American Osteopathic College of Anesthesiologists

Quarterly Newsletter

October 2020

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IMMEDIATE PAST PRESIDENT REFLECTION

Jeffrey Kyff DO, FAOCA, 2019 - 2020 AOCA President

What's my favorite movie? (I'm sure you've all been wondering).

Its Apollo 13. Why?

Not just because it is aviation and aerospace related, but because it is a story about people facing difficult, seemingly insurmountable problems and how they prevailed working as a team through their combined brain power and abilities. This year, in the face of problems and issues that no one could have reasonably expected, we have put on the best attended meeting, and arguably the best didactic meeting in the AOCA's history.

I need to acknowledge the contributions of the Board of Governors, Drs. Vandergraff, Ninan, Hargrave, Huffnagle, Laskey, Landman, Griffin, Hale, and Rickelman. Well Assembled Meetings team partners Julie

Vissers, Daphne Rosenbaum, and their staff. And, AOCA's management company AMR Julie Kahlfeldt, Executive Director, Lily Pennington, Nick Ruffin, and Tracy Tucker. I apologize to the people I failed to mention and all the people who the people I just mentioned relied on. None of us did this alone. Thank you everyone.

Today, we are a stronger, better, and more vibrant organization than ever before. Dr. Escher published an article in the ASA Monitor (printed below) describing the history of the AOCA. The article gave the AOCA exposure for the first time to the thousands of potential member DO's that took allopathic residencies and jobs. The Board of Governors took time to update bylaws, bringing them into compliance with Illinois law where AOCA is incorporated. The update also allows the College to operate more easily in today's virtual world. Although the Board of Governors and the Professional Education Committee were working on moving toward virtual education options, we suddenly and unexpectedly had to rapidly produce this year's virtual annual meeting and conference.

Drs. Hargrave and Goeller deserve special mention for their truly heroic efforts leading the team that produced this year's virtual didactic program on very short notice.

I welcome Dr. Vandergraaf to the presidency. I ask that you all not only support him but also ask you to join the team. This is a volunteer organization, please volunteer. Thank you.

PRESIDENT'S MESSAGE

Looking Forward

Robert Vandergraaf, DO, FAOCA, 2020 - 2021 AOCA President

I wanted to specifically thank you Dr. Kyff for your leadership this past year. What a year it has been! I also wanted to thank the Board of Governors for their leadership and time donated to the benefit of the College. Congratulations and welcome to Dr. Goeller as our newest Board member and as Program Director, for such a hugely successful meeting! My thanks to all of you!

Even though we were not able to in person celebrate our new Fellows this year, that does not take away the significance of their achievement. So, thank you to their sponsors and congratulations to our new Fellows! And Congratulations to Drs. Depa and Elamassian, terrific leaders distinguished among many!

I am very humbled and honored for the trust you have placed in me to be your next AOCA President. This is my 29th year of College membership and I have been grateful for the friendships that have developed during those years.

Over the years, our relationship with the AOA has evolved and the last couple of years the relationship has taken on a new tone as the AOA has reinvented itself. Dr Klauer has pledged himself and the AOA to be available to our College's needs. I have attended two major AOA meetings this past year and I believe that their offer is genuine, and I look forward to exploring what the AOA can do to help our College.

Congratulations to Dr. Elmassian, the ASA Secretary and only DO member of their Board. The ASA continues to look for areas of mutual interest and collaboration with our College. I look forward to continuing the discussion while maintaining our distinctiveness as osteopathic anesthesiologists. I will continue to reach out to our non-AOCA osteopathic allopathically trained anesthesiologists to encourage them to join our College.

I remember in our Board of Governors meetings a few years ago we were concerned about the AOA and ACGME changes and whether we would survive as a College and what relevance we would have. Well, we have weathered the storm and continue to be relevant thanks to previous AOCA leadership and to you the membership for maintaining the faith. I look forward to our continued future together and I pledge to work as hard as I can to support the principles of our College.

AOCA: PROMOTING OSTEOPATHIC EXCELLENCE IN ANESTHESIOLOGY

Allan R. Escher Jr., DO, FAOCA, FFSMB (Hon)

In 1949, a group of 36 DO anesthesiologists met in Detroit, Michigan to form the American Society of Osteopathic Anesthesiologists (ASOA). The name originated with J. Maurice Howlett, DO, who served as the first President. Claire E. Pike, DO, and Crawford M. Esterline, DO, served as the Vice President and Secretary-

Treasurer, respectively. The newly elected ASOA Board of Governors held certification in anesthesiology by the American Osteopathic Board of Surgery, itself formed in 1940.

The stated objectives of the ASOA were as follows:

1. To advance the standards of practice and quality of service in the field of anesthesiology.
2. To aid in improving the educational opportunities for training in anesthesiology.
3. To promote the osteopathic concept of disease as related to anesthesiology.
4. To establish standards for membership.
5. To maintain and promote the highest moral and ethical standards in the practice of anesthesiology.
6. To aid in the formation and oversee the function of component regional osteopathic societies of anesthesiology (asamonitor.pub/2NlGZqW).

In 1950, the ASOA set a $25 application fee for charter members and annual dues of $25.

During the Washington, DC meeting, J. Craig Walsh, DO, made a motion to form the American Osteopathic College of Anesthesiologists (AOCA). After approval by the American Osteopathic Association, the AOCA was incorporated in 1952.

At its first meeting in Los Angeles, the AOCA adopted the ASOA objectives and added the following:

"…Recognize outstanding accomplishment in the field of anesthesiology or outstanding service to this organization on the part of any member by conferring the degree 'Fellow' in the American College of Osteopathic Anesthesiologists.

Dedicated to the presentation of continuing medical education programs for the purpose of update and review of all areas in the specialty of Anesthesiology."

Continue reading about the vision of the AOCA today!

VAPOR RECAP

Benefits of Regional Anesthesia During a Pandemic and Opioid Epidemic

Feature Article from VAPOR Sponsor, Konica Minolta Healthcare Americas, Inc.

As hospitals and surgery centers navigate to resume elective and non-urgent surgical procedure volumes, there is heightened concern that the continued use of opioids for pain management before, during and after a procedure may perpetuate the current rise in opioid-related deaths. Similarly, the use of general anesthesia potentially exposes physicians and staff to viral contamination when intubating a patient, releasing aerosols and droplets, which is a primary mode of transmission of COVID-19.

Although there is no one simple solution to address the public health issues of the opioid epidemic along with the COVID-19 pandemic, there is a technique that can reduce the likelihood of both addiction and viral transmission associated with surgical procedures: regional anesthesia. Additionally, regional anesthesia provides an option for perioperative pain management in an era of drug and equipment shortages – a ventilator may be needed post-op after surgeries that require general anesthesia if the patient is unable to be safely weaned from mechanical ventilation.

J. Douglas Jaffe, DO, an anesthesiologist specializing in regional anesthesia and acute pain management, says, "There is a substantial benefit to reducing the number of aerosol-generating procedures, such as intubation and extubation, when utilizing regional techniques for perioperative management in lieu of a general anesthetic. We have also seen an increase in the acceptance, by both surgeons and patients, of spinal anesthesia for the same reasons."

Regional anesthesia is a safe and effective type of pain management that doesn't involve the potential side effects and complications of general anesthesia and sedation. Neuman, et al, compared the effectiveness of regional versus general anesthesia in adults with hip fractures undergoing surgery and found that regional anesthesia reduced pulmonary complications and death by 25-30 percent(1). In total hip or knee arthroplasty, Memtsoudis, et al, reported that patients with non osteoarthritic surgical indication and receiving general anesthesia required critical care services more frequently services and experienced more complications, received more blood transfusions and mechanical ventilation, had higher mortality rates, and incurred higher costs compared to those with neuraxial anesthesia(2). Lu, et al, also found that the use of spinal anesthesia in patients undergoing unicompartmental knee arthroplasty led to a decrease in adverse events, OR time and facilitated patient discharge(3).

Ultrasound guidance is instrumental in the growing adoption of regional anesthesia and analgesia by many anesthesiologists. Studies suggest increased success, decreased complication rates, reduced time and greater patient comfort in ultrasound guided peripheral nerve block injections(4-7). Ultrasound may also further advance approaches to administering new blocks(8) and by enabling the anesthesiologist to visualize the injectate, as well as reducing the risk of local anesthetic systemic toxicity(9).

Dr. Jaffe has also seen a marked increase in the utilization of ultrasound at the point of care for use in regional anesthesia and analgesia.

“Espousing the proven benefits of the use of ultrasound, which include reduced risk of vascular trespass and improved patient comfort and tolerance, otherwise reluctant patients who would have declined a regional technique are increasingly accepting,” Dr. Jaffe explains. “Our surgical colleagues are also mindful of the benefits, both the avoidance of aerosolizing and patient satisfaction with reduced pain and lower risk of postoperative nausea and vomiting. Ultrasound guided regional anesthesia techniques are in more demand. In fact, it’s often difficult to keep up with all the buy-in from new ‘customers’.”

Using ultrasound, the anesthesiologist can locate important anatomy, such as the median nerve, ulnar nerve, radial nerve, etc., and visualize the needle as it enters the field of view, enters the nerve to deliver the block and visualize the spread of the local anesthetic inside the region of interest. For example, if the spread of the local anesthesia is not seen inside a sheath, such as the brachial plexus, then the anesthesiologist has the information they need to immediately abandon the injection as the local anesthetic could be intravascular.

“Ultrasound is rapidly becoming one of the more useful imaging modalities to assist with neuraxial techniques. Indeed the more efficient the procedure, the less time spent in close proximity to the patient’s airway (or the avoidance of airway manipulation entirely), there is likely a reduced risk of viral transmission to providers,” Dr. Jaffe says.

“With the uptick in utilization of regional techniques for analgesia and anesthesia, we have seen a parallel increase in the adoption of emerging regional techniques despite not quite yet achieving the volume of published research as compared to more classic approaches to regional procedures,” Dr. Jaffe adds. “The ultrasound guided quadratus lumborum block and PENG block are two in particular that have seen increases in volume as a result of requests from our surgical colleagues.”

So which ultrasound system features are critical when using it for regional anesthesia?

Needle visualization is clearly key, but not all systems provide the same quality of needle visibility. Algorithms that utilize both in-plane and out-of-plane methods to improve needle visibility (both the tip and the shaft), especially in steep angle approaches, enable increased accuracy in needle placement.

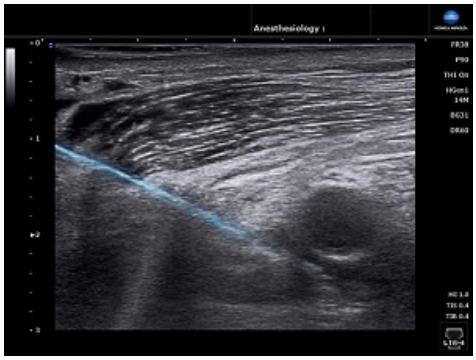
Superior image quality that enhances signal penetration, improves resolution and increases color flow sensitivity allows for detailed tissue differentiation and detection of small structures. An ultrasound probe that offers a trapezoid view, which extends the field of view, high sensitivity for scanning both deep and superficial structures, and provides a small footprint to reach difficult to access areas and maneuver around the area of interest facilitates a more efficient regional anesthesia injection.

Additional features that promote hands-free operation, such as voice-activated controls and foot pedals, can be crucial during interventions such as administering regional anesthesia. Ease of use is also important to allow the anesthesiologist to focus on the patient and not the machine.

The SONIMAGE® HS1 from Konica Minolta Healthcare meets all of these requirements for rapid and confident ultrasound guided regional anesthesia and pain management procedures.

Regional anesthesia delivers numerous benefits to patients and staff compared to general anesthesia, including reduced need for opioids, no airway manipulation that could release viral aerosols, fewer complications and adverse events leading to less dependence on critical care services for patients, and faster time to discharge. Ultrasound guidance is key to successful implementation of a regional anesthesia service. The ultrasound system should deliver excellent needle visualization and image quality for accurate placement, a high sensitivity probe that is easily maneuvered and provides a trapezoid view, a portable system to facilitate bedside use, and features that allow for hands-free operation during the procedure.

Continue reading for reference list.



Caption: Simple Needle Visualization on the SONIMAGE® HS1 Portable Ultrasound System incorporates an advanced algorithm that improves needle visibility (blue line) for increased accuracy in needle placement during regional anesthesia and analgesia injections.

KONICA MINOLTA

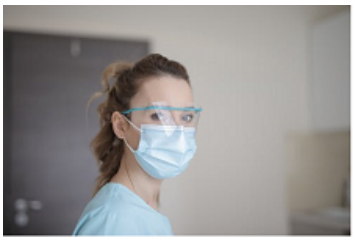
Recycling Opportunities in the Operating Room

Mackenzie Laurila, DO

20-30% of hospital waste comes from the operating rooms; 25% of operating room waste being from anesthesia. Most of us are not recycling at full capacity, and most of the barriers preventing this are fairly simple to overcome.

First, let's review the three main types of operating room waste: solid, biohazard, and pharmaceutical. Solid waste mostly consists of packaging materials from surgical and anesthesia equipment. This includes blue wrap, Tyvek, plastic, and cardboard; all of which can be recycled. Approximately 60% of anesthesia waste falls into this solid category and can be recycled. Contaminated personal protective equipment, used IV tubing, and anything in contact with blood or bodily fluids is considered biohazardous waste. Pharmaceutical waste includes expired drugs and controlled substances. Keep Reading and watch Dr. Laurila's VAPOR lecture, The Environmental Implications of Anesthesia: How Our Choices Change the World.

COVID-19 Resources



Review the below COVID-19 RESOURCES recommended by VAPOR speaker, Dr. Daniel Johnson, MD, FCCM and watch his VAPOR lecture, Viral Preparedness and Response From the Front Line to learn about the critical role anesthesiologists play in hospital leadership during a pandemic.

Centers for Disease Control and Prevention

Nebraska Medicine COVID-19 Resources for Providers

NETEC

NEWS YOU CAN USE

How to Survive the Zombie Apocalypse

Social Distancing and Staying Sane

Frank King

Social Distancing Saves Lives Slowing the Spread of Infection - But Can Be Toxic

"But what I do have are a very particular set of skills; skills I have acquired over a very long career."

Liam Neeson, from the movie *Taken*

A friend called me shortly after the Pandemic began, and social distancing became the order of the day, in need of advice and counsel. He began by saying, "I am really struggling with this social isolation.You work in the mental health field, right?" I replied, "Well, I'm not a clinician, but I do play one on stage." The humor in my retort was lost on him, and I realized that he was truly in need of help.

I said, "Tell me what's going on." He said, "There has got to be a name for what I'm going through mentally, dealing with this crisis." I said, "Tell me your symptoms." He said, "I sleep too much, or I can't sleep, I eat too much, or I can't eat, when I do sleep, I have trouble getting out of the bed in the morning, even to do something as simple as my personal hygiene. Is there a mental health term for that?" I replied, "Yes, it's called Tuesday."

I live with two mental illnesses, depression, and chronic suicidal ideation, better known, as some of my relatives term it, "not right in the head." So, I wake up in an uncertain world, every day, Pandemic, or no. Continue Reading

SAVE THE DATE!

48th Annual Mid Year Seminar

March 26 - 28, 2021

Details Coming Soon

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