



Society for Ambulatory Anesthesia

# Ambulatory Anesthesia<sup>SM</sup>

## **SAMBA 18th Annual Meeting in conjunction with the 5th International Congress on Ambulatory Surgery Boston, Massachusetts May 8-11, 2003**



**S**AMBA is proud to co-host the 5th International Congress on Ambulatory Surgery held for the first time in the United States on May 8-11, 2003, at the Hynes Convention Center in Boston, Massachusetts, with the Federated Ambulatory Surgery Association. This year's meeting offers an outstanding international educational and cultural experience with a wide selection of program topics.

The SAMBA 18th Annual Meeting and the 5th International Congress feature more than 60 educational sessions, including multidisciplinary panels and specialty breakout sessions, optional workshops on advanced cardiac life support and difficult airway management, scientific poster sessions and more than 200 technical exhibits. This event promises to provide networking opportunities with international leaders in ambulatory surgery and anesthesia and a chance for you to renew old acquaintances and make new ones — all within a few days' time.

### **Highlights include:**

- SAMBA founding member and Past President Burton S. Epstein, M.D., presenting the Fourth Nicoll Memorial Lecture, "Exploring the World of Ambulatory Surgery"
- The SAMBA Distinguished Service Award, which will be presented to Raafat S. Hannallah, M.D.
- Presentation of the SAMBA/Baxter Healthcare Resident Research Travel Awards, presentation of the White Mountain Institute Award for Research in Ambulatory Anesthesia and the ASA Update delivered by ASA President James E. Cottrell, M.D.
- The eagerly anticipated Saturday evening social event "An Off the Wall Opening" at the Museum of Fine Arts.

**Full meeting program information  
appears on pages 8-10 inside ...**

# An Evolving Society Needs YOUR Involvement

By the time you receive this newsletter, I hope you are registered for the SAMBA 18th Annual Meeting on May 8-11, 2003, in Boston, Massachusetts. Meeting Program Chair **Rebecca S. Twersky, M.D.**, New York, New York, has organized an excellent program that includes topics for all anesthesia practitioners. Detailed information on the meeting is included in this issue. In addition, **Lucinda L. Everett, M.D.**, Seattle, Washington, program chair of the next SAMBA Mid Year Meeting to be held during the ASA 2003 Annual Meeting in San Francisco, California, has planned a program on clinical and administrative challenges in ambulatory anesthesia. I highly recommend that you make plans to attend these meetings.

It is widely recognized that opioid-related side effects delay recovery after ambulatory anesthesia, which has increased the emphasis on the use of nonopioid analgesics (e.g., acetaminophen, nonsteroidal anti-inflammatory drugs [NSAIDs], COX-2 inhibitors and local anesthetics). Because ketorolac is the only parenteral NSAID available in the United States, it is commonly used in the perioperative period. **Kumar G. Belani,**

*I would like to request that our members get involved in the various aspects of SAMBA, including participation in committees. I encourage you to provide feedback on any topic that interests or concerns you.*

**M.D.**, Minneapolis, Minnesota, provides us with an excellent insight into the use of ketorolac in the pediatric population.

Anesthesiologists are increasingly requested to provide services outside the operating suite, which can be challenging. **Mary Ann Vann, M.D.**, Boston, Massachusetts, summarizes the Breakfast Panel presented at the ASA 2002 Annual Meeting, which dealt with anesthesia for off-site ambulatory procedures.

Patients with morbid obesity may have significant comorbidities, which



Girish P. Joshi, M.D.

can increase perioperative complications. **Babatunde O. Ogunnaike, M.D.**, Dallas, Texas, attempts to answer the question, "Should morbidly obese patients undergo outpatient surgery?"

Finally, I would like to request that our members get involved in the various aspects of SAMBA, including participation in committees. I encourage you to provide feedback on any topic that interests or concerns you.

I look forward to meeting you in Boston! 

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- Atul J. Prabhu, M.D.
- Mary Ann Vann, M.D.

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# Ketorolac: A Choice Pediatric Drug, With Some Limitations

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Opioids are excellent analgesics but may cause significant problems when used in infants and children for ambulatory surgical procedures. In addition to the well-known risk of ventilatory depression, postoperative nausea and vomiting (PONV) is more likely with opioid usage. Besides, required compliance with regulatory procedures whenever opioids are used increases ambulatory care center costs. Nonopioid analgesics do not induce sedation or predispose to respiratory depression, PONV and urinary retention. Because of these reasons, acetaminophen and non-steroidal anti-inflammatory drugs (NSAIDs) are preferred drugs during pediatric ambulatory surgical care. Both acetaminophen and ibuprofen are available for rectal use and may be administered soon after induction of anesthesia. They do not peak as rapidly as intravenously administered drugs, and therefore, ketorolac [Figure 1] is the agent of choice when rapidity and reliability of onset is desirable.

Ketorolac, a nonspecific NSAID, has a volume of distribution that is almost twice that of adults and an increased clearance but an elimination half-life ( $t_{1/2}$  beta) that is similar in children and adults. The practical point to remember is that the dosing interval is the same as in adults. A dose of 0.5 mg/kg results in therapeutic levels lasting six hours. Thus, when administered intravenously soon after induction, ketorolac may be continued orally six hours (0.3-0.5 mg/kg) postoperatively for the first day and then weaned over 48 hours. The daily maximum dosage should not exceed 90 mg. Ketorolac has not been implicated in postoperative bleeding following ambulatory surgi-

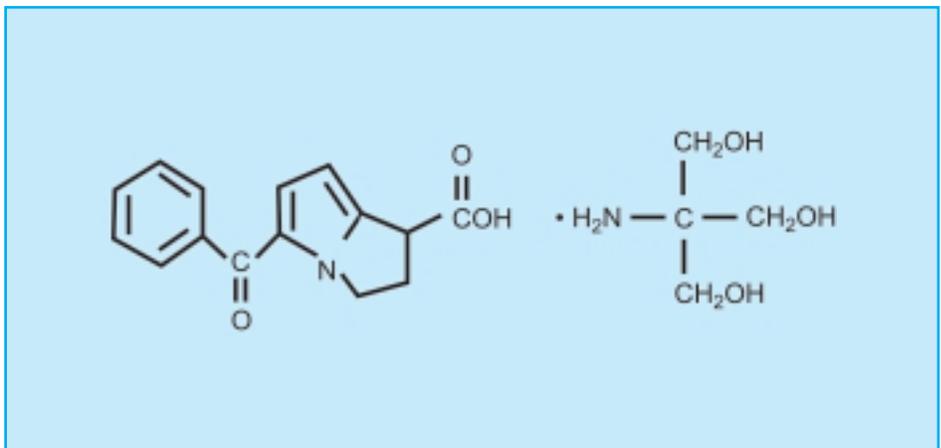
cal procedures with the exception of tonsillectomy. Ketorolac should not be used in children who are at risk of surgical bleeding, which is unlikely to be the case in ambulatory surgical patients. Ketorolac is especially effective in the control of orthopedic pain, urological surgeries and patients in whom pain has been a significant problem during previous surgical experiences. In a study by Chauhan and associates, ketorolac was found to be safe and effective in children undergoing ureteroneocystostomy. In another



Kumar G. Belani, M.D.

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Figure 1



Ketorolac tromethamine. (Exists as a racemic mixture of S- and R- forms. Only the S-form exerts analgesic action.)

Table 1: Benefits and Drawbacks of Ketorolac

Benefits	Drawbacks
<ul style="list-style-type: none"><li>• Adequate analgesic effect</li><li>• Parenteral use (I.V. and I.M.)</li><li>• No sedation</li><li>• Absence of respiratory depression</li><li>• Decreases emergence excitement accompanying inhalational anesthesia use</li><li>• Decreases PONV</li><li>• Absence of urinary retention</li></ul>	<ul style="list-style-type: none"><li>• Inhibitory effect on platelet function (may increase bleeding)</li><li>• Inhibitory effect on enchondral ossification (may interfere with bone healing)</li><li>• Cannot be used in patients with peptic ulcer disease</li><li>• Cannot be used when renal dysfunction is present</li></ul>

# Ketorolac: A Choice Pediatric Drug, With Some Limitations

Continued from page 3

study evaluating pain control and side effects in children, ketorolac was as effective as morphine but significantly decreased the incidence of nausea and vomiting following ambulatory dental surgery. In preschool children anesthetized with either halothane or sevoflurane for pressure equalizing tubes, Davis and associates found that ketorolac significantly decreased the incidence of emergence excitement.

Another limitation for ketorolac is its inhibitory effect on enchondral ossification and bone healing [Figure 2].

Several studies suggest that inhibition of cyclo-oxygenase can interfere with bone formation. It should not, therefore, be used in children scheduled for the correction of bone fractures or osteotomy procedures that require an intact enchondral ossification process for healing and bone formation. Preliminary experience suggests that COX-2 inhibitors may be safe in such situations. This is controversial, however, and until further experience is reported, COX-2 inhibitors must be used with caution in these children. Ketorolac is not recommended in infants and children with peptic ulcer disease and when renal and pre-existing platelet dysfunction is present.

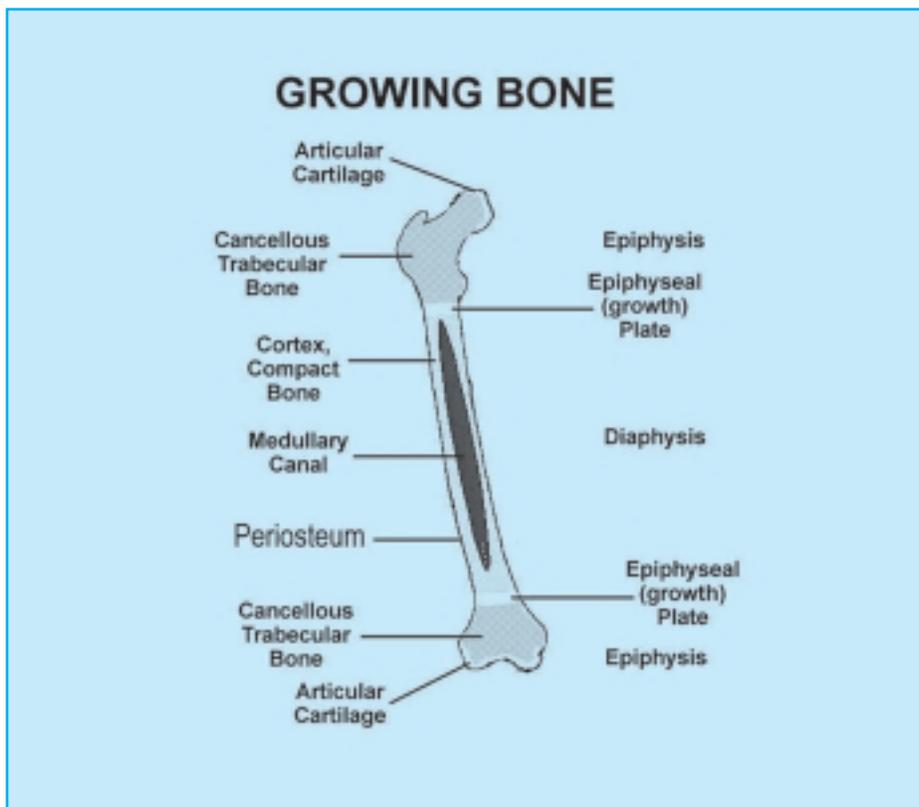
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Figure 2



Effect of ketorolac on bone growth and bone healing. Platelet-derived growth factor and prostaglandins are required for normal bone growth, enchondral ossification and bone healing. Ketorolac and other nonsteroidals interfere with these growth factors. (Picture courtesy of Edmund M. Kosmahl, P.T., Ed.D., University of Scranton.)

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# Is There a Weight Limit for Outpatients?

By Babatunde O. Ogunnaike, M.D.  
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**P**ressure for cost-containment and convenience for both patients and health care providers has led to more complex and extensive surgeries being performed as day-case procedures.<sup>1</sup> Advances in anesthetic and surgical techniques have led to less stringent criteria for acceptance of patients with pre-existing and multiple medical problems for ambulatory surgical procedures. These improvements also have led to the performance of a wide range of ambulatory surgical operations in morbidly obese patients. Interestingly, this patient population is categorized as being unsuitable for ambulatory surgery, according to the guidelines issued in 1992 by the Royal College of Surgeons of England.<sup>2</sup>

Ideal body weight (IBW) is the weight associated with the lowest mortality rate for a given height and gender. It can be estimated using the Broca index<sup>3</sup>: IBW (in kg) = height (in cm) minus x ("x" is 100 for adult males and 105 for adult females). Obesity is expressed in terms of body mass index (BMI) or Quetelet's index,<sup>4</sup> which is derived by dividing weight by the square of height to estimate the degree of obesity. Thus, BMI = body weight (kg)/height (meters<sup>2</sup>). A BMI of 30 and above represents obesity, and >35kg/m<sup>2</sup> constitutes morbid obesity.

A study focusing on pre-existing medical conditions as predictors of adverse events in ambulatory surgery cases found obese patients to have approximately four times the likelihood of developing perioperative respiratory events.<sup>1</sup>

Obesity has been linked to systemic diseases such as diabetes, hypertension and coronary artery disease, which elevate operative risk. Decreased functional residual capacity and sleep apnea also are common in obese patients and may account for the greater risk of respiratory compli-

cations.<sup>5</sup> A BMI greater than 27 was one of the major risk predictors in the analysis of a large series of patients undergoing noncardiac surgery.<sup>6</sup> In one study, obesity (BMI>30) along with severe hypertension, atrial fibrillation and chronic obstructive airway disease constituted the majority of avoidable cancellations of day-surgery patients.<sup>7</sup> Therefore, it was suggested that morbidly obese patients should undergo only simple surgical procedures on an outpatient basis.

A review of 258 obese patients undergoing ambulatory surgery, however, did not find any increase in postoperative complications or increase in unplanned admission rate in this patient population.<sup>8</sup> A questionnaire survey regarding current practice in day surgery units in the United Kingdom

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*A review of 258 obese patients undergoing ambulatory surgery... did not find any increase in postoperative complications or increase in unplanned admission rate in this patient population.*

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lends credence to not using weight cut-off as the sole criterion for ambulatory surgery qualification.<sup>9</sup> With a 96-percent response rate, 85 percent of units routinely anesthetize patients with BMI>30. This suggests that morbid obesity alone should not be an exclusion criterion for ambulatory surgery, and presence of significant comorbidities as well as type of surgical procedure should be considered.

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## 2002 Breakfast Panel Explores 'Rough' Ambulatory Issues

By Mary Ann Vann, M.D.  
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The 2002 SAMBA Breakfast Panel at the American Society of Anesthesiologists (ASA) Annual Meeting in Orlando, Florida, explored the challenges of "Roughing It: Anesthesia for Off-Site Ambulatory Procedures." The three speakers educated the audience about the potential pitfalls of off-site anesthesia and recommended strategies for success.

The first speaker, **Irene P. Osborn M.D.**, from Mount Sinai Medical Center in New York, New York, titled her presentation "Road Trips: New Destinations and Challenges." She opined that these sites often require a different mindset since the anesthesiologist is responsible for everything on these "field trips." The skills of anesthesiologists are useful at these locations in helping to make patients comfortable and able to lie still for long periods of time. Dr. Osborn stated that we should partake of these "field trips" to demonstrate the proficiency of our anesthetic techniques, learn new things and take a break from the usual operating room milieu. She warned, however, of oftentimes hostile environments and to avoid using substandard, outdated or improperly maintained equipment.

The anesthesiologist must be prepared to face complications such as hypoventilation, apnea, hypoxemia, airway obstruction, anaphylaxis and cardiac arrest. She described commonly used techniques such as sedation, analgesia, total intravenous anesthesia (or TIVA) and general anesthesia and airway management adjuncts, COPA, laryngeal mask airway (LMA) and endotracheal tubes.

Dr. Osborn emphasized two problems associated with magnetic resonance imaging (MRI) studies: the physical environment of the magnet requiring special equipment and the lack of access to the patient during the

scan. Also, even though these studies are painless, they are long in duration, and any patient movement may delay study completion.

The final off-site location Dr. Osborn mentioned was the gastrointestinal endoscopy suite. She discussed the use of propofol and remifentanyl in this setting and described endoscopy procedures performed through an anesthesia mask or next to an LMA in patients receiving general anesthesia. In her summary, Dr. Osborn proposed four ways that anesthesiologists can improve care for these patients: faster emergence, shorter recovery time, less expense and better patient acceptance. Her recommendation for success in

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*... [W]e should partake of these "field trips" to demonstrate the proficiency of our anesthetic techniques, learn new things and take a break from the usual operating room milieu.*

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these off-site procedures is to send motivated staff.

The second member of the panel, **Yvon F. Bryan M.D.**, from the University of Chicago, spoke on "Following the Trail: Monitors to Help Keep You on the Path." Dr. Bryan focused on monitoring in the MRI environment. Patients requiring anesthesia in this circumstance are usually children, anxious or claustrophobic adults, patients with multiple medical problems or those who failed sedation by the radiology team.

Dr. Bryan mentioned the technical limitations and mishaps inherent in the MRI environment and cited the case of a child killed by an oxygen tank that became a projectile when drawn to the magnet. The importance



Mary Ann Vann, M.D.

of maintaining standards and a continuum of care was stressed, and he reminded the audience that patient safety should not be compromised in off-site locations.

The type of monitoring equipment in these areas may vary from fixed to portable or a combination. He warned that care must be exercised as problems may occur with the monitors, including artifacts and interference that also may render MRI images useless.

Patient temperature may be an issue in off-site locations, especially for children receiving general anesthesia, since it is difficult to keep these patients warm in often cold environments. Since routine clinical temperature monitoring equipment may not be used during MRI scanning, Dr. Bryan discussed the significance of the temperature data from his research group at the University of Chicago. Interestingly, Dr. Bryan's group discovered that 42 percent of the children in the study did not become hypothermic ( $T < 36.1^{\circ}$  Celsius) when only covered with a blanket and hospital gown during the MRI. All these children received general anesthesia with sevoflurane via an LMA or endotracheal tube.

Dr. Bryan concluded his presentation with the prediction that future diagnostic studies and therapeutic interventions will pose significant challenges in patient monitoring.

**Charles J. Coté M.D.**, from Children's Memorial Hospital in Chicago, closed the panel with "Orienteering: Sedation Guidelines — Where We Came From and How We Got Here!" The American Academy of Pediatrics published the first sedation guidelines in 1983 in response to the deaths of children in dental offices. These guidelines described conscious sedation as a medically induced state of sedation where protective reflexes and the airway are maintained and there is an appropriate response to verbal commands or physical stimulation. On the other hand, deep sedation was characterized as a state where protective reflexes are diminished, the airway may be compromised and the patient is not responsive.

These guidelines were revised in 1992, addressing presedation evaluation and fasting, informed consent, monitoring with pulse oximetry, the recovery facility, discharge criteria and a limit on out-of-facility prescriptions for sedatives. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) established sedation guidelines in response to pa-

tient deaths that occurred in endoscopy units soon after the introduction of midazolam. JCAHO deemed the chief of anesthesia responsible for all sedated patients in his or her entire facility.

The ASA Task Force on Sedation and Analgesia by Nonanesthesiologists established practice guidelines

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*JCAHO deemed the chief of anesthesia responsible for all sedated patients in his or her entire facility.*

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based on evidence from review of the literature and expert opinions. \*Also, critical incident analysis was performed to dissect the sequence of events leading to an adverse event as well as recommendations to prevent similar incidents from occurring. The journal *Pediatrics* published a review of critical incidents in dental offices due to mishaps such as dispensing er-

rors, absent or inadequate monitoring, drug interactions, overdoses, improper cardiopulmonary resuscitation, insufficient work-up, premature discharge or inadequate staffing. A comparison of events occurring either in or out of a hospital revealed that respiratory depression was the primary event in both locations, but this occurred in older and healthier children in nonhospital settings. Cardiac arrest was three times more likely to occur as the second event in nonhospital locations, frequently complicated by failure to rescue and/or inadequate cardiopulmonary resuscitation skills.

Dr. Coté closed with a caution that sedation guidelines for office-based locations vary from state to state, and it is wise for anesthesiologists to be involved in the battle for adequate standards of care in these areas.

\* "Practice Guidelines for Sedation and Analgesia by Nonanesthesiologists" are available on the ASA Web site at <www.ASAhq.org> in the "Publications and Services" section.

SAMBA

## Proposed Bylaw Amendment

At its October 2002 meeting, the SAMBA Board of Directors approved a proposed bylaw amendment to the Society's bylaws, which changes the name of the Committee on Affiliation to the Committee on Affiliation Liaison. In accordance with the procedures to amend the bylaws, the proposed amendments must be distributed to the membership at least two weeks prior to the SAMBA Annual Membership Meeting to be held on May 11, 2002, at the Hynes Convention Center in Boston, Massachusetts. At the Annual Membership Meeting, the proposed

amendments will be read a second time followed by a vote. A two-thirds affirmative vote of the active members present and voting is necessary for the proposed amendment to become effective.

The proposed amendment to the Bylaws follow (additions noted by underlining; deletions noted by ~~strike throughs~~):

Section 7.3. COMMITTEE ON ~~AF-~~FILIATIONS AFFILIATION LIAISON

~~Affiliations~~ Affiliation Liaison shall

consist of a Chair, the President-Elect, who shall serve as Vice-Chair, three (3) members and two adjunct members.

~~Exceptions. The initial Chair of the Committee on Affiliations shall be eligible for reappointment on the committee for two (2) successive terms as Chair. One committee member shall be appointed for an initial term of one year.~~

Exceptions (Item d) are to be struck from the bylaws as it is no longer applicable. SAMBA

# SAMBA 18th ANNUAL MEETING

presented in conjunction with the



# 5<sup>th</sup> International Congress on Ambulatory Surgery

## Wednesday, May 7

3 p.m. – 7:30 p.m.

Registration

7 p.m. – 9:30 p.m.

Advanced Cardiac Life Support Workshop (Optional)

## Thursday, May 8

7 a.m. – 7 p.m.

Registration

8 a.m. – 4 p.m.

Advanced Cardiac Life Support Workshop (continued)

8 a.m. – 3 p.m.

HIPAA for ASCs Workshop (Optional)

8:30 a.m. – 11:30 a.m.

Difficult Airway Management Workshop (Optional)

12:30 p.m. – 3:30 p.m.

Difficult Airway Management Workshop (Optional)

9:30 a.m. – 12:30 p.m.

How to Achieve AAAHC Accreditation for ASCs

4 p.m. – 6 p.m.

Opening Ceremony

Nicoll Memorial Lecturer and Keynote Speaker

6 p.m. – 8 p.m.

Welcome Reception in Exhibit Hall

## Friday, May 9

7 a.m. – 7 p.m.

Registration

7 a.m. – 2 p.m.

Research posters and exhibits

7 a.m. – 8 a.m.

Continental breakfast in exhibit hall

8 a.m. – 10 a.m.

*Eight Concurrent Sessions*

- Sedation Analgesia in the Ambulatory Setting: Where Are We Now and Where Are We Going?
- Mastering Collections in Your ASC

- Changing Scene of Workers' Comp
- HIPAA for Owners and Board of Directors
- Choices in ASC Accreditation
- Basics of the U.S. Health Care System
- The Impact of Minimally Invasive Surgery (MIS) on Ambulatory Surgery
- Coding for ASCs

10 a.m. – 10:30 a.m.

Coffee break in exhibit hall

10:30 a.m. – 12 noon

*Seven Concurrent Sessions*

- HALT Surgical Procedure
- JCAHO's New Process
- Are the New Drugs Better?
- Basic Finances for Clinicians
- Waiver of and Reduced Fee Cases: Do Your Policies Comply With the Law?
- The Future Is Aging: Challenges in the Care of the Older Patient
- Washington Update

12 noon – 2 p.m.

Buffet luncheon in exhibit hall

2 p.m. – 3:30 p.m.

*Eight Concurrent Sessions*

- Using Financial and Other Rewards to Improve Staff Performance and Retention
- Regional Anesthesia: Simple and Cost-Effective Techniques
- Enhancing Your Profitability Using GI Procedures
- Vendors in the OR: An Asset or Liability?
- Barriers to the National Development of Day Surgery
- ASC Governance: Roles and Responsibilities of Board Members and Medical Directors
- New Challenges in Health Care: Emergency Preparedness for Ambulatory Surgery
- HIPAA Update

3:30 p.m. – 3:45 p.m.

Coffee break

3:45 p.m. – 5:15 p.m.

*Seven Concurrent Sessions*

- Chiropractors and ASCs
- Streamlining the Scheduling Process

- Discharge Issues and the PACU Nurse's Perspective
- Office-Based Anesthesia: A Wave of the Future?
- Web-Based Education: SkyMed
- Surgical Hospitals: What You Need to Know if Considering
- Performance Improvement Through Financial Benchmarking

6 p.m. – 10 p.m.  
Boston Brew Tour

## **Saturday, May 10**

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7 a.m. – 5:30 p.m.  
Registration

7 a.m. – 12 noon  
Research posters and exhibits

7 a.m. – 8 a.m.  
Continental breakfast in exhibit hall

- 8 a.m. – 10 a.m.  
*Six Concurrent Sessions*
- Medical Liability and the ASC Industry: What Can You Do?
  - Best Practices in Breast Surgery
  - Current Topics in Acute Postoperative Pain Management
  - Establishing Fee Schedules
  - Expanding ASC Procedures
  - Using Technology as a Clinical Tool

10 a.m. – 10:30 a.m.  
Coffee break

- 10:30 a.m. – 12 noon  
*Six Concurrent Sessions*
- Preoperative Screening and Patient Selection: Practical Applications
  - Complementary Medicine
  - Orthopedic Implants: Meeting Clinical Needs and Making Money
  - Cost Containment in an ASC
  - Creating Postsurgical Recovery Programs With Day Surgery Facilities
  - Social Security Insurance and Exhaustive Survey in Day Case Surgery: Methods and Analysis

12 noon – 2 p.m.  
President's Luncheon

- 2 p.m. – 3:30 p.m.  
*Seven Concurrent Sessions*
- Credentialing Advanced
  - How to Negotiate and Assess the Financial Impact of a Managed Care/Insurance Contract
  - Accreditation Around the World
  - Personal Challenges for the Practicing Physician
  - Best Poster Session #1
  - Current Controversies in Pediatric Anesthesia

- Making Your ASC a Desirable Place for Laparoscopic Surgery

3:30 p.m. – 3:45 p.m.  
Coffee break in exhibit hall

- 3:45 p.m. – 5:15 p.m.  
*Eight Concurrent Sessions*
- Chronic Pain Practices in ASCs
  - Infection Control: Is Your Center Safe?
  - Best Poster Session #2
  - Getting Physician Buy-In for Cost Management
  - What Every Health Provider Should Know About Antitrust
  - Road Map to ASC Financing Success
  - Regional Anesthesia: Innovations and Complications
  - Marketing Your ASC

6:30 p.m. – 9:30 p.m.  
An Off the Wall Opening — Museum of Fine Arts

## **Sunday, May 11**

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6:30 a.m. – 12:30 p.m.  
Registration

- 7 a.m. – 8 a.m.  
*Five Concurrent Sessions*
- Tame the Lions in Your Life
  - National Reports
  - Perspectives on International Anesthesia Practice
  - SAMBA Membership Meeting
  - FASA Membership Meeting

- 8:15 a.m. – 10:15 a.m.  
*Three Concurrent Sessions*
- ASC Compliance Update
  - In the Real World Cases
  - Day Surgery in the U.K.: The Brits Are Coming

10:30 a.m. – 12 noon  
Closing Ceremony  
Meeting Expectations: Patient Safety, Outcomes and Quality Management in Ambulatory Surgery

12:30 p.m. – 6 p.m.  
Pine Hills Golf Tournament

1 p.m. – 5:30 p.m.  
Welcome to Boston and Cambridge Tour

1 p.m. – 5 p.m.  
John F. Kennedy Library and Museum Tour

## **Monday, May 12**

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- 8:30 a.m. – 5:30 p.m.
- Fabulous Newport, Rhode Island Tour
  - Ambulatory Surgery Tours

*Meeting information continued on next page...*

## **We look forward to greeting you personally in Boston at the SAMBA 18th Annual Meeting and the 5th International Congress on Ambulatory Surgery!**



The Sheraton Boston Hotel has been designated the headquarters hotel for the SAMBA Annual Meeting/International Congress. The Sheraton Boston is New England's premiere convention venue and is connected via an indoor walkway to the Hynes Convention Center and to Boston's most distinctive shopping with over 200 fabulous stores at Copley Place. SAMBA members will receive the special rate of \$223 per night for a single or double guest room. Availability is limited and the guest room rate is guaranteed only until March 31, 2003. Call (800) 325-3535 to make a reservation.

The Congress has been planned and implemented in accordance with the Essentials and Standards of the Accreditation Council for Continuing Medical Education (ACCME) through the joint sponsorship of the American Society of Anesthesiologists (ASA) and SAMBA. ASA is accredited by ACCME to sponsor continuing medical education for physicians. ASA designates this educational activity for a maximum of 21.5 hours in category 1 credit toward the American Medical Association Physician's Recognition Award. Additional credits are provided for optional workshops.

Contact the SAMBA office for registration information or visit the SAMBA Web site to download a PDF file of the registration brochure and to register online for what promises to be a memorable event.

**SAMBA**  
**520 N. Northwest Highway**  
**Park Ridge, IL 60068-2573**  
**Telephone: (847) 825-5586**  
**Fax: (847) 825-5658**  
**E-mail: <samba@ASAhq.org>**



*For more information visit:*  
**[www.sambahq.org](http://www.sambahq.org)**

# Make a Committee Commitment!

Volunteer organizations such as SAMBA are only as vital as their membership makes them. Fortunately, we have some of the most talented members in the country to help us through their service on SAMBA committees. Using its member resources wisely has been SAMBA's goal, and we try to do this more effectively each year.

SAMBA strives to be more strategic and calls for members to serve on its committees as needed. Some committees require year-round activity while others are formed for specific reasons. Being more agile in the use of members' expertise is SAMBA's goal.

The Society committees allow you to choose the volunteer opportunity that best fits your interests and schedule. What can committee service mean to you?

- \* Exposure to how others work and to proven ideas you can use in your practice.
- \* Access to bright, imaginative people who will keep your enthusiasm high.
- \* A personal support network with expertise that otherwise might be difficult to obtain.
- \* Recognition as a leader who has a commitment to your profession.
- \* Development of your leadership skills and the ability to meet goals through consensus and persuasion.

SAMBA leadership opportunities will bring heightened skills and provide you with a new or renewed sense of pro-

fessionalism and self-worth! We encourage you to volunteer for service on one of the following SAMBA committees:

- \* Committee on Affiliation
- \* Committee on Annual Meeting
- \* Committee on Awards
- \* Committee on Bylaws
- \* Committee on Communications
- \* Committee on Development
- \* Committee on Education
- \* Subcommittee on E-Newsletter
- \* Committee on Finance and Budget
- \* Committee on International Relations
- \* Judicial Committee
- \* Committee on Membership
- \* Committee on Mid Year Meeting
- \* Nominating Committee
- \* Committee on Office-Based Anesthesia
- \* Committee on Private Practice
- \* Committee on Publications
- \* Committee on Research
- \* Subcommittee on Scientific Papers

E-mail your committee interests to <samba@ASAhq.org>. 

## Committee Seeks DSA Nominations



The committee on Awards advises that the Committee is seeking nominations for the SAMBA 2004 Distinguished Service Award. The Award will be presented during the SAMBA 19th Annual Meeting on April 30-May 2, 2004, at the Westin Seattle Hotel in Seattle, Washington.

The award, which represents the highest honor SAMBA can bestow upon an individual, is presented in recognition of outstanding achievement in ambulatory anesthesia. Raafat S. Hannallah, M.D., Washington, D.C., is the 2003 recipient. Past Distinguished Service Award Recipients were:

- Marie-Louise Levy, M.D. (1994), Chevy Chase, Maryland
- Bernard V. Wetchler, M.D. (1995), Chicago, Illinois
- Stanley Bresticker, M.D. (1996), Somerset, New Jersey
- Harry C. Wong, M.D. (1997), Salt Lake City, Utah
- Burton S. Epstein, M.D. (1998), Bethesda, Maryland
- Surinder K. Kallar, M.B. (1999), Richmond, Virginia
- Wallace A. Reed, M.D. (2000), Phoenix, Arizona
- Paul F. White, M.D., Ph.D. (2001), Dallas, Texas
- Herbert D. Weintraub, M.D. (2002), Bethesda, Maryland.

Nominations must include a cover letter, a copy of the nominee's curriculum vitae and no more than four letters of support of the nomination. Nominations must be received at the SAMBA office by no later than August 16, 2003. 

## Board of Directors

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# SAMBA 2003 Mid Year Meeting

## “Challenges in Ambulatory Anesthesia”

San Francisco, California

Friday, October 10, 2003

8 a.m. to 4:15 p.m.

Members planning to attend the American Society of Anesthesiologists Annual Meeting later this year in San Francisco, California, should mark their calendars now to arrive one day earlier to attend the SAMBA 2003 Mid Year Meeting to be held on Friday, October 10, at the San Francisco Hilton and Towers.

Lucinda L. Everett, M.D., Seattle, Washington, Program Chair, has assembled an exciting program addressing “Challenges in Ambulatory Anesthesia.” The meeting will focus on the latest topics of importance to practitioners of ambulatory anesthesia and be presented by a faculty of highly respected members.

Members are encouraged to check the Society’s Web site at <www.sambahq.org> and the SAMBA electronic newsletter, “SAMBA Talks,” for Mid Year Meeting updates.

Program highlights include:

### Clinical Challenges I: Pushing the Limits

- *How Big Is Too Big? Morbid Obesity in Ambulatory Surgery* — Kathryn E. McGoldrick, M.D.
- *How Young Is Too Young? Infants for Outpatient Anesthesia* — Lucinda L. Everett, M.D., Program Chair

- *How Old Is Too Old? Risk in the Geriatric Patient* — Lee A. Fleisher, M.D.

### Administrative Challenges I: Rules and Regulations

- *Accreditation Aggravation: Practical Solutions* — Mark A. Singleton, M.D.
- *Coding and Compliance: Reimbursement Considerations for MAC Services* — Alexander A. Hannenberg, M.D.
- *HIPAA How-Tos* — James E. Caldwell, M.D.

### Clinical Challenges II: Specialty Practices

- *Ambulatory Surgery in an Orthopedic Hospital* — Susan S. Porter, M.D.
- *Pediatrics in a Freestanding ASC* — Pat Browne, M.D.
- *Office-Based Anesthesia* — Meena S. Desai, M.D.

### Administrative Challenges II: Practical Information

- *Staffing and Supply: Information Systems* — Johnathan L. Pregler, M.D.
- *Credentialing and Quality-Improvement Programs* — Beverly K. Philip, M.D.

