ISCCM News Headlines

- ISCCM approves and welcomes 77 new members into its family.
- Five new City Branches approved. They are Siliguri, Patna, Jalandhar, Amritsar, and Guwahati. Make your city branch – 10 members needed to do it.
- ISCCM day celebrations on 27th November ISCCM will motivate, organize BLS programmes across the country.
- Overwhelming response to Indicaps study data collection. Next data collection falls on 13th October.
- City branches activated- lot of reports pouring in.
- New Delhi getting ready for another big event after CWG – Criticare 2011 at Vigyan Bhawan – fix your dates in your calendar.
- All members - Please update your Email ID and mobile phone nos in ISCCM records.
- Kavita tops IFCC, Mohan Kumar and Dsouza top IDCC.
- ISCCM forms separate cell for Nurses training in Critical Care.

ISCCM Day will be celebrated on 27th November 2010 throughout India

Will do BLS Courses for doctors / nurses / paramedical / general public
Please Start Planning - Preparing

- Dr. Manish Munjal

ISCCM Celebrates Day
27th November 2010

INDICAPS
Next data collection date
13th October 2010

We request our esteemed readers to send their valued feedback, suggestions & views at ccciscctcm@gmail.com
The editorial board is delighted to present the 3rd volume of this season’s “The Critical Care Communications.” I am happy at the response of the reader, critics, commentators, industry and advisors. We have traveled along quite a bit.

ISCCM is growing from strength to strength, so is CCC. There has been steady growth of membership of society. Large number of medical institutes including Medical Colleges has shown keen interest to run IDCC and IFCC courses. This indicates augmented qualitative strength of the society in terms of its academics and skill imparting training programmes. Research has also got a huge thumbs up with launch of Indicaps.

Information technology has fuelled growth throughout the world and made life much more easier. ISCCM also needs to move forward and exploit IT to its best advantage and save time, money and energy yet achieve the best. Therefore, we propose to hold elections of the society online as many societies in world have done already. The exercise of confidence building measures about validity, fairness, accuracy of the process is under scrutiny of designated committee. It is likely that the next elections of the society will be held online, subject to approval of the proposed constitutional amendment by EC and AGM. This will require all members to update their email IDs and Mobile numbers in the records of the society. I, therefore, request all the members, to kindly ensure that this is done before the year end. The branch executives have a key role to play in the process. PLEASE UPDATE YOUR EMAIL IDs and MOBILE NUMBERS IN SOCIETY’S RECORDS.

Last but no the least, The editorial board is trying to put all the information that we can muster about branch activities and achievements of individual members in the bulletin. I am sure all are watching Please let us know about all your activities, we will highlight them if you send us the information with pictures. Every activity of any branch is important to us. Also let us know about your individual achievements, we will be pleased to highlight them on our achiever’s column. This will not only let others know about your activities and achievements but also stimulate them to emulate. This is your Bulletin and it will carry your reports, pictures and achievements. I also call upon all readers to write for the bulletin, comments on the bulletin, send suggestions to improve the content quality.

The response to Indicaps study has been overwhelming – the next data collection date is falling on 13th October. ISCCM day falls on 9th October, however, because of ongoing Commonwealth games the celebrations will be done on 27th November. ISCCM day celebration committee under Dr Manish Munjal is working hard to make it a grand success. The theme is “LEARN AND TEACH BLS – FOR EVERY ONE.”

My thanks to Prof Yonshuk Koh for his message for CCC. My thanks to the President, Editorial Board and EC for their continuous support.

Thanks.
n behalf of ISCCM, I thank all of you who have participated in the first phase of the INDICAP Study. More than 80 ICUs have participated in the first phase to make it a great success. Data will be collected next on October 13, 2010. If you were unable to participate in the first phase, you can help by contributing in the second phase. Register your ICU by logging on www.isccm.org now!

Although the WHO has declared the H1N1 Influenza pandemic over, I am sure it is unwilling to leave our country in a hurry. ISCCM is planning to start an H1N1 registry to generate a database of this potentially fatal disease. Look for details on the society website and contribute to this endeavor as well. You can also share your experiences and thoughts on this disease with others through the news bulletin.

GREETINGS TO NEW AND OLD MEMBERS OF ISCCM FAMILY

As all of you must be aware, the election process is on and you must exercise your right to vote. It is not only your right but duty to participate. The Executive Committee plans to have online elections and hopefully the next year’s elections will indeed be online. For this purpose, I urge you to update your e-mail addresses and mobile nos. in the ISCCM database so that you can participate in voting next year. The preparations for the National Conference to be held in next February are in full swing and it promises to be an educational feast so be ready to attend. ISCCM is prospering well and the Executive Committee has approved 97 new members. I welcome all new members to the ISCCM family. In the last EC we also approved 6 new branches. I extend my welcome to all new branches to the ISCCM fold. The approved branches are as follows:

1. Amritsar (re approval)
2. Guwahati
3. Jalandhar
4. Patna
5. Siliguri
6. Vishakapatnam (re approval)

I hope all the new branches have a fruitful academic existence and long association with the parent body.

IDCC Examination 2010: 47 candidates appeared for the written examination held at Pune and Bangalore in the month of July 2010. Of the 43 who appeared for theory, 27 passed; while 23 out of 40 candidates who took practical examination were successful. Dr. N Ramakrishnan, our education coordinator, has done a fantastic job as usual and the results were collated and posted on the website within a week of the examinations. Following candidates were the toppers in these examinations: For IDCC - 1) Dr. D’Souza Ramys Thomas, Ruby Hall Clinic, Pune. 2) Dr. Mohankumar G, Christian Medical College, Vellore. For IFCC - Dr. Kavita Kamini, Apollo Hospital, Chennai. I congratulate them and wish them the best for their professional life.

Research: The ISCCM successfully launched its first ambitious research project “Indian Intensive Care Case Mix and Practice Patterns Study (INDICAPS”). The first data collection date was July 14, 2010. Out of 347 ICUs which had registered for the INDICAPS, 87 have contributed data for over 1200 patients in the online database for the study. I wish to congratulate Dr Divatia, the Chairman, ISCCM Research Committee for this success. I hope the ICUs which have not collected data this time will collect the data on the three remaining days of the study and contribute on the next three remaining study days: these are October 13, 2010 and January 12 and April 13, 2011. If your ICU is not registered you can still register your ICU and participate in the study. If you have not registered your ICU yet, please do so urgently. If you have any queries please contact Dr Divatia.

As you know, from 2011 onwards, elections of the society are going to be electronic and we will need your help to make this conversion successful. This change is not possible without your support. To be able to vote it would be essential for you to check your personal details including your correct e-mail ID from the database of ISCCM at www.isccm.org. If you have changed your e-mail ID recently or your ID at ISCCM is incorrect, you can correct it either by sending a signed request with your new e-mail ID on plain paper or download the form from the ISCCM website and send it to the central office at Mumbai. We will change your e-mail ID in our records only if your signature matches that with the signature in our records. Please do it today as this will not only help in conducting the next elections but also enable us to send you information of various activities of the society.

I also take this opportunity to invite you to attend the 17th Annual Conference of the Indian Society of Critical Care Medicine being held from 16th to 20th Feb. 2011 at Vigan Bhawan, New Delhi. The theme of the conference this year is “Reaching New Heights in Critical Care”. The conference will be followed by 17 post-conference workshops. We promise you excellent scientific content and other activities. Visit the congress website www.criticare.org for further details.

FROM THE DESK OF THE PRESIDENT

Dr. Rajesh Chawla
President, ISCCM • drchawla@hotmail.com

Saying hello to the members of ISCCM after attending Criticare 2010

Youmsuck Koh
yuskoh@amc.seoul.kr

I thank the organizing committee of Criticare 2010 for including me as an invited speaker at the congress. Dr. T. Shyamsunder, Dr. Palepu Gopal, and other faculties for Criticare 2010 showed cased their abilities to hold the scientific congress in Hyderabad from 10th to 14th March, 2010. This was my 2nd attendance to the Criticare. As like Criticare 2009 in Agra, it was a big scientific congress in terms of attendance number and scientific programs. Each session was delivered by well known foreign and domestic speakers. I felt that the quality and quantity of scientific programs were compatible with those of other good quality of foreign critical care or intensive care congress. I was impressed by active interaction between presenters and audiences. I might say that I experienced the vision of ISCCM to improve the critical care in India via the congress. One of my distinguished pleasures of the congress was to be acquainted with colleagues of ISCCM through scientific and social occasions. They were kind and welcomed me.

I also could not help mentioning the openness and passion of Dr. Jag Divatia and his colleagues for the development of critical care in Asian countries, which was revealed by their active participation in regional scientific meetings such as Asian Pacific Association of Critical Care Medicine (APACC), congress, and to multinational clinical research representing the ISCCM. The organizing committee of APACC is expecting active role of ISCCM, which became a new member of the society. Considering ISCCM’s capability and passion, I suggest that ISCCM consider to host 2014 APACC congress, which is followed by 2012 APACC congress in Japan. Additionally, I sincerely hope to build up strong relationship further between the Korean Society of Critical Care Medicine and the ISCCM. The official relationship between the two societies has begun since 2008.

Youmsuck Koh, MD, PhD
Past president of Korean Society of Critical Care Medicine
Professor of Medicine
Director of Intensive Care Units
Asan Medical Center, University of Ulsan College of Medicine
Seoul, Korea

FROM SECRETARY'S OFFICE

Dr. Atul Kulkarni
General Secretary, ISCCM
kaivalyaak@yahoo.co.in

Seoul, Korea

Asan Medical Center, University of Ulsan College of Medicine
Director of Intensive Care Units
Professor of Medicine
Past President of Korean Society of Critical Care Medicine

I also take this opportunity to invite you to attend the 17th Annual Conference of the Indian Society of Critical Care Medicine being held from 16th to 20th Feb. 2011 at Vigan Bhawan, New Delhi. The theme of the conference this year is “Reaching New Heights in Critical Care”. The conference will be followed by 17 post-conference workshops. We promise you excellent scientific content and other activities. Visit the congress website www.criticare.org for further details.

Research: The ISCCM successfully launched its first ambitious research project “Indian Intensive Care Case Mix and Practice Patterns Study (INDICAPS)”. The first data collection date was July 14, 2010. Out of 347 ICUs which had registered for the INDICAPS, 87 have contributed data for over 1200 patients in the online database for the study. I wish to congratulate Dr Divatia, the Chairman, ISCCM Research Committee for this success. I hope the ICUs which have not collected data this time will collect the data on the three remaining days of the study and contribute on the next three remaining study days: these are October 13, 2010 and January 12 and April 13, 2011. If your ICU is not registered you can still register your ICU and participate in the study. If you have not registered your ICU yet, please do so urgently. If you have any queries please contact Dr Divatia.

I also take this opportunity to invite you to attend the 17th Annual Conference of the Indian Society of Critical Care Medicine being held from 16th to 20th Feb. 2011 at Vigan Bhawan, New Delhi. The theme of the conference this year is “Reaching New Heights in Critical Care”. The conference will be followed by 17 post-conference workshops. We promise you excellent scientific content and other activities. Visit the congress website www.criticare.org for further details.
As the organizing chairman, it gives me great pleasure to report on behalf of the Congress Committee, that the “17th Annual Congress of the Indian Society of Critical Care Medicine (ISCCM) & International Critical Care Congress 2011” to be held in February 17th to 21st, 2011 is going to be a landmark ISCCM conference in New Delhi: The Capital city of India to be held at Prestigious Vigyan Bhavan in association with Ministry of Health and Family Welfare, Delhi government. A galaxy of international experts such as John Louis Vincent, John Marini, Luciano Gattinoni, Mervin Singer, Mitchel Levy and David Bihari (to name a few) as well as Asian experts will be there to share their knowledge and wisdom with the participants.

With all the inputs incorporated from various experts, ISCCM members, the Scientific Committee is now at the final stages of planning an exciting and varied scientific program that will include plenary and thematic sessions, presentation of research papers, workshops and ‘Meet the Expert’ sessions. The program is currently evolving through collaboration between local and international experts and is expected to be very creative. The content will be international in content with a blend of national, regional and international speakers recognized for achievements in their respective fields.

Workshops have been specially designed to be hands on and interactive to cover many areas of critical care including: FCCS, BASIC adult and Basic pediatric intensive care, ultrasound, nursing, infectious disease and simulation workshops to name a few. I am proud to inform the international experts such as Dr John Marini have volunteered to conduct the mechanical ventilation workshop in collaboration with our national experts. All major tertiary Hospitals in New Delhi NCR area have graciously committed to provide the venue, equipment and facilities for any workshops needed to be held at any of those hospitals . Thanks to the efforts of respective workshop chairpersons and coordinators.

We are confident that the main single goal that we all aspire for: ‘Enhancing the practice of Critical Care’, will be achieved; Thus the theme: “Reaching new heights in Critical Care”.

An ICU protocol book by ISCCM (by multiple section editor and authors) describing case based approach to various critical care problems is also planned to be released at the main conference. All efforts are being taken to make it evidence based, concise and easy to use manual for all critical care practitioners.

On a lighter note, New Delhi, the capital of India, is not only the political and trading hub of India, but also one of the most prominent places on the tourist map of India. This historical city is dotted with many architectural marvels that have been attracting tourists in hordes. We promise that your trip to this 1500-year-old city will be a truly memorable experience.

We invite everyone who is directly or indirectly involved in Critical Care to attend this Congress. Your active participation is vital to our objectives and you will reap utmost benefit in the day to day management of your patients.

For latest updates log on to www.criticare2011.org or facebook, or twitter.

We look forward to meeting you in Delhi in February 2011 and hope that this meeting will be a memorable experience for all of you, as it will be for us.

Sincerely

Praveen Khilnani
MD FCCM
Organising Chairman Criticare 2011
Chairman ISCCM Delhi and NCR
Senior consultant Pediatric critical care and pulmonology
Childrens intensive care Group
MAX healthcare hospitals. New Delhi.
Minimizing Medical Mishaps

Dr. Parshotam Lal Gautam

Head, Critical Care Division,
Prof., Department of Anesthesia & Resuscitation
Dayanand Medical College & Hospital, Ludhiana
parshotam@yahoo.com

"Too err is human and human factor is vital in prevention of medical mishaps."

There are incidents of missed or wrong diagnosis as well as, wrong prescription, wrong-site or wrong patient being operated upon. Drug errors from syringe or ampoule swapping, malfunctioning of delivery devices, misinformation or misinterpretation of data from malfunctioning monitors and ventilator do result in adverse outcome in patients with poor reserves in critical areas at times. All these mistakes are perceived as a medical error that should never happen, not a medical risk that the patient must accept, and therefore is a core patient safety problem. Legally, it qualifies under the principle of res ipsa loquitur [means in Latin, The thing speaks for itself]. We have to accept that trivial to major medical errors, accidents and mishaps do occur despite utmost care as any other accidents in day to day life. These medical accidents may be at times inevitable too. However it becomes difficult for anyone to swallow these accidents. It results in many losses; loss of very valuable human life, disrepute to medicos, hospital and the profession, along with financial and other consequences. It is difficult to report these mistakes and discuss openly due to various untoward pressures and consequences. But at the same time, it is difficult to improve without learning epidemiology and understanding pathogenesis of any problem.

Nonetheless adverse incidents do happen. The recognition that errors do occur and there is need to move away from a culture of blame to improving the system. In 1620 Sir Francis Bacon observed that: "...the human mind is prone to suppose the existence of more order and regularity in the work than it finds". Pioneer work was challenging, but gradually various reporting systems have been designed to get into the problems details. Initial reports and analysis of patient deaths came from confidential enquiries into maternal deaths of UK hospital insurance claims and US Closed Claims Project (1962 – 1991). Gradually it was realized that the problem is larger than imagined. An average of 1,95,000 people in USA died due to potentially preventable, in-hospital medical errors in each of the years 2000, 2001 and 2002, according to a study of 37 million patients published by Health Grades, the healthcare quality company in October JAMA. Although with advanced technology and evolving awareness about quality standards, a concern has been raised towards the means of safety of patients, doctors, hospital and medical profession. Emergency and intensive care services are evolving with establishing safety standards and practices.

Most of errors and mishaps occur in critical areas. Outcomes in complex work areas depend on the integration of individual, team, technical and organizational factors. A continuum of cascade of effects exists from apparently trivial incidents to near misses and full blown adverse events. Only the presence or absence of recovery mechanisms determines the actual outcome. The intensivists, anesthetists and surgeons being at the sharp end of these mishaps are often implicated directly as party to major catastrophes and failures. It is unfortunate that no one bothers to look into the error prone patient profile,ergonomics of area and system.

PSYCHOLOGY OF ERRORS

The "Theory of Planned Behaviour" is applicable to every skilled professional and specialty. In stressful environment demanding quick assessment and management decision, working hurriedly there are high chances of errors in gathering information (may be too little to make correct diagnosis and accurate decision). Even while picking up and loading drugs one may make mistakes due to giving less attention or inadequate attention while reading the label, particularly when labels are of similar color and spellings nearby e.g. Reading as pavulon perinorm, adrenaline as atropine, infusing metronidazole 100ml bottle for dextrose 25% 100ml bottle etc. Problem is compounded by small fonts, unlabeled drug etc. There is need to learn from safety system designs of aviation, naval and other high technology fields which have evolved with time to prevent these human errors. In common with other complex and well defended technologies, accidents usually result from the often unnoticeable combination of human and organizational failures in the presence of some weakness or cavities in the system. Various authors have addressed these human failures as

1. Slips and lapses versus mistakes
2. Errors versus violations
3. Active versus latent failures

Whereas active failures at the sharp end are clearly evident by virtue of its nature but these are unpredictable in precise details and thus hard to manage. Latent failures existing within the work context and the institution at large are, by definition, present before the occurrence of any incident or mishap lie dormant and are evident only if explored with appropriate system tools. For this reason, these are the precursors of unsafe acts; they represent the most suitable targets for treatment. In the case of critical and emergency practices, the nature and location of these swamps is both well known and universal. A lot of improvement and safety can be expected if we address the system and organizational issues.

To conclude there is need to shift attention from individual to system. The key to effective, efficient and safety management in any hazardous enterprise is to target the most tractable problems (to manage the manageable). Creating a culture of safety requires attention not only to the design of our tasks and processes, but to the conditions under which we work such as hours, schedules and workloads; how we interact with one another; and, perhaps most importantly, how we train every member of the healthcare team to participate in the quest for safer patient care. There is need for all concerned (Government and other health care agencies, hospital administrators, doctors, biomedical engineers and other paramedical teammates) to work for one goal that is patient safety.

Critical Care Nurses Training in India

Dr. Prasad Rajhans
Vice President, ISCCM
prajhans@gmail.com
Chief Intensivist, Deenanath Mangeshkar Hospital, Pune

Dr. Prakash Shastri
Executive Committee Member, ISCCM
prakashshastri@live.in
New Delhi

ISCCM would like to further this nursing education activity. The national executive under the leadership of our President Dr. Rajesh Chawla has decided that we start a two day FCCN [Fundamental Critical Care Nursing] Course. It would be a two day course. ISCCM will publish a student manual for the FCCN. There will be a pretest and a post test. There would be a Provider Course and an Instructor Course with their objectives well defined. The nurses would have acquired basic knowledge and definite skill set after completion of the course. We hope that this initiative of the ISCCM will get a good response from all the ICUs in the country. If any of the ISCCM teachers would like to get associated with the design of the course and help us with the academic content please do contact our National Advisor Dr Prakash Shastri. Email: prakashshastri@live.in
Aim: To create public awareness and train good number of candidates in attending any emergency situation. Emergency can arise anywhere, be it at home, in office, school or on the road. The bystander who comes to the initial rescue is always a layman. The initial 5 mins of management plays a vital role in determining the final outcome. Keeping this in mind we are teaching the masses to forget A for apple, B for ball, C for cat and to remember henceforth A-Airway, b-Breathing, C-Circulation.

Course Content:
It comprises of four Modules:
1. DO’s and DONT’s in burns victims, convulsions, choking, insect or snake bite, poisoning, drowning and heart attack. Dr Diptimala Agarwal
2. Road Traffic Accident-spine control, bleeding control, safe transportation. Dr Rakesh Tyagi, Dr Jitender Singh
3. Healthy body has a healthy mind. Update on lifestyle diseases and modification Dr Navneet Agarwal
4. Practical demo of CPR on the mannequin-rescue breath, chest compression, Hemilick manoeuvre, recovery position-Dr Ranvir Tyagi.

Duration: 2 hours
This is conducted regularly with 6 to 8 courses in a year since the past 4 years. We have conducted this training for army jawans, staff of 5 star hotels Ama Villas, Taj View, ITC Heritage, Jaypee Palace, Trident, at Air Force Station for the wives of the officers, St. Peters College, at summer camps organized by Pushpanjali hospital and Ram Raghu Hospital. The most recent course was held at DPS Agra on 12 May 2010 attended by 130 teachers and staff.

We have miles to go.........................
Until we train all brothers and sisters of our nation Great INDIA
Any body interested in getting the above course conducted please contact: 9837091030, 9837047812, 9837270140

Dr Diptimala Agarwal
Secretary

Dr Ranvir Tyagi
Treasurer

New Executive Team Takes Over Indore Branch

Election Held on 28.02.2010

CHAIRMAN - ELECTED
Dr. Sanjay Dhanuka

SECRETARY - ELECTED
Dr. Sanjay Geed

TREASURER - ELECTED
Dr. Vishvesh Mehta

EXECUTIVE MEMBERS - ELECTED
Dr. Jaipal Kataria • Dr. Kehri Agrawal • Dr. Arun Chopra • Dr. Vimal Kumar
Dear Friends

INDICAPS is a pioneering study in Indian critical care aimed at collecting vital data on patients and practices in Indian ICUs. We plan to collect data of all patients in the ICU on one particular day, and four such days spread throughout a one-year period have been selected: the second Wednesday of July and October this year, i.e. July 14 and October 13, 2010 and the second Wednesday of January and April next year, i.e. January 12 and April 13, 2011.

INDICAPS data collection started for patients in the ICU between 14th July 2010, 8.00 am to 15th July 2010, 8.00 am. On August 14 at 8.00 am, we completed 30 days from the first data collection day of INDICAPS, i.e. 14th July.

Phase I of INDICAPS is now over. Thank you for your overwhelming support and participation. 131 ICUs participated in this Phase of the study (see Table). INDICAPAS now has data on over 1040 patients from 81 ICUs, and data is still piling in.

We congratulate the Pragati Hospital ICU (Centre no. 108) from Assam for enrolling the first patient in INDICAPS! The top 10 contributors till date are the PD Hinduja Hospital (Mumbai), Apollo Hospital ICU (Chennai), AMRI Hospital (Kolkata), Sir Gangaram Hospital (Delhi), KEM Hospital (Pune), Artemis Health Institute (Gurgaon), NRI General and Superspeciality Hospital (Guntur), CHL Apollo Hospitals (Indore), SRMC (Chennai), and Bombay Hospital (Indore). Some ICUs still have to enter the data. Please do so as soon as possible. The website will remain open till August 31 for you to enter final data, and will then close down to prepare for the next phase. You will not be able to enter data on the website after August 31, 2010. We request you to preserve all filled paper forms after you have transferred the data on to the website. Please ensure that all data entry is complete. We may ask you to mail / courier paper forms to us.

Over 300 ICUs registered initially, 131 ICUs have entered some ICU data & 81 ICUs have entered patient data. So although we have done well we can do much better! Please enter the final outcomes and any remaining data on to your paper forms and on the website.

The next Data collection day is October 13!

In case you have not yet registered for this study, please logon to http://isccm.org/res_ISCCM_IndICAPS.aspx fill in the required details, create your own userid and password and Register your ICU

To see and download the INDICAPS invitation letter, protocol and other information, go to http://isccm.org/res_indicapLanding.htm

If you have already registered, you will receive today your username and password.

You need not register again for Phase II. Please logon to http://isccm.org/res_ISCCM_IndICAPS.aspx with the above details to access the data forms on the study day, i.e October 13.

We would prefer that each institution gets permission from the institution’s Ethics committee. If your hospital does not have an ethics committee, please obtain a letter from your hospital administrator stating that the hospital has no objection in taking part in this study. Your data is very important to make this a truly large and representative study. So whether your ICU is large or small, 5-star hospital or 5-bed nursing home, urban or rural, full or empty, surgical or medical or cardiac or neuro ICU, please do not hesitate to join this study.

We look forward to your participation in Phase II!

Thank you all once again for this effort.

Remember:

a. ICUs that have collected data on the July 14:
   Enter data on the website before August 31, 2010. Preserve all filled paper forms after you have transferred data on to the website. Please ensure that all data entry is complete.

b. All ICUs in India
   Next study day is October 13.
   Please participate in a big way on this day.

---

**INDICAPS**

**Dr. J.V. Divatia**

INDICAPS Steering Committee and ISCCM Research Committee
jddivatia@yahoo.com

---

### 5 New Branches » Approved

<table>
<thead>
<tr>
<th>BRANCH</th>
<th>CHAIRMAN</th>
<th>SECRETARY</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>AMRITSAR</strong></td>
<td>Dr. Sushmainder K. Sharma</td>
<td>Dr. Raman Chattrath</td>
</tr>
<tr>
<td><strong>GUWAHATI</strong></td>
<td>Dr. A.K.Deka</td>
<td>Dr. Vandana Sinha</td>
</tr>
<tr>
<td><strong>PATNA</strong></td>
<td>Dr. V.K.Thakur</td>
<td>Dr. Amit Sinha</td>
</tr>
<tr>
<td><strong>JALANDHAR</strong></td>
<td>Dr. Meenakshi Anand</td>
<td>Dr. Ashwani Nayar</td>
</tr>
<tr>
<td><strong>SILIGURI</strong></td>
<td>Dr. Iqbal Rahman</td>
<td>Dr. C.P. Sharma</td>
</tr>
<tr>
<td>Hospital</td>
<td>Co-ordinator</td>
<td>City</td>
</tr>
<tr>
<td>----------</td>
<td>--------------</td>
<td>------</td>
</tr>
<tr>
<td>P D Hinduja National hospital</td>
<td>Ashit Hegde</td>
<td>Mumbai</td>
</tr>
<tr>
<td>Apollo Hospitals</td>
<td>Dr N Ramakrishnan</td>
<td>Chennai</td>
</tr>
<tr>
<td>Advanced Medicare and Research Institute</td>
<td>Subhash Todi</td>
<td>Kolkata</td>
</tr>
<tr>
<td>Sir Gangaram Hospital</td>
<td>Sumit Raj</td>
<td>Delhi</td>
</tr>
<tr>
<td>K E M Hospital, Pune</td>
<td>Dr Bande B D</td>
<td>Pune</td>
</tr>
<tr>
<td>Artemis Health Institute</td>
<td>Dr. Rashma Basu</td>
<td>Gurugram</td>
</tr>
<tr>
<td>NRI General &amp; Super Specialty Hospital</td>
<td>Dr Shaik Arif Pasha</td>
<td>Guntur</td>
</tr>
<tr>
<td>CHL Apollo Hospitals Indore M.P</td>
<td>Dr Sanjay Dhanuka</td>
<td>Indore</td>
</tr>
<tr>
<td>Sri Ramachandra Medical College &amp; Research Institute</td>
<td>A S Arunkumar</td>
<td>Chennai</td>
</tr>
<tr>
<td>Bombay Hospital Indore</td>
<td>Dr Trishala Singhvi</td>
<td>Indore</td>
</tr>
<tr>
<td>Kalinga Hospital</td>
<td>Dr Samir Sahu</td>
<td>Bhubaneswar</td>
</tr>
<tr>
<td>Sassie Hospital</td>
<td>Dr Jani Chau</td>
<td>Mumbai</td>
</tr>
<tr>
<td>CARE Hospitals</td>
<td>S Srinivas</td>
<td>Hyderabad</td>
</tr>
<tr>
<td>Ruby Hall Clinic</td>
<td>Dr. Ramesh D'Souza</td>
<td>Pune</td>
</tr>
<tr>
<td>Prince Aly Khan Hospital, Mumbai</td>
<td>Dr Kedar Toraskar</td>
<td>Mumbai</td>
</tr>
<tr>
<td>Kovai Medical Center And Hospital</td>
<td>M S Sivakumar</td>
<td>Coimbatore</td>
</tr>
<tr>
<td>Medanta The Medicity</td>
<td>Dr. Jeetendra Sharma</td>
<td>Gurugram</td>
</tr>
<tr>
<td>Grant Medical Foundation, Ruby Hall Clinic, Pune</td>
<td>Dr Zirpe K.G.</td>
<td>Pune</td>
</tr>
<tr>
<td>Care Hospital, Nagpur</td>
<td>Dr Kamal Bhatada</td>
<td>Nagpur</td>
</tr>
<tr>
<td>Deenanath Mangeshkar Hospital and Research Centre, Pune</td>
<td>Dr Prasad Rajhans</td>
<td>Pune</td>
</tr>
<tr>
<td>Batra Hospital &amp; Medical Research Centre</td>
<td>Dr. Arun Dohall</td>
<td>New Delhi</td>
</tr>
<tr>
<td>Yashoda Hospital Somajiguda, Hyderabad</td>
<td>Manimalarao</td>
<td>Hyderabad</td>
</tr>
<tr>
<td>Pushpanjali Hospital and Research Centre</td>
<td>Dr. Ranuvi S. Tyagi</td>
<td>Agra</td>
</tr>
<tr>
<td>Apollo First Med Hospital</td>
<td>Dr Ashwin Kumar Mani</td>
<td>Chennai</td>
</tr>
<tr>
<td>Lokmanyatilak, M.M. Med College &amp; Gen Hospital</td>
<td>Dr. N. D. Moulick</td>
<td>Mumbai</td>
</tr>
<tr>
<td>Fortis Hospital, Noida</td>
<td>Dr. Mrinal Sinha</td>
<td>NOIDA</td>
</tr>
<tr>
<td>Seth Nandlal Dhoot Hospital, Aurangabad</td>
<td>Dr. Amol Kokarni</td>
<td>Aurangabad</td>
</tr>
<tr>
<td>Sir Ganga Ram Hospital</td>
<td>Dr. Dheeraj Gupta</td>
<td>New Delhi</td>
</tr>
<tr>
<td>Bombay Hospital, Bhiyai floor ICU</td>
<td>Dr. Sujata Mehta</td>
<td>Mumbai</td>
</tr>
<tr>
<td>Acharya Vinoba Bhare Rural Hospital</td>
<td>Amit Agrawal</td>
<td>Wardha</td>
</tr>
<tr>
<td>Yashoda hospital</td>
<td>Dr. T. Aditya</td>
<td>Hyderabad</td>
</tr>
<tr>
<td>Rungta Hospital</td>
<td>Dr. Manish Munjal</td>
<td>Jaipur</td>
</tr>
<tr>
<td>Regency Hospital</td>
<td>Dr. A. K. Singh</td>
<td></td>
</tr>
<tr>
<td>Indraprastha Apollo Hospital</td>
<td>Dr. Rajesh Chawla</td>
<td>Delhi</td>
</tr>
<tr>
<td>Fortis Escorts Hospital, Jaipur</td>
<td>Dr. Shabir H. K. Joad</td>
<td>Jaipur</td>
</tr>
<tr>
<td>Kamal Nayan Bajaj Hospital, Aurangabad</td>
<td>Dr. Shrikanth Sarasrabbudhe</td>
<td>Aurangabad</td>
</tr>
<tr>
<td>Institute of Medical Sciences, B.H.U Varanasi</td>
<td>Dr. D.K. Singh</td>
<td>Varanasi</td>
</tr>
<tr>
<td>BL Kapoor Memorial Hospital</td>
<td>Dr. Rajesh Pandya</td>
<td>New Delhi</td>
</tr>
<tr>
<td>Pt. B D S Post Graduate Institute of Medical Sciences</td>
<td>Dr. Dhruva Chaudhry</td>
<td>Rohtak</td>
</tr>
<tr>
<td>INHS Asvini</td>
<td>Dr Vivek Kumar</td>
<td></td>
</tr>
<tr>
<td>Bhalal Amin General Hospital</td>
<td>Dr. Ritesh J Shah</td>
<td>Vadodara</td>
</tr>
<tr>
<td>BAPS Pramukh Swami Hospital</td>
<td>Dr. Mitul P Chaukdar</td>
<td>Surat</td>
</tr>
<tr>
<td>IMS &amp; SUM Hospital, Bhubaneswar, Orissa</td>
<td>Dr. Sanghamitra Mahra</td>
<td>Bhubaneswar</td>
</tr>
<tr>
<td>Medanta Medicity ICU 4</td>
<td>Dr. Sachin Gupta</td>
<td>Gurgaon</td>
</tr>
<tr>
<td>Indira Gandhi Institute of Medical Sciences</td>
<td>Prakash K Dubey</td>
<td>Patna</td>
</tr>
<tr>
<td>Diapur Hospitals</td>
<td>Dr. Brajendra Lal</td>
<td>Guwahati</td>
</tr>
<tr>
<td>Shiriram Cardiac Centre</td>
<td>Dr. Shubha Sharma</td>
<td>Jalandhar</td>
</tr>
<tr>
<td>Bombay Hospital Institute of Medical Sciences 12th floor ICU</td>
<td>Dr. Sujata Mehta</td>
<td>Mumbai</td>
</tr>
<tr>
<td>Apollo Specialty Hospitals</td>
<td>Dr. Ashok E</td>
<td>Madurai</td>
</tr>
<tr>
<td>Kasturba Medical College, Manipal</td>
<td>Dr. Anitha Shenoy</td>
<td></td>
</tr>
<tr>
<td>Monilek Hospital &amp; Research Centre, Jaipur</td>
<td>Dr. Mukes Kumar Sarna</td>
<td>Jaipur</td>
</tr>
<tr>
<td>Kasturba Medical College, Manipal</td>
<td>Dr. Anitha Shenoy</td>
<td></td>
</tr>
<tr>
<td>Bombay Hospital 3rd floor ICU</td>
<td>Dr. Sujata Mehta</td>
<td>Mumbai</td>
</tr>
<tr>
<td>Spandan Multispeciality Hospital</td>
<td>Dr. Ankur Bhavva</td>
<td>Vadodara</td>
</tr>
<tr>
<td>Nemcare Hospital, Guwahati</td>
<td>Dr. Ajit K De</td>
<td>Guwahati</td>
</tr>
<tr>
<td>Tata Main Hospital</td>
<td>Dr. D.P. Samaddar</td>
<td>Jamshedpur</td>
</tr>
<tr>
<td>Shree Medical Foundation (Prayag Hospital)</td>
<td>Dr. Shrivast Prayag</td>
<td>Pune</td>
</tr>
<tr>
<td>Sterling Hospitals</td>
<td>Dr. Hetal Shah</td>
<td>Vadodara</td>
</tr>
<tr>
<td>Fortis Hospital/Vasant Kunj, New Delhi</td>
<td>dr vivek nangla</td>
<td>Delhi</td>
</tr>
<tr>
<td>Ashwini Hospital And Ramakant Heart Care Centre</td>
<td>Dr. Joshi Mukund M</td>
<td></td>
</tr>
<tr>
<td>Narhari Hospital</td>
<td>Dr. Kayur Acharya</td>
<td>Vadodara</td>
</tr>
<tr>
<td>Apollo hospital, secunderabad</td>
<td>Dr. Venkat raman kola</td>
<td>Hyderabad</td>
</tr>
<tr>
<td>SMS Medical College, Jaipur</td>
<td>Dr. Virendra Singh</td>
<td>Jaipur</td>
</tr>
<tr>
<td>Dayanand Medical College</td>
<td>Dr. P. L. Gautam &amp; Dr. Pranod sood</td>
<td>Ludhiana</td>
</tr>
<tr>
<td>Nizam's Institute Of Medical Sciences</td>
<td>Prof. R. Gopinath</td>
<td>Hyderabad</td>
</tr>
<tr>
<td>M M S R, Medical College &amp; Y.C. Rural Hospital</td>
<td>Dr. Amol R. Haralkar</td>
<td>Latur</td>
</tr>
<tr>
<td>Global hospitals &amp;Health city, Chennai</td>
<td>Dr. Jojo Kurien John</td>
<td>Chennai</td>
</tr>
<tr>
<td>Jehangir hospital and research centre</td>
<td>Dr. Kayansh Kadapatti</td>
<td>Pune</td>
</tr>
<tr>
<td>Riddhivisvanak Critical care &amp; Cardiac centre</td>
<td>Dr. Oza Prasen J</td>
<td>Mumbai</td>
</tr>
<tr>
<td>Bombay hospital 14 floor ICU</td>
<td>Dr. Sujata Mehta</td>
<td>Mumbai</td>
</tr>
<tr>
<td>Patidar Hospital</td>
<td>Dr. Madhurita Singh</td>
<td>Betul</td>
</tr>
<tr>
<td>Padmashree Hospital</td>
<td>Dr. Amrish Nanda</td>
<td>Dombivli</td>
</tr>
<tr>
<td>Shubh Hospital</td>
<td>Dr. Sudhir Khumtara</td>
<td>Jaipur</td>
</tr>
<tr>
<td>ACM C Med College, Dhule, Maharashtra</td>
<td>Dr. Pranod Patil</td>
<td>Dhule</td>
</tr>
<tr>
<td>Aditya Hospitals Critical Care and Emergency Centre</td>
<td>Dr. Barokar Raman</td>
<td>Nagpur</td>
</tr>
<tr>
<td>Yedige Super Speciality Hospital &amp; Critical Care Unit</td>
<td>Dr. Rohiniyadgire</td>
<td>Amravati</td>
</tr>
<tr>
<td>St. Joseph Hospital</td>
<td>Dr. V. B. Jindal</td>
<td>Gauhati</td>
</tr>
<tr>
<td>Tata Memorial Hospital</td>
<td>Dr. Shaurya Mistry</td>
<td>Mumbai</td>
</tr>
<tr>
<td>Critical Care Hospital</td>
<td>Dr. Deepak Jowani</td>
<td>Nagpur</td>
</tr>
<tr>
<td>Gangs Hospital &amp; Medical Centre</td>
<td>Dr. V. M. Balasubramaniam</td>
<td>Coimbatore</td>
</tr>
<tr>
<td>Pragati Hospital and Research Centre</td>
<td>Dr. Suraj Giri</td>
<td></td>
</tr>
<tr>
<td>Kurji Holy Family Hospital</td>
<td>Dr. V.K. Thakur</td>
<td>Patna</td>
</tr>
<tr>
<td>Swami Dayanand Hospital</td>
<td>Dr. M Venugopal</td>
<td>New Delhi</td>
</tr>
</tbody>
</table>
The modern art and skill of mechanical ventilation has made it possible to keep alive a lot of critically sick patients for a long period. This may sometimes go on for weeks and months. Airway maintenance in such patients is tricky. Evidence has proved that keeping ET tube in situ for a long period is associated with bad outcome; therefore tracheostomy is indicated early in such patients. More tracheotomies are being done now and probably we may be doing more of them in coming times because of added advantage and enhanced skill which will reduce cost, morbidity and improve outcomes in such patients. Art of doing tracheotomy has been evolving over the years and it is no more an instrument of ENT surgeons. Doctors in ICUs, Neurosurgical departments, trauma wards, and Plastic Surgeons would require it more often probably. Advancement in readily available bedside technique of Percutaneous tracheostomy has further revolutionized the respiratory care in these critically ill patients not withstanding its initial cost. However, due to paucity of handy resources, many of our trainees and colleagues working in the ICUs are either ignorant or trained in the advances in Percutaneous tracheostomy popularly called PCT.

In this context Principles and Practice of Percutaneous Tracheostomy, authored by Professor SP Ambesh provides a comprehensive overview on this important topic. The book contains 20 chapters and opens with fascinating history of origin of tracheostomy and recent developments. Each technique of percutaneous tracheostomy has been described in simple language in a dedicated chapter with generous and clear photographic illustrations to guide through the operation and avoiding potential difficulties and hazards. It contains comprehensive catalogue of complications, indications and contraindications. Chapters on anaesthetic considerations, Ultrasound guided approach, percutaneous tracheostomy in special situations, care of tracheostomy and comparison of different techniques are very interesting and unique. Various practical tips included reflect a wealth of underlying skill and experience.

This outstanding comprehensive and handy book may prove to be an invaluable resource to the trainees and consultant anaesthesiologists, intensivists, pulmonary physicians, nurses and chest physiotherapists working in critical care.

**Prehospital Life Support Manual**

Edited by Kundan Mittal

Kundanmittal@yahoo.co.in

Advance health care facility is limited to few only that too in limited cities only. Acute illnesses including trauma are major killer of human being. If acutely ill patients are handled at first contact by trained health staff including the doctor the outcome of illness will be better. In many developing countries including India the concept of pre-hospital life support care is not present or fully developed. Tremendous growth and development has put pressure on health system. Prehospital life support is an important and integral part of effective health delivery system. Prehospital life support includes extrication of trauma victim, assessment of acutely ill or trauma patient using ABCDE approach, initial stabilization of acute illnesses and arranging appropriate transport without doing further harm. Dr Kundan Mittal, Professor in Paediatric Emergency and Intensive Care at Pt. B D Sharma, PGIMS, Rohtak has written a manual on this subject namely Prehospital Life Support Manual published by JayPee Brothers Medical Publishers Ltd, New Delhi.

This manual written in simple language primarily focuses on all aspects of acute care including trauma management (extrication, ABCDE approach to assessment, initial stabilization of medical and non-medical emergencies including trauma, transport to appropriate health facility, ambulance care, effective communication in acute care.

This manual is recommended for all health care professionals who are involved in acute care of patient at primary level including paramedics involved in transport of acutely ill. Residents in ICUs, Emergency and Trauma rooms, Burns, Nursing personal in transport of Critically sick, 108 ambulances all over India should have such book on their tables.

**Readers Views**

The issues of CCC are coming great !!!!!!!!

Praveen khilnani

Chairman, ISCCM - Delhi

khilnanip@hotmail.com
The influence of atrial pressure on cardiac performance following myocardial infarction complicated by shock.

Summary
Six patients with cardiogenic shock and pulmonary edema were studied between 36 hours and 10 days after an acute myocardial infarction, which was diagnosed on the basis of ECG and enzyme studies. Four patients were investigated during spontaneous breathing, and two during intermittent positive pressure ventilation. The patients were catheterized with internal jugular lines, arterial, and pulmonary artery lines, from which mean systemic arterial and pulmonary artery pressures, right and left atrial pressures (RAP, LAP), heart rate, and cardiac output by thermodilution were measured. The left atrial pressure was recorded directly, using a modified transthoracic technique performed at the bedside without radiographic control. Stroke work index was derived and plotted against the respective mean atrial pressure to produce right and left ventricular function curves.

Serial measurements were made as atrial filling pressures were reduced by controlled, rapid venesection, increased by re-transfusion and inflation of endotracheal cuffs, and also during an isoproterenol infusion. The importance of the relationship between RAP and LAP and the impact of fluid removal or infusion in relation to formation and clearance of pulmonary edema was demonstrated.

Related references

Effect of isoproterenol, I-norepinephrine and intra-aortic counterpulsation on haemodynamics and myocardial metabolism in shock following acute myocardial infarction

Summary
This study investigated the effect of circulatory failure or shock on respiratory muscle performance in dogs. Thirteen spontaneously breathing dogs were compared with seven dogs that were paralyzed and artificially ventilated. In both groups, the cardiac output was reduced by >60% and held constant throughout the studies. None of the dogs were allowed to become hypoxic, and for the three hours following this circulatory insult, ventilatory parameters and respiratory muscle performance were assessed, by measurement of transdiaphragmatic pressure and recording electromyograms from the diaphragm, intercostals, abdominal muscles, and electrical activity of the phrenic nerve. During the study all the spontaneously breathing dogs died, but the seven artificially ventilated dogs survived the 3-hours protocol. Death in the spontaneously breathing dogs was secondary to respiratory failure, as reflected by the initially increase in transdiaphragmatic pressure being followed by a dramatic fall just before the death of the animals.

Related references

Respiratory muscle fatigue during cardiogenic shock

Author Aubier M, Tripeanu B, Roussos C
Reference J Appl Physiol 1981:51;499-508

Continuous recording of the ventricular fluid pressure in patients with severe acute traumatic brain injury: a preliminary report.

Author Lundberg N, Trupp H, Lorin H
Reference J Neurosurg 1965;22;581-590

Summary
Up to 1964, there were a number of reports of measurement of spinal fluid pressure made by lumbar puncture in cases of acute brain injury. Ryder et al. (1) measured spinal fluid pressure continuously in a few patients with acute brain injury. In the neurological

Dr. Sanjay Dhanuka
Prospective trial of supranormal values of survivors as therapeutic goals in high risk patients.

Author Shoemaker WC, Appel PL, Waxman K, Lee T
Reference Chest 1998;94;1176-1186

Summary
A previous study had shown that survivors of high-risk surgical operations had significantly higher mean cardiac index, oxygen delivery, and oxygen consumption than nonsurvivors. This generated the hypothesis that increasing cardiac index and oxygen delivery to values defined by the survivors in the earlier study would be beneficial. These supranormal values were cardiac index (CI)>4.3L/ min/m2, oxygen delivery (DO2)>600 mL/min/m2, and oxygen consumption (VO2)> 170 mL/min/m2. Fluid loading and the use of a variety of vasoactive agents, predominantly dobutamine, were used to achieve these goals in the protocol group.

The study was performed as two prospectively randomized series (i) in the first series, patients were prospectively allocated to either a protocol or control surgical team; (ii) in the second series, patients were pre-operatively randomized, irrespective of admitting surgical team, to either CVP control, PA control, or PA-protocol group.

Treatment with a PA catheter according to protocol was associated with a reduction in mortality, complications, duration of ventilation, and length of ICU and hospital stay.

Related references

Dr. Manish Munjal

Journal Scan

increased mean aortic pressure, coronary blood flow, and the mean myocardial oxygen consumption, and although myocardial lactate production changed to extraction, the myocardial oxygen extraction remained abnormally high at >77%. Cardiac index did not change. In contrast, intraventricular balloon counter-pulsation increased mean arterial pressure, cardiac index by an average of 0.5L/min/m2, and also coronary blood flow. Although myocardial oxygen extraction was unchanged, the myocardial lactate and oxygen extraction improved towards more normal values. Twenty one of the 23 patients in this study died.

Related references

Continuous recording of the ventricular fluid pressure in patients with severe acute traumatic brain injury: a preliminary report.

Author Lundberg N, Trupp H, Lorin H
Reference J Neurosurg 1965;22;581-590

Summary
Up to 1964, there were a number of reports of measurement of spinal fluid pressure made by lumbar puncture in cases of acute brain injury. Ryder et al. (1) measured spinal fluid pressure continuously in a few patients with acute brain injury. In the neurological
surgery department in Lund, Sweden, Lundberg and colleagues described the first study of continuous recording of intracranial pressure in patients with severe traumatic brain injury. In this preliminary report, the authors described a selected number of cases from their series of 30 cases. Notably, by the early 1960s, this group had continuously measured intracranial pressure in >350 patients with a variety of brain disorders. To this end, a ventricular cannula, designed to measure pressures in a range of −10 to +115 mmHg, was used. Intracranial pressure monitoring began as early as 3 hours after injury, and was maintained in some patients for as long as 9 days. Details described the titration of therapies (hypothermia, urea) targeting increases in the continuously monitored intracranial pressure were provided. In addition, a case of brain stem contusion with considerable symptomatology, but without increase in intracranial pressure, is described. Similarly, an early description of treatment of plateau waves is provided.

Related references

Computerized axial tomography of the head: the eMI-Scanner, a new device for direct examination of the brain ‘in vivo’

Author Ommaya AK

Summary
This article represents an account of the first report of the technique of cranial tomography by Ambrose and Hounsfield, which was presented at the November 1972 meeting of the Radiologic Society of North America. An overview of the apparatus, the x-ray beam, the circular motion, and the principle of operation of the scanner are presented. The potential value of the technique is discussed, including its ability to easily distinguish brain tissue, cerebrospinal fluid, and other substances. Computed tomographic scans of six cases, including hydrocephalus, craniopharyngioma, glioma, subdural hematoma, intracerebral hematoma, and cortical atrophy are presented. The discussion indicates that this technique is easy, required no specific preparation of the patient, and is noninvasive. The potential of this technique is discussed in relation to x-ray absorption. Computed tomographic scans of six cases, including hydrocephalus, craniopharyngioma, glioma, subdural hematoma, intracerebral hematoma, and cortical atrophy are presented. The discussion indicates that this technique is easy, required no specific preparation of the patient, and is noninvasive. The potential of this technique is discussed in relation to differences in x-ray absorption.

Related references

Assessment of coma and impaired consciousness: a practical scale

Author Teasdale G, Jennett B
Reference Lancet 1974;2:81-84

Summary
The authors indicate that there are a number of systems for describing impaired levels of consciousness or coma. However, none of these are consistent, and most clinicians ‘retreat from any formal scheme in favor of a general description of the patient’s state.’ To be able to assess and record changing states of altered consciousness reliably, for repeated bedside application to the monitoring and treatment of a wide range of conditions, the authors describe a practical scale with motor, verbal, and eye opening components. This consistency, and ease of application of this tool, was then demonstrated by having several groups of doctors and nurses examine the same group of patients. In this setting, the authors describe that disagreements were rare. The authors compared the use of this scale to the attempted characterization of patients by clinicians as either conscious or unconscious. In the latter setting, a 20% disappearance rate was reported. Although the authors describe unusual cases where selected aspects of this scale could not be assessed (such as the locked-in syndrome), they point out the willingness of the nurses in their intensive care unit to record this scale similar to the conventional recording of temperature, respiration, and pupil size. The application of this tool is to use in a general hospital—one that frequently admits patients with head injuries—is also described.

Related reference

Trafumic acute subdural hematoma

Author Seeil JM, Becker DP, Miller JD, Greenberg RP, Ward JD, Choi SC

Summary
A retrospective study of 82 patients over 2 years old admitted between 1972 and 1980 with traumatic acute subdural hematoma was conducted. All patients were comatose with a >5 mmHg midline shift, and all were treated with surgical decompression. Management strategies were used, based on the patient’s age and subdural hematoma between 25 and 30 mmHg, dexamethasone, and Phenobarbital for all patients. Also mannitol was given to all patients after diagnosis of surgical midline herniation. The use of computed axial tomography or air ventriculography. Surgical management involved rapid cranial craniectomy with partial evacuation of the hematoma before drainage. A ventricular canula or subarachnoid screw was placed for intracranial pressure monitoring. Intracranial hypertension was treated with hyperventilation, cerebrospinal fluid drainage, mannitol, and/or barbiturates. Evoked potential studies, including auditory and cortical somatosensory, and visual evoked potentials, were performed in 40 patients. Mortality rate was 37% in patients with traumatic acute subdural hematoma. The patients with subdural hematoma were older than those with other types of head injuries, and had severe neurological signs on admission (higher incidence of unreactive pupils, absent oculocephalic reflex, and decerebrate posturing). Among the patients with subdural hematoma, men had a higher mortality rate than women, as did patients with refractory intracranial pressure. When the time from injury until surgery was considered, the survivors were to surgery on average 3 hours earlier than non-survivors. The authors concluded that the patients that correlated with outcome in patients with acute subdural hematoma were sex, intracranial pressure, initial neurological exam results, and time to surgery.

Related references

Effect of hemorrhagic shock on the reactivity of resistance and capacitance vessels and on capillary filtration transfer in cat skeletal muscle

Author Melling S, Lewis DH

Summary
The reactions to sympathetic nerve stimulation in the series-coupled segments of the peripheral vasculature (resistance vessels, capillaries, and capacitance vessels) during hemorrhagic hypotension (40-50mmHg) were studied in the skeletal muscle in experiments on anesthetized cats. Sympathetic nerve stimulation induced a powerful increase in the resistance to blood flow (constriction of arteriole) early during hypotension, an inward movement of fluid from tissue to blood across the capillary wall, and a significant reduction of regional blood volume (constriction of venules and veins). During the course of hemorrhagic hypotension, there was almost complete abolition of both the resistance and the capacitance vessel response in the skeletal muscle. The reaction to intra-arterial infusion of noradrenaline was similar. The resistance vessel response faded away faster, and the time to abolition was faster than that of the capacitance vessels. This difference in response between the peripheral and the portal capacitance vessels influenced the fluid movements across the capillary wall. The inward movement of fluid became less pronounced, and eventually sympathetic nerve stimulation caused losses of fluid. After retransfusion, the effects normalized.

Related references

‘Hidden acidosis’ in experimental shock

Author Bergentz SE, Carlsten A, Geijn LE, Kreps J

Summary
Shock was produced by exteriorization of the small intestine for 2 hours. This caused hypotension, but only slight changes in acid-base balance in blood. After replacement of the gut, and fluid replacement with low molecular weight dextran, the blood pressure started to normalize. Arterial pH fell, and lactic acid and pyruvic acid increased initially but normalized after about 1 hour. The acidosis of the peripheral tissues was not reflected in the blood due to impaired tissue perfusion during shock. It was also concluded that dextran infusion in particular due to impaired tissue perfusion during shock. It was also concluded that dextran infusion in particular due to impaired tissue perfusion during shock. It was also concluded that dextran infusion in particular due to impaired tissue perfusion during shock. It was also concluded that dextran infusion in particular due to impaired tissue perfusion during shock. It was also concluded that dextran infusion in particular due to impaired tissue perfusion during shock. It was also concluded that dextran infusion in particular due to impaired tissue perfusion during shock.
Dear All,

ISCCM proposes to hold ISCCM day on 27th November this year. Though the Basic Life Support (BLS) day falls on 9th October, however, the celebration is postponed to 27th November because of ongoing Commonwealth Games.

On ISCCM day we propose the following programme as ISCCM day celebration:

1. Print one poster and send it across all members, they will put it in their ICUs and main notice board. The theme and matter of the poster is to be discussed.
2. Sensitize all members (Groups) to take up BLS Programme on that day all over India and train general public, nurses, paramedical or any other relevant population.
3. Bring out a special page in next Bulletin of ISCCM about the ISCCM day.

More ideas are welcome.

BLS Program:

As we are all aware of the importance of basic life support by any individual in the ultimate outcome in case of emergency / life threatening situation for any Individual, early resuscitation / CPR and prompt defibrillation during cardiac arrest (within 1-2 minutes) can increase chances of survival by more than 60%.

In this regard, we are pleased to offer Module for training of all ambulance drivers, paramedics, reception staff, nurses, doctors & persons who are having maximum public dealing like police personnel, public transport drivers, fire fighters, employees of mall, railways, transport corporation school teachers, bank employees, BPO employees etc. The module consists of comprehensive half day training which includes lectures, interactive sessions and workshops including hands-on for various topics of importance in basic life support.

Aims & outcomes:

The module has been designed to provide a structured framework for basic life support education in India, which will ensure that the maximum professional learning benefit can be gained from a relatively short period of study.

Objects of the module:

1. To help an individual to acquire knowledge and skills in the advanced technology of Basic Life Support which is so vital in the ultimate outcome in case of life threatening situation.
2. To create in society awareness about the need for continuous updating of knowledge and skills in the field of Basic Life Support.

Expected outcomes of training:

- To create awareness and preparedness of individual to do or assist in BLS in case of life threatening situation.
- To train them in Basic Life Support.
- To make a pool of Task Masters and instructors in India.

Who should attend?

Ideally every individual should attend this course. At least persons directly or indirectly related to public safety.

Topics to be covered in the module:

- Primary ABCD survey
- Adult Chain of Survival
- Pediatric Chain of Survival
- Special situation in BLS like FBAO, trauma victim, drowning, pregnant victim, neonatal & pediatric victims, mass casualties etc.

Skill Stations to be held during the programme:

- Cardio-Pulmonary Resuscitation (CPR)
- Airway Management
- Use of AED
- Transport of critically sick

How this course will be organized:

Their will be steering committee who will form this course, monitor and whenever required make changes in the course.

Those who are already conducting such course can be absorbed in our pool to organize this course.

Their will be one Director/ Task Master & 2-4 teachers or instructors (including Task master) in each course depending upon the number of candidates (one teacher on every batch of 10-12 candidates). Their can be 1 or 2 observers in each course, who will become Task Master / Instructor later.

Duration of Course:

<table>
<thead>
<tr>
<th>For Doctors &amp; Nurses</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Half day</td>
</tr>
<tr>
<td>For non medical personnel</td>
<td>1 hour</td>
</tr>
</tbody>
</table>

Certification & Course Material:

All participants will get certificate of completion of IBLS by ISCCM (Certificate will bear signatures of ISCCM office bearers, National Course coordinator & Task Master/ course director)

Course Material: Kindly Give inputs about book / Handout Certificate: Sample attached

Certificates will have signatures of office bearers of ISCCM, course coordinator & Team Leader/ Director. ISCCM office will provide blank certificates to the organizers. Certificates will be having serial number & security features or will have hologram of ISCCM

Distribution of Books & Course Material: Blank Certificates, course material will be supplied from central office. Task Master / director will provide list of candidates with serial number after completion of course.

Course fee: Free for General Public.

ISCCM Welcomes New Members

1. Anandhi Sachithanandam L.M.
2. Naveen Chitkara L.M.
3. Sachin Goyal L.M.
4. Ansu Chaudhuri A.L.M.
5. Prahalad K.A.Bayar L.M.
6. Sameer Kapoor L.M.
7. Dhaval Waghela L.M.
8. Prakash S.Patel L.M.
9. Palaniapan Thiruppathy L.M.
10. Sethuraman Alappagan L.M.
11. Shyam Mathur L.M.
12. Nareshkrumar & Barasarasa L.M.
13. Venkata Ramana Kunche L.M.
14. Umesh Dash L.M.
15. Chandramohan Kathiresan L.M.
16. Venugopal Kathikar L.M.
17. Hariprasad R. Bhumikanon L.M.
18. Manjusha Yadav L.M.
19. Sendhil Kumar Saraswathy L.M.
20. Manoj Bezbuzhar L.M.
21. Sohel Ahmed L.M.
22. Manab Gogoi L.M.
23. Amit Day L.M.
24. Debasis Chakrabarti L.M.
25. Tejas Karmata L.M.
26. Vikram Amale L.M.
27. Vipul Khandelwal L.M.
28. Sunil Dixhe L.M.
29. Joyish Pandey L.M.
30. Hemang Doshi L.M.
31. Kailal Halder A.L.M.
32. Sudhir Kumar L.M.
33. Arvind Pandey A.L.M.
34. Partha Chakrabarti A.L.M.
35. Archana Verma L.M.
36. Sahaj Sood L.M.
37. Dhurba Sastri A.L.M.
38. Madhuri Rayamane L.M.
39. Syed Javed L.M.
40. Pranav Patel L.M.
41. Karthikumar B.Patel L.M.
42. Bisaj Venkatachalam L.M.
43. Vijay Langer L.M.
44. Kapil Borowake L.M.
45. Vishal Aryan L.M.
46. Swapnil Day L.M.
47. Rahul Kumar L.M.
48. Kamal Jindal L.M.
49. Pushpraj Patel L.M.
50. Seema Mehandwadi L.M.
51. Padmidikulkala Vijaya L.M.
52. Palakorav V Sarma L.M.
53. Rachaputi M Baburao L.M.
54. Uma Shankar Srinivasan L.M.
55. Venkata Mahesh Amara L.M.
56. Partheb Sowjaya L.M.
57. Jannulla Prabhakhar Patro L.M.
58. Babalakshma Sahoo L.M.
59. Tumma Vengarambaba L.M.
60. Pataliapan Inambouthah L.M.
61. Prakash Dube L.M.
62. Artiga Ghodsi L.M.
63. Rama Prasen Ray L.M.
64. Prasad Deshmukh L.M.
65. Rohit Gupta L.M.
66. Sarat Kumar Sahoo L.M.
67. Cherian Gupta L.M.
68. Mitchel Guibab L.M.
69. Sarath Chander Pinapati L.M.
70. Roopa Karanam L.M.
71. Ketan Vijay Kargirwar L.M.
72. Kruthvendra Chandra Misra L.M.
73. Vikram Balwani L.M.
74. Etheshyam Qureshi L.M.
75. Dharmesh Mehta L.M.
76. Vijay Kapoor L.M.
77. Rafiq Ahmed Kadumuru L.M.
78. Prasanna Pranav Ray L.M.
## Forthcoming Events

<table>
<thead>
<tr>
<th>Date</th>
<th>Conference Name</th>
<th>Contact Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st to 3rd September 2010</td>
<td>Sepsis 2010</td>
<td>Paris, France Phone: +44 1794 5113 Email: <a href="mailto:Sepsis@indexcommunications.com">Sepsis@indexcommunications.com</a> Website: <a href="http://www.sepsisconference.com">http://www.sepsisconference.com</a></td>
</tr>
<tr>
<td>24th September 2010</td>
<td>Symposium on Shock</td>
<td>Dr RK Singh SGPGI, Lucknow Cell no. 09415189124 Email: <a href="mailto:ratender@sgpgi.ac.in">ratender@sgpgi.ac.in</a></td>
</tr>
<tr>
<td>25th to 26th September 2010</td>
<td>FCCS course</td>
<td>Dr RK Singh SGPGI, Lucknow Cell no. 09415189124 Email: <a href="mailto:ratender@sgpgi.ac.in">ratender@sgpgi.ac.in</a> Dr Manish Munjal Email: <a href="mailto:drmrmunjal@hotmail.com">drmrmunjal@hotmail.com</a></td>
</tr>
<tr>
<td>25th to 26th September 2010</td>
<td>14th Annual Workshop on Mechanical Ventilation</td>
<td>Ms Vidula Tapaskar, Secretary, ISCCM Pune Branch C/o Shree Medical Foundation, PRAYAG HOSPITAL 1247, Apte Road, Deccan Gymkhana, Pune- 411004. Maharashatra. India + 020- 2553 2812 / 2553 2490</td>
</tr>
<tr>
<td>1st to 3rd October 2010</td>
<td>2nd Criticare Update 2010 Annual Conference on Critical Care Related Issues</td>
<td>Prof (Dr) D K Singh CRITICARE UPDATE 2010 Department of Anaesthesiology &amp; Critical Care, Institute of Medical Sciences, Banaras Hindu University, Varanasi-221005 • Mobile : 09839927283 e-mail: <a href="mailto:varanasicriticare@gmail.com">varanasicriticare@gmail.com</a></td>
</tr>
<tr>
<td>7th to 9th October 2010</td>
<td>16th Congress of Asia Pacific Association of Critical Care Medicine</td>
<td>EDSA Shangrila Plaza Hotel, Mandaluyong City Manila, Philippines Org. by: Philippine Society of Critical Care Medicine (PSCCM) Secretariat Office : 2nd floor Heart Foundation Medical Arts Building, Philippine Heart Center, East Avenue, Quezon City, Philippines 1101 • TeleFax no. (+632) 9252401 local 3226</td>
</tr>
<tr>
<td>9th to 13th October 2010</td>
<td>23rd ESIICM Annual Congress</td>
<td>Barcelona, Spain Email: <a href="mailto:Barcelona2010@esicm.org">Barcelona2010@esicm.org</a></td>
</tr>
<tr>
<td>29th to 31st October 2010</td>
<td>12th National Conference of Pediatric Critical Care (Annual conference of IAP Intensive Care Chapter)</td>
<td>Surat Dr. Digant D. Shastry, Organizing Secretary - NPCCC, Surat Killol Children Hospital &amp; NICU, 303-304, Takshashila Apartment, Majuragate, Surat 395002 • Cell : 08141334554, 09879538800, (0261) 2470130 (Clinic) • <a href="mailto:drdigant@hotmail.com">drdigant@hotmail.com</a>, <a href="mailto:ncpcsurat@gmail.com">ncpcsurat@gmail.com</a> • website : <a href="http://www.iapsurat.org">www.iapsurat.org</a></td>
</tr>
<tr>
<td>16th to 18th November 2010</td>
<td>Doppler-Echocardiography in Intensive Care Medicine</td>
<td>Brussels, Belgium Phone: +32 2 555 3631 +32 2 555 3631 Fax: +32 2 555 4555 Email: <a href="mailto:sympicu@ulb.ac.be">sympicu@ulb.ac.be</a> Website: <a href="http://www.intensive.org">http://www.intensive.org</a></td>
</tr>
<tr>
<td>19th to 21st November 2010</td>
<td>2nd Eastern Zonal Critical Care Conference (EZCCCON)</td>
<td>Hyat Regency, Kolkata Dr. Dipankar Sarkar, Organizing Secretary Columbia Asia Hospital, IB 193 Salt Lake, Sector III, Kolkata 91 Dr.Amitabha Saha, Organizing Secretary Kasba Golpark EM Bypass, Kolkata 107 email: <a href="mailto:ezcccon@yahoo.in">ezcccon@yahoo.in</a> • website : <a href="http://www.ezcccon2010.co.cc">www.ezcccon2010.co.cc</a></td>
</tr>
<tr>
<td>3rd to 5th December 2010</td>
<td>The Difficult Airway Workshop</td>
<td>Dr Sheila Nainan Tata Memorial Hospital, Mumbai – Maharashtra Cell no.: +919820156070 • Email: <a href="mailto:sheila150@hotmail.com">sheila150@hotmail.com</a></td>
</tr>
<tr>
<td>10th to 12th December 2010</td>
<td>16th annual conference of the Indian Society for Parenteral and enteral nutrition</td>
<td>Dr. Sunil Singh, Organizing Chairperson Dr. Gurpeet Singh, Organizing Secretary PGI, Chandigarh</td>
</tr>
<tr>
<td>15th to 19th January 2011</td>
<td>Critical Care Congress (Society of Critical Care Medicine)</td>
<td>San Diego, United States Website: <a href="http://www.sccm.org">http://www.sccm.org</a></td>
</tr>
<tr>
<td>17th to 21st February 2011</td>
<td>17th annual Congress of the Indian Society of Critical Care Medicine</td>
<td>Praveen Khilnani, Organizing Chairmen Deepak Govil, Organizing Secretary Surinder S.Arora, Organizing Secretary Indraprastha Apollo Hospital, Sarita Vihar New Delhi Ph : +91 11 26923585 Email: <a href="mailto:congress@criticare2011.org">congress@criticare2011.org</a> / <a href="mailto:info@criticare2011.org">info@criticare2011.org</a> Web: <a href="http://www.criticare2011.org">www.criticare2011.org</a></td>
</tr>
<tr>
<td>13th to 17th March 2011</td>
<td>6th World Congress on Pediatric Critical Care</td>
<td>Sydney, Australia Phone: +61 2 9265 0700 begin_of_the_skype_highlighting +61 2 9265 0700 end_of_the_skype_highlighting Fax: +61 2 9267 5443 Email: <a href="mailto:pcc2011@tourhosts.com.au">pcc2011@tourhosts.com.au</a> Website: <a href="http://www.pcc2011.com">http://www.pcc2011.com</a></td>
</tr>
<tr>
<td>22nd to 25th March 2011</td>
<td>31st International Symposium on Intensive Care and Emergency Medicine</td>
<td>Brussels, Belgium Phone: +32 555 36 31 Fax: +32 2 555 4555 Email: <a href="mailto:sympicu@ulb.ac.be">sympicu@ulb.ac.be</a> • Website: <a href="http://www.intensive.org">http://www.intensive.org</a></td>
</tr>
</tbody>
</table>
Dear All

It is being proposed that most of the communication with members in future will be online to reduce delivery failures and ensure better exchange of information. This will also reduce cost to the society. It is very important to have correct email IDs of all members of the society and those members who do not have email IDs are requested to create one. This is, otherwise, too going to be almost a mandatory requirement for all doctors. It is also proposed that elections of the society will also be held online from next session and a constitutional amendment to this effect is being brought in the next EC and AGM respectively. All branch office bearers are particularly requested to ensure that the email ID, photos, mobile nos of all members are updated in the records. This is a continuous exercise we need to do for next several months.

Thanks

Dr. Narendra Rungta
President Elect and Chairman Election Committee

---

**ICU Protocol Pocket Book**

ISCCM under the editorship of Dr. S.K. Todi and Dr. Rajesh Chawla intends to publish a pocket book of ICU protocols, which can be used by our residents in their daily ICU practice. This book will neither be a condensed text book as some of the current pocket books are, nor it would be elementary. It will be small enough to carry around and big enough to contain all essential elements of ICU care and its target readers would be ICU residents. This book is designed to bring out stepwise management of ICU patients so that important steps in diagnostic workup and treatment are not missed by residents. Each chapter will start with a case scenario followed by important considerations in management. There will be an easy to read algorithm, flowsheet, tables and figures with each chapter for rapid browsing. Suggested annotated reading references and important weblinks will be added to each chapter. An appendix with important ICU formulae will be added. We have conceptualized 84 chapters covering all important aspects of ICU management. The editors view this book to be a ready reckoner for ICU residents in their daily work and to help post graduates. It will be a multi-author and multi-editor book released by our next Congress in Delhi.

---

**12th National Conference of Pediatric Critical Care**

(ANNUAL CONFERENCE OF IAP INTENSIVE CARE CHAPTER)

29th to 31st October 2010
Surat, Gujarat

SECRETARIAT
Dr. Digant D. Shastri
Organizing Secretary - NCPC, Surat
Killol Children Hospital & NICU, 303-304, Takshashila Apartment, Majuragate, Surat 395002
Cell: 08141334554, 09879538800, (0261) 2470130 (Clinic)
drdigant@hotmail.com, ncpccssurat@gmail.com
website: www.iapsurat.org

---

**2nd Criticare Update 2010**

ANNUAL CONFERENCE ON CRITICAL CARE RELATED ISSUES

1st to 3rd October 2010
Varanasi

SECRETARIAT
Prof (Dr) D K Singh
Organizing Chairperson
CRITICARE UPDATE 2010
Department of Anaesthesiology & Critical Care,
Institute of Medical Sciences, Banaras Hindu University,
Varanasi-221005
Mobile: 09839927283
e-mail: varanasicriticare@gmail.com

---

**2nd Eastern Zonal Critical Care Conference**

(EZCCCON)

19th to 21st November 2010
Hyatt Regency, Kolkata

SECRETARIAT
Dr. Dipankar Sarkar
Organizing Secretary
Columbia Asia Hospital, IB 193 Salt Lake, Sector III, Kolkata 91

Dr. Amitabha Saha
Organizing Secretary
Kasba Golpark EM Bypass, Kolkata 107
e-mail: ezcccon@yahoo.in
website: www.ezcccon2010.co.cc
Fast Acting Local Mucolytic

3 times more potent & 5 times faster acting than N-acetylcysteine (NAC)¹

- Fluidifies bronchial secretions and facilitates aspiration²
- Disintegrates blood clots by its lytic action upon the mucus embedded in the fibrin network³
- Effective on blood clots alone and on mixed blood and mucus clot⁴
- Improves patient status by reducing post-bronchoscopic complications⁵
- Can be co-administered with bronchodilators, such as salbutamol and with corticosteroids like methylprednisolone⁶

77 % increased solubilisation of structured mucus by Mistabron® unlike NAC, Saline

Inhaled substance  %
Saline 0
Propylene glycol 16
Tyloxapol 18
Argin 18
Urea 24
NAC 36
Alpha - chymotrypsin 55
Hyaluronidase 67
Mesna (Mistabron®) 77

Indications:

Via nebulisation:
- during the post operative period to prevent pulmonary complications
- in chronic bronchitis
- in bronchial emphysema
- in bronchiectasis

Via instillation:
- in bronchoscopy
- in tracheostomy
- in resuscitation

Dosage:

- Nebulizer: 3 – 6 ml per day in 1 to 4 sessions (maximum of 26 ml per day)⁷
- Instillation: 1 – 2 ml every hour until fluidification is achieved (maximum of 26 ml per day)⁷

Abbreviated Prescribing Information
MISTABRON® Injections (Mesna)

Comparison Table: 1 vs. NAC in vivo laboratory studies on bronchial mucous secretion with and without administration of NAC and Mistabron in patients with acute respiratory distress syndrome. NAC and Mistabron were compared with aspirin, 0.6 mg/kg; salbutamol, 0.25 mg/kg; and adrenaline, 0.05 mg/kg. After 24 hours, the fluidity of the secretions was measured. Results indicate that Mistabron is significantly more effective than NAC in reducing mucus viscosity. Furthermore, Mistabron has been shown to be safe and well tolerated in clinical trials. The onset of action is rapid and the duration of effect is prolonged. Adverse effects are rare and generally mild. Misuse or drug interactions are unlikely. Please refer to the full prescribing information before using this product.

References:
1. Mesna product monograph
5. Cupolo M, Mastrogiuseppe Di 
6. Mistabron Prescribing Information

Please refer to the full prescribing information before using this product.