The Department of Anesthesia, Perioperative and Pain Medicine has been commended for its emergency response in the aftermath of the crash of Asiana Airlines Flight 214 at San Francisco International Airport on July 6.

In an email to Drs. Ron Pearl and Jay Brodsky, Dr. Eric Weiss, medical director of the Office of Emergency Management, wrote, “Thank you so much for helping to coordinate the outstanding response…by Anesthesia. Everyone in Perioperative Services was very helpful and the rapid response and mobilization of Perioperative Services was exemplary,” he said. “Please pass on my compliments and appreciation to everyone who was there on Saturday,” he said.

The accident occurred mid-morning on a clear, beautiful Saturday as the pilot attempted to land the Boeing 777. The plane set down too early, hitting the landing gear against the seawall at the end of the runway, which ripped off the tail and sent the aircraft careening 1000 feet down the tarmac, leaving a trail of debris. The plane suffered extensive damage and burst into flames before it skidded to a stop.

Three of the 307 passengers and crew were killed and 180 were injured. The injured were sent to 9 different Bay Area hospitals for treatment. Stanford treated a total of 55 passengers.

A Code Triage Standby indicating a potential mass casualty event was announced at 12:05 and the official Code Triage followed at 12:45. Cross-functional teams were marshaled to handle the expected influx of patients. Dr. Anthony Doufas, who was on-call, coordinated the Anesthesia Department’s response, with the help of Drs. Ryan Derby, Fred Mihm, and...
Drew Patterson. Available anesthesiologists were called and the trauma rooms and ORs were set up.

Within 30 minutes, most of the patients in the ER at the time the Code Triage was called were either admitted to the hospital or discharged to make room in the ER for the influx of victims. A triage area was also set up outside of the ER. Six ORs were prepared and staffed right away and several more were subsequently readied. Seven trauma teams and five perioperative teams were mobilized.

Ultimately, more than 30 other anesthesiology attendings, residents, fellows, and techs called the operating room to indicate their availability and stood by in case they were needed.

Samantha (Sammi) Moore, who was working at the operating room control desk that afternoon, joined Dr. Weiss in recognizing the department’s outstanding response to the emergency.

“I would like to personally commend the Anesthesia Department for being readily available, showing up to assist, and calling in to provide support during this time,” she said. “[Everyone did] an exceptional job running the operating rooms, communicating effectively and remaining calm during a stressful and chaotic time. They were an excellent team.”

In an interview with Stanford’s Public Affairs office, Chief of Staff Dr. Ann Weinacker also underscored how well Stanford responded to the emergency.

“What was remarkable was how calm and smoothly everything was running. It was incredibly well-organized,” she said. “There was not a lot of drama. It was almost like business as usual — only there were many more people.”

The timing of the accident also played a role in facilitating the rapid response. “It helped that it was a Saturday,” Dr. Jay Brodsky said. “It might not have gone as smoothly if it had been a weekday and the ORs had all been occupied.”

Still, the prompt and efficient response reflects the professionalism and dedication of the staff as well as many hours of disaster planning and training. “[It] really paid off,” said Brandon Bond, administrative director of the Office of Emergency Management for the Stanford and Packard hospitals. “Throughout both of our hospitals, everyone immediately knew what to do to evaluate and treat these patients while maintaining normal hospital operations.”

Fortunately, given the scope of the crash, most of the patients sent to Stanford were not badly injured and many were treated and released within a few hours. Only one patient required surgery that day; several patients were operated on later that week.
After years of constrained growth, Stanford is rapidly expanding. As the two progressively enlarging holes and all of the construction equipment in front of the hospital remind us daily, in five more years we will have a new adult hospital and a new children’s tower. But that is only part of the picture. There will be further expansion at the Redwood City facility, the Byers Eye Institute, and the Hoover Pavilion. There will also be a new South Bay Cancer Center and new medical school buildings.

Several factors are driving the hospital expansion. There is a clear need for modern facilities with state-of-the-art equipment. When the new hospital buildings open their doors in five years, some of the current hospital areas will be 60 years old. Moreover, we are already the only major hospital in our area with a large number of shared patient rooms. The past few years have seen increasing consolidation among healthcare providers in the Bay Area, and a major hospital will not be able to survive without being part of a large provider network and a market share that allows competitive contracting. In addition, increased subspecialization has become a major driver of tertiary care.

These changes are more than just cosmetic—they will produce a major transformation in Stanford Medicine. As part of this process, each clinical department is creating plans to increase the depth and breadth of world-class faculty, who will provide outstanding subspecialty care and advances in their fields to improve patient outcomes. For example, neurosurgery and orthopedics each have 10 subspecialties, and adequate depth requires multiple physicians within each subspecialty, necessitating growth of the medical staff. The increased number of surgeons will result in increased referrals, requiring more operating rooms, clinic rooms, and hospital beds.

In the past, we have often had only one faculty member in a given area, which presented problems in providing optimal clinical care when that individual was away from Stanford for meetings or sabbatical. On the academic side, there is a similar need in a given area for developing a critical mass of investigators who have distinct but synergistic areas of expertise. Based on the extensive opportunities for interactions between Stanford’s world-class basic scientists and its outstanding clinicians, Stanford is an ideal institution for translational research. However, in this age of big data and personalized medicine, translational research frequently requires multiple investigators. Until the recent increase in the faculty billet cap, there was often no faculty position available for additional clinician scientists who could make major contributions. With the recent increase in faculty billet positions negotiated by Dean Minor, clinical departments now have the opportunity to recruit new faculty who can help transform clinical medicine.

Given today’s reality, it is no longer possible to remain small and still be a leading hospital and medical school. Although Stanford aims to grow, we must guard against growing so large and fast that we lose the flexibility that has been a traditional Stanford strength. Growth is expensive, particularly in these times of healthcare reform and constrained NIH budgets. Fortunately, Stanford has a remarkable record for fundraising, and the Campaign for Stanford Medicine is already well on its way towards its $2 billion goal. This fundraising goal is only possible because we have developed a true partnership between the university, the medical school, the two hospitals, and the community that will allow us to achieve these ambitious goals to transform Stanford Medicine.
For the Department of Anesthesiology, Perioperative and Pain Medicine, this planned expansion is both a problem and a liability. The growth of clinical services that require anesthesia, such as surgery, demands that our department grow at a similar pace. Fortunately, our residency and fellowship programs are graduating truly outstanding physicians who want to stay at Stanford, and this year we hired 20 new faculty, both from our programs and from programs across the country. Because much of the planned growth is in subspecialty areas, expansion provides opportunities for each of our faculty to develop areas of expertise, to partner with teams of surgeons and nurses to advance patient care and improve outcomes, and to participate in teams to advance translational research. Finally, because our academic programs can grow proportionally with our clinical programs, clinical expansion will allow the department to expand its roles in basic as well as clinical research.

When I became department chair 14 years ago, the future of Stanford medicine was in doubt, and a merger with UCSF was viewed as the only way to save the hospital from the myriad financial challenges that lay ahead. Today, both Stanford hospitals have record profits, an unprecedented fundraising campaign is in progress, our clinical and academic programs are successful and expanding, and our department is a recognized leader in innovative approaches to education, clinical care, and research. The success of the department is based on the cumulative contributions of all our faculty, trainees, and staff, and everyone should feel proud of helping us achieve our success.

Don’t forget to join us at the ASA for our annual Alumni Association reception from 6–8 PM on Sunday, October 13th, at the Fairmont Hotel in San Francisco. 🎉

Our department is a recognized leader in innovative approaches to education, clinical care, and research.
Clinical Case

You’re anesthetizing a 60-year-old woman for a thyroidectomy. The surgeon tells you, “If this woman bucks on the endotracheal tube on awakening, it could cause a neck hematoma and damage my surgical closure. Can you extubate her deep?”

Discussion

The patient has a normal airway, and she is healthy and slender. You decide to comply with the surgeon’s request and remove the endotracheal tube (ET tube) at the end of surgery while the patient is still fully anesthetized. You turn off the nitrous oxide, allow the patient to breath 100% oxygen and 3% sevoflurane, and suction the patient’s throat. You deflate the cuff on the ET tube and remove it. Once the tube is withdrawn, you turn off all anesthetics. At this point the patient coughs and her mouth fills with yellow gastric contents. You suction the mouth again, but the patient develops upper airway obstruction. The oxygen saturation drops to 80%. Your diagnosis is laryngospasm. You attempt to apply continuous positive airway pressure with an anesthesia mask, but her oxygen saturation falls to 70%. Panicked, you inject 100 mg of IV succinylcholine to re-paralyze the patient, and you perform laryngoscopy and reintubate her. After the ET tube is replaced, the oxygen saturation returns to 100%. You suction through the lumen of the ET tube, and you find yellow gastric material inside the lungs. You diagnose aspiration.

After a 10½ hour flight from Seoul, Korea, Asiana Airlines Flight 214 crashed on landing at San Francisco Airport in July. I cite this accident because aviation and anesthesia have certain similarities. The takeoff and landing of an airplane are more complex events than piloting the middle of a plane flight, just as induction and emergence from anesthesia is more complex than managing the maintenance phase of a long anesthetic.

The timing of the removal of the endotracheal tube at the end of an anesthetic requires skill and judgment. Does deep extubation ever make sense? During my first year after residency training, a gray-haired anesthesia attending at my new medical center told me, “Richard, in private practice you never extubate anyone deep.” Twenty-seven years later, I’m writing to convince you he was right.

Let’s define “deep extubation.” The following is from Chapter 50 of Miller’s Anesthesia,1 “Extubation may be performed at different depths of anesthesia, with the terms ‘awake,’ ‘light,’ and ‘deep’ often being used. ‘Light’ implies recovery of protective respiratory reflexes and ‘deep’ implies their absence. ‘Awake’ implies appropriate response to verbal stimuli. ‘Deep’ extubation is performed to avoid adverse reflexes caused by the presence of the tracheal tube and its removal, at the price of a higher risk of hypoventilation and upper airway obstruction. Straining, which could disrupt the surgical repair, is less likely with ‘deep’ extubation. Upper airway obstruction and hypoventilation are less likely during ‘light’ extubation, at the price of adverse hemodynamic and respiratory reflexes.

The medical literature describes deep extubation as extubating a patient who is still breaching 1.5 times the minimal alveolar concentration (MAC) of inhaled anesthetic. A 2004 study examined 48
children tracheally extubated while deeply anesthetized with 1.5 times the MAC of desflurane (Group D) or sevoflurane (Group S). No serious complications occurred in either group, and the time to discharge was not significantly different between groups. The study concluded that deep extubation of children can be performed safely with desflurane or sevoflurane.2

In a prospective trial, 100 children age <16 years undergoing adenotonsillectomy, each with at least one risk factor for perioperative respiratory adverse events (e.g., current or recent upper respiratory tract infection or asthma), were randomized to extubation under deep anesthesia or extubation when fully awake. There were no differences in perioperative respiratory adverse events (laryngospasm, bronchospasm, persistent coughing, airway obstruction, or desaturation <95%). Tracheal extubation in fully awake children was associated with a greater incidence of persistent coughing (60 vs. 35%, \( P = 0.028 \)), whereas the incidence of airway obstruction relieved by simple airway maneuvers in children extubated while deeply anesthetized was greater (26 vs. 8%, \( P = 0.03 \)).3

In another study, 7 healthy patients between 2 and 8 years of age who had elective strabismus surgery or tonsillectomy were randomly assigned to group 1 (awake extubation) or group 2 (anesthetized extubation). The incidence of airway-related complications such as laryngospasm, cough, sore throat, excessive coughing, and arrhythmias was not different between the two groups. The authors concluded that the anesthesiologist’s preference or surgical requirements may dictate the choice of extubation technique in otherwise healthy children undergoing elective surgery.4

In an informal poll of the private practice anesthesiologists at Stanford University, the incidence of deep extubation (i.e., patient extubated asleep while breathing >1.5 MAC of inhaled anesthetic) approached zero. Why do my colleagues and I avoid deep extubation? If you have a life-saving and life-preserving device such as an endotracheal tube safely in place in your patient, and your goal is to maintain the values of Airway, Breathing, and Circulation, why remove that life-preserving device prematurely without any evidence that such a removal is beneficial? Why leave your anesthetized patient with an unprotected airway?

I cannot cite you outcomes data that show awake extubation provides superior outcomes to deep extubation, but with modern, short-acting anesthetics such as propofol, sevoflurane, and desflurane, a well-trained anesthesiologist can decrease anesthetic depth quickly and have their patient very awake within minutes after the conclusion of surgery. Per Miller’s Aesthesia, “Rapid recovery of consciousness shortens the at-risk time during extubation and may reduce morbidity, particularly in obese patients. ... Nitrous oxide, sevoflurane, and desflurane all contribute to rapid recovery, particularly after prolonged procedures.”1

If your patient vomits on emergence and the ET tube is still in situ, the cuff on the ET tube will protect their lower airway. And if you choose to extubate your patient awake, the occurrence of laryngospasm will be, in this author’s experience, rare.

It’s true that coughing on an ET tube can disrupt surgical repairs, increase intracranial and intraocular pressure, or cause hypertension and tachycardia, but Per Miller’s Aesthesia, “Marked increases in arterial blood pressure and heart rate occur frequently at the time of ‘light’ extubation. These effects are alarming but normally transient, and there is little evidence of adverse consequences.”1

My advice: Use light levels of general anesthetics on your intubated patients, and learn how to wake your patients from general anesthesia quickly at the conclusion of surgery. Don’t suction the patient until you are ready to remove the ET tube, because the suction catheter stimulates early coughing.

The ET tube is your friend. I’d recommend you don’t pull it out until you’re certain you don’t need it any more.5

References

The department held a retreat the first weekend in June that was attended by more than 70 faculty. Before the retreat, several workgroups met to address a number of issues. I was the group leader for the education work group, which met several times, divided its work, and presented its findings at the retreat. Following is a summary of the education work group’s findings.

Stanford Anesthesia has widespread educational influence. The department currently teaches hundreds of medical students, residents, fellows, faculty, and members of the anesthesia community at large. Since its founding in 1960, Stanford’s anesthesia department has trained more than 600 anesthesia residents. The department has especially wide reach locally. Including the Palo Alto VA and the Valley Medical Center in Santa Clara, approximately 80 of the current 180 faculty were trained in the residency program at Stanford.

In 2013, the department offers the following options for anesthesia residents:
- 13 3-year advanced positions, including 4 affiliated internships at the Valley Medical Center and 2 positions at Kaiser in San Francisco
- 8 4-year categorical positions
- 2 combined 5-year pediatrics/anesthesia positions
- 3 combined 5-year medicine/anesthesia positions

At present, 70% of Stanford’s anesthesia residents continue on to complete a fellowship in anesthesia, and many of these choose to remain at Stanford for their fellowships. In fact, as of July 2013, the department has 42 new anesthesia fellows, which outnumbers the new residents. The fellowships are broken down by subspecialty as follows:
- 7 pain
- 6 pediatric
- 8 critical care
- 3 cardiac
- 3 OB
- 3 regional anesthesia
- 1 pediatric pain
- 1 pediatric difficult airway
- 1 neurology
- 1 advanced clinical anesthesiology
- 4 research

The education work group stressed that the quality of the education is proportional to the quality of clinical care and scholarship such that when we maximize the quality of patient care and physician knowledge, we improve the education of the residents.

Many factors affect resident training. The public has some voice in the process, demanding that residents perform at a higher standard because their Medicare dollars help pay for the residents’ training. In addition, physician training is becoming increasingly regulated and rigorous, which will ultimately test housestaff more than ever before.
When the education work group looked back at Stanford Anesthesia over time, we found three major trends:

- Twenty years ago, a resident was involved in the care of every patient in the hospital and OR. Today many cases have no trainee involvement at all.
- Patients today are presenting with more complex medical issues than they used to. As a result, today’s anesthesia faculty are more specialized and have a narrower clinical care focus, to enable them to gain the expertise and skills to manage these more complex patients.
- Clinical hospital growth has outpaced growth in the number of residents.

It is difficult to predict the long-term future of resident education. The department aims to match the best class of residents in the country and then provide them with the best training. Our graduates consistently go on to become leaders in their field. However, several factors are changing the field of education, including the exponential expansion of the role of information technology; the different learning styles of the current generation of housestaff; the institution of the new testing and assessment standards, such as the Milestones Project; the potential loss of Medicare funding of residents; and application of education and curricular theory to what once was an apprenticeship approach. The department has been at the forefront of many educational innovations throughout this evolution.

At the meeting of the CSA Residency Program Directors in May, the question was raised as to changes in how residents will be educated in the next 5–10 years. According to that discussion, the following areas will be increasingly emphasized:

- **OR management.** This will be an important aspect of training because residents must understand the nature of the business practice.
- **Perioperative care.** Anesthesiology residents will be trained to take a leadership role as the team model of care providers (surgeons, nurses, and other physicians) becomes more prevalent.
- **Leadership curriculum.** Individuals can be good OR managers but may not be good leaders. Leadership skills can be taught.

At Stanford, our goal is to provide the environment and resources to help fulfill the residents’ highest professional potential as anesthesiologists. This means that each resident’s training will be unique to some extent, based on individual background and interests. This is in line with the 2010 Carnegie study on medical education, which recommended creating individualized learning pathways to provide more opportunities to experience broader professional roles, and to create smaller learning communities within larger programs to promote career development.

In the next education report for the Gas Pipeline, I will summarize the initiatives we have taken or plan to take based on the deliberations and recommendations from the department retreat.

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**Secured Fellowships**

As I mentioned before, last year 70% of our residency graduates went on to a fellowship, which was an all-time high, and this year the percentage is likely to be even higher. The following CA3s have secured fellowships for next year:

- **Nick Anast**, cardiac anesthesia, Stanford
- **Kevin Blaine**, critical care medicine, National Institutes of Health, Bethesda, MD
- **Jorge Caballero**, FARM research, Stanford
- **Craig Chen**, critical care medicine, Stanford
- **Estee Garazi**, cardiac anesthesia, University of Miami, Miami, FL
- **Robert Groff**, critical care medicine, Stanford
- **Reed Harvey**, cardiac anesthesia, UCLA
- **Ryan Mountjoy**, regional anesthesia, Duke
- **Marie McHenry**, cardiac anesthesia, Texas Heart Institute, Houston, TX
- **Carter Peatross**, cardiac anesthesia, Mayo Clinic, Rochester, MN
- **Lindsay Raleigh**, combined cardiac anesthesia/critical care medicine, Stanford
- **Eric Sun**, FARM research, Stanford
- **Jim Tan**, regional anesthesia, Stanford

I am delighted with these results, so please join me in congratulating the new fellows! Several other CA3s are interested in pediatric anesthesia and pain medicine fellowships and the match for those is in the Fall, so when we know the results we will let everyone know. We will also announce which CA3s go on to community or academic practice.
On Saturday, June 15, 23 residents graduated from Stanford Anesthesia. The ceremony, reception, and dinner were held at the Faculty Club. Following is a list of the 23 graduates and their future plans:

- Jennifer Basarab-Tung, attending at Stanford
- Marianne Chen, critical care fellow at Stanford
- Samuel Chen, private practice in Oregon
- Morgan Dooley, assistant professor at Emory University
- Roy Esaki, Stanford pain fellow
- Estee Garazi, attending at Stanford and Santa Clara Valley Medical Center
- Brice Gaudilliere, research post-doc and clinical instructor at Stanford
- Melanie Gipp, pediatric anesthesia fellow at Stanford
- Annie Goodrich, pediatric anesthesia fellow in Houston
- Natalya Hasan, attending at Stanford
- Ashley Hawrylyshyn, private practice in the Bay Area
- Boris Heifets, attending, clinical instructor, and research fellow at Stanford
- Calvin Lew, private practice in San Francisco
- Michael Marques, critical care fellow at Stanford
- Ethan McKenzie, attending at Stanford
- Vanessa Moll, critical care fellow at Stanford
- Megan Olejniczak, cardiac fellow at Stanford
- Jared Pearson, pediatric anesthesia fellow in Colorado
- Catherine Reid, attending at the University of Bern, Switzerland
- Loren Riskin, OR management fellow at Stanford
- Vivianne Tawfik, research post-doc and clinical instructor at Stanford
- Tatiana Trakvina, attending at Stanford
- Luis Verduzco, critical care fellow at Stanford
- Ankeet Udani, research post-doc fellow at Stanford

Congratulations to all of the graduates and best wishes for success in their future endeavors!
In May, the Department of Anesthesiology, Perioperative and Pain Medicine hosted the 51st Western Anesthesia Resident Conference (WARC) at the University of New Mexico School of Medicine in Albuquerque. Former Stanford resident Dr. Elizabeth Steele was one of the main organizers of the event, and she did a splendid job of ensuring that everything ran like clockwork.

This year, more than 140 residents and 30 faculty attended the conference. Dr. Ronald Pearl and I represented Stanford faculty.

Stanford residents had a higher profile than any other institution, contributing 25 abstracts. Dr. Megan Olejniczak won first prize in the very popular airway division. Her work, completed in conjunction with Dr. Geoffrey Lighthall from the Palo Alto VA, was entitled “Proposal for routine use of airway exchange catheter during tracheostomy.”

Stanford anesthesia professor emeritus Dr. Larry Saidman gave the 2nd Annual Eger Lecture. Larry’s outstanding presentation was entitled “The Golden Age of Anesthesia—An Amazing Adventure.” The talk chronicled what anesthesiologists had to work with in the past and how far we have come.

Larry is a longstanding friend of Dr. Eger’s, and the two have teamed up to write a book recounting the world history of anesthesiology, which will be available for purchase in October. Larry asked me to work with another Norwegian and two Swedes to help write the section on the Nordic history of anesthesiology. This underscores that it is indeed possible for Scandinavians to work together…

As a special bonus many of us met on Saturday night with former Stanford residents Drs. Chris Stasny and Doug Brown (see photo), both of whom are now practicing anesthesiologists in Albuquerque. It was lovely to see them again and I know the residents enjoyed hearing their thoughts on what it is like to be in private practice as a clinical anesthesiologist.

Although most of the attendees left Albuquerque on Saturday afternoon or early Sunday morning, Drs. Sam Chen, Natacha Telusca, Rachel Wang, and I took the opportunity to go to the top of Sandia Mountain on Sunday. It was a magnificent day!
Annual Research Dinner

The annual research dinner was held on May 13, 2013, at the Sheraton in Palo Alto. There were about 70 posters presented at the meeting, so many, in fact, that we will have to increase the space available for posters next year. Members of the research committee read and evaluated the submitted abstracts, selecting six as winners of the best abstract in their category. They were:

- **Best basic science abstract**: Boris Heifets et al., *Improving deep brain stimulation through targeted synaptic modification*
- **Best clinical abstract**: Drew Patterson et al., *Vasopressin augments the decline of plasma cytokine levels in septic shock*
- **Best abstract by a FARM Fellow**: Brice Gaudilliere et al., *Systems immunology reveals a massive expansion of myeloid derived suppressor cells in patients undergoing surgery*
- **Best abstract by a T32 fellow**: Creed Stary et al., *Isoflurane augments neuronal growth in neuronal-astrocyte mixed culture*
- **Best case report**: Luis Verduzco et al., *Subdural hematoma after a blood patch*
- **Best educational abstract**: Matt Erlendson et al., *Successful transition to anesthesia residency training: A multicenter study of an online distance learning program designed to prepare interns for anesthesia residency training*

Each winner received a framed certificate. Winning faculty and staff also received a $200 gift card to the Stanford Bookstore, and winning residents and fellows received $200. Boris, Drew, Brice, and Creed were also selected to give a 10-minute oral presentation at the dinner.

Congratulations to all the winners and to everyone who presented a poster!

Dr. Mark Newman from Duke University was the guest evaluator and he said a few words about our department and outlined some of the challenges facing research. Dr. Dave Clark presented a short summary of the Research Division’s goals. The division aims to be one of the top anesthesia departments in the country in terms of:

- Depth and breadth of faculty research interests
- Research training at all levels, student through fellowship
- Research output in publications and presentations
- Research support at all levels, including local, federal, public, and private sources
- Leadership, as reflected by membership in professional societies, expert panels, and review groups

Continuing a trend that began in 2010 as one of the top-funded anesthesia departments in the country, the department is currently 4th in the nation in terms of NIH funding given to departments of anesthesiology, with just under $6.5 million per year.

The division has about 50 active research projects overseen by 23 principal investigators.

Small ($8000) grants are available from the department. All grant applications are reviewed internally one month before the sponsor’s deadline. Contact Mike Helms at mkelms@stanford.edu if you would like more information or to submit a research proposal.

Although the research dinner was an unqualified success, next year’s event will be held on a Friday evening to enable more clinical faculty, who have early morning duties during the week, to attend. See you next Spring!
In July, the department welcomed Dr. Jean-Louis Horn as the new Chief of the Division of Regional Anesthesia. Jean-Louis previously served as Director of Regional Anesthesia at Oregon Health Sciences University in Portland, a position that he held from 2003 until he moved to Stanford in June.

Jean-Louis, who originally hails from Belgium, began to develop his interest in acute pain management and regional anesthesia almost 25 years ago, when he was an anesthesiology fellow at Vanderbilt University Medical Center in Nashville. At that time, few anesthesiologists practiced the technique, although it had been in use for a long time. Dr. Louis Gaston Labat, who was one of the founders of the original American Society of Regional Anesthesia, first brought regional anesthesia to the US from France in the early 20th century. “It was popular 100 years ago because general anesthesia was not safe,” Jean-Louis said. However, it fell out of favor when safer methods of administering general anesthesia were developed.

Interest in regional anesthesia began to be revived during the 1970s and 1980s, with the development of improved placement techniques and anesthetics. More recent refinements, such as ultrasound-guided placement, have made it faster and easier for anesthesiologists to become proficient in performing nerve blocks, and have also made it possible to attempt blocks that were previously difficult to perform efficiently.

In addition, continuous infusion through an indwelling catheter provides sustained postoperative analgesia while decreasing the need for narcotic painkillers. These and other developments have not just piqued the interest of anesthesiologists—they have also led to greater acceptance by surgeons and patients.

Jean-Louis is quick to point out that regional anesthesia is often used as an adjunct to—not a replacement for—general anesthesia. It is an important tool in the armamentarium used to provide better postoperative pain relief, increased patient comfort, and improved recovery and outcomes.

Although evidence-based data on the benefits of regional anesthesia have been collected since the late 1980s, good outcomes research has really only been conducted for the last 10 years. One of Jean-Louis’s goals as division chief is to develop and promote research in regional anesthesia to provide hard outcomes data and further refine the specialty.

The Division of Regional Anesthesia currently comprises 10 faculty and 3 fellows, and all anesthesia residents spend one continuous month training with the regional anesthesia team.

Jean-Louis was attracted to Stanford because of its reputation, temperate climate and great opportunity. “[The Department of Anesthesia] is a solid department,” he said. “It provides excellent patient care, and is known for [providing] an excellent education for students, residents, faculty, and even the community. And Ron Pearl is a great chair; he is well-known and respected in the anesthesia community.”

Jean-Louis and his wife have a son and a daughter. His son is a student at Oregon State University. Jean-Louis said that he loves computers and his 1991 Alfa Romeo 164, which he enjoys working on. His daughter is a student at Palo Alto High School and an accomplished athlete. “She excels academically and in many sports, including water polo and skiing, and she has a low, single-digit handicap in golf,” he said.

If you have any questions for Jean-Louis or would simply like to welcome him to Stanford, he can be reached at hornj@stanford.edu.
Division News

Good News from the Research Division

By Michael K. Helms, PhD, MBA

As in previous issues of the Gas Pipeline, we have more good news this quarter from the research division.

After many delays by NIAAA, Drs. Jim Trudell and Ed Bertaccini finally received a notice of award for their R01 grant entitled “Defining alcohol binding sites in ligand-gated ion channels.” We note that Dr. Bertaccini was recently promoted to full professor. Also, Dr. Rona Giffard’s R01 grant entitled “Stress proteins in brain cell injury” was renewed by NINDS. This is her third active R01 grant.

In other news, Drs. Ed Mariano and colleagues won a “best of meeting” award for their abstract entitled “Replacing continuous femoral nerve blocks with continuous adductor canal blocks within a clinical pathway for total knee arthroplasty: a case control study of postoperative ambulation,” which was presented at the American Society of Regional Anesthesia and Acute Pain Medicine in Boston in May 2013. Their manuscript from this work has already been accepted for publication in Clinical Orthopaedics and Related Research.

Dave Yeomans and colleagues at Adynxx, Inc., recently published a paper in the journal Pain entitled “Transcription factor decoy AYX1 prevents acute and chronic post-surgical pain with a single intrathecal injection,” which describes their DNA decoy, AYX1. Their work with AYX1 led to a successful Phase I trial—the first time an oligonucleotide had been delivered intrathecally in humans—and an ongoing Phase II trial.

Year four of the Anesthesia Training Grant in Biomedical Research (NIH T32) began on July 1st. Dr. Creed Stary will begin his second year as a T32 trainee. Drs. Katie Martucci, Brice Gaudilliere, and David Feliciano are the newly appointed T32 trainees (starting July 1st). Dr. Robin White, a former NIH T32 trainee and postdoctoral fellow in the Giffard Lab, has been appointed as an Assistant Professor at Westfield State University in Westfield, Massachusetts. Also, Dr. Sean Mackey and colleagues were awarded a new T32 training grant entitled “Interdisciplinary Research Training in Pain and Substance Use Disorders” from NIDA. Having two T32 grants in the department is a major step forward in training the next generation of scientists!

Finally, we welcome the new CA1 residents to the FARM Fellows program—Drs. Victoria Fahrenbach, Quentin Baca, and Louise Wen.

Please join me in congratulating your colleagues on their many successes.
The most significant news from the Anesthesiology and Perioperative Care Service at the VA Palo Alto is that we held our second annual faculty development retreat on July 22, 2013, at the Li Ka Shing Center on the Stanford campus. Continuing the theme of faculty development from last year’s retreat and the mid-year retreat, which focused on the perioperative surgical home, this year’s retreat operationalized the concept of “teaching the teachers.” I want to thank Drs. Carlos Brun, Allegra Lobell, and Steve Howard for their hard work organizing this year’s event, which opened with guest lectures by Drs. Alex Macario and Larry Chu and featured hands-on interactive workshops on transthoracic echocardiography, with live models and high-fidelity simulators, a crisis management simulation session, and updates from section leaders on the various specialties that make up the Anesthesiology and Perioperative Care Service.

In the past quarter, two of our staff anesthesiologists made significant achievements. Dr. Carlos Brun was honored at the resident graduation with the 2013 Teacher of the Year Award, which is selected from among all department faculty, in recognition of his tremendous efforts to improve resident education in the operating room and intensive care unit at the VA Palo Alto. Dr. Edward Bertaccini was promoted to professor in the Medical Center Line, with a continuing term. This promotion is especially meaningful to Ed, who is a native of the Bay Area and comes from a family of teachers. Ed continues an active clinical practice as an anesthesiologist and intensive care physician, and teaches medical students, residents, and fellows. He is also involved in an internationally recognized research program studying the molecular modeling of anesthetic action.

Dr. David M. Gaba was honored at the 2013 International Anesthesia Research Society’s Annual Meeting in San Diego as the Dr. T. H. Seldon Memorial Lecturer. The topic of his talk was: “Simulation—another (unsung) gift to medicine from anesthesiology.”

At the 2013 American Society of Regional Anesthesia and Pain Medicine (ASRA) Spring Annual Meeting in Boston, Ms. Cynthia Shum and Drs. Steve Howard, Edward Kim, and Kyle Harrison shared their teaching expertise in innovative workshop and lecture sessions. Dr. Ed Mariano served as Chair of the annual meeting. Recent Stanford anesthesiology resident graduate, Dr. Ankeet Udani, was honored as the 2013 ASRA Resident of the Year, and Regional Anesthesia and Acute Pain Medicine fellow, Dr. Justin Workman, presented one of the three “Best of Meeting” abstracts on the topic: “Replacing continuous femoral nerve blocks with continuous adductor canal blocks within a clinical pathway for total knee arthroplasty: a case-control study of postoperative ambulation.”
Division News

Multi-Specialty Division

By Hendrikus (Harry) Lemmens, MD

Don’t forget that the M and M conference is held the first Thursday of every month from 16:30–17:00 in the anesthesia conference room.

Please join me in welcoming the following new attendings:
- Boris Heifets
- Xiang Qian (MSD and pain clinic)
- Rachel Outterson
- Tatyana Travkina
- Javier Lorenzo (MSD and ICU)
- Jennifer Basarab-Tung
- Praveen Kalra
- Ethan McKenzie
- Ankeet Udani
- Vivianne Tawfik
- Brice Gaudilliere
- Natalya Hasan

We wish the best for the following attendings, who have left Stanford to pursue opportunities elsewhere:
- Ying Tian
- Vanessa Henke
- Jens Bjerregaard

Please note that we have instituted three new resident teaching initiatives. Residents will now perform the scheduling task in the ASC under the supervision of the main OR scheduler. Residents will also be provided with a daily 15-minute lecture with discussion on a specific topic. Finally, former Stanford resident Dr. Barry Swerdlow will provide a teaching curriculum based on current private practice issues for interested senior residents and fellows. Barry is currently in private practice in Southern California.
Case Report: Emergent Tracheostomy in an “Un-intubatable” Patient with Hunter Syndrome

Zoel A. Quinonez, M.D. and Louise Furukawa, M.D.

Introduction

Patients with Hunter syndrome (mucopolysaccharidosis II), an X-linked recessive lysosomal storage disease, provide unique airway management challenges to the pediatric anesthesiologist. Accumulation of glycosaminoglycans (GAG) throughout the tissues of the body results in macroglossia, subglottic stenosis, tracheomalacia, pulmonary restriction, cardiomyopathy, hepatosplenomegaly, joint contractures, and variable degrees of CNS involvement, causing developmental delay. A thick short neck, limited TMJ mobility, and possible cervical spine instability make airway management in these patients all the more challenging. Most patients with Hunter syndrome die in the second decade of life as a result of airway or cardiac compromise. While largely thought of as inhabiting only the world of pediatric anesthesiology, some patients with more attenuated forms of the disease have been known to live into the fifth and sixth decades of life. With improved morbidity and mortality from enzyme replacement therapy (ERT) and the emerging benefits of hematopoietic stem cell transplantation (HSCT) for the treatment of lysosomal storage diseases, we may see an increasing number of patients surviving to adulthood. As anesthesiologists, we should thus be familiar with the anesthetic challenges presented by these patients. We highlight this case of an emergent surgical tracheostomy in a patient with Hunter syndrome.

Case

We were called to anesthetize a 40 kg, 11-year-old boy with MPS II (Hunter syndrome) and subglottic hypertrophy/stenosis for emergent tracheostomy. The surgeon states that he would like to perform an “awake tracheostomy.”

The patient had presented two days earlier with an upper respiratory infection and had rapidly progressive respiratory failure. He had been diagnosed with Hunter syndrome six years previously when he presented for dental restoration after failing to be intubated at a community hospital. He was seen by genetics and deemed a good candidate for stem cell transplantation. His initial intubation for dental repair prior to transplantation proved very difficult. An anesthetic performed two years after transplantation revealed improved airway anatomy. However, subsequent anesthetics revealed a progressively difficult airway. Six months prior to the present admission, the patient underwent microdirect laryngoscopy and bronchoscopy due to complaints of noisy breathing. This exam by an experienced pediatric otolaryngologist was notable for failure to visualize the larynx by both flexible and rigid bronchoscopy. Prior to admission, the patient had been in relatively good health, with a problem list notable for developmental delay, noisy breathing, hypertension controlled with clonidine, and an echocardiogram notable for mild mitral regurgitation, bicuspid aortic valve, and preserved ventricular function.

The patient was being supported in the pediatric intensive care unit (PICU) with nasal BiPAP (biphasic positive airway pressure) with pressures 18/12 on 100% O2. Inhaled Nitric Oxide (iNO) at 20 ppm had been empirically added in the face of oxygen saturations in the 80s. Improvement in oxygenation was noted. On physical examination, the patient had mild suprasternal retractions, but otherwise appeared in no distress, sedated with both propofol (40 mcg/kg/min) and dexmedetomidine (2.0 mcg/kg/hr) infusions. His vital signs included a noninvasive blood pressure reading of 111/76, HR 70 bpm, and oxygen saturations of 80–95%, with his arterial blood gas demonstrating a PaO2 of 50 mmHg on a FiO2 of 1.0.

The patient’s developmental delay precluded an awake surgical approach. Given
his known difficult airway, we felt strongly that manipulation of his airway, either for laryngeal mask airway insertion or endotracheal intubation, could lead to trauma, laryngospasm, and potential loss of airway. We chose to apply topical anesthesia with EMLA cream to the surgical site and subsequently moved the patient to the operating room (OR) with the help of the respiratory therapist and a nurse to transport the patient’s infusion pumps and the BiPAP machine. Prior to leaving the PICU, glycolpyrrolate 0.2 mg IV was administered for its antisialogogue effect.

Once in the OR, and on standard monitors, we began administering further sedation with intravenous boluses of 0.5 mg/kg of ketamine titrated carefully to provide adequate sedation while, closely monitoring oxygenation and ventilation. To provide ventilatory support, we maintained the patient on his BiPAP and iNO, and held an infant mask over the patient’s mouth at a CPAP of 12 mmHg to supplement airway stenting. This maneuver increased the patient’s SpO₂ to 100%. The patient tolerated infiltration of local anesthesia, transtracheal lidocaine, and the subsequent tracheostomy with a total of 140 mg of intravenous ketamine and the continued propofol and dexmedetomidine infusions. The surgeon performed a “starplasty tracheostomy,” suturing tracheal mucosa to skin due to concerns of the patient potentially pulling out his tracheostomy tube in light of his developmental delay. The patient remained stable for the rest of the case. Respiratory parameters remained stable and transport back to the PICU was uneventful.

Discussion

As previously mentioned, GAG deposition throughout the body in patients with Hunter syndrome complicates airway management. In the setting of acute respiratory decompensation, a surgical airway may be the only option and our role may simply be to support the patient for surgical airway access. This patient provided several challenges, but our main concern regarded both the transport of this patient to the operating room and our decision to either obtain a secure airway or simply provide noninvasive airway support until the tracheostomy was in place.

Given that the patient was in a shared and underequipped PICU room, we felt that the OR provided a more controlled environment for the procedure. The patient was sufficiently sedated to tolerate transport, and we were comfortable providing additional sedation with ketamine if necessary. Since the patient was stable on his current noninvasive ventilatory support, we decided to transport the patient while maintaining the status quo, that is, on his current infusions, BiPAP settings, and iNO.

Regarding airway management, there was brief discussion about attempting intubation with a flexible fiberoptic bronchoscope, but given the expected difficulty, recent failure to visualize the larynx, and impending respiratory arrest, we kept it simple by maintaining spontaneous ventilation via his current noninvasive settings, with some additional oropharyngeal CPAP (continuous positive airway pressure). In this manner, we avoided traumatizing an already difficult airway. The surgeon was in the operating room prior to induction of further anesthesia in case a surgical airway was needed sooner than expected. One might even consider this management decision tree simpler than if the patient presented as an outpatient for elective tracheostomy in that the options were extremely limited.

In conclusion, we were able to successfully manage this difficult airway with a “less is more” approach, honest discussion with the surgeon as well as family, and anticipation of problems that fortunately resulted in a successful surgery tolerated well by the patient.

References

ASA Annual Meeting and Alumni Reception

Anesthesiology 2013, the annual meeting of the ASA, will be held October 12–16 at the Moscone Center in San Francisco.

This year’s keynote speaker is Dr. Charles Denham, Editor-in-Chief of the Journal of Patient Safety and cofounder and chair of the Global Patient Safety Forum. Dr. Denham will be joined by actor and patient safety advocate Dennis Quaid, to discuss the progress being made in many hospitals in addressing issues of accountability and patient safety.

Annual Alumni Association Reception

The Stanford University Alumni Association will be hosting a reception on Sunday, October 13, in the Crown Room at the Fairmont Hotel in San Francisco. If you plan to attend, please email Carolyn Rebello at crebello@stanford.edu no later than October 1, and remember to include the names of your guests. ▲ Dennis Quaid and Dr. Charles Denham

For more information, please see ASA’s website at http://www.asahq.org/Annual-Meeting
Space is limited and you must register to attend the course. For more information, please see http://stanfordhospital.org/forPhysiciansOthers/cme/documents/2013-1116_airway_brochure.pdf.

2nd Advanced Airway Management Course

The 2nd Stanford Advanced Airway Management and Fiberoptic Course will take place on November 16—17 at Li Ka Shing Center for Learning and Knowledge.

The course received rave reviews last year and attracted many Stanford anesthesia alumni, as well as anesthesiologists from different parts of the country and abroad.

This intense, two-day course will discuss recent advances in airway management, and will define rational approaches to various difficult airway situations in the OR, ICU, and ED, in both adult and pediatric patient populations. Some of the highlights include 16 lectures and dynamic case presentations, a stand-alone fiberoptic course, and 10 state-of-the-art skills stations that will allow attendees to practice fiberoptic techniques for various scenarios, including supraglottic airway exchange and staged extubation, video laryngoscopy, pediatric difficult airway management, airway simulation, and others.

This year’s course will feature two guest speakers, Dr. Richard Cooper, President of the Society for Airway Management (SAM), and Dr. Seth Manoach, Director of Trauma and Critical Care Fellowship Rotation at Albert Einstein College of Medicine. They will lecture, participate in discussions, and provide hands-on training at the stations. Surgical colleagues from Stanford’s Department of Otolaryngology Head and Neck Surgery will also share their perspective on the difficult airway, and will present an interactive demonstration of a surgical cricothyrotomy technique on pig tracheas.

Do not miss this outstanding opportunity to acquire new knowledge and refine your airway skills.
Faculty Corner

Publications


Faculty Corner


Book Chapters


Abstracts, Posters, Oral Conference Presentations


Darnall BD. Less pain, fewer pills: Optimizing the mind–body connection in women with chronic pain. Presented at the 2013 Women’s Health Forum; Stanford University; May 15, 2013.

Darnall BD. The industry conundrum: The role of industry funding within the APS and at the national conference. Moderator, American Pain Society Ethics Special Interest Group panel presentation. Panelists: Michael Schatman, PhD, Michael Jarvis, PhD, Renee Manworren, RN, John Peppin, DO; New Orleans, LA; May 9, 2013.

Butwick A, Lazo T, Carvalho B. Multivariate analysis of factors associated with maternal temperature after cesarean delivery. Poster presented at SOAP 44th Annual Meeting; San Juan, Puerto Rico; April 2013.


Lam N, Baker E, Fishburn S, Mariano ER, Szabo E, Jaime F, Hammer A. A
double-blind randomized controlled trial on the effects of ultrasound probe position on ultrasound guided nerve block [abstract]. American Society of Regional Anesthesia and Pain Medicine; Boston, MA; May 13, 2013.


Mariano E. Served as meeting and workshop chair. 38th Annual Regional Anesthesiology and Acute Pain Meeting; Boston, MA; May 2–5, 2013.

Mariano E. Ultrasound Guided Perineural Catheter Insertion Workshop. Presented at 38th Annual Regional Anesthesiology and Acute Pain Meeting; Boston, MA; May 2–5, 2013.

Mariano E. Upper Extremity Intensive Workshop. Presented at 38th Annual Regional Anesthesiology and Acute Pain Meeting; Boston, MA; May 2–5, 2013.

Sultan P, Drover D, Carvalho B. Pharmacokinetic modeling and placental transfer of cefazolin administered prior to cesarean delivery. Paper presented at SOAP 44th Annual Meeting; April 2013; San Juan, Puerto Rico.


Websites


DVDs/CD-ROMs

Awards, Honors, and Appointments
Dr. Ed Bertaccini was promoted by the ABA to senior editor for the written board examination in anesthesiology.

Dr. Ed Bertaccini was promoted to full professor as of May 1.
Faculty Corner

Dr. Beth Darnall was appointed to the editorial board of the *Journal of Pain Research* in July.

Dr. Beth Darnall was appointed as a member of the American Pain Society’s Acute Pain Clinical Guidelines Committee.

Dr. Rona Giffard was promoted to full professor as of May 1.

**Invited Talks and Guest Professorships**

Dr. Juli Barr was invited to lecture on the PAD Guidelines at the UCSF Critical Care Medicine and Trauma Conference in June 2013.

Dr. Brendan Carvalho was invited to give the SOAP panel lecture on Analgesics in the breast feeding parturient, at the International Anesthesia Research Society (IARS) Clinical and Scientific Conference; San Diego; May 4–7, 2013.

Dr. Brendan Carvalho was invited to give two lectures at the American Society of Regional Anesthesia and Pain Medicine (ASRA) 38th Annual Meeting; Boston, MA; May 2013: (1) Update on labor and post-cesarean analgesia PBLD: failed regional anesthetic For cesarean section: What do I do now?; and (2) Acute pain medicine in pregnant patients. He was also an instructor in the Truncal Blocks and PBLD: Management of Post-Dural Puncture Headache workshops.

Dr. Brendan Carvalho was an instructor in the Transsthoracic Echocardiography for the Obstetric Anesthesiologist workshop at the Society for Obstetric Anesthesia and Perinatology Annual Meeting; San Juan, Puerto Rico; April 2012.

Dr. Brendan Carvalho gave three invited talks at the Santa Joana Hospital Obstetric Anesthesia Meeting; Sao Paulo, Brazil; April 2013: (1) Anesthetic management strategies for the morbidly obese pregnancy patient; (2) Ultrasound for the obstetric anesthesiologist; (3) Post-cesarean analgesia in the breast feeding parturient.

Dr. Beth Darnall served as chair of the American Pain Society (APS) Ethics Special Interest Group and chair of the steering committee and lead SIG programming at the 32nd Annual Scientific Meeting in Tampa, FL, May 8–10, 2013.

Dr. Beth Darnall delivered the Fundamentals of Pain Management Primer Course on Pain psychology & opioids, at the American Pain Society 32nd Annual Scientific Meeting; New Orleans, LA; May 7, 2013. Dr. Elliot Krane was visiting professor and presented the Robert Smith lecture, Pediatric regional anesthesia: the good, the bad, and the ugly, at Pittsburgh Children’s Hospital and University of Pittsburgh; May 15, 2013.

Dr. Rona Giffard gave the invited talk, Post-treatment with miR-181 antagonmir by intracerebroventricular infusion reduces injury after focal cerebral ischemia, at Lanzhou University Second Hospital and the Second Clinical Medical College of Lanzhou University, Lanzhou, China; May 12, 2013.

Dr. Rona Giffard gave the invited talk, The role of mitochondria in neurogenesis following cerebral ischemia, at Tiantan International Neurosurgical Anesthesia Symposium, Beijing, China; May 17–18, 2013. Dr. Rona Giffard gave the invited talk, Targeting a mechanism to increase plasticity improves recovery from stroke in mice, at Neuro 2013: 36th Annual Meeting of the Japan Neuroscience Society, 56th Annual Meeting of the Japanese Society for Neurochemistry, and 23rd Annual Conference of the Japanese Neural Network Society. Kyoto, Japan; June 20–23, 2013.


Dr. Rona Giffard gave the invited talk, Post-treatment with miR-181 antagonmir by intracerebroventricular infusion reduces injury after focal cerebral ischemia, at Lanzhou University Second Hospital and the Second Clinical Medical College of Lanzhou University, Lanzhou, China; May 12, 2013.
New Library Books

Anesthesia medical librarian Hillary Farkas announced these new additions to the anesthesia medical library. They are all updates of previously published works. Some of the cataloging has changed, so if there is something you use often, make certain you take a look at where it is located in the collection (most are the same as before).

Clinical Anesthesia, 7th ed. Barash, et al. (the 6th edition still available through http://solution.lww.com. Login is anesthes1a, password is ANESTHESIA) RD 81 C58 2013 (This book will soon be available online through www.inkling.com. It will also be available on all mobile devices. Stay tuned.)


Handbook for Stoelting’s Anesthesia and Co-existing Disease, 4th ed. Hines & Marschall, eds. (Includes online access through www.expertconsult.com. Login is hfarkas@stanford.edu, password is anesthes1a.) RD 87 A53 2013.

A Practical Approach to Cardiac Anesthesia, 5th ed. Hensley, Martin, and Gravlee, eds. RD 87.3 H43 P72 2013.

Cote and Lerman’s Practice of Anesthesia for Infants and Children, 5th ed. Cote, Lerman and Anderson, eds. (Includes ExpertConsult.com. Login is hfarkas@stanford.edu, password is anesthes1a.) RD 139 P73 2013.

Social Events

The Second Annual Arts and Anesthesia Soiree

By Craig Chen, MD

The Li Ka Shing Center buzzed with excitement as dozens of anesthesiologists, residents, staff, technicians, friends, and family members arrived for the Second Annual Arts and Anesthesia Soiree on May 30, 2013. As attendees sipped on wine and nibbled hors d’oeuvres, they admired the artwork on display, from fine wooden furniture carved by resident Eric Mehlberg to charcoal sketches by the daughter of VA administrator Ana Hammons to a digital photography slideshow with eight contributors from the department.

There was standing room only when the performances started. Pediatric anesthesiologist Louise Furukawa and her son Jordan opened the evening’s festivities with a Baroque trumpet duet. Classical music was a common theme this year; we had multiple pianists and even a quartet made up of Tessa Walters’s family. Several anesthesiologists reflected on their practices with moving poems as well as vignettes and song. The evening ended with senior resident Jennifer Basarab-Tung singing Schumann’s “Du Ring an Meinem Finger,” a love poem in German.

After a wildly successful event last year, the organizing committee, comprising residents, fellows, faculty, and staff, worked tirelessly the few months leading up to this year’s Soiree. We wanted to celebrate the creative and artistic talents of the department while enriching our sense of community. With more than 30 participants and 150 attendees, the event was a wonderful success. The Arts and Anesthesia Soiree was more than just a social party, however; we want such gatherings to contribute to the medical humanities, enriching discussion within the department about the experience of anesthesiology and offering an outlet for stress to prevent burnout. We are very grateful to department chairman Dr. Ron Pearl for his support of the arts and humanities at Stanford.
Dawn ushered in a beautiful day for the 11th Stanford Anesthesia Department Golf Tournament. Held on August 5, 2013, at Stanford University Golf Course, the tournament included 31 participants, broken into 7 teams of 4 golfers and 1 team of 3 golfers.

The format was a scramble. All players in a team teed off. The best ball was selected for the 2nd shot and all players hit from that position. The best ball was again selected and the whole process repeated until the ball was in the hole. The team with only 3 players was allowed one more drive and one more putt by a player of the team’s choice.

The team of Drs. Justin Pollock, Chris Press, Chris Miller, and Jan Sliwa came dressed up in their Hawaiian gear and looked terrific (see picture). This is the first time a team has actually dressed up and it added to the “general chaos” of the event. Thanks guys. It is a sad fact that I took photographs with my camera, but lost it during the tournament. If others took pictures from the event, please send me copies at brockutn@stanford.edu. Dr. Lorne Eltherington snapped the photos included here. Thank you, Lorne.

After the game, a finger supper and drinks were served on the patio overlooking the 18th green and prizes were awarded.

Reed Harvey (CA3) contributed four trophies that were given to the winners. The trophies were sculptures of golfers and included the inscription: “Winner Stanford Anesthesia Golf Scramble 2013” (see photo of the winners). The trophies were a great success and we are all grateful to Reed for this very nice gesture. Michael Chen has very kindly offered to buy next year’s trophies.

The winners, with a great score of 60, were Drs. Michael Chen (faculty), James Wall (pediatric surgeon), Francis Kim (pediatric intensivist), and Matias Buzoni (pediatric surgeon). We christened them the pediatric team. Well done!

Second-place winners, with a score of 61, were alumni Drs. John Kelley and Don Keating and OR tech Scott Barkman.

Third place, with a score of 64, went to last year’s previous winners, Drs. JJ Desai (alumnus), Reed Harvey (CA3), Ryan Mountjoy (CA3), and Adam Djurdjulow (CA3).

The closest to the pin on the 8th hole was Dr. Rob Meintz (alumnus), at 13 feet.

Dr. James Wall had the longest drive of the day, with a massive 280 yards on the 12th hole. Several of the other golfers made a lot of excuses about trees and birds that got in the way...

We are all grateful to the department for their support of this venture. I am hopeful that we will get together again in April. (Next year’s golf calendar won’t be out until later this year). As an aside, this year’s event was held in August because the golf restaurant was closed from February to July.

If you would like to play next year, please contact brockutn@stanford.edu
Play Ball!

By Ryan Mountjoy, MD

The time has come to venture out of the windowless operating rooms and into the bright sunshine for the first (and, it is hoped, annual) attending-versus-resident softball game and barbeque. We will play on Saturday, September 14, from 2:00 PM – 6:00 PM at Nealon Park in Menlo Park. We have the softball field and barbeque area reserved during that time.

Before the inevitable trash-talking and intimidation tactics of slow pitch softball begin, however, I need everyone who’s interested in playing to RSVP to me at ryanmountjoy@gmail.com. Also, if one of the attendings is interested in being a captain (i.e., to organize batting order, fielding positions, etc.) let me know.

The department has graciously offered to supply the barbeque after the battle on the diamond, so in your RSVP please note how many will be in your party so we can have an accurate headcount for the caterer. This is a family-friendly event, so the more spectators the better!

Brush off those cleats, hit the batting cages, and stretch out those hammies, and get excited for what should be a great afternoon!
Dr. Brice Gaudilliere and his wife are delighted to announce the birth of their daughter, Kalea, born on May 29 at 7:30 PM. Kalea weighed 8 lbs, 10 oz, and was 50 cm long. Her father is also happy to report that she came equipped with 10 toes, 10 fingers, 2 eyes, and 2 ears. “Special thanks to Nick Anast, Alex Butwick, and Jeremy Collins for extraordinaire OB anesthesia care!” Brice said.

Justin and Meghan Workman welcomed daughter Eleanor Rose Workman on Sunday, June 23. Calling her the “first addition to the Workman clan,” Justin proudly listed Eleanor Rose’s weight at 5 lbs, 11 oz.

Dr. Aileen Adriano and her husband Buddy are thrilled to announce the birth of their son, “Leo,” aka Lionel Xavier Adriano James, born July 1 at 9:25 AM. Leo tipped the scales at 9 lbs, 7 oz, and measured 21 ¾ inches. “Thanks to our great anesthesia team, Drs. Collins and Mirza for their wonderful care in the OR and Drs. Harvey (for my 16 g IV!), Quick (for my meds), and Jeter for their help during this joyous occasion,” Aileen wrote.
Dr. Aahmed Zaafran and his wife would like to introduce baby Ayah Zaafran. “Mom and baby are healthy, thank God. Much love to my new Stanford family,” Ahmed said.

Dr. Ed Mariano and his wife Karley have produced a baby brother for their son Luke. Max Eli Mariano was born at Lucile Packard Children’s Hospital on August 13 at 2:32 pm, weighing 8 lbs, 2 oz, and measuring 20 inches. “We are so grateful for our obstetrician, Dr. Christie Coleman, and our stellar anesthesiologist, Dr. Steve Lipman. Mom and baby are doing great! Thankfully, the pushing part didn’t take as long as last time! Luke has already been in to visit his new little brother, Max,” Ed said.

Stanford anesthesia alumnus Dr. Billy Hightower has apologized for submitting this birth announcement more than a year late, but he and his wife Tira would still like you to know that they are the proud parents of their third girl. Tessa Willow Hightower was born on February 23, 2012. She resides with her parents and sisters in Bloomfield, Michigan, where her father is in private practice.