



Society for Obstetric Anesthesia and Perinatology

Newsletter

www.soap.org

December 2005



William R. Camann, MD

President's Message

I'm looking forward to even more obstetric anesthesia offerings at future ASA meetings. Anyone with comments they'd like to pass on to the SOAP leadership should send these via email to: soaphq@soap.org. Comments are welcome and input is critical to keeping our society on top of the issues and interests of the SOAP membership. We actively seek your input!

document addressing issues of obstetric anesthesia practice. The original document was published in 1999. The task force is now working on an updated and revised version. We anticipate the new version will be even more comprehensive in scope and detail, and there will be plenty of opportunities for practicing anesthesiologists to have input as the parameters are developed.

Warm winter greetings to all. It was great seeing many of you at the ASA in Atlanta and now looking forward to warm weather and a chance to meet up with you all again in Hollywood, Florida - yes the hotel is still intact! But first let me give you some updates on hot button issues in the world of obstetric anesthesia.

With regard to member input, one of the most interesting aspects of my participation in SOAP is assisting our society's secretary, Lawrence Tsen, with fielding the various comments and questions that come into the society headquarters feedback e-mailbox. E-mails sent to the society's headquarters are forwarded to Dr. Tsen. These comments and questions cover a wide variety of topics and are sent from anesthesiologists, CRNAs, obstetricians, nurses, patients, and others. Some of the more common questions received involve fetal monitoring for non-obstetric surgical procedures in pregnancy, and oral intake policies for pregnant patients. Most of the queries request guidance in the form of policies or guidelines. SOAP members are aware and respect the fact that just as there are many good ways to 'skin a cat' there are often many reasonable approaches to any problem. In order to best review all the options and to promote good obstetric anesthesia practice, the ASA created a task force to put together an evidence-based and consultant-based

The pivotal role of the anesthesiologist in the multidisciplinary care of the pregnant patient continues to grow and will become even stronger in the future. As noted before, SOAP members are well represented on panels at the Society for Maternal-Fetal Medicine (SMFM) and North American Society for Obstetric Medicine (NASOM) meetings, and vice-versa.

continued on page two

“The pivotal role of the anesthesiologist in the multidisciplinary care of the pregnant patient continues to grow and will become even stronger in the future.”

The ASA annual meeting was quite well-attended, despite the last-minute relocation from New Orleans to Atlanta due to the Katrina tragedy. All of the "OB track" sessions were held, at their originally scheduled times, and attendance was excellent. The Sol Shnider Breakfast panel was sold out, as were most of the refresher courses. The panels and debates were lively and informative, and the SOAP/Anesthesiology Journal-sponsored special research session featured some truly excellent research and discussion.

Inside

OAPEF Contribution Listing	2
38th Annual Meeting Program	3
In Memoriam (Tom Joyce)	4
PRO/CON Debate	5
International Outreach Trip	8
SOAP/OAA Joint Meeting	9
NASOM Meeting Recap	10

President's Message – *continued*

The collaboration between our societies continues to be strong. I'd like to point out that a recent special edition of the Journal of Critical Care Medicine (October 2005) was entirely devoted to a series of articles on various medical issues in pregnancy.

Topics included, but not limited to, critical illness in pregnancy, airway problems (including SOAP member Maya Suresh as a co-author), cardiac and respiratory disease, hemodynamic assessment, and trauma in the pregnant patient.

“Our pregnant population is becoming older, younger, sicker, and heavier, with predictable challenges imposed upon all who provide anesthesia for the pregnant patient.”

I highly recommend those who are interested to seek out this issue for a timely review of these important topics. Moreover, a recent edition of both Internal Medicine News and OB/GYN News featured front-page articles about the evolving role of the obstetric medicine specialist. Links to these articles can be found at the "In The News" section of the SOAP website. It is clear that our pregnant population is becoming older, younger, sicker, and heavier, with predictable challenges imposed upon all who provide anesthesia for the pregnant patient. As one of my colleagues recently said, we are not just about epidurals anymore!

Plans are well underway for the 2006 Annual Meeting in Hollywood, Florida, April 26-30. A terrific scientific program is being assembled by Program Committee Chair, David Wlody, and the social program will feature several unique and memorable activities - stay tuned for further details!

I would like to close with a few notes on some remarkable SOAP members. We were recently saddened by the death of Tom Joyce, a SOAP founding father and a leader, mentor, role model and longtime friend to many in this society. A special tribute to Tom appears on page four of this issue. Finally, in a note of transition, David Birnbach has stepped down as Chair of the ASA Committee on Obstetric Anesthesia and ACOG liaison. The new chair of this committee is Sam Hughes. Dr. Birnbach has nobly served this role for many years. We all owe him a debt of gratitude for representing our specialty so well and with such dignity and professionalism. Going forward, I cannot think of anyone more suited and able to occupy this important position than Dr. Hughes; I am sure that he will serve our specialty of obstetric anesthesia in an equally forceful and dedicated manner. Best wishes to all,



OAPEF Contributions November 1, 2004 – October 31, 2005

Donors <\$50

Ferrari, Al
Hahn, Caroline
Martinez, Carlos
Owen, Medge
Sampathi, Venkata
Volpe, Lorraine
Winter, Clara

Silver Level

Donors \$50-99

Alleyne, Audrey
Brown, Jr., Walter
Bucklin, Brenda
Crone, Lesley-Ann
Currier, David
Dailey, Patricia
Dalby, Patricia
Devore, Jay S.
Diaz, Salvador F.
Duffy, Michael
Elder, Paul
Fineman, Sheldon
Fogel, Steven
Fragneto, Regina
Frost, Maria
Gilbertson, Lesley
Glassenberg, Raymond
Gomeri-Gascon, Perla
Greider, Philip
Hawkins, Joy
Hershey, Charles
Holliday, J.Scott
Holtmann, Barbel
Kassa, Allan
Kenepp, Nancy
Lee, Jeffrey
Li, Yunping
Loftus, John
Macarthur, Alison
Macaraeg, Emmanuel
McKellar, Sally
O'Connor, Terence
Panchal, Sumedha
Plumer, Michael
Pue, Alex
Ranasinghe, Jayanthi
Soskin, Vitaly
Steinberg, Paul
Strobel, Alan

Trojanowski, Andrezej
Vadhra, Rakesh B.
Webb, Pamela
Weeks, Sally

Gold Level

Donors \$100-249

Bartholomew, Edward
Birnbach, David
Camann, William
Carlin, James
Clark, Richard (in honor
of Gerald Burger)
Cohen, Sheila
Douglas, M. Joanne
Gutsche, Brett
Hoyt, McCallum
Hranac, Joseph
Hughes, James
Hughes, Samuel
Joyce, III, Thomas
Koffel, Bettylou
Kotelko, Dennis
Palmer, Craig
Palmer, Susan
Penning, Donald
Pue, Alex
Santos, Divina
Schwalbe, Steven S.
Smiley, Richard
Vasdev, Gurinder
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Gertie Marx Patron Level Donors \$250+

Arkoosh, Valerie
Bogard, Terrence
Gambling, David
Hicks, James
Hustead, Robert
Kenepp, Nancy
McKay, Robert
Minnich, Marie
Molina-Lamas, Edward
Norman, Patricia
Santos, Alan C.
Wissler, Richard

SOAP 38th Annual Meeting – Scientific Program

Wednesday, April 26, 2006

- 1:00 - 5:00 pm **Critical Care Obstetric Anesthesia Workshop (By Ticket Only – Limited Registration)**
Gurinder M. S. Vasdev, MD; et al.
- 6:00 - 8:00 pm **SOAP Opening Reception**

Thursday, April 27, 2006

- 7:00 - 7:45 am **Breakfast with Exhibitors; Posters**
- 7:45 - 8:00 am **Opening Remarks and Welcome**
William R. Camann, MD; David J. Wlody, MD; David J. Birnbach, MD; Jose Carvalho, MD, PhD, FRCPC
- 8:00 - 9:30 am **Gertie Marx Symposium (6)**
Moderator: G. M. Bassell, MD
Judges: Stephen Halpern, MD; Philip Hess, MD; Alan Santos, MD, MPH; Jonathan Waters, MD; Jess Weiss, MD
- 9:30 - 9:45 am **Distinguished Service Award**
Awarded to Felicity Reynolds, MD
Presenter: William R. Camann, MD
- 9:45 - 10:15 am **Coffee with Exhibitors; Posters**
- 10:15 - 11:30 am **Oral Presentations (5)**
Moderator: Linda S. Polley, MD
- 11:30 - 12:30 pm **PRO/CON Debate: A Non-Particulate Antacid Should be Used Routinely in All Patients Undergoing Cesarean Section**
Moderator: David J. Wlody, MD
Pro: Yaakov Beilin, MD
Con: Jose Carvalho, MD, PhD, FRCPC
- 12:30 - 1:30 pm **Lunch with Exhibitors; Posters**
- 1:30 - 2:30 pm **What's New in Obstetrics?**
Introduction: David J. Wlody, MD
Howard Minkoff, MD
- 2:30 - 3:30 pm **Zuspan Award Symposium (4)**
Moderator: M. Joanne Douglas, MD, FRCP
Judges: Samuel Hughes, MD; Barbara Leighton, MD; Howard Minkoff, MD; Shiv Sharma, MD
- 3:30 - 4:00 pm **Coffee Break with Exhibitors; Posters**
- 4:00 - 6:00 pm **SOAP Business Meeting – Awards Presentations**
Moderator: William R. Camann, MD

Friday, April 28, 2006

- 6:00 - 7:00 am **Fun Run/Walk**
- 7:00 - 8:00 am **Breakfast with Exhibitors; Posters**
- 8:00 - 9:00 am **Oral Presentations (4)**
Moderator: Barbara Scavone, MD
- 9:00 - 10:00 am **What's New in Obstetric Medicine?**
Introduction: Joy L. Hawkins, MD
Lynn Barbour, MD, FRCP
- 10:00 - 10:30 am **Coffee with Exhibitors; Posters**
- 10:30 - 11:30 am **Poster Review #1**
Moderator: Cynthia Wong, MD
- 11:30 - 1:00 pm **Panel: Simulation in OB Anesthesia Education**
Moderator: Stephen Pratt, MD
Panelists: Gubby Ayida, MD; Paul Preston, MD; Benjamin Sachs, MD
- 1:30 pm **SOAP Golf and Tennis Activities**

Saturday, April 29, 2006

- 7:00 - 8:00 am **Breakfast with the Experts**
Moderator: Robert Gaiser, MD
Experts: Jodie Buxbaum, MD; Jose Carvalho, MD, PhD, FRCPC (**Portuguese**); Helen Finegold, MD; John Figus, MD; Regina Fragneto, MD; David Hepner, MD (**Spanish**); Bupesh Kaul, MD; Gordon Lyons, FRCA; Edward McGonigal, MD; Mary McHugh, MD; Deborah Qualey, MD; Jayanthie S. Ranasinghe, MD; Edward Riley, MD; Gurinder M. S. Vasdev, MD; Lela Weems, MD
- 7:00 - 8:00 am **Continental Breakfast; Posters**
- 8:15 - 9:15 am **Gerard W. Ostheimer Lecture: What's New in OB Anesthesia?**
Introduction: Brenda Bucklin, MD
Roshan Fernando, FRCA
- 9:15 - 9:45 am **Coffee Break; Posters**
- 9:45 - 10:45 am **Poster Review #2 – Moderator: Edward Riley, MD**
- 10:45 - 11:45 am **Fred Hehre Lecture**
Introduction: William R. Camann, MD
David Chestnut, MD
- 11:45 - 1:00 pm **Lunch (On Your Own)**
- 1:00 - 2:30 pm **Best Paper Presentations (6)**
Moderator: Gordon Lyons, MD
Judges: William R. Camann, MD; Prof. Warwick Ngan Kee; Kiki Palacios, MD; Richard Smiley, MD, PhD
- 2:30 - 4:00 pm **Panel: Coexisting Diseases**
Moderator: Richard Wissler, MD, PhD
Panelists: Brendan Carvalho, MB, BCH; Manuel Vallejo, DMD, MD; Richard Wissler, MD, PhD
- 4:00 - 5:00 pm **Research Hour**
Robert D'Angelo, MD; Ruth Landau, MD; Jeff Mogill, MD; Richard Smiley, MD
- 6:00 - 11:00 pm **SOAP Banquet**

Sunday, April 30, 2006

- 7:00 - 7:30 am **Continental Breakfast**
- 7:30 - 8:30 am **Panel: Tort Reform**
Moderator: Donald Penning, MD, MSC, FRCPC
Panelists: Patricia Dailey, MD; Andrew Harris, MD, MHS; A. Terry Walman, MD, JD
- 8:30 - 9:30 am **Pro/Con Debate: Supplemental Oxygen Should Be Used Routinely During Cesarean Section**
Moderator: David J. Birnbach, MD
Pro: Scott Segal, MD
Con: Prof. Warwick Ngan Kee
- 9:30 - 10:30 am **Poster Case Reports: You did What? The Best Case Reports of the Year!**
Moderator: Robert McKay, MD
- 10:30 am **Adjournment**

IN MEMORIAM



THOMAS H. JOYCE III, MD
(10/21/1933 to 10/20/2005)

Tom Joyce had a very vital role in SOAP in its formative years (a member since 1975 and President in 1982-83). Together with the other OB Anesthesia greats, Tom will long be remembered by the many of us who knew him, including the residents, fellows and nurse anesthetists whom he inspired and trained while he was at the University of Cincinnati and Baylor College of Medicine.

Tom, a well-rounded anesthesiologist, researched and lectured on several anesthesia and related topics nationally and abroad. He has a long list of publications, abstracts and presentations in pre-eclampsia and other complicated OB anesthesia problems. In addition, he represented obstetric anesthesia actively at the ASA.

A selfless man, Tom was generous in giving opportunities to his trainees, content in knowing that he helped them get there.

Tom started his anesthesia training in the Navy, became Chief of Anesthesiology at the Naval Hospital in Portsmouth, West Virginia, and continued in the Naval Reserve until his retirement as Commander in 1984. He has chosen the Arlington Cemetery as his final resting place.

He is survived by his wife of 47 years, Joan, and his children Christopher, Michael, Ann, and Kathleen.

In lieu of flowers, a donation to the Thomas Joyce, III, MD Endowed Scholarship Fund in his medical school would be greatly appreciated.

Donations may be sent to:
Creighton University
Attn. Ruth Henneman
Joyce Scholarship Fund
2500 California Plaza
Omaha, NE 68178

The SOAP Board of Directors would like to express our gratitude to Divina Santos, MD for authoring this memorial.

Distinguished Service Award

Nominations for the 2007 Distinguished Service Award are being solicited by the SOAP Board of Directors. The Board selects the recipient(s) based on the following criteria:

- Has been a long-standing Society member
- Has made numerous contributions to the Society (i.e., served on the BOD, presented at Annual Meetings, served on Society committees)
- Has provided exceptional service to the OB anesthesia specialty

Nominations should be sent to soaphq@soap.org. The Board of Directors will select a recipient(s) during the next Board Meeting in Hollywood, Florida.

Past Recipients:

- 2000 - Gertie Marx
- 2001 - Mieczyslaw Finster
- 2002 - Robert Bauer, Richard Clark, James Elam, James Evans, Robert Hustead, and Bradley Smith
- 2003 - Brett Gutsche
- 2004 - Sheila Cohen
- 2005 - Frederick Zuspan

Use of SOAP Mailing List for Surveys/Research

Because of an increasing number of requests for the SOAP mailing list, the Board of Directors has established a protocol for requesting the official mailing list. As a benefit of SOAP membership, those conducting surveys or research studies may request the SOAP mailing list. Requirements are:

Offered to SOAP Members in good standing.

1. Mailing list for research use only.
2. The research survey must be IRB approved at the primary investigator's institution.
3. The survey and IRB approval letter must be submitted to SOAP Headquarters.
4. The survey will then be reviewed by the SOAP Research Committee.
5. A fee of \$100 will be charged for this one-time distribution/use of the mailing list. Requests for follow-up surveys will be handled on a case-by-case basis. (Note: No email addresses will be provided but, if preferred, the survey can be emailed from SOAP headquarters.)

For additional information contact:

Robert D'Angelo, MD
Chair, SOAP Research Committee
rdangelo@wfubmc.edu

or

Submit your request to:

Via Email: soaphq@soap.org

Via Fax: 216-642-1127

Via Mail: SOAP

2 Summit Park Drive, Suite 140
Cleveland, OH 44131

PRO

CON

PRO

Lidocaine is a Suitable Alternative for Spinal Anesthesia in Obstetric Practice

Audrey S. Alleyne, MD

Assistant Professor

Director of Obstetric Anesthesia Services

Medical College of Georgia

Augusta, Georgia

Lidocaine has a long history in clinical use because of its quick onset, short duration, intense sensory and motor blockade. Recent concerns about transient neurologic symptoms (TNS) have led anesthesia practitioners to avoid lidocaine for spinal anesthesia. Clinical alternatives to lidocaine, such as bupivacaine, mepivacaine, prilocaine, procaine and tetracaine also pose risks to patients (1). Lidocaine is appropriate for use in procedures of short duration in the supine position. After considering and communicating the various risks, options and benefits, practitioners should allow patients to assist in deciding their course of action.

Why is this trend taking place?

Lidocaine has been used clinically as a local anesthetic since 1948. In its long history, lidocaine gained a reputation for being a fast, reliable local anesthetic with a short recovery profile. In 1985, Flaatten and Raeder described an unusual form of back pain in a patient who received spinal anesthesia for vasectomy (2). Subsequent reports in the literature described cases of cauda equina syndrome after continuous spinal anesthesia. These cases were associated with the placement of microbore spinal catheters (3), and possible stretching of the cauda equina fibers in the lithotomy position (4). The lithotomy position has been suggested to increase the potential neurotoxicity of lidocaine especially when used in high concentrations (4).

The nature of TNS is under investigation. TNS has been described as the onset of lower back pain which often radiates to the lower extremity and lasts up to ten days in a patient who receives an otherwise uncomplicated neuraxial anesthetic. Of note, TNS has been associated with epidural anesthesia (5,6), continuous anesthesia and single injection spinal anesthesia with drugs as diverse as bupivacaine, lidocaine, mepivacaine, prilocaine, procaine and tetracaine (1). Rarely is this painful condition associated with any objective neurologic pathology. Pollock and coworkers evaluated volunteers with TNS after spinal lidocaine and failed to demonstrate a neurologic mechanism as assessed by electromyography (EMG), nerve conduction studies or somatosensory evoked potentials (SSEPs) (7). Oral analgesics are effective treatment when symptoms of TNS occur.

How is this trend happening?

Most practitioners who oppose the use of lidocaine in obstetric practice cite poor patient and surgeon satisfaction as reasons.

However, neurologic deficits varying from radicular symptoms to permanent paralysis have been described after both general and regional anesthesia (1). The onset of postoperative neurologic dysfunction is multifactorial in etiology, usually involving preexisting pathology, nerve trauma, or intraoperative positioning, not necessarily the result of any particular form of anesthesia. A Cochran review of randomized, controlled trials of 1347 patients by Zaric and colleagues (1), revealed no permanent neurologic sequelae after the use of lidocaine. While the incidence of TNS was higher in the lidocaine spinal group compared to the bupivacaine, prilocaine, or procaine group, symptoms were temporary and effectively treated with analgesics. The authors conclude that the increased risk of TNS must be weighed against the benefit of rapid, short-acting anesthesia.

While procaine, bupivacaine, and prilocaine are less commonly associated with TNS, their longer duration of action and lesser quality of anesthesia may be unacceptable to some patients. Procaine is also associated with nausea while bupivacaine is associated with a high incidence of urinary retention and in small doses, with inadequate surgical anesthesia (8-10). Prilocaine is not currently available in the United States in intrathecal form. Other alternatives such as chlorprocaine and ropivacaine which were originally intended for epidural use, are being explored (11-15) but there is too little data currently available regarding safety to support their substitution for lidocaine.

Where do we go from here?

More research is needed to clarify the mechanism of TNS. Current data suggests that drug dose and exposure time are causes, but patient positioning, needle trauma, and preexisting pathology also play a role (16). In the obstetric patient, there is data implying that pregnancy may offer protection because of the decreased incidence of TNS seen in this population (17-19). While it is known that all local anesthetics can be neurotoxic in high concentrations (20), further study is required to understand the mechanisms involving spinal anesthetic neurotoxicity.

Summary

Available evidence does not support the complete ban of lidocaine from anesthesia practice. There is an inherent risk of adverse effects any time a drug is administered. After proper disclosure to the patient of the risks, options and benefits available, it is acceptable to respect the patient's choice of anesthesia. Although lidocaine is associated with a risk of TNS, this risk appears to be lower in the obstetric population. Lidocaine does offer the benefit of reliable onset, short duration and rapid recovery. Many of the alternatives are unreliable at low doses or need institutional review board approval due to a lack of strong data to support safety. Therefore, if reliable onset, short duration spinal anesthesia is desired, lidocaine should be considered a suitable alternative.

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continued on page six

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Lidocaine Should NOT Be Used for Spinal Anesthesia

Robert S. F. McKay, MD

Clinical Professor and Chair

Department of Anesthesiology

University of Kansas School of Medicine

Wichita, Kansas

Learned readers, would my well-meaning colleague suggest we go back to the days of Model T Fords-with no seat belts or airbags-and those of intrathecal lidocaine? Indeed, millions of people have driven the Model T in relative safety and comfort. Similarly, millions have received intrathecal lidocaine, also in relative safety and comfort. The bumps along the road in a Model T seldom led to significant damage but they surely caused occasional pain in the rear end. Similarly, transient neurologic symptoms (TNS) are not believed to lead to permanent neurologic damage, but they certainly cause pain in the backside. Thus, I posit that spinal lidocaine should be abandoned in favor of spinal bupivacaine.

Members of SOAP owe a great debt to Nils Lofgren, whose team developed lidocaine in 1943. For many years, lidocaine appeared to be the safest amide local anesthetic available. It survived attacks suggesting it was harmful to the fetus and has a valued role in epidural anesthesia. We also owe gratitude to those who have alerted us to evils lurking in our syringes. Two of these "anesthesia canaries" are George Albright, who in 1979 reported 6 local anesthetic-related cardiac arrests (from presumed intravenous etidocaine and bupivacaine), and Markus Schneider and colleagues, who celebrated lidocaine's 50th anniversary by reporting, for the first time, that our very first amide local anesthetic, could lead to transient neurologic symptoms when injected intrathecally.

Notably, Schneider's group became concerned about lidocaine's potential neurotoxicity after Rigler and coworkers reported, in 1991, four cases of cauda equina syndrome in association with continuous subarachnoid anesthesia. Each case involved repeated doses of local anesthetic, and 5% lidocaine was used in 3 of the 4 cases. Of interest, in a follow-up to the findings reported by Rigler et al., Drasner and coworkers implanted intrathecal catheters in rats and demonstrated that hyperbaric 5% lidocaine was significantly more likely to prolong tail-flick latency than either hyperbaric 0.75% bupivacaine or hyperbaric 0.5% tetracaine.

They further noted that 11 of 12 cases of cauda equina syndrome documented at the time of their study had occurred in patients receiving lidocaine. Few would disagree that medical decisions, such as the choice of intrathecal local anesthetic, should be evidence-based. And though the evidence shows bupivacaine to be a better alternative for spinal anesthesia, many anesthesiologists continue to want the freedom to choose their preferred poison (or neurotoxin as the case may be).

continued on page seven

In their defense, studies have clearly shown that all local anesthetics in clinical use are relatively safe and that, when used in recommended doses, rarely lead to neurologic dysfunction. Though both Gerancher and Auroy, et al. reported that neurotoxicity could follow lidocaine even when used at recommended clinical doses, their cases all involved the upper end of such dosing. This suggests that modification of the recommended dose to <75 mg could prevent serious neurotoxicity related to lidocaine. I agree with the argument that intrathecal lidocaine is indeed safe and its use can be made even safer by avoiding repeated injections, limiting the dose and using meticulous technique. More germane to the CON argument than the very rare cases of clinically detectable neurotoxicity seen with higher doses of local anesthetics, however, is the significant incidence of TNS following intrathecal lidocaine use. Though apparently transient and self-limiting in their physical effects, these symptoms are often quite disturbing to the patient and furthermore, are nearly completely avoidable through the use of another intrathecal local anesthetic, i.e., bupivacaine. (Though other local anesthetics, e.g., prilocaine, may also lead to a decreased incidence of TNS, available data only support bupivacaine as being clearly advantageous.)

Why be concerned with TNS? As early as 1968, a prospective study of intrathecal lidocaine by Phillips, et al. showed that nearly one-third of patients with postspinal back pain refused subsequent spinal anesthesia. TNS is clearly worse than postspinal back pain and among patients with TNS, nearly one-third rate their pain at an 8 or greater on a 10-point scale. With TNS occurring in anywhere from about 2% to 40% of patients receiving intrathecal lidocaine, a large number of patients may subsequently refuse spinal anesthesia, even when its use may significantly decrease their anesthetic risk. The use of bupivacaine would likely significantly decrease TNS (reported TNS ranges from 0% in most studies, to a high of 7% reported by Phillip et al.), and thus provide increased perioperative comfort and acceptance of spinal anesthesia. Per a recent survey by Auroy of 156,083 regional anesthetics, the reduction in TNS would be 7-fold. Though this reasoning may be simplistic, one should not ignore the argument put forth by deJong that TNS is one end of the spectrum of neurotoxicity. One must ask whether a nerve exposed to lidocaine becomes more susceptible to damage from subsequent insults. To date, we simply don't know the answer to this question but we do know that lidocaine activates cellular apoptosis in cell cultures.

Proponents of lidocaine have suggested that limiting the concentration of lidocaine may reduce the incidence of TNS. However, TNS is not reduced by decreasing the concentration of lidocaine (TNS is not concentration dependent above a clinically administered concentration of 0.5%), nor is it diminished by the elimination of glucose or epinephrine. Further, reduction of the total dose leads only to a minimal (if any) reduction in TNS.

Proponents of lidocaine further argue that there are no substitutes for lidocaine's ability to provide reliable, rapid onset anesthesia of moderately short duration. They describe how spinal bupivacaine's

duration would limit its use in outpatients and/or add cost to postoperative care. I must ask, have they ever used spinal bupivacaine? Is the cost of 30 minutes of additional anesthesia and analgesia really so high, especially since it would lower the need for subsequent analgesia, if only for treatment of TNS? Further, during the first 48 h after intrathecal lidocaine, a small proportion of patients who had TNS experience functional impairment of walking, sitting, and sleeping. No advantage is found in this. Finally, the difference in duration of analgesia can likely be reduced through the use of lower bupivacaine doses.

In summary, intrathecal lidocaine should be abandoned at least until a better understanding of its neurotoxicity allows prevention of neurologic complications including TNS. Intrathecal bupivacaine is likely the best currently approved alternative.

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continued on page eleven

SOAP International Outreach Trip to Croatia

In September 2005, a multidisciplinary team headed to Croatia, with the goal of promoting the use of regional analgesia and anesthesia for childbirth. The members of the team originated from six countries and included 12 anesthesiologists, two of which were at the later stages of their training, an internist with a focus on high risk pregnancy, and a midwife.

Croatia is a country with 4.4 million inhabitants and 40,000 annual births. The country is rebuilding from a devastating war in the early 1990's. A huge effort is being undertaken for the construction of war affected areas and establishment of a sustainable modern economy. Tourism is a growing industry in Croatia due to its beautiful scenery, great beaches, and hospitable friendly people.

Our first stop was in Zagreb where we had a group orientation about Croatian Culture and the medical system. We learned that the maternal and perinatal mortality rates were low (7.4/100,000 live births and 5.8/1,000 live births respectively) and that the rate of cesarean section was 14% with most performed under general anesthesia. The use of epidural labor analgesia was variable and was mainly performed in two university hospitals in Zagreb and Split. In the rest of the country the use of these techniques was very low or nonexistent.

After spending one day in Zagreb, we headed to the beautiful coastal city of Bol, the site of the first ever obstetric anesthesia meeting in Croatia. This two day meeting included presentations about various aspects of obstetric anesthesia and was attended by 80 Croatian anesthesiologists.

At the end of the meeting, our team split up to work in seven different hospitals throughout Croatia for five days. In addition, doctors from a hospital in Slovenia, a neighboring country, had also heard about the program and requested a visit from a team member (which we accommodated). During our stay we presented formal and bedside teaching on various aspects of obstetric anesthesiology. We interacted with the anesthesiologists, obstetricians, and midwives at our host hospitals.

Our visit attracted some media attention. A TV news program, Croatia Today, met with our Split group to discuss the goals of the team's visit. A newspaper article, "Painless Child Birth," also covered some aspects of our outreach trip.

On the last day of our trip, the whole team reconvened in Zagreb. We shared our experiences and stories. While there were some differences in practice between the various hospitals, there were some common themes. In contrast to the optimism that was generally felt regarding the potential increase in the use of regional anesthesia for CS following our visit, there were uncertainties about the future use of neuraxial techniques for labor analgesia. We felt that manpower shortage and reimbursement issues were significant problems hindering the adoption and increased use of epidural labor analgesia. Croatian anesthesiologists were very reluctant to take on

this extra responsibility and work harder for no additional pay. It was also fairly obvious that some of the anesthesiologists were not willing to stand up for patient care issues to the obstetricians and that the obstetricians really dictate control.

Another common observation was that the labor and delivery suite was generally very poorly equipped compared to other services within the same hospital. For instance, automated blood pressure cuffs or even simple blood pressure cuffs and difficult airway equipment were not available on many units while the ICUs would be equipped with very modern monitors and infusion devices. The other common theme was the very high level of satisfaction and gratitude among all the parturients that our team was involved with.

We all returned home after this rewarding experience with the intention of continuing to foster relationships with interested physicians in the visited hospitals. We were very encouraged by what we heard about the impact of our visit. Dr. Dragica Kopic, our main host, and the driving force for spreading the use of regional techniques for obstetrics in Croatia, wrote: "I am in touch with my colleagues almost every day. We are preparing epidural protocols which will be introduced in all Croatian hospitals. It is the first time that anesthesiologists in Croatia work together." We also received e-mails from a number of our hosts describing their increased use of neuraxial techniques after our visit. The e-mails we received from some women who received labor epidurals were also very encouraging: "I was very lucky to have Dr. Kopic present to have an epidural and it was a wonderful experience. The epidural reduced pain tremendously. I was able to enjoy very much the moment when my baby girl was born since I did not experience a great pain or I could say any pain at all. I honestly hope that each woman in Croatia will have the opportunity to choose whether to have an epidural or not." Another woman who was also very happy with the pain relief that she got from her epidural added: "What we need to change, among other things, is the attitude towards women. I got this feeling only after my experience with the labor. The women in this, still patriarchal society, need more recognition."

Overall, we all enjoyed the experience tremendously. Our visit helped to highlight the major hurdles for the provision of regional anesthesia for obstetrics in Croatian hospitals. We are hoping that these issues can be addressed at a governmental level to improve pregnancy related health care services in Croatia. We continue to follow up and encourage our Croatian colleagues and eagerly await to see the future impact of our trip.

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See the Croatia Trip Team Photo on page ten.

Summer Update on Obstetric Anaesthesia Trinity College, Dublin, Ireland – August 9-11, 2006

Joint meeting organized by the Society for Obstetric Anesthesia & Perinatology and
the Obstetric Anaesthetists' Association

WEDNESDAY, AUGUST 9, 2006

- 9:00 am - 1:00 pm Difficult Airway Workshop (By ticket only - Limited Registration) Course Directors: Drs. Maya S. Suresh and Ashu Wali
- 2:00 - 5:00 pm High Risk Obstetric Workshop (By ticket only - Limited Registration) Course Directors: Drs. Barry A. Harrison and Gurinder M.S. Vasdev

THURSDAY, AUGUST 10, 2006

- 8:00 - 8:15 am Welcome and Announcements - Drs. Gurinder M.S. Vasdev; David J. Wlody - SOAP President; and Gordon Lyons - OAA President
- Session I:**
Obstetric Trends - Moderator: Dr. Geraldine O'Sullivan
- 8:15 - 8:40 am A View of Epidurals from the Bottom: The effect of epidurals on the perineal floor, labor and the outcome of labor - Dr. Colm O'Herlihy
- 8:40 - 9:05 am A View of Epidurals from the Back: The effect of epidurals on the perineal floor, labor and the outcome of labor - Dr. Cynthia Wong
- 9:05 - 9:30 am Rising Maternal Age; Private Grief and Public Health Hazard - Dr. Susan Bewley
- 9:30 - 9:55 am The Beginning of the End: Breech, Forceps, and VBAC Deliveries - Dr. Errol Norwitz
- 9:55 - 10:15 am Questions and Answers
- 10:15 - 10:40 am Break
- Session II:**
Labor Analgesia Controversies - Moderator: Dr. M. Joanne Douglas
- 10:40 - 11:05 am The Status of NPO in Labor: A Fluid Question! - Dr. Geraldine O'Sullivan
- 11:05 - 11:30 am Continuous Spinal in Labor and PCEA: The next steps - Dr. Samuel Hughes
- 11:30 - 11:55 am Non-neuraxial options for labor analgesia: Several choices to consider! (Inhaled-sevo, PCA - remi) - Dr. William R. Camann
- 11:55 am - 12:15 pm Questions and Answers
- 12:15 - 1:30 pm Lunch: Windows into World Anesthesia Opportunities - Drs. Medge Owen, Paul Howell, Gurinder M.S. Vasdev
- Session III:**
Complications in Obstetric Anesthesia - Moderator: Dr. Ingrid Brown
- 1:30 - 1:55 pm Morbidity via Miscommunications on the Labor Ward - Dr. David Birnbach
- 1:55 - 2:20 pm Epidural Failures: Why and What now? - Dr. Ruth Landau
- 2:20 - 2:45 pm Infection and Trauma due to Neuraxial Techniques - Dr. Felicity Reynolds
- 2:45 - 3:05 pm Questions and Answers
- 3:05 - 3:30 pm Break
- Session IV:**
Maternal Disease: Anesthetic Management - Moderator: Dr. William R. Camann
- 3:30 - 3:55 pm Preeclampsia: An update on anesthetic concerns - Dr. Linda Polley
- 3:55 - 4:20 pm The Anti-coagulated Parturient: What to do or not to do? - Dr. Rachel Collis
- 4:20 - 4:45 pm Ten top tips to managing the parturient with pre-existing cardiac disease - Dr. Steve Yentis
- 4:45 - 5:00 pm Bedside Coagulation Monitoring: How good and is it practical? - Dr. Gordon Lyons
- 5:00 - 5:20 pm Questions and Answers

FRIDAY, AUGUST 11, 2006

- 8:00 - 8:15 am Welcome and Announcements
- Session I:**
Anesthesia for Cesarean Delivery - Moderator: Dr. Gurinder M.S. Vasdev
- 8:15 - 8:40 am Does Spinal Local Anesthetic Density Really Matter? - Dr. Roshan Fernando
- 8:40 - 9:05 am Epidural Failure: To Spinal or Not To Spinal - Dr. M. Joanne Douglas
- 9:05 - 9:30 am General Anesthesia for Cesarean Delivery: Update and Clinical Pearls? - Dr. Robin Russell
- 9:30 - 9:55 am Postcesarean Analgesia: Making a choice! - Dr. Brendan Carvalho
- 9:55 - 10:15 am Questions and Answers
- 10:15 - 10:40 am Break
- Session II:**
Obstetric Hemorrhage: Preparation, Prevention, and Treatment - Moderator: Dr. Errol Norwitz
- 10:40 - 11:05 am Risk factors and Therapies for Uterine Atony - Dr. Vicki Clark
- 11:05 - 11:30 am Blood Conservation Techniques in Obstetrics (Predonation, Isovolemic Hemodilution, Cell Saver) - Dr. Steve Catling
- 11:30 - 11:55 am New and Novel Methods for Treating Obstetric Hemorrhage: Factor VII to the radiology suite and beyond. (Recombinant Activated Factor VII, Interventional Radiology, Balloon Catheters, Uterine Balloon Catheters) - Dr. Alison Macarthur
- 11:55 am - 12:15 pm Questions and Answers
- 12:15 - 1:30 pm Lunch: History of Obstetric Anesthesia - Dr. Doug Bacon
- Session III:**
Non-Obstetric Surgery - Moderator: Dr. Samuel Hughes
- 1:30 - 1:55 pm Anesthesia for Assisted Reproductive Surgery - Dr. Lawrence C. Tsen
- 1:55 - 2:20 pm Non-Obstetric Surgery in the Pregnant Patient - Dr. Giorgio Capogna
- 2:20 - 2:45 pm Anesthesia for In-Utero Fetal Surgery: We've come a long way - Dr. Mark Rosen
- 2:45 - 3:05 pm Questions and Answers
- 3:05 - 3:30 pm Break
- Session IV:**
Issues Affecting Cesarean Delivery - Moderator: Dr. John Loughrey
- 3:30 - 3:55 pm Vasopressors and Fluids: Timing (Prophylactic/Treatment) and Agents of Choice - Dr. Frederic Mercier
- 3:55 - 4:20 pm Avoiding Hypotension: Are Smaller Doses of Bupivacaine or CSE the Answer? - Dr. Marc Van de Velde
- 4:20 - 4:45 pm Stat Cesarean Delivery: How quick is quick enough? - Dr. Mike Kinsella
- 4:45 - 5:05 pm Questions and Answers
- 5:05 - 5:15 pm Closing Comments

Registration Limited - Visit www.soap.org
to download registration form.

Society for Maternal-Fetal Medicine
25th Annual Meeting
February 2005 Reno, Nevada

Successful outcomes in the practice of high risk obstetrics depend on the close interaction between obstetricians, anesthesiologists, neonatologists and subspecialty physicians trained in the care of critically ill patients. Medical education and continuing medical education efforts in these areas, therefore, have to mirror this reality.

SOAP recently collaborated with a multidisciplinary group to achieve just that. The result was a well received and highly successful workshop evidenced by the fact that it was totally sold out and even over-subscribed. This is a positive direction for SOAP to pursue increasing our visibility or our footprint, so to speak, in the world of obstetric practice.

Some of the workshops that were offered and will continue to be developed for future meetings include patient simulation. This affords the participant a chance to engage in realistic scenarios, practice basic techniques and familiarize themselves with accepted algorithms. This has shown real promise and is a rapidly developing field in medical education in general, and in acute and emergency care in particular.

The success of our workshop was a testimony both to the expertise of our faculty and the patience of both presenters and participants. The program ran in tightly formatted modules over a period of four hours with no breaks in between. However, all participants completed the course with several staying back to interact with our faculty on a one-to-one basis.

I am grateful to the Society for Maternal-Fetal Medicine for their cooperation and for the foresight they have shown in recognizing the

importance of a workshop like this. We look forward to an ongoing relationship between our two Societies and similar joint endeavors. This will, no doubt, enrich both our Societies and prove to be a positive move towards improving clinical care.

The workshop initiatives are outlined below:

Patient Simulation:

Drs. Patel, Vallejo, Anderson, and Canavan

Problem-Based Learning Discussions:

- * Hypertension: Drs. Miller, Scardo, Preston, Fragneto
- * Renal failure: Drs. Brost and Garovic
- * Coagulation: Drs. MacArthur, Pruthi, Contag, Vasdev
- * Anaphylaxis: Drs. Wong, Sullivan, Walker, Yamamura

Technology Education:

- * ECHO: Drs. Rehfeldt and Watson
- * Pulmonary Artery Workshop: Drs. Afessa, Vasdev and Kamath
- * Acute Respiratory Failure: Drs. Keegan and Harrison, Mr. Holets

Acknowledgment

I would like to thank the individual presenters, their department chairs and institutions but for whose support this workshop would not have been possible.

Respectfully,

Gary Vasdev, MD

Croatia Trip Team Photo - see article on page eight



Members of the International Outreach Group visiting Croatia are from left to right: Ashraf S. Habib (USA), John R. Schultz (USA), Naomi Kronitz (Canada), Lydia Grondin (USA), Laura McGarrity (Scotland), Susan Christmas (USA), Terry D. Bogard (USA), Medge D. Owen (USA), Phillipe Gautier (Belgium), Anna (our tour guide), Margaret M. Sedensky (USA), Amanda Baric (Australia), David M. Levy (England), Paul Gibson (Canada). Not pictured: Patricia Dalby (USA).

**You still have time to submit your abstract for
the SOAP 38th Annual Meeting.
The abstract submission deadline is January 6, 2006.
Again this year, abstracts for Case Reports will be accepted.
Visit www.soap.org for instructions and submission link.**

CON – *continued from page seven*

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SOAP Media Award

The Publications Committee is soliciting nominations for the SOAP Media Award. The award will be given to the piece from the print or broadcast media that best represents the specialty of obstetric anesthesia to the general public. This award will be presented at the Annual Meeting. Please send your nominations via email to soaphq@soap.org.

SOAP Future Meetings

**SOAP 39th Annual Meeting
Fairmont Banff Springs
"Castle in the Rockies"
Alberta, Canada
May 16 - 19, 2007**

**SOAP 40th Annual Meeting
Renaissance Chicago Hotel
Chicago, Illinois
April 30 - May 4, 2008**

**SOAP 40th Annual Meeting
Renaissance Washington DC Hotel
Washington, DC
April 29 - May 3, 2009**

**New This Year – International Scholar
Registration for the
SOAP 38th Annual Meeting**

Attend the Meeting for only \$250.00

Qualifications: Must be first time attendee to SOAP Annual Meeting and must reside outside the United States (applies to the first 25 registrants only).

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