



## Highlights of the Fall Executive Committee Meeting of the AAP Section on Anesthesia and Pain Medicine

The Section on Anesthesiology and Pain Medicine executive committee meeting was held on Thursday, October 10, 2003, in San Francisco, California

### GOALS OF THE SECTION

All Sections are required to give an Annual Report of section activities to the Council on Sections. Dr. Patty Davidson (Section Chair) outlined the following goals for the Section:

- Get section members on AAP Committees — particularly Committee on Pediatric Emergency Medicine and Committee on Hospital Care. Thereby increasing our networking ability and adding value to the membership
- Maintain and improve membership by providing better service to members
- Ensure safe perioperative conditions for children in all settings (hospital, surgery center and office surgery) by giving input into policy decisions
- Continue to evaluate whether the section is an appropriate “home” for the pediatric anesthesia fellowship
- Continue to work with the section on Pediatric Dentistry to unify divergent statements on sedation

### DENTAL GUIDELINES AND SEDATION

Representatives of the AAP and the American Academy of Pediatric Dentistry have continued to reconcile their organizational guidelines for the

elective use of sedation in children. This would afford children a single standard of care regardless of clinical setting as well as facilitate uniform training and education of pediatricians and pediatric dentists. There are still a few areas of disagreement. One issue of particular interest pertained to nitrous oxide and the explicit wording found in each document related to its use. Rather than single out N<sub>2</sub>O<sub>2</sub>, the Work Group plans to eliminate all reference to specific agents in the body of the document. Another area of concern or misinterpretation between the two documents deals with “reflex withdrawal” in terms of positioning the jaw for purposes of dental procedures versus a jaw thrust as an airway maneuver. Dr. Maxwell (Section on Anesthesiology and Pain Medicine liaison to the AAP Committee on Drugs) had suggested that while the concept of a step down area with prolonged observation is important, more research needs to be done with regard to optimal discharge criteria after sedation versus after anesthesia.

Dr. Maxwell and Dr. Cote had shared a draft of the revised statement with the Section on Anesthesiology executive committee. All these comments were returned to the Committee on Drugs, which met on November 1 and 2 at the NCE. The AAP and the AAPD reviewed the latest draft at this time.

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## **AIRWAY MANAGEMENT**

Given the decision to remove intubation information from the "Drugs for Pediatric Emergencies" statement, the section is considering preparing a review article for submission to *Pediatrics* or possibly a statement or guideline with the Section on Anesthesiology and Pain Medicine (SOA) serving as lead author. Sentiment is that the information would be timely considering technological advancements in airway management and recent recommendations from the Ambulatory Pediatric Association, which support competency in airway management as being an objective of pediatric training. While Advanced Pediatric Life Support (APLS) and Pediatric Advanced Life Support (PALS) courses contain information on airway management, it was felt that there is insufficient detail associated with some devices and procedures. Dr. David Polaner and the QA committee will work with staff to submit an Intent for Statement on airway management

The Section also noted that they should be more involved in AAP life support courses if they teach sedation modules. As noted in the Spring 2003 executive committee minutes, the editorial boards of the Neonatal Resuscitation Program (NRP) and Pediatric Advanced Life Support (PALS) do not include any anesthesiologists. The Section feels that it is important that anesthesiologists provide assistance in the development of training materials on intubation and

airway management.

## **APLS: THE PEDIATRIC EMERGENCY MEDICINE COURSE**

Dr. Lynne Maxwell has agreed to serve as the Committee on Drugs reviewer for the Sedation and Analgesia chapter in the next edition of APLS. She made many editorial comments and corrections to a draft, many of which were incorporated into the document. The Section was pleased to have an anesthesiology reviewer. However, they would like both the Committee on Drugs and the Section on Anesthesiology and Pain Medicine to review future editions of the APLS manual. (It was fortuitous that the COD has an anesthesiology liaison to the committee. However, this liaison position is not guaranteed.)

## **Surgical Action Panel meeting**

Dr. Patty Davidson will be attending the Surgical Advisory Panel meeting at the AAP meeting in New Orleans. (The Surgical Advisory Panel is a gathering of chairs of the 11 surgical sections.) Dr. Connie Houck has attended in the past. Among the issues discussed at the March SAP meeting were:

- Strategies for getting surgical topics and faculty accepted at AAP CME venues
- Subspecialty certification, and the AAP support of the Section on Urology's efforts
- Impact on IMG rules on surgical subspecialty training programs
- Chapter-Section interaction
- Ways to increase the value of

membership for surgical section members

Dr. Davidson has also been invited to attend the Section on Surgery executive committee meeting.

## **CALIFORNIA POLICY ON ANESTHESIA**

Dr. Alvin Hackel and Dr. Mark Singleton were invited to the executive committee meeting to report on the state of pediatric anesthesiology in California.

In 1998, the California Children's Services (CCS) approached the local Bay Area Pediatric Anesthesia Consortium in an effort to update their qualifications for anesthesiologists in California who care for children who are beneficiaries of CCS. The BAYPAC felt these requirements should be done in concert with the California Society of Anesthesiologists. This issue received renewed urgency after front-page media reports of two pediatric adverse events in 2003.

The taskforce then completed their policy on pediatric anesthesia. It was developed from principles set forth in the AAP statement on "Guidelines for the Pediatric Perioperative Environment." It suggests that medical staff at institutions that provide pediatric surgical services should determine what pediatric surgical services the institution is capable of providing. It also established criteria for privileging the anesthesiologists and surgeons. The CSA House of Delegates approved it in June 2003.

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This report was filed for information at an ASA reference committee. Representatives from the AAP and SPA stood up and supported this policy. Hopefully, other states will follow California's lead!

As an aside, Kaiser and BC/BS are analyzing data on outcomes and adverse events, but they are not willing to share the data. What would be ideal is to convince the health care providers of the importance of sharing this information and then raise \$20,000 to bring together a group of anesthesiologists to analyze the data. The executive committee queried whether there are any grants available for patient safety.

## Laryngeal Masks Airways

Dr. Singleton mentioned that he has approached LMA companies to see if they are interested in making a smaller mask size. This might be a campaign that can be supported by the AAP Sections on Anesthesiology and Pain Medicine, Perinatal Pediatrics, Plastic Surgery, and Otolaryngology/Bronchoesophagology. Dr. Davidson will communicate further with Dr. Singleton about his campaign to request that LMA companies manufacture masks in smaller sizes. Dr. Davidson will share this information with the Surgical Action Panel.

## SECTION ELECTIONS

Dr. Patty Davidson will end her term as chair in February 2004. Dr. Thomas Mancuso will assume the role of Chairperson. Therefore, we must elect a new chair-

elect this spring. Dr. Cravero has volunteered to run for this position. In addition, the two-year terms of Dr. Lynne Maxwell and Dr. Zeev Kain end this February. Dr. Lyn Ferrari (nominations chair) will confirm the willingness of Drs. Maxwell and Kain to run for re-election. Additional candidates may also be added to the ballot per the decision of the Nominations Committee.

## EDUCATION COMMITTEE REPORT

### 2003 National Conference and Exhibition:

Dr. Connie Houck (education chairperson) summarized the anesthesiology topics being presented at the NCE:

- *Sedation in the Radiology Suite: How to Make it Safe and Effective*, Shobha Malviya, MD
- *Postoperative Behavioral Changes in Infants and Children: What a Pediatrician Should Know*, Zeev Kain, MD, FAAP
- *Acupuncture Workshop for Pediatricians*, Yan-Chi Lin, MD, MPH, FAAP and Shu-Ming Wang, MD
- *Creating a "Pain Free" Pediatric Environment in the Pediatric Office*, Steven J. Weisman, MD, FAAP; Jolene D. Bean-Lijewski, MD, PhD

### 2004 National Conference and Exhibition:

Dr. Houck noted that only two of our proposals for the 2004 National Conference and Exhibition were accepted for presentation:

- *Creating a "Pain Free" Pediatric Environment*, Steven Weisman, MD  
Jolene Bean-Lijewski, MD
- *Acupuncture for Pediatricians*, Yuan-Chi Lin, MD, MPH

The acupuncture/acupressure workshop has been very successful at the NCE, and the planning group specifically requested that we submit this proposal again.

### ASA Breakfast Panel

The group brainstormed about topics for the 2004 ASA breakfast panel. The final result will be something along the lines of:

Regulatory impact on the practice of pediatric anesthesiology? Help or hindrance

- People/Patient safety (California issue)
- Drug labeling
- Equipment issues and JACHO guidelines

A final title and faculty will be submitted in April.

### AAP CME Recommendation Process

The AAP now has a "CME recommendation process" in place for submitting program ideas for an entire range of CME activities.

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- Live CME
- Print CME
- AAP Grand Rounds
- PREP The Curriculum™
  - Pediatrics in Review™
  - PREP Self Assessment
- Internet CME

The Section on Anesthesiology and Pain Medicine will take advantage of this opportunity to educate general pediatricians in a variety of CME venues.

### **COMMITTEE ON PEDIATRIC EMERGENCY MEDICINE**

COPEM met in September 2003, and reviewed the latest draft to the statement on "Pain Relief and Sedation in Emergency Medical Systems for Children." Dr. Joe Cravero had raised issues regarding parental presence and NPO status. COPEM agreed that family

presence during painful procedures is beneficial in decreasing stress for parents and children, does not decrease procedure success rate with experienced providers, and needs further study. The group also agreed that the section on NPO status should be rewritten to provide further clarification. Other COPEM comments included: 1) add more on consideration of anxiety, 2) add sedation to the abstract, 3) clarify family presence and NPO status, 4) include copies of the pain scales in the document, 5) insert the new name for the topical liposomal lidocaine cream, 6) expand on use of EMLA cream, 7) delete reference to use of nitrous oxide for sexual assault exams, and 8) rewrite the recommendations in active verb tense. Dr. Zempsky (lead author) incorporated these comments into yet another draft, which was included in the Section on Anesthesiology

and Pain Medicine agenda book for this meeting.

Dr. Cravero noted that the NPO guidelines in this latest draft are radically different from what he had proposed. The Section agreed that this language is still unacceptable, and Dr. Cravero will contest it. The Section wishes to use the same language as has been published in the AAP statement on "Evaluation and Preparation of Pediatric Patients Undergoing Anesthesia."

The Section would also like to ensure that educating parents about NPO guidelines is incorporated into a hospital's triage policy. All parents entering the ER should be notified not to feed their children while awaiting their turn in the ER.

## **Pain Medications and Sedatives in the Emergency Medical Environment**

*Submitted by Joe Cravero, MD, FAAP*

The Section on Anesthesiology and Pain Medicine continues to work with the Committee on Pediatric Emergency Medicine to craft a statement concerning the use of pain medications and sedatives in the emergency medical environment. The idea for this statement was born out of the liaison relationship between these two AAP entities over 2 years ago. After several iterations and a lot of negotiating, the statement is now completed and will be sent to the AAP board and interested sections for review. Highlights of the statement include recommendations to include pain assessment early on in EMS triage - including thoughts for the development of prehospital protocols for pain management. The statement goes on to outline the appropriate environment for pediatric care as well as recent advances in the use

of local anesthetics through various delivery systems. Neonatal pain is addressed along with various options for delivery routes for pain medications. Sedation needs are addressed in a general manner through the encouragement of appropriate protocols, safety equipment, and quality assurance review for sedation delivery in the emergency environment.

Section members will continue to work on the content of the statement as it returns from the sections that will review statement drafts over the next several months. Although it is at times contentious, we believe strongly that this type of interdisciplinary effort points out the critical role that the AAP Section on Anesthesiology and Pain Medicine can play in shaping child health policy.

## Report on AAP Committee on Drugs Activities

**Contributed by Lynne Maxwell, MD, FAAP**

*AAP Section on Anesthesiology and Pain Medicine liaison to the Committee on Drugs*

The AAP Committee on Drugs met at the AAP NCE on November 1-2, 2003. Many issues of interest to members of the Section on Anesthesiology and Pain Medicine were discussed.

### ***Prospects for congressional approval of a legislative replacement for the Pediatric Rule?***

On November 19, 2003, the U.S. House of Representatives overwhelmingly approved legislation that will require pharmaceutical companies to test specific medicines for use in children. Endorsed by the American Academy of Pediatrics (AAP), the Pediatric Research Equity Act (S. 650/H.R. 2857) passed the Senate on July 23 by unanimous consent, and was then introduced in the House by Reps. Jim Greenwood (R-PA), Anna Eshoo (D-CA), and Deborah Pryce (R-OH).

The bill has not been signed by President Bush as yet. Enactment of this bill should foster continued pressure for increased drug research in children. The one negative of this bill is that it has a sunset provision that would retire it in 7 years and therefore would require further legislation to reauthorize it. Lobbying by the AAP was instrumental in

getting this legislation passed; it will affect all who provide perioperative care for children by resulting in better information regarding the drugs we use. (See [www.aap.org/advocacy](http://www.aap.org/advocacy) and click on "News Releases & Press Statements" under "Federal Affairs Update.")

### ***Priority Drug and Pediatric Labeling Education Project***

One of the outgrowths of the FDAMA and Pediatric Rule and the resulting drug research and labeling of drugs for use in children is the necessity for disseminating study results and labeling changes to pediatricians. In addition, there are drugs that are currently used in children about which pediatricians need more information, or drugs which are not prescribed due to lack of information. The latter information could be used to guide decisions about which drugs should be studied (the priority drug list generated by the FDA/NICHHD). The AAP Committee on Drugs has been contracted by the FDA to survey pediatricians about these issues and to develop an educational mechanism to disseminate such information. The initial survey is going to be done of pediatricians involved with the AAP's sections and committees (including our Section) to have a representation of all subspecialties. This initial mini-survey will be used to refine the survey instrument

which will then be sent to a larger number of AAP members. In addition, the educational component will be developed to be made available through the AAP's PediaLink™ application. These modules would provide education, testing, and CME. The Committee on Drugs will be actively involved in the development of the survey and educational modules. In advance of the development of these tools, members of the COD are submitting vignettes to AAP News about updated drug labeling for pediatric indications. These drugs include midazolam, linezolid, and the statins.

Under the Best Pharmaceuticals Act for Children (from last year's priority drug list), the NICHHD has issued requests for proposals for the study of lorazepam for sedation and for the treatment of status epilepticus. There was also an RFP for the study of nitroprusside.

With regard to the current status of the priority drug list for studies in pediatric patients, the list for the coming year has been developed and includes:

- Ampicillin/sulbactam
- Diazoxide
- Isoflurane
- Lindane
- Meropenem
- Metoclopramide
- Piperacillin/tazobactam
- Promethazine

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The full information about the background of the priority drug list can be found on the FDA/CDER web site ([www.fda.gov/cder/pediatric/68FR48402.htm](http://www.fda.gov/cder/pediatric/68FR48402.htm)). The CDER web site also has other information which is of interest to pediatric anesthesiologists.

## ***Drug Research in Newborns***

In addition to these efforts, the FDA/NICHD have launched a Newborn Initiative to look at issues of drug research in newborns. There are five working groups (Drug Prioritization, Pulmonary, Pain Control, Neurology, and Cardiology; as well as an ethics panel). Drs. Anne Lynn, KJS Anand, Charles Berde, and Lynne Maxwell are involved in the Pain workgroup. A workshop to develop plans for guiding drug research in newborns will be held in March 2004.

## ***Preparing for a Pediatric Emergency: Drug Considerations***

This clinical guidance, originally published in 1998 (<http://aappolicy.aappublications.org/cgi/content/full/pediatrics;101/1/e13>) is a summary of drugs which should be available to deal with pediatric emergencies. It has been modified to correct errors in dosing, to make information more clear, and to eliminate drugs that shouldn't be used in emergency settings (i.e. pancuronium for intubation). The section about use of drugs for intubation that had appeared in the original document has been removed. The majority of the committee did not feel the document was complete enough to provide information about how to use the drugs for intubation and that the information about intubation was available elsewhere (e.g., PALS).

## ***APLS sedation module update***

Dr. Maxwell was asked through the Committee on Drugs to comment on the sedation module update for the APLS manual (a production of the AAP Committee on Emergency Medicine). Dr. Maxwell and other members of

the section had serious concerns about the inclusion of information on drugs such as remifentanyl and dilaudid and references to use of PCA in the context of a sedation document. Although we were able to provide some input to change information about pharmacokinetics which was flatly incorrect, not all of the objectionable material was removed. A request was made to involve the SOAPM earlier in the revision process the next time.

## ***AAP Sedation Guidelines***

The AAP "Guidelines for Monitoring and Management of Pediatric Patients During and After Sedation for Diagnostic and Therapeutic Procedures" are undergoing their 3-year review. A meeting was held in the spring that resulted in apparent agreement of the AAPD (pediatric dentists) to come up with a revision that would be acceptable to all and would create generally agreed-upon standards for the perisedation process and environment.

## ***AAP recommendation to the FDA regarding bar-coding of drugs***

As you may recall the FDA recommended bar-coding of drugs and blood products. The AAP recommended encoding expiration date and lot numbers in the bar-code in case of the necessity of investigation of adverse reactions, or recalls.



## Fire in the Airway!

*Sevoflurane Reported to be associated with Rare Reports of Spontaneous Airway Fires in Anesthesia Circuits*

### Submitted by Bob Valley, MD

In November of 2003, most readers should have received a letter from Abbott Laboratories ([www.fda.gov/medwatch/safety/2003/ultane\\_deardoc.pdf](http://www.fda.gov/medwatch/safety/2003/ultane_deardoc.pdf)) describing cases of extreme heat and/or fire in the respiratory circuit of patients receiving sevoflurane. The reported cases occurred in patients breathing through a circle system with an in-line CO<sub>2</sub> absorbent (either soda lime or barium hydroxide lime) that was apparently desiccated. According to Cheri Spath, RPh, Medical Information Coordinator for Abbott, at least 8 cases have occurred in the USA and additional cases have been reported overseas.

As a result of these case reports, Abbott worked with the FDA to revise its package insert for Ultane™ to warn about the possibility of spontaneous fires with the use of sevoflurane with desiccated CO<sub>2</sub> absorbents. ([www.abbotthosp.com/prod/anes/ultane.pdf](http://www.abbotthosp.com/prod/anes/ultane.pdf).)

It would appear that when soda lime or barium hydroxide lime become desiccated (as by fresh gas left on through a circuit that is disconnected from a patient for prolonged periods of time),

the heat production by the normally exothermic reaction of the absorbent with carbon dioxide is enhanced and canister will heat up. Temperatures have risen to over 200° C in one in vitro study (Holak, H et. al., *Anesth Analg* 2003; 96:757-764). This increase in temperature may enhance CO production, compound A production and the further breakdown of sevoflurane to potentially flammable compounds such as formaldehyde and methane.

In Abbott's letter to healthcare providers they suggest the following parameters/clinical guidelines to minimize the chance of an airway fire:

- If you suspect that the CO<sub>2</sub> absorbent may be desiccated it should be replaced.
- The anesthesia machine should be completely shut off (to prevent any flow through the CO<sub>2</sub> absorbent canister) at the end of clinical use or when a subsequent extended period of non-use is anticipated.
- Turn off all vaporizers when not in use.
- Verify the integrity of the packaging of new CO<sub>2</sub> absorbents prior to use.
- Periodically monitor the temperature of the CO<sub>2</sub> absorbent canisters.
- Monitor the correlation

between the sevoflurane vaporizer setting and the inspired sevoflurane concentration. A large discrepancy may suggest excessive sevoflurane breakdown and excessive heating of the CO<sub>2</sub> absorbent canister.

If excessive heat ("too hot to touch") is discovered or a discrepancy in inhaled agent and the vaporizer setting is noted, Abbott recommends disconnecting the patient from the circuit, turning off fresh gas flow to the circuit, replacing the CO<sub>2</sub> absorbent and checking the patient for signs of CO poisoning and thermal or chemical injury.

Most of the cases reports have been with Baralyme™ (barium hydroxide lime) CO<sub>2</sub> absorbent. Cases of extreme heat with soda lime have also been reported in Europe (Baum J, et. al., *Anaesthesiol Intntensivmed* 1998; 39:11-16). Usually these have been first cases of the day for the machine/CO<sub>2</sub> absorbent involved.

Finally, Abbott warns the practitioner that when this degree of heating occurs,

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### **Dr. Ted Striker named Robert M. Smith Award Recipient**

It is a pleasure to announce that Theodore W. Striker, MD, FAAP, has been selected as the 2003 Robert M. Smith Award recipient. The award will be presented on Saturday, March 6, at the 2004 Winter Meeting in Phoenix.

Dr. Ted Striker has served the pediatric anesthesia community exceedingly well for many years. As chairman of his department he has trained innumerable fellows and residents in the art and science of pediatric anesthesia. He has also shown us it can all be great fun. He has supported faculty members as academicians as well as human beings. He has advanced the position of his department within the hospital. He has served the AAP as executive committee member and chair and as a liaison to committees.

## Fire in the Airway!

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breakdown products of sevoflurane occur in quantities that may be increased and whose toxicity has not been thoroughly studied.

These findings are of concern to all of us that practice pediatric anesthesia. Many institutions no longer even have halothane (good bye-good riddance) available, so sevoflurane is the only practical and safe choice for an inhalation induction. Of course we could all go back to partial or non-rebreathing circuits and eliminate the need for a CO<sub>2</sub> absorbent altogether. This could get rather expensive with the high flow rates required.

Another possible solution is to find a different CO<sub>2</sub> absorbent. Amsorb™ (calcium hydroxide lime) is an alternative CO<sub>2</sub> absorbent that has not been associated with the breakdown of sevoflurane, the production of CO or excessive heating/combustion in the anesthesia circuit. (Murray JM, et. al., *Anesth*, 1999; 91:1342-1348). It has just recently become available in the USA.

## Election Update

Thank you to everyone who voted in the recent Spring elections! Joe Cravero won the position as Chair-Elect. He will begin his role as Chair-elect this February...when Tom Mancuso assumes the mantle of Chair. Joe will ultimately serve as Chairperson in 2006-08.

The executive committee had two openings this spring. This was a closely contested election, with four individuals vying for the two spots. The winners in the tight election were Zeev Kain and Lynne Maxwell. Our thanks and appreciation to Randall Clark and Jeff Koh for their interest in serving on the committee. We hope you will consider running again in the future!

Finally, our great thanks to Patty Davidson as she rotates off her position as Chairperson. Her able representation to the Academy over the years is vastly appreciated.



## The Guidelines for the Pediatric Perioperative Anesthesia Environment: How did it get translated into a policy statement of the California Society of Anesthesiologists? Where do we go from here?

*Submitted By Alvin Hackel, MD, FAAP*

It all began with informal discussions between a group of pediatric anesthesiologists in Northern California.

Physicians with the Bay Area Pediatric Anesthesiology Consortium (BAYPAC) brought their concerns about the safe delivery of anesthesia to infants and children to the attention of the Committee on Quality Assurance of the AAP Section on Anesthesiology. This QA Committee subsequently drafted guidelines that were reviewed and revised by the Study Group on Pediatric Anesthesia, the Board of the

Society for Pediatric Anesthesia and the ASA Committee on Pediatric Anesthesia. In 1999, the American Academy of Pediatrics published a document entitled, "Guidelines for the Pediatric Perioperative Anesthesia Environment" ([www.aap.org/policy/re9820.html](http://www.aap.org/policy/re9820.html)).

Its publication was strongly supported by our pediatric colleagues in the AAP. The premise of the document is that the safe administration of anesthesia to infants and children requires not *only* a

competent anesthesiologist with the appropriate training and experience, but also other health care providers with similar competence in the care of pediatric patients as well as the appropriate equipment and protocols. Furthermore, the department of anesthesia and the medical staff of a patient care facility are responsible for the anesthesia care of its infants and children.

The publication of the Guidelines was followed by an

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**The Guidelines for the Pediatric Perioperative Anesthesia Environment**  
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increased interest among anesthesiologists and pediatricians on the subject. It began to be used to shape hospital and ambulatory surgical center policies as they pertained to the care of infants and children. In 2002, the Task Force on Pediatric Anesthesia of the Committee on Pediatric Anesthesia of the ASA published a pamphlet entitled, "Pediatric Anesthesia: Practice Recommendations" ([www.asahq.org/clinical/PediatricAnesthesia.pdf](http://www.asahq.org/clinical/PediatricAnesthesia.pdf)). This pamphlet was the response of the ASA's Committee on Pediatric Anesthesia to the AAP Guidelines. The content was modified but the message was the same. A competent team of health care providers, including an anesthesiologist with the appropriate training and experience, is required to provide safe anesthesia care for infants and children. The department of anesthesia and the medical staff of a patient care facility are responsible for the anesthesia care of its

infants and children.

While all of the above was happening, the Florida Agency for Health Care Administration began to address the same issue. Pediatric anesthesiologists in California began discussions with the California Childrens Medical Services and the California Society of Anesthesiologists about the need for action. The above-noted documents were used as references. The CSA Board listened and prepared to act.

Then, several cases in which adverse outcomes occurred were publicized in the *Los Angeles Times*. Fortunately, because we were acting proactively and had supporting documents available, the CSA Board and its House of Delegates (led by Mark Singleton, Larry Sullivan, and Patsy Dailey) were able to quickly finalize their work and achieve agreement on a policy statement. The policy was then made public as a re-

sponse to the unfortunate incidents that had occurred recently.

Further action has occurred. Hospital organizations are looking seriously on how the CSA policy can be implemented. The CSA policy statement was reported to the ASA at its annual meeting with the hope that further action will occur either by the ASA, or more likely, by other State societies.

We invite anesthesiologists in all the states to further this concept — the safe administration of anesthesia to infants and children requires not only a competent anesthesiologist with the appropriate training and experience, but also other health care providers with similar competence in the care of pediatric patients as well as the appropriate equipment and protocols. The department of anesthesia and the medical staff of a patient care facility are responsible for the anesthesia care of its infants and children.

**AAP NEWS FOR THE SUBSPECIALIST**

The AAP has launched a new feature that began in January 2003. The Pediatric Subspecialist Page will feature issues and items of particular interest to pediatric medical and surgical subspecialists.

Dr. Zeev Kain wrote a piece on calming children before surgery, which was published in the March 2003 issue of *AAP News*. The Section on Anesthesiology and Pain Medicine is next scheduled for publication in August 2004. All articles are due to *AAP News* the first day of the month prior to publication (July 1 for August issue).

If you are interested in submitting an article on behalf of the section, please submit your name and topic idea to: Kathy Ozmeral, Section Manager, at [kozmeral@aap.org](mailto:kozmeral@aap.org). The chair of the Section's education committee will make the final selection if numerous story ideas are submitted.

# Pediatric Anesthesiology 2004

Submitted by Bob Valley, MD

Pediatric Anesthesiology 2004 is the joint meeting sponsored by the Society for Pediatric Anesthesiology and the American Academy of Pediatrics Section on Anesthesiology and Pain Medicine.

The annual meeting for 2004 will be held on March 4-7, 2004 at the Pointe Hilton at Squaw Peak, Phoenix Arizona. This is the third time for this location and it is a great family resort. Dr. Lynne Maxwell will again serve as the program chair for this meeting and she has put together an interesting, educational and fun event.

The initial day (March 4<sup>th</sup>) will be taken up with a PALS Course for those in need of certification. I think you will find the new PALS course both interesting and challenging compared to the previous courses. Pre-registration is required.

On Friday morning, Dr. Roger Litwiller will give the ASA presidential address. Following this, the remainder of the morning will focus on patient safety and the management of unexpected events and adverse outcomes. Dr. James Stevens will serve as moderator. Anaphylaxis and unexpected cardiac arrest in the OR will be discussed followed by sessions on management of bad outcomes. Tough topics including legal and media

management, personal/professional implications and the sentinel event process will be addressed.

The afternoon session will provide some excellent clinical updates on anesthetic management of complex pediatric patients. The session will be moderated by Dr. Aubrey Maze. Included will be presentations on management of patients following organ transplantation and children with congenital heart disease undergoing non-cardiac surgery.

The afternoon session will finish with the popular Jeopardy session with active audience participation.

Workshops will be offered late Friday afternoon. Topics will include Airway Management, Acupuncture, New Modes of Ventilation, Sedation, Epidural/Caudal Anesthesia/Analgesia, Magical Distractions and Contract Negotiations.

Saturday Morning will begin with a selection of 12 PBLD's, all of which are very interesting. This will be followed by the AAP sponsored Robert Smith Award and abstract presentations.

At 10 am the AAP Advocacy Lecture will be presented. This year Dr. Joanne Wolfe will speak on Pediatric Palliative Care. This is a timely and

important issue in Pediatric care and very relevant to those of us involved in the care of children in and out of the OR.

The remainder of Saturday's session includes the Walk-Around poster discussion, an "Ask the Experts" Panel and the AAP Business meeting (all AAP members are welcome). Following this is an excellent session for Pediatric Anesthesia Fellows presented by Jerrold Lerman, MD and Alan Tait, PhD. They will discuss topics of interest to the budding academician such as research skills, grant proposal writing and trial design.

In addition to the above-mentioned programs, participants will have the option of attending a number of refresher courses Friday and Saturday afternoon. These are open to all registrants and include 8 very interesting topics such as Complications of Acute Pain Management in Children, Myths of Pediatric Anesthesia, and Weaning Strategies for Opioid Tolerance in Children.

On Sunday morning, Dr. Quentin Fisher will moderate a session on International Medical Services. Four excellent speakers will discuss a number of relevant issues including medical *service* versus medical *education*.

Dr. Francis McGowan will then moderate a session titled

## Pediatric Anesthesiology 2004

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“Will the Anesthesia Make My Child Stupid, Doc?” Two discussants will present updates on the neurotoxicity and neuroprotective effects of anesthetic agents.

The meeting will conclude Sunday morning with a very interesting presentation by two California based Pediatric Anesthesiologists, Dr. Alvin Hackel and Dr. Mark Singleton. They will discuss recent events in their state that has made the California society of Anesthesiolo-

gists take a closer look the Pediatric Perioperative Environment and Performance-based Credentialing.

**For a more complete itinerary you can go the SPA website at [www.pedsanesthesia.org](http://www.pedsanesthesia.org) It should be another excellent meeting!**

## The First International Conference on Pediatric Sedation

Submitted by *Joe Cravero, MD, FAAP*

The AAP Section on Anesthesiology and Pain Medicine quality assurance committee has lent its support to a new conference on pediatric sedation to be presented on May 22, 2004 in Denver Colorado. This conference “The First International Conference on Pediatric Sedation” will be a multispecialty exploration of the current state of the art of pediatric sedation. Highlighted speakers will include Charles Cote MD (AAP SOAPM), Joseph Tobias MD (AAP SOAPM), as well as Steve Wilson (Pediatric Dentistry), Bo Kennedy MD (Emergency Medicine), Terri Voepel-Lewis (nursing).

In addition to formal lecture presentations, the conference will feature interactive sessions involving the experts and discussion of “hot button” issues in pediatric sedation. Additional faculty from the areas of pediatric ICU medicine, emergency medicine, and anesthesiology will be involved in breakout sessions cover-

ing topics from credentialing of sedation to the financial implications of sedation services.

The SOAPM executive committee is committed to providing leadership in the area of pediatric sedation practice as it evolves. It is hoped that this conference will lead to an ongoing improvement effort across specialties involved in sedation services for children.

Individuals seeking registration information can find this online at

<http://www.thechildrenshospital.org/pro/cs/detail.cfm?RecordID=1195>



## Small Patients, Big Pain:

Executive Committee member Dr. Joe Cravero highlighted in *Newsweek* article

Submitted by Bob Valley, MD, FAAP

As part of a May 19, 2003 Newsweek issue involving "Pain," editors turned to the AAP Section on Anesthesiology and Pain Medicine and Chairperson Patty Davidson MD.

Dr Davidson subsequently referred the publishers to Joe Cravero MD - executive committee member and Director of Pediatric Anesthesiology at Dartmouth Hitchcock Medical Center. The resulting article entitled "Small Patients: Big Pain" highlighted work that is being done through the SOAPM and the Committee on Pediatric Emergency Medicine.

Specifically, the authors noted the AAP statement that is in progress concerning the appropriate administration of pain medication and sedation for children in emergency medical systems. Dr. Cravero was quoted as citing new efforts to raise awareness for pain control in all areas of pediatric care, and the availability of new technologies for distraction and entertainment of children undergoing procedures. In addition, the article included photographs and a description of the PainFree program at the Childrens Hospital at Dartmouth which was initiated by Dr. Cravero for patients undergoing painful or stressful procedures.

### AAP CALL FOR ABSTRACTS

for the AAP National Conference and Exhibition

October 8-13, 2004 San Francisco, CA

SUBMISSION DEADLINE: April 16, 2004

Section programs 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 following Sections accept abstracts for presentation at the AAP National Conference and Exhibition. Abstracts are **not** accepted for general pediatrics or for other pediatric subspecialties or special interest areas not listed below.

**Administration & Practice Management**

**Adoption & Foster Care**

**Breastfeeding**

**Cardiology & Cardiac Surgery**

**Steering Committee on Clinical Information**

**Technology**

**Critical Care**

**Emergency Medicine**

**Epidemiology**

**Hospital Care**

**Injury & Poison Prevention**

**Orthopaedics**

**Perinatal Pediatrics**

**Residents**

**School Health**

**Sports Medicine & Fitness**

**Surgery**

**Transport Medicine**

**Urology**

Submit electronically from the AAP website

<http://www.aap.org>

under "Professional Education"

Questions? Contact [abstracts@aap.org](mailto:abstracts@aap.org)

or #847-434-4079.

**ABSTRACTS MUST BE RECEIVED BY APRIL 16TH, 2004**

## MEMBERSHIP Q&A: How Will the AAP Address the Needs of Surgical Subspecialists

*Chairpersons of surgical sections posed some specific questions to the AAP Committee on Membership about the special needs of hospital-based and surgical sections.*

- **Question:** Has the AAP considered a uniform graduated dues structure for all surgical subspecialists?
- **Response:** In 2000, an AAP bylaws referendum was passed so that all physicians who have completed training in a medical or *surgical* residency are eligible for the full rights and privileges of Candidate Fellowship. As such, surgical residents can remain Candidate Fellows for up to 7 years on a graduated dues scale.

First year	\$135	Fellow 1 <sup>st</sup> year	\$290
Second year	\$165	Fellow 2 <sup>nd</sup> year	\$340
Third year	\$215	Fellow 3 <sup>rd</sup> year	\$390
Fourth year	\$265	Fellow	\$450
Fifth year	\$290		
Sixth year	\$315		
Seventh year	\$340		

If they need additional time to complete boards or apply for section membership, they can request up to three 1-year extensions. Once they pass their boards, they have two years to upgrade to Fellow. Another bylaws referendum will be conducted in May 2004 seeking to eliminate the time limit for Candidate Fellowship altogether. This graduated dues scale is available to new AAP members only.

- **Question:** How about a membership enticement packet that would be directed at pediatric surgical specialists? Or perhaps the Academy could eliminate those aspects of the basic membership packet that have little relevance to surgical practice?
- **Response:** The Committee on Membership understands and agrees with the general concepts of

this request. The membership of the AAP has become increasingly diverse with many member segments questioning a “one size fits all” approach to benefits. However, making a transition away from this approach is a complex matter requiring careful forethought and business insight. The AAP staff are currently developing new integrated pricing and benefit models for the leadership to consider. New models will raise many new questions. For example, the AAP has a 60-year history of treating Specialty Fellows the same as Fellows — with the same benefits, rights, and privileges. Does this remain a priority?

- **Question:** Many members feel that the cost of AAP membership is relatively high in light of our need to belong to our parent surgical specialty societies and other surgical subspecialty groups. The additional cost of registration to the annual National Conference and Exhibition can be an impediment to greater surgical sections membership and NCE participation. Any chance of repricing the meeting registration fee?

- **Response:** The COM understands and agrees with the general concepts of this request and noted that it will be addressed in part, in the work described above. New models of pricing and benefits may allow for partial participation pricing for the National Conference and Exhibiton. In the interim, the COM encourages the surgical sections to continue dialogue with the Department of Education and the Board of Directors on the issue of a 2- or 3-day section meeting fee for the NCE. Again, pricing structures are complex and what may seem like easy solutions could trigger deleterious effects. Therefore, the COM suggested that a representative from the Surgical Action Panel become involved in these deliberations so Specialty Fellows are part of the dialogue and problem-solving team.

**SECTION ON ANESTHESIOLOGY AND PAIN MEDICINE**  
**2003-2004 Executive Committee**

**Chairperson**

Thomas J. Mancuso, MD  
Dept of Anesthesia  
Children's Hospital of Boston  
300 Longwood Avenue, Bader 3  
Boston, MA 02115-5724  
Office: 617/355-6457  
FAX: 617/739-2599-7887  
EM: thomas.mancuso@tch.harvard.edu

**Members**

Rita Agarwal, MD  
6765 W Princeton Ave  
Denver, CO 80235-3000  
Office: 303/861-6226  
FAX: 303/837-2899  
EM: agarwal.rita@tchden.org

Joseph Cravero, MD, FAAP  
Dartmouth-Hitchcock Medical Center  
1 Medical Center Drive  
Lebanon, NH 03756-0002  
Office: 603/650-5930  
FAX: 603/650-8980  
EM: joseph.p.cravero@hitchcock.org

Connie Houck, MD  
Dept. of Anesthesia  
Children's Hospital of Boston  
300 Longwood Avenue  
Boston, MA 02115-5737  
Office: 617/355-6580  
FAX: 617/739-2599  
EM: constance.houck@tch.harvard.edu

Zeev Kain, MD  
6 October Hill Rd  
Woodbridge, CT 06525-1147  
Office: 203/785-2802  
FAX: 203/785-6664  
EM: kain@biomed.med.yale.edu

Lynne Maxwell, MD  
Dept. Anesthesiology/Critical Care  
34th Street & Civic Center Blvd, Rm 9331  
Philadelphia, PA 19104  
EM: maxwell@email.chop.edu

Robert Valley, MD  
Univ of North Carolina, CB #7010  
223 Burnett-Womack  
Chapel Hill, NC 27599-0001  
Office: 919/966-5136  
FAX: 919/966-4873  
EM: rvalley@aims.unc.edu

**Ex-Officio:**

Patty Davidson, MD  
4444 Shull Rd  
Gahanna, OH 43230  
Office: 614/939-0311  
FAX: 614/939-0920  
EM: pattyda671@aol.com