



SLEEPY TIMES



VOLUME 9, ISSUE 3 MARCH 2015

Special Points of Interest

- **CT Fellowship Director**
- **Black History Month Series**
- **History of Anesthesiology and Medicine**

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MESSAGE FROM THE CHAIRMAN:

-SCOTT T. REEVES, MD, MBA

What Does Fly Fishing Have To Do With Anesthesiology?

As many of you know, I enjoy fly fishing. I took up the sport about seven years ago and find it extremely relaxing. Whether I'm fishing the flats within Charleston or a trout stream in Montana, it is just a wonderful way to relax and think about life. I still remember my daughter, Carolyn, calling several years ago saying that she was taking a leisure skill course in fly fishing at Clemson. She first told my wife, Cathy (who I am sure rolled her eyes). As the story goes, Carolyn said, "Dad never goes anywhere bad to fly fish; so, if I learn to fly fish, he will take me to all these great places as well."



Recently, one of my fishing buddies, Chas Boinske, wrote about the similarities between fly fishing and investing. That got me thinking about the qualities that make someone both a good fly fisherman as well as successful anesthesia provider. The more I thought about it, the more the two disciplines seem to have in common.

I believe there are a few key takeaways in this analogy:

1. Successful fishermen have diverse tactics. One of the fun things about fishing is that you get to collect a tackle box full of various flies, leaders and other equipment. Anesthesiology is no different. We have a host of drugs that we can choose from for any particular activity. Just as occurs when on the water, conditions affect which fly one chooses such as: weather, temperature, time of year, time of day and current. In our domain, conditions such as, age, weight, comorbidities, etc., come into play when we select a type of anesthetic to administer.
2. Great anglers rely on science to make informed decisions. Just like in the operating room, fishing has become very technical with fluorocarbon leaders, GPS devices to identify secret locations, etc. In our operating rooms, we have high fidelity monitors, anesthesia machines, cardiopulmonary bypass machines, etc. to help us take care of our patients.
3. Successful fishermen are patient. To successful fishermen, having a fly caught in a tree or a tangled line is only a temporary impediment to getting your line back on the water. You cannot let a short-term tangle distract you from your long-term objective of catching fish. In the operating room, there are lots of distractions, and it is important to be able to wade through the significant ones and eliminate the insignificant ones.

So, while this opening statement might be a stretch, I do think there are a lot of commonalities between fly fishing and our profession. It is important to use a wide range of tactics, to be patient, to rely on our monitors and other devices to help us make informed decisions. By doing so, we will take better care of our patients and also potentially "catch a fish."

WHAT DOES FLY FISHING HAVE TO DO WITH ANESTHESIOLOGY? BY: DR. SCOTT T. REEVES



Carolyn and Scott Reeves, MD fly fishing the Davidson River in North Carolina

CT FELLOWSHIP PROGRAM DIRECTOR, ERIC NELSON, DO BY JAKE ABERNATHY, MD

Together, we have grown the MUSC Cardiothoracic Anesthesiology Fellowship into a nationally recognized training program with a lasting and strong reputation. Most importantly, since 2007 we have trained 13 (and almost 15) excellent cardiac anesthesiologists who are now out on their own helping patients and contributing their knowledge to the field.

It is time for new energy to take the MUSC CT Anesthesiology Fellowship to new heights. It gives me great pleasure to announce Dr. Eric Nelson as the new Cardiothoracic Anesthesiology Fellowship Program Director. Dr. Nelson came to MUSC as a Cardiothoracic Anesthesiology Fellow after completing his anesthesiology residency at Rush University Medical Center. Since joining MUSC in 2010, he has dedicated much of his time and energy towards the education of our fellows and residents. He has been the recipient of the Golden Apple Award and is a member of the prestigious Academy of Medical Educators. Eric, we look forward to working with you as we continue to build an outstanding fellowship program.



TEAM SKINNY DIP BRINGS ITS “A-GAME” TO SEWE

BY: MIKE HAYES, THE CATALYST

Team Skinny Dip brings its 'A-game' to SEWE

[Tweet](#)

By Mikie Hayes
Public Relations



Nurse Anesthetist Deb Feller throws a bumper as Doni competes in a Big Air competition in Cherokee, N.C. Big Air is the long jump for dogs. Doni sprints down the dock as Deb throws the bumper. The dog with the longest measured distance wins. As a result, Doni was invited to the World Championship. *photo by Precise Video Productions*

[Click Here to View Full Article](#)

BLACK HISTORY MONTH SERIES EXAMINES CULTURE, HISTORY, HEALTH

BY: JANE MA, THE CATALYST

Carter Woods, the founder of the Association for the Study of African–American Life and History, writes, “We should emphasize not Negro History, but the Negro in history. What we need is not a history of selected races or nations, but the history of the world void of national bias, race hate, and religious prejudice.” The point of studying African-American history is not to write a separate narrative, but to fit the African–American experience into a collective narrative that acknowledges the vital role that it has played throughout history.

To that end, in 1976, President Gerald Ford established Black History Month, stating that it is an opportunity to “honor the too–often neglected accomplishments of black Americans in every area of endeavor throughout our history.” Black History Month is being celebrated all over the nation, and MUSC is no exception, with events and lectures hosted on campus for students, faculty and staff throughout the month of February.

Many of the planned speeches will address resolving racial disparities in health care and health care education but are also meant to celebrate diversity, inclusion and the contributions and achievements of African–Americans in health care and all fields. With this subject high on the list of the institution’s priorities, conversations such as these are important to the MUSC community.

One of these sponsored events is a lunchtime lecture series titled “A Century of Black Life, Culture, History, and Health,” and will be held in the Basic Science Building every Wednesday in February with lunch being provided for the first 50 guests. The speakers include MUSC President David Cole, M.D., FACS, and Willette Burnham, Ph.D., co–chairperson of the Diversity and Inclusion Strategic Planning Committee.

BLACK HISTORY MONTH SERIES EXAMINES CULTURE, HISTORY, HEALTH CONTINUED . . .

BY: JANE MA, THE CATALYST

Another featured speaker, Ebony J. Hilton, M.D., assistant professor in the Division of Critical Care Medicine, spoke passionately on why these talks are important and her own personal experiences as an African-American health professional.



Hilton is a native of Little Africa, which she joked, is “a tiny place out in Spartanburg County — you’ve probably never heard of it.” She attended College of Charleston for her undergraduate studies and then MUSC for medical school and residency. She is board-certified in both anesthesiology and critical care medicine. She is also the first female African-American anesthesiologist to be hired by MUSC.

She recalls the journey that she had to make in order to reach her position: “I had plenty of support from home, even as the child of a single parent, in a small-town household. My mother always supported me even as she pushed me. Ever since I was 8 and told her I wanted to be a doctor, she started calling me Dr. Hilton, even writing it in my birthday cards every year. But I think that African-Americans, particularly in medicine, feel alone in a professional sense. The further along I got in my chosen career path, the more I looked around and noticed that there was no one else like me. There was a lot that I had to figure out on my own.”

It is this paucity of professional mentorship that motivates her in her work and influences the message she hopes to convey in her lunchtime talk. She said, “Whenever things got tough or the work felt overwhelming, and I thought that maybe I couldn’t do it...I dug deep, and what I found was a voice that said ‘well, why not me?’ And so I continued, and I felt that my purpose was to serve as an example, to let others know they are not alone.”

Hilton draws inspiration and strength from her heritage and cultural history: “Lineage is important,” she said, “and it absolutely motivates me to think about how far African-Americans have come and how much they’ve overcome. My mother was in third grade when schools integrated in South Carolina. That’s one generation removed from where I stand.”

Finally, she advocates approaching medicine with a perspective informed by both history and compassion.

She discussed the historical relationship between African-Americans and medicine and the continued distrust that perpetuates even to this day. She cited the Tuskegee experiment, a study that allowed syphilis to go untreated in several hundred African-American subjects, as an example of just how recent this history is. The study lasted 40 years and was not formally terminated until 1972, following a public scandal and outcry. She said that the relationship between African-Americans and medicine is still healing from history, and that this process can be helped along by understanding its history and blazing a trail. [Click Here for Full Article.](#)

The Office of Student Diversity and the Multicultural Student Advisory Board (MSAB) presents BLACK HISTORY MONTH 2015

“A Century of Black Life, Culture, History, and Health”

PRESENTERS

1080 HOSPITAL STRIKE OF 1969
 Civil rights workers on labor duty, and elsewhere, organized a strike of the hospital from March 22 to July 16, 1969. Workers, mostly Black women, often received treatment and pay when their organized and walked out of the Medical College Hospital (MCH) on Daingerly St. and Charleston County Hospital (CCH) on Calhoun St. Some picketers were arrested. The strike of S.C. helped to establish a better, and safer, medical environment.

BASIC SCIENCE BUILDING (B5B) ROOM 302 • NOON - 1 P.M.
 (Lunch will be provided for the first 50 guests)

02.04.15 Willette S. Burnham, PhD, Assistant Professor, Executive Director, Offices of Student Program and Diversity, Co-Chairperson for the Diversity and Inclusion Strategic Planning Committee for the MUSC Enterprise

02.11.15 Campus and Community Diversity Panel

02.18.15 David Cole, M.D., FACS, President of the Medical University of South Carolina

02.25.15 Vivian Bea, M.D., Resident, Department of Surgery
 Ebony J. Hilton, M.D., Assistant Professor, Anesthesia and Perioperative Medicine, Division of Critical Care Medicine

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

Over the next several months, we will be reproducing the bulk of his recollections. Enjoy...

How does one look back and recall events which occurred some forty years ago? What does forty years do to one's memory? What was the practice of medicine like only four decades ago? And anesthesia? Were we really beginning to emerge from the "Dark Ages" into an "Age of Enlightenment" in medicine? We were. Not only in medicine, but in electronics, communication, transportation, exploration of space and men walking on the moon— each playing a significant role in the advancement of medicine.

From the recessed of my mind I have attempted to recall events which occurred and sketches of the practice of anesthesia during the beginning days of my career in medicine and anesthesiology. My purpose is to acquaint the anesthesiologists of the 1900's and beyond with what practice was like in Charleston when I was a medical student and resident in the 1950's, a by-gone era. The evolution and transformation to "now" techniques and knowledge is nothing less than remarkable, some might say miraculous.

I have had the opportunity and good fortune to practice medicine as an anesthesiologist during what historians will call the most exciting era of progress ever known in the field of medicine. My hope is that this and future generations of anesthesiologists will meet the challenges of our specialty with knowledge, understanding, empathy and love for all who are entrusted in our care.

Laurie L. Brown, MD

Notes on Early Residency Training in Anesthesiology

On September 1, 1949, John Marion Brown, MD began his medical practice as the first anesthesiologist in Charleston. I, Laurie L. Brown, MD entered medical school at the Medical College of South Carolina also in September of 1949. It was my good fortune to meet Dr. John Brown in August of the following year and to become his student, his resident, a colleague, and to have found a friendship which has lasted many years.

It was after my freshman year in medical school while I was serving as a Naval Reservist and working at the Navy Yard here in Charleston that I met Dr. Brown. He was acting as a consultant to the Navy and was coming to give a lecture to the Navy physicians and other medical personnel. He was about one hour late for his lecture and began telling the reasons he was late. It wasn't because of traffic jams which are so common in Charleston today, but had to do with medicine. He had been called to go back to Roper Hospital, which was the teaching hospital for the Medical College, to see a patient who was in critical condition in an operating room. When he got there he found that the nitrous oxide and oxygen tanks had been interchanged on the anesthesia machine and that the patient had been asphyxiated with nitrous oxide. He was at the time investigating a drug called "aramine," and with his knowledge of anesthesia and resuscitation he was able to resuscitate the patient for a short time. Of course the patient died shortly thereafter. Having very little knowledge of medicine at the time, I was nevertheless fascinated by this event. After the lecture, I talked to Dr. Brown and asked if I might come to the hospital and look in with him sometime when I had some time. He replied that he would be delighted for me to do that and shortly thereafter I began going to the hospital and watching him, and "helping" him on Saturday mornings. A big bonus of working with Dr. Brown on Saturdays was the he would take me to the hospital cafeteria to eat the noon meal with him and they always had steak on Saturday, something which was not common among us medical students during that time. This was the house staff and physician staff dining room which served meals free to all of those on duty.

During this early time, I knew of more than a few deaths of patients who were undergoing relatively minor surgical procedures. I could not understand this and finally asked Dr. Brown if this was something that could be prevented and he assured me that every one of them could have been prevented. It was then that I determined that I would learn

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

as much about anesthesia as possible regardless of whether or not I ever desired anesthesia as a career. As time progressed, I was taken to the delivery room with Dr. Brown to show me how obstetrical anesthesia was carried out. Not too long after that I began working as an obstetrical student anesthetist. Dr. Arthur Rivers who was the "Dean" for Obstetrics and Gynecology vowed that he would never have "a damn medical student" giving anesthesia to any of his patients. It was only a few months later that Dr. Rives would have me called at night to anesthetize any of his patients if I were available. That was the beginning of John Brown's Obstetrical Anesthesia program for students. Just prior to the beginning my Junior year in medical school I had progressed in anesthesia to the point that I was rotating on call with the nurse anesthetists for indigent patients. The surgical anesthesia call was at "Old Roper" Hospital, the hospital which was for all "colored" (Negro, black) patient and all indigent white patients, including all who could not afford hospitalization at "New Roper," known as the "private pavilion."

Meanwhile, in July, 1950, Dr. Brown began his resident Training Program, the first resident being Emily McDuffie Ferrara, MD. She was an excellent resident and I must say gave me much help and encouragement when I was a student. The next year, 1951, the second resident, Faye Miller Barnhard, MD, began her training. All medical school graduates during that time served a one year internship. The anesthesiology residency was a two year program following the internship.

During the year that I was a "student surgical anesthetist," it was not uncommon for me to be called upon to anesthetize a private patient at "New Roper" or a difficult case which the surgical resident had. This was very fun, busy scary. In the meantime, the Student Obstetric Anesthetist program became firmly entrenched and has lasted until this day. Students, friends, and classmates, J. Ray Ivester and J. "Jack" B. Williams, became obstetrical anesthetists also. Much interest in anesthesia was generated among our classmates because of the program in obstetric anesthesia, my experience, and the interesting lectures which were given by Dr. Brown and the Pharmacologists. A course was also conducted in the laboratory in which medical students rotated as anesthetist, surgeon, and scrub nurse, in which dogs were anesthetized and anesthesia and surgical and sterile techniques were taught, as well as the pharmacological actions of anesthetic and preanesthetic agents. (Woe be unto any student whose dog died during anesthesia!)

During internship, there was little time for anesthesia, but I would occasionally manage a case if the opportunity arose. I do not believe that Dr. Brown asked me directly at any time to specialize in Anesthesiology, but on July 1, 1954, along with a classmate, J. Ray Ivester, I began my residency in anesthesiology. Does everyone remember the first case done as a resident? I do, and it has been indelibly in my mind. I had been assigned to work with Dr. Brown and Dr. Ivester had been assigned to work with Dr. John Doerr who had also arrived recently in Charleston. The first case which Dr. Brown had that morning was a hysterectomy to be done by Dr. Lawrence Hester who was head of the OB/GYN department at the Medical College. Dr. Brown said to me, "Laurie, I'll be at Kiawah tonight and will be a little late coming in tomorrow morning. You go ahead and start the case." (Dr. Brown had a home on Kiawah Island. He was a friend of Mr. Royall, a "lumber man" in Augusta who had bought Kiawah for approximately \$300,000 after logging timber for the government during WWII. Dr. Brown gave me access to his home often and it was wonderful to explore that remote island with its miles of beautiful beaches and the abundant wildlife which was present. The island was a regular wildlife paradise). I did start the case in the morning on a private patient at Roper Hospital and the final sutures were being placed when Dr. Brown came into the operating room. That was my introduction into the Anesthesiology Resident Training Program. During the years 1954-1956, Dr. J. Ray Ivester and I were the third and fourth residents of Dr. John Marion Brown in the program at the Medical College of South Carolina and Roper Hospital. Six months of my last year of training were served in the new Medical College Hospital.

I hope you enjoyed the first installment of Dr. Laurie Brown's Recollections. There will be more to follow in future editions of Sleepy Times.

STANDARD PROCEDURE IS BELOW OUR STANDARDS PROGRESS NOTES, MUSC.ORG/YIR2014



Above: Anesthesiologist Dr. William R. Hand manages the blood pressure of a free flap tissue transfer patient during surgery by titrating three or more medications, which improves recovery and tissue graft success.

New Anesthesia Protocol Improves Outcomes for Cancer Patients

Surgeons at the MUSC Medical Center perform more than 1,000 surgeries a year for patients with cancers of the head and neck region. Of those, approximately 120 are microvascular free flap tissue transfers. This procedure requires transplanting tissue from one part of the body (e.g., the arm, leg, or back) to the head or neck to reconstruct an area after a tumor has been excised. These complicated surgeries can require three or four surgeons and take 12 to 18 hours. Patients recovering from such complex surgery and anesthesia may spend several days in the ICU followed by weeks in the hospital.

That recovery time is now a day or more shorter at MUSC Medical Center since surgeons and anesthesiologists began using a new Enhanced Recovery After Surgery (ERAS) protocol for free flap tissue transfers. This perioperative care plan is different from the traditional plan in that it includes specific nutrition given right up to two hours before surgery, more sophisticated management of anesthesia and blood pressure during surgery (a major factor in the body's acceptance of the transplant), earlier intake of food and liquids after surgery, and earlier mobilization. As a result, patients are leaving the operating room healthier and better prepared to heal.

[William R. Hand, M.D.](#), Assistant Professor in the [Department of Anesthesiology and Perioperative Medicine](#), and colleagues implemented the ERAS protocol with head and neck oncology surgeons in 2012. "Almost immediately, the results were noticeable," he states. "The resident physicians were calling me saying they had never seen so many patients awake and asking for pain medications. Previously, these patients were on a ventilator—sedated—for the first day or two. Now, some come out of the OR not on the ventilator at all and others are on it for only a few hours or a day. They just have fewer physiologically significant complications."

In 2014, Hand completed a study of ERAS use for 94 free flap surgeries. He has shown a significant decrease in ICU length of stay, a 50% decrease in the need for ventilator support in the ICU, and a savings of more than \$7,000 per patient for the hospital.

NEW CHIEF RESIDENTS ELECTED FOR FY16

It is with great pleasure that I present our newly elected chief residents for the 2015/2016 academic year. Dr. Chase Black, Dr. Clinton Pillow, and Dr. Ben Kightlinger will be taking over these important positions in the coming months. Please take a moment to congratulate them on their new positions. I look forward to working with each of them and know they will do a fantastic job !

George J Guldan III MD



Dr. Chase Black



Dr. Clinton Pillow



Dr. Ben Kightlinger

CHARACTERISTICS AND INTRAOPERATIVE TREATMENTS ASSOCIATED WITH HEAD AND NECK FREE TISSUE TRANSFER COMPLICATIONS AND FAILURES

BY: WILL HAND, MD



Otolaryngol Head Neck Surg, 2014 Dec 30. pii: 0194599814564366. [Epub ahead of print]

Characteristics and Intraoperative Treatments Associated with Head and Neck Free Tissue Transfer Complications and Failures.

Hand WR¹, McSwain JR², McEvoy MD², Wolf B², Algendy AA², Parks MD², Murray JL², Reeves ST².

Author information

Abstract

OBJECTIVE: To investigate the association between perioperative patient characteristics and treatment modalities (eg, vasopressor use and volume of fluid administration) with complications and failure rates in patients undergoing head and neck free tissue transfer (FTT).

STUDY DESIGN: A retrospective review of medical records.

SETTING: Perioperative hospitalization for head and neck FTT at 1 tertiary care medical center between January 1, 2009, and October 31, 2011.

SUBJECTS AND METHODS: Consecutive patients (N = 235) who underwent head and neck FTT. Demographic, patient characteristic, and intraoperative data were extracted from medical records. Complication and failure rates within the first 30 days were collected. **RESULTS:** In a multivariate analysis controlling for age, sex, ethnicity, reason for receiving flap, and type and volume of fluid given, perioperative complication was significantly associated with surgical blood loss (P = .019; 95% confidence interval [CI], 1.01-1.16), while the rate of intraoperative fluid administration did not reach statistical significance (P = .06; 95% CI, 0.99-1.28). In a univariate analysis, FTT failure was significantly associated with reason for surgery (odds ratio, 5.40; P = .03; 95% CI, 1.69-17.3) and preoperative diagnosis of coronary artery disease (odds ratio, 3.60; P = .03; 95% CI, 1.16-11.2). Intraoperative vasopressor administration was not associated with either FTT complication or failure rate.

CONCLUSIONS: FTT complications were associated with surgical blood loss but not the use of vasoactive drugs. For patients undergoing FTT, judicious monitoring of blood loss may help stratify the risk of complication and failure.

© American Academy of Otolaryngology—Head and Neck Surgery Foundation 2014.

CONGRATULATIONS TO CARLEE CLARK, MD FOR BECOMING AN AMERICAN BOARD OF ANESTHESIOLOGY ORAL BOARD EXAMINER



GREAT JOB ARTHUR SMITH, MD!

“I was referred to the best possible place to treat my pain. The service I received was best I could have received. Would continue to go back for pain with Dr. Arthur Smith.”



TANZANIA AMBASSADOR VISITS CHARLESTON, SC

Ambassador Liberata Mulamula of the Embassy of the United Republic of Tanzania recently visited Charleston. Cathy and I had the pleasure of meeting with her at the MUSC Heart and Vascular Board meeting and fundraiser. Several years earlier I had an opportunity to meet her at the Tanzania White House in Dar Salam, Tanzania. It was good to get reacquainted. February was also a successful month in that the department was able to get the necessary affiliation agreement signatures completed which will enable us to resume our work at the Bugando Medical Center. The new agreement goes through January 2016.



THROWBACK THURSDAY WITH RESIDENT KASSANDRA GADLIN, MD

As many of you may have seen I wore a scrub dress last Thursday in honor of Throw Back Thursdays. The dress was surprisingly comfortable, airy, and cinched at the waist, so makes you look extra skinny. I invite anyone who would like to join me in Throw Back Thursdays by wearing a scrub dress on Thursdays from here on out. Only requirement is you must wear tights, because apparently we are not allowed to show any leg in the OR. I've heard a few concerns about wearing the dress and feeling "limited" in your activity. Well, I was in a neuro/spine room the day I wore the scrub dress and I can attest that the dress did not impede my range of motion, ability to turn the patient prone, or limit my capacity to administer excellent anesthesia in any way. Scrub dresses can be obtained in the laundry next to the Starbucks on the first floor. If you have difficulty getting one let me know and hopefully I can help. One thing I can guarantee is that if you wear a scrub dress Dr. Reeves will take a picture of you and you will probably be showcased in the Sleepy Times.

Best,

Kassandra Gadlin, MD



CGH WIPE IMPLEMENTATION FOR ADULT SURGICAL PATIENTS

CGH Wipe Implementation for Adult Surgical Patients

Beginning Tuesday, March 3rd



Exclusions

- Procedures above the level of the mandible (e.g. ophthalmology, facial incision, ears, airway, bronchoscopy, craniotomy, etc.) Note: Cases with incisions on the neck *are* included in the CHG wipe protocol (e.g. carotid endarterectomy, radical neck, etc.)
- Any procedure for which an incision is not possible or planned (e.g. cystoscopy, laser hemangiomas, etc.) Note: Cases where the possibility, even a remote possibility, of opening exist (e.g. vaginal hysterectomy) *are* included in the CHG wipe protocol
- Any procedure with pre-existing infection, exposed bowel or mucosa (e.g. I&D, open abdomen, etc.)
- Level 1 procedures. Note: Level 2 and above cases (e.g. urgent laparoscopic appendectomy, etc.) *are* included

ANESTHESIA TECH DINNER



NEW BABY IN THE DEPARTMENT



**Congratulations Shanta Jager,
Anesthesia Tech**

**For the birth of Taevin Aniya
Born February 2, 2015 at 1:29pm
7lbs 5oz, 21in long**



GRAND ROUNDS FOR THE MONTH OF MARCH

“Awareness Under Anesthesia”

March 3, 2015

Marc Hassid, MD

Assistant Professor

Medical University of South Carolina



“Pediatric Transfusion”

March 10, 2015

Chris Heine, MD

Assistant Professor

Medical University of South Carolina

“MUSC Health: The Future is Now”

March 17, 2015

John R. Feussner, MD, MPH

Professor

Medical University of South Carolina



“Anesthesia Medically Challenging Case Conference”

March 24, 2015

George Guldán, MD and Ryan Gunselman, MD

Assistant Professors

Medical University of South Carolina

“Delirium for the Clinical Anesthesiologist:

Incidence, Types, and Cost”

March 31, 2015

Paul S. Garcia, MD, PhD

Assistant Professor

Emory University





DEPARTMENT OF ANESTHESIA AND
PERIOPERATIVE MEDICINE

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CHECK OUT OUR WEBSITE AT:

[HTTP://WWW.MUSC.EDU/ANESTHESIA](http://www.musc.edu/anesthesia)

Future Events/Lectures

Intern Lecture Series

5/March—Hematologic Disorders, Dr. Finley

19/March—Fluids, Electrolytes, Acid/Base,
Dr. Walton

CA 1 Lecture Series

4/March—Anesthesia for Neurosurgery,
Dr. Whiteley

11/March—Pediatric Anesthesia, Dr. Hassid

25/March—Obstetric Anesthesia PBL,
Dr. Tobin

CA 2/3 Lecture Series

2/March—Perioperative Cardiac Workup for
Noncardiac Surgery, Moodle, Dr. Guldan

9/March—Office-Based Anesthesia (Barash
Ch. 33), Moodle, Dr. Tobin

16/March—Anesthetic Management of Kidney
Transplantation PBLD (Barash Ch. 54),
Moodle, Dr. Hand

23/March—Management of Patients with
Ischemia Heart Disease (Stoelting Ch. 1),
Moodle, Dr. G. Whitener

23/March—Mock Oral Exam Preparation
Lecture, Dr. Guidry

30/March—Waking up Wrong:
Experimental Models of Abnormal Cognitive
Trajectories after General Anesthesia,
Dr. Garcia (Emory)

Grand Rounds

3/March—Awareness under Anesthesia,
Dr. Hassid

10/March—Pediatric Transfusion, Dr. Heine

17/March—MUSC Health: The Future is
Now, Dr. Feussner (MUSC)

24/March—Anesthesia Medically Challenging
Case Conference, Drs. Guldan/Gunselman

31/March—Delirium for the Clinical
Anesthesiologist: Incidence, Types, and Cost,
Dr. Garcia (Emory)



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!!

Amanda Burkitt, RN— "Establishing exemplary, highly reliable IV access for a case with potential for massive blood loss. Great Job!"



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

**Department Holiday Party: December 4, 2015,
Carolina Yacht Club**

March 2015

Standard of the Month

Provide a welcoming
environment for all.



We Would Love to Hear From You!

If you have ideas or would like to contribute to *Sleepy Times*, the deadline for the March edition will be February 23, 2015.