

# INTERCHANGE

Society of Critical Care Anesthesiologists Newsletter Volume 29 | Number 1 | WINTER 2018

## PRESIDENT'S CORNER Spring is Coming

Happy New Year and I hope you are keeping warm! I'd like to take this column to introduce some of the activities and tools that SOCCA members can look forward to as this (surprisingly) cold winter turns to Spring.

You may first notice that this newsletter has a new format! Instead of that stodgy old pdf (that few people read), we have now moved into a platform accessible from your computer, handheld, or even Anesthesia workstation. This platform is more dynamic and flexible, allows better integration of online content, is more closely aligned with our website and Twitter page, and (hopefully) more fun to read. Please take some time to check out our Pro-Con debate on Vitamin C as a treatment for sepsis, and Dr. Kevin Hatton's interview with past SOCCA president Dr. Todd Dorman!

If you're wondering where some of the new energy for SOCCA comes from, I'd like to introduce our new Society Manager, Vivian Abalama. Also the society manager for AUA, Vivian joined SOCCA in June of 2017 and almost immediately has infused our society with energy, optimism, and wonderful ideas about SOCCA's future. Among her excellent suggestions are the new online format for



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the Interchange (what you are currently viewing), how better to organize and market our annual meeting, and ways to improve our online presence. SOCCA's management team now consists of Vivian, Tom Cooper, the Executive director of IARS and Meghan Whitbeck, Meetings and education director for IARS. I can attest that SOCCA is in excellent administrative hands!

At the risk of inciting Vivian's wrath, let me "out" her email

address: [vabalama@iars.org](mailto:vabalama@iars.org). If you have ideas about how to make SOCCA better/more useful to our members, or issues with the website, membership renewal or meeting registration, please do email either her or myself ([atung@dacc.uchicago.edu](mailto:atung@dacc.uchicago.edu))! She has done a great job dragging SOCCA (and me) into the 21st century!

As springtime nears, so does the SOCCA annual meeting, which will take place this year in Chicago on Friday April 27th. Please do visit our (new) website at [socca.org](http://socca.org) to register and get a look at our preliminary program! Our annual meeting committee, chaired by Dr. Adam Evans, has done a great job creating cutting edge content relevant to critical care practitioners and this year's program includes metabolic

*continued on page 2*

## REGISTER NOW

**SOCCA 2018 Annual Meeting  
and Critical Care Update**

Friday, April 27, 2018

Hyatt Regency Chicago

Chicago, Illinois

[www.socca.org](http://www.socca.org)



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support for the critically ill, emerging practice paradigms, a 50 year retrospective on ARDS, and innovative use of ultrasound. I should also highlight the aligned “Critical Care Focus day” on Saturday, April 28. Although Saturday is part of the IARS meeting, your SOCCA meeting registration will get you into Saturday sessions where SOCCA members will discuss topics ranging from HFpEF to postoperative respiratory failure and eICU.

If you haven't been to the new website, please go take a look! In addition to the annual meeting webpage you can find this and older newsletters archived there, current and past meeting programs, names of SOCCA committee members, and a members only section (with our active Jobs board). This year we are working on a plan to capture annual meeting content and make it available online! Although the details have yet to be worked out, look for archived annual meeting content to become a perk of SOCCA membership.

Along with our twitter page @SOCCA\_Critcare and Interchange newsletter, this website is the “patient facing” portal for SOCCA. We welcome any suggestions you might have for how to make this content more valuable for members!

I'd also like to highlight a new IARS – supported research opportunity: the AUA Clinical Trials Initiative. This joint initiative is co-sponsored by AUA, eSAS, IARS, FAER, and SOCCA and seeks to fund multicenter trials in Anesthesiology. The goal is to utilize existing clinical trial support units and multicenter networks to generate large studies similar to those found in Australia, Canada, and Sweden, and provide seed funding (\$15,000) to allow the grant to be refined in anticipation of applying for NIH support. Although the submission deadline for this year's round is past, it's time to start planning for the next submission deadline in December 2018!

Let me close with a description about how to get more involved with SOCCA. If you are interested, SOCCA has openings in both the Communications (Newsletter) and Education (Annual Meeting) committees. Together, these committees produce the bulk of SOCCA's work products for the year.

The 4 person Education committee ([socca.org/committees/education/](http://socca.org/committees/education/), currently Drs. Steel, Evans, Pai, and Von Homeyer) is tasked with running the annual meeting. The commitment is 4 years, and a new member begins as a “Learner”, assisting the junior and senior members plan, organize, and execute the meeting. The next year that person becomes a Junior, and “Vice Meeting Chair”. Then, “Meeting Chair”, and finally, “Emeritus”. If you are interested, please send a CV and brief statement to Vivian at the above email address! Members will be chosen by the Board at the May meeting. You should already have some experience creating and/or delivering educational content at a regional or national level. If you are interested in getting started along this track but do not yet have experience, email me ([atung@dacc.uchicago.edu](mailto:atung@dacc.uchicago.edu)) and I can suggest ways to get that experience.

If you have an idea for content for the next annual meeting, send a brief description by email to the upcoming Meeting chair, Dr. Pai.

The Communications committee ([socca.org/committees/communications/](http://socca.org/committees/communications/)) is structured similarly. If you are interested in helping shape our new webpage, please send a CV and brief statement to Vivian at the above email address! As with the Education committee, members will be chosen by the Board and the Communications committee at the May meeting.

Finally, two slots for the SOCCA board ([socca.org/officers/](http://socca.org/officers/)) are opening up this May. Along with the Executive Committee (Drs. Tung, Brown, Cobas, Wall, and Shander), these “Directors” are responsible for decisions involving SOCCA affairs. If you are interested in becoming a board member, please submit a 1 page statement and CV to Vivian at the above email address. The Nominations committee, chaired by SOCCA's immediate past president (Dr. Shander), will then prepare a slate of candidates for electronic voting at the May meeting.

It's an exciting time to be involved with SOCCA! I look forward to our upcoming meeting, and making SOCCA relevant and engaging for our members. If you are not a member, consider joining! 🏠

## JOB BOARD



Have you visited SOCCA's [Job Board](#) recently? Recent listings include positions with **Mercy Medical Group of Sacramento, CA**; **Southern Arizona VA Health Care System of Tucson, AZ**; and **Oregon Health & Science University of Portland, OR**. Read more of the members-only job posts and, if you would like to post a job on this site, please email a description and /or flyer to SOCCA Society Manager, Vivian Abalama, CAE at [vabalama@iars.org](mailto:vabalama@iars.org).

## FEATURED ARTICLES

# Pro and Con: Vitamin C and Sepsis



## PRO

“Part of this complete breakfast.” This is the closing line of nearly every breakfast food commercial since at least the mid-1980s. The final scene universally depicts two mainstays: the product, and a cup of orange juice. In popular culture, citrus fruits are crucial to balanced nutrition and provide essential vitamin C. Colloquially, this nutrient is well known to stave off scurvy; but, medically, it has far more powerful potential as a tool to combat the sequelae of infection. The term sepsis comes from the Greek word *sipsi*, meaning ‘to make rotten.’ Putrefaction of tissue leads to rampant infections that ravage our patients, leaving them debilitated, disabled, or worse, dead. As cells die, connective tissue disintegrates. The decay process snowballs until multiple organ systems have failed and the condition is unsurvivable. Enter ascorbic acid. Research over the last 20 years has revived vitamin C as a pivotal adjunct in the treatment of sepsis with promising results. Therefore, critical care physicians should administer vitamin C to septic patients because it is safe, it arrests progression to multi-system organ failure, and it saves lives.

Vitamin C is safe. Naturally occurring and consumed for centuries, vitamin C is ubiquitous and without significant adverse effects when given intravenously.<sup>1</sup> Moreover, the commonly held misconception about a pro-oxidative effect has been debunked.<sup>2</sup> In higher doses than those used clinically, there is a theoretical risk of metabolizing vitamin C into oxalate, thereby running the risk of forming calcium-oxalate nephrolithiasis. However, this only holds true if 1) thiamine cannot prevent the formation of oxalic acid, 2) There exists severe renal impairment, and 3) continuous renal replacement therapy (CRRT) is not utilized, as dialysis clears vitamin C extremely effectively.<sup>3</sup> Since ICU patients are presumably well monitored and started on CRRT when indicated, Vitamin C can be administered safely, even to the most vulnerable patients.

Research suggests that vitamin C arrests progression to multi-system organ failure (MSOF). Sepsis 3 defined sepsis as “life-threatening organ dysfunction” caused by a “dysregulated host response to infection,” with septic shock being: a requirement for vasopressors to achieve a mean arterial pressure of 65mmHg, or a lactatemia above 2mmol/L without hypovolemia.<sup>4</sup> As illustrated by the SOFA score, sepsis progresses through sequential organ system failure with an incremental increase in mortality associated with each increase in SOFA value. Vitamin C works as an antibiotic and an anti-inflammatory to prevent apoptosis, decrease membrane and endothelial permeability,



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and ultimately halt the damage caused by sepsis.<sup>5</sup> Burn patients who received vitamin C required less IV fluid administration and had improved tissue edema—direct evidence of endothelial repair.<sup>6</sup> Vitamin C has been shown to decrease pro-calcitonin levels, SOFA score, and progression to MSOF.<sup>7</sup> Furthermore, vitamin C restores host function by improving microcirculatory blood flow, sensitizing cellular response to steroids,<sup>8</sup> and participating in the synthesis of adrenergic molecules, such as dopamine, norepinephrine, and epinephrine.<sup>9</sup> Septic patients are also notoriously vasopressin depleted,<sup>10</sup> and vitamin C acts as a critical co-factor for the manufacture of vasopressin. These effects decrease exogenous vasopressor requirements and improve circulatory stability.<sup>11</sup>

Vitamin C saves lives. In 2009, Wilson correlated vitamin C deficiency with multiorgan failure and death.<sup>12</sup> Over the last three years, vitamin C has repeatedly been shown to improve patient outcomes. Zabet and Marik demonstrated decreased mortality with vitamin C supplementation in sepsis.<sup>7,11</sup> Septic patients who received IV vitamin C were less likely to die, both when compared to initial APACHE II risk of death, and when compared to controls. These and other studies have also shown shorter mechanical ventilation times,<sup>6</sup> decreased vasopressor doses,<sup>7,11</sup> and a lower rate of requiring renal replacement therapy.<sup>7</sup> Although the Marik study combined vitamin C with hydrocortisone,<sup>7</sup> the recent ADRENAL study would seem to support a greater treatment effect with vitamin C than steroids, as this RCT failed to show that steroids improve mortality in sepsis.<sup>13</sup>

Septic patients are uniquely suited for vitamin C therapy for three reasons. Firstly, they are vulnerable to complications, so low-risk interventions without added side effects are ideal. Secondly, they suffer from metabolic disarray. Sepsis is characterized by a dysregulated host response to infection, and septic patients have abnormal levels of vasopressin, pro-calcitonin and vitamin C; restoring homeostasis and repleting deficiencies will favor an adaptive host response. Lastly, they are tenuous. Septic patients are at risk of rapid deterioration, thereby requiring acute, intensive care with the most logical, targeted therapies



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to rapidly decrease their SOFA score, halt multi-system organ failure and save lives. In conclusion, providing the best medical care that tackles disease at biomolecular, cellular, and macroscopic levels requires we take risks and improve practice. Administering IV vitamin C in sepsis is a low-risk, high-reward protocol for success, which may soon become standard of care. Orange juice isn't just for breakfast anymore. 🏠

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## SOCCA HEADQUARTERS HOTEL: HYATT REGENCY CHICAGO

**Make Your Hotel Reservation Today!** Hyatt Regency Chicago is the Headquarters Hotel for the SOCCA 2018 Annual Meeting. The hotel offers a chic, downtown retreat located steps from the Magnificent Mile and iconic Chicago destinations. All SOCCA education sessions, special events and tabletop exhibits will take place at the Hyatt Regency Chicago.

**HOTEL RESERVATIONS** SOCCA has secured a limited block of rooms for meeting attendees at the Hyatt Regency Chicago. To make your hotel reservation, call +1 312 565 1234 or visit [bit.ly/18AM\\_SOCCAhotel](http://bit.ly/18AM_SOCCAhotel).

**DEADLINES** Chicago, Illinois, in April is a popular travel destination and hotel rooms sellout rapidly! **Special hotel rates for SOCCA attendees end Thursday, March 29, 2018.** Rooms are limited and available on a first come, first-served basis. We highly recommend you book early to guarantee a room reservation at the Headquarters Hotel.

## FEATURED ARTICLES

# Pro and Con: Vitamin C and Sepsis



Is Vitamin C (ascorbic acid) the new and improved answer to decreasing sepsis-related mortality? It's unclear. Up until this point, ascorbic acid has been studied in small cohorts of mostly cancer or burn patients.<sup>1</sup> Studies in these populations have had variable results, some showing no

difference in outcomes and others displaying impressive benefits. One notable study, a small randomized control trial, showed that continuous dosing over 24 hours in burn patients could reduce the need for additional IV fluid resuscitation and vasopressors.<sup>2</sup> While impressive, these results were based on novel, continuous dosing, in a very specific population. There is minimal precedent for similarly impressive results in septic patients.

Currently, we lack a clear physiologic mechanism for how ascorbic acid improves immune function. In animal studies, there is evidence that ascorbic acid acts as an antioxidant and anti-inflammatory agent, scavenging free radicals and potentially reducing cell injury.<sup>3</sup> We know that septic patients have low vitamin C levels, but we do not know how normalizing levels impacts immune function. Sepsis is a complex, dysregulated inflammatory response marked by multiple abnormal hormone, mineral, and vitamin levels. Without a clear mechanism or understanding of the dose-response, it is very difficult to determine if higher vitamin C levels are responsible for lower sepsis-related mortality.

The 2017 study by Marik and colleagues that has made vitamin C in sepsis a hot topic of discussion should be interpreted with caution. At first glance, the results are astounding. Septic patients treated with to vitamin C, thiamine, and hydrocortisone had a estimated 31.9% decreased odds of mortality from sepsis.<sup>4</sup> However, this retrospective before-after cohort study has many limitations. It was conducted at a single center, with a small study group (n=47) that was matched to a control group from 2 years prior. While the investigators made reasonable efforts to minimize variation between groups in their statistical analyses, these measures do not account for confounding due to provider variability, unmeasured exposures, and variation in practice with time. For example, between the control cohort in 2015 and the study cohort in 2017, the Sepsis 3 guidelines were published, potentially impacting the time in which we diagnose, triage, and treat septic patients.<sup>5</sup> Time to intervention alone can dramatically impact sepsis related mortality.



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Vitamin C, while essential to survival, is not without side effects when administered in greater doses. High levels of Vitamin C can lead to undesirable side effects such as nausea, diarrhea, insomnia, and calcium oxalate stones. The current daily-recommended dose is less than 2g.<sup>6</sup> Many studies, including the Eastern Virginia Medical study, used doses much higher than this to normalize levels. There have been few trials to illustrate that higher doses in a clinical setting are tolerable, and no trials exclusively in patients with acute kidney injury.<sup>7</sup> Typically, vitamin C metabolites are excreted in the urine but could conceivably accumulate in acute kidney dysfunction.<sup>8</sup> Without further investigation, there is no reliable way to determine safe dosing at this time in patients with organ dysfunction.

While potentially an exciting and promising direction for sepsis management, there are still many questions to be answered on how best to use vitamin C in septic patients today. Until further studies help validate the findings, we should emphasize that early recognition and timely resuscitation, vasopressor use, and early antibiotics remain the mainstays for fighting sepsis. 🏥

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## MEMBER SPOTLIGHT

# A Brief Conversation with...**Todd Dorman**



**Dr. Todd Dorman MD, FCCM is the Senior Associate Dean for Education Coordination, the Associate Dean of Continuing Medical Education, the Vice-Chair for Critical Care and a Professor of Anesthesiology and Critical Care Medicine at the Johns Hopkins University School of Medicine. He is a past president of the Society of Critical Care Anesthesiologist and the Society of Critical Care Medicine and was the 2017 SOCCA Lifetime Achievement Award Winner.**

### **1. Can you briefly describe the path you took to become a Critical Care Anesthesiologist?**

Although many people would probably answer this question starting in medical school, I consider the development of my specific interest in science, and specifically physiology, built from my time and teachers during my undergraduate studies, as the start of my career. In those days, I had a keen interest in kidney physiology, which developed into a strong consideration for a career in either nephrology or urology after medical school. Eventually, I decided on an internal medicine residency and settled on critical care medicine because it combined my interests in physiology, including kidney physiology, nutrition, patient care, procedures, and patient-family interactions. During one of my resident ICU rotations, I had the good fortune to round with an anesthesiologist who covered some of the time in the ICU. I soon realized that adding the knowledge and skills base of anesthesiology could dramatically improve my ability to provide critical care to patients. I decided, then, after my medicine residency, to continue with an anesthesiology residency and eventually a critical care medicine fellowship.

### **2. What people were most important in developing that path? How did you develop your relationship with those people?**

Prior to medical school, my science-based faculty (in both high school and college) stimulated my search for knowledge and mental exploration of the unknown and to aim for new learning. Truthfully,

there was a constellation of individuals that ultimately pushed me to improve my knowledge, my life experiences and my drive to succeed. While on some levels, medical school, because of its structure, was an unfulfilling educational experience, my residencies and fellowship were very different because the administrative and educational leadership across the departments fostered an environment for educational success. Throughout my training, I caught on to the enthusiasm of my educators, which fed into my own enthusiasm for learning. I developed a network of mentors, not just a single mentor, which provided a robust but diverse perspective on my growth and experiences over the years.

### **3. What was the most important advice that your mentors gave you?**

Early in my career, I discussed my prospects for promotion with one of the department leadership. He looked at my CV and challenged me to clarify, both to myself and to him, what “story” I wanted to tell with my academic career. Did I want to be a physiologist, an educator, an administrator or an IT expert? He noted that the activities on my CV were not in alignment with the “story” and “successes” I told about myself. Were the committees, research, publications and other items on my CV telling the story that I wanted to tell about my “academic life” or did I have a significant mismatch between what I said I wanted to do and what I really spent my time and energy doing? I realized, with his help, that promotion, at any level, occurred when the actions taken in my job supported and reinforced my own “story”. As a junior faculty member, it’s appropriate to try many things, but focus and clarity are eventually needed for long-term success.



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### **4. What do you consider your greatest career success?**

While I’m not sure that it answers your question, at this point, I’m most proud of progressively being a better husband and father...of building and developing a family. It’s hard work to build a family and I’ve learned, as many others have, that while kids are fun they are as much work as anything else in life. Early in my life, I didn’t want to be a workaholic but I had made a commitment to my patients and my patients came first. I communicated that reality to my wife and to my children and while I wasn’t always able to attend every single event in my children’s lives, I made sure that they always knew that I was deeply involved in their lives. Fortunately, I was able to

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leverage computers and evolving technologies to make my work life fit with my family's life events...to stay engaged with my family when I couldn't physically be present. The goal was to always make my family feel needed and loved, regardless of where I was at that moment.

### 5. What advice do you have for fellows and/or junior faculty in our specialty?

My academic career, like many people, began in "fits and

starts". I started in a research lab with a respected mentor that, despite my hard work, did not pan out and ultimately only developed profoundly negative results. But I learned a lot from that experience. I went to research conferences and learned by osmosis how to think like a scientist and developed habits as a scientist that continue today. Throughout my career I learned that each failure was ultimately a learning opportunity. So, my advice would be: "Be willing to fail...but be willing to learn from those failures." To constantly ask, "What can I learn from what just occurred? How can I be a better person and better clinician and scientist from this experience?" 

## ANNOUNCEMENTS

# ACCM Fellowship Match

I wanted to provide an update on the ACCM fellowship match. The ACCM fellowship application process has been managed by SF Match for four match cycles now, and we are in the midst of our fifth. So far it has largely been viewed as successful, and most programs report seeing a larger number of applications since the match was instituted. At the time utilizing a match was agreed upon, many programs worried that they would lose applicants to the vagaries of the match who otherwise they would have been certain to recruit. To address these concerns, a "match exception" component was adopted, allowing programs to "pre-match" individuals falling into one of six categories:

1. Applicants who are in active military service at the time of application.
2. Applicants who are making a commitment to come to the institution of the CCM fellowship for more than one year.
3. Applicants who are enrolled in an anesthesiology residency outside of the USA at the time of the application.
4. Applicants who reside outside the USA at the time of application or who are not eligible for ABA certification due to non-US training.
5. Applicants whose spouse or partner is applying for a GME-approved post graduate training program in a medical specialty in the same region as the CCM fellowship.
6. Internal candidates.

This system has worked reasonably well, with the vast majority of exceptions being either internal applicants or applicants committing to two years at one institution. On occasions, however, because these requests were processed manually, exception requests were lost or misfiled. This year, for the first time, that process has become automated. Applicants and program directors each fill out a form online found on the SOCCA website, and an automated email is sent to those individuals as well as to the program directors' chair. The agreement is then posted on the "SOCCA match exceptions page" also found on the SOCCA website. That list will then be cross-checked with the match results before they are released on May 31. Applicants and program directors alike should appreciate this more streamlined process that is less vulnerable to human error. 



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[Learn more about ACGME Accredited ACCM Fellowship Programs.](#)

# SOCCA 2018 Annual Meeting and Critical Care Update

Welcome to the SOCCA 2018 Annual Meeting and Critical Care Update, a meeting I am confident you will find rewarding with many valuable takeaways and networking opportunities. The members of the SOCCA Committee on Education, Drs. Adam S. Evans, Sheila Pai Cole, and Peter Von Homeyer, have developed a cutting-edge education program, addressing the latest advances in critical care and investigating the most pressing issues in anesthesiology. Plus, stay through Saturday, April 28, for the Aligned Meeting and SOCCA Focus on Critical Care Day education sessions at the IARS 2018 Annual Meeting and International Science Symposium, available complimentary to SOCCA registrants.

Visit the SOCCA Tabletop Exhibits for the latest innovations in technology, equipment, and medical publications.

I hope your time with the leaders in critical care anesthesiology and your colleagues will energize you and give you the tools and skills you need to advance your practice and research while enjoying all Chicago has to offer.

Sincerely,

Avery Tung, MD, FCCM,  
*President, Society of Critical Care Anesthesiologists*

[Learn more, read the preliminary program, and register today!](#)



# April 28 is Aligned Meeting Day

The attendees of the SOCCA Annual Meeting will have the opportunity to take advantage of a special Aligned Meeting and SOCCA Focus on Critical Care Day on Saturday, April 28, complimentary as part of their registration fee. Thought leaders in anesthesiology will present a wide selection of robust education sessions, highlighting pioneering topics in anesthesia and celebrating advances in education, science, research and the art of anesthesiology.

Read more about [IARS Aligned Meeting and SOCCA Focus on Critical Care Day](#).

7:30 am – 9:00 am **Opening General Session and T.H. Seldon Memorial Lecture:**

***Personalizing Health Care in the Era of Big Data***

with Dr. Jeffrey R. Balsler

Over the past two decades, Dr. Balsler has guided expansion of Vanderbilt University School of Medicine research programs in personalized medicine, human subjects research, and population health, moving Vanderbilt University School of Medicine's ranking to eighth in the nation among U.S. medical schools in total grant support provided through the National Institutes of Health (NIH).

9:30 am – 12:00 pm **Symposium: AUA: Mitochondria and Bioenergetics in Health and Disease: It's Not Just a Power Failure!**

with Drs. Paul S. Brookes, Elizabeth A. Jonas, Y.S. Prakash, Douglas L. Rothman, and Douglas C. Wallace

This invigorating symposium will highlight important questions relating to mitochondria and bioenergetics that impact the perioperative environment. Examine the roles of altered mitochondrial structure and function as well as bioenergetics and unintended consequences of drugs or other interventions on mitochondria and bioenergetics and how this may help improve and individualize patient care.

12:00 pm – 1:00 pm **Problem-Based Learning Discussion: AUA: Why Study Time Doesn't Always Lead to Learning: How Do We Help the Struggling Trainee?**

with Drs. Ersne Eromo and Daniel Saddawi-Konefka

This hands-on session will provide various self-study methods available to trainees, including relative effectiveness of each technique, offering an approach to unpack a trainee's study habits and to prepare a study plan for a hypothetical trainee that combines effective learning modalities.

4:00 pm – 5:00 pm **Problem-Based Learning Discussion: AUA: Getting to the Heart of the Matter: Perioperative Focused Cardiac and Pulmonary Ultrasound, and The Hemodynamically Unstable Patient**

with Drs. Alexander S. Kuo and Abraham Sonny

Evaluate the role of anesthesiologist-performed focused cardiac and pulmonary ultrasound in the perioperative period and the role of focused ultrasound in hemodynamic assessment for guiding diagnosis and management of undifferentiated shock.

# UPDATE ON CLINICAL RESEARCH CONSORTIUM

## Collaborative Research Initiative for Perioperative Clinical and Translational Science Meeting

Towards the end of last year, a consortium of academic anesthesiology organizations launched an initiative to help establish a clinical trials network in the U.S., which would focus on perioperative medicine, critical care, pain management, and peri- and post-partum care. The consortium included the Association of University Anesthesiologists, Early-Stage Anesthesiology Scholar, the Foundation for Anesthesia Education and Research, the International Anesthesia Research Society, and the Society of Critical Care. In conceptualizing this initiative, it was thought that the new clinical trials network could naturally collaborate with other existing international networks.

There was a call for submissions of clinical research proposals. Despite a tight deadline, seasoned anesthesiology investigators around the United States submitted 17 letters of intent and brief proposals for pragmatic trials. The proposals are all high caliber, and all focus on outcomes that are clinically relevant and important to society. At very short notice, a study section was assembled to rank these, and to solicit expanded proposals from six of the 17 applications. From the six finalists, the study section will select three proposals. Two world experts in clinical and translational research are leading the study section. The other members of the study section are academic leaders representing the organizations that are spearheading this initiative.

The clinical research consortium will be formally launched at an exciting symposium on May 1, 2018, from 1:00 pm to 4:00 pm, following the IARS, AUA and SOCCA Annual Meetings in Chicago. This meeting will be open to all those interested in anesthesiology-related clinical and translational science. The agenda for the symposium will include:

- (i) A session on innovative and efficient approaches to multicenter clinical trials;
- (ii) Presentation and review of three selected clinical trial protocols. The review will include constructive feedback regarding clarity of hypotheses, merit of research methods, and feasibility. The format of this session will be somewhat similar to an NIH study section. The goal of this review session will be to address issues common to many proposals to ensure an educational experience for all investigators who attend the symposium, in addition to those whose proposals are selected.
- (iii) Presentations by the Duke Clinical Research Institute and the Multicenter Perioperative Outcomes Group. These exemplify organizations that can serve as data coordinating centers and provide other “core” support to clinical trials.
- (iv) A focus on PACT, the Canadian Anesthesiology clinical trials initiative. Potential for collaboration between pact and this new clinical trials initiative will be highlighted.

There is tremendous excitement regarding this clinical trials initiative in Anesthesiology, and if it is successful, it will be an important catalyst for advancing academic anesthesiology and for providing a platform for addressing some of the most relevant research questions confronting our field. 🏛️



**President-Elect, AUA**  
**Michael S. Avidan,**  
**MBBCh**  
Washington University  
School of Medicine  
St. Louis, Missouri



The 34th World Congress of Internal Medicine for 2018 will be held in the beautiful city of Cape Town in South Africa, at the International Convention Centre from 18 to 21 October 2018. All aspects of Internal Medicine will be covered during parallel sessions presented by an exciting faculty drawn from experts across the international community. The aim of the meeting is to provide an excellent academic programme for the general physician but of a standard that the specialty groups such as Rheumatologists, Cardiologists, Pulmonologists and so on would also benefit. **Register today!**



## **Second Announcement and Call for Abstracts**

18<sup>th</sup> - 21<sup>st</sup> October 2018 [www.wcim2018.com](http://www.wcim2018.com)





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**THE 37TH ANNUAL INTERNATIONAL SYMPOSIUM:**  
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**January 20-25, 2019 | ARUBA, Renaissance**

Final program and hotel information will be available in September, 2018.

Interesting cases and research abstracts will be accepted for oral presentation.

For abstract form contact: [menachem.weiner@mountsinai.org](mailto:menachem.weiner@mountsinai.org) (Deadline October 30, 2018).

For faculty information: [george.silvay@mountsinai.org](mailto:george.silvay@mountsinai.org)

For general information: [margorie.fraticelli@mountsinai.org](mailto:margorie.fraticelli@mountsinai.org)



# MEMBERSHIP

## About SOCCA



The Society of Critical Care Anesthesiologists (SOCCA) is the sole organization dedicated to the continuation of the role of anesthesiologists in providing critical care services. You do not have to be an intensivist to benefit from membership in this organization. Critical care practices are utilized in the post anesthesia care

unit, intermediate care unit, emergency department/trauma center as well as the intensive care unit. Practitioners with clinical case loads that are dominated by cardiac, neurosurgical, and transplant procedures may be frequently involved in the daily perioperative care of critically ill patients. Patients in all of these care areas may require aggressive monitoring and state of the art perioperative care. The continued enhancement of critical care services throughout the perioperative period is a founding goal of SOCCA.

### ADVOCACY

SOCCA is an educational organization that fosters the role of anesthesiologists as perioperative specialists and provides for continuing education and interchange of ideas

The Society provides representation for the practice of critical care medicine in the ASA House of Delegates

SOCCA provides input to the ASA and Society of Critical Care Medicine on key issues related to their advocacy for patient care and reimbursement

### BENEFITS OF MEMBERSHIP

Discounted pricing for the SOCCA Annual Meeting a forum for the specialist with broad-based interests, including respiratory therapy, postoperative cardiac surgical, neurological and transplant management, and trauma care

Discounted membership in the IARS, which includes access to two peer-reviewed journals-Anesthesia & Analgesia and A&A Case Reports, free journal CME, and eligibility to apply for IARS research grants

### FREE ICU RESIDENT'S GUIDE

Free quarterly newsletter Interchange, which covers ethically controversial issues, survey of practice patterns, and historical aspects of anesthesiology

### MEMBERSHIP LEVELS

#### Active Member | \$160.00 / year

Active members shall be physicians who should be members of the ASA and have an interest in critical care medicine. Each Active member shall have one vote on any matter on which Active members are entitled to vote by law or that is submitted to a vote of the membership, and shall enjoy all rights and privileges of membership.

#### Affiliate Member | \$110.00 / year

Affiliate members shall be physicians or scientists who are active in training programs or research relating to critical care medicine, but who do not fulfill the definition of Active member.

#### Educational Members | \$25.00 / year

Educational members shall be residents or fellows in full-time training in an accredited school of medicine in the United States or abroad.

#### Medical Student Members | Complimentary Membership

Medical Student members shall be individuals in full-time training in an accredited school of medicine in the United States or abroad.

#### Retired Members | Complimentary Membership

Retired members shall be individuals who have been Active members of the Society for ten (10) or more years and have completely retired from professional practice.

*Affiliate, Educational, Medical Students and Retired members shall have all rights and privileges of Active members, except that they may not vote, attend corporate business meetings (including, without limitation, the Annual Business Meeting) except by invitation, or serve as an officer or a director of the Corporation. Such members may serve on committees if requested by the Board of Directors.*

### MEMBERSHIP PROCESS

SOCCA membership does not require formal sponsorship and can be applied for online.

[Click here to Join.](#)

[Click here to Renew.](#)



# SOCCA Information

## EMAIL

Meetings: [SOCCAm eetings@iars.org](mailto:SOCCAm meetings@iars.org)

Membership information: [SOCCA@iars.org](mailto:SOCCA@iars.org)

**VISIT THE SOCCA WEBSITE at:**  
**[www.SOCCA.org](http://www.SOCCA.org)**

## MEMBERSHIP

Membership in SOCCA is open to all anesthesiologists who have an interest in critical care medicine; nonanesthesiologist-physicians and scientists who are active in teaching or research relating to critical care medicine; residents and fellows in approved anesthesiology programs; and full-time medical students in an accredited school of medicine.

## MEMBERSHIP BENEFITS

Discounted pricing for the SOCCA Annual Meeting, a forum for the specialist with broad-based interests, including respiratory therapy, postoperative cardiac surgical, neurological and transplant management, and trauma care

Discounted membership in the IARS, which includes access to two peer-reviewed journals – Anesthesia & Analgesia and A&A Case Reports, free journal CME, and eligibility to apply for IARS research grants

Free ICU Residents' Guide

Free quarterly newsletter Interchange, which covers ethically controversial issues, survey of practice patterns, and historical aspects of anesthesiology

Renew or join today at [www.SOCCA.org/membership.php](http://www.SOCCA.org/membership.php)

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### Fellowship Program Reviews

If you would like to contribute a review for a Fellowship Program at your institution in a future issue of the SOCCA Interchange, please contact: [jbrandmd@gmail.com](mailto:jbrandmd@gmail.com).

### Editorial Policy

The opinions presented are those of the authors only, not of SOCCA. Drug dosages, accuracy and completeness of content are not guaranteed by SOCCA.

## CALL FOR ARTICLES



If you have an interesting case report, an idea for a pro-con discussion, a review idea, or an opinion on a recently published article, please submit your proposal/article to Vivian Abalama, CAE, at [vabalama@iars.org](mailto:vabalama@iars.org) on or before Friday, April 20, 2018. If your article is chosen for the newsletter, we will contact you for editing and formatting. Thank you.

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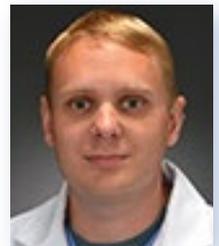
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