



SLEEPY TIMES

VOLUME 17, ISSUE 8 AUGUST 2023



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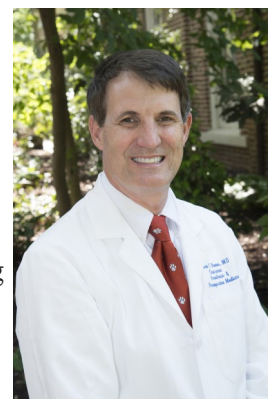
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MESSAGE FROM THE CHAIRMAN: RESEARCH INNOVATION AND TRANSLATIONAL RESEARCH INITIATIVES PART 1 OF 2

-SCOTT T. REEVES, MD, MBA

Over the past five years, the department has been expanding our research initiatives in Human Factor Engineering and Teamwork. This effort is led by Ken Catchpole, PhD with the recent addition of Connor Lusk, PhD. In addition, Mike Scofield, PhD, in collaboration with Dr. Sylvia Wilson, has developed a translation initiative using his bench rat models to understand addiction and whether novel clinical therapies can decrease narcotic requirements during surgery. This funded project will be looking at the effect of NAC on narcotic requirements during hysterectomies. Furthermore, our collaborations with Clemson University continue with a recent project involving Jane Swing, CRNA, receiving the APP innovation award from MUSC.

Take a few minutes to read about these interesting projects in this edition of *Sleepy Times*. The second part will be coming in September and will focus on the Drs. Mike Scofield and Sylvia Wilson collaboration.



RETAINED FOREIGN OBJECT REDUCTION AND MITIGATION (ReFORM) PATIENT SAFETY LEARNING LABORATORY

Ken Catchpole, Connor Lusk, Bruce Crookes

Retained Foreign Objects (RFOs) are one of the most well recognized and persistent patient safety problems, affecting between 3,000 and 50,000 patients per year, with an 80% morbidity rate. The primary defense is the manual counting of items that enter and leave the surgical field (the “surgical count”), which can be unreliable, while technologies, policies and training still leave many potential opportunities for failure.

The goal of the Retained Foreign Object Reduction and Mitigation (ReFORM) patient safety learning laboratory is to study the systems by which procedural objects are tracked, accounted for, and removed from the surgical field, to identify the characteristics of technologies and interventions that might feasibly reduce retained foreign objects. We consider the traditional ‘surgical count’ as just one component of the wider accounting system. We conceptualize the different stages of the counting process (Aim1), the wider accounting process (Aim2), and the organizational context and learning (Aim 3).



RETAINED FOREIGN OBJECT REDUCTION AND MITIGATION (ReFORM) PATIENT SAFETY LEARNING LABORATORY

This broader sociotechnical systems approach provides a greater breath of opportunities to understand and intervene, while also potentially moving from weaker solutions (such as training, teamwork, and clinical skills) to stronger solutions including technological and procedural changes that enhance visibility understanding, anticipation and learning. It may be possible to improve the counting process by making small alterations to the task (e.g., by counting in groups), by improving the spatial arrangement and visibility of items, and by improving the room acoustics to reduce communication problems. Beyond the count process, the pre-operative preparation, including the supplies and instrument documentation (on which the first count is based), the layout of the back table to enhance visibility, and supporting image interpretation during the intraoperative radiology process might also yield benefits, yet rarely appear in research or other literature. Finally, the organizational influences and interactions on the accounting process deserve more attention, including competing pressures (such as surgical targets), necessary or unnecessary variations between specialties, the collaborative atmosphere between OR staff and surgeons, and the structure and emphasis of training. Our overall aim will be to produce practical guidance for clinicians and surgical centers seeking to improve their accounting of procedural objects and reduce the instances of RFOs by developing a broader range of interventions than they might otherwise be familiar. This will include behavioral approaches; guidance for technology design and integration; for workspace design, and for organizational learning. Recommendations will be validated through analytical exercises, simulation of part and full tasks, and/or evaluation in clinical settings using a range of subjective, process and outcome measures.

This AHRQ-funded collaboration with Dartmouth-Hitchcock and Corewell Health will initiate the most fundamental reappraisal of the causes of and solutions to RFOs for more than 20 years.

WELCOME TO THE DEPARTMENT



Erin Meyer is thrilled to join MUSC's Department of Anesthesia as Education Program Coordinator following a 13 year career in the mortgage industry. Erin lives in Wagener Terrace with her husband, Jack, and 7-month-old son, Ryan. In her free time you may find her reading a good book, dining at Santi's, or spending time at one of Charleston's amazing beaches.

Erin Meyer,
Education Program Coordinator I

JANE SWING CRNA, RECEIVES THE MUSC APP INNOVATION AWARD FOR THE QUARTER

Dr. Millicent Peterseim (Professor Ophthalmology) and Jane Swing, CRNA, were working together one day in the OR when Dr. Peterseim mentioned that her son, John, a bioengineering student at Clemson, was looking for a senior design project idea. She asked me if I could think of something that would make our lives easier in the OR. We began brainstorming together and came up with the idea for an external device that could help maintain a patent airway, especially for use in oculoplastic cases. She mentioned it to her son and his group, and they liked the idea of using that as their design project.

Clemson's bioengineering program senior design project has several goals:

- identify an unmet medical need
- describe and analyze the need
- create a device that meets the need
- research the device
- explore existing patents
- and sell your solution

My role was to be the primary consultant as the Clemson students defined these goals and built out a solution. Multiple Zoom meetings, group texts, and emails occurred over the course of 7 months. I gave them a crash course in airway anatomy and taught them about reasons for and how to manage airway obstruction. They were very astute and asked great questions throughout the conversations. Their final project was the creation of the AnesthEZ, a device that would independently perform a jaw thrust and chin lift and was controllable away from the surgical field. Once the 3D image was perfected, they used a 3D printer to create the device. The project was presented at the Clemson's Senior Design Symposium at the Greenville Convention Center, where I got to meet them in person. What an exceptional group of young men that I had the pleasure of collaborating with for this unique project!



DEPARTMENT HURRICANE PLAN UPDATED

Department of Anesthesia and Perioperative Medicine

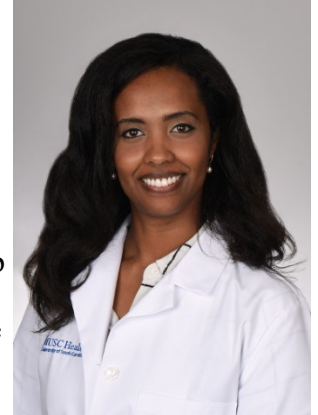
The 2023 Weather Plan can be found on our Department Intranet [here](#). Please review as we kick off Hurricane Season.



**Hazardous
Weather Plan**

CULTURAL AWARENESS CORNER: AAMC MINORITY FACULTY LEADERSHIP DEVELOPMENT SEMINAR BY MERON SELASSIE, MD

I had the opportunity to attend the AAMC Minority Faculty Leadership Seminar in Puerto Rico from June 22-25. I appreciate the nomination and support by our department in collaboration with the College of Medicine to attend. The conference is designed for early career under-represented in medicine (URM) faculty to learn what it takes for advancement in academic medicine and to design a career path for future leadership. Faculty from all specialties of clinical medicine and basic science researchers attended with representation from all regions of the country. A broad panel of accomplished and inspiring academicians and consultants lead group discussions and provided individualized career counseling. We talked about grant writing, academic promotion/tenure and other vital topics. I was most appreciative of the opportunity to connect with my peers and network. A common theme discussed was a feeling of isolation that URM faculty experience and strategies to combat this. Though we were together for a short period, many of us were able to bond and hopefully support each other moving forward. I came away from the conference feeling re-energized with a renewed commitment to academic medicine. I wanted to share a poem with you from one of our group exercises that I found meaningful. What does this poem mean to you?



The Summer Day by Mary Oliver

Who made the world?

Who made the swan, and the black bear?

Who made the grasshopper?

This grasshopper, I mean—

the one who has flung herself out of the grass,

the one who is eating sugar out of my hand,

who is moving her jaws back and forth instead of up and down—

who is gazing around with her enormous and complicated eyes.

Now she lifts her pale forearms and thoroughly washes her face.

Now she snaps her wings open, and floats away.

I don't know exactly what a prayer is.

I do know how to pay attention, how to fall down

into the grass, how to kneel down in the grass,

how to be idle and blessed, how to stroll through the fields,

which is what I have been doing all day.

Tell me, what else should I have done?

Doesn't everything die at last, and too soon?

Tell me, what is it you plan to do

with your one wild and precious life?

GRACE WOJNO, MD RETIREMENT

SMP honored Dr. Wojno throughout the entire last week of her employment. On Wednesday the department provided lunch for the anesthesia team at SMP, with Drs. Reeves and Clark attending. On Thursday the periop nursing staff hosted a Kombucha Tea party in her honor. On Friday all of SMP Periop hosted a salad bar. At the start of the week, a table was set up and each person filled out a personal note card for her. At the end of the day she was presented with a large box of cards. She was also gifted a small bit of artwork. Finally, we captured her very last pediatric induction and IV start (patient privacy protected).



RESIDENT MEET AND GREET

The annual resident welcome party was held this year at Bowens Island Restaurant on Sunday, July 9th. Historically the welcome event has been at a River Dogs game, unfortunately getting rained out several years in a row due to the seemingly common afternoon summer storms. Thankfully the weather held out this year for a beautiful afternoon with breathtaking views on the water. There was a great showing from our intern class who finished out their full first week as physicians at MUSC while still looking impressively well rested even for several of those coming from the ICU. The CA1 residents also came in force after finishing their first full week in the operating rooms and various sites throughout campus. It was nice to see many of our senior residents who can't pass up a free meal and fellows, both recently graduated MUSC fellows and new additions from across the country, make it to the event. Overall, it was a great opportunity for everyone to unwind and catch up as one academic year ends and another begins while introducing significant others who do much of the work behind the scenes to keep us all functioning. The food can't be forgotten as there was plenty of low country boil and hushpuppies to go around. Thank you to the residency Education Program Staff and Departmental staff for organizing this wonderful event!



RESIDENT MEET AND GREET



FIRST ANNUAL PEDIATRIC ANESTHESIA POOL PARTY

On July 9th, Dr. Michelle Rovner hosted the first annual pediatric anesthesia pool party. In attendance were pediatric attendings, CRNAs, anesthesia techs and our great administrative assistant, Kim Pompey. Families enjoyed drinks, barbeque and a beautiful afternoon of swimming while socializing outside the hospital. All of the pediatric team had a great time.

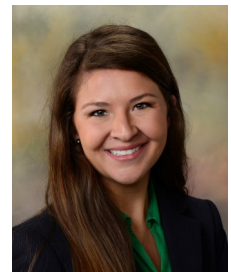


RESEARCH CORNER



Human Factors in Healthcare



Volume 4, December 2023, 100049



Connor Lusk, PhD

Original Article

The design and evaluation of a syringe hub for organizing syringes in anesthesia medication delivery

[Harrison Sims](#)^a, [Joshua Biro](#)^b, [Connor Lusk](#)^c, [David M. Neyens](#)^b, [Ken Catchpole](#)^c, [Abdus Sabour Shaik](#)^a, [Stephanie Munie](#)^d, [James H. Abernathy III](#)^e  



Ken Catchpole, PhD

GASTRIC PoCUS. TRAVIS PECHA, MD

Gastric Ultrasound How-'lo

Image Acquisition

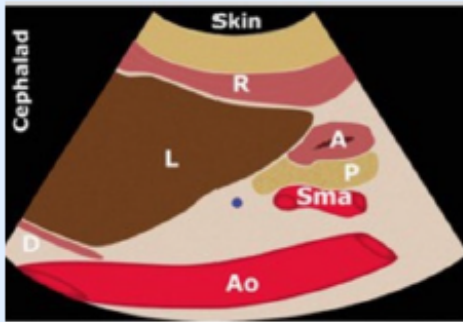
- Low frequency curved array transducer
- If patient size permits, high frequency linear transducer possible
- Right lateral decubitus position
- Must be at level of the Aorta in long axis view

Tips and Tricks:

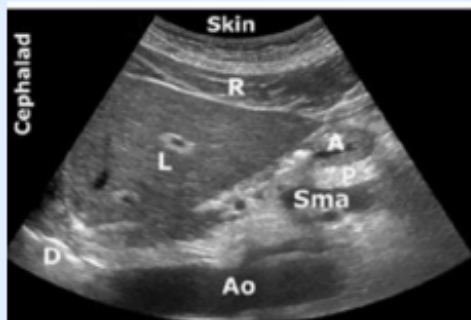
- IVC - thin walled, pulsatile in systole and diastole
 - lies to the right of the aorta
- Aorta - walls are brighter (more echogenic), pulsatile in systole
- if trouble finding aorta
 - may be crosscutting long axis - try slightly rotating probe to limit cross cutting
 - may be too low on abdomen - position probe just inferior to xyphoid process
- Find liver as a landmark and adjust ultrasound plane from this reference



Image Interpretation



- A = antrum
- Ao = aorta
- D = diaphragm
- L = liver
- P = pancreas
- R = rectus abdominis muscle
- S = spine
- Sma = superior mesenteric artery



- A = antrum
- Ao = aorta
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GASTRIC PoCUS. TRAVIS PECHA, MD



Empty stomach often with "bullseye" appearance – hypoechoic propria layer around hyperechoic mucosa layer



- Volume (mL) = 27.0 + 14.6 x right lateral CSA (cm²) - 1.28 x age (years)

Clear Fluid filled antrum Air bubbles within clear fluid may give "starry night" appearance as mobile, hyperechoic points



Full Stomach shortly after a solid meal, there can be a significant amount of air trapped along the anterior wall of the antrum. This creates a large area of air interface artifact that precludes visualization of the posterior wall of the antrum and deeper structures. This "frosted-glass" pattern is characteristic of a recent solid meal



Volume Measurement

GASTRIC PoCUS. TRAVIS PECHA, MD

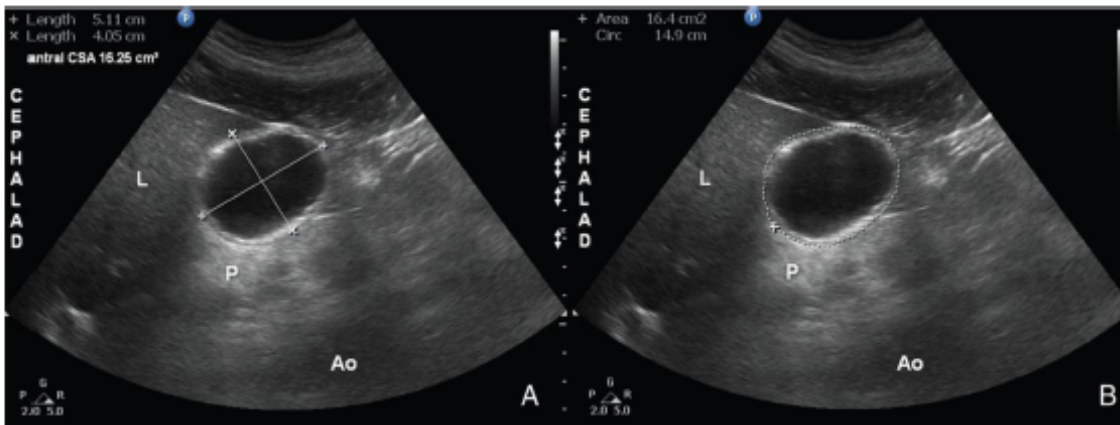
$$\text{Volume (mL)} = 27.0 + 14.6 \times \text{right lateral CSA (cm}^2\text{)} - 1.28 \times \text{age (years)}$$

- Trace dimensions of antrum using the outer muscular propria layer for cross sectional area and use calculation as above

→ if unable to measure a CSA given machine/software limitations

Cross Sectional Area of an ellipse

- use anterior/posterior dimension (AP) and cranial/caudal (CC) dimension
 - CSA = $(AP \times CC \times 3.14) / 4$



GLP-1 Agonist Study Inclusion/Exclusion Criteria

Inclusion Criteria

- Age \geq 18 years old
- ASA 1-3
- Diagnosed with type 2 DM
- Scheduled for elective surgery under GA
- Appropriately fasted

Exclusion Criteria

- BMI 40
- Previous gastric/esophageal surgery
- Abnormal gastric anatomy
- Pregnancy

Glucagon-like peptide 1 (GLP-1) receptor agonists have gained popularity, both for the treatment of diabetes mellitus and obesity. We have seen a dramatic increase in the number of patients presenting for surgery on this class of medications in recent months. Recently, the ASA released a statement with basic considerations regarding the care of these patients; however, these do not represent formal guidelines nor do they replace the ASA fasting guidelines.

What is GLP-1? GLP-1 is a peptide that lowers postprandial blood glucose levels by stimulating insulin secretion and inhibiting glucagon secretion. Further, GLP-1 slows digestion via effects on the stomach, pancreas, intestines, and liver. Most GLP-1 receptor agonists are administered subcutaneously, dosed once or twice daily to once weekly, though newer generations with daily oral administration have recently been developed. The weekly injectables, including semaglutide and tirzepatide, have also been targeted as weight loss aids. Because GLP-1 reduces proximal gastrointestinal motility, its effect on gastric emptying raises concerns regarding aspiration risk in surgical patients. At MUSC, we have now had reports of multiple patients with significant perioperative vomiting of particulate contents and/or full stomachs on ultrasound imaging prior to case start.

GASTRIC POCUS. TRAVIS PECHA, MD

The ASA recommends holding these medications before elective surgery, regardless of the indication for the medications. If patients are prescribed daily oral semaglutide, the ASA suggests holding the medication on the day of the procedure. If dosed weekly, the ASA suggests holding the medications for a week prior to surgery. These medications have a long half-life, with some literature suggesting up to 6 weeks is required to see complete resolution of drug effects. At MUSC, patients who visit preop clinic are advised to hold these medications. However, given that only 25-30% of patients visit preop clinic, one should expect to encounter numerous patients who have not held these medications and tailor anesthetic plans accordingly.

An appropriate history can guide management on day of surgery. As with any gastroparesis patient, degree of symptomatology is important. Consider gastric ultrasound to determine if patients have retained food in the stomach. Gastric ultrasound can be very helpful in deciding who requires intubation, and a study regarding this will soon be underway here at MUSC. Please see additional handout for tips and tricks on performing a gastric ultrasound. If you do not feel comfortable at this point performing this study, feel free to reach out to the POCUS faculty, who can help guide you. The POCUS team is also planning a dedicated faculty didactic session geared towards gastric ultrasound. Please email Travis Pecha if are interested in attending. Dates and times TBD.

If general anesthesia is planned, an endotracheal tube with rapid sequence induction may be a better choice than an LMA. Prior to extubation, passing an orogastric tube to remove stomach contents could be considered.

Deep propofol sedation without airway protection may present challenges in this patient population. For colonoscopy patients who have been on a clear liquid diet for 24-48 hours prior to their procedure, the chances of retained solid food in the stomach is likely much lower. Our gastroenterology colleagues are aware of recent concerns regarding these medications and that our anesthetic plans may change moving forward. There will soon be an endoscopy-directed GLP-1 agonist study underway as well.

Importantly, we should specifically discuss aspiration risk with these patients, regardless of anesthetic type chosen, and document accordingly in the pre-eval note. Clicking the "aspiration" risk button in the pre-eval note should be one part of this, as well as an additional statement regarding the steps taken to mitigate this risk.

Katie Bridges, MD, Travis Pecha, MD

References:

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- Smits MM, van Raalte DH, Tonneijck L, Muskiet MH, Kramer MH, Cahen DL. GLP-1 based therapies: clinical implications for gastroenterologists. *Gut.* 2016;65:702-711.
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- Umaphysivam MM, Lee MY, Jones KL et al. Comparative effects of prolonged and intermittent stimulation of the glucagon-like peptide 1 receptor on gastric emptying and glycemia. *Diabetes.* 2014;63:785-790.
- Friedrichsen M, Breitschaft A, Tadayon S, Wizert A, Skovgaard D. The effect of semaglutide 2.4 mg once weekly on energy intake, appetite, control of eating, and gastric emptying in adults with obesity. *Diabetes Obes Metab.* 2021;23:754-762.
- Joshi G et al. American Society of Anesthesiologists Consensus-Based Guidance on Preoperative Management of Patients (Adults and Children) on Glucagon-Like Peptide-1 (GLP-1) Receptor Agonists. <https://www.asahq.org/about-asa/newsroom/news-releases/2023/06/american-society-of-anesthesiologists-consensus-based-guidance-on-preoperative>

SYLVIA WILSON, MD CONTRIBUTION TO THE SCA NEWSLETTER

MEMBER
CORNER



RACER SIG

COMMENTARY

By ASRA RACER Member
Sylvia H. Wilson, MD, Professor
Medical University of South Carolina

Enhanced recovery after surgery (ERAS) for patient undergoing cardiac operation has required us to change thinking, practices, and protocols that we have clung to for decades. ERAS Expert Recommendations for Cardiac Surgery include a multimodal, opioid-sparing, postoperative pain management plan (class I recommendation, level of evidence B – randomized).[1] While high dose opioids have classically been the mainstay for the perioperative cardiac surgery patient, they are associated with sedation, respiratory depression, nausea, vomiting, ileus,[2] and may exacerbate or increase rates of delirium.[3] These undesirable side effects contradict the goals of postoperative analgesia including improvement in quality of life and acceleration of functional recovery. Inadequately treated acute pain may contribute to chronic pain in one out of five patients, and the reported incidence of chronic postoperative pain is even higher (30-50%) following coronary artery bypass surgery.[3] Thus, multimodal analgesia – the concurrent use of primarily non-opioid analgesics – is an essential component of for ERAS after cardiac surgery. This has stimulated an interest in the routine use of regional anesthesia as to improve postoperative analgesia.

The simplistic nature and low risk of both superficial parasternal intercostal facial blocks (formerly called pecto-intercostal facial plane blocks) and deep parasternal intercostal facial plane blocks (formerly call transversus thoracic facial plane blocks)[4] have made them an attractive option for ERAS after cardiac surgery. Although less evidence was published several years ago, several randomized controlled trials recently demonstrated decreased intraoperative opioid use[5] or improved postoperative outcomes[6-8] for patients receiving parasternal intercostal facial plane blocks. As outcomes differences have not been noted between the superficial and deep approaches,[9] the superficial approach may be preferable to avoid injury to the mamillary vessels. Unfortunately, as Simon and Meyer astutely remind us in their summary, parasternal blocks will not cover the chest tube site, the saphenous vessel harvest area, or the patient's chronic arthritis. Additionally, the majority of publications have focused on single injection blocks with limited durations rather than catheter-based techniques, and liposomal bupivacaine has not demonstrated superior analgesia when compared to ropivacaine or bupivacaine[10] consistent with other publications.[11, 12] Thus, future investigations are still needed.

Although parasternal blocks offer a relatively low risk and possibly high reward component for cardiac ERAS, it is also important that we remember that regional anesthesia is just one aspect of multimodal analgesia. As one with a love and strong belief in the benefits of regional anesthesia, it would be glorious to demonstrate that a simple nerve block solved everything. However, it is important to recognize that regional anesthesia is only one component of multimodal analgesia. Similarly, multimodal analgesia is only one component of ERAS. ERAS requires incorporating smoking cessation, improved nutrition, pre- and postoperative physical therapy, respiratory therapy, and sleep hygiene, to name a few. Thus, it requires engagement and education of the numerous providers, patients, and their families to redesign perioperative care and expectations.

2023-2024 MUSC RESIDENT OR FELLOW OF THE MONTH NOMINATION FORM**Resident or Fellow of the Month
Nominations**

Nominate a resident or a fellow that has gone above and beyond for recognition as resident or fellow of the month! Any GME resident or fellow may qualify for the Resident or Fellow of the Month if one or more of the following criteria are met:

- Demonstrates outstanding customer service in support of MUSC's goals;
- Has effectively and efficiently corrected something that has gone wrong for a customer, patient or co-worker;
- Demonstrates creativity or resourcefulness in assisting customers, patients or co-workers;
- Develops new and efficient ways to solve customer service or patient needs;
- Responds in an unusually fast or efficient manner, or completed a work project under a very tight deadline;
- Key contributor to a major institutional project;
- Went beyond normal duties in supporting another department, employee or patient;
- Other, as documented on the nomination form.

The nomination form can be found linked below or by scanning the QR code on the left.

College of Medicine nominations for resident/fellow of the month can easily be done [here](#) or by scanning the QR code above.

TRAVEL + LEISURE READERS' 15 FAVORITE CITIES IN THE UNITED STATES OF 2023**1. Charleston, South Carolina**

PHOTO: LINDSEY HARRIS SHORTER

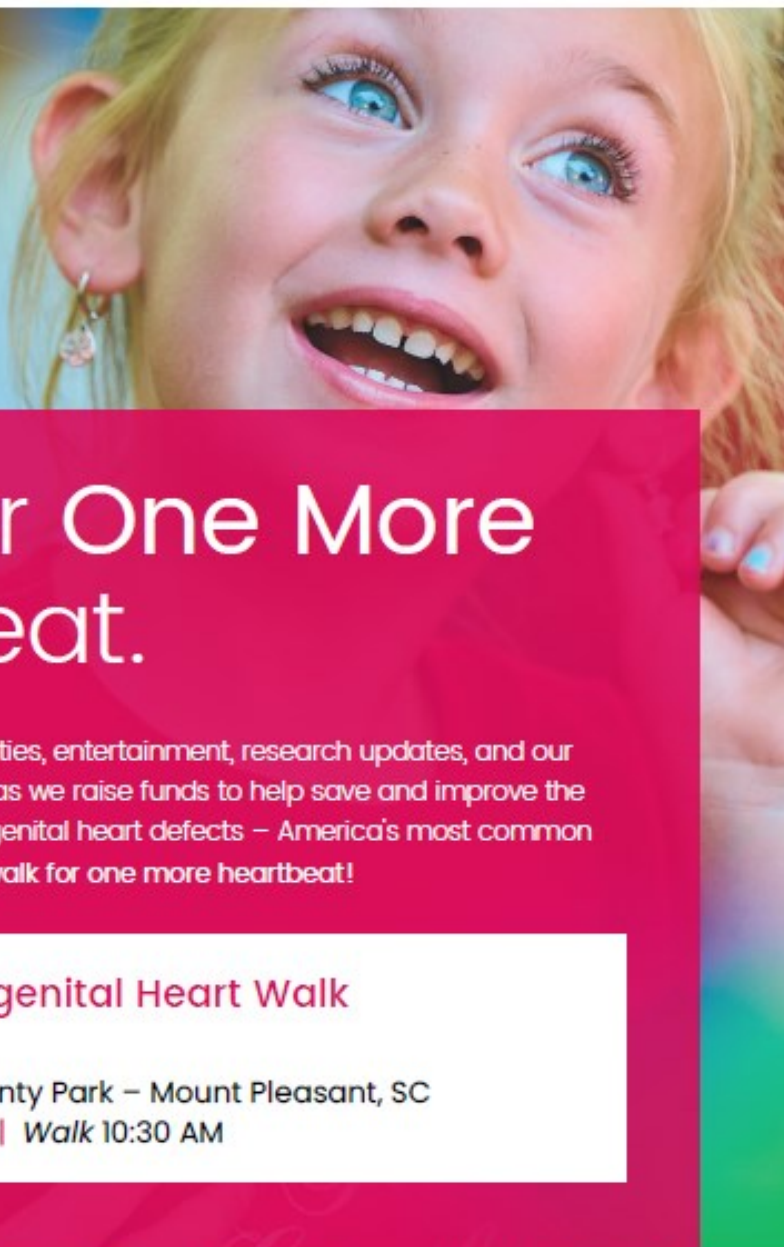
[Once again](#) named T+L readers' absolute favorite U.S. city, Charleston, also known as the Holy City, has the perfect combination of southern charm and city vibes. "This place is a destination to behold," gushed one reader. Others praised the friendly locals, historic sites, and the [shopping and dining](#) along King Street. "So many incredible restaurants" have made Charleston a foodie destination, and "the mix of hotels makes the city a perfect fit for any type of traveler."

2023 CHARLESTON CONGENITAL HEART WALK



Congenital Heart Walk

chfwalk.org



Walk for One More Heartbeat.

This event will have fun activities, entertainment, research updates, and our family-friendly walk. Join us as we raise funds to help save and improve the lives of those living with congenital heart defects – America's most common birth defect. Together, we'll walk for one more heartbeat!

Charleston Congenital Heart Walk

October 1, 2023

Palmetto Islands County Park – Mount Pleasant, SC

Registration 9:00 AM | Walk 10:30 AM



Photo Credits: (Background Photo) Vernick Photography, (Left to Right) Jess Roy Photography, Mike Kelly Photography



2023 CHARLESTON CONGENITAL HEART WALK



Charleston Community

Volunteers Needed

Volunteers are needed to bring awareness and help with our Charleston Congenital Heart Walk supporting congenital heart defect research for The Children's Heart Foundation.



Join Us
OCTOBER 1

PALMETTO ISLANDS
COUNTY PARK

WE NEED HELP WITH:

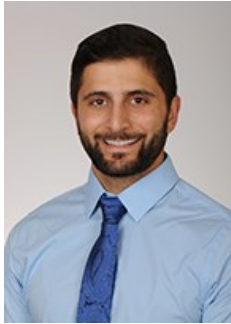
- Day Of Walk Activities
- Team Recruitment
- Dropping off flyers in the community
- In-Kind Donations

VOLUNTEERS GET EVENT T-SHIRTS

For more information, contact Chris Brown
cbrown@childrensheartfoundation.org

www.chfwalk.org

GRAND ROUNDS– AUGUST 2023

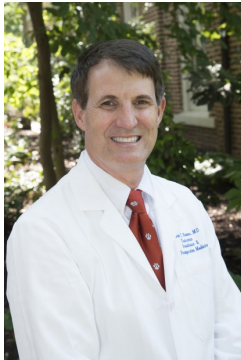


“Perioperative Management of Obese Ambulatory Patients ”

Mike Gukasov, DO, Assistant Professor

August 1, 2023

**Dept. of Anesthesia & Perioperative Medicine
Medical University of South Carolina**

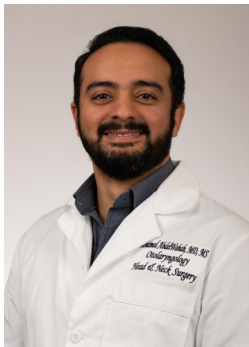


“State of the Department ”

Scott Reeves, MD, Professor

August 8, 2023

**Dept. of Anesthesia & Perioperative Medicine
Medical University of South Carolina**



“Sleepy Surgery: An Overview of Today's Algorithm ”

Mohamed Abdelwahab, MD, PhD, Assistant Professor

August 15, 2023

**Dept. of Otolaryngology
Medical University of South Carolina**



“TBD”

Chris Skorke, MD, Assistant Professor

August 22, 2023

**Dept. of Anesthesia & Perioperative Medicine
Medical University of South Carolina**



“Labor Management of Obstetric Complications ”

Eliza McElwee, MD, Assistant Professor

August 29, 2023

**Dept. of Obstetrics & Gynecology
Medical University of South Carolina**

DEPARTMENT OF ANESTHESIA AND PERIOPERATIVE MEDICINE

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I HUNG THE MOON

Please don't forget to nominate your co-workers for going 'Beyond the Call of Duty.' I Hung The Moon slips are available at the 3rd floor front desk and may

Regan McKinney, Liz Hare, Jennie Cannon, Riley Chambers, Cecelia Taylor, and Blake Frazier did a great job as an expedient, cohesive team during a code in the CT scanner which led to an emergent IR intervention after hours at ART. Thank you all for your hard work, positivity, and dedication! - Dr. Loren Francis

[CHECK OUT OUR WEBSITE](#)

Future Events/Lectures

Intern Lecture Series

CA 1 Lecture Series

- 8/2—Post Anesthesia Care—Natalie Barnett
- 8/9—Nonvolatile Anesthetic Agents—Ryan Wilson
- 8/16—Fluid Management & Transfusion—Joel Sirianni
- 8/23—Adrenergic Agonists & Antagonists; Hypotensive Agents—Jackson Condrey
- 8/30—Local Anesthetics; Adjuncts to Anesthesia—Clinton Pillow

CA 2/3 Lecture Series

Per Rotations



Follow us on Facebook, Instagram, and Twitter:



Follow @MUSC_Anesthesia



Department Holiday Party
Saturday, December 9th, 2023
Carolina Yacht Club

[ONE MUSC Strategic Plan](#)

We Would Love to Hear From You!

If you have ideas or would like to contribute to *Sleepy Times*, the deadline for the September edition will be August 20, 2023.