

January 2004

Dear ASA Member:

We are providing a copy of the January 2004 issue of *Ambulatory Anesthesia* to all members of the American Society of Anesthesiologists (ASA) in an effort to inform members of the anesthesiology community about the upcoming activities of the Society for Ambulatory Anesthesia (SAMBA). For nearly 19 years, *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.

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 anesthesiology.

This year's Annual Meeting will be held in the beautiful Pacific Northwest city of Seattle, Washington, on April 29-May 2 at the Westin Seattle Hotel. The SAMBA Annual Meeting has long been recognized as the premier ambulatory anesthesia event of the year, and the Society's 19th Annual Meeting in Seattle will be no exception. Information-packed scientific sessions, presented by leaders in the field of ambulatory anesthesiology, will address the challenges faced by anesthesiologists who practice in ambulatory settings, while intensive workshops will stimulate new ideas in approaches to your ambulatory practice. We invite you to review the Annual Meeting program found inside. All ASA members involved in ambulatory surgery are encouraged to attend this meeting. Mark your calendar now and plan to attend.

We also invite you to visit the SAMBA Web site, one of the most progressive Web sites of any subspecialty anesthesiology organization. The site is extremely user-friendly and includes membership application and renewal features, online meeting registrations, newsletters, a membership directory, patient information pages, discussion panels, surveys and much more.

A comprehensive list of membership benefits is provided on the back page of this issue. 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,



Frances Chung, M.D.
SAMBA President



CALL for ELECTRONIC SUBMISSION of ABSTRACTS and RESIDENTS' TRAVEL AWARDS

SAMBA 19th Annual Meeting
Seattle, Washington
April 29-May 2, 2004

The Committee on Annual Meeting has issued a call for electronic submission of abstracts for the SAMBA 19th Annual Meeting to be held at the Westin Seattle Hotel in Seattle, Washington, on April 29-May 2, 2004.

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 2004 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 for research in ambulatory anesthesiology presented by the White Mountain Institute. Papers presented at the SAMBA Annual Meeting are eligible for presentation at subsequent large anesthesiology meetings such as the annual meetings of the American Society of Anesthesiologists and the International Anesthesia Research Society (IARS). 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 submission instructions and grading criteria as well as to submit abstracts and complete cover letters, visit the SAMBA Web site at <www.sambahq.org>.

By printing out the submission 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 click on "Call for Abstracts." The instructions 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 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 a new cover letter.

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

The deadline for receipt of properly submitted abstracts to the SAMBA office is **February 10, 2004**. 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 2004 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 document.

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

* Abstracts submitted for presentation at the IARS 2004 Annual Congress may be submitted for the SAMBA 19th Annual Meeting.

Deadline:
February 10, 2004

Submit online at:
www.sambahq.org



Society for Ambulatory Anesthesia

Ambulatory AnesthesiaSM

PRESIDENT'S MESSAGE

SAMBA: A Great, Dynamic and Exciting Society

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

Ambulatory surgery accounts for 65 percent to 70 percent of all surgical procedures in North America. The percentage of ambulatory procedures also is increasing worldwide. The knowledge, skill and the research of anesthesiologists with special interest in ambulatory anesthesiology have transformed ambulatory surgery and anesthesia. SAMBA is a dynamic and evolving Society, and we strive for excellence in ambulatory anesthesiology. I invite members of the American Society of Anesthesiologists to join SAMBA's membership ranks, as there are many benefits to being a SAMBA member.

Ambulatory Anesthesia, the publication you are reading now, is published four times a year under the leadership of Girish P. Joshi, M.D., Dallas, Texas, and his Committee on Publications. It provides timely information on ambulatory anesthesiology and is an important component of our mission to educate anesthesiologists in the field of ambulatory anesthesiology. We always welcome the submission of articles pertinent to ambulatory anesthesiology.

This year SAMBA's Annual Meeting will take place in Seattle, Washington, on April 29-May 2. Lucinda L. Everett, M.D., Seattle, Washington, and her Committee on Annual Meeting have prepared a wonderful program. One of the important features of the SAMBA Annual Meeting is its

social benefit. At breakfasts, lunches and dinners, you can meet leaders in ambulatory anesthesiology and discuss clinical and practical issues. You will find friends and support at SAMBA. If you are a SAMBA member, your registration fee for the Annual Meeting will be reduced. Give our meeting a try! I guarantee that you will enjoy our program in Seattle.

I invite members of the American Society of Anesthesiologists to join SAMBA's membership ranks, as there are many benefits to being a SAMBA member.

The Committee on Education, under the leadership of Thomas W. Cutter, M.D., Chicago, Illinois, has just updated a bibliography of ambulatory anesthesiology that offers the most recent references in various areas of ambulatory anesthesiology. This major ongoing project is undertaken by the Committee on Education every two years, and the information is available to SAMBA members on our Web site <www.sambahq.org>.

This year SAMBA is committed to funding a major outcomes study equaling \$75,000 per year for two years. As always SAMBA is determined to promote meaningful research in ambulatory surgery and anesthesia. We recognize the importance of well-conducted research and



Frances Chung, M.D.

its significant impact on the practice of ambulatory surgery and anesthesia. T.J. Gan, M.D., Durham, North Carolina, and his Committee on Research is spearheading this prodigious project. We encourage all investigators to apply.

The Committee on Electronic Communications, under the leadership of Mary Denise Daley, M.D., Houston, Texas, is leading the way to the future. She and her committee have continued to service our Web site and to expand its features. The Web site serves as a strong link to our national and international members. Feel free to visit us at <www.sambahq.org> and you will obtain the latest and most useful information on ambulatory anesthesiology.

In the coming decade, globalization will be a key issue in our subspecialty,

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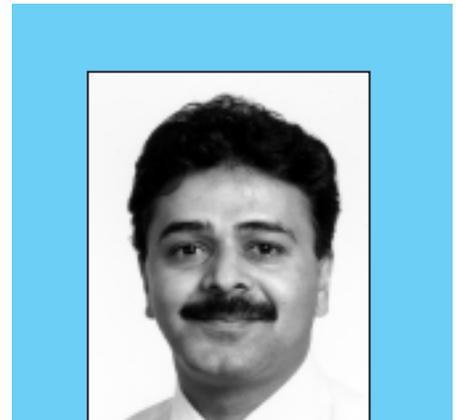
You Have a Voice: Sound Off About SAMBA!

Most of us believe that the “black box” warning on the use of droperidol is unwarranted, particularly with the low doses (less than 1.25 mg) used to prevent or treat postoperative nausea and vomiting. The Food and Drug Administration (FDA) imposed this limitation on our practice in spite of inadequate evidence that the lower doses of droperidol result in clinically relevant QT prolongation. Recently, **T.J. Gan, M.D.**, Durham, North Carolina, represented SAMBA at an FDA Advisory Committee meeting that re-evaluated the effects of droperidol on QT prolongation. As reported by Dr. Gan, it seems unlikely that the FDA will reverse the “black box” warning, probably because it considers the use of less than 2.5 mg doses as outside the “labeled” indication of droperidol and hence beyond its jurisdiction. Unfortunately the FDA did not specifically state that the “black box” warning only applies to the approved doses of 2.5 mg and above, which would have prevented practitioners from avoiding the use of an effective and cheap drug.

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

marizes the panel discussion on care of children with reactive airway disease and myelodysplasia disorders presented at the American Society of Anesthesiologists (ASA) 2003 Annual Meeting in San Francisco, California, last October. As always Dr. Belani has gone out of his way to obtain interesting pictures and graphics from the speakers. **Stephen A. Cohen, M.D.**, Lexington, Massachusetts, and **Mary Ann Vann, M.D.**, Boston, Massachusetts, review the SAMBA Breakfast Panel on “Whom Do We Invite to OUR Party? How and Why the Preoperative Evaluation of Outpatients Is Different,” which also was presented during the ASA Annual Meeting.

Through research and education, SAMBA has played a major role in the improvement of the quality and safety of ambulatory anesthesia practice. SAMBA continues to offer excellent educational opportunities to ambulatory anesthesia practitioners. The SAMBA 2003 Mid Year Meeting held just prior to the ASA Annual Meeting in San Francisco, was a great success. **Lucinda L. Everett, M.D.**, Seattle, Washington, put together an excellent program that addressed the chal-



Girish P. Joshi, M.D.

lenges we face not only in our clinical practice but also in the administrative and regulatory arena. Not surprisingly the Mid Year Meeting was very well attended and received rave reviews from the attendees. Similarly the SAMBA 2004 Annual Meeting to be held in Seattle, Washington, on April 29-May 2, will provide us with an update on the current state-of-the-art ambulatory anesthesia practice. The

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Ambulatory Anesthesia is published quarterly in January, April, July and October by the Society for Ambulatory Anesthesia (SAMBA), 520 N. Northwest Highway, Park Ridge, IL 60068-2573; (847) 825-5586; samba@ASAhq.org. The information presented in Ambulatory Anesthesia has been obtained by the Subcommittee on Publications. Validity of opinions presented, drug dosage, accuracy and completeness of content are not guaranteed by SAMBA. The views, recommendations and conclusions contained in this newsletter are the sole opinions of the individual authors. The Society for Ambulatory Anesthesia takes no responsibility for approving or disproving the information contained therein.

SAMBA

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'Black Box' Warning on Droperidol: A Report on the FDA-Convended Expert Panel

By T.J. Gan, M.D.
Durham, North Carolina

On November 18, 2003, the Food and Drug Administration (FDA) convened an expert panel of the Anesthetic and Life-Support Drugs Advisory Committee. The purpose of the meeting was for the committee to provide advice and recommendations regarding the assessments and management of risk related to QTc prolongation by droperidol. On December 5, 2001, the FDA had issued a "black box" warning on droperidol, a popular antiemetic for the treatment and/or prevention of postoperative nausea and vomiting (PONV).^{1,2} Droperidol previously carried a warning regarding the potential for sudden cardiac death at high doses (> 25 mg) in psychiatric patients. The revised warning cautioned that even low doses of droperidol should only be used when other "first-line" drugs fail.

tration of droperidol at doses of 1.25 mg or less. A review of these case reports shows that there are many confounding factors that make it impossible to establish the precise cause of the adverse cardiac events. Many concomitant drugs with the potential of causing QTc prolongation were administered around the time of the droperidol.³ Of note, since droperidol was approved in 1970, there has not been a single case report in a peer-reviewed journal where droperidol in doses used for the management of PONV has been associated with QTc prolongation, arrhythmias or cardiac arrest.¹

The meeting opened with the representatives from the FDA presenting background information on the droperidol approval process and the impact of the black box warning. Ten million vials of droperidol were sold in 2001 before the black box warning, and it was estimated that its use was re-



T.J. Gan, M.D.

Of note, since droperidol was approved in 1970, there has not been a single case report in a peer-reviewed journal where droperidol in doses used for the management of PONV has been associated with QTc prolongation, arrhythmias or cardiac arrest.¹

I represented SAMBA and presented during the public forum session to express the view that the FDA's black box warning is unwarranted for the antiemetic doses of droperidol and that the warning has effectively removed one of the most efficacious drugs for the management of PONV for our patients. I presented evidence that droperidol is a cost-effective antiemetic and that its safety profile when used in antiemetic doses is excellent. We have previously reported on the 10 cases in the FDA database in which serious cardiovascular events were possibly related to the adminis-

tration by 90 percent following the warning. It was recognized that there is a significant lack of data for the low doses of droperidol causing QT prolongation. The FDA had conducted a healthy human volunteer study (eight patients) investigating the effect of 0.625 mg, 2.5 mg and 5 mg bolus doses of intravenous (I.V.) droperidol on QT interval. The study was prematurely terminated due to adverse events (restlessness, anxiety and difficulty concentrating) seen in the higher doses. In addition the study was underpowered to detect the primary outcome. The option for further studies to address this

issue was explored. It was concluded, however, that a large-scale randomized study will be difficult to perform in view of the relatively low event rate and the enormous cost involved.

The panel heard evidence from an expert cardiologist on the frequency of drug-related QT prolongation and the complexity of measurement of the QT interval. The preoperative drugs reported to cause QTc prolongation include inhalational anesthetics^{4,5}, serotonin antagonists⁶, thiopental⁷, propofol⁸, neuromuscular reversal drugs⁹, metoclopramide⁶, succinylcholine^{7,10}, terfenadine¹¹ and macrolide antibiotics.¹¹

Measurement of QT interval is not an exact science. The relationship between the duration of cellular action potentials and the QT interval recorded at the body surface is complex. As a result, the QT interval is difficult to measure with precision. First, there is inherent imprecision in identifying the end of the T wave because of incomplete understanding of the recovery process and its projection on the body surface. Second, significant variation both in the onset of the QRS complex and the end of the T wave among some electrocardiogram leads provides different QT values depending on the leads selected for measurement.

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It's OUR Party: Panel Discusses Preoperative Evaluation



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Mary Ann Vann, M.D.

The SAMBA Breakfast Panel at the American Society of Anesthesiologists (ASA) 2003 Annual Meeting on October 14 in San Francisco, California, sold out early and was a rousing success. Nearly 450 anesthesiologists listened as the distinguished panel addressed the topic, "Whom Do We Invite to OUR Party? How and Why the Preoperative Evaluation of Outpatients Is Different."

SAMBA President Frances Chung, M.D., Toronto, Ontario, Canada, welcomed the assembled group. **Lee A. Fleisher, M.D.**, Philadelphia, Pennsylvania, opened the panel with a discussion of "Tailoring the Preop to the Procedure: The Evidence." He emphasized that we should guide the extent of our preoperative evaluation of patients based on evidence — but sometimes such evidence remains incomplete. Only anesthesiologists can "clear" a patient for anesthesia. In doing so, we should first attempt to identify unstable patients and intervene preoperatively to decrease the risk to the patient. Intraoperative and postoperative interventions undertaken may be influenced by the availability of monitoring, equipment and other personnel, such as cardiologists — that is one reason preoperative evaluation of ambulatory surgery patients is performed. Another reason to perform preoperative evaluation is to know the probability of the need for hospital ad-

mission. Dr. Fleisher noted that ambulatory patients have significantly lower mortality rates under our care than they do in the immediate two weeks postoperatively.

He noted that day-surgery settings could vary widely. Freestanding ambulatory surgical centers (ASC), for example, generally staff less than hospitals, and intraoperative and postoperative interventions, if necessary, usually require a visit to the emergency room (E.R.) of a nearby hospital. Outpatient facilities attached to hospitals may not require such a visit because other staff personnel, such as cardiologists, may be more readily available. At the other extreme, office-based settings require a more critical preoperative assessment because of the unavailability of other such personnel.

Dr. Fleisher emphasized that we must always balance the convenience and satisfaction of outpatient surgery with the risk that complications may be less readily treatable in these settings. He cautioned that the potential for admission always exists. In debunking a recent article that suggested "no testing" was needed for cataract surgery patients, Dr. Fleisher noted that the patients in that study had, indeed, been worked up by their primary care physicians. Hence no further workup was needed.

Dr. Fleisher discussed various car-

diac risk factors but emphasized that pulmonary, endocrine and other medical risk factors must be considered as well. He reviewed the major clinical predictors delineated by the 2002 revision of the American College of Cardiology and American Heart Association guidelines for the assessment of cardiac risk stratification for noncardiac surgery. He questioned whether we should perform surgery on patients with major clinical predictors on an ambulatory basis. According to the guidelines, low-risk surgery requires no further workup.

He also noted that unstable angina creates a hypercoagulable state. Compounding the hypercoagulability with surgery can lead to myocardial infarction and even death. Clearly these patients need to be admitted to the hospital for their angina, not taken to the operating room (O.R.) for their elective ambulatory procedure. He cited literature which suggested that if a preoperative cardiologic evaluation concluded that a patient needed percutaneous transluminal coronary angioplasty (PTCA), surgery should be delayed for 90 days because these patients have a similar incidence of adverse coronary outcomes compared to non-PTCA controls with coronary artery disease. Hence prophylactic PTCA for coronary artery disease does not seem to improve cardiac outcomes during this time period.

Patients who chronically take beta-blockers should not stop them prior to surgery. Anesthesiologists may, however, wish to withhold long-acting oral beta-blockers immediately prior to ambulatory surgery and use intravenous esmolol or metoprolol instead.

For ambulatory patients in general, the risk of admission increases significantly with medical comorbidities, O.R. times > 2 hours, general anesthesia and age > 85. In closing, Dr. Fleisher suggested that the key to safe ambulatory anesthesia rests in good history-taking and identification of those conditions that may require more intensive interventions. Patients with unstable conditions should not have surgery.

The next speaker, **L. Reuven Pasternak, M.D.**, Baltimore, Maryland, addressed "From the Guidelines to the Sidelines." He chronicled the life cycle of the ASA Task Force on Preanesthesia Evaluation, which was formed in 1994 and which he chaired. The task force began a massive literature survey in 1995 and grew to include academic and private practitioner, specialty society and regulatory industry members by 1997. When the task force first presented its results to ASA in 1997, they were rejected. Anesthesiologists were divided into three groups: one that wanted a firm guideline stating that every patient should be seen, a second that wanted maximum flexibility to decide which patients should be seen and a group in between that wanted a framework with some latitude. The task force adopted the middle group philosophy and produced an advisory whereby the individual anesthesiologist has the responsibility and freedom to decide who needs to be seen preoperatively and what needs to be done.

Ultimately the Task Force on Preanesthesia Evaluation recommended an advisory, not a guideline, which was approved by the ASA House of Delegates in 2001 and published in 2002. During the process, more than 3,000 scientific papers were consid-

ered, but only 198 of them were cited in the final advisory. Dr. Pasternak first outlined the preanesthesia evaluation of all patients and then focused on ambulatory anesthesia in particular. He cautioned that some surgeons, nurses and administrators mistakenly consider that ambulatory anesthesia should imply low risk, which appears to lower their concern. Ambulatory anesthesia is not "minor," however. Patients undergoing ambulatory procedures do have a risk of significant comorbidities, of dying and of being treated or admitted in the E.R. These risks should not be minimized in the preoperative process. Hence there is a need for ambulatory anesthesia patients to have greater, not less, preanesthesia evaluation, and the systems required to accommodate them must become more sophisticated. A system should be responsible for getting patient information to the anesthesiologist for assessment well prior to the day of surgery for appropriate evaluation.

Dr. Pasternak also remarked that the anesthesiologist must be the person who decides what constitutes an appropriate preanesthesia evaluation and hence ultimately "clears" patients for surgery and anesthesia. Only with our input and unique perspective can we increase ambulatory perioperative safety while enhancing patient convenience and maximizing productivity. He cautioned, however, to avoid turning the preoperative screening process into a chronic care system. Chronic, high-risk illnesses should be referred back to the primary care physician or other specialist physician instead.

Because modern anesthesia is extremely safe, some practitioners question the need for preanesthesia evaluation. Although anesthesia-related mortality is low, complications related to surgery lead to more deaths. Therefore, in assessing the risk of surgery for any patient, the patient's medical condition and the nature of the surgery are most important. In order to minimize poor outcomes, pa-

tient assessments must be individualized and a flexible system structure should be put into place. This may differ widely according to geographical, urban/suburban/rural or individual facility variations.

Dr. Pasternak concluded his talk by debunking some issues about which people remain misinformed. He noted that corporate America, the government, surgical societies and the public have all decided what constitutes "suitable care" in many medical areas, including our own. He advises that we should take the responsibility, regain the lead and be in charge of determining what is required for safe perioperative care: We must lead, not follow. Anesthesiologists should establish value for the patient, institution, providers, payers, regulatory industry and the larger corporate world. We must do this because we are losing ground in the emphasis of the importance of the preanesthesia evaluation, especially for the ambulatory patient. Routine perioperative laboratory testing can be expensive and is not generally warranted. It is becoming less of a substantial part of the entire cost analysis of perioperative care, however. Therefore Dr. Pasternak opines that stakeholders should address other areas of the perioperative process, which are the true cost-drivers of care, instead of focusing on preanesthesia assessment.

David Barinholtz, M.D., Chicago, Illinois, closed the panel with the topic "Working Without a Parachute: The Preoperative Process in an Office-Based Practice." First, Dr. Barinholtz commented on the title of his topic, which was chosen by the moderator. He stated that to survive in an office setting, one must have not only a good parachute, one must carefully check it, pack it well ahead of time and always have it ready for use.

Dr. Barinholtz provided a patient questionnaire, preoperative testing algorithm and his surgeon/primary care physician presurgical evaluation

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Panel Provides Information for Care of Children With Reactive Airway Disease and Myelodysplasia Disorders for Routine Surgery

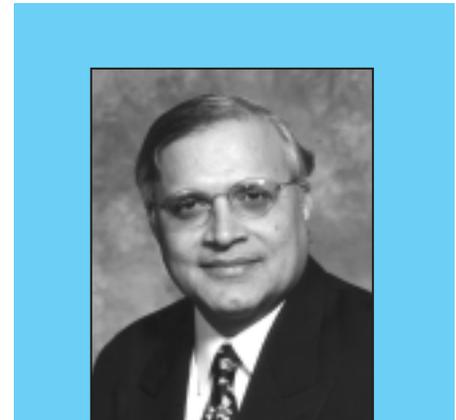
By Kumar G. Belani, M.D.
 J.J. Buckley Professor
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 Professor of Pediatrics
 University of Minnesota
 Minneapolis, Minnesota

At the American Society of Anesthesiologists (ASA) Annual Meeting on October 14, 2003, in San Francisco, California, **Linda Mason, M.D.**, Loma Linda, California, and **Sulpicio Soriano, M.D.**, Boston, Massachusetts, discussed the care of children for routine surgery at a pediatric panel chaired by **Raafat Hannallah, M.D.**, Washington, D.C. Dr. Mason focused on children with reactive airway disease while Dr. Soriano discussed myelodysplasia disorders.

Reactive airway disease or bronchial asthma affects 4 percent to 9

percent of children in the United States with 50 percent becoming known asthmatics by age 3 and 80 percent by age 5. While dyspnea and wheezing are commonly recognized symptoms, sometimes cough and chest tightness may be the only indicators of this problem. Severity of symptoms is related to the degree of airway inflammation, smooth muscle hypertrophy and edema in smaller airways, often leading to mucous plugging and plasma exudation secondary to shedding of epithelium and cilia.

Anesthesia providers need to be aware that respiratory infections (mainly viral), aeroallergens and pollutants (cigarette smoke), sudden changes in temperature (particularly cold air) and exercise as well as emotion and anxiety can act as triggering agents for exacerbation of symptoms. Children with asthma may be classified as mild, moderate or severe [Table 1].



Kumar G. Belani, M.D.

While beta-adrenergic agonists administered by metered dose inhalers (MDI) are the mainstay of treatment, many children will be on inhaled corticosteroids to diminish the airway inflammatory responses that are the

Table 1: Classification of Mild, Moderate and Severe Bronchial Asthma

Severity	Symptoms	Treatment
Mild	<ol style="list-style-type: none"> 1. Infrequent, brief 2. Good exercise tolerance, asymptomatic in-between 3. Infrequent nocturnal symptoms 	<ol style="list-style-type: none"> 1. Inhaled beta-adrenergic agonist (oral beta-adrenergic agonist in infants and young children)
Moderate	<ol style="list-style-type: none"> 1. Symptoms >2 per week 2. Decreased exercise tolerance 3. Exacerbations last several days 4. Symptoms at night 2 to 3 times per week 	<ol style="list-style-type: none"> 1. Cromolyn sodium 2. Inhaled corticosteroids 3. Beta-adrenergic agonists for acute attacks 4. Leukotriene pathway modifiers
Severe	<ol style="list-style-type: none"> 1. Continued symptoms 2. Limited activity 3. Frequent exacerbations 4. Nocturnal symptoms every night 5. Hospitalization 	<ol style="list-style-type: none"> 1. Oral plus inhaled corticosteroids 2. Beta-adrenergic agonists 3. Theophylline

pathophysiological basis of reactive airway disease. Newer agents that modify leukotrienes (leukotriene receptor antagonists, montelukast or Singulair®) are being prescribed for exercise and aspirin-induced asthma and are often chosen as first-line therapy to decrease the need for rescue beta-adrenergic agonists and oral glucocorticoids. In some patients, however, Advair®, a combination of fluticasone and salmeterol, may provide more effective asthma control than low-dose inhaled corticosteroid plus montelukast. Theophylline may still be used in some children for prophylaxis against acute attacks and for treatment of nocturnal bronchospasm. Theophylline may predispose children to arrhythmias with halothane, however.



Figure 1: A 19g 5 cm catheter attached to a syringe with a metered delivery inhaler will effectively increase drug delivery to the airways. (Photo courtesy of Linda Mason, M.D.)

Infants and young children are at a high risk for bronchospasm when suffering from acute upper-respiratory tract infections. Therefore elective surgery must be postponed for two to six weeks. Pediatric patients may receive preoperative oral midazolam to reduce anxiety. Inhaled beta-adrenergic agonists also will mitigate the bronchoconstrictive response to tracheal intubation. Contrary to popular belief, children with well-managed reactive airway disease may be cared for with a laryngeal mask airway. Propo-

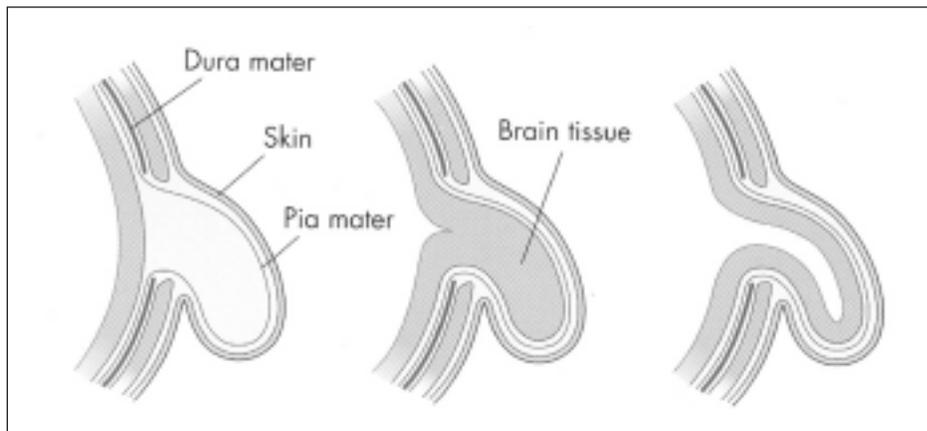


Figure 2: Types of myelomeningocele (figure courtesy of Sulpicio Soriano, M.D.)

fol and sevoflurane are induction agents of choice for routine elective surgery. Of note, intravenous (I.V.) lidocaine is better than airway spraying of lidocaine to attenuate reflex bronchoconstriction. Cisatracurium, rocuronium and vecuronium are preferred muscle relaxants because of a decreased histamine-releasing potential. Furthermore, reversal of these agents with neostigmine is safe as long as it is combined with atropine or glycopyrrolate.

To treat intraoperative bronchospasm, practitioners must first deepen the anesthetic and try inhaled beta-adrenergic agonists through the tracheal tube before resorting to epinephrine or corticosteroids. When delivering beta-adrenergic agonists via the tracheal tube, one must remember the possibility of toxicity and pay attention to the cumulative dose administered. The delivery of the beta-adrenergic agonist may be effectively increased by use of a 19g distally placed catheter [Figure 1].

Newborns with myelodysplasia [Figure 2] may have nerve tissue entrapment that may lead to neurological deficits. Hydrocephalus is common because of impaired development of the posterior fossa, necessitating the placement of a ventriculo-peritoneal (VP) shunt, a common procedure in these children. Every effort must be

taken to prevent latex exposure because of the demonstration of a higher incidence of increases in latex-specific serum IgE levels in these children. Avoidance of latex exposure decreases primary sensitization in children from 26.7 percent to 4.5 percent. When a history of latex allergy is present, these children may be pretreated with a combination of antihistamines and steroids.

Children with myelodysplasia often require multiple routine surgeries and require preoperative preparation with premedicants and parent involvement. They often have a difficult I.V. access. Because of increased use of laparoscopic surgery, one must be aware of the possibility of retrograde pneumocephalus via the VP shunt that also may serve as a conduit for infection. Keeping the insufflation pressure below 10-15 mmHg will decrease the likelihood of pneumocephalus. If severe sepsis or an abscess is present, exteriorizing the shunt may be required. 

April 29-May 2, 2004
Seattle Westin Hotel
Seattle, Washington

Photos courtesy of Seattle's Convention and Visitors Bureau

Thursday April 29, 2004

8 a.m. – 3:15 p.m.

Preoperative Evaluation and Perioperative Medicine
Preconvention Workshop

8 a.m. – 8:45 a.m.

Preop Evaluation: What's the Right System?
Sheila R. Barnett, M.D.

8:45 a.m. – 9:30 a.m.

Hypertension: Newer Treatment Regimens
Nason Hamlin, M.D.

9:30 a.m. – 9:45 a.m.

Coffee Break

9:45 a.m. – 10:30 a.m.

Cardiac Evaluation and Beta-Blockade
Catherine L. Cooper, M.D.

10:30 a.m. – 11:15 a.m.

Diabetes: Current Therapy and Perioperative Risk
Karen A. McDonough, M.D.

11:15 a.m. – 12 noon

Lunch (included in registration fee)

12 noon – 12:45 p.m.

Morbid Obesity and Co-existing Disease
Karen A. McDonough, M.D.

12:45 p.m. – 1:30 p.m.

Sleep Apnea: Outpatient Management
Kenneth L. Bachenberg, M.D.

1:30 p.m. – 1:45 p.m.

Coffee Break

1:45 p.m. – 2:30 p.m.

Asthma: Preoperative, Intraoperative and Postoperative Care
Margaret A. Hooks, M.D.

2:30 p.m. – 3:15 p.m.

Antibiotic Use and Infection Risk
Eugene Peterson, M.D., Ph.D.

4 p.m. – 6 p.m.

Workshop 1

Clinical Forum: Sheila R. Barnett, M.D., John A. Dilger, M.D., Hector Vila, Jr., M.D., Rosemary J. Orr, M.B., B.Ch., G. Alec Rooke, M.D., Ph.D.

Workshop 2

Technology in Anesthesia: Jeffrey M. Taekman, M.D., Gareth Kantor, M.D.

Friday April 30, 2004

7 a.m. – 8 a.m.

Breakfast in Exhibit Area
Research Poster Discussion

8 a.m. – 9:45 a.m.

General Session Panel 1

Expertise in Ambulatory Anesthesia

Moderator: Frances Chung, M.D.

Any Patient Can Be an Outpatient

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

Role of the Medical Director

Thomas W. Cutter, M.D., M.Ed.

Benchmarking in Ambulatory Anesthesia

Douglas G. Merrill, M.D.

9:45 a.m. – 10:15 a.m.

Break in Exhibit Area
Research Poster Discussion

10:15 a.m. – 10:45 a.m.

ASA Update

Roger W. Litwiller, M.D.

10:45 a.m. - 12:15 p.m.

Cases in the Real World

Moderator: Barbara S. Gold, M.D.

Theodore G. Cheek, M.D., Robbie Thomas, M.D.,

Garish P. Joshi, M.D., Meena S. Desai, M.D.

12:15 p.m. – 2 p.m.

Lunch on your own

2 p.m. – 4 p.m.

Workshop 3

Crisis Management

Joseph P. Cravero, M.D., Brian K. Ross, M.D., Ph.D.,

Jeffrey M. Taekman, M.D.

Simulator technology will be used to guide the group through various crisis situations that could occur during ambulatory anesthesia. Equipment for this workshop is supplied by Laerdal Medical.

2 p.m. – 6 p.m.

Workshop 4

Regional Anesthesia: Single Injection and Catheter

Techniques for Ambulatory Surgery

Susan M. Steele, M.D.

Workshop will feature live videocast from the Duke Ambulatory Surgery Center as well as the following workshop stations:

Upper Extremity

Susan M. Steele, M.D., Radha Sukhani, M.D.

Lower Extremity

Jean-Louis Horn, M.D., Admir Hadzic, M.D., Ph.D.

Central Neuraxial/Paravertebral Block

Roy A. Greengrass, M.D., Sugantha Ganapathy, M.D.

The video portion of this workshop is presented with support from Arrow International, Braun and AstraZeneca.

4 p.m. – 6 p.m.

Workshop 5

Workshop on Airway Management

Christopher M. Burkle, M.D.

Mayo Clinic Faculty:

Daniel R. Brown, M.D., Ph.D.; Michael J. Brown, M.D.; Bhargavi Gali, M.D.; Deepi G. Goyal, M.D.; Barry Harrison, M.D.; Gerard S. Kamath, M.D.; B. Mark Keegan, M.D.; Timothy R. Long, M.D.; Pamela A. Mergens, M.D.; Edwin H. Rho, M.D.; Laurence C. Torsher, M.D.; Gurinder Vasdev, M.B.B.S.; C. Thomas Wass, M.D.; Michael T. Walsh, M.D.; Nicole Webel, M.D.

Guest Faculty

J. Roger Bullard, M.D., Hsiu-chin Chou, M.D.

Ashu Wali, M.D., Tzu-lang Wu, M.D.

Equipment for this workshop has been provided by Laerdal Medical, LMA North America, Olympus America and Cook.

Experience "A Night in Seattle" on your own! Optional Group Tickets to Teatro ZinZanni available!

Saturday May 1, 2004

7 a.m. – 8 a.m.

Breakfast in Exhibit Area
Research Poster Discussion

8 a.m. – 9:45 a.m.

General Session 2

Patient Safety

Moderator: Walter G. Maurer, M.D.

New Thinking About Sedation Safety — You Snooze, You Don't Lose

Joseph P. Cravero, M.D.

Surgery in the ASC or Office - Is There Any Difference?

Hector Vila, Jr., M.D.

Nip, Tuck, Destruct

Ronald H. Wender, M.D.

9:45 a.m. – 10:15 a.m.

Break in Exhibit Area
Research Poster Discussion

10:15 a.m. – 12 noon

Medicolegal and Compliance Issues: Case Presentations

Moderator: Karen B. Domino, M.D., M.P.H.

John M. Fitzpatrick, Esq., William E. Partridge, Esq.,

Frederick W. Cheney, M.D., Brian K. Ross, M.D., Ph.D.

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12 noon – 1:30 p.m.

SAMBA Luncheon

Travel and Research Awards, SAMBA Outcomes Research Awards, SAMBA President's Address and Distinguished Service Award presented to Beverly K. Philip, M.D.

1:30 p.m. – 3 p.m.

General Session 3

The Problem Patient

Moderator: Kathryn E. McGoldrick, M.D.

Cost-Effective Management of the PONV-Prone Patient
T.J. Gan, M.D.

Preoperative to Postdischarge Techniques for Pain Management After Ambulatory Surgery
Girish P. Joshi, M.D.

Bladder Function After Anesthesia
D. Janet Pavlin, M.D.

1:30 p.m. – 3 p.m.

Resident Symposium: Life After Residency
Moderator: Thomas W. Cutter, M.D., M.Ed.

Staying Out of Court
John M. Fitzpatrick, Esq.

Finding What You Want in a Practice (and in Life)
Greg Gottlieb, M.D.

3:15 – 4:45 p.m.

Parallel Focus Session 1

Administrative Issues (presented in conjunction with the American Association of Ambulatory Surgery Centers)
Moderator: Lydia A. Conlay, M.D., Ph.D.

Anesthesiologists as Leaders in the Ambulatory Surgical Setting
Jane L. Thilo, M.D.

Administrative and Regulatory Issues in the ASC
David M. Shapiro, M.D.

Effective Peer Review
Walter G. Maurer, M.D.

Parallel Focus Session 2

Research and Teaching in Ambulatory Anesthesia
Moderator: Paul F. White, Ph.D., M.D.

Teaching Ambulatory Anesthesia
Martin S. Bogetz, M.D.

Clinical Research in Ambulatory Anesthesia
Paul F. White, Ph.D., M.D.

Publishing Articles in the Anesthesia Literature
Joseph M. Neal, M.D.

7 p.m.

SAMBA Social Evening at the Seattle Space Needle

Sunday May 2, 2004

7 a.m. – 8 a.m.

SAMBA Membership Meeting

8 a.m. – 9:45 a.m.

General Session 4

Regional Anesthesia

Moderator: Brian A. Williams, M.D., M.B.A.

Economic Issues and Patient Outcomes in Outpatient Regional Anesthesia
Brian A. Williams, M.D., M.B.A.

Paravertebral Blocks: The Duke Experience
Susan M. Steele, M.D.

Complications of Regional Anesthesia From the Closed Claims Study
Lorri A. Lee, M.D.

9:45 a.m. – 10 a.m.

Break

10 a.m. – 11:45 a.m.

General Session 5

Clinical Updates

Moderator: Mary Ann Vann, M.D.

Pediatric Patient Selection and Provider Issues
Anne M. Lynn, M.D.

Anesthesia for IVF and the Pregnant Outpatient: Myths and Maxims
Theodore G. Cheek, M.D.

Hypertension in the Geriatric Patient: How High Is Too High? (presented in conjunction with the Society for the Advancement of Geriatric Anesthesia)
Sheila R. Barnett, M.D.



Visit www.sambahq.org for more information

President's Message

Continued from page 1

and SAMBA is planning to play an important role in ambulatory anesthesiology worldwide. International membership is a mere \$25, making SAMBA very affordable to our colleagues overseas. This year we have completed our first Spanish version of the SAMBA E-newsletter, thanks to the effort and commitment of the members of the Committee on Latin American Relations, specifically Juan Carlos Duarte, M.D., Caracas, Venezuela, and Alonso Mesa, M.D., Tampa, Florida. SAMBA is indebted to their leadership in organizing the Spanish translation.

SAMBA committees are the main framework of our organization. The hard work of the committee chairs and their committee members make SAMBA a big success. Our Society greatly benefits from the inclusion of anesthesiologists interested in ambulatory anesthesiology and is always looking for dedicated SAMBA members willing to participate in committee work. We are now approaching the time of year when members are appointed to SAMBA committees for the following year. This is the duty of President-Elect Kathryn E. McGoldrick, M.D. If you would like to participate on a committee or would like to recommend a colleague, please contact Dr. McGoldrick at <kathryn_mcgoldrick@nymc.edu>.

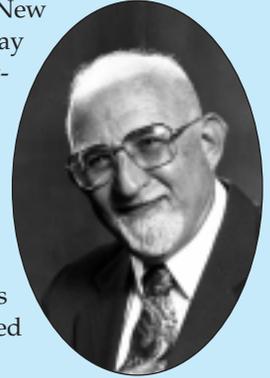
For more information on SAMBA committees, go to <www.SAMBAhq.org>, click on "Professional Info" and choose "Committees" from the pull-down menu.

In conclusion, SAMBA is a great, dynamic and exciting Society. We are dedicated to the advancement of ambulatory anesthesiology via research, education and scientific progress. Please accept my most sincere gratitude for the opportunity to serve you as SAMBA's President. And please join us in Seattle! It would be an extraordinary educational experience and a lot of fun. 

Stanley Bresticker, M.D.: 1926-2003

Stanley Bresticker, M.D., 77, Somerset, New Jersey, a founder of SAMBA, passed away December 28, 2003, in Jordan Hospital, Plymouth, Massachusetts.

Dr. Bresticker is credited with proposing the name Society for Ambulatory Anesthesia when SAMBA was a fledgling organization. He served as the first SAMBA Treasurer (1985-1990) and as an advisory director on the Board of Directors (1990-1992). Dr. Bresticker also is credited with writing the initial Society Bylaws.



Dr. Bresticker served on the Board of Directors of the American Society of Anesthesiologists and was a member of the College of Physician Executives and the American Academy of Medical Doctors. He was a past president of the New Jersey State Society of Anesthesiologists, the New Jersey Association of Medical Specialty Societies, the Somerset County Heart Association and the New Jersey Society of Ambulatory Surgery Centers.

During his professional career, Dr. Bresticker was on the staff at Robert Wood Johnson University Hospital, New Brunswick, New Jersey, for more than 30 years. He was the Assistant Chair of the anesthesiology department for 24 years before retiring in 1991. He also was an Assistant Clinical Professor of Anesthesia at the University of Medicine and Dentistry of New Jersey-Robert Wood Johnson Medical School and the Secretary-Treasurer and a member of the medical board at Robert Wood Johnson University Hospital for many years. He had previously served as the medical director and an administrator at the Middlesex Same-Day Surgical Center, East Brunswick.

Dr. Bresticker received his masters in science education from New York University and his medical degree from the University of Geneva, Switzerland.

Dr. Bresticker served in Army Air Forces during World War II.

Surviving are Eileen, his wife of 45 years; sons, Michael and David; a daughter, Julianne Murphy; a sister, Lee Bresticker-Raines, and nine grandchildren.

It's OUR Party: Panel Discusses Preoperative Evaluation

Continued from page 5

form. He emphasized the early collection of information so plans can be made with the surgeon and primary care physician for optimal perioperative management. Dr. Barinholtz also presented several real-life cases, including a child with cystic fibrosis who was found to be in suboptimal condition during a scheduled visit to the pediatrician the day prior to the

procedure. The procedure was canceled and rescheduled; once again, the pediatrician saw the patient preoperatively and this time confirmed that the child's medical condition was optimized and the anesthesia went uneventfully. He described a plastic surgery patient with a history of vague chest pains, so he canceled the surgery and the patient was referred for further evaluation. Also presented were many patients with pre-exist-

ing conditions that he was able to manage in the office as he was well prepared for them.

Finally Dr. Barinholtz suggested that with good working relationships with surgeons, undue pressures to proceed in a patient deemed unfit for anesthesia may be avoided. He commented that working in an office setting allows us to select the surgeons who respect the anesthesiologist's clinical judgment. 

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Boston, Massachusetts*

You Have a Voice: Sound Off About SAMBA!

Continued from page 2

educational program arranged by Dr. Everett will discuss current issues facing practitioners of ambulatory anesthesiology as well as office-based anesthesiology. As always the Society will provide travel awards to residents who present papers at the meeting. I encourage you to attend the Seattle meeting.

Finally I would like to acknowledge the hard work and dedication of the members of the Committee on Publications who offer their valuable time to

maintain the quality of this newsletter. I always welcome feedback regarding this newsletter — all feedback, both good and bad, is appreciated and will contribute greatly to the betterment of this publication. If you are not a member of SAMBA, I encourage you to join us and get involved in this rapidly growing Society. Your involvement will help us to further improve the practice of ambulatory anesthesiology and the safety of our patients.

I wish you and your family a happy and prosperous new year. See you in Seattle! 

'Black Box' Warning on Droperidol

Continued from page 3

Third, technical factors such as paper speed and sensitivity influence QT measurements with higher paper speed leading to shorter interval values and higher sensitivity resulting in QT prolongation.^{12,13} The above problems do not appear to be solved by automatic QT measurement techniques, which have been found to be less accurate in cardiac patients than in healthy controls. Calculation of QT interval corrected for heart rate is again ambiguous as there are numerous different formulae, each producing different results. The mathematical form of the different formulae is arbitrary and is not based on any physical or biological basis.¹⁴⁻¹⁶

At the end of the day, I did not get a sense that the FDA is closer to revers-

ing the black box warning on droperidol. The FDA claimed that the approved minimum dose of droperidol is 2.5 mg, and the use of lower doses is outside the label and hence beyond the administration's jurisdiction. The panel was unanimous in recommending that more information is needed in order to make an intelligent decision, although it is not clear as to what evidence would convince the FDA to reverse the black box warning.

For more information about the meeting, you may visit the FDA Web site at www.fda.gov/oc/advisory/acdrugs.html.

References available at www.sambahq.org. 

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 Joint Commission on Accreditation of Healthcare Organizations 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.
- White Mountain Institute Research Awards presented to authors of the best abstracts at the SAMBA Annual Meeting.
- Funding for ambulatory anesthesia-related research via SAMBA-Foundation for Anesthesia Education and Research 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.
- Progressive Web site with features rarely found on the sites of other subspecialty organizations, including online abstract submission, online new membership and membership renewal, multilanguage patient information, discussion panels, surveys and more.
- The advanced monthly electronic newsletter, *E-Newsletter*, featuring the latest Society news and articles, all designed for quick reading and links that take readers directly to topics of interest.