

January 2003

Dear ASA Member:

On behalf of the membership of the Society for Ambulatory Anesthesia (SAMBA), I am pleased to provide you with this copy of January's issue of *Ambulatory Anesthesia*. For nearly 18 years, this newsletter has provided SAMBA members with information regarding current issues in ambulatory practice, upcoming educational programs and other items of interest to our subspecialty. We hope that you enjoy this edition.

We also invite you to visit the SAMBA Web site <www.sambahq.org>, which is extremely user-friendly and includes an application for membership, online meeting registrations, membership directory, patient information pages, discussion panels, surveys and much more. In addition, we have created "SAMBA Talks," an electronic newsletter. The most recent version summarizes current articles of interest to our members, lists information on upcoming meetings and provides news for patients.

I would also like to take this opportunity to invite you to a very special event — SAMBA's Annual Meeting, which will be held in conjunction with the Federated Ambulatory Surgery Association and the International Association for Ambulatory Surgery on May 8-11 in Boston, Massachusetts. This "mega-meeting," known as the Fifth International Congress on Ambulatory Surgery, is the first of its kind and brings together ambulatory professionals from around the world for three days of comprehensive programs from a variety of perspectives in ambulatory surgical and anesthesia care. We invite all ASA members involved in ambulatory surgery, be it in a hospital setting, a freestanding surgery center or an office, to attend what promises to be one of the most exciting educational opportunities of the new year.

SAMBA members receive many benefits that facilitate the sharing of information relevant to our subspecialty, which now represents almost 70 percent of all anesthetics administered today. Examples include opportunities such as subscribing to *Anesthesia & Analgesia* at a reduced rate. We encourage you to complete the application found on the inside back cover of this newsletter and to become an active participant in SAMBA. My colleagues and I look forward to joining with you in the future and to a growing readership of *Ambulatory Anesthesia*.

Hope to see you in Boston in May!

Cordially,



Lydia A. Conlay, M.D., Ph.D.
President



CALL FOR ABSTRACT SUBMISSIONS

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

SAMBA and the Federated Ambulatory Surgery Association (FASA) have issued a call for abstracts for presentation at the International Association for Ambulatory Surgery 5th International Congress on Ambulatory Surgery to be held May 8-11, 2003, in Boston, Massachusetts. The Congress will be held in conjunction with the SAMBA 18th Annual Meeting and the FASA 29th Annual Meeting.

The 5th International Congress will accept only those abstracts that are submitted through the Congress Web site <www.iaascongress.org>. SAMBA members also may submit abstracts through their Society's Web site at <www.sambahq.org>. To download a copy of the typing instructions and grading criteria or to submit abstracts and complete cover letters, visit either of these Web sites.

Submission is 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. 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, a blinded and unblinded copy of the abstract is "uploaded" (saved) from the user's computer. Instructions will detail how to upload the already prepared document to the Web site for submission. Once this process is completed, the system will ask if another abstract is to be submitted. If yes, the process begins again with the cover letter.

Abstracts will be accepted in the following categories: Surgical Techniques and Clinical Practice Management; Anesthesia Techniques and Clinical Management; Patient Safety and Quality Improvement; and Business Operations Management. The Business Operations Manage-

ment category encompasses the various topics involved in running successful facilities and practices, including human resources, financial and business development as well as compliance issues.

To encourage resident research in ambulatory anesthesia, SAMBA will issue a limited number of travel awards to anesthesiology residents whose scientific abstracts submitted in the categories of Anesthesia Techniques and Clinical Management and Patient Safety and Quality Improvement are accepted for poster presentation at the Congress.

These travel awards will support residents in training with a grant of \$1,000 each. Those who receive a travel grant for their abstracts will remain eligible for cash awards presented by the White Mountain Research Foundation. Papers presented at the Congress are eligible for presentation at other ambulatory surgery and anesthesiology conferences.

Individuals need only submit their abstracts once. Individuals whose abstracts were not properly received will be contacted.

The deadline for receipt of properly submitted abstracts to the SAMBA office is **February 7, 2003**. A properly submitted abstract consists of an original abstract that has not been presented at a large anesthesia meeting during or before 2002, is accompanied by a completed official 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 institution(s) from the original.

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

**Deadline:
February 7, 2003**

**Submit online at:
www.sambahq.org**



Society for Ambulatory Anesthesia

Ambulatory AnesthesiaSM

Leading the Way

By Lydia A. Conlay, M.D., Ph.D.
2002-03 SAMBA President

Like practice venues within ambulatory anesthesia, SAMBA's membership and educational programs continue to grow and prosper. This success no doubt reflects the involvement of our members who so diligently fill out the surveys from which these programs are ultimately planned. On behalf of the SAMBA officers and directors, I would like to thank each of you for taking the time to do so. We read every single comment in an attempt to meet your needs. The participation of our members plays a vital role in SAMBA's continued success.

Boston 2003 — Charting the Course for Ambulatory Anesthesia

One of the most exciting — and certainly new — endeavors undertaken by SAMBA during the last decade is the upcoming 5th International Congress on Ambulatory Surgery to be held in Boston, Massachusetts, on May 8-11, 2003. This "mega meeting" represents the merger of the annual meetings of three different international societies. It will no doubt offer attendees an unprecedented experience with three days of educational programs covering a variety of topics from differing perspectives and types of ambulatory settings. In addition to issues of interest to anesthesiologists, the program will include a number of "crossover" topics of interest to surgeons and ambulatory administrative

personnel. SAMBA joins the Federated Ambulatory Surgery Association and the International Association for Ambulatory Surgery in bringing together these ambulatory surgical professionals from around the world and the more than 200 leading manufacturers who will provide access to the very latest developments in our field. Watch for the brochure, and join us — you'll be glad you did!

SAMBA'S Educational Mission — Revisited, Revised and Renewed

Efforts continue toward revitalizing SAMBA's education mission by revamping the annual and mid-year

SAMBA is recognized as a cohesive group that can speak to issues which benefit our membership.

meetings and thus enhancing the membership's practice with ambulatory patients. Walter G. Maurer, M.D., Cleveland, Ohio, has completed a strategic plan for the annual meetings, which will be a significant topic for discussion at the next meeting of SAMBA's Board of Directors. Two recent venues, the Mid Year Meeting addressing "Office-Based Anesthesia," organized by Lucinda L. Everett, M.D., Seattle, Washington, and the



Lydia A. Conlay, M.D., Ph.D.

SAMBA Breakfast Panel "Anesthesia in the Outback," organized by Thomas W. Cutter, M.D., Chicago, Illinois, drew record attendances. From the apparent interest in these topics as well as the general "buzz" around the meeting, it seems clear that such non-traditional venues represent not only the most rapidly expanding part of our businesses but also one of the most lucrative.

Nontraditional educational venues are gaining in popularity. For example, the most recent version of "SAMBA Talks," our electronic newsletter, summarizes current articles of interest to ambulatory anesthesiologists, discusses upcoming meetings and provides news for patients. SAMBA's other activities also are becoming increasingly Web-based and

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A Call for Participation

SAMBA continues its commitment to education and research in the fields of ambulatory anesthesia and office-based anesthesia. As mentioned by President Lydia A. Conlay, M.D., Ph.D., Philadelphia, Pennsylvania, SAMBA continues to grow and prosper. We would like all practitioners of ambulatory anesthesia to join SAMBA in its efforts to influence patient care and safety.

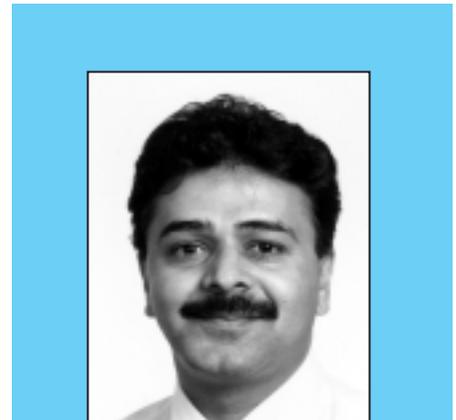
This newsletter projects the image and activities of SAMBA, and the quality and content of the newsletter are largely influenced by its members. Therefore, I would request our members to please share their ideas and vision and participate toward the advancement of the Society. I would like to reinforce the request from Committee on Annual Meeting Chair Walter G. Maurer, M.D., Cleveland, Ohio, to provide us with your views regarding the Annual Meeting by completing a survey that can be found on the SAMBA Web site <www.sambahq.org>; click on "SAMBA CME Program Survey."

In this issue, Kumar G. Belani, M.D., Minneapolis, Minnesota, pro-

vides us with an excellent review of the refresher course on regional anesthesia in pediatric patients presented during the American Society of Anesthesiologists (ASA) 2002 Annual Meeting in Orlando, Florida. Babatunde O. Ogunnaike, M.D., Dallas, Texas, and Brian M. Parker, M.D., and Raymond G. Borkowski, M.D., both from Cleveland, Ohio, summarize some of the scientific abstracts related to ambulatory anesthesia that were presented during the ASA Annual Meeting. These summaries illustrate recent advances in ambulatory anesthesia that allow improvement in outcomes, particularly with respect to postoperative pain management, nausea and vomiting.

We often face ethical dilemmas and wish we had some guidance with such difficult situations. Mary Ann Vann, M.D., Boston, Massachusetts, provides us with an excellent article on various ethical issues with emphasis on ambulatory anesthesia practice.

The SAMBA Sixth Mid Year Meeting held last October in Orlando, Florida, was a great success. The program covered a number of interesting



Girish P. Joshi, M.D.

topics related to office-based anesthesia practice. The next SAMBA Annual Meeting will be held on May 8-11, 2003, in Boston, Massachusetts. Detailed information and the preliminary program of this meeting will be available soon. I look forward to seeing you in Boston!

I wish you all a happy and prosperous 2003. 

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Highlights From the Ambulatory Anesthesia Abstracts

By Babatunde O. Ogunnaike, M.D.
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The following is a summary of select ambulatory anesthesia abstracts presented during the 2002 Annual Meeting of the American Society of Anesthesiologists (ASA), which was held on October 12–16, 2002 in Orlando, Florida. The ASA abstract numbers are shown in brackets for reference [e.g., A-7].

It is of interest to note that equipment for monitoring the depth of anesthesia (or hypnosis) occupied a noticeable share of these presentations, including the Bispectral EEG analysis (BIS™), PSA 4000™, which utilizes processed quantitative EEG to render a patient state index (PSI) number and the SNAP™, derived from the Nicolet numeric spectrum EEG algorithm.

Scott F. Cassingham, M.D., Lake Charles, Louisiana, used the PSA 4000™ to guide propofol administration and compared this to routine clinical monitoring with respect to propofol usage and the recovery time after laparoscopic gynecologic procedures [A-5]. Patients undergoing laparoscopic gynecologic surgery were randomized to receive propofol infusion titrated according to routine practice or titrated to PSI values between 38-50. A 32-percent propofol reduction was obtained in the PSI-guided group. PSI also allowed a 25-percent reduction in time to operating room (O.R.) discharge and a 19-percent reduction in time for postanesthesia care unit (PACU) discharge eligibility.

Jun Tang, M.D., University of Texas Southwestern Medical Center at Dallas, Texas, compared the sensitivity and specificity between the PSI and the BIS with respect to prediction of the level of consciousness during induction and emergence from general anesthesia [A-547]. Comparative PSI and BIS values were obtained at specific time intervals during induction

and emergence periods, namely, preinduction, preintubation, preincision, end-of-anesthesia and eye opening. The association between BIS and PSI values and probability of unconsciousness were assessed using a logistic regression analysis procedure. The authors concluded that the PSI appears to possess similar sensitivity and specificity to the BIS in assessing consciousness during induction and emergence from general anesthesia.

Cynthia A. Wong, M.D., Northwestern University, Chicago, Illinois, evaluated the relationship between the SNAP and BIS indices during outpatient gynecologic surgery. Patients undergoing gynecological procedures (n=14) received balanced general anesthesia (GA) consisting of propofol, fentanyl or sufentanil and sevoflurane 1 percent to 2 percent, during which BIS and SNAP values were recorded every five minutes. Frequency distributions of SNAP and BIS values showed a greater proportion of patients in the 50-65 range of the SNAP index during maintenance of GA and a greater proportion in the >65 range after discontinuation of the inhaled anesthetic compared to the BIS [A-553].

Vivian Oei-Lim, M.D., Ph.D., University of Amsterdam, Holland, Netherlands, investigated the correlation between BIS values and surgical quality [i.e., movement (>5 or none), asleep (continuous or not), talking (yes or no), need for encouragement (many or none) and cooperation (poor or good)] during propofol-induced sedation (using an effect site target-controlled infusion system) for ophthalmic surgery [A-7]. The authors report that the BIS values significantly correlate with surgical quality.

Postoperative nausea and vomiting (PONV) and postoperative analgesia, which have always been of great research interest to ambulatory anesthesiologists, also were featured prominently. **Daniel T. Goulson, M.D.**, University of Kentucky, Lexington, Kentucky, hypothesized that aggressive prophylaxis of high-risk patients



Babatunde O. Ogunnaike, M.D.

and minimal prophylaxis of low-risk patients should reduce the incidence of PONV with the fewest adverse consequences [A-34]. Data were collected on prophylactic antiemetic drug usage and the incidence of PONV in a two-month period. After this period, practice guidelines for prophylaxis of PONV were implemented that utilized dolasetron, droperidol and dexamethasone based on risk stratification. Patients were stratified into minimal risk (no prophylaxis administered), low risk (one prophylactic antiemetic), moderate risk (two prophylactic antiemetics) and high risk (three prophylactic antiemetics). The authors found no significant difference between the control (i.e., preimplementation period) and study groups (i.e., after implementation of guidelines) with regards to the incidence of prolonged PACU stay due to PONV or sedation. They concluded that their guidelines were effective and may improve antiemetic prophylaxis.

Evan G. Moore, F.R.C.A., Wirral Hospitals, United Kingdom, compared the incidence of PONV between anesthetic techniques in an adult day-case surgery [A-22]. More than 1,000 patients undergoing day-case gynecologic or orthopedic surgery were randomized to one of four groups, 1)

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Highlights From the Ambulatory Anesthesia Abstracts

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propofol induction and maintenance (TIVA), 2) propofol induction with isoflurane/N₂O maintenance, 3) propofol induction with sevoflurane/N₂O maintenance and 4) sevoflurane induction and sevoflurane/N₂O maintenance. No antiemetic prophylaxis was administered. The sevoflurane/N₂O group resulted in the highest incidence of PONV. Propofol TIVA resulted in the lowest incidence but was not statistically significantly lower than the propofol induction with volatile maintenance groups.

Gotaro Shirakami, M.D., Kyoto University Hospital, Kyoto, Japan, investigated the effect of the omission of fentanyl on the incidence of PONV during sevoflurane anesthesia when compared with propofol TIVA in patients undergoing breast cancer surgery [A-18]. Patients were randomized to one of three maintenance groups, 1) sevoflurane (no opioids), 2) sevoflurane-fentanyl or 3) propofol-fentanyl. All patients were induced with propofol 2 mg/kg intravenously (I.V.) and laryngeal mask airway placed for airway maintenance. The incidence of PONV and the need for antiemetic medication in the first 24 hours postoperatively in the sevoflurane-fentanyl group (68 percent and 46 percent, respectively) were significantly higher than in the sevoflurane-only group (19 and 4 percent, respectively) and propofol group (5 and 0 percent, respectively). The authors concluded that omission of fentanyl during sevoflurane anesthesia decreases the incidence of PONV, which is similar to that after propofol TIVA.

Harry J. Lemmens, M.D., Ph.D., Stanford University Medical School, Stanford, California, determined the antiemetic prophylaxis rate and the incidence of PONV in an ambulatory surgical center staffed by both private-practice and university anesthesiologists [A-21]. Although private-practice anesthesiologists administered prophylactic antiemetics more often than the university anesthesiologists

(66 percent versus 50.5 percent), no difference was found in the incidence of PONV between private-practice and university anesthesiologists. However, significantly more PONV occurred in patients who received prophylaxis when compared to patients who did not receive prophylaxis, which may indicate that patients at risk more often receive prophylaxis because of their known high risk.

Three of the posters presented [A-20, A-28, A-29] were part of a multicenter study that assessed the efficacy and safety of oral valdecoxib and its intravenous prodrug congener, parecoxib.

T. J. Gan, M.D., Duke University Medical Center, Durham, North Carolina, assessed the impact of a single dose of I.V. parecoxib preoperatively followed by oral valdecoxib on postdischarge experience and return to normal activity after laparoscopic cholecystectomy [A-20]. The analgesic

the parecoxib/valdecoxib analgesic regimen on postdischarge pain and patient symptoms experience. The analgesic regimen resulted in reduced opioid consumption, better pain relief and improved patient satisfaction when compared to the placebo/standard of care group.

Margarita Coloma, M.D., University of Texas Southwestern Medical Center at Dallas, Texas, examined the pre-emptive analgesic effect of rofecoxib compared to ibuprofen and ketorolac when administered prior to outpatient anorectal surgery [A-35]. Patients were divided into four groups: control (vitamin C by mouth [PO] and saline I.V.), ibuprofen group (ibuprofen PO and saline I.V.), ketorolac group (vitamin C PO and ketorolac I.V.) and rofecoxib group (rofecoxib PO and saline I.V.). Oral medications were administered 30-60 minutes preoperatively while I.V. medications

Postoperative nausea and vomiting (PONV) and postoperative analgesia, which have always been of great research interest to ambulatory anesthesiologists, also were featured prominently.

technique reduced PONV, improved oral intake and resulted in faster return to normal activity when compared to placebo/standard of care.

Eugene Viscusi, M.D., Jefferson Medical College, Philadelphia, Pennsylvania, assessed the impact of preoperative I.V. parecoxib on resource utilization before discharge from the hospital [A-28]. Preoperative parecoxib resulted in reduction of opioid requirements and improved maximum pain levels and reduction in resources to manage pain. Length of hospital stay also was shorter, concluding a favorable clinical and economic benefit of using parecoxib compared to the standard of care.

Girish P. Joshi, M.D., University of Texas Southwestern Medical Center at Dallas, Texas, assessed the impact of

were administered immediately prior to induction. Need for pain medication, quality of recovery and patient satisfaction with analgesia were evaluated at 24 and 72 hours postoperatively. The time to first pain-rescue medication was significantly longer in the ketorolac group compared to the other groups. The ibuprofen group needed more oral analgesics while the rofecoxib group reported less pain at home compared to the control group. The authors concluded that ketorolac was more effective in the pre-discharge period while rofecoxib was more effective after discharge from the hospital when compared to saline and ibuprofen.

Kevin W. Klein, M.D., University of Texas Southwestern Medical Center at Dallas, Texas, compared the analgesic efficacy and associated costs of

rofecoxib, celecoxib and acetaminophen when administered prior to outpatient ear, nose and throat surgery. Patients were assigned into one of four groups to receive two oral doses of any of the four study medications (placebo, acetaminophen 200 mg, celecoxib 200 mg or rofecoxib 50 mg). The first oral dose was taken 30 minutes before induction and the second oral dose on the morning after surgery. Peak postoperative pain scores, requirements for rescue fentanyl and overall costs were lower in the celecoxib and rofecoxib groups

when compared to acetaminophen and placebo [A-36].

Janet J. Pavlin, M.D., University of Washington School of Medicine, Seattle, Washington, compared postoperative pain in patients who received triple preincisional analgesic therapy (rofecoxib 50mg PO, postoperative field block with 0.25 percent bupivacaine mixed with 0.5 percent lidocaine and ketamine 0.2mg/kg I.V.) versus a control group that received none of the above. All patients received 10 ml of local anesthetic wound infiltration at the end of surgery, and pain in the

PACU was treated with I.V. fentanyl and then with oral acetaminophen-oxycodone combination before and after discharge. Maximum pain scores were lower and analgesic use less in the treatment group in the first 24 hours after discharge, concluding that this combination therapy employed before incision diminished pain and analgesic requirements in the first 24 hours after outpatient hernia repair when compared to a control group that did not receive preincisional analgesic therapy [A-27]. 

Preliminary Results of SAMBA Annual Meeting Survey

*Walter G. Maurer, M.D., Chair,
Committee on Annual Meeting*

By now, every member of SAMBA should be aware that a strategic review is under way to determine the direction of future annual meetings. The SAMBA annual meetings are, without a doubt, the largest financial effort that our Society embarks on every year. With the changing face of continuing medical education (CME) throughout the medical community, it is important that our Society develop a detailed strategic plan for this most critical of our educational efforts.

The Annual Meeting survey "SAMBA CME Program Survey" can be found on the SAMBA Web site at <www.sambahq.org>. Preliminary results from the nearly 200 members completing the survey show that although 37 percent have been SAMBA members for more than 10 years, a nearly equal percentage (36 percent) have been to only one SAMBA Annual Meeting.

The majority of those who do go to the annual meetings prefer to learn by going to the traditional

meeting lectures (86 percent). Although there is quite a great deal of interest in online and CD-ROM learning media, the vast majority (72 percent) would wish to pay less than

"meeting attendance..." depends on "...1) availability of time off from work, 2) lecture topics and 3) overall meeting content."

\$25 per CME credit hour. Office-based anesthesia continues to be the most frequently requested topic (55 percent) with geriatrics, pediatrics, practice management, regional anesthesia and pharmacology also very popular.

Those taking the survey still prefer to see the Annual Meeting held in early May (59 percent) on the traditional Friday, Saturday and Sunday weekend dates. The most popular

locations requested are San Francisco, San Diego, Scottsdale, Washington, D.C., and Chicago. Advanced cardiac life support continues to be the most frequently requested pre-meeting course (43 percent). The most important considerations in determining meeting attendance are 1) availability of time off from work, 2) lecture topics and 3) overall meeting content. The social event is still very popular (74 percent), and Saturday is the preferred day (74 percent). The Mid Year Meeting also has attracted interest with availability of time off work and the desire to attend the ASA Annual Meeting as the most frequent reasons to influence a decision to attend this meeting. Forty eight percent felt that the Mid Year Meeting should cover a broad variety of "update" topics.

The survey instrument was developed by J. Lance Lichtor, M.D., and it is hoped that more SAMBA members will complete this survey so as to guide the Committee on Annual Meeting in formulation of the strategic plan and presentation to the Board of Directors at its next meeting. 

Simple Peripheral Nerve Blocks in the Head and Neck Area Can Offer Significant Pain Relief in Ambulatory Pediatric Patients

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Multimodal approaches to the care of pain allow patients to recover comfortably without the high incidence of nausea and vomiting associated with opioid use. One option to decrease the use of opioids is to utilize regional nerve block techniques that have been shown in several studies to be effective in adults and children.

At the American Society of Anesthesiologists (ASA) 2002 Annual Meeting last October in Orlando, Florida, Santhanam Suresh, M.D., Assistant Professor of Anesthesiology at

Northwestern University Medical Center, Chicago, Illinois, reviewed the anatomy of peripheral nerves around the head and neck. He summarized the use of regional analgesia procedures that may be used in pediatric patients. While caudal and ilio-inguinal nerve blocks are commonplace in this age group, blocks around the head and neck, although new, are simple to perform and may be utilized in ambulatory pediatric surgical patients and in those with headaches related to sinusitis, craniotomy or other causes. Because pediatric patients are not likely to cooperate when they are awake, these blocks are usually performed with the child under deep sedation or general anesthesia.

Peripheral Blocks Around the Ear

The Great Auricular nerve supplies



Kumar G. Belani, M.D.

the mastoid and the external ear. As seen in Figure 1, it is easily accessible just posterior to the sternocleidomastoid at the level of the cricoid cartilage.

Figure 1



Figure: Anatomical distribution of the peripheral nerves in the head and neck area. Sites for performing peripheral nerve blocks are indicated by the numbers 1 through 4 (1 = site for greater auricular nerve block; 2 = site for greater occipital nerve block; 3 = site for infraorbital nerve block; 4 = site for supraorbital and supratrochlear nerve block) Modified from: Gray H. Anatomy of the Human Body. Philadelphia: Lea & Febiger, 1918. <www.bartleby.com/107/>. [May 2000].

Because pediatric patients are not likely to cooperate when they are awake, these blocks are usually performed with the child under deep sedation or general anesthesia.

This is a simple block to perform and effective in relieving pain following mastoid surgery and otoplasty.

Blocks Following Palate and Nasal (Rhinoplasty and Sinus) Surgery

This involves blocking of the infraorbital plexus of nerves emerging via the infraorbital foramen. Although an external approach can be used, Dr. Suresh recommended approaching the infraorbital nerve via an intraoral approach in the anesthetized child.

Table 1

Nerve Block	Agent and Volume	Indications	Problems/Remarks
Great Auricular	2-3 ml 0.25 percent bupivacaine with 1:200,000 epinephrine	Otoplasty and mastoid surgery, external ear procedures	Erythema at injection site; Horner's syndrome; phrenic N block; subarachnoid block
Infraorbital plexus	0.5-1 ml 0.25 percent bupivacaine with 1:200,000 epinephrine	Endoscopic sinus surgery; rhinoplasty, including septal reconstruction; cleft palate surgery	Ecchymoses is a possibility
Supraorbital and supratrochlear nerve blocks	1-2 ml 0.25 percent bupivacaine with 1:200,000 epinephrine	Frontal headache (secondary to sinusitis, craniotomy, other causes)	Ecchymoses is a possibility
Greater occipital nerve	2 ml 0.25 percent bupivacaine with 1:200,000 epinephrine	Occipital headaches (e.g., following VP shunt placement)	Accidental intra-arterial injection

Peripheral nerve blocks (performed with a 26- or 27-gauge needle) and their indications for postoperative pain control in infants and children. One must always aspirate prior to injection to prevent unwanted intravascular injection.

Thus, no external needle marks will be evident. With a finger placed externally over the infraorbital foramen, a 27-gauge needle is inserted and guided through the buccal mucosa approximately parallel to the second maxillary molar and directed to end up close to the infraorbital foramen where the local anesthetic is deposited.

Blocks for Frontal and Occipital Headaches

The supraorbital and supratrochlear nerves may be blocked for children with frontal headaches secondary to chronic sinusitis, craniotomy surgery or other causes. The supraorbital foramen is palpated, and with the help of a 27-gauge needle, the supraorbital nerve is blocked as it exits the foramen. The supratrochlear nerve is injected by directing the needle medially close to the foramen.

For occipital headaches, the greater occipital nerve is blocked at the nuchal line just medial to the artery. In a study reported by Dr. Suresh and associates at the ASA 2002 Annual Meeting, the authors reported on the success rate of these blocks. Sometimes serial injections may be necessary to break the cycle of neuropathic pain.

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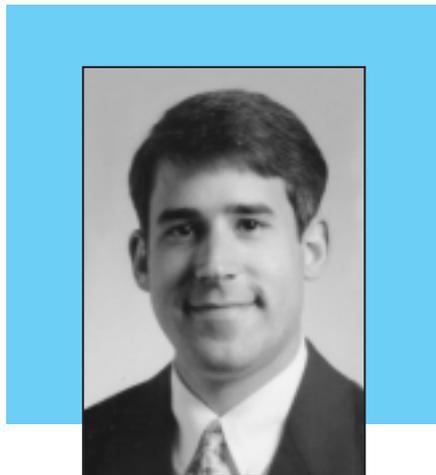
Ambulatory Anesthesia Abstracts From Around the World

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and

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The following is a summary of scientific abstracts that were presented at the 2002 American Society of Anesthesiologists (ASA) Annual Meeting in Orlando, Florida. The ASA abstract numbers are shown in brackets for reference [e.g., A-31].

In two separate prospective, placebo-controlled double-blind studies, investigators administered preoperative benzodiazepines to assess patient satisfaction, anxiety and the effect on postoperative nausea and vomiting (PONV).

Kevin P. Baurer, M.D., et al., from the University of Virginia, Charlottesville, administered intravenous (I.V.) midazolam or placebo to patients scheduled for surgery using a variety of anesthetic techniques approximately 20 minutes prior to their entrance to the operating room [A-32]. The researchers found that overall patient satisfaction was high and that patients who received I.V. midazolam had significantly less postoperative nausea ($p=0.038$).

Jorg Lessman, M.D., et al., from Mulheim, Germany, administered benzodiazepines both orally (on the evening before surgery) as well as by I.V. (on the day of surgery) to patients scheduled for peripheral surgical procedures under general anesthesia [A-33]. They found the rate of PONV was significantly less at 30, 60 and 90 minutes after arrival in the postanesthesia care unit (PACU) ($p<0.05$) in the benzodiazepine group, while anxiety scores did not differ significantly.

Karen C. Nielsen, M.D., and colleagues from Duke University Medical

Center, Durham, North Carolina, examined the use and success of regional anesthesia in obese patients compared to patients with a normal body mass index (BMI) [A-3]. Of the 7,161 patients studied, only 34.7 percent had a normal BMI. The authors stated that, as expected, patients with a BMI >40 kg/m² had a higher incidence of failed regional block ($p<0.0001$) compared to those with a normal BMI. In addition, acute block complications were similar between patients with a BMI <25 kg/m² and those with a BMI >35 kg/m². However, the authors did not define what specifically these acute block complications were. Despite obvious potential difficulties, the authors recommend regional anesthesia as a safe modality for obese patients in the ambulatory setting.

Adverse outcomes after ambulatory anesthesia were examined by **Lyna Atiyeh, M.D.**, and **Beverly K. Philip, M.D.**, from Brigham and Women's Hospital in Boston, Massachusetts [A-30]. Patients were interviewed in both phase I and phase II recovery and questioned regarding various adverse postoperative events. The authors noted a high incidence of pain (29 percent) and nausea (21 percent) after central neuraxial block as well as high incidences of pain (31 percent) and drowsiness (58 percent) after local anesthesia and monitored anesthesia care (MAC). After peripheral nerve

blockade, a high rate of pain (27 percent) and drowsiness (60 percent) also were noted. The observed high rate of occurrence of pain postoperatively was attributed to inadequate continuing analgesia after neuraxial block, inadequate local anesthesia administration by the surgeon during MAC and inadequate peripheral nerve block masked by intraoperative sedation. Despite the higher than anticipated postoperative adverse outcome rate, the overall rates of delayed discharges and admissions seen during the study were comparable to what has previously been reported in the literature.

Mark A. Warner, M.D., et al., from the Mayo Clinic, Rochester, Minnesota, performed a case-matched (age, gender, BMI, surgical procedure and anesthetic technique) retrospective medical record review of ambulatory surgery patients [A-31]. Those with either symptoms of disturbed breathing patterns during sleep or a diagnosis of obstructive sleep apnea (OSA) were compared to patients without either diagnosis. Neither the incidence of difficult/fiberoptic intubation nor the rate of unplanned hospital admission (related to surgical issues and postoperative pain control) differed significantly between the two study groups. Also, the incidence of adverse perioperative events did not differ significantly between the two matched patient groups. The authors concluded that OSA was

not an independent risk factor for unanticipated hospital admission or adverse perioperative events related to anesthesia.

Lee A. Fleisher, M.D., and colleagues from Johns Hopkins University, Baltimore, Maryland, analyzed available data on 783,483 outpatient procedures performed in New York since 1997 to determine the risk of hospital admission and/or death following ambulatory surgery [A-38]. A total of nine independent predictors were identified, including age >85, operating room duration of 60-119 minutes, operating room duration >120 minutes, cardiac disease, peripheral vascular disease, cerebrovascular disease, malignancy, HIV-positive and general anesthesia. By allowing one point to be assigned to each risk factor, a cumulative index score was calculated to predict adverse outcome in the ambulatory surgical setting. Dr. Fleisher proposed that this index could be used to identify high-risk patients who might benefit if the surgery is performed in ambulatory surgical centers from which prompt admission and emergency treatment is facilitated. However, validation of this index is needed before definitive recommendations can be made.

Outcome in geriatric patients with aortic stenosis following hip fracture repair was investigated by **Gary Heyburn, M.B.B.S.**, et al., from the Royal Group of Hospitals, Belfast, Northern Ireland [A-42]. They examined 52 patients with known aortic stenosis and divided them into groups based on type of anesthetic provided. There was no significant difference in mortality at 30 days or three months postoperatively between those patients who received subarachnoid block alone or general anesthesia with or without nerve blockade in select patients based upon echocardiography findings. However, those patients who received nerve block alone for hip fracture repair had the highest mortality at three months (60 percent). Although the number of patients in this subgroup was small, the authors attributed this finding to several factors, including

higher ASA physical status, higher gradient across the aortic valve and an increased duration between time of injury to surgical repair.

Elmer Cheah, M.D., and colleagues from Kaiser Permanente Medical Center, Baldwin Park, California, investigated postanesthesia care unit (PACU) bypass and patient home readiness after 992 cataract surgeries during a one-year study period [A-24]. The three anesthetic techniques used included general anesthesia, retrobulbar block or topical anesthesia. Criteria for both PACU bypass and home-readiness were established with the need for any therapeutic intervention during the patient's recovery phase being considered a PACU bypass failure. The authors stated that no patient receiving

“... unassisted transfer from the operating room table to the gurney is one simple test to help determine patient fast-track eligibility after outpatient gynecologic surgery.”

general anesthesia bypassed the PACU, illustrating their standard for recovery of the elderly patient. Those patients who received either retrobulbar block or topical anesthesia had PACU bypass rates of 88.69 percent and 96.58 percent, respectively ($p < 0.05$). In addition, home readiness was achieved fastest in the topical anesthesia group followed by the retrobulbar and general anesthesia groups. According to the authors, age, gender and ASA physical status did not appear to be related to the recovery profile of any of the patients having cataract surgery.

Shireen Ahmad, M.D., et al. from Northwestern University, Chicago, Illinois, demonstrated that unassisted transfer from the operating room table to the gurney is one simple test to help

determine patient fast-track eligibility after outpatient gynecologic surgery [A-23]. All 99 enrolled patients in this prospective, nonrandomized study received a standardized general anesthetic for gynecologic laparoscopy. Within 10 minutes of completion of surgery and emergence from anesthesia, patients were required to have a modified Aldrete score of nine or greater to be eligible for fast-track status and to bypass the PACU. Three patients were withdrawn from the study while four had a modified Aldrete score less than nine and required transfer assistance. The remaining 92 patients were eligible for fast-track status, and all were able to transfer to the gurney from the operating table without assistance. The authors state that unassisted patient transfer was demonstrated to be both simple and reliable for determining PACU bypass eligibility in this particular patient population.

Ralf E. Gebhard, M.D., and colleagues from the University of Texas, Houston, Texas, investigated 520 ambulatory surgical patients to determine postoperative pain scores within 24 hours of discharge [A-25]. Patients were asked to rate their greatest postoperative pain level since discharge on a pain intensity scale of 1-10. A total of 97 (18.7 percent) patients had orthopedic procedures performed with 35 of those patients undergoing a peripheral nerve block technique for surgery. On questioning, 40 percent of all ambulatory surgical patients had pain scores between four and 10 during the first 24 hours after discharge. Those patients who received peripheral nerve blocks for orthopedic surgery had significantly lower pain scores than those patients having similar procedures without regional anesthesia. The authors stated that overall postoperative pain was not optimally managed in this study. However, in a subgroup of orthopedic surgery patients, the authors concluded these individuals appeared to benefit the most through decreased pain scores during the first postoperative day when peripheral nerve blocks were utilized. 

Leading the Way

Continued from page 3

include online meeting registration and calls for abstracts.

One of the most interesting ideas for revitalizing educational programs comes to SAMBA from the American Society of Anesthesiologists (ASA). In an attempt to enhance its relationship with subspecialty societies, ASA has suggested that the subspecialties (including SAMBA) consider the possible merits of incorporating the Friday before the ASA meeting into a subspecialty track, which could conceivably include other ambulatory programs throughout the meeting. Such a track could reduce the likelihood of conflicts within ASA's educational program and offer other benefits to subspecialty anesthesiologists as well. SAMBA was one of the first groups to explore this relationship through its Committee on Affiliations, chaired by Jeffrey L. Apfelbaum, M.D., Chicago, Illinois. While this idea is very intriguing, it remains in its infancy at this time.

Are Outcomes in Ambulatory Anesthesia Related to the Location of Care?

Two years ago, SAMBA funded the Outcomes Research Award in an effort to expand knowledge regarding the practice of ambulatory anesthesia. The recipient of the award, Lee A. Fleisher, M.D., Baltimore, Maryland, presented the keynote address at the 2002 Mid Year Meeting in Orlando, Florida. Using a database of more than 500,000 surgical procedures, Dr. Fleisher demonstrated that ambulatory surgery is very safe. However, patients over age 85, those who have been admitted to the hospital within the previous six months or those who have serious comorbidities may be predisposed to the need for an overnight stay.

SAMBA is honored to have played a role in this work and continues to work toward structuring the Outcomes Research Award in a manner that will guarantee future funding.

Money for the Mission

Two years ago, a treasurer's task force was formed to evaluate and recommend strategies for management of the Society's finances. The good news is that after interviews and deliberations, this group recommended the engagement of a professional manager from Merrill Lynch to manage SAMBA's assets. While we have not been immune to the recent downturn in the market and interest rates, the organization has fared significantly better than it would have under its previous investment strategy, and we have fared better than some of our peers.

Now for the bad news: Given escalating costs, educational programs such as SAMBA's are increasingly challenged to break even, and SAMBA is no exception to this rule. This is a good time to extend thanks to our sponsors, whose generosity makes many of SAMBA's efforts possible. Special recognition goes to our Grand Patron Sponsors Abbott Laboratories, AstraZeneca Pharmaceuticals and the Baxter Health Care Corporation.

SAMBA: Speaking With One Voice

At a recent leadership gathering of another organization, it was acknowledged that SAMBA was one of the largest subspecialty societies. As I mentioned in my last "President's Message," our Board strives to be forward-thinking and always considerate of providing value to our members, many of whom are in private practice. With that in mind, I have significantly increased the representation in leadership within the organization from the private sector. Jeffrey Brand, M.D., an anesthesiologist from Salem Hospital in Salem, Massachusetts, has been appointed Chair of the Committee on Finance, and Meena S. Desai, M.D., an office-based practitioner from Philadelphia, Pennsylvania, was appointed Vice-Chair of the Committee on Office-Based Practice. In addition, Frederick W. Ernst, M.D., from Dothan, Alabama, has graciously

agreed to chair an ad hoc committee to examine ways that SAMBA can better serve private physicians.

We also are approaching the time of year when members are appointed to SAMBA's committees for the following year. This is the duty of President-Elect Frances F. Chung, M.D., Toronto, Ontario, Canada. When I appointed the committee members last year, I was fortunate to be able to honor every request that was received, and I am sure that Dr. Chung would be delighted to do the same. The Society greatly benefits from the inclusion of individuals interested in ambulatory anesthesia and is always looking for new talent willing to work on our behalf. If you would like to participate in a committee or would like to recommend a colleague, please contact Dr. Chung at <frances.chung@uhn.on.ca>.

SAMBA is recognized as a cohesive group that can speak to issues which benefit our membership. As president, I have done so on two occasions within the past month. First, I responded to senators on behalf of SAMBA and at the request of ASA to support the effort to correct the Medicare update for physicians. Earlier this month, I expressed SAMBA's support to the American Board of Anesthesiology for an appeal to the Educational Commission for Foreign Medical Graduates regarding sponsorship of J-1 visas for noncertified anesthesiology fellowships. Representing you as SAMBA President is an honor indeed. Also, in my opinion, it is important that the interests of anesthesiologists be expressed publicly, and I thank you for the opportunity to be such a spokesperson.

Once again, please accept my most sincere gratitude for the opportunity to serve you as SAMBA's president. And please join us in Boston. It should be an extraordinary educational experience and a lot of fun!



Ethical Practices in Ambulatory Anesthesia

By Mary Ann Vann, M.D.
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Ethical dilemmas can arise in any anesthesia practice. The principles of medical bioethics can guide ambulatory anesthesiologists in their management of these situations. Respect for a patient's autonomy and thereby their rights to adequately informed consent, privacy and accommodation of their values or beliefs cannot be neglected in the haste of the ambulatory surgery schedule.

Even during a time-limited patient interview, the physician who is conscious of ethical issues will more readily recognize them and promptly respond to the patient's needs.

A basic right of all patients is informed consent. Ethicists Tom Beauchamp and James Childress wrote: "... From the fact that actions are never fully informed, voluntary or autonomous, it does not follow that they are never adequately informed, voluntary or autonomous." The ethical guideline for disclosure is the subjective person standard. This model specifies that each patient requires a different amount of information based on his or her personal beliefs and medical history. Thus, the anesthesiologist should ascertain each patient's need for certain information. This may be more difficult to discern during a brief interview with a patient already on a stretcher compared to a relaxed visit in a preoperative clinic.

Informed consent must be voluntary and independent of influence. One may consider whether a patient who is gowned and awaiting imminent surgery can make a fully voluntary and uninfluenced decision. These patients have already committed themselves by taking time off work and arranging escorts and baby sitters. A study by David B. Waisel, M.D., and Robert D. Truog, M.D., showed that for parents of children having day surgery, "the decision to proceed with surgery appears to be a function of the

desire for surgery itself and is not affected by external considerations such as the anesthesia preoperative discussion." Their decisions also were swayed by the fact that many practical details of preparation had been accomplished. Some anesthesiologists believe that the patient who agrees to and presents for surgery and then changes his or her clothes gives implied consent for an anesthetic procedure. However, often the anesthesia has greater risks than the surgery itself and requires the full process of informed consent.

Therapeutic privilege is invoked when a caregiver withholds information from a patient because he or she thinks this would be harmful to them in some way. Does this allow an anesthesiologist to avoid discussing the risk of serious injury or death with a nervous 20-year-old patient minutes

Ethical teaching requires that the patients' interests take priority over others' interests.

away from a hernia operation? The patient should direct the discussion if the preoperative interview follows the subjective person standard. A study done in 1977 revealed that patients receiving more detailed information on anesthesia risks did not have significantly different anxiety levels at the time of surgery. However, these patients had their preoperative interview conducted the night preceding surgery, not immediately before.

The anesthesiologist also must assess the patient's capacity to understand the information and make an independent decision. In a surgical center, consultations on decision-making ability may not be available. In addition, surrogates or legal guardians should be provided with adequate information when the patient is unable



Mary Ann Vann, M.D.

to consent to prevent a "rubber-stamp" type of approval for a procedure.

A "Patient's Bill of Rights" seeks to assert a patient's autonomy through the rights of confidentiality and privacy. *Confidentiality* refers to the protection of the information provided by the patient to the caregivers, and *privacy* concerns the patient's right to control who may obtain access to his or her life. Respect for privacy should guide policy on the posting of schedules, preparing, labeling and storing of patient charts, obtaining medical history and protecting modesty. This is especially important in ambulatory facilities that allow family members greater access to patient care areas.

The autonomous patient has the moral right to veto familial involvement. The patient may not want family members present during a preoperative interview or details about him or her discussed with family during a preoperative telephone call. Unless granted permission to do so, a family member should not be asked to provide personal or medical information about the patient or be given instructions or details about the procedure.

Another scenario concerning privacy may arise when an escort is required to participate in discharge instructions and home care as well as accompany the patient to his or her residence. Some patients feel that this

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Ethical Practices in Ambulatory Anesthesia

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violates their right to privacy, especially if they are concealing their surgery from coworkers or family or are new in town and do not know anyone well enough to ask them to bear this responsibility. Perhaps a professional escort, home care service or recovery center could replace the "responsible escort" in this circumstance.

As more patients with complicated pre-existing diseases present to ambulatory surgical facilities, there will be greater attention focused on the issues of resuscitation and advance directives. The American Society of Anesthesiologists publishes "Ethical Guidelines for the Anesthesia Care of Patients with Do-Not-Resuscitate Orders or Other Directives That Limit Treatment" for these special situations in addition to "Guidelines for the Ethical Practice of Anesthesiology," which addresses the daily practice of anesthesia. *Advance directives* indicate the patient's wishes to accept or limit care, and a *health care proxy* designates a person to make medical decisions when the patient is unable. A process to establish the existence and content of these documents is a standard of the Joint Commission on Accreditation of Healthcare Organizations. When advance directives limit some aspects of care, a discussion on how to reconcile these wishes with the realities and limitations of ambulatory anesthesia should occur between the surgeon, anesthesiologist and patient.

While regarding the spiritual beliefs and ethnic or moral values of the patient are paramount to an ethical practitioner, one must also consider the value system of the caregivers. A replacement may be necessary for an employee who has moral objections to caring for certain patients or participating in specific procedures (e.g., Jehovah's Witness or therapeutic abortion). With limited staffing in ambulatory centers, it is helpful to know about these principles early to prevent last-minute delays.

Anesthesiologists practicing in the ambulatory setting are subject to extreme production pressures with the potential to affect their judgment. Ethical teaching requires that the patients' interests take priority over others' interests. However, many anesthesiologists are pressured to do cases regardless of nothing-by-mouth status, poorly managed comorbid conditions, abnormal electrocardiograms, etc., so as not to lose business or anger patients or surgeons.

Ethical dilemmas, defined as two options with competing moral obligations or values, occur in the daily practice of ambulatory anesthesia. Practitioners who are cognizant of these concepts will recognize and handle ethical situations as they arise. The environment of care will improve for patients and staff when they practice at a higher level of ethical awareness. 



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