



Society for Ambulatory Anesthesia

Ambulatory AnesthesiaSM

PRESIDENT'S MESSAGE

Future Looks Bright for Anesthesiology

By *Richard A. Kemp, M.D.*
SAMBA President

The new millennium will have arrived by the time you read this and I trust that we will have escaped the Y2K bug. Our lives will continue the same now as they did in the previous 1,000 years. Future physicians and the rest of the population, however will be interested in how we did things at this point in time.

A major activity for the society last year concerned a joint effort with ASA's Committee on Ambulatory Surgical Care, chaired by Rebecca S. Twersky, M.D., which developed guidelines for office-based anesthesia. This great effort produced a document with diverse points of view. The ASA's House of Delegates accepted the committee's report in October at the ASA Annual Meeting.

The guidelines are intended to educate anesthesiologists about the safeguards they should insist upon before agreeing to work in an office setting. They were written to inform anesthesiologists about the many potential problems that should be personally investigated concerning the adequacy of such areas as construction, equipment, education and training of personnel and emergency policies.

The guidelines about minimal standards for patient safety are likely to be seriously considered by state legislatures and regulators. In my own state of Connecticut this past year I was asked to respond to questions before a legislative hearing and a regulatory certificate of need commission about the adequacy of safety and quality in office settings. The legisla-

tive hearing was in response to a bill proposed by the state hospital association to eliminate office surgery and anesthesia. The bill was never reported out of the Public Health Committee and was never voted upon. However, the Office of Health Care Access (OHCA) held hearings and recently came out with a ruling that will require a Certificate of Need (CON) for any office surgical program which seeks accreditation or licensure. A list of procedures will be developed in the next six months for which a CON would be necessary.

The role SAMBA has played around the world, and the efforts of many of our members in the transformation to ambulatory surgery and anesthesia, is quite remarkable. I recently attended a Congress on Ambulatory Surgery and Anesthesia in Spain which featured 800 attendees, including many anesthesiologists, surgeons and nurses.

One individual from Costa Rica reported interest in office-based anesthesia. "The Americans are doing it!" he exclaimed. Not only are our guidelines going to be reviewed by Americans, but also by practitioners worldwide.

SAMBA will be sponsoring an additional meeting this year for one and one-half days in Montreal, Quebec, Canada on June 3-4, 2000. It will be presented in conjunction with the 12th World Congress of Anaesthesiologists. Frances F. Chung, M.D., Toronto, Ontario, Canada, and her committee have assembled an international group of speakers. I attended the previous meeting in Sydney, Australia, and found that the inter-



Richard A. Kemp, M.D.

change of many people from around the globe in an international setting is quite remarkable.

Plans are being made to jointly sponsor a meeting in Boston with the Federated Society of Ambulatory Surgery (FASA) and the International Association of Ambulatory Surgery (IAAS) in May 2003. SAMBA is the only professional ambulatory anesthesia organization that is a member of the IAAS. Raafat S. Hannalah, M.D., Washington, D.C., is our representative to the IAAS General Assembly (Board of Directors).

The SAMBA Midyear Meeting, held prior to the ASA meeting in October, was most successful thanks to the enthusiastic and careful preparations by chairperson Melinda L. Mingo, M.D., New York, New York. SAMBA will again be sponsoring a similar meeting in October 2000, which will be chaired by Andrew Herlich, M.D.

Charles H. McLeskey, M.D., has
Continued on page 10

Changes, Changes, Changes

As we enter the next millennium (aren't we all getting a little numb by the use of this word by now?), we are more than ever certain that each day will bring us new challenges and new opportunities to advance our specialty and to ensure the proper care of the patients entrusted to us. Much has happened since our last newsletter. Many interesting ideas have emerged from the SAMBA Midyear Meeting and from the ASA Annual Meeting in Dallas, Texas. We have included some of the meeting highlights in this issue of your newsletter.

Girish P. Joshi, M.D., has given us an excellent summary of new advances in recovery and discharge of the ambulatory patients. Hernando DeSoto, M.D., has a great review of a most interesting poster session on nausea and vomiting, which is without a doubt still the most frequent problem ambulatory anesthesiologists face on a daily basis. Adam F. Dorin, M.D., challenges us with a very thought-provoking letter to the editor. Certainly the contents of this newsletter should challenge all of us as we embark on the first year of this next thousand years. We were unable to

fully include work on deep sedation by Burton S. Epstein, M.D., as this is still a "work in progress." However, much of this interesting project can be found on the ASA Web site at www.ASAhq.org. The office-based anesthesia guidelines are also available for your review on the ASA Web site and Rebecca S. Twersky, M.D., and her task force on this subject continue to progress towards the final publication of a more detailed discussion of this rapidly expanding subset of the ambulatory anesthesiologists' practice.

I for one was very impressed by the presentation of Himat Vaghadia, M.B., Vancouver, B.C., at the SAMBA Breakfast Panel in Dallas, in which he discussed his "walking spinal." He has had great success with spinal regional anesthetics wherein patients actually do walk in and, most impressively, *walk out* of the operating room. He uses a 27 Whitaker spinal needle (obviously not the needle of choice for the casual user of subarachnoid anesthesia!) and works with a surgeon who does a laparoscopy in 45 minutes. Using a hypobaric lidocaine solution of 10-20 mg, with the addition of 10 mcg. of sufentanil, he is able to do



Walter G. Maurer, M.D.

something that I think we all felt was amazing.

The recent ASA Refresher Course in New Orleans (November 13-14) covered much of what is new and cutting-edge in office-based anesthesia. Attendees came not only from the classic ambulatory anesthesia background but also from the dental profession. Richard Finder, D.M.D., from the School of Dental Medicine at the University of Pittsburgh, stimulated some new thoughts with a description

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Washington, D.C. to Host SAMBA 15th Annual Meeting

Mark your calendar now and plan to attend the SAMBA 15th Annual Meeting on May 4-7, 2000, at the J. W. Marriott Hotel in Washington, D.C. Long recognized as the leading educational program in ambulatory anesthesia, the 15th presentation of 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 Charles H. McLeskey, M.D. 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 nine general scientific sessions and six hands-on workshop sessions. Also included in the program are two Research-Poster Breakfast Discussion sessions, a Luncheon with Experts and a luncheon featuring the popular "ASA Update" to be presented by Ronald A. MacKenzie, D.O., President of the American Society of Anesthesiologists. Rounding out the scientific program is a highly informative preconvention workshop on Advanced Cardiac Life Support taught by the staff of George Washington University.

Panels will present take-home information that can be applied to your practice on the following subjects: "Managing the Costs of Ambulatory Anesthesia," "Office-Based Anesthesia," "Effective Strategies for Accessing Medical Information on the Internet," "Alternative Medicine," "The ASA Closed Claim Project: Lessons for the Ambulatory Anesthesiologist," "Anesthetic Outcomes: Epidemiology and Implications for Healthcare Policy," "Presentations of Cases in the Real World," and "Postoperative Dilemmas."

Workshops will address such issues as: "Ambulatory Perioperative Pain Management in Children and Adults," "Update on Medicare Compliance," "New Airway Devices to Get Us Out of a Jam," "Managed Care Contracts:



The nation's capital will serve as host city to the SAMBA 15th Annual Meeting on May 4-7, 2000. (Photograph courtesy of Washington Area Convention and Visitors Bureau)

Negotiating Effectively," "Regional Anesthesia for Outpatients: From Nose to Toes," and "Malpractice Suits: Prevention and Management."

One of the many highlights of any SAMBA Annual Meeting is its accompanying social program - this year's social program promises to be extra-special as we gather in our nation's capitol. Members and their spouses and guests will be treated to an elegant buffet reception in the universally acclaimed Corcoran Gallery of Art, where presidents and heads of state have gathered. Special arrangements are being made with the gallery to accommodate children during the reception. In addition, SAMBA has hired a local destination company which will offer an array of Washington, D.C., tours that will fascinate newcomers as well as those who are frequent visitors to the city. Included is an overview tour which highlights the many monuments and attractions that the capitol has to offer. This excellent tour will be

beneficial to those whose time is limited and who would like to enjoy the flavor of our nation's capitol in a short period of time. It is also ideal for those who would like an overview of the city to help plan their stay. Other tours include evening excursions to selected monuments at night, a visit to the Museum of the National Freedom Forum, a tour of the capitol's oldest homes, a visit to embassy row and the National Cathedral, and a trip to Mount Vernon and historic Alexandria.

Registration information will be mailed to SAMBA and ASA memberships in mid-January. Registration will also be available online at the SAMBA Web site, whose address appears on the masthead of this newsletter. As a membership benefit, SAMBA members will receive a discount off the regular registration fees for the general meeting and the preconvention workshops.

We look forward to seeing you in Washington, D.C. next spring. 

New Concepts in Recovery After Ambulatory Surgery

By Girish P. Joshi, M.D.
Associate Professor, Department of
Anesthesiology and Pain Management
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Southwestern Medical Center
Dallas, Texas

Over the last two decades the practice of medicine has changed remarkably. There has been a shift in patient care from the inpatient to the ambulatory setting. Currently, 60-65 percent of all elective surgical procedures are being performed on an outpatient basis. Because ambulatory surgical units are typically high volume, rapid turnover settings (one of the important factors in the success of ambulatory surgery) are safe and recovery and discharges home are expeditious.

Unnecessary delay in discharge reduces the effectiveness and efficiency of an outpatient setting. On the other hand, premature discharge from the hospital may increase the incidence of readmission, postoperative complications and may lead to legal repercussions. In an effort to improve patient satisfaction, it is necessary to assure a smooth transition to the home setting.¹

The course of recovery after ambulatory surgery can be divided into three phases which serve as useful guides to patient management and also as benchmarks for comparing different anesthetic techniques. The early or immediate recovery phase occurs in the postanesthesia care unit [PACU], during which patients emerge from anesthesia and recover their protective reflexes and motor function. The intermediate recovery phase occurs in the Phase Two unit, during which time the patient recovers coordination and physiologic function and is considered ready for discharge home. The late recovery phase occurs after discharge from the hospital. At this time the patient recovers completely from both anesthesia and surgery and is ready to resume routine daily activities.

Recovery care after ambulatory

surgery is in a state of flux. Traditionally, discharge from an ambulatory setting has been time-based. However, there has been a move away from time-based discharge to clinical-based discharge. Utilization of appropriate scoring systems allows the patients to be safely discharged from the PACU (or to bypass the PACU) and to be discharged home. The modified Aldrete criteria are commonly utilized to determine if the patient is ready for discharge from the PACU to the Phase Two unit.²

With availability of newer, shorter-acting anesthetic, analgesic and neuromuscular blocking drugs and development of minimally invasive surgical procedures, it is now possible to have patients who are awake, alert and comfortable in the operating room. Therefore, the length and the need for PACU stay is in question. There is a trend towards transferring patients from the operating room directly to the phase II unit (i.e., bypassing the PACU). This concept is known as fast tracking. Increasingly, a number of studies have demonstrated the feasibility and safety of bypassing the PACU.^{3,5} Computer simulation techniques have been used to determine if rapid anesthetic recovery protocols, which decrease the time for emergence or increase the PACU bypass rate, affect staffing of an ambulatory surgery center.⁶ The process of fast tracking can be further extended to the Phase Two unit, resulting in an early discharge home. Thus, assessment of patient needs and time spent in the hospital is becoming an increasingly relevant issue from both a clinical and a cost standpoint. The Aldrete criteria have been modified to evaluate the eligibility of patients for fast tracking, which include an awake and oriented patient with stable vital signs (hemodynamic and respiratory stability), minimal pain, minimal nausea, and no vomiting.⁷

The postanesthesia discharge scoring system (PADS) is the most commonly used tool for determining home readiness.⁸ It was initially pro-



Girish P. Joshi, MB, BS, MD

posed that the patient tolerate oral fluids and/or void before being allowed home. However, mandatory oral intake and voiding before discharge have been challenged. Recent studies report that 10-20 percent of outpatients can be discharged earlier if drinking and voiding are eliminated from the discharge criteria.⁹ The current modified version of PADS does not include the requirement to drink and void.¹

One of the reasons for insistence on oral intake before discharge is to avoid post-discharge dehydration and to minimize the readmission rate. With the current practice of allowing oral intake (clear fluids) until two hours before surgery, patients are well hydrated preoperatively.¹⁰ Furthermore, patients receive liberal intravenous fluids intraoperatively because of reports of reduced incidence of postoperative nausea, thirst, dizziness and drowsiness.¹¹ Adequate preoperative and intraoperative hydration should reduce the incidence of postoperative dehydration. On the other hand, administration of oral fluids to a nauseated patient may further increase the incidence of postoperative nausea and vomiting. Therefore, mandatory drinking in the postoperative period may not be necessary and may in fact be deleterious.

Schreiner et al.¹² compared the effect of mandatory drinking and vol-

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untary drinking prior to discharge after outpatient surgery. Nine hundred eighty-nine children undergoing ambulatory surgery were randomized to one of two treatment groups. Children in Group One ("mandatory drinkers"), were required to drink clear liquids (minimum of 60 ml) prior to discharge; and those in Group Two ("elective drinkers") were allowed, but not required, to drink clear liquids before discharge home. These investigators found that insistence on drinking increased the incidence of vomiting and prolonged the duration of hospital stay. No patient in either group required readmission for vomiting or dehydration after discharge from the ambulatory center. These authors recommend that children who undergo brief surgical procedures (e.g., placement of myringotomy tubes) be discharged home without being required to drink.

Jin et al.¹³ evaluated the effects of withholding oral fluids before discharge home in adult outpatients. Seven hundred twenty-six patients were randomly assigned to one of two groups (mandatory drinkers and elective drinkers). These investigators found that patients who were required to drink fluids had a longer hospital stay than those who were discharged home without drinking. However, there was no difference in the incidence of postoperative nausea and vomiting between the mandatory drinkers and the non-drinkers. Of note, the patients in this study received large infusions of fluids (20 ml/kg) perioperatively, which has been shown to reduce the incidence of postoperative nausea, thirst, dizziness and drowsiness.¹¹

These studies suggest that eliminating oral fluid intake as one of the discharge criterion can shorten the hospital stay without increasing the incidence of adverse effects or readmission rate. The factors which determine the need for oral intake before discharge include preoperative medical condition, state of hydration, likelihood of complications if fluids are

not taken, and distance home.

Another criterion which is currently being evaluated is the need for voiding prior to discharge. Voiding has traditionally been considered a prerequisite to discharge home because overdistention of the bladder due to retention can cause bladder atony and lead to significant complications. However, there is mounting evidence that insistence on voiding before discharge in all patients is unnecessary and can delay discharge.⁹ It is recommended that voiding prior to discharge should be balanced against the type of surgery performed, prior history of urinary retention and anesthetic technique used.

Pavlin et al.¹⁴ designed a study to test a treatment algorithm for management of bladder function after ambulatory surgery. Three hundred twenty-four outpatients receiving general, regional or local anesthesia were classified into four risk categories for urinary retention. Patients in category one consisted of low-risk patients (n = 227) having non-pelvic surgery; those in category two were possible low-risk patients (n = 40) having vaginal or pelvic gynecologic surgery; category three patients were considered high-risk and were undergoing (n = 31) hernia or anal surgery; and those in category four were considered high-risk due to prior history of urinary retention (n = 31). Bladder volumes were measured using ultrasound on arrival in the PACU, at time of transfer to the Phase Two unit, and at hourly intervals thereafter until voiding occurred or patients were catheterized for inability to void at full bladder capacity (i.e., bladder volume > 600 ml). Patients in category one were allowed to be discharged without voiding if otherwise fit for discharge. Patients in categories two-four were required to void before discharge. These investigators found that urinary retention occurred in 0.5 percent of category one patients and no category two patients. Retention occurred in 5 percent of high-risk patients before discharge and recurred

in 25 percent after discharge. They concluded that patients at low-risk of urinary retention (including those undergoing routine gynecologic surgery) can be safely discharged home. This practice would reduce recovery time by approximately 75 minutes in 12 percent of patients. Patients at high-risk (i.e., patients undergoing inguinal or anal surgery, those with a prior history of urinary retention and patients receiving regional anesthesia) should be required to void or have their bladder evacuated if they are unable to void when otherwise ready for discharge. All patients should be cautioned to return to the medical facility if they are unable to void within 8-12 hours of discharge.

Pavlin et al.¹⁴ also evaluated the effect of liberal intravenous fluid administration on the incidence of urinary retention. Patients in the low-risk category were assigned to a high-fluid (250 ml plus 10 ml/kg Ringer's lactate solution) or low-fluid (250 ml plus 2 ml/kg Ringer's lactate solution) group. Although administration of high amounts of fluids increased bladder volume, it did not increase the incidence of urinary retention, nor did it hasten the onset of voiding. This suggests that attempts to hasten the onset of voiding by fluid administration may simply increase the likelihood of developing minor urinary symptoms after surgery. These investigators concluded that patients should receive perioperative fluids judiciously to avoid overdistending the bladder before they are ready to void, particularly in those at high risk for retention.

In summary, use of specific criteria that are simple, clear, objective and reproducible provide a reliable guide for safe discharge of outpatients. Each institution should modify the established criteria according to their patient population, surgical case mix and availability of nursing care. It is important to recognize that home readiness is not synonymous with

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SAMBA 15TH ANNUAL MEETING SCIENTIFIC PROGRAM

May 3-7, 2000
J.W. Marriott Hotel
Washington, D.C.

Wednesday, May 3, 2000

6 p.m. — 10 p.m. PRECONVENTION WORKSHOP
PART 1
Advanced Cardiac Life Support
**(Limited attendance. Separate
advance registration required.)**

Thursday, May 4, 2000

7:30 a.m. — 4:30 p.m. PRECONVENTION WORKSHOP
—PART 2
Advanced Cardiac Life Support
**(Limited attendance. Separate
advance registration required.)**

1:30 p.m. — 5:30 p.m. Social Tour: The Best of Washington
(Separate tour registration required.)

4 p.m. — 8 p.m. Registration

5 p.m. — 7 p.m. OPTIONAL CONCURRENT
WORKSHOPS
**(Limited attendance. Separate
advance registration required.)**

Ambulatory Perioperative Pain
Management
Moderator: Raafat S. Hannallah, M.D.

Update on Medicare Compliance
Moderator: Patrica A. Kaupur, M.D.

New Airway Devices to Get Us Out
of a Jam
Moderator: Andrew Herlich, M.D.

6 p.m. — 8 p.m. WELCOMING RECEPTION in the
Exhibits Area

6 p.m. — 10 p.m. Social Tour: Monuments By
Moonlight I
(Separate tour registration required)

7 p.m. — 8 p.m. Chief Residents Dinner

Friday, May 5, 2000

7 a.m. — 7:55 a.m. RESEARCH-POSTER
BREAKFAST DISCUSSION

7:55 a.m. - 8 a.m. Announcements
Charles H. McLeskey, M.D.

8 a.m. — 10 a.m. Managing the Costs of Ambulatory
Anesthesia
Moderator: Alex Macario, M.D.

10 a.m. — 10:30 a.m. COFFEE BREAK in Exhibits Area

10:30 a.m. — 12 noon Office-Based Anesthesia
Moderator: Rebecca S. Twersky, M.D.

12 noon — 1:30 p.m. ASTRAZENECA LUNCHEON
WITH EXPERTS
Charles H. McLeskey, M.D.
Facilitator: Ronald S. Litman, D.O.

1:30 p.m. — 3 p.m. Effective Strategies for Accessing
Medical Information on the Internet
Moderator: Keith J. Ruskin, M.D.

1:30 p.m. — 5:30 p.m. Social Tour: Washington's Oldest
Neighborhood
(Separate tour registration required)

1:30 p.m. — 5:30 p.m. Social Tour: Experience the News Like
Never Before
(Separate tour registration required)

6 p.m. — 10 p.m. Social Tour: Monuments By
Moonlight II
(Separate tour registration required)

Saturday, May 6, 2000

7 a.m. — 7:55 a.m.	RESEARCH-POSTER BREAKFAST DISCUSSION
7:55 a.m. - 8 a.m.	Announcements Barbara S. Gold, M.D.
8 a.m. — 10 a.m.	Alternative Medicine Moderator: Charles H. McLeskey, M.D.
10 a.m. — 10:30 a.m.	COFFEE BREAK in Exhibits Area
10:30 a.m. — 12 noon	The American Society of Anesthesiologists Closed Claim Project: Lessons for the Ambulatory Anesthesiologist Moderator: Frederick W. Cheney, M.D.
12 noon — 1:30 p.m.	AWARDS LUNCHEON Ambulatory Anesthesia Research Foundation Awards SAMBA Outcomes Research Award Distinguished Service Award Recipient: Wallace A. Reed, M.D. Presenter: Richard A. Kemp, M.D. ASA Update Ronald A. MacKenzie, D.O. President, American Society of Anesthesiologists
1:30 p.m. — 3 p.m.	Anesthetic Outcomes: Epidemiology and Implications for Healthcare Policy Moderator: Lucinda L. Everett, M.D.
1:30 p.m. — 5:30 p.m.	Social Tour: Embassy Row and The National Cathedral (Separate tour registration required)
1:30 p.m. — 5:30 p.m.	Social Tour: A Visit to Our Colonial Past (Separate tour registration required)
3 p.m. — 5 p.m.	OPTIONAL CONCURRENT WORKSHOPS (Limited attendance. Separate advance registration required.)

Moderator:	Managed Care Contracts: Negotiating Effectively Lydia A. Conlay, M.D.
Moderator:	Regional Anesthesia for Outpatients: From Nose to Toes Kenneth Zahl, M.D.
Moderator:	Malpractice Suits: Prevention and Management Medicolegal Risk How to Prevent/What to Do If Sued Katherin E. McGoldrick, M.D.
Moderator:	3 p.m. — 5 p.m. Residents Conference Peter S. A. Glass, M.D.
	6:30 p.m. — 9:30 p.m. BUFFET RECEPTION AT THE CORCORAN GALLERY OF ART

Sunday, May 7, 2000

7 a.m. — 8 a.m.	GENERAL MEMBERSHIP BREAKFAST MEETING Presiding: Richard A. Kemp, M.D. Secretary's Report Treasurer's Report Committee Reports Election of Officers and Directors Presidents Comments Passing of the Gavel Closing Remarks
8:15 a.m. — 10:15 a.m.	Presentation of Cases in the Real World Moderator: Burton S. Epstein, M.D.
10:15 a.m. — 10:30 a.m.	COFFEE BREAK
10:30 a.m. — 12 noon	Postoperative Dilemmas Moderator: Barbara S. Gold, M.D.

Ambulatory Anesthesia: Perioperative Nausea and Vomiting

Hernando De Soto, M.D.
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University of Florida, Jacksonville
Medical Director of the
Operating Room
Shands Jacksonville
Jacksonville, Florida

On Monday, October 11, 1999, during the American Society of Anesthesiologists' Annual Meeting in Dallas, Texas, there was a poster discussion session titled "Ambulatory Anesthesia: Perioperative Nausea and Vomiting." Eight posters were presented for view and the authors made presentations followed by a brief discussion of the topics. There were four posters from Germany, one from The Netherlands and three from the United States.

The first study, "A Simplified Risk Score for Predicting Postanesthetic Nausea and Vomiting," was presented by **Christian C. Apfel, M.D.**, of Germany. The study investigated whether risk scores are valid across centers and whether risk scores based on logistic regression coefficients can be simplified. Interestingly, the final score consisted of four predictors: female gender, history of motion sickness and/or postanesthetic nausea and vomiting, nonsmoking, and the use of postoperative opioids.

The second study, "The Relative Risk for Females to Vomit After Inhalation Anesthesia Increases With Age," was also presented by Dr. Apfel. The study analyzed the relative risk of postanesthesia vomiting for females in different decades. Dr. Apfel concluded that the impact of the female gender as a risk factor for postanesthesia vomiting increases with age and remains significant in menopause and is thus not related to menstruation. An interesting discussion ensued in regards to the relationship to menstruation as a nonfactor. Dr. Apfel based his theory on an apparent genetic predisposition by women on postanesthetic vomiting.

Eduardo Zarate, M.D., from the

University of Texas Southwestern Medical Center in Dallas, Texas, presented a study comparing the cost-effectiveness of dolasetron and ondansetron for prophylaxis of postoperative nausea and vomiting (PONV) after ambulatory surgery. It was concluded that dolasetron was a much more cost-effective drug than ondansetron for preventing PONV after ENT surgery. Excluding nursing labor costs did not change this finding. The findings make sense since nurses are a fixed cost to an institution.

Charles R. Roberson, M.D., from the Scott and White Clinic and Hospital in Temple, Texas, also presented a comparison between dolasetron and ondansetron. The talk compared the effectiveness of these drugs for PONV in the postanesthesia care unit (PACU) or day surgery unit. Results showed that 70 percent of patients in the ondansetron group required rescue medication versus 40 percent in the dolasetron group. Also, the time spent in the PACU/day surgery unit was 27 minutes shorter in the dolasetron group. The cost was significantly less with dolasetron. Interestingly, the dolasetron-treated patients had a significantly greater incidence of recurrent PONV within 24 hours of discharge (in spite of dolasetron being a longer-acting agent). This finding was explained by observing that the ondansetron group had received more antiemetics during their rescue. Nevertheless, 73 percent of patients were satisfied with management of PONV in dolasetron group versus 58 percent in the ondansetron group.

Another German study was presented by **Peter Kranke, M.D.**, on the effect of different antiemetics on a propofol-based anesthetic. Patients with an increased risk of postoperative vomiting received either tropisetron, dimenhydrinate, droperidol, metoclopramide or placebo. The results showed that all antiemetics were better than placebo in decreasing the incidence of postoperative nausea

and/or vomiting. Interestingly, the old drug dramamine (dimenhydrinate) had the best results.

Phillip E. Scuderi, M.D., from Wake Forest University, Winston-Salem, North Carolina, presented how a multimodal approach to management of PONV was superior to routine monotherapy prophylaxis. He studied three groups of patients undergoing outpatient laparoscopy. Group One patients received total intravenous anesthesia (propofol and remifentanyl), no N₂O, no neuromuscular blockade, aggressive IV hydration (25ml/kg), triple prophylactic antiemetics (ondansetron, droperidol and dexamethasone) and ketorolac. Group Two patients received a standard, balanced outpatient anesthetic with ondansetron prophylaxis. Group Three patients were the same as Group Two but without the prophylaxis. The results were very significant in that none of the Group One patients vomited prior to discharge (Group Two—7 percent, Group Three—22 percent). Also, one patient in Group One required treatment for PONV in the PACU, compared to 24 percent in Group Two and 41 percent in Group Three. Discharge time was also significantly shorter in Group One.

The last study presented was by **Klazina Visser, M.D.**, from The Netherlands. The study looked at the incidence of PONV following anesthesia with isoflurane/N₂O versus TIVA with propofol. Dr. Visser performed an observer-blind, patient-blind randomized clinical trial for unselected outpatients in a teaching hospital. The results showed that TIVA with propofol was far superior than isoflurane/N₂O in decreasing the incidence of PONV at discharge 24 hours after surgery and 48 hours after surgery.

Let's Meet the Challenge!

This is a letter of challenge to our specialty and to ourselves. The challenge is to make a specialty society that is more open, sensitive and responsive to the core constituents of the Society for Ambulatory Anesthesia (SAMBA). This letter was written at the urging of a growing number of colleagues and conference attendees I have met through SAMBA.

I have found a recurrent theme in the type of comments and questions waiting for me from audience members after the talks I have given at SAMBA meetings over the years. Attendees are appreciative of contributions made by members of the academic community, but they are also concerned about the lack of representation for the bulk of SAMBA membership who work at and run freestanding Ambulatory Surgical Centers (ASC). I come into contact with many anesthesiologists in my travels as a surveyor for the Accreditation Association for Ambulatory Health Care and personally utilize a large pool of locum tenens anesthesiologists. I have made it a priority to solicit open-ended comments from anesthesiologists in response to the question, **"What is your biggest concern for ambulatory anesthesia today?"** For the past year I have collected and collated these comments (some two hundred and twenty-one in all) and present this unscientific, yet I believe valuable, list to our readers. The top five concerns are presented with percentage representation and in order of decreasing number. The following consists more of observation than objective data, but it is my hope that a more formal survey of SAMBA members could bring out these and other important concerns of our members.

Fifty seven percent of respondents to the above question said the low quality of anesthesia and lack of sound perioperative medicine delivered at office-based surgical facilities troubled them. Interestingly, the majority referred to single-O.R. facilities which were serviced by independent

groups of "mobile" anesthesiologists. This is not inconsistent with data presented by Lee A. Fleisher, M.D., at the October 8, 1999 SAMBA Midyear Meeting in Dallas, which showed the highest degree of complications arising out of the office-based arena. It is noteworthy that Dr. Fleisher's data showed the lowest incidence of problems arising in the ambulatory surgery center environment (the hospital outpatient setting showed an intermediary incidence).

Twenty one percent of the respondents revealed a sincere desire to know more about possible Medicare fraud as it applies to anesthesia practice. There have been excellent presentations on the subject of Medicare rules (and Medicare payment schemes) by members of ASA and outside legal counsel (most recently by Karin Bierstein, Practice Management Coordinator, at the SAMBA Midyear Meeting in Dallas), but no one has touched on the sticky issue of what anesthesiologists are actually doing! People do not want to implicate themselves or their colleagues, but they do want to know the prevalence of these problems and how to avoid them. Collated group data from SAMBA could provide a much-needed source of information. As I confirmed with legal counsel from ASA, many people may falsely believe that implicit "green lights" from local carriers protect them from Medicare fraud prosecution.

Nine percent of our colleagues are concerned with the lack of representation of community outpatient departments and freestanding surgery centers in SAMBA. Whether this is true or not, the perception is real. Three respondents had a nearly identical comment: "Why do they think we have the resources and protocols for preoperative work-ups like University Hospital?" This is a valid comment as there are over 2,600 surgery centers in the U.S. (far more than the number of university hospitals) and most are practicing good preoperative medicine, but they are

doing it their way. Let's hear how they do it!

Seven percent of the respondents complained about the difficult political environment surrounding relations with CRNAs. ASA has done an excellent job representing the interests of medicine in general and anesthesiology specifically. Nevertheless, there are a lot of excellent nurse anesthetists working with our people - maybe we could speak constructively about the real-world anesthesia "teams" practicing together "in the trenches."

Six percent of the anesthesiologists questioned are worried about the future. Many in this category commented that they feel their colleagues are too competitive, leaving little room for cooperation and positive collegial exchange. This category, sadly, speaks for itself. I think we have all felt this to some extent.

In conclusion, I have no answers. However, I hope to bring our specialty to a better place by posing the questions and concerns of our fellow members and colleagues. Let's open the forum and see where it takes us.

Adam F. Dorin, M.D.
 Medical Director and
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 The Surgery Center of Chevy Chase,
 Chevy Chase, Maryland
 Member, SAMBA Committees on
 Publications and Meetings 

President's Message

Continued from page 1

been busily preparing for the upcoming SAMBA 15th Annual Meeting in Washington, D.C. The quality of the scientific programs continues to be superb, with excellent scientific discussions and enjoyable social events.

In other news, we are anxiously awaiting responses to the requests for proposals (RFP) for SAMBA's \$100,000 outcome research award. This is a challenge to our fellow academicians which will attract an exceptional outcomes-oriented research project for the purpose of elevating the quality of patient care in ambula-

tory anesthesiology and to increase the quality of ambulatory anesthesia publications. John M. Lewis, M.D., is the Chair of the committee and has been recruiting a five-member panel who will review the proposals and arrive at a recommendation.

Elsewhere you will see information about our Web site. The Internet is becoming a very important part of our outreach to patients on a direct basis. National advertising in print and radio has increased the number of "hits" to our Web site.

Lastly, my lifelong friend, Burton S.

Epstein, M.D., has been given the Distinguished Service Award by the ASA House of Delegates. A founding member of SAMBA, and a previous recipient of SAMBA's Distinguished Service Award, he has been a mentor to me and many others. Always a voice of reason, he has been a guiding force for ambulatory anesthesia. Once again, as moderator for the panel on the popular Real World Anesthesia program at the annual meeting, he will be asking the sharp, intuitive questions that make the program so worthwhile. 

Readers Respond to First Online Survey

By J. Lance Lichtor, M.D.
Professor

SAMBA's first online (but unscientific) survey asked two questions and had 46 respondents. Question One asked about the use of bispectral index system (BIS) monitors. Anesthesiologists (and, of course, patients) have always wanted a way to be sure that a patient is actually asleep during a surgical procedure. In addition, anesthesiologists do not want to use too much anesthesia because of possible effects on different organ systems and length of postoperative hospitalization. Of those who responded to the survey, 74 percent stated that the BIS monitor's effectiveness is not yet supported by scientific evidence. Twenty six percent said that the monitor was very useful in their practice, and were better able to gauge depth of anesthesia and could therefore get their patients out of the operating room quicker than they could have without the use of BIS.

Question Two asked participants about the use of spinal anesthesia for ambulatory surgery. Subarachnoid blocks (spinal anesthesia) were noted as superior for certain types of proce-

dures and for being associated with less postoperative pain. Their reliability can be unpredictable, though, because they may not wear off soon enough in some patients. Ideally, patients in an ambulatory center should go home soon after surgery but some cannot because of the unpredictability of subarachnoid blocks. Also, because patients try to function normally as soon as possible after surgery, the incidence of headache might be increased. Of the survey respondents, 46 percent found subarachnoid blocks useful for ambulatory surgery and 54 percent did not.

The current quarter's survey asks about the preference for conducting ambulatory surgery in a hospital-based, freestanding, or office environment. Office-based surgery may be considered unsafe by some, yet hospital-based surgery is much more expensive. Is the expense justified?

Readers are urged to go online to register their votes. The current survey will be online until February 1, 2000. 

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street fitness. Therefore, patients should be given clear instructions and cautioned against performing functions that require complete recovery of cognitive ability. Finally, appropriate modifications of the current discharge criteria based upon the recent literature should allow us to discharge patients expeditiously without compromising their safety.

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Changes, Changes, Changes

Continued from page 2

of his office-based dental anesthesia practice in the Pittsburgh metropolitan area. ASA President, Ronald A. MacKenzie, D.O., also attended and was able to participate in several discussion groups.

It is very gratifying to see our national organization addressing a very contentious and new area of ambulatory anesthesia. One hot topic of discussion was the unfortunate media attention that the specialty has gotten when anesthesia in the office setting is not given the same detailed attention

as in the classic hospital or freestanding ambulatory surgery facility. It was a very lively meeting with much discussion and even some heated arguments. We expect that the discussion will extend to those presentations relating to office-based anesthesia at the upcoming Annual Meeting in Washington, D.C. I hope that all of you can make it to this meeting and you will find registration materials in this issue. This SAMBA Newsletter is being sent to all members of ASA with the expectation that it will encourage

more people to become interested in the rapidly expanding area of ambulatory anesthesia.

Lastly, I would like to wish you all "good luck" with your New Year's resolutions. And remember: "Change is inevitable, but participation is optional."

— Walter G. Maurer, M.D.
Editor 

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New Electronic Submission of Abstracts at www.SAMBAhq.org

The SAMBA Committee on Annual Meeting has issued a call for abstracts for the SAMBA 15th Annual Meeting in Washington, D.C. **Submission deadline is February 18, 2000.** The Society encourages residents in anesthesiology training programs to become more involved in SAMBA.

To this end, the Society will issue a limited number of travel awards to anesthesiology residents whose scientific abstracts are accepted for presentation at the SAMBA Annual Meeting. These travel awards will support residents in training with a grant of \$1,000 each to attend the meeting. Those who receive travel grants will remain eligible for Ambulatory Anesthesia Research Foundation Awards. Case

reports are not acceptable. Papers presented at the SAMBA Annual Meeting are eligible for presentation at subsequent meetings of the American Society of Anesthesiologists and International Anesthesia Research Society. SAMBA will accept only abstracts that are electronically submitted over the Internet at the SAMBA Web site. To download a copy of the typing instructions and grading criteria as well as to submit abstracts and complete cover letters, visit the SAMBA Web site at <www.sambahq.org>. Complete instructions are provided.

Also check the SAMBA Web site in January to register for the SAMBA Annual Meeting online. 

SAMBA Presents....

Ambulatory Anesthesia 2000

June 3-4, 2000
Hotel Wyndham Montreal
Montreal, Quebec, Canada

Held in conjunction with the
12th World Congress of Anaesthesiologists

If you are planning to attend the 12th world congress of Anaesthesiologists on June 4-9, 2000 in Montreal, make it a point to arrive a day earlier to attend Ambulatory Anesthesia 2000, a comprehensive one and one-half days pre-Congress SAMBA symposium. A faculty of internationally renowned experts has been assembled to present a program on such pertinent topics as "Preparation for Ambulatory Anesthesia," "Optimal Ambulatory Anesthesia," "The Ideal Anesthetic Agent and Device," "Controversies in Ambulatory Surgery," "Update in Ambulatory Anesthesia" and "New Horizons in Ambulatory Anesthesia."

Contact the SAMBA office for registration information, or visit the Society's Web site and register on line at <www.sambahq.org>.