Mission (not yet) Accomplished!

Maurice S. Albin, M.D., M.S. (Anes)
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There are times when the confluence of random events can move one to action where ordinarily such individual happenings might have been ignored. I was examining some of my burgeoning files in my home office when I came across one labeled “The Future of Neuroanesthesia,” a position paper on subspecialty recognition that I prepared for the 2003 SNACC meeting. Since I was not overwhelmed by the positive response of our members, I put it together with other background material to be shredded. Included in this file was a paper by Art Lam entitled “SNACC Should Develop Neuroanesthesia Practice Guidelines: The Specialty Needs It, the Patient Deserves It, and the Third Party Will Soon Demand It,” Journal of Neurosurgical Anesthesiology, October 2003. An abstract of this paper by Dr. Lam follows below:

“Neuroanesthesia is a subspecialty that has come of age; it has wide recognition and exists as a division in virtually all academic centers, many with fellowship training programs. Neurosurgeons have come to expect neuroanesthesiologists for the provision of special care and expertise for patients with major neurologic disease, and many centers have developed local protocols based on scientific and physiologic principles. Thus, an information standard of neuroanesthesia already exists. It follows that not only is there a need and an urgency to establish standards or guidelines of neuroanesthesia, but also I believe the Society of Neurosurgical Anesthesia and Critical Care (SNACC) has a moral responsibility to the public and possibly an economic pressure to do so. This article will develop logically the arguments for establishment of such standards.” (1)

This file also contained a listing and description of the Neuroanesthesia Fellowships extant in the USA in 2003, many letters from neuroanesthesia colleagues expressing their opinions pro – or – con relating to the idea of specialty certification, and as many papers showing the positive relationship between outcome and volume of procedures (2) (3) carried out in the surgical environment.
I would like to begin by stating that our leadership has to reflect over and then develop a long range plan to serve as a framework for our future activities. An important area concerns the state of our Neuroanesthesia Fellowship Programs. It appears that we have only incomplete data as to the number of programs, Fellows, and descriptions of the makeup of the curriculum. There is no doubt that vibrant Fellowship Programs are the lifeblood of our subspecialty and we must obtain the demographics of all the programs in North America. I would make the suggestion that a special Fellowship Committee be formed to gather pertinent information about all Neuroanesthesia Fellowship Programs and report to the membership before the SNACC meeting in 2009. Once this information is available, it is suggested that SNACC develop clinical guidelines for our neuroanesthesia programs and practices. The establishment of these guidelines will allow us to standardize the educational, clinical, and research aspects of our Fellowship Programs so that if we decide to do so, we can petition to qualify for ACGME (The Accreditation Council for Graduate Medical Education) accreditation joining the other subspecialties including Critical Care Medicine, Pediatric Anesthesiology, Adult Cardiac Anesthesiology, and Pain Medicine. We do have many outstanding Neuroanesthesia Fellowship Programs throughout North America and the standardization of our Fellowship goals appears to be reasonable and attainable within a short period of time.

It is not difficult to recognize that the complexities of today's neurosurgical procedures necessitate an equivalent neuroanesthesia expertise. Today's inexorable move towards regionalization and centralization of health care makes it even more important to provide the skilled neuroanesthesia patient care. One of the fetters to this necessary growth of our Fellowship Programs is the inhibitory effect of assuming, as the ABA does, that a Diplomate is qualified to practice in any of the anesthesiology specialties – yet paradoxically, it allows certification in Pain Medicine, Critical Care Medicine, and Hospice Palliative Medicine, the rationale being to obviate competition from other specialties practicing in the same arena! I still cannot understand the harm that occurs when we try to reward those trying to increase the professional skills of the Anesthesiologist. Do we not see over and over again in most areas of endeavor that constant exposure and experience is rewarded with significant better outcomes as a rule – whether in carotid artery surgery, electrical engineering or in trying to repair a malfunctioning automotive transmission? It seems as if a minefield is laid down in front of us declaring "don't go over the extra mile to achieve better outcomes!" Or, as a neuroanesthesia colleague of mine once mentioned to me, "It appears as if the newly married bridegroom, carrying the bride in his arms, is barred from crossing the threshold into the bridal chamber, by the appearance of a barred double-locked door."

About two or three days later, I received the May 2008 ASA Newsletter and, on thumbing through it, I was intrigued by the article from Randall M. Clark, M.D. titled “Subspecialty Certification in Advanced Pediatric Anesthesiology.” The final leg of the “hat trick” occurred nearly 48 hours later, when, during a conversation with Andy Kofke on a different subject, mention was made of the recent paper by Dr. Clark (4), at which time Andy invited me to submit a paper to the SNACC Newsletter for the next issue on my thoughts regarding subspecialty certification in neuroanesthesia. I told him that I would take his kind offer under consideration and I spent the next five or six days reviewing the material in my nearly-shredded file. So after considerable reflection, I decided to come out of “mothballs,” not to shred my 2003 file, to evaluate the paper by Dr. Clark, and to again make my thoughts known about the status of current and future neuroanesthesia.

My paper for the 2003 SNACC meeting emphasized the remarkable changes that have transformed our neuroanesthesia practices since my own personal full-time involvement in 1962 and since the 1973 organization of the predecessor to SNACC - the Society of Neurosurgical Anesthesiology (SNA) (5). This progress has been manifested by our enhanced knowledge of the dynamics of brain and spinal cord physiopathology and its interaction with the anesthetic state; by the formation of Neuroanesthesia Fellowship Programs in many of our University Academic Centers; by developing standards of care for many neuroanesthesia procedures; by bringing neuroanesthesia considerations into the residency and medical school curriculum; by the formation of SNACC and its recognition as a spokesman for our subspecialty by the ASA; and by the existence of the dedicated Journal of Neurosurgical Anesthesiology with Cottrell and Hartung as Editors – making this publication a focal point for world neuroanesthesiology.

Five years have now elapsed since I presented my thoughts about the future of neuroanesthesiology and, to my mind, we do not appear to have made significant progress in many areas – economic pressures have worsened in terms of funding for academic programs and research, our Neuroanesthesia Fellowship Programs have not enlarged and fewer Residents appear to be interested in pursuing Neuroanesthesia Fellowships. Essentially, it appears that we are not moving forward and, while our SNACC membership appears to have stabilized, we have not increased our numbers significantly over the past five years.

I refuse to believe the conventional wisdom that our problems mainly reflect the doldrums due to pervasive effects of our economic downturn on the lack of research dollars and decreasing service income. I believe that our institutional malaise indicates a membership that has not been energized sufficiently over the past half a decade. The principal question is what can be done to move SNACC forward?
We certainly owe a debt of gratitude to Dr. Randall Clark who, like the biblical Joshua, is the trumpeter for the cause of specialty certification in Advanced Pediatric Anesthesiology and has delineated the trials and tribulations in circling the Jericho-like walls of the byzantine bureaucracy opposing this change. He has explained the steps that could be taken by the Society of Pediatric Anesthesiology (SPA) to move along their petition for certification. The players involved are the ABA, ACGME, the ABMS (The American Board of Medical Specialties) and the ASA. It is recommended that this paper be read in toto by our membership. Suffice it to say, there appears to be considerable opposition to the SPA's application for certification. The ASA Board of Directors overwhelmingly voted down the SPA application after submission. This decision will now be considered by the ASA House of Delegates this Fall where considerable opposition is expected.

The move to subspecialty recognition has a number of routes mentioned in the paper by Clark in the ASA Newsletter. Another special route not mentioned there has been organized by Neurologists who have set up a United Council for Neurological Subspecialties (UCNS, Inc.), drawn from 5 parent organizations whose mission is to, “...provide for accreditation and certification with the goal of enhancing the quality of training for physicians in neurological subspecialties and the quality of patient care. The UCNS focus will be on subspecialties too small in number to meet the accreditation requirements through the Accreditation Council for Graduate Medical Education (ACGME) and the certification requirements through the American Board of Psychiatry and Neurology (ABPN).”

Again, I have made a plea for strengthening our Fellowship Programs and have advocated that we aim for subspecialty certification. As I stated five years ago, I realize that we are now living in a difficult economic period and that it appears the hierarchy of organized Anesthesiology is against it, but I can think of no better way to insure the propagation of the high standards of care that we have fought for over the years than to have the expertise that subspecialty certification will bring in its wake. This would force the teaching departments in academic centers to move resources to develop teaching fellowship programs in neuroanesthesia. Certification would eventually force a change in credentialing standards and thus widen the available pool of much needed Neuroanesthesiologists. Perhaps then, we might be able to state, Mission Accomplished!

REFERENCES


(2) Birkmeyer JD, et al. NEJM, 2002.


The UCNS Pathway-
Something for NOW! ??
Andrew Kofke MD FCCM
University of Pennsylvania
SNACC Newsletter Editor

Think about being in the position of a graduating anesthesia resident, considering a subspecialty. You really enjoyed your neuroanesthesia rotations and perhaps have even done some neuro-oriented research. You do an informal analysis of current trends and try to project them to your future career over the next 40 years or so. You notice that the CRNA’s and other advanced practice nurses are making significant headway in most areas of medicine, efficient allocation of care givers is a likely future (ie, well patients see less well trained practitioners and complex patients see physicians), research dollars will be increasingly scarce, and you want a secure future. You
attended the AUA meeting last year and have bought into the notion promulgated by Schwinn that fellowship trained anesthesiologists will be best positioned to deal with these trends. So you look around and what is available? You can do fellowships in critical care, pain, and palliative medicine in accredited programs and take an exam earning a certificate documenting your competence in the field, perhaps an important, perhaps essential, defense against those suggesting they can match your skills. You can partake an ACGME accredited fellowship in pediatric or cardiac anesthesia, but no certificate of competence is available. Better than nothing you think. You can take a non accredited fellowship in neuroanesthesia, your real area of interest and simply claim you were well trained and know what you are doing with no real administrative defense vs the future CRNA or other advanced practitioner who claims as much skill as you have.

It should not take a neurosurgeon to figure out why so few talented young anesthesiologists are going into neuroanesthesia.

One solution is that proposed by Dr Albin, to follow the path being taken by our pedi anesthesia colleagues aiming to develop fellowship accreditation and subspecialty certification processes in neuroanesthesiology. This remains controversial and the pathway to this end will be both tortuous and torturous.

The United Council of Neurologic Subspecialties as described by Dr Albin (www.ucns.org) provides a non-ACGME pathway for both accreditation and certification in several small neurologic subspecialties. One of these is neurocritical care, for which SNACC is a sponsoring organization. As such neurocritical care certification by this pathway is available to anesthesiologists. This is a two year fellowship. My institution has bought into this program and we now have a robust two-year neurocritical care fellowship program. Notably, since this program’s inception I have fielded queries from three anesthesia residents regarding the possibility of undertaking this fellowship. This is previously unheard of......an anesthesia resident seeking a two year clinical fellowship. What is the attraction?

The above noted market force expectations are one likely factor. So if you like neuro and don't have any available pathway for societally recognized training in neuroanesthesia this seems a plausible route. The program requirements to sit for the two year neurocritical care exam follow:

- ≥ 12 months on clinical service ICU/OR
- ≥ 6 months neuro critical care emphasis (NICU)
- 12 months research or other electives

Examination of these requirements from the perspective of the graduating anesthesia resident reveals this as a pathway to acquire neuroanesthesia training, embellished by neurocritical care training plus participate in research, plus...... in the end have a certificate of competence. Just about perfect!! And this is available right now.

In the meantime SNACC can continue to debate this, perhaps concurrently evaluating the nationwide interest of anesthesiologists participating in the UCNS pathway and the success of our colleagues in cardiac and pediatric anesthesia in trying to secure an ACGME-ABA pathway.

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**Neuroanesthesia Practice Standards: We Need Data, Not Dogma**

**Gregory Crosby, MD**

Reprinted from *Journal of Neurosurgical Anesthesiology, Vol. 15, No. 4, 2003  with permission of the publisher*

Proposals to standardize training in and/or the practice of neuroanesthesia and neurocritical care are well intentioned and noble but are premature at best and at worst could retard the growth of our subspecialty.

The growing impetus for standardization comes from several sources—the increasing technical complexity of healthcare, the growing sophistication of consumers, hospitals and providers looking for competitive advantage, and too many lawyers. However, the most powerful driver
is probably money. In particular, huge bills for the healthcare of their employees confront large purchasers of healthcare (read “corporations”). Also, it’s been observed repeatedly that management of the same medical or surgical condition varies enormously by physician, institution, and even geographic region, often without evidence of better outcomes with more expensive treatments. Against this background, the goal of a CEO of a company who answers to a board of directors and shareholders expecting ever-higher returns would be clear: make patient care algorithmic and cheap. Being so blunt would generate hard feelings and bad press, however, so you’d claim instead you want to increase “value” (ie, reduce cost but improve patient outcomes). If you are really clever, and most people making tens of millions of dollars per year are, you’d band together with other companies having similar objectives and give the group a catchy name and a lofty agenda: the Leapfrog Group is born!

The Leapfrog Group is basically a consortium of public and private healthcare purchasers. Its CEO-led board has adopted three initiatives—computerized order entry, surgical procedure volume standards, and ICU staffing by intensivists—intended to increase the quality and value (read “decrease cost”) of healthcare. Maybe these things will work, but let’s not be naïve—it’s first and foremost about saving money. Remember, these are the same folks who sold “damaged care” as a way to improve healthcare for their employees, and we all know what an improvement that has been. These are also the same folks who have made accountants sexy, hand cuffs a fashion accessory for the well-attired CEO/COF, and thousands of employees wonder what happened to their retirement money. Think of the massive financial scandals at corporations like Enron, Tyco, Global Crossing, and WorldCom. Ironically, this corruption occurred despite hundreds of pages of existing, widely accepted accounting standards! The point is that especially in matters of healthcare, large corporations/healthcare purchasers cannot be trusted, because they have a major conflict of interest. The Leapfrog Group and its agenda should be viewed suspiciously and the highest level of proof demanded before adopting its proposals.

Even if one dismisses this cynical view and accepts the notion that standards could be useful, how would we design them? Presumably, we’d look at evidence. The problem is that in neuroanesthesia and neurocritical care, we have little good evidence to support practice standards. There are many controlled studies using surrogate endpoints for patient outcome such as intracranial pressure or cerebral blood flow. These things matter but are not the same as clinical outcome and don’t necessarily even have a relationship to it. In fact, neuroanesthesia and neurocritical care are nearly devoid of large, prospective randomized controlled trials (RCTs) examining patient outcome. There are some small RCTs in our field, but most show no striking differences between alternative treatments. Is expert opinion and consensus are frequently wrong. Consider recent trials of lung volume reduction surgery for COPD,(4,5) knee arthroscopy for osteoarthritis,(6) hormone replacement therapy in postmenopausal women,(7) and the use of pulmonary artery catheters.(8) In each case, the procedure or therapy was embraced by the experts, supported by clinical experience and many observational studies, and employed in thousands, if not hundreds of thousands, of patients. Yet, when put to the real test of a RCT, each was found to be ineffective at best, harmful at worst. We have our own examples of changing winds and disappointments. There was a time not long ago when dehydration and routine hyperventilation were standard for the management of the head-injured patient. Now we don’t routinely do either, although an independent review has judged the data to be inconclusive either way.(9) Similarly, despite overwhelmingly positive animal data, favorable clinical experience, and encouraging small clinical studies, the promise of mild hypothermia for brain protection of the head-injured patient has not matched expectations.(10) The point is simply that standards should not be a matter of opinion. Words like “standard” or “best practice” have a powerful, coercive effect on the way we think and practice. Accordingly, standards must be based on powerful evidence. In neuroanesthesia and neurocritical care, such evidence does not currently exist. Until it does, neither should standards.

Some will protest that there is evidence that a physician trained in critical care medicine improves the outcome of critically ill patients. Isn’t this an argument for standards? Indeed, some studies report that an intensivist-model critical care unit (ie, one covered by a physician who works mainly in the unit and is trained in critical care) reduces mortality, length of stay, and cost of care, at least for a few specific illnesses.(11,12) However, it is probably far more complicated than that. Even proponents of the intensivist model recognize the importance of other factors. Two of the more important ones seem to be nursing ratios and workload and organizational issues such as the ICU staffing model (ie, whether a unit is open, semi-open, or closed). Recently, for example, a large study of neonatal ICUs found that risk-adjusted mortality was related to nursing workload but not the availability of a physician.(13) In fact, physician availability was associated with an increased risk of nosocomial infections, presumably because the infants were subjected to more procedures in physician-intense units. The neuro ICU has not been as well studied as general and neonatal ICUs with respect to the role of critical care specialists. While a few reports suggest that neurocritical care reduces mortality from intracerebral hemorrhage, the results are less compelling because the studies were small or retrospective and/or used historical controls.(14,15) Overall, if studies of intensivist-model ICUs demonstrate anything, it is the value of adequate case volume and specialization, not standardization. Specialization is about focused knowledge and experience, critical thinking, and comfort and confidence in a certain environment. No one would argue that the experience of a specialized provider, whether it is a nurse or physician, with
specific kinds of patients, illnesses, and clinical problems is important. The critical care studies do not, however, make a case for standard curricula, treatment protocols, or sets of credentials. Specialization and standardization are not one and the same, and we must be careful not to confuse them.

Standardization of training and/or practice in neuroanesthesia or neurocritical care could actually harm the subspecialty. A new constraint or credential, if it prevents those who don’t meet the training or practice standards from working in the area, would in economic terms be called a “barrier to entry.” But it seems foolish to erect barriers when there aren’t many of us and we have so few new recruits even now. It’s never been particularly popular. While a handful of people nationally choose to do a neuroanesthesia fellowship, it’s never been particularly popular. While societies for cardiothoracic, pediatric, and ambulatory anesthesia have grown, membership in SNACC has declined or been relatively stagnant. Might we be working to create an exclusive club that still fewer will want to join? Adding time to training may add cost but not value for the trainee. There is a limited market for neuroanesthesiologists outside large academic medical centers or tertiary referral hospitals because there simply aren’t enough “big” neuro cases out there. Unlike a fellowship in cardiac or pain, a neuro fellowship is not bankable. Now, with a robust and lucrative job market in private practice beckoning and fewer university jobs offering time/opportunities for academic development, the opportunity cost of an extra year of training is huge and prospects for a fulfilling career in academe are unattractive. In fact, a large percentage of pediatric and critical care fellowship positions go begging each year, and these credentials are significantly more marketable than credentials in neuroanesthesia. This could be a major problem, even just within our own institutions, if it gets to the point where standards dictate that only a neuroanesthesiologist or neurintensivist can care for a sick neurosurgical or neurology patient. Will we be able to cover all the cases all of the time? Most institutions won’t have the personnel, and the pipeline is only a trickle. In addition, super-subspecialization is inherently inefficient from a staffing/economic perspective and results in lost skills required of a generalist. We should have good evidence it’s worth it and be sure someone sees enough value to be willing to pay for the inefficiency.

Far more importantly, standardization can have a chilling effect on innovation and discourse. Once a standard is adopted, people no longer think critically about the matter. A standard has an aura of authority and certainty that discourages open dialogue and discussion. For fields like ours in their adolescence, this can impede growth and development. Diversity in attitude, training, and practice is probably quite common across individuals and institutions in our field. Some would argue that such variability is bad and that there must be a “best” way. It’s this very argument that has been used by managed care organizations to eliminate variability—and cost—that does not produce better outcomes. But differences of opinion and practice, so long as they do no harm to our patients, can also have a positive influence because they force debate and reevaluation. From disagreement often comes research and hypothesis testing that helps strengthen the scientific basis of a field and moves it forward. If diversity is good in society and the workplace, why try to reduce it in our programs, operating rooms, and ICUs? As a young specialty, with much growing left to do, we adopt training or practice standards based on marginal evidence or well meaning opinion at the peril of creating an intellectually stifling atmosphere that hinders the attractiveness, inventiveness, and maturation of the field.

The fact is, we as physicians already have standards, and lots of them—national board exams, state licensing boards, credentialing committees, board certification, residency program certification, etc.—and more are being added as we speak. We probably have more standards than any industry. Before adding more, we must clearly define the problem additional standards are intended to address. Do we in neuroanesthesia and neurocritical care have a problem, or are we following the crowd to standardize to make ourselves seem special, needed, and secure? Is it about the patient or about us? Are neurosurgical patients being harmed when care is provided by a nonneuroanesthesiologist? Are there certain cases where we matter most and, if so, what are they? How much training is required, how many cases, and who should be doing the training? Are certain anesthetic techniques associated with superior neurologic outcomes? Before certification of pediatric anesthesia fellowship programs was approved, pediatric anesthesiologists had demonstrated a higher incidence of adverse events when young children were cared for by a non-pediatric anesthesiologist.(16,17) Cardiac anesthesia, likewise, had its infamous anesthesiologist #7.(18) By contrast, neuroanesthesia and neurocritical care have no comparable evidence that the training or experience of the practitioner matters. If we believe we do, we should be prepared to prove it.

What we need is science, not standards. First and foremost, we should define the problem by conducting prospective, appropriately powered studies to determine whether the provider’s training/experience and the care setting influence meaningful economic and patient outcomes. Do we, in fact, improve patient care and add “value”? Answering this question should be a minimum standard expected of those who support creating a standard. We also should establish a rigorous, data-driven process to evaluate the legitimacy of proposed standards for training and/or practice in neuroanesthesia and neurocritical care. The highly structured process used by the ASA to evaluate and develop its practice standards, though imperfect, is a reasonable model. Opinion and consensus are weak and unacceptable standards for setting standards. The best way to “raise the bar” of our subspecialty— increase its visibility, generate enthusiasm, attract the best and brightest—and improve the quality of care we provide
is to demonstrate convincingly that particular patterns of care and training/experience in neuroanesthesia or neurointensive care make a meaningful difference in patient outcome. We're not there yet, but healthy debate in a forum such as this is a good first step. Do any of us wish to be a standard neuroanesthesiologist or neurointensivist? I hope and trust we are aiming higher than that.

REFERENCES
SNACC: Basic and Clinical Neurosciences in Perfect Harmony

Sulpicio Soriano, M.D., F.A.A.P.,
President, Society of Neurosurgical Anesthesia and Critical Care
Harvard Medical School
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In an editorial titled “Anesthetic Neurotoxicity: The Collision Between Laboratory Neuroscience and Clinical Medicine,” Michael M. Todd, M.D., gave his assessment of a public discussion at the 31st Annual Meeting of the Society of Neurosurgical Anesthesia and Critical Care (SNACC) regarding the laboratory evidence on anesthetic-induced neurotoxicity and its relevance to anesthesia for the pediatric patient. This discourse between a world-renowned neuroscientist and clinicians in the audience exemplifies the provocative and intellectual nature of our annual meetings. Basic science clashed with clinical observation in a cacophony of debaters, which in turn continues to fuel an active dialogue within the SNACC community.

International Scientific Community
Since its founding in 1973 by prominent basic and clinical scientists in neuroscience, neuroanesthesia and neurosurgery, SNACC has emerged as the premier international society in this field. It is this multidisciplinary nature of SNACC that make it unique among the various subspecialty societies. Thirty-six years later, SNACC maintains this tradition of scholarly and provocative annual meetings. This success is largely due to the collective talents of our members. What sets us apart from the other subspecialty societies is our diversity. What other group can boast a membership composed of Ph.D.s, M.D.s, DVMs, anesthesiologists, intensivists, fellows, physiologists, molecular biologists, internists and pediatricians? The breadth of our practice has grown beyond neurosurgery into neuroradiology and neurocritical care in the clinics, and cognition, memory and mechanisms of anesthesia in the basic sciences.

James E. Cottrell, M.D., a SNACC past president, delivered the Emery A. Rovenstine Memorial Lecture at last year’s ASA Annual Meeting. He highlighted the broad research accomplishments by neuroanesthesiologists and intensivists and emphasized the significance of research and education in neuroanesthesia, which is at the core of the SNACC mission. Furthermore, no other subspecialty group has the international following that we do. Several of our recent past presidents are from Germany, Italy and the Netherlands. This union provides a rich environment, both at our annual meeting and our Web community, which truly promotes our mission to “advance the art and science of the care of the neurologically impaired patient.” This common goal brings us together as an international community and also prompts us to pursue initiatives designed to advance our specialty. Martin Smith, M.D. (United Kingdom) and Kristine R. Engelhard, M.D. (Germany) head the international affairs committee and have engaged our sister societies in Italy (DANTE), India (ISNACC), the U.K. and Asia (ASNACC). Their goal is to promote educational and scientific collaboration between these organizations. This is certainly uncharted water and promises to be a growth area for SNACC.

Neurocritical care is also at the core of our mission and is an area where SNACC vigorously promotes greater inclusion. With this in mind, the SNACC Board formally accepted the United Council for Neurologic Subspecialties (UCNS) invitation for a subspecialty membership. Ansgar Brambrink, M.D., W. Andrew Kofke, M.D., and Michael J. Souter, M.D., have been exploring avenues for accreditation of neuroanesthesia-based neurocritical care fellowship training. Recently, UCNS has established a certification process for neurocritical care. Several of our members met these requirements and received certification for neurocritical care. Given the prolonged nature of fulfilling both the traditional American Board of Anesthesiology critical care and the UCNS neurocritical care certification, our neurocritical care committee is developing recommendations for a hybrid fellowship training program that could satisfy both certifying bodies.
Spreading the Word
Our Journal of Neurosurgical Anesthesiology (JNA) also serves as the official journal of our sister subspecialty societies in France, Germany, U.K., Korea, Japan, Mexico and India. It just received an Impact Factor of 2.53 for 2007. Among journals categorized under anesthesiology by the Institute for Scientific Information, JNA showed the greatest gain since 2006, and it now ranks sixth out of 22, continuing a trend that began in 2002. Drs. Cottrell (editor) and John D. Hartung (associate editor) deserve our gratitude for enhancing the status of JNA and providing a forum for important research emanating from the worldwide neuroanesthesia and critical care community. Furthermore, two prominent past presidents of SNACC and renowned neuroanesthesiologists Adrian W. Gelb, M.D., and David Warner, M.D., serve on the editorial boards of Anesthesia & Analgesia and Anesthesiology, respectively.

Our Web site www.snacc.org and newsletter, SNACCNews, serve as focal points of SNACC programs and resources. Both are edited by Dr. Kofke. The Web site features a “SNACC Blog,” by Alex Bekker, M.D., which is a Web site problem-based learning discussion on challenging clinical problems in neuroanesthesia and critical care. Other members of the education committee are refining the content outline and bibliography for neuroanesthesia trainees.

36th Annual SNACC Meeting
Gregory J. Crosby, M.D., our Vice-President for Scientific Affairs and Education and Program Director, has assembled a compelling scientific program for our annual meeting at the Rosen Centre Hotel in Orlando on October 17, 2008. In keeping with the broad and diverse interests of the SNACC membership, the program will be highlighting two provocative topics in neurosciences, “Imaging of General Anesthesia-Induced Loss of Consciousness” and “The Aging Brain.” The former will be presented by Emery Brown, M.D., an anesthesiologist from Massachusetts General Hospital and a faculty member of both the Harvard Medical School and the Massachusetts Institute of Technology. Dr. Brown is a recipient of a 2007 Pioneer Award from the National Institutes of Health. The clinically relevant issue of the senescent central nervous system will be discussed by Dr. Crosby and Donald S. Prough, M.D., both renowned clinician-scientists in our field. Pekka O. Talke, M.D., and his scientific abstract review committee received more than 120 submissions from our membership. These topics range from molecular biology of CNS injury to evidence-based techniques in neuroanesthesia and critical care. Relevant publications in the field of neuroanesthesia and critical care will be discussed by a panel of editors from Anesthesia & Analgesia, Anesthesiology and JNA. This will be followed by a pro-con debate on the utility of intracranial pressure monitoring in clinical care. Original scientific research has remained an important focus of our SNACC annual meeting. It is through this discourse between clinician and scientist, molecular biologist and engineer, and statistician and behaviorist, that the SNACC community can co-exist in harmony.

References:

36th Annual SNACC Meeting 2008
Orlando Florida
October 17, 2008
BE THERE!
36TH ANNUAL MEETING

9.25 Hours CME Credit

Friday, October 17, 2008
Rosen Centre Hotel
Orlando, Florida

Plan to attend the Pre-Meeting Dinner Symposium Antihypertensive Management on Thursday, October 16.

Jointly sponsored by the American Society of Anesthesiologists (ASA). This meeting is presented one day prior to the ASA 2008 Annual Meeting.
Pre-Meeting Dinner Symposium - Thursday, October 16

This dinner symposium is made possible by an unrestricted educational grant from The Medicines Company and is a benefit of SNACC membership. Nonmembers may register for a fee.

Antihypertensive Management
Moderator: Monica S. Vavilala, M.D.

5:30-6:30 p.m.  Registration
6:00-6:30 p.m.  Reception
6:30-7:30 p.m.  Dinner
7:30-9:00 p.m.  Aneurysmal Rupture
                Michael J. Souter, M.B., Ch.B., F.R.C.A.

                Carotid Endarterectomy
                Adrian W. Gelb, M.B., Ch.B., F.R.C.A.

                Emergence from General Anesthesia
                Mary Sturaitis, M.D.

Friday, October 17, 2008

7:00 - 7:45 a.m.  Breakfast and Registration
7:55 - 8:00 a.m.  Welcome Address
                  Sulpicio G. Soriano, III, M.D., President
8:00 - 9:00 a.m.  Basic Science Keynote Lecture
                  Moderator: Deborah J. Culley, M.D.
                  Multimodal Imaging of General Anesthesia-Induced Loss of
                  Consciousness
                  Emery N. Brown, M.D., Ph.D.
9:00 - 9:30 a.m.  Poster Session Announcement and Coffee Break
                  Pekka O. Talke, M.D.
9:30 - 11:15 a.m. Poster Session 1 Walkaround with Moderators
11:15 a.m. - 12:30 p.m. Minisymposium 1 – The Aging Brain
                        Moderator: Sulpicio G. Soriano, III, M.D.
                        The Good, Bad and Ugly of Brain Aging
                        Gregory J. Crosby, M.D.

                        Vulnerability and Response of the Old Brain to Injury
                        Donald S. Prough, M.D.
12:30 - 2:00 p.m.  Business Lunch and Award Presentations
2:00 - 3:00 p.m.  Minisymposium 2 – The Editors Editorialize
                  Moderator: Michael M. Todd, M.D.
                  Adrian W. Gelb, M.B., Ch.B., F.R.C.P.C; John Hartung, Ph.D.;
                  David S. Warner, M.D.
3:00 - 3:20 p.m.  2008 John Michenfelder New Investigator Oral Presentation
                  Moderator: Ansgar Brambrink, M.D., Ph.D.
3:20 - 3:30 p.m.  Poster Session Announcement and Coffee Break
                  Pekka O. Talke, M.D.
3:30 - 5:00 p.m.  Poster Session 2 Walkaround with Moderators
5:00 - 6:00 p.m.  Clinical Forum – Controversies in Neuroanesthesia
                  Does ICP Monitoring and Management Influence Outcome?
                  Moderator: John C. Drummond, M.D., F.R.C.P.C.
                  Pro: Arthur M. Lam, M.D.
                  Con: Martin Smith, M.B.B.S., F.R.C.A.
6:00 p.m.  Closing Remarks
                  Sulpicio G. Soriano, III, M.D.
6-7:30 p.m.  Wine and Cheese Reception
              Sponsored by Aspect Medical Systems

Plan to attend the Pre-Meeting Dinner Symposium! Please check the appropriate box on the registration form!
Asian Society for Neuroanesthesia and Neurocritical Care

The first congress of Asian Society for Neuroanesthesia and Critical Care (ASNACC) will be held from Nov 28th to Dec 1st 2008 at one of the most vibrant city in the world, Beijing, China. Details are announced at http://www.asnacc.com/en/index.asp

Annual Italian Neuroanesthesia Meeting 2009

The 2009 Meeting will take place on May 20 – 23 at the splendid Certosi di Pontignano, property of the University of Siena (www.unisi.it/servizi/certosa). The panel will feature topics and speakers with strong multidisciplinary backgrounds. Therefore, you are all very welcome!

Dear friends and colleagues, as you already know the registration for the 2009 Meeting is already open. The final program will be shortly available. Your 2008 CME certificates will soon be ready.

First registration fee by October 31, Second registration fee by January 31, 2009, Third registration fee due after January 31st

The DANTE Association will sponsor the 3rd edition of the 2009 Neuroscience Award

- Nursing Award in Neuroscience 1000 Euros
- Neuroscience award for certified and resident physicians 2000 Euros

Abstracts and applications due by January 31st 2009

Complete paper submission due by March 31st

Bi Annual Autumn German Neuroanesthesia Meeting 2008

The next meeting will take place in Günzburg (29th of November 2008) and the program of this future meeting is on the web-page of the German Neuroanesthesia Society (http://www.neuroanaesthesie-online.de/index1.html).

Annual Meeting of the Neuroanesthesia Society of Great Britain and Ireland

Next year’s meeting is to be announced. Keep an eye on their web page for more information. http://www.nasgbi.org.uk

SNACC Breakfast Panel ASA 2008

Intraoperative Neuromonitoring: A window into the CNS

Moderator Marc Bloom MD PhD
October 18 7 AM-815 AM

Optimizing Conditions for Intraoperative Evoked Potential Monitoring
Tod Sloan, M.D., Ph.D., M.B.A
University of Colorado

Brain Oxygenation Monitoring
George M. Hoffman, M.D.
Medical College of Wisconsin

Brain Function Monitoring
Marc Bloom MD PhD
New York University
The 2008 ASA Meeting
Neuro Learning Track

**NEURO TRACK AT ASA 2008**
Organized by Dan Cole

**Breakfast Panel**

**Neuromonitoring: A Window Into the Central Nervous System**
- Marc J. Bloom
- George M. Hoffman
- Tod B. Sloan

**Clinical Forum**

**Clinical Forum in Neuroanesthesia**
- Alex Y. Bekker
- John C. Drummond
- Adrian W. Gelb
- Martin Smith

**Luncheon Panel**

**Controversies in Neuroanesthesia**
- Alex Y. Bekker
- Lauren C. Berkow
- William L. Lanier
- Jeffrey J. Pasternak

**Panels**

**Depth of Anesthesia: Awareness and Beyond**
- Michael S. Avidan
- Steven J. Barker
- Daniel J. Cole
- Karen B. Domino
- Terri G. Monk
- Paul S. Myles

**General Anesthetic Neurotoxicity: A problem for patients young and old?**
- Roderic Eckenhoff
- Vesna Jevtovic-Todorovic
- Piyush Patel
- Sulpicio Soriano

**Learning and Memory During Anesthesia**
- Karen Domino
- George Mashour
- Beverly Orser
- James Sonner
- Robert Veselis

**The Aging Brain: Why Is It So Vulnerable in the OR & ICU?**
- Gregory J. Crosby
- Mervyn Maze
- Mark F. Newman
- Avery Tung
Refresher Course Lectures/Sessions

1. Anesthesia for Spine Surgery
   Spine Surgery Management Update – Susan Black
   Avoiding Visual Complications – Steven Roth
   Spinal Cord monitoring – Marc J. Bloom

2. Fragile Brains –The Young and Old
   – James E. Cottrell


4. Update on CNS Injury
   Adult Head Injury Management: Are the Guidelines improving Outcome? – Audree A. Bendo
   Fluids and Metabolic Management – Donald S. Prough
   Pediatric Head Injury – Sulpicio G. Soriano

5. Anesthesia for Functional Neurosurgery – Barbara M. Van de Wiele

6. Misunderstandings in Neuroanesthesia: How may I hurt thee, let me count the ways – John C. Drummond


9. Update on Anesthetic Techniques for Neuroanesthesia—TIVA versus Volatile Anesthetics – Adrian W. Gelb and David S. Warner

10. Anesthetic Management of the Patient With Carotid Artery Disease – Daniel J. Cole
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<th>Presenter</th>
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<tr>
<td>Breakfast Panels</td>
<td>Neuromonitoring: A Window Into the Central Nervous System</td>
<td>Bloom Marc J. M</td>
<td>October 18 $30</td>
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<td>PBLD</td>
<td>Child With Polytrauma: Emergent Laparotomy or Crash Craniotomy?</td>
<td>Bhananker, Sanja</td>
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<td>Ramani, Ramach</td>
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<td>Refresher Courses</td>
<td>Fragile Brains –The Young and Old</td>
<td>Cottrell, James E.</td>
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<td>Sci. Papers - Oral Pr</td>
<td>CLINICAL NEUROSCIENCES: Monitoring Depth of Anesthesia</td>
<td>Rampil, Ira J. M.D.</td>
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<td>Sci. Papers - Poster</td>
<td>EXPERIMENTAL NEUROSCIENCES: Neurotoxicity of Anesthetic Agents</td>
<td>Perouansky, Mish</td>
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<td>Sci. Papers – Posters</td>
<td>EXPERIMENTAL NEUROSCIENCES: Cerebral Ischemia, Neuroprotection, and</td>
<td>Giffard, Rona G. M</td>
<td>October 18 $0</td>
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<td>Awake Craniotomy and Seizure Focus Excision in a young man</td>
<td>Koenig, Heidi M. M</td>
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<td>Awake Craniotomy in a Patient With Obstructive sleep apnea</td>
<td>Willmann, Karl M.</td>
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<td>Luncheon Panels</td>
<td>Controversies in Neuroanesthesia</td>
<td>Lanier, William L.</td>
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<td>PBLD</td>
<td>Traumatic Brain Injury: Neurogenic Pulmonary Edema and Cardiac Failure Due</td>
<td>McCunn, Maureen</td>
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<td>PBLD</td>
<td>Anesthesia for Awake Craniotomies in Children</td>
<td>Flack, Sean H. M</td>
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<td>Depth of Anesthesia: Awareness and Beyond</td>
<td>Domino, Karen B.</td>
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<td>Sci. Papers – Posters</td>
<td>CLINICAL NEUROSCIENCES: Monitoring the CNS II</td>
<td>Farag, Ehab S. M</td>
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<td>Sci. Papers – Posters</td>
<td>EXPERIMENTAL NEUROSCIENCES: Neurotoxicity of Anesthetic Agents II:</td>
<td>Soriano, Sulpicio</td>
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<td>PBLD</td>
<td>Anesthetic Management for Complex Posterior Spinal Fusion and Instrumentat</td>
<td>Lee, Chris C. M.D</td>
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Refresher Courses  Anesthesia for Spine Surgery       Black, Susan M.D  October 19    $20
Clinical Forum  Clinical Forum in Neuroanesthesia       Gelb, Adrian W. M October 19  $0
Sci. Papers – Posters  CLINICAL NEUROSCIENCES: Outcome and Complications III Kofke, W. Andrew October 19  $0
PBLD  Anesthesia for Awake Craniotomies in Children Flack, Sean H. M  October 19  $10
Refresher Courses Anesthesia for Functional Neurosurgery Van de Wiele, Ba October 19  $10
PBLD  Anesthesia for Selective Intraarterial Nicardipine Injection to Relieve Vasospasm Avitsian, Rafi M.D  October 19  $45
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Panel  The Aging Brain: Why is It So Vulnerable In the OR and ICU? Crosby, Gregory J  October 19  $0
Sci. Papers – Posters EXPERIMENTAL NEUROSCIENCES: Mechanisms of Anesthetic Action II Flood, Pamela M.  October 19  $0
Sci. Papers - Oral Pr CLINICAL NEUROSCIENCES: Outcome and Complications I Berkow, Lauren C  October 19  $0
Sci. Papers – Poster EXPERIMENTAL NEUROSCIENCES: CNS injury and Neuroprotection: Kass, Ira M.D. **  October 19  $0
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Sci. Papers - Oral Pr EXPERIMENTAL NEUROSCIENCES: Neuroimaging and General Anesthetic Me Maze, Mervyn M.D October 19  $0
Sci. Papers – Posters CLINICAL NEUROSCIENCES: Cerebral Blood Flow and Metabolism Culley, Deborah J October 19  $0
Sci. Papers – Posters EXPERIMENTAL NEUROSCIENCES: Mechanisms of Anesthetic Action, Neurotox Gingrich, Kevin M October 19  $0
PBLD  Anesthetic Management for Complex Posterior Spinal Fusion and Instrumentati Lee, Chris C. M.D  October 19  $0
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Refresher Courses  Update on Anesthetic Techniques for Neuroanesthesia—TIVA Versus Volatile AnGelb, Adrian W. M October 20  $10 10:20AM - 11:10AM
PBLD A Quick MAC Case in Interven Neuroradiology. Vertebroplasty, Kyphoplasty or Emb Frost, Elizabeth A October 20  $45 12:00PM - 1:15PM
Sci. Papers - Oral Pr CLINICAL NEUROSCIENCES: Outcomes and Complications II Soriano, Sulpicio October 20  $0 1:00PM - 2:30PM
Refresher Courses Anesthetic Management of the Patient With Carotid Artery Disease Cole, Daniel J. M. October 20  $10 2:10PM - 3:00PM
PBLD The Disappearing Waveforms: Cervical Spine Surgery with Evoked Potential Mo Metzner, Julia I. M October 20  $10 3:30PM - 4:45PM
PBLD The Heart or the Brain? Cardiac or Carotid Surgery? The Cutting Edge Controv Sundar, Eswar M October 20  $10 3:30PM - 4:45PM
PBLD MAC Case in Interventional Neuroradiology. Vertebroplasty, Kyphoplasty or Em Frost, Elizabeth A October 20  $10 3:30PM - 4:45PM
PBLD Traumatic Brain Injury: Neurogenic Pulmonary Edema and Cardiac Failure Due McCunn, Maureen October 20  $10 3:30PM - 4:45PM
Sci. Papers - Oral Pr CLINICAL NEUROSCIENCES: Monitoring the CNS Rusy, Deborah A. October 21  $0 8:00AM - 9:30AM
Panel Learning and Memory During Anesthesia Domino, Karen B. October 21  $0 8:00AM - 10:00AM
Sci. Papers – Posters CLINICAL NEUROSCIENCES: Monitoring Depth of Anesthesia Brambrink, Ansga October 21  $0 9:00AM - 11:00AM
Sci. Papers – Posters EXPERIMENTAL NEUROSCIENCES: Mechanisms of Anesthetic Action III Goldstein, Peter A October 21  $0 9:00AM - 11:00AM
Refresher Courses Perioperative Cognitive Morbidity in Elders: Do Surgery and General Anesthesia Crosby, Gregory J October 21  $10 9:10AM - 10:00AM
PBLD The Debate Between Clipping and Coiling of an Aneurysm - How Does the Man Ramani, Ramach October 21  $45 9:30AM - 10:45AM
PBLD The Disappearing Waveforms: Cervical Spine Surgery with Evoked Potential Mo Metzner, Julia I. M October 21  $45 12:00PM - 1:15AM
PBLD He Can't Be Blind: It Was Only Back Surgery Frost, Elizabeth A October 21  $45 12:00PM - 1:15AM
Sci. Papers - Poster EXPERIMENTAL NEUROSCIENCES: General Anesthetic Mechanisms: Ion Hemmings, Hugh October 21  $0 1:00PM - 2:30PM
Special Events and M Anesthesiology/FAER Session: Anesthesia and the Developing Brain: Jevtovic-Todorovi October 21  $0 1:00PM - 3:00PM
Sci. Papers – Posters EXPERIMENTAL NEUROSCIENCES: Molecular Mechanisms of Neuronal Isc Culley, Deborah J October 21  $0 2:00PM - 4:00PM
Refresher Courses Cerebral Protection by Hypothermia and Anesthetics: New Insights I Lanier, William L. October 21  $10 3:20PM - 4:10PM
PBLD The Debate Between Clipping and Coiling of an Aneurysm - How Does the Man Ramani, Ramach October 21  $10
### Announcing....

**Distinguished Teacher of the Year Award!**

To Be Presented at the

**SNACC 36th Annual Meeting**

**Friday, October 17, 2008**

**Orlando, Florida**

This year’s awardee is **Eberhard Kochs**. Professor Kochs is head of the Department of Anesthesiology, university hospital Universit"at M"unchen, Munich, Germany. Among many fields, his academic interests include interdisciplinary approach to monitoring depth of anesthesia, prevention and treatment of intraoperative awareness, neuroprotection, and postoperative cognitive deficit. He has a long track record of mentoring young trainees and faculty. The award will be presented at the annual SNACC business luncheon/meeting on October 17, 2008.

<table>
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<tr>
<th>Time</th>
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<td>3:30PM - 4:45PM</td>
<td>The Heart or the Brain? Cardiac or Carotid Surgery? The Cutting Edge Controv</td>
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<td>3:30PM - 4:45PM</td>
<td>Panel</td>
<td>General Anesthetic Neurotoxicity: A Problem for Patients Young and Old?</td>
<td>Crosby, Gregory J</td>
<td>October 22</td>
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<td>8:00AM - 10:00AM</td>
<td>Sci. Papers – Posters</td>
<td>CLINICAL NEUROSCIENCES: Miscellaneous</td>
<td>Pajewski, Thomas</td>
<td>October 22</td>
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<td>9:00AM - 11:00AM</td>
<td>Refresher Courses</td>
<td>Cervical Spine Motion, Cervical Spine Surgery and the Unstable Neck</td>
<td>Todd, Michael M.</td>
<td>October 22</td>
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The Society of Neurosurgical Anesthesiology and Critical Care, in its efforts to encourage anesthesiology residents, fellows, and junior faculty to become more involved in the Society, is excited to offer the John D. Michenfelder New Investigator Award. The award is presented annually to the resident, fellow or starting junior faculty whose research exemplifies the Society’s mission of improving the art and science of neurosurgical anesthesia, and the care of the critically ill, neurologically impaired patient.

This year’s awardee is Alexander Zlotnik, MD for his submission titled "Effect of Maleate on Blood Scavenging Activity and Neurological Outcome in Closed Head Injury in Rats"

The abstract for his submission follows:

**Effect of Maleate on Blood Scavenging Activity and Neurological Outcome in Closed Head Injury in Rats**

Alexander Zlotnik M.D., Shaun E. Gruenbaum B.S., Alan A. Artru M.D., Michael Dubilet M.D., Sergey Tkachov M.D., Evgeny Brotfain M.D., Yael Klin, Yoram Shapira M.D., PhD, Vivian I. Taichberg PhD

**Introduction:** Treatment with oxaloacetate following traumatic brain injury has been shown to decrease blood glutamate (Glu) levels, thereby protecting against the neurotoxic effects of Glu on the brain. A number of potential mechanisms have been suggested to explain the oxaloacetate-induced decrease of Glu. We hypothesize that the primary mechanism by which oxaloacetate provides neuroprotection is by activation of glutamateoxaloacetate transaminase (GOT), a glutamate-scavenging enzyme. If so, coadministration of maleate, a GOT-blocker, would be expected to prevent the neuroprotective effects of oxaloacetate.

**Materials and Methods:** A neurological severity score (NSS) was measured 1 h after closed head injury (CHI) in rats. Then, rats received 30 microliter/min/100g infusion of saline, or 1mmol/100g solution of oxaloacetate, maleate, or a mixture of oxaloacetate and maleate. NSS was reassessed at 24 h and 48 h after CHI. Blood Glu and glucose levels were measured at 0, 60, 90, and 120 min.

**Results:** NSS improved significantly at 24 h (p<0.0001) and 48 h (p<0.001) compared with the control group only in the rats treated with oxaloacetate. Blood Glu decreased significantly in the oxaloacetate-treated group at 90 min (the conclusion of oxaloacetate administration) compared with the control group (p<0.0001), but not in the maleate or oxaloacetate+maleate groups. A strong correlation was found to exist between the percent decrease in blood Glu levels and percent decrease (improvement) in NSS (p<0.001).

**Discussion:** The results of this study demonstrate that the primary mechanism by which oxaloacetate provides neuroprotective activity following CHI is related to its blood Glu scavenging activity. A greater understanding of this mechanism may have important implications in the treatment of acute brain conditions, including CHI and stroke.
**PBLD’s on the SNACC BLOG**

The Subcommittee on Education has successfully launched a new web-based, Problem Based Learning Discussion (PBLD) initiative. ([http://www.snacc.org/blog.php](http://www.snacc.org/blog.php)) Four cases have been posted on the SNACC blog since March. Michelle Lotto from the Cleveland Clinic had the privilege (not to mention the stress) of posting our first case. She moderated a discussion on the anesthetic management of a patient who was scheduled for resection of a seizure focus. Deby Montermorno from NYU Medical Center presented the second case. The second case was a 50-Year-Old Male Scheduled for Video-Assisted Thoracoscopic Discectomy and Spinal Fusion. The patient had required one-lung ventilation that resulted in a rather unusual complication. The third case was an Awake Craniotomy in a Patient with Obstructive Sleep Apnea and Karl Willmann, who is also from the Cleveland Clinic, presented it. Lorri Lee from Washington University is currently moderating a discussion on Perioperative visual loss during spinal surgery.

We believe that a web-based PBLD may play an important role in meeting the educational needs of practicing anesthesiologists. In addition, it is an excellent tool in evaluating clinical acumen and the knowledge base of a resident doing a Neuroanesthesia rotation. Their responses are open to comments. Finally, SNACC members are encouraged to submit their cases. Members of the educational subcommittee will review the submissions.

Please contact Alex Bekker directly if you have any questions or would like to contribute. alex.bekker@med.nyu.edu

SNACC 2008 Elections

Nominations

The Nominating Committee sought nominations for Secretary-Treasurer and two (2) Director-at-Large members for election at the October 2008 SNACC meeting. The bylaws read “Additional nominations for officers may be made by the membership by petitions duly filed with the Secretary/Treasurer at least thirty (30) days prior to an election at the annual membership meeting. In order to qualify as nominating petitions, there shall be affixed thereto the signatures of twenty-five (25) members of the Society as a minimum.” Individuals chosen for these positions are those who have demonstrated a commitment to SNACC and have served in a number of administrative positions. Their experience with these administrative responsibilities as well as their effectiveness in performing these tasks is crucial in their nomination. You may refer to the SNACC bylaws at www.snacc.org for the responsibilities expected from each position. Ballots will be distributed to SNACC members at the meeting on Friday, October 17, 2008.

Secretary-Treasurer

Ansgar Brambrink, M.D., Ph.D.

Ansgar M. Brambrink, MD, PhD is professor of Anesthesiology and Peri-Operative Medicine and associate director of the Neuro-Intensive Care Unit at Oregon Health & Science University. His primary clinical interests are neuroanesthesia and neuro-critical care; his research is focused on measures to improve outcome following cerebral ischemia. Dr. Brambrink completed his medical and doctoral degrees at the Westfälische Wilhelms-University in Münster, Germany and an anesthesia residency, a critical care fellowship, and the “Habilitation” at the Johannes Gutenberg-University in Mainz, Germany. He and his family relocated to the United States in 2003.
Directors at Large of the Board of Directors

Rafi Avitsian, M.D.

Dr. Rafi Avitsian is a staff anesthesiologist in Cleveland Clinic’s Department of General Anesthesiology and Assistant Professor of Anesthesiology at the Cleveland Clinic Lerner College of Medicine of Case Western Reserve University. Fellowship-trained in neurosurgical anesthesiology and board-certified in Anesthesiology, Dr. Avitsian practices neuroanesthesia, teaches residents, fellows and medical students, while also participating in clinical research.

Highly interested in promoting and elevating professional educational activities, Rafi has been active in the Resident & Medical Student and PBLD committees of ASA, as well as involving himself with the Society of Education in Anesthesia. He has won “Best Teacher of the Year” in his institution, as well as several other teaching awards.

Following his passion for neuroanesthesia and dedication to professional service, Dr. Avitsian has been an active member of SNACC since residency submitting posters and acting as poster session moderator. He is currently a member of SNACC’s Education Committee, where he has assisted in the formation of online PBL discussions. Dr. Avitsian envisions establishment of a nationally accepted curriculum for neuroanesthesia fellowships.

Antoun Koht, M.D.

After completing residency in anesthesiology and fellowship in neuroanesthesiology at Northwestern University, I joined the staff there and soon assumed the role of Director of Neuroanesthesia. One of my first accomplishments in that position was formalizing and strengthening the neuroanesthesia clinical fellowship, which saw continuous growth and productivity over the following ten years. During that period of time, Dr. Tod Sloan and I oversaw the clinical neuromonitoring service, and made great strides in the provision of intraoperative neuro-monitoring. A one year sabbatical in Germany with Professor Schramm (neurosurgeon) broadened my research base in intraoperative evoked potentials and paved the way for me to serve on the board of four international spinal cord monitoring symposiums. In 2006, I rejoined the faculty of Northwestern University as Director of Neuroanesthesia. Upon my return to academic practice, I was able to resurrect the neuroanesthesia fellowship, energize research efforts, and actively participate and present papers at both national and international meetings. Among my proudest accomplishments, I was named Teacher of the Year by my residents and honored by a mentorship award from our junior staff. My clinical interests are education and research.
in neurosurgical anesthesia in general, and intraoperative evoked potential monitoring in particular. If given the privilege to serve on the board, I will work with great pride and enthusiasm to promote our specialty and subspecialty.

**Thomas A. Moore, II, M.D.**

Graduate of Jefferson Medical College of Thomas Jefferson University, Philadelphia, PA; Surgical Internship, Portsmouth Naval Hospital, Portsmouth, VA; General Surgery Residency, Albert Einstein Medical Center, Philadelphia, PA; Anesthesiology Residency and Neuroanesthesia Fellowship at the University of Florida, Gainesville, FL.

Currently Associate Professor at the University of Alabama at Birmingham School of Medicine, Department of Anesthesiology, Birmingham, Al. Director of Neuroanesthesia since 1996; Chairman Clinical Competency Committee; Associate Chair for Faculty Professional Development; member of SNACC since 1994. I am primarily involved with clinical neuroanesthesia and resident teaching. My clinical studies involve spinal cord protection and the development of protocols for intracranial tumor surgery, both asleep and the triphasic "awake" anesthetic.
Many members have approached us and enthusiastically offered to work more closely with SNACC activities going forward. We need to maintain this momentum in order to strengthen our society. Given this outpouring of volunteerism, we have created a committee structure that will provide a venue for the talents of our membership. The committees, each with charge and chair, are listed below. Reports of those presented at the spring board of directors meeting follow below.

**International Relations** - Martin Smith-chair and Kristin Engelhard co-chair
1) Contact international neuroanesthesia societies
2) Propose joint programs with sister societies
3) Establish an international network for clinical trials

**Scientific** - Pekka Talke
1) 2008 annual meeting abstract grading and presentations
2) Propose clinical studies for research network

**Education** - Alex Bekker chair and Katherine Lauer co-chair
1) Case-studies for website
2) Trainee outline
   a. residents
   b. fellows

**Neurointensive Care** - Ansgar Brambrink
1) Liaison with Neuro Critical Care Society
2) Propose educational programs

**Neuroanesthesia fellowship** - Ansgar Brambrink and Sol Soriano
1) Survey US training programs offering neuro fellowships
2) Propose training guidelines

**Neuromonitoring Committee** - Marc Bloom chair and Tony Koht co-chair
1) Establish educational programs for neuromonitoring (website and meeting)
2) Propose clinical studies for research network

**Website-Newsletter** - Andy Kofke

**Nominations Committee** - Basil Matta

If you are interested in serving on any of these committees please send a note to president-elect Basil Matta (basil@bmatta.demon.co.uk). We are also soliciting ideas and content for our 37th annual SNACC meeting in New Orleans to be held on October 16, 2009.
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For more information check the SNACC Web site at www.snacc.org, or contact the Society’s office:

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