Society for Pediatric Anesthesia

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The Society for Pediatric Anesthesia (SPA) publishes the SPA Newsletter *three times a year. The information presented in the* SPA Newsletter *has been obtained by the Editors. Validity of opinions presented, drug dosages, accuracy and completeness of content are not guaranteed by SPA.*

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Editor's Note

Jayant K. Deshpande, MD

The Publications Committee is delighted to welcome Dr. Jeff Galinkin, Children's Hospital of Philadelphia, as its newest member. Jeff has already been a contributor to the past issue and will officially join the Committee as of the October meeting. I am also pleased to announce that Heather Spiess has joined the Society's central office as Director of Operations. One of her roles will be to help support the Publications Committee in producing the Newsletter. The Newsletter like many of the Society's endeavors depends largely on volunteers on the Publications Committee and other contributors. Ms. Spiess's help will facilitate our efforts to produce a timely and relevant Newsletter. In upcoming issues we will continue to update you on members efforts' in a variety of areas, including international aid and education missions.

For the first issue in the Year 2000 we will focus on the future of the specialty. Reflecting on Dr. Hall's comments elsewhere in this issue, I wonder where the Society Members think the specialty of Pediatric Anesthesiology should be/is headed. Pediatric intensivists, emergency medicine physicians and others now routinely provide total intravenous anesthesia for procedures in a variety of areas outside the operating room. Many anesthesiologists claim that this is the practice of anesthesiology by non-anesthesiologists and is unsafe. What are the data to support or refute this claim? What is the role of the pediatric anesthesiologist? *Are we merely the intra-operative intensivists and on occasion the experts in managing the difficult airway or do we possess a specific body of knowledge and clinical expertise that are of value in and out of the operating room?* I welcome your comments and thoughts via e-mail: jay.deshpande@mcmail.vanderbilt.edu.

I want to urge all of you who are interested in working with the Publications Committee or have ideas for the Newsletter to attend the Committee meeting in Dallas. Alternatively, you are welcome to forward your comments and ideas to me at jay.deshpande@mcmail.vanderbilt.edu.

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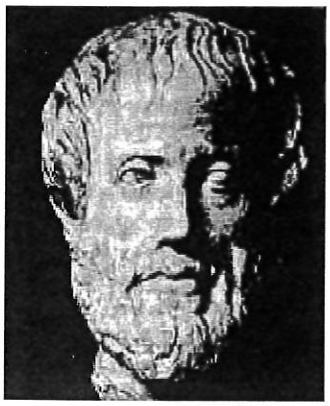

President's Message

Steven C. Hall, M.D.
SPA President
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It was Aristotle who said "It is the mark of an educated mind to be able to entertain a thought without accepting it." Over the years, the wisdom of that observation has become more apparent to me in a wide variety of situations. Probably the single best exercise in demonstrating this comes with having a teenager in the house, but I digress. It is the concurrence of conflicting ideas, ideals and options that forms many of the challenges we face today.

We are constantly exposed to situations where there are good rationales for two or more different solutions to a problem. Both sides present excellent reasons for a specific approach or course of action. Sometimes, it is relatively easy to decide what we will do. Yes, we will cover the call of a sick colleague instead of going out to dinner. No, we will not open for elective surgery on Sunday when we have open time at 1:00 p.m. on Friday. On other occasions, it is very hard to decide what is the right course of action. I would like to bring one such issue to your attention.

When many of us were residents, anesthesiologists were leaders in critical care medicine. In fact, critical care anesthesiologists were often a role model that attracted us into the field. This was true in both adult and pediatric practice. In the 70's, over half of the physicians practicing as intensivists were anesthesiologists. However, this has changed dramatically in recent years. Physicians in different disciplines found that critical care is a desirable area of practice and started to actively compete with anesthesiologists for opportunities to practice and control of intensive care units. There has been a steady decline in the percentage of anesthesiologists who actively or primarily practice critical care. Now, the most common specialty involved in critical care is pulmonology, on both the pediatric and adult sides. Pulmonologists dominate, at least in terms of numbers of physicians, the practice of critical care medicine today. This trend has not been lost on the anesthesiology community.

The leadership of one of our kindred organizations, the American Society of Critical Care Anesthesiologists (ASCCA), has become very concerned about what they feel is a crisis for both intensivists and anesthesiologists. They feel that the declining influence of anesthesiologists has led to reduced resident interest in critical care training, a decline in fellows, a loss of influence in the large critical care organization (SCCM), and a loss of influence at the individual institutional level. The job market, especially in community settings, for anesthesiology-trained intensivists is not strong, especially in the face of a buoyant job market for O.R. work.

The ASCCA leadership believes that the future of anesthesiology, as a whole, is intimately linked to the future of critical care, as supplied by anesthesiologists. They feel that anesthesiologist involvement in critical care is necessary for the profession of anesthesiology, and they would like to see anesthesiologists become the dominant force in critical care. ASCCA sponsored a special meeting in March of this year that I attended as a SPA representative. The ASA was represented by both the current president, John Neeld, and the upcoming president, Ron MacKenzie. At this meeting, the current status of critical care training and coverage was discussed, as well as potential changes for the future. A second meeting will be held in August.

What are some of the issues that ASCCA would like to address? They would like to see increased training in critical care in residency, increased administrative involvement of anesthesiologists at the institutional level, collaboration with surgeons in examining roles in surgical ICUs, and increased reimbursement for ICU practice. They want to publicize the opportunities for a career in critical care and the benefits they can bring in both academic and community settings. They, lastly, have indicated that increasing the length of the residency by a year would allow greater critical care training, as is common in many countries around the world.

So where, in all of this, does the quote about "able to entertain a thought without accepting it" apply? There are at least two major themes that I recognize. First, if the specialty of anesthesiology decides to increase resources in critical care training and promotion, should we, as a specialty organization, be contributing to increased anesthesiologist involvement in pediatric or neonatal intensive care units? What is the role of SPA in supporting this change? A simple answer is that SPA can increase the focus of our educational

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President's Message

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efforts to stress critical care topics and advocate job opportunities. However, does this truly serve the majority of our membership? There are limits to the number of topics we can cover in two meetings a year and, in general, the feedback from our meetings has not been directed towards greater depth and breadth of critical care topics. How do we balance what our members say they want versus expanding our horizons with material not normally covered? It is with great pleasure that I now remind you that the Chair of the Education Committee is Dr. Peter Davis, and his e-mail address is found on our website.

The second theme that fascinates me is the role of subspecialty organizations. ASCCA leadership is convinced that they are facing a crisis that threatens the very survival of anesthesiologists as critical care experts. Although ASCCA, like SPA, is a voluntary organization without specific regulatory powers, their leadership is attempting to influence organizations, such as the American Board of Anesthesiology and the joint Residency Review Committee, that do have regulatory or certification capabilities. The question for SPA is whether we are susceptible to the same pressures. How does the decline in the leadership of anesthesiologists in critical care units influence pediatric anesthesiology? Are we, as a group, glad to not be in the ICU as much or do we want to go storming back into a more prominent role? How much of an issue is this for the future of SPA and anesthesiologists providing care for children? It is not clear to me how much of an activist SPA should be on this issue. My e-mail address is schall@nwu.edu.

Steven C. Hall, MD
President

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Literature Reviews

Latex sensitization in spina bifida appears disease-associated

Zsolt Szepalusi, MD; Rainer Seidl, MD; Gunther Bernert, MD; Wolfgang Dietrich, MD; Susanne Spitzauer, MD; Radvan Urbanek, MD. *Journal of Pediatrics* Volume 134, Number 3, March 1999

Review: T he authors were interested in learning whether or not the latex sensitivity seen in children with Spina Bifida was related exclusively to frequent exposure or was associated with their disease. Two groups of children were compared all of whom had ventriculo-peritoneal shunts in place from an early age: children with spina bifida and children with hydrocephalus from other causes. The children were similar in regard to their age and number of surgeries undergone. In the Spina Bifida group, 43% of the children had latex-specific IgE antibodies while in the hydrocephalus group these antibodies were detected in 6%. These antibodies were detected by one year of age and one operation was sufficient to induce antibody production in the Spina Bifida patients.

Comments: Based on this study as well as others, it appears that there is an immunologic predisposition among children born with disorders of neural crest cell migration, such as Spina Bifida, to develop antibodies to latex. The patients in the two groups were similar with regard to the number of surgeries, the incidence of atopy, and age. A particularly important finding reported here is the development of IgE antibodies in two of nine patients following one surgical procedure. This indicates to me the importance of complete latex avoidance in the hospital. Given the numerous sources of latex in the environment, hospital exposure to latex should be scrupulously avoided in patients with Spina Bifida. It is certainly possible that children have developed sensitivity to latex from exposure outside the hospital so that their first hospital exposure may lead to an allergic or anaphylactic reaction.

Thomas J. Mancuso, MD, FAAP
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Efficacy of Parental Application of Eutectic Mixture of Local Anesthetics for Intravenous Insertion

Jeffrey L. Koh, MD; Debra Fanurik, PhD; JoAnne Stoner, MD; Michael L. Schmitz, MD; Maryelle VonLanthen, MD. *Pediatrics* Vol 103, No. 6 June 1999 e79

Review: 41 children were divided into 2 groups based on age (5-12 and 13-18 years) and then randomized into one of two experimental groups; parent-applied EMLA or clinician applied EMLA. EMLA was placed at least 60 minutes prior to IV insertion in all cases. Both the child's pain rating and observed behavioral distress were recorded. Parents and children were interviewed

to determine anxiety levels regarding the IV, prior needle sticks experience and prior difficulty coping with needles. Median and mean pain ratings were in the low to moderate range. the ratings did not differ significantly when analyzed by either age or experimental groups. There were no significant differences found in the measures of behavioral distress either between age or experiments groups. The dressings were more often partially off in the parent-applied group (19% vs 5%) and the parents difficulty in applying the occlusive dressing was the most frequently reported problem from the parents who applied the EMLA, followed closely by difficulty in obtaining EMLA. Younger children reported the most anxiety when EMLA was applied by the clinician, perhaps a manifestation of the white coat phenomenon, according to the authors.

Comments: This report documents success in a program of parental application of EMLA cream. With education and availability of this medication, children could easily have this done at home prior to coming to the hospital for elective procedures. Effectiveness would be assured since the 60 minutes waiting period would be easily achieved and children's anxiety, at least for the younger children, would be less. I cannot think of a reason that this practice should not be adopted.

Thomas J. Mancuso, MD, FAAP
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Dorsal Penile Nerve Block vs topical Placebo for Circumcision in Low Birth Weight Neonates

Michale A Holliday, MD; Thomas L. Pincert, MD; Shoron C. Kiernan, MD; Ildiko Kunos, MD; Pam Angelis, RN, MSN; Martin Keszler, MD. *Archives of Pediatric and Adolescent Medicine* Vol 153, May 1999

Editorial: Analgesia for Neonatal Circumcision, No More Studies, Just Do It

Lynne G Maxwell, MD; Myron Yaster, MD. *Archives of Pediatric and Adolescent Medicine* Vol 153, May 1999

Review: This randomized, blinded, controlled trial studied infants with weights between 1600-2500 gm at the time of circumcision. The infants were 25 +/- 25 days of age at the time of circumcision. Randomization into three groups was done, EMLA, DPNB (dorsal penile nerve block), and control (placebo). Of the 12 initially randomized to the EMLA group, 2 developed erythema and blistering on the penis, were not circumcised and the EMLA arm was stopped. 38 patients were included in the analysis, 19 in each of the remaining two groups. The dorsal penile nerve block (DPNB) was done using a tuberculin syringe with a 27-gauge needle. 0.4 ml 1% lidocaine was injected subcutaneously on each side of the base of the dorsal penis on the lateral sides (2 and 5 o'clock positions) 5 minutes prior to beginning the circumcision. A total of 0.8 ml 1% lidocaine was used.

Statistically significant differences were noted in heart rate, respiratory rate and behavioral score during and after circumcision when the DPNB group was compared to the placebo group. The most dramatic difference was in the crying component of the behavior score. During foreskin clamping, 805 of the DPNB group remained quiet while 95% of the control group cried inconsolably during foreskin clamping.

Comments: This study extends the practice of DPNB to ex-prematures. The authors show how in their hands this humane and sensible medical practice is safe and effective. The complication which developed in the EMLA group is difficult to explain, but, nevertheless, DPNB remains a safe, effective procedure for these patients. The accompanying editorial makes its point in the title. The text provides as much supporting data as one could want to justify the practice of providing analgesia for circumcision. The authors discuss the various reasons why circumcisions are still performed without analgesia and mention mechanisms by which this state of affairs might be changed. In closing they cite a recent AAP (American Academy of Pediatrics) publication with accompanying video demonstrating the technique of DPNB as evidence that at least one medical professional organization has taken a step toward improving that care of infants undergoing circumcision.

Thomas J. Mancuso, MD, FAAP
Children's Hospital, Boston

Transdermal fentanyl in children with cancer pain: Feasibility, tolerability and pharmacokinetic correlates

John L Collins, MBBS, FRACP; Ira Dunkel, MD; Suneel Gupta, PhD; Charles Inturrisi, PhD; Jeanne Lapin, RN; Leah Palmer RN, BSN; Sharon Weinstein, MD; Russell Portenoy, MD. *Journal of Pediatrics* Vol 134 No. 3 March 1999

Review: Thirteen patients were recruited into this study which aimed to assess the feasibility and tolerability of transdermal fentanyl in children with cancer pain and to estimate pharmacokinetic parameters of transdermal fentanyl. The patients were between 7 and 18 years of age, weighed over 10 kg and had pain related to an underlying malignancy treated with at least the equivalent of 45 mg oral morphine/day. Children were monitored until a stable dose had been found for 2 consecutive administrations (6 days) or the transdermal fentanyl was discontinued. Pain was assessed daily using VAS an adverse events were recorded. 11 of the initial 13 patients were evaluated for at least 2 consecutive administrations of transdermal fentanyl. These patients used the transdermal fentanyl for 6-275 days. 3

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patients required increasing the fentanyl during the study. The patients received from 25-300 mcg/hr transdermal fentanyl. 10 of the eleven patients continued transdermal fentanyl after completion of the study. Other than mild spontaneously resolving skin erythema, there was no skin toxicity. Clearance and volume of distribution were calculated and found to be similar to published adult values. The peak effect was demonstrated at 24 hours and a slow decline from the peak was demonstrated, again similar to values published for adults.

Comments: This small study suggests that transdermal fentanyl is an effective, safe treatment for cancer pain in children and adolescents. The patients in this study all had prior opioid treatment and were currently receiving at least moderate amounts of opioid prior to the introduction of the fentanyl. The authors report no episodes of respiratory depression with the doses used. The authors chose fentanyl doses based upon the preexisting opioid requirement of the patients and allowed ¼rescue½ doses of IV opioid and comment in the discussion that even when the chronic pain is well controlled, rescue doses may still be needed for breakthrough pain. Nevertheless, in these children who often have minimal PO intake and in whom IV access is always at a premium, transdermal fentanyl certainly has a place in their analgesic regimen.

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Evaluation of The Pediatric Patient With A Cardiac Murmur

Andrew Pelech, MD. *Pediatric Clinics of North America*, Volume 46 Number 2 April 1999

Comments: This review is an article "for the files". I will not summarize this summary of the evaluation of the child with a murmur. It thoroughly reviews the evaluation of such a child. The author discusses the history and physical exam findings in children with murmurs with particular emphasis, of course, on the respiratory and cardiovascular systems. The article concludes with a description of the various innocent murmurs of childhood, 4 systolic and 2 continuous. Stills vibratory murmur is the most common systolic murmur of childhood. It is usually found in a 2-6 year old child, is a grade 1-3 medium early systolic murmur heard at the lower left sternal edge. Its vibratory quality is characteristic and was described by Still as "a twanging sound". Other innocent systolic murmurs discussed include: the pulmonary flow murmur (grade 2-3 lower left sternal border heard in children to adolescents) and the murmur of peripheral pulmonic stenosis (grade 1-2 heard in infants best in the axillae and back). A copy of this paper would be an important addition to the references in a per-operative evaluation center. The article will certainly help the anesthesiologist decide when a murmur is indeed "innocent" and to ask for a cardiologist's opinion regarding a child with a murmur.

Thomas J. Mancuso, MD, FAAP
Children's Hospital, Boston

Clonidine in paediatric anaesthesia.

Nishina K, Mikawa K, Shiga M, Obara H. *Paediatric Anaesthesia* 9: 187-202, 1999 Blackwell Science Ltd

Review: Clonidine, an imidazoline alpha 2-adrenergic receptor agonist, has been used in adult practices since the late 1960s. In children, the most common uses for clonidine have been in the treatment of migraine, attention-deficit hyperactivity, neuropsychiatric disorders such as Tourette syndrome, sedation, and as a diagnostic tool for stimulating growth hormone in children of short stature. Clonidine has been used extensively in adults as an adjunct to anesthesia for surgery. A relatively large therapeutic index and the fact that clonidine can be administered effectively by multiple routes (oral, rectal, transdermal, spinal, caudal, epidural, etc.) suggests that clonidine also could be an attractive adjunct to anesthesia in children. As a preoperative medication (2-4 micrograms/kg), clonidine has an advantage over oral midazolam (0.5 mg/kg) or oral diazepam (0.4 mg/kg) in that it tastes better, results in less hemodynamic variability, bett attenuation of intubation responses, and has a highly desirable antisialogogue activity; a disadvantage is that it requires a significantly longer time of onset (30-60 minutes) to achieve similar levels of anxiolysis and ability to separate from the parents. The high bioavailability (95%) of rectal clonidine (2.5 micrograms/kg) over the bioavailability of other premedicants such as midazolam (52%) and morphine (30%) also confers a dosing advantage. Clonidine administered epidurally or intrathecally has been shown to potentiate local anesthetic agents and prolong the duration of anesthesia.

Jamali et al. studied 45 children (1-7 yrs) undergoing subumbilical general surgery. They observed that the duration of postoperative analgesia with caudal bupivacaine (0.25%, 1 ml/kg) was significantly increased by the addition of 1 microgram/kg of clonidine (16.5 h versus 7.7 h) without untoward side effects. Lee and Rubin studied children (1-10 yrs) undergoing orthopedic surgery, and demonstrated that adding clonidine 2 micrograms/kg to 0.25% bupivacaine, 1 ml/kg extended analgesia from 5.2 hrs to 9.8 hrs and that the total postoperative analgesic requirements for morphine and paracetamol were significantly lower in the clonidine group as well. In a study of 60 boys undergoing orchidopexy, the superiority of clonidine 2 micrograms/kg to adrenaline (5 micrograms/kg) added to 0.25% bupivacaine 1 ml/kg for caudal use was demonstrated. Concentrations of caudal clonidine up to 5 micrograms/kg have been studied in children. The higher doses of clonidine prolor the duration of analgesia and post-operative sedation but there

have been observations of transient and reversible effects on heart rate and blood pressure in some patients in the three hours postoperatively.

There is some evidence that preoperative clonidine decreases the amount of post-operative nausea and vomiting in strabismus and adenotonsillectomy patients, and that caudal clonidine does so as well in general surgery and urology patients. Side effects of clonidine can include a blood glucose lowering effect by blocking a stress response, suppressing plasma cortisol, and inhibiting the release of insulin from the pancreas. The authors suggest that children who have received clonidine should have intravenous infusions of 2% glucose.

Comments: This comprehensive and well-written review article nicely summed up the pharmacology, physiology, history, toxicity, and many studies done on the use of clonidine in children. One of its most useful features was the extensive (143 citations) listing of references.

Anne E. Dickison, MD
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Epidural Opioid Analgesia in Infant Rats: Mechanical and Heat Responses.

Marsh D, Dickenson A, Hatch D, Fitzgerald M. *Pain 1999, 82:23-32.*

Epidural Opioid Analgesia in Infant Rats: Responses to Carrageenan and Capsaicin.

Marsh D, Dickenson A, Hatch D, Fitzgerald M. *Pain 1999, 82:33-38.*

Review: These two studies further investigate the mechanisms of pain in the neonatal rat pup and by inference, will hopefully help us better understand pain and its mechanisms in babies. The authors studied pain responses in newborn rats to a variety of stimuli (mechanical, heat, carrageen-induced inflammation and capsaicin, and the effects of different opioid receptor agonists). They found that heat was very sensitive to spinal kappa opioids in neonatal rats and mechanical sensory thresholds are sensitive to all spinal opioids. Neonatal rats are capable of displaying both allodynia and hyperalgesia following experimental inflammation with carrageenan, and that these effects are blocked by all the spinal opioids. However, this effect was not blocked following application of capsaicin cream and noxious heat.

Comment: These studies are part of ongoing investigations trying to elucidate the effects of pain and opioids on the developing infant and as such are an extremely valuable contribution to anyone with an interest in pediatric pain management.

Rita Agarwal, MD
Children's Hospital, Denver

Neurologic Status of Newborns with Congenital Heart Defects Before Open Heart Surgery

Limperpoulos C, Majnemer A, Shevell MI, et al. *Pediatrics 1999, 103:402-407.*

Review: There is increasing evidence to support that newborns are at high risk for neurologic abnormalities, however most studies have focused on postoperative complications. This study is the first phase of an ongoing study examining the neurodevelopment of young children with congenital heart disease (CHD) before and after open heart surgery (OHS). The authors studied 56 children > 36 weeks gestational age with CHD requiring palliative or corrective OHS. They excluded patients with hypoplastic left heart, patients requiring closed surgical procedures and patients with known other neurologic abnormalities (Down's, perinatal asphyxia not involving the cardiac defect, etc.). The patients were examined by one of the neurologists and/or occupational therapist and a cardiologist. A series of standard neurodevelopmental testes were administered. They documented neurologic abnormalities in greater than half the patients. There was a higher incidence of problems (62%) in children with acyanotic disease, versus those wit6h cyanotic disease (47%). Over thirty-five percent (35.7%) were microcephalic, 12.5% were macrocephalic. Hypotonia, hypertonia, jitteriness, motor asymmetries and poor feeding were some of the abnormalities observed.

Comments: This is an interesting first phase study that should further our understanding of neurodevelopmental problems in children with CHD. This study may also be of great benefit in helping to determine the pathogenesis of brain injury in such children. One can't help but also appreciate the medicolegal ramifications (positive for a change) of such a study for all those involved in caring for such patients.

Rita Agarwal, MD
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SPA Newsletter Erratum

In the Awards Report in the Spring 1999 Newsletter, we published the wrong title for the First Place AAP Resident Research Award, which was awarded to Dr. Mike Neville. The correct title is: "The Negative Inotropic Effects of Propofol Are Not Age-dependent." We wish to apologize for any confusion this may have caused.

New Members

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Jahn, Uli-Ruediger, MD, Muenster , Germany
Jiang, Yandong, MD PHD, Newton, MA
Jolin, Steeve, MD, St-Laurent, PQ, Canada
Jones, Leslye, MD, Alabaster, AL
Joswick, David J., MD, Boston, MA
Kanevsky, Max, MD PHD, Brookline, MA
Karlakunti, Chandra, MD, Euclid, OH
Keijzer, C., MD, Uithoorn, The Netherlands
Kieta, Derek R., MD, Hoover, AL
Kitchens, II, Gerald T., MD, Indianapolis, IN
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Loy, Joy, MD, Parma Heights, OH
Loyal, Sabine, MD, PhD, Crystal, MN
Lu, Xiaowin, MD, Bronx, NY
Lynde, Grant, MD, Rockville, MD
Madabhushi, Gopal N., MD, Cincinnati, OH
Maddipati, Sreelata, MD, Brookline, MA
Mahmoud, Youssef, MD, Brooklyn, NY
Manookian, Edward, MD, Northridge, CA
Mara, Frank J., MD, Point Pleasant Beach, NJ
Maratea, Anthony, MD, Brookline, MA
Marcano, D. Andrade, MD, Aragua, Venezuela
Marcinkus, Susan R., MD, Towson, MD
Marica, Livia S., MD, Pittsburgh, PA
Martuscello, Teresa, MD, Everett, MA
Mauck, W. David, MD, Rochester, MN
Mc Cabe, Jessica A., DO, Galveston, TX
Mc Cammon, Andrew T., MD, Birmingham, AL
Michael, Arshavir I., MD, Crowley, LA
Millan, Daniel A., MD, Oklahoma City, OK
Miller, Matthew, MD, Dallas, TX
Moore, David L., MD, Seattle, WA
Moujan, Pablo M., MD, Richmond, VA
Mukherjee, Jana, MD, Yonerks, NY
Mungalpara, Vinod N., MBBS, Loveland, OH
Naushad, Abdul N., MD, Carmel, IN
Nelson, Chris S., MD, Indianapolis, IN
Nicodemus, Hector F., MD, Jamaica Plain, MA
Nogova, Lucia, MD, Tuebingen, Germany
Nychica, Andre, MD, Astoria, NY
Ostrovsky, Olga, MD, Madison, MS
Panigrahi, Tanmay, MD, Jackson, MS
Papenfuss, Tim, MD, Wuerzburg, Germany
Park, James, MD, Boston, MA
Paroli, Leonardo, MDn PhD, New York, NY
Patel, Anuradha P., MD, West Orange, NJ
Patel, Rajesh, MD, Jackson Hts, NY
Peggs, Cara F., MD, Indianapolis, IN
Peloquin, Robert G., MD, Boston, MA
Periskic, Sasa, MD, Charleston, MA
Peterson, Craig, MD, St. Paul, MN
Petrasek, John, MD, Toronto, ON, Canada
Pfeiffer, Birgit, MD, Greisfwald, Germany
Platt, Hugh C. R., MD, London, ON, Canada
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Provines, Michael, MD, Boston, MA
Pulido, Michael, MD, Galveston, TX
Purvez, Akhtar, MD, Chestnut Hill, MA
Que, Jocelyn C., MD, Manila, Philippines
Rajchert, Donna M., MD, Philadelphia, PA
Ramachandran, Sujatha, MD, Bronx, NY
Ramsey, N. Bruce, MD, PhD, Halifax, NS, Canada
Rangel, Jeffery M., MD, Elmhurst, NY
Rauch, Stefan, MD, Wuerzburg, Germany
Raufhake, Carsten, MD, Saerbeck, Germany
Regnier, Patricia L., MD, Roseville, MN
Resnick, Ellen, CRNA, Northbrook, IL
Rezainadimi, Lida, MD, Brooklyn, NY
Rios, Jose R., MD, Dorchester, MA
Robinson, Dan L., MD, Little Rock, AR
Rossberg, Mark I., MD, Baltimore, MD
Rother, Anne, MD, Brookline, MA
Rubin, Yair, MD, Calgary, AB, Canada
Runzer, Timothy, MD, N. Vancouver, BC, Canada
Ryan, Jason W., MD, Brookline, MA
Ryan, Michael H., MD, St. Louis, MO
Saager, Leif, MD, Luebeck, Germany
Sadoughi, Ali R., MD, Hinsdale, IL
Saha, Ashok K., MD, Machias, ME
Saindon, S0phie, MD, Pittsburgh, PA
Saraiya, Neeta R., MBBS, MD, New York, NY
Scheid, Annegret, MD, Chicago, IL

(Continued on page 10)

New Members

(continued from page 9)

Schilson, Jr., Donald L., MD, Indianapolis, IN
Schultz, Jan-Ake I., MD, New Fairfield, CT
Schwaerzler, Carola, MD, Chicago, IL
Scully, Michael E., MBBCh, Dublin, Ireland
Siddiqui, Mohammed K., FFARCSI, Riyadh, Saudi Arabia
Siddiqui, Muhammad A., MD, Cincinnati, OH
Silk, Lee, MD, Framingham, MA
Simpson, Gerald C., MD, Homewood, AL
Singbartl, Kai, MD, Charlottesville, VA
Skoumal, John, MD, West Des Moines, IA
Smith, Mark W., MD, Seattle, WA
Soejima, Kazutaka, MD, Galveston, TX
Sommers, David M., , Indianapolis, IN
Song, Chao, MD, Boston, MA
Sovani, Santwana, MD, Galveston, TX
Stoltzfus, Mark C., MD, Charlottesville, VA
Strickland, Jeff, MD, Framingham, MA
Stypula, Richard W., MD, Pittsburgh, PA
Sule, Harsh P., MD, Chicago, IL
Szmuk, Peter, MD, Houston, TX
Tang, Chao-Ying, MD, Jackson, MS
Tassone, Rosalie, MD, Chicago, IL
Telle, Todd R., MD, Boston, MA
Terrell, Kurt M., MD, Indianapolis, IN
Theobald, Peer O., MD, Chicago, IL
Thompson, Michelle A., MD, Indianapolis, IN
Thompson, P. David, MD, Jamaica Plain, MA
Tyrey, Scott J., MD, Brookline, MA
Uniat, Reuben W., MD, Hendersonville, NC
Upton, Jr., Charles, MD, Jackson, MS
Vatsar-Fail, Erika, MD, Galveston, TX
Vegiraju, Krishna R., MD, Leonia, NJ
Victorov, Victor, MD, Galveston, TX
Vilich, Fatima, MD, Glenview, IL
Vlassakova, Bistra, MD, Natick, MA
Vonderheide, Blake, MD, Galveston, TX
Wang, Chen, MD, Chicago, IL
Watkins, Laura M., MD, Homewood, AL
Weller, James F., MD, Brookline, MA
Whitty, Tina, MD, St. John's, NF, Canada
Williams, Paul M., MD, Salt Lake City, UT
Wohlfeld, Kamillus P., MD, Boston, MA
Wohlfeld, Ruth M., MD, Boston, MA
Womack, Bradley G., MD, Pelham, AL
Wright, Jonathan P., MD, Birmingham, AL
Xiong, Zhiling, MD PHD, Brookline, MA
Yao, Ning-Yen, MD, Cambridge, MA
Young, Stanford R., MD, Washington, DC
Yue, Paul, MD, London, ON, Canada
Zhang, Qiao, MD, New York, NY
Zheng-Heczko, Yuechun, MD, S. Pasadena, CA
Zhu, Yongyi, MD, Cincinnati, OH
Zuchner, Mikko B., MD, Chicago, IL
Zynger, Linda J., MD, Indianapolis, IN

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Pediatric Anesthesiology 2000

February 24-27, 2000

Sanibel Harbour Resort and Spa

Fort Myers, Florida

A joint meeting sponsored by the Society for Pediatric Anesthesia and the American Academy of Pediatrics - Section on Anesthesiology

Abstract Submission Deadline

December 1, 1999

This activity has been planned and implemented in accordance with the Essentials and Standards of the Accreditation Council for Continuing Medical Educaton through the joint sponsorship of the Society for Education in Anesthesia and the Society for Pediatric Anesthesia. The Society for Education in Anesthesia is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education for physicians.

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The Society asks that you give consideration to topics you would like to have addressed in future educational offerings.

1. What topics would you like to see addressed at future annual/winter meetings?

   1. _____ 4. _____
   2. _____ 5. _____
   3. _____ 6. _____

2. Do you like workshops at the winter meeting?

   Very Much - - - Not at All
   1 2 3 4 5

3. If you like workshops, which topic would you like to see included:

   1. _____ 4. _____
   2. _____ 5. _____
   3. _____ 6. _____

   a. Would you be interested in separate workshops during the year?

   Very Much - - - Not at All
   1 2 3 4 5

   b. Would you like the meeting to be co-sponsored with another organization (i.e., critical care, neurology, etc.)?

   Very Much - - - Not at All
   1 2 3 4 5

5. Additional comments and suggestions: _____

_____

_____

Mail / Fax to:

SPA
P.O. Box 11086 / 1910 Byrd Ave., Suite 100, Richmond, VA 23230-1086
phone (804) 282-9780 / fax (804) 282-0090
Email: spa@societyhq.com

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1910 Byrd Avenue, Suite 100, P.O. Box 11086, Richmond, VA 23230-1086
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We are currently searching for a Pediatric Anesthesiologist to join a private practice group at East Tennessee Children's Hospital in Knoxville, Tennessee. Our group currently consists of three physician anesthesiologists and eleven CRNA's. All types of pediatric surgeries, except for cardiac and transplantation, are performed. Board certification/ board eligibility in anesthesiology and pediatrics is required. Pediatric anesthesiology fellowship, or equivalent experience, is necessary. Knoxville is located in east Tennessee in the foothills of the Smoky Mountains and is surrounded by rivers and lakes with an abundance of recreational activity. Excellent housing, schools, and the University of Tennessee are also present here in the Knoxville area. If interested, please fax or mail your CV to: ATTN: J. Sanner, MD, East Tennessee Children's Hospital, Anesthesiology Department, 2018 Clinch Avenue, Knoxville, TN 37916; Fax: (423)541-8727 or email: hjsanner@etch.com.

University Hospitals of Cleveland

A full-time faculty position is available in the Division of Pediatric Anesthesiology, Department of Anesthesiology at Case Western Reserve University/University Hospitals of Cleveland. Clinical responsibilities include perioperative care of children undergoing procedures from all surgical disciplines. Other activities include medical student, resident and fellow education, and opportunities to participate in pain management, critical care and research. Applicants much be BC/BE and have subspecialty training in the care of children. An interest in cardiothoracic anesthesia is strongly preferred. Interested applicants should contact: Paul A. Tripi, MD, Chief, Division of Pediatric Anesthesiology, Department of Anesthesiology, University Hospitals of Cleveland, 11100 Euclid Avenue, LKSD 2500, Cleveland, OH 44106-5007, phone: (216)844-7330, email: paul.tripi@uhhs.com

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Albany Medical College is searching for a full time pediatric anesthesiologist to head the division, and serve as the director of the pediatric fellowship program. Applications are currently being accepted at the Instructor to Associate Professor levels. The successful candidate should be BC/BE, have experience in providing anesthesia for adults and children for general surgery, as well as for pediatric cardiac surgery including transplants. The Albany Medical Center currenlty consists of four pediatric anesthesiologists providing the majority of the 2,600 anesthetics to children each year. All pediatric surgical subspecialties are represented. Your efforts in research, clinical care and education will be appreciated. Our collegial group enjoys a competitive salary package and the Albany Medical College is an equal opportunity employer. For consideration please forward CV to: Kevin W. Roberts, MD, Professor and Interim Chairman, Albany Medical College, Department of Anesthesiology, 131, 47 New Scotland Avenue, Albany, NY 12208; Phone: (518) 262-4305; Fax: (518) 262-4736.

Society for Pediatric Anesthesia

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The Society for Pediatric Anesthesia (SPA) was founded in 1987 to promote quality perioperative care for infants and children. Membership in SPA has grown steadily to more than 4000 members. Membership consists of community-based and academic physicians who have an interest in pediatric anesthesia, as well as resident and affiliate members. The goals of SPA include:

1. To advance the practice of pediatric anesthesia through new knowledge
2. To provide educational programs on clinical, scientific, and political issues that are important to pediatric anesthesia practice
3. To promote scientific research in pediatric anesthesia and related disciplines
4. To provide a forum for exchange of ideas and knowledge among practitioners of pediatric anesthesia
5. To support the goals of the American Society of Anesthesiologists and the American Academy of Pediatrics