

President's Message: Accomplishments and Goals



Robert D'Angelo, M.D.
Wake Forest University
President, SOAP

Greetings fellow SOAP members! It seems like a short time ago that I attended my first SOAP meeting, instantly fell in love with the family-like atmosphere of the society, and vowed to perform clinical research to "guarantee" my ticket to each annual meeting. Flash forward 17 years and now I begin my term as President. It is truly a humbling experience. Once again, thank you for this amazing opportunity.

I would like to take this opportunity to briefly share with you my perspective on SOAP's current state of affairs. In short, SOAP is growing up! We are moving from a small "do the best that you can with what you've got" organization to becoming a professional society. Past president Gary Vasdev had the foresight to

charge a Strategic Planning Committee with creating a path for the society's future. The planning process took nearly two years, was inclusive, and well worth the effort. The result was the creation of a clear path that outlined where SOAP was, where we wanted to be, and how to get there. Short- and long-term goals were developed

in the areas of member benefits, education, research, outcomes, outreach, and financial vitality. Although many strategic initiatives utilized existing SOAP committee resources, successfully achieving all goals necessitated the creation of new committees such as the CME, Resident Affairs, and Legacy Committees.

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Current Society activities directly related to the strategic plan include:

- An enhanced website that is very much a "work in progress";
- Increased transparency through newsletters and e-blasts;
- Development by the Education Committee of educational materials of interest to members;

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President's Message

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- SOAP management of the Sol Shnider Obstetric Anesthesia Meeting;
- Enhancement of the Annual Meeting program to include clinical sessions, outside speakers, a resident forum, a fellow reception, and the Gertie Marx/ FAER Education Lecture;
 - As an aside, the 2010 Sol Shnider and SOAP Annual Meetings were arguably two of the best obstetric anesthesia meetings ever! Not only is SOAP expanding its meeting offerings, but is doing so without compromising quality;
- A special focus targeting fellows and residents in an attempt to increase membership long-term;
- Work by the Research Committee to design a multicenter trial as proof of concept with the goal of forming an Obstetric Anesthesia Research Network;
- Completion of the Serious Complication Registry project; and
- Fiscal responsibility and maintenance of a strong balance sheet with a healthy short-term reserve, resulting in:
 - Creation of a SOAP Research Grant by the Disbursement Committee
 - Strengthening of relations with the Japanese Society of Anesthesiologists, the OAA, and Kybele.

“SOAP is bigger, SOAP is better, and yet it hasn't lost that special feeling.”

Personal goals I have set for the coming year include:

- Ensuring the Society stays on the path to achieve its Strategic Goals;
- Developing the next phase of the complication repository to include a web-based interface;
- Exploring technology options that will enhance the website such as podcasts, webinars, and snippets;
- Ensuring continuity by including the President Elect, 1st VP, and 2nd VP in all decisions and communications;
- Being accessible; Please do not hesitate to contact me with questions or concerns at: rdangelo@wfubmc.edu; and
 - When my term ends, leaving the Society at least a little better off than when I began.

During the May, 2010 Board of Directors meeting, each member was asked

to list one achievement SOAP had made in the past year. Every single comment clearly described proactive steps taken to achieve a common goal. SOAP has a vision and is on the right track to achieve it. It is a privilege to be part of the process.

In closing, during a conversation I had with past president Charlie Gibbs in San Antonio, he made a comment that was music to my ears by saying “Bob, I don't know how you've done it but, SOAP is bigger, SOAP is better, and yet it hasn't lost that special feeling. Keep up the good work.” Thank you, Charlie, I couldn't have said it better myself.

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working to decrease maternal
and neonatal morbidity and
mortality worldwide**

Visit www.kybeleworldwide.org to
learn more about current
Kybele projects/plans.

*If you have ideas regarding
educational or patient safety related
topics for newsletter articles, please
contact SOAPeditor@gmail.com.*

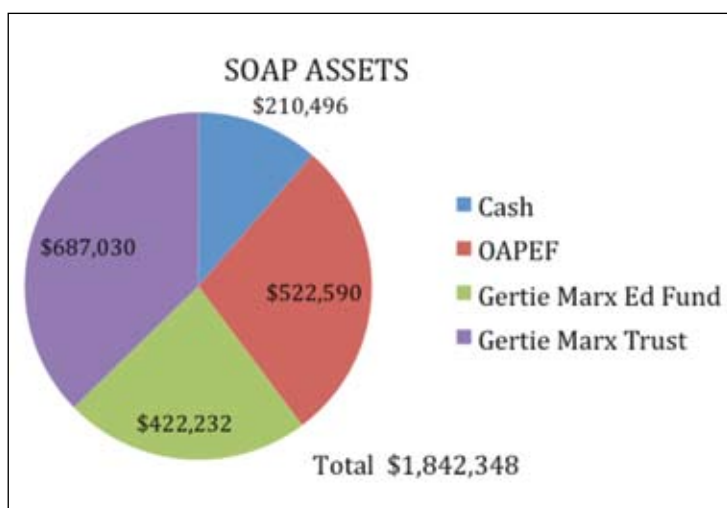
Treasurer's Report



John T. Sullivan, M.D., M.B.A.
Northwestern University
Treasurer, SOAP

I am pleased to report that SOAP's general financial status at end of 2009 was favorable. Our society's financial goals are the responsible stewardship of our members' assets, establishment of a healthy cash reserve and the funding of sustainable,

quality education and research programs. Our society's financial position has improved over the last year due to a very successful annual meeting in Washington D.C. in April of 2009, an increase in annual dues revenue, reduction in administrative expenses and partial recovery of the financial markets.

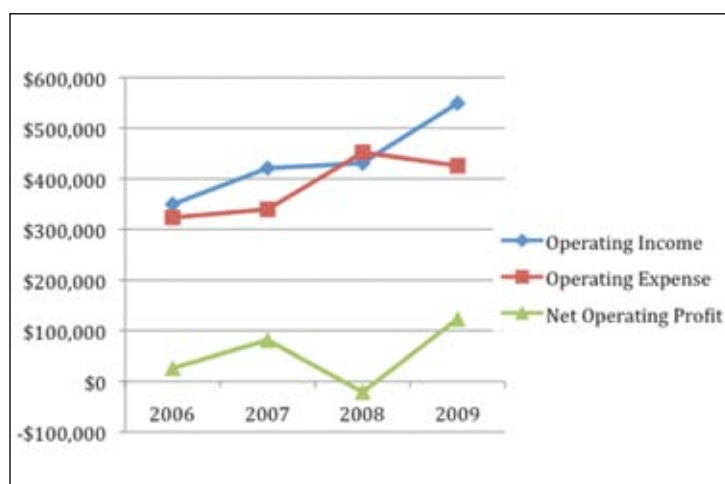


	FY07	FY08	FY09
Year End Net Assets	\$1,885,441	\$1,403,970	\$1,842,348
Change from Previous Year		(\$481,471)	\$438,378

OPERATING CASH FLOW

SOAP generates revenue through membership dues, meetings and a small amount of external support. Trends over the last four years reflect a general increase in dues and meeting income with more modest increases in expenses. Most importantly, the overall operating loss for 2008 has been reversed.

	FY08	FY09
Dues	\$99,058	\$192,233
Annual Meeting	\$324,076	\$351,863
Miscellaneous	\$7,917	\$5,000
TOTAL INCOME	\$431,051	\$549,096
Admin Expenses	(\$126,043)	(\$154,845)
Annual Meeting Expenses	(\$325,897)	(\$283,079)
TOTAL EXPENSE	(\$451,940)	(\$437,924)
GAIN/(LOSS)	(\$20,889)	\$111,172



ANNUAL MEETING 2009 (Washington, D.C.)

The annual meeting in Washington D.C., hosted by Bob Gaiser, M.D., was financially successful with high attendance and relatively low expenses. The meeting was also profitable despite the lowest level of industry exhibitors in recent years, presumably due to the uncertain economic climate in the months preceding the meeting.

ANNUAL MEETING	FY06 (Hollywood)	FY07 (Banff)	FY08 (Chicago)	FY09 (Wash. D.C.)
Revenue	\$226,300	\$301,647	\$324,076	\$351,863
Expenses	(\$192,681)	(\$279,618)	(\$325,897)	(\$281,844)
Gain/(Loss)	\$33,619	\$22,029	(\$1,821)	\$70,019

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COMMITTEE REPORTS

ASA Committee on OB Anesthesia: Implications of Health Care Reform



Craig Palmer, M.D.
University of Arizona Health
Sciences Center
Chair, ASA Committee on
Obstetric Anesthesia

The march toward “health care reform” continues, and with it have come a number of unforeseen consequences for anesthesiologists. Two of these deserve particular mention. First, as mentioned in the Report

from the Economics and Governmental Affairs Committee, in December 2009, just before the holidays, the Centers for Medicare & Medicaid Services, issued new “Revised Hospital Anesthesia Services Interpretive Guidelines”, clarifying provision of anesthesia services in the State Operations Manual (SOM) Appendix A for 42 CFR 482.52. Essentially CMS and the federal government redefined what anesthesia is... seriously! Page 2 of the 18 page document reads:

“During labor and delivery, the provision of acute analgesia (i.e., relief of pain, via an epidural or spinal route) is not considered ‘anesthesia,’ and a CRNA administering these forms of anesthesia services does not require supervision by the operating practitioner or anesthesiologist. However, if the operating practitioner decides that an anesthesia effect (loss of voluntary and involuntary movement and total relief of pain) is necessary for a safe operative delivery of the infant, then the CRNA supervision requirement would apply.”

Most of you reading this newsletter have spent a considerable portion of your professional careers administering epidural and spinal anesthesia to parturients for both labor pain relief and surgical anesthesia. Although we often refer to “low-dose” labor techniques as “analgesia,” it seems obvious that if you use the same medications, via the same route, acting in the same manner, on the same pathways, then you are describing a single entity.

Another portion of the guidelines states:

“In contrast, ‘analgesia’ involves the use of a medication to provide relief of pain through the blocking of pain receptors in the peripheral and/or central nervous system. The patient does not lose consciousness, but does not perceive pain to the extent that may otherwise prevail.”

Anyone who can tell me exactly what “receptors” this statement refers to will win a fabulous prize as yet to be determined! Winners announced in the next edition of the Newsletter.

A second troubling issue for anesthesiologists is the inclusion, in the recently passed omnibus health reform bill, of so-called “non-discrimination” provisions which seek to elevate the position of paraprofessionals in the health care marketplace by prohibiting health plans from appropriately differentiating between those paraprofessionals and physicians. This is merely the latest in a long series of attempts by many, including nurse anesthetists, to obtain by legislation the status and standing which they can’t

gain through education and training. You can do your part to change this: I urge every SOAP member to contact their elected representatives and ask them to support the bipartisan house bill, H.R. 5295, the “Healthcare Truth and Transparency Act of 2010” (<http://www.asahq.org/news/asanews051310.htm>), which prohibits “... misleading and deceptive advertising or representation in the provision of health care services, and (requires) the identification of the license of health care professionals.”

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On a clinical note, the ASA’s House of Delegates last October approved the “Practice Advisory for the Prevention, Diagnosis, and Management of Infectious Complications Associated with Neuraxial Techniques.” I encourage everyone who performs spinal and epidural techniques to review these important guidelines; neuraxial infections, while uncommon, can be devastating for both the patient and the anesthesiologist. Yet they are usually preventable by adherence to simple aseptic technique.

COMMITTEE REPORTS

Economics and Governmental Affairs Committee: Action on CMS Revised Guidelines



*Curtis Baysinger, M.D.
Vanderbilt University
Medical Center
Chair, SOAP Economics and
Governmental Affairs Committee*

On December 11, 2009, the Centers for Medicare & Medicaid Services (CMS) issued revisions to their hospital interpretive guidelines regarding anesthesia services (S&C-10-09-Hospital). These revisions

contain three elements of particular importance to SOAP members who practice in the United States:

1. Certified registered nurse anesthetists are specifically permitted to administer epidural labor analgesia without physician supervision;
2. All anesthesia services provided by a hospital (including analgesia services) must be organized into one department, which must be headed by a physician, and must develop institution-wide policies and procedures for anesthesia services; also, CMS mandated that hospital bylaws must include privileging criteria for anesthesia providers; and
3. Postanesthesia evaluations must be conducted within 48 hours of any surgery involving general, regional or monitored anesthesia care; this third element will most often pertain only to anesthesia for cesarean delivery, as procedures for labor and vaginal delivery will most often be categorized as “analgesia,” not “anesthesia.”

The implications of allowing neuraxial labor analgesia to be administered without physician supervision prompted this Committee to research and formulate rebuttal arguments which Past President Lawrence Tsen used to draft SOAP’s response letter to CMS. The letter, sent late February 2010, emphasized that the safety of both mother and fetus was potentially at risk. CMS’s ruling could make immediate physician intervention, necessary to treat the complications associated with the administration of neuraxial analgesia, or due to the rapidly changing nature of labor requiring emergency operative delivery, less likely. To reduce the physician role in anesthetic care when obstetrical patients are growing more complex seems unwise; ironically, the CMS rule changes came just before the Joint Commission’s January 2010 Sentinel Event Alert suggested that hospitals

take specific steps to address the increase in maternal morbidity/mortality that is associated with increasing numbers of more complicated obstetrical patients.

In addition, the ASA sent a letter to CMS dated January 18, 2010. This letter noted that CMS chose a position at odds with ASA’s Guidelines for Regional Anesthesia in Obstetrics (published, 2007). Both SOAP and ASA have recently received responses to their letters from CMS, the content of which will be reviewed by the leadership of both organizations. SOAP members will be able review SOAP’s response letter to CMS when it becomes available and ASA members of SOAP can review ASA’s response, a copy of the CMS guidelines, as well as ASA’s summary of the CMS guidelines on the ASA website in the Members Only section.

Despite the potential problems created by the first element noted above, the second element gives SOAP members the opportunity to formulate the policies and procedures for anesthetic care within an institution, **including those that govern the supervision of analgesia**, as well as establish the privileges of personnel allowed to administer anesthesia and analgesia. SOAP urges all members to become participants in policy establishment within their institutions.

“The implications of allowing neuraxial labor analgesia to be administered without physician supervision prompted this Committee to research and formulate rebuttal arguments which Past President Lawrence Tsen used to draft SOAP’s response letter to CMS.”

To assist SOAP members, I am available to answer questions at curtis.l.baysinger@vanderbilt.edu. ASA members of SOAP can refer to the Members Only section of the ASA website to review templates on how best to meet the new CMS guidelines. In addition, this Committee will begin initiatives that emphasize the importance of obstetric anesthesia to national women’s organizations and to investigate use of ASA’s Vital Health Campaign to achieve increased public awareness of obstetric anesthesia. SOAP members can become more involved in legislative issues through PAC memberships, direct involvement in candidates’ campaigns, and participation in ASA’s Grassroots Campaign, applications for which are available on the ASA website.

COMMITTEE REPORTS

Research Committee: Plans for the Future



*Richard Smiley, M.D., Ph.D.
Columbia University
Medical Center
Chair, SOAP Research Committee*

Abstract Submission/ Grading

The Research Committee is responsible for evaluating and scoring the research abstracts submitted for the Annual Meeting. Decisions about which abstracts are accepted and which are

presented orally at the general sessions are based on these scores, so we take this responsibility very seriously. For the 2010 Annual meeting, we increased the number of reviewers per abstract from the previous 3-4 to 6-8. We hope that by increasing the number of reviewers for each abstract the scores will be more fair and less subject to the particular preferences or opinions of one reviewer. This year, the Committee reviewed 145 research abstracts, each reviewer handling 50-60. Approximately 150 case report abstracts were reviewed by the Education Committee. There were some problems with the abstract submission website this year that we will try to fix for next year, especially a lack of the option to “save” a partially completed abstract. I welcome (and have received) comments on ways to improve the site and process; Contact me at rms7@columbia.edu.

Research Funding

This will be the inaugural year for the *SOAP/Gertie Marx Education and Research Grant*, an award of up to \$50,000 for a two-year project. As Chair of the Research Committee, I will be appointing members of the Committee, and possibly (depending on the subject matter of the proposals) outside reviewers to evaluate the grant submissions, much like NIH Study Sections, and report back to the Disbursement Committee and on to the Board of Directors. Deadline for submissions is September 1st, and we will announce the award at the ASA meeting in October.

Multi-Center Study Network

It is a major goal of SOAP to establish a multi-center research network capable of initiating and performing clinical studies in obstetric anesthesia. After long discussions of how to initiate such an effort, our committee has decided to initiate this effort with what will be a prospective, descriptive (no prescribed intervention or randomization) study of the practices and outcomes of accidental dural punctures (“wet taps”). Over the next 6 months or so, a group of 12-18 centers will collaborate to design a reporting tool, probably internet-based, to gather standardized information on all epidural needle dural punctures, management and outcomes at all sites over a 1-2 year period. It is hoped that this effort will yield the largest database ever on the outcome of various interventions after wet tap, which will be useful in and of itself, but

perhaps more importantly, will generate testable hypotheses for a possible interventional trial, and demonstrate the feasibility of the level of cooperation and communication between obstetric anesthesia sites for studies of other

issues. While many important and difficult questions regarding organization, funding, control and governance will undoubtedly emerge, I hope that over the next few years, a true multi-center research network in obstetric anesthesia will be created that can address (and apply for funding for addressing) important questions in obstetrics and obstetric anesthesia.

“It is a major goal of SOAP to establish a multi-center research network capable of initiating and performing clinical studies in obstetric anesthesia.”

The SOAP/Gertie Marx Education and Research Grant

Deadline is September 1, 2010. Find more information at the SOAP website:

www.soap.org/2010-gertie-marx.pdf

Dexmedetomidine: A Role in Obstetric Patients?

Joanne Hudson, M.D.

Virginia Commonwealth University Medical Center

Dexmedetomidine is a second generation alpha₂ adrenergic receptor (α₂-AR) agonist which activates G-proteins to inhibit adenyl cyclase, decreasing cyclic adenosine monophosphate and reducing norepinephrine. The prototype is clonidine; however, clonidine's package insert contains a box warning against its use in regional anesthesia in pregnant patients due to the development of severe hypotension and bradycardia. Dexmedetomidine may provide advantages over clonidine as it is a complete alpha₂ agonist rather than a partial one with high selectivity for α₂-AR (1620:1 vs. 220:1 for clonidine). Dexmedetomidine acts on all 3 receptor subtypes: alpha_{2a},^a alpha_{2b},^b and alpha_{2c},^c which exist on pre- and postsynaptic membranes in the central nervous system, including the spinal cord, in spinal nerves and ganglia, and in peripheral vascular smooth muscle. Primary actions include sedation from which the patient is easily aroused with minimal respiratory depression or delirium, central and peripheral sympatholysis, and enhanced cardiac vagal activity. The requirement for opioids, other sedatives, anesthetic inhalational agents, and potent vasodilators is greatly reduced. Dexmedetomidine has neuroprotective and anticonvulsant properties; it raises the seizure threshold for cocaine seizures and attenuates sympathetic outflow, thus decreasing its lethality.

Its onset is slow and duration is prolonged. Onset after a bolus dose is 5-10 minutes and peak effect occurs in 15-30 minutes. Mean elimination half-life is 2.7 hours. Because action is prolonged, changing the dose of an infusion is recommended no more frequently than every 30 minutes. The drug is extensively metabolized in the liver and eliminated by kidneys, a consideration when these organs are compromised. Major side effects include hypotension, bradycardia and arrhythmias. Cardiac conduction abnormalities and volume depleted states represent relative contraindications. Unlike clonidine, dexmedetomidine does not produce rebound hypertension when it is abruptly stopped.

Some problems have occurred due to a biphasic response. At low concentrations (0.7 ng/ml - 1.2 ng/ml), norepinephrine is decreased by 50 percent and sympatholysis and cardiac vagal activity predominate. At higher plasma concentrations (>1.9 ng/ml), a significant increase in systemic vascular resistance and a decrease in cardiac output occur.¹ A bolus dose of 1mcg/kg can produce irregular breathing, mild hypoxemia, hypercapnea, apnea, unresponsiveness, increase in blood pressure due to increased systemic vascular resistance, and reflex bradycardia.^{2,3} Cardiac arrest has occurred.¹ Most practitioners therefore avoid a bolus dose or use a reduced dose of 0.4 ug/kg over 20 minutes.

Should the possibility of hypotension and bradycardia preclude use of dexmedetomidine in pregnancy? No more so than the use of spinal and epidurals where expectant management with fluids and vasopressors is effective. Dexmedetomidine also relaxes lower esophageal sphincter pressure and may promote reflux. Dexmedetomidine readily crosses the placenta, and may decrease fetal heart rate by direct effect as well as an indirect effect on baroreflexes. Dexmedetomidine is removed faster than clonidine from maternal circulation but is retained in the placenta due to its greater lipophilicity. The fetal/maternal ratio of clonidine is 0.89; of dexmedetomidine is 0.12. At two hours, only 12.5 percent of dexmedetomidine is found in fetal circulation compared to 22.2 percent clonidine.⁵ Placental transfer is minimal and there is no evidence of serious effects on the neonate. It is a Class C teratogen. Interestingly, dexmedetomidine at therapeutic levels is a dose-dependent uterotonic agent, increasing the frequency and amplitude of contractions.⁶

For the obstetric anesthesiologist, the slow onset and hazards of intravenous bolus dosing are disadvantageous in acute obstetric emergencies. However, sedation with minimal respiratory depression is a great advantage in sedation of the obese and those with sleep apnea. Sympatholysis and hemodynamic stability is beneficial to patients with pregnancy-induced hypertension, pulmonary hypertension, in patients using cocaine or when ketamine is contraindicated. Under general anesthesia, dexmedetomidine reduces the total anesthetic delivered to mother and fetus and produces less nausea and vomiting. Continued exploration of its use in regional anesthesia where it prolongs duration without motor block and reduces requirement for local anesthetics and opioids may prove to be of great benefit in obstetric anesthesia.

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- Palanisamy A. *IJOA*. 2009; 18: 258-261.
- Abu-Halaweh S A. *Eur J Anaesthesiol*. 2009; 26: 86-87.
- Neumann MM. *IJOA*. 2009; 18: 403-7.
- de Sousa KM. *Rev Bras Anesthesiol*. 2005; 55: 212-216.
- Toyama H. *IJOA*. 2009; 18: 262-267.
- Esmooglu A. *J Critical Care*. 2009; 24: 551-555.

SOAP 2010 Meeting Summary: Emerging Technologies in San Antonio



*Michael Froelich, MD
University of Alabama
at Birmingham*

The 42nd Annual Meeting of the Society for Obstetric Anesthesia and Perinatology (SOAP), held at the Grant Hyatt on the Riverwalk Hotel in San Antonio, from May 12 to May 16, 2010, attracted more than 650 attendees. The theme of this year's

meeting was "Emerging Technologies in Obstetric Anesthesia" featuring several innovative technology-related sessions interspersed throughout the program.



SOAP Annual Celebratory Dinner with Awards Presentations.

Preliminary activities consistent with the theme included an Advanced Airway Management Workshop directed by Drs. Suresh, Wali, and Munnur, in which participants learned about several innovations to facilitate endotracheal intubation. Concomitantly, Dr. Jose Carvalho shared his expertise in the use of ultrasound to facilitate the placement of neuraxial blocks with a very interested group of attendees. The day was concluded with a very lively welcome reception over margaritas and nachos.

SOAP President Lawrence C. Tsen, MD (Brigham and Women's Hospital) and President-elect Robert D'Angelo, MD (Wake Forest University) opened the meeting on Thursday morning, along with meeting host Manny Vallejo, MD (University of Pittsburgh). The opening was followed by the Gertie Marx Research competition (table 1), open to residents, fellows, and medical students performing independent research. Of the six abstracts presented, Neeti Sadana, MD from the Brigham and Women's Hospital won

the first prize for her excellent presentation on a comparison of traditional versus new transfusion protocols for obstetric hemorrhage. Based on her work using thromboelastography, Dr. Sadana concluded that the ratio for the administration of red blood cells to fresh frozen plasma should be 1:1 rather than 3:1 as traditionally advocated.

Dr. Valerie Arkoosh, MD MPH (University of Pennsylvania) then presented the Distinguished Service Award to Mark A. Rosen, MD (University of California San Francisco) for his unique contributions and dedication to the subspecialty of Obstetric Anesthesiology (table 2). This was followed by an informative and thought provoking Pro/Con debate entitled " Lumbar Ultrasound: Useful Gadget or Time Consuming Gimmick? "The first to take a stance was Dr. Jose Carvalho from Mount Sinai Hospital (University of Toronto) who argued that ultrasound can be a very useful technique to facilitate spinal and epidural anesthesia. His opponent, Dr. David R. Gambling from Sharp Mary Birch Hospital (University of California San Diego) called the utility of this method into question. At the end, discussion moderator Paul Howell, M.B. Ch.B., F.R.C.A . called the debate a draw.

Three topics on labor pain research were presented next. Dr. James C. Eisenach (Wake Forest University) discussed the reasons for the variability in reported incidences of chronic pain after childbirth and explored new research conducted in this field. Dr. Pamela Flood (Columbia University) then introduced a current approach to predicting the progress of labor and the expected degree of pain associated with labor. This section was concluded by Ruth Landau, MD (University of Washington) who shed light on the use of genetics, in particular mu-opioid receptor polymorphism, to predict pain perception and analgesic requirements in laboring women.



Annual celebratory dinner revelers.

After the president of the American Society of Anesthesiologists, Dr. Alex Hannenberg, addressed the Society regarding some issues in health care reform, Dr. Steven Shafer (Columbia) presented a special research lecture entitled “The Role of Mathematical Modeling in Advancing Obstetric Anesthesia Research.” Dr. Shafer encouraged the audience to evaluate simple mathematical functions in regards to the understanding of biological phenomena such as the progress of labor as these may do a better job than the more traditional statistical framework that is based on fitting data into a Gaussian distribution framework. At the SOAP business meeting held at the end of day one of the meeting, Dr. Barbara Scavone (Northwestern University) was elected as Second Vice President and Dr. Kenneth Nelson (Wake Forest University), as Secretary to the Society.



Lawence Tsen thanks Manny Vallejo, Meeting Host.

Day two of the meeting started with oral presentations moderated by Dr. Barbara Scavone and was followed by the Gertie Marx/FAER Education Lecture given by Dr. Michael P. Pinsky (University of Pittsburgh). Consistent with this year’s theme, this presentation featured the “Use and Limitations of Non- and Minimally Invasive Hemodynamic Monitoring” a discussion of the technology available for use in today’s operating room environment. This presentation was followed by our annual lecture on recent advances in the field of obstetrics, which was given by Dr. George R. Saade from the University of Texas Medical Branch Galveston.

Friday afternoon featured the discussion panel “Clinical Update 2010” moderated by Dr. Joanne Douglas with excellent reviews on “Serious Obstetric Anesthesia Complications” (Robert D’Angelo, MD, Wake Forest University), the use of “Phenylephrine in Obstetrics” (Richard Smiley, MD, Columbia University) and the “Epidural Blood Patch” (Michael J. Paech, MBBS, FANZCA,

Royal Perth Hospital). This lively discussion was followed by the second oral presentation and poster review session. The daily activities ended with the Residents’ Forum and the Fellow Welcome Reception.

The most energetic group of SOAP attendees or possibly those who just can’t sleep in rose early Saturday to walk or run through the lushly landscaped areas of HemisFair Park in Downtown San Antonio, even after the Fun Run/Walk had to be cancelled due to inclement weather. The scientific session opened with the Best Paper Presentations. The winner of this competition was Dr. David Gambling (University of California San Diego), for his randomized controlled comparison of epidural analgesia (EA) and spinal epidural (SE) analgesia with respect to efficacy during first and second stages of labor and delivery. This competition was followed by a “Triple Debate Special” featuring a discussion about which continuous neuraxial technique (epidural, combined spinal epidural or continuous spinal) might be the most appropriate choice for the morbidly obese patient.

The debate was followed by the much-anticipated annual Gerard W. Ostheimer Lecture “What’s New in Obstetric Anesthesia?” presented by Dr. Jill M. Mhyre (University of Michigan) followed by the Annual Fred Hehre Lecture that was presented by Dr. Susan K. Palmer on the use of human albumin for obstetric patients. After an optional outing to admire the spectacular underground formations of limestone at Natural Bridge Caverns of San Antonio, meeting attendees gathered again for the Awards banquet held at the Institute of Texan Cultures. Several worthy individuals were honored for their contributions to the mission of SOAP (tables 1 & 2).

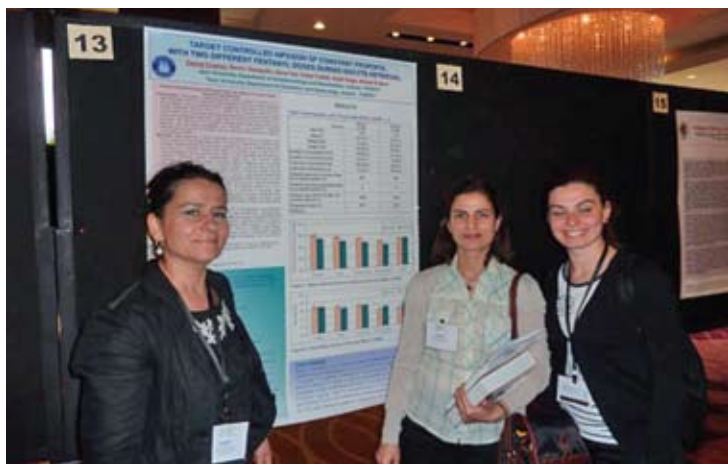


Ostheimer Lecturer Jill Mhyre.

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SOAP 2010 Meeting Summary: Emerging Technologies in San Antonio

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Poster viewing at Annual Meeting.



Valerie Arkoosh and Robert D'Angelo present DSA Award to Mark Rosen.

This year's meeting extended into Sunday morning starting with a Problem-Based Learning and Discussion Breakfast with the Experts moderated by Michael Paech, M.B.B.S., FANZCA (Royal Perth Hospital) and Craig Palmer, M.D. (University of Arizona). The breakfast session was followed by the clinically based Pearls & Pitfalls Session which featured discussions on recent innovations in the field including: an electronic obstetric medical record, TEG 2010, the use of intralipids during ACLS, the administration of remifentanyl during labor, and postoperative monitoring options for obstructive sleep apnea. This session was followed by the presentation of the best case reports of the year. Of the three best reports, first place was awarded to Dr. Terrence K. Allen (Duke University) for his account of "Remifentanyl for Fetal Immobilization and Analgesia during the EXIT procedure performed under Combined Spinal Epidural Anesthesia". With a special thanks to the meeting planners, SOAP 2010 adjourned. We look forward to an exciting SOAP 2011 meeting in the colorful desert terrain of Southern Nevada, Lake Las Vegas!



Table 1

Award	Winner	Institution
Distinguished Service Award	Mark A. Rosen, M.D.	University of California San Francisco
Research in Education Award	Subrata Chakravarty, M.D., M.B.B.S.	Mount Sinai Hospital, Toronto
Teacher of the Year Award: Over 10 years of experience	Sivam Ramanathan, M.D.	Cedars-Sinai Medical Center Los Angeles
Teacher of the Year Award: Less than 10 years of experience	Sabri Barsoum, M.D.	Cleveland Clinic
Media Award	Larry Hatteberg	KAKE ABC Channel 10

Table 2

Award	Winner	Institution	Abstract Title
<i>Gertie Marx Research Competition</i>			
1st	Neeti Sadana, M.D.	Brigham and Women's Hospital	Traditional vs. new transfusion protocol for obstetric hemorrhage. Which is better?
2nd	Vanessa Olbrecht, M.D.	Massachusetts General Hospital	The epidemiology of subarachnoid hemorrhage in pregnancy
3rd	Adrienne Kung, M.D.	Beth Israel Deconess Medical Center	The prevention vs. treatment of intrathecal opioid induced pruritis with ondansetron
<i>Resident/Medical Student Forum: Best Case Report</i>			
1st	Jeremy Deer, M.D.	Northwestern University Feinberg School of Medicine	Transfusion-related anaphylaxis during emergent cesarean section delivery
2nd	Tyler Burnett, M.D.	Ohio State University	Local anesthetic infiltration for cesarean section in a patient with spinal muscular atrophy type II
3rd	Debra McCutcheon, M.D.	Wake Forest University School of Medicine	Anesthetic management of a parturient with chronic renal failure, pulmonary embolism, coagulopathy from heparin infusion, and a difficult airway for urgent cesarean section
<i>Resident/Medical Student Forum: Best Original Research</i>			
1st	Christopher Goodier, M.D.	Medical University of South Carolina	Safety of epidural or spinal analgesia in parturients with thrombocytopenia
2nd	Sarah Armstrong, M.B.B.S.	University College London Hospitals	Lateral thinking – positioning for obstetric anesthesia and its effects on maternal cardiac output and fetal well-being
3rd	Andrew J. Deacon, M.D.	Calvary Healthcare	The learning curve of lumbar epidural ultrasonography – when is competency reached?
<i>Best Paper Award Recipient</i>			
	David Gambling, M.B.B.S.	Sharp Mary Birch Hospital for Women and Newborns	The EASE study: A randomized controlled comparison of epidural analgesia (EA) and spinal epidural (SE) analgesia: efficacy during first and second stages of labor at delivery
<i>Best Case Report Winners</i>			
1st	Terrence K. Allen, M.B.B.S., F.R.C.A.	Duke University Hospital	Remifentanyl for Fetal Immobilization and Analgesia During the EXIT Procedure Performed Under Combined Spinal Epidural Anesthesia
2nd	Erica D. Wittwer, M.D.	Mayo Clinic, Rochester	Bilateral TAP Blocks for Post Cesarean Delivery Analgesia in a Super Obese Parturient
3rd	James R. Dyer, M.D.	Oklahoma University Health Science Center	Repeat Cesarean Section in a Parturient with Neurocysticercosis and Progressive Neurological Symptoms
<i>Zuspan Award Recipient</i>			
	Mrinalini Balki, M.D.	Mount Sinai Hospital, University of Toronto	Contractile efficacy of different prostaglandins in pregnant rat myometrium pre-treated with oxytocin

Patient Safety: All Hands on Deck!



William Camann, M.D.
Brigham and Women's Hospital
Harvard Medical School



Roxane Gardner, M.D., M.P.H., D.Sc.
Brigham and Women's Hospital
Harvard Medical School

At the Brigham and Women's Hospital in Boston, when a call for "All Hands on Deck" (AHOD) goes out, perinatal personnel move quickly to assess the situation and triage resources on the labor and delivery (L&D) unit.

What triggers the call? Declaration of a "surgical variance" – deviation of a case from the normal course of events – e.g., severe peripartum hemorrhage – by any member of the care team initiates the protocol.

An AHOD call brings all obstetrical faculty, obstetrical anesthesiologists, midwives and the nurse-in-charge to a central location on L&D where resources are delegated and deployed. All personnel are expected to respond, not just those involved in the index case, to ensure that the care of other patients is not disrupted.

"Cooperation among staff and recognition of the importance of teamwork are vital to ensuring smooth operation of the remainder of L&D when one particular patient requires unusual resources."

Once the AHOD is called, all elective procedures are held until an "all clear" is called – indicating that the index case has been stabilized and the available resources are deemed acceptable.

We have developed a three-stage plan for management of "surgical variance" that details situational assessment as well as activation of resources internal and external to the labor and delivery suite. (See Table.) The AHOD protocol is well-suited to a large, busy maternity unit such as the one at Brigham and Women's, but the inability to predict the need for resources makes AHOD useful for clinical units of any size. Cooperation among staff and recognition of the importance of teamwork are vital to ensuring smooth operation of the remainder of L&D when one particular patient requires unusual resources.

AHOD drills are practiced regularly -- to simulate reality, the drills are intentionally not always at a convenient time! The involvement of senior members of the obstetric, anesthesia and nursing staffs demonstrates how seriously the AHOD protocol is taken by all departments. Mannequin simulation is often a feature of the drills, with observers noting elements of team and responder performance for feedback and improvement.

Areas of good performance have been identified: early call for help, avoiding panic, offers of assistance from non-involved physicians, and appropriate transfer of information to other responders. Some problem areas we've identified include a lack of consistent "closed-loop" communication, inconsistent designation of one "in-charge" person, overwhelmed unit secretaries, and failure to perform a "surgical pause," especially in a manner clear enough to be meaningful to all providers in the room.

We have found the AHOD to be a useful tool for enhancing the spirit of teamwork on our L&D unit, as well as supporting safe patient care in hectic situations. The protocol needs to be tailored to specific hospital needs, but the general principles can enhance the ability of any L&D team to rapidly respond when one particular patient requires high intensity resources, while ensuring the continued smooth operation of the remainder of the unit.

BWH Emergency System Response to Variance in Obstetric Surgery			
Stage	Action		Comments
Stage I Team identifies a variance	Intra-operative Surgical Pause	Surgeon, Attending anesthesiologist & circulating nurse discuss the surgical situation during a surgical pause. If surgery is on a variant path that is not normal, then a new plan is defined and recorded in the medical record.	Any member of the team can formally declare that the surgery is on a variant path and request that a new plan be developed.
Stage II Resources on L & D mobilized	"All Hands On Deck" Call for help from resources on L & D	All OB attendings in the hospital, Ob Chief resident and NIC are mobilized to deal with the emergency and reassign coverage resources for all patients on L & D	Resources on L & D mobilized to respond to surgical variance.
Stage III Resources not on L & D mobilized	Call for help from resources outside L & D Call #1, #2, #3 in rapid order	1) Call Senior Resident covering the Surgical Service: Beeper XX or Phone YY to obtain a surgical ICU bed, and respond to surgical and hemorrhage issues. 2) Call for Senior OB attending on-call to come to L & D 3) Call for Senior Gyn Attending on-call to come to L & D	Simultaneously calling for a Surgical resident, additional Senior OB & Senior Gyn, additional resources will be mobilized from outside L & D to care for the patient

Pioneer's Corner: Fred Hehre



Joanne Douglas, M.D.
University of British Columbia

Every year at SOAP a physician or scientist who has made a significant contribution to the science and clinical practice of obstetric anesthesia and perinatology gives a lecture titled the Fred Hehre Lecture. After attending a Fred Hehre Lecture you might think of him only as the gentleman

wearing a bow tie and holding a glass of wine – as in the photos that are often shown in the introduction. In common with many of you I have wondered: Who was Fred Hehre? What did he have to do with obstetric anesthesia? Why do we honor him at SOAP?

Fred was born December 19, 1923 and died of a heart attack on April 11, 1980. He received his M.D. degree from Columbia University, New York, in 1947. He subsequently interned at St. Clare's Hospital, New York City from 1947-1948 and did his anesthesia residency at Presbyterian Hospital in New York City from 1948-1950 where he worked with Virginia Apgar. In 1958 Fred became Director of Obstetric Anesthesia at Yale under Nicholas Greene. In 1975 he became chair of the Department of Anesthesia at Boston University where he remained until his untimely death.

Fred published many clinical research articles over the course of his career. One of his 1958 publications entitled "Early Events in the Development of Inhalation Therapy" ("inhalation of fictitious airs") was republished two years ago in the *Connecticut State Medical Journal*. From 1962-1972 he wrote a series of 10 articles on continuous lumbar epidural analgesia in obstetrics in *Anesthesia and Analgesia*. Some of the topics covered in this series were: attempts to produce spread of contrast media by

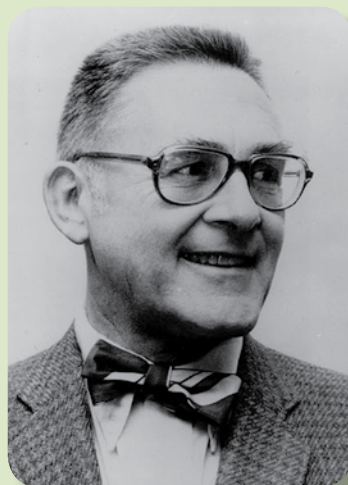
acute vena cava obstruction in dogs, comparison of the number of segments blocked in pregnant and non-pregnant subjects, the fetal effects of transplacental passage of local anesthetic agents, inadvertent lumbar puncture, further observations on inadvertent lumbar puncture, distribution of local anesthetic agents in maternal and fetal blood and a double-blind comparison of 2% lidocaine and 2% prilocaine. Fred also worked closely with Dr. Edward H. Hon in developing electronic fetal monitoring. In 1974 Fred wrote a chapter in *Clinical Anesthesia* (1974;10:323-33) entitled "Observations, Philosophic and Opinionated, on Obstetric Anesthesia Coverage." In it he opined about the lack of obstetric anesthesia coverage, especially at night, in many institutions; the financial considerations surrounding 24 hour coverage; problems with providing adequate training in obstetric anesthesia coverage to residents; and the role of nurse anesthetists. Does this sound familiar?

"Fred wrote a chapter about the lack of obstetric anesthesia coverage, especially at night, in many institutions; the financial considerations surrounding 24 hour coverage; problems with providing adequate training in obstetric anesthesia coverage to residents."

In reviewing his publications and in view of his interest in promoting not only the subspecialty of obstetric anesthesia but also lumbar epidural labor analgesia one can understand why SOAP chose to honor him. The

first Frederick W. Hehre Jr. Memorial Lecture was given by Dr. Gertie Marx at the 1981 SOAP annual meeting in San Diego. Dr. Marx's lecture was titled "Monitoring the Mother During Labor."

Thanks to Felicia Reilly of the WLM for a copy of Dr. Hehre's obituary and to A Celebration of Forty Years: Milestones and Pioneers published by SOAP under the leadership of Brad Smith and Alex Pue.



Fred Hehre wearing his signature bow-tie



Fred Hehre as often shown at the Annual Meeting's Hehre Lecture

Letters to the Editor

Dear Editor:

I congratulate the SOAP Board of Directors on a terrific meeting. However I believe SOAP has done a disservice to its membership and has failed in a part of its educational mission because of a long held anti general anesthesia bias.

The "triple debate" regarding anesthetic technique for morbid obesity was an example of this prejudice. The debate concerned which delivery method of regional anesthesia is better, rather than which type of anesthesia might be better.

As the debaters pointed out, each iteration of regional anesthesia has a well known and defined failure rate (in the range of up to 20%). The rescue method for all of these failures, unless diagnosed early, is general anesthesia. General anesthesia has a 100% success rate.

New skills are not necessary for one to provide general endotracheal anesthesia (GETA) to the morbidly obese parturient; an anesthesiologist should already know how to provide GETA safely, including for the morbidly obese with a non-optimal airway. However, someone who does not provide regional anesthesia on a daily basis to the very obese might be well out of their comfort zone trying to provide regional anesthesia to such a patient.

SOAP should entertain the fact that general anesthesia is just as safe as regional anesthesia, and in some instances may actually be the preferred method. Providing education and direction in the "best practices" of general anesthesia will help to make the practice even safer. This education has been sorely lacking for at least 10 years.

Thank you,

Richard Nishman, M.D.
Director of Obstetric Anesthesia
Providence Regional Medical Center
Everett, Washington

Dear Editor:

I was very pleased to see the article on "Patient Safety: Meningitis Following Neuraxial Labor Analgesia" in the Spring 2010 newsletter. I was shocked however, to hear that so many of our colleagues still have such a cavalier attitude towards the use of face masks during neuraxial procedures. While admittedly not everyone probably reads documents such as the CDC's 2007 "Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings" (<http://www.cdc.gov/ncidod/dhqp/pdf/isolation2007.pdf>) regularly, one should still be aware that they conclude "...there is sufficient experience to warrant the additional protection of a face mask for the individual placing a catheter or injecting material into the spinal or epidural space."

Even if one doesn't routinely scan the CDC website, there is little excuse to not be aware of the ASA's recent publication "Practice Advisory for the Prevention, Diagnosis, and Management of Infectious Complications Associated with Neuraxial Techniques: A Report by the American Society of Anesthesiologists Task Force on Infectious Complications Associated with Neuraxial Techniques" (*Anesthesiology*. 112(3):530-545, March 2010). This latter, of course, was strongly supported by Dick Wissler on behalf of SOAP at the ASA's House of Delegates. This document goes a step further and recommends "Aseptic techniques should always be used during the preparation of equipment (e.g., ultrasound) and the placement of neuraxial needles and catheters, including the following: Removal of jewelry (e.g., rings and watches), hand washing, and wearing of caps, masks (covering both mouth and nose and consider changing before each new case), and sterile gloves."

While serious complications such as meningitis and epidural abscess related to neuraxial block are rare enough that most of us will never see a case, when they do occur, they are too frequently devastating. In light of the recommendations cited above, if an anesthesiologist is unlucky enough to be involved in such a case, and is not wearing a face mask, their actions would be no more defensible than if they performed the procedure without putting on sterile gloves.

Sincerely,

Craig M. Palmer, M.D.
Chair, Committee on Obstetrical Anesthesia
American Society of Anesthesiologists
Professor of Clinical Anesthesiology
University of Arizona Health Sciences Center
Tucson, Arizona

The Newsletter welcomes reader input.

Please send letters to the editor to

SOAPeditor@gmail.com.

The Newsletter reserves the right to edit any contributions for clarity/length.

Coda

Opportunity Knocks



Barbara M. Scavone, M.D.
Northwestern University
Editor, SOAP Newsletter

Opportunity (noun):

1. an appropriate or favorable time or occasion;
2. a situation or condition favorable for attainment of a goal;
3. a good position, chance, or prospect, as for advancement or success; a chance for progress or advancement.

Craig Palmer, chair of the ASA Committee on Obstetric Anesthesia, informed us in this newsletter of new interpretive guidelines from the Centers for Medicare & Medicaid Services (CMS) and provisions in the recently passed omnibus health care reform bill that threaten the very definition of the practice of medicine. Curtis Baysinger, chair of the SOAP Economics and Government Affairs Committee, outlined SOAP's and the ASA's response to the CMS specifications. We can be sure of only one thing: These are unsure times, for physicians, including anesthesiologists, and including specifically, obstetric anesthesiologists.

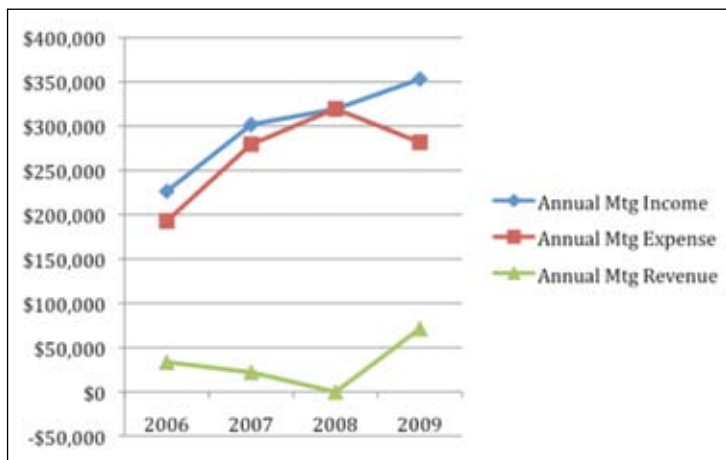
But in crisis lies opportunity. We can view the current climate as threatening, and take cover, or as an opportunity for positive change. Physicians have every reason to be wary of possible reimbursement inequities; however, we sometimes get so focused on them that we fail to see matters from any

other perspective, and this prohibits us from changing the conversation. Perhaps we could put our energies into somehow increasing the value delivered to our patients. Or we can take advantage of the increased scrutiny being given to health care to shine light on obstetric anesthesiologists' role in reducing maternal morbidity and mortality. Individuals can accomplish this to some extent, but SOAP has a stronger voice and garners more attention than any individual can. SOAP has a chance to educate decision-making bodies, organized medicine institutions and the lay public of the importance of obstetric anesthesia to women's health. This could prompt increased respect for the specialty and the subspecialty and might accelerate funding for obstetric anesthesia research and educational grants.

I have been thinking about opportunity lately. When faced with adverse circumstances, such as those warned of by Drs. Palmer and Baysinger, we should strive, against intuition, to view them as opportunities. The same lessons apply to individuals faced with impediments in their own lives. Thomas Alva Edison said, "Opportunity is missed by most people because it is dressed in overalls and looks like work." Most of the people I know in medicine do not shy away from hard work, but human beings get comfortable where they are. Afraid of change, afraid to move on, they get comfortable in their nests, and so miss opportunities.

We have the occasion to view an unfavorable condition such as the current health care reform effort, not as a negative, but as a "favorable time," as a "situation favorable for attainment of a goal," or even as a "chance for success."

Continued from page 3



SOL SHNIDER 2010

SOAP took over the management of the perennially successful Sol Shnider meeting. Attendance at the meeting was very good (437) after a hiatus of several years. The

financial performance of the meeting is not included in the 2009 financial results reported because it took place in March 2010, but I have included the preliminary results for your review.

SOL SHNIDER	FY 10
Revenue	\$204,668
Expenses	(\$139,830)
Gain/(Loss)	\$64,838

SUMMARY

SOAP's financial performance depends primarily on attendance at our two meetings, careful attention to expenses and membership. Our SOAP leadership has developed a strategic plan to ensure the planning and execution of quality educational programs and membership benefits which should help to ensure a sound financial future for our organization.



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