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News on the Web

Literature Reviews (Complete)

Resident Section

Web CME

CME Needs Assessment

Upcoming Meetings:

- 2002 Annual Fall Pain Meeting, Pointe Hilton at Squaw Peak
Online Abstract Submission Deadline: August 15, 2002
- 4th Regional Anesthesia International Symposium: *Equipment and Techniques for Peripheral Nerve Blockade*

Carl Koller Memorial Research Grant



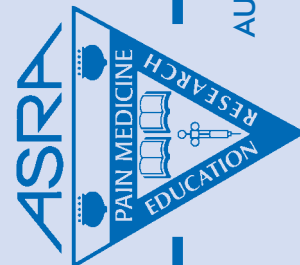
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4th Regional Anesthesia International Symposium: *Equipment and Techniques for Peripheral Nerve Blockade*

October 10-11, 2002
Orlando, Florida

*Sponsored by the University of Texas Medical School at
Houston in collaboration with the University of Florida
and the
American Society of Regional Anesthesia & Pain Medicine*

Watch for further program information at:
www.asra.com



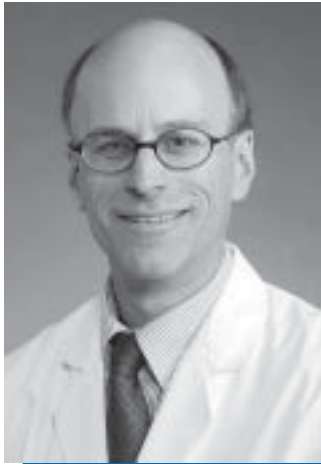
AUGUST 2002

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

ASRA NEWS

ASRA NEWS

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



James C. Eisenach, MD
President, ASRA

President's Message

Caring for professional athletes with sports injuries and those dying with cancer

I'm going to revisit the issue of my first message, and will probably do so again in the winter. American Society of Regional Anesthesia and Pain Medicine (ASRA) has gone to two major meetings, the Annual Spring Meeting and first Annual Fall Pain Meeting and Workshops (November 7-10 in Phoenix). The task given to Dan Carr and Jim Rathmell, co-directors of this first meeting, was to put together a meeting that would become THE meeting for anesthesiologists practicing pain medicine. They've succeeded marvelously.

Go to our website (www.asra.com) to see the meeting program. It is incredible, beginning with a half-day session on laboratory to clinic issues. One of the great frustrations of those doing pain research and those taking care of patients with chronic pain is the pseudo-science we talk about in the clinical condition. We talk

about sensitization phenomena, NMDA receptors, neuroplasticity, etc, but these are nearly all demonstrated in animals with subacute inflammation or artificial nerve injury. How do we know that any of this is relevant to the person suffering from chronic pain? Just as frustrating is the near total lack of application of pharmacology shown in these animal models to affect 'pain' threshold to humans. We just don't have the tools.

What Jim Rathmell and Dan Carr have done in the first half day of this meeting is to directly address these issues. Each of four topics (Peripheral nerve blocks in chronic pain; Opioid therapy for cancer pain; Preemptive analgesia; Use of quality-of-life assessments) is divided between a basic scientist and a clinician. There will no doubt be active debate about whether the knowledge from basic research has clinical utility or not. I don't know what the other groups will talk about, but my topic "Peripheral nerve blocks in chronic pain" will present new and exciting information in both animals and humans related to new uses of our skills in regional anesthesia to alter inflammatory processes surrounding nerve injury and reset the sensory system to normal.

What about professional athletes and sports injuries? As part of Dr. Brent Rich's presentation, "The professional athlete: Physical therapy and conditioning in the case of overuse injuries", Mike Morgan, Arizona Diamondbacks pitcher, will be discussing the impact of long-term physical therapy, exercise and flexibility techniques for the professional athlete. Anesthesiologists who take care of patients with chronic pain bring an incredibly useful and unique armamentarium of techniques and knowledge in the use of many drug classes for treatment of severe pain. But we also rely heavily on a team approach, including pharmacologists, physical therapists, oncologists, and psychologists. This meeting addresses each of these in a thoughtful and practical manner.

Acute pain straddles the two meetings of ASRA Fall Pain Meeting and Spring Annual Meeting. There's a nice mix of topics addressing acute postoperative pain, including a review by the anesthesiologist, supported by ASRA in the past, who has led the basic science study of mechanisms of postoperative pain, Tim Brennan. Tim and those who are following his lead, including my own research laboratory, are finding major differences between postoperative pain and what pain researchers normally study (inflammation and nerve injury). That's not surprising. On the other hand, too many people, clinicians and laboratory investigators alike, are trying to apply the knowledge gained in the study of inflammatory and nerve injury pain to the postoperative situation. In addition, surgery is thought to be the cause of chronic pain in a large number of individuals, and we are positioned in the operating room to affect this process. We have saved lives many months after surgery by administering b-adrenergic blockers in patients with coronary artery disease. I believe we can also save many cases of chronic pain from developing by what we do to treat pain in the peri-operative period. I also believe that will involve, for the near future at least, a reliance on regional anesthesia techniques.

I obviously am enthused about this meeting, and know that those who attend will be in for a real treat, a lot of useful discussion, and will go home having learned something important. Check it out on our website!

James C. Eisenach, MD
President

ASRA Quiz

- Which of the following statements about retrobulbar blocks is correct?
 - When the patient looks in superonasal direction the inferior oblique muscle is less likely to be injured by the needle.
 - When the patient looks in an inferomedial direction the optic nerve sheath is less likely to be injured by the needle
 - The needle is inserted in the inferotemporal quadrant of the orbit and directed in a posterior, superior, and medial direction.
 - All of the above are true.
 - None of the above are true.
- The Retrobulbar space is equivalent to the:
 - Epidural space
 - Peribulbar space
 - Pleural space
 - Subarachnoid space
 - Subdural space
- Which of the following are risk factors for puncture of the globe during Retrobulbar block?
 - Amblyopia
 - Astigmatism
 - Myopia
 - Presbyopia
 - Retinopathy of hypertension
- Compared to Retrobulbar blocks, peribulbar blocks:
 - Are the same technique
 - Have a decreased risk of retrobulbar hemorrhage
 - Have an increases risk of puncture of the globe
 - Have an increased risk of injection into the optic sheath
 - Have a shorter time to onset of anesthesia
- Noxious reflexes associated with ocular manipulation include:
 - The trigeminovagal (oculocardiac) reflex: bradyarrhythmias in response to ocular manipulation
 - The oculo-respiratory reflex: respiratory slowing in response to ocular manipulation
 - The oculoemetic reflex: nausea and vomiting in response to ocular manipulation
 - All of the above
 - None of the above.
- Which of the following is not an upper level of sedation as recognized by the ASA continuum of Depth of Sedation?
 - Anxiolysis
 - Conscious sedation
 - Deep sedation
 - General anesthesia
 - Stupor

Robert Kettler, MD

Answers are on page 4.

ASRA Breakfast Panel at ASA

Rosen Centre, Orlando Florida
Monday, October 15, 2002

Brachial Plexus Anesthesia: Essentials of Our Current Understanding

Moderator: JC Gerancher, MD

Associate Professor of Anesthesiology
Wake Forest University School of Medicine
Winston-Salem, NC

Anatomy and Pharmacology

Joseph Neal, MD
Associate Professor of Anesthesiology
Virginia Mason Medical Center
Seattle, WA

Approaches and Techniques

JC Gerancher, MD
Associate Professor of Anesthesiology
Wake Forest University School of Medicine
Winston-Salem, NC

Complications

James Hebl, MD
Assistant Professor
Mayo Clinic
Rochester MN



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Co-Editors

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

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Eric Wellmeyer, MD

Regional Anesthesia and Pain Medicine Editorial Updates

The *Regional Anesthesia and Pain Medicine* (RAPM) Editorial Office discussed the following topics at the April 27, 2002 ASRA Annual Meeting in Chicago:

- Editor-in-Chief transition
- Increasing number of manuscript submissions and a corresponding increase in rejection rate
- Journal page counts
- Electronic submission and review

I announced to Society headquarters my intent to hand over leadership of the Journal after five years of service. Increasing departmental responsibilities and national commitments are limiting the time needed for the creative work the Journal demands. Joseph Neal, MD of Seattle, Washington will be assuming the Editor-in-Chief role effective June 1, 2002, and our entire editorial team is delighted.

Submissions to *RAPM* continue to increase. From 2000 to 2001 the journal saw an 8% rise in submissions and another 4% increase from 2001 to 2002. 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.

Growing interest in the journal as the choice for submission has produced a corresponding increase in the journal's rejection rate. The journal's contract with W.B. Saunders allots 100 pages per issue including 6 color pages for the years 2002 and 2003. In order to meet this contractual obligation the Editorial Board has consistently and progressively raised its standard for publication. Since 1999 the rejection rate of Original Manuscripts has risen from 39% to 59% and Case Reports over the same period of time went from a 39% rejection rate to a 66% rate. This growth will be taken into consideration as the Society renegotiates the journal's contract.

The Editorial Office continues to research options for web-based manuscript submission, review, and tracking in order to improve the journal's efficiency and meet the growing preference for electronic systems over paper. For the first time the journal is experiencing a preference to submit electronically with 55% of the 2002 submissions (1/1/02-3/21/02) arriving via e-mail. After intensive investigation and review the Editorial Office recommended Editorial Manager by Aries Systems as the system that would best meet the journal's needs for its easy customization, cost effectiveness, and its user-friendly interface.

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. I thank you for the wonderful professional experience you have allowed me to have as Editor-in-Chief these last five years.

David L. Brown, MD
Editor-in-Chief, *Regional Anesthesia and Pain Medicine*

The Editorial Office of *Regional Anesthesia and Pain Medicine* (RAPM) has undergone a major relocation. After five years as the Editor-in-Chief, David L. Brown, MD, Professor and Chair of the University of Iowa Department of Anesthesiology, has stepped down to devote more time to his Department and national commitments. The Editorial Office has moved to the Virginia Mason Medical Center in Seattle, where Joseph M. Neal, MD became the new Editor-in-Chief on June 1, 2002. Dr. Brown's contributions to *RAPM* cannot be overemphasized. Under his leadership, the *Journal* enjoyed significant increases in total number of submissions and impact factor. The *Journal* provided its readership with innovative articles focused on imaging topics, translational vignettes, and also published important supplements, most notably the frequently cited *ASRA Consensus Statement on Neuraxial Anesthesia and Anticoagulation*. Dave's leadership and organizational skills will be missed, as will the very capable team of the Iowa City editorial assistants, Shawn A. Platt and Dorene A. Burr.

Although the general focus of *RAPM* will not change, the Editorial Board hopes to incorporate several new features. Most important of these will be a concerted effort to make *RAPM* the preferred publication vehicle for those pain medicine investigators whose work is of particular interest to the practicing anesthesiologist. To this end, I am most pleased to announce the appointment of James P. Rathmell, MD as the Associate Editor-in-Chief for *RAPM*. Jim has skillfully coordinated the *Journal's* Imaging Section for the last several years. As Chair of the ASA Committee on Pain, his expertise is well respected and frankly will be a valuable complement to my focus on the surgical applications of regional anesthesia. In addition to expanding our focus on pain management, we will continue to encourage the submission of high quality clinical and basic science research from throughout the world. This focus naturally includes a re-affirmation of the continued participation of a strong, internationally based Editorial Board. Meeting the financial challenges of publishing a medical journal in today's environment of increasing production costs and decreasing advertising revenue also brings opportunity for innovation. For example, we are exploring options for the electronic delivery of valuable but otherwise expensive information, most notably distribution of meeting abstracts and/or supplements from the recent conferences on Local Anesthetic Toxicity and the Anticoagulation Guideline updates. Opportunities are also present for increasing *RAPM's* availability amongst our international colleagues. Finally, we will continue to provide our readership with quality peer-reviewed information presented in an interesting format, and our authors with a rapid review process. To this end, an entirely Web-based manuscript submission and review process should be in place within the year.

As part of the transition from Iowa City to Seattle, we are most fortunate to have Jeff D. Baker join the Editorial Office as the new Managing Editor. Jeff has extensive publishing experience and will become the central force in assuring that you receive a new issue every other month and that your research is efficiently guided through the publication process. We are most interested to hear your thoughts and concerns regarding our efforts to continue *RAPM's* growth. Please feel free to contact us at RAPM@vmmc.org with your comments.

Joseph M. Neal, MD
Editor-in-Chief, *Regional Anesthesia and Pain Medicine*

Literature Reviews

Patient-controlled Regional Analgesia (PCRA) at Home: Controlled Comparison between Bupivacaine and Ropivacaine Brachial Plexus Analgesia.

Narinder Rawal MD, Ph.D; Renee Allvin CRNA, BSc; Kjell Axelsson MD, PhD; Jan Hallen MD; Gustav Ekback MD, PhD, Torbojorn Ohlsson CRN, MS, Anders Amillon MD. *Anesthesiology* 2002;96:1290-6.

Previously published studies have shown that 40-50% patients undergoing ambulatory surgery suffer from moderate to severe pain during the first 24-48 hours post-operatively. The aim of this double-blind study was to compare the efficacy of bupivacaine versus ropivacaine catheter brachial plexus analgesia for postoperative pain relief in patients undergoing outpatient hand surgery. A second goal was to determine the feasibility and safety of patient-controlled regional analgesia (PCRA) outside the hospital.

Methods

Sixty ASA I or II patients scheduled for a variety of ambulatory elective hand surgeries were consented for randomization in this study. During the pre-anesthesia visit, all patients were given an explanation of the visual analog scale (VAS) and verbal pain scoring, use of the "home pump" device (in this case a sterile, elastomeric, disposable balloon home pump from I-flow Corporation requiring the patient to open and close the clamp for it to function as a PCA device) and the importance of mailing the completed patient diary. Each patient was also familiarized with the use of PCRA. All surgeries were performed with an axillary brachial plexus blockade utilizing the paresthesia technique. Patients received 20 ml of 1.5% mepivacaine through the introducer cannula and then a contiplex catheter was threaded 2-3 cm beyond the tip of the introducer cannula and another 20 ml of local anesthetic was injected. After surgery, the catheter in the plexus was connected to the sterile home pump. Patients were kept in the PACU until the effects of the brachial plexus block had worn off, and patient's self-administered 1-2 doses of PCRA. Patients were randomized to receive either 0.125% bupivacaine or 0.125% ropivacaine for post-operative analgesia and were randomized to self-administer a bolus of 10 ml (12.5 mg) of the local anesthetic drug by opening the clamp on the PCRA device for 6 minutes. Each patient was given dextropropoxyphene tablets on discharge and instructed to take a 100-mg tablet if the PCRA was ineffective. Each patient received a patient diary. Every time patients used the home pump, they indicated their VAS before and about 20 min after treatment in the diary. The patients also graded their analgesia on a 5-grade scale. A research nurse who was blinded to the study protocol made a follow-up telephone call the day after surgery.

Results

All 60 patients recorded their pain scores before and after each treatment. Visual analog scale scores decreased after each treatment in both groups, but there were no significant differences between the two drugs. One patient in each group took rescue pain medications. In both groups, 87% of patients expressed their desire to have the same treatment again. There was a significant difference between the groups in regard to satisfaction with PCRA on the day of surgery: 81% of patients were satisfied or very satisfied with ropivacaine versus 52% with bupivacaine PCRA ($p < 0.05$). On the day after surgery, the percentage of satisfied or

very satisfied was similar with 79% and 83% for ropivacaine and bupivacaine, respectively. The main reasons for dissatisfaction were persistent numbness of fingers and inability to extend fingers; some patients also complained of inadequate analgesia and motor weakness of arm and fingers.

Comments

This is the first controlled trial to evaluate the efficacy of axillary PCRA using two different local anesthetics after ambulatory surgery. The results show that the both local anesthetic drugs provide effective analgesia and the authors were unable to detect any significant differences in VAS between the two drugs. Significantly more patients were satisfied with ropivacaine on the day of surgery. According to the authors, previous studies have shown that epidurally administered ropivacaine is up to 40% less potent than epidural bupivacaine. However, at high concentrations for axillary plexus block for surgery, the two drugs appear to be equipotent. Despite the absence of a control group in this study, the authors are to be commended for demonstrating that analgesia by perineural infusion is feasible outside the hospital. They are also to be commended for the rigorous pre-anesthetic measures taken to reduce the risk of toxic complications in this group of outpatients. These measure included 1.) clear verbal and written instructions to patients and escort about PCRA technique, 2.) use of timer to encourage proper dosing, 3.) information provided regarding symptoms caused by local anesthetic overdose, 4.) telephone and pager numbers of anesthesiologist at all times.

Continuous Infraclavicular Brachial Plexus Block for Postoperative Pain Control at Home: A Randomized, Double-blinded, Placebo-controlled Study.

Brian Ilfeld MD, Timothy Morey MD, Kayser Enneking MD. *Anesthesiology* 2002; 96:1297-1304

Previous investigations of hospitalized patients suggest that local anesthetic infusions via perineural catheters decrease postoperative pain and narcotic requirements after a variety of procedures. Although at-home perineural infusions have been described in several series of patients, their efficacy has not been investigated in a randomized, double blind, placebo-controlled manner. The objectives of this study were to determine 1.) if local anesthetic infused via an infraclavicular brachial plexus perineural catheter decreases postoperative pain, oral narcotic requirements, narcotic-related side effects, and sleep disturbances, 2.) if a small, portable, battery-powered, infusion pump that allows PCRA is reliable and can be used successfully by outpatients, and 3.) if patients accept and understand the catheter and pump system well enough for postoperative analgesia at home to be successful.

Methods

For surgery all 30 patients received an infraclavicular block with 50 ml of mepivacaine 1.5%, sodium bicarbonate 5 mEq, epinephrine 125 ug and clonidine 100 ug. This injection was followed by placement of a 20-gauge multiport polyamide catheter. Patients were randomized to 0.2% ropivacaine or 0.9% saline at 8 ml/hr with a 2-ml patient-controlled bolus available every 20 min.

Continued on page 4

Literature Review continued from page 3

Postoperatively, when patients met standard ambulatory home-discharge criteria, the catheter was tested for intravascular positioning with gentle aspirations followed by a 10-ml incremental bolus of study fluid into which 30 µg of fresh epinephrine had been added. Subsequently, a portable, programmable, battery-powered mechanical infusion pump was attached to the catheter with a reservoir containing 550 ml of study solution. Before discharge all patients were given oral methadone 5 mg.

Results

Patients receiving ropivacaine experienced significantly less postoperative pain compared with patients receiving normal saline during rest and limb movement ($p < 0.05$). The ropivacaine group used significantly fewer narcotic tablets to remain comfortable and experienced fewer narcotic-related side effects and sleep disturbances than the placebo group. The average satisfaction with post-operative analgesia on a scale of 0-10 was ranked 9.2 by those who received ropivacaine and 5.8 by those who received placebo. All patients who received ropivacaine would repeat this analgesic method, only 8 out of 15 patients receiving placebo would repeat the technique. Roughly 50% of patients complained of leakage of clear fluid from under the occlusive dressing, and approximately 30% of patients had at least one nonscheduled contact with the on-call physician during the course of their infusion.

Comments

This is the first randomized, placebo controlled study to show that after moderately painful orthopedic surgery of the upper extremity, ropivacaine infusion using a portable, mechanical pump and an infraclavicular brachial plexus perineural catheter at home decreased pain, sleep disturbances, narcotic use and related side effects and improved overall satisfaction. The authors are to be commended for the rigorous study design. Patients were carefully screened and study requirements included understanding of the possible local anesthetic-related complications and the care of the catheter and pump. Patients also were required to have a caretaker who would remain with them through the first postoperative night and be available and capable to remove the catheter in the evening of postoperative day 2. It is interesting to note that despite extensive pre-study training 30% of patients had nonscheduled contact with the on-call physician.

Literature Reviews continued on the website**A Comparison of Intrathecal Fentanyl and Sufentanil for Labor Analgesia.****Continuous Psoas Compartment Block for Postoperative Analgesia After Total Hip Arthroplasty: New Landmarks, Technical Guidelines, and Clinical Evaluation.**

Julia E. Pollock, MD

961 New Resident Members

Eighty-six (86) residency programs responded to the offer of a one-year complimentary membership in ASRA for CA2s, provided they were not already members.

Nine hundred and sixty-one (961) members were enrolled and will receive the Journal, Newsletter and web site access for the complimentary year.

Scholarships for Pain Fellows

Thanks to the support of Baxter Healthcare and AstraZeneca, there are six scholarships of \$1,000 each available for Pain Fellows for participation in the Fall Pain Meeting, November 7-10, 2002 in Phoenix, Arizona.

To be eligible, the Fellow must have been an ASRA member the year before entering the fellowship and have a letter of nomination from their Fellowship Director. Applications are due in the Administrative Office of the ASRA on or before September 16, 2002.

The scholarship will be applied to the registration fee (already reduced for member Fellows), air travel, hotel and any other necessities.

ASRA Quiz Answers

- ANS: D
Ref: McGoldrick KE Anesthesia and the eye. In: Barash PG, Cullan BF, Stoelting RK, eds. Clinical anesthesia. 3rd ed. Philadelphia: Lippincott-Raven; 1997. p. 929-21.
- ANS: A
Ref: Kupersmith MJ. Neuro-ophthalmologic and neurologic complications of ophthalmic anesthesia. In: Greenbaum S, ed. Ocular anesthesia. Philadelphia: W.B. Saunders Co.; 1997. p. 151-72.
- ANS: C
Ref: Concepcion M. Acute complications and side effects of regional anesthesia. In: Brown DL, ed. Regional anesthesia and analgesia. Philadelphia: W.B. Saunders Co.; 1996. p. 446-61.
- ANS: B
Ref: Tucker JH, Flynn JF. Head and neck regional blocks. In: Brown DL, ed. Regional anesthesia and analgesia. Philadelphia: W.B. Saunders Co.; 1996. p. 245-7
- ANS: D
Ref: Johnson RW, Forrest FC. Anaesthesia for ophthalmic surgery. In: Prys-Roberts C, Braun Jr. BR, eds. International Practice of Anesthesia. Oxford: Butterworth-Heinemann; 1996. Vol. 2, Ch. 114, p.3-4.
- ANS: E
Ref: American Society of Anesthesiologists. 2201 Directory of Members. P. 513.

Resident Section Committee Meeting Minutes

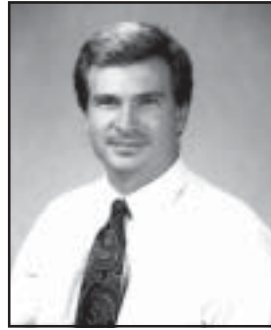
ASRA Resident Section Committee
 Sheraton Chicago Hotel and Towers, Chicago, IL
 Saturday, April 27, 2002, 11:00 AM

Call to Order

The biannual meeting of the ASRA Resident Section committee was called to order by Dr. Allan Escher, Jr. at the Sheraton Chicago Hotel and Towers, in Chicago Illinois at 11:00 am on Saturday, April 27, 2002.

In Attendance

Allan Escher, Jr., DO, Chair ASRA Resident Section
 Eric Wellmeyer, MD, Chair-Elect ASRA Resident Section
 Lynn Broadman, MD, President of the ASRA
 Kristin Smith, MD, Member-at-Large ASRA Resident Section
 Dan Warren, MD, CA-2, Virginia Mason
 Samer Narouze, MD, Pain Fellow, Cleveland Clinic



Eric Wellmeyer, M.D.
 Chair, ASRA Resident Section
 Committee

I. Old Business

- a. 2002 Annual Meeting
 - i. 8th Annual Resident Forum Cracker Barrel
 1. Title: Tricks of the Trade- Everything I Wished I had Learned in Residency
 2. Speakers: Alon Winnie, MD, James Rathmell, MD, Patrick McQuillan, MD
 3. Advertisement
 - ii. Scientific Program Committee Representation
 1. Preliminary program 2003 discussed
- b. Membership
 - i. New calculation methodology for Residents and Fellows 2002
 - ii. Welcome letters have gone out to the new CA-1 Residents
 - iii. Statistics:

Year	Total Res.	Member Res.	Percentage
1999	2673	922	34%
2000	3114	1692	54%
2001	2632	1660	63%
 - iv. Membership Committee Representation will be continued by Chair
 - v. ASRA journal access online and free to Resident members
 1. No hard copy journal sent to CA-1 Residents
 2. Hard copy journal sent to CA-2 Residents
 3. CA-3 and CA-4 Membership fees \$25/y which includes access to the ASRA journal online and hard copy of journal
 - vi. Matriculation Tracking
 1. Letter to be sent to graduating Residents to encourage continued membership
 2. Graduated pay scale for new Attending Anesthesiologists proposed by Dr. Escher, as is done with the ASA
- c. Web Page
 - i. General information and resource
 - ii. Needs further updating including links to useful sites

- d. Resident Section Committee
 - i. New Officers
 1. Chair: Eric Wellmeyer, MD, UCLA
 2. Chair-elect/Editor: Sandra Kopp, MD, Mayo Clinic
 3. Pain Fellow Rep.: Carlos Moreno, MD, Univ. of Michigan
 4. Canadian Rep.: Anahi Perlas, MD, Canada
 5. Faculty Advisor: Susan McDonald, MD, Virginia Mason
 - e. ASRA Resident Delegate to ASA
 - i. Chair: Eric Wellmeyer, MD, UCLA

II. New Business

- a. 28th Annual Spring Meeting and Workshops, April 3-6, 2003 (San Diego, CA)
 - i. Resident Forum Cracker Barrel 2003
 1. Title: Designing and Evaluating Clinical Research
 2. Speakers: Michael Ferrante, MD, & TBA
 3. Time of event under consideration to allow maximum Resident attendance
 - ii. ASRA Resident Component Meeting
 1. Time T.B.A.
 2. Advertisements to maximize Resident participation
- b. 1st Annual Fall Pain Meeting and Workshops, November 7-10, 2002 (Phoenix, AZ)
 - i. Focus of meeting on chronic pain
 - ii. No ASRA Resident Component activities planned
- c. Future ASRA Newsletter Articles done in conjunction with Resident Chair and Chair-elect/Editor
- d. ASA Annual Meeting, Orlando, Florida, October 12-16, 2002
 - i. ASRA Resident Section Meeting
 1. Saturday Morning
 2. Time and Place TBA

III. Adjournment

- a. By outgoing Resident Chair, Allan Escher, Jr., DO at 12:40pm



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AMERICAN SOCIETY OF REGIONAL ANESTHESIA & PAIN MEDICINE
Annual Fall Pain Meeting & Workshops



November 7-10, 2002

*Immediately follows
Society for Neuroscience (SFN) Meeting*

**Pointe Hilton at Squaw Peak
Phoenix, AZ**

Featuring

- Bonica Lecturer: Maria Fitzgerald, PhD
- Workshops / Master Classes
- Basic Science / Clinical Translational Sessions
- Poster presentations with on-line abstract submissions

Abstract deadline: August 15, 2002

(Abstracts of original work are encouraged and the same abstracts from the SFN meeting may be submitted.)

Watch for further program information at:

www.asra.com