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#### 28th ISICEM –Reflections

The 28th ISICEM, held in Brussels from March 18-21, was attended by almost 5000 participants from 84 countries. With a program of more than 700 separate sessions, it is difficult to select individual highlights and every attendee will have their own key points. So, rather than discussing individual sessions, I've selected some important themes that were covered in several presentations.

One area of common ground in many presentations, and the focus of a presymposium Round Table, was the problems with the design, conduct, and interpretation of randomised clinical trials (RCTs) in intensive care. Many interventions we use daily in our critically ill patients have never actually been tested in RCTs, and most of the few studies that have been conducted have been criticised or not confirmed in subsequent trials. This leaves practicing clinicians in considerable confusion. With the promotion of evidence-based medicine, there is pressure to perform more RCTs to prove that our interventions do work; however, perhaps we have been too hasty and need to return to the basics of clinical trial design to ensure trials are carefully thought-out and targeted so that some of the pendulum-like results we have seen in recent years are avoided.

Following the clinical trial theme, a topic of debate for many years, and yet for which there are relatively few RCT data is the optimal choice of vasopressor agent during resuscitation of patients with shock. Analysis of data from the recent observational SOAP study suggested that dopamine may be associated with higher mortality rates than noradrenaline, leading the SOAP investigators to compare the two drugs as first-line vasopressor in patients with shock. Dr. De Backer presented initial results from this recently completed RCT which included more than 1600 patients. There was no significant difference in outcomes between groups, although mortality rates trended to be higher in dopamine-treated patients who also more frequently developed complications (mainly cardiac arrhythmias).

Another subject of much controversy in clinical practice has been the optimal use of transfusions in critically ill patients. Since the often-cited study by Hebert et al. published in 1999, after which many clinicians reduced transfusion thresholds and developed a more restrictive approach to transfusion, blood transfusion has become safer with increased donor screening, improved blood sterilization treatments, and the introduction of leucoreduction. Indeed, some studies have suggested that transfusion is no longer associated with a worse outcome, and that transfused patients may rather have better outcomes. Faculty members presented arguments for and against use of blood transfusion in various situations, and created considerable debate.

Finally in my brief selection of this year's key 'themes' is the potential role of medical emergency or rapid-response teams in facilitating early diagnosis and therapy of potentially unstable acute patients. There does seem to be evidence that early appropriate therapy saves lives, but is the medical emergency team the best way to achieve this? This approach was first proposed in Australasia but is now employed in hospitals worldwide.

Protagonists believe that by sending the "ICU" to the patient, unnecessary ICU admissions can be avoided and therapy started sooner, thus improving outcomes. Antagonists are concerned that, by taking responsibility away from ward staff, levels of training will be reduced. In addition, with concerns about ICU staff shortages, where are the personnel necessary to be able to run such teams effectively going to come from? While such systems may work for larger centres, where does that leave smaller, less well-staffed hospitals? This discussion leads on to the larger question of the future of intensive care medicine as a whole. Patients treated in ICUs manned by dedicated ICU-trained physicians have better outcomes, but there are not enough such physicians to go round and the situation will worsen as the number of patients requiring intensive care continues to increase. How can we attract more intensivists into training? Should we be centralising ICU services so that resources are located in a few key centres? Should we be moving towards more tele-consultations, so that smaller hospitals can have support of trained ICU physicians if not onsite then online? These and many other questions need to be tackled urgently by today's ICU and hospital managers and leaders to ensure that in the future we will all be able to receive good intensive care when we need it.

