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American Academy of Pediatrics

Section on Anesthesiology and Pain Medicine Newsletter

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Letter from the Chair

by Thomas Mancuso, MD, FAAP

I am both honored and humbled as I begin my term as chair of this Section. Having been a member since I completed my fellowship (let's just say quite a while ago) I've had the opportunity to observe many talented people guide us through numerous challenges and lead us to many accomplishments.

The Section remains a very important voice for children as regards anesthetic care, pain treatment, and sedation/analgesia. We have been quite active in these areas. Section member Joe Cravero has co-authored a statement on "Relief of Pain and Anxiety in Pediatric Patients in Emergency Medical Systems" that was published in *Pediatrics* November 2004 (see page 20 of the newsletter). Lynn Maxwell continues as a voting member on the AAP Committee on Drugs. Jay Deshpande has just finished the AAP statement on "Do-Not-Resuscitate Orders for Pediatric Patients Who Require Anesthesia and Surgery" (see page 13 of the newsletter). Charlie Coté is completing the involved and complex task of revising the AAP Statement on "Guidelines for Monitoring and Management of Pediatric Patients During and After Sedation for Diagnostic and Therapeutic Procedures." Zeev Kain is in the second year of his 3-year term on the Editorial Board for the journal *Pediatrics*. Our section maintains strong relationships with sections and committees involved in emergency, hospital and ICU care of children as well. There are many other section activities all directed toward improving the care children receive as regards anesthesia, pain treatment, and sedation/analgesia.

Looking to our future activities, there are many areas where our advocacy for children is needed. Although there is much to do, we have help. During my term as Section chair, I want to strengthen the ties between our section and the two other important professional groups dedicated to the anesthetic care of children — the Society for Pediatric Anesthesia and the ASA Committee on Pediatric Anesthesia. These groups can be much more influential working together toward common goals. With simply greater awareness of each other's activities, duplicate efforts can become combined efforts. I have been a member of the SPA since its inception and also have served on the ASA Committee on Pediatric Anesthesia. Members of these organizations have a common

interest in improving the perioperative care of children and each brings a slightly different perspective and focus to bear on this common interest. A review of the mission statements of the SPA, the ASA Committee, and the Section reveals how much we have in common. Political advocacy, education, and advancement of knowledge are mentioned by both the SPA and the Section. The SPA mission statement specifically states its support of the AAP and ASA. The mission statement of the ASA Committee on Pediatric Anesthesia expresses similar sentiments about furthering knowledge and education in the area of pediatric anesthesia. The statement also specifically mentions the importance of maintaining liaisons with the AAP and other organizations (such as the SPA) concerned with pediatric anesthesia. I have the good fortune to have as my colleague the president of the SPA, Frank McGowan, and have developed an excellent working relationship with the chair of the ASA Pediatric Anesthesia Committee, Randall Clark. An example of what can be accomplished when the three organizations work together is the letter we jointly wrote to JCAHO in response to a sentinel event on intra-operative awareness (see page 5 of the newsletter). The JCAHO document was not written with children specifically in mind and the recommendations contained also were not appropriate for pediatric anesthesia. I think the response and critique of the JCAHO document will carry more weight coming from all three organizations. Frank and I have been wondering if we should take on the problem of vanishing traditional IV catheters next.

The next several years should be times of great progress in improving the perioperative care of children. Our section will be, as in the past, an important part of that progress.

HIGHLIGHTS IN THIS ISSUE:

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Pediatric Sedation Issues Remain A Priority for the AAP Section

Pediatric sedation remains a hot topic with the American Academy of Pediatrics and other organizations involved with the provision of pediatric care. The Section on Anesthesiology and Pain Medicine (SOA)



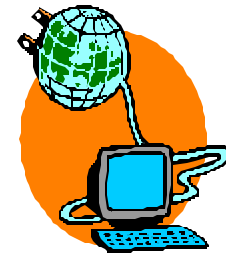
remains involved in this issue on many fronts. In addition to the current efforts to update the Sedation Guidelines (authored by SOA stalwart Charles Coté MD), this fall the American Academy of Pediatrics published a statement on *Pain Relief and Sedation in Emergency Medical Systems for Children* (Pediatrics 114 (5): 1348-1356). This statement was coauthored by the SOA executive committee and the Committee on Pediatric Emergency Medicine. After 2 years of editorial effort the statement provides a balanced approach to current thought on appropriate attention to, and treatment of, pain in children throughout the process of emergency care. In addition, the statement encourages the appropriate use of sedation for children in this setting and advocates for proper oversight and quality assurance.

In a related topic, the American College of Emergency Medicine (ACEP) convened a work group under a grant from Emergency Medical Systems for Children (EMSC) to develop the document: "*Clinical Policy: An evidence-based approach to pharmacologic agents used in pediatric sedation and analgesia in the emergency department*" (Ann Emerg Med 2004;44:342-377). This document used an extensive literature review to derive *graded* recommendations for the use of various sedatives and analgesics in the emergency department. Drugs included in this review were propofol, etomidate, methohexital, pentobarbital, fentanyl, midazolam and ketamine. Joseph Cravero MD from the SOA executive board took part in the process of developing the document. Ultimately this clinical policy received endorsement from the AAP and the ACEP Boards of Directors. Objections to its content were raised by the leadership of the AAP SOA and the ASA Board of Directors based on the fact that some of the papers that were used as "evidence" for the final recommendations were of questionable contextual relevance. Throughout the process of development for this document, the SOA executive committee debated the content and methodology, but felt that ongoing involvement by its representative resulted in a better final product than if they had opted out of the process.

Sedation is also a topic of discussion for the SOA Committee on Quality Assurance. The committee has thrown its support and considerable work hours behind the Pediatric Sedation Research Consortium (PSRC). The consortium is a group of 32 institutions from across the US and Canada dedicated to sharing information on pediatric sedation techniques for procedural sedation. At this time the PSRC has prospectively collected information on over 9,000 sedation encounters and is dedicated to improving the provision of sedation care for children through evaluation of procedural sedation outcomes. This group (along with Denver Children's Hospital Department of Anesthesiology) also sponsored the *1st International Conference on Pediatric Sedation* held in Denver Colorado in May 2004. Information on the PSRC and its activities are available at www.PediatricSedationRC.org. Individuals are encouraged to contact the AAP SOA executive committee if interested in more involvement in these projects.

Section Rosters Now Available on the Member Center

One of your benefits as a member of the Section on Anesthesiology and Pain Medicine is the ability to network with your peers in the field. To make it easier to find and contact your colleagues, the AAP has posted a roster of section members in the Section's area of the Member Center (formerly the Members Only Channel). The roster provides mailing address, phone number, fax number, and e-mail, when available. In addition, the AAP has posted the Section Executive Committee Roster.



To find the Section's Member Center home page, log on to the Member Center www.aap.org/moc and click on the Section's name on the left-hand side of the screen, under the heading "My Sections." When the home page downloads, you should see a link at the top of the page to the Section Membership Roster.

To ensure that your contact information is kept up-to-date (so your colleagues can find you), please take the time to visit the Membership Information Change Form (www.aap.org/moc/memberservices/updatesmemberinfoform.cfm). You need to be logged in to the Member Center to get to this link. If you prefer to contact us by phone or fax, you can do this by calling 888/227-1775 and providing one of our service representatives with your updated address information, or faxing your information to 847/228-7035.

*And the Winner is.....2004 Section on Anesthesiology and Pain Medicine
Program Winning Abstracts*



First Place

Actions of Local Anesthetics on Carageenan-Induced Hind-Paw Inflammation in Rats

II. Cytokines and MAP Kinases in Circulating Leukocytes, Dorsal Root Ganglia, and Spinal Dorsal Horn

(H. Beloeil, R. R. Ji, D. Zurakowski, C.B. Berde)

INTRODUCTION: Previous publications reported that local anesthetics (LAs) can reduce hyperalgesia, local edema, and systemic inflammation in a widely-used model of inflammatory pain, hind-paw injection of carageenan (C), in either rats or mice (1,2). These studies used different methods of LA administration and produced conflicting results regarding systemic, contralateral, local, and local conduction-block-related sites and mechanisms of LA action. We hypothesized that ipsilateral sciatic nerve blockade (SNB), contralateral SNB or systemic (subcutaneous in the upper back, SUB) injection using either bupivacaine (B) or tetrodotoxin (TTX) could diminish C-induced increases in lipopolysaccharide (LPS)-stimulated release of cytokines from circulating leukocytes, or could increase cytokines and MAP Kinases in ipsilateral or contralateral spinal dorsal horn (SDH) or dorsal root ganglia (DRG). Abstract I in this series examined hindpaw hyperalgesia and edema.

METHODS: Rats received C hind-paw injections after investigator-blinded injections of either active drugs [B or TTX, both with epinephrine] or saline in 3 sites: ipsilateral SNB, contralateral SNB, or SUB, using a paradigm that ensured continuous conduction blockade for > 15 hours. Tumor necrosis factor- α (TNF α), interleukin 1- β (IL1 β), p38 Mapk and phosphorylated-p38 Mapk (p-p38 Mapk) were measured by ELISA in the L4, L5 DRG, in the SDH, and in cultured whole blood leukocytes following stimulation with LPS. Data were analyzed using ANOVA and post-hoc Fisher PLSD tests or Kruskal-Wallis and post-hoc Mann-Whitney U tests as appropriate, with a $p < 0.01$ criterion for statistical significance.

RESULTS: B by all 3 routes (ipsilateral and contralateral SNB or SUB) significantly inhibited C-activated LPS-stimulated leukocyte production of TNF α and IL1 β , but it did not inhibit production of IL-10. TTX by all 3 routes had no effect on C-activated LPS-stimulated production of cytokines. C enhanced TNF α and IL1 β production in both bilateral DRGs and SDH, and p38 Mapk activation in bilateral DRGs. Neither B nor TTX had an effect on spinal cord or DRG cytokine and p38 Mapk activation after carrageenan injection.

DISCUSSION: B, but not TTX, inhibits cytokine production in leukocytes, whether by SNB or by systemic administration. B and other traditional LAs act on multiple cellular targets in addition to sodium channels, including K channels and Ca channels, while TTX shows high specificity for subtypes of sodium channels. C-induced bilateral activation of cytokines and Mapk in SDH and DRG may involve several mechanisms, including crossed peripheral innervation, bilateral dorsal horn termini of peripheral fibers, retrograde signaling from SDH to DRG, and systemic mechanisms (3). Bilateral SDH and DRG activation may be relevant to the occurrence of contralateral RSD/CRPS following unilateral injury. Actions of LAs and regional anesthesia on inflammation and hyperalgesia involve a complex interplay of local, systemic, and spinal mechanisms.



Second Place

Apoptosis gene products are detectable in urinary epithelial cells following congenital cardiac surgery (Sansan L. Lo)

INTRODUCTION: Apoptosis is a potential mechanism mediating cell death in ischemic renal injury. (1) Apoptosis gene products, which are upregulated following ischemia/reperfusion (2), are increased in shed urinary epithelial cells in adults with elevated creatinine following major surgery. (3) Bax, BAD, and caspase 8 are pro-apoptotic members of the signaling pathways which terminally activate caspase 3 to induce apoptosis, while Bcl2 is an anti-apoptotic member. (4,5) We obtained urine from children undergoing cardiac surgery to determine whether urinary apoptosis gene products (UAGP) are detectable and explored the relationship between elevated serum creatinine and UAGP abundance.

METHODS: The study was approved by the Columbia University IRB. Urine samples were collected after surgery and during the postoperative period. Total RNA was isolated from urine sediments to perform RT-PCR for detection of UAGP (Bax, BAD, caspase 3, caspase 8, and Bcl2) with G3DPH as the housekeeping gene. Data was analyzed by one way ANOVA or unpaired t test, and $p < 0.05$ was deemed significant.

RESULTS: We collected 45 urine samples from 23 patients. UAGP were detected in 19 patients. Data from the 10 children (ages 1 week-24 months, median=4 months) who had intraoperative and postoperative samples available are presented. 6/10 patients underwent circulatory arrest. Serum creatinine was normal in all patients both preoperatively and postoperatively. The most abundantly detected UAGP was caspase 3 (0.79 ± 0.28 arbitrary units, $p < 0.05$ compared to all other gene products). Circulatory arrest did not influence the relative abundance of UAGP. UAGP were most abundant during the intraoperative period, though there was no significant difference between intraoperative and postoperative UAGP in the 10 patients studied. In those patients who had multiple postoperative samples, there was no change in the relative abundance of UAGP during the first three postoperative days.

continued on page 4

And the Winner is.....(continued from page 3)

DISCUSSION: UAGP were detectable throughout the perioperative period in children undergoing cardiac surgery. None of our patients had abnormal serum creatinine. Therefore, the utility and the optimal timing for the detection of UAGP as early markers of renal dysfunction remain to be determined. Renal failure is one of the major morbidities following cardiac surgery, and the immature kidney may especially be at risk. (6) Early detection of renal failure allows greater opportunity to institute therapeutic measures. As caspase3 was the most abundant UAGP and is the most downstream in the pathways leading to apoptosis, future studies will examine its role as a noninvasive marker to assess perioperative renal function in the pediatric cardiac surgical patient.

1. Lieberthal W et al., Seminars in Nephrology 1998
2. Supavekin S et al., Kidney International 2003
3. Coleman DB et al., ASA Abs 415 2003
4. Adams JM et al., Science 1998
5. Thornberry NA et al., Science 1998
6. Chan K et al., Ann Thorac Surg 2003



Third Place

Comparison of a Needle Free Injection System for Local Anesthesia versus EMLA® for Intravenous Catheter Insertion in the Pediatric Patient (Nathalia Jimenez).

INTRODUCTION: Placement of intravenous (IV) catheters is a painful and stressful procedure in children. Pain free IV catheter placement can be achieved by the application of local anesthetic prior to cannulation. Topical local anesthetic preparations such as EMLA® have become the standard of care in most pediatric institutions. However its use is affected by the fact that effective analgesia requires application approximately 60 minutes before IV placement and that vasoconstriction can be present, leading to difficult IV placement in 36-40% of patients (1, 2). The J-Tip® is a new needle-less FDA approved injection system that can be used for delivery of local anesthetic. The lack of needle involvement, quick onset of action, and absence of vasoconstriction makes it an attractive option for local anesthetic delivery prior to IV placement in the pediatric population. This study compares the effectiveness of J-tip versus EMLA to provide adequate analgesia prior to IV cannulation. We report our interim results here (The study will be completed by January 2005).

METHODS: This study is conducted as a randomized controlled trial (RCT). Children between 7-18 years of age who required IV placement prior to elective surgery were eligible for the study. Subjects were randomized to receive either 2.5 grams of EMLA on both hands (dorsum) or 0.3 ml of 1% buffered lidocaine with J-Tip for local anesthetic prior to IV placement. Each subject was observed for the number of attempts for IV placement, pain during the application of local anesthetic and pain during IV cannulation using a 0 to 10 Visual analogue scale. Analysis includes calculation of descriptive statistics for pain ratings and number of attempts for cannulation, as well as Wilcoxon rank-sum tests comparing these outcomes between groups. A P value <0.05 was considered to be statistically significant.

RESULTS: Data from 93 children have been obtained, 56 children in the J-tip group and 37 children in the EMLA group (Difference in number of patients between groups is due to the use of simple randomization). Groups are similar in age and gender distribution 50% M/F, between ages 8 to 17 years old (median 13). In the EMLA group the mean time after application was 78.30 min (SD 33.57). There was a significant difference ($p=0.0001$) in pain ratings during IV cannulation between EMLA group (median: 3, IQR25-75: 1.5-5) and J-Tip group (median 0, IQR25-75: 0-2). There was no significant difference ($p=0.096$) in the pain ratings between groups at the time of application of the J-Tip (median: 0, IQR25-75: 0-0) compared to EMLA at the time of dressing removal (median: 0, IQR25-75: 0-1). Also, there was not significant difference between the number of attempts for IV cannulation between J-Tip (mean 1.17, SD 0.43) and EMLA (mean 1.22, SD 0.59).

DISCUSSION: The preliminary results suggest that: J-Tip application of lidocaine 1-3 minutes before IV cannulation had better anesthetic effectiveness compared to EMLA applied for 60 minutes. The number of attempts for IV cannulation was similar for both techniques. The characteristics of J-Tip, such as, decrease time for application prior to IV cannulation and lack of needle involvement make J-Tip an attractive method for local anesthesia application prior to IV cannulation in the pediatric population

References:

1. Galinkin J L, et al. Anesth Analg 2002;94:1484-8
2. Kleiber C, et al. Pediatrics Vol. 110 No 4 October 2002.
3. Lander J, et al. Pain 64 (1996)89-97.

These awards will be presented on Saturday, February 26, 2005, at the 2005 Winter Meeting in Miami, Florida.

Joint Response to JCAHO Sentinel Event Alert on Anesthesia Awareness

The following is a letter that was signed by the leadership of SPA, the AAP, the AAP Section on Anesthesiology and Pain Medicine, and the ASA Pediatric Anesthesia Committee

On behalf of the undersigned organizations, we are writing to express our concern with the recently issued *Sentinel Event Alert* titled "Preventing and Managing the Impact of Anesthesia Awareness".

The problem of awareness during general anesthesia is the focus of considerable interest and extensive research at the present time. We agree that awareness during surgical procedures under general anesthesia is an important problem that can have significant sequelae, that all prudent measures should be undertaken to avoid or prevent it, and that it should be aggressively identified and treated when it does occur. We also agree that awareness during general anesthesia is potentially an important issue in infants and young children where, of course, the problem is complicated by factors such as age, preverbal status, etc. However, it is our shared and firm opinion that the current peer reviewed scientific and medical literature are insufficient to support the *Sentinel Event Alert*, as published.

In particular, we are extremely concerned about this *Alert* as it relates to the problem of awareness in infants and children. There is in fact some evidence that children may be at somewhat greater risk for this problem. We agree that all prudent measures should be taken during pediatric anesthesia to minimize the risk of awareness during general anesthesia, and appropriate measures and practices should be in place not only to minimize this risk but also to detect it, treat it, and treat its aftermath when it does occur. We also agree that awareness may be difficult to recognize in infant and pediatric patients. We currently use our knowledge of pharmacology and pharmacodynamics of the drugs we use in infants and children to try to ensure safe and effective dosing. In those rare situations where patient condition (e.g. significant hemodynamic stability) might preclude "effective dosing" due to safety considerations, we support the use of alternative amnestic agents (e.g. scopolamine). As in adult patients, we must at the present time rely on the "typical indicators", such as high blood pressure, tachycardia, movement, other hemodynamic changes, tearing, etc. While we agree that these may be inadequate under some circumstances, we must emphasize that currently available "awareness monitors" regardless of their type or design, have not been demonstrated to be reliable in infant and pediatric patients. In fact there is a substantial amount of data at the present time to suggest that these devices are inadequate and inaccurate to detect awareness under general anesthesia in infants and younger patients; this may be in part due to differences in the immature EEG, its response to anesthetics, and the fact the current commercially available devices use processing and algorithms designed for the adult brain. Thus, at the present time, there is no evidence that these devices have a role in preventing and detecting anesthesia awareness in infant and pediatric patients, and some evidence that they in fact may be misleading. Research is ongoing in this area and we expect and encourage continued research and improvements in technology to address this issue. But again, we must emphasize that at the present time, it would be improper to recommend the use of brain activity monitors in infants and children.

Another area of concern regarding the *Alert* is the recommendation, either explicit or implied, regarding the use of anesthetic agents and adjuncts such as muscle relaxants. Given the lack of useful medical data, particularly in infant and pediatric patients, we believe it is unwise and unsound to either recommend or proscribe the use of specific drugs to address this issue at the present time. We further believe that such a recommendation has the potential to lead to other and equally or more significant types of morbidity (and potentially mortality), such as improper use or overdose of anesthetic and amnestic agents.

Finally, it appears from this *Alert* that the recommendations on "reducing the risk" and "managing the impact" of awareness under general anesthesia are based on a single publication from the February 2000 issue of *Anesthesiology*. Standards of care and recommendations on optimal clinical practice are rarely, if ever, based on a single or even a small set of publications. On the other hand, if this *Sentinel Event Alert* is a product of a panel of experts in the fields of anesthesiology and awareness under general anesthesia, then this information should have been included in the *Alert*.

In conclusion, we strongly recommend that this *Sentinel Event Alert* be withdrawn until such time as there is consensus among experts in anesthesiology that the conclusions and recommendations in the *Alert* are warranted. It is our firm opinion that these requirements are not yet met, particularly as they would apply to infants and children. We again wish to call your attention to the fact that the issues raised by the *Alert* are substantially more complicated when applied to the field of pediatric anesthesiology. These complexities will require a substantially greater body of scientific evidence than is available at the present time to elucidate "best practices" for the anesthesia care of infants and children regarding awareness. We fully support expanding research and educational efforts on this issue, in addition to efforts to identify high-risk patients, institution of appropriate follow-up measures, and appropriate referral for identified patients. The Society for Pediatric Anesthesia, in conjunction with its colleague organizations, has plans underway to sponsor a "consensus conference" in early 2005 on this issue. This effort will bring together experts in neuroscience, infant electroencephalography, pediatric anesthesia, and awareness to summarize current knowledge and identify areas that require further investigation and development in order to conclusively and safely address this problem.

Section Members Urged to Vote for Section Representatives

It's that time of year! Elections will soon be held to fill new vacancies on the Section on Anesthesiology and Pain Medicine executive committee. The following individuals have thrown in their hat for the campaign:

Karen Bender **Elizabeth Drum**
Eugene Fried **Connie Houck**
Jeff Koh **David Polaner**



Why should you vote?

Your Section Executive Committee is responsible for:

- 1) Developing educational programs for section members and for the general membership of the AAP;
- 2) Developing and influencing AAP policy, including policy statements;
- 3) Advancing the interests of your section and subspecialty both within the AAP and in interactions with outside organizations;
- 4) Providing expertise to AAP committees and to the AAP Board of Directors; and
- 5) Interacting with other sections representing the spectrum of pediatric medical and surgical specialties and special interest groups.

The on-line ballot, as well as the candidates' biographical information, will be available beginning March 1 at a dedicated election URL; www.aap.org/elections. Because not all members have computer access or capability, and because voting is a right and a privilege, paper ballots are available by contacting the AAP Department of Committees and Sections at 800/433-9016, extension 4079.

Ballots, whether paper or on-line, must be received by the AAP no later than Friday, April 29, 2005, in order to be counted. If section members inadvertently vote both by paper ballot and on-line, **only the on-line ballot will be counted**. It is hoped that the Web-based ballot is found to be an efficient and enjoyable means by which to vote for the candidate(s) of your choice.

For the Web-based election, section members will receive an e-mail notification when the on-line ballot is available, which will contain the link to the ballot site. A letter will be sent to members who do not have an e-mail address on file. There will be a link to the ballot site from the Member Center on the AAP Web site. In order to enter the ballot, section members will need to enter the pre-assigned login number and password, which will be provided on the each member's e-mail notification or letter. For those who are unable to locate their Login number and password, instructions will be provided on the election Web site. In addition, a technical support e-mail address also will be provided.

Those elected will take office in November 2005. Any questions about this service may be directed to Carolyn Mensching, Manager, Section Administration, Department of Committees and Sections, AAP, 847/434-4079 or cmensching@aap.org.

EMSC Update

The Emergency Medical Services for Children (EMSC) program is among the AAP's top legislative priorities for the 109th Congress (2005-2006). Once again, AAP is working to ensure that the EMSC program is not eliminated by Congress.

In 2004, legislation was introduced that would have combined EMSC with the trauma care programs, which are also administered by the Health Resources and Services Administration (HRSA). All trauma and EMSC activities would have been combined into a single program and required to compete against each other for funds. Under this scenario, it is likely that EMSC would obtain only a small fraction of the \$20 million it is currently allocated.

AAP opposed this initiative, H.R. 3999, and worked to educate lawmakers about its disadvantages for children's EMS research and education. At the end of last year, no action had occurred on H.R. 3999, meaning that it died with the election of a new Congress.

AAP has learned that it is highly likely that this proposal will be re-introduced in Congress in the coming months. Although the previous sponsor of H.R. 3999 retired, it appears that Rep. Michael Bilirakis (R-FL) will introduce a new version of the legislation. AAP is working with allies in both the House and Senate to continue building support for EMSC and its work. Furthermore, AAP is urging lawmakers not to make any significant changes to federal emergency medical programs until the Institute of Medicine panel, "The Future of Emergency Care in the United States Health System", has the opportunity to issue its report in early 2006.

AAP's Washington Office will keep all interested parties apprised of any legislative developments related to EMSC. Last year, pediatric emergency physicians proved a potent lobbying force. If and when EMSC is threatened again this year, AAP will lead the charge to preserve this vital program. For more information, contact Cindy Pellegrini in AAP's Washington Office at 202-347-8600, x. 3007 or cpellegrini@aap.org.



Education: One of the Prime Missions of the Section



Section members help decide what seminars and hot topics on anesthesiology and pain management are offered to general pediatricians at national conferences. Faculty are Section on Anesthesiology and Pain Medicine members. The Section also plans workshops and lectures at the ASA and the Winter Meeting.

Below are some of the recent offerings presented at various educational venues. Please contact Membership Chair Connie Houck (constance.houck@tch.harvard.edu) if you would like to suggest a topic or volunteer as faculty for an upcoming meeting.

2004 ASA Meeting, Section on Anesthesiology Breakfast Panel

Anesthetic Concerns for "Healthy" Kids
Moderator: Juan Gutierrez, MD,
Obesity: Paul Samuels, MD
Upper Respiratory Infections: Shobha Malviya
ADHD and Depression: Navil Sethna

2004 AAP National Conference, San Francisco, CA

Acupuncture Workshop for Pediatricians
Yuan-Chi Lin, MD

Creating a "Pain Free" Environment in the Pediatric Office
Steve Weisman, MD

Assessment of Pain in the Verbal and Nonverbal Child
Santhanam Suresh, MD

Approaches to Management of Chronic Pain
Santhanam Suresh, MD, Kathleen Lemanek, PhD

2005 SPA/AAP Winter Meeting, Miami Beach, FL

AAP Ask the Experts lunch panel:
Perioperative Considerations for Children with Cerebral Palsy
Moderator: Constance S. Houck, MD; Panelists: John B. Rose, MD
Laura Torres, MD, Corrie T.M. Anderson, MD

2005 AAP National Conference, Washington, DC, Oct. 8 - 11

Cleared for Surgery: What Are the Important Considerations Before Anesthesia or Sedation?
Lynne Maxwell, MD

Acupuncture Workshop for Pediatricians
Yuan-Chi Lin, MD

Airway Management for Pediatricians
To be taught by Sabine Kost-Byerly and an ED physician from Washington, D.C. area

Call for Abstracts!

Share your research with your pediatric colleagues. Consider submitting an abstract for presentation at an AAP Section Educational Program if your anesthesiology research has implications in any of the specialties listed below:

Administration & Practice Management
Adoption & Foster Care
Breastfeeding
Cardiology & Cardiac Surgery
Clinical Information Technology
Critical Care
Emergency Medicine
Epidemiology
Hospital Care
Injury & Poison Prevention
Orthopaedics
Perinatal Pediatrics
Plastic Surgery
Residents
School Health
Sports Medicine & Fitness
Surgery
Transport Medicine
Urology

The AAP Section-Programs-for-Section-Members provide a forum for the discussion of clinical matters or research related to a particular subspecialty or special interest area. Submissions by AAP members and nonmembers are welcome; participation is open to health professionals in any field. (However, some sections require a sponsor for any papers whose authors do not include a member of the Section.)



The submission deadline is April 15, 2005. Submit electronically from the AAP website at <http://www.aap.org> under "Professional Education" Questions? Contact abstracts@aap.org or 847-434-4079.

Welcome New Members!

The Section currently has 299 members and 14 affiliates. Rita Agarwal (Membership Chair) approved the following new members since March 2004.

| | | |
|-------------|-----------|----------------------|
| Corrie | Anderson | Seattle, WA |
| Ziya | Aras | Burin Peninsula, NF |
| Philip | Bailey | Chesapeake, VA |
| Richard | Blum | Waban, MA |
| Carlene | Broderick | Hempstead, NY |
| Jonathan | Clarke | Moraga, CA |
| James | Fehr | St. Louis, MO |
| Mary | Fox-Dubus | Englewood, CO |
| Robert | Friesen | Denver, CO |
| Gregory | Hammer | Stanford, CA |
| Jonathan | Jahr | Los Angeles, CA |
| Jeannette | Kierce | Richmond, VA |
| Helen | Lauro | Croton On Hudson, NY |
| Yuan-Chi | Lin | Boston, MA |
| Gregg | Lobel | Demarest, NJ |
| Andreas | Loepke | Cincinnati, OH |
| Philip | Ludmer | Glendale, CO |
| Beth | Katubig | Denver, CO |
| Shobha | Malviya | Ann Arbor, MI |
| Christopher | Mann | Houston, TX |
| James | McLane | Fort Sam Houston, TX |
| George | Mychaskiw | Jackson, MS |
| Eli | Ohayon | Coronado, CA |
| Stuart | Rice | Basking Ridge, NJ |
| Abhaya | Seshachar | Oklahoma City, OK |
| Navil | Sethna | Boston, MA |
| Michael | Tobin | Chicago, IL |
| Laura | Torres | Missouri City, TX |
| Myra | Wheaton | Jackson, MS |

Please encourage your colleagues to join us! The Section welcomes the following categories of members:

Pediatric anesthesiologists who are 1) dual boarded by the American Board of Anesthesiology *and* the American Board of Pediatrics; or 2) boarded only by the American Board of Anesthesiology, and who must have completed 8 months of pediatric anesthesia training within the anesthesia residency training or during the CA4 year or its equivalent. No more than two (2) months of this time may be spent in the area of critical care.

All candidates must devote a minimum of 50% of the professional time to the perioperative or critical care management of infants, children and adolescents age 21 and under.

Note: Candidates who meet the above requirements but who devote less than 50% of their professional time to the anesthetic care of children may be recommended for membership if they are in one of the following categories: a) in charge of the teaching of pediatric anesthetic care of

children in a medical school, or b) the Department of Anesthesia designate for the clinical care of pediatric anesthesia problems in a university hospital, children's hospital, or a pediatric department approved for residency training in pediatrics and affiliated with a medical school.

Post-Residency Training Fellows/Candidate Fellows who have completed an ACGME-approved anesthesia residency, and who have completed or are currently enrolled in an advanced training program leading to proficiency in pediatric anesthesia or pediatric critical care.

Physician affiliate members are licensed physicians not eligible for the Fellowship/Specialty Fellowship who have adequate training in the field in which they are specializing, and who devote a minimum of 50% of their professional time to the perioperative, critical care, or pain management of infants, children and adolescents age 21 and under

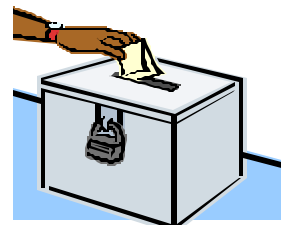
For membership information go online to <http://www.aap.org/sections/anes/>, or contact Membership Chair Rita Agarwal (agarwal.rita@tchden.org) or Staff Manager Kathy Ozmeral (kozmeral@aap.org).

Section Bylaw Referendum

The Section recently approved a change in the Section on Anesthesiology and Pain Medicine bylaws.

- 1) To allow Post-Residency Training Fellows and Candidate Fellows to become national members of the Section on Anesthesiology and Pain Medicine; and
- 2) To shift the terms-of-office of executive committee members from two-year terms of office (with possible re-election to two additional two-year terms of office) to the new schedule: a three-year term of office, with possible re-election to an additional three-year term of office.

Thank you to everyone who responded and voted!



Section on Anesthesiology and Pain Medicine
Executive Committee Meeting Highlights
October 23, 2004

EMSC bill

The agenda book contained an update on HR 3999 – the pending trauma care reauthorization bill in the House of Representatives Health Subcommittee of the Energy and Commerce Commission. At the behest of Dr. Carden Johnston (President of the AAP), Dr. Mancuso wrote letter of support, asking that the EMSC program be maintained in its current form.

JCAHO Sentinel Event

The executive committee discussed a recent JCAHO *Sentinel Event Alert* titled “Preventing and Managing the Impact of Anesthesia Awareness.” The group agreed that awareness during general anesthesia is potentially an important issue in infants and young children. However, they felt that the current peer reviewed scientific and medical literature is insufficient to support the *Sentinel Event Alert*, as published. Specifically, currently available “awareness monitors” regardless of their type or design have not been demonstrated to be reliable in infant and pediatric patients. There is no evidence that these devices have a role in preventing and detecting anesthesia awareness in infant and pediatric patients, and some evidence that they in fact may be misleading. The executive committee made a recommendation that the Section make a formal response to JCAHO that this *Sentinel Event Alert* be withdrawn until such time as there is consensus among experts in anesthesiology that the conclusions and recommendations in the *Alert* are warranted. Dr. Mancuso will approach SPA and ASA about making a joint response to JCAHO.

World Federation of Societies of Anaesthesiologists

The WSFA established a pediatric anesthesiology fellowship in Santiago, Chile, in 1996. Individuals from Central/South America are invited to train for 6-12 months, and then return to their country of origin to serve as local experts in pediatric anesthesiology and to train others. There have been 8 trainees since the program began. The program has since been replicated in Tunisia; is in the organizational stage in South Africa; and has been proposed for Hungary, Poland and India. In order to operate six programs per year, the WSFA is seeking financial support of 70,000 – 80,000 euros per year from pediatric societies throughout the world. The section will investigate whether there is some way to financially support these activities.

IV Safety Catheters

Apparently, there is an FDA posting to the Federal Register regarding IV safety catheters. The ASA Committee on Pediatrics has been asked to comment. The AAP Section debated how best to lend their voice to this discussion. Conventional catheters work better with children, but do not meet the federal mandate for use of safety catheters. Perhaps it would be appropriate to advocate for a better design of safety catheters. Dr. Mancuso will contact Dr. Randy Clark (chair, ASA Committee on Pediatric Anesthesia) to lend its support to any initiatives regarding IV safety catheters

Sedation Guidelines

Dr. Coté was happy to report that the all parties have apparently resolved their differences in the revision of “Guidelines for Monitoring and Management of Pediatric Patients During and After Sedation for Diagnostic and Therapeutic Procedures.” The American Academy of Pediatrics/American Academy of Pediatric Dentistry Work Group is finalizing a draft, and a conference call will be held in January 2005 to sign off on the final document. It will then be distributed to various AAP committees and sections for peer review.

ASA Guidelines on Perioperative Sleep Apnea

Two pediatric pulmonologists and six pediatric anesthesiologists are serving as consultants to an ASA Task Force on Perioperative Management of Patients With Sleep Apnea. A draft should be complete by the middle of November 2004. The AAP will have an opportunity to endorse the completed guideline.

AAP Committee On Drugs (COD Report)

Dr. Maxwell reported on the spring 2004 meeting of the COD. (She is missing the fall meeting, because it is being held concurrent with the ASA meeting.) The spring meeting was completely devoted to the process of survey and web-based education pursuant to the contract to the COD from the FDA to develop education for pediatricians regarding new drug labeling (PLEP: pediatric drug labeling education project). This project will ultimately provide web-based education associated with the AAP Pedia-Link about drug label changes.

Prior to initiating the web-based education, the committee has worked on writing drug vignettes for *AAP News*. One vignette, about potassium iodide, was published in the June 2004 issue of *AAP News*. Others that have been completed include mometasone (Nasonex), linezolid, famotidine, statins, Accutane, midazolam, and fentanyl (Duragesic). Others in development are orlistat (Xenical), budesonide (Pulmicort), atovaquone and proguanil, fosinopril/lisinopril/enalapril, montelukast, and atomoxetine.

The development process for PLEP has included a survey sent to AAP members as well as to AAP section members (including our section). The response rate was nearing 80% and that a reasonable goal would be in the 90%-95% range. The response rate is based on 91 responders of 121 individuals who had agreed to participate in the Delphi process. The actual number of intended participants may be slightly higher. The responses to the first questionnaire are being used to develop a second questionnaire. The purpose of the survey is to identify how pediatricians get their drug information and what kind of drug information they need.

The committee has been involved in discussion regarding antidepressants and suicide in children.

The statement, "Preparing for Pediatric Emergencies: Drugs to Consider" (formerly known as "Drugs for Pediatric Emergencies") is in the last stages of revision. The sedation guidelines document is embargoed but will be discussed on the morning of our board meeting.

Quality Assurance Report

The Quality Assurance Committee is involved in two main projects:

1. Airway management policy statement
2. Database of complications of regional block anesthesia.

The Quality Assurance committee will meet in February to further refine this web-based collection tool.

- The group must decide whether to reach out to all institutions...or just to 10 – 30 motivated institutions that will faithfully respond.
- The group has to define the parameters of data collection. At what point will the database have everything it needs: What complication? What type of block? What type of needle?
- The QA committee must be cognizant of how user friendly the database is, and how quickly respondents will be able to enter data.

AAP News Focus on Subspecialties

AAP News features a monthly column that allows sections to promote a new idea, procedure, or topic. The items should be newsworthy, and should have a "hook" that makes it of interest to the general pediatrician. The 600-word articles may be clinical in nature, but must be written in news style, rather than scientific/medical journal style. Past submissions include:

- Taking the 'ouch' out of doctor visits easier than ever
AAP News 25 (2) 66 August 2004
Connie Houck
- Calming children before surgery: Data show anxiety is associated with behavioral problems postoperatively
AAP News 22 (3) 108. March 2003
Zeev Kain

The section's next contribution is scheduled for August 2005. The group discussed possible topics for future issues, including:

- Post-op pain management: new modalities for hernia, circumcision and ear tubes
- Challenges we face taking care of their patients: MPS patient receiving an MRI under general anesthesia; bone marrow transplant patient with mucositis; esophageal dilation in a child with EB; etc.
- Options for managing the patient with a difficult airway (or a syndrome that includes a difficult airway)
- Preoperative fasting guidelines
- Simulator training

Dr. Valley will write an article on pre-operative fasting and submit to AAP News. (The newspaper may wish to run it in our August 2005 slot...or use sooner if another Section misses their deadline.)

AAP Grand Rounds

Every month, physician experts from the Academy's Sections scan more than 75 journals for the most recent advances in pediatrics, summarize them, and add their expert commentary. Editorial board members then make the final selections. Criteria for selection include methodological soundness as well as relevance to practicing pediatricians. Dr. Mancuso has served two terms as contributing section editor to the *AAP Grand Rounds*. His term will expire in December 2004. Dr. Valley was appointed as the new contributing section editor.

Elections

Dr. Zeev Kain and Dr. Lynne Maxwell were re-elected to a second two-year term of office. Dr. Joseph Cravero was elected Chair-Elect. Drs. Robert Valley and Rita Agarwal are due to rotate off the executive committee, having served six years in office. Dr. Houck is eligible to serve an additional two-year term of office if so nominated.



Pediatric Pain Management for Primary Care – 2nd edition

(Edited by Joseph D. Tobias, MD, FAAP, and Jay Deshpande, MD, FAAP)

The treatment of pain in infants and children is now recognized as key to ensuring successful and quick recovery from illness, injury, and surgery. The updated and expanded edition of this practical, clinical guide to pediatric pain management and sedation includes four new chapters plus new, detailed diagrams demonstrating the nuances of treatment – an essential resource for effective, safe pain management.

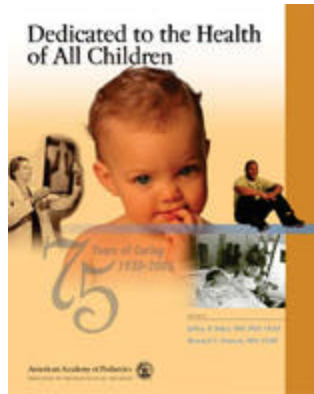
The four new chapters provide new and expanded coverage on:

- Postoperative and acute pain management
- Chronic and cancer pain management
- Regional nerve blocks and interpleural analgesia
- Neonatal pain management
- Sedation in the pediatric intensive care unit
- Sedation for imaging and invasive procedures

To order these or other publications visit the online bookstore at <http://www.aap.org/bst/index.cfm?DID=15>

Dedicated to the Health of All Children

This official commemorative volume of the 75th Anniversary of the AAP is a richly illustrated and thoroughly researched historical record, tracing the practice of pediatrics from Colonial times, through the founding of AAP in 1930 to the present day. Many AAP-led advances in pediatrics are recounted in essays and archival photographs, while a look at the future offers hope for continued progress in the face of new threats to child health.



About Children

Like a documentary film in print, this unique new book explores nearly every facet of modern American childhood. Essays by renowned health and policy authorities blend with evocative photography and informative charts and graphs to provide vivid insights into more than 40 wide-ranging topics, such as child abuse, immunization, education, poverty, ADHD, obesity, and more!



And coming soon...

Guidelines for Air and Ground Transfer of Neonatal Pediatric Patients
(edited by the AAP Section on Transport Medicine)

Available by the end of 2005, this updated and significantly revised version will include: organization, administration, team composition, training and assessment, communications, equipment, quality improvement, legal issues, safety, vehicle requirements, altitude physiology, family-centered care, marketing, outreach, financial considerations, database development, research, ethical considerations, accreditation, international transport, telemedicine, stress debriefing, integration with EMS, and unique transport considerations.

Save the Date!

AAP National Conference and Exhibition
October 8-11, 2005
Washington, DC

SPA 19th Annual Meeting
October 21, 2005
New Orleans, LA

Pediatric Anesthesiology
February 16-19, 2006
Sanibel Harbour Resort and Spa
Fort Myers, FL



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2004-2005**

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