2015 – A Year of Critical Care

Rob Mac Sweeney NEICS Spring Meeting 2016

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Health Research Board of Ireland

Health Research Board of Ireland

Irish Critical Care Trials Group





Effect of Hypothermia in Severe

Traumatic Brain Injury-Associated

Intracranial Hypertension



ICP > 20 mmHg > 5 min





Stage 1	
Sedation	
Ventilation	
Head Up	
NAP > 80 mm Hg	

Stage 1	
Sedation	
Ventilation	
Head Up	
MAP > 80 mm Hg	
Ventriculostomy	
Surgery	

Standard Management

or

Hypothermia 32 - 35°C







Stage 3

Barbiturates

Decompressive Craniectomy

Further Surgery





















Primary Outcome EGOS 1 - 4 acOR 1.53 (1.02 to 2.30) P=0.04












Erythropoietin in Traumatic Brain Injury

and a second second

Erythropoietin

Neurocytoprotective

Anti-excitotoxic

Anti-oxidant

Anti-inflammatory

Anti-oedematous







Safety Measures

Stopping critieria

DVT Screening



















GOS-E1-

46 (16%)	7 (2%)	52 (18%)	27 (9%)	66 (22%)	38 (13%)	33 (11%)	25 (9%)
y thropoiet in	(n=302)						
32 1 (11%) (49	1 6) (58 (19%)	33 (11%)	73 (24%)	42 (14%)	31 (10%)	22 (7%)
	now Outco	o me Scale sco	re				
1 2	3	4 🗖 5	6 🗆 7 🗖	8			

Day 180 Mortality



Figure 3: Kaplan-Meier estimates of the unadjusted probability of death at 6 months in patients receiving erythropoietin or placebo

Day 180 Mortality EPO 11% Placebo 16% RR 0.68, 95% CI 0.44 – 1.03; P=0.07

Day 180 Mortality – Diffuse TBI

EPO 9.1%

Placebo 15.2%

RR 0.60, 95% CI 0.36 – 0.99; P=0.04







PROPPR



Blood product ratios in traumatic haemorrhage



Plasma : Platelets : RBCs

1:1:1 **vs** 1:1:2







Boxes



1:1:1 1 platelets | 6 FFP | 6 RBCs







1 platelets | 6 FFP | 6 RBCs

3 FFP | 6 RBCs







1 platelets | 6 FFP | 6 RBCs

3 FFP | 6 RBCs

1 platelets | 3 FFP | 6 RBCs

Sequence



Sequence



1:1:1 1 platelets 6 x (1 RBCs | 1 FFP)



Sequence



1:1:1 1 platelets 6 x (1 RBCs | 1 FFP)



3 x (2 RBCs | 1 FFP) + 1 platelets



End Point

Cessation of requirement for blood

Surgeon

Radiologist



Mortality



Mortality

580 Patients

0.044 ∆ **10%**

21% to 11%


Mortality 580 Patients 0.044 $\Delta 10\%$ 21% to 11% 0.044 Δ 12% 35% to 23%







1:1:1	1:1:2	Baseline
34.5	34	Age
78%	83%	Male
26.5	26	ISS
-8	-8.5	Base Excess
27.5	25.4	Time to Recruitment





Plasma : RBCs Platelets : RBCs





Plasma : RBCs Platelets : RBCs



	1:1:1	VS	1:1:2
Plasma :	1.0		0.5
RBCs Platelets : RBCs	1.5		0.4



Blood Products during Intervention







Blood Products after Intervention



















	1:1:1	1:1:2	
Plasma	7	5	P<0.001
Platelets	12	6	P<0.001

















Mortality	1:1:1	1:1:2
24 Hours	12.7%	17.0%
30 Days	22.4%	26.1%



Deaths from Exsanguination at 24 hours



Deaths from Exsanguination at 24 hours





Deaths from Exsanguination at 24 hours

1:1:1	1:1:2
9.2%	14.6%

difference -5.4%

95% CI, -10.4% to -0.5%

P = 0.03



Haemostasis



Haemostasis





Methodologically robust

Limitations few

Overall outstanding







Paracetamol in fever from suspected infection



Inclusion

Fever

Antimicrobials



End Point

Cessation of fever Cessation of antimicrobials ICU Discharge Contraindication Day 28

Confounders Rescue pyrexia management Open label paracetamol








Age	59	Baseline
Male	65%	
APACHE II	19	
Vasopressor	50%	
Ventilated	50%	
Microbe	62.5%	
Peak Temp	38.7°	
	C	









Figure S6. Average mean daily temperature by treatment group.*

*Error bars are plus or minus one standard deviation. The number of patients contributing data to each study point by treatment group is shown on the horizontal axis. Day zero is the day of randomization.

ICU-Free DaysParacetamol23IQR 13 - 25Placebo22IQR 12 - 25			
Paracetamol 23 IQR 13 - 25 Placebo 22 IQR 12 - 25	ICU-Free Days		
Placebo 22 IQR 12 - 25	Paracetamol	23	IQR 13 - 25
	Placebo	22	IQR 12 - 25

ICU-Free Days

Δ 0 days; 96.2% CI, 0 to 1; P = 0.07







Contamination 30%

Methodologically good Limitations several Overall good





Effect of plasma-lyte 148 vs 0.9% saline on AKI in ICU patients

Saline harmful

Hyperchloraemia

Metabolic acidosis



Design Investigator Initiated Multicentre

Blinded

Cluster-Randomised

Double-Crossover

			The second	
ICU 1	ICU 2	ICU 3	ICU 4	
Fluid A	Fluid B	Fluid A	Fluid B	
Fluid B	Fluid A	Fluid B	Fluid A	
Fluid A	Fluid B	Fluid A	Fluid B	
Fluid B	Fluid A	Fluid B	Fluid	



Study fluid encouraged

Open-label crystalloid

Clinician determined



Acute Kidney Injury

Power calculation





















Acute Kidney Injury Λ 0.4% [95% CI, -2.1% to 2.9%] RR, 1.04 [95% CI, 0.80 to 1.36] P = 0.77 P = 0.77








Methodologically excellent Limitations few **Overall** strong





High flow nasal oxygen

in acute hypoxaemic respiratory failure

High flow nasal oxygen Face mask oxygen **Non-Invasive Ventilation**

Inclusion

ICU Patient

Acute hypoxaemic respiratory failure



Design Multicentre Randomised **Controlled trial**





Standard Oxygen

Nonrebreather mask

O₂ ≥ 10 l/min

SpO₂ ≥ 92%

Standard Oxygen

FiO₂ 1.0 O₂ 50 I/min SpO₂ ≥ 92%

Duration ≥ 2 days

HFNO

HFNO

HFNO

Standard Oxygen

PS aiming Vt 7 -10 ml / kg PEEP 2 -10 cm H₂O FiO₂ adjusted SpO₂ \geq 92%

Sessions \geq 8 hours / day

Endpoints

Haemodynamic instability Neurological deterioration Ongoing respiratory failure















Standard Oxygen

13±5 l/min

48±11 l/min

FiO₂ 0.82±0.2

Standard Oxygen

13±5 l/min

8±3 / 5±1

48±11 l/min FiO₂ 0.82±0.2

Vt 9.2±3.0

FiO₂ 0.67±0.2

8 hours/day













HFNO

More comfortable

Better in P/F < 200




Critical Care Reviews Meeting 2016

Titanic Centre, Belfast

