MESSAGE FROM THE CHAIRMAN:

~SCOTT T. REEVES, MD, MBA

So Blessed.

It has been about a year since the department and MUSC graciously arranged for a substantial donation of surplus medical equipment to be sent to 4 hospitals in Tanzania. The donation consisted of approximately 50 Phillips monitors and 100 Nelcor pulse oximeters. This equipment was slated to be sold as scrap. After the donation was finalized, the department worked with a Non-Governmental Organization (NGO), Madaktari Africa, to arrange to have a container ship transport the donated equipment for free to the Tanzania sea port of Dar Es Salaam on the Indian Ocean. This transportation took several months to arrange and another two months on the ship. Once the materials arrived in Dar, establishing distribution throughout Tanzania took another 6 months. I have to admit there were times that I felt that it would never get to the donated hospitals.

During the week of March 18, I traveled to Tanzania with one of our biotechnicians, Robert Tritt, and we installed the equipment at the Bugando Medical Center in Mwanza and the Muhimbili National Hospital in Dar Es Salaam. The national response to MUSC’s donation was amazing. Other organizations had made small donations over the years but none of them took the time to actually assist with installation and training of the local biotech, nursing and physician personnel. Once they learned what capacity Robert had and his extensive expertise with the equipment, he was treated like a rock star!

We met with Dr. Marina Njelekela, the Executive Director of the Muhimbili National Hospital complex as well as other leaders. The highlight of the trip for Robert and me was a 30 minute personal thank you from President Jakaya Kikwete in the Tanzania White House.

As we were leaving, Drs. Peter Zwerner and Eric Powers were arriving. They were assisting in opening a new cardiac facility in Dar Es Salaam. After getting home, I received a copy of our Affiliation Agreement with Bugando Medical Center for FY 2014 which will allow the department to continue to send residents to this underserved country. MUSC is doing great things to improve patient safety and delivery of care in this East African country, but we are the ones who are so blessed to have the opportunity to help.
PERSONAL THANK YOU FROM TANZANIA PRESIDENT, JAKAYA KIKWETE

Dr. Reeves with Tanzania President, Jakaya Kikwete in the Tanzania White House.

IARS ANNUAL MEETING UPDATE

MUSC’s Department of Anesthesiology and Perioperative Medicine was well represented at the 2013 International Anesthesia Research Society annual meeting in San Diego, CA by Drs. Sylvia Wilson, Dorothea Rosenberger and David Stoll. Dr. Wilson served as an instructor for both the Advanced Ultrasound Guided Regional Anesthesia Workshop and the Ultrasound, Simulation and Stimulation for Peripheral Nerve Block Workshop. Dr. Wilson also gave a lecture on proximal ultrasound guided sciatic nerve blocks preceding the Advanced Ultrasound Guided Regional Anesthesia workshop. Dr. Stoll presented a poster regarding his research on the Application of the Surgical APGAR Score as an Outcome Measure in Cadaveric Kidney Transplant Patients.

From Left to right (front) Dr. Jacques Chelly, University of Pittsburgh; Dr. Sylvia Wilson, MUSC; (back) Dr. Peter Foldes, University of Iowa; Dr. Vicki Modest, Massachusetts General Hospital; Dr. Vincent Chan, University of Toronto, with his wife Anne Chan
IARS Annual Meeting Update continued...

Dr. David Stoll presenting his poster at the IARS Annual Meeting: Application of the Surgical APGAR Score as an Outcome Measure in Cadaveric Kidney Transplant Patients. Authors: Seth Palesch, MD; W. David Stoll, MD; and Latha Hebbar, MBBS, MD

Society of Obstetric Anesthesia and Perinatology (SOAP) Annual Meeting

Above: Effect of Intraoperative Phenylephrine Infusion on Redistribution Hypothermia during Cesarean Section under Spinal Anesthesia.
Authors: Latha Hebbar MD, FRCA; Sylvia Wilson MD; and Ebony Hilton MD

Below: Ethnic Differences in Labor Epidural Request and Subsequent Pain Relief.
Authors: Sylvia H. Wilson, MD; Matthew Elliot, MD; and Latha Hebbar, MD, FRCA
I am happy to announce that Dr. Scott Walton will be the new division chief for pediatric anesthesiology. Scott arrived at MUSC in 1981 as a medical student. He returned in 1990 for residency and has been serving as faculty in the department of Anesthesia and Perioperative Medicine since 1998.

Scott has been a longtime leader in the department having served as Medical Director for the main operating rooms for many years prior to 2007 and section head of the pediatric cardiac anesthesia section since 2008.

He is Board Certified in Anesthesiology and Intraoperative Transesophageal Echocardiography and is a Fellow of the American Academy of Pediatrics.

Charles Wallace (first pediatric anesthesiologist at MUSC) and Calvert Alpert (first pediatric cardiac anesthesiologist at MUSC) have served as primary mentors for Scott’s development as a pediatric anesthesiologist at MUSC. With those roots as his foundation, he will lead MUSC’s pediatric anesthesia division as the subspecialty becomes officially recognized by the American Board of Medical Specialties. Subspecialty certification becomes available this year, and the goal of the division will be 100% certified within 2 years.

Outstanding clinical care has led to Scott being named one of America’s Best Doctors® since 2007. Outstanding clinical care will be a significant focus of the pediatric anesthesia division going forward. The division’s education of residents, fellows and medical students will occur in the setting of outstanding care and progressive collegiality.

Scott can be reached in the department at 792-2322 or by email at waltonjs@musc.edu. Please contact him regarding your pediatric anesthesiology questions and concerns.
At the beginning of May, I had the pleasure of traveling to Washington D.C. for the ASA Legislative Conference with the intent of learning what challenges our specialty faces in the coming years and educating our national legislators on what it means to administer care in the field of Anesthesiology. I'm confident that we are all aware of how much is changing in healthcare, which only serves to emphasize how essential political activism is to ensure our collective goal of quality care and patient safety. I felt compelled to share what I learned while there as political awareness is becoming increasingly important for all of medicine and especially for the field of Anesthesiology.

The conference this year focused on a number of topics which are central to our practice. One of the most compelling was the Perioperative Surgical Home. This model is comprised of a robust Preoperative Clinic focused on complete evaluation and optimization of patients prior to their procedure. Then, patients are led into an EBM intra-operative phase followed by the comprehensive support of an anesthesia-led post-operative management team. This model presents a unique opportunity for Anesthesiology to show our value in healthcare by highlighting our competitive advantage in perioperative medicine. In addition, it has the potential to dramatically lower healthcare costs. There currently is no Medicare billing model for this concept. This deficiency presents an opportunity for a political platform to advance patient care and our specialty.

The PPACA or Obamacare created the IPAB (Independent Payment Advisory Board) which is comprised of an unelected 15 member council which may not be made up of more than 7 healthcare professionals who are not permitted to practice medicine for a specified period of time in order to qualify as a member. Their primary purpose will be to modify Medicare reimbursements. On the national level, the ASA does not support this and is pushing to repeal this section of the law.

An old but increasingly important topic in our field was brought up again this year. Medicare reimbursements for Anesthesia services are 33% percent of private insurance rates as compared to 60-80% for other specialties. This was a result of a legislative error and years later still remains to be fixed.

The SGR has been a topic of contention for a long time now for all physicians. This year there is a unique chance to repeal SGR legislation as the CBO projected that a repeal of SGR would only cost $138 billion (Bargain!) as opposed to the previous estimate of $330 billion.

After discussing state and national issues regarding our specialty among members from all over the country, we traveled to Capitol Hill to meet with our representatives. We discussed all of the above topics in detail. I was impressed with the knowledge of the staff on these issues affecting our specialty. All were in agreement of the need to repeal IPAB and the unique opportunity the new CBO estimate of the cost of SGR repeal presents this year. We described the excessive burden that such a low Medicare reimbursement rate presents to our specialty and encouraged legislation to address this topic. We presented the Perioperative Surgical Home as a potential political platform to cut costs while improving care. We went on to describe how Anesthesiology has promoted patient safety through evidence based protocols for many years and continues to pioneer optimum healthcare delivery. Finally, we emphasized how an Anesthesia Care Team works together at MUSC to deliver superb healthcare to our complex patient population. To that end, we extended sincere invitations to any and all of the staff or Congressmen to come observe what we do as a department and how we can implement a Perioperative Surgical Home in this state. Overall, we highlighted our value as leaders both inside and outside of the operating room, and learned how important political advocacy is for our specialty.

The national forum put into perspective how our practice patterns at MUSC resonate throughout the state and country. I would like to thank the department for the opportunity to learn and represent us in Washington.
**MAY 3, 2013: WATER MAIN BREAKS, CLOSING RUTLEDGE TOWER**

On May 3rd, Rutledge Tower Hospital experienced a main water line break which resulted in no water and a disrupted air supply. Four of the operating rooms were not allowed to start their first cases of the day. In order to prevent cancellation of cases, it was decided to try to move half of the cases to the main ORs. This was accomplished by opening four closed rooms in the main ORs and staffing them with RT OR and PACU nursing staff. Anesthesia staff, OR staff, and all of the required equipment were brought to the main with only a delay of less than an hour to facilitate the change. The end result was a new record of cases being completed in the main totaling 70 for the day. This could not have been achieved without everyone’s hard work and flexibility to make sure these patients did not get cancelled and still received the best care possible.

Not to be outdone, ART ran a room of plastic surgery from RT. After a room in service from Jane Swing CRNA, RT CRNA Phil Ridgley and Dr. Jerell Brown provided anesthesia for the cases. Despite only having 3 anesthesia technicians, the additional room was covered in their typically professional fashion. Both the UH and ART PACUs were phenomenal in expediting patients through to accommodate the increase volume.

Excellent team work. We truly "did what was possible!" Dr. Tom Epperson, UH Doctor of the Day, and Heather Highland, CRNA coordinator, in front of a completed OR scheduling board.
As chairman of the ASE’s Council of Perioperative Echocardiography (COPE) and president of the Society of Cardiovascular Anesthesiologists, it is my pleasure to announce that the document Basic Perioperative Transesophageal Echocardiography Examination: A Consensus Statement of the American Society of Echocardiography and the Society of Cardiovascular Anesthesiologists has been published in the Journal of the American Society of Echocardiography. COPE considers this a pivotal document summarizing and clarifying the scope of basic perioperative transesophageal echocardiography (PTE). The ASE/SCA have a long history with this concept resulting eventually in the formation of the National Board of Echocardiography (NBE) to administer an examination in both advanced and basic PTE. For the first time, an anesthesiologist will be able to delineate what a basic PTE is in a single document.

CONGRATULATIONS TO DR. HILTON, DR. BROWN, AND DR. HEINKE FOR BECOMING BOARD CERTIFIED BY THE AMERICAN BOARD OF ANESTHESIOLOGY

Ebony Hilton, MD  Jerell Brown, MD  Timothy Heinke, MD
Dr. Sylvia Wilson was first author on a featured article in Anesthesiology News this month entitled, “Regional Anesthesia for Ambulatory Surgery: The Ideal Technique for a Growing Practice.”

This review examined the general principles of regional anesthesia and the indications for different techniques by surgical procedure. Evidence for the benefits and drawbacks of regional anesthesia were presented with special regards to an ambulatory patient population. Management of regional anesthesia in a busy practice was discussed including required nursing assistance, surgical support, and infrastructure. Benefits of continuous peripheral techniques were discussed as well as potential economic benefits. The article concluded with some future directions in regional anesthesia. If you would like to read the full article, please visit..

http://www.anesthesiologynews.com/download/Ambulatory_AN0413_WM.pdf
or

Great job Dr. Wilson!
A CAREER IN MEDICINE — WHERE THE JOURNEY BEGAN

In 2004 the department established a staff position for a research specialist. While the primary purpose of this position was to fulfill the need for assistance to faculty engaged in research, the secondary purpose was to provide a year of employment in the medical field for an aspiring medical student. After the success of the position’s first year as well as increased department research and collaboration with the Department of Psychiatry (Dr. Jeff Borckardt), the position was expanded to two slots.

This year marks not only the ninth year of the position but the completion of medical training for our first “success stories.” Three of our research specialists are finishing their residency this year.

Audrey Barry, MD – Research Specialist 2004-2005
Medical School: MUSC
Residency: University of Tennessee, OB/GYN

Amanda Barnhorst, MD – Research Specialist 2005-2006
Medical School: MUSC
Residency: Medical College of Virginia – Emergency Medicine
Fellowship: Critical Care Medicine, Montefiore

Medical School: MUSC
Residency: Georgetown University Hospital – Emergency Medicine, Chief Resident
Private practice Fairfax, VA

Since 2004 the department has had fifteen research specialists, and all except one have entered the field of medicine. Our upcoming success stories:

Caroline Hunter, MD (2006-07) Rising PGY3 Anesthesia, Mass General
Haley Moore, MD (2007-09) Finishing MUSC, starting Emergency Medicine residency, West VA University
Will Beam, MD (2008-09) Finishing USC, starting Internal Medicine residency Greenville Hospital System
Luke Dong (2009-10) Rising 4th year medical student MUSC
Heather Frohman (2009-10) Rising 4th year medical student University of South Florida
Josh May (2010-11) Private industry
Kevin Ryan (2010-11) Rising 3rd year medical student MUSC
Lauren Anderson (2010-11) Rising 3rd year medical student USC
Sarah Fredrich (2011-12) Rising 2nd year medical student USC
Milty Kerdemelidis (2011-12) Rising 2nd year medical student MUSC
Molly Hook (2012-13) Rising 1st year medical student MUSC
Tim Fletcher (2012-14) Rising 2nd year Anesthesia research specialist
In March, I had an opportunity to visit Tanzania, Africa, for a week. It took about a year to prepare for Dr. Scott Reeves and myself to go on this trip. The trip came about because in January of 2011 the Neonatal Nurseries updated their bedside monitoring, and sent the old ones to the warehouse for scrap. For a year they sat, until Dr. Reeves saw them and had a vision for where they should go. He was able to get MUSC to donate them to Madaktari Africa.

Madaktari Africa is a volunteer organization which focuses on training local healthcare providers via the “teach the teacher” idea. I was asked if I would go and teach them how to install, use and service the monitors, and of course, I said yes. Now the hard work starts—organizing and crating the monitors and equipment going to the hospitals in three different cities. It took several months to ship, get through customs and arrive at the hospitals. In October of 2012, the equipment had arrived at the port of Dar Es Salaam but it would not be until March that it would be at their final hospital designations.

The first week in March, it was thumbs up. On Thursday the 14th Dr. Reeves and I are on a plane going to Africa. We landed in Kilimanjaro late Friday night. By Sunday, we had made the trip by Land Rover from Kilimanjaro to Mwanza passing through the Serengeti. On Monday, we went to Bugando Medical Center and joined morning rounds for the Anesthesia Nurse Anesthetists students. Even though the primary language was Swahili, English was spoken with a thick accent allowing communication between our team and our hosts to occur.

Following the two hour morning teaching rounds, we met with the Bugando biomed team to unpack the equipment from their shipping crates and to see where they were to be installed. We got 4 monitors up in the ICU that replaced the broken ones that day. We came back the next day to finish up with the pulse oximeters. We changed the batteries and put them throughout the hospital (PACU, ER, and ICU). I also trained the biomed team on how to install and service the monitors, and the ICU staff on how to use their new monitors. Wednesday was a travel day from Mwanza to Dar es Salaam on about a 45 minute plane ride. We had lunch and dinner with Dr. Mohammed Janabi, our host and the Physician to the President.

Thursday the 21st we went to Muhimbili National Hospital, and met with Dr. Marina Njelekeka, who is the Executive Director. We also met the biomed staff and started to go to work mounting the monitors in a newly planned 16 bed ICU. We were able to get one up and running before we left to go and meet Jakaya Kikwete the President of Tanzania. That night we went out for dinner with Dr. Njelekeka and some of the doctors from her staff.

Friday morning the Muhimbili biomed team and I got right to work and got the other monitors up and running in that ICU. The biomed team had worked after we left the day before and got three mounting brackets up which made it so we were able to knock them out quicker. They only had 4 monitors in the ICU, and we added 6 before I left. I also trained the biomed team on how to install and service them. I heard at dinner that the biomed team had started hanging the mounting brackets in other areas of the hospital after we left. By midnight we were on a plane heading back home. We did not stop moving from the time the plane landed until wheels up on the return flight. It was an awesome trip to go and be of service to Tanzania and see the monitors in their new homes.

At Buganda Medical Center’s ICU with biomed team and staff along with newly hung donated monitor.
Tanzania Summary with Robert Tritt, MUSC Biotechnician continued...

Left: At Muhimbili National Hospital ICU with their biomed team and the head of the ICU.

Below: At Muhimbili National Hospital with Dr Reeves, Dr. Marina Njelekela the Executive Director, Dr. Mohammed Janabi and other staff members.

Above: Crated monitors in Dar es Salaam at Muhimbili National Hospital

Neonatal Communication Board Highlighting the Tanzania Trip
Professor Andrea Gabrielli, MD, FCCM, from University of Florida College of Medicine, Gainesville was our “2013 Redding Lecturer.”

Dr. Gabrielli is Program Director, Fellowship Director and Division Chief of Critical Care Medicine at University Hospital in Gainesville, Florida. He oversees 48 surgical critical care beds and an additional 30 neurocritical care and step-down beds on campus. Twelve fellows and seven fulltime faculty members that are on his team. No doubt, it is a very powerful Anesthesia Critical Care Division!

Andrea Gabrielli is an Anesthesiologist and Critical Care physician, trained in Italy and the United States. He holds board certifications in multiple disciplines (surgery, internal medicine and anesthesiology with critical care), and talks English as fast as Italian. “Renaissance Man” describes him best!

Dr. Gabrielli’s expertise and passion is critical care medicine. He is an author of at least 5 text books and co-author of countless book chapters in critical care and neurocritical care medicine, more than 50 peer reviewed original research papers in high wire journals and a lecturer and board member for the ASA, SCCM and SOCCA.

We were fortunate to have him present lectures in our interdisciplinary critical care grand rounds, residents’ lecture series and anesthesiology grand rounds. He presented two lectures, “Neurocritical Care Update” and “Neuroinjuries and the OR: A Crash Course for Anesthesiologists.” We learned a lot about managing patients with elevated ICP and altered cerebral perfusion pressure. We also were informed about the latest research on cerebral autoregulation and how to make use of new “gadgets” to measure ICP, CPP and cerebral oxygenation.

Dr. Gabrielli was a true “Redding lecturer.” Why? Because Dr. Redding was also a “Renaissance Man!”

Dr. Joseph S. Redding earned his MD degree from the University of Maryland in 1948, completed his internal medicine residency followed by anesthesiology. He was a Professor at Johns Hopkins University in Maryland prior to joining MUSC in 1974. He built up the “Division of Critical Care” for the Department of Anesthesia. He was recognized as an expert, educator, researcher and pioneer in critical care medicine and cardiorespiratory resuscitation. In honor of his accomplishments, the Joseph S. Redding, MD Critical Care Fund was established to support the department and the university in their missions of service in patient care, research and education. These funds provide support for guest lecturers with expertise in the area of critical care medicine.

I am sure Dr. Redding would have been pleased with us inviting Dr. Andrea Gabrielli.
DEPARTMENT HURRICANE PLAN: THE SEASON BEGINS IN JUNE
START PREPARING NOW

Department Weather Emergency Staffing:

• During weather emergencies, the Rutledge Tower ambulatory surgery facility will be closed to surgical procedures.

• The University Hospital Operating Room will be staffed by the following members of the Activation Team (designated, essential personnel):

  o Faculty: Two faculty scheduled to cover the date of the anticipated Weather Emergency (Step 3 above) will be assigned in house call.
    • If the scheduled in-house call attending is pediatric capable (peds, peds CT) then the second in house attending will be the Bold 1 faculty.
    • If the in house call attending is not peds capable then the second faculty in house person will be determined by the following order. The first available pediatric capable faculty will assume the in house duty.
      o Bold 1(peds, peds CT faculty)
      o Bold 2(peds, peds CT faculty)
      o Peds

  o Residents: The designated CA 3, CA 2, two CA 1s, and liver call residents scheduled for duty on that date.

  o CRNAs: The scheduled 24 hour call CRNA or the late CRNA when a 24 hour individual is not scheduled. A second 24 hour CRNA volunteer will be designated. The Chief CRNA will make this determination during the Step 1 (weather watch) planning stage.

  o Anesthesia Technicians: Two anesthesia technicians will remain in the hospital commencing with Step 3 conditions. These individuals will be named by the Anesthesia Technician supervisor from anesthesia tech “Team A” during the Step 3 planning phase.

• The Ashley River Tower Operating Room will be staffed by the following members of the Activation Team (designated, essential personnel):

  o Faculty: The cardiothoracic anesthesia and critical care attending scheduled to cover the date of the anticipated Weather Emergency (Step 3 above).

  o Residents: ART and the MSICU call residents.

  o CT and Critical Care Fellow: The on call CT and Critical Care fellows will stay in house. If no CT or Critical Care fellows are assigned on call, one of the fellows will be assigned as determined by the CT and CC Fellowship Program Directors.

  o CRNAs: A CRNA will be assigned to stay in-house. The Chief CRNA will make this determination during Step 1 (weather watch) planning stage.
IV. Post-Storm Staffing:

Reinstitution of surgical services following the weather emergency will be contingent upon the demand for service, sustained structural damages, impediments to emergency services access, and the ability to resume clinical activities. The Medical Center Command Center will determine whether operations will resume at normal or reduced capacity. This information will be accessible through the hospital’s aforementioned designated telephone line or the OR emergency line. Continuation of “emergency-only” surgical operations will be covered by the in-house storm call team until they can be replaced by the in-house and pediatric call attendings scheduled to cover on the date facility re-access is permitted. The call team should plan for the possibility of staying in-house for up to 72 hours post-storm.
GRAND ROUNDS FOR THE MONTH OF JUNE

“Anesthesia Medically Challenging Case Conference”
June 4, 2013
George Guldan, MD/Ryan Gunselman, MD
Medical University of South Carolina
Assistant Professors

“PreOp Evaluation of the Renal Transplant Patient
(2012 AHA Update)”
June 11, 2013
Latha Hebbar, MD
Medical University of South Carolina

“Current Concepts in Coagulation Management in Liver
Transplantation”
June 18, 2013
Kenichi Tanaka, MD, MSc
UPMC Presbyterian
Professor

“History of Transplantation and Important Developments at
MUSC”
June 25, 2013
Charles Bratton, MD
Medical University of South Carolina
Assistant Professor
I HUNG THE MOON

Don’t forget to nominate your co-workers for ‘Beyond the Call of Duty’. I Hung The Moon slips are available at the 3rd floor front desk, and may be turned in to Janine Sims or Kim Crisp. Thanks so much!!

Emily Munday, CRNA; Pat Tobin, CRNA; Myra Coe, CRNA; and Hill Felton, Anesthesia Tech: Standing by and helping during a difficult case and being supportive! Great team player!

Gregory Schnepper, MD: Doing a great job taking care of a cardiac baby for non-cardiac surgery. Pleasure to work with!

Tina Willett, CRNA: Stayed to help during a difficult case in CT Scanner! Thank you! Great team player!

Kathy Comley, CRNA: Running to assist when my case turned ugly! Thank for always being available.

Grayce Davis, MD and Marc Hassid, MD: Assisted in helping with a difficult case! Always helpful when needed! Thank you!

Resident Graduation: June 21, 2013
Location: Francis Marion Hotel

Do Not Forget to Complete Your Annual CATTS Training by June 30 Through the Link Below:
www.musc.edu/catts

We Would Love to Hear From You!
If you have ideas or would like to contribute to Sleepy Times, the deadline for the July edition will be June 19, 2013.