



Society for Ambulatory Anesthesia

Ambulatory AnesthesiaSM

PRESIDENT'S MESSAGE

Let's Answer Some Pressing Questions for the Future

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

Anesthesiology has seen extraordinary advances over the past few decades. Even those of us who are in mid-career can remember when a relatively healthy patient undergoing a minor surgical procedure (such as a D&C) would stay in the hospital overnight before surgery. Now, of course, the bulk of surgical procedures are performed on an ambulatory basis. In addition, the concept of Phase I versus Phase II recovery has been questioned (initiated by a leader of our own membership) and, in many institutions, has been currently combined to one all-purpose recovery area that meets the needs of both. Even the Accreditation Council for Graduate Medical Education, the organization that accredits our residency training programs, has recently deleted the previously held requirement to educate residents about issues germane to ambulatory anesthesia. Presumably this requirement was no longer necessary because "ambulatory" was thought to be so common.

What Is the Purpose of a Society as Its Subspecialty Matures?

How do we set a course that best serves the interests of our membership? These and many other issues were considered during a strategic planning session by SAMBA's Board of Directors, which was called by Past President Rebecca S. Twersky, M.D., Brooklyn, New York, approximately five years ago. SAMBA's central missions, to provide education for our

membership and to enhance the body of knowledge regarding ambulatory anesthesiology, are alive and well indeed. Our educational programs are well-attended, and SAMBA has proven to be a leader with respect to communications through the efforts of current and former newsletter editors and through our own wizard with electronic media, J. Lance Lichtor, M.D., Iowa City, Iowa. The fruits of SAMBA's outcomes awards have been similarly exciting, yet challenges exist for the future. As my boss used to say: with challenges come opportunities.

First let me take a moment to explain how our organizational leadership works. Almost a decade ago, I received my first two committee appointments in SAMBA. Both were "working appointments," one to the



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

laws, then I went to the Board and then I became an officer. Almost all of the other officers have followed a similar path, as do the individuals who are

How do we set a course that best serves the interests of our membership?

How can we best improve the knowledge base in practical ways that will benefit the typical SAMBA member?

Could the Society benefit from an affiliation with other groups?

Is workshop attendance sufficient to justify the associated expenses?

Committee on Education and the other to the Subcommittee of the Newsletter. After spending time "in the trenches" and working for the Society for several years, I was fortunate enough to be appointed to chair the Committee on By-

currently contributing so generously of their time and efforts and those who will follow us. The path takes many years to travel. As we confront the

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We're Busy, and You Should Be Too!

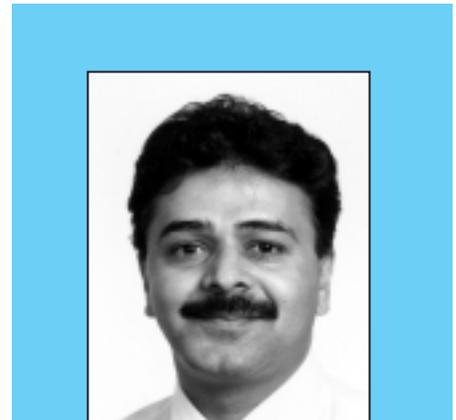
The SAMBA 17th Annual Meeting was held May 2-5, 2002, at the Hilton at Walt Disney Resort, Orlando, Florida, and was a great success. Approximately 500 attendees came from across the country and all parts of the world. This year's program featured presentations on state-of-the-art topics that were targeted to practitioners involved in the care of outpatients undergoing ambulatory surgery in hospital-based, freestanding and office-based surgery facilities. The Committee on Annual Meeting as well as Annual Meeting Chair **Walter G. Maurer, M.D.**, Cleveland, Ohio, and Vice-Chair **Andrew M. Herlich, M.D.**, Philadelphia, Pennsylvania, must be congratulated for providing an excellent program that included panel sessions, workshops and social activities.

In addition to providing education, such meetings allow an excellent opportunity for our members to share ideas and experiences with their peers. A family-oriented social evening at Universal Studios Jurassic Park Islands of Adventure was a rousing success as judged by the smiles and laughter of young and old alike, and it was typical of the social interaction at SAMBA annual meetings.

In this issue, Dr. Herlich provides us with a summary of the meeting. With an increasing number of elderly patients undergoing more extensive surgical procedures on an outpatient basis, emphasis is being given to the

It is our aim to publish articles that address important and controversial issues affecting the practice of ambulatory and office-based anesthesia. I urge our members to send us topics or ideas that they would like to see included in our newsletter.

effect of advanced age on perioperative outcomes. **Lee A. Fleisher, M.D.**, Baltimore, Maryland, attempts to answer the question, "How Old Is Too



Girish P. Joshi, M.D.

Old for Ambulatory Surgery?" It is noteworthy that some of the information provided by Dr. Fleisher was derived from a study conducted with funding from a SAMBA Outcomes Research Grant.

Registrants for the meeting were provided the opportunity to participate in a comprehensive pre-convention workshop on advanced cardiac life support (ACLS). The ACLS protocol now includes new resuscitative

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Ambulatory Anesthesia Workshops: A Simulating Experience

By Andrew M. Herlich, M.D., Vice-Chair
Committee on Annual Meeting
Philadelphia, Pennsylvania

The SAMBA 17th Annual Meeting was held in Orlando, Florida, on May 2-5, 2002, and was a resounding success. Included in the meeting was a heavily attended premeeting workshop on advanced cardiac life support (ACLS). It was so successful that many attendees inquired as to the possibility of a premeeting ACLS instructor workshop in the future.

On May 2, the meeting started with two well-attended workshops. The very popular Problem-Based Learning Discussion (PBLD) workshop was moderated by **Lee A. Fleisher, M.D.**, Baltimore, Maryland; **Kathryn P. McGoldrick, M.D.**, Valhalla, New York; and **Grover R. Mims, M.D.**, Winston-

sonal digital assistants. **Kirk H. Shelley, M.D., Ph.D.**, New Haven, Connecticut, moderated the workshop. Other participants included **Martin S. Bogetz, M.D.**, San Francisco, California; **Thomas P. Engel, M.D.**, Sacramento, California; and **J. Lance Lichtor, M.D.**, Iowa City, Iowa. Each participant gave his own "spin" on the devices, ranging from the available devices to the potential for interfacing with other technological devices such as personal computers. Dr. Lichtor presented pros and cons of Web links and downloading of information from Web sites.

Friday morning, May 3, prior to the General Session, **Girish P. Joshi, M.D.**, Dallas, Texas; **Melinda L. Mingus, M.D.**, New York, New York; **Brian M. Parker, M.D.**, Cleveland, Ohio; and **Yung-Fong Sung, M.D.**, Atlanta, Georgia, facilitated poster discussions.



F. Kayser Enneking, M.D., center, discusses continuous blocks during the "Double Workshop on Regional and Pain Management Procedures for the Ambulatory Surgery Center" at the SAMBA 2002 Annual Meeting in Orlando, Florida.

Salem, North Carolina, also participated. Each panelist presented an interesting case, and there was lively give-and-take from the audience. Obstructive sleep apnea was presented from two points of view: a patient presenting for airway surgery and a patient presenting for orthopedic surgery. Additionally, a patient with existing coronary artery disease who required a knee arthroscopy was discussed.

Concurrent to the PBLD workshop was a workshop devoted to technology, "Practical Uses of Technological Toys — The Advanced Course." This year's emphasis was placed upon per-

Many interesting posters were presented and the moderators had lively discussions with the presenters.

Walter G. Maurer, M.D., Cleveland, Ohio, Chair of the Committee on Annual Meeting, introduced the first general session after the poster-discussion session, which addressed "New Practice Guidelines" and was moderated by SAMBA Past President **Burton S. Epstein, M.D.**, Bethesda, Maryland, with three panelists.

Frances Chung, M.D., Toronto, Ontario, Canada, discussed the latest recommendations for the recovering patient prior to discharge to home.



Andrew M. Herlich, M.D.

Routine monitoring should include respiratory rate, airway patency and oxygen saturation. Additionally, pulse rate, blood pressure, pertinent physical examination of the patient's neuromuscular status (adequacy of reversal of neuromuscular blockade when appropriate) and mental status should be monitored. Only selected patients require electrocardiograms, assessment of neuromuscular blockade with a peripheral nerve stimulator, temperature, voiding and drainage and bleeding. Finally, the adequacy of the treatment of pain and postoperative nausea and vomiting (PONV) also should be assessed.

L. Reuven Pasternak, M.D., Baltimore, Maryland, addressed preoperative testing using the ASA preanesthesia advisory and guidelines. Almost all testing should be individually determined by the acuity of the patient's baseline medical status and the risk of the procedure that he or she will undergo. It was clearly emphasized that any testing deemed unnecessary for the performance of the surgical procedure and related anesthetic should be referred to the patient's primary care physician.

Ronald A. Gabel, M.D., Yarmouth Port, Massachusetts, had the difficult task of relating the Joint Commission on Accreditation of Healthcare

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Ambulatory Anesthesia Workshops: A Simulating Experience

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Organizations (JCAHO) "Standards for Sedation and Anesthesia Care" to assist in the development of institutional policies and procedures related to sedation and anesthesia. The most recent "ASA Practice Guidelines for Sedation and Analgesia by Nonanesthesiologists" has been the basis for JCAHO standards, and it appears that they will be so in the future. He emphasized that the ability to rescue the patient from a deeper level of sedation than intended was an important benchmark. Additionally, those individuals providing the sedation had the appropriate credentials and were duly qualified to provide the sedation. Dr. Gabel provided numerous Web sites for members to access in the preparation of sedation and analgesia policies and procedures for their respective institutions. At the end of the panel, Dr. Epstein conducted a question-and-answer session that extended well into the morning break.

Terri G. Monk, M.D., Gainesville, Florida, hosted the second general session. It addressed outpatient anesthesia for the geriatric patient.

Several workshops took place on Friday afternoon. The theme of this year's resident workshop concerned federal rules and regulations that impact upon the anesthesiologist. Covered topics included the Centers for Medicare & Medicaid Services (CMS), the Healthcare Insurance Portability and Accountability Act (HIPAA) and patient confidentiality, JCAHO and working with nurse anesthetists. **Thomas W. Cutter, M.D.**, Chicago, Illinois, moderated this session.

Two concurrent workshops included the very popular regional anesthesia workshop moderated by **Kenneth Zahl, M.D.**, Morristown, New Jersey. Live human models were used to assist the participants to learn block techniques more accurately. Assisting Dr. Zahl were **Lucinda L. Everett, M.D.**, Seattle, Washington; **Michael F. Mulroy, M.D.**, Seattle, Washington; **F. Kayser Enneking, M.D.**, Gainesville,

Florida; and **Admir Hadzic, M.D., Ph.D.**, New York, New York. The block techniques that were taught addressed continuous blocks, pediatric blocks, head and neck blocks, and upper and lower extremity blocks.

The other workshop, which was new to the SAMBA Annual Meeting, involved simulators. Moderated by



Participants practice intubation on a simulator during the workshop "Anesthesia Simulators — The Training Tool of the Future."

John J. Schaefer III, M.D., Pittsburgh, Pennsylvania, and assisted by **Rene M. Gonzalez, M.D.**, Sellersville, Pennsylvania, and Dr. Herlich, this workshop introduced the concept of crisis management and simulation to the participants. The use of difficult airway algorithms and techniques, videos and the team approach to patient management in the crisis situation were emphasized by the workshop instructors.

After the conclusion of the workshop session, the highly popular SAMBA Social Evening took place at Universal Studios Jurassic Park Islands of Adventure. Many meeting attendees and family members enjoyed a

lovely buffet meal and amusement-park rides. The evening concluded with a D.J., music and dancing as well as a wonderful dessert buffet.

Program Vice-Chair **Andrew M. Herlich, M.D.**, Philadelphia, Pennsylvania, introduced the third general session on Saturday morning. **Tong J. Gan, M.D.**, Durham, North Carolina, moderated a session called "What's New in Postoperative Pain?," which addressed new therapies in postoperative pain. Dr. Gan was the first speaker to address JCAHO guidelines and patient experiences in acute postoperative pain. Dr. Gan noted that despite pain management guidelines, less-than-optimal pain control and changes in practice patterns have occurred. It was remarkable that many patients were aware of side effects of analgesics and that 72 percent of a sampled population would choose nonnarcotic agents. The issue of addiction as a result of acute postoperative opiate therapy was a main concern of patients.

The second speaker of the session was **Peter S. Glass, M.D.**, Stony Brook, New York, who addressed the diversity of agents that have recently appeared on the horizon to treat postoperative pain in "Pain Management in the Ambulatory Environment — An Ever-Growing Cook Book of New Recipes." Some of the agents included COX-2 inhibitors, which have fewer side effects than their COX-1 relatives. Good early data suggest that COX-2 agents should be utilized preoperatively to reduce postoperative pain. Additional agents and techniques, including N-methyl-D-aspartate agonists ketamine and dextromethorphan, may be helpful. The perioperative use of low-dose naloxone and nalmefene may prevent postoperative opioid tolerance and increased dose requirements. Finally, the use of acupuncture may sufficiently activate the intrinsic endorphin system that reduces postoperative opioid requirements as well.

Dr. Everett addressed "Issues in Pain Management for Pediatric

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How Old Is Too Old for Ambulatory Surgery?

By Lee A. Fleisher, M.D.

Professor of Anesthesiology

Vice-Chair for Clinical Investigation

Joint Appointments in Medicine,

Health Policy and Management

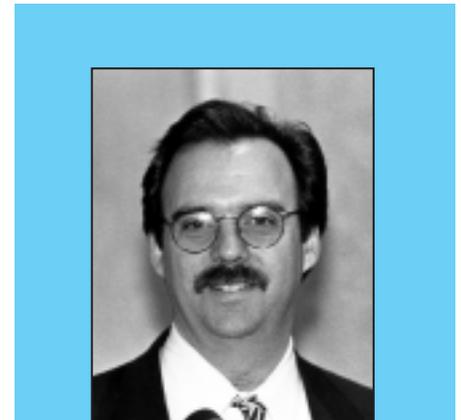
The Johns Hopkins Medical Institutions

Baltimore, Maryland

Because of the aging population, an increasing percentage of elderly patients are presenting for surgery. In fact, it is quite common to anesthetize patients over the age of 65 and discharge them home the same day. This is particularly true for the very large number of cataract patients who

logic age. In the gerontology literature, there is increasing emphasis on the concept of frailty.³ Frail elderly respond to stress differently than their healthy counterparts; therefore, it is critical to carefully evaluate the elderly to assess their functional status and comorbidity in order to determine fitness for outpatient surgery.

Despite this variability, there appears to be a point at which the vast majority of patients have significant alterations in physiologic status that is associated with increased morbidity. With funding from the Society for Ambulatory Anesthesia Outcomes Research Grant, we have recently an-



Lee A. Fleisher, M.D.

Frail elderly respond to stress differently than their healthy counterparts; therefore, it is critical to carefully evaluate the elderly to assess their functional status and comorbidity in order to determine fitness for outpatient surgery.

undergo surgery. A recent randomized trial assessing the value of preoperative laboratory testing demonstrated exceedingly low rates of morbidity and mortality after cataract surgery.¹ Importantly, analyses stratified according to age and medical history revealed no benefit of routine testing. However, the risks associated with advanced age may be much more pronounced in more invasive surgery.

Aging is associated with defined alterations in cardiovascular and other homeostatic processes. The number and severity of comorbid conditions increase with age. For example, the prevalence of cardiovascular disease increases with age, affecting approximately 65 percent of individuals between 65-74 and between 70 percent and 80 percent of those over the age of 75.² Yet within any given age cohort, there is significant variability. Physiologic aging may be very different than chrono-

logical discharge data from both a national sample of Medicare patients and from a sample of patients undergoing hospital-based outpatient surgery in New York state. In a cohort of more than 1.2 million surgeries that span from 1994 through 1999, an age range greater than 85 years was found to be one of the strongest predictors of admissions and death within seven days of surgery. Similarly, the New York State data showed that admission within one week of outpatient surgery demonstrated an age of greater than 85 years as a strong predictor of readmission.

Taken together, our data suggest that 85 years of age is a point at which even the young-appearing elderly have increased risk. Our data should not be utilized to suggest that outpatient surgery in this very old age group is inappropriate, but rather additional systems should be in place to ensure their safety. It may be prudent

to operate on these patients in locations that allow easy transfer to an inpatient setting if a complication develops. These patients also may warrant further surveillance once they are home, and family should be involved in ensuring their continued good health.

In summary, the elderly warrant increased surveillance for complications after outpatient surgery. It is important to assess the individual's physiologic age and severity of comorbidity rather than pure chronological age; however, those individuals over age 85 appear to warrant the greatest degree of perioperative surveillance and concern.

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Use of Amiodarone and Vasopressin During PALS

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

Improvements in pediatric perioperative care have resulted in reduced perioperative mortality.¹ Enhanced technology and newer drugs may be responsible for this change. New re-

suscitative agents, namely amiodarone and vasopressin, are now discussed as medications that one may consider during pediatric resuscitation. During pediatric advanced life support (PALS), amiodarone is listed either as a class IIb or intermediate, level of evidence 7 [Tables 1-3]. Vasopressin, on the other hand, is listed as class indeterminate, level of evidence 2 and 6. Vasopressin use during pediatric resuscitation is more controversial than



Kumar G. Belani, M.D.

amiodarone. Vasopressin is naturally occurring in humans and has a significant effects on the splanchnic circula-

Vasopressin has been successfully used to treat refractory hypotension in pediatric patients; however, there is not sufficient evidence to recommend its routine use during PALS.

tion and produces hemodynamic effects similar to epinephrine. It does not increase myocardial oxygen consumption, and tachyphylaxis is not an issue. Vasopressin has been successfully used to treat refractory hypotension in pediatric patients; however, there is not sufficient evidence to recommend its routine use during PALS. While some studies suggest improved outcomes with vasopressin when compared to epinephrine following cardiac arrest, a triple-blinded study done in 200 in-hospital cardiac arrests did not reveal it to be superior to epinephrine.²

Amiodarone is less controversial

Table 1: Classes of Recommendation for Drugs Used During PALS*

Class I	Definitely recommended
Class II	Acceptable and useful
IIa	Good to very good evidence
IIb	Fair to good evidence
Class III	Not acceptable, may be harmful
Indeterminate	Preliminary evidence needs confirmation; no harm

*PALS = Pediatric Advanced Life Support

Class of recommendation reflects quality of evidence and not clinical preference.

(Modified from: Guidelines 2000 for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care. International Consensus on Science. *Circulation* [suppl]. 2000; 102(8):I253;I370.)

Table 2: Levels of Evidence for Recommended Drugs Used During PALS*

1. Positive *RCTs — new treatment significantly better
2. Neutral RCTs — new treatment no better than control treatment
3. Nonrandomized prospective observational study utilizing new treatment compared with control group
4. Retrospective, nonrandomized observational study compared with a control group
5. Case series of patients receiving new treatment (past or future) — reporting outcomes only without a control group
- 6.(A&B) Studies employing animals or mechanical models (A-level higher than B-level studies)
7. Extrapolations from existing data or data gathered for other purposes
8. Common sense rational conjectures; no evidence of harm

*RCT = randomized control trial

(Modified from: Guidelines 2000 for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care. International Consensus on Science. *Circulation* [suppl]. 2000; 102(8):I253;I370.)

Table 3: Dosage During PALS³

Amiodarone (pulseless *VF/VT)	5 mg/kg I.V./I.O.	Rapid I.V. bolus
Amiodarone for perfusing tachycardias	Loading dose: 5 mg/kg I.V./I.O. Maximum dose: 15 mg/kg per day	I.V. over 20 to 60 minutes (Routine use in combination with drugs prolonging QT interval is NOT recommended. Hypotension is most frequent side effect.)
Vasopressin	Dose in adults: 40 U I.V. bolus	Dosage for PALS not established

VF = ventricular fibrillation; VT = ventricular tachycardia

when compared to vasopressin use during the pharmacotherapy care of pediatric patients during cardiac arrest. Amiodarone is an alternative to lidocaine during the treatment of perfusing and pulseless tachyarrhythmias that one encounters during PALS. Even though it has undesirable side effects and an unfavorable pharmacokinetic profile, it is recommended as the first-line therapy for shock-resistant ventric-

ular tachycardia and ventricular fibrillation. The dosage recommendations for amiodarone are listed in Table 3.

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1. Morray JP. Anesthesia-related cardiac arrest in children: An update. *Anesthesiology Clinics of North America*. 2002; 20 (1):1-28.
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3. Guidelines 2000 for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care. International Consensus on Science. *Circulation* (suppl). 2000; 102(8):I253-I370.

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Herbert D. Weintraub, M.D., Receives Distinguished Service Award

The SAMBA Distinguished Service Award, the highest honor conferred by the Society for achievements in ambulatory anesthesiology, was presented to Herbert D. Weintraub, M.D., Bethesda, Maryland. Dr. Weintraub becomes the ninth individual to receive this honor. The presentation was made on Friday, May 3, during luncheon ceremonies at the SAMBA 17th Annual Meeting in Orlando, Florida. The award is presented to individuals who have made outstanding contributions to the practice of ambulatory anesthesia. Dr. Weintraub's long-time colleague and friend, Burton S. Epstein, M.D., Bethesda, Maryland, presented the award.

In making the presentation, Dr. Epstein commented that he met Dr. Weintraub in 1964 when they were on the faculty at the Hospital of the University of Pennsylvania (HUP). Immediately prior to this, Dr. Weintraub was a resident in anesthesiology and a fellow at Columbia Presbyterian Hospital, New York, New York, under Emanuel M. Papper, M.D., Ph.D. After five years on the faculty at HUP and two years at Michael Reese Hospital in Chicago, Illinois, Dr. Weintraub joined the faculty at the George Washington University School of Medicine where he served for 26 years before achieving emeritus status in 1997. At George Washington University, Dr. Weintraub was Interim Chair of the Department

of Anesthesia for six years and attained the rank of professor.

Dr. Weintraub has been actively involved in SAMBA since its inception, serving as a founding member of the Society in 1985 when he was first elect-

Dr. Weintraub's contributions were crucial to the field because in the early years of outpatient anesthesia and the formative years of SAMBA, both the subspecialty and Society were in need of recognition and visibility.

ed to the Board of Directors as an at-large director. In 1988, he was elected Second Vice-President and served in that position until becoming President-Elect in 1991. In 1992, he became SAMBA President. In addition to his service on the Board of Directors and as an officer of the Society, Dr. Weintraub chaired the Committee on Scientific Pa-

pers for many years and moderated the Free Papers and Awards Program at the SAMBA Annual Meeting in 1990-97. He has lectured on various topics in outpatient surgery for more than 24 years in this country at national meetings such as the American Society of Anesthesiologists Annual Meeting and abroad in Canada, China and Southeast Asia. Dr. Weintraub has edited and contributed his expertise in the field of ambulatory anesthesia to several monographs and many book chapters.

Dr. Epstein noted that Dr. Weintraub's contributions were crucial to the field because in the early years of outpatient anesthesia and the formative years of SAMBA, both the subspecialty and Society were in need of recognition and visibility.

Dr. Weintraub joins previous Distinguished Service Award recipients Marie-Louise Levy, M.D., (1994) Chevy Chase, Maryland; Bernard V. Wetchler, M.D., (1995) Chicago, Illinois; Stanley Bresticker, M.D., (1996) Somerset, New Jersey; Harry C. Wong, M.D., (1997) Salt Lake City, Utah; Burton S. Epstein, M.D., (1998) Bethesda, Maryland; Surinder K. Kallar, M.D., (1999) Richmond, Virginia; Wallace A. Reed, M.D., (2000) Phoenix, Arizona; and Paul F. White, M.D., Ph.D., (2001) Dallas, Texas. [SAMBA](#)



Herbert D. Weintraub, M.D., left, is presented with the SAMBA 2002 Distinguished Service Award, the Society's highest honor, by Burton S. Epstein, M.D.



Past Distinguished Service Award recipients Harry C. Wong, M.D., left, Bernard V. Wetchler, M.D., and Dr. Epstein, far right, congratulate Dr. Weintraub on his award.

Ambulatory Anesthesia Workshops: A Simulating Experience

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Ambulatory Anesthesia." Dr. Everett discussed the importance of postoperative analgesia and its relation to altered behavior changes for several weeks after surgery. Adequate analgesia and avoidance of opioids to reduce PONV are important. PONV leads to poor oral intake and possible unanticipated readmission to the hospital. The prudent use of acetaminophen and nonsteroidal anti-inflammatory drugs was emphasized in their opioid-sparing affect and quality of postoperative analgesia. The use of ketamine, clonidine and dexamethasone also was mentioned, including their potential side effects. Depending upon the surgery and surgical techniques, pediatric postoperative pain may vary widely. Finally, the use of regional anesthesia and peripheral nerve blocks are gaining popularity, including the injection of local anesthesia by the surgeon.

After the morning break, SAMBA President (2001-02) **Barbara S. Gold, M.D.**, Minneapolis, Minnesota, moderated the highly popular "In the Real World Cases" as the fourth general session. Panelists included Dr. Enneking, **Ronald S. Litman, D.O.**, Philadelphia, Pennsylvania, **Scott R. Springman, M.D.**, Madison, Wisconsin, and SAMBA President-Elect **Lydia A. Conlay, M.D., Ph.D.**, Philadelphia, Pennsylvania. Cases discussed included a geriatric patient who presented for open reduction and fixation of a distal radial fracture and who also happened to have had a recent CVA and was taking coumadin. Additional cases included a 5-year-old boy with Down syndrome who presented for outpatient adenoidectomy and complete oral rehabilitation. The final case presented was an apparently healthy gentleman who suffered two episodes of syncope in the past, was evaluated by imaging studies and electroencephalogram and presented for inguinal herniorrhaphy under monitored anesthesia care. He presented a history of bicycling more than 100 miles per

week. His case was quite fascinating in that he had a postoperative cardiac arrest in the parking lot and was successfully resuscitated. He had experienced the Bezold-Jarisch reflex, and its consequences were discussed extensively by the panelists.

On Sunday, Dr. Conlay gave an incoming president's message after the general membership breakfast meeting. Following her address, Dr. Mims moderated the fifth general session concerning critical issues in ambulatory anesthesia. **Phillip E. Scuderi, M.D.**, Winston-Salme, North Carolina, addressed new issues in PONV. He emphasized the recent "black box"

Good early data suggest that COX-2 agents should be utilized preoperatively to reduce postoperative pain.

warning given to droperidol and lack of Food and Drug Administration investigation prior to issuing this warning. He compared other scenarios in terms of mortality and suggested that a patient has a better chance of dying from many other more mundane activities of daily living, including dog bites!

Dr. Scuderi suggested that multimodal management is the key to successful treatment in high-risk patients. Two or three drug regimens are more likely to be successful than single-drug therapy. Additional treatments that may be helpful include the use of supplemental oxygen, dexamethasone and stimulation of the P6 acupoint with electrical stimulation.

Beverly K. Philip, M.D., Boston, Massachusetts, discussed the latest regulatory issues from JCAHO, the Accreditation Association for Ambulatory Health Care, Inc. (AAAHC) and the American Association for Accreditation of Ambulatory Surgery Facilities,

Inc. (AAAASF). The ability to rescue from a deeper level of sedation/ anesthesia than planned was a key point. Identifying the responsible professionals and their qualifications was emphasized. Additionally, minimal equipment and monitoring standards as well as protocols for surgical aftercare were discussed.

Finally, Dr. Conlay presented concerns about compliance, including HIPAA and issues from the Office of the Inspector General (OIG). Much of Dr. Conlay's discussion centered on the complexities of HIPAA and its overwhelming costs of implementation. The law is so complex that a 17,000-word clarification followed as well as deferring the implementation date. She emphasized that HIPAA will truly be a "big deal."

Subsequently, Dr. Conlay addressed the recent report condemning the quality of oversight in ambulatory surgical facilities. Much of the concern raised by the OIG concerned the fact CMS had little oversight in the facilities that received Medicare funds. Unfortunately, there was much sensationalism intertwined with reasonable suggestions. Contrary to the OIG report, SAMBA's funding of outcomes research conducted by Dr. Fleisher shows just the opposite: surgery in ambulatory surgical centers in the elderly is actually quite safe!

Dr. Twersky moderated the sixth and final general session concerning office-based anesthesia. **Karen B. Domino, M.D.**, Seattle, Washington, presented ASA Closed Claims data comparing office-based anesthesia malpractice awards with ambulatory surgical center data for the same period. She carefully pointed to the considerably greater payments for office-based injury as compared with ambulatory surgical center injury. Additionally, the range of payments also was greater for office-based injury. These are early data, and monitoring in the postoperative period may have prevented injury.

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Let's Answer Some Pressing Questions for the Future

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challenges that are present for almost every organization in academic medicine today, this combination of continuity and experience combined with new and fresh ideas is what makes SAMBA the vibrant and growing organization that it is.

Like most other organizations our size, SAMBA faces challenges in the future. What are the optimal ways of meeting our educational mission that also may be financially self-sustaining? How can we best improve the knowledge base in practical ways that will benefit the typical SAMBA member? Should SAMBA seek affiliation with other anesthesiology organizations to enhance our educational programs? Last but not least, is a path to succession the best for the future?

SAMBA's Educational Mission

The SAMBA Annual Meeting is no doubt the cornerstone of SAMBA's educational program. Several years ago, this effort was joined by a Mid Year Meeting, traditionally held on the Friday prior to the American Society of Anesthesiologists (ASA) Annual Meeting. An exciting event is planned for May 2003 when SAMBA will join with the Federated Ambulatory Surgery Association and the International Association for Ambulatory Surgery to host a "megameeting" in Boston. Planning for this meeting is under way, with a special ad hoc committee chaired by the very capable Dr. Twersky.

So during the year of my presidency and for the first time in the history of our organization, SAMBA's annual meeting committee does not have an annual meeting to plan. Therefore, I have asked the chair of the Committee on Annual Meeting to strategically examine the meeting component of SAMBA's educational mission. Walter G. Maurer, M.D., Cleveland, Ohio, will be aided by his committee that is made up of previous annual meeting chairs and the current chairs of the committees on education and Mid Year Meeting. This group will examine issues

such as: How do the Annual and Mid Year meetings interrelate? What are the ideal venues for SAMBA's Annual Meeting (resort locations or metropolitan locations where "walk-ins" may be more common, etc.)? Should the meeting look like an educational forum, or is there perhaps more interest in exhibits? Is workshop attendance sufficient to justify the associated expenses? Do some types of workshops work better than others? Should the program ideally include more lecture sessions? Is an afternoon "off" a good idea? And last but certainly not least, how can SAMBA leadership best access the Society's membership to determine which topics would ideally be of interest? Any other topics of interest to the membership would be welcome by Dr. Maurer.

Improving the Knowledge Base in Ambulatory Anesthesia

SAMBA has led our specialty in awarding an outcomes research grant, which has already been the topic of discussion and will hopefully lead to a broadly led publication in a leading medical journal. Should SAMBA continue down this road and award another outcomes research grant? Could the Society benefit from an affiliation with other groups, either within anesthesiology or within industry to aid in this mission?

Should We Affiliate?

In the most recent Emery A. Rovestine Memorial Lecture delivered at the 2001 ASA Annual Meeting, ASA Executive Director Glenn W. Johnson announced ASA's desire to increase representation of subspecialty organizations at the ASA Annual Meeting. Should SAMBA consider affiliating with ASA with respect to its educational programs, and is this an optimal time to consider this question? These and the questions that follow have been left to the Committee on Affiliations, chaired by SAMBA Past President Jeffrey L. Apfelbaum, M.D., Chicago, Illinois.

The Path to Succession

During the term of my predecessor,

Barbara S. Gold, M.D., Minneapolis, Minnesota, questions were raised regarding the one-year term of SAMBA presidents. Dr. Gold has asked the Council of Past Presidents to examine this issue. (Please note that under the current bylaws, any potential changes in the term of presidency of this organization could not affect my own term.)

SAMBA — Past, Present and Future

I was recently at a dinner where a sage and respected president of another organization mentioned that he had seen the SAMBA newsletter and that our organization seemed to be thriving, vibrant and growing. SAMBA's officers and its Board strive to be forward-thinking and always mindful of providing value to our members. With this in mind, I also have increased the representation in leadership of this organization from the private sector. Jeffrey B. Brand, M.D., an anesthesiologist at Salem Hospital, Salem, Massachusetts, has been appointed to chair the Committee on Finance. Similarly, Meena S. Desai, M.D., an office-based practitioner in Philadelphia, Pennsylvania, has been asked to sit as vice-chair for the Committee on Office-Based Anesthesia. Mary Ann Van, M.D., Boston, Massachusetts, has been asked to chair the Committee on Bylaws, and Frederick W. Ernst, M.D., Dothan, Alabama, has graciously moved from his position with the bylaws committee to chair the ad hoc Committee on Private Practice. We look forward to their help as well as any assistance or advice from each and every member as we seek to provide education, knowledge and service for our members.

Please understand that I am deeply honored to assume the post as your president and remain grateful to a number of individuals, particularly Drs. Apfelbaum, Lichtor and Gold and, of course, to Executive Director Gary W. Hoormann.

Thank you for this wonderful opportunity. Look forward to October!

 SAMBA

We're Busy, and You Should Be Too!

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drugs such as amiodarone and vasopressin, which also are being used in pediatric resuscitation. **Kumar G. Belani, M.D.**, Minneapolis, Minnesota, discusses the use of new resuscitative drugs during pediatric advanced life support.

Each year, SAMBA presents a Distinguished Service Award to an individual who has made outstanding contributions to the field of ambulatory anesthesiology. This year, **Herbert D. Weintraub, M.D.**, Bethesda, Maryland, received the award for his service to SAMBA and his extensive contributions to ambulatory anesthesiology.

As mentioned in the January 2002 issue of the SAMBA newsletter, **Raafat S. Hannallah, M.D.**, Chair of Anesthe-

sia at Children's National Medical Center in Washington, D.C., was the first Sujit K. Pandit, M.D., and Uma A. Pandit, M.B., Distinguished Lecturer at the University of Michigan Department of Anesthesiology. SAMBA Executive Director **Gary W. Hoormann** summarizes the report from Dr. Hannallah regarding this lectureship.

Next year, SAMBA will host the Fifth International Congress on Ambulatory Surgery with the Federated Ambulatory Surgery Association. The event will take place at the Harry Hines Convention Center in Boston, Massachusetts. The dates of the meeting are May 8-11, 2003, and we encourage everyone to mark his or her calendars now and reserve these dates for what promises to be the largest ambulatory surgery event of the year. In

2004, SAMBA will conduct its 19th Annual Meeting on April 30-May 2, 2004, at the Seattle Westin Hotel in Seattle, Washington.

The next educational program organized by SAMBA will be the Mid Year Meeting just prior to the ASA Annual Meeting in Orlando, Florida. **Lucinda L. Everett, M.D.**, Seattle, Washington, will offer an excellent program discussing the medical, regulatory and business aspects of office-based anesthesia practice. I encourage you to attend this meeting in October.

It is our aim to publish articles that address important and controversial issues affecting the practice of ambulatory and office-based anesthesia. I urge our members to send us topics or ideas that they would like to see included in our newsletter. 

Raafat S. Hannallah, M.D., Delivers First Pandit Lectureship

"Pediatric Ambulatory Anesthesia" was the title of the first Sujit K. Pandit, M.D., and Uma A. Pandit, M.B., Distinguished Lectureship presented by Raafat S. Hannallah, M.D., Washington, D.C. The lecture was presented on April 17 at the University of Michigan, Ann Arbor, Michigan. The Department of Anesthesiology at the University of Michigan initiated the lectureship honoring the Pandits for their combined 90 years in medicine and 50 years of service to the university.

Dr. Hannallah commented that he selected pediatric ambulatory anesthesia as the theme of the lecture as pediatric anesthesia was Dr. Uma Pandit's specialty, while ambulatory anesthesia was Dr. Sujit Pandit's interest. Dr. Sujit Pandit served as SAMBA President in 1997-98.

In his presentation, Dr. Hannallah stated that children are excellent candidates for ambulatory surgery. They are generally healthy, undergo simple procedures and benefit from the lack of separation from parents that is fostered during ambulatory anesthesia

Raafat S. Hannallah, M.D., left, receives a plaque from Kevin K. Tremper, M.D., Ph.D., far right, that commemorated Dr. Hannallah's address for the inaugural Pandit Lectureship. Anesthesiology pioneers Uma A. Pandit, M.B., left center, and Sujit K. Pandit, M.D., are the lectureship's namesakes.



and surgery. The lecture outlined many of the advances in pediatric ambulatory anesthesia, especially in the areas that the Pandits contributed to research and literature. Problems of children who have an upper respiratory infection or who require preoperative sedation were discussed, and current fasting guidelines were reviewed. Discussed also were the results of a survey of SAMBA members that was conducted by the Pandits, which

showed less-than-full acceptance of the new ASA guidelines that allow toast and tea in the morning before surgery.

The lecture was very well-attended. Kevin K. Tremper, M.D., Ph.D., Chair of the Department of Anesthesiology at the University of Michigan, presented Dr. Hannallah with a commemorative plaque honoring his selection as the first speaker at this lectureship. 

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Call for DSA Nominations

The SAMBA Committee on Award has issued a call for nominations of possible recipients of the 2003 Distinguished Service Award (DSA) for presentation at the SAMBA Annual Meeting in Boston, Massachusetts.

The award represents the highest honor that SAMBA can bestow upon an individual and is presented in recognition of one's outstanding contributions and distinguished service to the subspecialty of ambulatory anesthesia.

Nominations must include a cover letter, a copy of the nominee's curriculum vitae and no more than four letters of support of the nomination. Nominations must be received at the SAMBA office by no later than **August 15, 2002.** 



Ambulatory Anesthesia Workshops: A Simulating Experience

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Dr. Twersky then presented a comprehensive panorama of state regulations concerning office-based anesthesia. She presented some of the regulations that organizations such as JCAHO, AAAHC and AAAASF also have promulgated in the interest of patient safety. Dr. Twersky's presentation included an extensive bibliography and contact individuals by state for office-based regulations.

The last speaker of the session was

Thomas W. Andrews, M.D., Longwood, Florida. He gave a tally of all the items needed to truly set up an office-based anesthesia practice. When his discussion was completed, the audience clearly understood that office-based practice is a large undertaking requiring a significant amount of planning, including the concept of back-up personnel in the event of acute disability of the anesthesiologist during the administration of an office-based anesthetic. 