When I attended my first SOAP meeting I was impressed by the high quality meeting content, surprised by how much I learned in just a few days, and captivated by the warm welcoming atmosphere. Twenty years later I am honored and humbled to have spent my first few months as president of SOAP!

It has been a busy couple of months. To catch you up on some of what SOAP has been doing:

- We have had a successful transition to our new management company, Svinicki Association Management, Inc. (SAMI). With our new managers’ help we plan to produce a new Procedure Manual, outlining how SOAP accomplishes all of the things we do every year. This project will be spearheaded by Dr. David Wlody’s Bylaws Committee, and they will be receiving help from other SOAP Committees and Committee Chairs. Our new managers are also exploring options for our ACCME accreditation process, now that we are no longer being managed by the ASA. In addition, they are working with LaToya Mason (chair, SOAP Membership Committee) to promote and publicize SOAP membership. We will continue to work closely with Jane Svinicki and Jenni Kilpatrick from SAMI to assure a seamless transition.

- In addition to our official journal affiliation with Anesthesia & Analgesia (A&A), we are now an affiliate of the International Journal of Obstetric Anesthesia (IJOA). Many of you responded to Manny Vallejo’s Member Survey indicating you might like to receive an IJOA subscription with your membership, and so we are exploring that possibility now, as our new relationship affords us the opportunity to bring you IJOA at a discounted price. We will keep you posted! This affiliation also brings SOAP increased exposure and influence. I am happy to announce that Robert D’Angelo has agreed to be SOAP’s official representative on the IJOA Executive Board.

Continued on page 2
PRESIDENT’S REPORT
Continued from page 1

• Brendan Carvalho’s group continues to hone the SOAP Consensus Statement on Maternal Arrest. Look for the experts’ recommendations to be published in A&A soon and then posted on the web site. The publication of Consensus Statements is a new undertaking for SOAP and represents a great step forward in our efforts to improve provider education and clinical care.

• Michael Froelich has been working with the ASA so that soon the SOAP Newsletter will be sent via electronic link to all ASA members. This will widen SOAP’s exposure and enhance our potential for continued growth.

• We are working to strengthen our ties with the American Congress of Obstetricians and Gynecologists (ACOG) and the Society for Maternal Fetal Medicine (SMFM). At ACOG’s invitation, SOAP representatives are actively participating in a multidisciplinary Consensus Panel to Improve Maternal Health and Safety and Reduce Harm, which is a working group aiming at decreasing maternal mortality and severe morbidity.

The group is focusing on hemorrhage, severe hypertensive disease, and thromboembolic disease. In addition, we have reached out to SMFM and hope to increase and formalize cross-educational efforts between the two societies.

In the meantime, plans are underway for the Sol Shnider Obstetric Anesthesia Meeting in one of my favorite cities – lovely San Francisco – March 6-9, 2014. It is always a highly rated meeting in a wonderful setting, and Dr. Cally Hoyt – along with colleagues from Stanford and the University of San Francisco – is putting on another great program this year. Meanwhile, Drs. Jose Carvalho and Bob Gaiser are overseeing the planning of our 46th Annual Meeting in Toronto May 14-18, 2014. The theme will be “New Approaches to Old Problems in Obstetric Anesthesia.” I hope to see all of you at one (or both?) of our top-of-the-line meetings!

I hope you all are having a great summer! I am proud to serve as our society’s president and remain committed to furthering its mission to promote excellence in obstetric anesthesia care through the support of education and research. I hope you will contact me (bscavone@dacc.uchicago.edu) if you have ideas that you feel would benefit SOAP.

EDITOR’S CORNER
How SOAP is Adapting to Recent Changes

Michael Froelich, MD MS
University of Alabama at Birmingham
Birmingham, AL

A s the Society for Obstetric Anesthesia and Perinatology is reaching its 45th birthday, we are witnesses to the ongoing evolution of our organization and the practice of anesthesiology in general. Important milestones have been the approval of the ACGME accredited Obstetric Anesthesiology Fellowship, our first Latin American Symposium on Obstetric Anesthesia this year and our change of management to SAMI (Svinicki Association Management, Inc.). The inclusion of the Latin American audience is a continuation of our society’s long-standing tradition of global outreach and perhaps represents the continued economic growth of Latin American countries. But development and growth is not limited to the Americas. This edition of the newsletter also features an article on the formation of the League of Obstetric Anesthetists of Nigeria (LOAN), an example of organized health care in Africa.

Our promotion of expertise in the anesthetic care of the pregnant woman is not limited to clinical care. We are also broadening our scope of research collaborations as we now routinely collaborate with colleagues in the United Kingdom, Canada, Japan, China and Brazil. We also observe a broadening clinical scope in anesthesiology and its subspecialties. There is a renewed focus on translational science, investigation of outcomes that are relevant to patient care and on patient safety concerns. This shift is being reflected by the inclusion of a patient safety portal on the SOAP website and the inclusion of patient safety contributions in the SOAP newsletter. These trends also reflect our specialties expanding perioperative role within the hospital system as encouraged by the Affordable Care Act that encourages an integrated health care system.

In all, we continue to prosper as a subspecialty society with a strong dedication to advance clinical care through excellence in clinical practice, research and education.
The 45th Annual Meeting for the Society of Obstetric Anesthesia and Perinatology (SOAP) was held at the Caribe Hilton Hotel in San Juan, Puerto Rico from April 24-28, 2013, with over 600 attendees. The meeting’s theme, “Global Perspectives,” was highlighted by the meeting’s location and featured the well-attended 1st Latin American Symposium on Obstetric Anesthesia, which was held in Spanish. A continental breakfast was generously offered every morning to start off the day. Pre-meeting activities started on Wednesday and included the very popular ultrasound and transthoracic echocardiography workshops as well as a sold out seminar on preeclampsia. The evening ended with appetizers and cocktail drinks in a delightful welcome reception.

On Thursday, 2013 SOAP meeting host Vilma E. Ortiz, M.D. (Massachusetts General Hospital, MA) and 2013 SOAP Scientific Chair and President Elect Barbara M. Scavone, M.D. (University of Chicago, IL) opened the meeting alongside 2013 SOAP President McCallum R. Hoyt, M.D., M.B.A. (The Cleveland Clinic Foundation, OH). The Gertie Marx Research Competition followed, featuring six abstracts. The winning abstract was presented by Hans P. Sviggum, M.D. (Brigham and Women’s Hospital, MA) for his fine presentation on the effects of bupivacaine temperature on epidural labor analgesia.

The Distinguished Service Award was then presented to Alex F. Pue, M.D. (Anesthesia Service Medical Group, CA) by Dennis C. Shay, M.D. (Anesthesia Service Medical Group, CA) for his continuous dedication to the field of Obstetric Anesthesiology. The poster viewing and poster walk-arounds were also part of the morning session and was followed by the Gertie Marx/FAER Education Lecture, delivered by Ndola Prata, M.D., M.Sc. (University of California, Berkeley, CA), who covered “Maternal Mortality in Resource Poor Settings.”

The day continued with Poster Session 1, moderated by Kenneth E. Nelson, M.D. (Wake Forest University Health Sciences, NC) and Oral Presentation Session 1 (6 papers) moderated by Katherine W. Arendt, M.D. (Mayo Clinic, MN). These sessions were followed by a Clinical Forum on “Evolving Practices”, featuring lectures on “A Balanced View of General Anesthesia for Cesarean” by Joy L. Hawkins, M.D. (University of Colorado, CO), “Anesthesia for External Cephalic Version” by Carolyn Weiniger, M.D., B.Ch. (Hebrew University, Tel Aviv, Israel), and “Internal Iliac Balloon Occlusion for Placenta Accreta” by Ashley M. Tomicandell, M.D., M.S. (Wake Forest University Health Sciences, NC). The day concluded with a Fellow’s Reception and the always-exciting Resident’s Research Forum.

Friday morning started off with a Zumba class for those wanting to brush-up on their dancing skills. The educational sessions opened with the Best Paper Session, moderated by Jill M. Mhyre, M.D. (University of Michigan Health System, MI). Six interesting papers were presented with the winning award given to Scott Segal M.D., MHCM (Tufts Medical Center, MA) for his novel work on the effect of noninfectious inflammatory fever on the fetal brain. The morning continued with “What’s New in OB? The Obstetrician’s Perspective: Obstetrical Directions in the Near Future,” presented by Michael Greene, M.D. (Massachusetts General Hospital, MA), who focused on thrombophilias and the risks for obstetrical complications, recent developments in noninvasive screening for fetal aneuploidy, and developments in high-resolution assessment of fetal genomic abnormalities.

After a break for poster viewing and poster walk-around, the morning continued this time with “What’s New in OB Medicine? The Cardiologist’s Perspective: Peripartum Cardiomyopathy,” presented by Dennis McNamara, M.D. (University of Pittsburgh, PA). He described the current strategies for the management of peripartum cardiomyopathy as well as worldwide regional differences in prevalence and outcomes.

The afternoon ended early after Poster Session 2, moderated by May Pian-Smith, M.D., M.S. (Wake Forest University Health Sciences, NC). The day concluded with a Fellow’s Reception and the always-exciting Resident’s Research Forum.

Saturday commenced with a panel breakfast with the experts, followed by Oral Presentation 2, which was animatedly moderated by Wendy Teoh, MBBS, FANZCA (KK Women’s and Children’s Hospital, Singapore). The day continued with, “The Neonatologist’s Perspective – The Challenge of Premature Births in Puerto Rico: Why Are So Many Born So Soon In Paradise?”, presented by Jose Cordero, M.D. (University of Puerto Rico, PR). Dr. Arvind Palanisamy, M.D., FRCA (Brigham and Women’s Hospital, MA), delivered an outstanding Gerard W. Ostheimer Lecture, “What’s New In OB Anesthesia?” In this highly anticipated lecture, Dr. Palanisamy was charged with reviewing over 100 journals over the period of January 2012 to December 2012 and condensed published articles of highest interest in the fields of obstetric anesthesia, anesthesiology, obstetrics, perinatology, pediatrics, epidemiology, developmental neuroscience, and...
The 2013 SOAP Banquet was quite entertaining. It started off with an animated open dance floor. The day continued with the Fred Hehre Lecture, “Passion,” by Richard Smiley, M.D., Ph.D. (Columbia University, NY). In a very emotional presentation, Dr. Smiley described the attributes that seem critical for a successful and enjoyable career in obstetric anesthesia. The lecture was followed by Poster Session 3, moderated by Ellen Lockhart, M.D. (Washington University, MO). The International Outreach Panel followed this session. It was moderated by Ashraf Habib, M.D., BCh, MSc, FRCA (Duke University, NC) and included panellists Medge Owen M.D. (Wake Forest University School of Medicine, NC), Emmanuel K. Srofenyoh M.D., FWACS (Ridge Regional Hospital, Ghana), and Cynthia A. Wong M.D. (Northwestern University, IL).

The educational session concluded with the Research Hour, “Epidural Fever,” moderated by Scott Segal M.D., MHCM (Tufts Medical Center, MA). Laura Goetzl M.D. (Temple University, PA) and Michael A Froelich M.D., M.S. (University of Alabama at Birmingham, AL) were the guest speakers.

The 2013 SOAP Banquet was quite entertaining. It started off with a group dance lesson (mostly salsa), followed by a delicious dinner buffet, and the awards presentation (Table 1). The evening ended with an animated open dance floor.

Sunday kicked off with a spirited Pro-Con Debate between Yaakov Belin, M.D. (Mount Sinai School of Medicine, NY) and John Thomas, M.D. (Wake Forest University School of Medicine, NC), and it was provocatively moderated by David Bogod, MB, BS, FRCA, LLM (Nottingham University Hospitals, United Kingdom). The proposition was, “General Anesthesia is the Technique of Choice for Suspected Placenta Accreta.”

Sunday continued with a Clinical Forum 2 centered on “Obstetric Emergencies.” P. Allan Klock, M.D. (University of Chicago, IL) infused a fundamental anesthesia topic with new perspectives as he discussed “The Obstetric Airway.” Sharon Einav (Shaare Zedek Medical Center, Jerusalem, Israel) continued the theme of Obstetric Emergencies with an in-depth discussion on “Maternal Cardiopulmonary Arrest.”

Robert Gaiser, M.D. (University of Pennsylvania, PA) finished the sessions with an animated review of the meeting’s Best Case Reports. The Best Case Report was awarded to, “Successful management of cardiac arrest from amniotic fluid embolism with ondansetron, atropine, and ketorolac” which described a novel way of managing this rare complication.

Overall, the meeting was very well organized; it nicely incorporated the first Latin American Symposium in the field, and offered a relevant educational content, surpassing the expectations of many of the attendees. We now look forward to The 2014 SOAP 46th Annual Meeting from May 14-18, 2014 in Toronto, Ontario, Canada!

Table 1. Awards Presented at the 2013 Society for Obstetric Anesthesia and Perinatology Annual Meeting

<table>
<thead>
<tr>
<th>AWARD</th>
<th>RECIPIENT</th>
<th>INSTITUTION</th>
<th>ABSTRACT TITLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resident Research Forum: Best Original Research</td>
<td>Kelly Ellerman, M.D.</td>
<td>Brigham and Women’s Hospital</td>
<td>Teaching the Lumbar Epidural Technique to Millennial Learners: The Impact of an Educational Video</td>
</tr>
<tr>
<td>Research in Education Award</td>
<td>Clemens M. Ortner, M.D.</td>
<td>University of Washington</td>
<td>Competency Level for Performing Safe General Anesthesia for Urgent Cesarean Delivery Evaluated with Repeated Simulation Based-Training: Long Term Retention and Frequent Management Mistakes</td>
</tr>
<tr>
<td>Gertie Marx Award</td>
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<td></td>
</tr>
<tr>
<td>1st Place</td>
<td>Hans P. Sviggum, M.D.</td>
<td>Brigham and Women’s Hospital</td>
<td>A Randomized Controlled Study Assessing Bupivacaine Temperature on Epidural Labor Analgesia</td>
</tr>
<tr>
<td>2nd Place</td>
<td>Mubeen Khan, M.D.</td>
<td>University of Toronto</td>
<td>Carbetocin at Elective Cesarean Delivery: A Randomized Controlled Trial to Determine the Effective Dose, Part 3-Final</td>
</tr>
<tr>
<td>3rd Place</td>
<td>Mohammed A. Abdel Rahim, M.D., B.Med.Sc.</td>
<td>University of Miami Miller School of Medicine</td>
<td>Analysis of Dose Response of Intravenous Anesthetic for Fetal Procedures</td>
</tr>
<tr>
<td>Patient Safety Award</td>
<td>Emmanuel K. Srofenyoh, M.D., FWACS</td>
<td>Ridge Regional Hospital</td>
<td>Measuring Performance of a Continuous Quality Improvement Program Designed to Reduce Maternal Mortality in a Regional Referral Institution in Ghana</td>
</tr>
<tr>
<td>Obstetric History Award</td>
<td>David A. Olsen, M.D.</td>
<td>Mayo Clinic</td>
<td>The Evolution of Epidural Infusion Devices in Obstetric Anesthesia</td>
</tr>
<tr>
<td>Best Paper Award</td>
<td>Scott Segal, M.D., MHCM</td>
<td>Tufts Clinic</td>
<td>Non-infectious Inflammatory Fever Causes Fetal Microglial Activation</td>
</tr>
<tr>
<td>Frederick P. Zuspan Award</td>
<td>Emmanuel K. Srofenyoh, M.D., FWACS</td>
<td>Ridge Regional Hospital</td>
<td>Measuring Performance of a Continuous Quality Improvement Program Designed to Reduce Maternal Mortality in a Regional Referral Institution in Ghana</td>
</tr>
<tr>
<td>Distinguished Service Award</td>
<td>Alex F. Pue, M.D.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Media Award</td>
<td>Kevin Pho, M.D. and Craig Palmier, M.D.</td>
<td>KevinMD.Com, June 30, 2012</td>
<td>“Obstetric anesthesiologists not only relieve pain, they save lives”</td>
</tr>
<tr>
<td>SOAP Teacher of the Year &gt;10 years of experience</td>
<td>Curtis Baysinger, M.D.</td>
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</tr>
<tr>
<td>SOAP Teacher of the Year &lt;10 years of experience</td>
<td>Mark Rollins, M.D.</td>
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</table>
International Outreach

Ashraf Habib, MD
Duke University
Durham, NC

International outreach efforts in obstetric anesthesia are continuing to expand. This was quite evident during the 2013 SOAP meeting in Puerto Rico. Several abstracts presented at the meeting highlighted those efforts and their impact on practice and outcomes in different parts of the world. Dr. Emmanuel Srofenyoh’s presentation at the best paper of the meeting session described a continuous quality improvement project designed to reduce maternal mortality at the Ridge Hospital in Accra, Ghana, where collaboration has been ongoing since 2006 between the Kybele group led by Drs. Yemi Olufolabi and Medge Owen and the Ghana Health service. He reported that despite a 55% increase in patient admission and a four-fold increase in high-risk cases from 2006-2011, stillbirth rate was reduced by 52% and the maternal mortality ratio was reduced by 23%. Dr. Srofenyoh is the head of clinical services at the Ridge Hospital, and his presentation was awarded the Patient Safety Award as well as the Zuspan award. In the oral presentations session, Dr. Virgil Manica presented the results of his efforts in Cuza Voda Maternity, Iasi, Romania, where the use of spinal anesthesia for cesarean delivery increased from 19% in 2007, before initiating the Kybele program, to 78% in 2011 following several years of collaboration. Dr. Borislava Pujic, from Klinicki Centar Vojvodine in Serbia, presented a poster describing the impact of the Kybele group’s first visit, led by Drs. Ivan Velickovic and Curtis Baysinger, to her country, which resulted in an increased use of regional anesthesia for cesarean delivery. Two abstracts were also presented about the No pain Labor N’ Delivery initiative in China, led by Dr. Ling Hu, describing the impact of the marked increase of labor epidural analgesia use (from 0 to 57%) on oxytocin augmentation and postpartum hemorrhage and reporting improved obstetric outcomes and reduction in cesarean delivery rates at The Second Hospital of Wenzhou. In addition to the programs mentioned above, other international outreach efforts are currently taking place in Armenia, led by Drs. Simon Millar and Gordon Yuill, and Vietnam, led by Dr. Marge Sedensky.

The SOAP/Kybele international outreach grant presents an opportunity for funding to collaborate with a country where an international outreach program is conducted and perform a project that will advance the practice of obstetric anesthesia in that country. At this year’s SOAP meeting, Dr. Onyi Onuoha, who was awarded the first SOAP/Kybele international outreach grant in 2011, presented the results of her project, reporting improvements in decision to delivery interval at Ridge Hospital in Accra, Ghana following a number of changes including the introduction of a dedicated maternity OR. The 2013 recipient was Dr. Ling Hu, an assistant professor of Anesthesiology at Northwestern University Feinberg School of Medicine, Chicago, IL, for his proposal entitled: The Impact of Continuation of Neuraxial Analgesia during the Second Stage of Labor on Newborn and Maternal Safety in a Chinese Academic Medical Center. The site for this impact study will be the Second Hospital of Wenzhou Medical College. Next grant will be awarded at the SOAP meeting 2014, with an application deadline of April 11, 2014.

The SOAP international Outreach Committee is currently working on collecting useful resources related to international outreach that will be made available on the SOAP website. This will include a list of global fellowship programs and residency programs offering global health rotations. If your program offers any of those opportunities that you would like to include in the SOAP website, please contact Dr. Ashraf Habib (habib001@dm.duke.edu).
The League of Obstetric Anesthetists of Nigeria was formed in 2011 in Port Harcourt, Nigeria to address the issues in anesthesia specific to the sub-specialization. A second Annual Scientific Meeting took place in September 2012 also in Port Harcourt. This was attended by anesthesiologists, many in teaching hospitals from Nigeria, United Kingdom (UK) and the USA. With the theme “Safe anesthesia, Safe delivery”, the 2-day conference focused on strengthening the profile of the specialty towards improving the care and outcome of the pregnant woman and baby.

This is the first subspecialty in Anesthesia in Nigeria and probably in Africa, and there was palpable excitement amongst participants. The current National President, Dr. Sotonye Fyneface-Ogan, an anesthesiologist at the University of Port Harcourt Teaching Hospital, emphasized the need for full engagement by members towards making a lasting impact. The meeting hoped that external interests from the Society of Obstetric and Perinatology in the USA and the Obstetric Anesthesia Association in the UK would support its educational and research thrust. Airway equipment including monitors and an Ambu fiberoptic scope was donated to the local university hospital by Dr. Yemi Olufolabi from Duke University and Dr. Hassan Adeniji-Adele of Washington Hospital Center. Ambu® also donated 130 Ambu laryngeal masks which were distributed to attendees. The 2012 meeting was attended by about 70 anesthesiologists from all over Nigeria, and some from the UK and USA.

Anaesthesia safety still remains a significant problem in Nigeria, a problem which is growing as the surgical case load increases. While maternal mortality in Nigeria (with an estimated population, 170 million) is as high as 630 per 100,000 deliveries, World Bank 2010, anesthesia-associated mortality is about 10 in 150. The deaths that occur amongst parturients compound the tragedy to any surviving child/children. This unacceptable high rate of avoidable anesthesia-related deaths in Nigeria is due to lack of adequate training, lack of functioning anesthesia equipment, patient monitors and drug and oxygen supplies. However a significant part of the problem is due to the severe shortage of adequately trained personnel.

Through the support of the World Federation of Societies of Anesthesiologists (WFSA), two Fellows of the league have obtained post-fellowship training positions in Obstetric Anesthesia. With the mission, “Achieving safe childbirth through multidisciplinary care”, the league seeks collaborative efforts of established societies both home and abroad to assist in reducing the scourge of anesthesia-related maternal mortality and enhance greater commitment towards improving maternal comfort during childbirth.

The birth of LOAN is a cause for celebration. The league needs the necessary support to grow! In the words of Confucius (551 BC - 479 BC), “Journey of a thousand miles begin with a single step”. It is indeed a long journey from birth to maturation.
Dr. Fyneface-Ogan presiding in a scientific session

Dr. Olufolabi presiding during a Scientific Session

Dr. Olufolabi with participants at the Airway workshop

A demonstration of various airway devices
Although the Affordable Care Act establishes strong incentives to create Accountable Care Organizations, how healthcare providers and administrators will interact with payers is not well defined. For the immediate future, many things will stay the same. Documentation requirements for payment for obstetrical anesthesia services are unlikely to change in the immediate future. The rules by which the Joint Commission inspects obstetrical anesthesia services are unlikely to be revised very soon either. The demonstration of quality in obstetrical anesthesia care is evolving; but because it is hard to define and measure, new quality standards are a distant thought. Recently, questions of what constitutes an obstetrical emergency and how this should be documented have been asked.

What constitutes an emergency in obstetrical anesthesia?

Recently, the documentation and the definition required for emergency anesthetic obstetrical care have been actively examined. The Federal Emergency Services Program defines an “emergency medical condition” as a medical condition (including emergency labor and delivery) that manifests itself by acute symptoms of sufficient severity in which the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to a patient’s health or serious impairment to bodily functions, organs, or parts. The March 2001 ASA Newsletter noted that anesthesia for a vaginal delivery or scheduled cesarean delivery would most likely not constitute an emergency1, although some anesthesiologists note that patient conditions in those circumstances would be similar enough to those found among many patients presenting for emergency surgery that the billing code modifier for emergency could be used. Even though some Medicaid programs consider labor an emergency, which can then be billed as such on the appropriate claim forms, this is not true in all states. Obstetrical anesthesiologists deal with emergencies for both fetal and maternal indications, so the use of the emergency modifier is appropriate for anesthesia for delivery for severe fetal stress (i.e. a Category III fetal heart rate tracing) and potentially life-threatening obstetric conditions (i.e. maternal hemorrhage). Less clear is whether an emergency designation is appropriate for fetal stress indicated by a Category II fetal heart rate tracing or in an indicated non-scheduled cesarean section for arrest of labor. In all circumstances, when an emergency designation is used, one must document the reason(s) in the preoperative anesthesia assessment. This documentation by the anesthesiologist must be present even if the obstetrician documents the need for emergency delivery in the patient’s record.

What are the preoperative and postoperative documentation requirements of Centers for Medicare and Medicaid Services (CMS)?

CMS has mandated that the completion of the history and physical examination be performed within 30 days of surgery provided that a review is performed and documented within 48 hours of surgery and before the start of the anesthetic. A post anesthetic evaluation must occur within 48 hours, although it can occur before the patient is discharged from the post anesthesia recovery area after delivery. The following necessary items are assessment for respiratory function including respiratory rate, airway patency, and oxygen saturation; cardiovascular status to include pulse rate and blood pressure; mental status; temperature; pain assessment; nausea and vomiting; and hydration status. Many providers will also choose to address other issues in that note, such as a neurological or headache assessment or patient satisfaction with anesthesia services. Many anesthesia practices provide post cesarean section pain services. Documentation for such services must include a consultation request from the obstetrician and a separate follow-up note from the one that documents the post anesthetic evaluation.

Work by American Society of Anesthesiologists on behalf of obstetric anesthesia is ongoing. Recently, the ASA Committee on Obstetric Anesthesia established communication with the Association of Women’s Health, Obstetric and Neonatal Nurses (AWOHN) to work on issues of mutual interest.

References

Following the elections at the annual meeting in San Juan, we are now finishing the process of ensuring a thorough turnover of our society’s financial oversight. This has occurred only a few weeks prior to a transition in our management company from the ASA to Svinicki Association Management, so particular vigilance is required to maintain the continuity of our corporate memory. We are pleased to report that our financial position is favorable this summer following two successful spring meetings. Our assets also continue to grow through gains in the equity markets.

The books are almost closed on the Sol Shnider Meeting from March of this year. Consistent attendance coupled with our increasing experience in running the meeting has led to a steady, modest gain in revenue after its re-introductory year in 2010 (honoraria weren’t paid to speakers in 2010 artificially lowering expenses and raising revenue that year).

The SOAP Annual Meeting held in San Juan was particularly successful this year from a financial perspective. Although the expenses from this meeting are incomplete as of this writing, the preliminary estimates are excellent. Revenue from the Annual Meeting is almost entirely from paid registrants who attended the main session and the pre-meeting workshops in record numbers.

<table>
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<tr>
<th>Annual Meeting Paid Registrants</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
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<td>Main Meeting</td>
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<td>575</td>
<td>537</td>
<td>549</td>
<td>595</td>
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<tr>
<td>Workshop &amp; Symposia</td>
<td>100</td>
<td>98</td>
<td>175</td>
<td>207</td>
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SOAP introduced a new policy for the annual meeting in 2013 which mirrored the World Anesthesia Society’s discounted registration for low- and middle-income countries defined according to the World Bank classification. Thirty-two registrants attended from these countries. The highly attended pre-meeting activities included ultrasound and echo workshops, a preeclampsia seminar and a Latin American symposium. We saw a modest return of exhibitors to support the meeting this year. The total income at the annual meeting rebounded and exceeded our previous high in San Antonio and we believe that our final expenses will be lower in Puerto Rico as compared to the last few years primarily due to lower food and beverage costs.

As the baton is passed from your treasurer of the last four years, John Sullivan, to your new treasurer, Scott Segal, we hope to continue to report strong financial health in a transparent and accessible format. It will be our primary goal to ensure maximum value for your membership dollar.
The 2012 SOAP/Gertie Marx Education and Research Grant was awarded to Brian Bateman, MD and Richa Saxena, PhD, both of Harvard University and the Massachusetts General Hospital. Their grant is entitled “The Genetic Predisposition to Cardiovascular Disease and the Risk of Preeclampsia.”

Dr. Bateman did his undergraduate work at Yale and then received the M.D. from the Columbia University College of Physicians and Surgeons in 2006. He completed his Anesthesiology residency at MGH in 2010 and joined the Harvard/MGH faculty, where he is currently an Assistant Professor of Anaesthesia. He recently received an M.S. in Epidemiology from Harvard. He has already published over 30 manuscripts in major peer-reviewed journals, many of them as first author. Most of his work has been involved with studying large databases in order to investigate the epidemiology of medical, surgical and pregnancy complications, including stroke, sepsis and postpartum hemorrhage.

Dr. Saxena did her undergraduate work at Cornell and received the Ph.D. in Biology from the Massachusetts Institute of Technology in 2000 and did postdoctoral work in human genetics at MGH/Brigham and Women’s Hospital in Cambridge, MA from 2003-2009. She is an Assistant Professor of Anaesthesia at the Massachusetts General Hospital and Harvard Medical School. She has over 60 peer-reviewed publications, many of them in the area of human genetics, especially in the area of mitochondrial genetics, and the genetics of type 2 diabetes.

It is well established that preeclampsia (PEC) is associated with future maternal risk of cardiovascular disease (CVD), with the greatest risk seen in women with severe PE. Based on preliminary genetic association studies, the investigators hypothesize that some genetic markers (risk alleles) may be shared between preeclampsia and cardiovascular disease and that identification of common genetic factors could lead to biological insights into causal mechanisms for preeclampsia. Drs. Bateman and Saxena will have access to samples of genetic material drawn from 8000 cases of PEC from the MGH and Brigham and Women’s Hospital, in addition to separately collected samples, allowing them to assess dozens of single nucleotide polymorphisms (SNPs) known to be associated with CVD (stroke, myocardial infarction, coronary disease, and venous thromboembolism) for association with preeclampsia in a large multi-ethnic population. The investigators hope to identify genes associated with PEC in European-Americans, African-Americans and Hispanic women. It is hoped that work funded by the SOAP/Gertie Marx grant will lead to further, sustainable funding for these investigators in this area.

The purpose of the SOAP Gertie Marx Grant is two-fold; to enhance progress in obstetric anesthesia and to promote the careers of (usually) junior investigators to increase their chances of obtaining sustainable federal and other major funding. Nine proposals of very good quality were submitted in this 3rd annual award cycle; unfortunately at this time funds are only available to award one grant per year. The deadline for applications for the 4th annual cycle is October 1, 2013; the application and details regarding eligibility and additional information can be found on the SOAP website (http://www.soap.org/gertie-marx-award.php).
The Disbursement Committee was formed to consider and make recommendations to the SOAP Board of Directors as to the disbursement of funds from the Obstetric Anesthesia and Perinatology Education Fund (OAPEF), the Gertie Marx Education Fund and other requests that may come to the Board. The Committee is comprised of four past SOAP Presidents (Valerie Arkoosh (Chair), Gerald Bassell, Joy Hawkins, Alan Santos), the SOAP Treasurer (Scott Segal), the Chair of the SOAP Education Committee (Mark Zakowski), and the Chair of the SOAP Research Committee (Richard Smiley). In order to improve communication and continuity of information with the SOAP Board of Directors, the Disbursement Committee recommended and the Board approved adding two non-voting members to the Committee: the 2nd Vice-President (John Sullivan) and 1st Vice-President (Manual Vallejo).

During 2012 the Committee was pleased to award the 2013 SOAP/Gertie Marx Education and Research Grant to:

**Brian T. Bateman, MD and Richa Saxena, PhD**

*Department of Anesthesia, Critical Care and Pain Medicine*  
*Massachusetts General Hospital / Harvard Medical School*  
*“The Genetic Predisposition to Cardiovascular Disease and the Risk of Preeclampsia”*

Investigator brief description: Preeclampsia (PE) increases maternal risk of cardiovascular diseases (CVD), but whether PE and CVD share underlying disease mechanisms is unknown. We will test for association of validated Genome wide association (GWAS) CVD gene variants with risk of preeclampsia in discovery and replication case-control samples to identify causal CVD genes and pathways influencing PE.

The funds for this $50,000 (over two years) grant are available thanks to an extremely generous bequest to SOAP from the estate of Dr. Marx. The Committee would like to thank all of the submitters and the grant reviewers who graded the submissions using an approach similar to the one used by the NIH. The Grant will be offered again in 2014 with applications due October 1, 2013. Initial funds will be disbursed in January 2014. Application details can be found at: [http://www.soap.org/gertie-marx-award.php](http://www.soap.org/gertie-marx-award.php)

The Committee would also like to alert the membership to the Obstetric Anesthesia and Perinatology Education Fund (OAPEF). First, we encourage all members to consider donating to this tax-deductible fund. Donations are solicited with annual dues and at the time of meeting registration. Second, OAPEF funds may be requested to fund small projects (<$15,000) that would not be eligible for the SOAP/Gertie Marx Education and Research Grant. Members interested in soliciting these funds should contact Committee Chair, Joy Hawkins, MD.

The Committee is honored to serve the membership and Board and encourages and welcomes feedback on any of the items discussed above. On a personal note, I am stepping down from the Committee in order to run for the U.S. House of Representatives in 2014. Dr. Joy Hawkins has assumed Chairmanship of the Committee. It has been an honor and pleasure to serve SOAP as Chair of the Disbursement Committee.
Historically, regional anesthesia was safer than general anesthesia for cesarean delivery. Between the years 1985 and 1990, the rate for anesthesia-related maternal death in the United States was 16.7-fold higher with general anesthesia when compared with regional anesthesia. Over the subsequent 20 years, an increasing proportion of cesarean deliveries were conducted under regional anesthesia. And yet, between 1985 and 2002, the rate of anesthesia-related maternal death from general anesthesia for cesarean delivery fell by 80%, yielding a safety record that now rivals that of regional anesthesia. What should anesthesia providers make of this recent development? Will general anesthesia become a common choice for elective obstetric anesthetics?

No, because our patients and obstetricians prefer neuraxial techniques, and regional anesthesia has many benefits for the mother and newborn. Neuraxial anesthesia allows the mother to be awake for delivery, facilitates superior postoperative analgesia, and limits the risks of failed airway management and undesired intraoperative awareness. Moreover, many mothers prefer to limit neonatal exposure to anesthetics both in utero and through early breastfeeding.

Nevertheless, there will be clinical situations in an obstetric anesthesia practice where general anesthesia is the most appropriate choice and should be used. For example umbilical cord prolapse or hemorrhage with hemodynamic instability require emergent provision of surgical anesthesia. In these cases general anesthesia should not be avoided; the maternal mortality rate is only about 6.5 per million general anesthetics – a remarkable safety record. Recent reports have shown that the incidence of failed intubation has been remarkably stable since first reported in 1985 (1:238-1:280). What has changed is that maternal mortalities are exceedingly rare in modern practice. This probably relates to our use of difficult airway algorithms and rescue devices such as the laryngeal mask airway. In the ASA Closed Claims Project database, all cases of difficult intubation in obstetric patients resulting in liability occurred before 1999.

A review of anesthesia-related complications associated with cesarean delivery found general anesthesia was more likely to be used when ASA status was > 4 and the decision-to-delivery interval was < 15 minutes – our sickest patients and most emergent cases. Yet even in these worst case scenarios, obstetric anesthesia is remarkably safe. As our obstetric patients become older and have additional co-morbidities, it is likely we will have more clinical situations where neuraxial anesthesia is relatively or absolutely contraindicated. Some examples might be a parturient with a recent thrombus or a mechanical heart valve who cannot be off anti-coagulation, women with a cardiac lesion that is preload-dependent such as pulmonary hypertension, or a morbidly obese woman who cannot lay supine on the operating room table. We can reassure these parturients we have the skills to provide their general anesthetic safely.

We try to provide neuraxial anesthesia for our obstetric patients whenever possible, but that may lead us to err on the side of inappropriately delaying induction of general anesthesia. The most recent ASA Closed Claims analysis found that when anesthesia delay was alleged in cases of newborn death or brain damage, one factor was inappropriately prolonged attempts to establish a neuraxial anesthetic. Obstetric anesthesiologists also get sued for “minor” complaints such as emotional distress or pain during surgery. These cases are often related to an inadequate neuraxial block and the anesthesiologist’s reluctance to convert to a general anesthetic. This is a disservice to the patient and may make her reluctant to have a regional anesthetic for surgery in the future.

General anesthesia should be neither widely used nor consistently avoided. When choosing the anesthetic for a cesarean delivery, we should be making individual assessments based on the patient’s history, her preferences, and the immediate clinical situation rather than using a blanket approach of neuraxial anesthesia for every patient. Most women and most obstetricians will prefer neuraxial blocks, but both regional and general anesthesia can be safely provided if common sense and evidence-based medicine in the form of practice guidelines are used.

Key Points:
1. Adhere to basic safety principles whether providing general or regional anesthesia; maternal complications can occur with either technique.
2. There are emergent clinical situations when general anesthesia may be preferable for cesarean delivery. Evaluate on a case-by-case basis, and do not cause unnecessary delays in delivery.
3. In the future, we are likely to see more maternal co-morbidities that make neuraxial techniques relatively or absolutely contraindicated.

References
5. Obstet Gynecol 2005;106:281-7
6. Anesthesiology 2009;110:8-9
Buprenorphine (Subutex) is a partial mu opioid agonist and at high doses a weak kappa antagonist that is taken as a sublingual tablet. It attenuates the effects of illicit opioid drugs. Historically, methadone was the drug of choice to treat illicit opioid dependence. Studies suggest that high dose buprenorphine is an alternate choice that may be associated with less severe withdrawal symptoms. Patients taking buprenorphine can be treated as outpatients without the need for daily visits to a licensed opioid dependency program. Other advantages of buprenorphine over methadone for the parturient include a lower risk of overdose, fewer drug interactions, and less severe neonatal abstinence syndrome compared to methadone exposed neonates. An American College of Obstetrics and Gynecology (ACOG) committee recently released their opinion regarding opioid abuse, dependence, and addiction in pregnancy. Their statement includes: “Medical supervised tapered doses of opioids during pregnancy often result in relapse to former use. Abrupt discontinuation of opioids in opioid dependent pregnant women can result in preterm labor, fetal distress or fetal demise.” The committee opinion recognized buprenorphine as an alternative to methadone for decreasing risks associated with illicit opioid dependency during pregnancy.

Increased use of buprenorphine is expected to lead to an increase in the number of parturients presenting for delivery who are receiving this maintenance therapy. Parturients receiving buprenorphine do not have increased pain medication requirements during labor but do have an increased requirement after cesarean section. Management of post Cesarean section pain is challenging in these patients due to the effects of buprenorphine. One approach to addressing this issue is the development of buprenorphine referral centers for the obstetric population. Obstetricians working synergistically with pain medicine specialists are an integral interaction necessary to manage patients who are receiving this therapy and their special needs. It is important to engage clinicians who are familiar with the drug and its effects and to utilize a multimodal analgesic regimen for these patients to manage their post-operative pain.

High dose buprenorphine has a high affinity for the mu opioid receptor which can lead to significant difficulties with pain control after trauma or surgery. Supplemental doses of opioid will not displace buprenorphine, which leads to attenuation of the effect of the pain medication. A good practice is to convert buprenorphine to a short acting opioid such as oxycodone prior to an elective surgical procedure. This allows the buprenorphine effects to dissipate before post-operative pain medication is required. Buprenorphine has a long half-life of 20–73 (mean 37) hours, necessitating the discontinuation of the drug several days prior to surgery. Conversion for parturients should be performed by a practitioner familiar with the drug and its metabolism to prevent withdrawal symptoms in both the mother and the fetus. This plan will work well for patients scheduled for an elective cesarean delivery who deliver on the planned date. The parturient would be converted to a short acting opioid under the guidance of pain physicians several days, usually four, before their procedure. A conversion period of four days to short acting opioids allows time for disassociation of buprenorphine from the mu receptors to improve post-operative opioid efficacy. Longer periods of conversion may increase the risk of postpartum relapse to illicit drug use and the concern for potential diversion with a larger supply of opioid in their possession. Lost or stolen opioids would lead to withdrawal for both mother and fetus. A longer period of opioid use negates the beneficial effects of buprenorphine on neonatal abstinence syndrome and requires frequent post-partum visits to titrate buprenorphine to their maintenance therapy. Continued compliance is always a concern with reintroducing the buprenorphine postpartum. A short break in therapy allows a sooner return to maintenance therapy, obviating the need for reinstitution of buprenorphine.

The conversion to short acting opioids and return to buprenorphine may be difficult and involves risk. Optimally, conversion should be limited to those patients scheduled for an elective Cesarean section no more than one week prior to the surgery date. All other buprenorphine parturients would be continued on their maintenance dose. Facilities lacking pain management specialists to facilitate this conversion would maintain their patients with buprenorphine and continue treatment through labor and delivery.

Patients who are not converted to a short acting opioid presenting for Cesarean section require additional supplemental analgesia for adequate pain control. They may require early and aggressive pain management with non-opioid analgesics in addition to maintenance buprenorphine. Higher than expected dosages of supplemental opioids may be necessary to control their post-operative pain.
A multimodal analgesia plan may include:

1. Regional anesthesia when appropriate with long acting intrathecal or epidural opioid administered at the higher end of the suggested therapeutic range (200-300 mcg or 3-4 mg Duramorph).

2. Intra-operative ketamine (0.15 mg/kg IV following regional anesthesia). In a study of elective cesarean sections, a continuous intravenous infusion of ketamine (0.15 mg/kg) started after administration of spinal anesthesia using bupivacaine allowed for a longer time to first request for analgesia, lower postoperative pain scores, and lower analgesic requirements in the first 24 hours.

3. Continuous wound infiltration (ropivacaine 0.2% at 5cc/hr). A prospective study comparing wound infiltration to epidural morphine showed lower pain scores at 24 and 48 hrs.

4. Transabdominus plane block. Compared to PCA alone, TAP block resulted in better analgesia with less opioid consumption post Cesarean Section.

5. Acetaminophen (15mg/kg IV or 650mg per rectum immediately post operatively). Acetaminophen has been shown to be an effective adjunct to post-cesarean pain control.


7. Morphine patient controlled analgesia (1.5 mg q7 mins with 4hr limit of 40 mg begun in PACU). Morphine PCA is the primary analgesic modality in the only reported cesarean sections performed on buprenorphine maintained patients. If opioid requirement is significant, admission to a monitored bed may be necessary to monitor patient for respiratory depression.

8. Ketorolac (30mg IV q6 hr for 1st 24 hrs). Intravenous ketorolac produced a dose reduction in patient-controlled epidural meperidine requirements. A meta-analysis of randomized controlled trials demonstrated that administration of NSAIDs mainly consisting of IV ketorolac in patients receiving intravenous morphine PCA reduced the relative risk of nausea and vomiting as well as sedation.

9. Ibuprofen (400mg PO q6hr. after 24 hrs).

The above multimodal therapy can be used in various combinations to provide non-opioid supplemental analgesia and opioid supplemental analgesia in addition to maintenance opioid continuation. This will maximize analgesia while preventing withdrawal in the buprenorphine maintained parturient. Providers' options will depend on their institutional and departmental resources.

At The Western Pennsylvania Hospital we prefer to transition parturients to a short acting opioid if they are scheduled for an elective Cesarean section. Our Pain Medicine physicians oversee this conversion. We continue buprenorphine therapy for patients who are expected to labor and deliver vaginally because they generally do not have increased pain medication requirements. For those patients who require a non-elective Cesarean section, we continue buprenorphine and request that the surgeon place a wound infiltration device for continuous local anesthesia distribution. Local anesthetic wound infiltration alone is recommended when the surgeon is not comfortable with a continuous local anesthetic wound infiltration catheter. We utilize all the multimodal adjuvants listed above with the exception of the transabdominus plane block. This block is not routinely performed at our institution, although many practitioners experienced in performing this block would utilize this as a viable adjunct.

A common brand name for buprenorphine is Subutex. Suboxone is a brand name for buprenorphine combined with naloxone. Naloxone is not absorbed sublingually or by the gastrointestinal route but is added to the narcotic to deter abuse by the intravenous route. If Suboxone is injected intravenously, the naloxone portion of the mixture can cause withdrawal. Suboxone is not commonly used in pregnant patients as it has not been studied in this population, as has buprenorphine alone. If a patient were to present for delivery on Suboxone, the management would be the same as the buprenorphine dependent patient.

References


Education Committee: Post Cesarean Pain Management in the Buprenorphine (Subutex) Dependent Patient

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FUTURE MEETINGS OF INTEREST TO ALL ASA MEMBERS WHO PRACTICE OBSTETRICAL ANESTHESIA

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