



I-CCSN
INTENSIVE & CRITICAL CARE
SOCIETY OF NIGERIA

IN COLLABORATION WITH



World Federation of
Intensive and Critical Care

ABUJA '26

11th Scientific Conference & Annual General Meeting

THEME:
**SUSTAINABLE FINANCING FOR
INTENSIVE CARE UNITS (ICUs) IN
PUBLIC HEALTH FACILITIES**
CHALLENGES, OPPORTUNITIES AND SOLUTIONS

SUB THEMES

- DATA IN CRITICAL CARE
- SEPSIS IN NIGERIA FROM DIAGNOSTICS TO SURVIVAL
- MECHANICAL VENTILATION IN LOW RESOURCE SETTINGS



6TH TO 9TH
JULY 2026



TRANSCORP HILTON, ABUJA
AGUIYI IRONSI STREET, MAITAMA
ABUJA



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Programme Brochure



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National Anthem & Pledge

I

Nigeria, we hail thee,
Our own dear native land,
Though tribe and tongue may differ,
In brotherhood we stand
Nigerians all,
Are proud to serve our sovereign
Motherland.

II

Our flag shall be a symbol
That truth and justice reign,
In peace or battle honoured,
And this we count as gain,
To hand on to our children
A banner without stain.

III

O God of all creation,
Grant this our one request:
Help us to build a nation
Where no man is oppressed,
And so with peace and plenty
Nigeria may be blessed.

I pledge to Nigeria my country
To be faithful, loyal and honest
To serve Nigeria with all my strength
To defend her unity
And uphold her honour and glory
So help me God.

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SOCIETY OF NIGERIA



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ABUJA
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HIS EXCELLENCY
BOLA AHMED TINUBU GCFR
PRESIDENT, COMMANDER-IN-CHIEF OF THE ARMED FORCES
FEDERAL REPUBLIC OF NIGERIA

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MUHAMMAD ALI PATE CON
COORDINATING MINISTER OF HEALTH AND SOCIAL WELFARE
FEDERAL REPUBLIC OF NIGERIA
SPECIAL GUEST OF HONOUR



DR. IZIAQ ADEKUNLE SALAKO

HONOURABLE MINISTER OF STATE FOR HEALTH AND SOCIAL WELFARE
FEDERAL REPUBLIC OF NIGERIA
SPECIAL GUEST OF HONOUR



GEN. CHRISTOPHER GWABIN MUSA(RTD) OFR
HONOURABLE MINISTER OF DEFENCE
FEDERAL REPUBLIC OF NIGERIA
SPECIAL GUEST OF HONOUR

11th
**Scientific Conference &
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PROF. AFEKHIDE OMOTI
PRESIDENT
NIGERIAN MEDICAL ASSOCIATION
GUEST OF HONOUR



ALHAJI DR. MUHAMMADU SAMBO HARUNA
EMIR OF WASE
ROYAL FATHER OF THE DAY

11th
Scientific Conference &
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DR. MUHAMMAD RAJI
CHIEF MEDICAL DIRECTOR
NATIONAL HOSPITAL, ABUJA
HOST

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DR. OLALEKAN OLATISE
MEDICAL DIRECTOR
ZENITH MEDICAL AND KIDNEY CENTRE, ABUJA
CHAIRMAN OF THE OCCASION



DR. JOB ATOKWALA
PRESIDENT
INTENSIVE AND CRITICAL CARE SOCIETY OF NIGERIA
ICCSN

**11th
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World Federation of
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JAVIER PEREZ FERNANDEZ
PRESIDENT
WORLD FEDERATION OF INTENSIVE AND CRITICAL CARE

Executive Council



DR. IRENE AKHIDENO
VICE PRESIDENT



DR. JOB OTOKWALA
PRESIDENT



DR. PAUL UFOEGBUNAM
GENERAL SECRETARY



DR. ADERONKE O. OWOADE
TREASURER



DR. YETUNDE DARAMOLA
ASST. GENERAL SECRETARY



DR. ABIODUN OJEDOYIN
PUBLIC RELATIONS OFFICER



PROF. BABATUNDE OSINAIKE
EX-OFFICIO 1



DR. IFEANYI OKPARA.
TRAINEE REPRESENTATIVE

Local Organizing Committee



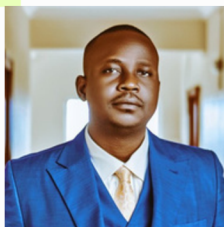
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CHAIRMAN
WELFARE AND ENTERTAINMENT
COMMITTEE



DR HARRISON NWOGU
LOC CHAIRMAN



DR NIKE OWODE
ASSISTANT CHAIR
WELFARE AND ENTERTAINMENT



DR OMONIYI FALANA
CHAIRMAN
PRE-CONFERENCE WORKSHOP
COMMITTEE



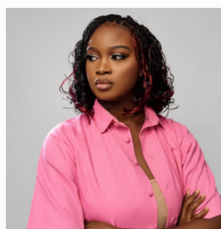
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DR CHIDIEBERE OCHEME
CHAIRMAN
CONFERENCE VENUE &
ACCOMMODATION COMMITTEE



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SCIENTIFIC COMMITTEE



DR FADILA MUAZU
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Intensive and Critical Care Society of Nigeria (I - C C S N)

PROGRAMME OF EVENTS

A PRECONFERENCE WORKSHOP

Venue: National Hospital Trauma Centre, Abuja

Dates: July 6 – 7, 2026

1. ACLS Course — AHA Instructors
2. Basics of Bedside Echocardiography for Rapid Cardiac Assessment for the ICU Physician
3. Hands-on Mechanical Ventilator Workshop — Alpha Specialties
4. Advancing ICU Care: Patient Monitoring & Digital Solutions in Critical Care — Dräger

B CONFERENCE

Venue: Transcorp Hilton Hotel, Abuja

CONFERENCE THEME

“Sustainable Financing for Intensive Care Units in Public Health Facilities: Challenges, Opportunities, and Solutions.”

DAY 1 — WEDNESDAY, JULY 08, 2026

PART I

TIME	EVENT	SPEAKER / CHAIRPERSON
07:30 – 08:30 AM	Arrival & Registration	LOC Secretariat
08:30 – 9:45 AM	Abstract Presentations	LOC
09:45 – 10:30 AM	Drug Presentation / Plenary Session I	9:45 – 10:00 am · Supreme Meditech 10:00 – 10:15 am · Nizamiye Hosp 10:15 – 10:30 am · Lagoon Hosp
10:30 – 11:15 AM	Short Video of Maj. Gen. (Prof.) Obashina Ogunbiyi Professor Obashina Ogunbiyi Annual Lecture — By Prof. Ezekiel Taiwo Adebayo <i>Topic: Oxygen as Lifeline — Building a Resilient Critical Care System in Nigeria</i>	
11:15 – 11:30 AM	Tea Break	
11:30 – 2:30 PM	Opening Ceremony	
2:30 – 3:00 PM	Exhibition and Lunch	
3:00 – 3:30 PM	Drug Presentation / Plenary Session II	3:00 – 3:15 pm · AEONMED 3:15 – 3:30 pm · Pfizer
3:30 – 4:30 PM	Keynote 1: Surviving Sepsis Campaign 2026 — Highlights <i>Prof. Craig Coopersmith (USA)</i>	

DAY 2 — THURSDAY, JULY 09, 2026

TIME	PRESENTATION	SPEAKER / CHAIRPERSON
08:00 – 9:50 AM	Abstract Presentations	
9:50 – 10:20 AM	Drug Presentation / Plenary Session III	9:50 – 10:05 am · Evercare 10:05 – 10:20 am · Limi Hosp
10:20 – 11:00 AM	Keynote 2: Applied Physiology and Mechanical Ventilation <i>Prof. Lluís Blanch, PhD (Spain)</i>	

11:00 – 12:00 PM	Panel Discussion: Financing Intensive Care Units in Nigerian Public Hospitals <i>(feasible models)</i>	Discussants: • Prof. B.B. Osinaike • Prof. Afekhide Ernest Omoti (NMA President) • Dr. A.A. Sanusi • Brig. Gen. O. Adole • Dr. Zakari Usman • Dr. Yakubu Agada-Amade (NHIA)
12:00 – 12:15 PM	Questions and Answers	Speakers
12:15 – 12:30 PM	Drug Presentation / Plenary Session IV	12:15 – 12:30 pm · Draeger
12:30 – 12:50 PM	Tea Break / Group Photograph	All Participants
12:50 – 1:20 PM	Drug Presentation / Plenary Session V	12:50 – 1:05 pm · AMCE 1:05 – 1:20 pm · CHMS-Mindray
1:20 – 2:00 PM	Keynote 3: ICU Data for Quality Improvement <i>Prof. Fathima Paruk</i>	
2:00 PM	Annual General Meeting	EXCO

OPENING CEREMONY

TIME: 11:30 AM – 2:30 PM

11:00 – 11:30 am	Arrival of participants and guests
11:30 – 11:45 am	Constitution of High Table
11:45 – 11:50 am	National Anthem
11:50 – 11:55 am	Opening Prayers
11:55 – 12:00 pm	Welcome Address by LOC Chairman <i>Dr. Harrison Nwogu</i>
12:00 – 12:10 pm	Address by I-CCSN President <i>Dr. Job Otokwala</i>
12:10 – 12:20 pm	Address by WFICC President <i>Prof. Javier Perez-Fernandez (USA)</i>
12:20 – 12:30 pm	Opening Remarks by Chairman of the Occasion <i>Dr. Olalekan Olatise (CMD, Zenith Medical & Kidney Centre)</i>
12:30 – 1:00 pm	Goodwill Messages Representatives of FMOH, National Assembly, Nigerian Medical Association, Institutional Host, Nigerian Society of Anaesthetists, Society of Obstetric Anaesthetists of Nigeria, Paediatric Anaesthetists Society of Nigeria, and Society of Specialists in Airway Management.
1:00 – 1:40 pm	Keynote Address: Sustainable Financing for Intensive Care in Public Hospitals in Nigeria <i>Prof. Daprim Ogaji, PhD, FWACP</i>
1:40 – 2:10 pm	Awards and Investiture / Launching of ICU Guidelines <i>Prof. B.B. Osinaike</i>
2:10 – 2:15 pm	Vote of Thanks
2:15 – 2:20 pm	National Anthem
2:20 – 2:30 pm	Group Photographs
2:30 – 3:00 pm	Tour of Exhibition Stands

LOC Chair's Welcome Address

Your Excellency, the Honourable Minister of State for Health and Social Welfare, Dr. Izaq Adekunle Salako;
Your Royal Highness, Alhaji (Dr.) Muhammadu Sambo Haruna – The Emir of Wase;
The President, Nigerian Medical Association (NMA), Professor Afekhide Ernest Omoti;
Professor Alhassan Datti Mohammed – President, Nigerian Society of Anaesthetists;
The President, Intensive and Critical Care Society of Nigeria;
The Chairman of the Occasion and Medical Director, Zenith Medical and Kidney Centre, Abuja – Dr. Olalekan Olatise;
The Chief Medical Directors present;
Distinguished Guests, Esteemed Colleagues, Ladies and Gentlemen.

Good morning,

It gives me great pleasure to welcome you to the 11th Intensive and Critical Care Society of Nigeria Conference and AGM meeting, taking place at the Transcorp Hilton Abuja from July 6–9, 2026.

Our theme this year— “Sustainable Financing for Intensive Care Units in Public Health Facilities: Challenges, Opportunities, and Solutions.” could not be more timely nor more urgent in Nigerian healthcare today.

Across Nigeria, critically ill patients—whether from accidents, childbirth complications, infections, or surgical emergencies—desperately need access to well-functioning ICUs. Yet the truth is sobering: many public hospitals either lack ICUs entirely or operate units that are poorly funded, understaffed, and lacking essential equipment. Ventilators sit broken due to neglected maintenance. Skilled personnel are in short supply. Essential supplies run out. And the expense of modern critical care far exceeds what public facilities receive.

This gathering is more than an academic discussion—it is a summons to act. We have brought together leading voices in intensive care, anaesthesia, health administrators, and policy makers to develop workable, lasting solutions to the ICU financing gap. Over the coming days, we will identify the underlying reasons for chronic ICU underfunding, examine creative funding approaches such as public-private partnerships, insurance integration, diaspora investment, and blended finance, learn from military hospitals, private providers, and global exemplars, and formulate concrete policy proposals for the Federal Ministry of Health and other decision-makers. For this, we have carefully selected distinguished speakers and resource persons to challenge and inspire us.

We are proud to debut the Professor Obashina Ayodele Ogunbiyi (Maj. Gen. Rtd) Lecture Series at this conference, featuring keynote speaker Prof. Ezekiel Taiwo Adebayo. A towering figure in our discipline—soldier, innovator, and teacher—Professor Ogunbiyi's legacy of commitment and excellence inspires our work. Launching this series in his name aligns perfectly with our mission.

LOC Chair's Welcome Address

As the Local Organizing Committee, our heartfelt thanks go to our sponsors and collaborators, the National executive committee of the Intensive and Critical Care Society of Nigeria, and to all contributors who made this event possible. Special recognition goes to Conference Chairman Dr. Olalekan Olatise for his indispensable leadership. We are also deeply honored by the presence of the President NMA, whose attendance highlights the essential need to uplift healthcare in all sectors. As the LOC Chairman I congratulate my team who have worked diligently to ensure a seamless and rewarding experience.

As we engage in these discussions, let us keep in mind that the frameworks and decisions emerging from this conference can save innumerable lives. Let us collaborate across professions and industries taking advantage of the exhibitions and networking opportunities to create a Nigeria where quality intensive care is available to every citizen, regardless of geography or means.

**Thank you for joining this landmark occasion. I wish you a fruitful and energizing conference.
Welcome to Abuja 2026.**

Dr. Harrison Nwogu FMCA

President' Address

PROTOCOL

The Honourable Coordinating Minister of Health and Social Welfare, ably represented;
The President of the Nigerian Medical Association;
Chief Medical Directors and Medical Directors;
Past Presidents and Members of the Board of Trustees of the Intensive and Critical Care Society of Nigeria;
Our Distinguished International Faculty and Development Partners;
Representatives of Professional Associations;
Distinguished Consultants, Intensivists, Physicians, Anaesthesiologists, Surgeons, Nurses, Pharmacists, Physiotherapists, Residents and Allied Health Professionals;
Members of the Press;
Distinguished Ladies and Gentlemen.
Good morning.

It is with profound gratitude to Almighty God and a deep sense of humility that I welcome you all to the **11th Scientific Conference and Annual General Meeting of the Intensive and Critical Care Society of Nigeria (I-CCSN)**. It is both an honour and a privilege to stand before you today as President of this great Society. I warmly welcome our distinguished guests, international faculty, policymakers, development partners, sponsors, exhibitors and delegates who have travelled from different parts of Nigeria and beyond to participate in this important scientific gathering. Your presence underscores our shared commitment to advancing intensive and critical care medicine in Nigeria.

Before I proceed further, permit me to recognise an individual whose commitment and perseverance have been instrumental in making this conference a reality. We are gathered here today because one man refused to allow this vision to fade. At a time when organising a national scientific conference has become increasingly challenging due to prevailing economic realities, he consistently convened weekly and, at times, fortnightly planning meetings, coordinated committees, encouraged members, mobilised resources and ensured that preparations continued uninterrupted. What makes this even more remarkable is that he is not an intensivist but a distinguished nephrologist. Yet he embraced anaesthesiologists, intensivists, physicians, surgeons, nurses and every member of the multidisciplinary critical care team as his professional family. His selfless leadership reminds us that critical care transcends specialities because critical illness concerns us all. May I therefore respectfully request a resounding round of applause for the Chairman of our Local Organising Committee, **Dr Olatise**, whose dedication, sacrifice and unwavering commitment have made this conference possible. Dr Olatise, on behalf of the Intensive and Critical Care Society of Nigeria, we sincerely thank you.

Today also provides us with the opportunity to honour one of the finest icons of intensive and critical care medicine in Nigeria. We celebrate a former World Council Member of the World Federation of Intensive and Critical Care, a former President of this great Society, a former Commandant of the Nigerian Army Medical Corps, an accomplished Anaesthetist and Intensivist, an exceptional researcher, a master strategist and an outstanding leader whose appreciation of cultural diversity continues to inspire healthcare professionals across generations. We are privileged to celebrate **Major General Professor Obashina Ogunbiyi, mni**, whose remarkable contributions to neurocritical care, intensive care medicine, leadership and medical education have left an enduring legacy both within Nigeria and internationally. Professor, on behalf of the Executive Committee and the entire membership of the Intensive and Critical Care Society of Nigeria, we thank you for your exemplary service, mentorship and visionary leadership. Ladies and gentlemen, please join me in celebrating Professor Obashina Ogunbiyi, MNI.

President' Address

Distinguished colleagues, our conference theme, **"Sustainable Financing for Intensive Care in Public Hospitals in Nigeria,"** is much more than the title of a scientific meeting. It is the collective voice of every intensivist, anaesthesiologist, physician, surgeon, nurse and healthcare professional who has stood helplessly beside a critically ill patient, knowing exactly what should be done medically, yet being unable to proceed because the resources required to save that life were unavailable. This theme arose from our daily experiences within Nigerian public hospitals and from extensive discussions with colleagues across the world regarding how critical care services are financed and sustained.

Recently, I had the privilege of engaging colleagues in the United Kingdom and several other developed countries on the financing and delivery of intensive care services. One observation became immediately apparent. Even in countries with significantly stronger economies and substantially larger healthcare budgets, critical care services remain under considerable pressure. Their healthcare systems generally operate a two-tier structure comprising government-funded hospitals alongside private healthcare institutions. Yet public hospitals continue to struggle with inadequate funding, increasing patient demand, workforce shortages and limited critical care capacity. If these challenges persist in high-income countries, then the magnitude of the difficulties confronting low- and middle-income countries such as Nigeria is understandably much greater. Universal access to quality intensive care, therefore, remains more an aspiration than a reality for millions of people.

However, this reality should never discourage us. Rather, it should strengthen our resolve to advocate for meaningful and lasting change. We must continue engaging governments, policymakers, legislators and development partners to recognise that investment in intensive care is not a luxury but an essential component of every resilient healthcare system. Critical illness does not discriminate. It affects the rich and the poor, the young and the old, public servants and private citizens alike. When critical illness strikes, the only question that matters is whether timely, safe and effective intensive care is available.

Permit me to illustrate why this conversation is so urgent. Imagine a 25-year-old woman admitted to the Intensive Care Unit following a ruptured uterus complicated by overwhelming septic shock. She has survived emergency surgery but now requires blood transfusion, broad-spectrum antibiotics, laboratory investigations, vasopressor support, mechanical ventilation and continuous organ support. Her husband arrives exhausted and emotionally overwhelmed. He has no money. He cannot even afford food for himself. He cannot purchase blood. He cannot pay for laboratory investigations. He cannot buy the prescribed antibiotics. He cannot procure the most basic consumables, including personal protective equipment required for her care. The vasopressors required to sustain her blood pressure are purchased in aliquots because neither the patient nor the hospital can afford continuous therapy.

As healthcare professionals, we begin making frantic telephone calls. We seek assistance from colleagues, hospital management, philanthropists and charitable organisations while simultaneously processing applications for financial waivers. In many public intensive care units—including ours in Port Harcourt—more than sixty per cent of critically ill patients eventually depend on official waivers before they can settle their hospital bills. Distinguished ladies and gentlemen, I ask you: **How sustainable is this model?** Can a nation truly build a resilient intensive care system upon emergency waivers, personal sacrifices and the goodwill of healthcare workers? Should access to life-saving critical care depend on the size of one's bank account? Has healthcare become a privilege reserved for the wealthy while becoming a burden for the poor? These are not hypothetical questions. They represent the painful realities confronting our intensive care units every single day.

President' Address

An intensive care unit is far more than a collection of beds. It is uninterrupted oxygen supply, mechanical ventilation, multiparameter monitoring, infusion technology, dialysis support, imaging services, laboratory diagnostics, essential medicines, biomedical engineering support and highly trained multidisciplinary professionals working continuously to preserve life. None of these can be sustained through goodwill alone. Across Nigeria, our public intensive care units continue to receive increasing numbers of patients with severe trauma, obstetric emergencies, stroke, sepsis, poisoning, burns and complicated postoperative conditions. Yet the financial resources required to sustain these services have failed to keep pace with this increasing demand. We cannot continue expecting first-world outcomes while providing third-world resources.

This conference therefore challenges us to move beyond merely describing the problem and begin designing practical, evidence-based solutions. How do we diversify financing beyond annual government appropriations? How do we strengthen the National Health Insurance Authority to provide realistic reimbursement for intensive care? How do we establish effective public-private partnerships without compromising equitable access? How do we demonstrate that investment in intensive care saves lives, reduces disability, shortens hospital stay and ultimately lowers national healthcare expenditure? Most importantly, how do we ensure accountability so that every naira invested in critical care translates into measurable improvements in patient outcomes?

As a Society, we remain committed to providing leadership in answering these questions. We shall continue advocating for national standards in intensive care practice, strengthening workforce development, expanding educational programmes for doctors, nurses and allied health professionals, supporting research and engaging government and development partners in developing sustainable policies for critical care financing. Our responsibility extends beyond clinical excellence; we are advocates for every critically ill Nigerian.

While advocating for sustainable financing, we must also acknowledge an equally important truth: **the most cost-effective intensive care bed is the one that is never occupied.** The future of healthcare in low- and middle-income countries will not depend solely on building more intensive care units. It will equally depend on investing in preventive medicine, robust primary healthcare systems, maternal and child health services, vaccination programmes, road safety, environmental sanitation, health education and early disease detection. Every road traffic accident prevented, every stroke avoided through effective hypertension control, every child protected through immunisation, and every septic patient treated before progressing to multiple organ failure represents countless lives saved and enormous financial savings for families and government alike. Critical care is essential, but prevention remains indispensable.

As we deliberate over the next two days, let this conference become more than another scientific meeting. Let it become the platform where we develop bold, practical and sustainable solutions capable of transforming intensive care financing in Nigeria. Let history remember this conference as the gathering where we moved beyond describing the challenges to implementing realistic strategies that ensure no Nigerian is denied life-saving intensive care because of inability to pay.

To Government, we respectfully appeal for dedicated and protected funding for public intensive care services. To hospital management, we encourage strategic investment in infrastructure, equipment maintenance, workforce retention and clinical governance. To development partners and industry, we seek enduring partnerships that support research, innovation, education and sustainable capacity development. To every member of this Society, I encourage us to continue generating high-quality Nigerian evidence because data remains our strongest voice at every policy table.

President' Address

Finally, I express my profound appreciation to the Scientific Committee, the Local Organising Committee, our invited faculty, sponsors, exhibitors, development partners and every member of the Intensive and Critical Care Society of Nigeria whose dedication, sacrifice and commitment have made this conference possible.

It is now my singular honour and privilege to declare the **11th Scientific Conference and Annual General Meeting of the Intensive and Critical Care Society of Nigeria** officially open.

Thank you for your attention.

God bless the Intensive and Critical Care Society of Nigeria.

God bless the Federal Republic of Nigeria.

Dr Job Gogo Otokwala, MBBS, DA, FWACS, Fellowship in Intensive Care Medicine (CMC, Vellore), BLS, ACLS

President

Intensive and Critical Care Society of Nigeria (I-CCSN)

Secretariat Report

Presented at the Annual General Meeting (AGM) and Scientific Conference of the Intensive and Critical Care Society of Nigeria (I-CCSN) held from the 8th to 9th of July, 2026 in FCT Abuja

Introduction

Honorable colleagues, I am delighted to present the secretariat report for the period 2025- 2026. In this report we are going to explain the major administrative activities, communications, collaborations, and institutional supportive activities embarked upon since our last AGM held in Enugu in 2025.

It is important for us to remember that I-CCSN is registered as a non-profit, non-governmental association whose membership cut across Intensive Care Physicians, Anesthetists, and other doctors with interest in intensive Care Medicine. I-CCSN is registered with the world Federation of Intensive Care (WFICC) and affiliated to Nigerian Society of Anesthetist (NSA)

Let me remind us that I-CCSN has four main aims and objectives namely

1. Coordinating and promoting different fields of intensive care medicine
2. Provide recommendations and guidelines for improving critical care in Nigeria
3. Roster education and research in the field of intensive care
4. Organize national and international congresses and meetings

Present executive members were elected for a 2 year tenure (2025-2027) during Enugu AGM in July 2025.

The executive Committee members are as follows:

President:	Dr Job Gogo Otokwala
Vice President:	Dr Irene Akhiden
General Secretary:	Dr Paul Maduabuchi Ufoegbunam
Assistant Gen Secretary:	Dr Yetunde Daramola
Treasurer:	Dr Owoade Aderonke
PRO:	Dr Ojedoyin Olaboisi Abiodun
Trainee Representative:	Dr Ifeanyi Okpara
Ex-Officio 1:	Prof Babatunde Osinaike

First exco meeting after the AGM Enugu, 2026 was held on Wednesday 16th July 2025 and the meeting set agenda for the 2025-2027 exco.

Secretariat Report

The following are the core of the agenda we set for the association

1. Need to increase the visibility of the association through advocacy visits to federal ministry of Health (FMOH), NDDC, NPMCN
2. Collaboration with Critical Care societies and similar associations namely Indian Society of Critical care, ESICM, SCCM, ESAAC, Dubai Emirates Critical care society, Pan African Cardiac Society
3. Increasing social media presence
4. Holding of Regular Webinars
5. Expanding ICU Registry
6. Producing critical advocacy documents/ guidelines like ICU Categorization/ Stratification guideline, ICU book of protocols, Publication of Brain Death guideline

The communique of I-CCSN 2025 AGM was published in guardian newspaper of 14th July 2025 and the abstracts of Enugu 2025 AGM was published on our website on 3rd August 2025. The report of our 10th I-CCSN conference held in Enugu in July 2025 was finally submitted on 7th September, 2025

Online Visibility and communication

I-CCSN Youtube channel namely <https://www.youtube.com/@I-CCSN> was opened on 24th July 2025 and LinkedIn page namely <https://www.linkedin.com/groups/15821029> was opened on 19th October, 2025.

Regular updates and notices were disseminated via WhatsApp platforms, and the Society website (www.iccsnnigeria.org)

We were able to support communication with members and improved responds time to inquiries. Celebrations of birthdays and Joyful occasions of members were done regularly.

I-CCSN recommended the following members for Merck foundation Scholarship namely Dr Imadiyi Best Isaac, Dr Okonkwo Thankgod, Dr Amaka Ezenwabachili

Executive Meetings and activities

The I-CCSN executive committee has held a total of 6 meetings and on 26th August 2025, the LOC of Abuja 2026 was formed with Dr Harrison Nwogu nominated as chairman. On Monday 8th September, 2025, I-CCSN Exco had a meet and greet session with resident Doctors who were ably led during the interaction by Dr Ifeanyi Opara (I-CCSN trainee rep) and NSA trainee rep.

Committee on ICU categorization was formed on 25th November 2025 with the following members Dr Ken Adegoke, chairman, Dr Ufoegbunam Paul, Dr Owoade Aderonke, Dr Fummi Akindele, Dr Mangai, Dr Abimbola Akindolire and Prof Datti Ahmed. The committee submitted their report to the exco on 9th May, 2026

Secretariat Report

Education and Training

I-CCSN bi-monthly webinar has been held consistently from 24th August 2025 with AKI in the ICU presented by Dr Obiora Udezor, Fluid Management in Septic Shock on Sunday 28th September by Prof. Olfa. How to navigate stormy seas to fluid stewardship in critically ill on Sunday 19th October 2025 by Prof Manu Malbrain. Ethic, Policy and Art of withholding and withdrawing of life support on Sunday 26th October, 2025 by Prof. Alison Fox-Robichaud. Transport of Critically ill on Sunday 15th February, 2026 by Dr Victor Ayanwale Raji. Intracerebral bleed and current management concept presented on 19th April 2026 by Prof. Benjamin Anyanwu. RRT in ICU on Sunday 24th May, 2026 presented by Dr Kanwal Preet Sodhi from India and finally Quality improvement in the ICU on Sunday 14th June, 2026 and presented by Dr Rasaq Badamosi. We have had a total of eight topics so far. After the last presentation, collaboration on ICU quality improvement was initiated with Dr Rasaq Badamosi.

We are happy to witness the renewed vigor from the new members of education committee appointed on 22nd October 2025 ably led by our Vice President Dr Irene Akhiden, other members are Dr Affiong Elumelu, Dr Obiora Udezor, Dr Ojedoyin Abiodun, Dr Daramola Yetunde, Dr Ifeanyi Opara.

3rd Neurocritical Care workshop:

A new protocol for holding the neurocritical care workshop was approved by the Society and the hosting right was given to Regions Hospital Owerri. Focus areas were Neuromuscular & Neurodegenerative disorders in the ICU: Multidisciplinary critical care, Neurological examination of ICU neuromuscular patient, EMG & nerve conduction interpretation, Physiotherapy and postural drainage technique, Percutaneous Tracheostomy demonstration and ventilator weaning techniques. However, the workshop was cancelled at the last minute by the society because of poor preparation by the LOC. We have taken measures to ensure that such will never happen again.

Conferences

I-CCSN attended the 17th WFICC congress in Vancouver Canada. Twelve (12) of our members attended, 10 papers were presented from our members with Prof Saidu Yakubu chairing a session. The following were our gains from the congress, world President promised to attend our 2026 AGM in Abuja, Regional block was created for Africa chaired currently by South Africa and SCCM stepped down their membership fees to \$140 for I-CCSN members but Nigeria lost the bid for council membership.

We celebrated world sepsis day on 13th September 2025 with a radio programme anchored by our President on Rhythm 93.7FM Abuja.

I-CCSN signed a dual membership agreement with ESICM with benefit of reduced membership fee of 90 euro instead of 120 euro and access to all educational programs of ESICM. I-CCSN endorsed Dubai Emirates critical care society 2026 conference and ESAAC (Egyptain Society of Anasthesia and acute care) with benefits to I-CCSN. I-CCSN endorsed the WFSA declaration on patients' rights to essential emergency and critical care on 17th March, 2026.

A committee to look for patrons for I-CCSN was discussed by exco with the following persons nominated Maj Gen, Obashina Ogunbiyi Chairman, Prof Saidu Yakubu, Dr Irene Akhiden, Dr Paul Ufoegbunam, Dr Owoade Aderonke

Secretariat Report

Membership and records

Our Membership has grown from 298 to 312, with breakdown as follows

Full Members: 189
Trainee Members: 90
Diaspora Members: 33

We had our Ordinary General meeting virtually on Tuesday 19th May, 2026.

Financial Oversight in collaboration with the Treasurer)

The secretariat worked closely with the Treasurer to monitor membership dues and conference payments. Receipts and acknowledgements were issued to ensure transparency and accountability.

Nigerian Critical Care Registry:

The Society has decided to publish the result of the pilot study currently on going in 2 locations and expand the project to include all the ICUS in Nigeria.

Nigerian Journal of Critical Care;

The 3-man committee appointed and inaugurated by the last exco are yet to submit their report to the current exco.

Fund Raising:

The Society instituted the Annual Prof. Maj. Gen Obashina Ogunbiyi Lagacy lecture to commence during the Abuja AGM in July, 2026 in honor of our past president for his exemplary role in advancing critical care in Nigeria.

The Society approved Prof. Benjamin Anyanwu Prize with an endowment of seventeen million (17 million naira). It was made in recognition of his contribution to neuro critical care in Nigeria. The prize is to be awarded annually to a public hospital ICU with the best standard in neuro intensive care services.

Challenges:

We are yet to start work on the ICU book of protocols to be used in Nigeria. We care yet to make meaningful progress in starting the Nigerian journal of critical care.

We have not been able to expand our revenue source beyond annual dues and income from AGM and workshops

Conclusion:

We are committed to continuing to provide robust secretarial support to the society in its daily operations. We want to appreciate the support and guidance of our outgoing president, current president and members of the executives in guiding me and the secretariat. We appreciate the cooperation of our honorable members especially my able assistant General secretary Dr Yetunde Daramola.

It is my pleasure to welcome everyone to the 11th Scientific Conference and AGM in FCT Abuja with the scenic beauty, tranquility and hospitality, which gives us great opportunity for networking, knowledge acquisition and tourism.

We are all set and poised for renewed hope, continued growth and advancement of critical Care medicine in our country.

Thank you for listening and long live I-CCSN

Signed

Dr Paul Ufoegbunam
General Secretary
Intensive and Critical Care Society of Nigeria (I-CCSN)

Discussants



PROF. B.B. OSINAIKE



PROF. AFEKHIDE OMOTI
NMA PRESIDENT



ASSOC. PROF. ARINOLA ADEYOOLA SANUSI



BRIG. GEN O. ADOLE



DR ZAKARI USMAN
SENIOR TECHNICAL ADVISOR
TO KOGI STATE GOVERNOR
ON HEALTH SYSTEMS STRENGTHENING
AND PHC.



DR YAKUBU AGADA-AMADE
DIRECTOR, STRATEGIC PURCHASING,
NHIA



Meet

Prof. Daprim Samuel Tamuno-Ojuemi Ogaji,

MBBS, MHQI, MBA, PhD (Manchester),
MNIM, MWACP, FMCPH, FISQua

Keynote Speaker

Topic:
Sustainable financing in intensive care units in
public hospitals

Professor Daprim Samuel Tamuno-Ojuemi Ogaji is a distinguished Professor of Health Systems and Public Health and Director of the Africa Centre of Excellence in Public Health and Toxicological Research (ACE-PUTOR), University of Port Harcourt, Nigeria.

He previously served as Head of the Department of Community Medicine at the University of Port Harcourt Teaching Hospital and Head of the Department of Preventive and Social Medicine at the University of Port Harcourt.

An internationally respected scholar, educator, and health systems expert, Professor Ogaji's research focuses on healthcare quality improvement, health systems strengthening, healthcare financing, access to care, health equity, patient experience, human resources for health, and the management of long-term conditions. His methodological expertise spans quantitative research, evidence synthesis, psychometrics, programme evaluation, field trials, and implementation research. With more than two decades of experience in medical and public health education, he has played a pivotal role in developing health workforce capacity across Africa. He has led the establishment of sixteen nationally and internationally accredited postgraduate programmes and spearheaded the creation of the University of Port Harcourt School of Public Health and the World Bank-funded Africa Centre of Excellence in Public Health and Toxicological Research (ACE-PUTOR), both recognised as leading centres for advanced public health training and research in Africa.

Professor Ogaji serves on several strategic academic and governance bodies, including the Senate of the University of Port Harcourt, the Board of the School of Graduate Studies, and the Board of the Centre for Medical Research and Training. He has supervised more than 100 Master's dissertations and over 30 doctoral theses, while authoring over 120 peer-reviewed scientific publications in national and international journals.

He is the Editor-in-Chief of the Nigerian Health Journal and serves on the editorial boards and review panels of several prestigious international journals, including Patient Experience Journal, BMJ Open, BMC Health Services Research, Primary Health Care Research & Development, and numerous other scholarly publications. He is also an accredited healthcare quality surveyor and reviewer for international public health accreditation bodies.

Professor Ogaji has successfully secured and managed several highly competitive research grants and international collaborations, including the World Bank African Centres of Excellence Impact Project, Wellcome Trust-funded initiatives, the French Development Agency (AFD) research networks, and the European Union-supported Intra-Africa Academic Mobility Programme. His leadership has attracted millions of dollars in research and capacity-building funding to Nigeria and the African region.

Beyond academia, Professor Ogaji has held several notable leadership and public service positions, including Vice President of the National Association of Resident Doctors of Nigeria, Chief Physician to the Governor of Bayelsa State, National Technical Officer for the Millennium Development Goals (MDGs) Conditional Grants Scheme, and consultant to numerous national and international health organisations.

A passionate advocate for universal health coverage, quality healthcare, and health systems transformation, Professor Ogaji continues to influence policy, research, education, and practice across Africa and beyond through his commitment to excellence, innovation, and evidence-informed decision-making.



Meet

Prof. Ezekiel Taiwo Adebayo

BDS, FWACS, MPH

Inaugural Lecturer

Topic:
Professor Obashina Ogunbiyi Mni
Lecture

Professor Ezekiel Taiwo Adebayo is a distinguished Oral and Maxillofacial Surgeon, academic leader, public health specialist, and researcher with over three decades of professional experience in dental and surgical practice. He obtained his Bachelor of Dental Surgery (BDS) degree from the University of Benin, Nigeria, and subsequently completed specialist training in Oral and Maxillofacial Surgery at the Ahmadu Bello University Teaching Hospital, where he earned the prestigious Fellowship of the West African College of Surgeons (FWACS). He also holds a Master of Public Health (MPH) degree from Ahmadu Bello University, Zaria.

With more than 30 years of clinical and academic experience, including over 23 years as a consultant Oral and Maxillofacial Surgeon, Professor Adebayo has established himself as a leading authority in oral healthcare, maxillofacial surgery, trauma management, and public health. His research contributions span a wide range of healthcare issues, including oral and maxillofacial trauma, facial tumour management, obesity among military personnel, rational use of medicines, and broader public health challenges affecting Nigerians.

Professor Adebayo has authored and co-authored over 80 peer-reviewed scientific publications in reputable national and international journals. His scholarly work has significantly contributed to advancing knowledge and improving clinical practice in oral and maxillofacial surgery and public health. He has also presented scientific papers and keynote lectures at more than twenty national, regional, and international conferences, earning recognition for his expertise and contributions to healthcare research and education.

In recognition of his academic excellence and leadership, he was promoted to the rank of Reader in 2019 and attained the rank of Professor in 2022. Since 2021, he has served as Acting Dean of the Faculty of Dental Sciences at the University of Medical Sciences (UNIMED), Ondo, where he has played a pivotal role in strengthening dental education, research, and institutional development.

In 2024, Professor Adebayo was appointed Deputy Chairman of the Medical Advisory Committee (Dental) of the University of Medical Sciences Teaching Hospital, Ondo. The same year, he was elected Chairman of the Committee of Deans of the University, appointed Editor-in-Chief of the Annals of Health and Allied Sciences (the official journal of UNIMED), and named Chairman of the Senate Business Committee, reflecting the confidence reposed in his leadership and administrative capabilities.

A respected educator, mentor, clinician, and scholar, Professor Adebayo has dedicated his career to advancing oral healthcare, training future generations of health professionals, and promoting excellence in academic medicine. In January 2025, he delivered the 7th Inaugural Lecture of the University of Medical Sciences, Ondo, titled **"Man and His Oral Health: Exploits of a Maxillofacial Surgeon,"** a lecture that highlighted his lifelong commitment to improving oral health outcomes and advancing the practice of maxillofacial surgery in Nigeria and beyond.

Professor Adebayo remains an influential voice in oral and maxillofacial surgery, public health, healthcare leadership, and medical education, with an enduring legacy of service, scholarship, and professional excellence.



Meet

Craig Coopersmith

USA

Speaker

Topic:
Surviving sepsis campaign 2026:
Highlights

Professor Craig M. Coopersmith is one of the world's leading authorities in sepsis, shock, and surgical critical care. He serves as Director of the Emory Critical Care Center, Vice Chair for Research in the Department of Surgery, and Professor of Surgery at the Emory University School of Medicine in Atlanta, Georgia, USA. He also directs the Surgical Critical Care Fellowship and has played a pivotal role in shaping modern critical care practice in the United States.

His scientific work has transformed the understanding of sepsis pathophysiology, particularly the interaction between the gastrointestinal tract, immune dysfunction, and multiple organ failure. Widely recognised as one of the foremost investigators in sepsis and septic shock

Professor Coopersmith has authored more than 450 peer-reviewed publications and accumulated over 63,000 citations, making him one of the most influential researchers in critical care medicine globally.

Professor Coopersmith was President of the Society of Critical Care Medicine (SCCM) and has contributed extensively to international critical care guidelines. He was a key contributor to the Sepsis-3 definitions and the Surviving Sepsis Campaign, which remain foundational references for clinicians managing critically ill patients worldwide.

During the COVID-19 pandemic, he served on national guideline committees and provided expert advice on critical care preparedness and management.

His numerous honours include election to prestigious scientific organisations and recognition for excellence in research, education, and clinical leadership. Through his mentorship of young investigators and clinicians, Professor Coopersmith continues to shape the future of critical care medicine internationally.



Meet

Lluís Blanch

Spain

Speaker

Topic:
Applied Physiology and
Mechanical Ventilation

Professor Lluís Blanch, MD, PhD, is an internationally acclaimed intensivist, biomedical innovator, and researcher based in Barcelona, Spain. He serves as Senior Consultant in Critical Care Medicine at Parc Tauli University Hospital, Director of Research and Innovation at the Corporació Sanitària Parc Tauli, and Associate Professor at the University of Barcelona. He also coordinates ITEMAS, Spain's national healthcare innovation platform under the Carlos III Health Institute.

Professor Blanch is globally recognised for pioneering work in mechanical ventilation, respiratory physiology, patient-ventilator interaction, and the application of artificial intelligence in critical care medicine. His research has significantly advanced the understanding of respiratory failure and the optimisation of ventilatory support in critically ill patients.

An accomplished scientist, he has authored more than 350 scientific publications and accumulated over 12,000 citations. His work has received international recognition for bridging clinical medicine, biomedical engineering, and digital health technologies. He is also an inventor, holding patents related to monitoring systems that improve patient safety and ventilator management.

Beyond academia, Professor Blanch has held several influential leadership positions, including President of the Spanish Society of Intensive Care Medicine and President of the Catalan Critical Care Society. In 2025, he was elected Corresponding Member of the Royal Academy of Medicine of Catalonia in recognition of his outstanding contributions to medical science and innovation.

His career exemplifies the integration of clinical excellence, technological innovation, and translational research, making him one of Europe's most respected leaders in intensive care medicine.



Meet

Fathima Paruk

South Africa

Speaker

Topic:
Data and Quality Improvement
in ICUs

Professor Fathima Paruk is one of Africa's most distinguished critical care physicians and a prominent advocate for the advancement of intensive care medicine across low- and middle-income countries. She is Full Professor and Clinical and Academic Head of the Department of Critical Care at Steve Biko Academic Hospital and the University of Pretoria, South Africa.

Professor Paruk made history as the first female President of the Critical Care Society of Southern Africa (CCSSA), a milestone that underscores her leadership and influence in African healthcare. Over the past two decades, she has played a major role in strengthening critical care education, training, and research throughout the continent.

Her research interests encompass sepsis, antimicrobial stewardship, tele-intensive care, HIV-related critical illness, obstetric critical care, trauma, medical ethics, and post-ICU outcomes. She has contributed extensively to both regional and international research collaborations aimed at improving outcomes for critically ill patients in resource-limited settings.

Professor Paruk has delivered hundreds of invited lectures at major scientific conferences worldwide and has served in leadership positions within the World Federation of Societies of Intensive and Critical Care Medicine (WFSICCM). She currently serves as Treasurer of the Federation and remains an influential voice in global critical care policy, education, and research.

Her commitment to excellence, mentorship, and equitable healthcare delivery has earned her international respect as one of the leading female figures in contemporary critical care medicine.

ICCSN/26/01

Title: A Five-Year Review of Paediatric Admissions into Three Intensive Care Units at the National Hospital Abuja, Nigeria

Authors: Osazuwa M.O.¹, Agbawn D.A.¹, Abone S.C.²

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²Department of Anaesthesia, University Hospitals of Morecambe Bay, Cumbria, UK

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Abstract

Background: Critically ill paediatric patients are usually managed alongside adult patients in the intensive care unit in Nigeria, as there are very few dedicated paediatric Intensive Care Units (ICUs). This study reviewed the pattern and outcomes of paediatric admissions into ICUs in a Nigerian tertiary hospital.

Methods: A retrospective cross-sectional study of patients aged <18 years admitted into three ICUs in a tertiary hospital in Nigeria from January 2016 to December 2020. Data obtained from case files in the Records department and from ICU records were analysed.

Results: One hundred and sixty-one (out of 203) complete records were analysed. More than a third (38.5%) of children were >1-5 years old, 84 (52.2%) were male. The commonest indications for ICU admission were sepsis (14.9%) and respiratory insufficiency (13.7%). The most frequent admissions had a GCS of 3-8 (39.8%).

Length of stay in ICU was ≤ 24hrs for 55 (34.2%) patients, 1-7 days for 75 (46.6%), and > 1 month for 2 (1.2%) patients. 104 (64.6%) children were intubated, of which 55 (52.9%) were intubated for ≤ 24 hr. Ninety-two (57.1%) children were mechanically ventilated, of which 45 (48.9%) were ventilated for ≤ 24 hours.

Mortality was 5.6% in the Cardiac ICU compared to 46.8% and 42.1 % in the Main and Trauma ICUs respectively, $p < 0.001$. Medical cases (55.8%) and mixed medical and surgical cases (75%) had higher mortality than surgical (27.8%) and trauma cases (16.7%), $p = 0.004$.

Sixty-seven (41.6%) patients died. Mortality was highest in patients with GCS of <8 ($p < 0.001$), and patients who were mechanically ventilated ($p < 0.001$).

Conclusion: There is an increasing number of paediatric admissions into ICUs at the National Hospital Abuja, Nigeria, with 58% survival rate. Sepsis and respiratory insufficiency are leading indications for admission. Patients admitted in the cardiac ICU fare better. Mechanical ventilation, low GCS score, and medical cases are associated with higher mortality.

Keywords: Paediatric critical care, Intensive Care Unit, PICU, ICU admissions, outcomes

ICCSN/26/02

Title: Have patterns of admissions into the intensive care unit changed? Report from a tertiary hospital in Nigeria.

Affiliation: ¹Department of Anaesthesiology, Rivers State University Teaching Hospital, Port Harcourt.

Authors: Chisor-Wabali N¹, Opusunju M.B¹

Corresponding Author: Chisor-Wabali N, nkaogunka@gmail.com

Abstract

Background:

Intensive care units (ICUs) are vital for managing life-threatening conditions. In many developing countries, critical care delivery is constrained by bed and equipment shortages and insufficient skilled personnel, with admission patterns tilting towards non-communicable diseases. Mortality rates in African ICUs remain high, about 30% in Nigeria and 60% in Kenya. Characterising the local epidemiology of ICU admissions at the Rivers State University Teaching Hospitals (RSUTH) is essential to strengthening critical care delivery. This study assessed the mortality and pattern of ICU admission in RSUTH over 31 months.

Methods: A retrospective descriptive study. Secondary data were abstracted from the hospital register for all patients admitted to RSUTH's 8-bed mixed medical-surgical ICU from June 2023 through January 2026. Data analysis was done using SPSS

Results: A total of 367 patients were admitted within the period. A mean age of 47.9 ($\pm$ 19.8) years, with a male preponderance (52.6%). Neurological conditions accounted for the highest indication for ICU admission (34.9%), while renal conditions were the least (1.9%). Study found 42.5% of patients on admission were on invasive mechanical ventilation, while 41.1% had inotropic support. Duration of stay ranged from 1 hour to 32 days, with a mean of 6.5 ($\pm$ 5.3) days. While 49.3% of the patients were transferred from the ICU to other wards, 43.3% of the patients died while in the ICU.

Conclusion: Neurological conditions dominate ICU admissions at RSUTH, with a mortality of 43.3%, highlighting the need for enhanced critical care resources to reduce mortality in resource-limited settings.

Keywords: Intensive care unit, admissions, pattern and RSUTH.

ICCSN/26/03

Title: OUTCOME OF SEVERE PENETRATING TRAUMATIC BRAIN INJURY (TBI) IN THE INTENSIVE CARE UNIT OF UNIVERSITY OF NIGERIA TEACHING HOSPITAL (UNTH) ENUGU: A CASE REPORT

Affiliation: ¹Department of Anaesthesia/Intensive Care Unit, UNIVERSITY OF NIGERIA TEACHING HOSPITAL (UNTH) ENUGU

Authors: CO Iloabachie¹, FG Okonna¹, CJ Ejezie¹

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Case Report

Background

Traumatic brain injury (TBI) is a leading cause of mortality and morbidity worldwide. It is a disturbance of brain function caused by an external mechanical force, causing a spectrum of cranium-implicated pathologies. Classification of severity is typically based on the Glasgow Coma scale (GCS). Severe TBI is defined as a GCS of ≤ 8 with poor prognosis. TBI can also be classified based on the mechanism of injuries into penetrating or blunt injury.

Case Presentation

A 22-year-old male found around a 3-storey building impaled on a 16 mm rod through the cranium and right lower limb. Admitted with a GCS of 8, he had an emergency frontoparietal craniotomy, debridement and foreign body removal. Intraoperative findings included eviscerated brain tissues, a rusty rod lodged in the brain, comminuted skull fractures, a deep crater in the impaled fractured bone and a tense non-pulsatile brain.

In the ICU, he was mechanically ventilated and managed for neurosepsis due to high grade continuous fever on the 4th day of admission. Microscopy, culture and sensitivity samples were collected. Intraoperative antibiotics; IV Flagyl, Vancomycin and Ceftazidime were escalated to Dalacin C, Piperacillin, Tazobactam and Amikacin. He had re-exploration and abscess drainage with placement of External Ventricular Drain a week after admission. This followed worsening clinical state and CT findings of multiple pockets of Intracranial abscess collections along the foreign body tracts, communicating with the left lateral ventricle and obstructive hydrocephalus.

Percutaneous tracheostomy was done on the 14th day in the ICU, with documented clinical and laboratory evidence of MRSA which was managed by multi-specialty approach and resultant improvement. He was eventually discharged to the ward after 44 days of admission in ICU with GCS of 11T/15.

Conclusion

TBI management requires the multi-specialty approach to prevent mortality and limit its morbidity.

Keywords: Trauma, brain and injury.

ICCSN/26/04

Title: Multidisciplinary Intensive Care Management of Severe Malaria with Multiorgan Failure

Affiliation: ¹Intensive Care Unit, Nizamiye Hospital Abuja.

Authors: Husseini. H¹, Jaja UC¹, Mshelia N¹, Bashir S¹

Corresponding Author: Dikko Y. yusufdikko@gmail.com

Case Report

Background

Severe malaria is a major cause of critical illness and mortality in sub-Saharan Africa and may require intensive care.

Case Presentation

A 51-year-old woman was referred eight months ago with severe malaria, complicated by sepsis, altered consciousness, acute kidney injury, metabolic acidosis and jaundice. On presentation, she was unconscious with Glasgow Coma Scale of 8/15 (EO:2 VR:2 MR:4), pale, icteric, dehydrated, and hypoxic, requiring oxygen therapy. Initial evaluation showed evidence of systemic inflammatory response with multiorgan involvement.

Methods

Investigations included arterial blood gas analysis, microbiological cultures, brain MRI, thoracic CT, and abdominal ultrasonography. Intensive care management comprised mechanical ventilation, haemodialysis (six sessions), blood transfusions (five pints), broad-spectrum antibiotics, antifungal therapy, anticoagulation, and nutritional support.

Results

Laboratory findings showed elevated inflammatory markers, leucocytosis, severe anaemia, thrombocytopenia, metabolic acidosis, renal and hepatic dysfunction, elevated lactate dehydrogenase, hypoalbuminemia, and hyperbilirubinemia. Thoracic CT revealed diffuse ground-glass opacities with reticular changes and atelectatic bands. Cultures isolated *Klebsiella*, *Proteus*, *Enterobacter* species, and urinary yeast. The patient developed respiratory failure requiring intubation and ventilation. With comprehensive intensive care, renal replacement therapy, and targeted antimicrobials, there was progressive clinical and biochemical recovery. She regained full consciousness, was extubated, resumed oral feeding and discharged stable.

Conclusion

This case demonstrates that early recognition of deterioration, timely organ support and coordinated multidisciplinary critical care can yield favourable outcomes in severe malaria complicated by multiorgan failure.

Key words: Severe malaria, Multiorgan failure, ICU management, Multidisciplinary care.

Abstracts

ICCSN/26/05

Title: Pattern of Electrolyte Disturbances and Their Association with Length of Stay and Mortality Among Adult Intensive Care Unit Patients

Affiliation: ¹Department of Anaesthesia, College of Medicine, University of Ibadan, Ibadan, Nigeria

Authors: Olusola Idowu¹, Demilade Omoniyi², Mathias Orji¹, Kehinde Adebayo¹

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Abstract

Background: Electrolyte disturbances are common among critically ill patients and have been associated with adverse clinical outcomes. This study evaluated the patterns of electrolyte abnormalities among adult intensive care unit patients and their relationship to ICU length of stay and mortality.

Methods: A retrospective analytical study was conducted among adult patients admitted to the ICU. Demographic characteristics, primary diagnoses, electrolyte profiles at admission, and clinical outcomes were reviewed. Electrolyte abnormalities involving sodium, potassium, chloride, bicarbonate, urea, and creatinine were assessed. Associations between electrolyte disturbances and patient outcomes were evaluated using chi-square tests. Multivariable logistic regression analysis was performed to identify independent predictors of mortality and prolonged ICU stay after adjusting for age, Glasgow Coma Scale score, and ventilator use.

Results: A total of 282 adult ICU patients were included, with a slight male predominance. Neurological disorders (23.0%), trauma (19.1%), and sepsis (18.0%) were the most common primary diagnoses. The most prevalent electrolyte abnormalities at admission were hypokalaemia (40.4%), metabolic acidosis (33.8%), hyperchloraemia (20.7%), hypernatraemia (19.9%), hyponatraemia (10.4%), hyponatraemia (9.6%), and hyperkalaemia (6.7%). Univariate analysis demonstrated significant associations between abnormalities in sodium ($p=0.013$), potassium ($p=0.038$), chloride

($p=0.012$), and creatinine ($p<0.001$) and patient mortality. Post-hoc analysis showed significantly higher mortality among patients with hypernatraemia, hyperkalaemia, hypochloraemia, and hypercreatinaemia. After adjusting for confounders, hyperkalaemia (AOR=5.781, 95% CI: 1.173–28.488, $p=0.031$) and hypercreatinaemia (AOR=2.537, 95% CI: 1.110–5.796, $p=0.027$) remained independent predictors of mortality. Increasing age (AOR=1.023, $p=0.010$) and ventilator use (AOR=3.613, $p=0.001$) were also independently associated with mortality. Hypernatraemia independently predicted prolonged ICU stay (AOR=3.074, 95% CI: 1.101–8.584, $p=0.032$), while ventilator use was likewise associated with longer ICU stay (AOR=2.390, 95% CI: 1.211–4.717, $p=0.012$).

Conclusion: Electrolyte abnormalities are highly prevalent among adult ICU patients. Hyperkalaemia and elevated creatinine levels independently predict mortality, whereas hypernatraemia is associated with prolonged ICU stay. Early recognition and prompt correction of electrolyte disturbances may improve outcomes among critically ill patients.

Keywords: Electrolyte disturbances, Intensive Care Unit, Length of stay, Mortality

ICCSN/26/06

Title: Reversal of Septic Shock and Multiorgan Failure Following Source Control of Perforated Appendicitis with MDR Klebsiella Infection

Authors: T. A. Owoniya, S.K. Phillips, L.E Mba, O. Olatise, R. Mohammed

Affiliations: Zenith Medical and kidney Centre, Abuja

Corresponding Author: Dr Owoniya, owoniyafolahan@yahoo.com

Case Report

Background

Sepsis is a leading cause of global mortality, contributing roughly one-third of global deaths. The largest global sepsis burden is borne by low and middle-income countries. Therefore, early diagnosis, prompt antibiotic use and timely infection source control improves survival.

Case Presentation

A 51-year-old man with a background history of hypertension, diabetes mellitus, and previous stroke was referred from a private hospital with septic shock, acute kidney injury (AKI), and severe respiratory failure. He initially presented with a 5-day history of generalized abdominal pain, abdominal distension, vomiting, diarrhea, and fever, which progressed to hypotension, respiratory distress, and oliguria requiring ICU admission, vasopressor support, and hemodialysis. On arrival, he was febrile

(38°C), hypoxic (SpO₂ 80–87% on NRFM), tachypneic, and had a distended tender abdomen with feculent nasogastric aspirates. Investigations revealed neutrophilic leukocytosis, markedly elevated urea and creatinine, metabolic acidosis, and multiple intra-abdominal abscesses on ultrasound. He subsequently had an emergency laparotomy done and intraoperative findings revealed a ruptured appendix with 700 ml intra-abdominal pus drained. He was managed with broad-spectrum antibiotics, vasopressors, CRRT, and ventilatory support postoperatively. Cultures grew multidrug-resistant *Klebsiella* spp. Clinical improvement followed source control, with resolution of shock, recovery of renal function, successful extubation, and transfer to the ward by postoperative day 10.

Discussion

This case demonstrates the life-threatening progression of perforated appendicitis to severe intra-abdominal sepsis, septic shock, acute kidney injury, and respiratory failure. Despite multiple organ dysfunction and multidrug-resistant *Klebsiella* infection, prompt source control, targeted antimicrobial therapy, and intensive organ support resulted in recovery.

Keywords: Acute Kidney Injury, Continuous Renal Replacement Therapy, Non Rebreathing Face Mask

ICCSN/26/07

Title: From Respiratory Tract Infection to Multiorgan Failure: A Case of Severe Paediatric Sepsis With AKI and Fungal Superinfection

Affiliations: ¹Zenith Medical and kidney Centre, Abuja

Authors: T. A. Owoniya¹, S.K. Phillips¹, O.C.Epundu¹, O. Olatise¹

Corresponding Author: Dr Owoniya: owoniyafofahan@yahoo.com

Case Report

Background:

Paediatric sepsis causes major morbidity and mortality, accounting for more than 8% of paediatric intensive care unit admissions and over 4.5 million deaths globally, with early detection challenging due to complex physiology and variable presentations.

Case Presentation

A 2-year-old boy was referred with severe sepsis complicated by acute kidney injury following a 6-day history of progressive cough and catarrh. Initial symptoms were managed at home with no improvement, after which he presented to a referral centre with fever, anaemia, and worsening clinical status requiring transfusion. He subsequently deteriorated post-transfusion and was referred for

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specialist care. At presentation he was in severe respiratory distress with suboptimal oxygen saturation, tachycardic, hypotensive, febrile, jaundiced and had an episode of convulsion that was aborted. Laboratory findings showed marked leukocytosis, elevated CRP, thrombocytopenia, hyponatraemia, hyperkalaemia, elevated urea and creatinine, elevated liver enzymes and deranged clotting profile. Chest X-ray was suggestive of pulmonary oedema, and abdominal Ultrasound done revealed ascites, and poor cortico-medullary differentiation and increased renal cortical echogenicity. He was diagnosed with severe sepsis with AKI, intubated, ventilated, and commenced on vasopressors, artesunate, and broad-spectrum antibiotics. Renal function improved with conservative management. Persistent fever led to antibiotic modification and later identification of *Candida albicans* from ETT, treated with fluconazole. He improved gradually, was extubated, weaned off support, and discharged home on day 23.

Discussion

This case illustrates fulminant paediatric sepsis with multiorgan dysfunction (AKI, respiratory failure, shock). Early intensive care, antimicrobial escalation, and timely ventilatory and vasopressor support were crucial. Secondary *Candida* infection highlighted the risk of prolonged invasive device use in critically ill children.

Keywords : Paediatric Intensive Care Unit, Acute Kidney Injury, Endotracheal Tube

ICCSN/26/08

Title: Cost of Intensive Care Management of Hypertensive and Diabetic Patient with Kidney Failure, Acute respiratory distress syndrome and Haemorrhagic stroke: A Case Report from a Resource-Rich Setting

Affiliation: ¹Department of Anaesthesia and Intensive care, MEMFYS HOSPITAL, Enugu, Enugu State.

Authors: P. Ufoegbunam¹, Emedike-Anwah I¹

Corresponding Author: Emedike-Anwah ifeoma, ifeomadactor014@gmail.com,

Case Report

Background

The major causes of chronic kidney disease and end-stage renal disease worldwide are hypertension and diabetes. These comorbidities lead to haemorrhagic stroke. These are resource-intensive and pose a significant financial burden in low income countries. The cost implications of intensive care unit admission may provide valuable information for health care planning and policy development.

Case Presentation

We report the case of a 48-year old business man with basal ganglia haemorrhage and severe chest infection associated with longstanding hypertension and controlled type 2 diabetes. He presented with sudden loss of consciousness. Neuroimaging confirmed a hemorrhagic stroke. The patient subsequently developed acute on chronic kidney failure requiring renal replacement therapy and was admitted to the ICU for advanced organ support. The patient remained in ICU for 22days. Direct costs were calculated from hospital billing records and included ICU bed occupancy, medications, investigations, imaging, dialysis, ventilation, consumables, and professional fees.

Result

The patient gradually improved and was transferred to a high dependency unit for further care and rehabilitation.

Conclusion

This case highlights the high cost with the psychological effect of financing management of patients in ICU. Health care financing and health insurance and sponsorships are needed for efficiency in intensive care unit.

Keywords:

Intensive care, Cost analysis, Haemorrhagic stroke

ICCSN/26/09

Title: Percutaneous Tracheostomy as a facilitator of weaning from anticipated prolonged mechanical ventilation: A case report.

Affiliation: ¹Department of Anaesthesia and Intensive care, MEMFYS HOSPITAL.

Authors: P. Ufoegbunam¹, Emedike-Anwah IU¹

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Case Report

Background: Mechanical ventilation is a life-saving intervention in critically ill patients. However prolonged endotracheal intubation is associated with complications such as ventilator- associated pneumonia, increased sedation requirements and prolonged intensive care unit stay. Percutaneous tracheostomy is a bed side procedure to enhance weaning from ventilator.

Case Presentation:

This is a case of a 33yrs old male admitted to ICU with severe traumatic head injury that had decompressive craniotomy. Due to anticipated need for extended ventilatory support, a bed side percutaneous tracheostomy was performed. Subsequently, patient demonstrated improved tolerance

to ventilatory support, reduced sedation requirements, and progressive advancement through weaning protocols. Ventilatory parameters, sedation needs and haemodynamics were stable and within normal range.

Result: The procedure was performed without complication. Improved airway clearance and patient comfort were observed.

Conclusion: This procedure highlights the potential role of percutaneous tracheostomy as an effective facilitator of weaning in patients with anticipated prolonged mechanical ventilation.

Keywords: Percutaneous tracheostomy, ventilator weaning, prolonged mechanical ventilation.

Abstracts

ICCSN/26/10

Title: Socioeconomic Influences on Critical Care Delivery and Outcomes in a Hospital in Southern Nigeria: A Prospective Observational Study

Affiliation: ¹University of Port Harcourt Teaching Hospital

Authors: Danagogo T¹, Hart F¹, Otokwala J¹

Corresponding Author: Otokwala J Email: Job.otkwala@uniport.edu.ng

Abstract

Background: Critical care services are resource-intensive and often inaccessible in low- and middle-income countries because of high out-of-pocket healthcare costs. This study evaluated the impact of socioeconomic factors on access to critical care services in Southern Nigeria.

Methods: This prospective observational study was conducted in the Intensive Care Unit (ICU) of the University of Port Harcourt Teaching Hospital over one year. Data collected included patient demographics, ICU costs, rebate requests, length of stay, and outcomes. The ICU admission fee was ₦70,000, with daily charges of ₦10,000 for non-ventilated patients and ₦12,000 for mechanically ventilated patients.

Results: A total of 143 patients were admitted. Ninety-one (63.6%) requested financial rebates despite the relatively low ICU charges. The mean expenditure within the first 24 hours of admission was ₦246,000 for oxygen, medications, investigations, drugs, disposables. Mean total hospital bill per patient was ₦953,328, while the mean rebate granted was ₦582,708. ICU stay ranged from 7 to 120 days, but even those with short stay usually request for rebate. Overall mortality was 58.7% (84 patients). The high demand for rebates likely reflects economic hardship, as Nigeria's national minimum wage (₦70,000/month) is equivalent to the ICU admission fee.

Conclusion: Even with relatively low ICU charges, critical care remains financially burdensome for many households. High rebate utilization highlights the influence of socioeconomic status on access to intensive care and underscores the need for expanded health insurance and financial support mechanisms.

Keywords: Critical Care Delivery, Healthcare Financing, Out-of-Pocket Expenditure, Nigeria.

Abstracts

ICCSN/26/11

Title: Saving Lives Against the Odds: Neurocritical Care Success in a Resource-Constrained Environment

Affiliation: ¹University of Port Harcourt Teaching Hospital

Authors: Otokwala J¹, Anyanwu B¹, Hart F¹

Corresponding Author: Otokwala J Email: Job.otokwala@uniport.edu.ng

Abstract

Background: Persistent coma in patients with diabetic ketoacidosis (DKA) after correction of metabolic derangements warrants urgent evaluation for concomitant neurological pathology. The coexistence of acute ischaemic stroke, seizures, and cerebral oedema presents significant diagnostic and therapeutic challenges, particularly in low-resource settings.

Case Presentation: We report the case of a 47-year-old hypertensive and diabetic woman with a previous right hemispheric ischaemic stroke who presented with sudden loss of consciousness. Initial evaluation revealed severe hyperglycaemia (RBS 30 mmol/L), ketonuria, glycosuria, metabolic acidosis, and reduced consciousness (GCS 8/15). She subsequently developed generalized tonic-clonic seizures. Computed tomography demonstrated chronic right hemispheric infarcts without acute haemorrhage. Despite aggressive fluid resuscitation, insulin therapy, and intensive care management, she remained comatose with persistent metabolic acidosis and developed anisocoria. Repeat neuroimaging revealed a large left middle cerebral artery territory infarction with significant mass effect and midline shift suggestive of malignant cerebral oedema. Persistent depressed consciousness raised concerns for non-convulsive status epilepticus, recurrent stroke, and evolving cerebral herniation. Mechanical ventilation and neurocritical care support were instituted while arrangements for transfer to a specialized neurocritical care centre were made.

Conclusion: This case highlights the complex interplay between diabetic ketoacidosis, acute ischaemic stroke, seizures, and cerebral oedema. Persistent coma despite apparent metabolic improvement should prompt urgent neurological reassessment, repeat neuroimaging, and consideration of

continuous electroencephalographic monitoring. Early transfer to a dedicated neurocritical care facility may improve neurological outcomes in resource-constrained environments.

Keywords: *Diabetic ketoacidosis, acute ischaemic stroke, malignant cerebral oedema, neurocritical care, non-convulsive status epilepticus.*

Abstracts

ICCSN/26/12

Title: Acute Stroke Outcomes in Public and Private Intensive Care Units: A Two-Year Comparative Cohort Study from Southern Nigeria

Affiliation: ¹University of Port Harcourt Teaching Hospital

²Prime Medical Consultants Hospital

Authors: Otokwala J^{1,2}, Hart F^{1,2}, Danagogo T^{1,2}

Corresponding Author: Otokwala J Email: Job.otokwala@uniport.edu.ng

Abstract

Background: Stroke is a major cause of intensive care admission, disability, and mortality worldwide. In Nigeria, differences in healthcare access, prompt intervention, and availability of resources may significantly influence patient outcomes.

Methods: This retrospective comparative cohort study reviewed the records of all stroke patients admitted to the Intensive Care Unit (ICU) of the University of Port Harcourt Teaching Hospital (UPTH) and Prime Medical Consultants Hospital between January 2024 and January 2026. Demographic characteristics, time from symptom onset to presentation, and clinical outcomes were extracted and analysed. Primary outcome measures included ICU mortality and survival rates.

Results: Ninety one stroke patients were admitted during the study period, comprising 60 patients managed in the public ICU and 31 patients in the private ICU. The overall mean age of the patients was 53 years, with males constituting most admissions in both centres. Marked differences were observed in healthcare-seeking behaviour and access to care. Patients generally presented > 6 hours compared to within four hours of symptom onset in the public and private ICU respectively. Outcome analysis demonstrated substantial differences between the two healthcare systems. Mortality among stroke patients admitted to the public ICU was 60.0% (36/60), compared with 24.0% (7/31) in the private ICU. Correspondingly, survival rates were 40.0% and 76.0% in the public and private ICUs, respectively. The lower mortality observed in the private ICU was associated with earlier presentations and more timely access to specialised critical care interventions.

Conclusion: Stroke patients admitted to the private ICU had significantly lower mortality and better survival than those managed in the public ICU due to early presentation. Strengthening emergency stroke pathways, improving public awareness, and enhancing critical care services in public hospitals may contribute to reducing stroke-related mortality in Nigeria.

Keywords: Stroke; Intensive Care Unit; Mortality; Public Hospital; Private Hospital.

Abstracts

ICCSN/26/13

Title: Level of Serum Bilirubin and Outcome in Patients Admitted to Intensive Care Unit: A Single-Centre Retrospective Observational Study

Affiliation: ¹Department of Anaesthesia, College of Medicine, University of Ibadan, Ibadan, Nigeria

²Department of Anaesthesia, University College Hospital, Ibadan, Nigeria

Authors: Olusola Idowu¹, Kehinde Adebayo¹, Mathias Orji¹, Olaoluwa Adeyanju²

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Abstract

Background: Bilirubin has been proposed as a potential biomarker of disease severity and prognosis in critically ill patients due to its association with hepatic dysfunction, systemic inflammation, and oxidative stress. Its prognostic significance among intensive care unit (ICU) patients remains incompletely understood.

Methods: This retrospective observational study included 80 patients admitted to the ICU. Demographic characteristics, clinical parameters, liver function indices, and patient outcomes were analysed. Outcome measures included ICU mortality and duration of stay. Descriptive statistics were used to summarise patient characteristics. Associations between clinical variables and mortality were assessed using Chi-square and Mann–Whitney U tests. Multivariate binary logistic regression models were constructed to identify independent predictors of mortality, while multiple linear regression analysis was used to evaluate predictors of ICU length of stay.

Results: The mean age of the patients was 57.13 ± 19.20 years, and 52.5% were males. Forty six (57.5%) patients died, while 34 (42.5%) survived. Hypertension (43.8%) and diabetes mellitus (16.3%) were the commonest comorbidities, whereas cerebrovascular accident (22.5%) and sepsis (18.8%) were the leading admission diagnoses. Median total bilirubin levels were higher among non-survivors than survivors [0.82 (0.50–1.67) mg/dL versus 0.65 (0.43–1.44) mg/dL], although the difference was not statistically significant ($p = 0.263$). In multivariate logistic regression analysis, total bilirubin demonstrated a positive but non-significant association with mortality (adjusted odds ratio

[aOR] = 1.141, 95% CI: 0.987–1.318, $p = 0.074$). Similarly, the bilirubin-to-albumin ratio showed a non-significant trend toward increased mortality risk (aOR = 1.519, 95% CI: 0.976–2.363, $p = 0.064$). Glasgow Coma Scale (GCS) score was the only consistent independent predictor of survival, with each point increase associated with a reduction in mortality risk (aOR = 0.862, $p = 0.038$). Total bilirubin was not significantly associated with the duration of ICU stay ($B = -0.359$, $p = 0.313$).

Conclusion: Serum bilirubin levels though higher among non-survivors was not independently associated with ICU mortality or length of stay after adjustment for potential confounders. GCS remained the strongest independent predictor of outcome. Further studies with larger sample sizes are required to establish prognostic value of serum bilirubin levels in critically ill patients.

Keywords: Bilirubin, Intensive Care Unit, Mortality, Glasgow Coma Scale, Critical Illness.

Abstracts

ICCSN/26/14

Title: Fluid Management Practices and Outcomes in Intensive Care Unit Patients with Sepsis in Low-Resource Settings

Affiliation: ¹University College Hospital, Ibadan

Authors: B.B. Osinaike¹, D.G. Efe¹, D.A. Omoniyi¹

Abstract

Background: Sepsis remains a leading cause of morbidity and mortality in Intensive Care Units (ICUs) globally, particularly in low-resource settings where challenges in diagnostics, treatment, and sustainable financing are prevalent. Fluid management is a cornerstone of sepsis resuscitation, yet optimal strategies and their impact on patient outcomes, resource utilization, and overall sustainability in these environments require further investigation.

Methods: A retrospective analysis was conducted on 41 ICU patients with sepsis. Baseline characteristics, including demographics, admission diagnoses, Modified Early Warning Score (MEWS) on admission, and length of stay, were collected. Fluid management parameters, specifically daily fluid input and balance, were assessed. Univariate analyses were performed to determine the relationship between ICU admission characteristics, fluid status, and patient outcomes (discharge status and length of stay).

Results: The study population comprised 56.1% males and 43.9% females, with 48.8% aged ≤ 40 years. Common admission diagnoses included post-operative-related (46.3%) and trauma-related (17.1%) conditions. A significant proportion of patients (48.8%) presented with MEWS >4 on admission. Regarding fluid management, 78% of patients received $>3L$ daily fluid input, and 63.4% had a daily fluid balance $>1L$. Univariate analysis revealed a significant association between the need for vasopressors ($P < 0.001$) and invasive ventilation therapy ($P = 0.014$) with increased ICU mortality. Fluid input and balance did not show a statistically significant direct relationship with length of stay or discharge status in this cohort, which may be due to a limitation with the sample size of the study.

Conclusion: The study suggests that the need for advanced life support interventions like vasopressors and invasive ventilation in the management of sepsis is associated with higher mortality in the ICU. Further studies with large sample sizes and randomized control trials are needed.

Keywords: Fluid management, Sepsis, Patient outcomes,

ICCSN/26/15

Title: Acute Cerebral Syndrome with Transient Blindness, Sensorineural Hearing Loss, Aphasia, and Quadriparesis in a Child with Homozygous Sickle Cell Disease Despite Normal Neuroimaging

Affiliation: ¹Department of Anaesthesia, Intensive Care Unit, and Pain Management, Cedarcrest Hospital, Abuja, Nigeria.

Authors: K.I. Edionhon¹, A.A. Akinrinmade¹

Corresponding Author: Kate Iyore Edionhon; Email: kateiyoreedionhon@yahoo.com

Case Report

Background

Acute neurological complications of sickle cell disease (SCD) may present with severe deficits despite normal neuroimaging, creating diagnostic challenges. We report a rare case of acute cerebral syndrome with remarkable neurological recovery following exchange blood transfusion. Sedation and anxiolytics helped the child tolerate the acute shut down

Methods

An 8-year-old boy with SCD presented with fever, bone pain, sudden blindness, sensorineural hearing loss, aphasia, behavioural changes, quadriparesis, and seizures. Investigations showed severe anaemia, leukocytosis, thrombocytosis, malaria parasitaemia, and normal brain CT and MRI. He received multidisciplinary intensive care including oxygen, intravenous fluids, analgesia, antimicrobials, artesunate, nutritional support, physiotherapy, seizure control, mild sedation, vasopressor support, and four exchange blood transfusions.

Results

The patient showed progressive recovery of vision, hearing, speech, cognition, and motor function following serial exchange transfusions. He was discharged after three weeks with near-complete neurological recovery except for mild residual stuttering. Neuroimaging remained essentially normal throughout admission.

Conclusion

Acute cerebral syndrome should be suspected in children with SCD presenting with severe neurological deficits even when CT and MRI are normal. Early multidisciplinary management and prompt exchange blood transfusion may be lifesaving and can result in excellent neurological recovery.

Keywords: Sickle cell disease; Acute cerebral syndrome; Exchange blood transfusion; Normal neuroimaging; Paediatric stroke

Goodwill Message



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Paediatric Anaesthesia Society of Nigeria (PASoN)

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30 June 2026.

GOODWILL MESSAGE FROM THE PRESIDENT, PAEDIATRIC ANAESTHESIA SOCIETY OF NIGERIA (PASoN)

It is my pleasure, as the President of the Paediatric Anaesthesia Society of Nigeria (PASoN) and Special Guest of Honour, to extend warm greetings and congratulations to the Intensive and Critical Care Society of Nigeria on the occasion of its 11th International Conference holding in Abuja on 8th and 9th July 2026.

The theme of this year's conference, "Sustainable Financing for Intensive Care Units in Public Health Facilities: Challenges, Opportunities and Solutions," is timely, relevant and highly important to healthcare delivery in Nigeria and other low- and middle-income countries. The sustainability of critical care services remains a major challenge, particularly in the face of rising healthcare costs, increasing demand for intensive care services and limited public resources.

Access to quality intensive care should not be determined by a patient's ability to pay. Sustainable financing models are essential for ensuring equitable access, maintaining critical care infrastructure, supporting workforce development and improving patient outcomes across all age groups, including our vulnerable paediatric population.

This conference provides an important platform for policymakers, clinicians, administrators, health economists and other stakeholders to share experiences and develop innovative, practical and context-appropriate solutions to strengthen critical care financing in Nigeria.

On behalf of the Paediatric Anaesthesia Society of Nigeria, I commend the organisers for their vision, dedication and commitment to advancing intensive and critical care practice in our country. I am confident that the deliberations and recommendations from this meeting will contribute significantly to policies and strategies for resilient and sustainable critical care services.

I wish all participants a productive conference, stimulating discussions and a memorable stay in Abuja.

Thank you.

Desalu

Professor Ibrinke Desalu
President, Paediatric Anaesthesia Society of Nigeria
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GOODWILL MESSAGE TO I-CCSN

On behalf of the Executives, Board of Trustees and the highly esteemed members of Society of Obstetric Anaesthetists of Nigeria (SOAN), I congratulate the President and the entire members of I-CCSN at the 11th I-CCSN Conference (Abuja 2026). I also write to felicitate with you as you launch the Inaugural Professor Obashina Ayodele Ogunbiyi Lecture Series, to honour a Pioneer of Critical Care Medicine in Nigeria. Let us celebrate the partnership and collaboration towards reducing maternal mortality in Nigeria by your pragmatic critical care interventions. Thank you.

Prof. Simeon Olugbade Olateju (MBChB, PgWACS, MPH, FMCA, FICS)
SOAN President

Goodwill Message

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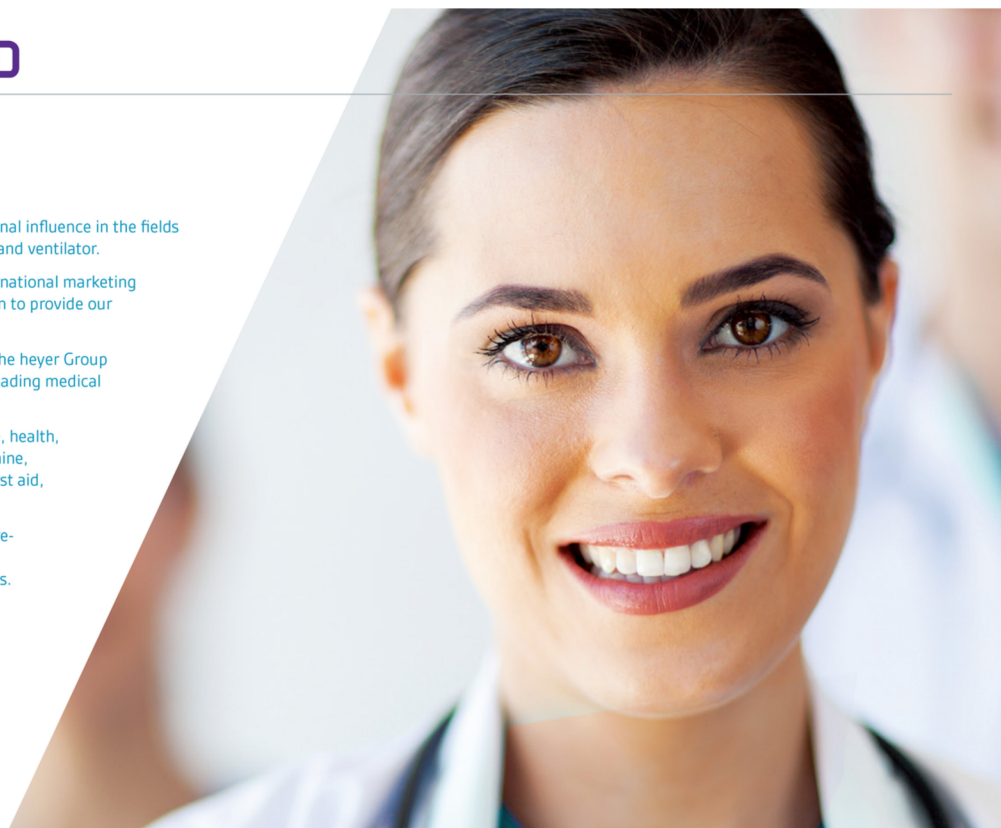
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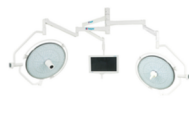
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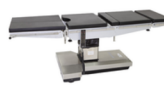
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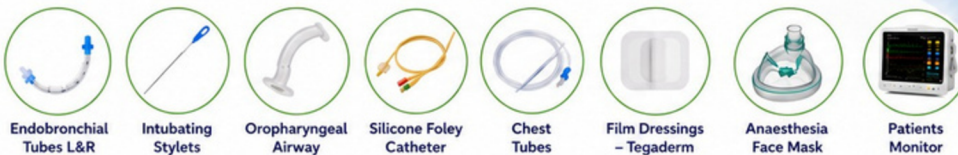
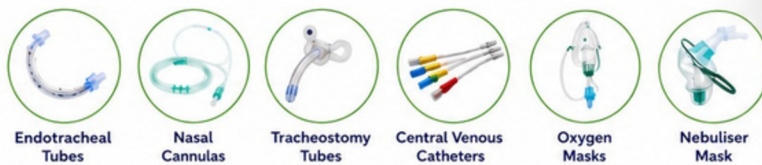
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