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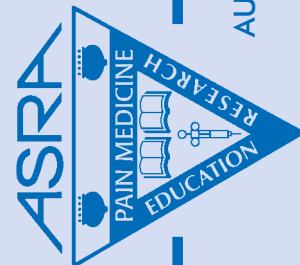
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www.asra.com

Email: asra@societyhq.com

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AUGUST 2001

ASRA News

A PUBLICATION OF THE AMERICAN SOCIETY OF REGIONAL ANESTHESIA AND PAIN MEDICINE

ASRA NEWS

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Lynn M. Broadman, MD
President, ASRA

President's Message

I just returned from a twelve day trip to the People's Republic of China (China). I led a delegation of twenty-nine regional anesthesia and pain medicine physicians and their family members on a three city tour. All of the physicians were members of The American Society of Regional Anesthesia and Pain Medicine. The delegation was composed of people from eight countries and four continents. The tour was under the auspices of The People to People Ambassadors Program. The People to People Ambassadors Program was founded by our late President Dwight D. Eisenhower in 1956 to help promote world understanding and peace. We visited nine hospitals in Beijing, Shanghai, and Guiyang. Three of the hospitals were centers of excellence in Traditional Chinese Medicine (TCM) and six were major centers that specialized in Western medicine.

We learned that the people of China face many of the same payment problems with health care funding that people in the Western world face. There is no health insurance in China. In the cities, all inpatient health care is provided by the government and the patient's employer. All outpatient health care is fee for service and there is no public funding for such care. The same is true for both inpatient and outpatient care in the rural areas of China, there is no public funding and all services are fee for service. This is very difficult in a country where the average wage is \$150.00 US per month.

In the Western hospitals in Shanghai the anesthesia equipment is very modern and the only difference from Western standards is that the Chinese do not employ capnography. They are very dependent upon regional anesthesia and use epidural anesthesia in about 50% of their cases. Lumbar epidural anesthesia is used alone for most cases below the umbilicus and thoracic epidural anesthesia is used in conjunction with general anesthesia for most upper abdominal and thoracic cases. They continue their epidural infusions into the postoperative period to provide acute pain management. The most common agent used for acute pain management is 0.25% bupivacaine. They do not use much epidural fentanyl or morphine. They also use combined spinal epidural anesthesia for most gynecological surgery. Finally, they employ nerve blocks in about 10% of their cases; however, all of the nerve blocks are for upper extremity surgeries, and are limited to axillary and interscalene blocks.

Chronic pain services are very lacking. They are provided primarily by the TCM hospitals and outpatient clinics. The services are limited to acupuncture, moxibustion, cupping and herbal medicine. In the Western hospitals, pain clinics are just beginning to evolve, but they operate only one or two days a week in a facility with 1,000 inpatient beds. The use of narcotics does not occur for chronic benign pain, and only sparingly for cancer pain. Most cancer pain patients are admitted and given an epidural catheter to control that pain. Again, the infusate is 0.25% bupivacaine. They do not have spinal cord stimulators, intrathecal pumps or DuPen type catheters. There is no interventional pain medicine in China.

While there teaching, we learned a great deal about China, its people and its medicine. We earned 18 hours of continuing medical education credit for our trip. It is hoped that there will be enough interest within the society to send another delegation to China, Cuba or Russia in two years. If you are interested in participating in a future delegation please contact <asra@societyhq.com>, and indicate the country you would like to visit.

ASRA is offering three exciting educational programs in the summer and fall of 2001. The first is the 8th Annual Comprehensive Review of Pain Management course which was held at the Hyatt Newporter in Newport Beach, California from August 2-5, 2001. Michael Ferrante, the course director, and a panel of nine internationally recognized experts conducted this intensive three and one-half day review session. More than 220 people registered for the program. The second offering is a joint venture between the University of Texas and ASRA. It is a two-day seminar and workshop on continuous blocks for orthopedic surgery and acute pain management. The course is being held at the Sheraton New Orleans on the Thursday and Friday, October 11-12, 2001, just prior to the ASA meeting. The course directors are Drs. Jacques

Chelly and Kayser Enneking. A faculty of thirty national and international experts will be on hand to teach the course. The registration fee is \$1000.00 but there are substantial discounts for residents and members of the armed forces. You can register for this course on-line at <<http://www.regional-utmed.org>> or wait until the flyer for the course is mailed and register by mail. The third offering is an ASRA Conference on Local Anesthetic Toxicity which will be held November 17-18, 2001, at the Fontainebleu Hilton in Miami Beach, Florida. The faculty will discuss neuro, myo and cardiac toxicity. Discussions will also center on the current concepts of resuscitation and whether we should continue to use bupivacaine. I know many of you will want to attend this conference.

Finally, due to the great degree of interest generated by the public, the FDA has postponed the meeting on oxycontin and related drugs until the fall of 2001. The new meeting dates are September 13-14, 2001. This meeting is open to the public. A new meeting site has not been selected. If you would like to make comments or enter testimony at this meeting, I suggest you get in touch with the contact person, Kimberly Topper. You can reach Ms. Tooper at 301- 827-7001, by e-mail at <topperk@cder.fda.gov>, or FAX 301-827-6801. This is an important problem. I plan to be at the fall meeting as does your ASA president Dr. Neil Swissman.

Lynn M. Broadman, MD
President, ASRA

ASRA Committees Meet at ASA

Sunday, October 14

- The Pain Fellowship Director's will meet at the Hilton New Orleans Riverside in Marlborough A at 8:30 am.
- The ASRA Resident's Section will meet at the Hilton New Orleans Riverside in Eglinton Winton at 7:00 am.

Upcoming ASRA Events !

Several events sponsored by ASRA will take place in conjunction with the American Society of Anesthesiologists meeting in New Orleans, La., in October. The Third Regional Anesthesia International Symposium will be presented on Friday October 12th. The focus of the symposium this year will be Regional Anesthesia for Ambulatory Orthopedics and Acute Pain Management. Program directors for this meeting are Drs. Jacques Chelly and Kayser Enneking. The format of this symposium: brief coverage of a variety of topics by international experts, allows a maximum of time for questions and answers. The format has been very popular with participants in the past. This years' topics include discussion of single injection and continuous catheter techniques for peripheral nerve blocks, and the use of central neuraxial blockade in ambulatory patients. To register for this meeting go to www.asra.com on-line for more information.

The Pain Fellowship Director's meeting will be held at the Hilton New Orleans Riverside in Marrlborough A, 2nd floor , at 8:30 am on Sunday, October 14, during the annual meeting of the ASA. This meeting provides an opportunity for the Pain Fellowship Directors to discuss current events in pain education.

The ASRA Resident's Section will also meet on October 14, at the Hilton New Orleans Riverside in the Eglinton Winton, at 7:00 am. This is the fastest growing segment of ASRA membership. We are delighted to see this segment of anesthesiologists enthused about regional anesthesia and pain medicine.

Finally ASRA will present a Consensus Conference on Local Anesthetic Toxicity in Miami Beach on November 17 -18, 2001. Dr. Terese Horlocker is organizing the conference. An expert panel on local anesthetic toxicity both neurologic and cardiovascular will be assembled to discuss this ever important component of regional anesthesia risk. Dr. James Eisenach will moderate the sessions in what should be a lively debate on the theoretical and practical risks associated with local anesthetic administration.



ASRA News

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Co-Editors

F. Kayser Enneking, MD
Julia E. Pollock, MD

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How Do I Do... Infraclavicular Brachial Plexus Blocks

The infraclavicular approach to the brachial plexus is one of many approaches described to produce anesthesia and analgesia of the upper extremity. It has rapidly gained acceptance in our institution for the following reasons: 1. The major landmark, the coracoid process, is easily palpated even in obese patients. 2. Teaching this block is easy because the needle is redirected along a single sagittal plane. With the nerve stimulation technique there are several redirection cues that allow intelligent redirection rather than blind guesses. 3. The onset of this block, when stimulation of the hand or wrist is seen at 0.4 mA is extremely rapid. 4. The block facilitates catheter placement in a secure position anchored in the pectoralis muscle.

Indications: The infraclavicular approach to the brachial plexus is suitable for operations on the hand, forearm, and elbow. It is not appropriate for surgery of the shoulder or proximal humerus. Occasionally there is insufficient anesthesia in the distribution of the ulnar nerve. This can be overcome by specifically searching for ulnar nerve stimulation.

Technique: The patient is placed in the supine position with appropriate monitors. The coracoid process is palpated and the most prominent portion is marked. A point 2 cm medial and 2 cm caudal to the coracoid prominence marks the entry point. A 22 gauge-stimulating needle is inserted perpendicular in all planes. The pectoralis major muscle will be stimulated as the needle passes through its mass. The patient should be warned about this. The average depth from the skin to the brachial plexus is 4 cms and should be no more than 7 cms in obese patients. If stimulation of the wrist or fingers does not occur than the needle should be redirected along the sagittal plane (north or south). The needle should NEVER be redirected medially. When stimulation of the wrist or fingers is apparent at below 0.45 mA the mass of local anesthetic, 40-50 cc, is injected. Rapid development of dense anesthesia can be anticipated within 10 minutes.

Equipment: An insulated needle designed for stimulating techniques is required: For thin patients a 2 inch (50 mm) needle is appropriate, 4 inch (100 mm) is indicated for larger patients.

Local Anesthetic: 50 cc of 1.5% mepivacaine with NaHCO₃, 1:400,000 epinephrine, and 1 mg/kg of clonidine are the choice for rapid onset of anesthesia.

Pearls: It is extremely important to search for wrist or finger motion when utilizing the infraclavicular block. Particularly resist the urge to accept a musculocutaneous twitch. This is at the most superior aspect of the brachial plexus at this level and you will not get good spread to the posterior and medial cords.

For rapid onset aim for stimulation of the nerve between 0.40 and 0.45 mA

Remember the axillary artery is surrounded by the brachial plexus. Puncture can occur so careful aspiration is essential. This is particularly true for the blunter large bore needles used for catheter placement.

Redirection cues: The subscapular nerves (scapular motion or serratus stimulation) are deep and caudal to the rest of the posterior trunk redirect more cephalad.

For musculocutaneous stimulation (pronation of the forearm) redirect more caudal.

References:

1. Sims JK. A modification of landmarks for infraclavicular approach to brachial plexus block. *Anesth Analg* 1977; 554-555.
2. Whiffler K. Coracoid block- a safe and easy technique. *Br. J Anaesth* 1981; 53:845-848.
3. Rodriguez J, Barcena M, Rodriguez V, Aneiros F, Alvarez J. Infraclavicular brachial plexus block effects on the respiratory function and extent of the block. *RAPM* 1998;23: 564-568.
4. Wilson JL, Brown D, Wong GY, Ehman RL, Cahill DR. Infraclavicular brachial plexus block; parasagittal anatomy important to the coracoid technique. *Anesth Analg* 1998;87:870-873.

F. Kayser Enneking, MD
Co-Editor, ASRA Newsletter

ASRA Resident Section



Allan R. Escher, Jr., DO

The ASRA Resident Section Committee will hold its biannual meeting during the ASA Annual Meeting October 13-17, 2001. Important items include ways of improving regional anesthesia training for residents, reviewing the current literature on the experience and adequacy of regional anesthesia training in the U.S., and suggestions to the RRC resulting from these discussions. For the first time in the history of the ASRA Resident Section, the Chair and Chair-Elect/Newsletter editor will take their place as full voting members of the ASA Resident House of Delegates. The Chair on the Committee's behalf will introduce legislation.

The "Big Easy" provides a dramatic backdrop to the ASA Annual and ASRA biannual meetings; we will work hard and play hard for the coming battles ahead that face our subspecialty. I will update the members on a number of fast-moving news stories that are unfolding at this moment. One example is the Drug Enforcement Administration's proposal to restrict the use of opioids in chronic benign pain patients. We invite all interested residents/fellows to attend this important meeting and look forward to seeing you there.

Allan R. Escher, Jr., DO
Chair, ASRA Resident Section

Regional Anesthesia and Pain Medicine Editorial Update

The *Regional Anesthesia and Pain Medicine* Editorial Office discussed the following topics at the May 2001 ASRA Annual Meeting in Vancouver:

- Continued improvement of the journal's impact factor
- Development of innovative features such as a Clinical Case Report section linked with evidenced-based medicine commentary as well as more patient-created pain articles
- Conversion to web-based manuscript submission and review
- Increasing number of manuscript submissions

The influence of *Regional Anesthesia and Pain Medicine* continues to grow as indicated in the ISI Journal Citations Reports report of impact factor, a measurement recording the average number of times articles from a journal were cited in a particular year. The journal's impact factor continues to experience significant growth and is amongst the top five for anesthesia journals. An adjustment to the ISI report to account for the journal's title change in 1998, may even place *Regional Anesthesia and Pain Medicine's* impact factor as high as third amongst anesthesia titles.

Some of the growing interest in the journal can be attributed to the innovative Imaging and Translational Vignette sections. As these sections become an established part of the journal, the Editorial Office continues to explore additional features such as articles about pain management from a patient's perspective. The Editorial Board also expressed interest in a new Clinical Case Report Section and the Editorial Office is pursuing the development of this section linked to evidence-based medicine commentary.

A major change in manuscript processing will occur in the near future due to a corporate merger in the software industry. The Editorial Office's paper-driven manuscript tracking process will be replaced by a web-based system that efficiently integrates the functions of submission, tracking, and review in an electronic format.

Submissions to *Regional Anesthesia and Pain Medicine* continue to increase. From 1999 to 2000 the journal saw an 8% rise in submissions. The proliferation of medical journals, especially pain titles, makes this increase surprising. However, the commitment to provide quick, quality reviews makes the journal an attractive choice for authors. On average, the Editorial Office is returning manuscript decisions in just under five weeks. This high standard of performance is possible because of the dedication and quality of the journal's review board.

In conclusion, the journal continues to succeed through efforts of its editorial board members, contributors, and specialists in the field. Through their valuable contributions the journal remains a useful forum for the presentation of science and clinical issues related to regional anesthesia and pain medicine.

David L. Brown, M.D.

Editor-in-Chief, *Regional Anesthesia and Pain Medicine*

ASRA Breakfast Panel at ASA

The following program is planned for the ASRA Breakfast Panel at the 2001 ASA Annual Meeting in New Orleans, Louisiana. It is our understanding that the Breakfast Panel will be held from 7:30 - 8:45 am on Monday, October 15, 2001.

Teaching Regional Anesthesia in the New Millennium – Will Hands-on Techniques Become Obsolete?

Moderator: Marc B. Hahn, DO

Director, Pain Medicine Division
Associate Professor of Anesthesiology
Pennsylvania State University College of Medicine
Milton S. Hershey Medical Center
Hershey, Pennsylvania

New Hands-on Techniques

Frederick Burgess, MD, PhD

Director of Pain Management and Regional Anesthesia
The Rhode Island Hospital
Associate Professor of Surgery/Anesthesiology
Brown University School of Medicine
Providence, Rhode Island

The Use of Computer Programs to Teach Anatomy and Techniques

Patrick M. McQuillan, MD

Director of Acute Pain Management and Regional Anesthesia
Associate Professor of Clinical Anesthesiology and Pediatrics
Associate Chair for Clinical Affairs
Pennsylvania State University College of Medicine
Milton S. Hershey Medical Center
Hershey, Pennsylvania

Will Haptic Technology Replace Patients for Learning Critical Psycho- Motor Skills?

W. Bosseau Murray, MB ChB, FRCA, MD

Director, Simulation Development and Cognitive Science Laboratory,
Departments of Anesthesiology, Nursing, and Surgery
Professor of Anesthesiology
Pennsylvania State University College of Medicine
Milton S. Hershey Medical Center
Hershey, Pennsylvania

ASRA Conference on Local Anesthetic Toxicity

November 17-18, 2001

Fontainebleau Hilton Resort & Towers
Miami Beach, FL



Meeting Objective

This two-day program will (1) review the etiology, diagnosis and prognosis of neurotoxicity associated with local anesthetics and adjuvant medications; and (2) discuss the mechanism and treatment of local anesthetic-related cardiac toxicity.

Target Audience

This program is intended for Practicing Physicians, Residents, Fellows, and CRNAs interested in the latest developments in anesthesiology.

Accreditation

The American Society of Regional Anesthesia and Pain Medicine is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

The American Society of Regional Anesthesia and Pain Medicine designates this continuing medical education activity for 13 credit hours in Category 1 of the Physicians Recognition Award of the American Medical Association. Each physician should claim only those hours of credit that he/she actually spent in the educational activity.

Register online at: www.asra.com

Faculty

John F. Butterworth, MD
Wake Forest University School of Medicine
Winston-Salem, NC

Robert A. Caplan, MD
Virginia Mason Medical Center
Seattle, WA

Kenneth Drasner, MD
San Francisco General Hospital
San Francisco, CA

James C. Eisenach, MD
Wake Forest University School of Medicine
Winston-Salem, NC

Roy A. Greengrass, MD
Mayo Clinic Jacksonville
Jacksonville, FL

Leanne Groban, MD
Wake Forest University School of Medicine
Winston-Salem, NC

James E. Heavner, DVM, PhD
Texas Tech University Science Center
Lubbock, TX

Quinn H. Hogan, MD
Medical College of Wisconsin
Milwaukee, WI

Terese T. Horlocker, MD
Mayo Clinic
Rochester, MN

Michael E. Johnson, MD, PhD
Mayo Clinic
Rochester, MN

Michael F. Mulroy, MD
Virginia Mason Medical Center
Seattle, WA

Joseph M. Neal, MD
Virginia Mason Medical Center
Seattle, WA

Julia E. Pollock, MD
Virginia Mason Medical Center
Seattle, WA

Per H. Rosenberg, MD
Milhati Hospital
Helsinki, Finland

Denise J. Wedel, MD
Mayo Clinic
Rochester, MN

Guy Weinberg, MD
University of Illinois Hospital
Chicago, IL

Tony L. Yaksh, PhD
University of California, San Diego
La Jolla, CA

ASRA Conference on Local Anesthetic Toxicity

Saturday, November 17, 2001

6:30 am	Registration
7:00-8:00 am	Continental Breakfast with Exhibitors
	NEUROLOGIC TOXICITY
	Moderator: <i>James C. Eisenach, MD</i>
8:00-8:15 am	Welcome
8:15-9:00	Neurotoxicity- Cultured Neuronal Cells and Isolated Nerves — <i>Michael E. Johnson, MD, PhD</i>
9:00-9:45 am	Cauda Equina Syndrome— <i>Kenneth Drasner, MD</i>
9:45-10:30 am	Transient Neurologic Symptoms — <i>Julia E. Pollock, MD</i>
10:30-10:45 am	Break with Exhibitors
10:45 am-12:00 n	Panel Discussion - Do Laboratory Investigations Reflect Clinical Observations?
12:00-1:00 pm	Lunch on own
1:00-1:30 pm	Neurotoxicity of Epinephrine, Antioxidants and Preservatives — <i>Joseph M. Neal, MD</i>
1:30-2:00 pm	Neurotoxicity of Opioids — <i>Tony L. Yaksh, PhD</i>
2:00-2:30 pm	Neurotoxicity of Encapsulated Preparations — <i>John F. Butterworth, MD</i>
2:30-3:00 pm	Myotoxicity — <i>Quinn H. Hogan, MD</i>
3:00-3:15 pm	Break with Exhibitors
3:15-3:45 pm	Evaluation of a Postoperative Neurologic Complication — <i>Denise J. Wedel, MD</i>
3:45-4:15 pm	Neurologic complications- the ASA Closed Claims Database — <i>Robert A. Caplan, MD</i>
4:15-5:00 pm	Panel Discussion - Minimizing the Risk of Neurotoxicity <i>Quinn H. Hogan, MD; Joseph M. Neal, MD; John F. Butterworth, MD; Denise J. Wedel, MD; Robert A. Caplan, MD</i>

Sunday, November 18, 2001

6:30 am	Registration
7:00-8:00 am	Continental Breakfast with Exhibitors
	SYSTEMIC TOXICITY
	Moderator: <i>James C. Eisenach, MD</i>
8:00-8:15 am	Historical Perspective/FDA Labeling — <i>Terese T. Horlocker, MD</i>
8:15-9:00 am	Cardiac Toxicity in the Isolated Heart Model — <i>James E. Heavner, DVM, PhD</i>
9:00-9:45 am	CNS and Cardiac Toxicity in the Intact Animal Model — <i>Leanne Groban, MD</i>
9:45-10:00 am	Break with Exhibitors
10:00-10:30 am	Clinical Studies and Post Marketing Data — <i>Roy A. Greengrass, MD</i>
10:30-11:00 am	Medicolegal Aspects — <i>Robert Caplan, MD</i>
11:00-11:45 am	Panel Discussion - Should We Continue to Use Bupivacaine? <i>Terese T. Horlocker, MD; James E. Heavner, DVM, PhD; Leanne Groban, MD; Roy A. Greengrass, MD; Robert Caplan, MD</i>
11:45 am-1:00 pm	Lunch on own
1:00-1:30 pm	Efficacy of the Test Dose — <i>Michael F. Mulroy, MD</i>
1:30-2:00 pm	Maximum Local Anesthetic Dose — <i>Per H. Rosenberg, MD</i>
2:00-2:30 pm	Current Concepts in Resuscitation — <i>Guy Weinberg, MD</i>
2:30-3:00 pm	Questions and Answers - Where Do We Go From Here? <i>Entire Faculty</i>
	Adjourn

*AMERICAN SOCIETY OF REGIONAL ANESTHESIA
& PAIN MEDICINE*

**27th Annual Meeting & Workshops
April 25-28, 2002**

Chicago Sheraton Hotel & Towers
Chicago, IL

**Online Abstract Submissions
www.asra.com**

**Abstract Deadline is 12 noon (EST),
January 4, 2002**

Abstracts for the 27th Annual Meeting will be submitted online electronically through the ASRA Website at www.asra.com.

Beginning November 1, 2001, you may paste your abstract into the site or work directly online and send it electronically. You must use a browser that is 4.0 or higher. No paper or disk submissions will be accepted.

American Society of Regional Anesthesia & Pain Medicine
Phone (804) 282-0010 • Fax (804) 282-0090
Email: asra@societyhq.com

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