MESSAGE FROM THE CHAIRMAN:
SCOTT T. REEVES, MD, MBA

New Year’s Resolutions and MUSC’s Strategic Plan

January is a time for making New Year’s resolutions. Each year I personally challenge myself to learn Spanish, read more, watch less television, and take better care of myself. Setting New Year’s resolutions is a worthy goal, but research has shown that to be successful we need to pick only a few small goals that are easily measurable and attainable. Many of us in Charleston must be doing something correct as we were recently chosen the #3 city for most attractive locals by Travel and Leisure magazine.

MUSC is in the process of revising our five-year university wide strategic plan. In distinction to a New Year’s resolution, a strategic plan is by design a process to identify stretch goals that are to be achieved over a period of time. Under the leadership of President David Cole, a kickoff process occurred December 18, involving over 300 participants from the MUSC family. MUSC’s new vision statement is Leading health innovation for the lives we touch. It is campus leadership’s desire to have as diverse representation as possible in the process. A new web page has been established www.imaginemusc.com. As the MUSC community works on our strategic plan and implementation strategies, I would encourage all of us to stay informed and participate in the process.
MUSC SIMULATION LAB ALLOWS HOSPITAL STAFF TO PREPARE FOR EBOLA
BY: LAUREN SAUSSE, POST & COURIER

Dr. John Schaefer explains how a simulation program, which can be run from a tablet computer, helps hospital staff prepare to treat patients with Ebola, if necessary. The program measures how proficient doctors and nurses are taking the necessary protective gear on and off. Schaefer is the director of the Healthcare Simulation Center at MUSC.

There aren't any active Ebola cases in the United States right now, but that's not stopping volunteer staff at the Medical University Hospital from preparing for a potential patient right around the corner.

That includes practicing how to take the recommended protective gear on and off correctly - over and over again - using the precise, new steps that the Centers for Disease Control and Prevention outlined in October after two nurses in Dallas caught the disease from an infected patient. It's not clear how the nurses became ill - hospital administrators insist they followed recommended protocols - and both have since recovered.

Dr. John Schaefer, director of MUSC's Simulation Center, said doctors and nurses at MUSC who have volunteered to treat patients with Ebola must undergo a three-day course at the center. His team developed a new tablet-based program that allows staff to practice the guidelines until they become proficient. It's like an iPad game for Ebola gear.

"It takes a lot longer than people realize - 20 minutes just to get (the gear) on," said Schaefer, an anesthesiologist by training. "I can let you do it until you get it right."

The Simulation Center, which occupies 11,000 square feet in the College of Nursing building, is one of the largest such labs in the country.

It is used by medical students, physicians, nurses and hospital staff to practice complicated procedures, such as a breach infant delivery, for example, in a setting that allows mistakes to be made. High-tech mannequins, instead of real people, fill up the hospital beds inside the simulation center.

"It's a good way to learn because no one gets hurt if you make a mistake," Schaefer said. "I'd rather have the student practice in here and, in fact, if they haven't done it in a while, I'd rather have the physician do it in here, too."

Of course, taking care of patients with Ebola requires expertise that's new for everyone. The program designed at the simulation center measures participants' competency on 31 unique steps.

The new CDC guidelines set a firmer standard for the protective gear, calling for full-body garb and hoods that protect worker's necks; setting rigorous rules for removal of equipment and disinfection of gloved hands; and calling for a "site manager" to supervise the putting on and taking off of equipment.

They also say health workers who may be involved in an Ebola patient's care should repeatedly practice and demonstrate proficiency in donning and removing gear - before ever being allowed near a patient.

Dr. Danielle Scheurer, chief quality officer at MUSC, said about 30 staff have been trained at the hospital, so far. It allows them to practice communicating with each other with the gear on and conducting simple tasks. For example, putting an IV in a patient's arm is usually easy for nurses to accomplish, but it's made much more difficult with an Ebola patient because the protective gear is so bulky and cumbersome.

"We really are very blessed to have this sim lab in our backyard," Scheurer said. "The amount of training it takes to become proficient in donning and doffing takes hours - it's not like you can just do that overnight."

MUSC is one of a few large hospitals in South Carolina that agreed to accept patients with Ebola, should the need arise. There have been no cases of the virus in this state, to date.

Click Here for Full Article
PACEMAKER QI PROJECT

Dear Department,

With the hard work of Drs. Kassandra Gadlin, Clinton Pillow, Loren Francis, and Stephanie Robinson, we now have a shortcut on the desktops of preop holding and the anesthesia machines with helpful tips and an algorithm for dealing with patients who have an AICD or pacemaker. The icon is a little cartoon of a pacemaker and says "Pacemaker AICD" underneath it. It opens up a PDF file which contains helpful phone numbers, information, and a flow chart regarding these patients and how to best manage them. The data in the file is the latest and most up-to-date from the ASA and HRS.

These four residents should be commended for their hard work and dedication to this project, and also their ingenuity in seeing a need and coming up with what we think is a viable and helpful solution to improving patient care and educating our own department.

Sincerely,
Eric Nelson, MD

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### PACEMAKER BASICS

<table>
<thead>
<tr>
<th>Position</th>
<th>I</th>
<th>II</th>
<th>III</th>
<th>IV</th>
<th>V</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category</td>
<td>Chamber(s) paced</td>
<td>Chamber(s) sensed</td>
<td>Response to sensing</td>
<td>Rate modulation</td>
<td>Multisite pacing</td>
</tr>
<tr>
<td>0 = None</td>
<td>0 = None</td>
<td>0 = None</td>
<td>0 = None</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A = Atrium</td>
<td>A = Atrium</td>
<td>T = Triggered</td>
<td>A = Atrium</td>
<td></td>
<td></td>
</tr>
<tr>
<td>V = Ventricle</td>
<td>V = Ventricle</td>
<td>I = Inhibited</td>
<td>V = Ventricle</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D = Dual (A + V)</td>
<td>D = Dual (A + V)</td>
<td>D = Dual (I + T)</td>
<td>D = Dual (A + V)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

A for atrium, V for ventricle, D for dual/both.

Position 2: Chamber(s) sensed: 0 for no sensing - the device will pace automatically at a specified rate and ignore any intrinsic rhythm

Position 3: How a device responds to a sensed event: I - sensed event inhibits output pulse; T - sensed event triggers output pulse; D - dual modes of response (only available in dual chamber systems); 0 - No response to sensed input.

Position 4: Rate modulation: This is the ability of the pacemaker to adjust its programmed paced rate based on patient activity, which can be sensed as vibration, minute ventilation, or change in right ventricular impedance.

### IMPLANTABLE CARDIOVERTER-DEFIBRILLATOR BASICS

indicated in patients with cardiomyopathy and EF < 30-35%, VT, VF, HOCM, Long Q-T syndrome, Brugada syndrome

<table>
<thead>
<tr>
<th>Position</th>
<th>I</th>
<th>II</th>
<th>III</th>
<th>IV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category</td>
<td>Shock chambers</td>
<td>Anti-tachycardia pacing chambers</td>
<td>Tachycardia detection</td>
<td>Anti-bradycardia pacing chambers</td>
</tr>
<tr>
<td>0 = None</td>
<td>0 = None</td>
<td>0 = None</td>
<td>0 = None</td>
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<tr>
<td>A = Atrium</td>
<td>A = Atrium</td>
<td>A = Atrium</td>
<td>A = Atrium</td>
<td></td>
</tr>
<tr>
<td>V = Ventricle</td>
<td>V = Ventricle</td>
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<tr>
<td>D = Dual (A + V)</td>
<td>D = Dual (A + V)</td>
<td>D = Dual (A + V)</td>
<td>D = Dual (A + V)</td>
<td></td>
</tr>
</tbody>
</table>

Function by measuring each R-R interval and categorizing the heart rate as normal, fast, or slow. After a certain number of fast heart beats, an anti-tachycardia mode is activated and this can be anti-tachycardia pacing or a shock. Typically, ICDs deliver 6 – 18 shocks per event. After a certain number of slow heart beats, anti-bradycardia pacing is begun.
PACEMAKER QI PROJECT CONTINUED . . .

Preoperative Key Points

1. The following information must be sought prior to the patient having surgery or a procedure and documented in their pre-op note:
   • Manufacturer model number/type of device, location of the device, contact number of company representative, date when device placed
   • Date when the device was last evaluated and results of interrogation
   • Indication for device
   • Battery longevity documented >3 months
   • Any of the leads <3 months old?
   • Programming (Pacing mode? ICD therapy? Is rate responsiveness CNF)?
   • Is the patient a pacemaker patient?
   • What is the response to magnet?
   • Need for reprogramming after procedure
   • Has patient received recent or frequent shock therapy from ICD?

2. All patients with AICDs must have their device interrogated within the past 6 months. All pacemakers must have their device interrogated within the last 12 months. If a device has been interrogated at an outside facility the report must be sent to our hospital.

3. Patients with ICDs and/or pacemakers are preferably scheduled as second cases to avoid OR delays.

4. Program all rate enhancements off.

5. Pending case type consider changing pacing rate to optimize O₂ delivery.

6. Disable anti-tachycardia therapy if a defibrillator.

7. Assure that programming device and qualified personnel are available prior to start of procedure.

Intraoperative Key Points

1. Is the procedure associated with EMI: RF ablation, ECT, TENS unit, Radiation therapy, surgeries above umbilicus, use of monopolar electrocautery? If EMI is likely to occur use flow chart algorithm. Alterations to device are preferably accomplished by programming instead of magnet application.

2. If no EMI is anticipated, it is not necessary to suspend the anti-tachycardia therapy (defibrillator) function of an ICD or to change the pacing function to asynchronous.

3. Every effort should be made to avoid or reduce EMI by: correct placement of current return pad, use of Bipolar electrocautery when possible, use of defibrillators, and avoid use of electrocautery while active above the patient, use of harmonic scalpel (ultrasonic).

4. Place the current return pad as far as possible from the pulse generator. Electro-cautery should not be used within 15 cm of generator.

5. Rate-adaptive functions of Pacemakers should always be suspended for surgery.

6. All patients who have ICDs disabled must have pacing/defibrillation pads in place and monitored continuously.

7. All pace-dependant pacemaker patients who are having battery or leads modified must also have pacing pads placed. This also applies to any patient who may lose the function of their device intra-operatively and is dependent on that device.

8. Pacing/Defibrillator pads should be placed so that potential current does not pass through the device. Example: For a side neck surgery pad should be placed on right side chest and NOT on lower extremity. Be vigilant regarding pad positioning by OR staff.

9. Pads should be placed in an anterior/posterior position with anterior pad more than 8 cm away from generator.

8. For non-pacer dependent patients, NO SPECIAL CHANGES ARE NEEDED. Simply proceed with the procedure.

9. Magnets use to disable the tachycardia therapy (defibrillator) function of a device is acceptable in emergent/urgent situations or upon recommendation of a cardiologist/epidemiologist.

10. Turn on pacing detection on ECG monitor.

11. Monitor cardiac rhythm/peripheral pulse with plethysmography or arterial waveform.

12. External Defibrillator equipment should be available in the OR.

Postoperative Key Points

1. If a device needs to be altered for the patient to undergo surgery, arrangements must be made to re-activate the device to its original pre-procedure programming immediately after the procedure in the OR, PACU, or ICU.

2. Have the device interrogated by appropriate personnel post-operatively.

3. Some rate enhancements can be re-initiated and optimum heart rate and pacing parameters determined.

4. ICD patients must be monitored until the anti-tachycardia therapy is restored.

Contacts

<table>
<thead>
<tr>
<th>Device Company</th>
<th>Phone number</th>
<th>Wand/Programmer Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Boston Scientific</td>
<td>800-227-3422</td>
<td>ART – Echo cart in OR equipment room, Main – Echo lab (6th floor)</td>
</tr>
<tr>
<td>Medtronic</td>
<td>800-723-4636</td>
<td>ART – Echo cart in OR equipment room, Main – Echo lab (6th floor)</td>
</tr>
<tr>
<td>St. Jude</td>
<td>800-722-3774</td>
<td>ART – Echo cart in OR equipment room, Main – Echo lab (6th floor)</td>
</tr>
<tr>
<td>Sorin</td>
<td>877-663-7874</td>
<td>ART – Echo cart in OR equipment room or 3rd floor EP lab, Main – none</td>
</tr>
<tr>
<td>Biotronik</td>
<td>800-264-6689</td>
<td>ART – Echo cart in OR equipment room, Main – none</td>
</tr>
</tbody>
</table>

Call the respective company and they can tell you all about the device and give you the on-call device rep for MUSC.

Device Nurses Practitioners at MUSC:
1. Tammy Gottshall 1-3162
2. Pete Bearden 1-2702

Search patient notes by Nurse Practitioner last name to find device interrogation report.
PACEMAKER QI PROJECT CONTINUED . . .

Information to gather:
- Indication for device and placement date
- Type of device, manufacturer
- Last test date
- Battery status if known
- Revisions of leads
- Patient's underlying rhythm
- Recalls on equipment

Device < 3 months?
ERI < 3 months?

Yes. STOP. Consult EP physician

No. Proceed

EMI likely?
Surgery above the umbilicus?
OR
Lithotripsy, MRI, ECT, TURP, nerve stimulator, cardioversion, radio frequency ablation.

EMI May Cause:
Pacer oversensing
AICD misfire
Damage to leads or pulse generator
Resetting of pacemaker
Runaway pacemaker

To reduce EMI...
- Bipolar cautery
- Grounding pad placed perpendicular and away from device
- Short, <5 sec burrs
- Harmonic scalpel
- Cut mode preferred over coag

Type of device.

Yes

No

AICD

Ensure interrogation in the last 6 months. Identify mode and events.
- Have magnet and defibrillator pads available.

Pacemaker

Interrogated in last 12 months?

Yes

- mode?
- magnet mode?
- battery/ERI?
- events?

Consider contacting device rep.
Reprogram to asynchronous mode (DOO) at rate appropriate for patient.
Turn off rate enhancements.
Turn off AICD or place magnet (if applicable).
Place the defibrillator pads on

No. Proceed to interrogation.

After case, place device back to original settings and remove magnet

AICD

Interrogated in last 6 months?

Yes

- events?
- mode?
- battery?
- pacing?

Tips:
- All AICDs have a bradycardia pacing function, but not all pacemakers have AICD function.
- For pacers, magnet mode does not necessarily equal asynchronous mode. Any magnet mode CAN be disabled.
- Disable artifact filter on EKG monitor.

No. Proceed to interrogation

Ensure interrogation in the last 12 months. Identify mode and magnet mode setting.
- Is patient pacemaker dependent?
- Have magnet and defibrillator pads available.

Place magnet over device to disable anti-tachyarrhythmia function. This will not affect the pacing capabilities.
Place defibrillator pads on patient

After case, place device back to original settings and remove magnet
Remove pads once AICD
LEWIS BLACKMAN ACT

It is critical we are all familiar with the Lewis Blackman Hospital Patient Safety Act. Dr. John Schaefer holds the Lewis Blackman endowed chair.

November 26, 2014

MUSC Medical Staff and Residents:

About the Lewis Blackman Act

Lewis Blackman was a 15-year-old who underwent elective surgery at MUSC in November 2000. Unfortunately, due to a delay in contacting the attending physician, Lewis died. As a result, the South Carolina General Assembly enacted the “Lewis Blackman Hospital Patient Safety Act” in 2005. The law requires the following elements:

- All hospital clinical staff and trainees wear badges that identify their role on the team.
- Patients are informed prior to or at the time of admission about those involved in their care, including the role that medical students, interns, and residents play in their care.
- In particular, patients are informed of who the attending physician is responsible for their care.
- When asked for by patients, attending physicians must be available to patients to address any concerns and/or answer questions.

What this means at MUSC

As an academic medical center in South Carolina, there are many layers of providers involved in patient care. Every year, the principles of this Act are covered in resident orientation and there are three policies in the MUSC Policy Manual which specifically address how this Act applies to care at MUSC:

C-074, Resident Supervision, specifically states that “Attending physicians must always be available and willing to speak with patients when hospitalized patients wish to contact their attending physicians about their medical care in accordance to the SC Blackman Patient Safety Act.”

The second is C-109, Chain of Command and Physician Notification, which states the following:

“In the event a patient or family asks to speak to an attending physician, the following steps must occur, in accordance with S.C. state law “Lewis Blackman Hospital Patient Safety Act” Failure to follow this state law may be considered “reckless behavior” in terms of just culture and may result in disciplinary action up to and including termination.

1. If the patient/family member asks a non-licensed - non-clinical MUHA employee to call the attending, the MUHA employee relays that request to the patient’s nurse or other licensed clinician (MD, respiratory therapist, pharmacist, etc.)
2. MUHA licensed clinicians consult with the patient/family as soon as possible (within 20 minutes) and ask if they can resolve the problem. If the issue cannot be resolved and/or the family still wishes to speak to the attending, the attending should be immediately paged via Simon Paging. The text page to the attending should include that the family wishes to speak to him/her. The MUHA employee should also document in the medical record that this call was placed.”

The third policy is C-124, Pacing, Availability and Response Time, which lays out the standardization of urgent page requests. These guidelines should be used to assure timely response of attending physicians when requested.

Sincerely,

Bruce M. Elliott, MD
Interim Vice President for Medical Affairs

Daniel A. Handel, MD
Chief Medical Officer, Medical Center

*An equal opportunity employer, promoting workplace diversity*
HISTORY OF ANESTHESIOLOGY AND MEDICINE

This month we have reproduced the 1983 British Journal of Anesthesia article by Dr. A Brain describing the Laryngeal Mask Airway. His summary stated;

*A new type of airway is described, which may be used as an alternative to either the endotracheal tube or the face-mask with either spontaneous or positive pressure ventilation. The results of a pilot study involving 23 patients are presented and the possible merits and disadvantages of the device are discussed, bearing in mind that the study is of a preliminary nature.*

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*T. Macmillan Press Ltd 1983*
lorazepam or papaveretum and hyoscine. Anaesthesia was induced with thiopentone, and alcuronium 0.2 mg·kg⁻¹ was used to provide neuromuscular blockade. This relatively small dose was chosen because it was not considered likely that relaxation was essential to insertion of the device. During the procedure a form was completed which gave the following information:

(1) Ease of insertion, graded as: easy/difficult/impossible.

(2) Time taken to insert device: measured from moment mouth was opened to moment when mask was in position (excluding time taken to inflate cuff).

(3) Whether or not a laryngoscope was used.

(4) Whether leaks were detected at 2.0 kPa inflation pressure using a stethoscope held to the side of the neck overlying the larynx. The pressure was measured with reference to the Manley ventilator aneroid pressure gauge.

(5) Total air in cuff (ml).

(6) Greatest peak airway pressure on IPPV (kPa).

(7) Inspired and expired minute volumes, the latter using Wright’s mechanical respirometer.

RESULTS

In all 16 patients undergoing laparoscopy, ventilation of the lungs was achieved successfully using one of the prototype laryngeal masks (which varied slightly from one another in size and shape), with a Manley Blease ventilator. Adequacy of ventilation was measured by comparing expired with inspired minute volumes and by auscultation of the neck laterally at a point overlying the larynx.

In all patients the device was inserted without the aid of a laryngoscope, by placing the head and neck in the usual intubating position and inserting the deflated mask with its lumen facing backwards to facilitate negotiation of the angle behind the tongue. The dorsum of the mask was liberally coated with “KY” jelly to facilitate this manoeuvre. No analgesic throat spray was used. Downward descent of the mask could be discerned by observation of the front of the neck, where a slight but unmistakable bulging of the tissues overlying the larynx served to indicate that the mask was in position. The mask was designed in such a way that when its distal tip reached the triangular base of the hypopharynx, further downward progress could not occur unless excessive force were used. A definite end-point was felt at this level, which also coincided with correct placement of the mask against the laryngeal inlet. In practice, it was found that by observing the front of the neck and feeling for resistance to further down-
LARYNGEAL MASK

ward progress, the mask could be reliably positioned.

The results, as tabulated on the questionnaire,
were as follows: Insertion was graded as easy in all
patients, although experience led to more frequent
correct placement at the first attempt. The average
time taken to insert the device was 7.3 s (range
2–15 s). Leaks were present initially in six patients,
but were successfully abolished in all (table I). Of
the leaks which developed, all occurred after inser-
tion but before surgery was started and all were
overcome with little difficulty. No case of obstruc-
tion occurred, either partial or complete. The aver-
age volume of air required to inflate the cuff suffi-
ciently to form a gas-tight seal at 2.0 kPa was 17.5 ml
(range 7–25 ml).

During IPPV the average peak airway pressure
was 1.8 kPa (range 1.5–2.3 kPa). The readings ob-
tained from the Wright respirometer were all greater
than the inspiratory minute volume as measured by
rotameter readings, presumably reflecting the
known inertia characteristics of this respirometer,
which in fact gave readings which were on average
14.68% greater than the measured inspired minute
volumes (range 10.6–25%).

Following reversal of neuromuscular blockade,
suction was performed and judged to be easy in all
patients and no laryngospasm was provoked by
pharyngeal toilet. The mask was removed after
complete deflation of the cuff using a 20-ml syringe,
and was judged easy in all patients. There were no
instances of coughing, laryngospasm, retching,
vomiting or apnoea before, during or after removal
of the mask. On all occasions, spontaneous respira-
tion, which had been established before removal was
attempted, continued without change in respiratory
pattern. Following operation, three patients com-
plained of sore throat, all graded as mild (< 20%).
No other symptoms were reported.

Of the six patients who were allowed to breathe
spontaneously, three received suxamethonium elec-
tively to facilitate insertion and, by way of compar-
ison, three received no neuromuscular blocking
drug. All six patients maintained an unobstructed
airway throughout the operation. Those patients in
whom the device was inserted without the help of
neuromuscular blockade required a level of anaes-
thesia sufficient to abolish the gag reflex and relax
the jaw before it became possible to insert the mask.
Once this level was reached, insertion was not
judged to be more difficult than under conditions of
neuromuscular blockade.

One patient undergoing a difficult dental extrac-
tion was studied. The fact that the mask took up
most of the space in the hypopharynx reduced the
volume of packing required and it was found that
the mask afforded more protection to the larynx
from fragments of teeth, blood and debris than an
endotracheal tube. Insertion and removal of the
mask were easy and without incident, and a good
airway was maintained throughout the procedure.

DISCUSSION

Although endotracheal intubation has a long history
as one of the most widely accepted techniques in
anaesthetic practice (Keys, 1945; Armstrong Davi-
son, 1965) it is not without complications, most of
which arise from the need to visualize and penetrate
the laryngeal opening (Kambic and Radsel, 1978).
The laryngeal mask was designed primarily as a
means of offering some of the advantages of endo-
tracheal intubation while avoiding this fundamental
disadvantage, since the vocal cords need be neither
visualized nor forced apart.

It should be stated that this study was of a very
preliminary nature and that the number of patients
studied was too small for firm conclusions to be
drawn. Nonetheless, ease and simplicity of use and
the fact that the device was well tolerated without
serious side-effects, were positive features. In two
patients the anatomy was such as to suggest that
endotracheal intubation might have presented at
least moderate difficulty. Neither presented diffi-
culty with regard to insertion of the laryngeal mask.
In carrying out pharyngeal toilet, it was noted that
the catheter tip could not irritate the larynx since the
mask effectively shielded it. It was also apparent
that the secretions were easily accessible since the
bulk of the mask when inflated caused secretions to
pool above it rather than behind it. In the one dental
patient studied, the shielding action of the mask was
appreciated since it prevented blood or tooth frag-
HISTORY OF ANESTHESIOLOGY AND MEDICINE CONTINUED...

BRITISH JOURNAL OF ANAESTHESIA

study is too small for firm conclusions to be drawn, the concept would appear sufficiently promising to justify more extensive trials, which are under way. A further 108 patients have been studied to date and the results have so far confirmed the safety and efficacy of the device when used as an alternative to the face-mask in the spontaneously breathing patient. Once experience has been gained, difficulty in insertion can be expected in less than 1% of patients. In only one patient has it been found that apparently correct insertion failed to provide an adequate airway. However, sufficient depth of anaesthesia is essential to successful insertion, unless a neuromuscular blocking agent is used. It is sometimes necessary, in patients with a large epiglottis, to pull this structure forward, using a laryngoscope in the usual way. This problem has not occurred in females and it is felt likely that it could be eliminated by improved design of the device, which is still in the form of a relatively crude prototype.

The laryngeal mask would appear to be of particular value where difficulty is experienced in maintaining the airway, or when operating on the face or eyes, where it offers a less invasive alternative to tracheal intubation. It may be of similar value where the patient is a professional singer and it has been found useful in cases of difficult intubation (fig. 3).

ACKNOWLEDGEMENTS

Thanks are due to Portex Ltd for agreeing to supply prototypes; to Dr Edward Major for advice in setting up the study; to Dr Peter Seidel for his help in preparing the manuscript; and to Miss Mandy Miller for typing it.

REFERENCES


LE MASQUE LARYNGE—UN NOUVEAU CONCEPT DANS L’ATTITUDE VIS-A-VIS DES VOIES AERIENNES

RESUME

Un nouveau type de matériel permettant d’assurer la liberté des voies aériennes est décrit, que l’on peut utiliser à la place soit d’une sonde d’intubation, soit d’un masque facial, en ventilation spontanée ou pression positive. Les résultats d’une étude pilote impliquant 23 patients sont présentés et les mérites éventuels et désavantages de ce dispositif sont discutés, en gardant à l’esprit que cette étude est de nature préliminaire.

Click Here to View Full Article.
Medical University Hospital used to be located exclusively on the Charleston peninsula. Now, it's everywhere.

The hospital has forged relationships with a number of community hospitals across the state - in Georgetown and Beaufort, and more recently, in Hartsville and Camden. The Board of Trustees discussed a potential affiliation with an Orangeburg hospital on Thursday. These new partnerships will grow MUSC's patient base, its revenue potential and also extend its expertise to residents in underserved pockets of South Carolina where primary and specialty care can be harder to come by.

"We need to not just sit in Charleston. We need to be spreading out," said Dr. Pat Cawley, Medical University Hospital's chief executive officer. "That's no different than any health system in the entire United States. Everyone is doing the same thing."

Hospital mergers, acquisitions and affiliations across the country have become commonplace - especially as smaller hospitals struggle to comply with new quality standards and Affordable Care Act mandates and as larger systems compete for market share.

MUSC can't technically buy another hospital because it's a state entity. In November, the hospital announced it would team up with Capella Healthcare, a for-profit company, to establish the Midlands HealthONE Network. That network will take over operations at Carolina Pines Regional Medical Center in Hartsville and Kershaw County Medical Center in Camden early next year.

Medical University Hospital is extending its footprint to other hospitals around the state through partnerships.

Click Here for Full Article
HOLIDAY DOOR DECORATING CONTEST

This is the 3rd year the department held the holiday door decorating contest. Participation has grown each year, as has the competition. This year we had 10 participants and awarded a 1st place winner, 2nd place winner, and an honorable mention. It was something really fun for the department to do to show our holiday spirit! We were also holding resident interviews during this time, so it was great for the applicants to see and enjoy all the festivities. Our department is spread across campus from Rutledge Tower, Storm Eye Institute, The Children’s Hospital, and Ashley River Tower. A panel of three judges went to see all the participating doors in all of these locations and chose the winners. We look forward to even greater participants next year!

1st Place Winner, ART
Anesthesia Techs

2nd Place Winner,
Anesthesia Residents

Honorable Mention,
Anesthesia Research
CONGRATULATIONS LESTER KITTEN, CRNA FOR RECEIVING THE CLINICAL EXCELLENCE AWARD AT ART

Dear Mr. Kitten,

Clinical instructors perform a crucial role in the ability of nurse anesthesia programs to educate excellent CRNA practitioners. They not only teach students the art and science of nurse anesthesia practice but also serve as role models, mentors, and supporters.

In recognition for your distinction in all of these roles, the MUSC Anesthesia for Nurses Class of 2014 selected you to receive the Award for Excellence in Clinical Instruction at the Medical University of South Carolina: Ashley River Tower.

On behalf of the program faculty, I would like to thank you for the considerable part you play in the quality of our graduates. Please join us and be recognized at the Class of 2014 Graduation Ceremony at 3pm on December 5th, 2014. Following the ceremony, a reception will be held honoring the graduates. The graduation ceremony will take place at St. Luke’s Chapel on the MUSC campus at the corner of Bee Street and Ashley Avenue. The reception will be held in the Artium at the College of Health Professions, 111A Rutledge Avenue.

RSVP by December 2nd, 2014 to msd@musc.edu

Respectfully,

Angela Maud CRNA DNP
Program Director
Anesthesia for Nurses
FAMILIES HELPING FAMILIES

For the past several years, we have participated in the Families Helping Families Program, which provides gifts, clothing, food, and necessary items to families in need throughout the lowcountry. This year we sponsored a large 11 member family in need and raised a total of $1,135.00 to buy gifts. We appreciate everyone’s efforts and donations for this great cause!
NEW BABY IN THE DEPARTMENT

Congratulations Joel Barton, MD
Malachi James Barton
Born December 10, 2014 at 6:31pm
8 lbs, 4 oz, 21.25 inches

DEPARTMENT STAFF CHRISTMAS BREAKFAST AT HOMINY GRILL
DEPARTMENT HOLIDAY PARTY, CAROLINA YACHT CLUB, DECEMBER 12, 2014
DEPARTMENT HOLIDAY PARTY, CAROLINA YACHT CLUB, DECEMBER 12, 2014
DEPARTMENT HOLIDAY PARTY, CAROLINA YACHT CLUB, DECEMBER 12, 2014
Charleston locals have grown more beautiful over the past year, according to Travel + Leisure magazine readers. The Lowcountry landed at No. 3 this year in the publication's annual ranking of cities with the most attractive people behind Miami and San Diego, California.

Last year, Charleston was voted No. 10 while San Francisco and Providence, R.I. took the top slots.

Travel + Leisure surveys its readers each year to rank top American cities for their public parks, shopping destinations, and attractive locals.

"In the attractive category, this year's survey results saw some shake-ups," said Katrina Brown Hunt, who reported the findings of the survey last month. "Some of the hipster winners from last year have faded in the eyes of the T+L community, which favored cities with a tendency toward sunshine, smiling residents, and serious style."

It seems Charleston fit the bill for those preferences pretty well. But, the Holy City's reputation for hospitality, politeness and historic architecture may have influenced readers' preferences as well, according to the Travel + Leisure article.

"These South Carolina locals consistently land among the survey's top 10 for head-turners," Hunt said. "One secret of their success, no doubt, is that pretty-is-as pretty-does hospitality: Charleston also ranked well for being polite. Another factor, though, may be that with age comes beauty. The city scored highly for its charming old architecture and lovely antiques."
GRAND ROUNDS FOR THE MONTH OF JANUARY

Subspecialty Team Meetings and All-Resident Meeting
January 6, 2015

“Spinal Cord Stimulators”
January 13, 2015
Ryan Nobles, MD
Assistant Professor
Medical University of South Carolina

“Stress Response to Pain”
January 20, 2015
Arthur Smith, MD
Associate Professor
Medical University of South Carolina

“Anesthesia Medically Challenging Case Conference”
January 27, 2015
GJ Guldan and Ryan Gunselman, MDs
Assistant Professors
Medical University of South Carolina
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 Kim Crisp. Thanks so much!!

Molly Sekar, Anesthesia Tech – Staying late to help out second shift. Great Job!

Ashley Haselden, Anesthesia Technicians — Willing to stay later and cover extra shift! Great Teamplayer!

Larry Banks, Anesthesia Tech — Showing up at MRI at the right time and stepping in to help during a difficult time! Thank you!

Resident Graduation: June 19, 2015, at Founders Hall

We Would Love to Hear From You!

If you have ideas or would like to contribute to Sleepy Times, the deadline for the February edition will be January 19, 2015.