



# Society for Pediatric Anesthesia NEWSLETTER

Volume 10 Number 1

Winter/Spring, 1997

## President's Message

By Mark A. Rockoff, M.D.  
Children's Hospital, Boston

The Society for Pediatric Anesthesia is only ten years old, yet it already appears to be the largest organization in the world devoted to anesthesia for children. There are more than 1,600 members including individuals from 26 countries outside the USA and Canada, and approximately 2,500 additional resident members. Expenses of the Society are currently greater than \$300,000 annually. Recently, the professional management group - Ruggles Service Corporation - located in Richmond, Virginia was hired to assist the Society in its administrative affairs.

The Society offers two educational meetings every year. The annual meeting is a one-day event, just before the annual meeting of the American Society of Anesthesiologists. The other meeting is a three-day, midwinter program

held in a resort location designed to also provide a less hectic opportunity for members to get to know one another better. These meetings are each attended by 300-500 individuals.

In addition, the Society publishes a high-quality Newsletter and a membership directory that facilitate communication (by mail, phone, FAX and E-mail) among its members. It also publishes a directory of fellowship programs designed to assist anesthesiology residents and program directors in understanding the many options available for additional training in pediatric anesthesiology. The Society has recently established a site on the World Wide Web to facilitate electronic access to information and discussion groups of interest to anesthesiologists who care for children. This ongoing project is constantly being updated to provide more useful information to our membership (such as job offerings and research opportunities).



Furthermore, the Society actively encourages and supports research in pediatric anesthesiology in many ways, including providing a forum (and awards) for abstract presentations and financial stipends for research projects (in association with the Foundation for Anesthesia Education and Research). It is currently developing the mechanism to institute large-scale, collaborative, multi-

*(Continued on page 3)*

## 10th Annual Meeting of the Society for Pediatric Anesthesia

### 423 attend national meeting in New Orleans

By Gail E. Rasmussen, M.D.  
Vanderbilt Children's Hospital

The tenth annual meeting of the Society for Pediatric Anesthesia was held in New Orleans, LA on October 18, 1996. The meeting was attended by 423 people and had a diverse program for all interests. The meeting was introduced

by the SPA president, William J. Greeley, M.D. of the Children's Hospital of Philadelphia and Joseph Tobin, M.D. of Bowman Gray School of Medicine, the Program Chairman.

The first session of the morning was moderated by David G. Nichols, M.D., The Johns Hopkins Institutions, Baltimore and dealt with developmental

physiology in Pediatric Anesthesia. The first speaker, Walker Long M.D. of University of North Carolina, Chapel Hill, reviewed "The Developing Heart," including the development of cardiac function, the changing parameters of transitional circulation to the systemic circulation, the impact of the ductus arteriosus and

*(Continued on page 6)*

## SPA Contents

President's Message .....	1
SPA Meeting in New Orleans .....	1
Newsletter Editor's Message .....	2
The New Anesthesiologists .....	3
New Directors & Committees .....	4
Out and About the ASA .....	9
Literature Reviews .....	12
Pediatric Anesthesiology 1997 .....	15
Hot Topic: Accreditation for Training Programs .....	24
SPA Homepage .....	26

*The Society for Pediatric Anesthesia (SPA) publishes the SPA Newsletter twice a year: the Winter-Spring issue and the Summer-Fall issue. 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.*

### Editor:

Jayant K. Deshpande, M.D., Departments of Anesthesiology and Pediatrics, Vanderbilt Children's Hospital, T-0118 MCN, Nashville, TN 37232-2591

### Associate Editor:

Gail E. Rasmussen, M.D., Departments of Anesthesiology and Pediatrics, Vanderbilt Children's Hospital, T-0118 MCN, Nashville, TN 37232-2591

### Assistant Editors:

Rita Agarwal, M.D., Department of Anesthesiology, The Children's Hospital, 1056 E 19th Ave., Denver, CO 80218

Karen S. Bender, M.D., 120 Stonepost Rd, Longwood, FL 32779

Anne E. Dickison, M.D., Department of Anesthesiology, Dartmouth-Hitchcock Medical Center, 1 Medical Center Drive, Lebanon, NH 03756

Lawrence H. Feld, M.D., Director - Pediatric Anesthesiology, California Pacific Medical Center, San Francisco, CA 94120

Brian J. Gronert, M.D., Department of Anesthesiology, Children's Hospital of Pittsburgh, 3705 Fifth Ave. at DeSoto Street, Pittsburgh, PA 15213-2583

Howard B. Gutstein, M.D., Section of Pediatric Anesthesia, Mott Children's Hospital, 1500 E. Medical Center Drive, Ann Arbor, MI 48109

Zeev N. Kain, M.D., Department of Anesthesiology, Yale University School of Medicine, 333 Cedar St., P.O. Box 3333, New Haven, CT 06510

Alan S. Klein, M.D., Pediatric Anesthesia Consultants, 818 E. 19th Ave., Denver, CO 80218

Ronald O. Litman, D.O., Strong Memorial Hospital, 601 Elmwood Ave., Box 604, Rochester, NY 14642

Thomas Mancuso, M.D., Egleston Hospital for Children, Dept. of Anesthesia, 1405 Clifton Rd. NE, Atlanta, GA 30322

Francis X. McGowan, M.D., Dept. of Anesthesiology, Boston Children's Hospital, 300 Longwood Ave., Boston, MA 02115

Thomas Vetter, M.D., Children's Hospital Medical Center of Akron, 1 Perkins Sq., Akron, OH 44308

Mehernoor F. Watcha, M.D., Department of Anesthesia, University of Texas Southwestern Medical Center, 5323 Harry Hines Blvd., Dallas, TX 75235-9068

### SPA Headquarters

Society for Pediatric Anesthesia, 1910 Byrd Ave., Suite 100 / P.O. Box 11086, Richmond, VA 23230-1086; (804) 282-9780; Fax (804) 282-0090; Email: 75112.2053@compuserve.com; Internet: <http://www.uams.edu/spa/spa.htm>

© 1997



## Editor's Corner

By Jayant K. Deshpande, M.D.  
Vanderbilt Children's Hospital

This edition marks a new era for the SPA Newsletter for several reasons. Peter Davis and Frank McGowan have done a tremendous job in editing the newsletter for the past five years and have decided to move on to other challenges, turning over the responsibilities to me. Our publisher has also changed beginning with this edition from the American Society of Anesthesiologists to the Ruggles Service Corporation, which is also the professional management firm for the Society. The Publications Committee welcomes three new members, Rita Agarwal (Denver Children's Hospital), Ron Litman (University of Rochester) and Gail Rasmussen (Vanderbilt Children's Hospital). Finally, we begin this "new" effort under new leadership of the Society, with Mark Rockoff (Children's Hospital, Boston) assuming the President's office at the business meeting on October 18, 1996. I am honored to be named the editor of the Newsletter and delighted to be working with our new team. I want to thank the publications committee for volunteering their expertise and time to contribute to the

upcoming editions. In particular, I want to thank Gail Rasmussen for agreeing to assume the position of associate editor.

In future editions of the Newsletter we will include a president's message in which Mark Rockoff will be able to highlight the activities of the SPA Board of Directors and other information of importance to our membership. We plan to continue the section on literature reviews by members of the Publications Committee - an anticipated and welcomed staple. The winter and spring editions will feature the SPA fall and winter meetings, respectively. We plan to reinstitute a section - "POINT/COUNTERPOINT" - which will invite members with opposing views on controversial issues to express their opinions. We will invite SPA members who are members of the ASA House of Delegates to outline the active issues that are pertinent to the readership.

Finally, we want to invite and encourage you to send in (via mail, e-mail or fax) your comments and suggestions for future issues. This is your Newsletter and we welcome your contributions. ❖

## Try Out the New SPA Website!

The SPA website (<http://www.uams.edu/spa/spa.htm>) is now up and running. Drs. Raeford Brown and Joe Previte, Children's Hospital of Little Rock and the University of Arkansas Medical Sciences, have devoted a lot of energy and forethought to this exciting endeavor. We hope to provide timely and up-to-date information about the Society's activities and other information important to our membership. There is also an e-mail link that allows you to send comments and suggestions for both the website itself and the Society. Please try it out and let us hear from you. Thanks to both Drs. Brown and Previte for their tremendous voluntary effort. ❖

(See related article on page 26)

---

# The New Anesthesiologist

By Juan F. Gutierrez, M.D.  
*Children's Hospital of Alabama*

**T**he role of the anesthesiologist, both in the academic setting and in private practice, must be expanded in order to survive in the current health care system. No longer can the competent anesthesiologist just come in early, do the needed operating room cases and recovery room management, discharge or admit the patient and then go home. In the new restricted world of managed care the anesthesiologist must have several areas of extended service for continued survival.

Many centers have developed an efficient and expedient system for the preoperative evaluation and work up of patients prior to the scheduled day of surgery. The pre-anesthesia clinic must accommodate the patients and parents and the fast paced world of modern medicine.

In the operating room, the anesthesiologist must continue to provide patient care and be able to provide factual data and documentation of the choice of drugs and techniques used as well as their cost

effectiveness. The management and efficiency of a well run post anesthesia care unit needs to remain in the direction of the anesthesia care team as well as the modalities for postoperative pain management. Once the patient is either sent to the same day surgery unit or admitted to a hospital ward, the anesthesiologist must be involved in the ongoing management until the time of discharge. We must develop practice guidelines and policies, have mechanisms in place for continued quality assurance and follow up all incidences of morbidity and mortality in the patient population cared for at the respective institution.

To further expand our horizons, we need to offer our expertise in areas of the hospital that require sedation procedures, whether conscious or deep. We must supply our input, guidance and manpower for these areas; such as the cardiac catheterization laboratory, the radiology suite (MRI, CT scan, PET scan and diagnostic radiologic procedures), oncology and gastroenterology clinics and the emergency room.

Additionally, the anesthesiologist must be involved in the process of policy making, governing and running the institution they work for. We must be willing to participate in various hospital committees that govern an institution; such as the OR committee, ACGME, Credentialing and Promotions Committees, Blood Bank, Surgical and Anesthesia Case Review, Critical Care Management and Transport, and other appropriate hospital governing bodies.

Not only are hospital committees important, but also participation in community, state and national associations (AMA, ASA) are essential. In addition, attendance at meetings will give us a voice and allow our opinions and views to be heard.

The future is uncertain with the constraints of corporate management of American medicine, but we can help guide and direct our destiny by participating in the process. In order for your voice to be heard and for your opinion to be counted, active participation by all anesthesiologists is needed. ❖

---

## President's Message

*(Continued from page 1)*

institutional, clinical investigations designed to answer some of the more vexing problems facing clinicians who care for children (such as the best way to deal with children with recent respiratory infections scheduled for surgery). Last year, the Society affiliated with the journal *Anesthesia & Analgesia*, to provide an opportunity to further enhance research and transmission of information related to pediatric anesthesia. We are involved in selecting the Section Editor for Pediatric Anesthesiology and recommending review articles on topics of pediatric interest. We will use *A&A* and the Newsletter forum to report on recently-held educational meetings and announce future ones.

The Society is also active in representing the interests of children in the perioperative period and of anesthesiologists who care for them. Its members work with the American Society of Anesthesiologists and the American Academy of Pediatrics to represent our community on matters as diverse as government action (such as the hearings that resulted in the revision of the labeling for succinylcholine) and relations with the Accreditation Council on Graduate Medical Education (see the accompanying article on the status of the application for formal accreditation of fellowship programs in pediatric anesthesiology).

There are many more projects the leadership of your Society is consider-

ing. In order to take advantage of the talents of our membership, a more formal system of committees has been established. These include committees on Bylaws, Communications, Education, Finance, Government Affairs, Long-Range Planning, Membership, Nominations, Publications and Research. (See Box) The Chairs of these committees all welcome suggestions or comments, as do I. Finally, I would like to take this opportunity to thank all the members of the Society who volunteer their creative ideas and time to be involved with SPA's activities. It is a pleasure for me to serve as your President. I welcome any ideas you have for making this Society more beneficial to all. ❖

# SPA Elects New Members of the Board of Directors:

## New Members

### Directors at Large

**J. Michael Badgwell, MD**

Chief of Pediatric Anesthesia  
Professor of Anesthesiology and Pediatrics  
Children's Hospital at Texas Tech University  
Lubbock, Texas



**Ann G. Bailey, MD**

Associate Professor  
Departments of Anesthesiology and Pediatrics  
University of North Carolina Hospitals  
Chapel Hill, North Carolina



**Peter T. Rothstein, MD**

Division of Pediatric Anesthesia  
and Intensive Care  
Babies and Children's Hospital  
Columbia-Presbyterian Medical Center  
New York, New York



### Secretary

**Peter J. Davis, MD**

Professor of Anesthesiology and Pediatrics  
Children's Hospital and University  
of Pittsburgh School of Medicine  
Pittsburgh, Pennsylvania



### Treasurer

**Anne M. Lynn, MD**

Professor, Anesthesiology and Pediatrics  
University of Washington School of Medicine  
Children's Hospital and Medical Center  
Seattle, Washington



Congratulations to our  
new Board Members

Mariela Agurto, MD  
Iquique, Chile  
Sigma R. Alpha, PhD, MD  
Grand Junction, CO  
John T. Apostolakis, MD  
San Francisco, CA  
Lynda R. Arai, MD  
Wilmington, DE  
Matthew Atlas, MD  
Tucson, AZ  
Cathy Bachman, MD  
River Forest, IL  
W. Walter Backus, MD  
Stony Brook, NY  
Glenn S. Bacon, DO  
Newport, RI  
Carolyn F. Bannister, MD  
Stone Mountain, GA  
John D. Bennett, MD  
Dublin, OH  
Gregory J. Benson, MD  
Gahanna, OH  
John B. Bentley, MD  
Tucson, AZ  
Jeffrey M. Berman, MD  
Galveston, TX  
Jeanne Bezstarosti, MD  
Schiedam, The Netherlands  
Alex Blajicher, MD  
Vienna, Austria  
W. George Blikken, MD  
Holland, MI  
Chris Bolton, MBBS  
Melbourne, Victoria, Australia  
Sharon J. Boudreau, CRNA, MS  
Roslindale, MA  
Jane Brock, DO  
Nashville, TN  
Linda K. Brown, MD  
Shawnee Mission, KS  
Sally Bubbers, MD  
Den Haag, The Netherlands  
Julie Buch, MD  
Northville, MI  
David H.F. Buckley, MB, ChB  
Grey Lynn, Auckland, New Zealand  
Caryn J. Carranza, MD  
LaGrange, IL  
Christopher Chin, MBBS  
London, England, UK  
Shu-May Choo, MD  
Toronto, ON, Canada  
Camille Colomb, MD  
Houston, TX

(Continued on page 27)

# 1997 Committee Listing

## Executive Committee

**Mark A. Rockoff, MD, Chair**  
Steven C. Hall, MD  
Peter J. Davis, MD  
Anne M. Lynn, MD  
William J. Greeley, MD

## Publications Committee

**Jayant K. Deshpande, MD, Chair**  
Rita Agarwal, M.D.  
Karen Bender, MD  
Anne E. Dickison, MD  
Lawrence H. Feld, MD  
Brian J. Gronert, MD  
Howard B. Gutstein, MD  
Zeev Kain, MD  
Alan S. Klein, MD  
Ronald O. Litman, DO  
Thomas Mancuso, MD  
Francis X. McGowan, MD  
Gail E. Rasmussen, MD  
Thomas Vetter, MD  
Mehernoor Watcha, MD

## Education Committee

**Steven C. Hall, MD, Chair**  
Ann G. Bailey, MD  
Joseph F. Cassady, Jr., MD  
Patricia J. Davidson, MD  
Lynne R. Ferrari, MD  
Letty M.P. Liu, MD  
Lynne Maxwell, MD  
Francis X. McGowan, MD  
*Program Chair, Winter Meeting*  
Anneke E.E. Meursing, MD  
Linda Jo Rice, MD  
Stephen Rimar, MD  
Douglas G. Ririe, MD  
Mark A. Rockoff, MD  
Mark S. Schreiner, MD  
Joseph R. Tobin, MD  
*Program Chair, Annual Meeting*  
James Viney, MD  
Jordan Waldman, MD  
Maurice S. Zwass, MD

## Membership Committee

**Peter J. Davis, MD, Chair**  
Wendy B. Binstock, MD  
Eugene B. Freid, MD  
Gerald Goresky, MD  
John K. Hall, MD  
Heidi Jerome, MD  
Bruce P. Kingsley, MD  
Elliot J. Krane, MD  
James J. Steven, MD  
Suzanne C. Ulyot, MD

## Research Committee

**David G. Nichols, MD, Chair**  
Peter J. Davis, MD  
Sheldon R. Furst, MD  
Jerrold R. Lerman, MD  
Lynn Martin, MD  
Francis X. McGowan, MD  
Susan Nicholson, MD  
Mehernoor Watcha, MD  
Myron Yaster, MD  
Aaron Zuckerberg, MD

## Finance Committee

**Anne M. Lynn, MD, Chair**  
Charles B. Berde, MD  
Joseph D. Tobias, MD  
Peter J. Davis, MD  
Myron Yaster, MD

## Nominations Committee

**William J. Greeley, MD, Chair**  
Steven C. Hall, MD  
Lynda J. Means, MD  
Charles H. Lockhart, MD  
Mark A. Rockoff, MD

## Governmental Affairs Committee

**J. Michael Badgwell, MD, Chair**  
Frederic A. Berry, MD  
Charles Coté, MD  
Juan F. Gutierrez-Mazorra, MD  
Mark Singleton, MD  
D. Alan Tingley, MD

## Communications Committee

**Raeferd E. Brown, Jr., MD, Chair**  
Scott LeBard, MD  
Judy Margolis, MD  
Joe Previte, MD

## Bylaws Committee

**James Viney, MD, Chair**  
Robert Greenberg, MD  
G. Duggan Hannon, MD

## Long-range Planning Committee (Ad Hoc)

**Mark A. Rockoff, MD, Chair**  
Patrick Donahue, MD  
William J. Greeley, MD  
Steven C. Hall, MD  
Harry G.G. Kingston, MB  
Jerrold R. Lerman, MD  
Lynda J. Means, MD  
Myron Yaster, MD

## Special thanks to SPA Corporate Sponsors who have provided Educational Grants

1996

Abbott Laboratories  
(Audience Response System)

ASTRA USA, Inc.

Becton Dickinson Co.

Cook Critical Care

Marquette Electronics

Nellcor Incorporated

Preferred Medical  
Products/Ballard Medical

Roche Laboratories

Siemens

1997 to Date

Abbott Laboratories  
(Audience Response System)

ASTRA USA, Inc.

Becton Dickinson Co.

Cook Critical Care

Gensia

Marquette Electronics

Nellcor Puritan Bennett

Roche Laboratories

# 10th Annual Meeting of the Society for Pediatric Anesthesia

(Continued from front page 1)

related development of pulmonary circulation. Mark Hanson, D.Phil., The University College, London, presented an excellent overview of the "Development of Respiratory Control," focusing on the effects of hypoxia on respiratory output and fetal breathing movement.

The second session, "Advances in Technology/Support", was moderated by Susan C. Nicholson, M.D., Children's Hospital of Philadelphia. Dr. Peter C. Laussen, Children's Hospital, Boston, discussed "New Methods of Cardiovascular Support" in the management of children with congenital heart disease. He discussed a variety of topics including the management of physiologic derangements imposed by cardiopulmonary bypass, myocardial protection, role of nitric oxide in weaning from Cardiopulmonary Bypass (CPB), post cardiotomy support, and methods of mechanical circulatory support (ECMO and ventricular assist devices). An interesting new technique was discussed that involved delayed sternal closure after CPB to allow for

hemofiltration and diuresis, and fluid reequilibration prior to sternal closure. John H. Arnold, M.D., Children's Hospital, Boston, gave an enlightening talk entitled "New Methods of Respiratory Support". He discussed acute hypoxemic respiratory failure in the neonatal population and the role of nitric oxide, high frequency oscillatory ventilation and the potential use of liquid ventilation with perflubron in treatment. Dr. Arnold presented impressive data on the use of liquid ventilation, including both gross anatomic specimens and histopathologic slides of sheep lungs treated with perflubron showing better preservation of lung structure and function.

The afternoon sessions began with a "Practical Update" session moderated by Patty J. Davidson, M.D., Children's Hospital, Columbus, regarding the issue of postoperative nausea and vomiting (PONV). Alan D. Miller, Ph.D., Rockefeller University, New York, gave an overview of the physiology of postoperative nausea and vomiting, including

the various input pathways, the central nervous system coordination of input signals and the pre-motor and motor output pathways for vomiting. He mentioned newer pharmacologic agents to combat nausea and vomiting include the serotonin receptor agonists and the emerging neurokinin type 1 receptor antagonists. In addition, the use of the P6 acupuncture point stimulation to reduce the nausea and vomiting of motion sickness appears promising. The next session was the popular **PRO-CON** debate session on "Prophylactic Antiemetic Treatment". Peter J. Davis, M.D., Children's Hospital, Pittsburgh, gave us his "No brainer" approach in favor of anti-emetic therapy for appropriate patients. Lynn G. Maxwell, M.D., The Johns Hopkins Institutions, Baltimore, argued that prophylactic treatment is not necessary. She posited that designing the anesthetic to be less likely to induce nausea and vomiting, and hydrating the child properly may be just as important as the administration of an anti-emetic agent.

## Meeting Speakers



Walker Long, MD



John Arnold, MD



Peter C. Laussen, MD



Patty J. Davidson, MD



Alan D. Miller, PhD



Lynne G. Maxwell, MD



Mark A. Hanson, D.Phil



Alan W. Grogono, MD



William J. Greeley, MD



Mark A. Rockoff, MD

Jeffrey Morray, M.D. of Children's Hospital Medical Center, Seattle, moderated the session "Contemporary Management Issues." The first speaker, William Greeley, M.D. The Children's Hospital of Philadelphia, gave a detailed and informative talk entitled "Effective Perioperative Management of Decreasing Resources". He emphasized the need to optimize perioperative resources via three main guiding principles: definition of cost and identification of priorities, economic disciplinary strategies, and implementation of cost effective and cost reducing measures. Alan W. Grogano, M.D. of Tulane University School of Medicine, New Orleans, discussed "Academics with For-Profit Management". He talked about the changing climate of academic medicine and the increasing pressures on academic institutions to reduce costs at the expense of many academic pursuits including educating medical students, research and the training of resident physicians. The best strategy for achieving the traditional goals of academic health centers in the new environment is still unclear.

The Honorary Lecture of the Tenth Anniversary of the Society of Pediatric Anesthesia was presented by the keynote speaker, Dr. John J. Downes, who was the Anesthesiologist-in-Chief and Director of Anesthesiology at The Children's Hospital of Philadelphia from July 1972 to June 1996. Dr. Myron Yaster, the Johns Hopkins Medical Institutions, Baltimore, introduced Dr. Downes in a fashion suitable for such a distinguished figure in pediatric anesthesiology: he listed the names of all of the more than 300 former students of Dr. Downes, and asked all of these former students attending the meeting to stand; then all of the attendees who work with any of those standing were also asked to stand. Needless to say there were not many people sitting after this. Dr. Downes then delivered an inspirational talk "Pediatric Anesthesia: Where We've Been, Where We're Going", on the history and development of pediatric anesthesiology and what the future holds for the specialty. He included the continued training of subspecialists, the care and management of the extremely premature infant, and the ongoing efforts in the field of pain management.

The day's sessions were capped off by a lovely buffet reception held at the spacious New Orleans Museum of Art (weren't those small plates?), including New Orleans jazz accompaniment. ❖



(left to right) Myron Yaster, MD, introduces John J. Downes, MD, in remarkable fashion.



(left to right) Mark Hansen, MD, Walker Long, MD



Frederic (Fritz) Berry, MD, addresses the General Meeting.



(left to right) Mike Badgwell, MD, Alan Klein, MD, Sal Goodwin, MD



(left to right) Peter Laussen, MD, John Arnold, MD



Coffee Breaks afford valuable time for discussion.

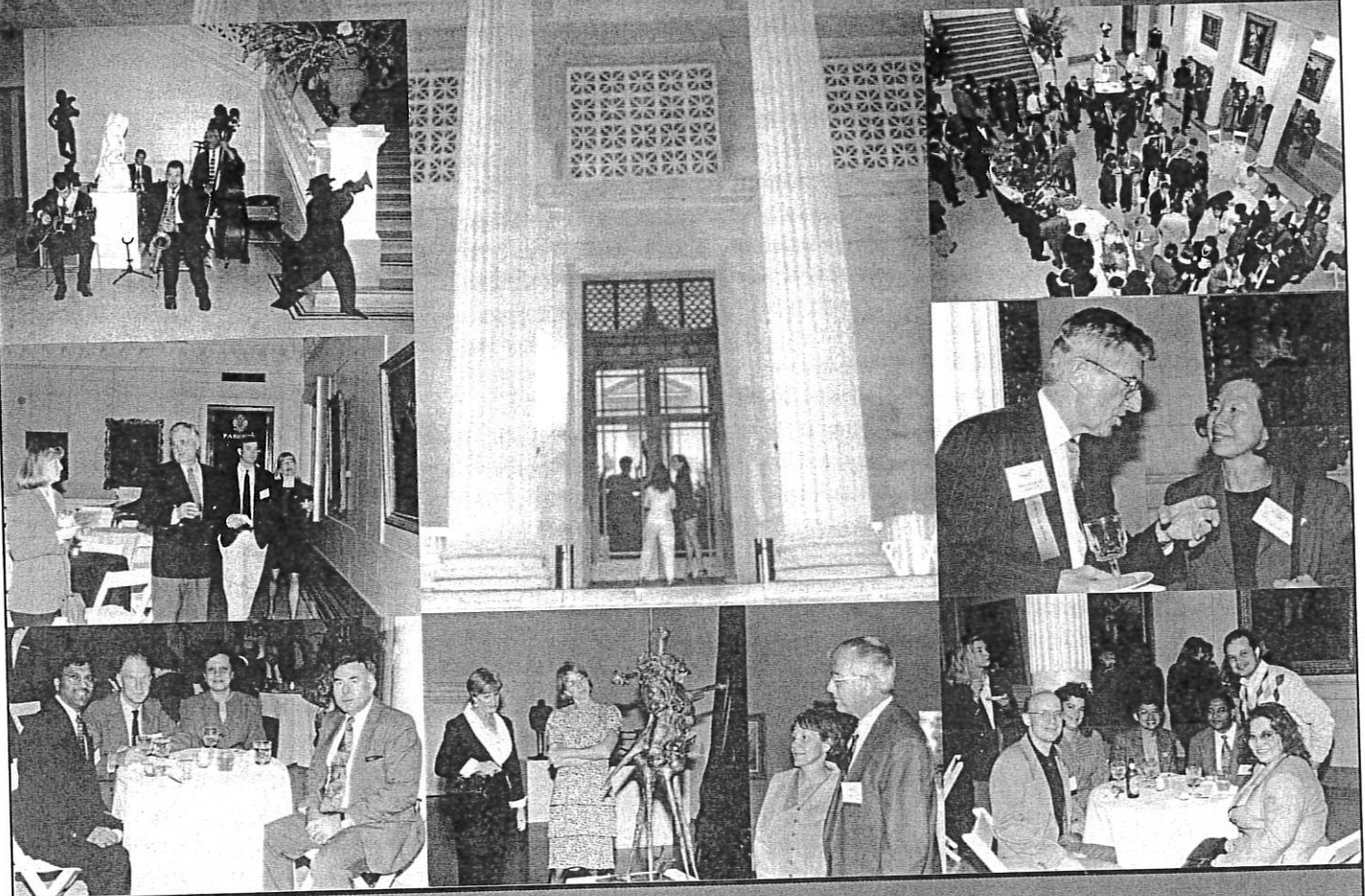


(left to right) Drs. Rice, Gutierrez-Mazorra, Nicolson and Welborn (not pictured) are thanked for serving on the Board of Directors.



(right) Todd Englander; Cook Critical Care

# SPA Reception at the New Orleans Museum of Art



## Exhibitors



Cook Critical Care



Ballard Medical Products



# Out and About the ASA

## Highlights of the 1996 Annual Meeting in New Orleans

### Poster Session

By Mehernoor F. Watcha, M.D.  
UT Southwestern Medical Center

In the first session of poster presentations, papers were presented on (1) the use of neuromuscular blocking drugs, (2) pre-anesthetic sedation, (3) regional anesthesia and, (4) miscellaneous topics.

#### **Neuromuscular blockade:**

O'Neill presented data showing that lower cis-atracurium infusion rates were required during sevoflurane anesthesia compared to nitrous oxide-opioid anesthetics. Kaplan et al confirmed that ORG 9487, a new steroidal, nondepolarizing muscle relaxant, has a rapid onset (within 100 seconds) with minimal hemodynamic effects. These characteristics would make ORG 9487 useful in rapid sequence tracheal intubation. Simhi et al. studied the pharmacokinetics of mivacurium in anesthetized patients and reported shorter half-lives of all isomers of mivacurium in children compared to adults. Ririe et al showed that children with Duchenne's Muscular Dystrophy had an increased sensitivity to vecuronium. Ross et al demonstrated that 600 g/kg of rocuronium is more advantageous than 450 g/kg for rapid onset of neuromuscular blockade.

**Premedication:** Z. Kain et al surveyed the use of premedication in the United States and reported that oral medication with midazolam is the most commonly used sedative premedicant. Having the parents present during induction is a less frequent practice. In another study, the same group found that the vast majority of parents preferred to have comprehensive information regarding the possibility of all complications during the procedure, rather than no or limited discussion.

**Regional anesthesia:** Studies of regional anesthesia included a compari-

son of apnea and bradycardia in preterm infants randomized to receive unsupplemented spinal anesthetics or a general anesthesia for hernia repair. There were no differences in the number of events of apnea and bradycardia between the two groups, confirming that continuous monitoring is required following surgery of preterm infants. These patients must be admitted for observation and not discharged home as outpatients.

There were also case reports of children undergoing pediatric axillary blocks with sedation (Margolis et al), and a study assessing heart rate and blood pressure responses in children given IV bupivacaine with varying doses of epinephrine to mimic inadvertent intravascular test doses (Felberg et al). In this study, systolic blood pressure was found to be a more reliable indicator of inadvertent intravascular injection compared to increases in heart rate.

**Miscellaneous topics:** Two papers were presented on the use of oral transmucosal fentanyl citrate (OTFC) including a comparison with midazolam for preoperative sedation. In this study, Kindscher et al noted that both OTFC and midazolam provided good sedation, but the incidence of nausea was higher with OTFC. In the other study, pharmacokinetic data on OTFC and IV fentanyl were presented by Dsida et al. Papers were also presented to demonstrate urinary cortisol excretion as an objective method for evaluation postoperative pain (Yoruzu et al), and a study demonstrating exposure to environmental tobacco smoke was associated with an increased risk of unexpected hospital admission, ICU admission or return to the hospital in the postoperative period (Skolnick et al). In a study comparing tidal breathing with vital capacity inhalation for induction with sevoflurane, Juarez et al found that vital capacity inductions were faster, associated with less excitement and no dif-

ferences in cardiovascular changes compared to induction by tidal breathing. Finally, Plattner et al demonstrated that non-shivering thermogenesis failed to increase metabolic heat production in anesthetized infants.

### Current Concepts in Malignant Hyperthermia

By Alan Klein, M.D., FAAP  
University of Florida

The panel on Current Concepts in Malignant Hyperthermia (MH) provided some useful pearls of information. The recent North American experience with MH reveals that of the cases reported to the MH Registry, 72% were male (vs. 39% of the general surgery population (GSP)); 43% had previous unremarkable general anesthetics; 25% occurred during ENT surgery (vs. 2% of GSP); 25% occurred during orthopedic surgery (vs. 7% of GSP); 25% occurred during emergency surgery. In a discussion of masseter muscle rigidity (MMR) it was revealed that of all patients reported with MMR, 30% of cases had isolated MMR (and 30% of those patients biopsied were positive for MH; 30% of cases had MMR as the first sign of full MH. The practical recommendation for MMR is that patients who have isolated MMR that significantly interferes with passive jaw opening, without associated TMJ dysfunction, should be referred for MH testing.

The discussion about succinylcholine (sux) use in pediatric patients centered around unrecognized myopathy and hyperkalemia. 25 patients were reported to the FDA in the past ten years, with CPR on induction. 92% were male. Mean age

(Continued on page 10)

# Out and About the ASA

(Continued from page 9)

52+/- 39 months. There were no family histories of MH. 67% had volatile anesthetics (VA) + sux; 24% remarkably had VA but no sux; 1 patient each had sux but no VA, and neither VA or sux. In 33% of the cases sux was given for emergency reasons. The MH rating was >5 in only 20%. SaO<sub>2</sub> was < 90% in only 4%. Hyperkalemia occurred in 52%. Myopathy was reported in 48%, but is > 80% if looked for in postmortem biopsy. Peak K<sup>+</sup> was 7.8 +/- 2.8. and Peak CPK 118,558 +/- 1741. 14/15 of the patients who survived CPR now lead normal lives. (That's twice the normal recovery rate for pediatric inpatient CPR).

In summary, the consensus was that sodium bicarbonate and calcium should be reinstated into the algorithm for pediatric CPR, to treat lethal hyperkalemia. Routine CK screening should be recommended within a few days of birth to rule out muscular dystrophy. The test has 100% negative specificity. Finally, always obtain a pertinent history, such as whether there is a family history of muscle problems, and whether the child is walking and developing normally.

## Panel on Pediatric Pain Management

By Peter J. Davis, M.D.  
*Children's Hospital and University of Pittsburgh School of Medicine*

The Panel on Pediatric Pain Management was moderated by Peter J. Davis, M.D., Professor of Anesthesia and Pediatrics at the University of Pittsburgh School of Medicine. The panel included pediatric pain experts from across the country. Although the panel was mostly didactic in nature, abundant interaction with the audience added depth and further insight into the problems practitioners face in dealing with infants and small children with pain.

Maureen Strafford, M.D., from the New England Medical Center, Boston,

addressed the developmental aspects of pain. Dr. Strafford noted that pain significantly influenced the neural network and neural circuitry in the developing child. She discussed the potential implications of chronic pain and developmental outcome in neonates. Anne Lynn, M.D., Professor of Pediatrics and Anesthesia, University of Washington, and the Seattle Children's Hospital, Seattle, reviewed the developmental pharmacology of opioids and the issue of opioid respiratory sensitivity. Dr. Lynn noted that although age may alter the pharmacokinetics of opioids, at any given opioid plasma concentration, age does not affect respiratory drive. Lynn Broadman, M.D., Professor of Anesthesia at the University of West Virginia, discussed the practical aspects of regional blocks in children. In a "How do I do it" presentation, Dr. Broadman discussed techniques of caudal blocks as well as upper and lower extremity blocks. Constance Houck, M.D., from the Harvard Medical School and the Children's Hospital, Boston, addressed the use of the nonsteroidal drugs ketorolac and acetaminophen in children. Dr. Houck discussed the literature's findings of ketorolac complications as well as recommendations for ketorolac's use in children. Dr. Houck also discussed the pharmacokinetics of acetaminophen in children and noted that there were marked differences in the pharmacokinetics and bioavailability between the oral and rectal routes of administration. Because of the marked differences in bioavailability and prolonged half-life associated with rectal acetaminophen, practitioners need to administer higher initial doses. For repeat administrations, the dose should be lower. The panel concluded with an excellent discussion by Dr. Ira Landsman, Associate Professor of Anesthesia and Pediatrics, the Children's Hospital of Pittsburgh. Dr. Landsman discussed patient-controlled analgesia and spinal axis opioid administration. He addressed the concerns as well as the paucity of large clinical scale trials regarding spinal axis

opioid use in small infants. Dr. Landsman outlined guidelines for the safe administration of spinal axis opioids as well as suggestions for patient monitoring.

## Poster Discussion Session

By Sandra V. Lowe, M.D.  
*Vanderbilt University Medical Center*

A separate session highlighted scientific abstracts displayed throughout the meeting in a poster-discussion format. The moderator was Dr. Steven J. Hall of the Children's Memorial Hospital, Chicago and Dr. Sandra V. Lowe, Vanderbilt's Children Hospital, Nashville, was the discussant. "New techniques in Single Lung Ventilation in Pediatric Patients" was presented by Dr. Gregory Hammer of Stanford University Medical Center. He showed how a balloon-tipped, end-hole catheter allowed for selective blockade with the ability to provide CPAP and suction of the non-ventilated lung for video-assisted thorascopic surgery (VATS). "The Effect of Positive End Expiratory Pressure on Respiratory Mechanics and Oxygen Saturation in Infants and Children Under General Anesthesia" was presented by Dr. Etsuro Motoyama of the University of Pittsburgh. His data suggested that PEEP should be used routinely for infants less than one year of age under general anesthesia.

Other abstracts presented included the "Timing of Penile Blocks and Postoperative Pain Control in Hypospadias Repair in Children," by Ashwani Chhibber, the University of Rochester Medical Center, New York. He suggested that performing a penile block both before and after a hypospadias repair provides better postoperative pain control than performing a block only at either end of the procedure. Dr. Shahnaz Hamid from the Hospital for Sick Children in Toronto, discussed the "Prophylactic Therapy for Postoperative Vomiting af-

# Out and About the ASA

ter Adenotonsillectomy: A comparison of Dimenhydrinate, Ondasetrone, or Placebo." She reported that ondasetrone significantly reduced the incidence of postoperative vomiting but warned about masking the signs of occult blood loss postoperatively.

Emad Mossad, M.D. from the Cleveland Clinic Foundation presented "Blood Pressure Monitoring in Children and Comparison of Noninvasive to Invasive Methods in Different Age Groups" and suggests that oscillometric monitoring overestimated blood pressure in cardiopulmonary bypass cases compared to invasive peripheral arterial measurement. "The Dura to Spinal Cord Distance in Children" was presented by Dr. Raju Krishna from the Wilford Hall Medical Center in Lackland AFB, Texas. He presented data showing equations to estimate the distance from skin to epidural space in the lumbar and thoracic regions.

The "Incidence of Arterial Oxygen Desaturation Following General Anesthesia in Children with Family Members Who Smoke," presented by Bimal Massand, M.D., Maimonides Medical Center, Brooklyn, New York concluded that a strong correlation exists between exposure to environmental tobacco smoke and arterial oxygen desaturation in the immediate postoperative period. The audience suggested transporting the patient with supplemental oxygen to the PACU. "Detection of Tracheal Stenosis by Cineangiography in Infants with Congenital Heart Disease" was presented by Naoki Yahagi, M.D. from the National Cardiovascular Center Suita in Osaka. The authors concluded that cineangiography is a convenient method for detection of tracheal stenosis in infants with CHD who undergo surgical repair of their anomaly.

## Breakfast Panel on Pediatric Anesthesia

*sponsored by the American Academy of Pediatrics, Section on Anesthesiology*

*By Jayant K. Deshpande, M.D.  
Vanderbilt Children's Hospital*

This year's AAP Panel discussion focused on the "Anesthetic Management of the Child with Airway Pathology." The Panel was moderated by Dr. J. Michael Badgwell, Texas Tech University, Lubbock. Dr. Peter J. Davis, Children's Hospital of Pittsburgh, spoke on the care of the child with Obstructive Sleep Apnea Syndrome. He discussed the preoperative concerns and status of many of these children, who may have significant hypoventilation and right sided cardiovascular compromise. Perioperative care includes judicious use of premedication and preparedness to care for upper airway obstruction during induction. A variety of anesthetic techniques may be used for these children. The postoperative care includes monitoring for obstructive sleep apnea, as many of these children will have pharyngeal dysfunction which will resolve only over time. Dr. Letty M. Liu, Robert Wood Johnson School of Medicine and Dentistry, Newark, NJ, spoke on the anesthetic management of children with Foreign Body Aspiration. Precautions for the care of these children include the careful use of premedication, preparedness for acute surgical intervention should the foreign body cause complete airway obstruction and postoperative observation for airway compromise. Jayant K. Deshpande, MD, Vanderbilt Children's Hospital, Nashville, addressed the topic of "the Child requiring Laser Surgery of the Airway". Children present for laser surgery for a variety of reasons including laryngeal papilloma, subglottic stenosis and tumors. Many for these children are at risk for life threatening upper airway obstruction.

Therefore, the anesthesiologist and the surgical team must be prepared to deal with acute loss of the airway patency. A thorough history is essential. Premedication should be used only if airway patency can be guaranteed in the event of airway compromise. Dr. Deshpande reviewed basics of how lasers work and the different types of lasers that are available for surgical use. Safety precautions for laser use include protecting the health care workers from errant laser beams that can cause eye or cutaneous injury. Protection of the patient includes appropriately shielding the eyes and using specially shielded endotracheal tubes. Fire hazards can be reduced by using helium:oxygen in the fresh gas flow and NOT using nitrous oxide, which can support combustion. The talk also reviewed the use of jet ventilation, including safety precautions and indications. In summary, all three talks emphasized proper preoperative evaluation of the child, judicious use of premedication and preparedness to handle acute loss of airway patency. ❖

## Meeting Announcement

The 4<sup>th</sup> European Congress of Paediatric Anaesthesia, chaired by Dr. C. Saint-Maurice, will be held in Paris, France May 21-24, 1997. The meeting will offer a comprehensive scientific program with oral and poster scientific sessions. Abstract deadline is January 1, 1997. For further information contact: Sophie Nicol, Departement d'Anesthesie-Reanimation, Hopital Saint-Vincent de Paul, 82, av Denfert-Rochereau, 75674 Paris, France.  
Tel: 33 1 40 48 80 91,  
Fax: 33 1 40 48 83 41.

# Literature Reviews

The following literature reviews have been selected from recent issues of international journals concerning pediatric and surgical studies that may be of interest to the pediatric anesthesiologist.

## Predictors of Extubation Success and Failure in Mechanically Ventilated Infants and Children.

Khan N, Brown A, Venkataraman ST. *Critical Care Medicine* 1996; 24:9, pp. 1568-1579

Reviewed by *Anne E. Dickison, M.D.*

This prospective study of 208 children intubated for respiratory failure attempted to identify predictors for reintubation necessitated in less than 48 hours after initial extubation. Patients with neurologic disease and those reintubated for upper airway obstruction were excluded from the analysis. The incidence of reintubation in this study was found to be 16.3%, in comparison to the 17-19% incidence reported in adults and 22-28% in neonates. A variety of traditional bedside measurements and calculated ratios were established pre-extubation in an effort to identify the best predictors of success and failure if subsequent reintubation occurred. No one single parameter, nor threshold cut-off values within the parameters studied, were found to correlate well with prediction of success or failure.

It was concluded that infants and children fail extubation due to poor effort (as best assessed by decreased tidal volume indexed to body weight per spontaneous breath), increased load on the respiratory muscles (as best assessed by high peak inspiratory pressure and a low dynamic compliance), and a decreased inspiratory drive (as assessed by decreased mean inspiratory flow). Not surprisingly, a higher level of pre-extubation ventilatory support (a high mean airway pressure, oxygenation index, or fraction of total minute ventilation provided by the ventilator) was also associated with an increased incidence of failure. Importantly, integrated indices often used in the

assessment of adults (such as the frequency to tidal volume ratio, and the compliance, rate, oxygenation, and pressure index) were poor predictors of extubation success and failure in infants and children.

## A Survey of the American Academy of Pediatric Dentistry Membership: Nitrous Oxide and Sedation.

Wilson, S. *Pediatric Dentistry* 1996, 18:287-293

Reviewed by *Ron O. Litman, DO*

This article reports the results of a 48-question survey given to 1,758 members of the AAPD on their sedation practices. Eighty-nine percent of respondents use N<sub>2</sub>O regularly, mostly in the range of 31-50%. Seventy-four percent of respondents do not use any monitoring when N<sub>2</sub>O is used alone. Only 53.7% of respondents always use a pulse oximeter during sedation with a combination of N<sub>2</sub>O and other sedatives, and 25.5% stated they never use a pulse oximeter when using a combination of N<sub>2</sub>O and other sedatives. Fifteen percent stated they do not use any type of monitor when using a combination of N<sub>2</sub>O and other sedatives. Thirty percent stated they had experienced a "compromised airway" when using a combination of N<sub>2</sub>O and other sedatives. The majority of respondents (59%) do not use a time-based record of physiologic parameters and 5% stated they had used an emergency medical service because of an oversedation.

Since the American Academy of Pediatrics (AAP) and the American Academy of Pediatric Dentistry (AAPD) published separate guidelines for monitoring and management of sedated children during medical procedures, the controversy over whether or not the use of N<sub>2</sub>O in combination with other systemic sedatives constitutes deep sedation is largely unresolved. The AAP guidelines state that when this combination of sedative agents is employed, the monitoring and personnel requirements should be consistent with those during deep sedation. The results of this survey by a reputable propo-

nent of pediatric dental sedation are, at best, alarming. It illustrates the increased need for training in airway management and use of monitors during pediatric dental sedation. Pediatric anesthesiologists should take active roles in the education of pediatric dentists in their communities to decrease morbidity of children in the dentist's office. Since this study only surveyed pediatric dentists, I can only imagine that conditions in general dentistry offices are worse!

## Why Do Infants and Children Breathe Faster?

Kerem E. *Pediatric Pulmonology* 1996, 21:65-68.

Reviewed by *Ron O. Litman, DO*

The author of this brief and informative review describes recent advances in the understanding of pulmonary physiology and respiratory mechanics in infants and children. The author describes the reasons why children breathe faster than adults. The two major reasons are the increased demand for carbon dioxide clearance, and the need to decrease the overall work of breathing which depends on both elastic and resistive forces. This is an easily readable review suitable for all levels of pediatric anesthesiology trainees.

## Comparison of Chloral Hydrate and Midazolam for Sedation of Neonates for Neuroimaging Studies.

McCarver-May, D.G., Kang, J., Aouthmany, M., Elton, R., Mowery, J.L., Slovis, T.L., and Kauffman, R. *Journal of Pediatrics* 1996, 128:573-576.

Reviewed by *Ron O. Litman, DO*

In this crossover study of seven term neonates recovering from meconium aspiration and persistent pulmonary hypertension, patients received either oral chloral hydrate, 75 mg/kg, or intravenous midazolam, 0.2 mg/kg, prior to undergoing neuroimaging studies. Efficacy of sleep onset was better with chloral hydrate than with midazolam but infants slept longer with chloral hydrate. A significant number of infants in both

# Literature Reviews

groups developed hypoxemia (SpO<sub>2</sub> < 90%) and decreased MAP.

The importance of this study is that ventilatory and hemodynamic deterioration commonly occurs when chloral hydrate and midazolam are administered to neonates who are not supported by mechanical ventilation. The effects of most sedatives on neonates are largely unknown and require further study. Sedation of neonates for medical procedures should be performed by trained personnel and by careful titration, if done without the use of mechanical ventilation.

**The Myth of Conscious Sedation.** Maxwell, L.G. and Yaster, M. *Arch Pediatr Adolesc Med* 150:665-667, 1996.

Reviewed by **Ron O. Litman, DO**

Maxwell and Yaster have written a landmark editorial in a leading pediatric journal in response to two articles in that journal that deal with the use of sedatives in children for so-called "conscious" sedation.

Since I was the author of one of those reports, I admit to being biased, but its importance for the pediatric community cannot be overemphasized. Maxwell and Yaster appropriately condemn the use of the term "conscious" sedation for what we all know is really "unconscious" sedation. "Conscious" sedation implies an element of cooperation and volunteerism from the patient - something seen only rarely in the pediatric population. They support the notion that pediatric anesthesiologists should take an active role in their communities in supporting the education and training of nonanesthesia personnel in the efficacious and safe practice of pediatric sedation. This editorial is a "must-read" for all who administer sedatives to children.

**Epidural Anatomy Examined By Cryomicrotome Section: Influence Of Age, Vertebral Level And Disease.**

Hogan QH. *Reg Anesth* 21:395-406, 1996.

Reviewed by **Rita S. Agarwal, M.D.**

Cryomicrotome images were made of frozen intact spines at different vertebral levels and in different aged cadavers. A heavy duty cryomicrotome was used to reveal sectional anatomy. High resolution color photographs were then made of the unstained block at 1 mm intervals. Examination under a 10X binocular microscope allowed detailed study of the photographic images. Twenty six adults ranging in age from 32-80 years old and 2 children aged 2 and 10 years old were studied.

In adults the major differences noted in the thoracic and cervical regions compared to the lumbar regions were diminished epidural space and the presence of a frequently discontinuous ligamentum flavum. A large basivertebral vein in the anterior epidural space occurred in the lower thoracic and upper lumbar areas.

The 2 year old child had nearly confluent and abundant posterior epidural fat. The 10 year old, however had the adult pattern of posterior epidural space anatomy with dural contact separating the epidural compartments.

The article also examines the effects of age and disease on the epidural anatomy. The photographs and illustrations are easy to follow and extremely informative. It is a fascinating look at epidural anatomy and I highly recommend it for everyone who performs epidural blocks.

**Regional Anesthesia For Pain Associate With Terminal Pediatric Malignancy.**

Collins JJ, Grier HE, Sethna NF, Wilder RT, Berde CB. *Pain* 65; 63-69, 1996.

Reviewed by **Rita S. Agarwal, M.D.**

This is the first English language review of pediatric patients with terminal malignancy who required regional anesthesia for relief of pain. The charts

of 11 patients who died of advanced malignancy were reviewed. They ranged in age from 5 months to 16.3 years old. Four patients received epidural infusions, 2 had subarachnoid infusions, 3 had epidural infusions initially, that were replaced by subarachnoid infusions, 1 had intermittent morphine injections via a caudal catheter and 1 had a thoracic epidural followed by a celiac plexus block. The duration of the infusions ranged from 2 days to 9 weeks. Complications included respiratory depression, postdural puncture headache, tachyphylaxis and blockage of the epidural catheter by tumor, each in one patient. The analgesia achieved was satisfactory in all cases. The discussion provides helpful guidelines for determining patients that might benefit from these techniques. Solid organ tumors are less common in children than in adults, and demise tends to occur more rapidly. Consequently far fewer children will be candidates for these techniques. This paper is valuable in presenting the authors experiences with the problems and pitfalls with these uncommon procedures in pediatrics.

**Oral Midazolam Premedication For Paediatric Day Case Patients.**

Cray SH, Dixon JL, Heard CMB, Selsby DS. *Paediatric Anaesthesia* 6:265-270, 1996.

Reviewed by **Rita S. Agarwal, M.D.**

There have been a multitude of articles examining the utility of midazolam for pre-anesthetic sedation, however this study is interesting because it tries to measure premedication parental and child anxiety and the effect of midazolam on the latter. Forty nine ASA I-II day surgery patients, ages 1-12 years were studied. Parents were asked to rate how anxious they felt their child would be during induction of anesthesia. The children were asked to rate their anxiety and finally an observer ranked the child's behavior. (see table 1)

(Continued on page 14)

# Literature Reviews

(Continued from page 13)

Midazolam 0.75 mg/kg or placebo was administered and a blinded observer assessed the children's behavior in the operating room. Times to eye opening and fitness for discharge were recorded. The incidence of confusion unrelated to pain was also noted.

The results demonstrated that most children presented for anesthesia in a calm state irrespective of the administration of midazolam. Midazolam did appear to be more effective in decreasing anxiety scores in children < 6 years. Emergence and discharge times were delayed, and the incidence of postoperative confusion unrelated to pain seemed to be higher in patients receiving midazolam. The authors concluded that routine sedation in all children is unnecessary and that recovery may be delayed or complicated by agitation.

## **Pain In Pediatric Human Immunodeficiency Virus Infection: Incidence And Characteristics In A Single Institution Pilot Study.**

Hirschfeld S, Moss H, Dragisic K, Smith W, Pizzo PA. *Pediatrics* 98: 449-452, 1996.

## **Immunodeficiency Virus Infection In Children.**

Yaster M, Schecter N. *Pain And Pediatrics* 98: 455-456, 1996.

Reviewed by *Rita S. Agarwal, M.D.*

Most adult patients with HIV infection who seek clinical care have a symptoms of pain. Little is known about the prevalence and causes of pain in children with HIV infection. This study is a pilot study to assess the incidence of pain children infected with HIV, compared to a group of children with cancer. The authors also seek to determine the impact of pain on the lives of these patients. Sixty one parent-child dyads were randomly selected and interviewed from a population of 200 patients registered at the Pediatric Branch of the National Cancer Institute. Nineteen children with cancer and their parents were chosen for comparison and to validate the questionnaire used in the interviews.

The children with HIV ranged in age from 4-18 years, average age was 10.4 years. Fifty nine percent of patients and 55% of their care givers report pain as a component of their illness. Twenty percent of patients and 34% of parents felt the pain interfered with an activity. Eighteen percent of patients and 29 % of parents reported that the pain interfered with sleep. The youngest children had the highest perceived incidence of pain (67%), and sleep disruption. Foster parents tended to react less to the pain and its impact than did natural parents. Girls reported more pain than boys (76% V.s. 47%). The reported pain tended to arise from the gastrointestinal tract or limbs and seemed to respond to non-opioid analgesics.

The present study did not address the nature of the pain in great detail, however it is a good start in increasing awareness of the problem. The accompanying editorial by Drs. Yaster and Schecter address the general problems in appropriately assessing and treating such patients. Some of these problems are related to the loss of patients' natural parents, mentally incapacitated patients (from AIDS related encephalopathy), and concerns with regard to opioid use (abuse) in vertically infected children with substance abusing parents. In addition the dose of NSAID's and opioids must be carefully titrated in patients receiving zidovudine.

In conclusion these are two papers that should be of interest to any one who is involved in pain management in children. Clearly there is a lot more research that needs to be done in patients with HIV.

## **Ketorolac Acute Renal Failure in a Previously Healthy Adolescent.**

Buck ML, Norwood VF. *Pediatrics* 98: 294-5, 1996.

Reviewed by *Rita S. Agarwal, M.D.*

This is an interesting case presentation of a healthy adolescent who received ketorolac after extraction of wisdom teeth. The patient was 17 years old and had been NPO for 12 hours prior to the procedure. She was given 500 mg

penicillin G orally every 6 hours for bacterial prophylaxis because of the presence of mitral valve prolapse and ketorolac, 10 mg every 4-6 hours for pain. She developed nausea and vomiting the next day, but continued to take her medications, a total of 10 tablets in 30 hours. The patient was found to be mildly dehydrated after admission to a local emergency department. A urinalysis revealed an elevated blood urea nitrogen, creatinine, 3+ protein, increased white and red blood cells on urinalysis. She was diagnosed with acute tubular necrosis, that ultimately required hemodialysis before resolving. The girl was hospitalized for a total of 15 days.

The nephrotoxic effects of NSAID'S are well known, however they are thought to be unusual when used appropriately. The only predisposing factor in this patient seems to have been possible dehydration. The article discusses the causes of NSAID'S renal effects and reviews some of the previously reported cases. ❖

## **Society Ties & Totes**

Lovely ties and bags featuring the SPA logo in full color are available for sale from SPA headquarters. All profits support the Society's activities. They make great gifts for all occasions

Yes, Please send me

\_\_\_ Ties @ \$25 = \_\_\_\_\_

\_\_\_ Bags @ \$25 = \_\_\_\_\_

Total Amount \$ \_\_\_\_\_

\_\_\_\_\_  
Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State Zip

\_\_\_\_\_  
Phone

*or fax your order to*  
(804) 282-0090

---

# Pediatric Anesthesiology 1997

Society for Pediatric Anesthesia



education • research • patient care



---

Hyatt Regency Hill Country Resort  
San Antonio, Texas  
February 13-16, 1997

---



# There's still time to register...

## Pediatric Anesthesiology 1997

The Third Annual Winter Meeting of the Society for Pediatric Anesthesia (SPA) and the American Academy of Pediatrics-Section on Anesthesiology will take place at the Hyatt Regency Hill Country Resort in San Antonio, Texas, from Thursday, February to Sunday, February 13-16, 1997.

This year's scientific program will include plenary sessions on Controversies in Neonatal Anesthesia, Safety Advocacy at the AAP, Managed Care: The Race to the Bottom, Complications of Pediatric Intubation, Advances in Pediatrics/Anesthesia and Future Concerns of Pediatric Anesthesiologists. The workshop offerings have been expanded this year to meet demand, and will include sessions on Airway, Pain, CPR/Intraosseous, Managing your Ventilator, Echocardiography, Computer/Internet Use, Women Looking at Power and Pediatric Anesthesia: Where Can I Go from Here? Oral and poster presentations of clinical and laboratory work will be another feature, and will include a moderated poster-discussion session. The ever-popular audience response system will be utilized to give participants instant information on practice trends. Committees will be able to meet on Saturday afternoon at 1:00pm.

The Hyatt Regency Hill Country Resort has quickly become a premier destination for business and vacation travelers. The resort has a Ramblin' River, two swimming pools, tennis courts and an 18-hole championship golf course designed by Arthur Hills. Camp Hyatt is offered for children ages 3-12 years with part- and full- day programs.

On Saturday night, there will be a special group cook-out (known as a "Smokehouse"), and kids will have their own buffet and set-up. Dusty Britches and the Bunkhouse Band will provide the musical entertainment, and trick roper Doug Whitaker will make a guest appearance. The attire for the evening is casual at the hotel's Luchenbach Pavilion.

### Meeting Schedule

#### Wednesday, February 12, 1997

6:00pm - 9:00pm Meeting, Long-range Planning Committee - S

#### Thursday, February 13, 1997

8:00am - 12noon Meeting, Long-range Planning Committee - S  
1:00pm - 5:00pm Meeting, Board of Directors - SPA  
2:00pm - 5:00pm Meeting, Executive Committee, AAP, Section on Anesthesiology  
3:00pm - 6:00pm Early Registration  
6:00pm - 8:00pm Welcome Reception

#### Friday, February 14, 1997

7:00pm - 7:50am Continental Breakfast with Exhibitors  
7:50pm - 8:00am Welcome  
8:00am - 10:30am Controversies in Neonatal Anesthesia  
8:00am Neonatology Update  
8:45am Apnea  
9:05am Pain Management - Theory  
9:35am Pain Management - Practice  
9:50am Anesthesia Concerns  
10:15am Discussion  
10:30am - 11:00am Break / Exhibitors / Scientific Posters  
11:00am - 1:00pm Oral Abstract Presentations  
1:00pm - 2:00pm Lunch  
2:00pm - 4:00pm Oral Abstract Presentations  
2:00pm - 4:00pm Parallel Workshops  
A1) LMAs, Lightwands  
A2) Fiberoptics  
B2) Advanced Regional Blocks  
B3) Managing the Epidural Space  
B4) Upper Extremity/Lower Extremity Blocks  
B5) Reimbursement for Pain Service  
B8) Setting up a Chronic Pain Service  
C) CPR / Intraosseous  
D) Managing your Ventilator: Intraoperative and ICU  
E) Echocardiography  
F) Computer / Internet Use: What's Out There and How to Get It?  
H) Pediatric Anesthesia: Where Can I go From Here?



4:00pm - 5:00pm Practice Survey Update  
 5:00pm - 5:30pm Business Meeting - AAP, Section on Anesthesiology  
 5:00pm - 6:30pm Wine and Cheese Reception with Exhibitors

### Saturday, February 15, 1997

7:00am - 8:00am Education Committee - SPA  
 7:00am - 8:30am Continental Breakfast at the Posters  
 8:30am - 10:30am Poster Discussion  
 8:30 am - 10:30am Parallel Workshops  
 A1) LMAs, Lightwands  
 A2) Fiberoptics  
 B1) Common Regional Blocks  
 B2) Advanced Regional Blocks  
 B3) Managing the Epidural Space  
 B5) Reimbursement for Pain Service  
 B6) Setting Up a Pain Service-Academic and Private Practice Perspectives  
 B7) Setting Up an Acute Pain Service  
 C) CPR / Intraosseous  
 D) Managing your Ventilator: Intraoperative and ICU  
 E) Echocardiography  
 F) Computer / Internet Use: What's Out There and How to Get It?  
 G) Women Looking at Power: Its Diverse Sources and Optimum Uses  
 10:30am - 11:00am Break / Exhibitors / Scientific Posters  
 11:00am - 11:30am SPA /AAP Awards Presentations  
 11:30am - 12noon Safety Advocacy at the AAP  
 12noon - 1:00pm Managed Care: The Race to the Bottom  
 1:00pm - 2:00pm Exhibits / Scientific Posters  
 1:00pm - 2:00pm SPA / AAP Board Luncheon Meetings  
 6:30pm - 9:30pm Hill Country Smokehouse Dinner (by ticket only)

### Sunday, February 16, 1997

7:00am - 8:00am Education Committee - SPA  
 7:00am - 8:00am Continental Breakfast  
 8:00am - 9:00am Grand Rounds Presentation  
 9:00am - 9:30am Complications of Pediatric Intubation  
 9:30am - 10:00am Break  
 10:00am - 12:30pm Advances in Pediatrics/Anesthesia  
 10:00am Asthma - What's New  
 10:30am Asthma - Implications for Anesthesia  
 11:00pm Myopathies - What's New  
 11:30pm Myopathies - Implications for Anesthesia  
 11:45am Colds in Kids - Implications for Anesthesia  
 12:15pm Developing a Multi-Institutional Pediatric Anesthesia Clinical Study of URIs  
 12:30pm - 1:00pm Future Concerns of Pediatric Anesthesiologists  
 1:00pm **Adjournment**

**For a full meeting program and more information contact:**

**SPA**  
**P.O. Box 11086**  
**1910 Byrd Avenue, Suite 100**  
**Richmond, VA 23230-1086**  
**Ph: (804) 282-9780 • Fax: (804) 282-0090**  
**Email 75112.2053@compuserve.com**

# Learning Objectives

## Goals

Pediatric Anesthesiology 1997 will focus on several specific areas of pediatric anesthetic management. The overall goals for attendees of the program are to reinforce and enhance their existing fund of knowledge in these areas, introduce them to new and state-of-the-art issues that affect their practice, and improve the perioperative and critical care of pediatric patients.

## Scope and Types of Activities

The Program has brought together experts from clinical and basic science disciplines related to pediatric medicine, surgery, anesthesia. Topic areas range from pathophysiology and pharmacology to new techniques and technology and updates on health-care reform. The presentation format includes formal lectures, panel discussions, and hands-on workshops. Additionally, abstracts of new clinical and basic research will be presented in oral and poster-discussion forums moderated by leaders in the field. Significant attendee involvement and feedback are encouraged in all aspects of the program, and will be facilitated by the use of real-time computerized audience polling.

## Audience

This program is intended for pediatric anesthesiologists and other practitioners who care for children in their practice of anesthesiology and/or critical care. It is also intended for clinical and basic researchers whose areas of investigation relate to pediatric anesthesia.

***Upon completion of this Program, the attendee will be able to ...***

## Primary Objectives

- . . .Review and expand current knowledge of pediatric perioperative practices.
- . . .Introduce and incorporate new information and techniques from anesthesiology, surgery, and pediatric medicine.

## Secondary Objectives

- . . .Understand and apply issues involved in the perioperative and anesthetic care of the neonate, including recent advances in neonatal medicine, pain sensation and pain treatment, apnea, and the anesthetic care of the ex-premature infant.
- . . .Discuss and apply new information affecting the perioperative evaluation and anesthetic management of children with asthma, myopathies, and upper respiratory infections.
- . . .Describe complications of tracheal intubation in infants and children along with the approach to their evaluation and treatment.
- . . .Understand current issues in health care reform and managed medical care.
- . . .Be aware of the practice patterns and approaches of his/her colleagues through case presentations and surveys of management choices using computerized real-time audience polling.
- . . .Describe child safety advocacy and the role of child health care providers.
- . . .Use fiberoptic, lightwand, and/or laryngeal mask airway techniques, including indications, contraindications, complications, and adjunct techniques.
- . . .Understand the uses of transesophageal echocardiography in children for both cardiac and non-cardiac surgery. Be familiar with issues regarding credentialing and quality assurance as they relate to pediatric TEE
- . . .Understand and apply selected pediatric critical care methods, including cardiopulmonary resuscitation, intraosseous infusion, and management of mechanical ventilation.
- . . .Describe relevant resources available through his/her personal computer and the Internet and be able to access them.
- . . .Organize and administer a pediatric pain treatment service, including protocols, billing procedures and quality assurance issues.
- . . .Perform a variety of regional anesthetic techniques, including caudal, axillary, epidural, and other upper and lower extremity blocks.
- . . .Understand indications, contraindications, drug selection, side effects, and complications of these regional anesthetic procedures.
- . . .Relate current clinical and basic research issues in pediatric anesthesia.
- . . .Be more informed about future concerns--scientific, educational, and practical--in pediatric anesthesia.

## Accreditation

The Society for Education in Anesthesia (SEA) designates this continuing medical education activity for 16 credit hours in Category I of the Physician's Recognition Award of the American Medical Association.

# Workshop Descriptions

- A) **Airway Workshops.** Organizers: Lynne R. Ferrari, MD; Charles D. Nargozyan, MD.  
Faculty: Lynne R. Ferrari, MD; Guy D. Dear, MD; Joseph Frassica, MD, DMD; Charles D. Nargozyan, MD; Robert J. Moynihan, MD; Lynne Maxwell, MD; Ira Landsman, MD; Scott D. Cook-Sather, MD.
- A1) **LMAs, Lightwands**  
Theoretical and hands-on uses of lightwands and LMAs. Includes use of rigid LMAs including new smaller sizes and the recently available flexible reinforced LMA. New 2 hour format to allow for increased discussion of sedation, topicalization, problem solving, difficult airway issues, etc.
- A2) **Fiberoptics**  
Also in a new 2 hour format to allow for increased discussion of sedation, topicalization, problem-solving, difficult airway issues, etc. Hands-on use of fiberoptic scopes in pediatric applications.
- B) **Pain Workshops.** Organizer: Linda Jo Rice, MD.
- B1) **Common Regional Blocks.** Faculty: Blaine R. Miller, DO.  
Caudal, continuous caudal, Ilioinguinal, and penile blocks; doses, toxicities, use of opioids.
- B2) **Advanced Regional Blocks.** Faculty: Nancy L. Glass, MD; Myron Yaster, MD.  
Overview of axillary, femoral, sciatic, epidural, continuous epidural/caudal. Those seeking more in-depth coverage of specific blocks should attend B3 and/or B4.
- B3) **Managing the Epidural Space.** Faculty: James McNeely, MD; Ann Bailey, MD.  
Caudal to cervical approaches, single-shot techniques, catheter placement and confirmation, monitoring, problem-solving, patient selection. More in-depth treatment of these selected techniques than B2 "Advanced Blocks".
- B4) **Upper Extremity/Lower Extremity Blocks.** Faculty: Alison K. Ross, MD.  
In-depth presentation of axillary, interscalene, supraclavicular, femoral, sciatic, knee, ankle blocks.
- B5) **Reimbursement for Pain Services.** Faculty: Robert T. Wilder, MD, PhD; David E. Cohen, MD.  
Specific billing codes and how to use them, interacting with insurance companies to maximize chances of reimbursement; covers both acute and chronic services.
- B6) **Setting Up a Pain Service-Academic and Private Practice Perspectives.** Faculty: Corrie T.M. Anderson, MD; Thomas R. Vetter, MD.  
Successful academic and private practice approaches to pain service management, including reimbursement, management with and without residents and in-house anesthesia providers.
- B7) **Setting Up an Acute Pain Service.** Faculty: Yuan-Chi Lin, MD.  
Similar to B6, except more specific for acute pain services. How to begin from scratch, hiring and the role of the pain nurse, promoting the service to other hospital departments, monitoring, management with and without residents and in-house anesthesia providers.
- B8) **Setting Up a Chronic Pain Service.** Faculty: Charles B. Berde, MD.  
Similar to B6, but specific to chronic pain. How to begin from scratch or after successful acute service start-up, promoting the service to hospital and community, how to provide 24 hour coverage, how to identify and enlist multidisciplinary team members, monitoring and pain assessment tools.
- C) **CPR / Intraosseous.** Organizer: Charles L. Schleien, MD. Faculty: G. Patricia Cantwell, MD; Jayant K. Deshpande, MD; Hal Shaffner, MD.  
Review and practice pediatric CPR guidelines and intraosseous infusion techniques; new information and controversies in pediatric CPR.
- D) **Managing your Ventilator: Intraoperative and ICU** Organizers: Frank H. Kern, MD; Ira Chieffetz, MD.  
Understanding and using conventional and advanced modes of ventilation and the newer monitors of lung and ventilator function to optimize pulmonary and cardiac performance in the OR and ICU.
- E) **Echocardiography.** Organizers: Anne M. Lynne, MD; Robert H. Friesen, MD.  
Uses of transthoracic and transesophageal echocardiography/Doppler, including introduction to standard techniques and imaging, lesions, quality assurance and accreditation issues.
- F) **Computer / Internet Use: What's' Out There and How to Get It?** Organizers: David S. Jardine, MD; Joseph D. Previte, MD.  
Hardware and software for Internet access, how to connect, what's there and how to find it?
- G) **Women Looking at Power: Its Diverse Sources and Optimum Uses.** Organizer: Helen W. Karl, MD;  
Faculty: Lois Margaret Nora, MD, JD; Maureen Strafford, MD.  
An exploration of the ways that women's perspectives on power can enhance their own lives and the lives of those with whom they interact. (Note: Men certainly welcome and encouraged to attend.)
- H) **Pediatric Anesthesia: Where Can I go From Here?** Organizer: Thomas R. Vetter, MD.  
Participants will learn more about their skills and individual personality profiles and how they might best apply them in the current changing practice environment. Also includes information about non-medical advanced degree options. Extra fee includes processing of a professional questionnaire/skills profile that will be sent to participants for completion before the meeting; from this an individualized 15 page report (confidential) is generated that will be handed out at the start of the workshop and be used as a basis for discussion.

# Workshop Registration

			1st Choice	2nd Choice	3rd Choice	4th Choice	Cost (\$)
Session I	Friday, February 14	2:00pm - 3:00 pm	_____	_____	_____	_____	_____
Session II	Friday, February 14	3:00pm - 4:00 pm	_____	_____	_____	_____	_____
Session III	Saturday, February 15	8:30am - 9:30 am	_____	_____	_____	_____	_____
Session III	Saturday, February 15	9:30am - 10:30 am	_____	_____	_____	_____	_____
							Workshop Total \$ _____

*Shaded areas reflect 2 hour workshops. Please note that 1 and 2 hour workshop prices vary. Figure your workshop cost based on your first choice selection, any difference in price will either be billed or refunded at the time of confirmation. Enter the above workshop total to the reverse side of this registration form.*

Session I • Friday, February 14 • 2:00pm - 3:00 pm							
<b>A1</b> \$40 (2hr)	<b>A2</b> \$40 (2hr)	<b>H</b> \$40 (2hr)	<b>B2</b> \$25 (1hr)	<b>B4</b> \$25 (1hr)	<b>B8</b> \$25 (1hr)	<b>D</b> \$25 (1hr)	<b>F</b> \$25 (1hr)
Session II • Friday, February 14 • 3:00pm - 4:00 pm							
<b>A1</b> Cont.	<b>A2</b> Cont.	<b>H</b> Cont.	<b>B3</b> \$25 (1hr)	<b>B5</b> \$25 (1hr)	<b>C</b> \$25 (1hr)	<b>E</b> \$25 (1hr)	

Session III • Saturday, February 15 • 8:30am - 9:30 am							
<b>A1</b> \$40 (2hr)	<b>A2</b> \$40 (2hr)	<b>G</b> \$25 (2hr)	<b>B1</b> \$25 (1hr)	<b>B6</b> \$25 (1hr)	<b>B7</b> \$25 (1hr)	<b>C</b> \$25 (1hr)	<b>E</b> \$25 (1hr)
Session IV • Saturday, February 15 • 9:30am - 10:30 am							
<b>A1</b> Cont.	<b>A2</b> Cont.	<b>G</b> Cont.	<b>B2</b> \$25 (1hr)	<b>B3</b> \$25 (1hr)	<b>B5</b> \$25 (1hr)	<b>D</b> \$25 (1hr)	<b>F</b> \$25 (1hr)

## Workshop Selections

### A) AIRWAY WORKSHOPS

**A1)** LMAs, Lightwands (2hr)

**A2)** Fiberoptics (2hr)

### B) PAIN WORKSHOPS

**B1)** Common Regional Blocks

**B2)** Advanced Regional Blocks

**B3)** Managing the Epidural Space

**B4)** Upper Extremity/Lower Extremity Blocks

**B5)** Reimbursement for Pain Service

**B6)** Setting Up a Pain Service-Academic and Private Practice Perspectives

**B7)** Setting Up an Acute Pain Service

**B8)** Setting Up a Chronic Pain Service

**C)** CPR / Intraosseous

**D)** Managing your Ventilator: Intraoperative and ICU

**E)** Echocardiography

**F)** Computer / Internet Use: What's Out There and How to Get It?

**G)** Women Looking at Power: Its Diverse Sources and Optimum Uses (2hr)

**H)** Pediatric Anesthesia: Where Can I go From Here? (2hr)



# Membership Application



Society for Pediatric Anesthesia  
 1910 Byrd Avenue, Suite 100, P.O. Box 11086, Richmond, VA 23230-1086  
 Phone (804) 282-9780 • Fax (804) 282-0090  
 Email 75112.2053@compuserve.com

SPA MEMBERSHIP #: \_\_\_\_\_ PLEASE MAKE MY MEMBERSHIP EFFECTIVE: JANUARY 19\_\_\_\_ OR JULY 19\_\_\_\_

Name (Last) _____ (First) _____ (MI) _____		<input type="checkbox"/> M.D.	<input type="checkbox"/> D.O.	<input type="checkbox"/> Ph.D.
PREFERRED MAILING ADDRESS <input type="checkbox"/> This is my Home Address, <input type="checkbox"/> This is my Business Address		<input type="checkbox"/> CRNA <input type="checkbox"/> Other:		
CITY _____		STATE/COUNTRY _____	ZIP/POSTAL CODE _____	
OFFICE PHONE _____	FAX _____	EMAIL _____		
DATE OF BIRTH _____	Month / Day / Year	TYPE OF PRACTICE <input type="checkbox"/> PRIVATE <input type="checkbox"/> UNIVERSITY <input type="checkbox"/> GOVERNMENT <input type="checkbox"/> OTHER:		
HOSPITAL AFFILIATION _____				
ACADEMIC DEGREES AND OTHER PROFESSIONAL CERTIFICATION W/DATES _____				

**I HEREBY MAKE APPLICATION FOR:**

**ACTIVE MEMBERSHIP (PHYSICIAN)\*:**

1.  SPA Membership ..... \$100.00
2.  SPA membership with subscription to ANESTHESIA & ANALGESIA, includes joint membership in IARS ..... \$200.00

**AFFILIATE MEMBERSHIP (NONPHYSICIAN)\*:**

1.  SPA Membership ..... \$100.00
2.  SPA membership with subscription to ANESTHESIA & ANALGESIA, includes joint membership in IARS ..... \$200.00

**INTERNATIONAL MEMBERSHIP\*:**

1.  SPA Membership ..... \$50.00
2.  SPA membership with subscription to ANESTHESIA & ANALGESIA, includes joint membership in IARS ..... \$150.00

\* For additional information on optional joint membership with the Society of Cardiovascular Anesthesiologists and the Society for Ambulatory Anesthesia contact the IARS office at (216) 642-1124.

**RESIDENT MEMBERSHIP: Residency Membership Requires Endorsement By Program Director** (Please complete the below section on Residency)

1.  INCLUDES MEMBERSHIP IN SPA, IARS, SCA, AND SAMBA ..... \$60.00

Residency Location \_\_\_\_\_

Residency Completion Date \_\_\_\_\_ Signature of Program Director \_\_\_\_\_

**PAYMENT OPTION:**

Check or Money Order Enclosed (US Funds) Made Payable to SPA, P.O. Box 11086, Richmond, VA 23230-1086.

Charge My Membership Fees to:  AMEX  Master Card  Visa

Card # \_\_\_\_\_ Expiration Date \_\_\_\_\_

Printed Name on Card \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

**For Office Use Only:**

Check #	_____
Date:	_____
Member:	_____

- International Members receive the journal by surface air lift at no additional charge. Airmail delivery for overseas subscriptions is available for an additional \$167. Canadian members receive the Journal by 2nd Class Mail. Optional expedited delivery for Canadian subscription is available for an additional \$75. (Please Include this amount when paying dues.)

# Hotel Reservation Form

## Pediatric Anesthesiology 1997

February 13-16, 1997  
Hyatt Regency Hill Country Resort  
9800 Hyatt Resort Drive  
San Antonio, TX 78251  
(210) 647-1234  
(210) 520-4075 Fax

Complete this Reservation Form and send Deposit to:

Hyatt Regency Hill Country Resort  
Reservations Department

### Please print or type

Name \_\_\_\_\_  
Last First MI

Preferred Mailing Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Office Phone \_\_\_\_\_ Home Phone \_\_\_\_\_ Fax # \_\_\_\_\_

Accompanying Person(s) Name(s) \_\_\_\_\_ Adults \_\_\_\_\_ Children \_\_\_\_\_

Children under 18 are complimentary in the same room with parents.

**Rates**                       \$189 Single       \$189 Double       \$285 1-Bedroom Suite  
All rates quoted are exclusive of state/local tax, currently 15%.

### Please Reserve:

\_\_\_\_\_ Rooms    My Arrival Date is: \_\_\_\_\_ Arrival Time: \_\_\_\_\_ My Departure Date is: \_\_\_\_\_

Check in time is 4:00pm, check out time is 12 noon. For suites, please contact hotel directly.

Non Smoking     Smoking             King             Double/Double             Suite - please inquire  
(Based on availability)

Special Requests: \_\_\_\_\_

**In order to guarantee your reservation, please include the first night's deposit.**

Enclosed is my check in the amount of \$ \_\_\_\_\_.

Please charge first night's deposit to my       VISA     MasterCard     American Express     Diners Club

Card No. \_\_\_\_\_ Exp. Date \_\_\_\_\_

Signature \_\_\_\_\_ Name Printed on Card \_\_\_\_\_

18. Credit Card charged upon receipt. Reservations cancelled 72 hours prior to arrival date will receive a full refund.

**Cut-off date: January 23, 1997**

All rooms are subject to availability

---

## HOT TOPIC:

# Accreditation for Training Programs in Pediatric Anesthesiology

By Mark A. Rockoff, M.D.  
Children's Hospital, Boston

Many of you are aware that an application is pending for formal accreditation of fellowship programs in pediatric anesthesiology. This application was submitted by the leadership of all four organizations with an interest in pediatric anesthesiology, including the Society for Pediatric Anesthesia (SPA), the Section on Anesthesiology of the American Academy of Pediatrics (AAP), the Committee on Pediatric Anesthesia of the American Society of Anesthesiologists (ASA), and an informal study group of pediatric anesthesiologists who have been discussing pediatric anesthesia issues for several years. These individuals have subsequently organized into a Council of Pediatric Anesthesiology Fellowship Programs in order to guide the application through the process necessary for approval.

The method by which training programs in medicine receive formal accreditation is a slow, laborious one. First, an application must be submitted to the Residency Review Committee (RRC) in the appropriate specialty (in our case, Anesthesiology). This was done in August, 1995. It included not just a thorough description of the requirements for training in pediatric anesthesiology, but also an extensive justification for the application and a statement discussing the impact this would have on training programs in other specialties.

The RRC (Anesthesiology) is composed of representatives from the ASA, the American Board of Anesthesiologists, and the Council on Medical Education of the American Medical Association. In April, 1996, Dr. Mike Badgwell and I, serving as representatives of the Council, appeared before a hearing of the RRC (Anesthesiology) to review the ap-

plication and answer questions about it. The RRC (Anesthesiology) made some changes in the document and the RRC (Anesthesiology) representatives from the ASA then noted in their annual report to the ASA's House of Delegates in September, 1996, that comments were welcome.

---

*The method by which  
training programs  
in medicine  
receive formal  
accreditation is a  
slow, laborious one.*

---

At the Annual Meeting of the ASA in New Orleans in October, representatives from all the pediatric anesthesia organizations that submitted the original application spoke in favor of it. Some opposition was noted from individuals who confused accreditation of training programs with credentialing or certification of individuals. Some were concerned that accreditation of training programs would lead to restriction of privileges for general anesthesiologists who care for children. After much discussion with anesthesiologists from around the country, this matter was presented for a vote to the ASA's House of Delegates on the final day of the meeting. The final Resolution contained a statement supporting the concept of accreditation of training programs within certain subspecialties of anesthesia, but oppos-

ing certification of individuals by the American Board of Anesthesiology in additional subspecialties of anesthesiology. This was the only close vote at the entire meeting, but it did pass. However, Board certification of individuals in pediatric anesthesiology was not being sought, so the Resolution should have no adverse impact on the application for accreditation of fellowship programs in pediatric anesthesiology; it can perhaps even be viewed as supportive of this effort.

The RRC has also submitted the application to the parent organizations of the Accreditation Council on Graduate Medical Education (ACGME) for review. These are 1) the American Medical Association, 2) the American Hospital Association, 3) the American Board of Medical Specialties, 4) the Association of American Medical Colleges, and 5) the Council of Medical Specialty Societies. The process of final review by the RRC and ACGME will take another year or so. Hopefully, both groups will approve the application and it will be effective on July 1, 1998. Then, anesthesiology will join the approximately twenty other medical and surgical specialties that already have accredited training programs in subspecialties of pediatrics. I will keep you apprised of developments in this regard and want to express my sincere thanks to all of the many pediatric anesthesiologists who have worked so hard to get to this stage. ❖



---

---

# Continuing Medical Education Needs Assessment

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 annual/winter meeting?

<b>Very Much</b>	-	-	-	<b>Not at All</b>
1	2	3	4	5

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

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

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

<b>Very Much</b>	-	-	-	<b>Not at All</b>
1	2	3	4	5

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

<b>Very Much</b>	-	-	-	<b>Not at All</b>
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: 75112.2053@compuserve.com

---

# SPA develops a homepage on the WWW

## The Super Highway of Technology

By Joseph Previte, M.D.  
Arkansas Children's Hospital

The Society for Pediatric Anesthesia has joined many other organizations by developing a homepage on the "World Wide Web." The purpose of creating a homepage is multi-fold. In our day of rapidly expanding technological communications, the SPA will be available at all times to providers of pediatric anesthesia, as well as other anesthesia providers.

Currently, the SPA homepage provides the Internet "surfer" with the mission statement of the Society. The mission statement was recently revised at the Executive Board Meeting of the SPA in the Fall of 1996, and the revisions will be incorporated onto the site in the near future. In addition to the above, users can access the bylaws of the SPA, a list of the officers, directors, and other chairs of the Society, a list of future meetings of interest to providers of pediatric anesthesia, and a list of current job opportunities for full and part-time pediatric anesthesiologists. A link to available research funding is also being considered, but currently remains "Under Construction." The homepage continues to strive to be as user friendly as possible, and contact phone numbers, and e-mail addresses are provided under the appropriate sections.

There exists a link to review information regarding the upcoming joint meeting presented by the Society for Pediatric Anesthesia, the American Academy of Pediatrics-Section on Anesthesiology, and the Society for Education in Anesthesia in San Antonio, Texas, February 13-16, 1997. Information contained on the link includes the educational program, list of the planning committee, faculty, the scientific program, general information, learning objectives, workshop descriptions, and a copy of the registration form. Although the registration form can not be completed by e-mail at

this time, plans in the future include the ability not only to be able to register for meetings, but also to apply for membership in the SPA for both North American anesthesiologists as well as anesthesiologists abroad.

---

*...the upcoming meeting in San Antonio will include a workshop concerning 'Computer/Internet Use: What's Out There and How to Get It'*

---

Of interest, the upcoming meeting in San Antonio will include a workshop concerning "Computer/Internet Use: What's Out There and How to Get It" presented by David S. Jardine of Seattle Children's Hospital and Joseph Previte of Arkansas Children's Hospital. It will encompass how to obtain and implement the appropriate hardware to gain access to the Internet, and how to conduct searches on the Internet and access information that may not be intuitively easily accessible. David Jardine presented a similar workshop at last year's SPA meeting that was well attended.

Plans in the future for the homepage include presentation of select articles from the SPA newsletter, and may extend to providing abstracts and presentations included at the bi-annual meetings of the SPA. The members of the Executive Board wisely decided at the most recent meeting to not include the entire



Joseph Previte, M.D.  
"Webmaster"

newsletter on the homepage, as this would relinquish a privilege of membership of the SPA. Other suggestions for uses of the homepage continue to arrive, and are currently being considered for inclusion.

The Society for Pediatric Anesthesia Homepage's current address is: <http://www.uams.edu/spa/spa.htm>, and can also be readily accessed by conducting a search on most servers looking for "Society for Pediatric Anesthesia." The University of Arkansas-Little Rock recently changed servers, and the Division of Pediatric Anesthesia at Arkansas Children's Hospital, where the homepage is based, expects to be connected in the near future. Because of this, the address may change again, but access via searches on the 'net' should still easily connect one to the page. Check out the site, and if you have any comments or suggestions, contact Joseph Previte at: [jprevite@anesmail.ach.uams.edu](mailto:jprevite@anesmail.ach.uams.edu). ❖

# New Members

(Continued from page 3)

Ana J. Corcino, MD  
Philadelphia, PA  
Joseph P. Cravero, MD  
Hanover, NH  
Turakhia Daksha, MD  
Bossier, LA  
James D. Davis, MD  
La Grange, TX  
Renato S. Del Carmen, MD  
Fullerton, CA  
Josephine E. Detar, MD  
Plattsburgh, NY  
Mark S. Donnell, MD  
Silver City, NM  
John Donnelly, FANZCA  
Cremorne, NSW, Australia  
Miguel A. Eliza, MDA  
San Juan, PR  
Frank Faillace, MD  
Reston, VA  
Bill A. Falinski, MD  
Chattanooga, TN  
R. Peter Farran, MD  
Calgary, AB, Canada  
Ricardo Feliciano, MD  
Santurce, PR  
David J. Fischer, MD  
Santa Barbara, CA  
Erin P. Foley, MD  
Brighton, MA  
Brent S. Follweiler, MD  
Coatesville, PA  
Charles Fox, MD  
Dallas, TX  
Mark Goldfinger, MD  
Cleveland, OH  
Helena B. Gunnerson, MD  
Maywood, IL  
Chike B. Gwam, MD  
Hinsdale, IL  
Shaanaz Hamid, MB, FRCA  
Mt Vernon, Glasgow, Scotland  
Lynn G. Henson, Pharm.D  
Research Triangle Park, NC  
Rodrigo Herreros, MD  
Vitacura, Santiago, Chile  
Ronald M. Isaac, MD  
Libertyville, IL  
Lawrence Jacobson, MD  
Seattle, WA  
Peter A. Jensen, MD  
Anchorage, AK  
Wandana Joshi, DO  
Wilbraham, MA

Raymond M. Josen, Jr., MD  
Fountainville, PA  
Kaoru Kagao, MD  
Minneapolis, MN  
Michael J. Karbowski, MD PhD  
Seattle, WA  
Prasad R. Kilaro, MD  
Longmeadow, MA  
Mathis Kirby, MD  
Richmond, VA  
Sandor R. Kiss, MD  
Portland, OR  
Graciela M. Koch, MD  
Mendoza, Argentina  
George P. Koclanes, MD  
Metairie, LA  
James Koppel, MD  
Rockville Center, NY  
Maria R. G. Lagade, MD  
Old Field, NY  
Dennis F. Landers, MD PhD  
Dallas, TX  
Mark Levine, MBBCh  
Willowdale, ON, Canada  
Elizabeth McLeod, MD FRCPC  
Toronto, ON, Canada  
Petra Meier, MD  
Bern Switzerland  
Gil F. Mendoza, MD  
Huntington, WV  
Amy E. Mesa-Jonassen, MD  
Pleasantville, NY  
Dennis Molinari, MD  
Sarasota, FL  
Richard A. Moore, MD  
Grand Junction, CO  
John Mullican, MD  
Albuquerque, NM  
Carrie Murdoch, MD  
Tampa, FL  
Stephan P. Nebbia, MD  
Amherst, NY  
Michael A. Nemirov, MD  
Port Jefferson, NY  
Dolores B. Njoku, MD  
Baltimore, MD  
Ray Noble, PhD  
London, UK  
Erez A. Ofir, MD  
Blacksburg, VA  
Babatunji O. Omotoso, MB, BS  
Biloxi, MS  
Bernhard Ott, MD  
Munster, Germany  
Ira Padnos, MD  
New Orleans, LA  
Sally Parker, BM  
Seattle, WA  
William Peterson, MD  
Okemos, MI  
Robert Rauch, MD  
New York, NY

Alexander Reich, PhD  
Havixbeck, Germany  
Clay Risk, MD  
Potomac, MD  
Efrain Rivera, Jr., MD  
El Paso, TX  
Frederick A. Robertson, MD  
Milwaukee, WI  
Hafez M. Sami, MD PhD  
Naperville, IL  
Pheodora L. Shin, MD  
Bedminster, NJ  
Renata D. Sibarani-Ponsen, MD  
Amsterdam, The Netherlands  
Donna J. Slayton, MD  
Charleston, WV  
Scott E. Smith, MD  
Dallas, TX  
Joseph L. Staggenborg, MD  
Springfield, IL  
Red E. Starks, MD  
San Antonio, TX  
Susan R. Staudt, MD  
Colleyville, TX  
Craig M. Steiner, MD  
Downingtown, PA  
Harvey Stern, MD  
Worthington, OH  
Jo Swartz, MD FRCPC  
Winnipeg, MB, Canada  
Susan Sweden, MD  
North Ridgeville, OH  
G. M. Tan, MBBS  
Ladywood, Birmingham, UK  
Lee A. Taylor, MD  
Portland, OR  
James J. Thomas, MD  
Raymond, MO  
Caroline Thompsett, MD  
Ann Arbor, MI  
Abraham Van Der Spek, MD  
Ann Arbor, MI  
Daniel Vischoff, MD  
Montreal, PQ, Canada  
Patrick J. Vlahos, DO  
Pittsburgh, PA  
Kim L. Walker, MD  
Hershey, PA  
Scott G. Walker, MD  
Indianapolis, IN  
Jonathan H. Warren, FANZCA  
Auckland, New Zealand  
Daniel D. Wert, DO  
Lancaster, PA  
David P. Whalen, MD  
Sacramento, CA  
Tamara J. Wheeler, MD  
Nashville, TN  
Roland B. Wilson, Jr., MD  
Wabash, IN  
Susan D. Yost, MD  
Annandale, VA

---

## Society for Pediatric Anesthesia



1910 Byrd Ave., Suite 100  
P.O. Box 11086  
Richmond, VA 23230-1086

Non-Profit Org.  
U.S. Postage  
**PAID**  
Permit No. 956  
Richmond, VA

---

### Officers

#### President

**Mark A. Rockoff, MD**  
*Chair, Executive Committee*  
Boston Children's Hospital  
Boston, MA

#### Vice President

**Steven C. Hall, MD**  
*Chair, Education Committee*  
Children's Memorial Hospital  
Chicago, IL

#### Secretary

**Peter J. Davis, MD**  
*Chair, Membership Committee*  
Children's Hospital of Pittsburgh  
Pittsburgh, PA

#### Treasurer

**Anne M. Lynn, MD**  
*Chair, Finance Committee*  
Children's Hospital  
Seattle, WA

#### Immediate Past President

**William J. Greeley, MD**  
Children's Hospital of  
Philadelphia  
Philadelphia, PA

---

### Board of Directors

**Lynda J. Means, MD**  
*Chair, AAP, Anesthesia Section*  
Riley Children's Hospital  
Indianapolis, IN

**J. Michael Badgwell, MD**  
*Chair, Government Affairs  
Committee*  
Children's Hospital at Texas Tech  
University Health Sciences  
Center  
Lubbock, TX

**Ann G. Bailey, MD**  
University of North Carolina  
Hospitals  
Chapel Hill, NC

**Raeferd E. Brown, Jr., MD**  
*Chair, Communications  
Committee*  
Arkansas Children's Hospital  
Little Rock, AR

**Jayant K. Deshpande, MD**  
*Chair, Publications Committee*  
Vanderbilt University Medical  
Center  
Nashville, TN

**David G. Nichols, MD**  
*Chair, Research Committee*  
Johns Hopkins Hospital  
Baltimore, MD

**Peter T. Rothstein, MD**  
Babies and Children's Hospital  
Columbia-Presbyterian Medical  
Center  
New York, NY

**James Viney, MD**  
*Chair, Bylaws Committee*  
Primary Children's Medical  
Center  
Salt Lake City, UT

---

### Program Chairs

**Joseph R. Tobin, MD**  
*Annual Meeting*  
Bowman Gray School of  
Medicine  
Winston-Salem, NC

**Francis X. McGowan, Jr., MD**  
*Winter Meeting*  
Boston Children's Hospital  
Boston, MA