



PRESIDENT'S MESSAGE

Farewell and Congratulations to PSA's Executive Director, Susie Wilson

by Andy Herlich, M.D.



I first met Susie shortly after I joined the Board of Directors of the PSA. Little did I realize that she had become our association's director in 2008. I thought that she had held the position for a very long time. She had total mastery of all events, times, personalities, and of course Pennsylvania Medical Society (PAMED) protocols. Susie was always perfect! She was, in a sense, Yoda except for the fact that she was much younger and more pleasant!

She knew all and used her knowledge to help us "steer the ship" in an appropriate direction. She knew how to "herd the cats" and get us to fall in line to accomplish our goals. Her opinions and suggestions were always succinct, well accepted, and mostly perfect.

Susie was omniscient and ubiquitous. Her tolerance of our deliberations over our investments and the cost of meetings demonstrated the patience of Job. Susie's memory of what we said at what meeting was better than most of the group's collective memory. Even on her vacations, work seemed to get done.

Her tolerance of laggards (yours truly) when deadlines occurred was not only fair but strategic— she made those deadlines magically change to accomplish the business of PSA. She made us shine! PSA was successful in so many ways because of Susie.

Susie is a "California girl." She grew up in California but made her way to Harrisburg over the years for a number of personal reasons. Luckily, Susie made her way to us. Her retirement as PSA's executive director was a shock to most of us. The next phase of her life will be caring for developmentally challenged children which has been a personal passion since high school. Most of us were unaware of this passion.

Her transition was inevitable and we celebrate her next phase! I will miss her, the board of directors will miss her, and PSA/PAMED will miss her. We wish her great health and Godspeed. We were lucky to work with her!



PENNSYLVANIA
society of
ANESTHESIOLOGISTS

Sentinel

Pennsylvania Society of
Anesthesiologists Newsletter

Editor

Richard P. O'Flynn, M.D.

President

Andrew Herlich, M.D.

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PSA Newsletter
777 East Park Drive,
P.O. Box 8820
Harrisburg, PA 17105-8820
717/558-7750 ext. 1596

www.psanes.org

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Former Naval Flight Surgeon Receives Heroism Award 40 Years Late

by Frank Ready

Better late than never.

It's a handy little expression, the optimist's take on tardiness, made popular thanks to a broad utility spanning any number of unfortunate and yet all too familiar scenarios.

Overslept? Better late than never. Forgot to file that report? Better late than never. Christmas lights still up in August? Better late than — well, honestly, at that juncture it's better to just let it ride through to the holidays.

Anyway, the point is that sometimes these things are best taken in good cheer — and for a man who has waited nearly 40 years to receive his Navy and Marine Corps Medal, Dr. Edward Dench is downright sprightly.

"Awards are not just for me. They are to instill pride and hopefully inspire others to do those kinds of acts," Dench said.

The trick of it is probably in knowing how to keep things in perspective.

For example, four decades and more than a little red tape pales in comparison to dangling from a helicopter hovering precariously close to the edge of a cliff, which in turn overlooks an approximately 4,000-foot drop into the scenic waters of Hawaii.

The year was 1976, and a then Lt. Cmdr. Dench was attempting to rescue a Marine corporal who had slipped and fallen 200 feet down the cliffs of the Kalalau Valley. The Marine had landed on a ledge with a 70-degree slope, meaning that it was dry land and not water that broke his fall — and his back — by a very narrow



margin.

By the time a rescue mission was mobilized, Dench's patient had already been waiting for three hours in the hot Hawaiian sun.

It was a situation fraught with complications. The helicopter was unable to land and could only angle down so far without the blades striking the side of the cliff and sending the chopper into a tailspin.

Somebody was going to have to tether down to solid ground, where they could tend to the injured, immobile Marine.

And Dench had specifically promised his then wife that he wouldn't do anything stupid before leaving home that day.

In the end, it was an easy decision.

"All I cared about and all I knew was that he was going to die and that I had a chance to save him," Dench said.

Dench spent nearly 5 hours down on the ledge, applying splints, intravenous fluid and basic first aid.

"I was getting dehydrated," Dench said.

He loaded the corporal into a rescue basket and dragged him 30 yards across the ledge into position for the helicopter.

Once they successfully returned to base, two things happened: Dench vomited for 10 minutes against the side of an airplane, and a naval captain approached with the news that the good doctor had been recommended for the Navy and Marine Corps Medal.

The honor is the highest non-combat decoration awarded for heroism — and for nearly 40 years, that was the last that Dench heard about it.

Today, he is a practicing

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Pennsylvania Society of Anesthesiologists 2016 Nominating Committee Report

Committee Members: Shailesh Patel, M.D. (Chair), Ed Dench, M.D., Dave Gratch, M.D., Donald Martin, M.D., Kristin Ondecko-Ligda, M.D., and Tom Witkowski M.D.

The PSA Nominating Committee held a meeting on Thursday, May 5th after follow-up telephone calls and email correspondence. Additionally, the Committee members who were present at the ASA Legislative Conference held conversations. Furthermore, new candidates were interviewed in person at the ASA Legislative Conference, via telephone calls or previous face-to-face interview by the Committee members. The following are nominations for the **2016-2017 term**.

The following members are nominated for **PSA Officers:** (1-year term except where noted)

President

Bhaskar Deb, M.D.

President-Elect

Richard Month, M.D.

Vice President

Tom Witkowski, M.D.

Past President

Andy Herlich, M.D.

Secretary/Treasurer

Meg Tarpey, M.D. (2-year term)

Assistant Secretary/Treasurer

Pat Vlahos, D.O.

(At the conclusion of this term, Pat will be stepping down from the position.)



The following members are nominated for District Director & Alternate Dist. Director to ASA: (3-year term)

District Director to ASA

Erin Sullivan, M.D.

Alternate Dist. Director to ASA

Joe Answine, M.D.

The following members are nominated for **Delegate to ASA:** (3-year term except where noted)

Jim Cain, M.D.

Bhaskar Deb, M.D.

Mike Entrup, M.D.

Joe Galassi, M.D.

Kristin Ondecko-Ligda, M.D. (2-year term)

Meg Tarpey, M.D.

The following members are nominated for **Alternate Delegate to ASA:** (1-year term)

Al Belardi, M.D.

Andrew Boryan, M.D.

Lee Fleisher, M.D.

Shannon Grap, M.D.

Mark Hudson, M.D.

A Joseph Layon, M.D.

Philip Mandato, D.O.

Don Martin, M.D.

Ben Park, M.D.

Shailesh Patel, M.D.

Mark Shulkosky, M.D.

Anthony Silipo, D.O.

Pat Vlahos, D.O.

The following members are nominated for **PSA Delegate to PAMED and Representative to PAMED Specialty Leadership Cabinet:** (1-year term)

Delegate – Donald Martin, M.D.

Alternate Delegate – Shannon Grap, M.D.

The following members are nominated for **PSA Representative to the Carrier Advisory Committee:** (1-year term)

Representative – Jim Cain, M.D.

Alternate Representative – Shailesh Patel, M.D.

Pennsylvania Prescription Drug Monitoring Program (PA PDMP) – It's Time to Register

by Donald E. Martin, MD and Shannon M. Grap, MD

PSA Representatives to the Pennsylvania Medical Society (PAMED) Specialty Leadership Cabinet



The last edition of the *Sentinel* included a description of the growing problem of opioid abuse in Pennsylvania and a detailed comparison of current national and state guidelines for the prescription of opioid pain medications. It also mentioned the Pennsylvania's Prescription Drug Monitoring Program (PA PDMP) and PSA's role in its development. A majority of the Specialty Leadership Cabinet Meeting on August 16 consisted of a discussion of the PA PDMP and its implications for medical specialties, including anesthesiology and pain management. Lauren S. Hughes, MD, MPH, MSc, FAAFP Deputy Secretary for Health Innovation, Pennsylvania Department of Health (DOH), who is responsible for developing the program, presented information about PDMP and discussed the

implementation of the PA PDMP program with the SLC specialty representatives.

The PA PDMP is now ready to begin operation. In order for Pennsylvania anesthesiologists to fulfill their roles as pain consultants and leaders in the treatment of pain, they must also lead in participation in the PA PDMP. You have likely already received communications from the DOH describing the registration process, which began on August 8, and actual use of the database, which began on August 25.

To use the PDMP database, each physician must register. In addition, the Q & A page of the DOH website states that all physicians licensed in Pennsylvania must register with the program, whether or not they expect to use the PDMP database. So, the Pennsylvania Medical Society (PAMED) and PSA would recommend that you register now via the dedicated DOH website: <http://bit.ly/2cm4W28>. Online registration is free and requires less than five minutes. To register, you will need only your medical license, DEA, NPI, and driver's license number. Physicians may also delegate one or more of their employees to query the database on their behalf. The DOH PA PDMP website above provides the direct link to the registration website, which is specific to your web



browser.

It is possible that a special session of the legislature will be convened this fall specifically to deal with the problems associated with opioid abuse in Pennsylvania, and this session may consider further physician mandates. The more that physicians use the PDMP program voluntarily now, the less chance there will be for the legislature to enact more mandates for physicians to use it in the future.

The PA PDMP program applies to all Schedule II to V controlled substances, and not just opioids, prescribed or dispensed to patients in Pennsylvania. It does not apply to controlled substances administered directly to patients. Therefore, as discussed in Robert Hoffman's companion article, it does not apply to most controlled substances used directly as part of a surgical anesthetic. It would,

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PA PDMP

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however, apply to medications dispensed or given to patients for them to administer to themselves as outpatient premedication or for acute or chronic pain management.

CME Opportunities

Optimal treatment of pain, including the appropriate

prescription of opioid pain medications, remains a high priority for PSA and PAMED. More information can be found on the website of PAMED at:

<https://www.pamedsoc.org/tools-you-can-use/topics/opioids/OpioidsForPainInitiative>

In addition, more than four excellent online CME programs regarding both opioid prescription and the PA PDMP program are available free of charge on the PAMED website at:

<https://www.pamedsoc.org/learn-lead/topics/medications-pain-management-opioids/OpioidsCrisisCME>

Finally, the DOH website dedicated to the program provides a complete overall description of PA PDMP at: <http://bit.ly/2cm4W28>



The Department of Health website dedicated to the program provides a complete overall description of PA PDMP



CME Opportunity – Optimal Treatment of Pain



CME programs regarding both opioid prescription and the PA PDMP program are available free of charge



EXCEPTIONAL ANESTHESIOLOGY OPPORTUNITIES

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Position Profile:

- Case volume is 3,000/year with approximately 100 heart cases per/year
- 6 board-certified MDs and 12 CRNAs
- 8 rooms plus 1 OB room during the day with call shared equally among all providers
- All bread and butter cases including cardiac

Schuylkill Health – Pottsville, PA

Hospital Profile: 179-bed community hospital that is part of a two-hospital system with outpatient services including a surgery center

Position Profile:

- Case volume is 4,700/year – mostly bread and butter
- Care Team Model with MDs and CRNAs
- 9 operating rooms plus L&D

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The New Prescription Drug Monitoring Program: How Does It Apply to Surgical Anesthesia?

by Robert B. Hoffman, Eckert Seamans Cherin & Mellott, LLC



In early to mid-August, most PSA members likely received a letter from the Department of Health (the “DOH”). The letter began by recounting the current opioid epidemic. It then “introduce[d]” physicians to “a new powerful tool to help combat” it — DOH’s Prescription Drug Monitoring Program (the “PDMP”). PDMP’s goal is to “prevent ‘doctor shopping’ by allowing practitioners access to other patient dispensing data.” The legislation that created the PDMP, referred to as Act 191, was enacted in October 2014, but funding and other issues delayed its implementation.

Broadly stated, the PDMP requires pharmacies and other dispensers to report information on controlled substances “prescribed and dispensed” to a state website. Via these reports, the PDMP system will create, on an individual patient basis, a controlled substances database. Prescribers must query the website for information on a patient’s prescription history before they first prescribe

a controlled substance for that particular patient and/or when the physician believes the patient may be abusing or diverting a controlled substance. (Anesthesiologists are almost always seeing patients for the first time.) A summary of the query’s results must be entered in the chart. The PDMP opened for prescriber queries in late August and the letter asked physicians to “begin using the system at that time.” The letter further advised that “prescribers are required by law” to query the database.

On reading the letter, or otherwise hearing about the PDMP, you may have wondered how it applies to anesthesia. Its application to a pain medicine practice, where physicians commonly write prescriptions for opioids and other controlled substances on an out-patient basis, makes sense and is discussed in a separate article in this edition of the *Sentinel*. Those practices may well be confronted by doctor-shopping patients seeking opioids from multiple physicians at the same time. Identifying those patients, via access to their prescription history, benefits both doctors and patients.

But its application to surgical anesthesia seems a very different matter. First, no patient seeks out surgery so as to receive the anesthetic. Second, an anesthetized patient, unlike one who is prescribed a course of opioids, doesn’t take a controlled substance home with him for

potential use or misuse, except for the ever decreasing amount of the drug that has not yet metabolized. Third, it would be a rare instance in which someone prescribing a controlled substance would benefit from knowing what controlled substance anesthetics the patient received during surgery. Finally, an opioid history may have some medical relevance to an anesthesiologist, but an anesthesiologist can’t responsibly say to a surgical patient “sorry, I looked you up on the database and no pain meds for you.” Having listed all those negatives, querying the system might provide a benefit in the form of a more complete prescription history than the patient has provided.

The PDMP letter did not address any exceptions at all to the requirements. It noted in passing that the database will “contain[] all schedule II-V prescriptions dispensed to *outpatients*.” The PDMP website, www.doh.pa.gov/PDMP, includes a brief recitation of several express exceptions to the definition of “dispenser.” But neither says anything at all about the central issue for anesthesiologists and other hospital-based physicians: what constitutes a “prescription?” That may be too much detail for a letter, although not for a website. But, like all regulatory programs, the PDMP program covers only what the language of the Act that created it reasonably extends to and not any more broadly.

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The New Prescription Drug Monitoring Program: How It Applies to a Pain Management Practice

by Robert B. Hoffman, Eckert Seamans Cherin & Mellott, LLC

There are several important legal issues concerning the application of the Department of Health's Prescription Drug Monitoring Program to surgical anesthesia. But its application to a pain management practice is relatively straightforward.

Below are basic how-to-comply instructions. You may have done some or all of this by the time this Sentinel arrives. If not, get started.

1. Register Yourself: Access the PDMP website, www.doh.pa.gov/PDMP, and register.

2. Register Your Delegates: Have persons who work with you, such as a nurse or practice manager, register. They can then access the database on your behalf. Check directions at the website. It appears that these delegates register in their own name but use a physician's email to access the system on the physician's behalf.

3. Query: Query the database (or have your delegate do so): and/or (a) before you first prescribe a controlled substance for a particular patient and (b) when you believe a patient may be abusing or diverting a controlled substance. It is unclear at present if you need to access if you have already prescribed a controlled substance for the patient and are adding a new one. "Sound clinical judgment"

is the criteria for the latter and the statute provides if you exercise it and decide not to query, you satisfy your obligations.

It might make sense for your delegate to access the database in one sitting for all patients being seen on a given day (or days) and flag those with issues for physician review. If the system permits, consider downloading the query screen into your medical records, or print off the screen and add it to your chart. DOH advises that the documents can be copied and inserted into electronic medical records (whether this works remains to be seen) or downloaded in PDF or CSV (Comma Separated Values) formats, both of which can be printed.

4. Document in the medical record what the query showed. You must do so if the individual is a new patient (effectively creating a third category in which you must access the database) or if you opted not to prescribe based upon the information from the system. But you can chart the website information routinely, and your delegate can write routine entries, subject to review and countersigning. You do not have to document why you did or didn't think criteria (b) above in #3 was or wasn't met.

The DOH website recommends an entry such as this: "Checked the PA PDMP; no red flags identified; safe to proceed with prescription" or "Checked the PA PDMP; opted not to prescribe a narcotic after determining patient had filled six prescriptions from four different prescribers over the past five weeks. Discussed findings with patient." Develop your own shorthand; you do not have to be as specific as the DOH model is; it is sufficient to say "checked website; determined not to Rx in light of prescription Hx" or "Checked website, no issues noted."

5. Enter Dispensing Data.

If you have written a prescription, it is the pharmacist's obligation to enter data concerning it in the website. If you are dispensing directly to the patient, it is your responsibility. You must do so within 72 hours. DOH contemplates receiving summary reports from dispensers every 72 hours, but it does not need to be done that way; you or a delegate can do so after every relevant patient encounter. DOH further contemplates that dispensers will submit a report, termed "a zero-report" even if the physician did not dispense any controlled substances in the 72-hour period. That is inconsistent with the statute,

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As of this writing, it is unclear what the DOH and the PDMP itself think about this and related questions; DOH has made conflicting statements, and no definitive one. But my view is that the Act and the “query the database” requirement is completely inapplicable to surgical anesthesia. My view is likewise that there is no need for surgical anesthesiologists to electronically submit information to the system regarding each controlled substance dispensed, an obligation imposed on pharmacies and dispensers. I explain why below.

Controlled Substances Used in Surgical Anesthesia are not Provided via a “Prescription”

A physician’s obligation to “query the database” arises in the first instance when the physician “prescribe[s] a controlled substance,” (it arises secondarily when the physician believes the patient may be abusing or diverting a controlled substance.) Neither “prescribes” nor “prescription” is defined in Act 191, so we need to look elsewhere for its meaning. Fortunately, “prescription” is defined several times in Pennsylvania regulations, including in DOH regulations that address controlled substances, and those of the medical and pharmacy boards (both of which should know something about “prescriptions”.) These regulations are all quite similar and they make an important distinction between what qualifies as a “prescription” and what does not.

- What *qualifies* is a written, electronic or oral order issued by a licensed medical practitioner in the course of professional practice for a controlled substance, other drug or device, or medication to be dispensed “to or for” or “for use by” an “ultimate user,” i.e., a patient.
- What does *not qualify* is what is often referred to as a “drug order”—an order for medication to be dispensed for “immediate administration to the ultimate user” in an office or hospital.
- Both the DOH and Pharmacy Board regulations give similar examples of what is not a “prescription:” “an order to dispense a drug to a bed patient for immediate administration in a hospital” or “an oral or written order issued by a medical practitioner which is either written on or entered by computer into the medical record of a patient in an institution for the dispensing of a drug or device for *administration to the patient.*”

Summarizing these slightly different formulations, a “prescription” is dispensed “for use by a consumer” or “to or for” an ultimate user. “Drug Orders” are issued in the hospital context and are intended for administration *to the patient.*”

Clearly, given these various definitions, the use of a controlled substance anesthetic is not a “prescription.” It is clearly dispensed for “immediate administration to the ultimate user” and not for “use by a consumer.” If, as a DOH regulation states, an order for medication for a bed patient in a hospital is not a prescription, surely one

for a patient in the operating room is not. These regulations, each consistent with the others, confirm that the use of controlled substances in surgical anesthesia does not involve a “prescription.”

Surgical Anesthesia is Not Dispensing

Dispensers must provide data to the PDMP site within 72 hours of dispensing a controlled substance. “Dispensing” is the actual delivery of medication to a patient. Most commonly, pharmacists do the dispensing, as per a prescription. When physicians directly provide prescription medication to patients, eliminating the pharmacists’ role, the physician becomes a dispenser. The PDMP website discussion on “dispensers” is focused on pharmacists and not physicians. Whether or not the PDMP believes the term extends to physicians, there are statutory exceptions to the definition of “dispensing” that exclude surgical anesthesia from it.

Among the exceptions are:

- “A licensed health care facility that distributes the controlled substance for the purpose of administration in the licensed health care facility.”
- “An authorized person who administers a controlled substance, other drug or device.”
- “A prescriber at a licensed health care facility if the quantity of controlled substances dispensed is limited to an amount adequate to treat the patient for a maximum of five days and does not allow for a refill.”

These exceptions are not stated with great clarity and the DOH materials do not provide any guidance on their

meaning. Any or all could apply to surgical anesthesia. Overall, they suggest that the use of controlled substances in a hospital to hospital patients is not covered. That is consistent with the statement in the PDMP letter, referenced earlier, that the database will “contain[] all schedule II -V *prescriptions dispensed to outpatients.*”

The DOH website defines a “dispensing practitioner” as “a medical practitioner that stocks controlled substances and distributes the medication to a patient, who then leaves the facility and is responsible for administering the medication themselves.” Surgical anesthesia clearly does not fit within that definition.

Complicating matters somewhat, the PDMP website makes a conflicting statement. After noting the requirement that a physician query the database the first time a patient is prescribed a controlled substance by the prescriber” adds that DOH interprets this requirement “to apply to inpatient or outpatient (including emergency department) settings ...” As I have explained above, with the possible exception of “discharge medications,” physicians ordering medication for hospital inpatients, do not write “prescriptions.”

Must Anesthesiologists Register Even if They Don’t “Prescribe” Controlled Substances?

DOH’s website includes the following Q&A:

Q: If I don’t prescribe any controlled substances, do I need to register for the PDMP system?

A: A prescriber who does not prescribe controlled substances still needs to register for the system and is required to query the system if they believe or have reason to believe, using sound clinical judgment, that a patient may be abusing or diverting drugs.

The Act itself is at best vague as to this requirement and it makes little sense, at least for physicians, like pathologists or radiologists, who do not have direct patient contact. There is, however, some practical logic for the requirement. Apparently, the website is structured, probably for security reasons, to have an interim period between registration and when the physician can query. Accordingly, physicians who have not registered in advance, will not be able to query the system when they want to or are required to do so. Registering is likely a relatively de minimis imposition, albeit in the context of a busy practice. There is a theoretical risk of licensure sanctions for non-compliance with the Act’s various requirements. I recommend registering even if you never access the website again.

My *Sentinel* articles often discuss new legal issues that have not been decided and whose outcome cannot be confidently stated as I write. I usually conclude with “stay tuned.” That applies here in full. So “stay tuned” as the issues discussed here and others are resolved or not between now and the next *Sentinel*.



PDMP website

IMPORTANT

Upcoming Highmark Policy Change Regarding Anesthesia Billing

Highmark recently sent notification that effective October 15, 2016, they will implement a payment policy change. The new policy states that payment for medical anesthesia procedures will be based on the actual time spent administering anesthesia in place of the current policy of rounding minutes billed to the next 15-minute time unit. They state that this change aligns with CMS direction and is a more accurate payment methodology.

It has been estimated by various billing companies that this change will cost anesthesia practices in Pennsylvania between \$2.35 - \$3.00 per unit or about ½ unit decrease per case depending on the practice’s per unit case profile. Individual billing companies should be able to calculate the exact impact for their practices.

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which instead requires a report be made “no later than 72 hours after dispensing a controlled substance.” There is a process to obtain a waiver from submitting zero-reports and a form on the website.

On limited occasions, a pain management physician may inject a controlled substance, either directly or in connection with an intraspinal pump. In general, those scenarios do not constitute dispensing that must be reported to the PDMP.

6. What Should I Do If A Patient Screen Shows A History Of Doctor

Shopping? A doctor-shopping patient presents both a medical problem and a potential criminal violation. You need to apply sound medical judgment about how to treat the patient. That can include reevaluating the patient’s subjective symptoms entirely; prescribing non-controlled substances instead of controlled; and/or referring patients to substance abuse treatment. Prescribing controlled substances in that instance may be medically appropriate, particularly if supported by non-subjective symptoms, but a detailed record entry explaining why can be important to avoiding future problems.

Under the Controlled Substances Act, a physician can only lawfully prescribe, administer, or dispense controlled substances when three criteria are met: the prescription is (i) in good faith in the course of professional practice, (ii) within the scope of the patient relationship, and (iii) in accordance with treatment principles accepted by a responsible segment of the medical profession. Prescribing controlled substances when these criteria are not met can lead to a criminal violation of the Controlled Substances Act, with very serious consequences. The Act allows a physician to prescribe a controlled substance to a “drug dependent person” for up to 14 days pending the confirmed admission of the patient to a hospital or rehabilitation center.



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Chris Mulvey, cmulvey@hmc.psu.edu, 717-531-7988

* requires completion of online performance improvement plan

Save the Date!



**PSA Annual Meeting
Luncheon
Saturday, October 22
Chicago, IL
Hyatt Regency
McCormick Place
Room: Clark ABC
12:00 p.m. -1:30 p.m.**

***Invitation to all
members, residents,
and their guests.***

Legislative Update for Summer 2016

by Kevin Harley, Quantum Communications



As the Pennsylvania General Assembly prepares to return to Harrisburg for the remaining weeks of the legislative session, we are working diligently on several fronts.

In the Senate we are working to block the passage of SB 481 that would amend the Professional Nursing Law to provide a definition of “certified registered nurse anesthetist.” The position of PSA is opposition to the bill because it does not establish a scope of practice for CRNAs i.e., what medical tasks they can and cannot do and under what degree of supervision.

Senator Patricia Vance, who was a nurse prior to being elected to office, is the prime sponsor of the legislation. The bill has moved out of the Senate Consumer Protection and Professional Licensure Committee. Our aim is to get the bill tabled in the Senate.

Another bill advanced by Senator Vance, who is retiring, is the nurse practitioner bill, SB 717. The bill would amend the Professional Nursing Law primarily to remove the prior requirement that CRNPs practice in collaboration with a physician.

The bill is supported by the Hospital and Healthsystem

Association and would allow nurse practitioners in the state to practice independently without the need for physician supervision after they have worked under supervision for three years and 3,600 hours.

The bill passed the Senate in July and is now in the House Professional Licensure Committee. Although the legislation does not include CRNAs, we are coordinating our lobbying efforts with the Pennsylvania Medical Society’s government affairs team to block its passage in the House.

We continue to lobby on behalf of HB 1277, legislation that would place into the Medical Practice Act a state Department of Health hospital licensing regulation requiring that a physician either provide anesthesia directly or supervise others, such as nurse anesthetists, who provide anesthesia care. The bill is stalled in the Professional Licensure Committee.

We are asking the retiring chair of the House Professional

Licensure Committee, Representative Julie Harhart, to bring the bill to a vote.

We are also advancing the position of PSA as the Pennsylvania Department of Health rewrites the Hospital Regulations. We have met with the Secretary of Health’s policy director and are working with our general counsel and the Pennsylvania Medical Society to make sure that the Department clearly understands the functions and responsibilities of an anesthesiologist and the important role they play in patient safety.

Please contact your senator and representative and let them know that the priority of the Pennsylvania General Assembly must be to protect patient safety. Especially ask them to bring HB 1277 to a vote.

If you are not certain who to contact, go to <http://www.legis.state.pa.us/> to find your legislator’s name and contact information.

Please do it NOW!



Q&A with Joseph F. Answine, M.D.: Sugammadex as a “Rescue” after Neostigmine

by Joseph F. Answine, M.D.



Sentinel: What should we know up front about sugammadex?

Answine: Sugammadex is a binding agent that quickly reverses rocuronium and vecuronium induced neuromuscular blockade. I have been active with sugammadex for years as a member of advisory boards and as a speaker for its use. In my opinion, it fills a major void that up until now, neostigmine and other acetylcholinesterase inhibitors could only partially fill.

Sentinel: Is sugammadex supposed to be used as a rescue after neostigmine failure?

Answine: That is not its indication. It is to be used instead of acetylcholinesterase inhibitors. Its mechanism of action is very different but it's similar in its indication only differing in that it can reverse all levels of blockade from moderate to deep.

Sentinel: Then why the concern with its use after neostigmine?

Answine: Although this is not an “approved” use of

sugammadex, the drug will be given quite commonly as a “rescue” for failed or incomplete reversal with neostigmine. Furthermore, the situation and patient population in which it will be used in this way will not likely be optimal or routine, and it may also be the first time that the provider uses the drug. I can imagine that in many cases, the endotracheal tube will have been removed followed by signs of an inadequate airway with airway obstruction and arterial oxygen desaturation. The patient will also commonly have limited reserve whether secondary to age, lung disease, obstructive sleep apnea or significant obesity necessitating further intervention because the clinical problem is usually a combination of residual blockade and patient factors.

Sentinel: What does the data show about the use of sugammadex in this way?

Answine: That is the biggest problem. Sugammadex after neostigmine has not been extensively studied. De Menezes in 2012 published a case report about the utilization of sugammadex after neostigmine which described a successful recovery but did not delve into the stability of the hemodynamics (1). Lenz described the utilization of sugammadex after neostigmine in another case report with successful recovery and stable hemodynamics (2). Also, there have been studies performed looking at sugammadex in

combination with neostigmine for reversal of neuromuscular blockade (3). That is the extent of the literature on this subject.

Sentinel: What are your concerns about sugammadex use after neostigmine?

Answine: Not only is there a concern of success in completing the reversal, but, also whether there is a potential negative effect of unopposed enhanced acetylcholine exposure at the nicotinic neuromuscular receptor and to a lesser extent at the muscarinic receptor in the heart. It has been noted that sugammadex reversal of rocuronium blockade can lead to rare profound bradycardia which can logically be assumed to be related to unopposed acetylcholine effect at the cardiac muscarinic receptors.

In addition to hemodynamic effects, Herbstreit in 2010 demonstrated that neostigmine after spontaneous reversal can lead to clinical signs of re-



paralysis (4). It can therefore be assumed that unopposed acetylcholine after neostigmine and then rapid sugammadex reversal could lead to the same findings.

Sentinel: Do you have personal experience with the use of sugammadex after neostigmine?

Answeine: I do, and have a case report accepted for publication (5). I will outline a couple cases below, however, I stress that a true study on its use in this fashion is greatly needed. The two patients that I will present here had surgical procedures at a free-standing surgical center, both receiving sugammadex after incomplete reversal with neostigmine. Furthermore, both had diseases or morphologic features consistent with potential airway compromise.

The first patient was a 46-year-old, 92 kilogram male (BMI 36 kg/m²), and his past medical history was significant for hypertension and obstructive sleep apnea requiring continuous positive airway pressure with sleep. He was given neostigmine and glycopyrrolate with two faint twitches present after a

rocuronium intubation. Four twitches were then present and the patient was extubated. Within three minutes, obvious airway obstruction and upper extremity weakness were noted with an arterial oxygen saturation in the range of 85% to 88% with assisted mask ventilation. Sugammadex 200 mg (2.2 mg/kg) was given as a rapid IV bolus with complete resolution of the obstruction, and there were no signs of upper extremity weakness within two minutes after administration. The arterial oxygen saturation was maintained at >94% with a nasal cannula at 4 l/min, and the hemodynamics were overall maintained with the heart rate decreasing from 93 beats/minutes prior to sugammadex to 79 beats/minute after sugammadex administration. The change in heart rate was assumed to be related to a decrease in patient stress with improved ventilation.

The second patient was a 38-year-old male, 102 kg (BMI 41 kg/m²) with a medical history significant for diabetes type 2 and hypertension. He underwent right knee arthroscopy with a failed laryngeal mask airway placement and urgent endotracheal intubation with rocuronium. The surgical procedure was short, lasting 32 minutes. Neostigmine and glycopyrrolate were given with three twitches present using qualitative TOF monitoring. The patient was extubated after five minutes with four twitches and a qualitative sustained tetanus as well as a respiratory tidal volume greater than 800 ml. The patient began showing signs of obstruction with quick desaturation to 78% and tachypnea at 30 breaths/minute. Sugammadex 200 mg (1.96 mg/kg) IV was given

followed by a saline push with relief of obstruction in 1.5 minutes after administration. There was no significant change in HR when comparing prior and after sugammadex administration. Arterial oxygen saturation rose to 97% by face mask with no postoperative complications noted.

Both patients were discharged from the facility within the usual timeframe without signs of continued airway compromise and stable hemodynamics.

Sentinel: So the take home message is?

Answeine: These case reports demonstrate the safe and successful use of sugammadex after neostigmine. Although more extensive studies should obviously be done, this brings to light a situation where sugammadex could lead to improved patient safety and outcomes. I still think vigilance needs to be maintained because of the still lingering concern of a “cholinergic crisis” for lack of better words.

Sentinel: Any final thoughts?

Answeine: Although I believe that sugammadex will improve our ability to care for our anesthetized and paralyzed patients, it is new in our hands. Therefore, as with all new drugs and therapies, we need to tread with caution and care until enough time and patients are behind us.

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anesthesiologist at Clearfield Hospital and also performs Federal Aviation Administration medical exams on pilots from his home office in State College.

They are valued opportunities for Dench, who has spent the better part of the past 54 years with his feet off of the ground, to talk shop.

The doctor has a Piper Aztec twin engine that he bought in 1988 that has since touched down at airports in Las Vegas, San Antonio and Florida.

Dench's passion for the skies provides him with insight into his patients that goes beyond the medical. He knows that a pilot will say or do anything to stay in the air.

"If you haven't been a pilot, it's very hard to get into the mentality of a pilot," Dench said.

It was one of the pilots he was examining who eventually

referred Dench to a website that listed past recipients of the Navy and Marine Corps Medal — and sure enough, his name was listed under 1976.

Dench contacted the office of U.S. Rep. Glenn Thompson, R-Howard Township, and after nearly four decades, he is finally scheduled to be officially presented with the Navy and Marine Corps Medal on April 14 by the commanding officer at the Pacific Missile Range Facility, Barking Sands in Kauai County, HI.

"My office was effective in working with the Navy to ensure that Dr. Dench would receive his accommodation, even if it is now 40 years later. This medal will serve as a reminder of his service to a fellow crewman in a time of need and his steadfast service to our great nation," Thompson said.

Either way, the occasion will at least provide a new ending to an old story.

"I used to tell people that I was nominated because that's the only thing I could say," Dench said.

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Q&A With Joseph Answine continued from page 15

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Proceedings of the August 2016 ASA Board of Directors

by Erin A. Sullivan, M.D., District Director, Pennsylvania



The American Society of Anesthesiologists Board of Directors (BOD) convened on August 20-21, 2016 in Chicago to discuss the governance, regulatory and scope of practice issues that impact our specialty and our patients. Members of the Board of Directors provided testimony before the following reference committees: Administrative Affairs, Professional Affairs, Scientific Affairs and Finance. Highlights of each of these reference committees are discussed below.

Administrative Affairs

There has been considerable concern expressed about the size of the ASA House of Delegates (HOD) handbook and the near impossibility of a delegate's or alternate delegate's ability to read it in its entirety if it is not received until 2-3 weeks prior to the annual meeting. Since a large amount of the material in the handbook is information that first appeared

in the BOD handbooks, staff will now notify HOD members of the availability of this information, with the appropriate links to the members only section of the ASA website, at the same time as the Directors throughout the year. Along these same lines, all BOD members, HOD members and Committee Chairs will have access to pre- and post-BOD and pre- and post-HOD meeting materials posted at the ASA website under the members only section.

The Committee on Membership presented recommendations for the application, approval and maintenance of status as a Fellow of the American Society of Anesthesiologists (FASA). This new designation is the result of the ASA membership survey and the desire of ASA members to offer a fellow designation as many other medical professional societies do. Some of the criteria for consideration to become a FASA are:

- 5-year ASA member
- 5-year ASA state component member
- Unrestricted medical license
- Board certification by the American Board of Anesthesiology or the American Osteopathic Board of Anesthesiology
- 2 letters of endorsement from an ASA Active member
- Curriculum vitae and optional bibliography
- Application fee of \$350

In addition to the above criteria, applicants must meet certain requirements in the areas of professionalism/leadership, advocacy and education/scholarly activities. The eligibility criteria are referred to the Committee on Bylaws to craft the appropriate bylaws language that will be considered before the 2016 ASA HOD.

The Committee on Membership also proposed and the BOD approved the expansion of the Educational Membership category to include anesthesia practice administrators. Membership is free for practice administrators if at least 90% of the physicians in their practice are ASA members. There is an annual membership fee of \$250 for practice administrators with less than 90% of physicians in their practice holding ASA membership.

Professional Affairs

New practice parameters were presented by the Committee on Standards and Practice Parameters and approved by the BOD. They include *Practice Guidelines for Preoperative Fasting and the Use of Pharmacologic Agents to Reduce the Risk of Pulmonary Aspiration: Application to Healthy Patients Undergoing Elective Procedures*; and *Practice Advisory for the Prevention, Diagnosis and Management of Infectious Complications Associated with Neuraxial Techniques*.

continued on back cover

Carbon Dioxide Absorption: A Brief Review of Principles, Canisters, Efficiency, And Toxicity

by Christopher M. Lam M.D., Bradford Cardonell M.D., and Brian Monroe M.D., Geisinger Medical Center
Department of Anesthesiology



Carbon dioxide absorbents sequester carbon dioxide from the circle system and allow for the reuse of alveolar gas, preservation of heat and humidity, and minimization of pollutants and anesthetic waste. This article is a brief review of carbon dioxide absorption, absorbent characteristics (exothermic reaction, mesh size), potential degradation products, and new lithium based absorbents.

Carbon Dioxide Absorption

Carbon dioxide absorbent granules are composed of calcium hydroxide with a strong hydroxide base and catalyze the removal of carbon dioxide in the system, forming carbonic acid and

sodium carbonate (Figure 1)¹. This process minimizes the amount of anesthetic waste and reduces the need for additional fresh gas flow.

Absorbent Characteristics: Exothermic Reaction

Absorbents are on the expiratory limb between the adjustable limiting valve and fresh gas inflow (Figure 2)¹. The temperature gradient increases when absorbents interact with CO₂ during use, which produces water through condensation³. To increase the efficiency and reduce the cost of general anesthesia, temperature gradient reduction (TGR) and temperature gradient correction (TGC) canisters were developed to minimize

these temperature variations. Hirabayashi et al. compared conventional canisters to TGC and TGR canisters using a simulated oxygen consumption system which showed that there was an increase in absorbent longevity from 434 minutes to 563 minutes when TGC/TGR canisters were used². Soda lime with calcium hydroxide, sodium hydroxide, and potassium hydroxide catalyst had the longest longevity while soda lime containing only calcium hydroxide without strong base exhausted the quickest³. Other factors that increase temperature include high fresh gas flow and the use of sevoflurane in the presence of a strong base.

Absorbent Characteristics: Mesh Size

Mesh size, the number of openings per linear inch of a wire mesh through which the absorbent is sifted, is inversely proportional to the particle size. Though small particle sizes offer increased surface area for carbon dioxide removal, it also increases

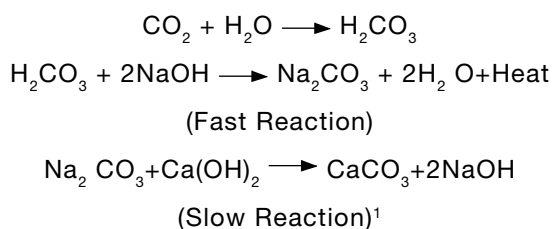


Figure 1: CO₂ Absorption Chemical Reaction.

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Carbon Dioxide

continued from page 19

the resistance and impedance to flow of the anesthetic gas. With increased resistance, channeling may occur where the gas flows through tracts of lower resistance resulting in non-uniform absorbent exhaustion. In clinical practice, size 4-8 mesh is generally used.

Smaller particles have a higher likelihood of entering the breathing system where it can irritate the patient's airway causing bronchospasm. Yamakage et al. compared calcium hydroxide absorbents with a strong base but without a hardening agent against calcium hydroxide absorbent with calcium sulfate hardener without strong base, calcium hydroxide absorbent with methylcellulose hardener without strong base, and calcium hydroxide absorbent alone without strong base or hardener. By comparing the weights of pre and post-agitated absorbent and filtering the samples with 1 mm mesh diameter sieve to determine dust production from routine wear and tear, they found that calcium hydroxide absorbent with calcium sulfate hardener produced the least amount of dust while calcium hydroxide absorbent without any type of hardener produced the most dust⁴.

Degradation Products

Compound A (2-(fluoromethoxy)-1,1,3,3,3-pentafluoro-1-propene) is a sevoflurane degradation product. In animal models, Compound A was found to cause nephrotoxicity in rats⁵. Though a study of anesthetic use on human volunteers did reveal renal injury (microproteinuria), evidence of in vivo human kidney injury from

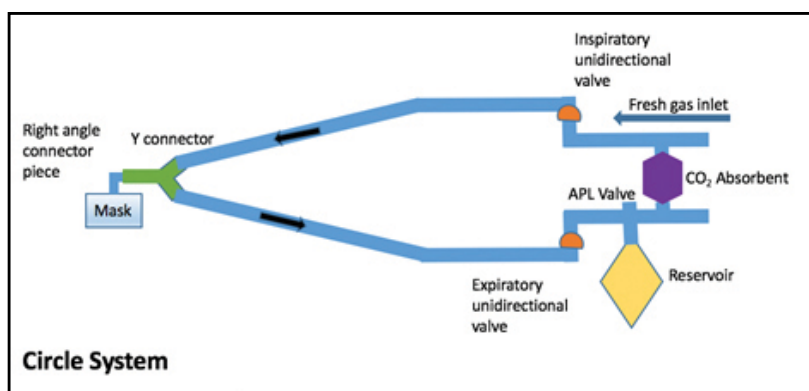


Figure 2: Anesthesia Circle System

Sevoflurane use on patients has yet to be shown⁶. Compound A formation increases in low flow states and depends on the absorbents. Keijzer et al. found that completely desiccated 83.2% calcium hydroxide absorbent alone yielded the most Compound A formation followed by calcium hydroxide absorbent with 0.003% potassium hydroxide and 2% sodium hydroxide and desiccated calcium hydroxide absorbent with 0.003% potassium hydroxide and 3% sodium hydroxide. Meanwhile neither 84% calcium hydroxide absorbent alone or 79.5% calcium hydroxide absorbent alone yielded any Compound A formation. In normally hydrated conditions, neither lithium hydroxide nor 83.2% calcium hydroxide alone generated any Compound A. This suggests absorbents containing strong bases such as sodium or potassium hydroxide have a higher propensity to form Compound A compared to absorbents made of lithium or calcium hydroxide alone⁷.

Carbon monoxide (CO) formation may occur when the absorbents are exposed to volatile anesthetics, specifically those with the -CHF₂ moiety. The overall risk of forming carbon monoxide is greatest with desflurane, followed by enflurane and isoflurane while it is barely detectable with halothane

or sevoflurane. Keijzer et al. compared 1 MAC of low fresh-gas flows of volatile anesthetics with soda lime absorbent (82% calcium hydroxide, 0.003% potassium hydroxide, 2% sodium hydroxide). Carbon monoxide concentrations were continuously measured with gas chromatography. At the peak concentrations of carbon monoxide formation, desflurane formed 13,889 ppm, enflurane formed 10,187 ppm, isoflurane formed 2,512 ppm, halothane formed 185 ppm, and sevoflurane formed 113 ppm of carbon monoxide⁹. More CO is produced when using barium hydroxide than with soda lime. Desiccated absorbents formed more CO than partially wet absorbents. The "Monday morning" phenomenon may occur if the gas flows are left on over the weekend, leaving a desiccated absorbent which increases the risk of CO production. Carbon monoxide formation also increases with higher absorbent temperatures¹⁰.

Lithium Absorbents

Recently, new premium absorbents use chemical catalysts instead of strong bases to reduce and prevent formation of toxic metabolites from anesthetic gas degradation while providing more reliable indicators of absorbent

fatigue. These absorbents are often sold at a higher price than traditional absorbents¹¹. Lithium-based catalysts offer similar benefits as premium absorbents but at a lower price, comparable to traditional absorbents. Lithium absorbents exhibit less Compound A and CO formation and less exothermic activity. Because they do not use a strong base catalyst, certain lithium absorbents have irreversible ethyl violet indicators which more accurately reflect absorbent fatigue^{12,13}. Though no recent study has compared these absorbents head to head, several abstracts and industry-funded studies indicate that these new absorbents may offer safer and more affordable alternatives to traditional absorbents. Industry studies have shown that lithium absorbents have the capacity to absorb 150 L CO₂/kg compared to 120 L CO₂/kg in absorbents with only calcium hydroxide¹³.

Summary

There are many aspects of the absorbent system involved in providing the safest inhaled anesthetic possible. With the use of volatile inhaled anesthetics, there is always the risk of developing toxic metabolites. Factors such as the chemical composition of the absorbents, presence of hardener and mesh size influence the efficacy and efficiency of gas delivery within the system. Research developments may lead to safer products available for our anesthesia delivery systems.

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1. **Where in the circle system is the CO₂ absorbent canister located?**
 - A. Distal inspiratory limb
 - B. Between the APL valve and fresh gas inlet
 - C. Distal expiratory limb
 - D. Between the expiratory unidirectional valve and the APL valve
 - E. Between the inspiratory unidirectional valve and the expiratory unidirectional valve
2. **Which of the following factors will least likely increase temperature inside the absorbent canister?**
 - A. CO₂ absorption
 - B. Sevoflurane use with calcium hydroxide with sodium hydroxide absorbent
 - C. High fresh gas flow
 - D. Low fresh gas flow
 - E. Sevoflurane use with calcium hydroxide with potassium hydroxide absorbent
3. **What is the name of the concept where gas preferentially flows through tracts of lower resistance resulting in non-uniform absorbent exhaustion?**
 - A. Channeling phenomenon
 - B. Monday morning phenomenon
 - C. Equilibration loss phenomenon
 - D. Temperature gradient phenomenon
 - E. Flow gradient phenomenon
4. **Which of the following best illustrates the risk among the different volatile anesthetics in forming carbon monoxide?**
 - A. Halothane > Desflurane > Enflurane
 - B. Desflurane > Halothane > Enflurane
 - C. Desflurane > Enflurane > Halothane
 - D. Sevoflurane > Enflurane > Halothane
 - E. Desflurane > Halothane > Isoflurane
5. **Which of the following is NOT a benefit associated with lithium absorbents?**
 - A. Less degradation compounds
 - B. Less exothermic activity
 - C. Less expensive than traditional absorbents
 - D. More reliable indicator of absorbent fatigue
 - E. More carbon dioxide absorption capacity

Answers: 1. B 2. D 3. A 4. C 5. C

Proposed PSA Bylaws Changes – Recommended by vote of the PSA Board of Directors September 10, 2016

Amendment 1: Changes to the Resident Activities Committee

Background:

While medical student membership exists within our Bylaws, medical student members have always been few and far between within our Society. With the advent of our combined applications and billing with ASA, we have greatly expanded our medical student membership (from one last year to 75 as of 9/2016).

However, there is no current structure within our Organization to provide them with leadership or mentorship. Upon discussion, the Board believes the most logical group to task with this responsibility would be a renamed Committee on Resident Activities.

Amendment 1: It is moved that Bylaw 6.414 be amended as below, renaming the Committee on Resident Activities to the Committee on Residents and Medical Students and providing for that committee's involvement in Medical Student affairs.

Current Bylaw:

6.414 Committee on Resident Activities - This committee shall provide guidance, mentorship, and oversight to the resident component across the state. All requests for funds for the Resident Component and its members, including funds for travel and for resident initiatives, require the approval of this committee. This committee shall be composed of: one or more Resident Component Liaisons charged with direct oversight of and assistance with the day-to-day functions of the Resident Component; the Resident Component President; one member of the Executive Committee; and one additional member of the Board of Directors.

New Bylaw, Tracked:

6.414 Committee on Residents and Medical Students Activities - This committee shall provide guidance and, mentorship to, and oversight ~~of the resident component across the state~~ Resident, Fellow, and Medical Student members. All requests for funds ~~for the Resident Component and its members, including funds for travel and for resident initiatives~~ for Resident, Fellow, or Medical Student initiatives or travel, require the approval of this committee. This committee shall be composed of: one or more Resident Component Liaisons charged with direct oversight of and assistance

with the day-to-day functions of the Resident Component; the Resident Component President; one member of the Executive Committee; and one additional member of the Board of Directors. With the approval of the Executive Committee, a Medical Student member may be added to this committee.

New Bylaw, Clean

6.414 Committee on Residents and Medical Students - This committee shall provide guidance and mentorship to, and oversight of Resident, Fellow, and Medical Student members. All requests for funds for Resident, Fellow, or Medical Student initiatives or travel, require the approval of this committee. This committee shall be composed of: one or more Resident Component Liaisons charged with direct oversight of and assistance with the day-to-day functions of the Resident Component; the Resident Component President; one member of the Executive Committee; and one additional member of the Board of Directors. With the approval of the Executive Committee, a Medical student member may be added to this committee.

Amendments 2 and 3: Adjustments to Membership Categories

Background:

Upon review of both the PSA and ASA membership categories, we found discrepancies in two different categories:

Resident and Fellow Membership:

ASA requires Resident and Fellow members to be ACGME trainees (that is, requires fellow members to be only from ACGME-accredited fellowships), while PSA allows unaccredited fellows to retain Resident/Fellow membership as long as continued training is endorsed by a program director and the total training time is not greater than six years.

When adding Fellow members to our Bylaws, this was done specifically to help unaccredited fellows (who are typically credentialed as faculty) and who would otherwise qualify as Active members, avoid the added cost of membership in their first year of practice. Since PSA has taken a policy of waiving the first-year dues of all active members, this is no longer an issue.

Retired Membership:

ASA requires Retired members to be an Active or Affiliate Member of ASA for 20 or more years and be either:

- 70 years of age, OR
- fully retired from professional practice.

PSA requires Retired members to have been an Active member of PSA for 10 or more years and be fully retired from professional activity, regardless of age.

This discrepancy in membership categories may create circumstances in which someone would be eligible for Retired membership in one organization while not being eligible in the other (for example: a 72-year old, 40-year member of ASA who moved from New York to Pennsylvania 5 years ago would be eligible for ASA retired status, but not PSA).

With the new combined application process to both ASA and PSA, PSA membership is now granted within the same category as ASA membership. Without objection from the PSA Board of Directors, it was felt that maintaining the discrepancies serves no major purpose. Therefore:

Amendment 2: It is moved that Bylaw 1.123 be amended as below, to align the PSA definition of Resident and Fellow Membership with that of the ASA.

Old Bylaw:

1.123 Resident or Fellow Member - A physician within the continuum of training in Anesthesiology in an accredited residency in the Commonwealth of Pennsylvania, or a physician training in a fellowship in the Commonwealth of Pennsylvania, who holds the degree of Doctor of Medicine, Bachelor of Medicine or Doctor of Osteopathy shall be eligible to become a Resident or Fellow member of this Society for a period of no longer than six years.

No person shall continue as a Resident or Fellow Member upon the completion or discontinuance of the member's training, or for more than six total years, except as otherwise provided in the Bylaws.

Provided further that any extension beyond six years of Resident or Fellow Membership must have written approval of the Director of his or her training program, as well as the written approval of the Secretary-Treasurer of this Society.

The resident and fellow membership annually, by mail or electronic ballot or at an appointed meeting, shall elect officers, one of whom shall serve on the Board of Directors of the Society for one year.

New Bylaw, Tracked:

1.123 Resident ~~/ or~~ Fellow Member - A physician in full-time training in an anesthesiology within the continuum of training in Anesthesiology in an accredited residency in the or fellowship program accredited by the Accreditation Council on Graduate Medical Education

(ACGME) or the American Osteopathic Association (AOA) within the Commonwealth of Pennsylvania, or a physician training in a fellowship in the Commonwealth of Pennsylvania, who holds the degree of Doctor of Medicine, Bachelor of Medicine or Doctor of Osteopathy shall be eligible to become a Resident or Fellow member of this Society for a period of no longer than six years.

No person shall continue as a Resident or Fellow Member upon the completion or discontinuance of the member's training, or for more than six total years, except as otherwise provided in the Bylaws.

Provided further that any extension beyond six years of Resident or Fellow Membership must have written approval of the Director of his or her training program, as well as the written approval of the Secretary-Treasurer of this Society.

The resident and fellow membership annually, by mail or electronic ballot or at an appointed meeting, shall elect officers, one of whom shall serve on the Board of Directors of the Society for one year.

New Bylaw, Clean:

1.123 Resident/Fellow Member - A physician in full-time training in an anesthesiology residency or fellowship program accredited by the Accreditation Council on Graduate Medical Education (ACGME) or the American Osteopathic Association (AOA) within the Commonwealth of Pennsylvania.

The resident and fellow membership annually, by mail or electronic ballot or at an appointed meeting, shall elect officers, one of whom shall serve on the Board of Directors of the Society for one year.

Amendment 3: It is moved that Bylaw 1.125 be amended by replacement as below, to allow any member eligible for ASA Retired membership to be eligible for PSA Retired membership.

Old Bylaw:

1.125 Retired Member - A physician who has been an active member of this Society in good standing for ten or more years and has retired from professional activity shall be eligible to become a Retired Member, provided, however, that the Board of Directors may, at its discretion, modify the time requirements and that Retired membership terminates upon resumption of professional activity.

New Bylaw (amendment by replacement):

1.125 Retired Member - A physician living within the Commonwealth of Pennsylvania who is eligible for Retired Membership in the American Society of Anesthesiologists shall be eligible for Retired Membership in this Society.

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Scientific Affairs

The BOD approved the Committee on Annual Meeting Oversight's recommendation to change the time required to select future sites for the ASA annual meeting from 12 years out to 15 years out for tentative destinations and from 8 years out to 10 years out for confirmation of a selected city.

The BOD also approved San Diego, CA as the tentative site for ANESTHESIOLOGY 2029.

Finance

The BOD approved the 2016 budget and the draft 2017 budget.

Protect Safe VA Care

We cannot thank each of you enough for your tremendous support and advocacy during the 60-day comment period on VA's proposed "Advanced Practice Registered Nurses" rule. Together, ASA reached a record level of advocacy for our patients, including Veterans who have

earned and deserve access to safe, high-quality anesthesia care.

Due to overwhelming advocacy, the regulations.gov website has received a total of more than 223,000 comments on the proposed rule, a record number of comments for a proposal in the Department of Veterans Affairs (VA). When the comment period closed, the website reflected 167,000 comments that could be viewed. Since that date, additional copies of hard-copy comments have been periodically posted — some in support of our position, others supporting full practice authority for APRNs or nurse anesthetists.

During the 60-day public comment period, there were over 90,000 comments submitted to the Federal Register expressing support for physician-led anesthesia care for Veterans. Considering the comments specific to the anesthesia section of the rule, there can be no doubt that America has spoken in overwhelming support of physician-led anesthesia care.

Among those comments, approximately 11,200 were sent from Veterans, and an additional 14,600 were from relatives of Veterans. Another 5,000 comments were submitted from Veterans and their family members in support of physician-led anesthesia care in VA as part of ASA's advocacy efforts during Memorial Day.