



SLEEPY TIMES



VOLUME 9, ISSUE 1 JANUARY 2015

Special Points of Interest

- **MUSC Simulation Lab Allows Hospital Staff to Prepare for Ebola**
- **Pacemaker QI Project**
- **Lewis Blackman Act**
- **Holiday Party**

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MESSAGE FROM THE CHAIRMAN:

-SCOTT T. REEVES, MD, MBA

New Year's Resolutions and MUSC's Strategic Plan

January is a time for making New Year's resolutions. Each year I personally challenge myself to learn Spanish, read more, watch less television, and take better care of myself. Setting New Year's resolutions is a worthy goal, but research has shown that to be successful we need to pick only a few small goals that are easily measurable and attainable. Many of us in Charleston must be doing something correct as we were recently chosen the #3 city for most attractive locals by *Travel and Leisure* magazine.



MUSC is in the process of revising our five-year university wide strategic plan. In distinction to a New Year's resolution, a strategic plan is by design a process to identify stretch goals that are to be achieved over a period of time. Under the leadership of President David Cole, a kickoff process occurred December 18, involving over 300 participants from the MUSC family. MUSC's new vision statement is *Leading health innovation for the lives we touch*. It is campus leadership's desire to have as diverse representation as possible in the process. A new web page has been established www.imaginemus.com. As the MUSC community works on our strategic plan and implementation strategies, I would encourage all of us to stay informed and participate in the process.



MUSC SIMULATION LAB ALLOWS HOSPITAL STAFF TO PREPARE FOR EBOLA

BY: LAUREN SAUSSER, POST & COURIER



There aren't any active Ebola cases in the United States right now, but that's not stopping volunteer staff at the Medical University Hospital from preparing for a potential patient right around the corner.

That includes practicing how to take the recommended protective gear on and off correctly - over and over again - using the precise, new steps that the Centers for Disease Control and Prevention outlined in October after two nurses in Dallas caught the disease from an infected patient. It's not clear how the nurses became ill - hospital administrators insist they followed recommended protocols - and both have since recovered.

Dr. John Schaefer, director of MUSC's Simulation Center, said doctors and nurses at MUSC who have volunteered to treat patients with Ebola must undergo a three-day course at the center. His team developed a new tablet-based program that allows staff to practice the guidelines until they become proficient. It's like an iPad game for Ebola gear.

"It takes a lot longer than people realize - 20 minutes just to get (the gear) on," said Schaefer, an anesthesiologist by training. "I can let you do it until you get it right."

The Simulation Center, which occupies 11,000 square feet in the College of Nursing building, is one of the largest such labs in the country.

It is used by medical students, physicians, nurses and hospital staff to practice complicated procedures, such as a breach infant delivery, for example, in a setting that allows mistakes to be made. High-tech mannequins, instead of real people, fill up the hospital beds inside the

Dr. John Schaefer explains how a simulation program, which can be run from a tablet computer, helps hospital staff prepare to treat patients with Ebola, if necessary. The program measures how proficient doctors and nurses are taking the necessary protective gear on and off. Schaefer is the director of the Healthcare Simulation Center at MUSC.

simulation center.

"It's a good way to learn because no one gets hurt if you make a mistake," Schaefer said. "I'd rather have the student practice in here and, in fact, if they haven't done it in a while, I'd rather have the physician do it in here, too."

Of course, taking care of patients with Ebola requires expertise that's new for everyone. The program designed at the simulation center measures participants' competency on 31 unique steps.

The new CDC guidelines set a firmer standard for the protective gear, calling for full-body garb and hoods that protect worker's necks; setting rigorous rules for removal of equipment and disinfection of gloved hands; and calling for a "site manager" to supervise the putting on and taking off of equipment.

They also say health workers who may be involved in an Ebola patient's care should repeatedly practice and demonstrate proficiency in donning and removing gear - before ever being allowed near a patient.

Dr. Danielle Scheurer, chief quality officer at MUSC, said about 30 staff have been trained at the hospital, so far. It allows them to practice communicating with each other with the gear on and conducting simple tasks. For example, putting an IV in a patient's arm is usually easy for nurses to accomplish, but it's made much more difficult with an Ebola patient because the protective gear is so bulky and cumbersome.

"We really are very blessed to have this sim lab in our backyard," Scheurer said. "The amount of training it takes to become proficient in donning and doffing takes hours - it's not like you can just do that overnight."

MUSC is one of a few large hospitals in South Carolina that agreed to accept patients with Ebola, should the need arise. There have been no cases of the virus in this state, to date.

[Click Here for Full Article](#)



PACEMAKER QI PROJECT

Dear Department,

With the hard work of Drs. Cassandra Gadlin, Clinton Pillow, Loren Francis, and Stephanie Robinson, we now have a shortcut on the desktops of preop holding and the anesthesia machines with helpful tips and an algorithm for dealing with patients who have an AICD or pacemaker. The icon is a little cartoon of a pacemaker and says "Pacemaker AICD" underneath it. It opens up a PDF file which contains helpful phone numbers, information, and a flow chart regarding these patients and how to best manage them. The data in the file is the latest and most up-to-date from the ASA and HRS.

These four residents should be commended for their hard work and dedication to this project, and also their ingenuity in seeing a need and coming up with what we think is a viable and helpful solution to improving patient care and educating our own department.

Sincerely,
Eric Nelson, MD

PACEMAKER BASICS

Position	I	II	III	IV	V
Category	Chamber(s) paced	Chamber(s) sensed	Response to sensing	Rate modulation	Multisite pacing
	o = None A = Atrium V = Ventricle D = Dual (A + V)	o = None A = Atrium V = Ventricle D = Dual (A + V)	o = None T = Triggered I = Inhibited D = Dual (I + T)	o = None R = Rate modulation	o = None A = Atrium V = Ventricle D = Dual (A + V)

A for atrium, **V** for ventricle, **D** for dual/both

Position 2: Chamber(s) sensed: **o** for no sensing - the device will pace automatically at a specified rate and ignore any intrinsic rhythm

Position 3: How a device responds to a sensed event: **I** - sensed event inhibits output pulse; **T** - sensed event triggers output pulse; **D** - dual modes of response (only available in dual chamber systems); **o** - No response to sensed input.

Position 4: Rate modulation: This is the ability of the pacemaker to adjust its programmed paced rate based on patient activity, which can be sensed as vibration, minute ventilation, or change in right ventricular impedance.

IMPLANTABLE CARDIOVERTER-DEFIBRILLATOR BASICS

indicated in patients with cardiomyopathy and EF < 30-35%, VT, VF, HOCM, Long Q-T syndrome, Brugada syndrome

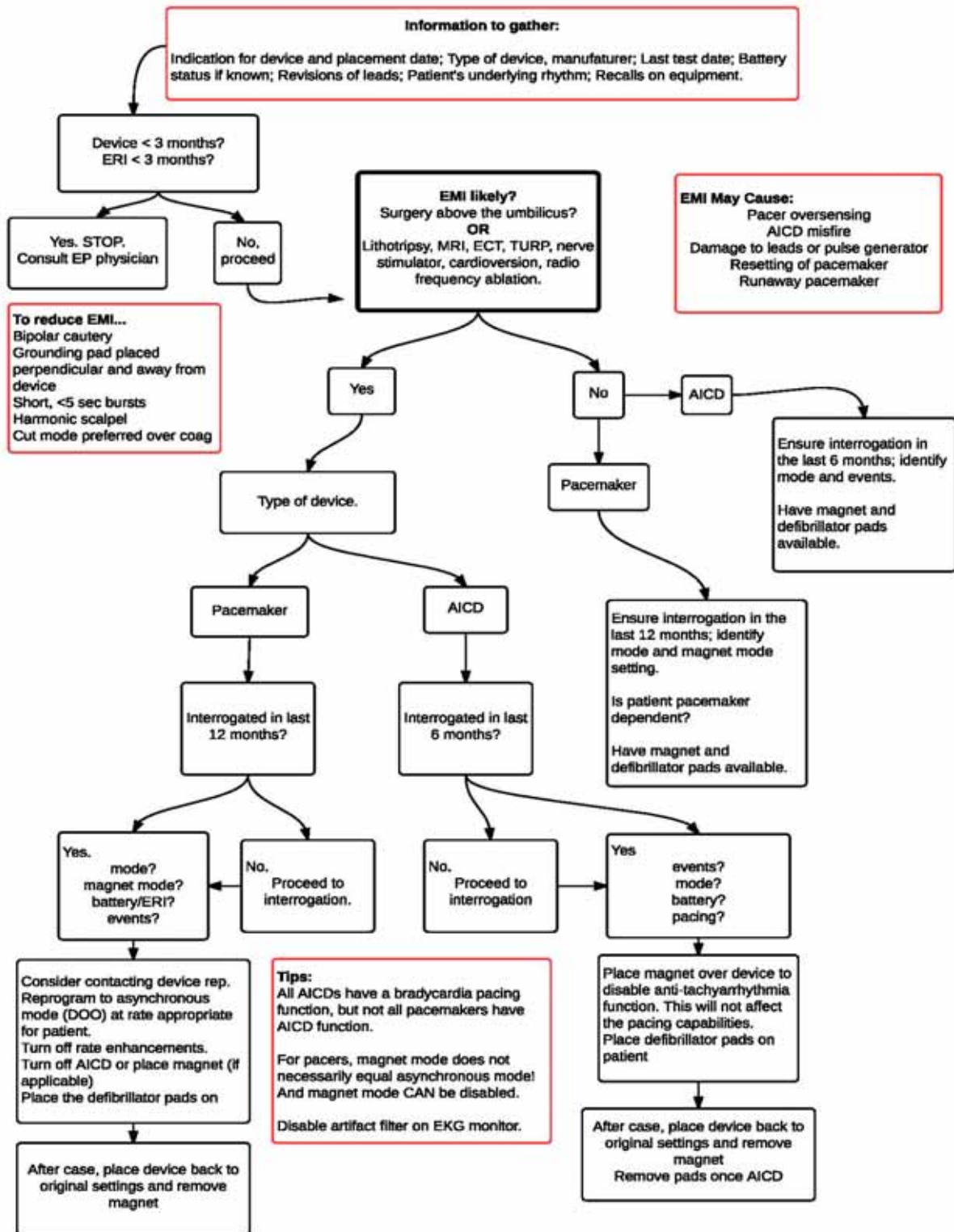
Position	I	II	III	IV
Category	Shock chambers	Antitachycardia pacing chambers	Tachycardia detection	Antibradycardia pacing chambers
	o = None A = Atrium V = Ventricle D = Dual (A + V)	o = None A = Atrium V = Ventricle D = Dual (A + V)	E = Electrogram H = Hemodynamic	o = None A = Atrium V = Ventricle D = Dual (A + V)

Function by measuring each R-R interval and categorizing the heart rate as normal, fast, or slow. After a certain number of fast heart beats, an anti-tachycardia mode is activated and this can be antitachycardia pacing or a shock. Typically, ICDs deliver 6 – 18 shocks per event. After a certain number of slow heart beats, anti-bradycardia pacing is begun.

PACEMAKER QI PROJECT CONTINUED . . .

Preoperative Key Points	Intraoperative Key Points																		
<ol style="list-style-type: none"> The following information must be sought prior to the patient having surgery or a procedure and documented in their pre-op note: <ul style="list-style-type: none"> Manufacturer model number/type of device, location of the device, contact number of company representative/date when device placed Date when the device was last evaluated and results of interrogation Indication for device Battery longevity documented >3 months Any of the leads < 3months old? Programming (Pacing mode? ICD therapy? Is rate responsiveness ON?) Is the patient Pacer dependant? What is the response to Magnet? Need for reprogramming after procedure Has patient received recent or frequent shock therapy from ICD? All patients with AICDs must have their device interrogated within the past 6 months. All pacemakers must have their device interrogated within the last 12 months. If a device has been interrogated at an outside facility the report must be sent to our hospital Patients with ICDs and/or pacemakers are preferably scheduled as second cases to avoid OR delays. Program all rate enhancements off Pending case type consider changing pacing rate to optimize O₂ delivery Disable antitachycardia therapy if a defibrillator Assure that programming device and qualified personnel are available prior to start of procedure. 	<ol style="list-style-type: none"> Is the procedures associated with EMI: RF ablation, ECT, TENS unit, Radiation therapy, surgeries above umbilicus, use of monopolar electrocautery. If EMI is likely to occur see flow chart algorithm. Alterations to device are preferably accomplished by programming instead of magnet application. If no EMI is anticipated, it is not necessary to suspend the anti-tachyarrhythmia therapy (defibrillator) function of an ICD or to change the pacing function to asynchronous. Every effort should be made to avoid or reduce EMI by: correct placement of current return pad, use of Bipolar electrocautery when possible, use short bursts of electrocautery (<5 sec), not waving the electrocautery while active above the patient, use of harmonic scalpel (ultrasonic). Place the current return pad as far as possible from the pulse generator. Electro-cautery should not be used within 15 cm of generator Rate-adaptive functions of Pacemakers should always be suspended for surgery. All patients who have ICDs disabled must have pacing/defibrillation pads in place and monitored continuously All pacer-dependent pacemaker patients who are having battery or leads modified must also have pacing pads placed. This also applies to any patient who may lose the function of their device intra-operatively and is dependent on that device. Pacing/Defibrillator pads should be placed so that potential current DOES NOT pass through the device. Example: For L side neck surgery pad should be placed on right opposite shoulder and NOT on lower extremity. Be vigilant regarding pad positioning by OR staff. Pads should be placed in an anterior/posterior position with anterior pad more than 8 cm away from generator For non-pacer dependent patients, NO SPECIAL CHANGES ARE NEEDED. Simply proceed with the procedure Magnet use to disable the tachyarrhythmia therapy (defibrillator) function of a device is acceptable in emergent/urgent situations or upon recommendation of a cardiologist/electrophysiologist Turn on pacing detection on ECG monitor Monitor cardiac rhythm/peripheral pulse with plethysmography or arterial wave form External Defibrillator equipment should be available in the OR 																		
<p style="text-align: center;">Postoperative Key Points</p> <ol style="list-style-type: none"> If a device needs to be altered for the patient to undergo surgery, arrangements must be made to revert the device to its original pre-procedure programming immediately after the procedure in the OR, PACU, or ICU. Have the device interrogated by appropriate personnel post-operatively Some rate enhancements can be re-initiated and optimum heart rate and pacing parameters determined ICD patients must be monitored until the antitachycardia therapy is restored 	<p style="text-align: center;">Contacts</p> <table border="1"> <thead> <tr> <th>Device Company</th> <th>Phone number</th> <th>Wand/Programmer Location:</th> </tr> </thead> <tbody> <tr> <td>Boston Scientific</td> <td>800-227-3422</td> <td>ART – Echo cart in OR equipment room Main – Echo lab (6th floor)</td> </tr> <tr> <td>Medtronic</td> <td>800-723-4636</td> <td>ART – Echo cart in OR equipment room Main – Echo lab (6th floor)</td> </tr> <tr> <td>St. Jude</td> <td>800-722-3774</td> <td>ART – Echo cart in OR equipment room Main – Echo lab (6th floor)</td> </tr> <tr> <td>Sorin</td> <td>877-663-7674</td> <td>ART – Echo cart in OR equipment room or 3rd floor EP lab Main – none</td> </tr> <tr> <td>Biotronik</td> <td>800-284-6689</td> <td>ART – Echo cart in OR equipment room Main – none</td> </tr> </tbody> </table> <p>Call the respective company and they can tell you all about the device and give you the on-call device rep for MUSC. Device Nurses Practitioners at MUSC: 1. Tammy Gottshalk 1-3162 2. Pete Bearden 1-2702 Search patient notes by Nurse Practitioner last name to find device interrogation report.</p>	Device Company	Phone number	Wand/Programmer Location:	Boston Scientific	800-227-3422	ART – Echo cart in OR equipment room Main – Echo lab (6 th floor)	Medtronic	800-723-4636	ART – Echo cart in OR equipment room Main – Echo lab (6 th floor)	St. Jude	800-722-3774	ART – Echo cart in OR equipment room Main – Echo lab (6 th floor)	Sorin	877-663-7674	ART – Echo cart in OR equipment room or 3 rd floor EP lab Main – none	Biotronik	800-284-6689	ART – Echo cart in OR equipment room Main – none
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PACEMAKER QI PROJECT CONTINUED . . .



LEWIS BLACKMAN ACT

It is critical we are all familiar with the Lewis Blackman Hospital Patient Safety Act. Dr. John Schaefer holds the Lewis Blackman endowed chair.



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November 26, 2014

MUSC Medical Staff and Residents:

About the Lewis Blackman Act

Lewis Blackman was a 15-year-old who underwent elective surgery at MUSC in November 2000. Unfortunately, due to a delay in contacting the attending physician, Lewis died. As a result, the South Carolina General Assembly enacted the "[Lewis Blackman Hospital Patient Safety Act](#)" in 2005. The law requires the following elements:

- All hospital clinical staff and trainees wear badges that identify their role on the team.
- Patients are informed prior to or at the time of admission about those involved in their care, including the role that medical students, interns, and residents play in their care.
- In particular, patients are informed of who the attending physician is responsible for their care.
- When asked for by patients, attending physicians must be available to patients to address any concerns and/or answer questions.

What this means at MUSC

As an academic medical center in South Carolina, there are many layers of providers involved in patient care. Every year, the principles of this Act are covered in resident orientation and there are three policies in the MUSC Policy Manual which specifically address how this Act applies to care at MUSC:

[C-074, Resident Supervision](#), specifically states that "*Attending physicians must always be available and willing to speak with patients when hospitalized patients wish to contact their attending physicians about their medical care in accordance to the SC Blackman Patient Safety Act.*"

The second is [C-109, Chain of Command and Physician Notification](#), which states the following:

"In the event a patient or family asks to speak to an attending physician, the following steps must occur, in accordance with S.C. state law "Lewis Blackman Hospital Patient Safety Act". Failure to follow this state law may be considered "reckless behavior" in terms of Just Culture and may result in disciplinary action up to and including termination.

1. *If the patient/family member asks a non licensed - non clinical MUHA employee to call the attending, the MUHA employee relays that request to the patient's nurse or other licensed clinician (MD, respiratory therapist, pharmacist, etc.)*
2. *MUHA licensed clinicians consult with the patient/family as soon as possible (within 20 minutes) and ask if they can resolve the problem. If the issue can not be resolved and/or the family still wishes to speak to the attending, the attending should be immediately paged via Simon Paging. The text page to the attending should include that the family wishes to speak to him/her. The MUHA employee should also document in the medical record that this call was placed."*

The third policy is [C-124, Paging, Availability and Response Time](#), which lays out the standardization of urgent page requests. These guidelines should be used to assure timely response of attending physicians when requested.

Sincerely,

Bruce M. Elliott, MD
Interim Vice President for Medical Affairs

Daniel A. Handel, MD
Chief Medical Officer, Medical Center

"An equal opportunity employer, promoting workplace diversity"

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HISTORY OF ANESTHESIOLOGY AND MEDICINE

This month we have reproduced the 1983 British Journal of Anesthesia article by Dr. A Brain describing the Laryngeal Mask Airway. His summary stated;

A new type of airway is described, which may be used as an alternative to either the endotracheal tube or the face-mask with either spontaneous or positive pressure ventilation. The results of a pilot study involving 23 patients are presented and the possible merits and disadvantages of the device are discussed, bearing in mind that the study is of a preliminary nature.

Br. J. Anaesth. (1983), 55, 801

THE LARYNGEAL MASK—A NEW CONCEPT IN AIRWAY MANAGEMENT

A. I. J. BRAIN

SUMMARY

A new type of airway is described, which may be used as an alternative to either the endotracheal tube or the face-mask with either spontaneous or positive pressure ventilation. The results of a pilot study involving 23 patients are presented and the possible merits and disadvantages of the device are discussed, bearing in mind that the study is of a preliminary nature.

Viewed mechanically, tracheal intubation is a procedure in which two tubes, one man-made and the other anatomical, are connected together by inserting one into the other, a cuff being inflated on the inner tube to effect a gas-tight seal. In engineering terms, this solution to the problem of forming a gas-tight junction between two tubes is rather unsatisfactory, since it necessarily involves a degree of constriction at the point of junction unless the outer tube is itself expanded to compensate. Ideally, it is desirable that both tubes are of the same internal diameter at their point of junction, since this has clear advantages in terms of gas flow. This involves connecting them end to end, since the option of expanding the anatomical tube is not practicable.

An examination of postmortem specimens of the adult male and female larynx was made to assess how such a joint might be achieved. It was noted that an airtight seal could be effected against the perimeter of the larynx posteriorly by an elliptical cuff inflated in the hypopharynx. This observation led to the concept of the Laryngeal Mask.

MATERIALS AND METHODS

A prototype was constructed (fig. 1) by forming a shallow mask with an inflatable rubber cuff, joined to a tube communicating with the lumen of the mask at right angles. The rubber cuff of a Goldman paediatric dental mask was stretched onto the diagonally-cut endotracheal end of a Portex 10-mm clear plastic tube and fixed in position using acrylic glue. The resulting apparatus resembles a spoon. A means of inflating the elliptical cuff was provided by re-routing the pilot tube used to inflate the endotracheal cuff. The pilot tube was provided with a

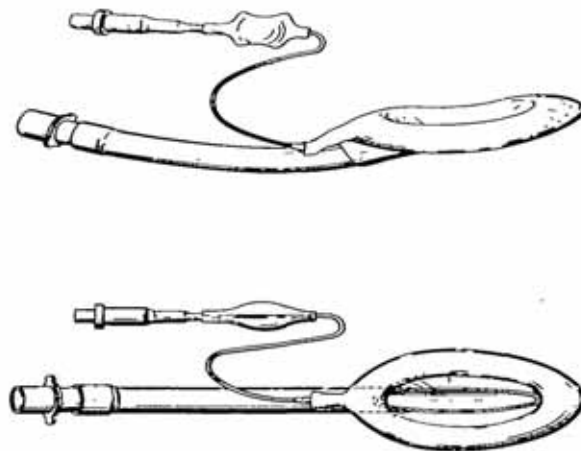


FIG. 1. Prototype of the laryngeal mask.

non-return valve.

Further reference to anatomical specimens served to confirm that the device could be inserted easily into the hypopharynx via the mouth, provided that it was inserted facing backwards and then rotated through 180 degrees as it was passed downwards into position behind the larynx (fig. 2).

Twenty-three patients who gave informed consent were studied. Sixteen were female patients undergoing laparoscopic investigation or sterilization, or both. These were studied first to assess the feasibility of positive pressure ventilation using the laryngeal mask. Premedication was with either

A. I. J. BRAIN, F.F.A.R.C.S.I. Anaesthetics Unit, The London Hospital, Whitechapel, London E1 1BB.

HISTORY OF ANESTHESIOLOGY AND MEDICINE CONTINUED . . .

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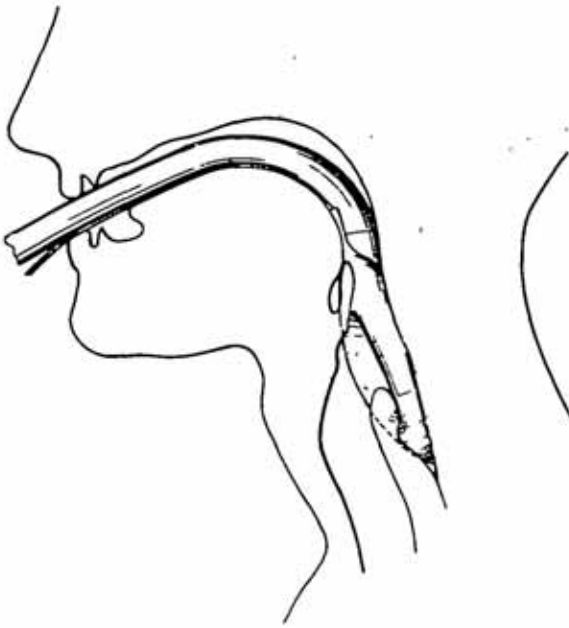


FIG. 2. The laryngeal mask in position.

lorazepam or papaveretum and hyoscine. Anaesthesia was induced with thiopentone, and alcuronium 0.2 mg kg^{-1} was used to provide neuromuscular blockade. This relatively small dose was chosen because it was not considered likely that relaxation was essential to insertion of the device. During the procedure a form was completed which gave the following information:

- (1) Ease of insertion, graded as: easy/difficult/impossible.
- (2) Time taken to insert device: measured from moment mouth was opened to moment when mask was in position (excluding time taken to inflate cuff).
- (3) Whether or not a laryngoscope was used.
- (4) Whether leaks were detected at 2.0 kPa inflation pressure using a stethoscope held to the side of the neck overlying the larynx. The pressure was measured with reference to the Manley ventilator anaeroid pressure gauge.
- (5) Total air in cuff (ml).
- (6) Greatest peak airway pressure on IPPV (kPa).
- (7) Inspired and expired minute volumes, the latter using Wright's mechanical respirometer.

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- (8) Action taken to decrease any leak developing.
- (9) Whether blind suction, using a soft catheter to effect pharyngeal toilet after reversal of neuromuscular blockade, was associated with problems attributable to the presence of the laryngeal mask.
- (10) Whether removal of the mask was easy, difficult, required a laryngoscope or was associated with coughing, retching, vomiting, or laryngospasm.
- (11) Whether removal of the mask was preceded by any of the above.

Patients were questioned on recovering consciousness and again on the following day, concerning the development of sore throat, difficulty in swallowing or difficulty in phonation, or any other symptoms that might be attributable to use of the laryngeal mask.

A further six patients were studied to assess the performance of the laryngeal mask in patients breathing spontaneously. The mask was also used in one dental patient to assess its value in this situation.

RESULTS

In all 16 patients undergoing laparoscopy, ventilation of the lungs was achieved successfully using one of the prototype laryngeal masks (which varied slightly from one another in size and shape), with a Manley Blease ventilator. Adequacy of ventilation was measured by comparing expired with inspired minute volumes and by auscultation of the neck laterally at a point overlying the larynx.

In all patients the device was inserted without the aid of a laryngoscope, by placing the head and neck in the usual intubating position and inserting the deflated mask with its lumen facing backwards to facilitate negotiation of the angle behind the tongue. The dorsum of the mask was liberally coated with "KY" jelly to facilitate this manoeuvre. No analgesic throat spray was used. Downward descent of the mask could be discerned by observation of the front of the neck, where a slight but unmistakable bulging of the tissues overlying the larynx served to indicate that the mask was in position. The mask was designed in such a way that when its distal tip reached the triangular base of the hypopharynx, further downward progress could not occur unless excessive force were used. A definite end-point was felt at this level, which also coincided with correct placement of the mask against the laryngeal inlet. In practice, it was found that by observing the front of the neck and feeling for resistance to further down-

HISTORY OF ANESTHESIOLOGY AND MEDICINE CONTINUED . . .

LARYNGEAL MASK

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ward progress, the mask could be reliably positioned.

The results, as tabulated on the questionnaire, were as follows: Insertion was graded as easy in all patients, although experience led to more frequent correct placement at the first attempt. The average time taken to insert the device was 7.3 s (range 2–15 s). Leaks were present initially in six patients, but were successfully abolished in all (table I). Of the leaks which developed, all occurred after insertion but before surgery was started and all were overcome with little difficulty. No case of obstruction occurred, either partial or complete. The average volume of air required to inflate the cuff sufficiently to form a gas-tight seal at 2.0 kPa was 17.5 ml (range 7–25 ml).

During IPPV the average peak airway pressure was 1.8 kPa (range 1.5–2.3 kPa). The readings obtained from the Wright respirometer were all greater than the inspiratory minute volume as measured by rotameter readings, presumably reflecting the known inertial characteristics of this respirometer, which in fact gave readings which were on average 14.68% greater than the measured inspired minute volumes (range 10.6–25%).

Following reversal of neuromuscular blockade, suction was performed and judged to be easy in all patients and no laryngospasm was provoked by pharyngeal toilet. The mask was removed after complete deflation of the cuff using a 20-ml syringe, and was judged easy in all patients. There were no instances of coughing, laryngospasm, retching, vomiting or apnoea before, during or after removal of the mask. On all occasions, spontaneous respiration, which had been established before removal was attempted, continued without change in respiratory pattern. Following operation, three patients complained of sore throat, all graded as mild (< 20%). No other symptoms were reported.

Of the six patients who were allowed to breathe

spontaneously, three received suxamethonium electively to facilitate insertion and, by way of comparison, three received no neuromuscular blocking drug. All six patients maintained an unobstructed airway throughout the operation. Those patients in whom the device was inserted without the help of neuromuscular blockade required a level of anaesthesia sufficient to abolish the gag reflex and relax the jaw before it became possible to insert the mask. Once this level was reached, insertion was not judged to be more difficult than under conditions of neuromuscular blockade.

One patient undergoing a difficult dental extraction was studied. The fact that the mask took up most of the space in the hypopharynx reduced the volume of packing required and it was found that the mask afforded more protection to the larynx from fragments of teeth, blood and debris than an endotracheal tube. Insertion and removal of the mask were easy and without incident, and a good airway was maintained throughout the procedure.

DISCUSSION

Although endotracheal intubation has a long history as one of the most widely accepted techniques in anaesthetic practice (Keys, 1945; Armstrong Davison, 1965) it is not without complications, most of which arise from the need to visualize and penetrate the laryngeal opening (Kambic and Radsel, 1978). The laryngeal mask was designed primarily as a means of offering some of the advantages of endotracheal intubation while avoiding this fundamental disadvantage, since the vocal cords need be neither visualized nor forced apart.

It should be stated that this study was of a very preliminary nature and that the number of patients studied was too small for firm conclusions to be drawn. Nonetheless, ease and simplicity of use and the fact that the device was well tolerated without serious side-effects, were positive features. In two patients the anatomy was such as to suggest that endotracheal intubation might have presented at least moderate difficulty. Neither presented difficulty with regard to insertion of the laryngeal mask. In carrying out pharyngeal toilet, it was noted that the catheter tip could not irritate the larynx since the mask effectively shielded it. It was also apparent that the secretions were easily accessible since the bulk of the mask when inflated caused secretions to pool above it rather than behind it. In the one dental patient studied, the shielding action of the mask was appreciated since it prevented blood or tooth frag-

TABLE I. Instances in which leaks developed at the laryngeal mask – larynx interface

No. of patients	Action required to eliminate leak
1	Change mask position
1	Reduce cuff volume
1	Increase cuff volume
1	Change to wider mask prototype
1	Change to larger mask prototype
1	Leak stopped spontaneously

HISTORY OF ANESTHESIOLOGY AND MEDICINE CONTINUED . . .

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FIG. 3. The site and extent of this malignant growth made visualization of the larynx difficult. The airway could not be adequately maintained with a face-mask in spite of insertion of a Guedel airway. A laryngeal mask, shown in position, was inserted without difficulty, requiring neither laryngoscope nor neuromuscular blocking agent.

ments dropping into inaccessible positions. Since no neuromuscular blocker was used, time spent performing a venepuncture was saved and the patient spared the side-effects of suxamethonium.

The disadvantage which became of importance during the study was the initial failure to obtain a good seal in six of the patients when an inflation pressure of 2 kPa was applied to the airway, although the problem was overcome without difficulty in all of these (table I). Clearly, improvements can be made in the construction of the prototypes which need to be available in a range of sizes. While this

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study is too small for firm conclusions to be drawn, the concept would appear sufficiently promising to justify more extensive trials, which are under way. A further 108 patients have been studied to date and the results have so far confirmed the safety and efficacy of the device when used as an alternative to the face-mask in the spontaneously breathing patient. Once experience has been gained, difficulty in insertion can be expected in less than 1% of patients. In only one patient has it been found that apparently correct insertion failed to provide an adequate airway. However, sufficient depth of anaesthesia is essential to successful insertion, unless a neuromuscular blocking agent is used. It is sometimes necessary, in patients with a large epiglottis, to pull this structure forward, using a laryngoscope in the usual way. This problem has not occurred in females and it is felt likely that it could be eliminated by improved design of the device, which is still in the form of a relatively crude prototype.

The laryngeal mask would appear to be of particular value where difficulty is experienced in maintaining the airway, or when operating on the face or eyes, where it offers a less invasive alternative to tracheal intubation. It may be of similar value where the patient is a professional singer and it has been found useful in cases of difficult intubation (fig. 3).

ACKNOWLEDGEMENTS

Thanks are due to Portex Ltd for agreeing to supply prototypes; to Dr Edward Major for advice in setting up the study; to Dr Peter Sebel for his help in preparing the manuscript and to Miss Mandy Miller for typing it.

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LE MASQUE LARYNGE—UN NOUVEAU CONCEPT DANS L'ATTITUDE VIS-A-VIS DES VOIES AERIENNES

RESUME

Un nouveau type de matériel permettant d'assurer la liberté des voies aériennes est décrit, que l'on peut utiliser à la place soit d'une sonde d'intubation, soit d'un masque facial, en ventilation spontanée ou en pression positive. Les résultats d'une étude pilote impliquant 23 patients sont présentés et les mérites éventuels et désavantages de ce dispositif sont discutés, en gardant à l'esprit que cette étude est de nature préliminaire.

[Click Here](#) to View Full Article.

MEDICAL UNIVERSITY HOSPITAL GROWS BEYOND LOWCOUNTRY, ESTABLISHES PRESENCE IN RURAL AREAS OF SOUTH CAROLINA

BY: LAUREN SAUSSER, POST & COURIER

Medical University Hospital used to be located exclusively on the Charleston peninsula. Now, it's everywhere.

The hospital has forged relationships with a number of community hospitals across the state - in Georgetown and Beaufort, and more recently, in Hartsville and Camden. The Board of Trustees discussed a potential affiliation with an Orangeburg hospital on Thursday. These new partnerships will grow MUSC's patient base, its revenue potential and also extend its expertise to residents in underserved pockets of South Carolina where primary and specialty care can be harder to come by.

"We need to not just sit in Charleston. We need to be spreading out," said Dr. Pat Cawley, Medical University Hospital's chief executive officer. "That's no different than any health system in the entire United States. Everyone is doing the same thing."

Hospital mergers, acquisitions and affiliations across the country have become commonplace - especially as smaller hospitals struggle to comply with new quality standards and Affordable Care Act mandates and as larger systems compete for market share.

MUSC can't technically buy another hospital because it's a state entity. In November, the hospital announced it would team up with Capella Healthcare, a for-profit company, to establish the Midlands HealthONE Network. That network will take over operations at Carolina Pines Regional Medical Center in Hartsville and Kershaw County Medical Center in Camden early next year.

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Medical University Hospital is extending its footprint to other hospitals around the state through partnerships.

[Click Here for Full Article](#)



HOLIDAY DOOR DECORATING CONTEST

This is the 3rd year the department held the holiday door decorating contest. Participation has grown each year, as has the competition. This year we had 10 participants and awarded a 1st place winner, 2nd place winner, and an honorable mention. It was something really fun for the department to do to show our holiday spirit! We were also holding resident interviews during this time, so it was great for the applicants to see and enjoy all the festivities. Our department is spread across campus from Rutledge Tower, Storm Eye Institute, The Children’s Hospital, and Ashley River Tower. A panel of three judges went to see all the participating doors in all of these locations and chose the winners. We look forward to even greater participants next year!



**1st Place Winner, ART
Anesthesia Techs**



**2nd Place Winner,
Anesthesia Residents**



**Honorable Mention,
Anesthesia Research**



DOOR DECORATING CONTEST CONTINUED . . .



CONGRATULATIONS LESTER KITTEN, CRNA FOR RECEIVING THE CLINICAL EXCELLENCE AWARD AT ART



Division of Anesthesia for Nurses
Department of Health Professions
151-B Rutledge Annex, MHC 362
Charleston, SC 29425-8420
Phone (843) 792-2787
Fax (843) 792-0884

Dear Mr. Kinen,

Clinical instructors perform a crucial role in the ability of nurse anesthesia programs to educate excellent CRNA practitioners. They not only teach students the art and science of nurse anesthesia practice but also serve as role models, mentors, and supporters.

In recognition for your distinction in all of these roles, the MUSC Anesthesia for Nurses Class of 2014 selected you to receive the Award for Excellence in Clinical Instruction at the Medical University of South Carolina: Ashley River Tower.

On behalf of the program faculty, I would like to thank you for the considerable part you play in the quality of our graduates. Please join us and be recognized at the Class of 2014 Graduation Ceremony at 3pm on December 5th, 2014. Following the ceremony, a reception will be held honoring the graduates. The graduation ceremony will take place at St Luke's Chapel on the MUSC campus at the corner of Bee Street and Ashley Avenue. The reception will be held in the Atrium at the College of Health Professions, 151A Rutledge Avenue.

RSVP by December 2nd, 2014 to mud@musc.edu

Respectfully,

Angela Mund CRNA DNP
Program Director
Anesthesia for Nurses



FAMILIES HELPING FAMILIES

For the past several years, we have participated in the Families Helping Families Program, which provides gifts, clothing, food, and necessary items to families in need throughout the lowcountry. This year we sponsored a large 11 member family in need and raised a total of \$1,135.00 to buy gifts. We appreciate everyone's efforts and donations for this great cause!



NEW BABY IN THE DEPARTMENT



Congratulations Joel Barton, MD

Malachi James Barton

Born December 10, 2014 at 6:31pm

8 lbs, 4 oz, 21.25 inches

DEPARTMENT STAFF CHRISTMAS BREAKFAST AT HOMINY GRILL



**DEPARTMENT HOLIDAY PARTY, CAROLINA YACHT CLUB,
DECEMBER 12, 2014**



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TRAVEL + LEISURE DUBS CHARLESTON NO. 3 CITY FOR MOST ATTRACTIVE LOCALS

BY: ABIGAIL DARLINGTON, POST & COURIER

Charleston locals have grown more beautiful over the past year, according to Travel + Leisure magazine readers.

The Lowcountry landed at No. 3 this year in [the publication's annual ranking of cities with the most attractive people](#) behind Miami and San Diego, California.

Last year, Charleston was voted No. 10 while San Francisco and Providence, R.I. took the top slots.

Travel + Leisure surveys its readers each year to rank top American cities for their public parks, shopping destinations, and attractive locals.

"In the attractive category, this year's survey results saw some shake-ups," said Katrina Brown Hunt, who reported the findings of the survey last month. "Some of the hipster winners from last year have faded in the eyes of the T+L community, which favored cities with a tendency toward sunshine, smiling residents, and serious style."

It seems Charleston fit the bill for those preferences pretty well. But, the Holy City's reputation for hospitality, politeness and historic architecture may have influenced readers' preferences as well, according to the Travel + Leisure article.

"These South Carolina locals consistently land among the survey's top 10 for head-turners," Hunt said. "One secret of their success, no doubt, is that pretty-is-as-pretty-does hospitality: Charleston also ranked well for being polite. Another factor, though, may be that with age comes beauty. The city scored highly for its charming old architecture and lovely antiques."



[Click Here for Full Article](#)

GRAND ROUNDS FOR THE MONTH OF JANUARY

**Subspecialty Team Meetings and All-Resident Meeting
January 6, 2015**



**“Spinal Cord Stimulators”
January 13, 2015
Ryan Nobles, MD
Assistant Professor
Medical University of South Carolina**

**“Stress Response to Pain”
January 20, 2015
Arthur Smith, MD
Associate Professor
Medical University of South Carolina**



**“Anesthesia Medically Challenging Case Conference”
January 27, 2015
GJ Guldan and Ryan Gunselman, MDs
Assistant Professors
Medical University of South Carolina**



DEPARTMENT OF ANESTHESIA
AND PERIOPERATIVE
MEDICINE

Medical University of South Carolina
167 Ashley Avenue

Email: kinmic@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

8/Jan—Anesthesia for GI Surgery, Dr. Bridges
22/Jan—GI Morbidity (liver, pancreas),
Dr. Stoll

CA1 Lecture Series

7/Jan—Maternal and Fetal Physiology and
Anesthesia & Obstetric Anesthesia, Dr. Hebbar
14/Jan—Anesthesia for Patients with Endo-
crine Disease and Neuromuscular Disease,
Dr. S. Whitener
21/Jan—Hepatic Physiology & Anesthesia and
Anesthesia for Patients with Liver Disease,
Dr. Hebbar
28/Jan—Anesthesia Machine and Technology,
Dr. Bridges

CA 2/3 Lecture Series

5/Jan—Chronic Pain Management (Barash Ch.
58), Dr. Smith
12/Jan—Management of Patients with Psychi-
atric/Substance Abuse (Stoelting Ch. 22),
Dr. Skorke
19/Jan—Sympathetic Nerve Blocks (Barash
Ch, 26), Dr. Nobles
26/Jan—Financial Planning, Carolina Capital
Management

Grand Rounds

6/Jan—Subspecialty Team Meetings and All-
Resident Meeting
13/Jan—Spinal Cord Stimulators, Dr. Nobles
20/Jan—Stress Response to Pain, Dr. Smith
27/Jan—Anesthesia Medically Challenging
Case Conference, Drs. Guldán/Gunselman



I HUNG THE MOON

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 Crisp. Thanks so much!!

Molly Sekar, Anesthesia Tech – Staying late to help out second shift.
Great Job!

Ashley Haselden, Anesthesia Techs— Willing to stay later and cover extra
shift! Great Teamplayer!

Larry Banks, Anesthesia Tech—Showing up at MRI at the right time and
stepping in to help during a difficult time! Thank you!



**Resident Graduation: June 19, 2015, at Founders
Hall**

January 2015

Standard of the Month

Use kind words and actions to
show empathy when others are
distressed.



We Would Love to Hear From You!

If you have ideas or would like to contribute
to *Sleepy Times*, the deadline for the February edition will be
January 19, 2015.