N E W S L E T T E R

ASCCA INTERCHANGE

AMERICAN SOCIETY OF CRITICAL CARE ANESTHESIOLOGISTS

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President's Message

What Will *YOU* Do to Help Our Society?

By Gerald A. Maccioli, M.D.
Raleigh, North Carolina

"It was the best of times, it was the worst of times."
— Charles Dickens, *A Tale of Two Cities*

Thus is the state of critical care medicine (CCM) in ASCCA today. While the American Society of Anesthesiologists (ASA) leadership, hospital administrators, federal and private payers, the job market and patients are all clamoring for "quality and safety" (read: *CCM provided by trained intensivists*), ASCCA has slowly but surely slipped from the radar screen.

Our organization needs corporate CPR, and we are going to do it!

Our goal is to reinvigorate ASCCA, identify our strengths as an organization, and leverage those attributes to contribute to and once again assume a leadership role in the CCM movement. I want to hear from you directly and am open to consideration of any suggestions you may have to help us advance our agenda and foster the growth of ASCCA.

In the wake of our Executive Committee Strategic Planning Session in Atlanta in 2005 and at this year's outstanding Annual Meeting in Chicago, what do I see as our organization's core strengths?

C — Core Mission: Education of intensivists and nonintensivists
P — Promulgate: Promote and publicize our successes as a subspecialty
R — Retain (and Recruit): Give value to our members and grow our membership

Let me describe some of the efforts that are already under way. The **Committee on Membership** was restructured last year, allowing a more regionally directed effort. This paradigm has been successful in increasing our membership, and we will continue in the same fashion. ASCCA membership is near an all-time high! Our regional recruiting directors (Fareed Azam, M.D., Daniel Brown, M.D., Ph.D., Louis Brusco, M.D., F.C.C.M., Steven A. Deem, M.D., Andrea Gabrielli, M.D., F.C.C.M., Steven Hatta, M.D., Michael F. O'Connor, M.D., Manuel C. Pardo, M.D., Stephen D. Surgenor, M.D., Michael H. Wall, M.D., and Christopher Young, M.D.) have done an outstanding job!

Gerald A. Maccioli, M.D.

At this year's ASCCA Annual Meeting, we trialed a "**Resident Mentor Program.**" In my opinion, it was the single best and most successful idea we have implemented over the past decade to attract and recruit new intensivists and members. Kudos to Dr. O'Connor for thinking "outside of the box" and making a new idea work. For those of you who are fellowship directors, serving as a "mentor" to a resi-

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"But at the top of my threat list is apathy, the 'someone else will do it attitude' that just won't fly anymore. We have too much to do, and we need your help to do it!"

ASCCA

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MEMBERSHIP INFORMATION

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Meeting information:
asccameetings@ASAhq.org
Membership information:
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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 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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> ***"Our organization needs corporate CPR, and we are going to do it!"***

dent attending our Annual Meeting is a golden opportunity to recruit new fellows.

Of course membership needs value, and this year's record attendance at the meeting demonstrated that with a fine point. Congratulations to Dr. Brusco and Dr. O'Connor on a marvelous job. Now under the able leadership of Dr. O'Connor, and with the expert assistance of Avery Tung, M.D., our **Committee on Education** is going to continue to "raise the bar" on the quality of our Annual Meeting. In addition ASCCA is working more closely with the ASA Scientific Content Subcommittee on Critical Care to coordinate program offerings at the ASA Annual Meeting.

Your leadership and the editorial team of the newsletter are recommitted to bringing you timely and valuable communication of important issues via our quarterly publication. We are looking for new blood to join the **Committee on Communications**, and if you are a secret "My Space" user, try contributing to this endeavor — if anyone is interested, please contact me directly at <gmaccioli@mac.com>.

In light of the many new legal and regulatory requirements regarding corporate donations, Aryeh Shander, M.D., and Heidi B. Kummer, M.D., M.P.H., are actively working on a new plan for ASCCA to successfully interface with targeted vendors.

Other ongoing projects include:

Critical Care Workgroup (CCWG)

ASCCA is set to assume a two-year cycle as "lead organization" of the CCWG. By way of review, in February 1995, the Centers for Medicare & Medicaid Services (CMS) [HCFA at the time] issued a memorandum to all Medicare regional offices instructing them to notify carriers in their regions about Medicare's policies regarding payment for critical care services. As a result, six organizations united as the "Critical Care Workgroup" in 1997 to address these issues with CMS. These six organizations include the American College of Chest Physicians, the American Association for the Surgery of Trauma, ASCCA, the American Thoracic Society, the National Association for Medical Direction of Respiratory Care and the Society of Critical Care Medicine. Todd Dorman, M.D., who has been serving ably as our liaison to the CCWG, will become chair starting January 1, 2007, and will do an outstanding job chairing the work group and representing the interests of intensivists and ASCCA. His term will last two years.

Organ Donation After Cardiac Death (DCD)

In partnership with the ASA committees on Transplant Anesthesia and Critical Care Medicine, ASCCA is drafting a "Model Department Policy" on organ donation after cardiac death. This project grew out of a request from the ASA Committee on Ethics, and it provides an excellent opportunity to showcase the intellectual capital of ASCCA and demonstrate our value to the community of anesthesiologists at large.

Bylaws Revision

At present we are working on a major revision of our corporate bylaws to bring them up to date and address areas previously lacking. These revisions will be brought to the entire membership for review and approval at our next Annual Meeting.

Upon reflection, what do I see as the two major threats to us as a community of subspecialists, our subspecialty Society and critical care medicine as a whole?

One threat, very disturbing to me, is the rise of the "amateur intensivist"! Who are these people? They are the hospitalists! Mind you I have great respect for hospitalists as in-patient, noncritical care physicians, and I acknowledge the large body of peer-reviewed literature demonstrating their value to the non-ICU patient population. We, as specialists in critical care medicine, need to be leaders in developing a strategy to deal with this controversial intrusion into critical care practice. The reality is, this trend will continue, and (at present) not enough of "us" exist to fill the void of actual patient care needs. Perhaps this will stimulate us to design partnered models of care leveraging the best of both groups to better serve our patients.

But at the top of my threat list is apathy, the "someone else will do it attitude" that just won't fly anymore. We have too much to do, and we need your help to do it! I know a large number of you want to get involved and have not known how – well, here is your chance. If you are interested in participating in the many facets of ASCCA, then just e-mail me directly at <gmaccioli@mac.com>.

Finally all of the activity discussed above addresses the attempts by ASCCA and its leadership to increase participation by current members, but that is *NOT* enough! Once the aforementioned "foundational/organizational" issues are resolved, we need to seriously and thoughtfully address the puzzle of training more critical care anesthesiologists and how we can attract others who are not part of the fold.

This is your Society, make it so!

Thank you for the privilege of serving as your president.

ASCCA 2006 Annual Meeting Review

Chiwing Auyeung, M.D.
Northwestern University,
Feinberg School of Medicine,
Critical Care Medicine Fellow
Chicago, Illinois

The ASCCA 2006 Annual Meeting was held in Chicago, Illinois, on October 13, an unusually cold day for early October in Chicago. Registration and continental breakfast began promptly at 7 a.m., followed by words of welcome from meeting chairs **Louis Brusco, Jr., M.D., F.C.C.M.**, New York, New York, and **Michael F. O' Conner, M.D.**, Chicago, Illinois.

The morning lecture series consisted of two sessions. The first was moderated by **Andrew Rosenberg, M.D.**, Ann Arbor, Michigan. **Aryeh Shander, M.D.**, Englewood, New Jersey, gave us an update on the risks and complications of transfusion. He reminded us about the persistent danger of ABO incompatibility and its resistance to our current efforts of error prevention. The emergence of alternate sources of transfusion-related infections (Simian Foamy Virus, West Nile Virus, Trypanosomiasis [Chagas Disease]) might overshadow the successes in the reduction of HIV and HCV transmission.

Significant attention had been directed recently to "transfusion-related immune modulation," or TRIM, and "transfusion-related acute lung injury," or TRALI, although their precise underlying pathophysiology had yet to be elucidated. Data on outcome measures in blood transfusion remain largely unfavorable — infectious complications (prospective study on hip fracture, cardiac, colorectal surgery and trauma patients), SIRS (prospective data on 9,539 trauma patients), multiorgan failure and mortality (prospective data on 1,915 CABG). Current hypotheses for these complications include time-dependent adverse effects on stored blood products and long-term persistence of donor leukocytes in the recipient circulation. In conjunction with the shortage and increasing cost of allogenic blood, these transfusion-related complications have raised the pressure and need to minimize the inappropriate use of allogenic blood products.

Chiwing Auyeung, M.D.

The discussion then turned to mechanical ventilation during hypoperfusion states. **Andrea Gabrielli, M.D., F.C.C.M.**, provided laboratory and clinical evidence for the American Heart Association 2005 cardiopulmonary resuscitation (CPR) guidelines, which de-emphasize positive pressure ventilation with more frequent chest compression in the event of dysrhyth-

Richard C. Prielipp, M.D., Carolyn J. Farrell, M.D., and Douglas B. Coursin, M.D., pose for a photo between sessions. Dr. Coursin was given the Lifetime Achievement Award at this year's meeting.

Nilesh M. Mehta, M.D., with the plaque for ASCCA's 2005 Young Investigator Award.

mic cardiac arrest (a classic ultimate example of low flow state). The deleterious effects of positive pressure ventilation during low flow state, largely due to its impairment on cardiac preload and output, outweighs its potential benefits for the correction of hypoxia and hypercapnia. In animal models, survival and neurological outcome up to 48 hours were not different when ventilation was withheld during resuscitation. The American Association of Neurological Surgeons also recommended that hyperventilation ($PaCO_2$<36mmHg) should be avoided during the first 24 hours after traumatic brain injury as a number of recent studies had demonstrated an association of excessive ventilation ($ETCO_2$<30) with increasing mortality rate. The detrimental effect of hyperventilation also was observed in hemorrhage shock.

In general the duration of increased intrathoracic pressure is proportional to the ventilation rate when positive pressure ventilation is applied and blood pressure is inversely proportional to ventilation rate. On the other hand, preliminary data on the Impedance Threshold Device, which generates negative intrathoracic pressure during CPR, appears to provide results for improved resuscitation outcomes.

Jeffrey M. Dodd-O, M.D., Baltimore, Maryland, presented an update on the inflammatory mediators of ARDS/ALI. IL-1beta, TNF-alpha, ICAM-1 have emerged as potential important players in the scheme of mechanism of lung injury. Despite the lack of impact on survival with the usage of steroid on late-phase ARDS (ARDSNet, *New England Journal of Medicine*, 2006), research is aiming at more specific immune modulators. Moreover, given the intimate relationship between coagulation and inflammation, activated protein C may have a role as a general inflammatory inhibitor in ARDS.

After the first morning break, **Joel B. Zivot, M.D.**, Cleveland, Ohio, moderated the second lecture session. **Richard I. Cook, M.D.**, Chicago, Illinois, shared his experiences on the Medical Event Data Collection and Analysis Service (MEDCAS) with the audience. MEDCAS is a project of the Cognitive Technologies Laboratory from the University of Chicago, which attempts to demonstrate how an independent professional service can assist acute care hospitals in learning from and reducing adverse events. Current internal investigational systems (risk management, etc.) of individual hospitals are limited by their lack of independency and failure to generate insights for future improvement. MEDCAS established itself as an independent investigator, incurring no financial obligation, for the hospitals that request its service on a voluntary basis. Staffing coverage is 24/7.

Dr. Cook's team was recognized for continuing the tradition of anesthesiology being the leader in patient safety.

This year, the meeting program incorporated a new ASCCA/Society of Cardiovascular Anesthesiologists joint panel with two presentations: "CVP/TEE vs. PAC in ICU" and "ARDSNet Update."

Michael H. Wall, M.D., Dallas, Texas, took on the hot topic of pulmonary artery catheter (PAC) utilization. The recurrent well-documented problems with the PAC were summarized as: pressure as surrogate for volume, knowledge deficiency of health

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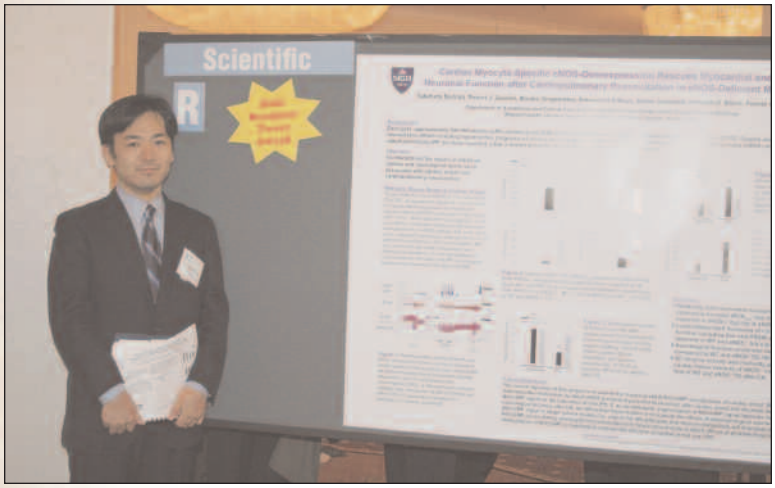
ASCCA
American Society of Critical Care Anesthesiologists

19th Annual Meeting

Friday, October 13, 2006 - 7:30 a.m. - 5:30 p.m.

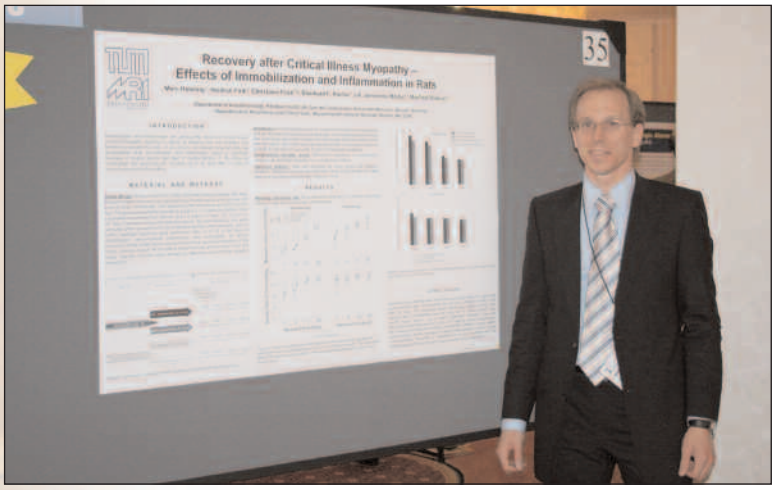
PROGRAM SCHEDULE

7:00 a.m. – 5:30 p.m.	Registration – Waldorf Room Foyer
7:00 a.m.	Continental Breakfast – Marquette Room
7:45 a.m. – 7:50 a.m.	Welcome and Introductions – Waldorf Room Co-Chairs: Louis Brusco, Jr., M.D., FCCM; Michael F. O'Connor, M.D.
MORNING SESSION LECTURES	
FIRST LECTURE SESSION:	*Waldorf Room*
7:50 a.m. – 8:20 a.m.	Complications of Transfusion Aryeh Shander, M.D.
8:20 a.m. – 8:50 a.m.	Hyperventilation during and after CPR Andrea Gabrielli, M.D., FCCM
8:50 a.m. – 9:20 a.m.	Inflammatory Drivers of Acute Lung Injury Jeffrey M. Dodd-O, M.D.
9:20 a.m. – 9:30 a.m.	Q&A
9:30 a.m. – 9:50 a.m.	Break – Marquette Room
9:30 a.m. – 9:50 a.m.	Poster Viewing-Williford Room B and Astoria Room
SECOND LECTURE SESSION:	*Waldorf Room* Moderator: Joel B. Zivot, M.D.
9:50 a.m. – 10:20 a.m.	The Future of Medical Accident Investigation Richard I. Cook, M.D.
ASCCA/SCA Joint Panel:	*Waldorf Room*
10:20 a.m. – 10:50 a.m.	The Combination of CVP and Echo is Superior to the PA Catheter in the ICU Michael H. Wall, M.D.
10:50 a.m. – 11:20 a.m.	Acute Lung Injury – Update on ARDS and ARDSNet Peter Rock, M.D.
11:20 a.m. – 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 – *Marquette Room*
SCIENTIFIC AND LEADERSHIP SESSION:	*Waldorf Room*
1:30 p.m. – 1:40 p.m.	Presentation of Residents Travel Awards
1:40 p.m. – 1:50 p.m.	Introduction of ASCCA/FAER/Research Award
1:50 p.m. – 2:30 p.m.	Young Investigator Award and Presentation of Abstract
2:30 p.m. – 3:00 p.m.	Recombinant Factor VIIa – use in the OR and ICU Per Thorborg, M.D., Ph.D., FCCM
3:00 p.m. – 4:00 p.m.	Break, Poster Viewing and Professor Walk Rounds Williford Room B and Astoria Room
	Facilitators: Philip D. Lumb, M.B., B.S.; Steven J. Allen, M.D., FCCM; Michael H. Wall, M.D.
4:00 p.m. – 4:30 p.m.	Lifetime Achievement Award Presentation and Lecture Presenter: Clifford S. Deutschman, M.D., FCCM Recipient: Douglas B. Coursin, M.D.
4:30 p.m. – 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., FCCM (Pro) William E. Hurford, M.D., FCCM (Con)



Jimmy K. Wong, M.D., 2006 Resident Travel Award winner with his poster.

Nilesh M. Mehta, M.D., the 2005 Young Investigator Award winner.



Marc Helming, M.D., a 2006 Travel Award winner stands next to his poster.

Attendees discuss a poster session topic.

Sharing insights during the poster discussion sessions.

Hannah Wunsch, M.D., M.Sc., 2006 Young Investigator Award Winner, with Louis Brusco, Jr., M.D.

Richard I. Cook, M.D., talks on "The Future of Medical Accident Investigation."

ASCCA 19th Annual Meeting

Chicago

ASCCA 2006 Annual Meeting Review *continued from page 5*

The ASCCA General Session was well attended.

care providers and lack of positive outcomes studies. On the other hand, from various studies, transesophageal echocardiography (TEE) appears to have demonstrated its safety and capability of providing additional information that impacts management decisions. Moreover intensivists were able to acquire sufficient skills for focused TEE examinations — volume status, contractility, regional wall motion abnormalities, severe valvular lesions and tamponade — in a reasonable period of time (48 supervised examinations in one study). In order to avoid a "rerun" or "sequel" of the current PAC debate, however, various audience members raised the concern of the support of TEE before establishing its efficacy. Premature proliferation of usage of TEE may "echo" with the scenario of PAC in the 1980s.

Peter Rock, M.D., Chapel Hill, North Carolina, then proceeded to present summaries of the two recent ARDSNet trials on pulmonary artery catheter and fluid management. The findings of the trials appear to add to the current literature that there is a lack of support and benefit of routine use of a PAC. Of interest, use of albuterol and timing of enteral feeding are two areas of research focus on the horizon for ARDSNet.

To conclude the morning session, **Mark J. Lema, M.D, Ph.D.**, Buffalo, New York, ASA President-Elect, addressed the assembly. He drew our attention to the economic situation of anesthesiology. Decreasing reimbursement, expanding scope of practice from other subspecialties and the independent practice of nurse anesthetists are all challenges that need to be handled judiciously in the near future. The terrain ahead appears to be rocky.

Various research awards were presented during lunch. **Pratik Pandharipande, M.D.**, Nashville, Tennessee, was the winner of the ASCCA/Foundation for Anesthesia Education and Research Award for "Double-Blind Randomized Control Trial Comparing Sedation With Dexmedetomidine versus Lorazepam in Mechanically Ventilated Medical ICU Patients." **Nilesh M. Mehta, M.D.**, Boston, Massachusetts, was given the 2005 Young Investigator Award for "Pharmacokinetic Considerations During Extracorporeal Membrane Oxygenation — Results From an Ex-Vivo Simulation." Finally, **Hannah Wunsch, M.D., M.Sc.**, New York, New York, was the winner of the 2006 Young Investigator Award for "Increased Mortality Associated With Acute Hypoxemic Respiratory Failure of Extra-pulmonary Origin."

The lecture session resumed in the afternoon with **Per Thorborg, M.D., Ph.D., F.C.C.M.**, Portland, Oregon, discussing recombinant factor VIIa. He acknowledged the increasing off-label use of recombinant

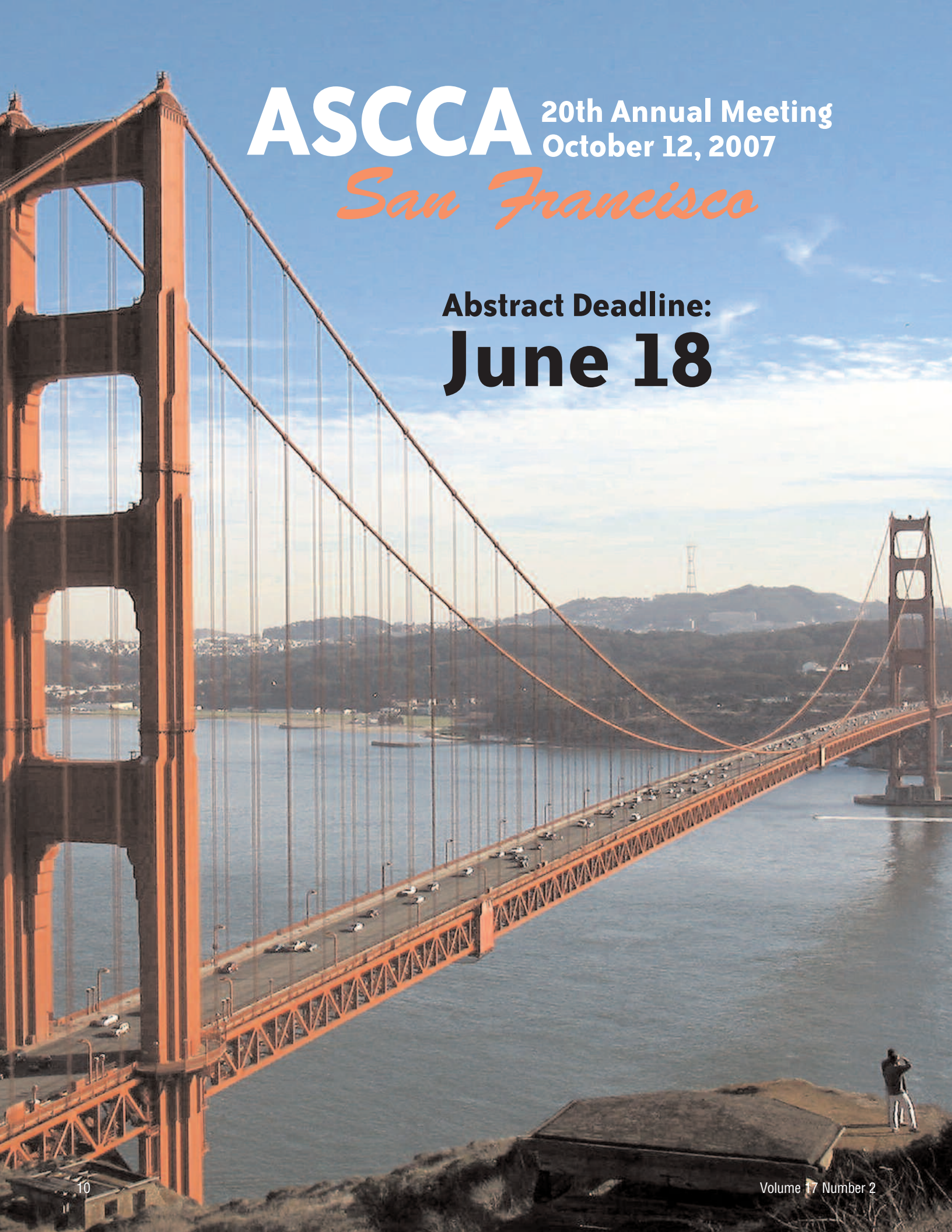
factor VIIa, especially in the area of intracranial hemorrhage, trauma and perioperative massive transfusion. Based on internal data, the Oregon Health & Science University has abandoned the use of rFVIIa as a "last ditch" effort secondary to the 100-percent mortality rate associated with those circumstances. On the other hand, efficacy of rFVIIa in perioperative bleeding appeared to be promising. There are many ongoing clinical trials on off-label use of rFVIIa with results pending. Members of the audience, however, voiced caution in drawing premature conclusions as a majority of the data were based on case series and observational studies. Moreover the cost-effectiveness of rFVIIa will be another area that deserves further investigation.

This year's Lifetime Achievement Award went to **Douglas B. Coursin, M.D.**, Madison, Wisconsin. His lecture focused on the future of anesthesiology/critical care medicine as a subspecialty. The decline in the number of trainees and mentors has been a recurrent challenge to this subspecialty. Furthermore the shortage of intensive care physicians has been persistent and sustained with no immediate relief in sight. Dr. Coursin stressed the need to aggressively explore the means to develop integrated and innovative programs that would facilitate cross-disciplinary training. He illustrated the benefit of interdisciplinary training through his personal experience as an anesthesiologist, internist and intensivist. A separate but integrated American Board of Medical Specialties board in critical care medicine — with support and direction from various primary specialty boards, including anesthesiology — might be the ultimate solution to the progressive demands for the critical care workforce.

The conference ended with a debate between **Clifford S. Deutschman, M.D., F.C.C.M.**, Philadelphia, Pennsylvania, and **William E. Hurford, M.D., F.C.C.M.**, Cincinnati, Ohio, on the topic of "You Can't Have Too Much Inflammation." Dr. Deutschman took on the "pro" aspect of the debate and argued the importance of the post-traumatic inflammatory response in tissue repair and recovery (the anabolic phase of injury). He emphasized the various endocrinopathy in sepsis (cortisol, aldosterone, thyroid function, growth hormone, prolactin, etc.) as indicators of underlying insufficient inflammatory response — "The patient died with inflammatory deficiency."

Dr. Hurford supported his "con" argument from various angles. Acute, frantic inflammatory response is likely responsible for the immediate complications of infection. He provided an example with which a patient suffered from loss of all four limbs secondary to vasculitis from meningococcal disease. Nonsurvivors of sepsis seem to have elevated levels of different pro-inflammatory cytokines. Finally, chronic, "low-grade," persistent inflammation may be responsible for coronary artery disease or associated with obesity, depression and diabetes. Dr. Deutschman rebutted by warning us on the difficulty of interpreting the elevation of proinflammatory cytokines in sepsis. Elevation in proinflammatory cytokines may be a result of lack of response from the immune system (e.g., leukocyte) which may, in reality, imply an inflammatory insufficiency. Ultimately both sides agreed on the limitation of our current understanding of inflammatory cytokines and their interactions. Further research is needed before final conclusions can be drawn.

After this lively debate, the meeting was adjourned. Please plan to attend the next ASCCA Annual Meeting, which will take place on October 12, 2007, in San Francisco.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Abstract Deadline:
June 18

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