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Society for Ambulatory Anesthesia

Ambulatory Anesthesia℠

SOCIETY FOR AMBULATORY ANESTHESIA
520 N. NORTHWEST HIGHWAY • PARK RIDGE, IL 60068-2573 • 847/825-5586 • 847/825-5658

Valued SAMBA Member:

Our organization is at a crossroads. As with most subspecialty anesthesia organizations, we have been facing increasing financial challenges, prompting the SAMBA leadership to call for a review of the Society's benefits and programs. Our leadership is strongly committed to maintaining the quality of benefits and services SAMBA provides its members but also wishes to remain fiscally responsible.

The Board of Directors has charged a select committee to conduct a comprehensive review of the SAMBA Continuing Medical Education (CME) Program, including the Society's Annual Meeting and Mid Year Meeting. The information gathered during this review will help SAMBA to continue providing you with an exceptional CME program designed to meet your needs while maintaining fiscal responsibility.

Please take a moment to complete the survey on page 7 of this newsletter. If the check boxes do not fit your thoughts, please feel free to write comments and suggestions. Every submission will be read and carefully considered. You also can complete the survey online by going to the Society's Web site <www .sambahq.org> and clicking on "CME Program Survey" under the "What's New" column. But please do it now! Your input is extremely important and valuable to us as we face these challenges and strive for new horizons.

Thank you in advance for your valuable time, your continued interest in ambulatory anesthesia and your faith in SAMBA.

Yours truly,

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

EDITOR'S PAGE

Help Us Survey SAMBA's Future

SAMBA has made numerous changes to keep up with the times. As with most subspeciality organizations, however, SAMBA faces financial challenges. Therefore, it has become necessary to critically review the SAMBA educational programs so as to maintain excellent quality as well as remain fiscally responsible. We are asking that you please complete the "CME Program Survey" found on the SAMBA Web site <www.sambahq.org> under the "What's New" section of the homepage. If you prefer, you may complete the survey included in this newsletter and mail it to SAMBA headquarters in Park Ridge, Illinois.

With expansion of ambulatory surgery, we increasingly encounter older and sicker patients with multiple comorbidities who undergo more extensive surgical procedures on an outpatient basis. In this era of change, it is necessary that we keep up with new information regarding the management of this complex group of patients. **Mary Ann Vann, M.D.**, Boston, Massachusetts, provides us with an excellent review of management of a diabetic patient on insulin. **Babatunde O. Ogunnaike, M.D.**, Dallas, Texas, summarizes the session on "Outpatient Anesthesia in the Geriatric Patient," which was presented during the SAMBA 17th Annual Meeting held last May 2002 in Orlando, Florida. The session on geriatric patients was held in association with the Society for the Advancement of Geriatric Anesthesia. **Suntheralingam Yogendran, M.D.**, Toronto, Ontario, Canada, discusses the complications of arthroscopic shoulder surgery.

> ***… It has become necessary to critically review the SAMBA educational programs so as to maintain excellent quality as well as remain fiscally responsible.***

This year's Mid Year Meeting will be held on Friday, October 11, at the Peabody Orlando Hotel, Orlando, Florida (the day prior to the American Society of Anesthesiologists Annual Meeting). The program for this year's meeting features presentations about outstanding topics on clinical as well as regulatory issues associated with office-based anesthesia. I would encourage all members to attend the SAMBA Mid Year Meeting.

Girish P. Joshi, M.D.

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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.*

Insulin Management for the Surgical Patient With Diabetes

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

There are many advantages of ambulatory surgical procedures for the patient with diabetes treated with insulin. A stress-free, minimally invasive, short procedure that allows a rapid return to a normal routine constitutes an ideal scenario for these patients. However, the dosing of insulin and optimum blood glucose management in the perioperative period is crucial to the ultimate success and optimum recovery from the procedure.

The newest insulin products on the market make the perioperative management of diabetes easier and safer. Two new forms of human insulin, insulin glargine and insulin lispro, will be discussed in this article along with a brief review of other insulin treatments.

Many anesthesia practitioners take a reactive approach to the management of blood glucose levels for the patient on insulin. The fear of hypoglycemia leads many physicians to allow hyperglycemia in the perioperative period. New recommendations suggest that for the best outcome, however, blood glucose levels should be maintained between 120-150 mg/dl. Surgical stimuli and general anesthesia both cause a release of stress hormones, including epinephrine, norepinephrine, glucagon, growth hormone and cortisol, all which elevate blood glucose. Hyperglycemia in the perioperative period can cause dehydration, electrolyte abnormalities, impaired wound healing and a predisposition to infection as well as ketoacidosis in Type I diabetics.

Blood glucose management in the surgical patient requires provision of insulin to meet basal requirements as well as coverage for elevated glucose levels. Glargine has the advantage of providing a patient's basal insulin without a peak, decreasing the risk of hypoglycemia compared to isophane (NPH) or insulin zinc suspension. Insulin glargine is a modified form of human insulin, which is soluble at a pH of 4. Glargine is for subcutaneous use only, since after injection the acidic solution is neutralized, forming microprecipitates or stabilized aggregates that slowly dissolve over a period of 24 hours. Glargine is dosed once daily at bedtime. It should not be mixed with other insulins or diluted, which could alter its absorption. The time from injection to the end of its pharmacological effect is 24 hours, significantly longer than the 14.5 hours for NPH. In the perioperative period, the nighttime dose of glargine, given the day before surgery, may be reduced to 80 percent or maintained at a normal level to provide basal insulin requirements in the face of impending surgical stressors. The important point to remember about glargine is that there is no peak, and insulin levels are stable over the daytime period.

Insulin lispro, on the other hand, is a rapid-acting insulin analog. The reversal of amino acids lysine and proline in the B chain of human insulin resulted in its characteristic of faster absorption of the product. The half-life of a dose of lispro injected subcutaneously is one hour, compared to 1.5 hours for regular human insulin. This rapid absorption also occurs after intravenous administration where the half-life is 26 minutes for lispro and 52 minutes for regular insulin. Lispro is injected subcutaneously by patients 15 minutes prior to a meal. One advantage of this rapid absorption is less postprandial hyperglycemia, since after eating, glucose levels peak and come down quickly after lispro but stay elevated for two to three hours and decrease slowly after regular insulin.

Additionally, there is less nighttime hypoglycemia after lispro since blood sugar levels come down quickly, and the lispro is gone; there is no insulin hanging around later at night that could bring down glucose levels during sleep. Similarly, a lispro injection given to a hyperglycemic patient in the preoperative area or postanesthesia care unit will be gone in a shorter period of time and is less likely to cause hypoglycemia hours later.

Mary Ann Vann, M.D.

Most insulin pumps today utilize insulin lispro. The pumps deliver a basal rate of lispro, usually only a few units per hour, and boluses are given via the pump to cover for meals. The basal rate of insulin pumps should usually be maintained in the perioperative period. Regardless of the type of insulin or dosage schedule, however, many diabetic patients will know their basal insulin requirement as well as their "sick day regimen," which their doctor has prescribed for them for days on which they are too ill to adhere to their normal meal plan. This information may be useful when instructing a patient on changes in insulin doses for surgery.

Other insulin regimens utilizing NPH or zinc suspension insulins also may need to be altered in the perioperative period. The dosing of insulin will depend on the length, complexity and time of day of the procedure and the frequency of dosing of insulin, i.e. single versus multiple daily doses. The November 8, 1999, issue of the *Archives of Internal Medicine* contains an excellent and concise review article on the perioperative management of diabetes. Although it was published be-

Continued on page 12

Outpatient Anesthesia in the Geriatric Patient

By Babatunde O. Ogunnaike, M.D.
Assistant Professor of Anesthesiology and Pain Management
University of Texas Southwestern Medical Center
Dallas, Texas

The session on outpatient anesthesia for the geriatric patient was held in May 2002, in association with the Society for the Advancement of Geriatric Anesthesia. This session was moderated by **Terri G. Monk, M.D.**, Gainseville, Florida. **Lee A. Fleisher, M.D.**, Baltimore, Maryland, discussed the application of the new American Heart Association/American College of Cardiology "Perioperative Cardiovascular Evaluation Guidelines" to the elderly outpatient. These guidelines represent an update of those published in 1996, which deal with perioperative cardiovascular evaluation for noncardiac surgery.

The guidelines were presented in the form of an algorithm featuring the integration of surgery-specific risk, clinical risk factors and exercise tolerance in the decision to perform further diagnostic testing. The risk predictors were divided into three levels: major, intermediate and minor.

Major clinical predictors of increased perioperative cardiovascular risk were described as the "things we see and ask ourselves whether we should proceed with anesthesia and surgery." The major predictors include unstable coronary syndromes such as recent myocardial infarction (MI) (< 30 days) and unstable or severe angina, decompensated CHF, significant arrhythmias (high-grade AV block, symptomatic arrhythmias in the presence of underlying heart disease and supraventricular arrhythmias with uncontrolled ventricular rate), and severe valvular disease (refers mostly to aortic stenosis). It was emphasized that patients with acute coronary syndromes such as unstable angina or decompensated CHF of ischemic origin should not undergo elective noncardiac surgery because of their high risk of developing further decompensation, MI and even death during the perioperative period.

Intermediate clinical predictors include: stable angina, prior MI (> 30 days), compensated CHF, diabetes mellitus and renal insufficiency (recently added). These factors are associated with higher-than-usual perioperative risk.

If a patient has angina, the functional (exercise) capacity determines his or her surgical risk and determines whether or not the patient needs further invasive or noninvasive testing before elective surgery. In a patient with stable angina with excellent exercise tolerance, the myocardium can be stressed without becoming dysfunctional. Exercise tolerance can predict outcome if age adjusted. During exercise, one should look for chest pain and dyspnea on minimal exertion. These symptoms point toward the probability of extensive coronary artery disease. On the other hand, walking a mile without dyspnea suggests a small probability of cardiac decompensation. In patients who are unable to exercise, the size of cardiac defect and wall motion abnormality in more than five segments (as determined by dobutamine stress echocardiogram) are indicators of perioperative cardiac complications.

Major clinical predictors of increased perioperative cardiovascular risk were described as the 'things we see and ask ourselves whether we should proceed with anesthesia and surgery.'

The *minor predictors* of risk were advanced age, abnormal electrocardiogram, rhythm other than sinus, low functional capacity, previous stroke and uncontrolled hypertension. These

Babatunde O. Ogunnaike, M.D.

factors are associated with coronary artery disease, but their relationship to perioperative cardiac complications is not well-established. Further diagnostic testing is usually not indicated if these patients have good functional capacity.

The surgical procedure itself was noted to have a significant impact on perioperative risk as well as the need for preoperative evaluation. Surgical procedures that are not associated with significant stress can be performed safely without further evaluation because the risks of evaluation are often greater than the perceived benefits of the new information.

The discussion was then focused on the advantages and disadvantages of preoperative percutaneous translumal coronary angioplasty (PTCA)/stenting on perioperative outcome. Although selected patients undergoing high-risk surgery may benefit from surgical intervention (i.e., coronary artery bypass grafting/PTCA), there is no benefit in patients undergoing low-risk surgery. Recent studies suggest that there was no improvement in perioperative outcome in patients who had undergone PTCA within 90 days of the noncardiac surgical procedure. Importantly, at least two weeks (and preferably four weeks) should elapse before elective surgery is performed after coronary artery stenting because of increased incidence of

complications (e.g., major bleeding, MI and death).

It was emphasized that ß-blockers (e.g., atenolol and bisoprolol) have been found to significantly reduce the incidence of perioperative cardiac complications. Despite these advantages, ß-blockers are underutilized in high-risk patients.

The next speaker, **Stanley Muravchick, M.D., Ph.D.**, Philadelphia, Pennsylvania, presented "The Aging Process: Anesthetic Implications in the Elderly Outpatient." It was noted that age-related, altered physiology occurs at the mitochondrial level and that the changes in nervous system function have the most direct and important implications for the anesthetic management of an elderly outpatient.

Healthy elderly patients have reduced global cerebral blood flow in response to decreased cerebral metabolic demands. In addition, as one ages, cardiac output is reduced in proportion to decreased skeletal muscle and lean tissue mass. Ventricular pump function becomes a reflection of conditioning and aerobic demand as age increases. The elderly rely on sinus rhythm to maintain cardiac output; however, fibrotic infiltration of the cardiac conduction pathways predisposes them to dysrhythmias. Furthermore, due to aging, ventricles become stiff and noncompliant; therefore, small fluctuations in filling volume produce large alterations in pressure changes.

A discussion of altered pharmacological responses in the elderly emphasized the decline in drug dosage requirements in the elderly and an increase in the volume of distribution due to an increase in the percentage of total body fat. Also mentioned was slower drug biotransformation and elimination. However, drugs with organ-independent metabolism (e.g., remifentanil and cisatracurium) are usually not affected by aging.

Dr. Muravchick suggested that preoperative assessment of the elderly should center on accurate estimates of the physiological disruption that will be produced by the intended surgical procedure as well as the determination of cardiopulmonary reserve and overall metabolic and nutritional status. It was emphasized that routine preoperative testing contributes little to the quality of perioperative patient care as abnormal values are not predictive of adverse outcome. Studies have shown that patient status assessment and appropriate surgical risk stratification can help to predict adverse outcomes in elderly patients. Outcome and risk discussion started with the mention of the increased probability of perioperative death in the elderly population due to progressive age-related increases in prevalence of cardiovascular disease and erosion of cardiopulmonary functional reserve and autonomic homeostasis. Minor sequelae such as postoperative nausea and vomiting, however, are less common in the elderly.

Surgical procedures that are not associated with significant stress can be performed safely without further evaluation because the risks of evaluation are often greater than the perceived benefits of the new information.

It was suggested that postoperative delirium may predispose the elderly to long-term cognitive impairment. The effect of anesthetic technique on speed of cognitive recovery and freedom from residual delirium was discussed. Postoperative delirium is equally common in elderly surgical patients whether regional or general anesthesia is used. Furthermore, regional anesthesia in older patients may be associated with increased risk of neurological complications (e.g., nerve palsies).

The third speaker, **F. Kayser Enneking M.D.**, Gainesville, Florida, focused on "Peripheral Nerve Blocks for Outpatient Geriatric Surgery: The Ideal Candidates for Regional Anesthesia." The physiologic changes in the elderly with respect to regional anesthetics were reviewed. The sensitivity to local anesthetics is increased due to decreased hepatic blood flow and increased body fat, which results in decreased local anesthetic clearance and increased volume of distribution. This correlated with the clinical perception that peripheral nerve blocks last longer in the elderly patient with less pain after block resolution. Hence, there is high patient acceptance of regional anesthesia.

With respect to dosing of local anesthetics in the elderly, Dr. Enneking stated that there is no change with age in the levels of alpha 1-acid glycoprotein (high-affinity, low-capacity buffer) in contrast to decrease in albumin (low-affinity, high-capacity buffer) levels with age. This means that normal local anesthetic concentrations are well-tolerated, and doses do not need to be decreased with aging, but inadvertent high blood levels may not be well-tolerated. With respect to detection of intravascular injection using epinephrine test doses in sedated elderly patients, it was suggested that increased systolic blood pressure and a decreased T-wave amplitude appear to be more reliable than a heart rate change.

The discussion of complications of regional anesthesia quoted a large prospective multicenter study that showed that the incidence of cardiac arrest and neurologic injury related to regional anesthesia was generally very low, but both are greater after spinal anesthesia than after peripheral nerve blocks. SAMBA

Complications of Arthroscopic Shoulder Surgery

By Suntheralingam Yogendran, M.D.
Toronto Western Hospital
Toronto, Ontario, Canada

Shoulder arthroscopy presents increased risk of complications over knee arthroscopy with regard to vascular and neurological injury.[1] As shoulder arthroscopy becomes increasingly common, complications associated with this procedure are becoming more apparent with an overall incidence of 6 percent to 9 percent.[2] Complications relevant to anesthesiologists include airway and respiratory injuries, nerve injuries and vasovagal syncope.

Airway and Respiratory Complications

Complete airway obstruction[3] and tracheal compression[4] are observed with shoulder arthroscopic surgery, presumably due to inadvertent extra-articular administration of irrigation fluid, which usually is infused at pressures in excess of 80 mm Hg.[3,4] Acute pulmonary edema from inadvertent intravascular administration of irrigation fluid also has been reported.[5] Dietzel et al.[6] reported four cases of spontaneous pneumothorax that occurred after shoulder arthroscopic surgery in patients with history of smoking or asthma, presumably caused by rupture of underlying bullae. In addition to life-threatening tension pneumothorax,[6] pneumomediastinum and subcutaneous emphysema also have been reported.[7,8]

Neurological Complications

Incidence of neurological complications associated with shoulder arthroscopy can be as high as 30 percent.[9] The mechanisms of neurological injury after arthroscopic surgery include traction and direct nerve injury.[10] Excessive extension and abduction of the arm increases traction and imposes tension on the brachial plexus, particularly in the lateral decubitus position. The use of beach chair position instead of the lateral decubitus position reduces the tension on the brachial plexus. In addition, suprascapular nerve injury following transglenoid surgical stabilization has been reported.

Hypoglossal nerve palsy after shoulder surgery performed in the beach chair position has been observed; however, the cause of this complication could not be determined.[12] Transient neurological injury of the lower limb in a patent in lateral decubitus position has been reported as well.[11]

Rarely chronic complication such as reflex sympathetic dystrophy can occur after shoulder arthroscopic surgery. This may be due to a pressure injury secondary to extravasation of irrigation fluid, which acts as a tourniquet in association with the wrapping of the extremity.[10]

Although several mechanisms for vasovagal syncope have been postulated, activation of the Bezold-Jarisch reflex is the most commonly accepted cause.

Most nerve injuries being neuropraxias improve with time. However, Pittman et al.[13] recommended the use of somatosensory evoked potential to monitor intraoperative nerve function in patients at risk of developing nerve damage.

Miscellaneous Complications

Vasovagal syncope has been reported in an awake patient undergoing shoulder arthroscopy in a sitting position under interscalene block. The reported incidence ranges between 13 percent and 17 percent.[14] In a retrospective study involving 116 shoulder arthroscopy patients, 20 patients suffered sudden hypotension and bradycardia.[14] Their symptoms included fainting, nausea, pallor and clamminess as well as hypotension, bradycardia and oxygen desaturation. These symptoms occurred abruptly and typically about 30 minutes after sitting up.

Although several mechanisms for vasovagal syncope have been postulated, activation of the Bezold-Jarisch reflex is the most commonly accepted cause. Venous pooling and increased sympathetic tone reduce cardiac filling, which results in a hypercontractile ventricle. This leads to activation of the parasympathetic nervous system and sympathetic withdrawal, causing bradycardia and hypotension.

The treatment includes placing the patient supine and introducing intravenous fluids, ephedrine and atropine. In addition, an early use of epinephrine is recommended. Head-up tilt and isoproterenol infusion provocation tests have been shown to identify susceptible patients. This reflex activity may be prevented by beta-adrenergic blockade and with prophylactic anticholinergics.

Other complications observed during shoulder arthroscopy include those associated with excessive systemic absorption of the irrigation fluid, e.g., temporary blindness due to glycine and hemolysis,[16] epinephrine-induced arrhythmia[15] and fatal air embolism.[17]

In conclusion, high index of suspicion and appropriate monitoring should allow for early diagnosis and intervention and prevent life-threatening complications and long-term morbidity.

References availabe from the SAMBA office or at <www.sambahq.org>. SAMBA

CME Program Survey

You also can complete the survey by going to the Society's Web site <www.sambahq.org> and clicking on "CME Program Survey" under the "What's New" column.

Please complete survey by November 1, 2002!

GENERAL INFORMATION

1. Age: ☐ <40 years ☐ 41-50 years ☐ 51-60 years ☐ 60+ years

2. Are you a current SAMBA Member? ☐ Yes ☐ No

   2a. If Yes, how long have you been a SAMBA Member? ☐ < 1 year ☐ 1-5 years ☐ 6-10 years ☐ 10+ years

   2b. If No, have you ever been a SAMBA Member? ☐ Yes ☐ No

   2c. If Yes to 2b., why did you terminate your SAMBA membership?

   _____

   _____

3. Which of the following learning methods do you prefer? (You may check more than one.)
   ☐ Meeting lectures ☐ Hands-on workshops
   ☐ Problem-Based Learning Discussion (PBLD) case discussion groups
   ☐ CD-ROMs for home use ☐ Web-based online CME programs ☐ Other_____

4. If CD-ROMs of SAMBA CME programs were available for sale, which of the price ranges would you believe appropriate for such a product? (*Note: The SAMBA Annual Meeting program is generally accredited for 18 CME hours while the SAMBA Mid Year Meeting is generally accredited for 6 CME hours.*)
   ☐ <$25 per hour ☐ $25-$50 per hour ☐ $50-$100 per hour ☐ $100+ per hour

5. How long would you expect to devote to learning in any one sitting?
   ☐ < 1 hour ☐ 1 hour ☐ 2 hours ☐ 2+ hours

6. Please indicate your learning method preference should SAMBA produce CD-ROMs of its CME programs.
   ☐ A CD that features slide presentation and audio
   ☐ A CD that combines program video with slide presentation and audio
   ☐ A CD that combines program video with slide presentation and audio interspersed with reviews

7. How should SAMBA verify that the CD program was completed?
   ☐ Return of a signed card verifying completion of the program
   ☐ Return of a completed written examination of the program
   ☐ Other

8. What topics would you like to see offered at the SAMBA CME Programs? (You may check more than one.)
   ☐ Accreditation ☐ Ethics ☐ Geriatrics Anesthesia ☐ Office-Based Anesthesia ☐ Pediatric Anesthesia
   ☐ Practice Management ☐ Regional Anesthesia ☐ Pharmacology ☐ Other_____

9. SAMBA accepts educational grants from industry in support of its general mission and not in support of its CME mission or programs. In recognition for their support, industry is provided year-round recognition by SAMBA, including (but not limited to) display space at the Society's Annual Meeting and Mid Year Meeting and recognition in SAMBA publications and on the Society's Web site.

   Please address this issue should you have any suggestions for improvement.

   _____

   _____

survey continued on next page…

ANNUAL MEETING INFORMATION

10. How many SAMBA Annual Meetings have you attended (either as a member or nonmember)?
☐ 1 ☐ 2-3 ☐ 4-8 ☐ >8

11. The SAMBA Annual Meeting is traditionally held in either late April or early May to avoid conflicts with other meetings and summer vacations. Please indicate your preference of meeting dates:
☐ Earlier in the year (March or April) ☐ Early May (status quo)
☐ Fall (September, shifting the Mid Year Meeting to the Spring) ☐ Other_____

12. The location of the SAMBA Annual Meeting is rotated yearly between the East and West coasts and the central region of the country. Please indicate which cities should host an annual meeting. (You may check more than one).
☐ Washington, DC ☐ Boston, MA ☐ Chicago, IL ☐ Las Vegas, NV
☐ New Orleans, LA ☐ New York, NY ☐ Orlando, FL ☐ Palm Springs, CA
☐ Philadelphia, PA ☐ San Antonio, TX ☐ San Diego, CA ☐ San Francisco, CA
☐ Scottsdale, AZ ☐ Seattle, WA ☐ Vancouver, BC ☐ Toronto, ON
☐ Other(s)_____

13. Do you prefer attending a meeting that is held at a: ☐ Downtown hotel ☐ Resort hotel

14. On which days would you prefer the SAMBA Annual Meeting be held?
☐ Friday, Saturday, Sunday morning (arrival on Thursday and departure on Sunday afternoon)
☐ Monday, Tuesday, Wednesday morning (arrival on Sunday and departure on Wednesday afternoon)
☐ Other_____

15. In what format do you prefer to receive a meeting syllabus? (Check only one.)
☐ Printed only ☐ Online ☐ CD-ROM

16. What topic(s) should a premeeting course (presented one day prior to the Annual Meeting) cover?
☐ Advanced Cardiac Life Support (ACLS) ☐ Pediatric Advanced Life Support (PALS)
☐ Update on Internal Medicine ☐ Other (please specify)_____
☐ Do not conduct a premeeting course

17. Please rank the following according to importance when considering attendance at a meeting.
(1 = least important, 4 = most important)
____ Availability of time from work
____ Registration fee
____ Lecture topics
____ Location
____ Overall meeting content
____ Speakers
____ Number of CME credit hours
____ Cost of attendance (airfare and hotel room rate)

18. Which type of registration fee do your prefer?
☐ One fee for the entire program
☐ Pay-per-use basis with workshops having separate registration fees (as we do now).

19. Social events at previous SAMBA Annual Meetings have included buffet receptions at museums, amusement attractions or ballgames on either Friday or Saturday evening.
a. This social evening should be continued: ☐ Yes ☐ No.
b. If yes, on which night would you prefer the event be held: ☐ Friday ☐ Saturday

20. Should meals served at the Annual Meeting be included in the registration fee? ☐ Yes ☐ No

21. If meals should be included in the registration fee, but to reduce expenses, we did not include all meals (currently 2 breakfasts, 2 lunches and 1 dinner), what is the minimum you would be willing to accept?
☐ 2 lunches and 1 dinner ☐ 1 lunch and 1 dinner ☐ 1 breakfast, 1 lunch and 1 dinner
☐ 2 breakfasts, 1 lunch and 1 dinner ☐ 1 lunch ☐ 2 lunches

22. Please share other thoughts that you may have on the SAMBA Annual Meeting.

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MID YEAR MEETING INFORMATION

23. How many Mid Year Meetings have you attended?
☐ None ☐ 1 ☐ 2-3 ☐ >3

24. If you attended the Annual Meeting in the spring, would you also attend the Mid Year Meeting in the fall?
☐ Probably ☐ Possibly ☐ Probably not

25. If you would attend the Mid Year Meeting, what would most influence your decision? (You may check more than one.)
☐ Availability of time off from work ☐ Registration fee ☐ Desire to attend the ASA Annual Meeting
☐ Lecture topics ☐ Location ☐ Number of CME credit hours
☐ Speakers ☐ Program content ☐ Cost of attendance (airfare and hotel room rate)

26. What should be the format of the one-day Mid Year Meeting? (Check all that are applicable.)
☐ A single unifying theme ☐ Broad variety of "update" topics ☐ More clinically oriented
☐ More management oriented ☐ Balance of clinical, scientific and management topics

27. Please share any other thoughts you may have on the SAMBA Mid Year Meeting.

_____

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Any other comments would be appreciated. Also, if you would like to further explain your answers to any of our questions, please enter that information here.

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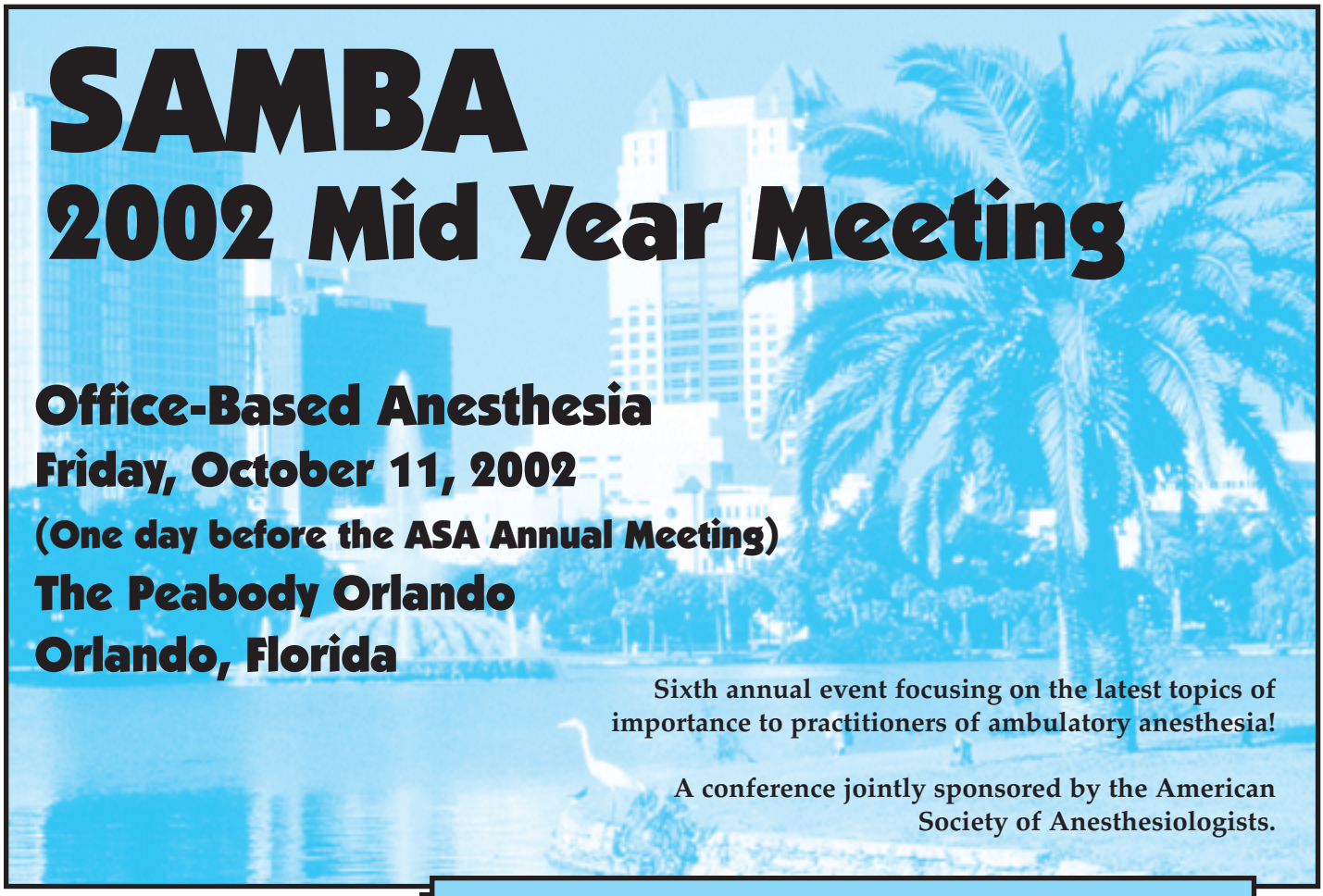
Please return completed surveys by ***November 1, 2002****, to*:

SAMBA
520 N. Northwest Highway
Park Ridge, IL 60068-2573
Fax (847) 825-5658



SAMBA
2002 Mid Year Meeting

Office-Based Anesthesia
Friday, October 11, 2002
(One day before the ASA Annual Meeting)
The Peabody Orlando
Orlando, Florida

Sixth annual event focusing on the latest topics of importance to practitioners of ambulatory anesthesia!

A conference jointly sponsored by the American Society of Anesthesiologists.

Register on site or at <www.sambahq.org>

SAMBA is proud to introduce "Office-Based Anesthesia" as the topic for the Mid Year Meeting 2002. We invite you to join your friends and colleagues on October 11, 2002, one day prior to the ASA Annual Meeting in Orlando, Florida.

Registration Information

Registration for the SAMBA 2002 Mid Year Meeting is $150 for SAMBA members, $250 for non-SAMBA members and $75 for residents. This registration fee includes the course syllabus, all educational presentations, a continental breakfast, a luncheon and coffee breaks.

Hotel Reservations

Hotel reservations must be made through the ASA Annual Meeting housing bureau at (800) 974-7916. Members residing outside the United States and Canada should telephone (847) 940-2155. Hotel reservations may also be made through the ASA Web site at <www.asahq.org>.

CME Credits

This activity has been planned and implemented in accordance with the Essentials and Standards of the Accreditation Council for Continuing Medical Education through the Joint Sponsorship of the American Society of Anesthesiologists and the Society for Ambulatory Anesthesia. The American Society of Anesthesiologists is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education for physicians.

The American Society of Anesthesiologists designates this educational activity for a maximum of 6 hours of category 1 credit toward the AMA Physician's Recognition Award. Each physician should claim only those hours of credit that he/she actually spent in the educational activity.

7 a.m. - 7:55 a.m.
Continental Breakfast

7:55 a.m. - 8 a.m.
Welcome
Lucinda L. Everett, M.D., Program Chair

8 a.m. - 9:45 a.m.
Session 1: *Clinical Update for Office-Based Anesthesia*

8 a.m. - 8:25 a.m.
Have Pump, Will Travel: TIVA for the Office Setting
Peter S. Glass, M.B., Ch.B.

8:25 a.m. - 8:50 a.m.
Fluid and Symptom Management — Implications for OBA
Tong J. Gan, M.D.

8:50 a.m. - 9:15 a.m.
Practical Use of Regional Anesthesia in an Office-Based Practice
Raymond Borkowski, M.D.

9:15 a.m. - 9:45 a.m.
Discussion

9:45 a.m. - 10:15 a.m.
Coffee Break

10:15 a.m. - 12 noon
Session 2: *Regulatory Issues*
Moderator: Rebecca S. Twersky, M.D.

10:15 a.m. - 10:40 a.m.
Who Are the Regulators? What Do They Want?
Beverly K. Philip, M.D.

10:40 a.m. - 11:05 a.m.
Sentinel Events, Safety and Successful Surveys
Larry B. Grossman, M.D.

11:05 a.m. - 11:30 a.m.
State Office Surgery Regulations in One Year: The South Carolina Experience
Hector Vila, Jr., M.D.

11:30 a.m. - 12 noon
Discussion

12 noon - 1 p.m.
Luncheon

1:15 p.m. - 2:15 p.m.
Session 3: *SAMBA Outcome Research Grant Recipient Address*
Introduction: Lydia A. Conlay, M.D., Ph.D.
SAMBA President
Outcomes in Ambulatory Anesthesia Related to Location of Care
Lee A. Fleisher, M.D.

2:15 p.m. - 2:45 p.m.
Coffee Break

2:45 p.m. - 4:30 p.m.
Session 4: *Practical Office-Based Anesthesia*

2:45 p.m. - 3:10 p.m.
OBA as an Outgrowth of a Hospital or University Practice
Louis M. Guzzi, M.D.

3:10 p.m. - 3:35 p.m.
Office Practice as a Private Contractor
Melinda L. Mingus, M.D.

3:35 p.m. - 4 p.m.
Anesthesia for the Dental Office
Dee W. Isackson, D.D.S., M.D.

4 p.m. - 4:30 p.m.
Discussion: *Does Office Practice Force Us to Compromise Standards?*

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Insulin Management for the Surgical Patient With Diabetes

Continued from page 3

fore the widespread use of lispro or the introduction of glargine, this article still provides informative guidelines and an easy-to-follow algorithm for the management of diabetic patients on several different treatment modalities.

For short procedures in the early morning, the article recommends delaying the full morning dose of insulin until after the procedure. This plan is advocated since it results in the least amount of disruption to the insulin regimen, yet it requires patients to resume their meal schedule promptly after the surgery. If patients will not be able to eat breakfast but will likely eat lunch, the article recommends two-thirds of a single dose of insulin or one-half of the morning dose of insulin for patients receiving twice-daily doses of intermediate-acting insulin such as NPH. Patients missing lunch, if they usually take a single morning dose, should receive one-half of the total insulin dose (including intermediate- and short-acting insulins); if administering twice daily, they should administer one-third of their total morning dose. If patients are scheduled for a procedure later in the day, a glucose infusion at 5gm/hr may be required to prevent hypoglycemia from these doses of insulin.

The ambulatory anesthesiologist can improve outcomes for patients with diabetes by understanding their insulin therapy, scheduling patients early in the day, minimizing the stress of surgery and providing a smooth and prompt return to normal dosing regimens and meal plans. SAMBA

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