The ASCCA Interchange is back! Our new co-editor, Kenneth G. Smithson, D.O., Ph.D., from Vanderbilt University, has put together the current edition. One change to the newsletter is the inclusion of a case report section where fellowship programs have been invited to submit case reports and highlight their fellowship program. This issue features the fellowship at the Massachusetts General Hospital in Boston (page 3).

Membership
Through the efforts of Michael F. O’Connor, M.D., and his band of brothers and sisters who serve as regional membership directors, membership in the ASCCA is improving. All lapsed ASCCA members and fellowship-trained anesthesiologists who are not ASCCA members have been contacted. In addition the directors have attended regional anesthesiology resident conferences to promote membership in ASCCA. Since January of 2005, we have added 39 new/lapsed members (about a 10-percent increase); and for the current year, we have added more than 15 new members. Congratulations to his group!

Education
The ASCCA Annual Meeting is shaping up to be a great one. The preliminary program is published on page 20 in this issue. In addition, letters have gone out to all anesthesiology residency programs asking the chair/program director to sponsor at least one CA-2 resident to the Annual Meeting. In exchange for that sponsorship, the registration fee will be waived. That resident will be paired with a seasoned intensivist and mentored through the day. Thus far about 15 programs have responded with the intention of sending at least one resident.

The ASCCA Breakfast Panel at the American Society of Anesthesiologists (ASA) Annual Meeting will be on Sunday, October 15, 2006, from 7 a.m. to 8:15 a.m. The theme will be “The ICU of the Future.” Michael J. Breslow, M.D., will discuss “eICU — An Opportunity to Improve Care? The Industry Perspective,” and Sean M. Berenholtz, M.D., will talk about “An Opportunity to Improve Care: What Can We Do on the Frontline?”

There will be an ASCCA/Anesthesiology poster discussion on Monday, October 16, with eight posters to be presented. Clifford S. Deutschman, M.D., and I will moderate that session. Similar to previous years, there is a critical care track with lectures relevant to critical care interspersed throughout the entire ASA Annual Meeting. A number of ASCCA members are speaking in those venues.

Daniel S. Talmor, M.D., from Beth Israel Deaconess Hospital in Boston, has assumed editorship of the “Resident’s Guide to Learn—

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MEMBERSHIP INFORMATION

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General inquiries:
ascca@ASAhq.org
Meeting information:
asccameetings@ASAhq.org
Membership information:
asccamembership@ASAhq.org

Membership
Membership in ASCCA is open to all anesthesiologists and residents in approved anesthesiology programs. Membership applications may be obtained by writing to ASCCA, 520 N. Northwest Highway, Park Ridge, IL 60068-2573 or through the ASCCA Web site at <www.ascca.org/membership.html>.

Web Page
You may visit the ASCCA World Wide Web site at: www.ascca.org

ASCCA Dues
Dues are $150 for active and affiliate members; $100 for international members and free for residents/fellows. Dues may be paid online at <www.ascca.org/cart.html> by credit card or by mailing payment to the ASCCA office. Remember, payment of your dues allows you to enjoy the full privileges of ASCCA membership.

EDITORIAL NOTES

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

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**CASE STUDY:**

**Fatal Arterial Thrombosis From Heparin-Induced Thrombocytopenia Following Thoracoabdominal Aneurysm Repair**

Aman Kalra, M.D.
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The Critical Care Fellowship Program of the Department of Anesthesia and Critical Care, and the Division of Vascular and Endovascular Surgery of the Massachusetts General Hospital, Boston.

Heparin-induced thrombocytopenia (HIT) is a syndrome of thrombocytopenia and thrombosis caused by circulating IgG antibodies (“HIT” antibodies) that may form against heparin-platelet factor-4 (PF-4) complexes. Although HIT antibodies may form in as many as 50 percent of patients receiving unfractionated heparin (UFH), significant thrombocytopenia (a platelet count <100,000/mm³ or a decrease ≥ 50 percent of baseline) and thrombosis occur in only 1 percent to 5 percent of cases.

Patients with HIT have high mortality rates, and approximately 50 percent develop a major new thrombotic event such as myocardial infarction, stroke, limb ischemia, deep-vein thrombosis (DVT) and pulmonary emboli.

The onset of thrombocytopenia (the first sign of HIT in >90 percent of the cases) occurs generally within five to 12 days, but occasionally earlier. It is believed that a “rapid onset HIT” is due to the presence of circulating HIT antibodies that were formed after exposure to UFH within the previous 100 days.

We describe a case of early onset, fatal HIT following repair of a thoracoabdominal aortic aneurysm (TAA) in a patient who received UFH at least a year prior to the current admission.

**Case Report**

A 77-year-old woman was scheduled for elective repair of a 6-cm, type 3 TAA. Her medical history was significant for hypertension, hypercholesterolemia, cigarette smoking, a partial colectomy, a hysterectomy and vulvar surgery. Her last surgery, which occurred one to two years prior to the present admission, was complicated by a right lower extremity DVT that was treated with intravenous UFH followed by warfarin. Approximately eight months prior to admission, the patient suffered a fall, complicated by a DVT, which was treated with low-molecular weight heparin (LMWH). Her preoperative evaluation was unrevealing, and her platelet count was 383,000/mm³.

The patient underwent the first stage of the planned TAA repair, which consisted of resection and grafting of the juxtarenal portion of the aneurysm, with additional aortic grafts to the right and left renal arteries, superior mesenteric artery and aortoceliac axis. She received 5,000 U of UFH intravenously before an 18-minute suprarenal cross clamping. Her intraoperative course was complicated by the presence of multiple adhesions from her previous surgeries. Over a period of six hours, she lost approximately 3 L of blood and received 9 L of crystalloids, two units of red cells and one L of salvaged blood. Following completion of the procedure, the patient was transferred to the surgical intensive care unit (SICU) intubated and mechanically ventilated on no vasoactive medications. Her arterial blood gas showed a moderate metabolic acidemia (pH 7.25, PaCO₂ 39), and her platelet count was 186,000/mm³ [Figure 1]. Over the ensuing several hours, despite what seemed adequate volume resuscitation by clinical and instrumental parameters, her acidemia worsened (pH 7.14, PaCO₂ 37, serum lactate 8.2 mmol/L). An abdominal ultrasound revealed patency of all visceral grafts. Twelve hours after admission, her serum lactate concentration had increased to 14.1 mmol/L, her AST to 5,760 U/L, ALT to 7,481 U/L, and her platelet count had dropped to 54,000/mm³. An HIT antibody screen was obtained. A computed tomography of the abdomen showed occlusion of the aortic grafts to the right renal, celiac and superior mesenteric artery [Figure 2]. The patient was taken to the operating room for re-exploration, which revealed primary thrombotic occlusion.
Continued from page 3

of all aortic grafts, ischemic but viable liver and bowel and a necrotic spleen, which was removed. Multiple thrombectomies were performed. The abdomen was closed and a second-look laparotomy planned for within 24 hours. Given the clinical picture consistent with HIT, all heparin sources were discontinued and an argatroban infusion initiated. The patient returned to the SICU requiring ongoing resuscitation with volume, blood products and vasoactive agents. Her general status continued to deteriorate, however, with worsening metabolic acidosis, increasing vasopressors requirement, coagulopathy and oliguria. After discussions with the family, it was elected to withdraw aggressive care and continue comfort measures only. The patient expired shortly thereafter. Her HIT antibody assay was positive.

Discussion
The most important teaching points of this case are:

1. HIT can have a hyperacute, devastating course. “Rapid onset HIT” can occur within hours of exposure to UFH, reflecting the existence of circulating HIT antibodies. Different from other antibody-mediated reactions, the immunologic memory for the heparin PF-4 complex is short-lived, and serum HIT antibody titers are generally undetectable after three months from the original exposure. Patients have been challenged safely with UFH under these circumstances.

2. Previous exposure to UFH occurred more than a year prior to the event, a time interval significantly longer than described in the literature. A previous case report describes a patient with positive HIT test 165 days after receiving UFH, and this patient had an uneventful clinical course. Our patient, however, received LMWH within a few months after the original UFH administration. Although this exposure also is remote in relationship to the present event, one could hypothesize that LMWH reactivated a previous UFH-mediated immunization.

3. The significance of decrease in platelet count after aortic surgery is difficult to interpret. Open aortic aneurysm resection and grafting are predictably associated with thrombocytopenia due to platelet adhesion to the synthetic graft material, dilution coagulopathy or DIC. Hence the most common warning sign of HIT, thrombocytopenia, is less specific under these circumstances.

Conclusion
Rapid-onset HIT can have devastating effects. Routine HIT testing would identify all patients with HIT but also include a larger number of patients with HIT antibody without the syndrome, leading to overuse of nonheparin anticoagulants. At present a high index of suspicion for HIT, with watchful vigilance for a postoperative drop in platelet count of more than 100,000/mm3 or 50 percent of baseline, seems a reasonable criterion for HIT testing, heparin discontinuation and start of a nonheparin anticoagulant. If the HIT antibody test turns out to be negative, UFH may be resumed.

References:

Abdominal computed tomography with contrast obtained approximately 12 hours postoperatively. The three-dimensional reconstruction shows failure of opacification of the celiac, superior mesenteric and right renal aortic grafts.

The Fellowship in Critical Care Medicine of the Department of Anesthesia and Critical Care at the Massachusetts General Hospital (MGH) in Boston is accredited by the Accreditation Council for Graduate Medical Education and the American Board of Anesthesiology. Our department has provided training in critical care for more than 40 years.

Currently we provide state-of-the-art critical care training to a group of five to six fellows per year. Our 20-bed surgical intensive care unit is the core of our training and offers an unmatched mix of patients, including complex general surgery, thoracic, vascular and trauma patients.

In addition fellows have ample educational and clinical opportunity in the weaning unit and medical and neurology intensive care units.

Our faculty is 100-percent critical care board-certified or eligible, and it includes anesthesia-, surgery- and medicine-boarded staff. We strive to provide the highest quality care to our patients, to educate trainees to become outstanding physicians and leaders, and to promote clinical research.

Our Web site <www.etherdome.org/Education> contains additional information on our faculty, facilities and on how to apply for a fellowship position.
I. Mission:
The ASCCA is dedicated to educating anesthesiologists in the care of critically ill patients and to fostering the knowledge and practice of critical care medicine by anesthesiologists.

II. Vision:
The ASCCA will be the premiere organization of anesthesiology intensivists dedicated solely to matters regarding the critically ill patient.

III. Objectives:
A. Enhance the understanding of the value that anesthesiologist/intensivists bring to patient care by educating accrediting agencies, regulators, purchasers, payers and the consumer;
B. Provide educational opportunities to the anesthesiology community regarding the care of the critically ill by providing vehicles to educate individual practices and practitioners.
C. Support research through joint grants with the Foundation for Anesthesia Education and Research (FAER).
D. Increase the number of anesthesiologist/intensivists;
E. Provide our members with an avenue for advocacy.
F. Ensure the viability of our organization.

IV. Goals:
A. Recruit new members, engage members and retain existing members.
B. Elevate the profile of ASCCA within the American Society of Anesthesiologists (ASA).
C. Have input into the Critical Care Pay-for-Performance Initiative.

V. Strategy to achieve goals:
A. Recruit new members, engage members and retain existing members.
1. Identify board-certified intensivists and contact them via letter and telephone calls — President contacts regional membership directors.
2. Direct regional membership directors to call program directors encouraging them to send one CA-2 Resident to the ASCCA Annual Meeting — President contacts regional membership directors.
3. Send letter to Society of Cardiovascular Anesthesiologists President to partner with SCA in having a meeting — President and Committee on Education Chair contacts SCA President.
4. Request for proposal for the ASCCA Annual Meeting and the ASA Critical Care Medicine Track — Annual Meeting Co-chairs and ASA Critical Care Track Chair coordinate tracks of ASCCA with ASA.
5. Create a Resident Section within ASCCA — Chair of the Committee on Membership to coordinate.
6. Finalize the new “Resident Guidelines to Learning in the Intensive Care Unit” — President to contact involved parties.
7. Send electronic newsletter to all residents and provide free membership.
8. Create new brochure.
9. Re-price the Annual Meeting registration.
B. Elevate the profile of ASCCA within ASA.
1. Have ASCCA slide at all CCM track sessions.
2. Create new brochure.
   a. Use company approved at Board of Directors meeting.
b. Investigate the possibility of having a more usable link from the the ASA Web site to the ASCCA Web site.
4. President sends out letters to ASCCA Membership requesting nominations for ASCCA committee membership (President will forward recommendations to First Vice-President immediately following the Annual Meeting).
a. Critical Care Medicine
b. Governmental Affairs
c. Economics
d. Respiratory care committees
5. President or designee attends ASA Board of Directors meetings.
6. Badge holders or ribbons for ASCCA members at ASA Annual Meeting.
7. Advertisement in Anesthesiology for the Annual Meeting.
8. Make the chair of the Committee on Critical Care Medicine an ex officio member of the ASCCA Board of Directors.
C. Have input into the Critical Care Pay-for-Performance Initiative.
1. Liaison with Committee on Performance and Outcomes Measurement (CPOM) and Committee on Critical Care Medicine.
2. Help to explore and develop individual performance elements — members for each individual element will be appointed by the President.
3. Make sure that we have proper input (e.g., CCWG) for our initiatives.
D. Continue to support research with joint grants with FAER. Partner with industry to ensure two annual FAER Awards. FAER will fund the second year of each award.
ASCCLA Election Nominations

The ASCCA Nominating Committee announces the 2006-2007 slate of candidates for election at the Society’s Annual Membership Business Meeting. Positions to be elected are President-Elect, Secretary, Treasurer and three Directors-at-Large. Nominees for these positions are as follows:

**President-Elect**
Todd Dorman, M.D.

**Treasurer**
Heidi Kummer, M.D.

**Secretary**
Michael F. O’Connor, M.D.

**Directors-at-Large**
Daniel R. Brown, M.D., Ph.D.
Christine A. Doyle, M.D.
Brenda G. Fahy, M.D.
Nicholas Sandovnikoff, M.D.
Aryeh Shander, M.D.
Avery Tung, M.D.

Members may submit nominations for the positions of Directors-at-Large from the floor of the business meeting which will be held Friday, October 13, 2006, at the Chicago Hilton Hotel.

Interchange Returns, Other Developments in Our Subspecialty

Continued from page 1

...ing in the Intensive Care Unit.” Recruitment of associate editors has occurred. He hopes to have the guide completely revised by the end of this calendar year.

**Governmental Affairs**
Todd Dorman, M.D., reports that the Relative Value Scale Update Committee submitted a proposal for increased relative value units for critical care codes to the Centers for Medicare & Medicaid Services (CMS) and is awaiting a final decision. In addition a final decision regarding adjustment of practice expenses will be made by CMS.

**Critical Care Medicine as a Specialty**
Mitchell P. Fink, M.D., and Peter M. Suter, M.D., published an article in the June issue of Critical Care Medicine titled “The Future of Our Specialty: Critical Care Medicine a Decade From Now.” This article is a synopsis of a consensus of a Round Table Conference of intensivists from diverse backgrounds. One of the interesting proposals cited in the paper is the establishment of a primary specialty in critical care medicine, such as exist in Japan and Spain, for instance. As proposed by the authors, the development and implementation of this pathway would be carried out in parallel with the training pathways that already exist within other specialties (e.g., anesthesiology, surgery and internal medicine). Of note here is that the American Board of Anesthesiology, spearheaded by former ASCCA presidents Douglas B. Coursin, M.D., and Neal H. Cohen, M.D., has been working with the American College of Surgeons toward a joint subspecialty certification examination.

The Society of Critical Care Medicine (SCCM) recently conducted a survey of its members regarding the future of critical care medicine. The primary focus was on the methodology by which future intensivists should be trained and certified. An individual specialty in critical care medicine was listed as one of the options in addition to several others. The results of the survey are pending.

Taking into account the proposal by Drs. Fink and Suter, it will be interesting to see what the SCCM membership thinks of a separate critical care medicine specialty.
The following is a brief report on the American Society of Anesthesiologists (ASA) Board of Directors (BOD) spring meeting, held March 4-5 in Chicago. Gerald A. Maccioli, M.D., ASCCA President-Elect, was in attendance in his role as ASA Director for North Carolina, and Heidi B. Kummer, M.D., Ph.D., pinch-hitting for President Stephen O. Heard, M.D., represented ASCCA.

ASA Public Relations Efforts
In an attempt to add breadth and depth to its public relations and advocacy teams, ASA hired Donna E. Habich as new in-house Public Relations Manager at ASA headquarters and Sarah Paff, M.A., as the new Advocacy Communications Manager for the Washington Office. Both boast track records in all forms of media. Ms. Paff has experience working in both houses of Congress and will coordinate the “marketing” aspects of ASA advocacy.

Conflict of Interest Form
The BOD considered a new, rather comprehensive “conflict of interest form” for all ASA members who serve on committees, task forces, etc. ASCCA members serving on or appointed to ASA committees should be seeing these forms shortly.

Reorganized HOD Handbook
The Handbook for Delegates to the Annual Meeting has been completely reorganized and color-coded in a much more user-friendly and logical fashion. The goal is to provide as much as possible in electronic format in the future.

Nonanesthesia Professionals Guidelines
The ASA “Credentialing Guidelines for Practitioners Who Are Not Anesthesia Professionals to Administer Anesthetic Drugs to Establish a Level of Moderate Sedation” was (again) discussed by the BOD, in a continuation of last October’s debate at the Annual Meeting. The issue here focuses on whether or not to endorse the concept of nonanesthesiologists performing “deep” versus moderate sedation, and also the qualifications for “rescue.” Certain national specialty organizations continue to push the Food and Drug Administration to remove the current restrictions on propofol. While this may appear to be mainly a turf battle, it is in fact really a patient safety issue. The BOD charged the Executive Committee with referral to a task force to differentiate credentialing versus privileging of nonanesthesiologists for sedation. This issue is far from being settled.

ASA leadership continues to meet with the American Association of Nurse Anesthetists (AANA). Much of the discussion centered on AANA’s opposition to the change in the Medicare anesthesiology teaching rule.

Katrina Assistance
The Anesthesia Foundation and ASA made extraordinary efforts and provided financial assistance to help residents displaced from their homes and training programs by Hurricane Katrina to relocate so as to minimize any interruption in their educational continuum. It is gratifying to note that among all the medical specialties, anesthesiology, along with its subspecialties, was the only one to assist residents, fellows and other physician colleagues in such a broad manner.

Reimbursement Issue
The ASA delegation to the American Medical Association (AMA) and AMA are working together to have the Centers for Medicare & Medicaid Services (CMS) re-evaluate its reimbursement policies for anesthesiology services. In addition AMA has become very interested in the training and certification standards for “limited licensure health care providers” – this is of considerable importance to ASA and the ongoing agenda for patient safety.

P4P Quality Measures
Under the astute direction of ASA Vice-President for Professional Affairs Alexander A. Hannenberg, M.D., ASA has produced five pay-for-performance (P4P) quality measures (timely antibiotic administration, perioperative normothermia, chronic pain management planning, catheter-related blood stream infection and ventilator-associated pneumonia), which are now slated for review and ultimate implementation. Several ASCCA members, including Stephen O. Heard, M.D., Todd Dorman, M.D., Clifford S. Deutschman, M.D., Michael F. O’Connor, M.D., Dr. Kummer and Dr. Maccioli, were intricately involved in
the design of the two intensive care unit-related measures.

The BOD reviewed and approved a new statement on “Principles for Quality Incentive Programs in Anesthesiology,” which incorporates eight key principles:
1. Demonstrable Relevance to Quality of Perioperative Care
2. Inclusive of Practice Styles and Settings
3. Meaningful Reward
4. Supporting Collaborative Care
5. Viable Economic Environment
6. Low Burden of Implementation
7. Disclosure
8. Advance the Specialty

In addition ASA has representatives at the Surgical Quality Alliance (SQA) and Ambulatory Care Quality Alliance (AQA). Much like “managed care,” we can choose to either be “at the table” or “on the menu.” ASA involvement and collaboration in these multispecialty forums on P4P are crucial to the specialty of anesthesiology, and by extension, critical care, and provide a direct conduit for relevant input into the process. Some keep thinking P4P will just go away, but that is not going to happen. Thus we need to choose between managing the process and conversely (perversely?) being managed ourselves!

**Medication Verification Rule**
Due to outstanding work by the Committee on Equipment and Facilities — along with the Committee on Quality Management and Departmental Administration and ASA’s Joint Commission on Accreditation of Healthcare Organizations representatives — the proposed rule for medication verification by two individuals was modified to apply only when “the person preparing the medication is not the person administering the medication.” The change should significantly minimize the concerns this new rule had posed for anesthesiologists.

**Ethics Issues**
A last-minute resolution introduced by the director from California, dealing with “Physician Participation in Executions,” was referred to the Committee on Ethics after over an hour of testimony and considerable debate. The resolution will be revisited at the August BOD meeting, and the full House of Delegates (HOD) will undoubtedly have the opportunity to review this matter during ASA’s Annual Meeting this October 14-18 in Chicago.

**Future ‘Face Time’ at ASA BOD**
The ASCCA Executive Board is committed to having at least one, but preferably two, representatives attend every ASA BOD gathering as well as at the upcoming ASA Legislative Conference at the beginning of May in Washington, D.C. “Face time” is the best way to ensure that the channels of communication remain open and our input continues to be sought and valued. Since Dr. Maccioli becomes ASCCA President in October 2006, and he already attends the ASA BOD meetings as North Carolina Director, he has asked that the Executive Committee provide an alternative representative to “carry the ASCCA flag.”

Should you have any further questions, please do not hesitate to contact either of us.

“Some keep thinking P4P will just go away, but that is not going to happen. Thus we need to choose between managing the process and conversely (perversely?) being managed ourselves!”
The Hilmar Burchardi Award is an award that is jointly sponsored by ASCCA and the Society of Critical Care Medicine (SCCM) Anesthesiology Section. It was named after its first recipient, Hilmar Burchardi, M.D., a pioneer in the field of anesthesiology/critical care, a revered teacher and a founding member of the European Society of Intensive Care Medicine, which he presided over from 1998-2000. The award was first established in 2002 at the SCCM Annual Congress and is presented every two years, alternately at an ASCCA or SCCM event.

The recipient must be an anesthesiology-based intensivist who has been practicing for at least 12 years and who has held a leadership position in at least one of the established national or international critical care societies/organizations. Each recipient of the honor has made considerable contributions to the specialty, not necessarily in terms of research, but especially in terms of ability to motivate and touch people. His/her greatness and leadership are defined equally by competence, humility, humanity and a sense of humor; in short, this is a “Good Guy/Good Gal” award. The award recipient must be a member of at least one but preferably both sponsoring organizations, ASCCA and/or SCCM.

Philip D. Lumb, M.B., B.S., F.C.C.M., Chairman of the Department of Anesthesiology at the Keck School of Medicine of the University of Southern California, was recently named the third recipient of the Hilmar Burchardi award. He received this honor while attending the SCCM 33rd Annual Meeting in January 2006 in San Francisco. This well-deserved tribute recognized his career-long commitment to furthering the role of anesthesiologists in multidisciplinary critical care in the United States and abroad. Through his multiple leadership roles in ASCCA, SCCM and the World Federation of Intensive Care Societies (WFICS), he has worked tirelessly to disseminate new knowledge and advances in the care of the critically ill. As president of ASCCA, he was a strong and effective advocate for expanding the scope of anesthesiology practice into the perioperative management of the surgical patient. As a member of SCCM’s Council and the American College of Critical Care Medicine Board of Regents, he worked tirelessly to aid in the development of practice parameters and the dissemination of evidence-based guidelines. Finally as the recent President of WFICS, he again fostered international ties for the specialty of critical care medicine.

Dr. Lumb has written and edited extensively. He has been a visiting professor at multiple institutions and has lectured widely on a host of germane topics that include cardiovascular medicine and critical care resource utilization. He continues to be a strong and effective advocate for resident education through his efforts as a representative to the Anesthesiology Residency Review Committee (RRC) and as the liaison to the Accreditation Council for Graduate Medical Education RRC on Transitional Year Training. The latter role will facilitate enhanced resident education in critical care as the scope of practice continues to evolve.

As a critical care practitioner, educator and leader, Dr. Lumb has emulated the high standards established by Dr. Hilmar Burchardi, founding member and past president of the European Society of Intensive Care Medicine and Emeritus Professor and Chair of the departments of anesthesiology, emergency and intensive care medicine at the University Hospital in Goettingen, Germany. His continued efforts reflect highly on ASCCA and our specialty.
Please see meeting program information on the following pages.
Friday, October 13

7 a.m. - 5:30 p.m.
Registration

7 a.m.
Continental Breakfast

7:45 - 7:50 a.m.
Welcome and Introductions
Co-Chairs: Louis Brusco, Jr., M.D., F.C.C.M.
Michael F. O’Connor, M.D.

Morning Session Lectures
First Lecture Session:
Moderator: Andrew Rosenberg, M.D.

7:50 - 8:20 a.m.
Complications of Transfusion
Aryeh Shander, M.D.

8:20 - 8:50 a.m.
Hyperventilation During and After CPR
Andrea Gabrielli, M.D., F.C.C.M.

8:50 - 9:20 a.m.
Inflammatory Drivers of Acute Lung Injury
Jeffrey M. Dodd-O, M.D.

9:20 - 9:30 a.m.
Q&A

9:30 - 9:50 a.m.
Break and Poster Viewing

Second Lecture Session:
Moderator: Joel B. Zivot, M.D.

9:50 - 10:20 a.m.
The Future of Medical Accident Investigation
Richard I. Cook, M.D.

10:50 - 11:20 a.m.
Acute Lung Injury — Update on ARDS and ARDSnet
Peter Rock, M.D.

11:20 - 11:30 a.m.
Q&A

11:30 a.m. - Noon
Address by the ASA President-Elect Mark J. Lema, M.D., Ph.D.

12 Noon - 1:30 p.m.
Lunch and Business Meeting

Scientific and Leadership Session
1:30 - 1:40 p.m.
Presentation of Residents’ Travel Awards

1:40 - 1:50 p.m.
Introduction of ASCCA/FAER Research Award

1:50 - 2:30 p.m.
Young Investigator Award and Presentation of Abstract

2:30 - 3 p.m.
Recombinant Factor VIIa — Use in the O.R. and ICU
Per A. Thorborg, M.D., Ph.D., F.C.C.M.

3 - 4 p.m.
Break, Poster Viewing and Professor Walk Rounds
Facilitators: Philip D. Lumb, M.B., B.S., Steven J. Allen, M.D., F.C.C.M.

4 - 4:30 p.m.
Lifetime Achievement Award Presentation and Lecture
Presenter: Clifford S. Deutschman, M.D., F.C.C.M.
Recipient: Douglas B. Coursin, M.D.

4:30 - 5:30 p.m.
Pro-Con: “You Can’t Have Too Much Inflammation”
Moderator: Patrick J. Neligan, M.D.
Discussants: Clifford S. Deutschman, M.D., F.C.C.M. (Pro)
William E. Hurford, M.D., F.C.C.M. (Con)
Faculty

ASCCA Interchange

| Steven J. Allen, M.D., F.C.C.M. | William E. Hurford, M.D., F.C.C.M. | Andrew Rosenberg, M.D. |
| University of Texas | University of Cincinnati Medical Center | University of Michigan |
| Houston, Texas | Cincinnati, Ohio | Ann Arbor, Michigan |
| Louis Brusco, Jr., M.D., F.C.C.M. | Mark J. Lema, M.D., Ph.D. | Aryeh Shander, M.D. |
| Columbia University | Roswell Park Cancer Institute | Englewood Hospital |
| New York City, New York | Buffalo, New York | Englewood, New Jersey |
| Richard I. Cook, M.D. | Philip D. Lumb, M.B., B.S. | Per A. Thorborg, M.D., Ph.D., F.C.C.M. |
| University of Chicago | University of Southern California | Oregon Health Sciences University |
| Chicago, Illinois | Los Angeles, California | Portland, Oregon |
| Clifford S. Deutschman, M.D., F.C.C.M. | Patrick J. Neligan, M.D. | Michael H. Wall, M.D. |
| University of Pennsylvania Health System | University of Pennsylvania | UT Southwestern Medical Center |
| Philadelphia, Pennsylvania | Philadelphia, Pennsylvania | Dallas, Texas |
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ASCCA Breakfast Panel

Join us Wednesday, October 18, from 7 a.m. to 8:15 a.m. for the ASCCA Breakfast Panel at the Hilton Chicago, Grand Ballroom, during the ASA Annual Meeting.

Title of Program: Making Perioperative Care Safe

Presenters: Jeanine P. Wiener-Kronish, M.D., Sean Berenholz, M.D., M.H.S., and Daniel H. Burkhardt III, M.D.

- To present an update on activities and efforts undertaken by the American Society of Critical Care Anesthesiologists and the American Society of Anesthesiologists.
- To present current basic and clinical research relevant to the art and science of critical care anesthesia.
- To review the state of the current understanding of the complications of transfusion and their treatment.
- To discuss the management of ventilation during and after CPR events and how it can alter physiology and recovery.
- To compare the information provided by the combination of central venous pressure monitoring and echocardiography to that obtained with a pulmonary artery catheter and to review how this information can be used to manage patients with unstable circulations.
- To understand what the future of medical accident investigation is and how it will help shape critical care in the future.
- To review the physiology of inflammation as it relates to lung injury and the modulators that are presently believed to drive injury in a variety of clinically important lung injuries.
- To review the results from the various ARDSnet protocols that have closed, to review the status of ongoing ARDSnet studies and to discuss their application to clinical practice.
- To learn from a critical care lifetime achievement award recipient about state-of-the-art critical care anesthesia.
- To discuss the scientific and clinical importance of posters presented at the meeting with acknowledged clinical leaders in critical care.
- To debate the role of the inflammatory response and its modulation in critical illness.

This activity has been planned and implemented in accordance with the Essentials and Standards of the ACCME through the Joint Sponsorship of ASA and ASCCA. ASA is accredited by ACCME to sponsor continuing medical education for physicians.

ASA designates this educational activity for a maximum of 7 AMA PRA Category 1 Credit(s)™. Physicians should only claim credit commensurate with the extent of their participation in the activity.
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Please see the updated Bylaws from the October 2005 Annual Meeting on the ASCCA Web site at: [www.ascca.org](http://www.ascca.org).