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ASRANEWS is a publication of the American Society of Regional Anesthesia & Pain Medicine.

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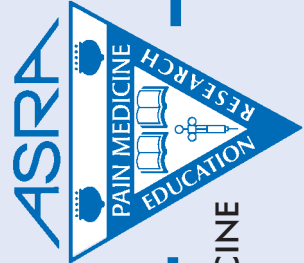
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ASRA NEWS

President's Message

ASRA at Disney World

Welcome to the Hall of Presidents...

The following is an excerpt of the address by Dr. Mark Lema, ASRA President-Elect to the assembly at the Spring Annual Meeting.

"Last summer, the ASRA Board voted to extend the officers' terms to two years for better continuity and more effective stewardship of our society. Because of my previously stated intentions to run for the First Vice-President's position in the ASA, this change in term limits could not begin with either Dr. Horlocker or me.

I am now running unopposed for this ASA office and expect to become ASA's next First Vice-President in October. To avoid any real or perceived conflict of interest by serving as an executive officer for both ASRA and ASA simultaneously, I would need to resign from the ASRA presidency in mid-term at the end of the fall ASA annual meeting.

The Executive Committee of ASRA believes that the affairs of ASRA would be best served by allowing Dr. Horlocker to extend her presidency, effectively starting the two-year terms of office now. Therefore, I will resign my presidency of ASRA today to allow for this transition to occur.

My anticipated election to a major ASA office which leads to the ASA presidency, will greatly benefit the ASRA-ASA educational relationships and their mutual interests in developing both pain medicine and regional anesthesia practices.

Over this past year, Dr. Horlocker has worked tirelessly in our behalf to advance ASRA's program offerings and to refine administrative policies. Her ability to influence meaningful change and continued improvement in ASRA resources will be greatly enhanced by extending her presidential powers.

I look forward to carrying ASRA's mission and philosophy to the ASA Executive Committee. I will work closely with Drs. Horlocker and Rosenquist as well as the ASRA Board to expand ASRA's influence and growth in the larger community of anesthesiologists. Moreover, I will serve ASRA as its past-president to solidify the ASRA-ASA partnership during this historic transition.

Please join me in congratulating Dr. Horlocker for her excellent service as ASRA president over this past year, and for her historic continuation as our president through 2005."

Dr. Lema has served ASRA for over two decades as a valued speaker and workshop instructor, Annual Meeting Chair (1994), Research Committee Chair (1996-2001), Member of the Board of Directors (1996-2004), Vice-President (2002-2003), and President-Elect (2003-2004). Although his term brief, he is recognized as a Past-President of the Society and admired for his selflessness and dedication.

- T. T. H.



Mark J. Lema, MD, PhD
President Elect

...and Tomorrowland

The 29th Annual Spring Meeting and Workshops showcased the Society's ongoing efforts to educate clinicians in not only the technical aspects of regional anesthesia and pain medicine, but also the safe practice of the specialty. The **Consensus Conference on Infectious Complications** reviewed the existing literature on aseptic technique, mode of colonization and infection, and risk factors for infectious complications following regional block and interventional pain techniques. The proceedings will be published in *Regional Anesthesia and Pain Medicine* and placed on the website (www.asra.com) later this year. Likewise, participation in the Sunday morning session **New Techniques and Approaches in Regional Anesthesia—Theory and Practical Application**, which included 2.5 hour hands-on workshop (with live models), was complimentary with registration. Future programs also include special sessions designed to provide a service to our membership. For example, the upcoming 2004 Fall Pain Meeting (November 11-14, 2004 at the Pointe Hilton at Squaw Peak, Phoenix, AZ) addresses **Palliative Care and End-of-Life Issues**, while a full-day conference on **Neurologic Complications of Regional Anesthesia** is scheduled *within* the 2005 Spring Meeting (April 21-25, 2005 at the Sheraton Centre, Toronto, ON, Canada).

These programs, full of endless wonder, transform an ASRA meeting into a Disney theme park- a magical storybook land of beloved characters, timeless tales and bold adventures. Make all your dreams come true (and your blocks successful)...plan to attend.

Terese T. Horlocker
President, ASRA



Terese T. Horlocker, MD
President



Resident Section Committee Meeting Report



Thelma B. Wright, MD

The 2004 Annual Spring Meeting of ASRA was held at the Walt Disney Swan, Orlando Florida on March 11-14. The meeting was a huge success with a good turnout of residents. The meeting gave residents a wide spectrum of educational opportunities which included Refresher Courses, four hour Upper and Lower Extremity Intensive Workshops and nine 90-minute workshops which covered a wide spectrum of regional techniques.

On Saturday, March 13, 2004, the bi-annual meeting of the ASRA Resident Section Committee (RSC) was held at 10:00 am. Dr. Sandra Kopp, Chair of the ASRA RSC called the meeting to order. In attendance were: Terese Horlocker, MD (President of ASRA), Susan McDonald, MD (ASRA RSC Faculty Advisor), Thelma Wright, MD (ASRA RSC Chair-Elect), David Maine, MD (ASRA RSC Newsletter Editor), Anthony Eidelman, MD (ASRA RSC Member-at-Large), Eric Crabtree, MD (ASRA RSC Member-at-Large), Richard Melucci, MD (ASRA RSC Member-at-Large), Christian Gonzalez, MD (ASRA RSC Member-at-Large).

Dr. Kopp began by welcoming the attendees and thanking Drs. Terese Horlocker and Susan McDonald for their continued support of the ASRA RSC. The incoming Chair of the ASRA RSC, Dr. Thelma Wright (University of Virginia), Newsletter Editor/Chair-Elect, Dr. David Maine (Johns Hopkins) and Members-at-Large were introduced.

The 2004 Annual Resident Forum Cracker Barrel was a huge success. The title was *Ultrasound-An Innovative Approach to Teaching Regional Anesthesia*. The speaker was Dr. Vincent Chan (Toronto Western Hospital) who discussed various ways of performing blocks with ultrasound guidance. Dr. Sandra Kopp served as moderator and introduced the new Chair, Newsletter Editor/Chair-elect and Members-at-Large. There were approximately 100-150 people present; and a wide selection of wine, beer, cheese and crackers was available during the session.

Once again, five \$1000 Resident Research Awards were given to residents/fellows who submitted abstracts for the Spring meeting to help with the cost of attending the ASRA meeting.

2004 Spring Scholarship recipients were:

Brad Davis

Virginia Mason Medical Center

Amit Gupta

Children's Hospital of Philadelphia

Adam Kozowski

University of Colorado Health Sciences Center

Shruti Shah

St Luke's-Roosevelt Hospital Center/New York

Christopher Grubb

University of Virginia Health System

Scholarships are also available to ASRA residents/fellows for the Annual Fall Pain Meeting. Information on award application and abstract submission deadline information is available on the ASRA website and in the Newsletter.

Membership to the ASRA resident section continues to be on the rise. Currently we have 1659 resident members. Benefits of being a member include access to the ASRA journal on-line and free membership to CA-2 residents with hard copy journal. The membership fee for the CA-3 and CA-4 members is \$25/yr. Application for membership is on the ASRA website.

The ASRA website is a good source of information for residents and fellows. We are currently updating the site to include

links to other useful sites. The website contains membership information, upcoming meetings, listings of pain and regional fellowships and useful blocks encountered in our day-to-day practice.

This year's Annual ASA meeting will be held in Las Vegas, Nevada and will be the forum for the biannual ASRA RSC. The time and place, to be announced. The ASRA representation to the ASA Resident Component House of Delegates will be the Chair. The Chair-elect will serve as the alternate delegate.

At the 2005 Annual Spring Meeting, the Resident Cracker Barrel will include a panel of three well acclaimed regional and pain medicine physicians. They will talk about, *What to Look for in a Regional Fellowship*-Dr. Joseph Neal, *What to Look for in a Pain Fellowship*-Dr. John Rowlingson and *Carving a Career Pathway: Academic vs Private Practice*-Dr. Richard Rauck. We are sure this will be of great interest to anesthesia residents looking into fellowships, and if not, how to determine which career path to take. Scholarships will also be made available to help residents/fellows defer some of the travel costs. The biannual meeting will be held at this meeting, time and place to be announced.

Regional Anesthesia Block Fairs are planned for various sections of the country to help with "basic block" skills for residents in institutions that do not have adequate regional experience. The Fairs will be held in conjunction with the Resident Regional Conferences. Faculty from the ASRA will work closely with the faculty from the host institution. Further information will be posted on the ASRA website or appear in the ASRA Newsletter.

Due to the close proximity between time of announcing Newsletter Editor and deadline for ASRA resident section newsletter article, it was decided that the Chair author two of the four articles. This will help in a better transition for the Editor into the job. We welcome articles from new residents/fellows. Please forward them to dmaine2@JHMI.edu.

We currently have 15 new Members-at-Large. They are: Dr. Richard Melucci, Dr. Michail Fuller, Dr. Christopher Beck, Dr. Juan Pulido, Dr. Daniel Choi, Dr. David Burns, Dr. Dan-Thuy Tran, Dr. Eric Crabtree, Dr. Christian Gonzalez, Dr. Zach Lipman, Dr. Diana Thant, Dr. Richard Buill, Dr. Anthony Eidelman, Dr. Daniel Warren and Dr. John Adesioye.

Thank you all for your continued support and interest. I hope to see all of you at the ASA this October and invite you to attend the biannual ASRA RSC meeting.

Thelma Wright, MD
Chair, Resident Section

ERRATUM

In the February 2004 ASRA Newsletter, the correct title but wrong abstract by McCartney, et al was presented as the Best of Meeting Abstract - Spring 2003. The correct abstract is in the web version of the ASRA News.

Wrist Block for Procedures in the Hand: A Surgeon's Perspective

Michael Marshall, MD
Orthopedic Surgery
TTUHSC
Lubbock, TX



Wrist level nerve blocks are valuable tools for the surgical treatment of traumatic and degenerative conditions in the hand. Advantages include less expense and time compared to alternatives. Patients appreciate the 6-8 hours of analgesia provided by long acting local anesthetic agents. Dosage is typically lower and administration is distant to major vascular structures, giving a safety advantage compared with other regional techniques (intravenous regional or plexus blocks). Nausea, confusion and other problems seen with general anesthetics are not encountered. The ability of a comfortable awake patient to cooperate with the surgeon intraoperatively may be of considerable value, especially in tendon transfer or balancing procedures, where extrinsic muscular activity is desired.

There are risks related to toxicity of local anesthetics and inadvertent needle injury to neurovascular structures. Risks can be minimized by proper needle placement and adherence to guidelines for maximum anesthetic dosage. The volume of agent required for successful wrist level nerve block is usually well below the maximum permissible dose. Aspiration prior to injection decreases systemic risk from injection into arteries or veins. Use of epinephrine is appropriate at the wrist but more distal injection may result in avascular tissue injury. Epinephrine prolongs the block and decreases bleeding. Bupivacaine produces a block of four times the duration of lidocaine, but requires more exact block placement and has a slower onset. I usually use 0.5% bupivacaine. Significant nerve injury can occur from intraneural injection of anesthetic. Proper technique places the anesthetic into the space surrounding the nerve. An awake patient is essential for safety; they can report paresthesias from inadvertent intraneural needle placement prior to injection. The needle is then withdrawn slightly prior to injection.

Block Placement

Three major and two minor nerves supply the hand. For complete anesthesia of the hand, each must be blocked. However, many procedures are site specific in which case only some nerves must be blocked. The median nerve innervates the dorsal digits, palmar thumb, index, long and half of ring digits. The ulnar nerve supplies the remainder of the palm and fingers. The radial sensory nerve territory includes the dorsal surface bridging the thumb and index digits, as well as a variable portion of the dorsal hand. A minor branch of the ulnar nerve, the dorsal ulnar sensory nerve transits from palmar to dorsal at the level of ulnar styloid to supply the dorsoulnar hand. A palmar sensory branch of the median nerve is located between the flexor carpi radialis tendon and the tendon of the palmaris longus.

Blocking the Median Nerve:

The median nerve is located slightly radial and deep to the tendon of palmaris longus. This tendon becomes prominent when the patient touches the thumb to the small finger with the wrist slightly flexed. A needle placed perpendicular to the skin at the wrist flexion crease, slightly ulnar to palmaris longus tendon, will enter the carpal canal without endangering the median nerve (Figure 1, A). Penetration to a depth of 3/4 inch with a 25 gauge needle will allow placement of 5-10 cc of local anesthetic around the median nerve.

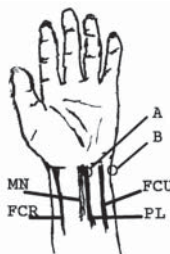


Figure 1

Blocking the Ulnar Nerve:

The hard spot in the "heel" of the hand (hypothenar prominence) corresponds to the carpal pisiform. Moving proximal to the wrist crease allows palpation of the flexor carpi ulnaris tendon; the ulnar artery and nerve lie beneath. Their relationship is the same orientation as radial artery and median nerve: the artery is radial. Therefore, a needle stick dorsal and ulnar to the tendon directed ulnar to radial will reach the nerve before the artery (Figure 1, B). A 5/8" 25 gauge needle has enough length to allow 5-10 cc of local anesthetic injection around the artery. Aspirate prior to injection and be alert to paresthesias from nerve irritation.

The ulnar nerve may also be blocked at the elbow. There is advantage in the precise superficial anatomic location of the nerve. It can be palpated readily one finger width below the bony medial epicondyle in the cubital tunnel. After block at this level, the patient will have a motor block of ulnar innervated extrinsic muscles as well, a potential problem during tendon surgery. Having personally experienced painful paresthesias from ulnar nerve block at this level, I prefer block at the wrist.

Blocking the Radial Sensory Nerve:

The radial nerve exits from under the brachioradialis muscle 4 cm proximal to the wrist. At the level of the wrist the nerve divides into 3 branches, supplying the dorsal thumb and index finger. Subcutaneous injection from the radial styloid prominence to the midline dorsum of the wrist will adequately block this nerve. (Figure 2)

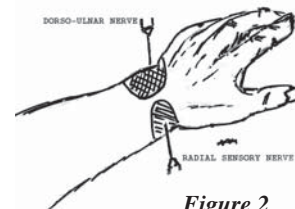


Figure 2

Minor nerves:

Usually the dorsal ulnar sensory nerve and palmar cutaneous nerve can be ignored, especially for procedures involving the digits. For complete anesthesia they can be blocked subcutaneously dorsal and radial to the ulnar styloid and radial and superficial to the palmaris longus tendon. (Figure 2)

Practical Points:

Patients are put at ease by a confident approach and a simple explanation of the technique. The use of NEUT (SODIUM Bicarbonate) mixed 1:10 with the local anesthetic will decrease the initial burning pain after injection. Total volumes can be limited to 10 - 20 cc's with well placed blocks. Injecting slowly will also decrease patient discomfort and anxiety, allowing analgesia to slowly take effect. 25 or 27 gauge needles are appropriate.

The position of the patient's hand is sometimes a problem during block of ulnar or median nerves. Many patients cannot supinate the hand sufficiently to achieve a comfortable position. In this case, have the patient turn on their side to gain the needed rotation of the hand.

Most problems of inadequate anesthesia occur when the block is hurried or poorly placed. Therefore, I prefer to perform the block in the preoperative area, allowing adequate light, space and time.

Prolonged use of a tourniquet may be difficult. The area under the upper arm tourniquet cuff, and more importantly, the muscles of the arm and forearm are not anesthetized by these techniques. If the required bloodless field is for 10-15 minutes, most patients can cope with the discomfort. For longer procedures, tightly wrapping only the distal forearm with an elastic bandage may provide a well tolerated dry surgical area. A rubber penrose drain 1/4" wide may be secured as a digital tourniquet.

Continued on page 4

Continued from page 3

Analgesia of the hand and wrist lasts well beyond the surgical procedure. This provides good post operative pain control yet allows the patient to move digits as encouraged by the surgeon. However, patients should be cautioned of the unnoticed injury that may occur in the numb hand including cuts and burns. Special caution should be exercised when applying dressings and splints, to avoid tightness or pressure leading to injury.

Good Times in the Land of Mickey

Over 425 participants suffered through clear blue skies and 70° temperatures to attend the 29th Annual ASRA Spring Meeting in Orlando, March 11-14th. Despite this sacrifice, all available data suggest that most attendees actually returned home with enthusiasm for regional anesthesia and a renewed sense of connection with old friends and colleagues.

Several new initiatives highlighted this year's spring meeting. One of these was ASRA President, Terese Horlocker's, unflinching effort to have every faculty member and dignitary wear the ASRA logo as a tattoo...but that's a story best left for another time. The *Consensus Conference on Infectious Complications of Regional Anesthesia* considered available literature and expert opinion to help guide everyday practice issues that have 'no good answer'. Examples include what constitutes acceptable aseptic technique during block placement, when to offer regional anesthesia to the infected or immunocompromised patient, or how to deal with infected interventional pain management hardware. Recommendations from this conference will be published in *Regional Anesthesia and Pain Medicine* later this year. Another successful new concept was the New Techniques and Approaches in Regional Anesthesia—Theory and Practical Application. This session solely occupied Sunday morning, holding the interest of over 100 participants. In essence, experts presented 15-minute mini-lectures on five relatively new regional techniques, followed by rotating workshop sessions. For many of the participants, it was their first exposure to neonatal spinals, cervical paravertebral blocks, or new approaches to the sciatic nerve. Other unusual presentations included a fascinating history of the epidural blood patch, plus the ASRA Special Lecture, which dealt with veterinary pain medicine.

More traditional topics included updates on regional anesthesia and pain medicine practice. Newer methods for nerve localization were discussed, including improvements in peripheral nerve stimulation and ultrasonography. Evidence was presented to help define best practices for such common surgeries as knee arthroscopy or total knee arthroplasty. Outcome data was critically assessed for the role of regional anesthesia and analgesia in optimizing patient care after major or ambulatory surgery. Lastly, David L. Brown, MD, Professor and Chair, University of Iowa, presented an enthralling Labat Lecture. In it, he chronicled how the anesthesiologist's concept of risk has changed and expanded during the time from Labat until present day.

The success of this meeting was in no small part due to the extraordinary efforts of the faculty, management personnel, and attendees. In addition, the presence of our many international guests added spirit and valuable insights. I extend my personal thanks to all of these wonderful colleagues. Orlando is now in the past, so we hope you will plan to attend ASRA's 30th Annual Spring Meeting in Toronto, April 21-25, 2005.

Joseph M. Neal, MD
Program Chair

Op Ed

Atta boy/atta girl! In the last issue of the Newsletter I commented about not enough or too much analgesia (Has the pendulum swung too far in post operative pain control?). This time I write about getting it just right – an epidural for labor and delivery for someone near and dear to me. Reluctant at first to have an epidural, the patient now “loves” her anesthesiologist for giving it to her. What the epidural did far exceeded her expectations – good pain relief with non painful sensation and motor function. Mother and baby are fine, dad is as happy and as proud as can be. Good science, good teaching, good application, fair reimbursement (and wonderful patients) – it is great when they are in synch. Note for the chart: APA – another perfect anesthetic!

James E. Heavner, DVM, PhD
Editor

Resident Research Award

The American Society of Regional Anesthesia and Pain Medicine is awarding a \$1000 stipend to five residents and/or pain fellows to facilitate attendance at the 2004 Annual Fall Pain Meeting and Workshops. Applicants must be a member of ASRA. Preference will be given to resident members who have submitted abstract(s).

Applications should include:

- Letter of nomination from the applicant's fellowship director
- 1-2 page bibliography
- A copy of the submitted abstract.

Please send completed application to:

Timothy J. Brennan, MD, PhD

Chair, ASRA Research Committee

The American Society of Regional Anesthesia and Pain Medicine

2209 Dickens Road • P.O. Box 11086 • Richmond VA 23230-1086

Scholarship recipients will be notified in September.

2004 Spring Meeting Supporters

ASRA would like to thank the following 2004 Supporters and Exhibitors:

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Literature Review

Safety of chronic intrathecal morphine infusion in a sheep model

Gradert TL, Baze WB, Satterfield WC, et al.

Anesthesiology 2003;99:188–98.

A sheep model was used to test the safety of chronically administered intrathecal (IT) morphine sulfate. The model assessed the behavioral and neurological effects, as well as the direct neurotoxicity of morphine on neural structures. Eighteen sheep were implanted with IT infusion systems and received morphine (3, 6, 9, 12, or 18 mg/day) or saline placebo as a continuous infusion. The sheep were examined daily for changes in behavior and neurological function. After a month the animals were sacrificed and their spinal cords were analyzed.

Animals in the highest dose groups exhibited hind-leg gait deficits. Examination of their spinal cords revealed intradural–extramedullary inflammatory masses that compressed the cords at the catheter tips. The location of the masses corresponded to the side of gait deficit and there was a direct correlation between the degree of compression and the amount of inflammation. The toxicity of IT morphine was dependent on the amount of morphine infused; however, the impact of the concentration used was not fully assessed by this study.

IT administration of morphine has been used for at least two decades to control severe pain, initially for patients with malignancies, but now also for those with nonmalignant pains and therefore longer life spans. In addition, the concentration of the morphine used in the implantable pump has been increased to reduce the frequency of pump refill. As use has increased so have reports of complications, including the development of masses at the catheter tip. This study systematically shows that in a sheep model granulomatous masses develop at the catheter tip when morphine is chronically infused. The mechanism is unclear but the morphine may directly activate lymphocytes to proliferate in the region. The findings are important as they significantly alter the risk:benefit ratio for patients contemplating IT placement of an infusion pump. Physicians will need to consider these results when obtaining informed consent from their patients.

Sunil J. Panchal, MD

*H. Lee Moffit Cancer Center
Tampa, FL*

Peripheral Nerve Blockade: Principles and Practice

Authors: Admir Hadzic, MD, PhD and Jerry Vloka, MD, PhD

Interest in regional anesthesia seems to be exploding in many directions simultaneously. Neuroanatomy, pharmacology, imaging and nerve localization tools, outcomes research, and many other facets of regional anesthesia are all receiving increasing attention. Thus it seems appropriate that a number of new texts and atlases are now being published. One such text, *Peripheral Nerve Blockade: Principles and Practice*, is reviewed here.

The text is published as part of the broader educational mission of the New York School of Regional Anesthesia. This school, as well as its enormously successful web site (www.nysora.com) has been a leader in the clinical application of neuroanatomy to the practice of regional anesthesia. The founders of this school are the authors of this text.

Peripheral Nerve Blockade: Principles and Practice is an educational resource that fits neatly between the scope of an atlas and an encyclopedic textbook. Unlike an atlas, nearly 30% of the contents are devoted to an introduction to neuroanatomy, local

anesthetic pharmacology, toxicology, and practice management. The discussion of peripheral nerve stimulation is the most thorough I have ever read. The discussion of these introductory topics is thorough, yet concise. However, the chapters are not considered exhaustive reviews. Suggested readings follow each chapter rather than complete referencing.

The writing style is remarkably consistent throughout, reflecting that Drs. Hadzic and Vloka authored the entire text, as opposed to editing the work of numerous contributors. There is also a palpable passion and enthusiasm present in the prose. The authors consistently weave anatomy, physiology, and “what works” together into a highly readable format.

Each nerve block chapter begins with a bulleted “Block at a Glance” section which very briefly covers the indications, landmarks, nerve stimulation, and a complexity rating for the block. Following this a “General Considerations” section discusses the approach to the block in 100-150 words. The chapter then continues with “Regional Anesthesia Anatomy”, “Surface Anatomy”, “Patient Positioning”, “Block Technique”, and “Trouble Shooting” sections. Each chapter concludes with potential complications and (more importantly) suggestions for avoiding complications.

One of the many high points of this text is the illustrations. Actual patients are used, with appropriate surface markings. In many instances, photographs of an anatomic dissection are superimposed on an adjoining photograph, allowing one to easily make the transition from surface landmarks to deeper anatomy.

Although very thorough for an intermediate size text, there are a few areas that I think merit consideration in future editions. One is a brief chapter on outcomes; there has been much research for inclusion on patient satisfaction and OR economics surrounding the use of regional anesthesia. Retrobulbar and peribulbar blocks are performed by a reasonable number of anesthesiologists, and merit inclusion. The chapter on infraclavicular blocks does not discuss the paracoracoid approach, which has achieved widespread popularity for both single injection and continuous techniques. Finally, there is only a very brief discussion of pharmacologic adjuvants. Clonidine has been widely studied, and appears to consistently speed nerve block onset and prolongs postoperative analgesia when intermediate duration local anesthetics are used. Within the IVRA chapter, there is only a brief discussion of adjuvants. In this reviewer’s opinion, this does not do justice to the considerable work demonstrating improvements in block efficacy and postoperative analgesia with the addition of clonidine, dexmedetomidine, ketamine, or ketorolac to the local anesthetic.

In conclusion, Admir Hadzic and Jerry Vloka are to be congratulated on the publication of a superb regional anesthesia textbook. The text has all of the advantages of an atlas, as well as more in-depth discussion of pharmacology, resident education, and practice management. The figures are superb. Best of all, the passion and intellectual devotion of the authors is noticeable throughout. The vast educational and practice experience of these two anesthesiologists is crystallized in *Peripheral Nerve Blockade: Principles and Practice*. The library of every anesthesia department and everyone interested in regional anesthesia should have one.

Christopher Viscomi, MD

*University of Vermont
Burlington, VT*

The Bonica Lecture at the 2004 FALL Pain Meeting

We are proud to announce that Daniel B. Carr, MD will be delivering the keynote lecture at the 3rd Annual ASRA Fall Meeting in Phoenix, AZ this November. It is so fitting that Dr. Carr will be presenting in a lecture series that honors the abundant contributions of John J. Bonica, MD to the fields of anesthesiology and pain medicine.

Dr. Carr is currently the Saltonstall Professor of Pain Research in the Departments of Anesthesia and Medicine at the New England Medical Center in Boston, MA. Dan was diverted from careers in internal medicine/endocrinology, laboratory research and OR anesthesiology by a series of guided decisions that fortuitously led him into pain medicine.

He treasures and respects the acquaintances he forged in his early years with the pioneers in the field, values the collaborations he has fostered with colleagues across disciplines throughout his very active career, and enjoys the success of his trainees (of which there are many!). His industrious clinical and research efforts have brought insight and understanding to many in pain medicine. He has helped us appreciate the nuances of clinical trials that are so fundamental in under-girding everyday practice, as well as the significance of outcomes research. But, isn't this what we should expect from an individual who has been called investigator, consultant, co-chair, technical expert, grant reviewer, editorial board member, lecturer, panel member, author, collaborator, APS Distinguished Service Award winner and current AAPM Secretary?

You'd better come and hear his lecture - Dan's a guy in the know and on the go, so catch him while you can. You won't be disappointed.

John C. Rowlingson, MD
Chair, Bonica Lecture Committee

Call For Abstracts

The American Society of Regional Anesthesia and Pain Medicine is now accepting abstracts to be considered for presentation at the 2004 Annual Fall Pain Meeting and Workshops, November 11-14 in Phoenix, Arizona.

Please visit www.asra.com and submit your abstract electronically.

DEADLINE FOR SUBMISSION IS AUGUST 13, 2004.



1928 - 2004

IN MEMORIUM

Eason Cockings, MD

Born before lidocaine, instigator and proponent of the transarterial brachial plexus block, scholar, physician, anesthesiologist, teacher, a principled and feisty gentleman, longtime member of ASRA. He will be missed by his family, patients, students, colleagues and friends.

Best Darn Breakfast in Vegas



How to Stack the Deck Against Neurologic and Infectious Complications While Beating the Odds on Neural Localization

Monday, October 25, 2004
7:30 am to 8:45 am

Moderator: Honorio T. Benzon, MD
*Professor of Anesthesiology
Northwestern University Feinberg
School of Medicine
Chicago, Illinois*

Infectious Risks Associated with Interventional Pain Management
James P. Rathmell, MD
*Professor of Anesthesiology
University of Vermont College of Medicine
Burlington, Vermont*

Neural Localization with Ultrasound
Vincent W.S. Chan, MD, FRCPC
*Professor of Anesthesiology
University of Toronto
Toronto Western Hospital
Toronto, Ontario, Canada*

Neurologic Complications of Regional Anesthesia: Issues to be Addressed at the Upcoming ASRA 2005 Consensus Conference

Joseph M. Neal, MD
*Staff Anesthesiologist
Virginia Mason Medical Center
Seattle, Washington*

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PLAN NOW TO ATTEND!!

2004 Annual Fall Pain Meeting & Workshops

November 11-14, 2004

Pointe Hilton at Squaw Peak • Phoenix, AZ