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President's Message: Furthering the Mission of SOAP

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With the New Year, and the realization that I am half way through my tenure as President of the Society for Obstetric Anesthesia and Perinatology (SOAP), it is a good time to reflect on SOAP's mission statement, and highlight some strategic plan initiatives that will enable SOAP's goals to be realized.

The mission of SOAP is to improve the pregnancy-related outcomes of women and neonates through the support of obstetric anesthesiology research, the provision of education to its members, other providers, and pregnant women, and the promotion of excellence in clinical anesthetic care.

A key SOAP mission aim is the provision of education to its members, other providers and pregnant women. In addition to our annual scientific meetings, the Sol Shnider refresher meeting, collaborative pre-meeting symposiums (Latin American, Chinese and Japanese) and other educational and international outreach programs, we are rolling out several strategic initiatives in the coming months to further fulfill our education provision goals. Initiatives include: adding a clinically-oriented track to the annual meeting; offering free SOAP membership to medical students, residents and fellows; increasing trainee discounts to the annual meeting; and redesigning the SOAP website to deliver more obstetric anesthesia content for practitioners and patients. We hope that establishing a greater online digital presence (through our website, Twitter and Facebook), and promoting a stronger brand will allow us to broaden our influence and educational outreach. We recently published a consensus statement (*SOAP Consensus Statement on the Anesthetic Management of Pregnant and Postpartum Women Receiving Thromboprophylaxis or*

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Editor's Corner

Heather C. Nixon, MD

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Welcome to the Winter Edition of the SOAP Newsletter!

In this Newsletter, our current SOAP President, Dr. Carvalho shares updates on how the Board of Directors of SOAP are fulfilling and furthering the societal mission of supporting education, research and clinical care in obstetric anesthesiology. This newsletter aims to do the same.

Several of our committees have provided pieces that focus on continuing education of obstetric anesthesia providers and guidance to improve clinical care. Drs. Toledo and Dalby provide insights on ways to utilize meetings and electronic resources for continuing education. Drs. Bray Broughton,

Higgins, Kacmar, Kromach, Lim, and Tiouririne have created resources to approach complex patient care and highlight issues of patient safety in obstetric anesthesia. Finally, Drs. Klumpner and Month provide us with an update on the Media Committee initiatives to provide more support to our members, including a website redesign project and improving our digital presence through social media.

We hope you enjoy the educational and thought provoking articles and please let us know if there is a topic you are particularly interested in seeing in the Newsletter.

Thank you!
Heather C. Nixon, MD

President's Message continued from page 1

Higher Dose Anticoagulants) and an online communication (*SOAP Comments in response to the ACOG/SMFM Practice Advisory on Codeine and Tramadol for Breastfeeding Women*), and have several more SOAP consensus statements and recommendations in the pipeline.

Research has always been a key SOAP mission goal, and several changes are being made to continue to fulfill this aim. The board has taken actions to revamp several research and educational programs to better align with SOAP's financials and long-term goals and priorities. For fiscal reasons we have decided to discontinue the *SOAP-Gertie Marx Education and Research Grant*, but will continue to support the *SOAP Young Investigator Grant* which recognizes and invests in our talented future researchers. Our strategic research plan will shift from individual awards to multi-center research initiatives, with the future establishment of a SOAP multi-center research network or collaborative.

Promotion of excellence in clinical anesthetic care is considered a key SOAP mission goal, and we hope that the following unique key strategic plan initiative, *Centers of Excellence for Anesthesia Care of Obstetric Patients*, will further advance SOAP's clinical care improvement mission. SOAP wants to recognize institutions and programs that demonstrate excellence in obstetric anesthesia care. This *Centers of Excellence* award will be granted to hospitals

that apply and meet the goals and best practices for obstetric anesthesia care, and will assist programs to initiate or negotiate necessary practice changes. To promote excellence in clinical care, SOAP continues to collaborate with several societies including the *American College of Obstetricians and Gynecologists (ACOG)*, the *Society for Maternal Fetal Medicine (SMFM)*, the *Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN)*, the *International Anesthesia Research Society (IARS)*, and the *American Society of Anesthesiologists (ASA)*. We hope these collaborations and initiatives will improve clinical care provided to pregnant women, and validate the value that our sub-specialty brings to optimal patient care.

Overall, I am very encouraged that SOAP is fulfilling its mission goals and am optimistic that several strategic initiatives are going to grow the society and ensure that we continue to prosper. I look forward to the *Sol Shnider, M.D. obstetric anesthesia, clinician-focused, refresher meeting* (March 8-11, 2018 at the Grand Hyatt Hotel, San Francisco, California), and our *50th SOAP Annual Scientific Meeting* (May 9-13, 2018 at Loews Miami Beach Hotel, Miami, Florida). The annual meeting promises to deliver the highest quality educational and scientific material that will appeal to trainees, mid and senior level clinicians, private practice practitioners and academicians.

Annual Meeting: Host's Message for Miami 2018

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On behalf of our society, we would like to invite you to join us for the 2018 SOAP Annual Meeting, which will take place at the Loews Miami Beach on May 9-13th, 2018. This year will be SOAP's 50th Annual Meeting, and the theme of the meeting will be ***Obstetric Anesthesia: Past, Present, and Future.***

The elegant Loews hotel is a Miami Beach icon, and the perfect setting for the Annual Meeting. All of the workshops and conference events will occur on site at the Loews. The property is situated on three and a half acres of ocean front property, and many of the meeting rooms have direct views of the ocean. In addition to the beach, the hotel has one of the most beautiful pools in Miami. The hotel recently underwent renovation, and has 790 guest rooms, all of which have complementary in-room Wi-Fi available. The SOAP meeting room block is now available at: <https://www.loewshotels.com/miami-beach/soap-annual-meeting>.

In order to take advantage of Miami's weather, the Annual Meeting will kick off with an outdoor welcome reception on May 9th. The 50th anniversary banquet will take place on Saturday May 12th, and will be a must attend event! While you are in Miami, take advantage of the hotel's central location and enjoy the shopping at Lincoln Road, Miami Beach's pedestrian-only outdoor mall. Also, make sure to enjoy the historic Art Deco district, located between 5th Street and 23rd Street. For those who are bringing their families, there are several attractions for children 15-20 minutes from the hotel including the Miami Children's Museum, Jungle Island, and the Miami Seaquarium. Miami is known for its food scene, with hundreds of choices near the hotel.

I look forward to welcoming all of you to my hometown this May! More information about the Annual Meeting will be available on the SOAP website (www.soap.org). We look forward to seeing you in Miami!



Education Committee: Obstetric Anesthesiology Self-Education Resources

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It may be difficult for the general or obstetric anesthesiologist to know where to find reliable obstetric anesthesiology educational resources. There are several educational resources upon which an anesthesiologist looking to improve or update their obstetric anesthesia knowledge can rely. We present four types of supplemental obstetric anesthesiology education that may be useful.

1. **ANESTHESIOLOGY Annual Meeting OnDemand** - The American Society of Anesthesiologists (ASA) product which includes material from the ASA 2016 and 2017 Annual Meeting Obstetrical Anesthesia Track
2. **The ASA Obstetrical Anesthesiology Self-Assessment Modules (SAM-OB)**, produced by the ASA with content generated by Society for Obstetric Anesthesiology and Perinatology (SOAP) experts
3. **The Obstetric Anesthesia Digest**, a compendium of abstracts synthesized from current obstetric anesthesiology literature
4. **Sol Shnider on Anesthesia Illustrated**, recorded online video lectures featuring content from the Sol Shnider annual meeting, focused on high-yield obstetric anesthesia topics relevant to the practicing clinician

The ASA Annual Meetings are one of the world's largest educational meetings supporting the specialty. In 2016, ANESTHESIOLOGY Annual Meeting OnDemand was produced; the program brings the meeting to a subscriber's own home with special pricing options for members. It provides up to 141.5 AMA PRA Category 1 Credits™ and features recordings of annual meeting sessions along with PDF files of presentation slides. An entire OnDemand section is devoted to obstetrical anesthesia with high-yield topics featuring SOAP experts. The 2017 OnDemand obstetric anesthesia track includes topics such as, "Nitrous Oxide for All Parturients," "Post Dural Puncture Headache and Epidural Blood Patch Update," and "Improving Safety on Labor and Delivery." The OnDemand program also includes ASA's Self Study Course. This bonus educational content is a collection of nine modules covering topics: neuropathic pain, respiratory physiology, neuraxial labor analgesia, pulmonary hypertension, postoperative delirium, obesity and obstructive

sleep apnea, population health, complications in ambulatory surgery, and hemostasis and anticoagulation. A portable hard drive is included with a subscription to OnDemand, and the program is easily accessible online from any tablet, smart phone, or computer. Program access can be switched between devices and picked up without interruption from where it was last stopped. There are slides with synchronized audio recording that recreates live lectures. MP3 audio files are included that can be easily loaded onto a MP3 player, allowing one to listen to sessions while on-the-go. PDF files of slides from the Annual Meeting Refresher Course Lectures and Problem Based Lecture Discussions are available.

The ASA sponsored Self-Assessment Modules are the perfect way to ascertain whether you are up-to-date with the current knowledge base in the field. Self-Assessment Module – Obstetrics (SAM-OB) is a computer-based self-study CME program that covers established knowledge in obstetric anesthesia, enabling the subscriber to target ongoing education in their desired specific areas. This program encompasses 100 clinical scenario-based, multiple-choice questions with instant feedback and discussion of the correct answer choices. The questions and answers are each followed by an in-depth discussion of the topics relevant to the particular scenario. References for the subscriber's further study are included. SAM- OB subscribers complete the program at their own pace and submit the answers online to receive CME, with a deadline of 2020 for complete submission. They receive up to 30.00 AMA PRA Category 1 CME Credits™.

Obstetric Anesthesia Digest is a unique resource that provides timely summaries of the world's literature in obstetric anesthesia. The comprehensive coverage includes editorials and reviews, special articles, case reports, and "Short Takes"—abbreviated abstracts of secondary papers. Experts contribute commentary and opinions on approximately a third of the manuscripts reviewed each quarter. The surveyed articles cover all aspects of anesthesia and analgesia as they relate to the mother, fetus, and neonate. Subscribers receive fully searchable online access to articles from Volume 1 to the present on a powerful new website. This website platform uses Web 2.0 functionality to provide an enhanced online

Education Committee continued on next page

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experience through such features as: saved searches, personal article collections, easy image downloads to PowerPoint, and more. An individual subscription includes 4 print issues plus full-text online access to all current and back issues (www.obstetricanesthesia.com).

Finally, the Sol Shnider annual meeting in obstetric anesthesia began almost 40 years ago at the University of California San Francisco. Hosted by SOAP, the meeting focuses on clinical updates in obstetric anesthesia, featuring 20-30-minute lectures delivered by leaders in the subspecialty. The lectures seek to enlighten obstetric anesthesia clinical practice by providing new insight and knowledge. Key lectures from previous meetings have been recorded and are featured online on Anesthesia Illustrated (<http://www.anesthesiaillustrated.com/soap/>).



**SOAP SOL SHNIDER, MD
OBSTETRIC ANESTHESIA
MEETING**

March 8-11, 2018

Grand Hyatt Hotel

San Francisco, California



Education Committee: Perspectives on Implementing Enhanced Recovery (ERAS) Pathways for Cesarean Delivery

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The perioperative management of patients undergoing elective cesarean delivery has historically consisted of long fasting hours, limited postoperative rehabilitation, and postoperative pain management dominated by opioid use. In recent years, enhanced recovery after surgery (ERAS) protocols have emerged as patient-centered and multidisciplinary perioperative care pathways aimed at facilitating patients' recovery of baseline physiological functions following surgery. Studies in the general surgical population have consistently reported improved outcomes after ERAS implementation, including reduced hospital length of stay, increased patient satisfaction, and decreased opioid use¹. ERAS for cesarean delivery should provide mothers with the same benefits, by offering a comprehensive approach to the delivery experience and positively impacting the well-being of the mother-infant dyad. Growing interest in implementing ERAS for cesarean delivery is evidenced by a steady increase in publications² and presentations at national meeting such as the American Society of Anesthesiologists and the Society of Obstetric Anesthesia and Perinatology. Most of these budding reports show improvements in healthcare metrics and outcomes³, like the non-obstetrical surgical populations. For example, at our institution the implementation of an ERAS for cesarean delivery resulted in a significant decrease in opioid consumption as well as length of stay, similar complication and readmission rates (Table 1). Moreover, the percentage of patients not using opioids increased from 5% in the pre-ERAS era to 16% in the ERAS era, corroborating recent reports of the potential role of ERAS protocol in mitigating the impact of the opioid crisis⁴.

To date, there are no specific ERAS guidelines for patients undergoing cesarean delivery. Both the ERAS Society and the American Society for Enhanced Recovery (ASER) have not incorporated cesarean delivery in their list of published protocols. Nonetheless, the application of reasonably the same guiding ERAS principles and components [Table 2] used in the non-obstetrical population appear to offer the same benefits.

In addition to reduced length of stay and reduced opioid requirements, there are several secondary advantages

to implementing ERAS for cesarean delivery. First, multidisciplinary team management favors engagement and communication among stakeholders and a commitment to patient care beyond routine. Second, standardization of care decreases variabilities and inconsistencies in care delivery among practitioners, and improves quality outcomes for patients. Third, patients undergoing cesarean delivery are motivated to feel well soon after surgery, to fully participate in the intense physical and emotional tasks associated with the care of a newborn. ERAS offers an ideal venue for providing new mothers with the necessary tools to engage themselves in their recovery from surgery and to shape their expected experiences.

Implementation of an ERAS for cesarean delivery requires participation from key members including anesthesiologists, obstetricians or a maternal fetal medicine specialists, neonatologists, and nursing. An "ERAS leader" is vital for success. The leader, usually an advanced practice nurse with background in management, is responsible for facilitating practice change [Table 2], resource allocation, team coordination, and unit staff training. He or she provides timely feedback and performs audits to insure continuous improvement⁵. Implementation is often faced with challenges and barriers, typically stemming from provider uneasiness to adopt new practice methods that may not be compatible with their own. Often, the institution is not aligned with the proposed change because of financial constraints or resources that are allocated to other projects. It takes time, effort, guidance, and encouragement to rally all team members to embrace the new paradigm in providing care for patients undergoing cesarean delivery.

Simply stated, the goal of an enhanced recovery for cesarean delivery pathway is to provide parturients with the best quality of care with a systematic, multidisciplinary and tailored approach to enhance physical, mental and psychological aspects of well-being.

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| Demographics | PRE-ERAS (N=195) | ERAS (N=162) | P-value |
|---|------------------|--------------|---------|
| Demographics | | | |
| Maternal age | 31[20-45] | 32 [20-42] | NS |
| BMI (kg/m2) | 35 | 34.7 | NS |
| Outcomes | | | |
| Morphine equivalent consumption | 37[19-65] | 22[10-43] | <0.0001 |
| Highest pain score | 8 [7-9] | 7[6-9] | <0.037 |
| Pain score POD#0 | 4[2-5] | 3[2-5] | <0.1 |
| Pain score POD#1 | 4[3-5] | 4[3-5] | <0.7 |
| Pain score POD#2 | 4[3-5] | 4[3-5] | <0.3 |
| Number of patients not taking opioids (%) | 5% | 16% | NS |
| Hospital length of stay (days) | 3 [2-3] | 2[2-3] | <0.001 |
| Hospital length of stay (hours) | 69[50-75] | 58[49-73] | <0.001 |
| Maternal readmission | 6% | 5% | NS |
| Foley Reinsertion | 2% | 1% | NS |

NS, not significant

Data are reported as mean and interquartile range

| | |
|-----------------------|---|
| PREOPERATIVE | Approach between 32-34 weeks, plan for term birth Patient Education: 1:1 meeting with RN Comprehensive Education Booklet to Patient: www.uvaeras.com Breastfeeding education Discuss NPO guidelines (NPO for solid 8 hours prior to intended surgery time) Encourage Fluid Intake up to 2 hours prior to surgery: Patients are asked to drink Gatorade™ Encourage Exercise Patient called the day prior to the procedure: RUN an ERAS checklist |
| INTRAOPERATIVE | Admission Confirm ERAS patient Confirm compliance with education material IV cannula insertion: Saline Lock Surgical ticket signed: OK to transfer to OR Check-in (WHO Surgical Checklist) Antibiotic prophylaxis Spinal Anesthesia (Bupivacaine, Fentanyl, PF Morphine) Fluid Co-load and Phenylephrine infusion (50ug/min) at CSF sight Time Out (WHO Surgical Checklist) Incision/Delivery/ Delayed cord clamping Pitocin controlled infusion (15 UI/H) Skin to Skin/ Breastfeeding/Room Temperature 72F PONV Prophylaxis |
| POSTOPERATIVE | PACU Recovery: ice chips Multimodal Scheduled Non-Opioid Analgesia Oxycodone 5mg for breakthrough pain up to 6 tablets a day (30 mg total) Resume feeding when in postpartum unit Early mobilization soon after block wears off Urinary catheter removal at 12 hours post- surgery VTE prophylaxis (6-8 hours) Lactation visit Neonatologist visit: Next day Decannulate IV 24 hours post-surgery (low risk only) |
| POST DISCHARGE | POST-DISCHARGE PHONE CALL, MANDATORY |

Education Committee: Programmed Intermittent Epidural Bolus: Practical Considerations

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Labor neuraxial analgesia has progressed from intermittent provider-administered epidural bolus, to continuous epidural infusion (CEI), to patient-controlled epidural analgesia (PCEA) with or without a continuous infusion. A recent FDA-approved epidural pump feature has enabled the implementation of a programmed intermittent epidural bolus (PIEB) technique for labor analgesia. The PIEB technique automatically administers intermittent epidural boluses at a preset time interval without a continuous epidural infusion. Intermittent patient and/or provider administered bolus dosing are also included in the settings. One of the advantages of the PIEB pump is the capability of delivering double the flow rate (up to 500ml/hr) of a conventional epidural pump (up to 250ml/hr). The higher flow rate delivered by the PIEB pump may allow for better spread of local anesthetic within the epidural space.

Studies published before the commercially available PIEB pump comparing automated intermittent boluses to CEI have reported that intermittent boluses provide:

1. Wider, more uniform epidural space spread
2. Better quality analgesia
3. Lower pain scores
4. Lower incidence of breakthrough pain
5. Reduced local anesthetic consumption

A systematic review demonstrated greater maternal satisfaction evaluated by a verbal rating scale in the automated intermittent bolus group. Capogna et al. reported decreased motor blockade and reduced instrumental delivery rates with the intermittent epidural bolus technique. Wong et al. reported fewer provider administered epidural boluses for inadequate pain control. Therefore, the workload for a high volume obstetric anesthesia service may be reduced.

A more recent study by Delgado et al. comparing CEI, PCEA and PIEB utilizing the PIEB device showed no statistical difference in the three groups with regards to the number of physician intervention for labor analgesia. Although, the ideal PIEB pump parameters have yet to be determined, Delgado et al. indicated a programmed bolus interval time

of 60 mins may be too long of an interval time to note a decrease in physician intervention. Epsztein et al. previously reported 40 mins as the best PIEB interval time where no patient or physician bolus was administered for 6 hours after the initiation of epidural analgesia.

As the management of labor analgesia evolves, further understanding of the interaction and effect of the various programmable parameters will be useful in determining the ideal PIEB settings. Currently, the algorithm required for PIEB pumps necessitate an upgrade of the conventional epidural pump. An anesthesia provider may adjust both the volume of local anesthetic delivered for both programmed and provider/patient delivered boluses and the interval time for each PIEB, as well as the PCEA bolus lock-out intervals.

The following internal pump features may also affect the net delivery of the PIEB pump and possibly affect labor analgesia:

1. Next bolus interval: Time between activation of the epidural pump and the first PIEB
2. Flow rate: Pre-selected ml/hr at which PIEB and PCEA boluses will be delivered into the epidural space
3. Interaction between the PCEA boluses and PIEB doses which can be set in one of two ways:
 - a. Bolus interval time: PCEA bolus would delay the next PIEB by the preset interval time between each PIEB dose
 - b. Lock out interval time: Delivery of the next PIEB dose may be delayed by the PCEA lock out time.

Concerns with the PIEB technique include abrupt hypotension, motor block, delayed recognition of a malpositioned epidural catheter, and epidural pump occlusion. Despite those disadvantages, most authors report that PIEB does not pose additional risk. There has been no difference in neonatal

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| PIEB pump parameters from 4 major US obstetric anesthesia institutions | | | | |
|--|---|---|---|--------------------------|
| Institutions | UWMC ¹ | MGH ² | Stanford ³ | Cedar-Sinai ⁴ |
| Number of delivery | 2500 | 3,400 | 5500 | 7,000 |
| Epidural infusion solution | Bupivacaine 0.0625% plus fentanyl 2mcg/cc | Bupivacaine 0.0625% plus fentanyl 2mcg/cc | Bupivacaine 0.0625% plus 0.4mcg/cc Sufentanil | Ropivacaine 0.15% |
| PIEB | 10cc every 45 mins | 8cc every 45 mins | 9cc every 45 mins | 9cc every 45mins |
| Clinician bolus | | 8cc | Variable | 10 |
| PCEA bolus | 5cc | 6cc | 8-10cc | 10 |
| Lock-out time | 10 mins | 10 mins | 15mins | 15 |
| Hourly limit | 20 cc | 25cc | | |
| Maternal readmission | 6% | 5% | NS | |
| Foley Reinsertion | 2% | 1% | NS | |

¹UWMC = University of Washington Medical Center

²MGH = Massachusetts General Hospital

³Stanford = Stanford University

⁴Cedars-Sinai = Cedars Sinai Medical Center

outcomes, Apgar scores or side effects reported. The benefits of better labor analgesia, improved maternal satisfaction and decreased local anesthetic consumption may be of value to obstetric patients.

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Education & Patient Safety Committees: Critical Intravenous Fluids Shortages after Hurricane Maria: Safe Strategies on Labor & Delivery

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Suppliers of intravenous fluids to the United States suffered major losses in the capacity to provide IV fluids after 85 medical manufacturing plants in Puerto Rico were destroyed by Hurricane Maria. Shortages of fluids, antibiotics, and other medications are expected to last into the first quarter of 2018, but some estimates place the shortage lasting up to 18-24 months. For some institutions, these shortages are only beginning to emerge, and it may be helpful for all providers of obstetric anesthesia to begin to think about alternative intravenous fluid management options.

Certain fluids—e.g., glucose in 50 mL and 100 mL, metronidazole 500 mg in 100 mL, 0.9% NaCl 50 mL and 100 mL—are available from Ireland and Australia, but in extremely limited quantities. Canada and Mexico have certain fluid products available, but FDA-approval is pending. Mylan Pharmaceuticals has facilities based in Spain and open orders exist for 0.9% NaCl and other crystalloids in various volumes, with an unknown estimated time of arrival to the United States.

Some suppliers to the United States (e.g. Baxter) house storage facilities that are currently mitigating the shortage.

However, the supply is not expected to be replenished in the foreseeable future. These considerations have led many hospitals to make conservation efforts now, while there are still fluids available. Some strategies have included:

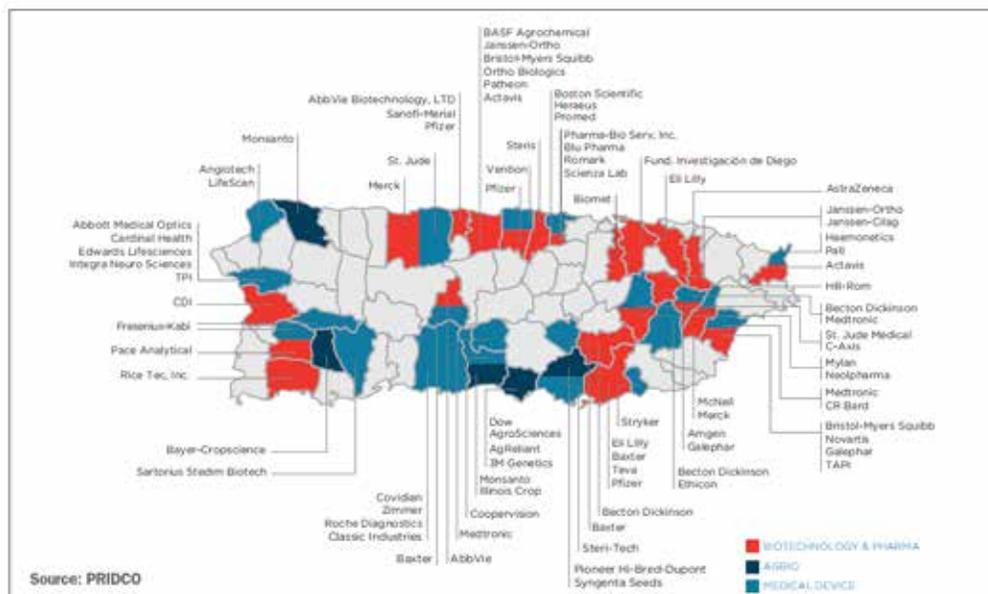


- Increased utilization of premixed products (however, some of these products have also been affected by the shortage)
- Intravenous push administration
- Increased utilization of syringe pumps or large volume pump syringe adapters
- Compounding utilizing empty intravenous bags (e.g. divide liter fluid bags into smaller-volume, empty sterile bags)
- Utilization of buretrol solution sets, elastomeric pumps

Here are a few strategies that are being implemented on labor and delivery units across the nation.

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Map of Puerto Rico's life science manufacturing facilities



Source: <http://www.pharmexec.com/country-report-puerto-rico>

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| Institutions | University of Arkansas | Mount Sinai NY | Baylor | Cottage Hospital Santa Barbara | Stanford | UCLA | Creighton University Medical Center | Magge-Womens Hospital of UPMC | Mayo Clinic | University of Illinois Chicago |
|--|---|---|------------------------------------|--------------------------------|---|----------------------|-------------------------------------|--|------------------|---|
| Has your hospital been affected by IVF shortage in the last month? | Yes 50 and 100 mL NS bags (not critical at this time) | Yes | Yes Normal Saline | Yes | Yes Normal Saline, Dextrose 5% & Dextrose 10% 50/ 100/ 250/ 500 mL | Yes Normal Saline | Yes | Yes Critical | No | No |
| What is your preferred IVF on labor and delivery? | Lactated Ringers | Lactated Ringers | Lactated Ringers | Lactated Ringers | Lactated Ringers 1000 mL | Lactated Ringers | Lactated Ringers | Lactated Ringers | Lactated Ringers | Lactated Ringers |
| Has this changed due to shortage? If yes, to what? | No | We changed rate from 125 m/hr to 20 mL/hr for labor | No | No | No | No | No | Eliminated maintenance rate and saline locking IV in anticipated uncomplicated vaginal delivery IV patency check "rounds" by nursing | No | No |
| Have you altered your pre-load/ co-load policy for neuraxial analgesia/ anesthesia due to IVF shortages? If yes, how? | No | No, do not currently pre- or co-load | No | No | No | No | No | No But increasing rigor around 500 mL crystalloid co-load | n/a | n/a |
| For (anticipated) uncomplicated vaginal deliveries, would you consider allowing PO Gatorade hydration rather than maintenance IVF (with either IV saline lock/ KVO fluids only)? | Not requested by patient population | Yes | No | Yes | Yes | No | Yes | Yes Current practice | Yes | Yes |
| Due to IVF shortage on L&D, have you changed your postpartum oxytocin regimen? If yes, how? | No, current practice is to infuse 1 hr postpartum | No | No, oxytocin is premixed in LR bag | No | No | No | No | No but have centralized storage of limited supply oxytocin--not stored in OR as was previously done | n/a | n/a |
| Due to IVF shortage on L&D, have you needed to use alternative medications to achieve postpartum adequate uterine tone? (e.g. Misoprostol rather than oxytocin first line) | No | No | No | No | No | No | No | No | n/a | n/a |
| Due to IVF shortage on L&D, have you started crystalloid restriction in uncomplicated cesarean deliveries (i.e. < 1500 mL)? | No | No | No | No | No | No | No | Yes with increased attention to losses & hemorrhage | n/a | n/a |
| Due to IVF shortage on L&D, have you altered the way antibiotics are administered? I.e. bolus/ IV push cephalosporin rather than piggyback infusion? | No | No | No | No | No | No | No | Yes changed from piggyback infusions to 20ml syringe given slow bolus | n/a | Purchase Premade Antibiotics in DUPLEX® Container |
| What other changes have been made to obstetric/ anesthetic management on labor and delivery due to IVF shortages? | 100 mL bags will change how phenylephrine infusions are mixed | For labor: using 500 mL IV bags instead of 1000 mL IV bags and running the IV at 20 mL/hr and encouraging PO fluids | None | None yet | None | None | None yet | Division of solutions into 50mL aliquots Reduced maintenance infusion rate or elimination completely | n/a | n/a |

Responses not listed:

University of Kansas – shortage of 250 mL normal saline bags

University of Iowa – shortage of 100mL lactated ringers bags

International Outreach Committee: Bedside Transthoracic Echocardiography (TTE) in a Low Resource Country: Experience From Kigali, Rwanda

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It is 12:00 PM in Kigali, the sun in its apogee impolitely scorches down the foothills of “*Le pays des milles collines*”. Unfazed by the heat, our anesthesiology resident colleague meandered us through the Centre Hopitalier Universitaire de Kigali (CHUK) grounds eager to demonstrate his recently acquired learning: FOCUS EXAM. As volunteers for the CASIEF/ASA¹ global health initiative program, we had arrived three weeks earlier and were tasked to provide the cardiovascular system teaching block series to in-training anesthesia residents in Kigali which included the TTE-FOCUS EXAM. The resident expressed his worries about a patient transferred from a district hospital with generalized edema, tachycardia, low blood pressure, and shortness of breath. We also learned the patient had delivered a healthy baby four days earlier. Upon arrival to the intensive care unit the resident performed a FOCUS exam. He interpreted the exam as globally reduced cardiac function which in this patient’s clinical context was compatible with a peripartum cardiomyopathy.

The use of bedside ultrasound has become an ubiquitous tool in the diagnostic and therapeutic arsenal of anesthesiologists. Ultrasound lends itself well to quickly and accurately diagnosing a host of conditions across a wide range of organ systems and physiologic states.²⁻⁴ Along with the obvious clinical benefits, we think that there are particular economic and sustainability aspects of ultrasound that are particularly suited to its use in the perioperative period in developing countries.

In locations where consult services, advanced imaging, and invasive monitors are scarce or absent, a practical understanding of using bedside ultrasound to evaluate the cardiovascular system can be an invaluable tool. While recently teaching anesthesiology residents in Rwanda, it was our experience that many times patients would present to the operating theater with limited prior medical care. Although the facilities we were working in had no invasive monitors and limited access to various vasopressors or inotropes, there was a supply of portable ultrasounds.

In order to improve medical outcomes in developing areas of the world we must recognize that leveraging the tools and resources these medical systems already have in place is just as important as providing them with new equipment. Once we learned the trainees had access to portable ultrasounds we began to teach them the clinical applicability of the FOCUS TTE exam. We also realized this was the first time they received this type of teaching. We therefore, primarily concentrated on providing guided hands on training. We did this by having eight hours of hands of simulation over a two week period with emphasis on obtaining the appropriate views on their peers. Next we transitioned what they learned in simulation to performing the exam on patients daily in the operating theater or the intensive care unit. Although the trainees we were working with had little experience with using these devices, once they were trained to obtain



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basic transthoracic views they quickly started incorporating it into their practice both perioperatively and in the critical care setting. On several occasions, the use of perioperative transthoracic ultrasound focus exam drastically influenced perioperative planning and management.

Cost and value based care are omnipresent in developing healthcare systems as much as they are in western health systems. These systems face a tremendous amount of pressure when it comes to building healthcare infrastructure, maintaining tenuous supply chains, and generating operational funding. Admittedly we are unclear as to how the ultrasounds we were using were obtained, likely through donation, and realizing that the up-front cost of portable bedside ultrasounds can be high, we believe there are many aspects of ultrasound that could lend itself well to utilization in developing countries. Some of these include being able to gain valuable information about numerous organ systems with one device, portability, and the lack of dependence upon medical supply chains for disposable components. In areas of the world with little healthcare funding, allocating resources and maintaining supplies of disposable monitoring systems may not be feasible as this also may represent the main reason for their absence in the first place. Along with the large cost of ultrasounds, there might be other obstacles to overcome before the systems can be adequately utilized. A reliable constant supply of human capital investments involved with training individuals to use these can be a considerable obstacle.

Physicians practicing in developing countries face enormous challenges when it comes to evaluating and managing acutely ill patients in the perioperative period. While there are various monitoring techniques that one could use to help manage these patients, we feel that leveraging the vast array of ultrasound techniques to improve patient monitoring and management could be of great benefit to these developing healthcare systems.

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Media Committee: Update on Initiatives

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Website Subcommittee Update:

The Media Committee is very excited to announce our upcoming plan to rebuild the SOAP website. Earlier in the year, members of the SOAP media committee and members of the management company interviewed several possible vendors to help in this endeavor. After much deliberation, SOAP has selected JMC Studios to assist in this project and we are looking forward to the opportunity to build a contemporary, responsive platform that continues to serve our membership, while also expanding the target audience of the site so that it will become an important resource for our patients, clinicians (including those that are not SOAP members) and trainees. We are particularly enthusiastic about developing a new patient-focused portal, which will essentially be an endeavor of its own that will incorporate work from other SOAP committees.

To assist with the new patient-focused website portal and ensure that our new website remains consistent with our society's mission, we are currently in the process of evaluating bids from several marketing firms. We anticipate that this marketing expertise will be vital as we grow our web presence and try to expand our digital presence.

The new website will also be an opportunity to improve upon some of the existing features of our current site, including streamlining membership services, meeting support, abstract submission, grant submission, education, social media integration, and communication of important news and clinical information.

Finally, we are interested in hearing from you.

- What new features would you like to see in our new SOAP website?
- What improvements should be made?
- What content should be included in the new patient portal?
- What websites should serve as inspiration for the design of the new site?

We look forward to the opportunities that the new SOAP website will create to better engage with our members, with the public and with our patients.

Social Media Subcommittee Update:

SOAP had an exciting year in the Social Media realm, and we hope to continue the expansion of this important way of reaching patients, members, and practitioners. While SOAP had a Facebook presence for several years, this year marked a significant expansion with our wide adoption of Twitter (@SOAPHQ)!

The Media Committee used @SOAPHQ as a way to share information, achievements, articles (both media and scientific) and educational materials with practitioners, patients, and the public, and to interact with our membership in a way unlike any before. After a very busy annual meeting (#SOAPAM2017), the momentum has continued, and @SOAPHQ has become the home for Obstetric Anesthesia on Twitter. If you're not already on Twitter, it is very easy to join: go to <http://www.twitter.com> and click "Sign Up," or download the Twitter app from your favorite App Store and follow the instructions. Be sure to search for @SOAPHQ and click "Follow" to get all of our updates.

In addition to our Twitter presence, SOAP has also expanded our Facebook presence over the past year and will continue to do so into 2018. We also plan to expand into other platforms, including Instagram, for our 2018 Annual meeting, and are developing a way in which members can request a "Social Media Blast;" those details are coming soon. Finally, we will be utilizing marketing expertise to expand and develop our Social Media plan.

We also want and need your ideas:

- How do you envision social media being utilized by SOAP?
- Are there social media avenues that we should be using that we are not?
- Who should we be targeting through individual social media portals?

It's a time of expansion and renewal for the media outlets of SOAP and an exciting (and busy) time for the Media Committee. We're proud of our advancement in the past year and look forward to using a robust Social Media presence to better advance SOAP as the leader in Obstetric Anesthesia!



Patient Safety Committee: “How We Do It” Expert Opinion Management of Obstructive Sleep Apnea and Morbid Obesity on Labor and Delivery

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Any woman with a body mass index (BMI) greater than 24.9 is classified as overweight, however severe complications are generally associated with obesity, ≥ 30 kg/m², and in particular super morbid obesity (BMI > 50 kg/m²).¹ Obesity is often and accompanying co-morbidity with metabolic and cardiovascular disease (e.g. hypertension and diabetes), but these conditions may also develop during pregnancy,² and complicate obstetric anesthesia management. Pregnant women with a BMI > 30 kg/m² are at a 3-fold increased risk for preeclampsia, that when severe, may lead to hypertensive urgency, stroke, pulmonary edema, among other end-organ dysfunction.³

When feasible, an obstetric anesthesiology consultation in the early third trimester can help optimize the care of obese pregnant women, to discuss her anesthesia risks and options and to alert the treating team for airway, positioning and other concerns.³ This early consultation enables an available care plan if the patient presents pre-term emergently, or for a cesarean delivery. The consult referral criteria should be developed in conjunction with the center’s obstetrician colleagues, depending on the volume of obese pregnant women at the institution, and the capacity of the anesthesiology team to perform the consults. One strategy is to refer all pregnant women with a BMI between 40 and 50 kg/m² plus co-morbidities, and all women with BMI ≥ 50 kg/m² regardless of co-morbidities. During this consult, co-morbidities can be reviewed, screening for obstructive sleep apnea (OSA) can be conducted, the airway and spine can be examined, and any history of difficult intubation or difficult neuraxial placement can be assessed. This population may have a higher rate of difficult neuraxial placement, and these consultations are an excellent opportunity to discuss any residual fears from past experiences, and to plan for and encourage early epidural placement. Transthoracic echocardiography can be recommended if any cardiac compromise is suspected during the consult. Women with more severe co-morbidities such as pulmonary hypertension or cardiomyopathy require careful interdisciplinary planning in addition to the obstetric anesthesiology consult.

Obstructive sleep apnea (OSA) is a common comorbidity among obese pregnant women that may worsen at term, in part due to increased airway edema or co-morbid pregnancy-induced hypertension. It is essential to assess the severity of symptoms (loud and frequent snoring, abrupt nocturnal awakening, observed apneic episodes, excessive daytime sleepiness or fatigue, headaches, chronic hypertension), review treatment modalities (CPAP, oral appliances), and perform a thorough airway exam, as these women may pose airway challenges with mask ventilation or tracheal intubation.⁴ It can however, be logistically challenging to facilitate a sleep medicine consultation, overnight polysomnography or home sleep test, and prescription of CPAP prior to delivery if the patient is in her third trimester. A history of worsening or poorly controlled OSA may trigger precautionary plans to optimize conditions for these women. Interventions include fluid restriction, fasting status, and early epidural placement, with the aim to avoid general anesthesia and tracheal intubation in case of emergent cesarean delivery. Therefore, it may be prudent to encourage early epidural catheter placement, rather than alternative analgesic modalities (e.g. IV-PCA, opioid agonist-antagonists, nitrous oxide).³

Morbidly obese pregnant women and those with OSA are at risk for respiratory depression in labor and delivery. Respiration patterns are altered in normal pregnancy⁵ related to the gravid uterus elevating the diaphragm,⁶ elevated progesterone⁷ and increased metabolic demands.⁸ Hypoxemia may occur in the supine position and is more likely in obese women.⁹ More extreme respiratory function deviations are seen among morbidly obese women, or those with OSA.⁶

The American Society of Anesthesiologists have Practice Guidelines for the Prevention, Detection, and Management of Respiratory Depression Associated with Neuraxial Opioid Administration.¹⁰ These guidelines recommend additional monitoring, (e.g. pulse oximetry) to detect impending respiratory depression following opioid administration for patients at-risk (such as obesity and OSA). For example,

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Abouleish¹¹ demonstrated oxygen desaturation (SpO₂<85%) during sleep in obese women (mean weight 105 kg) after a relatively high intrathecal morphine dose, 200 micrograms. These obese women had additional features associated with OSA such as snoring and short neck, and the oxygen desaturation was not corrected by naloxone administration. The risks associated with IV PCA or larger doses of oral narcotics outweigh the risk of delayed respiratory depression following neuraxial opioid administration, and therefore intrathecal morphine (100 – 150 mcg) may be administered to women with obesity and OSA for post-cesarean analgesia.

Respiratory rate, sedation scores and as needed pulse oximetry are the most commonly utilized clinical modalities to detect respiratory depression.¹² Capnography or transcutaneous carbon dioxide measurements may be suitable to alert for apnea¹³ and hypercarbia¹⁴ respectively, however are not routinely used clinically. Measuring respiratory rate as recommended by the ASA guidelines may also be unreliable to alert for respiratory depression.¹⁵ Pulse oximetry is likely the most frequently used additional monitor for morbidly obese/OSA pregnant women, however it is important to be aware that pulse oximetry may not alert providers until after the respiratory depression occurs especially if the patient is receiving supplemental oxygen.¹⁶

Cesarean delivery rates are increased in obese pregnant women for several reasons, including severe preeclampsia related complications, and macrosomia leading to cephalopelvic disproportion. Pulmonary aspiration is a particular concern in obese pregnant women due to elevated intra-abdominal pressure from a large pannus. Thus, if a cesarean delivery is necessary it is ideal to pretreat with a non-particulate antacid, H₂ receptor blockers and/or metoclopramide, to decrease gastric acidity, and promote gastric emptying, respectively.⁴ For neuraxial block placement, long needles may be required and ultrasound may assist identification of the block placement site. Other equipment considerations include availability of a suitable sized blood pressure cuff, knowledge of the maximum weight allowed on the operating table, use of a Hover mat or other inflatable equipment for transferring patients to the operating table and availability of equipment for difficult tracheal intubation. It may be difficult to achieve a proper non-invasive blood pressure cuff fit for some women with very high BMI (super morbid obesity). In these cases, where arterial line placement in an emergency could be difficult, pre-operative placement of an arterial line with ultrasound guidance can be considered. The anesthesia considerations for obese women were recently detailed by Lamon and Habib, who also describe equipment for positioning to optimize respiratory and hemodynamic function using pillows, blankets and a commercially available padded ramp.³

When providing anesthesia for cesarean delivery to the obese pregnant woman, care should be individualized and hospitals have varying approaches (see Table 1). Depending

on the degree of morbid obesity or the severity of OSA, minimizing the use of opioids should be considered. Lower doses of intrathecal opioid should be considered; 100-150 mcg intrathecal morphine is as efficacious as higher doses.¹⁷ Trans abdominus plane (TAP) blocks do not provide the same degree of analgesia as intrathecal preservative free morphinebut should be considered as a non-opioid adjuvant especially if a lower intrathecal dose of an opioid is chosen.¹⁸ Further, 24 hour monitoring in a monitored setting should be considered to assess the respiratory depressant effect on the individual woman for cases of severe OSA or cardiopulmonary disease.¹⁰

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Table 1.

| Question: | <i>Dr. Dominguez (Duke University, Durham, NC)</i> | <i>Dr. Weiniger (Hadassah Hebrew University Medical Center, Jerusalem, Israel)</i> | <i>Dr. Beilin (Mount Sinai, NY, NY)</i> | <i>Dr. Rubin (Yale University, New Haven, CT)</i> |
|--|--|--|---|--|
| What is the average BMI of your patient population? | 11 % BMI > 40 | 30 | | |
| Does your unit have a BMI "cut-off" above which you either change the dose or do not give long-acting neuraxial narcotics such as PF morphine? | NO | NO | NO | NO |
| Do you either change the dose or avoid long-acting neuraxial narcotics such as PF morphine in OSA patients? | NO | NO | NO | NO |
| Do you routinely change preferred neuraxial technique for morbidly obese laboring or cesarean patients? What is your preferred/ usual technique? | Labor epidural (placement involves CSE or DPE technique); CSE for planned cesarean with BMI > 40 | Labor epidural or single-shot-spinal | Labor - DPE or CSE and cesarean - CSE | No, CSE preferred but not routine |
| Are all known OSA patients on continuous pulse ox while on L&D and/or postpartum? | No, severe OSA goes to step-down or SICU. | NO | YES - postpartum in monitored setting | NO |
| Does your unit have the ability to use CPAP and BiPAP for parturients and postpartum women? | YES | YES | YES | YES |
| Does your unit routinely use special devices in obese parturients? | Yes: Hover mat; Traxi, Provena(wound care), surgical bed extenders | | NO | |
| Ultrasound for neuraxial block | YES | YES | NO | NO |
| Traxi sticker (self-retractor sticker) | Yes-- Traxi is great-much better than the old retraction poles | no - we have special way to place the drapes for retraction | NO | YES |
| Troop pillow or other ramping device | No- we create a ramp in select patients | NO | NO | NO |
| Videolaryngoscope as first look for GA for cesarean | YES | YES | NO | YES |
| Do you routinely see morbidly obese patients for antepartum consultation? Above what BMI? | Yes: BMI 40-50 with a comorbidity; All above 50. We have a dedicated consult clinic in MFM office. | No although we have asked that BMI >50 be sent | Not routine but we see most with BMI > 60 | Not routine (as many of our patients have BMI 40-50's. BMI >60 should be seen in our high risk clinic. |
| Do you routinely see known sleep apnea patients for antepartum consultation? | Yes - indication for anesthesia consultation. | NO | Not routine but we see most with OSA | NO |

Patient Safety Committee: Medication Shortages - When Substitutions May Pose Safety Risks

Nicole Higgins, MD

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Chicago, IL



Drug shortages are becoming increasingly commonplace and can have serious consequences for patient care and safety. Anesthesiology is affected more frequently than other specialties because the majority of shortages involve sterile injectable medications.^{1,2} When medications become unavailable, clinicians often need to make drug substitutions in an attempt to provide comparable patient care. These substitutions may not be equivalent and can lead to adverse events, including dosing errors.^{2,3} In addition, the medication shortages have significant financial impact on institutions and may result in patient complaints.^{3,4} As of November 2017, the American Society of Hospital Pharmacists lists 136 current drug shortages.⁵

On our labor and delivery unit, in the past several years, we have seen critical shortages in many standard medications and intravenous fluids, including: 3% 2-chloroprocaine, 2% lidocaine, succinylcholine, nitroglycerin, ketamine, naloxone, phenylephrine, epinephrine, sodium bicarbonate, ranitidine, fentanyl, and on several occasions, morphine (which continues to be on shortage). I describe below our history with the morphine shortage on the Labor and Delivery unit and the recent operational challenge we experienced with the substitute product.

Preservative-free morphine, Duramorph (West-Ward Pharmaceutical Corp, NJ), has been used extensively in obstetric anesthesia for both epidural and intrathecal post-cesarean analgesia, due to its well-established safety record, efficacy, convenience, cost-effectiveness and breastfeeding compatibility.

In 2013, we were alerted to the shortage and limited availability of Duramorph. (Figure 1) This shortage led to a substitute morphine product for epidural administration, as the pharmacy reserved the limited Duramorph supply for intrathecal administration only. Our pharmacy obtained a substitute morphine sulfate preparation (Hospira, IL) that was a preservative-free,



Figure 1

antioxidant-free, 2mg/mL carpuject cartridge. (Figure 2) The carpuject cartridge itself has no wording regarding route of administration, however the packaging states, “Intravenous Use Only.” (Figure 3) The obstetric anesthesiology team never saw the outer packaging materials, only the actual carpuject cartridges. We had been using this carpuject preparation, off-label, for post-cesarean epidural analgesia since 2013 with no known adverse events. Recently, we were alerted that the Hospira carpuject cartridge is no longer available, with no estimated timeframe for its return availability. This led to another substitution by our pharmacy: a Simplist™ prefilled syringe of preservative-free, antioxidant-free, morphine sulfate 2mg/mL (Fresenius Kabi, IL). (Figure 4) However, this prefilled syringe clearly states, “Not for Intrathecal or epidural use.” This led to several obstetric anesthesiologists expressing concern over the safety of the product. It is worth noting that our routinely used bupivacaine products also state, “not for intrathecal use.”

Upon further inquiry with Fresenius, the statement, “not for intrathecal or epidural use” was placed on the syringe for



Figure 2

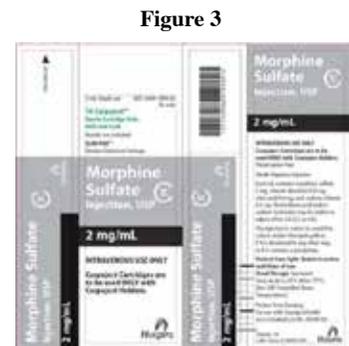


Figure 3

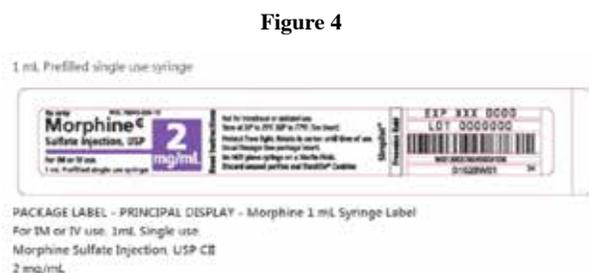


Figure 4

Patient Safety Committee continued on next page

several reasons, including: 1) the company did not have FDA approval for the intrathecal or epidural route and 2) while the product was sterile and free of preservatives and antioxidants, one of the inactive ingredients is edetate disodium. Edetate disodium is a chemically designated disodium (ethylenedinitrilo) tetraacetate dihydrate. It has also been described as the disodium salt of ethylenediamine tetraacetic acid (EDTA).⁶

After the preservative metabisulfite was labeled as the causative substance in the 2-chloroprocaine neurotoxicity cases in the 1980s, EDTA was substituted in the new preparations.⁷ However, EDTA was then implicated as the causative agent in the cases of severe back pain and muscle spasms after 2-chloroprocaine epidural anesthesia in the late 1980s and early 1990s, especially when large volumes were used.⁸ The back pain was thought to be due to the chelation of calcium which resulted in sustained muscle contraction. This led to the removal of EDTA from 2-chloroprocaine preparations.

Thus, the EDTA and label designation of the substitute morphine syringes was a source of concern for our faculty. Upon further examination, we discovered that the Hospira carpuject product also contained a small amount of EDTA and other ingredients (Table 1) and we had used that formulation for over 3 years without complication. After discussions with the hospital P&T committee, we ultimately decided to continue the off-label use of the prefilled morphine syringes for post-cesarean epidural analgesia.

There were brief discussions about eliminating epidural morphine from the post-cesarean analgesia regimen completely and switching to preservative-free hydromorphone, however some of the same safety and availability concerns associated with morphine existed for the hydromorphone products as well: 1) Fresenius Kabi, West-Ward, and Teva all report supply shortages⁹ 2) epidural administration would be off-label 3) anesthesiologists are not as familiar with the medication and dosing errors could be a significant concern and 4) neuraxial hydromorphone may be a reasonable substitute for morphine, but its analgesia duration is not equivalent to morphine.¹⁰

Unfortunately, drug shortages are here to stay and anesthesiologists and pharmacists will continue to be faced with difficult decisions. There must be a notification system

Table 1.

| | Duramorph Each mL Contains | Hospira Carpuject Each mL Contains | Simplest™ Prefilled Syringe Each mL Contains |
|--------------------------|-------------------------------|---------------------------------------|---|
| Morphine sulfate | 0.5 mg | 2 mg | 2 mg |
| Edetate disodium | | 0.2 mg | 0.111 |
| Citric Acid | | 0.4 mg | 0.74 mg |
| Sodium chloride in Water | 9 mg | 8.5 mg | 8.4 mg |
| Sodium Citrate | | | 2.3 mg |
| Calcium Chloride | | | 0.053 mg |
| Hydrochloric acid | | May contain | |
| Sodium Hydroxide | | May contain | |
| pH range | 2.5-6.5 | 2.5-4.0 | |

in place to disseminate information about shortages and anticipated shortages and the plan to manage the shortages. Do we omit a medication from practice protocols altogether or work to find substitutes? For over 30 years, preservative-free neuraxial morphine has been a mainstay in the post-cesarean analgesia regimen.¹¹ The preservative-free morphine availability shortage is long-standing, with no foreseeable change. Our patients deserve better.

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Announcements

SOAP/Kybele International Outreach Grant

The Society for Obstetric Anesthesia and Perinatology (SOAP) is pleased to announce that it is seeking applications for the SOAP/Kybele International Outreach Grant. The application deadline will be April 6, 2018 with expected funding of the grant in spring/ summer 2018.

The goal of this program is to provide funding needed to get involved with international outreach projects to identify and train future leaders in international outreach from SOAP members. Specifically, the grant is designed to encourage research in collaboration with host countries with the goal of enhancing the practice of obstetric anesthesia in those countries.

Information regarding the 2018 SOAP/Kybele International Outreach Grant application process can be found at: <https://soap.org/2018-kybele-grant-announcement-guidelines.pdf>

Call for Nominations: Teacher of the Year, Media Award

The deadline for nominations for SOAP Teacher of the Year and SOAP Media Award is fast approaching (February 9, 2018). Don't miss out on your opportunity to acknowledge someone special who has contributed to the world of obstetric anesthesia. The categories and criteria are:

SOAP Teacher of the Year Award

- **Over 10 Years of Experience Award**
- **Less than 10 Years of Experience Award**

The SOAP Teacher of the Year Award was created to recognize outstanding practitioners of obstetric anesthesiology who have demonstrated superior teaching primarily of anesthesiology residents and fellows, and secondarily of obstetricians, nurses, midwives, and the lay public.

The SOAP Education Awards Subcommittee is charged with the task of evaluating candidates and would like nominators to consider the following attributes of the candidates: clinical teaching, mentoring, and the advancement of obstetric anesthesia outside of our own community. Any SOAP member may nominate a candidate. Please forward your nominations to Joy Schabel, joy.schabel@stonybrook.edu. Nominees will be contacted by the SOAP Awards Committee and will be asked to provide the following: CV and/or teaching portfolio, teaching evaluations and a letter of recommendation from their department chair.

SOAP Media Award

The goal of the SOAP Media Award is to acknowledge the contribution of a member of the media in furthering public awareness of the important role obstetric anesthesiology plays in the care of the parturient.

Journalists, photographers, producers, directors and any other media professionals involved in the development and advancement of the above content will be considered. All relevant media genres including but not limited to print, radio, television and the Internet are eligible. The award is given for merit, and may not be awarded every year. Any SOAP member wishing to submit a candidate for consideration should send relevant information to Joy Schabel, joy.schabel@stonybrook.edu.

Board Nominations

SOAP is calling for nominations for the elected positions of 2nd Vice President and Secretary. Interested members should send a short statement and picture to kelli@soap.org for posting to the SOAP website.

If you have any questions, please do not hesitate to contact SOAP headquarters at (414) 389-8611.

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