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President's Message

Lisa R. Leffert, MD

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Greetings to all!

It's a tremendous pleasure to share with you several of the ongoing initiatives within our organization. Look for more information about these on the website, e-mail, and social media in the upcoming days and months. It is my hope that you will share your work and ideas for SOAP going forward.

- 1. Governance Project:** The growing interest in SOAP and rapid expansion of a broad range of activities provides an ideal opportunity to evaluate our current organizational structure. With the help of expert consultants, over the course of the next several months, we will be exploring ways to restructure to increase the diversity of representation and effectiveness of our collective efforts. You will be hearing more about this work as it moves forward.
- 2. Obstetric Anesthesiology Fellowship:** Thanks to the tireless work of Michaela Farber, Rebecca Minehart, Libby Ellinas and the Fellowship Committee, SOAP has formally contracted with the SF Match for the academic year 2021-22. The Program Directors are to be congratulated for working together on this match, which provides us with just the right amount of structure for our programs and our candidates.
- 3. Centers of Excellence (COE):** There continues to be a high level of engagement in the SOAP COE initiative. Designated Centers have been receiving great feedback from their institutions and health systems. In addition, COE members are actively engaged in discussing clinical challenges and pearls. We look forward to additional opportunities to share best practices across the entire community. In the meantime, the second cycle of COE submissions has recently closed, and applications are currently being reviewed.

President's Message continued on next page

4. **SOAP 2020 Annual Meeting:** Based in Halifax, Nova Scotia, this meeting is devoted to “Raising the Standard for Each Woman Everywhere.” Featuring 15 clinical refresher courses, joint panels with national organizations (e.g., ASRA) and international expert speakers, and numerous “lunch and learn” sessions. Ruth Landau and Ronald George, leading their Annual Meeting Program Committee, have created a program that augments the Annual Meeting favorites and promises something for everyone.
5. **Research Committee:** In addition to Young Investigator Award (\$10,000 grants geared towards investigators at the early stages of their careers), Phil Hess and the Research Committee are configuring a new opportunity for the SOAP community. More details to follow in the coming months.
6. **International Meetings with a SOAP Panel:** SOAP members, Michelle Simon and Vilma Ortiz, launched the Simposio Costa Rica on Obstetric Anesthesia, which featured an official SOAP Panel on Enhanced Recovery After Cesarean Delivery (ERAC). Several other SOAP members from our national and international community were also speakers in this highly successful meeting.

7. **SOAP Consensus Statements:** SOAP continues to provide consensus statements using the best available evidence on topics that are important to your clinical practice. We will solicit your feedback on these statements, via the SOAP website, prior to publication. If you have ideas of important areas to address, please contact me and I will help you to submit a formal proposal. Current works-in progress include:
 - i. The SOAP/American Society of Hematology (ASH)/ACOG/SMFM/ASRA Taskforce on Thrombocytopenia in Pregnancy: The goal of this initiative is to provide a practical clinical decision support tool to guide the choice of anesthetic management, particularly decisions about neuraxial anesthesia, in obstetric patients with thrombocytopenia.
 - ii. The SOAP/ASRA/SMFM Taskforce on Peri-delivery Pain Management in Women with Opioid Use Disorders.

Finally, as we enter the holiday season, I want to take thank each of you for your dedication to excellence in maternal and fetal care and to our organization. I look forward to leading SOAP into the New Year!

Respectfully Submitted,
Lisa

Editor's Corner

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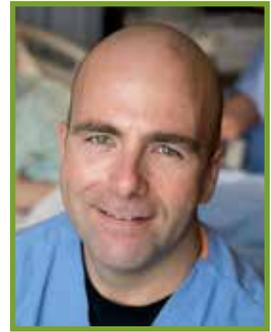


I always enjoy reading the SOAP Newsletter, but particularly this edition which gives us a glimpse into how SOAP began as a subspecialty society within anesthesia. I've never stopped to think that SOAP hasn't 'always been.' I wonder what the pioneers in obstetric anesthesia envisioned when

they started this society. I imagine they would be pleased with the impact this society has made on the care of obstetric patients in the U.S. and beyond. I am certainly proud to be a part of such an innovative, driven and caring group.

SOAP 52nd Annual Meeting Update: The Best Things to Consider for Halifax 2020

Ronald B. George, MD, FRCPC
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The capital city of Nova Scotia, Halifax has a rich maritime history, beautiful architecture and a magnificent coastline. It is a busy seaport and the economic hub of Eastern Canada. Halifax was originally inhabited by the First Nations people, the Mi'kmaq. The first European settlers to arrive in Halifax were the British in 1749, erecting the fortification at the centre of Halifax, Citadel Hill. The outpost was named in honor of George Montague-Dunk, 2nd Earl of Halifax.

Below the historic Citadel Hill fortress, the new Halifax convention centre is set to be a show stealer. The expansive entrance parlor will house conference registration, the coolest SOAP engagement lounge, and showcase our opening reception. This will be the best location to welcome our members and attendees to Halifax, showcase local food and drinking offerings, and highlight local cirque talent.

Thursday evening will see opportunities for resident and fellow receptions, meet and greets for our international visitors, and catching up with SOAP friends at a traditional Atlantic Canada Pub, such as Gahan House, brewers of handcrafted ales, and conveniently located within the convention centre complex (<https://gahan.ca>). Another great option for that perfect meeting spot might be a 2 minute walk from the convention centre at East of Grafton (shorturl.at/howJ5), a modern version old English pub, or Stillwell, the place to go for great craft beers from Nova Scotia's booming craft brewing community.

Friday is Alumni evening, the best time to gather friends from your Alma Mater in one of Halifax's fine eateries. Some of my favorites include; 1) Highway Man - a Spanish inspired restaurant offering tapas-style dishes, a Raw Bar, and innovative drinks. My favorite dishes include the Boquerone & Stracchino, a marinated white anchovies with Italian cow's milk cheese, 2) Gio - Conveniently located at the Prince George Hotel, it has always been one of the



Photo Credit: Tourism Nova Scotia



Photo Credit: Tourism Nova Scotia

top rated restaurants. Gio is a fine dining restaurant offering a diverse menu based on local and global ingredients for the season, 3) Cut - an eloquent steakhouse with simply the best table side cesaer salad you've ever had - ask for extra anchovies! If these three don't entice you, two other favorites are Five Fisherman and The Barrington Steakhouse

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& Oysterbar. Craving some delicious Atlantic lobster – we’ve got that covered with an abundance of opportunities for this local delicacy.

Halifax is a walking city, everything is in walking distance from our central location. Walk along the waterfront in downtown Halifax - Try strolling along the two-mile Harbor walk, which winds along the colorful waterfront. Start off at the Historic Properties, where three blocks-worth of warehouses and Victorian-era buildings dating back to the 1700s have been beautifully restored. This area houses some very popular dining spots including Lower Deck, Salty’s, and at the other end of the waterfront, The Bicycle Thief.



Photo Credit: Tourism Nova Scotia

Places to visit with your family include the Maritime Museum of the Atlantic. Displaying artifacts and providing interactive exhibits, this specialty museum recounts the city’s days as a pirate haven, a commercial shipping hub and a military player in World Wars I and II. Learn how Halifax fits into the 1912 sinking of the Titanic, recounting local efforts to recover lost passengers and any remaining parts of the ship. In downtown Halifax, the Art Gallery of Nova Scotia is the largest art museum in the Atlantic provinces. There is a particular emphasis on the work of Nova Scotian folk artist, Maud Lewis, and part of the gallery’s collection includes her shed-sized house that is decorated with vibrant paintings.

If you’re visiting Halifax for the first time, I’d suggest booking extra time for the trip and explore activities around the city and short road trips. Iconic places to consider include the fortress at Citadel Hill, built back in 1749 to protect the city, the star-shaped fort overlooks the harbor. A visit to Nova Scotia would not be complete without a visit to Peggy’s Cove Lighthouse, one of Nova Scotia’s most visited attractions. The red and white lighthouse is still in

operation today. The drive from the city to the community of Peggy’s Cove is along the scenic Lighthouse Route. Peggy’s Cove Lighthouse, one of the world’s most famous lighthouses, is one of Atlantic Canada’s most photographed structures. Other fabulous add-ons to consider would be an excursion to St. John’s, Newfoundland. SOAP 2020 happens to coincide with “Iceberg Season”. Iceberg Alley stretches along the southeast coast of Newfoundland and late May is prime time to see nature’s enormous snowy works of art float by. Prefer the golfing green over snowy white, then try some of the premier golf courses. Nova Scotia is home to three courses in the Golf Digest Top 100 golf courses. (<http://nsga.ns.ca/article/nova-scotia-has-three-course-in-worlds-top-100>) There are some avid SOAP golfers planning some pre-meeting golfing; if you’re interested we can put you in contact.

Nova Scotia is an adventurer’s dream - want more tips for restaurants or ideas for day trips, don’t hesitate to contact me at ronald.george@ucsf.edu or Dr. Hilary MacCormick (hilarykate@Dal.Ca) from Halifax.

Education Committee: Best Practice for Anesthesia in Placenta Accreta Spectrum (PAS): General, Neuraxial, Both?

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Background

Placenta accreta spectrum (PAS) describes a range of pathologic adherent placentation.¹ Depth of placental invasion delineates placenta accreta, placenta increta and placenta percreta (Table 1).¹ The incidence of placenta accreta is approximately 1 in 533 with more recent reports suggesting an incidence as high as 1 in 272.^{2,3} The incidence has increased substantially over time, in parallel with increased cesarean delivery rates.⁴ Prior cesarean delivery is a known risk factor of PAS with the incidence of invasive placentation increasing with the number of prior cesarean deliveries (Table 2).⁴ Other risk factors include the presence of placenta previa (Table 2), prior uterine surgeries, and advanced maternal age.^{4,8}

PAS is associated with severe maternal morbidity and mortality. The adherent placenta leads to significant hemorrhage risk with an average estimated blood loss of two to five liters.⁶⁻⁹ Massive transfusion is often indicated with 40% of PAS cases requiring more than ten units of blood products.¹⁰ PAS is a risk factor for peripartum hysterectomy, and in the US the rate of peripartum hysterectomy due to invasive placentation has increased 1.2 fold over 14 years.¹¹⁻¹² The mortality rate for complications due to PAS has been quoted as high as 7%.¹⁰



Table 1: Placenta accreta spectrum definitions*

| | |
|--------------------------|---|
| Placenta accreta | Villi invade into the myometrium |
| Placenta increta | Villi invade the full depth of myometrium |
| Placenta percreta | Villi invade through the uterine serosa |

**Degree of invasion is not predictive of hemorrhage severity*

Table 2: Risk of placenta accreta spectrum with number of cesarean deliveries

| | All parturients | Parturients with placenta previa |
|----------------------------------|------------------------|---|
| First cesarean delivery | 0.24% | 3.3% |
| Second cesarean delivery | 0.31% | 11% |
| Third cesarean delivery | 0.57% | 40% |
| Fourth cesarean delivery | 2.13% | 61% |
| Fifth cesarean delivery | 2.33% | 67% |
| ≥ Six cesarean deliveries | 6.74% | 67% |

Adapted from Silver et al.⁴

Planning for the surgical management of PAS requires a multidisciplinary approach, not limited to interventional radiology, maternal fetal medicine, obstetric anesthesiology and surgical intensivists.^{1,13-15} With the rapid increase in incidence of PAS, a perioperative surgical approach with preoperative planning and a designated postpartum setting (surgical intensive care unit), can help create a team comfortable with the unique physiologic changes associated with these patients. However, debate exists on the ideal anesthetic management for PAS patients. The American Society of Anesthesiology guidelines state that neuraxial anesthesia is the preferred anesthetic for cesarean delivery;¹⁶ however in PAS there is a high conversion rate to general anesthesia when neuraxial anesthesia is used.¹⁷⁻¹⁹ This article will cover evidence and considerations surrounding general and neuraxial anesthesia for the patient with PAS.

General Anesthesia

Cesarean delivery complicated by PAS requires close monitoring of volume status, blood loss, and hemodynamics. Due to these rapid changes in volume and physiologic parameters, coupled with risk for high-volume resuscitation and transfusion, general anesthesia seems to make intuitive sense.¹ In a recent survey study from Israel, 96% of respondents reported general anesthesia as the preferred anesthetic for cases with high suspicion for PAS.²⁰ General anesthesia may be preferred to allow for the comfortable placement of central

Education Committee continued on next page

venous access in anticipation of major blood loss, as well as for airway protection in cases where massive transfusion is likely. Furthermore, general anesthesia may be desirable when high abdominal dissection is anticipated.²¹ Because general anesthesia can often be achieved more quickly than regional anesthesia, it is the anesthetic of choice in the setting of antenatal hemorrhage as it allows for expedited delivery times while mitigating the risk of performing a neuraxial technique in a parturient presenting with continued bleeding and potential coagulopathy.²²

On the other hand, there are disadvantages to the use of general anesthesia. In addition to maternal airway challenges leading to morbidity and mortality associated with general anesthesia,²³ general anesthesia can diminish the childbirth experience. However, one may argue that this experience is already challenged in cases of PAS, given that these patients often have deliveries prior to full term, and a full awareness in anticipation of, or during, the planned hysterectomy could be psychologically difficult to handle for many women. The difference in risk between neuraxial and general anesthesia in obstetric patients has decreased substantially over time, likely due to advances in airway equipment and the difficult airway algorithm.²⁴ Further, the use of general anesthesia increases neonatal drug transfer, particularly when anesthesia induction-to-delivery times are prolonged. PAS under general anesthesia may require additional time for line placement or surgical exposure, resulting in increased exposure of the neonate to soluble anesthetics.

Neuraxial Anesthesia

Neuraxial anesthesia for PAS has a favorable reported safety profile. A retrospective cohort study by Markley et al. showed that 95% of patients with suspected PAS received neuraxial anesthesia as their primary anesthetic.²⁵ Interestingly, in that study, the majority of patients who were deemed high-risk (e.g. morbid obesity, multiple prior cesarean deliveries (>3), complex PAS physiology), successfully received neuraxial anesthesia.²⁵ Advantages of neuraxial anesthesia include avoiding airway manipulation in a population where airway management may be more challenging.²⁶⁻²⁸ Neuraxial anesthesia supports the childbirth experience for patients that desire to be awake for delivery, and is arguably more patient- and family-centered than general anesthesia. Further, a neuraxial technique has less risk for neonatal drug transfer compared to general anesthesia.

Neuraxial anesthesia for PAS is not without its disadvantages. Neuraxial anesthesia can fail to provide adequate anesthesia. Parturients may not tolerate prolonged surgical times under neuraxial anesthesia, and often it requires a highly motivated patient with extensive preoperative counseling. Markley et al reported an intraoperative conversion rate to general anesthesia of 21%.²⁵ Neuraxial anesthesia may not provide adequate abdominal relaxation for proper visualization in these surgically complex procedures. Consideration should be given to those cases where massive transfusion is needed,

as the incidence of transfusion related acute lung injury in pregnancy has been reported to be as high as 19% and airway protection may be indicated in these circumstances.²⁹ There are multiple reports of successful planned conversion from neuraxial to general anesthesia for patients with PAS, although the specific timing of intubation and expert consensus is yet to be elucidated.^{17,18} In a survey of Society of Maternal Fetal Medicine members, 60% reported a preference towards neuraxial anesthesia with conversion to general anesthesia if necessary.^{30,31}

Conclusions

Planned conversion from neuraxial to general anesthesia is a reasonable initial approach to patients with PAS. Factors to be taken into account for selective (planned) conversion include: understanding and communication with patient regarding this plan, degree of surgical complexity (if placenta is easily removed, may defer intubation) and degree of anticipated airway difficulty. Furthermore, if selective conversion is planned, patients may benefit from immediate intubation post-delivery as airway edema may occur with rapid administration of blood products. The anticipated ability to achieve successful intraoperative conversion to general anesthesia remains an essential component in perioperative planning for patients with PAS. Prudent patient selection is necessary to identify good candidates for neuraxial vs. general anesthesia. Lastly, given the rapid increase in PAS incidence, an accepting unit with surgical intensive care expertise is essential for perioperative surgical strategy and for the successful anesthetic management of these patients.

References

1. Committee on Obstetric P Committee opinion no. 529: placenta accreta. *Obstet Gynecol* 2012; **120**: 207-11.
2. Wu S, Kocherginsky M, Hibbard JU Abnormal placentation: twenty-year analysis. *Am J Obstet Gynecol* 2005; **192**: 1458-61.
3. Mogos MF, Salemi JL, Ashley M, Whiteman VE, Salihu HM Recent trends in placenta accreta in the United States and its impact on maternal-fetal morbidity and healthcare-associated costs, 1998-2011. *J Matern Fetal Neonatal Med* 2016; **29**: 1077-82.
4. Silver RM, Landon MB, Rouse DJ, et al. Maternal morbidity associated with multiple repeat cesarean deliveries. *Obstet Gynecol* 2006; **107**: 1226-32.
5. Wright JD, Pawar N, Gonzalez JS, et al. Scientific evidence underlying the American College of Obstetricians and Gynecologists' practice bulletins. *Obstet Gynecol* 2011; **118**: 505-12.
6. Miller DA, Chollet JA, Goodwin TM Clinical risk factors for placenta previa-placenta accreta. *Am J Obstet Gynecol* 1997; **177**: 210-4.
7. Fitzpatrick KE, Sellers S, Spark P, Kurinczuk JJ, Brocklehurst P, Knight M The management and outcomes of placenta accreta, increta, and percreta in the UK: a population-based descriptive study. *BJOG* 2014; **121**: 62-70; discussion -1.
8. Usta IM, Hobeika EM, Musa AA, Gabriel GE, Nassar AH Placenta previa-accreta: risk factors and complications. *Am J Obstet Gynecol* 2005; **193**: 1045-9.
9. Hudon L, Belfort MA, Broome DR Diagnosis and management of placenta percreta: a review. *Obstet Gynecol Surv* 1998; **53**: 509-17.
10. O'Brien JM, Barton JR, Donaldson ES The management of placenta percreta: conservative and operative strategies. *Am J Obstet Gynecol* 1996; **175**: 1632-8.

11. Wright JD, Bonanno C, Shah M, Gaddipati S, Devine P Peripartum hysterectomy. *Obstet Gynecol* 2010; **116**: 429-34.
12. Bateman BT, Mhyre JM, Callaghan WM, Kuklina EV Peripartum hysterectomy in the United States: nationwide 14 year experience. *Am J Obstet Gynecol* 2012; **206**: 63 e1-8.
13. Russo M, Krenz EI, Hart SR, Kirsch D Multidisciplinary approach to the management of placenta accreta. *Ochsner J* 2011; **11**: 84-8.
14. Taylor NJ, Russell R Anaesthesia for abnormally invasive placenta: a single-institution case series. *Int J Obstet Anesth* 2017; **30**: 10-5.
15. Eller AG, Bennett MA, Sharshiner M, et al. Maternal morbidity in cases of placenta accreta managed by a multidisciplinary care team compared with standard obstetric care. *Obstet Gynecol* 2011; **117**: 331-7.
16. American Society of Anesthesiologists Task Force on Obstetric A Practice guidelines for obstetric anesthesia: an updated report by the American Society of Anesthesiologists Task Force on Obstetric Anesthesia. *Anesthesiology* 2007; **106**: 843-63.
17. Lilker SJ, Meyer RA, Downey KN, Macarthur AJ Anesthetic considerations for placenta accreta. *Int J Obstet Anesth* 2011; **20**: 288-92.
18. Riveros-Perez E, Wood C Retrospective analysis of obstetric and anesthetic management of patients with placenta accreta spectrum disorders. *Int J Gynaecol Obstet* 2018; **140**: 370-4.
19. Grant TR, Ellinas EH, Kula AO, Muravyeva MY Risk-stratification, resource availability, and choice of surgical location for the management of parturients with abnormal placentation: a survey of United States-based obstetric anesthesiologists. *Int J Obstet Anesth* 2018; **34**: 56-66.
20. Ioscovich A, Shatalin D, Butwick AJ, Ginosar Y, Orbach-Zinger S, Weiniger CF Israeli survey of anesthesia practice related to placenta previa and accreta. *Acta Anaesthesiol Scand* 2016; **60**: 457-64.
21. Patil V, Ratnayake G, Fastovets G, Wijayatilake DS Clinical pearls part 3: anaesthetic management of abnormally invasive placentation. *Curr Opin Anaesthesiol* 2018; **31**: 280-9.
22. Butwick AJ Managing patients with abnormal placentation: what are the best anesthetic and transfusion strategies? *Anesthesiology* 2012; **116**: 1156-7; author reply 7-8.
23. Hawkins JL, Koonin LM, Palmer SK, Gibbs CP Anesthesia-related deaths during obstetric delivery in the United States, 1979-1990. *Anesthesiology* 1997; **86**: 277-84.
24. Hawkins JL, Chang J, Palmer SK, Gibbs CP, Callaghan WM Anesthesia-related maternal mortality in the United States: 1979-2002. *Obstet Gynecol* 2011; **117**: 69-74.
25. Markley JC, Farber MK, Perlman NC, Carusi DA Neuraxial Anesthesia During Cesarean Delivery for Placenta Previa With Suspected Morbidly Adherent Placenta: A Retrospective Analysis. *Anesth Analg* 2018; **127**: 930-8.
26. Lyons G Failed intubation. Six years' experience in a teaching maternity unit. *Anaesthesia* 1985; **40**: 759-62.
27. Hawthorne L, Wilson R, Lyons G, Dresner M Failed intubation revisited: 17-yr experience in a teaching maternity unit. *Br J Anaesth* 1996; **76**: 680-4.
28. Barnardo PD, Jenkins JG Failed tracheal intubation in obstetrics: a 6-year review in a UK region. *Anaesthesia* 2000; **55**: 690-4.
29. Teofili L, Bianchi M, Zanfini BA, et al. Acute lung injury complicating blood transfusion in post-partum hemorrhage: incidence and risk factors. *Mediterr J Hematol Infect Dis* 2014; **6**: e2014069.
30. Jolley JA, Nageotte MP, Wing DA, Shrivastava VK Management of placenta accreta: a survey of Maternal-Fetal Medicine practitioners. *J Matern Fetal Neonatal Med* 2012; **25**: 756-60.
31. Wright JD, Silver RM, Bonanno C, et al. Practice patterns and knowledge of obstetricians and gynecologists regarding placenta accreta. *J Matern Fetal Neonatal Med* 2013; **26**: 1602-9.



SAVE THE DATE

SOAP 52nd Annual Meeting May 13-17, 2020

Halifax Convention Centre • Halifax, Nova Scotia, Canada

*Raising The Standard For
Each Woman Everywhere*

- Sol Shnider Clinical Track (NEW)
- Problem-Based Learning Luncheons
- Clinical Workshops
- Gerard W. Ostheimer Lecture: What's New in Obstetric Anesthesia
- Fred Hehre Lecture
- ASRA and SOAP Educational Panel (NEW)
- SMFM What's New in Obstetrics Lecture
- International Symposiums
- Showcase for Best Obstetric Anesthesia Research in the World

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For more information, please visit www.soap.org

Patient Safety Committee: An Argument for and Against Neuraxial Catheter Placement in Parturients Receiving Therapeutic Anticoagulation

Pro Argument:

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Laurence Ring, MD
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New York, NY

Con Argument:

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Laura Sorabella, MD
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Pro: Neuraxial techniques should be offered to high-risk parturients receiving therapeutic anticoagulation

Updated ACOG guidelines as well as advances in management of significant pulmonary, hematologic and cardiac disease have led to the more widespread use of anticoagulation, including therapeutic anticoagulation, in pregnancy. Parturients requiring anticoagulation for treatment of recurrent stroke, pulmonary embolus or mechanical heart valves may be amongst the women who might most benefit from neuraxial analgesia for labor, or the opportunity to avoid general anesthesia for cesarean delivery. Yet, many anesthesiologists are hesitant to use neuraxial techniques in anticoagulated parturients.

While somewhat new in the field of OB anesthesiology, the safety of epidural placement is well documented in the cardiac literature. In a meta-analysis of patients undergoing cardiac surgery with epidurals placed pre-operatively, there were no cases of epidural hematomas, despite full heparinization intraoperatively¹. Similar conclusions can be drawn from interventional pain management injections on anticoagulated patients². There are no reported cases of epidural hematomas in anticoagulated pregnant patients from 1952 to the present, making the incidence in the obstetric population 1:200,000-1:250,000³.

When using a neuraxial technique for an anticoagulated parturient, a multidisciplinary approach to the care of the patient is imperative. This should include detailed antepartum discussions of the timing of heparin infusion initiation and cessation as well as the timing of neuraxial placement and catheter removal. The care team must be trained to identify the signs of an epidural hematoma (i.e. neurological assessment) and a protocol must exist to address suspected hematoma, including emergent MRI and neurosurgical consult. In summary, we support offering neuraxial techniques to high-risk parturients with proper guidelines in place.

Con: Alternative methods of analgesia should be offered to high-risk parturients receiving therapeutic anticoagulation

Labor is generally regarded as one of the most painful events in a woman's lifetime and neuraxial techniques are unquestionably the most effective at decreasing labor pain. Neuraxial techniques are commonly requested for parturients with comorbid conditions because they blunt the sympathetic response to pain⁴ and permit the avoidance of general anesthesia.

Safe neuraxial placement in a patient receiving systemic anticoagulation requires precise coordination of the timing of anticoagulant administration, catheter placement, laboratory testing, and neurologic assessment. Such coordination is difficult during induction of labor and near-impossible with spontaneous onset of contractions. Most labor and delivery nurses are not certified to perform neurologic exams, which require expertise when there is expected lower extremity paresthesia and weakness.

The 2018 ASRA guidelines allow for initiation of a heparin infusion after neuraxial catheter placement⁵. These guidelines were created for non-pregnant patients having general anesthesia in an immobilized state—greatly decreasing the risk for unintentional catheter dislodgement. The risk for

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Table. Current recommendations for safe timing intervals between therapeutic anticoagulation and neuraxial technique placement or removal in parturients

| Anticoagulant, typical doses for therapeutic anticoagulation | Time to hold anticoagulant before neuraxial placement | Time to wait after neuraxial placement before reinitiating therapeutic anticoagulation | Laboratory Testing | Time from neuraxial catheter removal to reinitiation of therapeutic anticoagulation |
|---|---|--|--|---|
| SQ UFH >10,000 units per dose or > 20,000 units total daily dose | ≥ 24 hours | Per ASRA guidelines not recommended while catheter in place | Normal aPTT or undetectable anti-factor Xa level | ≥ 1 hour |
| IV UFH Titration to aPTT 1.5-2.5 times the patient's baseline | ≥ 4-6 hours | > 1 hour | Normal aPTT or undetectable anti-factor Xa level | ≥ 1 hour |
| SQ enoxaparin 1 mg/kg every 12 hours or 1.5 mg/kg daily | ≥ 24 hours | Per ASRA guidelines not recommended while catheter in place | None required | ≥ 4 hour |
| SQ dalteparin 120 units/kg every 12 hours or 200 units/kg daily | | | | |

SQ, subcutaneous; UFH, unfractionated heparin; aPTT, activated partial thromboplastin time

Adapted from: Leffert L, Butwick A, Carvalho B, et al. Anesth Analg. 2018;126(3):928-944 and Horlocker TT, Vandermeulen E, Kopp SL, et al. Reg Anesth Pain Med. 2018;43(3):263-309.

hematoma formation is as high with catheter removal as insertion⁶. Laboring parturients change position and alter epidural venous plexus pressure with Valsalva (pushing)⁷. Furthermore, patients having non-obstetric surgery typically receive thoracic epidurals, which spare lower limb motor neurons, simplifying neurological examination.

Lastly, the duration of labor is typically longer than one anesthesia shift. Some of our providers are uncomfortable systemically anticoagulating patients with neuraxial catheters. For these reasons, our institutions offer systemically anticoagulated parturients pain management via remifentanyl patient-controlled analgesia or nitrous oxide.

Conclusion:

The benefit-risk balance of neuraxial anesthesia in parturients on therapeutic anticoagulation is altered by the obstetric situation and airway considerations. If a neuraxial technique is warranted, multidisciplinary coordination for appropriate discontinuation and reinitiation of anticoagulation is essential (Table). Most parturients that require peripartum therapeutic anticoagulation will receive low molecular weight or unfractionated heparin because these drugs do not cross the placenta and there is evidence of lack of fetal anticoagulation.

References:

1. Bignami E, Landoni G, Biondi-Zoccai GG, et al. Epidural analgesia improves outcome in cardiac surgery: a meta-analysis of randomized controlled trials. *J Cardiothorac Vasc Anesth.* 2010;24(4):586-597.
2. Goodman BS, House LM, Vallabhaneni S, Mallempati S, Willey MR, Smith MT. Anticoagulant and Antiplatelet Management for Spinal Procedures: A Prospective, Descriptive Study and Interpretation of Guidelines. *Pain Med.* 2017;18(7):1218-1224.
3. Leffert L, Butwick A, Carvalho B, et al. The Society for Obstetric Anesthesia and Perinatology Consensus Statement on the Anesthetic Management of Pregnant and Postpartum Women Receiving Thromboprophylaxis or Higher Dose Anticoagulants. *Anesth Analg.* 2018;126(3):928-944.
4. Shnider SM, Abboud TK, Artal R, Henriksen EH, Stefani SJ, Levinson G. Maternal catecholamines decrease during labor after lumbar epidural anesthesia. *Am J Obstet Gynecol.* 1983;147(1):13-15.
5. Horlocker TT, Vandermeulen E, Kopp SL, Gogarten W, Leffert LR, Benzon HT. Regional Anesthesia in the Patient Receiving Antithrombotic or Thrombolytic Therapy: American Society of Regional Anesthesia and Pain Medicine Evidence-Based Guidelines (Fourth Edition). *Reg Anesth Pain Med.* 2018;43(3):263-309.
6. Vandermeulen EP, Van Aken H, Vermeylen J. Anticoagulants and spinal-epidural anesthesia. *Anesth Analg.* 1994;79(6):1165-1177.
7. Martins AN, Wiley JK, Myers PW. Dynamics of the cerebrospinal fluid and the spinal dura mater. *J Neurol Neurosurg Psychiatry.* 1972;35(4):468-473.

International Outreach Committee: Kybele Worldwide: Improving Access to Safe Obstetric Anesthesia Care in the Balkans

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Kybele is an international non-profit organization that aims to create healthcare partnerships to improve childbirth safety. Since its founding in 2001, and with a focus on local capacity-building through education and training of anesthesia providers in locales in which it has a presence, Kybele has successfully implemented programs that have improved the quality and safety of healthcare during childbirth in 13 countries worldwide. Dr. Ivan Velickovic and Dr. Curtis Baysinger have led the Eastern Europe program, both within the USA and educational conferences abroad. In 2011, Kybele developed a partnership with Dr. Borislava Pujic and Klinicki Centar Vojvodine, a teaching hospital in Novi Sad, Serbia with the goal of increasing regional anesthesia (RA) for cesarean delivery (CD) and neuraxial analgesia for labor. The use of RA for CD has increased from 14% in 2011 to 25% in 2015¹ and now approaching 60% in 2019. As a result of the success seen in Novi Sad, the project has expanded to include locations in Bosnia and Herzegovina in 2016 and most recently Macedonia in 2018.

Kybele volunteers in Serbia have focused on education and making efforts to introduce the use of RA. Anesthesiologists initially encountered significant resistance from the obstetricians. It was common to have patients willing to receive RA for their CD and then the obstetrician commanding the anesthesiologist to stop the spinal and administer general anesthesia. In addition, patients with a spinal anesthetic were often treated as though they were under general anesthesia. Nurses, surgeons, and most

anesthesia providers did not interact with the patient, and newborns were often rushed out of the room soon after being born.

Visits to Novi Sad in 2018 and 2019 were very encouraging because of the acceptance of RA that had occurred. In addition to biannual Kybele trips, during this period Dr. Craig Palmer also spent time in Novi Sad through the Fulbright U.S. Scholar Program and the influence of his experience and dedication were apparent. Use of RA had increased, and was more widely accepted by the obstetrics and anesthesiology teams. There were no longer blatant objections to RA use for CD by the obstetricians. Furthermore, conversations with the obstetricians about spinal anesthesia revealed that they liked it in the appropriate circumstances. There was also a noticeable change in provider interactions with patients. During spinal placement and surgical preparation, the anesthesiology team would talk to the patient. The surgeon would often talk to the patient and hold the baby up over the drape for the mom to see. The baby was then taken to the warmer for evaluation then brought back to mom for a quick introduction and kiss before being taken out of the room. The mother was now the focus of everyone's attention in the operating room. During the two weeks Kybele was in Novi Sad in May 2019, 47 spinals and 1 combined spinal-epidural (CSE) for CD and 20 CSEs for labor analgesia were performed.

Kybele participants have also been visiting Tuzla for the last 4 years and have directed their efforts on the education of local anesthesiologists at UKC Tuzla, the main referral hospital, on the safe provision of neuraxial analgesia and



International Outreach Committee continued on next page



anesthesia in parturients. Even in this short period, Kybele's efforts, along with a phenomenal degree of local engagement, interest, and a willingness to make positive change have helped transform the landscape of neuraxial anesthesia in Tuzla. Similar initial resistance and apprehension is still noticeable amongst obstetricians and patients as was seen in Novi Sad, but this too appears to be changing for the better in Tuzla. As of spring 2019, 34% of patients having CD now receive spinal anesthesia (compared to less than 1% only 2 years ago)! Led by anesthesiologists Dr. Denis Odobasic and Dr. Senka Keser, members of the anesthesia department team in Tuzla are now taking on the role of local experts and have begun sharing their knowledge and experience with practitioners from many other parts of the country. This May, Kybele volunteers had the opportunity to participate and teach at Tuzla's "School of Obstetric Anesthesia", in



which 10 physicians from 5 other hospitals in Bosnia and Herzegovina benefitted from didactic lectures, hands-on practice with models, and performing neuraxial procedures in patients.

One of the fascinating products of Kybele's work in Tuzla has been increased local awareness, interest, and acceptance of neuraxial anesthesia by patients and their families. Through outreach endeavors such as interviews on local television stations, as well as simple word-of-mouth, many patients now present in labor or for scheduled CD inquiring about whether they too may be candidates for spinal or epidural analgesia/anesthesia. We hope this continues, as this is likely one of the most effective ways to bring about cultural changes that will be necessary for widespread uptake of these techniques by anesthesiologists, obstetricians, and their patients in Bosnia and Herzegovina.

As Kybele's work continues to grow and evolve in the Balkans, we hope future trips will show continued progress with implementation of RA for labor and cesarean delivery. In addition, expanding the educational offerings to allow more local anesthesiologists to benefit and in turn take those learnings to their own hospitals, clinics, and practices will hopefully exponentially increase Kybele's impact. Seeing this in action over the past few years has been one of the most fulfilling and tangible benefits we have experienced as volunteers with Kybele, and we encourage anyone with a passion for Obstetric Anesthesia and Global Health to support, donate material resources, and/or volunteer their time and knowledge to allow Kybele to continue to improve anesthesia care for mothers and their newborns worldwide.

References:

1. Baysinger CL, Pujic B, Velickovic I, Owen MD, Serafin J, Shotwell MS, Braveman F. Increasing Regional Anesthesia Use in a Serbian Teaching Hospital through an International Collaboration. *Front Public Health*. 2017 Jun 9;5:134.

International Outreach Committee: Fulbright Scholarship? What is that?

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In 2015, I was privileged to receive an opportunity which few of us have had the chance to enjoy: I was awarded a Fulbright Scholarship to spend 5 months in central Europe living, working, and (most importantly!) teaching modern obstetric anesthesia practice in a country which for many reasons had missed the dramatic advances we have made over the last 30-odd years.

What is a Fulbright Scholarship? I will offer a quick overview of the program, its purpose and processes.

The Fulbright program (started in 1946) has the stated purpose to "...sponsor U.S. and foreign participants for exchanges in all areas of endeavor... (and) to increase mutual understanding between the people of the United States and the people of other countries." Today, the Program operates in 155 countries across the globe. The Program provides expense and salary support for scholars, as does the U.S. State Department.

There are a few important details to understand, however. Anyone can apply for a scholarship which can be either for teaching or research. Scholarships are awarded once per year, and an applicant can submit only one application per year, for a single country. Scholarships are funded in part by the host countries (as well as your tax dollars!), so there are limits on eligible disciplines. The catalogue is available at <https://awards.cies.org/>. It can be searched by country, region, and discipline. Not all countries are looking for medical professionals, which does limit choices significantly.

Having identified an open award, you submit an application, or proposal. This process is open-ended, and you can apply to be funded for almost anything. The key is to make your idea or proposal appealing to the reviewers who make the awards, including representatives of both countries.

The award process is "black box" - Fulbright does not release the numbers of applications they receive for any country or even year. No feedback is given regarding proposals, pro or con. Awards for each country are limited in number, with no distinction among disciplines. You are competing against everyone else, be they geologists, historians, anything. And you never know how many there are.

You must submit letters of recommendation and invitation. Fulbright reviewers probably have no background in your field. I have served as a Fulbright reviewer, and none of the applications I reviewed had anything to do with medicine! So the plans and objectives should be very clear to a lay person looking at them. Once you have polished it all up as best you can, you submit it on-line and wait. You will not get any feedback for 2-3 months, and if actually approved, notification will take 6 months or more.

Scholarships are awarded on a semester basis, either for 1 or 2 semesters, basically 4 or 9 months, with starting dates in November and January, usually. Even with a successful application, you would not actually head overseas for at least a year after applying, likely 18 months.

If you do clear all the hurdles, your reward will be the experience of a lifetime. I spent 5 months working and teaching in Serbia. I spent most of my time at a "Klinika" in Novi Sad, an hour north of Belgrade, doing 6,000+ deliveries per year. When I arrived, the cesarean delivery (CD) rate was over 30%, with over 90% under GA! Regional anesthesia for labor was virtually non-existent. Thanks to the hard work and efforts of the staff, the rate of regional anesthesia for CD is currently over 60%. Due to manpower issues, coverage for labor analgesia has been harder to tackle, but the anesthesiologists are all well-versed in epidural, CSE, spinal, and even intravenous analgesia for labor. I also visited and spent time in several other facilities throughout Serbia.

Outside the hospital, the opportunity to live in a very different society was fascinating. Navigating the local shops, markets, and restaurants was a daily challenge, as was learning to communicate. My wife and I (yes, awards support family also) were able to visit some of the great cities of Europe, broaden our experience and briefly escape the brutal Serbian winter.

But by far the most rewarding part of my experience was the way I was received by virtually everyone. It is hard to relate the degree of appreciation the physicians had for my time and efforts, which I still feel as strongly as the day I left. And while we were colleagues on the labor deck, most

Fulbright Scholarship continued on next page

have become good friends whom I try to keep in contact with, as best a 9 time-zone difference allows. I have been back to Serbia several times since my Scholarship stint, and I will return again, not only to continue the work, but to catch up with friends and renew the old acquaintances.

The author wishes to acknowledge the inspiration and support provided by SOAP's first Fulbright scholar, Medge Owen, and the advice and guidance of Ivan Velickovic.

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 March 27, 2020 with expected funding of the grant in spring/summer 2020.

The goal of this program is to provide funding needed to get involved with international outreach projects and encourage research in collaboration with host countries with the goal of enhancing the practice of obstetric anesthesia in those countries.

Information regarding the 2020 SOAP/Kybele International Outreach Grant application process can be found at: <https://soap.org/grants/soap-kybele-international-outreach-grant/>

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 8, 2020. 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, Secretary, ASA Delegate, ASA Alternate Delegate and Director at Large. Interested members should send a short statement and picture to info@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.

Resident Affairs Committee: A Reflection on Obstetric Anesthesiology Fellowship

Jack Peace, MD

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Nicole Higgins, MD, FASA

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It has been over 12 years since I completed my obstetric anesthesiology fellowship and it is remarkable how many things have changed and how many have remained the same. We now have ACGME accreditation, PIEB, maternal safety bundles, increased use of tranexamic acid, ACOG's levels of maternal care and SOAP centers of excellence, to name just a very few. It is truly an amazing time to be an obstetric anesthesiologist and I often think back to my experience when I made the decision to pursue OB anesthesiology. Many of my attendings tried to talk me out of the fellowship, primarily because they believed it was not necessary. Every day I am thankful that I did not listen to their "advice." I was curious to see if the opinions and environment have changed for residents over this past decade, so I asked current fellow, Jack Peace, to give his personal account of choosing an OB anesthesiology fellowship and how SOAP has influenced his decision.

– Nicole Higgins, MD

“You don't need a fellowship to do obstetric anesthesiology.” This was a common refrain I heard when I told my attendings that I was interested in doing an obstetric anesthesiology fellowship. In some ways they were correct: I completed residency at an institution where I had the chance to perform hundreds of epidurals and participate in the care of high-risk obstetric patients on a regular basis and I certainly would have been well prepared to participate in the routine care of healthy parturients. Fortunately, my mentors were quick to remind me that there is so much more to obstetric anesthesiology than epidural placement and as I transition to fellowship, I realize just how much I have left to learn.

My days as a fellow have been challenging, exciting, and rewarding and my learning curve has been steep. I have had to learn how to be a better educator, aiming to teach residents new skills and concepts. I have had to learn how to be a consultant, meeting with patients with complex health issues and learning how to solve difficult clinical problems. I have gained new skills in focused cardiac ultrasound to provide real-time care to our sickest patients. I am learning to be a clinical researcher and the protected time has given me

the opportunity to answer some of my own clinical questions. Most importantly, fellowship has given me an opportunity to reflect on how I want to shape my own career and how I hope to have an impact on the obstetric anesthesia community.

I first attended the Society for Obstetric Anesthesia and Perinatology Annual Meeting in 2018, when I was a CA-2, and saw first-hand the tightknit group that comprises our subspecialty society. I enjoyed seeing my mentors reconnect with other faculty with whom they had trained, completed projects, or were simply great friends. I saw how it brought together so many individuals who are passionate about advancing the safety and comfort of obstetric patients both in the U.S. and abroad. I began to fully appreciate this dynamic, influential and cutting-edge field of obstetric anesthesiology. Being a member of the SOAP community has fueled me with exciting new research ideas and provided opportunities for mentorship that span institutions.

As I reflect on my decision to pursue a fellowship in obstetric anesthesiology, I could not be more confident in my choice. I have joined a community that is focused on using innovative research and clinical techniques to provide the best possible care for our increasingly complex patients. I've had the chance to impart what I have learned to the next generation of anesthesiologists. In my own institution and through SOAP, I have found mentors who are willing to invest in my future with their time, knowledge, and dedication. Ultimately, I know fellowship has positioned me well to contribute to our dynamic and growing field and to drive the practice of obstetric anesthesiology forward. For those residents thinking about obstetric anesthesiology fellowship, I say follow your heart, take advantage of SOAP membership to connect with the leaders of this field and experience the energy and collaboration of this community. There is so much more to do.



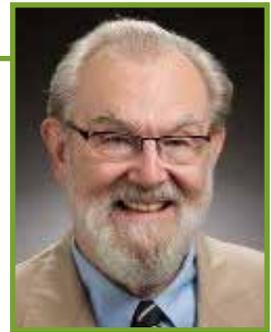
Past President's Committee – Legacy

Subcommittee: What's in a Name?: Buddy Giesecke's Recollection of How SOAP was Named

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Adolph H. (“Buddy”) Giesecke is arguably best known for his work in forwarding anesthetic care for the trauma patient, but his work in improving care of the parturient during his early years at Parkland Hospital in Dallas may be as important and is probably less well appreciated. In 1966, three years after finishing his anesthesia training, then Chair M.T. “Pepper” Jenkins “volunteered” Dr. Giesecke to try to increase the safety and comfort of anesthesia for the 12,000 parturients treated yearly. In a short three years, he succeeded in influencing OB anesthesia practice in Dallas, Texas, and in the U.S. What may be most important to our society is that he first suggested words at the First Annual Meeting from which the SOAP acronym was created. We reproduce Dr. Giesecke’s personal recollection of the event below from the September 19 – 21, 1969 gathering at the University of Kansas Postgraduate Center in Kansas City, KS.

“The venue was terrific. We were sequestered in a conference room on the top floor of a hotel in Kansas City with large picture windows on one wall overlooking the city, the river and the airport, but we were paying attention to business. The business of the day was the possible formation of a new society. The group was large; twelve to fifteen and I dare not try to name them. Dr. Bradley Smith has produced a list but I could not guarantee its accuracy. Dr. Robert Husted, the host, opened the meeting and posed the important question, “Should we form a society?” Those in favor stated that the traditional societies did not satisfy our need for a forum of discussion, research, and study to advance the science and practice of obstetrical anesthesia. Those opposed countered with opposition to endless proliferation of subspecialty societies, which would weaken the fabric of the ASA and its political influence. After considerable discussion we decided to form the new society.

I enjoy doodling during these kinds of meetings. I was drawing pictures of those in the room and playing alphabet games on my pad. Dr. Husted then asked, “Who should we invite to be members?” We decided we wanted to be an interdisciplinary society and include anyone who might be interested in the parturient and the fetus; obstetricians, anesthesiologists, and

pediatricians. I wrote those down on my pad. Then Dr. Husted asked the really tough question, “What will we call the society?” Immediately the motion was made to call it the Virginia Apgar Society. Those in favor argued that Dr. Apgar’s name was synonymous with progress in neonatology and maternal safety and that we should honor her in this significant way. Those opposed held that Dr. Apgar had indeed devised the neonatal evaluation system, but that she had abandoned the practice of OB anesthesia in favor of a cushy desk job with the March of Dimes. The discussion went on for an hour and promised to go on much longer. I looked at my pad, and “Society of Obstetricians, Anesthesiologists and Pediatricians” or SOAP jumped into my mind. I made the substitute motion, saying that this would be the cleanest society in the world. The group massaged the name to “Society of Obstetrical Anesthesia and Perinatology” and this name passed without dissent.”

Dr. Richard Clark and Dr. Bradley Smith attended this meeting and largely agree with the recollection above. Although Dr. Giesecke wrote that there were “ten to fifteen in attendance”, there were 64 attendees at that First Annual Meeting and they form SOAP’s Charter Members; however, ten to fifteen may have been at the meeting where the naming of SOAP was discussed. The real importance for SOAP is not its name but in its advancement of care for parturients and their neonates. The final sentence of Dr. Giesecke’s recollection summarizes it well.

“What’s in a name? A wonderful, productive, enduring society which has done phenomenal good for parturients, neonates and those physicians interested in their welfare.”



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