

January, 2002

Dear ASA Member:

In an effort to inform members of the anesthesiology community about the upcoming activities of the Society for Ambulatory Anesthesia (SAMBA), we are providing a copy of the January issue of *Ambulatory Anesthesia* to all members of the American Society of Anesthesiologists (ASA). During the last decade, *Ambulatory Anesthesia* has provided SAMBA members with information on current practice patterns in our subspecialty. In addition, the newsletter keeps our membership abreast of educational activities in this dynamic organization. The SAMBA Board of Directors is delighted by the tremendous growth enjoyed by the ambulatory anesthesia community in the last decade.

When SAMBA was organized 17 years ago, the subspecialty of ambulatory anesthesia was in its infancy. Today, almost 70 percent of all elective surgical procedures in the United States are performed on an ambulatory basis. Accordingly, SAMBA has grown to include nearly 5,000 members. With changes in the health care delivery system occurring almost daily, it is likely that even more surgical procedures will be performed in an ambulatory setting. Especially in our field, it is essential to keep up with new advances and stay connected. We therefore invite you to become a part of SAMBA.

SAMBA has a very diverse membership among anesthesiologists. Members hail from both adult and pediatric practices, from community practice, academic medicine, hospital-based units, freestanding ambulatory surgical centers and office-based settings. The SAMBA Annual Meeting, which is recognized as one of the premier educational events in anesthesiology, presents exciting programs on topics relevant to the practice of ambulatory anesthesia. This year's meeting will be held on May 2-5, 2002, at the Hilton at Walt Disney World, Orlando, Florida. Information-packed scientific sessions, presented by leaders in the field of ambulatory anesthesia, will address the challenges faced by anesthesiologists in such areas as office-based anesthesia, cases in the "real world," regional anesthesia, medicolegal issues and new practice guidelines. We will also offer intensive workshops designed to stimulate new ideas in approaches to such subjects as practical uses of technological toys, perioperative medicine, anesthesia simulators, and regional and pain management procedures for the ambulatory surgical center.

Education and research are at the forefront of SAMBA's mission, as evidenced by the Society's awarding a \$100,000 Outcomes Research Award and co-sponsorship of research grants with the Foundation for Anesthesia Education and Research (FAER). These efforts provide funding for programs designed to further our understanding of clinical practice related to ambulatory anesthesia. All members of SAMBA are encouraged to apply for these funding opportunities. SAMBA also provides travel awards for our Annual Meeting and research awards for outstanding scientific presentations at the Annual Meeting.

We also invite you to visit the SAMBA Web site, one of the most progressive Web sites of subspecialty anesthesiology organizations. Newly designed and user friendly, the site includes membership application and renewal features, online meeting registrations, online audiovideo of meeting presentations, meeting abstracts, newsletters, membership directory, patient information pages, discussion panels, surveys and much, much more.

A comprehensive list of membership benefits is provided on the inside of this cover. We encourage you to complete the membership application found on the inside back cover of this newsletter and become an active participant in this exciting organization. My colleagues and I look forward to your future participation in SAMBA and to a growing readership of *Ambulatory Anesthesia*.

Sincerely yours,



Barbara S. Gold, M.D.
President

MEMBERSHIP BENEFITS

Ambulatory anesthesia is the fastest growing subspecialty within clinical anesthesiology practice. Nearly 70 percent of surgeries have moved to the outpatient setting. The Society for Ambulatory Anesthesia is dedicated to providing those interested in ambulatory anesthesia with valuable, cost-effective membership benefits, including:

- Support for the role of anesthesiologists in perioperative care of the ambulatory surgical patient.
 - Education and support for the office-based anesthesiologist.
 - Representation in the ASA House of Delegates.
 - Representation in the JCAHO Ambulatory Health Care Professional and Technical Advisory Committee, the Accreditation Association for Ambulatory Health Care and the International Association of Ambulatory Surgery.
 - Subscription to the quarterly SAMBA newsletter, *Ambulatory Anesthesia*.
 - *Educational Guidelines for Subspecialty Training in Ambulatory Anesthesia*, which includes an extensive annotated bibliography.
 - Discounts on registration fees for SAMBA Annual Meetings, Mid Year Meetings and special workshops.
 - Resident Travel Awards to authors of abstracts selected for presentation at the SAMBA Annual Meeting.
 - Ambulatory Anesthesia Research Foundation Awards presented to authors of the best abstracts at the SAMBA Annual Meeting.
 - Funding for ambulatory anesthesia-related research via SAMBA-FAER Grants and SAMBA Outcome Research Awards.
 - Interaction with a diverse membership from community and academic practices in hospital-based, freestanding and office-based settings.
 - Annual subscription to *Anesthesia & Analgesia*, the official journal of SAMBA.
 - The chance to publish articles relevant to ambulatory anesthesia in *Anesthesia & Analgesia*, a respected, peer-reviewed journal.
 - Representation on the editorial boards of *Anesthesia & Analgesia*, *Anesthesiology* and other leading journals.
 - International influence through the Society's representation in overseas organizations and participation in international conferences.
 - Members-only section on the SAMBA Web site, including online chat rooms and a membership directory that places, at your fingertips, a network of anesthesiologists with special interest in ambulatory anesthesiology.
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Society for Ambulatory Anesthesia

Ambulatory AnesthesiaSM

PRESIDENT'S MESSAGE

Meeting New Challenges — Together

By Barbara S. Gold, M.D.
SAMBA President

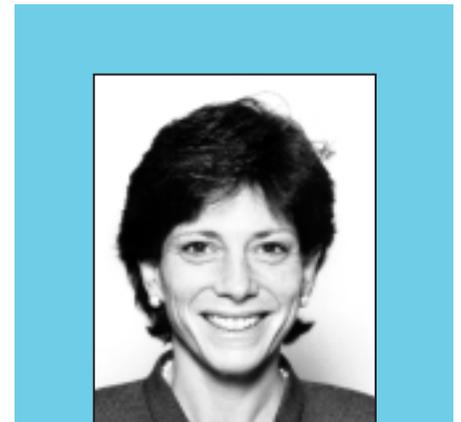
On behalf of the SAMBA Board of Directors, I would like to wish all of you a healthy and prosperous new year. May this coming year bring peace. We go forth this new year in a changed world, where the impact of terrorism resonates throughout our land: loss of life, property, increasing strains on an already weakened economy and tremendous pressure on our public health services. Our national priorities, including health, have had to be refocused. Specifically, our health care systems are quickly learning how to recognize, treat and prevent bioterrorism. The implications are staggering. We are compelled to think about organisms we probably have not thought of since medical school. Consider, for example, smallpox, which in the 20th century is estimated to have killed more people than all of the wars and epidemics combined, including the influenza epidemic of 1918. The eradication of this disease is considered one of the greatest medical achievements of the 20th century, yet we cannot take that for granted.

As physicians, we of course need to be well-versed in the diagnosis, management and containment of agents of bioterrorism. But how, you may ask, does this relate to ambulatory anesthesia? Should we not be relatively insulated from these problems? After all, our area of expertise deals with anesthetizing patients having elective "minor" surgery. That may be the

case. However, the impact of refocusing our national, state and local health care priorities in the setting of a wounded economy will undoubtedly and eventually impact us all. Forgetting about bioterrorism for a moment, consider the following statistics: Health care premiums for employer-sponsored programs are up 11 percent in the past year; Medicare reimbursement to physicians is declin-

I expect that eventually these stressors will force increased productivity with fewer resources.

ing; and seasonally adjusted unemployment for October 2001 was 5.4 percent as compared to 4 percent for 2000 (and 65 percent of Americans under the age of 65 get insurance through their employer). I expect that eventually these stressors will force increased productivity with fewer resources. For ambulatory anesthesia, this is an extension of issues that we have spent the last decade trying to master, namely providing safe, high-quality ambulatory anesthesia care to ill patients at the extremes of age undergoing increasingly complex procedures in an efficient, cost-effective manner. Over the past 17 years, SAMBA has played a critical role in this process by providing a forum to learn from one another. For today's



Barbara S. Gold, M.D.

challenges, it is more important than ever to keep current and to share ideas.

Many of you may wonder how we can provide more with less — all the while remaining faithful to our credo of patient safety. I have no doubt that we will be able to rise to this challenge through education, hard work and innovation — and by using SAMBA effectively. By providing a fertile environment for education, the exchange of ideas, problem solving and research, SAMBA can be quite valuable to us. For example, the SAMBA Mid Year Meeting held this past October in New Orleans was extremely well-attended and provided an opportunity to discuss several difficult issues ranging from ethics to Medicare compliance. Looking forward, I hope to see many of you this coming spring at the SAMBA Annual Meeting in

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Sharing Ideas for a Better SAMBA

Over the past several years, SAMBA has expanded considerably and continues to grow. Success of any organization depends on the involvement of its membership, and so I encourage the members to share their ideas and vision and contribute to the betterment of the Society.

For those who are not members, I invite you to become a SAMBA member and contribute to the success of the Society. There are numerous benefits to becoming a SAMBA member. You can join SAMBA by completing the application form contained within this newsletter, or you can apply online by visiting our Web site <www.sambahq.org>.

The SAMBA Fifth Annual Mid Year Meeting held last October in New Orleans, Louisiana, was a great success and drew more than 125 attendees. The program was organized by **Johnathan L. Pregler, M.D.**, Los Angeles, California, and covered a number of interesting topics, including recent developments in perioperative care, pediatric anesthesiology,

obstructive sleep apnea and financial/regulatory issues. In this issue, **Andrew Herlich, M.D.**, Philadelphia, Pennsylvania, summarizes the various lectures that highlighted the controversies in adult and pediatric anesthesia.

Kumar G. Belani, M.D., St. Paul, Minnesota, provides us with an excellent review of the refresher courses presented during the recent American Society of Anesthesiologists (ASA) Annual Meeting in New Orleans. **Lucinda L. Everett, M.D.**, Seattle, Washington, summarizes the poster-discussion session on preoperative evaluation and postoperative pain management.

Kevin K. Tremper, M.D., Ph.D., Ann Arbor, Michigan, announces the establishment of a permanent endowed lectureship devoted to ambulatory and pediatric anesthesia. This lectureship is to honor **Uma A. Pandit, M.B.**, and her husband, **Sujit K. Pandit, M.D.** This is one of the first lectureships devoted to ambulatory anesthesia. Dr. Sujit Pandit is a past president of SAMBA.



Girish P. Joshi, M.D.

The SAMBA 17th Annual Meeting will be held on May 2-5, 2002, in Orlando, Florida. Detailed information and the preliminary program of this meeting are included in this issue. I look forward to seeing you in Orlando.

Have a happy and prosperous 2002!



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Controversies in Ambulatory Anesthesia Revisited

By Andrew M. Herlich, M.D.
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Under the expert direction of Committee on Mid Year Meeting Chair Johnathan L. Pregler, M.D., Los Angeles, California, last year's theme of "Controversies in Ambulatory Anesthesia" was continued. Dr. Pregler selected a fine group of speakers, some of whom have not previously spoken at our meetings.

The first speaker of the day was **Meg A. Rosenblatt, M.D.**, New York, New York. She very enthusiastically endorsed the use of regional blocks to improve the quality of postoperative pain relief. The resurgence of single-bolus nerve blocks, including femoral nerve block, inguinal-hypogastric nerve block and paravertebral nerve block, was emphasized. These techniques permit less postoperative nausea and vomiting and earlier home readiness as well as a reduction in the use of systemic opioids in the perioperative setting. She highlighted the use of continuous catheter techniques that permitted the delivery of a fixed rate of local anesthesia. Dr. Rosenblatt carefully pointed out, however, that patients with continuous catheter techniques should have rapid access to the hospital and surgeon's office so that the catheters may be adjusted or removed when problems arise.

The next speaker, **Vincent W. Chan, M.D.**, Toronto, Ontario, Canada, focused on postoperative analgesia. He began his lecture by discussing the use of nonsteroidal anti-inflammatory drugs (NSAIDs). He emphasized that initial current doses of acetaminophen are probably too low. Forty mg/kg in conjunction with opioids seems to be a more favorable dose at the outset, assuming there is no hepatic dysfunction. Conventional NSAIDs still have a beneficial use in patient management. There is no clear-cut data to suggest

that any NSAID is superior to another in postoperative analgesia.

Dr. Chan then turned his attention to the COX-2 agents celecoxib and rofecoxib. They have been shown to be superior to placebo agents but have not been shown to be superior to standard NSAIDs. However, they reduced the need for supplemental opioids in major orthopedic surgery. Recently, a parenteral COX-2 agent, parecoxib, was introduced for clinical testing. It was shown to have a longer duration of action than ketorolac 30 mg.

The use of small doses of ketamine for postoperative analgesia was discussed. In small doses, it had minimal side effects. When combined with morphine, the analgesic efficacy improved dramatically. Interestingly, despite subanalgesic plasma levels of ketamine, the dosing still produced clinically noticeable analgesia.

Finally, Dr. Chan described a new

There is no clear-cut data to suggest that any NSAID is superior to another in postoperative analgesia.

transdermal delivery system for fentanyl called E-TRANS[®], which is undergoing phase III trials at this time. It uses a small electric current to permit delivery through the skin; there is an active anode and pharmacologically inactive cathode. Side effects are reported to be similar to systemic fentanyl as well as topical irritation to the hydrogel such as erythema.

The third speaker in the morning session was **Beverly K. Philip, M.D.**, Boston, Massachusetts. Dr. Philip discussed the current "hot buttons" of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) 2001 pain and sedation standards. Critical definitions such as levels of sedation and



Andrew M. Herlich, M.D.

anesthesia within the context of arousability, respiratory function and cardiovascular function were discussed. Key to these areas of interest was the credentialing of individuals who will manage sedated patients. JCAHO is interested in competency-based education, training and experience.

After detailing the sedation issues, Dr. Philip turned her attention to pain assessment and management. JCAHO has indicated that it is interested in the areas of patient rights, assessment of patients, care of the patients and education of pain relief providers as well as the patients themselves. Finally, Dr. Philip emphasized that the American Society of Anesthesiologists (ASA) has a Committee on Quality Management and Departmental Administration as well as a publication she prepared with **Jerry A. Cohen, M.D.**, Gainesville, Florida, titled "How to Prepare for a Joint Commission Survey." Additionally, Dr. Philip emphasized that personnel at the ASA Washington Office in Washington, D.C., or the ASA Executive Office in Park Ridge, Illinois, are ready and willing to assist ASA members with questions concerning JCAHO issues.

Following the morning break, **Lucinda A. Everett, M.D.**, Seattle, Washington, discussed pediatric

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Controversies in Ambulatory Anesthesia Revisited

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patient care issues in a case presentation format. She titled her talk "Who Posted This Child for the Ambulatory Surgery Center?" Prior to discussing her selected cases, Dr. Everett mentioned the issues of appropriateness of the procedure in the context of type of care setting, available personnel, skill of personnel, comorbidities and home-support systems. It is easier to perform ambulatory surgery in a hospital-based setting rather than a free-standing surgery center where layers of support for adverse events may become problematic.

Dr. Everett used four cases to illustrate her point. She used a complex patient with Down syndrome and a cardiac anomaly with airway resistance/obstruction presenting for orchiopexy. The second case was a 5-month-old ex-preemie, born at 30 weeks' gestation and a four-week postnatal hospital course presenting for bilateral inguinal hernia repair. Dr. Everett immediately "cut to the chase" and asked whether or not this patient was appropriate for outpatient surgery. The two other cases included a child who had many previous anesthetics, latex allergy and parental wishes to be present for induction of anesthesia. Audience polling took

place to assess how many practitioners permitted (and when did they permit) parental presence during induction of anesthesia. The final case was a 4-year-old child with gastroesophageal reflux disease presenting for upper gastrointestinal endoscopy with a family history of malignant hyperthermia. The audience clearly enjoyed her presentation.

The second speaker in the pediatric session, **Swati N. Patel, M.D.**, Los Angeles, California, presented the issues of planning an out-of-the-operating-room pediatric sedation service. She discussed the problems and resolutions encountered in Los Angeles in coordinating such a service. Issues of insufficient pediatric anesthesiologists, coordinating their availability with operating room demands and scheduling conflicts with the other services were highlighted in her talk. Judging by audience response, it seemed that many had similar experiences.

A novel discussion came from the presentation by **Gail A. Van Norman, M.D.**, Seattle, Washington. Dr. Van Norman's topic was "The Ethical Boundries of Persuasion, Coercion and Restraint of Pediatric Patients in Anesthesia Practice." She started her discussion with differentiation between "coercion" and "restraint."

After defining these terms, Dr. Van Norman then described the differences between adults and children with respect to these concepts. She continued with the pros and cons of mentioning that there are instances when coercion may be legally and socially acceptable, such as in the domain of public health issues. Further discussion revolved around autonomy and competence.

Finally, Dr. Van Norman described a case scenario in which an 8-year-old child refuses surgery. With respect to an 8-year-old, she addresses the four main ethical principles: respect for human dignity, beneficence, non-maleficence and justice. As recent federal interest has taken place in child rights, we must consider their wishes if refusal means no harm will come to them. At what age children may make these decisions rationally is not clear.

Overall, the Mid Year Meeting was a resounding success. The planning by the Committee on Mid Year Meeting, under the direction of Dr. Pregler and through the practical advice of SAMBA Executive Director Gary W. Hoormann, has proven to be much of the reason why the Mid Year Meeting is always well attended.

 SAMBA

Membership Dues Change

Last month, members received their SAMBA 2002 dues statements. As a convenience, SAMBA members can renew their membership online at www.sambahq.org by clicking on membership renewal under the "What's New" column. Your colleagues can join SAMBA online by clicking on new membership under the same column.

The Board of Directors has set the dues for 2002 at \$125, the first increase in SAMBA dues since 1995 and only the second increase since

the inception of the organization in 1985.

The Society's leadership prides itself on the fact that SAMBA membership dues have always been the lowest among subspecialty anesthesia organizations. Conditions within the medico-economic environment have changed in recent years, including reductions in corporate support and increases in expenses for new and existing programs. These changes have made it necessary for SAMBA to implement a rev-

enue enhancement program. The extra revenue received from the dues adjustment will permit the Society to continue to offer program and services at the level of quality members expect. Even with the adjustment, SAMBA membership remains the most affordable among the other subspecialty organizations.

We encourage members to remit their 2002 dues payment as soon as possible.  SAMBA

NPO Guidelines for Children, Discharge Criteria Reviewed

By Kumar G. Belani, M.D.
 Professor of Anesthesiology
 and Pediatrics
 Interim Head, Anesthesiology
 University of Minnesota
 Minneapolis, Minnesota

Preparation, Premedication and Induction of Anesthesia in Children

Charles J. Coté, M.D., Chicago, Illinois, gave a refresher course on the "Preparation, Premedication and Induction of Anesthesia in Children" at the ASA Annual Meeting in New Orleans, Louisiana. Dr. Coté began by indicating that "when one is anesthetizing the child, one is anesthetizing the entire family." He reminded the audience that this is a major family undertaking, and every effort must be made to evaluate and prepare pediatric patients in advance to avoid the likelihood of cancellation of a procedure due to unrecognized but previously noted medical problems. He reiterated the benefit of "nothing by mouth" (NPO) guidelines that allow infants and children to be less dehydrated and therefore less irritable when presenting for ambulatory diagnostic or surgical procedures.

Suggested NPO guidelines

Age	Solids/milk	Clear fluids
≤ 6 mths	4 hrs	2 hrs
7-36 mths	6 hrs	3 hrs
> 36 mths	6-8 hrs	3 hrs

He suggested the three-hour clear fluid restriction in children older than 7 months to permit last-minute changes in schedule, allowing patients to be moved up as long as they were NPO for at least two hours for clear liquids. The only routine laboratory requirement prior to anesthesia was a Hgb level in former preterm infants and in children less than 6 months of age (to evaluate the extent of physiological anemia). He also suggested Hgb eval-

uation in those with a history of anemia, sickle cell disease, congenital heart disease and when significant blood loss was anticipated.

Dr. Coté stressed that children are protective of their individuality, and therefore anesthesia care providers should "talk to the child first" when seeing the child with a parent. Children have the same fears as adults, and explaining the process of premedication and anesthesia induction is key to the administration of a smooth anesthetic. A structured approach to anesthetic evaluation will help in the formulation of an anesthesia care plan and will improve efficiency. Through recognition of their fears and appropriate premedication, children become more accommodative of the operating room environment. He suggested using ketamine by the I.M. route only for special occasions and was not in favor of intranasal drugs because of the possibility of neurotoxicity to the exposed olfactory receptors. Although fentanyl is the only opioid approved for transmucosal use, he favored the use of oral midazolam syrup. This is the only benzodiazepine currently approved for all ages that does not affect the recovery profile of pediatric patients. Midazolam is effective in doses as low as 0.25 mg/kg; higher doses only decrease onset time. When used in 377 ASA physical status 1 pediatric patients, he did not experience a single episode of desaturation.

Dr. Coté emphasized the value of educating parents before they accompanied their children to the operating room for induction. He reminded the audience that parental presence is for the benefit of children, not the parents.

Some preoperative medical conditions in children will require close attention. Children with bronchial asthma must be in optimal shape before administration of anesthesia. Endotracheal intubation, deep extubation and use of a laryngeal mask airway in such patients should be a judgment call. Children requiring elective surgery and newly diagnosed anemia must be evaluated prior to the proce-



Kumar G. Belani, M.D.

cedure. One should not hesitate to consult a neurologist when caring for children with a seizure disorder and a hematologist for those with sickle cell disease. Dr. Coté suggested that it would be wise to postpone the administration of anesthesia in children with acute onset upper respiratory infection (URI), particularly if they have a "wet cough" and demonstrate a purulent discharge. Because of persistent changes in spirometry, one should wait seven to eight weeks for an elective procedure. He indicated that after a URI proceeding, less than four weeks does not decrease the risk of complications (x 10 increase in bronchospasm; x 5 increase in laryngospasm; increased incidence in desaturation episodes and croup).

For children with congenital heart disease, it is essential to know whether a palliative procedure or definitive surgery was conducted. Despite corrective surgery, one should assume that residual defects are still very likely to be present (e.g., small ventricular septal defect after correction). One also should observe for sequelae, namely arrhythmias, following corrective surgery. One should not forget the need for SBE prophylaxis.

Dr. Coté concluded his refresher course lecture by reviewing discharge criteria for the former preterm infant. He recommended admitting former

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NPO Guidelines for Children, Discharge Criteria Reviewed

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preemies less than 60 weeks postconceptional age. Anemia will increase the likelihood of an apnea episode in the former preemie and, because of a variable half-life, caffeine does not guarantee protection against an apnea episode.

Recovery and Discharge of the Ambulatory Anesthesia Patient

Rebecca S. Twersky, M.D., New York, New York, a SAMBA past president, discussed the recovery and discharge of the ambulatory anesthesia patient. She reminded the audience that the current environment of fast-tracking necessitates not only complete familiarity with discharge criteria for ambulatory surgical patients but also complete participation by anesthesia providers in ensuring their smooth postoperative recovery. She indicated that there is no basis for minimum stay requirement policies (e.g., 60 minutes each in postanesthesia care unit [PACU] and phase 2 unit). By using the modified Aldrete scoring system, patients with a score ≥ 9 may be able to bypass the PACU. With proper planning, analgesic and antiemetic prophylaxis, more than 80 percent of monitored anesthesia care patients and approximately 40 percent of general anesthesia patients can bypass the PACU. Besides system delays, common medical reasons for delay in discharge from phase 2 recovery is the presence of pain, postoperative nausea and vomiting (PONV), unrecovered regional block, drowsiness and inability to void. She emphasized and quoted the study by Schreiner et al. that patients need not be required to drink before discharge as this may actually increase the incidence of vomiting (Should children drink before discharge from day surgery? *Anesthesiology*. 1992; 76:528-533). Although the Schreiner study addressed only children, she informed the audience that drinking liquids prior to discharge is not mandatory at her center. Patients who are considered to be low-risk need not void before going home. However, after

Prophylaxis Algorithm

Risk	Prophylaxis	Rescue Rx
Low	None	Ondansetron/dolasetron
Mild	Droperidol	Ondansetron/dolasetron
Moderate	Droperidol + ondansetron/dolasetron + dexamethasone	Ondansetron/dolasetron
High*	Droperidol + ondansetron/dolasetron + dexamethasone \pm metoclopramide	Phenothiazines

* = Use multimodal approach; reduce intraoperative emetogenics.

inguinal hernia repair or anal surgery (high-risk group), patients are required to stay until they void because of the risk of urinary retention. Similarly, after subarachnoid block, patients must void and ambulate before going home. With upper extremity regional analgesia techniques, patients may go home with proper discharge instructions even if complete recovery is not evident. With lower extremity blocks, however, they should be able to ambulate steadily prior to discharge. She also emphasized that newer monitors and anesthetics play less of a role in cost containment when compared with the costs associated with the recovery areas. Cross-training of people for performing both preoperative and postoperative duties is essential to contain costs.

One factor that can facilitate optimal tracking of patients through an ambulatory surgical center is the inclusion of pain, nausea and vomiting control plans. Team effort in these areas is key to surgical success. Use of preprinted orders allows for timely treatment of these adverse events. She advocated using a multimodal approach to these problems, and indicated that the use of COX-2 inhibitors with local analgesic techniques appear promising. Low-dose ketamine also is being used as a preemptive technique to decrease post-surgical pain. Nonsteroidal anti-inflammatory drugs are opioid-sparing and thus indirectly decrease nausea risk. Hydroxyzine is not as effective in controlling PONV as are

ondansetron and droperidol. These two antiemetics work by different mechanisms and thus should help in difficult situations. Because of cost issues, Dr. Twersky has popularized the dolasetron and droperidol combination used at her institution. Dexamethasone (8-10 mg I.V. in adults; 0.15 mg/kg children up to adult max) increases the sensitivity of the receptors to serotonin antagonists. Thus it has recently been popularized to prevent and treat PONV, especially in combination with ondansetron or dolasetron. She recommends using nausea prophylaxis for those at high risk; for example, those with a history of motion sickness, prior history of PONV and anticipated use of opioids postoperatively. An algorithm (see table above) is helpful for taking into consideration presence of a risk factor, age, gender, type of surgery, duration and type of anesthesia to help decide who needs prophylaxis.

Use of the above approaches will minimize unanticipated admission or transfer to an inpatient facility. The risk of unanticipated admission following ambulatory surgery is 0.28-9.5 percent. Age, gender, ASA physical status, type of surgery (otolaryngology, urology; extensive surgery), bleeding, severe pain, PONV and anesthesia technique are the most common reasons for admission. Usually, surgical factors more than anesthesia factors are responsible for return to the hospital.

SAMBA

A Myriad of Ambulatory Anesthesia Abstracts

By *Lucinda L. Everett, M.D.*
Associate Professor of Anesthesiology
University of Washington
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This article will summarize the ambulatory anesthesia abstracts presented at the 2001 American Society of Anesthesiologists (ASA) Annual Meeting in New Orleans, Louisiana, which addressed preoperative evaluation and postoperative pain control. ASA Abstract numbers are specified in brackets (e.g., [A-14]).

Raymond G. Borkowski, M.D., and colleagues from the Cleveland Clinic Foundation, Cleveland, Ohio, looked at the effect of a comprehensive preoperative evaluation system on cardiac-related intraoperative quality indicators [A-32]. Same-day or ambulatory surgery patients reviewed had either preoperative evaluation guided by their surgeon (N=2,939) or through a preoperative clinic involving a computer-based assessment and medical evaluation by "perioperative internal medicine specialists," if indicated (N=47,874). Cardiac-related intraoperative quality indicators included hypertension, hypotension, tachycardia, bradycardia, new arrhythmia, significant ST depression, myocardial infarction and cardiac arrest. Of the patients evaluated by the surgeons, 1.2 percent had adverse events while only 0.17 percent of those evaluated through the comprehensive preoperative assessment had intraoperative cardiac events. Although the authors were unable to identify specifically what intervention was responsible for this difference, the observation certainly warrants further study.

In the area of postoperative pain control, just as with nausea and vomiting, research indicates that symptoms persist after discharge from ambulatory surgery. An abstract from Oregon Health Sciences University suggests that a significant number of ambulatory patients have moderate to severe pain on the first postoperative day [A-33].

Peter J. Mollenholt, M.D., Portland, Oregon, surveyed patients after ambulatory surgery and found that the incidence of moderate to severe pain ranged from 34 to 60 percent, with the highest incidences in patients having general, orthopedic and neurosurgery [A-33]. Up to 17 percent of patients had no relief or only slight relief with the prescribed medication. The choice of oral medication did not correlate with the degree of pain relief. The results in the current study were somewhat more dramatic than those in a prior ambulatory study where Chung et al. (*Anesth Analg.* 1997; 85:808-816)

In the area of post operative pain control, just as with nausea and vomiting, research indicates that symptoms persist after discharge from ambulatory surgery.

found an overall incidence of moderate or severe pain to be 26.1 percent in a combined surgical population. In Chung's study, as in prior studies, patients with severe pain had a higher incidence of unanticipated admission to the hospital following ambulatory surgery.

Several abstracts evaluated the efficacy of the COX-2 inhibitors rofecoxib and celecoxib in the ambulatory surgery setting. **Tijani Issioui, M.D.**, University of Texas Southwestern Medical Center, Dallas, Texas, presented a study of the efficacy of celecoxib 200 mg with or without acetaminophen given prior to outpatient otolaryngology surgery [A-36]. This study found that celecoxib alone did not provide significant pre-emptive analgesia but that the combination of celecoxib and acetaminophen did



Lucinda L. Everett, M.D.

reduce opioid requirements and postoperative pain compared with either agent alone or with placebo. **Kevin W. Klein, M.D.**, also from University of Texas Southwestern Medical Center, presented a similar study using rofecoxib [A-35]. In this series, premedication with rofecoxib 50 mg alone or in combination with acetaminophen significantly decreased postoperative pain and the need for analgesic rescue medication.

Shailesh Y. Bhopatkar, M.B., and colleagues from Baystate Medical Center, Springfield, Massachusetts, looked at administering rofecoxib in a pre-emptive manner [A-34]. Patients undergoing arthroscopic meniscectomy under local anesthesia with propofol/midazolam sedation were randomized to receive rofecoxib 50 mg, either prior to surgery or after the completion of surgery, or placebo. The analgesic duration was significantly longer when rofecoxib was administered prior to incision compared with either rofecoxib after surgery or with placebo, suggesting a pre-emptive effect.

Finally, two abstracts described pilot studies on the administration of local anesthetic infusion through a perineural catheter in the outpatient setting. **Brian M. Ilfeld, M.D.**, from the University of Florida, Gainesville,

Continued on page 12

Mark your calendar now and plan to attend the SAMBA 17th Annual Meeting on May 2-5, 2002, at the Hilton in Walt Disney World in Orlando, Florida. Long recognized as the leading educational program in ambulatory anesthesia, the 17th presentation of the SAMBA Annual Meeting will once again feature outstanding scientific programs, business sessions and exciting social activities.

Program Chair Walter G. Maurer, 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.

Registration information will be mailed in mid-January and will also be available on the SAMBA Web site. As a membership benefit, SAMBA members will receive a discount off the regular registration fees for the general meeting and the preconvention workshop.

We look forward to seeing you in warm and sunny Orlando!

SAMBA

17th Annual Meeting Scientific Program

May 2-5, 2002
Hilton in Walt Disney World
Orlando, Florida



Photo courtesy of the Hilton in the Walt Disney World Resort

Wednesday, May 1

5 p.m. – 9 p.m. Advanced Cardiac Life Support
Preconvention Workshop

Thursday, May 2

8 a.m. – 5 p.m. Preconvention Workshop continued
5 p.m. – 7 p.m. WORKSHOP 1
Practical Uses of Technological Toys – The Advanced Course
Moderator: Kirk H. Shelley, M.D., Ph.D.
Martin S. Bogetz, M.D.
J. Lance Lichtor, M.D.

5 p.m. – 7 p.m. WORKSHOP 2
Perioperative Management Dilemmas: A Problem-Based Discussion
Moderator: Lee A. Fleisher, M.D.
Patient With Coronary Artery Disease Undergoing Knee Arthroscopy
Lee A. Fleisher, M.D.

Patient With Sleep Apnea Undergoing Airway Surgery
Kathryn E. McGoldrick, M.D.
Obese Patient for Shoulder Arthroscopy
Grover R. Mims, M.D.

Friday, May 3

7 a.m. – 8 a.m. Research Poster Breakfast and Discussion

8 a.m. – 9:45 a.m. GENERAL SESSION PANEL I
New Practice Guidelines
Moderator: Burton S. Epstein, M.D.
ASA Postanesthetic Care Guidelines
Frances F. Chung, M.D.
ASA Preoperative Practice Advisory
L. Reuvan Pasternak, M.D., M.P.H., M.B.A.
Participating in Sedation Guidelines for Nonanesthesiologists – Where Can We Get Help?
Ronald A. Gabel, M.D.

9:45 a.m. – 10:15 a.m. Coffee Break in Exhibit and Poster Area

10:15 a.m. – 12 noon GENERAL SESSION PANEL II
Outpatient Anesthesia in the Geriatric Patient
Moderator: Terri G. Monk, M.D.
Applying the New AHA Cardiac Preoperative Evaluation Guidelines to the Elderly Outpatient
Lee A. Fleisher, M.D.
The Aging Process: Anesthetic Implications in the Elderly Outpatient
Stanley Muravchick, M.D., Ph.D.
Peripheral Nerve Blocks for Outpatient Geriatric Surgery: The Ideal Candidates for Regional Anesthesia
F. Kayser Enneking, M.D.

12 noon – 1:30 p.m. Lunch
Lunch With Discussion Leaders
Ronald S. Litman, D.O.
Recognition of sponsors
SAMBA President's Message
Distinguished Service Award
Introduction of proposed SAMBA 2002-03 officers
ASA Update
Barry M. Glazer, M.D., ASA President

1:30 p.m. – 3 p.m. Desserts in Exhibit Area and Poster Review/Discussion

2 p.m. – 6 p.m. "DOUBLE" WORKSHOP 3
Anesthesia Simulators — The Training Tool of the Future
Moderator: John J. Schaefer III, M.D.
René M. Gonzalez, M.D.
Andrew Herlich, M.D.

2 p.m. – 6 p.m. "DOUBLE" WORKSHOP 4 Regional and Pain Management Procedures for the ASC
Orbital and Facial Blocks
Moderator: Kenneth Zahl, M.D.
F. Kayser Enneking, M.D., *Continuous Block Techniques*
Lucinda L. Everett, M.D., *Pediatric Blocks*
Admir Hadzic, M.D., *Lower Extremity Blocks*
Michael F. Mulroy, M.D., *Upper Extremity Blocks*

2 p.m. – 4 p.m. Residents Conference
Federal Rules (HCFA, patient confidentiality), JCAHO, CRNAs
Thomas W. Cutter, M.D.

6:30 p.m. – 9:30 p.m. SAMBA Social Evening at Universal Studios Jurassic Park Island of Adventure

Saturday, May 4

7 a.m. – 8 a.m.
Research Poster Breakfast Discussion

8 a.m. – 9:45 a.m. GENERAL SESSION PANEL III
What's New in Postoperative Pain

Moderator: Tong J. Gan, M.D.
Acute Pain Management — Patients Experience and Meeting JCAHO Guidelines
Tong J. Gan, M.D.
Pain Management in the Ambulatory Environment — An Ever Growing Cook Book of New Recipes
Peter S. Glass, M.D.
Issues in Pain Management for Pediatric Ambulatory Anesthesia
Lucinda L. Everett, M.D.

9:45 a.m. – 10:15 a.m. Coffee Break in Exhibit and Poster Area

10:15 a.m. – 12 noon GENERAL SESSION PANEL IV
In the Real World Cases
Moderator: Barbara S. Gold, M.D.
Lydia A. Conlay, M.D., Ph.D.
F. Kayser Enneking, M.D.
Ronald S. Litman, D.O.
Scott R. Springman, M.D.

12 noon – 4 p.m.
Board of Directors Meeting

Sunday, May 5

7 a.m. – 8 a.m.
General Membership Breakfast Meeting
Presiding: Barbara S. Gold, M.D.

8 a.m. – 9:45 a.m. GENERAL SESSION V
Critical Ambulatory Issues
Moderator: Grover R. Mims, M.D.
What's New in PONV
Phillip E. Scuderi, M.D.
Regulatory and Administrative Issues, Certification by JCAHO, AAAHC, AAAASF
Beverly K. Philip, M.D.
Concerns About Compliance: Medicare, HIPPA and Everything Else
Lydia A. Conlay, M.D., Ph.D.

9:45 a.m. – 10:15 a.m. Coffee Break in Exhibit and Poster Area

10:15 a.m. – 12 noon GENERAL SESSION VI
Office-Based Anesthesia (OBA)
Moderator: Rebecca S. Twersky, M.D.
Closed Claims Study of OBA
Karen B. Domino, M.D.
State Regulations Regarding OBA
Rebecca S. Twersky, M.D.
How I Do OBA in the Trenches, in Florida, in Orlando
Louis M. Guzzi, M.D.

Call for Electronic Submission of Abstracts and Residents' Travel Awards

The Committee on Annual Meeting has issued a call for the electronic submission of abstracts for the SAMBA 17th Annual Meeting to be held at the Hilton Hotel at Walt Disney World in Orlando, Florida, on May 2-5, 2002.

The Society encourages residents in anesthesiology training programs to become 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 poster presentation at the SAMBA 2002 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 for their abstracts will remain eligible for cash awards presented by the Ambulatory Anesthesia Research Foundation. Case reports are not acceptable. Papers presented at the SAMBA Annual Meeting are eligible for presentation at subsequent large anesthesia meetings such as the annual meetings of the American Society of Anesthesiologists and the International Anesthesia Research Society.

The Society will once again be accepting only those abstracts that are submitted over the Internet through 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>. Individuals who submitted abstracts for the SAMBA 2001 Annual Meeting found the online submission process to be user-friendly and easy to follow.

By printing out the typing instructions, one is able to prepare an unblinded and blinded abstract on his or her computer. To submit an abstract, visit the SAMBA Web site and double click on "abstract submission." The instructions will walk one through the entire submission process by first asking the visitor to complete a required cover letter. Once the requested information on the cover letter is completed, the next step in the process is to "upload" a blinded and unblinded copy of the abstract from the user's computer. Instructions will detail how to save (upload) the already prepared document to the Web site for submittal. Once this

process is completed, a prompt will ask if another abstract is to be submitted. If yes, the process begins again with the cover letter.

Individuals need to submit their abstracts only once. The Society will contact anyone whose abstracts were not properly received.

The deadline for receipt of properly submitted abstracts to the SAMBA office is **February 11, 2002**. A properly submitted abstract consists of an original abstract that has not been or will not be presented at a large anesthesiology meeting before the SAMBA 2002 Annual Meeting, is accompanied by a completed official SAMBA cover letter (this step must be completed to proceed to the next step in the electronic submission process) and one blinded copy of the abstract (which must be included to complete the submission process). Abstracts are blinded by deletion of the author(s) and institutions from the original.

Questions regarding abstract submissions may be directed to the SAMBA office by telephone at (847) 825-5586 or by e-mail to <samba@asahq.org>. 

Bylaws Change

At its October 2001 meeting, the Board of Directors approved a proposed amendment to Section 5.5 of the SAMBA Bylaws that will provide the Nominating Committee flexibility in its efforts to recommend qualified individuals for leadership positions within the Society.

The proposed amendment is presented here in accordance with the procedures to amend the Bylaws, stating that a proposed amendment must be distributed to every mem-

ber of the Society at least two weeks prior to the SAMBA Annual Membership Meeting to be held on May 5, 2002, in Orlando, Florida. At the meeting, the proposed amendment will be read a second time, followed by a vote. A two-third affirmative vote of the active members present and voting is necessary for the proposed amendments to become effective.

The proposed amendment reads as follows (addition noted by underlining):

A candidate for Director must be a current director, who is eligible for re-election to either a first full two-year term or a second two-year term, or a current or past committee, subcommittee or ad hoc committee chair.

The Board concurred that the proposed change maintains the intent of the Bylaws in the nominations of director candidates while providing flexibility to the Nominating Committee. 

Distinguished Lectureship Honors Sujit Pandit, M.D., and Uma Pandit, M.B.

The Department of Anesthesiology at the University of Michigan, Ann Arbor, has initiated a lectureship honoring Sujit K. Pandit, M.D., and Uma A. Pandit, M.B., for their combined 90 years in medicine and 50 years of service to the university. This endowed lectureship will provide support for distinguished faculty to visit the University of Michigan and lecture on the topics of ambulatory and/or pediatric anesthesia. Dr. Sujit Pandit served as SAMBA President in 1997-98.

The University and SAMBA are proud that Uma and Sujit have chosen to dedicate the majority of their career to the University of Michigan.



Sujit K. Pandit, M.D., and Uma A. Pandit, M.B., were honored by the University of Michigan.

In addition to their productive investigative efforts, Sujit and Uma have been dedicated educators and clinicians who have always kept the care of their patients as their primary concern. At the same time, they have both been recognized as kind and considerate teachers to the many residents and students who have worked under their supervision.

We are proud to announce that Raafat S. Hannallah, M.D., Chair of Anesthesia at Children's National Medical Center in Washington D.C., will be the first Sujit and Uma Pandit Distinguished Lecturer and will visit Ann Arbor in the spring of 2002. 

Meeting New Challenges — Together

Continued from page 1

Orlando, Florida. Under the direction of Walter G. Maurer, M.D., Cleveland, Ohio, this promises to be a terrific meeting — a great mix of clinical updates, practical problem solving and plenty of time to enjoy the company of friends and family. Until then, I would like to leave you with a thought from Ralph Waldo Emerson: "What lies behind us and what lies before us are tiny matters compared to what lies within us."

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The following is a list of new SAMBA members from September 2001 to the present

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Armin Azad, M.D.	Los Angeles, California
Deborah M. Barron, M.D.	Richmond, Virginia
Lucia Capellaro, M.D.	Graglia, Italy
Kathleen K. Crawford, M.D.	Peoria, Illinois
Robert L. Cross, Jr., M.D.	Portland, Oregon
Francis O. Davis, M.D.	Conroe, Texas
Mary Diggles, M.D.	West Linn, Oregon
John M. Dinger, M.D.	Duncansville, Pennsylvania
Juan Carlos Duarte, M.D.	Miami, Florida
F.B. Florence, M.D.	Commack, New York
Jason P. Fontenot, M.D.	Opelousas, Louisiana
Maria Gutierrez, M.D.	Maumee, Ohio
Brian M. Ilfeld, M.D.	Gainesville, Florida
Peter A. James, M.D.	Kogarah, Australia
Jill R. Kaufman, M.D.	Gainesville, Florida
Werner W. Lingnau, M.D.	Tirol, Austria
Frank G. Mathers, M.D.	Cologne, Germany
Donald M. Mathews, M.D.	New York, New York
Charles J. Militana, M.D.	Wilton, Connecticut
Akihiko Nonaka, M.D.	Kofu, Yamanashi, Japan
Babatunde O. Ogunnaike, M.D.	Irving, Texas
Janice Omlor, D.O.	Lewisburg, Pennsylvania
Centk Ozdogan, M.D.	Houston, Texas
Nicholas S. Ranno, M.D.	Marietta, Georgia
Pamela L. Reese, M.D.	Chicago, Illinois
Michael P. Rudolph, D.O.	Hermantown, Minnesota
Roger Schmid, M.D.	Bonn, Germany
Richard P. Schockley, M.D.	Wellesley, Massachusetts
Arup Sen, M.D.	Essex, United Kingdom
Salomon E. Serur, M.D.	San Bernardino, Caracas, Venezuela
Yoshihiro Sugiura, M.D.	Tsuruga Fukui, Japan
Ravi Thadaka, M.D.	Auckland, New Zealand
Terrence D. Wall, M.D.	Totowa, New Jersey
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 Dallas, Texas

ASA Ambulatory Anesthesia Abstracts

Continued from page 7

described the performance of peripheral nerve blocks followed by a continuous infusion of local anesthetic through a perineural catheter [A-37, A-38]. These included interscalene, infraclavicular, posterior popliteal and psoas compartment catheters. Ropivacaine 0.2 percent was infused postoperatively at 6 ml/h with the availability of a 2 ml patient-controlled bolus every 20 minutes. A total of 12 patients were included in the report; half received ropivacaine and half normal saline; all had access to traditional oral analgesics. Patients having ropivacaine in the peripheral nerve blocks had significantly less pain, better sleep quality and

increased satisfaction. In addition, the patients having anterior cruciate ligament repairs were better able to tolerate physical therapy with local anesthetic infusion. In this small cohort of patients, there were no complications of the postoperative local anesthetic infusion, and patients were able to safely remove their own catheters with telephone backup from physicians.

As these abstracts indicate, progress continues to be made in the areas of preoperative evaluation and postoperative pain management for the ambulatory surgery patient. 

To access ASA abstracts, go to:
www.asa-abstracts.com.

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