



Society for Ambulatory Anesthesia

Ambulatory AnesthesiaSM

PRESIDENT'S MESSAGE

Outgoing President Praises Growing Global Influence

By Frances Chung, M.D.
2003-04 SAMBA President

It seems like only yesterday that I was confirmed as SAMBA President. In my acceptance speech, I challenged the Committee on Finance and Budget to conduct a strategic review of the Society's finances. The purpose of this review was to study and recommend means of strengthening the financial status of our Society and to make recommendations concerning investment of the Society's long-term assets. The committee also was directed to examine the Society's income and expenses and to make recommendations as to where improvements may be made to both sides of the ledger.

I am pleased to report that under the astute leadership of Committee on Finance and Budget Chair Jeffrey B. Brand, M.D., Marblehead, Massachusetts, in cooperation with SAMBA Treasurer Walter G. Maurer, M.D., Cleveland, Ohio, the committee has conducted a thorough investigation of the Society's finances. To achieve the committee's objectives, Dr. Brand solicited input from various SAMBA committee chairs. Each committee chair was asked to present a five-year review of his or her committee activities and to identify the impact these programs had on the income and expenses of the organization. This process was able to help the Committee on Finance and Budget discover possible means to increase revenue while reducing expenses.

I do wish to clarify that SAMBA is in strong financial health with its targeted reserve fund intact. SAMBA

needs to continue this strong, healthy growth in the years ahead so that it can continue to fund ambulatory anesthesiology research without impacting its financial strength. One way to accomplish this is to create a reserve that can fund research while perpetuating itself.

The outcome of the committee's diligent efforts can be seen in the fact that I have called for a strategic planning session of the Board of Directors that will take place just prior to the SAMBA 2004 Annual Meeting in Seattle, Washington, on April 29-May 2. Committee chairs have been invited to participate in this session. Our agenda will include a review of the Society's mission statement, its finances and the current long-range plan, which is now more than five years old. Through the assistance of a facilitator, the board will then focus on developing goals and objectives for the next five years in such areas as research, member services and increased member participation. While we do not know what the exact outcome of this session will bring, we are confident that once completed, we will have an enhanced sense of clarity and more and better programs for you, the member, provided in a fiscally responsible manner.

SAMBA's influence on research can be seen in the pages of *Anesthesia & Analgesia*, the Society's official journal. The number of journal pages devoted to ambulatory anesthesiology has increased over the past several years. This increase in the number of pages along with a corresponding increase in the number of submissions can be



Frances Chung, M.D.

... what we have achieved this past year could not have been possible without the support of the officers, directors, committee chairs and committee members of SAMBA.

attributed to the efforts of Paul F. White, M.D., Ph.D., Dallas, Texas, who serves as the journal's ambulatory anesthesia section editor. I would like to thank Dr. White for his hard work and dedication of time and energy in promoting our subspecialty.

In my president's acceptance speech, I spoke of the globalization of

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We've Come a Long Way, and We've Got a Long Way to Go

Ambulatory anesthesiology has come a long way with the help of excellent studies that allow us to make informed decisions (i.e., evidence-based and cost-effective). The comprehensive program planned for the SAMBA 2004 Annual Meeting should help disseminate this current information. There are, however, numerous areas of our practice that need further enlightenment through appropriate research. The SAMBA Outcomes Research Award should allow us to move a step forward and help our practice <www.sambahq.org/professional-info/outcomes-proposal.html>.

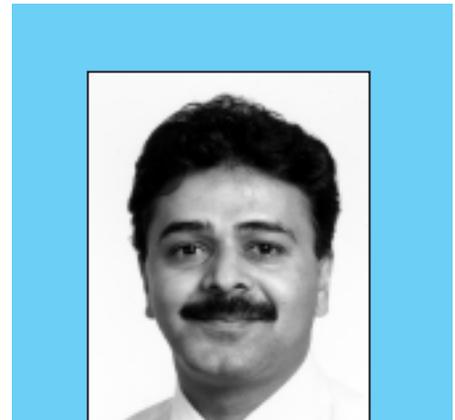
Herbs have been used for medical treatment since the beginning of civilization. Even though herbs are natural products, they have active ingredients that may have pharmacological effects similar to several medications and may interact with other medications. Certain herbal medications may prolong the duration of anesthesia while others may increase the risk of bleeding or cause hemodynamic instability. Anesthesiologists, in their role as perioperative physicians, should be familiar with commonly used herbal medicines and their po-

tential adverse effects in the perioperative period. In recent years, the inappropriate use of herbal medications has escalated. This has prompted the Food and Drug Administration to impose a ban on ephedra-containing supplements, one of the many herbal medications known to cause significant complications. **Mary Ann Vann, M.D.**, Boston, Massachusetts, reviews the current status of the use of herbal medications, particularly ephedra-containing supplements. Of note, during the 2004 Annual Meeting, Dr. Vann will moderate a session called "Clinical Updates," which is geared toward providing anesthesiology practitioners with new information on herbal medications.

Also in this issue, **Babatunde O. Ogunnaike, M.D.**, Dallas, Texas, summarizes a presentation on anesthetic implications of obesity and sleep apnea, which was discussed during the 2003 Mid Year Meeting held prior to the ASA Annual Meeting last October in San Francisco, California.

Janet van Vlymen, M.D., Kingston, Ontario, Canada, reports on two

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Girish P. Joshi, M.D.

The SAMBA Web site provides information that is helpful not only to anesthesiology practitioners but also to our patients.

www.sambahq.org

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Herbs and Supplements: Clinical Update

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On April 12, 2004, the Food and Drug Administration (FDA) rule barring the sale of dietary supplements containing ephedra becomes effective. Ephedra, one of the most widely used herbal products, "poses an unreasonable risk to those who use it," according to Health and Human Services Secretary Tommy Thompson. The removal of ephedra from the national market follows 16,000 reports of adverse health effects and more than 150 deaths. Ephedra users are at risk of events under anesthesia such as hypertension, hypotension and arrhythmias.

The ban of ephedra-containing supplements is partly attributable to the high-profile death of a Baltimore Orioles pitcher during spring training in 2003. Although his official cause of death was heat stroke, the high level of stimulants, including ephedra, in his system reportedly contributed to his demise. Weight loss and sports performance-enhancing supplements containing ephedra often provide an "ephedrine stack." The addition of ephedra to other stimulants increases the likelihood of achievement of desired results. Some of these products were removed from the market due to unsafe stimulant combinations or unlawful claims about effectiveness. There is currently a class-action lawsuit informational Web site for people who think that they may have had an adverse health event from dietary supplements containing ephedra.

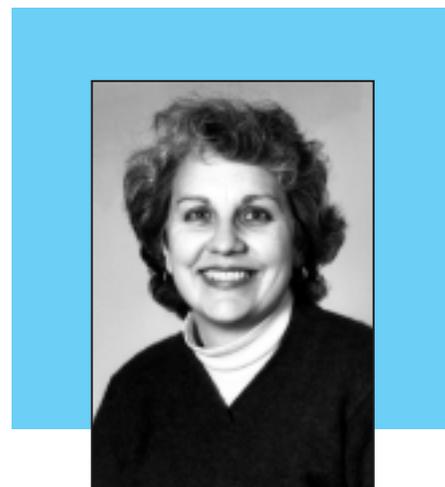
It took the FDA many years after the initial reports of adverse events to actually remove ephedra from the market. Some of the reasons for the delay are the limitations on the oversight of dietary supplements delineated by the Dietary Supplement Health and Education Act (DSHEA) of 1994. The DSHEA requires supplement labels to list ingredients and limit statements as to the health benefits of the substances.

Also the labels must display a disclaimer stating that the product has "not been evaluated by the FDA" and is "not intended to diagnose, treat or prevent any disease." The FDA bears the burden of proof to establish that a dietary supplement is unsafe. For prescription or over-the-counter drugs, manufacturers must demonstrate safety prior to marketing. Three states, California, Illinois and New York, all took action and banned ephedra before the FDA ruling. Secretary Thompson has recommended that Congress rewrite the DSHEA to provide more protection for consumers.

The final FDA ruling only prohibits the sale of dietary supplements containing ephedra, but initial recommendations considered banning its use as well. While the ephedra ban was discussed and preliminary rulings were announced, ephedra sales skyrocketed. Many consumers stocked up for the future despite health warnings. An article in the *New York Times* (February 17) discussed how "Despite FDA Ban, Ephedra Won't Go Away." Specifically excluded from the FDA interdiction



ASA's updated "What You Should Know About Herbal and Dietary Supplement Use and Anesthesia" and "Considerations for Anesthesiologists: What You Should Know About Your Patients' Use of Herbal Medicines and Other Dietary Supplements" are helpful guides on herbal medicines. Both are available at <www.ASAhq.org>.



Mary Ann Vann, M.D.

was the administration of ephedra by practitioners of traditional Asian medicine. Acupuncturists and herbalists may still prescribe ephedra for treatment of asthma, colds and coughs since this is not considered use as a dietary supplement. The article stated, however, that traditional medicine providers have seen a rise in insurance premiums if they prescribe ephedra, also known as ma huang. According to the *New York Times*, these alternative practitioners do not dispense ephedra for weight loss or sports performance, limit its use to one to two weeks and do not combine it with other stimulants.

Prior to this final FDA ruling, many weight-loss products removed ephedra from their formulations to maintain sales in light of bad publicity surrounding the herb. The alternative ingredients replacing ephedra, as described in the University of California-Berkeley Wellness Letter of October 2003 <www.berkeleywellness.com> may still cause harmful effects. Green tea extract has a high caffeine content and can cause nervousness, insomnia and restlessness. Bitter orange extract, which contains synephrine and methyltyramine, may raise blood pressure and heart rate. Dimethylaminoethanol can increase blood pressure and lead to insomnia. In addition these weight-loss products

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Morbid Obesity and Sleep Apnea in Ambulatory Surgery

By Babatunde O. Ogunnaike, M.D.
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At the 2003 Mid Year Meeting held last October just prior to the ASA Annual Meeting in San Francisco, California, **Kathryn E. McGoldrick, M.D.**, Valhalla, New York, discussed the implications of morbid obesity in ambulatory surgery with emphasis on the management of such patients with obstructive sleep apnea (OSA).

One of the problems of morbid obesity is the high preponderance of sleep apnea in this patient population. There are several predisposing risk factors to OSA with obesity being an important independent risk factor because 60 percent to 90 percent of people with OSA are obese.¹ Therefore it is safe to assume that any morbidly obese person who walks into your ambulatory surgical center may have sleep apnea. Sleep apnea is present in up to 40 million Americans and has become a public health problem. Untreated sleep apnea, even when moderate, has a cumulative eight-year mortality rate of 37 percent compared to only 4 percent in patients with mild OSA. The increased mortality is probably due to development of deleterious cardiac dysrhythmias, pulmonary hypertension and right-sided heart failure eventually leading to biventricular failure.¹

There are three main types of sleep apnea.² Central sleep apnea (Ondine's curse) is rare. Ondine's curse describes the mythological man who was condemned by his rejected mermaid lover to have to stay awake to breathe. Obstructive sleep apnea (OSA), defined as episodes of cessation of air movement (despite respiratory efforts) for at least 10 seconds occurring at least five times per hour, is usually associated with a decrease in arterial oxygen saturation (SaO₂) of greater than 4 percent. Obstructive sleep hypopnea (OSH) constitutes a decrease in airflow of more than 50

percent for more than 10 seconds 15 or more times per hour and is usually associated with snoring and a possible decrease in SaO₂ greater than 4 percent. Mixed sleep apnea is a combination of central and obstructive components.

There are several reasons why obesity causes OSA. First, the incidence and severity of OSA correlates with neck circumference. There is an inverse relationship between obesity and the pharyngeal area.^{3,4} Magnetic resonance imaging (MRI) studies have shown that the decreased pharyngeal area in obesity results from deposition of adipose into pharyngeal tissues. This increases the likelihood of collapse of the soft-walled pharynx between the uvula and epiglottis from relaxation of upper airway muscles.⁵ Second, pharyngeal patency is determined by compliance of the pharyngeal wall and transmural pressure



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negative pressures to develop the same inspiratory flow. Since obstruction can occur at any level in the upper airway and may be occurring in many patients at multiple levels (above, below or at the level of the

Untreated sleep apnea, even when moderate, has a cumulative eight-year mortality rate of 37 percent compared to only 4 percent in patients with mild OSA.

across its wall (difference between the extraluminal and intraluminal pressure). Extraluminal pressure can be increased by superficially located fat masses in obese patients externally compressing the airway.^{6,7}

Sleep apnea has both mechanical and neurological components. The neurological component comes to play in terms of insufficient neural input to the airway dilator muscles, or the neural input may be ill-timed with the mechanical input into the diaphragm. In addition the negative pressure generated during inspiration vastly exceeds the muscular-distending pressure, leading to airway collapse. Because the pharyngeal area is markedly reduced in obese patients, they have to generate much higher

uvula), if corrective surgery is performed to address only one level, the patient may not be markedly helped.

Snoring is usually the most prominent feature of OSA. Not everybody who snores has sleep apnea, however. The other symptoms of OSA include excessive daytime somnolence, accidents related to sleepiness, morning headaches, poor memory and concentration, nocturia and witnessed apneas. The signs of OSA include central obesity, increased neck circumference, edematous palate, hypertension (systemic and pulmonary) and related complications. Polysomnography is the "gold standard" for the diagnosis of OSA; however, it is a costly study and may not be available for routine use in ambulatory surgical patients.

Therefore one may have to rely on history and physical examination findings and a high index of suspicion. Computerized tomography (CT) scan, MRI and intraluminal pressure monitoring can be used to determine the level of obstruction.

How should patients with sleep apnea be managed? Over the past 25 years, various modalities have been developed in treating patients with OSA. Weight loss as a part of therapy for OSA cannot be overemphasized. Interestingly atrial overdrive pacing has been shown to significantly reduce the number of episodes of central as well as obstructive sleep apnea without reducing the total sleep time.⁸ Surgery has been advocated in some patients and is either aimed at enlarging the upper airway (e.g., tonsillectomy, uvulopalatopharyngoplasty) or bypassing it (e.g., tracheostomy). Laser-assisted uvulopalatoplasty has been shown to provide good results for about 12-18 months. Postoperative scarring and fibrosis of the hard palate, however, can lead to constriction of the upper airway and worsening OSA.

Does the type of anesthesia for ambulatory surgery matter in the OSA patient? Dr. McGoldrick emphasized that the type of surgical procedure and the postoperative opioid requirements are more important determinants of postoperative complications than the anesthetic technique. If postoperative opioid requirements are expected to be high, it may not be prudent to perform the surgical procedure on an outpatient basis. It needs to be appreciated that central nervous system depressants relax the pharyngeal dilator muscles and may promote airway collapse.⁹ Opioids have the additional side effect of respiratory depression on top of the airway collapse.¹⁰ The risk of prolonged apnea may exist for about one week in the postoperative OSA patient, particularly with high analgesic requirements and increased REM sleep.^{11,12} Airway collapse is particularly common during REM sleep.

What are the anesthetic implications of OSA? It is important to appreciate other comorbid conditions in the morbidly obese patient with OSA, including but not limited to, reflux disease, cardiovascular disease and susceptibility to deep venous thrombosis. Meticulous airway assessment should be completed, and review of recent anesthetic records may be helpful. Short-acting opioids at the lowest possible dose and low-solubility inhalation agents should be preferred. Patients on a continuous positive airway pressure device should be instructed to bring them to the operating room and also demonstrate how the device works. Non-opioid analgesics (e.g., local anesthetic techniques and nonsteroidal anti-inflammatory drugs or COX-2 specific inhibitors) should be used to provide postoperative pain relief. Caution should be exercised at extubation, which should be done with the patient fully awake and meaningfully following commands. Postoperative pulse oximetry will detect possible repeated episodes of desaturation, which should encourage low threshold for overnight admission. Supplemental oxygen is helpful except in chronic carbon dioxide retainers.

Does the ambulatory (in-hospital or freestanding) facility matter? This depends on the experience of the personnel, the comorbid diseases and the type of surgical procedure. It was emphasized that whatever the choice of ambulatory facility, equipment for difficult airway management and personnel experienced in the provision of surgical airway should be available.

In summary emphasis should be placed on clinical judgment regarding perioperative management of obese patients, particularly those with sleep apnea, with careful attention paid to tracheal intubation and extubation as well as pain control.

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CAS Meeting Report: What's New in Ambulatory Anesthesiology in Canada?

By Janet M. van Vlymen, M.D.
Kingston, Ontario, Canada

The Canadian Anesthesiologists' Society (CAS) Annual Meeting was held in Ottawa, Ontario, in June 2003. Several interesting papers were presented during the Ambulatory Anesthesia Poster Discussion. The prize-winning paper, "What Are the Ambulatory Surgical Patient Selection Criteria in Canada?"¹ was presented by **Zeev Friedman, M.D.**, Toronto Western Hospital.

Dr. Friedman reported the results of a questionnaire sent to all practicing anesthesiologists who are CAS members. The standardized questionnaire specified 31 clinical situations, and recipients were asked to indicate if they would provide ambulatory anesthesia for an adult with each of the isolated conditions. Of the 1,337 questionnaires sent, 47 percent were completed and returned.

The results showed that although the selection criteria differed among centers, there were several conditions where there was a clear consensus. More than 90 percent of anesthesiologists were willing to include in their selection criteria stable ASA physical status 3 patients, patients with angina pectoris class 2, prior (more than six months) myocardial infarction, New York Heart Association (NYHA) grade 1 congestive heart failure, asymptomatic valvular heart disease, morbid obesity with a body mass index (BMI) of 35-44 kg/m² without cardiovascular complications and insulin-dependent diabetes mellitus.

Similarly more than 90 percent of respondents agreed that the following patients would be unsuitable for ambulatory anesthesia: angina pectoris class 4, NYHA class 4 congestive heart failure and morbid obesity with a BMI >45 kg/m² with cardiovascular or respiratory complications. There were many areas where a consensus was not clear.

Obstructive sleep apnea (OSA) remains a very controversial area in ambulatory anesthesiology. The majority of anesthesiologists would provide ambulatory anesthesia for OSA patients under monitored anesthesia care or regional anesthesia and if postoperative opioids were not required. Only 36 percent of respondents, however, would provide anesthesia for outpatient surgery under regional anesthesia if postoperative opioids were required. Interestingly 64 percent of anesthesiologists would allow OSA patients to be discharged after general anesthesia as long as postoperative opioids were not required. This clearly demonstrates that anesthesiologists recognize the potential risks involved with postoperative opioids and are less concerned about the anesthetic technique and reflects the widespread use of short-acting general anesthetics with excellent recovery parameters.

Opinions were less clear for several other clinical scenarios. There was almost even distribution among respondents for patients with morbid obesity (BMI >45) without cardiovascular or respiratory complications, proven malignant hyperthermia, sickle cell anemia and age greater than 90. Many anesthesiologists (>60 percent) would provide ambulatory anesthesia for patients on hemodialysis or peritoneal dialysis, malignant hyperthermia susceptibility, active substance abuse or concurrent monoamine oxidase inhibitor treatment. Surprisingly 10 percent would allow outpatient anesthesia for a patient with no escort. CAS "Guidelines to the Practice of Anesthesia" clearly state that "patients must be discharged from the facility under the care of a responsible adult," and there have been successful lawsuits in this country for failure to discharge a patient with an escort.

One of the limitations in drawing conclusions from this type of survey is the lack of information about the pro-



Janet M. van Vlymen, M.D.

posed surgical procedure. The decision to proceed with surgery as an outpatient is most often a result of both the patient condition and the surgical procedure. An anesthesiologist may be willing to proceed with a peripheral procedure under monitored anesthesia care in a patient with significant medical problems but would not be willing to do so during laparoscopic surgery. This interesting survey provides insight into the clinical practice of ambulatory anesthesiologists in Canada and emphasizes the need for further research in the area of patient selection for ambulatory surgery.

Damon Kamming, M.D., Toronto Western Hospital, presented a poster called "Postoperative Pain Following Discharge After Ambulatory Surgery."² The authors investigated the severity of pain, need for further advice, clarity of postoperative instructions and overall patient satisfaction following an assortment of ambulatory surgical procedures. Of the 12,085 patients having surgery over a 17-month period, 5,703 were successfully contacted by telephone 24 hours after surgery. Patients graded their pain using a 10-point, self-assessing verbal scale and answered standardized questions regarding the need to seek advice or medical care, the clarity of postopera-

tive instructions for pain medication and satisfaction with their experience. Thirty percent of patients had moderate to severe pain (pain score from 4-10). The most painful ambulatory surgical procedures were microdissection, laparoscopic cholecystectomy, shoulder, elbow/hand, ankle, inguinal hernia and knee surgery. More than 85 percent of patients found the instructions for taking pain medication clear and were able to alter the dosage and timing of anal-

gesics to augment pain relief. Despite 30 percent of patients experiencing significant pain, overall satisfaction ratings were very high.

This study helps to identify procedures associated with significant pain after ambulatory surgery. The procedures should be targeted for a multimodal approach to perioperative pain management and appropriate prescriptions and instructions for postoperative pain control.

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Outgoing President Praises Growing Global Influence

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anesthesiology, including ambulatory anesthesiology. Efficient air travel and the proliferation of the Internet have opened the doors for SAMBA to play an important role in ambulatory anesthesiology worldwide, especially in Central America and South America, given their proximity to the United States. The Committee on Latin American Relations, which I established upon taking office, was given the charge to increase clinical interest among Latin American anesthesiologists engaged in ambulatory anesthesiology. Since its creation, the committee has created a Spanish version of the Society's highly popular monthly electronic newsletter, which is distributed to anesthesiologists throughout the Spanish-speaking world.

The Committee on Latin American Relations also was given the charge to help foster educational opportunities in Latin America. Suggestions already have been received for SAMBA to host an Annual Meeting or a similar program in Cancun, Mexico.

Speaking of the Annual Meeting, I would like to encourage all of our members to make plans to attend the upcoming Annual Meeting in Seattle, about which much has been written in

this issue of *Ambulatory Anesthesia*. The SAMBA 2004 Annual Meeting, chaired by Lucinda L. Everett, M.D., Seattle, Washington, has been slightly reformatted this year to provide a concentrated amount of clinically relevant information in a few days and still provide opportunities to enjoy the local attractions with friends and family.

Your Society has accomplished much over its lifetime and has grown to become the leading medical society for education and research in ambulatory anesthesiology. I see continued growth and new accomplishments ahead. This growth, however, would not have been possible, nor will it continue to be possible, without the volunteer support of SAMBA members who donate valuable time and services to participate in the Society's programs and serve on committees and the Board of Directors.

As you can surmise from my earlier comments, SAMBA is a committee-driven organization. The programs and services enjoyed by the members all originated at the committee level. Many of the ideas that developed into a program or service actually came to the attention of the committees from a member or members who made a suggestion. It is important that SAMBA have an active membership for its con-

tinued success. Executive Director Gary W. Hoormann reminds us that when an individual stands up and yells, it will only sound like a whisper; but when a thousand individuals stand up and whisper, it sounds like a yell. SAMBA needs you, together with your friends and colleagues in ambulatory anesthesiology, to be its yell, for it is through you that SAMBA will achieve its goals.

I have enjoyed my term as SAMBA President, and I know that when I turn the reins of leadership over to the very capable Kathryn E. McGoldrick, M.D., Valhalla, New York, I do so knowing that SAMBA has a world of opportunity before it. Again, what we have achieved this past year could not have been possible without the support of the officers, directors, committee chairs and committee members of SAMBA. I am thankful to these individuals not only for the assistance they have provided me this past year but also for their guidance and friendship over the many years when I first began my involvement in SAMBA as a member of the Committee on Publications.

I also would like to thank my husband and family for their support during the past year. 

Proposed Bylaws Amendments

At its October 2003 meeting, the Board of Directors approved several amendments to the SAMBA Bylaws as presented by the Committee on Bylaws. The proposed amendments 1) create an Operations Primer that would serve as a manual for officers and committee chairs, 2) establish certain committees as standing committees of the Society and 3) make the Chair of the Committee on Development a standing member of the Committee on Annual Meeting.

The amendments are presented here in accordance with the procedures to amend the Society's Bylaws, stating that proposed amendments must be distributed to every member of the Society at least two weeks prior to the SAMBA Annual Membership Meeting to be held on May 2, 2004, in Seattle, Washington. At the meeting, the proposed amendments will be presented a second time, followed by a vote. A two-thirds affirmative vote of active members present and voting is necessary for the proposed amendments to become effective. The proposed amendments follow:

Operations Manual

Article V – BOARD OF DIRECTORS

Section 5.1. – Powers and Duties

- a. Maintain a Society Operations Primer, which contains job descriptions and practical knowledge for officers and committee chairs. The primer shall be provided to each incoming officer and committee chair at the beginning of their terms. The primer shall be reviewed annually and updated as necessary by current office holders and chairs. The Secretary shall be responsible for collecting and editing job descriptions for the primer.

Standing Committees

ARTICLE VII – COMMITTEES

Section 7.20 – Committee on Development

- a. Composition: The Committee on Development shall consist of a

chair and six (6) other members and a board advisor appointed by the President-Elect. The Treasurer shall serve as an adjunct member of the committee.

- b. Functions: The Committee on Development shall serve to work with industry in generating educational grants in support of the Society's mission statement. The Committee shall establish a recognition program to honor those organizations that provide support to the Society. The Committee shall perform its duties in accordance with continuing medical education accreditation guidelines.

Section 7.21 – Committee on Scientific Papers

- a. Composition: The Committee on Scientific Papers shall consist of a chair and six (6) other members and a board advisor appointed by the President-Elect. The Chair of the Committee on Annual Meeting shall serve as an adjunct member of the committee.

- b. Functions: The Committee on Scientific Papers shall solicit abstracts related to new research in ambulatory anesthesia for possible presentation at the Society's Annual Meeting. The Committee shall utilize an administrative staff, appointed by the Board of Directors, to develop and issue a call for abstract for distribution to the membership and to members of allied organizations. The Committee shall assemble abstract submissions through electronic submission, whenever possible, and distribute such submissions to the Committee members for grading in accordance with grading procedures established by the Committee. The Committee shall notify individuals whose abstracts were graded acceptable for presentation and inform those individuals whose abstracts were graded unacceptable for presentation.

Should the Society receive funding for awards related to the ab-

stracts for presentation at the Annual Meeting, the Committee shall establish a process for the determination of those abstract submitters who shall receive such awards.

Section 7.22 – Committee on Mid Year Meeting

- a. Composition: The Committee on Mid Year Meeting shall consist of a chair and six (6) other members and a board advisor appointed by the President-Elect. The Chair of the most recently convened Mid Year Meeting shall serve as an adjunct member of the committee.
- b. Functions: The Committee on Mid Year Meeting shall prepare the Mid Year Meeting, which shall be an educational meeting for members and nonmembers held annually in conjunction with the ASA Annual Meeting. The place and structure of the meeting shall be planned by the Committee subject to approval by the Board of Directors.

Section 7.23 – Committee on Latin American Relations

- a. Composition: The Committee on Latin American Relations shall consist of a chair and six (6) other members and a board advisor appointed by the President-Elect.
- b. Functions: The Committee on Latin American Relations shall serve to develop efforts to increase the clinical interest of the number of Latin American anesthesiologists engaged in ambulatory anesthesia in countries of Central and South America; to provide educational opportunities in the United States at SAMBA meetings and ambulatory surgery centers as well as to work to create ambulatory anesthesia fellowships for Latin American anesthesiologists; and to help foster education opportunities in Latin America, including programs presented at ambulatory facilities.

The Committee also shall serve to encourage the exchange of research opportunities and possibly

multicentered clinical research projects and to cultivate leadership relationships that may occur in Pan-American anesthesia meetings and in international anesthesia venues.

Section 7.24 – Committee on Regional Anesthesia

- a. Composition: The Committee on Regional Anesthesia shall consist of a chair and six (6) other members and a board advisor appointed by the President-Elect.
- b. Functions: The Committee shall serve to develop educational tools and guidelines for the practice of regional anesthesia in ambulatory settings. The Committee shall also address economic issues in the practice of regional anesthesia, including fair reimbursements for regional anesthesia procedures.

Section 7.25 – Committee on Electronic Communications

- a. Composition: The Committee on Electronic Communications shall consist of a chair and six (6) other members and a board advisor appointed by the President-Elect.
- b. Functions: The Committee on Elec-

tronic Communications shall facilitate communication and education throughout the SAMBA membership and others interested in the field of ambulatory anesthesia by publication of the monthly SAMBA electronic newsletter. To accomplish these goals, the committee will review the literature on a regular basis, liaise with the SAMBA leadership and SAMBA committees to ensure the timely dissemination of information related to events within the Society and direct an interactive Professional Discussion section in the electronic newsletter.

The above amendments will also require changes to Section 7.3 Classification of Standing Committees and Subcommittees as follows:

Section 7.3a – Classification of Standing Committees and Subcommittees

- Committee on Development
- Committee on Office-Based Anesthesia
- Committee on Scientific Papers
- Committee on Mid Year Meeting
- Committee on Latin American Relations
- Committee on Regional Anesthesia

Committee on Electronic Communications

Composition of the Committee on Annual Meeting

Section 7.13. – Committee on Annual Meeting

- a. Composition: The Committee on Annual Meeting shall consist of a chair, the chair of the Committee on Education, the chair of the Committee on Development and five (5) additional members, of which one is to serve as a vice-chair, and a board advisor. The two immediate past chairs of the committee on Annual Meeting shall serve as adjunct members.

Comments regarding the proposed amendments may be directed in writing to SAMBA, 520 N. Northwest Highway, Park Ridge, IL 60068-2573. Comments must be received by April 1, 2004. 

We've Come a Long Way, and We've Got a Long Way to Go

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interesting studies presented during the Canadian Anesthesiologists' Society Annual Meeting last June. It is widely recognized that patient selection is the key in providing safe anesthesia to our patients. Patient selection remains a major dilemma for ambulatory anesthesiology practitioners, however. Production pressures force us to provide anesthesia for patients with significant comorbidities undergoing extensive surgi-

cal procedures in ambulatory facilities. Unfortunately we have very little information on an evidence-based approach to appropriate patient selection. A survey of common practice allows us to recognize the areas of necessary research, which may be the first step toward improving our practice. The other areas that need our attention are postoperative pain and nausea and vomiting (particularly after discharge home). In order to achieve overall improvement, it is impera-

tive that we educate our surgical colleagues as well as our patients. The SAMBA Web site provides information that is helpful not only to anesthesiology practitioners but also to our patients. Through education and research, SAMBA has a great potential to be a national as well as an international force in ambulatory anesthesiology.

I look forward to seeing you in Seattle. 



SAMBA 19th Annual Meeting

Seattle, Washington

April 29 - May 2

Mark your calendar now and plan to attend the SAMBA 19th Annual Meeting on April 29-May 2, 2004, at the Seattle Westin Hotel in Seattle, Washington. Long recognized as the leading educational program in ambulatory anesthesiology, the SAMBA Annual Meeting will once again feature the Society's unique blend of scientific and business sessions and an outstanding program of social activities. Program Chair Lucinda L. Everett, M.D., Seattle, Washington, and Vice-Chair Tong J. Gan, M.D., Durham, North Carolina, and the Committee on Annual Meeting have assembled a faculty of renowned experts who will address issues of latest concern to SAMBA members.

The Committee on Annual Meeting has developed a comprehensive meeting program consisting of six general scientific panel sessions, two parallel focus sessions and five hands-on workshop sessions. Also included in the program are two Research-Poster Breakfast Discussion sessions, the popular "ASA Update" to be presented by American Society of Anesthesiologists (ASA) President Roger W. Litwiller, M.D., Roanoke, Virginia, and the SAMBA Luncheon featuring the presentation of the SAMBA Distinguished Service Award. The 2004 Distinguished Service Award recipient is Beverly K. Philip, M.D., Boston, Massachusetts. Rounding out the scientific program is a highly informative pre-convention workshop on "Preoperative Evaluation and Perioperative Medicine."

The "Preoperative Evaluation and Perioperative Medicine" pre-convention workshop will feature a faculty of internists and anesthesiologists to discuss topics such as mechanisms for preoperative evaluation, evaluation and optimization of disease states (e.g., hypertension, diabetes, asthma and cardiac disease) and morbid obesity and sleep apnea. The educational activity is approved for a maximum of 6.5 hours in

category 1 credit toward the American Medical Association Physician's Recognition Award.

Panels will present take-home information that can be applied to your practice on the following subjects: "Expertise in Ambulatory Anesthesia," "Presentation of Cases in the Real World," "Crisis Management," "Patient Safety," "Medicolegal and Compliance Issues: Case Presentations," "The Problem Patient," "Regional Anesthesia" and "Clinical Updates." Parallel focus sessions will target "Administrative Issues" and "Research and Teaching in Ambulatory Anesthesia." The "Administrative Issues" session will be presented in conjunction with the American Association of Ambulatory Surgery Centers.

The "Expertise in Ambulatory Anesthesia" panel will present issues in patient selection for ambulatory anesthesia as well as discuss the role of the anesthesiologist/medical director in the ambulatory setting. The program also will present information on benchmarking specific outcomes of interest in ambulatory care. The popular "Presentation of Cases in the Real World" will present challenging clinical situations that could be encountered by an anesthesiologist practicing in an outpatient or office setting. Panelists will discuss perioperative management strategies with input from the audience.

The panel on "Patient Safety" will discuss issues of safety in sedation of the adult and pediatric patient, particularly by nonanesthesiologists. Data will be presented on safety in office-based anesthesiology. Safety issues in the setting of plastic surgery will be discussed as well. The roles of defense and plaintiff attorneys and expert witnesses on various legal cases relevant to ambulatory/office-based anesthesiology will be illustrated in the thought-provoking "Medicolegal and Compliance Issue" panel.

"The Problem Patient" panel will address common postoperative concerns seen in the setting of ambulatory anesthesiology, including postoperative nausea and vomiting, pain and bladder function. Participants will learn what is known about the incidence, etiology and treatment of these problems. Participants in the "Administrative Issue" panel will discuss the leadership role of the physician/anesthesiologist as well as regulatory issues that affect ambulatory surgery and the anesthesiologist/medical director's role in these issues. Mechanisms for effective peer review also will be presented.

At the "Research and Teaching in Ambulatory Anesthesia" panel, members will discuss how to set up clinical research for the ambulatory setting and learn what it takes to publish a study. Approaches to teaching residents and medical students in ambulatory anesthesiology will be discussed. Various facets of regional anesthesia applicable to the outpatient setting will be addressed during the panel on "Regional Anesthesia," including the cost-effectiveness of regional anesthesia in ambulatory surgery and its impact on outcomes. Specific information on paravertebral blocks will be presented using information from a large academic practice that uses these techniques successfully. Complications in regional anesthesia from the ASA Closed Claims Project will be presented.

The "Clinical Updates" panel will provide an opportunity to discuss issues related to various specialty populations in ambulatory surgery, including the implications of hypertension in the elderly patient, selection criteria for the pediatric outpatient and issues relating to provider expertise and outcomes in pediatric anesthesiology and anesthetic concerns in the pregnant patient for outpatient surgery as well as patients presenting for in-vitro fertilization.

Workshops will address such topics as: "Technology in Anesthesia," "Re-



gional Anesthesia: Single-Injection Catheter," "Airway Management" and "Crisis Management." A separate workshop will provide a forum to discuss current clinical issues.

The "Technology in Anesthesia/PDA Workshop" will present basic applications of the personal digital assistant, or PDA, advanced uses of hand-held computers and applications specific to the practice of anesthesiology, including case tracking, clinical support software and educational and literature management applications. Participants at the "Regional Anesthesia for Ambulatory Surgery" workshop will witness demonstrations of single-injection and catheter techniques in a live video cast from Duke University in Durham, North Carolina, and then discuss these techniques in more detail in breakout sessions using models and illustrations. Workshop attendees will learn the risks and benefits of blocks for ambulatory anesthetic management as well as post-

operative pain relief. Breakout sessions will cover upper-extremity, lower-extremity and neuraxial and paravertebral blocks. The option to practice with various devices for management of the difficult airway, including rigid and flexible fiberoptic scopes as well as laryngeal mask airways and other alternatives, will be available to attendees at the "Airway Management" workshop.

As the public demands greater preparedness of anesthesiologists for future problems, the anesthesia simulator is the tool that will assist in experiencing rare events in real time. The "Crisis Management/Simulator" workshop will help participants to work through various crisis scenarios that might occur in the ambulatory or office setting. The "Clinical Forum" workshop will address cases that might occur in the ambulatory and office setting in a guided audience discussion. Clinical scenarios will cover pediatric, adult and geriatric patients. Case discussions will include

sleep apnea, pain management issues and postoperative delirium and discharge considerations.

One of the many highlights of any SAMBA Annual Meeting is the accompanying social program. Members and their spouses and guests will be treated to an evening at the Seattle Space Needle where they will enjoy a buffet dinner with an opportunity to taste a variety of wines from the Pacific Northwest, the second largest wine-producing region in the United States. The Society also has reserved a private section of the observation deck for dessert and coffee for SAMBA meeting attendees.

Registration information is available online at <www.sambahq.org>. As a membership benefit, SAMBA members receive a discount off the regular registration fees for the general meeting and pre-convention workshops.

We look forward to seeing you in the enchanting Pacific Northwest and Seattle, America's "Emerald City!" 

Committee on Awards Seeks DSA Nominations

The Committee on Awards is seeking nominations for the SAMBA 2005 Distinguished Service Award (DSA). The award will be presented during the SAMBA 20th Annual Meeting to be held May 12-15, 2005, at the Marriott's Camelback Inn Resort and Spa, Scottsdale, Arizona.

This prestigious award, which represents the highest honor SAMBA can bestow upon an individual, is presented in recognition of outstanding achievement in ambulatory anesthesiology. Beverly K. Philip, M.D., Boston, Massachusetts, is the 2004 recipient. Past DSA winners are:

- | | | | |
|------|--|------|---|
| 1994 | Marie-Louise Levy, M.D.
Chevy Chase, Maryland | 2002 | Herbert D. Weintraub, M.D.
Bethesda, Maryland |
| 1995 | Bernard V. Wetchler, M.D.
Chicago, Illinois | 2003 | Raafat S. Hannallah, M.D.
Washington, D.C. |
| 1996 | Stanley Bresticker, M.D.*
Somerset, New Jersey | | * Deceased |
| 1997 | Harry C. Wong, M.D.
Salt Lake City, Utah | | |
| 1998 | Burton S. Epstein, M.D.
Bethesda, Maryland | | |
| 1999 | Surinder K. Kallar, M.B.
Richmond, Virginia | | |
| 2000 | Wallace A. Reed, M.D.
Phoenix, Arizona | | |
| 2001 | Paul F. White, M.D., Ph.D.
Dallas, Texas | | |

Nominations must include a cover letter, a copy of the nominee's curriculum vitae and no more than four letters of support for the nomination. Nominations must be received at the SAMBA office no later than August 16, 2004. 

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Beverly K. Philip, M.D.
Boston, Massachusetts

Herbs and Supplements: Clinical Update

Continued from page 3

often combine several substances with similar stimulant effects.

The FDA also has cracked down on the online marketing of some herbal substances that have effects similar to illicit drugs as well as "illegal street drugs masquerading as dietary supplements." The Internet is teeming with products for sale touting miraculous results. Spam e-mails fill inboxes advertising products for male sexual enhancements, breast enhancement or as alternatives for some well-known prescription drugs. The FDA has recently gone after compounds sold on the Internet that falsely claim to treat anthrax or other bioterrorism threats and those purporting to lower cholesterol levels. An herbal version of sildenafil (Viagra®) was pulled from the market after discovery of sildenafil in the tablets. Similarly an antihypertensive and a prostate symptom-relief agent were found to be adulterated with prescription drugs. Quality control for these substances is often poor.

Contamination of herbal products with heavy metals or other herbs such as ephedra is well documented. There is even concern today that some supplements may be contaminated with mad cow disease during harvest or processing. Herbal products tested by companies such as Consumer Laboratories are sometimes shown to contain trace or no evidence of the actual compounds (i.e., ginkgo products containing none of the

active ingredient bilobalide necessary for effect on memory).

Middle-aged women, especially those who are college-educated and living on the coasts, are the most frequent users of herbs and supplements. A major market for herbal products is symptom relief for perimenopausal and menopausal women. These nonprescription alternatives have been advocated by many since the studies of traditional hormone replacement therapy demonstrated unexpected risks. Patients do not, however, always ask their physicians for advice about supplements; instead they rely on friends, family and the media or the Internet for information. Black cohosh, motherwort and soy are all marketed for amelioration of symptoms such as hot flashes. There are no reports of adverse events with these products at this time.

Concerns for patients undergoing surgery or anesthesia who use herbs and supplements still remain despite the ephedra ban. A thorough history of use of all over-the-counter herbal supplements is necessary. Patients may not always disclose their use, e.g., those still taking ephedra after the ban. Six substances of concern are those that may cause excessive bleeding, including vitamin E, feverfew, ginkgo, ginseng, ginger and garlic. Other herbals and supplement products may be contaminated or not contain the herbs listed on the label. A good plan for action remains: ask, be aware and expect the unexpected. 