



SLEEPY TIMES

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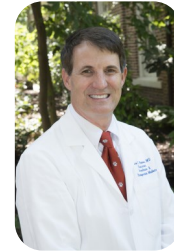


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Message from the Chairman: *There is no I in team.*

-SCOTT T. REEVES, MD, MBA



The state of South Carolina is having a very interesting year for our college basketball teams. Both the University of South Carolina and Clemson University are surprising the critics with excellent seasons within their respective conferences, the South Eastern Conference and Atlantic Coast Conference. Neither of the teams has a true super star player but a cast of players who understand that collectively as a team they can accomplish greater things than acting as individuals. This concept has led to the saying, *there is no I in team.*

Recently, we celebrated the contributions of our players to the Anesthesia Care Team. We celebrated National CRNA Week from January 24-30 and National Anesthesiologists Week from January 31 -February 6. It was an opportunity to come together over lunch and celebrate our contributions to the Anesthesia Care Team at MUSC. We have seen significant growth and an ever-increasing complexity to our case mix this past year. Leadership from both groups worked together to plan our new Children's Hospital and Women's Pavilion to be a state-of-the-art facility. We continue to modify our plans for two multispecialty medical office buildings (MOB) and ambulatory surgical centers (ASC). One will focus on children and will be located on Rivers Avenue close to the I-526 /26 junction. The other will be primarily an orthopedic center and be located in West Ashley. These three facilities will be built between now and 2019. What an exciting time period to be in the department!

I want to thank our faculty, CRNAs, residents, anesthesia techs and staff for the excellent teamwork we have each day. The extraordinary care we give to our patients daily would not be possible without the dedication and compassion we have for each other.

CONGRATULATIONS KATIE SMITH FOR BEING NAMED THE MUSC EMPLOYEE OF THE QUARTER

On February 13th, I surprised Katie Smith at the UH OR desk with a plaque for MUSC Employee of the Quarter. I was so excited to present this to her for all her hard work and dedication to the staff and our department. Please help me congratulate Katie! -Carlee Clark, M.D.



ERIC BOLIN, M.D. APPOINTED REGIONAL ANESTHESIOLOGY TEAM CHIEF

Following the transition of Dr. Sylvia Wilson to the Medical Director position at Rutledge Tower, it was only appropriate to identify a new chief for the regional anesthesiology team. Fortunately, the department has significant talent within the RAPS team, and Dr. Eric Bolin was chosen. I want to thank Sylvia for her dedication to the RAPS Team and shepherding its substantial clinical and academic growth.



Eric Bolin is originally from North Carolina. He graduated from medical school at the University of North Carolina at Chapel Hill. After medical school, he moved to Charleston, SC where he was a resident at MUSC. Eric worked in private practice in town for several years after residency. He completed his fellowship in Regional Anesthesia and Acute Pain at UNC Chapel Hill and subsequently returned to MUSC. Since returning to MUSC post fellowship, he has been an active member of the regional and acute pain service both clinically and by participating in research. In his spare time, Eric enjoys travel and spending time with his two boxer dogs, Stewie and Stella.

Eric will immediately be busy working with our existing and new orthopedic surgeons to maintain the rapid growth in the discipline.

MEET THE NEW ANESTHESIOLOGY CHIEF RESIDENTS

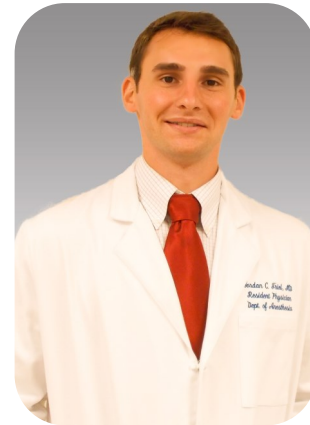
It is my pleasure to share with you the results of our 2016-17 Anesthesia chief resident elections. The new chiefs will be Drs. Loren Francis, Stefanie Robinson, and Jordan Friel. Please join me in congratulating them on their new positions! We will begin transitioning to the new chiefs in the coming weeks and will let everyone know when they are up to speed. -George J Guldán III, M.D.



Dr. Loren Francis

Loren Francis was born in Poughquag, NY where her parents still live. After high school, she moved to Providence, RI to attend Brown University where she met her husband Eric. After completing a degree in Applied Mathematics/Biology she attended medical school in Valhalla, NY at New York Medical College. Loren was excited to match into her first choice program, move to sunny Charleston, and adopt 2 dogs. In 2015 she and Eric got married on Folly Beach and moved into a house nearby. Outside of the hospital, she loves to spend time at the beach, hang out with her dogs, volunteer at animal shelters, cook, garden, and nap. She also loves to travel when time allows, and she and her husband are working on visiting all the Caribbean islands. This year has been her favorite of residency so far, and she has decided to apply for a cardiothoracic fellowship. Loren is honored to be selected as a chief resident and looks forward to working with her co-chiefs to help the next year run smoothly.

Jordan Friel hails from Chillicothe, Ohio - a small southern Ohio town nestled in the foothills of the Appalachians. Upon graduation from high school, Jordan attended the Ohio State University on an Appalachian scholarship. While at Ohio State, he earned a bachelors of science in molecular genetics, graduating magna cum laude with honors. A lifelong fan of Ohio State Football, Jordan decided to spend four more years of fall Saturdays in the 'Shoe and remained at Ohio State to complete his medical education. A member of the Alpha Omega Alpha medical honor society, Jordan graduated cum laude with his medical degree and was fortunate enough to match at his first choice anesthesia residency program, MUSC! In his spare time, Jordan enjoys SCUBA diving, skiing, and spending time outdoors with his wonderful girlfriend Nicole and their two dogs, Scarlett and Ruffles. Jordan has had an amazing time learning the practice of anesthesia with the exceptional group of residents at MUSC. He is very honored to have been elected as a Chief Resident for the coming year and is looking forward to contributing to the evolution of the MUSC residency program in any way that he can!



Dr. Jordan Friel



Dr. Stefanie Robinson

Stefanie is a Charleston native, growing up in Mt Pleasant where her parents still live part time. She attended Clemson University for undergrad where she earned a BS in Public Health, and then returned to the Lowcountry in 2009 to attend MUSC for medical school. Stefanie married her high school sweetheart, Tradd, in 2010. She was overjoyed to stay and join the department after matching into anesthesia residency here. Stefanie and her husband are avid Clemson fans and enjoy spending days off at the beach or out on the water. They also treasure their rescue pup, Dubya. She is excited and honored to be chosen as a chief resident for the upcoming year and thanks everyone for their support!

SOCIETY OF PEDIATRIC ANESTHESIA MOBILE APP

I would encourage us all of us to upload this app onto our smart phones. It is an excellent tool for emergency management of our pediatric patients.



Update Your SPA Mobile App Today!

We love that you're using our SPA mobile app on Apple, Android, and Blackberry devices. But to ensure we offer the best user experience, we've updated the SPA app.

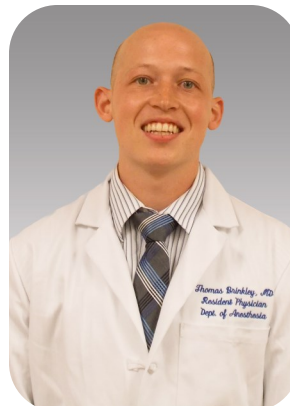
Upgrading your app is critical so that it will work properly. If you're unable to install the update for some reason, you can always delete the app from your device and reinstall it from your app store.

If you haven't downloaded the SPA app, please do so by going to the Apple App Store, Google Play, or BlackBerry World and search "SPA Anesthesia".



SOUTH CAROLINA CHAPTER OF ALPHA OMEGA ALPHA

Congratulations to Drs. Loren Francis and Thomas Brinkley for being nominated and accepted as resident members to the South Carolina Chapter of Alpha Omega Alpha.



WELCOME NEW CRNA, KEVIN ATCHISON



Kevin is very excited to have joined the Department of Anesthesia at MUSC. Kevin is a native of St. Louis, Missouri and moved to Charleston in 2013. He received his B.S. in Biology from the University of Missouri and later attended Saint Louis University for his B.S. in Nursing. Kevin worked as a critical care nurse at Barnes-Jewish Hospital in St. Louis before attending MUSC's AFN program; where he recently graduated in December with his Master's degree in Nurse Anesthesia. Outside of work, Kevin enjoys playing golf, going to the beach, happy hour, and watching St. Louis Cardinals baseball. He and his wife Heather are expecting their first child in June! They are attempting to make the most of their free time in Charleston until they are hit with the joys of parenthood.

WELCOME NEW ANESTHESIA TECH, NICHOLAS GERMANO



Nick is a recent graduate of the College of Charleston and holds a Bachelor of Science in Biology. He has worked in the hospitality industry throughout his schooling and is excited to finally transition into the healthcare field. He has also recently completed CNA training and Alzheimer's care certification in preparation to join the MUSC family. Nick attended a pre-health, science academy in Myrtle Beach before college and is ecstatic to have the opportunity to stay in the lowcountry for work. In his free time he likes to fish, paddleboard, and geek-out about English horseback riding to anyone who will listen. He is grateful to be able to work as an Anesthesia Technician and have the opportunity to learn every day.

WELCOME ANESTHESIA TECH MOLLY SEKAR TO ART, SHE IS TRANSFERRING FROM THE MAIN



Molly is a graduate from the College of Charleston, and while in school she worked as an EMT and is applying to medical schools across the country. She grew up in Indiana and moved to Charleston five years ago. Molly is excited to be part of the incredible team at the Medical University of South Carolina.

NITROUS OXIDE FOR LABOR ANALGESIA

BY: DR. LATHA HEBBAR

Nitrous Oxide for labor Analgesia: No ‘Laughing’ Matter

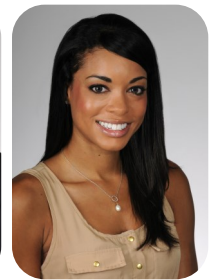
During Grand Rounds presentation of nitrous oxide for labor (and its long awaited arrival at MUSC), I assumed that I was the only person in the room to have experienced nitrous for labor.

At the end of the presentation I was approached by a medical student who also had nitrous for her labor - two moms separated by 24 years (and the Atlantic Ocean) in their birthing experience with nitrous and both very pleased with it. MUSC will be the first hospital in Charleston and the second in South Carolina to offer nitrous oxide to laboring moms though there are some birthing centers which currently offer nitrous.

Nitrous oxide is the most common inhalational agent used globally for labor analgesia. It is used in several countries, including the United Kingdom, Finland, Australia and New Zealand. The incidence of use of nitrous is < 1% in the USA, 43% in Canada and 62% in the United Kingdom where a premixed mixture of 50% nitrous in oxygen is piped into individual labor rooms. The interest for its use in the U.S. has been primarily advocated by nurse-midwives. A position statement from the American College of Nurse-Midwives indicated that ‘all women should have access to many different means of dealing with the process of labor, with nitrous oxide being one of them’.

The renewed interest in the use of nitrous oxide for labor analgesia in the United States could possibly be due its lower cost, ease of use and ‘less invasive’ nature relative to neuraxial labor analgesia. However, nitrous does not provide the same degree of analgesia as does an epidural. It certainly will assist in the management of labor in certain patient populations; the key to maternal satisfaction will be education and clarification of expectations with the use of nitrous. It also serves as an opportunity to attract moms to deliver at MUSC.

Nitrous oxide at MUSC will be administered as a 50/50 mix with oxygen using a blender device. It will be self-administered by the mother using a facemask, with the mother inhaling it at least 45 seconds (ideally 2 mins) before the contraction. Nitrous SHOULD NOT be administered within 2 hours of narcotic use. There will be NO CONCURRENT use of nitrous and labor epidural, though it can be used during placement of the epidural.




NITROUS OXIDE FOR LABOR ANALGESIA CONTINUED . . .

BY: DR. LATHA HEBBAR

The risks are minimal for the mom - the adverse effects consist of nausea (30 percent), dizziness (3-5 percent) and drowsiness (4 percent). Nitrous oxide does not interfere with the progress of labor. Nitrous oxide readily crosses the placenta with no apparent detrimental effects of FHR, APGAR scores or cord blood gases. Environmental pollution is not a concern as the exhaled nitrous is scavenged from the breathing system.

We are delighted to offer this mode of labor analgesia to our expectant moms and hope to roll it out on March 14th.

Housekeeping prior to roll out: Ebony Hilton (education) and Robert Harvey (EPIC, consent) are the clinical nitrous champions from anesthesia. A multi-disciplinary education plan has been created for anesthesia providers, L&D nursing and obstetricians. This will be delivered via 2 modules on MyQuest and an in-service on February 29th/March 1st with the Praxiar rep. EPIC documentation processes are in progress, and we should have screen shots before we go live. Patient education brochures and consent will be available in English and Spanish. If you have any questions regarding the use of nitrous on L&D, please do not hesitate to send Ebony, Robert or myself an e-mail.

		
Consent for Administration of Nitrous Oxide for Labor <small>Page 1 of 1</small>		
<small>Form Origination Date: 9/2015 Version: 1</small>	<small>Version Date: (2/2016)</small>	<small>Patient Name _____ MRN _____</small>
Consent Form for Administration of Nitrous Oxide for Labor		
<p>I understand that I can stop using nitrous oxide at any time and discuss alternate interventions for pain management with my medical providers.</p>		
<p>I understand that breathing nitrous oxide may make me unsteady and that there is a risk of falling associated with using nitrous oxide if I am standing or ambulating. If I need or want to get out of bed or walk while using nitrous oxide, I understand that I should do so only with the assistance from a support person or staff member.</p>		
<p>I understand that I am the only person who can hold the mask to my face to administer nitrous oxide and that no one else can hold the mask to my face. This allows for the administration of nitrous oxide only when I require it for pain relief. The risks of someone else holding the mask to my face includes administering nitrous oxide when I am not in pain and can result in oversedation, airway obstruction and decreased oxygen to myself and my baby.</p>		
<p>I understand that the nitrous oxide is for my use and my pain control only. I understand if I allow anyone else to use the mask or inhale the nitrous oxide, that person will be asked to leave and/or the use of my nitrous oxide will be terminated. I understand that nitrous oxide is a controlled substance and that providing a controlled substance to anyone without a prescription may subject me to state and/or federal, civil and/or criminal penalties.</p>		
<p>All of my questions have been asked and answered, but I understand that my providers are available to continue answers my questions as they arise.</p>		
<small>Patient</small> _____	<small>Date</small> _____	<small>Time</small> _____
<small>Informing Physician</small> _____	<small>Date</small> _____	<small>Time</small> _____
<small>Witness</small> _____	<small>Date</small> _____	<small>Time</small> _____



Nitrous Oxide (Laughing Gas) For Labor



What is it Nitrous Oxide? Nitrous oxide is a colorless, odorless, tasteless gas, which is used to decrease pain during painful experiences. Nitrous oxide used for labor pain is a mixture of 50% nitrous gas and 50% oxygen that is inhaled through a mask. Nitrous oxide is not a new method. It was first used in labor in the 1930s and is currently widely used in Europe.

How does it work? You hold your own mask and begin to inhale the gas mixture about 45 seconds before a contraction begins. Starting to inhale before a contraction begins helps the gas to reach its peak effect at about the same time as the contraction reaches its peak, which provides the greatest relief.

Will my provider be administering nitrous? No, nitrous is self-administered by the laboring woman, breathing it in as you feel the need. Once you decide you want to use it, your provider will order it and a member of the anesthesia team will come to your room, set it up, and review how to use it.

Does it have any side effects? Some women have reported nausea after prolonged use. There are medications to help ease the nausea if that happens. Nitrous oxide can also cause some unsteadiness when up, which is why there should always be a family member or staff person in the room when you would like to get out of the chair or bed, in case you need assistance.

Is there any extra baby monitoring required? No. Intermittent fetal monitoring can still be used if you do not have reasons to be monitored continuously.

Can I use nitrous and have intravenous narcotics at the same time? No. Nitrous cannot be used with intravenous narcotics. The combination of narcotics and nitrous can slow your breathing.

Are there any reasons I could not use it? Yes: you cannot use it if you:

- » Cannot hold your own facemask;
- » Have received a dose of narcotic in the past 2 hours;
- » Have pernicious anemia or a B12 deficiency for which you take B12 supplements;
- » Have one of a very few other rare medical conditions which a member of the anesthesia team will assess when they speak with you.

Are there any effects on the baby? No, there are no known effects on the baby. Nitrous is the only pain relief method used for labor that is cleared from the body through the lungs, so as soon as you stop breathing the gas, the nitrous effect is gone within a breath or two.

Do I have to choose between either using nitrous oxide OR having an epidural? No. Some women may use nitrous prior to having an epidural placed. Though they would not be used together (the epidural and nitrous), it is perfectly fine to use nitrous first, and then move on to a different type of pain relief if you find you need to change to something else.

There are only a handful of hospitals in the country that offer this option for pain relief to laboring women; we are so pleased that we are able to make this option available to you! Please talk with your obstetrical or anesthesia provider if you have additional questions.

RESEARCH CORNER



Dr. James Abernathy

A Human Factors Engineering Study of the Medication Delivery Process during an Anesthetic

Self-filled Syringes versus Prefilled Syringes

Yushi Yang, Ph.D., Antonia Joy Rivera, Ph.D., Christopher R. Fortier, Pharm.D., James H. Abernathy, III, M.D., M.P.H.

ABSTRACT

Background: Prefilled syringes (PFS) have been recommended by the Anesthesia Patient Safety Foundation. However, aspects in PFS systems compared with self-filled syringes (SFS) systems have never been explored. The aim of this study is to compare system vulnerabilities (SVs) in the two systems and understand the impact of PFS on medication safety and efficiency in the context of anesthesiology medication delivery in operating rooms.

Methods: This study is primarily qualitative research, with a quantitative portion. A work system analysis was conducted to analyze the complicated anesthesia work system using human factors principles and identify SVs. Anesthesia providers were shadowed: (1) during general surgery cases (n = 8) exclusively using SFS and (2) during general surgery cases (n = 9) using all commercially available PFS. A proactive risk assessment focus group was followed to understand the risk of each identified SV.

Results: PFS are superior to SFS in terms of the simplified work processes and the reduced number and associated risk of SVs. Eight SVs were found in the PFS system *versus* 21 in the SFS system. An SV example with high risk in the SFS system was a medication might need to be “drawn-up during surgery while completing other requests simultaneously.” This SV added cognitive complexity during anesthesiology medication delivery. However, it did not exist in the PFS system.

Conclusions: The inclusion of PFS into anesthesiology medication delivery has the potential to improve system safety and work efficiency. However, there were still opportunities for further improvement by addressing the remaining SVs and newly introduced complexity. ([ANESTHESIOLOGY 2016; 124:00-00](#))

NATIONAL CERTIFIED NURSE ANESTHETISTS WEEK

The American Association of Nurse Anesthetists (AANA) recognized the inaugural celebration of National Nurse Anesthetists Week (NNAW) in January 2000 with the goal to raise awareness of and shine a spotlight on the work of Certified Registered Nurse Anesthetists (CRNAs). National CRNA Week is the AANA’s annual celebration of anesthesia patient safety and the nation’s 49,000+ Certified Registered Nurse Anesthetists and student registered nurse anesthetists who provide approximately 40 million anesthetics each year. Known as National Nurse Anesthetists Week as recently as 2014, the new name for this popular event helps patients, hospital administrators, healthcare professionals, policymakers, and others become more familiar with the CRNA credential and the exceptional advanced practice registered nurses who have earned it.



NATIONAL CERTIFIED NURSE ANESTHETISTS WEEK CONTINUED . . .



Rutledge Tower



The Main



Ashley River Tower



NATIONAL PHYSICIAN ANESTHESIOLOGISTS WEEK

January 31st through February 6th marked the 2nd annual Physician Anesthesiologists week. This week follows celebration of National CRNA week and allows for positive reinforcement to all anesthesia team members. Lunch was provided by the CRNAs for the faculty and department members at the Main. Thanks for everyone's kind words throughout the week. It is truly a team approach here at MUSC and subsequently makes for a very enjoyable place to work. —David Stoll, M.D.



HISTORY OF ANESTHESIOLOGY AND MEDICINE: A BRIEF COLLECTION OF *RECOLLECTIONS* FROM DR. LAURIE BROWN

EXTRA-CORPOREAL CIRCULATION

As soon as we were satisfied that laboratory experiments were sufficient, the technique was removed to the operating room at the new Medical College Hospital. The first case was accomplished after hypothermia had been established and then the patient was connected to the bypass apparatus and the operation proceeded. This was not easily accomplished, and often the blood in the bubble oxygenator would foam to the extent that it poured out of the end of the oxygenator. An antifoaming spray was sometimes used in the oxygenator to attempt to prevent the foaming, but this appeared to me to be of little value.

Anesthesia records and description, operative records, etc., of the first case which was accomplished with this technique is in the Department Archives. I believe that this case was done by us during the same week that Dr. Denton Cooley did his first such case in Houston, Texas. Oxygenators soon began improving and have become more and more sophisticated over the years, but to the best of my knowledge, the ideal oxygenator has not yet (early 1990's) been developed.

NERVE BLOCKS

Dr. John Brown apparently could do any type of nerve block that was necessary to be done. He taught his residents spinal blocks, caudal blocks, supraclavicular blocks, and various small peripheral nerve blocks against the face, the legs, the arms and the hand. Once a physiatrist from New York was traveling through the area, was involved in an automobile accident, and sustained a fractured leg. He adamantly refused to have spinal anesthesia and objected to general anesthesia for working on the extremity. He was deathly afraid of these types of anesthesia and after Dr. Brown told him that it could be done under nerve block, he then had to consult with his own physiatrist by telephone before anything could be done. As I recall, Dr. Brown did a sciatic-femoral block of the extremity and the operation was carried out without problems.

I was taught techniques to perform peripheral nerve blocks to utilize dilute solutions of subarachnoid anesthesia to alleviate ischemic lower extremity pain, segmental spinal anesthesia for diagnosis of abdominal pain, subarachnoid alcohol destruction of nerve roots in treatment of intractable pain (I never had courage to inject alcohol into the cervical region, but it seemed not to bother John Brown at all), and to inject large amounts of alcohol intrathecally to relieve the "mass spasms" in some paraplegic patients.

DIFFICULT AND DIFFERENT ANESTHETIC PROCEDURES

Cataract extraction was a difficult procedure for the surgeon who had no suture etc. of present day quality. The patient was often under general anesthesia, and often the surgeon would be opposed to endotracheal anesthesia but wanted the patient asleep. These patients were given IV Pentothal, an oral airway inserted into the mouth and through the airway was insufflated oxygen and nitrous oxide. The surgeon also used local anesthesia, but it appeared to me that the blocks were not nearly as efficient as the blocks of today. This was hazardous anesthesia, but to the best of my knowledge, we had no real patient difficulties with the anesthesia.

Soon after we began operating on ruptured or expanding abdominal aortic aneurysms, when an aneurysm was suspected, an aortogram was desired. The patient was sent to the x-ray department and the procedure for the aortogram was to turn the patient onto the prone position, inject local Novocaine anesthesia into the area in the lumbar region and insert a long #15 or #16 gauge needle into the aorta. The contrast media was injected and, as I recall, there was a cassette which would take 8 pictures in fairly rapid succession. The insertion of the needle into the aorta was often painful and when the dye was injected it was almost always very painful. Therefore, the patient was given doses of Pentothal sufficient to relieve the pain and keep the patient fairly quiet while the films were being taken. Often more than one injection was required. Although hazardous, this type of anesthesia was not as dangerous as one would expect due to the fact the patient was N.P.O., was prone, and could be brought to the side of the table and the head hung over the table if vomiting or regurgitation occurred.

HISTORY OF ANESTHESIOLOGY AND MEDICINE: A BRIEF COLLECTION OF *RECOLLECTIONS* FROM DR. LAURIE BROWN

DIFFICULT AND DIFFERENT ANESTHETIC PROCEDURES CONTINUED . . .

In a pneumoencephalogram procedure the patient was taken to the x-ray department, and in the sitting position, a lumbar tap was accomplished. The spinal fluid was withdrawn with a 10 cc syringe, and as each syringe full of spinal fluid was withdrawn and discarded, a syringe full of air was injected. This procedure was carried out until no more spinal fluid could be obtained and the system was evidently filled with air. This became very painful at times and while the patient was sitting, the anesthesia resident often gave enough Pentothal intravenously to have the patient very groggy in order that there would be amnesia for the most painful part of the procedure. X-rays were then accomplished and whatever therapy was indicated was carried out in the operating suite.

During a ventriculogram, the patient was taken to the operating room and burr holes were drilled into the skull under local anesthesia plus Pentothal for sedation and amnesia. After the burr holes were properly made, the patient was then transferred to the x-ray department where needle were put into the ventricles and fluid removed and air injected. This was a very painful procedure usually, so the patient received Pentothal as a means of sedations and amnesia. After the air was injected and x-rays made, the patient was returned to the operating room if there was a tumor which was deemed operable. If craniotomy was to be done, a regular general endotracheal anesthesia was accomplished on return to the operating suite. I might add here, that sudden projectile vomiting might occur with either pneumoencephalogram or ventriculogram and this was a hazard which had to always be expected.

A chordotomy was done occasionally in people who had intractable pain. The procedure was accomplished by the neurosurgeon by using Novocaine local infiltration anesthesia, and Sodium Pentothal in a dilute IV drip solution was administered by the anesthesiologist as an hypnotic or amnestic agent. The patient was in the semi-awake state in order that he could express himself or herself as to whether or not the pain in a certain area had been alleviated during certain points while severing the pain tracts.

The above procedure with which I associated at that time was performed by Dr. Luther C. Martin, a neurosurgeon who had come to Charleston during my residency training. Dr. John Brown or his residents managed most of his patients. Prior to this time, all neurosurgery was performed by the Chairman of the Department, Dr. Frederick A. Kredel, or by the surgery residents under his supervision. The general surgery residents were trained in neurosurgery under his teaching at that time. Most craniotomies and like procedures were usually performed under local Novocaine anesthesia.

ANESTHESIA HERE AND THERE

One of the unusual places where I was called upon to administer anesthesia was at the Florence Crittendon Home on St. Margaret Street. This was a home for unwed mothers who could come to live and would give their babies for adoption. This was prior to the era of the woman having a choice of having her baby or having it aborted legally by some physician or at some "abortion clinic." The patient was usually given a pudendal-cervical block for delivery of the baby. The deliveries were done by the obstetrics department of the Medical College and the OB-GYN resident who was in charge at this time was Dr. Edward J. Dennis, Jr. Dr. Dennis expected one of the girls who was in labor to have a difficult delivery so he asked me if I could come and help him. I agreed, and with an anesthesia bag and mask and a can of Ether and a bottle of Vinethene, I headed one night for St. Margaret Street. The delivery room was just a room in the house and it had minimal surgical equipment and a simple delivery table. Of course there were open electrical outlets around, plug in electrical lamps, and no safety precautions whatsoever. The anesthesia was administered by me, the delivery was accomplished, everybody was happy, and I went away feeling that a wonderful deed had been done.

HISTORY OF ANESTHESIOLOGY AND MEDICINE: A BRIEF COLLECTION OF *RECOLLECTIONS* FROM DR. LAURIE BROWN

ANESTHESIA HERE AND THERE CONTINUED . . .

The “training school for nurses” was a small “hospital” on Cannon Street in which a few patients were treated and some operations were performed. One day, Dr. John Brown received a call from the hospital asking if someone could come over and assist with a patient who had undergone a gynecological operation and could not be awakened. I was sent to assist and found that the operating room was simply a glassed-in and screened-in porch on the regular house that was being used for the hospital. The facilities even at that time were ancient. I could find nothing physically wrong with the patient and I merely sat with her and administered oxygen until she awakened approximately one hour later. The problem was, as was so often at that time, a very large overdose of Ether. Sometimes it would take a patient several hours to awaken (some never awakened) and he or she was exhaling Ether for seemingly several days. The present day McClellan-Banks Hospital, which is no longer used as a hospital, was named in honor of the physicians who were pioneers at the old hospital on Cannon Street.

The McClellan-Banks Hospital was constructed during the era of segregation of the races in order that the “colored” would have a hospital for the physicians and patients. Those patients previously were admitted to old Roper Hospital, but they were always under the care of either a private white physician or the all white house staff.

RECOVERY ROOM

There were no recovery rooms in Charleston during my medical school days, my internship and the early part of my anesthesiology residency training. I was anxious to have a recovery room and had requested space for this endeavor, being refused several times. All that we asked for was a room in which we could put several oxygen tanks and suction machines, but this was to no avail. In 1955 a recovery room, which was called a “Post Anesthesia Observation Area” or PAO, was deemed to be necessary and one was established with Mrs. Elaine Thompson as Supervisor. Two small adjoining rooms near the operating rooms at new Roper Hospital were utilized. One room was for white patients and one room was for black patients. Although there was legal segregation at that time, all black patients from old Roper Hospital were brought to the “Private Pavillion” for operations. At that time all black patients and all indigent patients were in old Roper. It was a long and scary trip taking a fully anesthetized patient from new Roper back through a long corridor to old Roper. The recovery room was a godsend from this standpoint, even though all patients at both hospitals were reacted in their own beds at night and on weekends. We as anesthesiologists attempted to have patients awake or at least in control of their airway prior to leaving the operating suite. The reason for doing this is because we knew of the consequences of taking an anesthetized patient to a room or a ward and leaving in the care of someone who really knew nothing about airway management. We knew of several tragedies which had occurred for that very reason. During those days it was not unusual to hear one of the long time general surgeons encourage the anesthetist to “get the patient out of the operating room and back to the ward before he dies.” Looking back, it is really difficult to realize that there were so few physicians and nurses who knew how to manage a patient’s airway.

When the new Medical College Hospital opened, we had a modern recovery room with oxygen and suction supplied in wall outlets. Mrs. Frasier was in charge of the recovery room and I trained all nurses in the operating room in airway management prior to their caring for patients during the postoperative period.

NEW BABY IN THE DEPARTMENT



Congratulations to Dr. Katie Bridges and her family

Alexander Lucas Bridges

Born February 19, 2016 at 9:50am

8 lbs, 11 oz, 20 inches

DEPARTMENT WELLNESS INITIATIVE

Recently, MUHA requested that each department in the College of Medicine and each unit within our hospitals develop a wellness initiative with the desire to improve the overall health of all MUSC faculty, students and employees. We have worked with perioperative services to have an identical initiative with our operating room nurses and other caregivers for this first year. Each month we will be concentrating on either an exercise goal or an educational opportunity as outlined below.

January: Kick-off Biggest Loser Completion – will run for one year with monthly weigh ins.

February: Encourage all staff to walk up one flight of stairs and down two flights instead of taking the elevator. This initiative is called Steps 1 Up /2 Down

March: Healthy Recipe Swap

April: Steps 1 Up /2 Down

May: Mindfulness/stress management speaker from the Institute of Psychiatry (TBA)

June: Steps 1 Up /2 Down

July: Wellness center speaker on benefits of physical activity, how to build and maintain fitness routine, Wellness Center programs, demonstrations

August: Steps 1 Up /2 Down

September: Chaplain Terry Wilson to discuss Second Victim Syndrome and Coping

October: Steps 1 Up /2 Down

November: Sodexo quest speaker “Healthy Thanksgiving Meal” options and a possible Perioperative Turkey Trot

December: Steps 1 Up /2 Down; Biggest Loser Winner announced.

COLLEGE OF MEDICINE STANDARDS OF CONDUCT COMMITTEE

Dr. Susan Harvey has been selected to chair the MUSC College of Medicine's Standards of Conduct Committee. Dr. Ebony Hilton has been selected as a faculty member representative. The Standards of Conduct committee addresses issues of abuse, harassment and discrimination of medical students. It seeks to foster a learning environment in the College of Medicine that is conducive to learning, professional development and becoming a competent and compassionate physician. It is our aim to promote an environment free of misconduct and towards that end, policies and procedures have been established to address these issues should they arise. The committee meets on an as needed basis to hear allegations of violations of the standards of conduct. Please find more information about the Standards of Conduct policy on the web at: [Please Click Here for the Link](#)

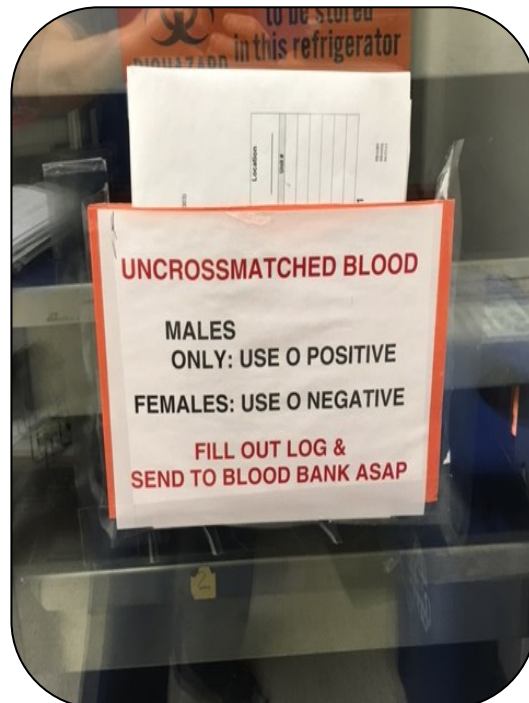
Congratulations to Drs. Harvey and Hilton for representing our department on this critical committee.



LOCATION FOR UNCROSSED BLOOD IN OR

BY: DR. TOM EPPERSON

Since I received more than 1 question about availability and exact location of the 8 units of emergency O type blood, I have taken two pictures showing where they live. When the OR lab moved downstairs, they left behind a refrigerator that is located near the dumb waiter in the old lab. Please see the pictures below. I hope this is clear to everyone now.



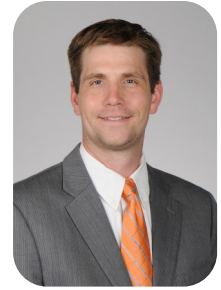
GRAND ROUNDS FOR THE MONTH OF MARCH

“CT Research Update ”

March 1, 2016

James Abernathy, M.D.; Walead Hessami, M.D.; Doug McDonald, M.D.

Medical University of South Carolina



“Human Factors in Cardiac Surgery, What Can We Learn from Little People”

March 8, 2016

Kenneth Catchpole, Ph.D.

Professor

Medical University of South Carolina

“Cardiopulmonary Bypass and Evidence-Based Update ”

March 15, 2016

George Guldán, M.D.

Assistant Professor

Medical University of South Carolina



“Can We Do Better? Can Quality Measurement Help?”

March 22, 2016

Laurent Glance, M.D.

Professor

University of Rochester Medical Center

“Complex CT Cases Morbidity and Mortality Conference”

March 29, 2016

James Abernathy, M.D.

Professor

Medical University of South Carolina





DEPARTMENT OF ANESTHESIA AND
PERIOPERATIVE MEDICINE

Email: pooleal@musc.edu
Phone: 843-792-7503
Fax: 843-792-9314

CHECK OUT OUR WEBSITE AT:
[HTTP://WWW.MUSC.EDU/ANESTHESIA](http://www.musc.edu/anesthesia)

Future Events/Lectures

Intern Lecture Series

March 3rd — Fluids, Electrolytes, Acid/Base, Dr. Walton

March 17th — Anesthesia for Peds, Dr. Sabbagh

March 24th — Hematologic Disorders, Dr. Finley

March 31st — OB, Dr. Hebbar

CA 1 Lecture Series

March 2nd — Anesthesia Complications, Dr. Freely

March 9th — Postanesthesia Care, Dr. Roberts

March 23rd — Geriatric Anesthesia, Dr. Skorke

March 30th — Anesthesia for Neurosurgery, Dr. Whiteley

CA 2/3 Lecture Series

March 7th — Pericardial Diseases and Cardiac Trauma PBLD (Stoelting Ch.7), Dr. Heinke

March 14th — Heart Failure and Cardiomyopathy PBLD (Stoelting Ch.6), Dr. Abernathy

March 21st — Transfusion: Evidence-based or Faith-based - All Residents, Dr. Glance (Univ. of Rochester)

March 28th — Anesthesia for Heart & Lung Transplantation (Barash Ch.54), Dr. Heinke

Grand Rounds

March 1st — CT Research Update, Dr. Abernathy and CT Fellows

March 8th — Human Factors in Cardiac Surgery, What Can We Learn from Little People, Dr. Catchpole

March 15th — Cardiopulmonary Bypass, and Evidence-Based Update, Dr. Guldán

March 22nd — Can We Do Better? Can Quality Measurement Help?, Dr. Glance (Univ. of Rochester)

March 29th — Complex CT Cases/ M&M, Dr. Abernathy



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 be turned in to Kim Pompey. Thank you!

Greg Kottkamp, M.D., Resident — Thank you so much for being supportive, kind, energetic and an awesome team player. You are appreciated!

Susan Harvey, M.D., Associate Professor — Excellent team leadership during a fast paced and dynamic case. Thank you!

Adrienne West, CRNA — Adrienne quickly responded to help me during a critical case. Her assistance made it possible to focus on patient care. She assisted me until a transition and she was invaluable to me. Thank you!

Tammie Matusik, Administrative Assistant — Assistance with medical student rotations. You have gone above and beyond with helping everything run smoothly. Thank you!!



Resident Graduation, June 17
Founders Hall at 6:00pm

Department Holiday Party, December 2
Carolina Yacht Club

March 2016

Standard of the Month

**Be on time and ready for
work and meetings.**

We Would Love to Hear From You!

If you have ideas or would like to contribute to *Sleepy Times*, the deadline for the April edition will be March 21, 2016.