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## Looking Back on 2011

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**For this edition of ICU Management, we asked four influential leaders in critical care medicine, "What was the most important or interesting development in intensive care in 2011?" with the aim of pinpointing the hot topics in critical care and emergency medicine during the year just past, and identifying trends for the future. Each contributor provided a different and important viewpoint that identifies key strengths and weaknesses in the provision of care today, from the availability of ICU beds to driving greater awareness with regards to the need for greater attention to quality control.**

Intensivists are used to describing the patient's condition at the time of handover or when speaking to family members as stable, suggesting that nothing new has happened during the last period of clinical treatment or evaluation, usually one day. Families generally receive this information as positive news, thinking that as there has been no further deterioration, that this will give space for future improvement. In actuality, things may be quite different, because even staying in an ICU itself, receiving care over a long time may expose the patient to serious complications, such as sepsis, which can ultimately be responsible for death. A positive evaluation of a patient receiving ICU care should contain at least some minor improvement, such as in terms of reduced support (for instance, lower FiO<sub>2</sub>) or better vital parameters (e.g. increased oxygenation, as in our example).

A paper of some significance shed some light on this: Authored by Prof. J-L Vincent and published in Critical Care Medicine in 2011, by identifying a common pattern in sepsis patients prior to their death, it provided a new way in which to evaluate the likelihood of patient mortality. This paper demonstrates that persistent, rather than worsening, organ failure is the more common pattern before death in patients with severe sepsis. The authors performed a retrospective analysis of the 1,201 patients with severe sepsis who died within 28 days, collected in five trials in 28 countries, and found that non-survivors had only small increases in individual organ SOFA scores in the 4-day period before death. The finding that SOFA scores were relatively stable in the days preceding death reflects persistent rather than dramatically worsening organ failure. The authors claim that they could not exclude a potential impact of specific actions or non-actions of the clinical team during the dying process on trends in SOFA scores. However, we would expect that any withdrawal be associated with a consistent increase in SOFA score, which was not found. This study helps physicians to understand the evolution of septic non-survivor ICU-admitted patients. We now wait to know whether non-septic patients show the same finding.

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