



Society for Ambulatory Anesthesia

Ambulatory AnesthesiaSM

PRESIDENT'S MESSAGE

Ambulatory Anesthesia in the News

By J. Lance Lichtor, M.D.
SAMBA President

Some physicians wonder whether ambulatory anesthesia has gone too far. Others, and I am among them, argue that ambulatory anesthesia has not gone far enough. I came across two news items recently that can be used to support either argument. After reading these items, I hope you will agree that the future of ambulatory anesthesia is more positive than negative.

The first item was the announcement of the death of Irving Lichtenstein, M.D., in June. To the anesthesia community, Dr. Lichtenstein's name may be unfamiliar, but it is well known among surgeons. Dr. Lichtenstein's practice displayed the development potential of ambulatory anesthesia quite vividly. Laparoscopic surgery may be the buzzword today, but the development of techniques for hernia surgery has contributed just as much to the advancement of ambulatory surgery.

When I was an anesthesiology resident (not that long ago), it was common for patients to be admitted to the hospital before a scheduled hernia operation and to stay in the hospital for as long as one week afterward. When they were discharged, patients were told not to do heavy lifting for several months. Dr. Lichtenstein, however, thought that a week of bed rest was too long; he based this opinion on research showing that wound tensile strength is related to muscle use. In an article published in 1966, he described a series of 244 patients who underwent inguinal and femoral hernia repair under local

anesthesia. Those patients walked away from the operating room without assistance; they required no parenteral pain medication postoperatively and were discharged from the hospital in less than 24 hours. They resumed normal activities immediately. During follow-ups that varied from three months to five and one-half years later, rate of recurrence was less than 5 percent.

Dr. Lichtenstein's study was groundbreaking. Before his results, patients generally stayed in the hospital for one week after hernia repair and refrained from returning to work for two

Anesthesia administered by a registered nurse is an example of ambulatory anesthesia gone too far.

months. Dr. Lichtenstein made practice changes based on a study of wound tensile strength and altered patient care without altering hernia repair techniques. This example of fostering change can be applied to other aspects of ambulatory anesthesia.

The second item I would like to mention is a report from the annual meeting of the American Gastroenterological Association held in San Diego, California, the week before Memorial Day. At the meeting, John A. Walker, M.D., Medford, Oregon, described his technique for endoscopy and colonoscopy for which an induction dose of propofol (200 mg) with 10-mg increments was administered — not by an anesthesiologist or nurse



J. Lance Lichtor, M.D.

anesthetist, but rather by a registered nurse. Of the 1,400 patients, one had hypotension requiring ephedrine. Gregory Zucarro, M.D., a Past President of the association, remarked that all gastroenterologists either have experienced firsthand the death of a patient in the middle of a scoping procedure or know a colleague who has. I ask you, dear reader, how is Dr. Walker's anesthetic regimen any different, or even more dangerous, than a combination of meperidine and a benzodiazepine? Anesthesia administered by a registered nurse is an example of ambulatory anesthesia gone too far.

The future holds limitless possibilities for ambulatory anesthesia. The old ways of doing things deserve to be challenged. Past mistakes, however, must not be revisited. Join us online to talk about this topic; you will notice that our Web site has a new look. You may read about these changes and preview our new design on page 11 of this issue. 

EDITOR'S PAGE

An Advanced Role in Ambulatory Anesthesia

First of all, I would like to thank the Board of Directors of SAMBA for selecting me to be the Editor of the SAMBA newsletter — *Ambulatory Anesthesia*.

With the scope of ambulatory anesthesia increasing exponentially, the role of SAMBA has become even more crucial. As reiterated by J. Lance Lichtor, M.D., President of SAMBA, the main goals of SAMBA are to educate physicians and patients as well as to encourage research in the field of ambulatory anesthesia.

The SAMBA newsletter and the SAMBA Web site are excellent avenues for transfer of knowledge and ideas. It is important to recognize that most of the articles published in *Ambulatory Anesthesia* are contributed by the members of the Subcommittee on Publications. It is their hard work and dedication that makes it possible to maintain the high quality of the newsletter. However, I would also like to emphasize that this is a publication of the readership. Thus I invite readers to submit articles to be considered for publication. Please consult the "Information for Authors" option on the SAMBA Web site <www.sambahq.org>

or contact the SAMBA office at (847) 825-5586 for guidelines for submission of articles.

The educational programs organized by SAMBA (i.e., the Annual Meeting and the Mid Year Meeting) provide unique opportunities to expand our knowledge base by the exchange of information and ideas with regard to the latest trends and controversies in the subspecialty of ambulatory anesthesia. Furthermore, the meetings provide an outstanding networking opportunity for us to share experiences with our peers.

The SAMBA 15th Annual Meeting, held at the J. W. Marriott Hotel, Washington, D.C., was a great success. It was attended by more than 600 anesthesia practitioners. The Committee on Annual Meeting, co-chaired by Charles H. McLeskey, M.D., and Barbara S. Gold, M.D., must be congratulated for providing an exceptional educational program that included high-quality presentations with a wide range of interesting topics. In her article on page 7, Mary Ann Vann, M.D., reviews the session on complementary and alternative medicine, which is a rapidly growing area of health care.



Girish P. Joshi, M.D.

The next Mid Year Meeting is on October 13, 2000 (one day prior to the ASA Annual Meeting), at the Argent Hotel, San Francisco, California. Andrew Herlich, M.D., has put together an exciting program on "Controversies in Ambulatory Anesthesia" for this meeting.

SAMBA's commitment to research is indicated by sponsorship of research either independently or in collabora-

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IMMEDIATE PAST PRESIDENT'S REPORT

Dr. Reed Receives Distinguished Service Award

Richard A. Kemp, M.D.
Immediate Past President

The following is a transcript of the presentation given by Dr. Kemp at the Annual Meeting in Washington, D.C., on May 6, 2000.

Thirty years ago, on February 12, 1970, two anesthesiologists, the sons of physicians, anesthetized five patients in a freestanding ambulatory surgery center. What occurred over the next months was a word which spread like wildfire from coast to coast and even internationally. And a herd of visitors trekked to Phoenix to see what our honoree and his associate were involved with. It was not very easy. There were a lot of political problems. There were financial problems. There were problems in dealing with third-party insurance. But they prevailed, and over a period of two years, opened The Surgicenter in Phoenix in 1970.

Our honoree is Wallace A. Reed, M.D., known by all of his friends as "Wally." Dr. Reed has had a very distinguished career. He has worked diligently at getting the word out on ambulatory anesthesia. He published extensively and gave many, many lectures. In fact, I first heard Dr. Reed speak in 1973. When I was working in Massachusetts, he came to Boston. I tried myself to develop a freestanding ambulatory surgery center in the People's Republic of Massachusetts and, as you can well imagine, that was not possible.

Dr. Reed took things one step further. He established an accrediting organization and was basically the founding member and the second President of the Accreditation Association for Ambulatory Health Care, Inc. He was also a fixture in establishing the Freestanding Ambulatory Association, now known as the Federated Ambulatory Surgery Association, and has received numerous awards and accolades.

His main concerns were in dealing with the political problems and the

problems of creating a climate in which surgeons and patients would come in to his surgery center. This led to an explosion of surgery centers developing after 1982, when Medicare then allowed for Medicare patients to be treated in freestanding centers.

It is with a great deal of pride that I give this award to Dr. Reed. He has certainly been a mentor for me, even though from afar, over many years and I know that he has also been for many, many other people. When you think about it, his concerns about the cost of care and the quality of care have really changed the atmosphere for providing medical care throughout the United States and internationally.

So, on behalf of the Society for Ambulatory Anesthesia, I would like to present this Distinguished Service Award, which reads: "Presented in recognition for outstanding achievement in Ambulatory Anesthesia."

Dr. Wallace A. Reed:

Well, thank you very much. You presented it better than I could, I think — the description of what has gone on. There are a few things I would like to expand on a little bit. I want to thank you very much for what you have done in connection with SAMBA. I want to thank you for your part in seeing that I might be recognized with this award; and also I have just learned that Louis Freeman, M.D., was on the Nominating Committee. I knew there had to be someone on that Nominating Committee whose memory went back over the last 15 to 30 years ago. So I am very grateful for that and all others on the Nominating Committee and on the Board who had anything to do with this award.

I would like to just say a few things about the unique partnership that Jack Ford and I had. Jack Ford was sort of a medical gadgeteer. He designed stirrups, and he designed an insufflator that were very successfully used. He also was somewhat mischievous. I remember one occasion at St. Joseph's Hospital here in Phoenix when he had gone to the trouble of putting a gold-



Richard A. Kemp, M.D.

fish in an I.V. bottle and running the I.V. tubing down under the sheets, so it looked as though the patient could be receiving the solution that was coming from the goldfish-I.V. bottle. The nursing supervisor, who was a Sister of Mercy, when she saw that situation was very astonished and did not withhold her remarks about how unbecoming that was. The rest of us thought it was pretty humorous.

Well, I would describe myself as sort of a political strategist, a medical/political strategist. I had been a member of the County Medical Society and state medical associations, and when I came to Phoenix I thought that by serving on hospital committees I could prove that the anesthesiologist of those days was more than just an etherizer; he was also a real doctor. And whenever I would be on those committees, the other doctors would kindly withhold any criticism they might have of anesthesiologists, and I think that that helped us develop our center here in Phoenix.

As you mentioned, we had our groundbreaking in August of 1969, and on February 12, 1970 (Lincoln's birthday), we sort of declared a little bit of independence by having our first five cases at The Surgicenter.

There's one other thing that I want to mention which led to the confidence

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On-site registration is still available for the...



**Mid Year Meeting 2000:
Controversies in Ambulatory Anesthesia**

October 13, 2000

The Argent Hotel San Francisco, San Francisco, California

A conference jointly sponsored by
the American Society of Anesthesiologists (ASA)

Meeting Agenda — Friday, October 13, 2000

7:30 a.m. — 8:30 a.m.

CONTINENTAL BREAKFAST AND REGISTRATION

8:25 a.m.

Welcome

Moderator: Andrew Herlich, M.D.

8:30 a.m. — 10 a.m.

SESSION 1

8:30 a.m. — 9 a.m.

Ambulatory Procedures: Have We Gone Too Far or Not Far Enough?

J. Lance Lichtor, M.D.

9 a.m. — 9:30 a.m.

Pediatric Procedures Out of the Operating Room: Are We Safe Enough?

Ronald S. Litman, D.O.

9:30 a.m. — 10 a.m.

Difficult Airways in the Ambulatory Setting: Is Safety Being Compromised?

Martin S. Bogetz, M.D.

10 a.m. — 10:30 a.m.

BREAK

10:30 a.m. — 12 noon

SESSION 2

10:30 a.m. — 11:30 a.m.

Prophylactic Antiemesis: Pro and Con

10:30 a.m. — 12 noon

Pro Comments

Mehernoor F. Watcha, M.D.

11 a.m. — 11:30 a.m.

Con Comments

Phillip E. Scuderi, M.D.

11:30 a.m. — 12 noon

Has the Preoperative Evaluation Process/Clinic Saved Us Time and Money?

Walter G. Maurer, M.D.

12 noon — 1:15 p.m.

LUNCHEON

1:30 p.m. — 3 p.m.

SESSION 3

1:30 p.m. — 2:30 p.m.

Succinylcholine in the Ambulatory Environment Is Dead

1:30 p.m. — 2 p.m.

Pro Comments

Tom C. Krejcie, M.D.

2 p.m. — 2:30 p.m.

Con Comments

Stephen F. Dierdorf, M.D.

2:30 p.m. — 3 p.m.

Generic Medications: Tempest in a Syringe?

Peter S. A. Glass, M.D.

3 p.m. — 3:30 p.m.
BREAK

3:30 p.m. — 4:30 p.m.
SESSION 4
Threats to Our Well-Being

3:30 p.m. — 4 p.m.
Hey Doc, Are You Okay?
Gail I. Randel, M.D.

4 p.m. — 4:30 p.m.
Frustrated With Clinical or Academic Medicine? New
Horizons Await You
David B. Mayer, M.D.

Lecturers

Program Chair

Andrew Herlich, M.D.
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School of Medicine
Winston-Salem, North Carolina

Mehernoor F. Watcha, M.D.
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Critical Care Medicine
Children's Hospital of Philadelphia
Philadelphia, Pennsylvania

See the on-site registration form on page 6.

**On-Site Registration Form
Mid Year Meeting 2000
Friday, October 13, 2000**

Name _____

Degree _____

Address _____

City, State, Country _____

ZIP/Postal Code _____

Daytime telephone _____

Fax _____

E-mail Address _____

Payment:

Personal check payable to "SAMBA"
(in U.S. funds drawn on a U.S. bank)

Bill my credit card: VISA MasterCard

Credit Card Number _____ Expiration Date _____

Billing Street Address and ZIP Code for Credit Card User _____

Signature _____

Registration Fee:

SAMBA Member \$125 (U.S.)

Nonmember \$175 (U.S.)

Resident \$50 (U.S.)

Payment Total: _____

**Complete this form and submit
it on-site at the Argent Hotel,
San Francisco, California.**

SAMBA Distinguished Service Award

Continued from page 3

that people had in our facility and in our personnel. That was the Saturday that the Governor came to The Surgicenter. We were not having any scheduling on Saturdays at that time. The urologist, who was caring for the Governor, was of the opinion that the procedure that he wanted to do would require general anesthesia. The Governor did not want it to be known that he was having an operation because the political environment was such that it would have worked against his term as Governor. So it was worked out that the Governor would come with the surgeon to The Surgicenter; I was there to do the



Wallace A. Reed, M.D.

anesthesia, and our circulating nurse was Sharon Schaefer, who is now the administrator of the unit. In the postanesthesia room, we had L. J. and Fairborn. We carried out the operation successfully and, fortunately, the biopsy that was taken was benign. The Governor and the surgeon went out on their way, very happy about the situation, and the two Secret Service people who came with the Governor accompanied him home. The public was never aware of the event, and the secret was not let out for many, many years. Actually, the Governor is now deceased.

So that was an indication of the extent to which the doctors and the public had a confidence in our performance. I just thought that I would like to add that because it was the team that we put together. It was a unique team, and everybody shared in the excitement of what was ahead and what they hoped would be a hit. They have just come from a 30th anniversary celebration, at which time they all agreed that our wildest hopes went beyond what had been realized.

So I am very grateful for this award, and thank you. I thank the SAMBA Board. 

SAMBA Panel on Complementary and Alternative Medicine

By Mary Ann Vann, M.D.
Staff Anesthesiologist
Beth Israel Deaconess
Medical Center Instructor
Harvard Medical School
Boston, Massachusetts

Agrowing branch of medicine today, complementary and alternative medicine (CAM), was the subject of a popular panel at the SAMBA Annual Meeting in Washington, D.C., last May. Moderator Charles H. McLeskey, M.D., led off the discussion with an overview of the scope of CAM.

One-third of Americans use an herbal preparation and one-half use dietary supplements or megadose vitamins. Up to 15 million U.S. adults are at risk for unexpected prescription drug-herbal interactions. However, 60 percent of the herb and "nutriceutical" use is not reported to health care providers. Dr. McLeskey presented results of a survey done at the Scott and White Clinic, Temple, Texas, which showed that 17.4 percent of surgical patients used at least one herbal supplement, and some took as many as 12. Women used herbs more frequently than men, and the most commonly used substances were ginkgo, garlic, ginger and chromium. Dr. McLeskey commented that the actual consumption of nutraceuticals by patients in the study was probably higher than reported since patients are less likely to disclose this information on a survey than by direct interview.

Jessie A. Leak, M.D., who was instrumental in the American Society of Anesthesiologists (ASA) advisory on the perioperative use of herbal products and the production of pamphlets for patients and practitioners, discussed the impact these products may have on patients undergoing ambulatory anesthesia. Dr. Leak warned that the Food and Drug Administration (FDA) minimally regulates herbal preparations; they are considered dietary supplements, not drugs, due to their ineligibility for a patent, which is required to enter the FDA drug-approval process. In Europe, however,

they are subject to the same overview and scrutiny as other pharmaceuticals.

A unique aspect of herbal supplements is the wide variety of preparations, which may contain these substances: pills, capsules, decoctions, infusions or teas, tinctures, extracts, syrups, miels, powders, pastes, suppositories, creams, gels, lineaments, oils and compresses. However, there are no randomized studies on their efficacy or side effects. The World Health Organization has adopted the view that herbals' long history of worldwide



These two ASA pamphlets, "What You Should Know About Your Patients' Use of Herbal Medicines" and "What You Should Know About Herbal Use and Anesthesia" help patient and physician understand the complexities of alternative medicine.

use is adequate demonstration of their safety and efficacy. Surveys, case reports and anecdotes provide the basis for extrapolated conclusions on the consequences of their use. Adverse events can be reported voluntarily through the Special Nutritional Adverse Event Monitoring System (SN/AEMS).

Certain herbs lead to increased propensity for bleeding due to antiplatelet action or augmentation of the effects of concomitant anticoagulant or antithrombotic therapy. Therefore, excess bleeding may occur despite normal hematological studies. The herbs

associated with enhanced bleeding included garlic, feverfew, ginkgo, ginseng and ginger.

The most prevalent herbal ingredient is ephedra sinica (ma-huang), which may be present in 17 percent of all commercially available herbal products. In 1998 alone, the SN/AEMS Web report listed 380 adverse events due to this substance. These reports included multiple deaths as well as strokes, cerebral hemorrhages, arrhythmias, palpitations, headaches, chest pain or angina, memory loss and panic attacks. Ephedra is known to interact with heart glycosides and halothane, enhance sympathomimetic effects with guanethidine or monoamine oxidase inhibitor (MAOI) and cause hypertension with oxytocin. Patients chronically using ephedra may be receptor-depleted and experience hypotension under anesthesia. There is no optimal method for restoring blood pressure in these patients, but beta-agonists should be avoided.

St. John's wort, commonly used for treatment of anxiety and depression, is the subject of a government-sponsored study. Patients using this herb may experience prolonged effects of anesthesia. Also, potential exists for interactions with MAOI, and blood levels of protease inhibitors may decrease. Exaggeration of anesthetic effects may also be seen with valerian, which augments barbiturate-induced sleep, and kava-kava, which intensifies the effects of alcohol, barbiturates and benzodiazepines. Ginseng may produce hypertension and tachycardia, and licorice may induce hypertension, hypokalemia or edema. Echinacea use may result in hepatic damage, especially when combined with other hepatotoxic drugs. It also reduces the effectiveness of corticosteroids. Goldenseal causes increased free-water excretion and sodium retention.

Dr. Leak explained that the suggestion of ASA that herbal preparations be discontinued two weeks prior to a surgical procedure is similar to guidelines

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SAMBA Panel on Complementary and Alternative Medicine

Continued from page 7

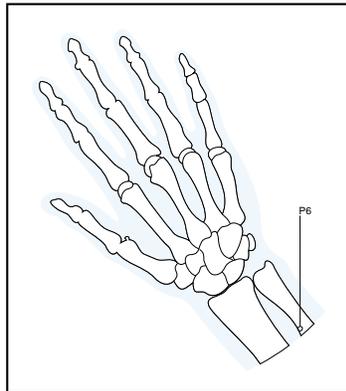
for MAOI, aspirin and ticlid. Her presentation emphasized that the most important aspect of management of these patients is obtaining a thorough medication history of all over-the-counter, prescription, herbal and nutritional supplements. She advised the audience to become familiar with the most commonly used substances in their geographical area.

The utilization of nonpharmacologic therapy for the treatment of nausea and vomiting and pain was the subject of the next two speakers, Tons J. Gan, M.D., and Paul F. White, M.D., Ph.D. They both advocated the use of acupuncture techniques, citing its lack of side effects and potential for lowered costs.

The term “acupuncture” encompasses various modes of stimulation of anatomical points. These include acupressure, acupuncture needling, electro-acupuncture and transcutaneous electrical nerve stimulation (TENS). Acupuncture has been used for 2,000 years to treat gastrointestinal disorders and nausea and vomiting. The National Institutes of Health Office of Alternative Medicine in 1997 confirmed acupuncture’s efficacy for the treatment of postoperative and chemotherapy-induced nausea and vomiting, morning sickness and postoperative dental pain.

Stimulation of the Nei Guan, or P6 acupuncture point, has been proven effective in several studies of postoperative nausea and vomiting (PONV). It is located approximately two inches proximal to the distal wrist crease between the palmaris longus and flexor carpi radialis tendons. Commercial devices (e.g., Sea Band® and Relief Band®) have been created to stimulate P6. The mechanism for relief of PONV by acupuncture is undetermined. It may be attributed to modulation of the release of endogenous opioids, serotonin or neuropeptides or the relief of pain. The Chinese believe it restores the normal flow of energy, or “Qi,” to the body. The clinical efficacy of

acupuncture for prevention of PONV in adults was reported in a meta-analysis in *Anesthesia & Analgesia* in 1999. These studies compared acupuncture, acupressure and TENS to standard antiemetics, placebo and sham acupuncture. Dr. Gan commented on the difficulty in performing blinded studies of acupuncture, since some of



The P6, or Nei Guan, acupuncture point is a key area for treatment of PONV.

its clinical benefits may be due to a placebo-type mechanism. Responding to a question about timing, he noted his preference to initiate this remedy as early as possible in the procedure. Also, one herb with potential benefit in treatment of nausea and vomiting, the magnolia leaf, was mentioned.

Dr. White cited the challenge of treatment of postoperative pain in ambulatory patients as he discussed the benefits of an approach that could reduce opioid use and thereby minimize side effects. He noted that the treatment of pain is a large business, which is rapidly growing.

The clinical benefit of TENS was illustrated in studies of patients undergoing thoractomy and knee arthroscopy whose opioid consumption was decreased by its application. Other studies have not replicated these findings. Variables in TENS treatment include the location of the device and the intensity and duration of stimulation. TENS may be placed at an acupoint or

on the dermatome corresponding to the affected site. Best results were obtained when both sites were stimulated. Additionally, a combination of low- and high-stimulus intensities resulted in the greatest decrease in opioid consumption. This may be attributed to the release of two different CNS substances.

Percutaneous electrical nerve stimulation (PENS) is a combination of TENS and electro-acupuncture. It utilizes acupuncture needles placed in a dermatomal distribution that deliver an electrical stimulus close to nerve endings in the affected area’s soft tissue, muscle and periosteum. Dr. White’s group has demonstrated that PENS is effective in the treatment of acute herpes zoster (with decreased pain and more rapid healing) and post-traumatic or migraine headache. Patients with chronic pain secondary to metastatic bone cancer, low back pain, sciatica and diabetic neuropathy have all benefited from this therapy. Dr. White commented that PENS does not require special training, just knowledge of anatomy. His technique uses 32-G needles placed in a dermatomal distribution at a depth of 2-4 cm. A low-voltage electrical generator delivers stimulation in a fixed or variable combination of frequencies. This treatment has been found effective when administered for 30 minutes three times weekly.

Dr. White also mentioned that magnets and yttrium aluminum garnet laser stimulation have not been proven useful for the treatment of pain. However, he reported findings of a study that reported sedation and analgesic sparing effect of music.

The take-home messages from the panel on CAM were: 1) Approach herbs and nutraceuticals with prudence and common sense, and 2) Some nonpharmacologic treatments of PONV and pain are effective, and ambulatory anesthesiologists may consider integration of these therapies into their practices. 

Outcomes Data Can Elucidate the Art of Our Trade

*Adam F. Dorin, M.D.
Medical Director and Chief of Anesthesia
The Surgery Center of Chevy Chase
Chevy Chase, Maryland*

When I finished my training at Johns Hopkins University in 1993, having received SAMBA's first-place resident research award at that year's annual meeting in Scottsdale, Arizona, I did not realize how many years would pass in private practice without any formal connection to academic research. After seven years, my interest in studying my trade resurfaced in an interest in outcomes research data collection.

It all started with a frantic telephone call from a private practice surgeon in Baltimore, who I had known through family connections and through contacts made during my training at Johns Hopkins. The surgeon's wife was undergoing her third lengthy plastic surgery procedure in a few weeks. The first two surgeries had been quite horrible in that the patient had vomited so profusely for exactly eight hours postoperatively that she had to be admitted to the hospital both times for severe nausea and dehydration and taken back to surgery one of the times for retching-induced dehiscence and bleeding. The surgeon asked my opinion for avoiding nausea in the upcoming third surgery. Having used the suggested anesthesia technique, the patient reported that she felt great and was wide awake and eating with no nausea.

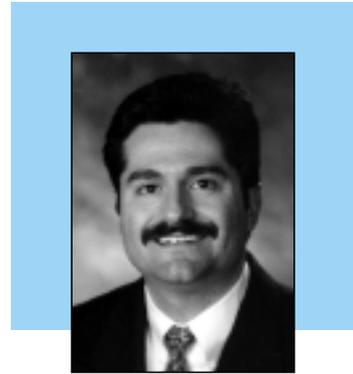
My journey had just begun with this telephone call. Clearly I was not

alone in having a technique or two that had merit in providing good patient care. But also, there had to be a better way to collect this and other data at the point of service in a continuous, real-time fashion—one that would lend itself to easy collection, collation, study and presentation in a scientific format.

With the help of the health care industry, the information technology field and academic medicine outcome research data collection and analysis are being developed. The model is as follows:

...systems like this one can enable all of us to make valuable contributions to the body of knowledge and experience in anesthesiology...

After customized software is loaded onto a hand-held device (a Pentab™ similar to a Palm Pilot™), data is collected at the point of service in an ongoing fashion. As much data as possible is loaded into the device on every patient and circumstance throughout a day's work. At intervals during the day or at the end of the day, the data are beamed via infrared light into an on-site PC that is online via the Internet. Prism Systems centralized server then passively (from the perspective of



Adam F. Dorin, M.D.

the user-site PC) pulls up the data at intervals during every working day. The data is stored, analyzed, processed and put in any of an assortment of reports for the user sites as requested. An advantage of the centralized server is that data systems can be upgraded and modified continuously with uniformity across all sites, regardless of their location throughout the country, or the world for that matter.

What is really profound, I think, is that systems like this one can enable all of us to make valuable contributions to the body of knowledge and experience in anesthesiology, regardless of our distance from the hallowed halls of university hospitals or major affiliate institutions. Outcomes data collection can be a powerful and insightful tool to advance the quality, awareness and practice of our profession.

 SAMBA

The SAMBA Annual Meeting Returns to Beautiful Palm Springs, California.

Mark your calendar now!

SAMBA
16th Annual Meeting
May 3-6, 2001
Renaissance Esmeralda Resort
Indian Wells, California



To be held in one of America's premier resort areas, the SAMBA 2001 Annual Meeting will be the perfect educational escape from the coming winter. **Look for registration information in January or register online at the SAMBA Web site.**

Call for Resident Abstract Submission

The Committee on Annual Meeting has issued a call for abstracts for the SAMBA 16th Annual Meeting to be held at the Renaissance Esmeralda Resort in Indian Wells (Palm Springs), California, on May 3-6, 2001.

The Society encourages residents in anesthesiology training programs to become involved in SAMBA. To this end, the Society will issue a limited number of travel awards to anesthesiology residents whose scientific abstracts are accepted for poster presentation at the SAMBA 2001 Annual Meeting.

These travel awards will support residents in training with a grant of \$1,000 each to attend the meeting. Those who receive a travel grant for their abstracts will remain eligible for cash awards presented by the Ambulatory Anesthesia Research Foundation. Case reports are not acceptable. Papers presented at the SAMBA Annual Meeting are eligible for presentation at subsequent large anesthesia meetings such as the annual meetings of the American Society of Anesthesiologists and the International Anesthesia Research Society.

The Society will once again be accepting only those abstracts that are submitted over the Internet through the SAMBA Web site. To download a

copy of the typing instructions and grading criteria, as well as to submit abstracts and complete cover letters, visit the SAMBA Web site at <www.sambahq.org>. Individuals who submitted abstracts for the SAMBA 2000 Annual Meeting found the online submission process to be user-friendly and easy to follow.

For detailed information on submission of abstracts, visit:

www.sambahq.org

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

document to the Web site for submission. Once this process is completed, the system will ask if another abstract is to be submitted. If yes, the process begins again with the cover letter.

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

The deadline for receipt of properly submitted abstracts to the SAMBA office is **February 23, 2001**. A properly submitted abstract consists of an original abstract that has not been or will not be presented at a large anesthesia meeting before the SAMBA 2001 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 institution(s) from the original.

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

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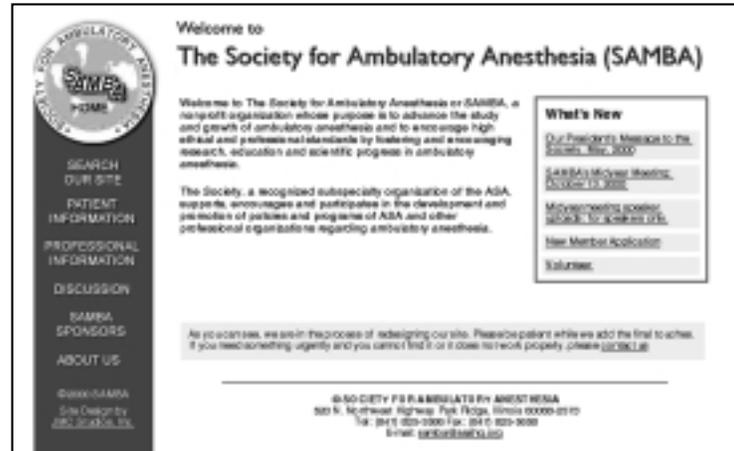
Ambulatory Anesthesia
Research Foundation

SAMBA Web Site Makes the Grade

J. Lance Lichtor, M.D.
SAMBA Webmaster

I have been the one primarily responsible for the development and programming of the SAMBA Web site since its inception. It was, and continues to be, fun for me as a means of highlighting the Society. As the Web site has expanded, though, it has required more and more work on my part. At first, I could hire college students to handle some of the expansions. As the site has expanded, the programming capabilities have exceeded those of most college students. Also, the overall day-to-day management took up quite a bit of my time, and I felt this could not go on. In addition, my programming abilities are better than my design abilities.

As the site has become more complex, it was apparent that someone with more of an artistic touch was needed. With the Board's approval, we have hired an outside firm to take care of the day-to-day programming requirements. This firm was a perfect fit because it has had experience both with artwork and also designing Web sites. The company was particularly desirable because it had experience working with small organizations



Thanks to JMC Studios, Chicago, Illinois, SAMBA offers members, and potential members, a new and improved Web site. Internet technology allows easy access by all to the latest developments in ambulatory anesthesia.

such as ours and could work around a reasonable budget.

The old Web site was housed on a computer next to the one I used in my office. Although the computer was working fine, at times power would go out in my office area and I was not always right there to turn everything back on. The old Web site was housed on a new iMac™. The computer worked fine, but some Web items were more easily configured using a Win-

dows® machine. As part of the upgrade to the site, therefore, we have also outsourced the serving portion of the site. The particular company we chose is comfortable in both a Macintosh and PC environment; some parts of the site are served from a Macintosh and others from a PC.

The functionality of the site has not changed. In my President's Message (page 1 of this issue), I stated that I wanted to develop a SAMBA Discussion list where physicians in the United States exchange information daily with their international colleagues. In particular, I hoped that comments could be sent out daily by electronic mail to all interested in exchanging information, but also that the information could be accessed on the Web site. This has taken a little extra work and so is not available at this time. Hopefully, the functionality of the site will be expanded to include this important function. We have other ideas in mind and will tell you about them as soon as they are available.

We hope that those of you who are connected to the Internet will visit our site. 



A truly open forum. On the Web site's Discussion Board, patients can receive answers to questions concerning ambulatory anesthesia at the click of a button.

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The Society for Ambulatory Anesthesia Welcomes the Following New Members:

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Evergreen, Colorado

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Berlin, Germany

Miami, Florida

Boucherville, Quebec, Canada

Santa Rosa, California

An Advanced Role in Ambulatory Anesthesia

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tion with the Foundation for Anesthesia Education and Research (FAER). Lee A. Fleisher, M.D., Johns Hopkins Medical Center, received the SAMBA \$100,000 Outcomes Research Award for his project on "Impact of Location of Care and Patient Factors on the Rate of Complications and Readmissions After Outpatient Surgery." David Sinclair, M.D.,

University of Pittsburgh Medical Center, was awarded the SAMBA/FAER grant for the study titled "Driver Fatigue and Simulated Driving After Ambulatory Anesthesia."

I look forward to working with the members of the Subcommittee on Publications and receiving suggestions from the readers for changes in the newsletter. 