GARY PELTZ, MD, PHD, BRINGS COMPUTATIONAL GENETIC EXPERTISE
BY PATRICIA ROHRS

Now that the human genome has been sequenced, what’s next? Enter Gary Peltz, MD, PhD, an expert in the field of computational genetics and pharmacogenomics, who joined the Department as Professor of Anesthesia in July 2008. He had a successful career as a researcher and research manager within the pharmaceutical industry, first at Syntex and then at Roche, where his most recent position was Head of Genetics and Genomics. In those settings, he worked in such areas as pain, infectious diseases, and drug metabolism, collaborating with 25 academic institutions, including Stanford. For example, he collaborated with Dr. David Clark and Dr. Martin Angst on pain and narcotic drug addiction research. At Stanford, he has continued to work with these investigators and with Dr. Sean Mackey on a grant proposal to the National Institutes on Drug Abuse (NIDA) to develop new treatments for narcotic drug addiction. In collaboration with Dr. Toshi Nishimura, Stanford Anesthesia and investigators at CIEA in Kawasaki, Japan, Dr. Peltz developed a method for producing mice with entirely human livers. This mouse model will be used to further study stem-cell development and to perform pharmacogenetic analysis.

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Dr. Peltz’s interest in medicine commenced as a teenager, when he helplessly witnessed his mother’s decline with cancer. Although he had intended to pursue a career in academic medicine after completing his MD and PhD training at Stanford, the constrained funding environment and greater opportunities at that time led him to industry instead. Since joining the faculty, he has enjoyed being highly self-directed, without worrying about slow-moving regulatory bodies or corporate bureaucracies. When asked what had surprised him most about Stanford so far, he responded, “I was happily surprised by the rich intellectual life of the entire biomedicine...
community at Stanford, but I did not expect to devote so much time to raising funds and paying attention to the business end of science.”

The Lab—Peltz’s chief challenges so far have involved obtaining the funding for and setting up of The Peltz lab, which contains an amazing array of tools, technologies, computing power, and biobubble-housed mice. At 800 Welch Road at Stanford, the tissue culture room is fully equipped for mammalian and insect cell-tissue culture. Stem cells can make model mice with human livers, helping predict human metabolism. The genomics room contains analytic equipment, including a mass spectrometer that will analyze drugs, metabolites, gene-expression arrays, and genotypes. The molecular biology/biochemical room is fully equipped to enable molecular biology and biochemical experiments. At In Vivo Science International Lab in Mountain View, transgenic derivatives of the highly immuno-compromised NOG mice are housed inside biobubbles within a clean room to avoid being exposed to infectious agents. Any drug dosing, biopsies, and blood draws are performed in a sterile environment. The laboratory of Dr. Lola Reid, University of North Carolina, School of Medicine, will prepare the liver and pancreatic stem cell lineages that are the source for the hepatic stem cells that will generate a human liver within the mice.

Peltz plans to build a talented, multidisciplinary, collaborative-minded team of 10 experts (biology, statistics, genetics, mass spectrometry, etc.) Some experts are already in place. Dr. Ming Zheng directs statistical analysis for anesthesia research at Stanford. Previously, at Roche, he analyzed gene expression and genetic association data, developed the haplotype maps for 18 inbred mouse strains, and became familiar with all aspects of computational genetic mapping. Dr. Manhong Wu, whose expertise is in mass spectrometry, will generate all experimental data required for analysis of drug metabolism and for changes in endogenous metabolites (metabolomic analysis). Dr. Yajing Hu, the lab’s first Stanford post-doctoral fellow, will be developing and analyzing ‘mice with human livers.’

To accomplish his experimental work, Peltz also plans to utilize other core facilities at Stanford, such as The Stanford University School of Medicine Transgenic Research Center and The Stanford Histology Core Lab.

The Research— In an interview, Peltz responded to several questions about his research areas.

What is the next big endeavor for genetic and genomic research? Now that the human genome has been sequenced, we are developing tools to analyze DNA sequence data to enable us to understand how genetic variation affects disease susceptibility and drug response. Although most of the DNA sequence in the human population is identical, differences in DNA sequence—genetic variation—do exist. This variation plays a key role in determining a person’s risk of particular diseases or response to a particular medication. We can apply this knowledge to discovering and developing new diagnostics and medicines.

Why study mice? We use a mouse model because mice and humans share much of their genomes and many biochemical pathways. We can raise and study mice in controlled environments and inbreed them to be genetically identical. Understanding genetic variation in the mouse will take us a long way toward understanding how genetic variation in humans relates to diseases and responses to drugs.

Why and how did you develop a computational approach to study genetic variation? Conventional methods for genetic analysis in mice required many years to complete. Our computational methods dramatically accelerate the rate of genetic discovery that can be mined from the vast amount of DNA sequence data. With combined expertise in computer programming, mathematics, statistics, informatics, gene sequencing, gene expression analysis and functional biology, we can harness the power of computers to develop new, faster ways to analyze the mouse genome. We measure a property related to a human disease across inbred mouse strains. Some strains display evidence of disease properties like those in humans with advanced disease; other strains
display little or no evidence of these properties. We enter the measured data into our computer program, which correlates them with a pattern of genetic variation among the strains.

What advantages does this approach offer researchers? It offers an unprecedented combination of speed and precision for mouse genetic analysis. With conventional methods it takes five scientists working over a period of five years (25 scientist-years) to find a causative gene. With our method one scientist can complete the genetic analysis in a single afternoon, with results that are 1000-fold more precise than in the original method that was developed in 2001.

FROM THE CHAIRMAN
by Ron Pearl, MD, PhD, Professor & Chairman
Department of Anesthesia
rpg@stanford.edu

Fifteen years ago when market forces produced dramatic decreases in anesthesia salaries, “May you live in interesting times” was frequently noted as an ancient Chinese curse. Our specialty has subsequently done well, but we are again entering interesting times. The country (and the world) are in the middle of a recession the depths of which many of us have never seen. Financial struggles plague not only banks and companies, but also states such as California and universities such as Stanford. The cost of the American health care system continues to increase as does the number of Americans without health insurance. Balancing these daunting challenges, we have a new president with a mandate for change. In the first few days of his presidency, we have already seen major new economic initiatives and discussions regarding future directions in health care.

The specialty of anesthesia has its own set of challenges. Our national organizations and societies have seen the value of their endowments plummet, forcing cuts in budgets, including funding for anesthesia research. Reform of the American health care system is needed, but the potential implications for anesthesia reimbursement are concerning. The future of the specialty of anesthesia is threatened by surgical advances which may obviate the need for anesthesia and by a rapid increase in the number of mid-level providers who claim that their training is similar to that of anesthesiologists and requires no physician supervision.

In these challenging times, it is critical to recognize all that is positive about our specialty. Our resident and fellow trainees represent the future of anesthesiology. The number and the quality of residency and fellowship applicants this year is unprecedented. At Stanford, we received over 700 residency applications. There were over 80 applicants who had been elected to AOA and 100 applicants with USMLE scores above 240. Almost two dozen applicants had combined MD-PhD degrees, and a similar number had MPH or MBA degrees. Our department is one of the few programs that offers all 4 ACGME-approved fellowships (pediatrics, critical care, cardiothoracic, and pain management), and the number and quality of applicants in each fellowship is at a historic high.

The future of the specialty of anesthesia will depend upon anesthesiologists being involved in organized medicine and in the political process. As a result of advocacy at the local and national levels, this past year resulted in a marked increase in Medicare reimbursement rates for anesthesiologists and in passage of the Teaching Rule reform bill (H.R. 6331), which will restore full Medicare payment to anesthesiology teaching programs in which two residents are supervised. These changes are critical to the survival of academic anesthesia. Across the country, there is
optimism that physician involvement in the political process can help preserve our specialty. Our faculty have a long history of involvement in leadership. Our residents are getting involved, too. Sam Seiden, a CA-2 resident, was elected this year to the ASA Resident Component Governing Council, and he serves on the anesthesiology RRC (Residency Review Committee) of the ACGME (see article on page 6).

Clinical anesthesiology at Stanford continues to thrive. The increases in clinical activity that have occurred every year over the past decade have continued. Packard Children’s Hospital’s new operating rooms, which opened in December, are already at full capacity. Next month the opening of the Stanford Medicine Outpatient Center (SMOC) in Redwood City will triple the size of our pain management clinic and provide dedicated operating rooms for the growth of orthopedic surgery. Like our current ASC (which opened only two years ago), the new facilities are spectacular. Both the adult and the children’s hospitals continue to do well financially, and the current economic challenges may temporarily delay but should not stop the plans for a new pediatric tower and a new adult hospital, both with state-of-the-art operating rooms.

If anesthesia is going to continue to advance as a medical specialty, it is essential that we continue to generate new knowledge. Over the past six years we have tripled our research funding and promoted the careers of our faculty. Recognizing that the best research frequently involves a multidisciplinary approach, we have developed extensive interactions with faculty from many of the existing medical school institutes (Immunity, Transplantation and Infection; Neuroscience; Cardiovascular), medical school departments (pediatrics, medicine, psychiatry, neurology, neurosurgery, cardiac surgery, obstetrics and gynecology, pathology, genetics, bioengineering, health research and policy), university departments (psychology, engineering), and multiple other institutions.

During the past two months, I met with over 100 resident applicants. Their enthusiasm for an anesthesia career and their optimism regarding our specialty was reassuring and contagious. They are committed to creating a future where anesthesia may evolve but where anesthesiologists will remain leaders in medicine. Winston Churchill stated, “The pessimist sees difficulty in every opportunity. The optimist sees the opportunity in every difficulty.” These may be challenging times in the world around us, but there is every reason to be optimistic about the future of the specialty of anesthesiology.

FROM THE DEPUTY CHIEF
BY RICK NOVAK, MD
ASSOCIATED ANESTHESIOLOGISTS MEDICAL GROUP
rjnov@yahoo.com

Clinical Case for Discussion: An anesthesia colleague of yours dilutes a 50-microgram ampoule of sufentanil with 9 cc of normal saline, so the final syringe concentration is 5 micrograms per cc. He then injects 10 micrograms of sufentanil from this syringe into the clean IV line of three different patients during his OR day.

Is this practice OK? What do you do?

Discussion: Your colleague claims this practice is without risk because he injects into an IV port that is six feet proximal to the IV catheter. He’s done this for twenty years, since his residency training. He’s “never had a complication” and sees no reason to change.

He needs to change, and here’s the most recent evidence why: In January 2008, investigators from...
the Center for Disease Control (CDC) responded to a request from the Southern Nevada Health District to help investigate three persons with acute hepatitis C virus (HCV) infection (MMWR Morb Mortal Wkly Rep. 2008 May 16;57(19):513-7). All three persons had undergone procedures at a Las Vegas endoscopy clinic. CDC went on to identify a total of six cases of HCV infection among patients who had undergone procedures at the clinic in the 35–90 days prior to onset of symptoms. These patients had no other risks for HCV infection.

On investigation of the clinic, CDC observed practices that had the potential to transmit HCV. The May 2008 issue of Anesthesiology News reported that “certified registered nurse anesthetists (CRNAs) at the center had been improperly administering anesthesia to patients undergoing routine endoscopic procedures.” The California Department of Public Health mailed a letter to all California physicians, dated March 27, 2008. Per this letter, the infected Nevada patients were most likely exposed in the following manner: “(1) A clean syringe and needle were used to draw a sedative medication from a new single-use vial. (2) The sedative was administered to a hepatitis C infected patient, and backflow of blood from the patient into the syringe presumably contaminated the syringe with hepatitis C virus. (3) The needle was replaced on the syringe with a new, sterile needle, but the syringe was reused to draw additional sedative from the same vial for the same patient, presumably contaminating the vial with blood containing hepatitis C virus. (4) A clean needle and syringe were used for subsequent patients, but the contaminated vial was reused, exposing subsequent patients to hepatitis C virus.”

Because these practices had prevailed at this clinic for years, nearly 40,000 Nevada patients had to be notified by letter that they should visit their primary care provider to be tested for hepatitis C, hepatitis B, and HIV.

The same March 27, 2008 letter from the California Department of Health included a list of Safe Injection Practices, drawn from the CDC website (Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings 2007, Standard Precautions [www.cdc.gov/ncidod/dhqp/gl_isolation.html]). These Safe Injection recommendations include the following: “(1) Use aseptic technique to avoid contamination of sterile injection equipment. (2) Do not administer medications from a syringe to multiple patients, even if the needle or cannula on the syringe is changed. (3) Use fluid infusion and administration sets for one patient only and dispose appropriately after use. (4) Use single-dose vials for parenteral medications whenever possible. (5) Do not administer medications from single-dose vials or ampoules to multiple patients or combine leftover contents for later use. (6) If multi-dose vials must be used, both the needle or cannula and syringe used to access the multi-dose vial must be sterile.”

Viral infections have been reported secondary to unsafe anesthesia practitioners. A cluster of four patients with hepatitis C virus (HCV) infection was identified in a single surgery clinic (Germain JM et al, Patient-to-patient transmission of hepatitis C virus through the use of multi-dose vials during general anesthesia. Infect Control Hosp Epidemiol. 2005 Sep;26(9):789-92). Molecular characterization revealed close homology between viruses, and this cluster was deemed to be due to intra-operative unsafe injection practices by anesthesia personnel using multi-dose vials.

From this point forward, your friend’s method of administering sufentanil must be stopped. You show him the above references, and urge him to change his practice for the safety of his patients. Other verboten procedures include the following: (1) Using an infusion pump to administer portions of a 60 cc syringe of propofol or remifentanyl to more than one patient, even though you change the tubing; (2) Drawing 250 micrograms of fentanyl into one syringe, and then giving 100 micrograms to one patient, and 150 micrograms to the next patient from the same syringe; (3) Using a single 20 cc vial of labetalol to give repeated and multiple doses to more than one patient, if either the needle or the syringe used to draw any dose from that vial was reused.
We’ve urged our freestanding surgery centers to cease stocking large ampoules of drugs such as 5 cc Decadron, 5 or 10 mg midazolam, 5 cc Robinul, or 20 cc labetalol. Reuse of larger ampoules gives practitioners the opportunity to spread viral infection to more than one patient if aseptic technique is ignored. The larger vials may save the institutions money, but the saving of pennies is trivial compared to isolating each patient from the patient(s) that preceded them.

May all your present and future intravenous injection techniques comply with CDC guidelines.

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**Representing Residents on The Anesthesiology RRC**

**By Sam Seiden, MD**

Since July 2008 I have had the pleasure of serving as the national resident representative to the Residency Review Committee (RRC) for Anesthesiology for the Accreditation Council on Graduate Medical Education (ACGME). I began my term just as new requirements for anesthesia residency programs took effect July 1, 2008 (These requirements apply to residents who began their CBY or clinical anesthesia training after July 1; residents who began training prior to July 1 must fulfill program requirements in place when they started their training).

What changed were requirements for the clinical base year (CBY), rotations, and the minimum number of cases.

- The CBY often lacked a connection to residents’ training needs during their clinical anesthesia years. In addition, anesthesia residency programs received little information about a resident’s performance during the CBY. Now residency programs are encouraged to offer a four-year integrated curriculum encompassing both the CBY and clinical anesthesia years. All non-integrated CBYs must provide quarterly progress evaluations to anesthesia residency programs.

- Rotation requirements changed as follows: two-months each in anesthesia subspecialties of neuro, cardiothoracic, obstetric, and pediatric anesthesia; one month of pre-operative evaluation clinic; three months of pain medicine (divided into one month of acute pain, one month of chronic pain, and a suggested one month in regional anesthesia).

- Minor revisions were made in the required number of cases.

In conjunction with the recently mandated changes, the RRC is discussing many other topics:

- Continued oversight of the new multidisciplinary pain medicine fellowship from the disciplines of anesthesiology, neurology, physical medicine and rehabilitation, and psychiatry.

- The role of simulation in anesthesia education. Simulation experience will now be required to maintain board certification in anesthesia. Most residency programs are not as fortunate as we are to have a world-class simulator experience. The RRC is discussing how simulator experience might be incorporated for all residents.

- Potential for creating an accredited fellowship in obstetric anesthesia (currently a non-accredited fellowship).

- Oversight of residents displaced due to disasters, such as Hurricane Katrina and Ike. During such disasters, a training institution may temporarily or permanently close, necessitating relocating residents, minimally
disrupting their training and eligibility for board certification.

- Development of a mandatory ACGME web-based, case-log system that takes effect in July, 2009.
- Lastly, the ACGME and the anesthesiology RRC are having ongoing discussions of the Institute of Medicine’s (IOM) recent report on resident work hours. Stay tuned!

I also represent anesthesia residents on the Council of Review Committee Residents (CRCR), comprised of the resident members from each of the 27 specialty review committees. The CRCR is considering the following: (1) recommending national ACGME policy to accommodate residents’ and fellows’ medical and dental appointments; (2) creating a resident bill of rights (a draft is circulating among the AMA Resident and Fellow section), and (3) asking the Federation of State Medical Boards Credentialing Verification Service (FCVS) to clarify its language regarding disclosure of “negative reports” and “disciplinary action” when one submits credentialing applications via their service.

Please feel free to talk to me about any questions you have about the above or the anesthesiology RRC.

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**HOW DO YOU BECOME AN EXPERT ANESTHESIOLOGIST?**

**BY T. KYLE HARRISON, MD, DIRECTOR FOR 2010 RESIDENCY CLASS**

As we reach the middle of the academic year and senior residents prepare to graduate, let’s reflect on just how one becomes an expert anesthesiologist. Those who study how expertise is acquired note a consistent pattern: deliberate practice; detailed, immediate feedback; and repetition. According to Ericsson\(^1\), one must spend over 10,000 hours of deliberate practice to achieve expert status—whether in music, athletics or complex cognitive endeavors, such as the practice of anesthesia. Deliberate practice occurs when trainees are instructed to improve some aspect of performance for a well-defined task. If we assume our average anesthesia resident trainee works 60 hours/week for 50 weeks/year for three years—an accumulated 9,000 hours of anesthesia training—the trainee will still lack 1,000 hours of deliberate practice. Any practicing anesthesiologist will attest that the learning curve for the first few years of practice is as steep as that during residency training, a likely reason that more than 50% of our residents pursue fellowship training.

Second, trainees need to receive detailed, immediate feedback about their performance. Deliberate practice alone is insufficient, even for highly motivated students. Trainees also need expert supervision and feedback to reach mastery. Opportunities for such supervision and feedback are widely available. They occur daily in our ORs, ICUs, and pain clinics. They also occur in interactive regional anesthesia and difficult airway workshops and in simulation experiences (ACRM and OB Sim). In addition, Dr. Aileen Adriano’s daily debriefing form gives constructive feedback to CA1 residents and faculty working in the GenOR.

The last component in developing expertise is repetition. The trainee must perform the same or similar task repeatedly. Part of what makes our department’s training program world-class is the volume and complexity of cases residents will perform.

Even after obtaining expertise, one must continuously work to maintain it. Ericsson argues that the goal for trainees performing every day professional activities is to rapidly reach a stable, satisfactory level of virtually automatic performance. However, experts go beyond automaticity; expert clinicians, for example, improve their performance over decades, developing increasingly more complex mental representations that result in higher performance. They seek opportunities to learn and improve (new drugs, techniques, and environments), setting goals that exceed their current performance levels.

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\(^1\) Ericsson KA. Deliberate practice and the acquisition and maintenance of expert performance in medicine and related domains. *Academic Medicine, 79*:10, October Supplement 2004.
The significance of life-long learning is reflected in the ACGME’s having identified competency in Practice-Based Learning and Improvement as a core competency. See http://www.acgme.org/outcome/comp/GeneralCompetenciesStandards21307.pdf

Since my formal training ended five years ago, several new techniques and technologies have been introduced—ultrasound-guided regional anesthesia, the glidescope for difficult airway management, the 3-D TEE, and the use of dexmedetomidine in operative anesthetic management. Keeping up-to-date to attain and maintain mastery requires continuous on-the-job training. I am proud that our department not only prepares world-class anesthesia providers, but also promotes life-long learning, so that our graduates will always be experts in the field.

CONGRATULATIONS TO OUR STELLAR RESIDENTS-OF-THE-MONTH

- Dr. Kate Polhemus, July 2008
- Dr. Jerry Ingrande, August 2008
- Dr. Rich Cano, September 2008
- Dr. Eddie Kim, October 2008
- Dr. Alyssa Hamman, November 2008
- Dr. Marshall Jones, December 2008

22ND ANNUAL ANESTHESIA UPDATE
BIG SKY MONTANA, FEBRUARY 15-20 2009

Attention all faculty, residents, fellows, and nurse anesthetists! Learn and earn for six fabulous days—February 15–20 2009—while enjoying your family and skiing in the breathtaking, powder-filled Big Sky resort near the Yellowstone and Grand Teton national parks.

“Perfect ratio of clinical/academic presentations….Big Sky is phenomenal for skiing and other activities. I have attended several other Anesthesia conferences, but I will now plan my schedule around this conference.”

Sponsored by the Stanford School of Medicine and Stanford Hospital & Clinics, this noted symposium will be co-chaired by Stanford faculty members Sean Mackey, MD, PhD, Associate Professor, Department of Anesthesia, Director, Pain Management and Andrew J. Patterson, MD, PhD, Associate Professor, Department of Anesthesia, Division of Critical Care Medicine.

The symposium’s focus is to update the national community of general and subspecialty anesthesiologists and nurse anesthetists on the latest advances and published guidelines in the field.

You won’t want to miss presentations from our outstanding co-chairs and our distinguished, internationally renowned faculty: Joseph Annis, MD, Dartmouth College School of Medicine; Talmage Egan, MD, University of Utah; Carin A.. Hagberg, MD, University of Texas at Houston; Steve Hollenberg, MD, University of Medicine and Dentistry New Jersey; Ronald G. Pearl, MD, PhD, Stanford University; Robert A. Peterfreund, MD, PhD, Harvard University; and Myer H. Rosenthal, MD, Stanford University.

These experts will cover essential topic updates for both the practicing anesthesia generalist and the subspecialty practitioner, for example ACLS, Acute and chronic pain, Opioids, Fluid resuscitation, Transfusion medicine, Thyroid disease, Intraoperative awareness, Arrhythmia management, Drug interactions, Cardiovascular medicine, Propofol formulations, Quality assurance, Intravenous drug infusions, Practice management, Difficult airway management, Diabetic management, International medical missions, and Obstructive sleep apnea.

Recertification and maintenance of certification will be covered, and accreditation for four units of Risk Management (of particular importance to Massachusetts physicians) is pending.

During evening clinical forums, faculty will lead discussions and debates about complex anesthesia cases, which attendees are encouraged to submit in advance.

For details about registration, events, and recreation, click this link: http://anesupdate.stanford.edu/
47TH WARC—REGISTER NOW; SUBMIT ABSTRACTS

Residents, fellows, and medical students! Register now for the May 1-3 Western Anesthesia Resident Conference (WARC) at Rancho Las Palmas Resort and Spa, Rancho Mirage (near Palm Springs), CA. WARC, designed for you by anesthesiology residents, is packed with academic and social events.

Your abstracts, which form the basis of the program, are due March 15, 2009. You can submit case reports, clinical investigations, and laboratory research. Please see http://www.warc2009.com/ for more details.

Please tell Dr. Brock-Utne if you would like to share your abstract at the April 30 FNR meeting at 5:00 pm and receive helpful feedback.

FROM OUR LIBRARIAN

- Primer of Biostatistics, 6th ed. (RA 409 G55 2005)
- The Washington Manual of Medical Therapeutics, 32nd Ed. (RC 71 W37 2007)
- Handbook of Critical Care, 2nd Ed. (RC 86.8 H33 1997)
- Cardiac Arrest: the Science and Practice of Resuscitation Medicine, 2nd Ed. (RC 682 C36 2007)
- Anaesthesia and the Practice of Medicine: Historical Perspectives (RD 79 S95 2007)
- Principles of Physiology for the Anaesthetist, 2nd Ed. (RD 82 P66 2008)
- A Practical Approach to Regional Anesthesia, 4th ed. (RD 84 M85 2008)
- A Practical Approach to Pediatric Anesthesia (RD 139 H65 2008)

- A Practical Approach to Obstetric Anesthesia (RG 732 P72 2009)
- Pharmacokinetics: Regulatory, Industrial, Academic (RM 301.5 P48 1995)

WHAT LOVELY PARTIES!

6TH ANNUAL GOLF TOURNAMENT
BY JOHN BROCK-UTNE, MD, PHD

The 6th Annual Department Golf Tournament was held on Sunday 15 June at the Stanford University Golf Club. We had 36 registered players—by far the largest group we have ever had (usually the number is 20-24). It would seem this tournament is maybe getting recognition. Many players flew in from other parts of the country. One came all the way from Hawaii. So the word may be getting out….

This golf tournament is a no-pressure type of golf. It is a scramble, meaning that all 4 players in the group tee off, and the best ball is selected. All 4 players then hit (no blowing, use of hands or kicking is allowed) from that position. The best ball is then selected, and all 4 players then hit or putt from that position, until the ball is holed out. Every team must use at least 2 drives from each of the four players.

We had a terrific day. The sun shone, there was hardly any wind, and the temperature was 82 F. The out-of-state visitors quickly discovered they did not need all their foul-weather gear.

Participants ranged in age from 15 (Kevin Macario) to 72 (fellow unnamed). Scott Rudy, a 4-time winner in past tournaments, decided to stay away this year, to “give someone else a chance. Nice touch, Scott, but we really missed you. We were pleased to welcome again Mike Bigelow (private practice SF), who has been to all 6 golf outings. Poor Pieter van der Starre (Cardiac Faculty) had done his knee in. He had been practicing too hard…..
The winners were CA1 Shea Aiken (Shea’s father, flew in as a “Ringer” from Seattle); CA1 Milo Lochbaum; and Stanford Gen OR surgical technician, Scott Barkman. They were 9 under—a score of 62. Second place was shared by 3 teams with scores of 4 under (67): Stephen King (SCV), his wife Diane, Rich Cano (CA2) and his friend Dave Pfanenstiel; Fred Mihm (ICU, Gen OR), Michael Chen, (Peds Faculty), Don Armstrong (Bio-engineering) and Ivar Brock-Utne; and Dan Hamman (Orthopedic Resident), Mike Wagner (CA3), John Brock-Utne and Mark Pratt (a friend and clinical psychologist whose skill as a sport psychologist was put to good use).

In point behind this group was Dad Larkin (F), Kathy Larkin (Peds Faculty), Sue Brock-Utne (F), and Peter Gardiner (F).

Diane King won the longest drive for the ladies, and for the second year in a row, Dave Pfanenstiel hit the longest drive for the men—260 yards!. Katie Larkin (Peds Faculty) won closest to the pin for women, and Bill Feaster (Peds Faculty) for men.

After the round we enjoyed drinks and lot of different snacks on the patio near the 18th green. The prizes were handed out under great applause. We had a great time. If you are interested in playing next year, please let me know.
(brockutn@Stanford.edu)

For your interest, Dr. Pearl has kindly agreed to have a plaque erected in the department’s conference room indicating the yearly winners of this esteemed trophy.

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**Renee Grys Retires**

On a lovely summer August day, faculty, staff, and family of Renee Grys gathered on a Faculty Club terrace to wish her well after 30 years of service to the Department. During those years, Renee participated in significant growth in the department. One hat she wore with joy was events coordinator. Every year she organized five events from the residents’ graduation to the holiday party. Renee especially enjoyed putting on the alumni event at the annual ASA meeting, where she visited with emeritus faculty.

The party lived up to her high standards—the weather was stunning, the food and drink delicious, and the conversation sparkling and warm.

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**New Residents Welcomed to the Gates of Hell**

On a perfect, summer evening under sunlight-filtering oaks in Stanford’s magnificent Rodin sculpture garden Stanford faculty and staff welcomed new residents at a delightful party catered by CoolEatz. Attendees mingled for cocktails and hors d’oeuvres, while the children were entertained by the patient, friendly Callie, a 5-month-old golden retriever. Credit for the lovely event goes to Janine Roberts, the chief residents, Alan Winkleman, Jill Wilson and Erin Reiland.
ANNUAL HOLIDAY PARTY GOES MAD FOR KARAOKE

What began as a conventional, gala, holiday party replete with seafood bar, cocktails, buffet dinner, and dressed-up Department members and their guests was transformed after dinner into a “mad for karaoke” blast. Intertwined in a “loving” embrace, Ron Pearl and Rich Cano (CA3) brought down the house with their rendition of Sonny and Cher’s famous song, “I Got You Babe.”

Drs. Pearl and Cano “in love”

Jennifer Hah (CA3) belted out “Girls Just Wanna Have Fun” while John Brock-Utne, high-prancing dancer and singer, punctuated the act (think Mick Jagger).

Drs. Hah and Brock-Utne having fun

Many other groups (each division each class, and staff) performed “rehearsed” karaoke acts. The dancing lasted until 11 pm. Anesthesiologists and Staff just wanna have fun!
**Published Articles**

- Carvalho, B. Respiratory depression after neuraxial opioids in the obstetric setting: Review. *Anesth Analg* 2008 Sep;107(3):956-61,
- Coleman L, Carvalho B, Lipman S, Schmiesing C, Riley E. Accidental intrathecal sufentanil overdose during combined spinal-epidural labor analgesia. Accepted to Int J Obstet Anesth
ABSTRACTS AND POSTERS


- Carroll I, McCue R, Clark D, Mackey S. Lumbar sympathetic block with botulinum toxin type A for complex regional pain syndrome. International Association for the Study of Pain (IASP) 12th World Congress on Pain, Glasgow, Scotland, August 16-22, 2008.


GRANTS
• Martin Angst, MD, and David Clark, MD, are co-principal investigators for NIH, R01-DA023063-01A1 Opioid efficacy in humans: A twin study.

• Ian Carroll, MD, MS, has been awarded an NIH NIDA K23 award to study Prescription Opioid Use, Misuse, and Pain in Post-Surgical Patients.

• Dr. Sean Mackey, MD, PhD, and his collaborators (Drs. Allan Reiss, Gary Glover, Brian Knutson, Ian Gotlib, Fumiko Hoeft, Meredith Barad, and Paul Hamilton) were awarded a Bio-X Interdisciplinary Initiatives Program grant for Development and Applications of Real time fMRI Technology.

• Martin Angst, MD, was awarded DARPA, W911NF-07-1-0462 (Phase II): Feedback Regulated Drug Delivery System Based on Polymer Hydrogels and Vesicles.

• Tim Angelotti, MD, PhD, received an award supplement (to his K08 entitled Sympathetic Neuron alpha2 Adrenoceptor Structure/Function) from the National Institute for Neurological Disorders and Stroke (NINDS) for Administrative Supplements for High-Quality Low-Cost Monoclonal Antibodies for Studies of the Nervous System.

INVITED TALKS AND GUEST PROFESSORSHIPS
• Gareth Ackland, MD. PhD, spoke about Murine Strain-specific Differences in Cardiac Physiology during Endotoxemia at the European Society of Intensive Care Medicine, in Lisbon Portugal, September 22, 2008.

• Scott M. Ahlbrand, MD, spoke about Nanoparticle Microarrays: The Future of Bedside Pathogen Detection? at the American Society of Critical Care Anesthesiologists 21st Annual Meeting in Orlando FL, October 17, 2008.

• Martin Angst, MD, spoke about Update on Opioid Safety and Tolerability: Current Concepts to Minimize Side Effects and Risk at the Plenary Session Annual Meeting of the American Society of Anesthesiology in Orlando, FL, October 2008.

• Martin Angst, MD, spoke about From Mice to Men: Translational Experimental Protocol to Study Nociception and Inflammation in Tissue Injury at the Retreat of the Stanford Institute of Immunity, Transplantation and Infection in Asilomar, CA, November 2008.

• Brendan Carvalho, MBBCh, FRCA, MDCH, spoke on two subjects at the First National Conference on Obstetric Anesthesia (Association of Obstetric Anesthesiologists) in Chennai, India in September 2008: (1) Cardiac disease in the pregnant patient and (2) High-dose vs low-dose bupivacaine for LSCS.

• Brendan Carvalho, MBBCh, FRCA, MDCH, spoke on three subjects at the Obstetric Anaesthetists Association (OAA) 3-Day Course in London in November 2008: (1) Patient-controlled epidural analgesia for labor analgesia: why isn’t everyone using it? (2) Fluid preloading prior to neuraxial anesthesia: a waste of time? and (3) Optimizing pos-cesarean delivery analgesia.

• Al Hackel, MD, FAAP, Professor of Anesthesia and Pediatrics, Emeritus (Active) spoke about Disaster Preparedness: The California Focus on Neonatal Care and Preparation and The Role of the Anesthesiologist” to the Society for
Pediatric Anesthesia at its Spring Meeting in San Diego, CA, April 5, 2008.

- Greg Hammer, MD, was visiting professor at the following institutions during November 2008 and January 2009: (1) Chinese University, Prince of Wales Medical Center, Hong Kong, China on November 20; (2) University of Hong Kong, Queen Mary Hospital, Hong Kong, China on November 21; (3) Department of Anesthesia, Zhejiang University, in Hangzhou, China on January 12; (4) Department of Anesthesia, Peking University Medical College, Beijing, China on January 13; and (5) Department of Anesthesia, Shandong University, Jinan, China on January 14.

- Greg Hammer, MD, spoke about three topics at the Hong Kong Commissioned Training for COC (Anaesthesiology) on November 20, 2008 in Hong Kong, China: (1) Awareness in Pediatric Anaesthesia, (2) Emergence Delirium, and (3) TIVA in Infants and Children.

- Greg Hammer, MD, spoke about two topics at the Hong Kong Annual Scientific Meeting in Anaesthesiology on November 22-23, 2008 in Hong Kong, China: (1) Dexmedetomidine in Children: Do We Have Enough Evidence? and (2) Single Lung Ventilation in Infants and Children.

- Greg Hammer, MD, spoke about The use of sevoflurane in pediatrics at the Anesthesia International Summit in Shanghai, China on January 10, 2009.

- Kyle Harrison, MD, spoke about two topics at the International Patient Safety and Prevention of Medical Errors Meeting, sponsored by the National University of Colombia in Bogota, Colombia on November 7 and 8, 2008: (1) High-Reliability Organization and Healthcare and (2) Using Simulation to Improve Patient Safety.

- Steven Lipman, MD, Department of Anesthesia and Kay Daniels MD, Department of Obstetrics and Gynecology, spoke at the CRICO-Stanford Symposium November 17 and 18, 2008 in Palo Alto, CA about Risk Management 101: Creating Culture Change on the Labor & Delivery Ward.

- Steven Lipman, MD, Department of Anesthesia and Kay Daniels MD, Department of Obstetrics and Gynecology, spoke about From idea…To new care, To education, To operations: simulation in labor & delivery at the LPCH Leadership Forum at the Arrillaga Alumni Center, Stanford University in October 2008.

- Sean Mackey, MD, PhD, spoke about Biofeedback: Past, Present and Future at the American Pain Society Annual Meeting, in Tampa, FL, in May 2008.

- Sean Mackey, MD, PhD, spoke about What Neuroimaging Reveals About Pain at the International Association for the Study of Pain 12th World Congress on Pain, Pain Info Exchange Symposium in Glasgow, Scotland in August 2008.

- Sean Mackey, MD, PhD, spoke about Illuminating our Understanding of Pain at the 12th Congress of the European Federation of Neurological Sciences, Pain Info Exchange Symposium in Madrid, Spain in August 2008.

- Sean Mackey, MD, PhD, spoke about The Strain in Pain Lies Mainly in the Brain at the University of California San Diego in San Diego, CA in September 2008.

- Sean Mackey, MD, PhD, spoke about Cortical Changes in Neuropathic Pain at the University of California San Diego in San Diego, CA in September 2008.

- Sean Mackey, MD, PhD, spoke at Grand Rounds at the Massachusetts General Hospital in Boston, MA in September 2008.

- Sean Mackey, MD, PhD, spoke about Fibromyalgia: From Mechanisms to Treatment at the California Society of Physical Medicine & Rehabilitation in San Jose, CA in October 2008.

- Sean Mackey, MD, PhD, spoke about Evaluating Outcomes in Pain Medicine, at the
American Society of Anesthesiologists Annual Meeting in Orlando, FL in October 2008.

- Sean Mackey, MD, PhD, was forum moderator for *How Do I Treat Neuropathic Pain and Complex Regional Pain Syndrome?* at the American Society of Anesthesiologists Annual Meeting in Orlando, FL in October 2008.

- Sean Mackey, MD, PhD, spoke about *Imaging Pain Medicine: Is FAER Focused?* at the American Society of Anesthesiologists Annual Meeting in Orlando, FL in October 2008.

- Sean Mackey, MD, PhD, spoke about *The Strain in Pain Lies Mainly in the Brain*, at the Science Writers New Horizons in Science Conference at Stanford, CA in October 2008.

- Sean Mackey, MD, PhD, spoke about *Brain Imaging and Pain Perception* at the Wake Forest Advances in Physiology and Pharmacology in Anesthesia and Critical Care at Wake Forest University in Sulphur Springs, WV in November 2008.

- Sean Mackey, MD, PhD, spoke about *The Neuroscience of Pain* at the Stanford Center for Law & The Biosciences, Neuroimaging, Pain & The Law Conference at Stanford, CA in November 2008.

- Sean Mackey, MD, PhD, spoke about *Neural Circuits of Pain* at the North American Neuromodulation Society Annual Meeting in Las Vegas, NV in November 2008.

- Sean Mackey, MD, PhD, spoke about *Clinical Trial Designs* at the North American Neuromodulation Society Annual Meeting in Las Vegas, NV in November 2008.

- Andrew J. Patterson, MD, PhD, spoke about *Jumping to Inaccurate Conclusions: How Health Care Watch Dog Groups are Forcing Physicians to Treat Patients Inappropriately* at the American Medical Writers Association Pacific Coast Conference in Asilomar, CA on April 2, 2008.

- Andrew J. Patterson, MD, PhD, spoke about *Beta Blockade: Is it the Standard of Care?* to the American Society of Anesthesiologists Annual Meeting in Orlando FL on October 19, 2008.

- Andrew J. Patterson, MD, PhD, spoke about *Perioperative beta Blockade Protocol: A Bureaucrats Guide to Forcing Clinicians into Unsafe Clinical Practice* at Grand Rounds, Vanderbilt University Department of Anesthesia in Nashville, TN on November 14, 2008.

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**Books Chapter**


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**Promotions, Awards, and Honors**

- Gary Peltz, MD, PhD, was appointed Professor, effective July 1, 2008.

- David C. Yeomans, MD, was promoted to Associate Professor, effective November 1, 2008.

- M. Gail Boltz, MD, was appointed Clinical Professor of Anesthesia, effective December 1, 2008.

- Ruth M. Fanning, MD, was promoted to Clinical Assistant Professor of Anesthesia, effective December 1, 2008.

- David A. Clark, MD, was promoted to Professor of Anesthesia at the Veterans Affairs Palo Alto Health Care System, effective January 1, 1909.

- John B. Pollard, MD, was reappointed Associate Professor of Anesthesia at the Veterans Affairs Palo Alto Health Care System, effective December 1, 2008.
• Gerald Goresky, MD, was appointed as Clinical Associate Professor of Anesthesia, effective January 1, 2009.

• Pedro P. Tanaka, MD, was appointed Clinical Associate Professor of Anesthesia, effective January 1, 2009.

• Kyle Harrison, MD, was appointed Associate Program Director for the class of 2010.

• Sean Mackey, MD, PhD, serves on the following: NIH NHLBI Workshop on Sickle Cell Disease Sub-Committee on Pain; NIH NIDA Study Section; International Association for the Study of Pain Clinic Guidelines Taskforce; ASA Pain and Pain Directors committees; and California Department of Workers Compensation Committee.

• Sean Mackey, MD, PhD, has been appointed Director at Large by the American Academy of Pain Medicine.

**Popular Press**

• The Placebo Effect at its Simplest is an Effect Produced by Nothing *Stanford Medicine* Summer 2008

• Just Another Lab Rat *Stanford Medicine* Summer 2008

• Taking Your Life Back from Pain’s Control – with Mind, Body and New Medical Vision *Palo Alto Weekly* July 23, 2008.

• Son Finds Hope for Dying Father on Internet. *San Francisco Chronicle* February 8, 2008.

**Life’s Transitions: Babies**

Chief Resident Jen Wagner, MD, and her husband, Mike Wagner, MD, are proud to announce the birth of their daughter, Paige Reese Wagner on Tuesday, Aug. 26, 2008, born early with some complications. She weighed 5 lbs 3oz. They are very thankful to Drs. Collins, Nekhendzy, Atkinson, Butwick and Ting, who assisted in various ways.

Dr. Nicholette Roemer and Ian Kasman announce the birth of Nicholas Tenzing Kasman August 27, 2008. He weighted 8 lbs. 6 oz. and measured 21.5 inches. They thank their anesthesia A-team: Drs. Ting, Atkinson, Collins and Carvalho, who welcomed Nicholas into the world.
Erin Reiland’s healthy baby boy, Kyler Matthew Reiland, was born August 10, 2008, weighing 8 lbs, 2 oz and measuring 21 inches long. Erin gives special thanks to Drs. Butwick, Collins, and Chu for their special care.

Drs. Jonay and Charles Hill are happy to announce the birth of their daughter, Avery Kathryn Hill, born July 7, 2008. She weighed 7.5 lbs and measured 20 inches. They thank Dr. Carvalho for a perfect epidural.

**LIFE’S TRANSITIONS: MARRIAGE**

Patricia Rohrs and Edwin Jones, PhD were married July 6, 2008 at The Garden Court Hotel in Palo Alto after a courtship of 23 years. The 4-year-old ring bearer’s toast, “Here’s to beautiful bride and the handsome groom...FINALLY!” summed it up. The ceremony was marked by a classical string quartet and many spontaneous, comedic moments among the groom, bride, judge, and guests.

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