17th course is scheduled for Sep 26 to Oct 1, 2011. He has been Director of many PALS courses and Editor of the Pediatric Section of JJCCM. He was also Associate Editor of "Indian Pediatrics" for several years.

Sir Ganga Ram Hospital is one of the first five centers in the country where "One-Year Fellowship in Pediatric Intensive Care" was started. The National Board of Examination also chose this PICU as its first center for starting a Fellowship program in Pediatric Intensive Care.

He was the President of ISCCM Delhi Branch for year 2009. He is presently the Chairman of Pediatric Section of ISCCM.

Dr. Krishan Chugh
Director, Institute of Child Health,
Sir Ganga Ram Hospital, New Delhi

Dr. Urmila Jhamb
Date of Birth : 30.9.1959.

Educational qualifications

MCI Reg No. : 2848

Present post + Professor : Department of Pediatrics, Maulana Azad Medical College and associated LN Hospital, New Delhi (Faculty in Maulana Azad medical college for 15 years).

In charge : Pediatric Intensive care unit (for 15 years).

Faculty and examiner for National board of examinations for Pediatric critical care medicine fellowship course. Also expert for examining suitability of institutions for DNB pediatric critical care fellowship course.

International Fellowships
Awarded Commonwealth fellowship by Commonwealth Commission UK, in 2004 at St Marys Hospital, London, UK.

Contributions
• Many publications and contribution of chapters in the books.
• Faculty participation in critical care conferences.
• Conducted CMEs and workshops in Pediatric critical care.

Dr. Urmila Jhamb

Form for Correction of Authorised Email ID and Mobile Number

To,
Indian Society of Critical Care Medicine

I would like to request you to change email/mobile number in ISCCM database.

ISCCM Membership Number : ..........................................................

Name : .......................................................................................................... ...........................................................

Residential Address : .................................................................................................................................

..................................................................................................................................................................................................

New Email Address : ........................................................................................................ New Mobile Number : .................................................................................................................................

Signature : ..........................................................................................................................

(Please note that any form without signature will not be accepted)

Indian Society of Critical Care Medicine
Building No. 3, Office No.12, 5th floor, Navjivan Premises Co-op Society Ltd, Dr D.Bhadkamkar Road,
Mumbai Central – 400008 • Tel No. 022-65268504 • Telefax : 022-23054843 • email : isccm1@vsnl.net

India’s total population - 118 crore. Each day, number of deaths - 62389. Each day, number of births - 86853. Total number of blinds - 682497.

If each day dead person lets donate his/her eyes, within 11 days India will be free from blindness.
Ear Dr Rungta and ISCCM members,

Thank you all for your support.

It was a few months ago when I had initiated the discussion about the Critical Care course for Post MBBS doctors. I was extremely happy to read that ISCCM has taken a decision to restart this course.

I thank you very much and sincerely hope it helps in improving the society and the environment we are forced to work in.

Thank you all the members of the Critical Care Forum. It would have not been possible without support from all you guys out there. I sincerely thank senior member Dr Palepu Gopal, Dr Sanjay Dhanuka, Dr George John ... just to mention a few of them who understood the need of the hour and voiced their strong recommended for the course.

Lastly ISCCM President and senior Members for respecting our views and restarting the course, which definitely would make a big impact on the Indian medical community.

Hope ISCCM stands up and creates more courses in critical care for Paramedical staff and Non-medical staff which can definitely help in the improving the quality of health care and to some extent the living standards of Indian society.

Once again thank you all very much,

Dr. Chenna Keshava

Intensivist, Columbia Asia Hospital
Bangalore

Argument is bad but, discussion is good;
because argument is to find out 'WHO' is right!

and
discussion is to find out 'WHAT' is right!

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3rd EZCCCON 2011

3rd Eastern Zonal Critical Care Conference
3rd EZCCCON - 2011
19th & 20th November 2011
Venue: Hotel The Crown, Bhubaneswar

Organised by:
ISCCM

INDIAN SOCIETY OF CRITICAL CARE MEDICINE
Bhubaneswar Branch

CONFERENCE SECRETARIAT:
Dr. Samir Sahu - 9437005552
Mr. Subrat Mohanty - 9437178735

3rd EZCCCON 2011
1st Floor, MICU, Apollo Hospitals, 251, Sainik School Road,
Bhubaneswar 751005 • email : samirsahu_kol@yahoo.co.in
Website : www.isccm-bbsr.org

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Chennai Chapter

June 22, 2011 (Wed) - Journal Club
Topic: A Novel Antimicrobial and Antithrombotic lock solution for hemodialysis catheter. A multi center RCT.
We are planning to have Mechanical Ventilation course (Basic & Advanced) on August 20, 21 & 22, 2011 (Sat, Sun & Mon).

Dr. R. Senthil Kumar, Secretary
ISCCM Chennai Chapter

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Agra Criticare 2011

2nd Annual Conference of Indian Society of Critical Care Medicine
UP & Uttrakhand Chapter
Agra Criticare 2011
2-4 September 2011
Hotel Orient Taj, Fatehabad Road, Agra

Theme
Time Decision Intervention
SAVE LIFE

CONFERENCE SECRETARIAT:
Organising Secretaries
Dr. Ranvir Singh Tyagi • Dr. Rakesh Tyagi
Scientific Secretary
Dr. Diptimala Agarwal
1276, Sec-11-A, Avas Vikas Colony, Sikandra, Agra - 282 007 (U.P.)
email: info@agracriticare2011.com • agracriticare2011@gmail.com
Website: www.agracriticare2011.com

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DCCS 2011

9th Annual Conference of Indian Society of Critical Care Medicine
(Delhi & NCR Chapter)
19th-21st August 2011
Hotel Le Meridien, New Delhi, India

Theme: Achieving Critical Excellence

CONFERENCE SECRETARIAT:
Dr. Prakash Shastri
Chairman, Organising Committee
Dept. of Critical Care Medicine, 4th floor ICU, Super Speciality Block,
Sir Ganga Ram Hospital, Rajinder Nagar, New Delhi-110060
Ph. 91-9810937295, Tel: 91-11-42252401
email: delhicriticalcare2011@gmail.com • www.dccs2011.com

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Reader's Feedback

"Argument is bad but, discussion is good;
because argument is to find out 'WHO' is right!

and
discussion is to find out 'WHAT' is right!"
**Sample Size Calculation**

Sample size calculation is important part of any trial/study. If not done properly may affect the results and cost of study. There are lot of ways to calculate the sample size but here are few simple methods to use in day to day practice in emergency and intensive care units.

1. **Minimum sample size calculation depends on specific input based on various objectives and type of outcome variable (quantitative or qualitative), nature of universe (homogeneous or heterogeneous), number of class or group proposed, type of sampling (simple random or any other), level of confidence and power of study and budget available.**

2. **Sample size determination also depends of certain prior information e.g. mean, standard deviation, proportion, odd ratio, relative risk, and level of confidence and power of study.**

3. **Rule of thumb is that small study requires minimum 30 subjects, medium size study need 100 subjects and large study require minimum of 300 subjects in each group.**

**Various formulae to calculate sample size**

A. **Estimation of mean:**
- Minimum inputs required are:
  - Expected mean of variable in study group 1 = \( \bar{x}_1 \)
  - Expected mean of variable in study group 2 = \( \bar{x}_2 \)
  - Level of confidence = \( Z_{\frac{1-\alpha}{2}} \)
  - Power of study = \( Z_{\beta} \)
  - Allowable error = \( d \)

  \[
  n = \frac{Z_{\frac{1-\alpha}{2}}^2 \left( \frac{\bar{x}_1 - \bar{x}_2}{2} \right)^2}{d^2}
  \]

B. **Comparison of mean:**
- \( p_1 \) patients with disease = \( p_1 \)
- \( p_2 \) patients without disease = \( p_2 \)
- Anticipated relative risk (RR) = \( \frac{p_1}{p_2} \)
- Allowable error = \( d \)
- Level of confidence = \( Z_{\frac{1-\alpha}{2}} \)

  \[
  N = \frac{Z_{\frac{1-\alpha}{2}}^2 \left( [1-(1-p_1)]p_1/1-p_1 + [(1-p_1)/p_1] \right) \left( \log (1-d) \right)^2}{(p_1-p_2)^2}
  \]

C. **Estimation of proportion:**
- Minimum inputs required are:
  - Prevalence of event in study group 1 = \( p_1 \)
  - Prevalence of event in study group 2 = \( p_2 \)
  - Level of confidence = \( Z_{\frac{1-\alpha}{2}} \)
  - Power of study = \( Z_{\beta} \)
  - Allowable error = \( d \)

  \[
  N = \frac{Z_{\frac{1-\alpha}{2}}^2 \left( \frac{p_1(1-p_1) + p_2(1-p_2)}{2} \right)^2}{d^2}\]

D. **Comparison of two proportions:**
- Inputs required:
  - Prevalence of event in study group 1 = \( p_1 \)
  - Prevalence of event in study group 2 = \( p_2 \)
  - Level of confidence = \( Z_{\frac{1-\alpha}{2}} \)
  - Power of study = \( Z_{\beta} \)
  - \( p \) = \( \frac{p_1 + p_2}{2} \)

  \[
  N = \frac{Z_{\frac{1-\alpha}{2}}^2 \left( \frac{2(\bar{p}(1-p)) + Z_{\frac{1-\beta}{2}} \sqrt{p_1(1-p_1) + p_2(1-p_2)}}{(p-p)^2} \right)^2}{d^2}
  \]

**Commonly used values for \( Z_{\beta} \)**

<table>
<thead>
<tr>
<th>Power (%)</th>
<th>0.05</th>
<th>0.01</th>
</tr>
</thead>
<tbody>
<tr>
<td>P</td>
<td>3.8</td>
<td>6.6</td>
</tr>
<tr>
<td>50</td>
<td></td>
<td></td>
</tr>
<tr>
<td>80</td>
<td>7.9</td>
<td>11.7</td>
</tr>
<tr>
<td>90</td>
<td>10.5</td>
<td>14.9</td>
</tr>
<tr>
<td>95</td>
<td>13</td>
<td>17.8</td>
</tr>
</tbody>
</table>

**Examining sample size calculation using normogram:**

G. **Comparison of two survival rates:**
- Anticipated survival rate in treatment group = \( p_1 \)
- Anticipated survival rate in control group = \( p_2 \)
- Level of confidence = \( Z_{\frac{1-\alpha}{2}} \) two sided test and \( Z_{\frac{1-\beta}{2}} \) for one sided test

  \[
  N = \frac{(Z_{\frac{1-\alpha}{2}} + Z_{\frac{1-\beta}{2}})^2 \left( \log p_1 - \log p_2 \right)^2}{(p_1 - p_2)^2}
  \]

H. **Comparison of two median survival times:**
- Anticipated median survival time in treatment group = \( p_1 \)
- Anticipated median survival time in control group = \( p_2 \)
- Level of confidence = \( Z_{\frac{1-\alpha}{2}} \) two sided test and \( Z_{\frac{1-\beta}{2}} \) for one sided test

  \[
  N = \frac{2(Z_{\frac{1-\alpha}{2}} + Z_{\frac{1-\beta}{2}})^2}{(\log H)^2}
  \]

I. **Sample size calculation using normogram:**
- Calculate standardized difference = \( \frac{\text{Target difference}}{\text{Standard deviation}} \)

J. **Sample size calculation using formula in two equal group:**

  \[
  N = \frac{2}{d^2} \times \left( \frac{1}{p \text{ power}} \right)
  \]

**Normogram for calculating sample size**

Draw straight line between S difference and power of study.
To get the real perspective into the journey of conducting online elections for ISCCM, one must step back and see how the society has grown and evolved to use Information Technology for its growth.

For many years our organization, Prometheus Solutions, has been offering Information Technology solutions for Associations and Non-for-Profit, mainly to clients in US. In 2007, when we decided to start exploring Indian clients, we were looking for similar organizations in India who had the appetite to use Information Technology. ISCCM became one of our first clients in India. Our first assignment with ISCCM was to revamp its website. Over the course of following years we undertook many projects and assignments, including centralization of database, automation of administrative system and online scientific studies, to mention a few.

As the society was gaining more confidence in using IT to increase efficiency and serve the members better, we were looking for more and more possibilities. It was somewhere around Feb 2009 that I discussed the possibility of Online elections with Dr. Chawla, the President-Elect and Election Commissioner at the time. During one of our discussions he expressed his dissatisfaction over the participation of members in the election process he had just overseen. He asked me if we could come up with suggestions on how we can solve this problem by using IT. Coincidently we had recently completed online election for one of our other clients. Dr. Chawla invited us to give him a demonstration of the software and discuss the implementation process. He saw the software and thought it would tremendously benefit the organization. However, apart from the software itself, there were many other challenges like gaining the confidence of all the stakeholders, updating the database, making members aware.

Our next major milestone was to present the online elections to the Executive Committee at Hyderabad. Based on their feedback we made more modifications to the process. In the meanwhile the ISCCM team had already begun a parallel exercise of updating the membership database.

By July 2010 we were ready to start testing the software with the members. At that time Dr. Rungta was serving as the Election Commissioner. He suggested that we do a few mock elections as a test. We got very encouraging results in our mock elections.

By February 2011 we had successfully tested the process of electronic voting through various online mock elections with the members. However Dr. Rungta and Dr. Chawla did not want any angle to be ignored. Hence, MCA Management Consultants were appointed to perform a thorough audit of the software and the process as a third party. Based on the feedback and inputs by MCA, the entire process has now taken its final shape and ready to be deployed for elections starting 1st of August 2011.

I wish to thank everyone involved in this process, especially Dr. Chawla and Dr. Rungta for their guidance and support.

Reference:

Journey of Electronic Elections at ISCCM

Nilay Jani
CEO, Prometheus Solutions • njani@pssinfo.com

Electronic Elections at ISCCM

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Reference:

Electronic Elections at ISCCM

Nilay Jani
CEO, Prometheus Solutions • njani@pssinfo.com

ISCCM E-Ballot 2011 - Election Process Validation

R. Hariharan
Senior Vice President, MCA Management Consultants Ltd.

The mandate given were to perform a Security Testing of the Online Election Portal developed by a third party software development company called Prometheus Solutions (PSS) and also to conduct the system’s functionality testing, apart from suggesting recommendations to enhance the same. MCA was also requested to comment on the complete election process and assist in executing the election process by playing the role of an Independent Election Administrator, Observer and Returning Officer. All this, without compromising on the key principle of any electoral process, being a free, fair and transparent election and upholding the sanctity of the ballotting process.

Approach: MCA has adopted the PDCA approach (PLAN – DO – CHECK – ACT) in executing the given assignment. As part of the engagement planning, MCA held a series of meetings with the ISCCM President, ISCCM Secretariat and Chief Election Commissioner to understand ISCCM Objectives and Vision. They studied ISCCM’s rules, regulations & by-laws about administration of the election process to ensure adherence & compliance to the same. A core election team was formulated consisting of key ISCCM functionaries including the Chief Election Commissioner, ISCCM Secretariat officials, PSS CEO and key representatives from MCA who would work jointly in the smooth conduct of the election process. As part of this planning exercise, MCA developed a detailed project plan, replete with activities, timelines and assignment of responsibilities that assisted in periodic project monitoring. They then proceeded to execute the project plan commencing with the election process validation exercise, wherein MCA provided value added inputs on database accuracy of the ISCCM electoral voters and checks that need to be performed by the ISCCM Secretariat. They conducted functionality testing of the Online Portal application and suggested changes like, rigorous application validations, functionality changes in line with industry best practices and incorporating key audit checks and control points into the whole election, apart from providing better aesthetic look & feel to the portal as a whole. Finally, system security was tested to ensure that no system vulnerabilities are exposed at the time of elections and key observations during the testing phase have been since addressed.

All observations and recommendations arisen out of the exercise have been well accepted by ISCCM and PSS representatives and have taken earnest steps in early resolution of the same. All stakeholders have been apprised of the current situation and an agreed action plan was formulated before the draw up to the final election. MCA has also verified that the key recommendations have been implemented / acted upon successfully. The final candidate’s database and voter’s database will be delivered to MCA by ISCCM secretariat after internal certification and ratification by the Chief Election Commissioner. The Chief Election Commissioner and the key ISCCM team would personally test / check the election setup and conduct due diligence checks as required satisfying themselves in the final election web portal before the commencement of the elections. The election and the voting link will then be sent to all eligible members who have updated their email ids with the ISCCM Secretariat as per the earlier communications which had been sent forth in this respect.

The election window would be upon for a period of one week starting from August 1, 2011 to August 7, 2011 5 p.m. to facilitate eligible members to cast their vote. Provision has been made to intimate the voters through SMS as well once the voting link has been sent, ongoing reminders to vote on daily basis until the election window is open in case a member has not voted and finally a confirmation through SMS after the member has cast his vote. These SMS intimations would be received by members who have updated their correct mobile numbers with the ISCCM Secretariat.

The candidate information, the posts contested and their candidate database, the voter’s database and the final election web portal before the commencement of the elections. The election and the voting link will then be sent to all eligible members who have updated their email ids with the ISCCM Secretariat as per the earlier communications which had been sent forth in this respect.

The election window would be upon for a period of one week starting from August 1, 2011 to August 7, 2011 5 p.m. to facilitate eligible members to cast their vote. Provision has been made to intimate the voters through SMS as well once the voting link has been sent, ongoing reminders to vote on daily basis until the election window is open in case a member has not voted and finally a confirmation through SMS after the member has cast his vote. These SMS intimations would be received by members who have updated their correct mobile numbers with the ISCCM Secretariat. The candidate information, the posts contested and their profiles have been put in the ISCCM website and also made available in the voting page as well for the member community to go through and make an informed selection at the time of voting.

Election result announcement will be made during the executive meeting on August 7, 2011.

K. Sample size calculation for difference in proportions

\[ S.Difference = \sqrt{\frac{p_1(1-p_1)}{n_1} + \frac{p_2(1-p_2)}{n_2}} \]

\[ N = \left( \frac{p_1 + p_2}{p_1 + p_2} \right)^2 \times \frac{1}{C_{power}} \]
Real-time ultrasound-guided subclavian vein cannulation versus the landmark method in critical care patients: A prospective randomized study

Author: Fragou M, Gavras A, Dimitriou V et al.
Authors compared the real-time ultrasound-guided subclavian vein cannulation versus the landmark method in a prospective randomized ICU study. This single center study was done in 463 mechanically ventilated patient rows. Among those, 231 patients were allocated to the ultrasound group (200 patients) was compared with the landmark method (201 patients). Usual cannulation was faster in the ultrasound group (p<.05). Catheter misplacements occurred in 4.4%, hemothorax in 5.4% of patients, respectively, hemothorax in 4.4%, and numbers of attempts were significantly reduced in the ultrasound group (p<.05). in the landmark study, of which 174 patients received and 156 did not receive ultrasound-guided cannulation. In the ultrasound group, artery puncture and hematoma occurred in 3.5% of patients (6.3%; 95% confidence interval, 2.6 –10.3) and 5.63; 95% confidence interval) 0.5–3.9; (p = .51). Authors concluded that prevention of mechanical ventilation-induced diaphragmatic weakness. this important new finding indicates that mitochondria are a primary source of reactive oxygen species production in the diaphragm during prolonged mechanical ventilation. These results could lead to the development of a therapeutic intervention to impede mechanical ventilation-induced diaphragmatic weakness.

Effect of open and closed endotracheal suctioning on transmission of Gram-negative bacteria: A prospective crossover study

Author: Jongerden IP, Buining AG, Hall MAL et al.
It is unknown whether closed suction systems, as compared with open suction systems, prevent cross-transmission of Gram-negative bacteria. This prospective crossover study tried to determine whether closed suction systems, as compared with open suction systems, reduce the incidence of Gram-negative bacterial colonization in ICU. This Dutch study tested both systems in four ICUs between January 2007 and February 2008. Study included all patients aged >18 years in the ICU for >24 hrs. Closed suction systems and open suction systems were used for all patients requiring routine endotracheal ventilation. The authors concluded that closed suction systems were preferred for ventilated patient-days at risk during closed suction period and open suction period, respectively (adjusted hazard ratio, 1.14; 95% confidence interval, 0.98–1.35). During closed suction period, adjusted hazard ratios for acquisition were 0.66 (95% confidence interval, 0.45–0.97) for Pseudomonas aeruginosa and 2.03 (95% confidence interval, 1.15–3.57) for Acinetobacter species; acquisition rates of other pathogens did not differ significantly. Adjusted hazard ratios for Pneumocystis jiroveci and cytomegalovirus were 0.9 (0.4 –1.9) for P. aeruginosa, 6.7 (1.5–30.1) for Acinetobacter, and 0.3 (0.03–2.7) for Entero bacter species. Overall, close suction was preferred for 5.9 (closed suction systems) and 4.7 (open suction systems) per 1,000 patient-days at risk. Closed suction systems failed to reduce cross transmission and acquisition rates during closed suction. Gram-negative bacteria in intensive care unit patients.

Nicotine replacement therapy in critically ill patients: A prospective observational cohort study

Author: Cartin-Ceba R, Warner DO, MD; JT Hays, Afessa B
This prospective observational cohort study from Mayo clinic USA, looked at the impact of nicotine replacement therapy on the outcomes of critically ill patients, because many studies have questioned the safety of giving nicotine replacement therapy to prematurely born infants. Among 231 active smokers were included in the study, of which 174 patients received and 156 did not receive nicotine replacement therapy. There were no significant differences in the unadjusted hospital mortality between the two groups: 14 patients (7.8%, 95% confidence interval, 4–12) died in the nicotine replacement therapy group as compared with ten patients (6.3%; 95% confidence interval, 2.6 –10.3) in the non-nicotine replacement therapy group (p=0.59). After adjusting for severity of illness and propensity score for administration of nicotine replacement therapy on intensive care unit admission, nicotine replacement therapy was not associated with increased hospital mortality in critically ill patients. However, no clinically significant

Mitochondria-targeted antioxidants protect against mechanical ventilation-induced diaphragm weakness

Author: Powers SK, Hudson MB, Nelson WB et al.
Prolonged mechanical ventilation is associated with significant diaphragmatic weakness. Although many pathways contribute to diaphragm weakness during mechanical ventilation, it is established that oxidative stress is required for diaphragm weakness to occur. This study tested the hypothesis that elevated mitochondrial reactive oxygen species emission is required for mechanical ventilation-induced oxidative stress, atrophy, and contractile dysfunction in the diaphragm. This was examined by preventing mechanical ventilation-induced mitochondrial reactive oxygen species emission in the diaphragms of rats using a novel mitochondria-targeted antioxidant (SS-31). It was observed that compared to mechanically ventilated animals treated with saline, animals treated with SS-31 were protected against mechanical ventilation-induced mitochondrial dysfunction, oxidative stress, and protease activation in the diaphragm. Treatment of animals with the mitocondria antioxidant also protected the diaphragm against mechanical ventilation-induced myofiber atrophy and contractile dysfunction. Authors concluded that prevention of mechanical ventilation-induced increases in diaphragmatic mitochondrial reactive oxygen species emission protects the diaphragm against mechanical ventilation-induced diaphragmatic weakness. This important new finding indicates that mitochondria are a primary source of reactive oxygen species production in the diaphragm during prolonged mechanical ventilation. These results could lead to the development of a therapeutic intervention to impede mechanical ventilation-induced diaphragmatic weakness.

Diagnostic use of serum procalcitonin levels in pulmonary aspiration syndromes

Author: El-Sohh AA, Vora H, Paul R, Knight PR, Porthomayon J
This prospective observational single center US study was done to assess the predictive accuracy of serum procalcitonin in distinguishing bacterial aspiration pneumonia from nonbacterial aspiration pneumonia in 65 consecutive patients admitted with pulmonary aspiration and 7 control subjects intubated for airway protection. Quantitative cultures from BAL fluid were conducted on all participants at the time of admission and serial serum procalcitonin levels were measured on day 1 and day 3 using the procalcitonin-fluorescent immunoassay. There were no differences in the median serum concentrations of procalcitonin between patients with positive bronchoalveolar lavage cultures (n = 32) and patients with negative BAL cultures (n = 33) on either day 1 or day 3-post admission. The areas under the receiver operator characteristic curves were 0.59 and 0.63 respectively (p = .74). However, duration of mechanical ventilation and antibiotic therapy were shorter in those who had a decrease in their procalcitonin levels on day 3 from baseline compared with those who did not (6.7 ± 7.1 days and 11±12.35 days, p=0.03; and 8.2 ± 6.6 days vs. 13.8 ± 6.6 days; p < .001, respectively). Hospital mortality was associated with radiographic multilobar disease (adjusted odds ratio, 1.14; 95% confidence interval, 1.01–1.31; p =.04) and increasing procalcitonin levels (adjusted odds ratio, 5.63; 95%
Economic implications of nighttime attending intensivist coverage in a medical intensive care unit

Author: Banerjee R, Naessens JM, Sefarian EG et al.

Reference: Crit Care Med 2011; 39:1257–1262

The study objective was to assess the cost implications of nighttime intensivist staffing model from on-demand presence to mandatory 24-h in-house critical care specialist presence. A pre-post comparison was performed comparing the prospectively assessed costs of patients admitted during the day or at night. Costs were modeled using a generalized linear model with log-link and γ-distributed errors. The study enrolled all patients admitted to the adult medical ICU on or after January 1, 2005 and discharged on or before December 31, 2006. Patients receiving care under both staffing models were included. The intervention included changing the ICU staffing model from on-demand presence to mandatory 24-h in-house critical care specialist presence. Total costs of care (inclusive of admission) were calculated for each patient starting from the day of ICU admission to the day of hospital discharge. Adjusted mean total cost estimates were compared between the groups for the post-period relative to the pre-period (0.5 vs. 4.8) with no change in non-intensive care unit length of stay. The study concluded that 24-h intensive care unit intensivist staffing reduces lengths of stay and cost estimates for the sickest patients admitted at night. The costs of introducing such a staffing model need to be weighed against the potential total savings generated by such a model in smaller ICUs, especially ones that predominantly care for lower-acuity patients.

Will polymerase chain reaction (PCR)-based diagnostics improve outcome in septic patients? A clinical view?

Author: Pletz MV, Wellhausen W, Welte T


Polymerase chain reaction (PCR)-based techniques allow more rapid and sensitive detection of pathogens compared with conventional blood culture. The current study hypothesized that current PCR can supplement but not replace blood culture and the combined detection rate of both methods was significantly higher when compared with PCR or blood culture alone. Complete determination of antibiotic resistance can currently be performed only by blood culture only. Further increase of the panel of multiplex PCR is complex and associated with high workload and cost. Except for diagnostics of patients in whom unusual, not culturable, or fastidious pathogens are detected more often, such as immunocompromised or post-surgery patients, or post-infection, etc., it might even be not necessary to further increase the spectrum of detectable species. If the primary aim of PCR diagnostics is to decrease inappropriate empirical treatment and improve patient outcome, detection should focus on those pathogens or resistance determinants that are not covered by routine ICUs ordered treatment regimens and that have been identified as the major cause of inappropriate treatment according to current studies. In the authors’ opinion, such a narrower assay is more cost-effective, may achieve higher accuracy due to reduced interassay interference, and would better address current and emerging clinical needs.

The birth of intensive care medicine: Bjorn Ilbensen’s records.

Author: Reinsen Se ne Le R


Excellent, a must read article which looks back at the historical event - the birth of intensive care medicine that took place in Rygaaben, Denmark, during and after the poliomielitis epidemic in 1952/1953. The events that led to the creation of the first intensive care unit in the world in December 1953 are well described and it is generally agreed upon that the start of the process was the fact that an anesthesiologist (Björn Ilbensen) was brought out of the operating theatre and asked to use his skills on a 12-year-old girl suffering from polio. The medical record of the girl contains a minute-by-minute description of the historical event. This part of the record is published as an Online Resource to the article. The role played by the epidemiologist Mogens Bjoernboe is also described. Here is the account of the process, being the one with the idea that the skills of an anesthesiologist could be used for other purposes than anesthetics. The detailed realization that could be done with his skills, he proved to be one of the most progressive and inventive doctors seen in modern medicine. He is a Biography of Prof. Ilbensen in 2006 is published as a Resource to the article.

Early and late outcome after single step dilatational tracheostomy versus the guide wire dilating forceps technique: a prospective randomized clinical trial.

Author: Fikkerts BG, Staatsen M, van den Hoeven B, Johan Hagen V, van der Hoeven JG


Percutaneous tracheostomy is frequently performed in long-term ventilated patients in the ICU. Despite many years of experience in performing percutaneous tracheostomy in long-term ventilated patients in ICU, the optimal technique is still unknown, especially in terms of complications. The aim of this prospective randomized Dutch study was to determine which of the two most frequently used percutaneous tracheostomy techniques performs best with the emphasis on late complications. The trial involved 120 patients, comparing two techniques of percutaneous tracheostomy, the guide wire dilating forceps (GWDF) and the single step dilatational tracheostomy (SSDT) technique. Sixty patients in each group underwent a percutaneous tracheostomy and were followed for up to 3 months after decannulation. Intra-operative complications in both groups were minor (58.3% in the GWDF group and 61.7% in the SSDT group). The study found a trend towards more major perioperative complications in patients undergoing tracheostomy versus the SSDT group, 10.0 versus 1.7% (P = 0.06). One patient in the SSDT group developed a significant tracheal stenosis. However, this may also have been related to prolonged tracheal intubation. Results of magnetic resonance imaging (MRI) investigations showed only minor tracheal changes. Only 37.5% of patients in the SSDT group versus the GWDF group had no complaints after their percutaneous tracheostomy. The authors have concluded that SSDT when compared with the GWDF technique shows a trend towards less major perioperative complications with a comparable long-term outcome.

High-dose selenium reduces ventilator associated pneumonia and illness severity in critically ill patients with systemic inflammation.

Author: Manzares W, Biester A, Torre MH et al.


This single center prospective, placebo-controlled, randomized, single-blinded phase II study was done in Italy to confirm the pharmacodynamics and evaluate the efficacy of high-dose of selenium (Se) administered by continuous intravenous infusion (CIVI) for the prevention of ventilator associated pneumonia, on clinical outcome in critically ill patients with systemic inflammatory response syndrome (SIRS). Two groups of patients with SIRS, aged ≥ 18 years, and APACHE II ≥ 15 (n = 35) were randomized to receive either placebo or intravenous selenium as a bolus-loading dose of 2.0 μg Se followed by continuous infusion of 1.600 μg Se per day for 10 days. Blood samples were analyzed before randomization (day 0) then at days 3, 7, and 10. Clinical outcome was assessed by a set of secondary endpoints. The SOFA score decreased significantly in the selenium group at day 10 (1.3 ± 1.2 versus 4.2 ± 2.6; P < 0.05). Selenium concentrations were higher in the selenium group (6.7% versus 37.5%, P = 0.04) and hospital acquired pneumonia was lower after ICU discharge (28%) (P = 0.03). Glutathione peroxidase-3 (GPx-3) activity increased in both groups, reaching a maximum at day 7 (0.62 ± 0.24 versus 0.28 ± 0.14 U/mg; P = 0.001) in the selenium group. No adverse event attributable to selenium was observed. The study concluded that daily infusion of 1600 μg Se (as selenium), following an initial bolus of 2.0 μg, is novel and without serious adverse effect. High-dose parenteral selenium significantly increases Se status, improves illness severity, and lowers incidence of hospital acquired pneumonia including early VAP for SIRS patients in ICU.

Eosinopenia, an early marker of increased mortality in critically ill medical patients

Author: Khalid Abidi K, Belayachi J, Derras Y et al.


Inflammatory markers may have a role in predicting severity of illness of ICU patients. This prospective 4-month study from Morocco tried to determine whether low eosinophil count could predict 28-day mortality in medical ICU. The authors compared the variations in eosinophil count from ICU admission to seven days between patients who survived and those who died. The best cutoff value was chosen using Youden’s index for identification of patients with high risk of mortality. The patient outcome was 28-day mortality. A total of 200 patients were eligible for analysis. Overall, in the ICU mortality was 28.0% (n = 56). At ICU admission, the median eosinophil count was significantly different in survivors [30 cells/mm3; interquartile range (IQR), 0–100 cells/mm3] and nonsurvivors (0–100 cells/mm3; IQR, 0–300 cells/mm3; P = 0.004). Absolute eosinophil counts remained significantly lower in non-survivors from admission to seven days, but did not persist beyond 28 days. Only 21.8% were higher in patients with eosinopenia [40 cells/mm3 (P = 0.011)]. Multivariate analysis by Cox model with time-dependent variables demonstrated that eosinophil count <40 cells/mm3 hazard ratio (HR), 1.85; 95% confidence interval (CI), 1.01–3.42; P = 0.04; high APACHE II score (HR, 1.11–1.14; P = 0.014), high SOFA score (HR, 1.14; 95% CI, 1.03–1.25; P = 0.008) and use of mechanical ventilation (HR, 27.48; 95% CI, 12.62–62.28; P = 0.001) were independent predictors of 28-day all-cause mortality. The authors suggested the possibility to use eosinophil cell count at admission and during their hospital stay as a prognosis marker of mortality in medical ICU.
On behalf of ISCCM Pune Branch, & the Organising Committee of CRITICARE Congress 2012, it is a pleasure & privilege to invite you all to the “18th Annual Congress of the Indian Society of Critical Care Medicine & International Critical Care Congress”, being held in at Marriott Hotels & Convention Centre, Pune from February 15th to 19th, 2012. Over the last decade critical care in India has grown by leaps & bounds and hence the theme of this year’s conference is, ‘Critical Care in India - Coming of Age’. We have invited some of the world’s most renowned faculties who are pioneers in their respective fields with original work in critical care.
Welcome to Pune

ISCCM Pune branch was the first city Branch of ISCCM, formed in 1993 and has been at the forefront in the ISCCM in various activities. The 4th National Congress held in Pune in 1998 is still remembered by the attending delegates as one of the most outstanding ones. We in Pune look forward to welcoming you once again for CRITICARE 2012.

Pune is known as the ‘Oxford of the East’, and is home to famous educational institutions like the University of Pune, Fergusson College, National Defence Academy, Armed Forces Medical College, B J Medical College, National Chemical Laboratory, National Insurance Academy, College of Military Engineering, The College of Engineering, etc. We now also boast of newer institutions like Symbiosis, Bhati Vidyapeeth, D. Y. Patil College and the Sinhgad Institutes.

Pune known for its salubrious weather and historic places to see, it offers an ideal place to unwind from hectic schedules. You can meet colleagues and exchange ideas on the sidelines of the conference. We look forward to your active participation.
### Table of Events for conduct of ISCCM Elections – August 2011

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<th>S.No.</th>
<th>Activity Description</th>
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<td>Email to be drafted to be sent to all Voters by the Chairman elections</td>
<td>Chairman Elections_ISCCM &amp; MCA</td>
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