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Spring 2002 Newsletter

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President's Message

SOAP To Honor Our Founders at Annual Meeting

On January 29th I gave birth to twins via scheduled cesarean delivery. As I lay on the operating room table with left uterine displacement, after drinking sodium citrate and receiving a spinal anesthetic expertly placed by my friend and colleague Jodie Buxbaum, M.D., I experienced a moment of extraordinary gratitude to all of the obstetric anesthesiologists who had contributed to making this a completely routine and uneventful procedure. The 2002 Distinguished Service Award will honor six physicians who had the foresight and perseverance to create an organization that would facilitate intellectual exchange among obstetric anesthesiologists.

On May 25, 1968 six visionary anesthesiologists with a love for obstetric anesthesia met at Chicago's O'Hare International Airport to discuss the formation of an obstetric anesthesia interest group. The "Chicago Six" were Robert D. Bauer, M.D. (University of California at Los Angeles), Richard B. Clark, M.D. (University of Arkansas at Little Rock), James O. Elam, M.D. (Chicago Lying-In), James A. Evans, M.D. (Emory University), Robert F. Hustead, M.D. (Johns Hopkins), and Bradley E. Smith, M.D. (University of Miami). In January 1968 Dr. Elam had formally proposed the idea of this society to Dr. Otto Phillips, the outgoing chairman of the ASA's Committee on Obstetrical Anesthesia. Dr. Elam suggested that the interest group would provide "education of physicians and nurses on the safe practice of obstetric anesthesia..., (education of) the public on their right to receive the best possible care…, (stimulation of) the intellectual development of OB anesthesia…, (and fostering) proper…fee schedules for obstetrical and neonatal care". In October 1968 Dr. Smith became chairman of the ASA Committee on Obstetrical Anesthesia and it fell to him to implement the goals of the O'Hare group.

In October 1968, an informal meeting was held in conjunction with the annual ASA convention. All persons known to be interested in obstetric anesthesiology were invited. During the next few months much discussion ensued about whether or not this group should be independent or formally affiliated with either the ASA or ACOG. After just a few months the decision was reached to establish an independent organization. Dr. Smith observed in a letter to Dr. Evans "the ASA has no provisions for associating in any way with independent groups of any nature". The first formal meeting of this new group was organized by Dr. Robert Hustead and held in September 1969. During this meeting, attended by approximately 60 physicians, it was resolved that a new organization had been born and that it should tentatively be called the Society for Obstetric Anesthesia and Perinatology.

The second meeting was held the following September in Nashville, hosted by Dr. Smith. At the first formal business meeting of the society a committee was charged to create bylaws for the organization. Dr. Smith assumed the position of President and Dr. Evans that of Secretary for the year of 1970-71. The 1971 meeting was held in Atlanta in April. The Emory University Departments of Anesthesiology, Gynecology and Pediatrics sponsored this meeting, hosted by Dr. Evans. The "What's New in OB Anesthesia" lecture, delivered by Drs. Sol Shnider and Paul Poppers, debuted at this meeting. Bylaws

were approved and SOAP was up and running.

As we look forward to the 34th Annual Meeting of SOAP I hope that every member will make an effort to attend and join the Board of Directors in presenting the 2002 Distinguished Service Award to our Founders. Drs. Clark, Hustead and Smith will be in attendance and Ms. Cybill Evans Hunt will accept the award for her father, Dr. Evans, who passed away in January. Drs. Bauer and Elam will be honored posthumously. These individuals gave birth to an organization that has had tremendous impact on the safety and quality of care delivered to mothers and babies for the last three decades. By fostering a uniquely supportive environment for the exchange of ideas our founders have created a legacy that will benefit our patients and the professional development or our members for decades to come.
Acknowledgement: Thanks to Dr. Smith for providing me with the manuscript from which the historical information was taken.

Valerie Arkoosh, MD
President

Treasurer's Report

I recently received the financial report from our accounting firm, Goodman and Company, LLP. Although I plan to present the actual numbers at the Hilton Head business meeting along with comparison figures from the year before, I would like to summarize a few points now.

• Although investment income from the year was less than the year before - not surprising in the current climate - we still grew overall.

• While a great many of our operating expense items were less than the previous year, website expenses, increased bank fees, and accounting fees were up. The upshot is that cumulative operating expenses increased $1287 from the year before. Given the overall expense budget, this is a nearly flat change.

• The bottom line is that we grew; modestly, but we grew from the year before. The drop in membership dues and stock market situation kept our revenue growth slight. Coupled with a slight decrease in overall expenses, our net assets at the end of our fiscal year came to $554,414.

With an economic recovery projected for this year, we should see our investment income improve. Our investment portfolio is well diversified and I think that was made evident by the fact that we did not suffer large investment losses like so many others.

Beyond our investments, we need to promote membership and attendance at the annual meeting in Hilton Head. Current registration looks to be ahead of last year, which is great news so I'm hopeful that we'll meet all our budget predictions. However, please remember that one of the ways you can make this meeting a success is to stay at the host hotel. In the last newsletter I wrote about a budget-busting assessment called an **attrition fee**. This is the fee assessed by the host hotel when a meeting does not fill a guaranteed number of rooms for the meeting. The fee can be very large and wipe out any profit. Please keep this in mind when making accommodations for the meeting. If you are having troubles with the hotel, please contact Ruggles.

I look forward to seeing all of you at Hilton Head and hope you will attend the business meeting for a complete Treasurer's report.

McCallum R. Hoyt, MD, MBA
Treasuer

Dear Dr. Wlody,

I recently read the SOAP newsletter, which had been forwarded to me because it had the article by Penny Simkin regarding the presence of the doula at the mother's side during a surgical birth. I was very pleased to see that you included it for your subscribers so they can consider the "whole" person's/patient's needs during a time of great worry and stress and thus mitigate any negative impact the event can have. I know anesthesiologists have the best interests of the client close to the heart.

I then, of course, continued to read the rest of the newsletter and am writing to you about my concerns regarding the "pro" and "con" letters discussing "Combined Spinal-Epidural Technique Should be offered to All Laboring Parturients" (CSE). The "pro" letter was disturbing to me because of the phrase "offered to all laboring parturients" and the seemingly cavalier way "transient fetal bradycardia" was glossed over.

The "con" letter was more reassuring in that "transient fetal bradycardia" was explored in more detail, including a statement for more research about the risks and advocating caution in the use of CSE. I was also pleased that the writer took a more reserved stance about the offering of CSE anesthesia to all laboring clients and included the phrase "those that ask for it". The concluding sentence "At this time, therefore, we should not offer CSE labor analgesia to all routine laboring parturients" is one that has my whole-hearted support.

My question is: Has there been discussion in this newsletter about the value of a woman's labor reaching it's natural conclusion without the use of medication for anesthesia and recognition of her subsequent empowerment?

In the light of the debate about making CSE available to "all parturients", I think this is a necessary discussion for anesthesiologists. I wonder if practitioners who offer OB anesthesia also have studied and educated themselves about the "normal", unmedicated birth process and the psycho-social-emotional-spiritual benefits of such a birth. Are such births observed during the clinical training for

anesthesiologists?

I am among the first to recognize the value and benefits of OB anesthesia. Thanks heavens for its availability when it is needed! However, I ask the above question from a variety of viewpoints: as a woman, mother, health care consumer, nurse, childbirth educator and doula.

Thank you for taking the time to read my letter and consider my question.

Sincerely,

Kris Avery, RN, BSN, LCCE, CD(DONA)

RESEARCH COLUMN

The Research Committee of SOAP, in an effort to assist members in conducting and evaluating research in obstetric anesthesia, presents this column. If you have ideas, suggestions, or questions for future topics, please write, phone, fax, or E-mail me:

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Medical Literature On The Web: A (Very) Short Introduction

Back in prehistoric days, 1991 or 1992, I (RS) remember being very excited that because of some Columbia University agreement, for less than $20/month I could get access to MEDLINE searches from a dial-up connection to a service called BRS/Colleague. I could print the output, and after a while even figured out that I could save the output to text files. I was one of the first members of the Department to use the service. The ability to do a quick literature search from the lab (not yet from the "bedside" or clinical environment of course) was, for its time, an incredible convenience and advance over the searches done for us by the librarian, or the rudimentary searches available at library terminals.

Over the past 10 years the Internet has developed into a vast and flexible tool to access information on medical progress; scarcely a day can go by now without our resorting to some accessing of professional information using a computer. The Internet has the means to store large amounts of information for rapid access and to serve as a medium for publications of major importance while bypassing the delays of printing and distribution. While the majority of medical research reaches the Internet after a process of peer-review, it also provides researchers and theorist the opportunity to publish bypassing the reviewing process. This leads to even speedier spread of ideas, but leaves the reader with the responsibility for critical thinking. In this article, we will (*very briefly*) discuss some of the resources available for obtaining useful medical information on the internet. Obviously, we will barely touch the surface of such an immense body of information here, but we hope that a few new ideas or websites will be presented.

The most popular website for medical literature search is PubMed (http://www.ncbi.nlm.nih.gov/PubMed/) a site maintained by the National Library of Medicine. It is an

Internet-based MEDLINE database search of peer-reviewed journals from 1966, and it is free (actually, taxpayer supported, so don't feel guilty, you do support it!) Literature searching is based on basic MEDLINE principles: it uses the terms given for search and MEDLINE keyword MeSH (Medical Subject Heading) search. A useful option is the Related Articles option (to the right from the article title), which will produce all papers related by MeSH-keywords. One caveat is that as default the papers start from the year of publication of the reference article rather than the current year and you may have to scroll for pages before finding more current references. Journals with on-line access are linked to the website. Some of these journal sites may require logon and password (see below). Some keywords are linked to books. However these are mainly basic science texts and serve as refreshers in molecular biology rather than useful comments from major medical textbooks. Although the use of PubMed is pretty straightforward (much smoother than the old MEDLINE was) there is a small tutorial linked to the website if you need any further help. An alternate access is via biomednet (www.biomednet.com), which has numerous links to journals and texts, too.

An even easier way to navigate through PubMed is to access it through the bibliography and footnoting program EndNoteâ (ISI ResearchSoft, Berkeley, CA; (http://www.endnote.com). While this software is not inexpensive ($239.95 for a downloadable copy, $299.95 for the CD) it may be the most useful single piece of software I (RS) have ever purchased. It was originally written for and used for bibliography/footnote creation in manuscripts, and is indispensable for that purpose, but searching PubMed via EndNoteâ is vastly more useful than a standard browser-based search. The search strategy is entered in the EndNoteâ program, and the results appear in an EndNoteâ library, which is completely transferable, in whole or in part, to your own computer for storage, printing, or further selection and classification. Free demo versions (Macintosh or Windows) are available through the company website.

As far as searching on the Internet for actual journal and book contents, major publishing houses have different policies on public access. Some like Springer (http://link.springer.de/ol/medol/), Blackwell Science/Munksgaard (www.blackwell-synergy.com) and Elsevier (www.sciencedirect.com) have more or less free access to their publications and provide a search engine to help the reader. Many others, including the publishers of most of the commonly cited clinical anesthesiology journals have restrictions, often limiting online access to subscribers to the printed versions. Most academic libraries have a list of journals available on-line to the faculty and students of the institution. This may give you access to journals not open to the public (e.g. non-accessible from your computer at home). As mentioned above, the journals you subscribe to probably offer websites with access for subscribers only. Activate your online subscription. This will allow you to access papers from any computer terminal with an Internet connection (for initial activation you usually need your subscription number). If you come across a paper in a journal (of obstetric interest for example) which demands membership for on-line access, one of your specialist colleagues may have a subscription and may be able to log you in.

The Web has a large number of sites containing medical information. Some are commercial while others are maintained by institutions, enthusiastic professionals or governments. In general commercial sites tend to address the lay public and have little valuable clinical information (very useful though if you need well organized material for patient education). Simply taking material off websites and using it for your

own purposes may involve issues of copyright infringement, but many of these sites are pleased to give permission to use their material for educational

purposes (often that is their purpose), asking that credit be given to the site or authors. If you need information on drugs the best sites are those maintained by governments or independent non-profit bodies (it should come as no surprise that drug company sites *may* be biased, and commercial sites are usually very superficial). My (IR) favorite is a website from New Zealand (www.medsafe.govt.nz/search.htm), which is concise and thorough. Numerous sites cater to the interest of anesthesiologist. GASNet (Global Anesthesiology Server Network) is probably the best known. However, while surfing the web you will come across numerous very useful and interesting sites such as the ASA Closed Claims Project website (www.asaclosedcalims.org) which provide you with quality reviews of important topics.

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SOAP Meeting Update:

SOAPERS: I hope you are packing your bags and making reservations for our great meeting on Hilton Head Island. Latest weather forecast — a beautiful 80ºF daytime temperature and 68ºF evening temperature. Almanac predicts < 10% chance of rain during the meeting period.

Pack your bags with beach wear and suntan lotion; enjoy great golf, tennis, and outdoor activity before and after the meeting. Our dress code will be resort casual for the duration of the meeting.

Please remember to sign up for the neonatal life support class. We need to close this two weeks prior to the meeting to get the education material to all participants. Whether you are directly involved in neonatal resuscitation or not, the OB anesthesiologist is the person people turn to when there is an obstetrical neonatal disaster — familiarize yourself with the art of neonatal resuscitation. This course is designed to be maximally beneficial with no stress. You will enjoy this immensely, and it is an excellent documentation for professional development.

The airway course has a variety of ventilation, visualization and surgical intervention devices. ENT surgeons will be present to demonstrate and participants will practice surgical airways. Soap will issue a special CME certificate for the difficult airway workshop.

Our meeting is the largest in the recent history of SOAP. We have reviewed all the suggestions and recommendations, summarized the last two meetings, and attempted to satisfy all the suggestions made by our members. Refresher courses and parallel sessions have been included. Your review of this meeting is critical to the future development of our society. In keeping with our vision, SOAP is a society for its members; please remember to turn in your evaluation. Change can only be achieved by documented, validated data. Your honest appraisal of the meeting is vital. If you feel you would like to discuss the meeting with me directly, please call (507-284-9695) or e-mail (vasdev.gurinder@mayo.edu).

Association Travel Concepts (ATC) has been selected as the official travel agency for SOAP's 34th Annual Meeting in Hilton Head, May 1-5, 2002. ATC has negotiated discounts with US Airways and Alamo Rental Car to bring you special airfares and car rental rates that are lower than those available to the public. When calling ATC, you will save 10% to 15% off on US Airways Airline tickets purchased more than 60 days prior to the meeting. For tickets purchased less than 60 days prior, the discounts will be 5% to 10% off of the lowest available fares. Some restrictions may apply and a service fee may apply. ATC will also search for the lowest available fare on ANY airline serving Hilton Head or Savannah.

ATC provides personalized service, advance seat assignments, special meal requests on airline flights, frequent flier programs, electronic ticketing, and E-mail access for convenient booking of your tickets. To take advantage of these great rates and personalized service, call: ATC: Phone 1-800-458-9383; Email: atc@assntravel.com; on the web at <www.assntravel.com> or Fax: (858) 581-3988. ATC is available for reservations from 9:00 am until 8:30 pm Eastern Standard Time, Monday through Friday.

You may also call your own agency or the vendors directly and refer to the following I.D. numbers listed:

US Airways: 63162109 877-874-7687
Alamo: 72620 GR 800-732-3232

I hope you have a safe journey. This will be a landmark meeting where we will honor the Founding Fathers of OB anesthesia. I look forward to meeting you in Hilton Head. I will be available at any time for assistance to the members regarding their trip to our annual meeting. Please call or e-mail.

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Journal Update

American Journal of Obstetrics and Gynecology

July-December, 2001

Progress of labor and risk of cesarean section

Sheiner E, Shoham-Vardi I et al. ***Infertility treatment is an independent risk factor for cesarean section among nulliparous women aged 40 and above.*** *Am J Obstet Gynecol* 185:888-92, 2001.

The investigators analyzed the deliveries of 115 nulliparas aged >40 years with singleton gestations. There were 80 spontaneous pregnancies, and 35 were the result of infertility treatment. The women treated for infertility were more likely to deliver low birth weight (<2500 g) infants (34% vs. 10%). There were no differences in obstetric risk factors or labor characteristics between the two groups. Interestingly, the use of epidural analgesia was not mentioned in the study. Cesarean section was more likely in the infertility group (71.4%) than in the spontaneous pregnancy group (41.3%). The authors suggest that decision making in this setting is influenced by anxiety about the outcome of what is often referred to as a "precious pregnancy".

Ecker JL, Chen KT et al. ***Increased risk of cesarean delivery with advancing maternal age: indications and associated factors in nulliparous women.*** *Am J Obstet Gynecol* 185:883-7, 2001.

3715 term nulliparous term deliveries were identified at the Brigham and Women's Hospital over a 12-month period. Patients were classified into four age groups (<25, 25-34, 35-39, ³40). The rate of cesarean delivery rose continuously from 11.6% in women <25years old to 43% in the oldest age group. A portion of this increase was due to cesarean section performed prior to the onset of labor, for such indications as prior myomectomy and malpresentation, conditions likely to increase with increased maternal age. The authors make note of the fact that there is limited support in the literature for elective cesarean section in women with a previous myomectomy. Older women were more likely to undergo induction of labor, and once in labor older women were more likely to be diagnosed with failure to progress or fetal distress. These authors, like those of the previous study, make mention of the possible role of physician anxiety in the decision to perform cesarean section in older patients.

Chauhan SP, Magann EF et al. ***Mode of delivery for the morbidly obese with prior cesarean section: vaginal versus repeat cesarean section.*** *Am J Obstet Gynecol* 185:349-54, 2001.

Over a two year period, the authors cared for 69 patients with a previous cesarean section and a weight of >300 pounds at their first prenatal visit. 39 underwent elective repeat cesarean section, and 30 attempted VBAC. Only 4 patients (13%) who underwent a trial of labor delivered successfully. Reasons for failure

included labor arrest (46%), fetal distress (38%), and failed induction (15%). The infectious morbidity rate was significantly higher in women who underwent a trial of labor compared to those who underwent elective cesarean (53% vs. 28%). This study has obvious implications for anesthetic practice, not the least of which is further support for the routine early placement of epidural catheters in morbidly obese patients, especially those attempting VBAC.

Zhang J, Yancey MK et al. ***Does epidural analgesia prolong labor and increase risk of cesarean delivery? A natural experiment.*** *Am J Obstet Gyneco*l 185:128-34, 2001

Over a one year period, the use of epidural analgesia for labor at a tertiary military medical center rose from 1% to 84% (!). Anesthetic technique consisted of a standard epidural (not CSE), a 3 ml lidocaine/epinephrine test dose, 8 ml bolus of 0.125% bupivacaine with 100 mcg fentanyl, and an infusion of 0.125% bupivacaine with fentanyl 2-4 mcg/ml infused at 10 ml/hour, adjusted to maintain a sensory level of T10. There were no significant changes in obstetric practice over the study period. Despite the dramatic increase in epidural use, there was no increase in the use of oxytocin augmentation, the duration of the first stage of labor, the overall cesarean section rate, or the rate of instrumental delivery. The length of the second stage was increased by 25 minutes. It would be interesting to see what would happen to the duration of the second stage if a more dilute local anesthetic infusion were used.

Lucas MJ, Sharma SK et al. ***A randomized trial of labor analgesia in women with pregnancy-induced hypotension.*** *Am J Obstet Gynecol* 185:970-5, 2001.

In this study from the University of Texas Southwestern Medical Center, 736 women with pregnancy induced hypertension (diastolic BP >90 mm Hg, no evidence of chronic hypertension) were randomized to receive either IV analgesia (meperidine 50 mg+promethazine 25 mg bolus, followed by PCA meperidine 15 mg bolus/10 minute lockout interval) or epidural analgesia (bupivacaine 0.25% boluses to achieve aT10 level, followed by an infusion of 0.125% bupivacaine with fentanyl 2 mcg/ml to "maintain analgesia". The authors felt that the validity of this study was enhanced compared with earlier studies of a similar design because of minimal crossover between treatment groups; nevertheless, 54% of patients in the epidural group considered their analgesia to be excellent, compared to 19% in the IV group, and 51% of the patients in the IV group felt their pain relief was poor, compared to 14% in the epidural group. The authors stated that the duration of labor was increased "significantly" in the epidural group, although analysis of their data showed no difference in the length of the first stage (epidural 271 minutes, IV 266 minutes) and only a slight increase in the length of the second stage (53 minutes vs. 40 minutes). The use of forceps was increased in the epidural group (14% vs. 7%), but the difference in duration of the second stage was so small that it is difficult to avoid the conclusion that the use of forceps might have been encouraged by the presence of adequate maternal analgesia. The C/S rate was the same in both groups. The authors state in their abstract that the incidence of chorioamnionitis was increase in the epidural group; in reality, this was based on an increased incidence of maternal fever in the epidural group, and not on any objective measure of maternal infection. Finally, the authors were concerned about the 11% incidence of hypotension requiring treatment in the epidural group. I think most anesthesiologists would find this an admirably low incidence of what is in most cases a minor side effect, and would contrast this with the 12-fold increase in the need for neonatal naloxone administration in the

IV group.

Fetus and newborn

Ghidini A, Spong CY. ***Severe meconium aspiration syndrome is not caused by aspiration of meconium.*** *Am J Obstet Gynecol* 185:931-8, 2001.

A finely reasoned argument for the position that the pulmonary pathology seen in meconium aspiration syndrome (MAS) is due to *in utero* injury. The authors suggest that too much emphasis has been placed on the delivery room management of infants born through meconium stained amniotic fluid. They suggest that the diagnosis of MAS should be one of exclusion, i.e. the presence of respiratory distress in infants born with meconium staining should not lead to the diagnosis of MAS until other causes are ruled out.

Schmidt B, Cao L et al. ***Chorioamnionitis and inflammation of the fetal lung.*** *Am J Obstet Gynecol* 184:173-7, 2001.

Fetal exposure to inflammatory cytokines has been shown to increase the risk of chronic lung disease. In this study, the presence of documented chorioamnionitis was linked to increased concentrations of inteleukin-8 messenger RNA in fetal lung tissue. Thus, maternal infection may play a role in newborn respiratory distress independent of other factors.

Maternal complications

Singla AK, Lapinski RH et al. ***Are women who are Jehovah's Witnesses at risk of maternal death?*** *Am J Obstet Gynecol* 185:893-5, 2001.

332 Jehovah's Witness patients had 391 deliveries over a 12-year period. Despite aggressive antepartum treatment with iron and recombinant erythropoetin, 2 hemorrhagic deaths occurred, yielding a maternal death rate of 512 deaths per 100,000 live births, a 44-fold increase compared to non-Witness patients. While it is hard to base conclusions on such small numbers, this study reinforces the need to obtain full informed consent from patient's refusing blood products. It also points out the need for maintaining a low threshold for performing cesarean hysterectomy or arterial ligation procedures in patients who refuse blood.

Guid Oei S, Kho SN. ***Arterial balloon occlusion of the hypogastric arteries: a life-saving procedure for severe obstetric hemorrhage.*** *Am J Obstet Gynecol* 185:1255-6, 2001.

A report of two cases of otherwise uncontrollable obstetric hemorrhage that serves as a reminder that interventional radiology has an important role to play in the management of these patients.

Preeclampsia

Regan CL, Levine RJ. ***No evidence for lipid peroxidation in severe preeclampsia.*** *Am J Obstet Gynecol* 185:572-8, 2001.

It has been suggested that the production of oxygen free radicals plays a role in the development of preeclampsia. In this study, urinary concentrations of a specific, chemically stable breakdown product of free radical-catalyzed lipid peroxidation reactions were measured in severely preeclamptic women, and were found to be no different from controls. The authors argue that the lack of evidence for oxidative stress in severe preeclampsia would suggest that studies of antioxidant treatment in preeclampsia are unlikely to be fruitful.

David J. Wlody, MD
Editor

The Gertie Marx Symposium: Celebration of a life in obstetric anesthesia

In celebration of her 90th birthday, Dr. Gertie Marx was honored at a Symposium held in her name at the New York Academy of Medicine on February 20, 2002. Organized by Dr. Ingrid Hollinger of Albert Einstein College of Medicine and Alan Santos of St. Luke's-Roosevelt Medical Center, the meeting was attended by many friends, colleagues, and former residents of Dr. Marx.

After cocktails and hors d'oeuvres, the scientific program began with an introduction from Dr. Mike Finster, who eloquently touched on the life and many contributions of Dr. Marx. Dr. Irwin Merkatz, Chair of Obstetrics and Gynecology at Einstein, spoke of his long association with Dr. Marx.

The scientific program speakers included Dr. Gerard Bassell of the University of Kansas, who discussed anesthesia-related maternal mortality, an area in which Dr. Marx has contributed enormously through her tireless efforts to promote regional anesthesia. Next, Dr. David Birnbach of St. Luke's-Roosevelt Medical Center spoke on new developments in obstetric anesthesia, with special emphasis on the combined spinal-epidural technique. Dr. David Wlody of the State University of New York-Downstate Medical Center discussed the prevention and management of post-dural puncture headache. Finally and most memorably, Dr. Marx was kind enough to deliver a brief address to the audience.

The evening's festivities closed with dinner and, of course, a birthday cake. I know I speak for all the attendees when I say that it was a great pleasure to be able to pay homage to someone who has given so much to our specialty and to pregnant women around the world. Happy birthday, Gertie, and many more!

David J. Wlody, MD
Chair, Publications Committee