# TABLE OF CONTENTS

## SNACC NEWS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>President’s Report</td>
<td>2</td>
</tr>
<tr>
<td>Best Abstract Award Winner</td>
<td>3</td>
</tr>
<tr>
<td>Editor’s Corner</td>
<td>3</td>
</tr>
<tr>
<td>SNACC 41st Annual Meeting Preliminary Exhibitors</td>
<td>3</td>
</tr>
<tr>
<td>Neuroanesthesia Fellowships from the Perspective of Trainees</td>
<td>4</td>
</tr>
<tr>
<td>Opening Minds and Eyes to Neuroanesthesia</td>
<td>6</td>
</tr>
<tr>
<td>SNACC Newsletter Schedule</td>
<td>6</td>
</tr>
<tr>
<td>Education Committee</td>
<td>7</td>
</tr>
<tr>
<td>Call for Nominations</td>
<td>8</td>
</tr>
<tr>
<td>Letter to the Editor</td>
<td>10</td>
</tr>
<tr>
<td>A Message from the Neurocritical Care Society</td>
<td>11</td>
</tr>
<tr>
<td>SNACC 41st Annual Meeting</td>
<td>12</td>
</tr>
</tbody>
</table>
At the time of writing I have recently returned from the Board of Directors meeting, which was co-located with the International Anesthesia Research Society (IARS) meeting in San Diego. This was the first IARS meeting at which SNACC awarded a prize for the best neuroscience research, and I would like to congratulate the winner, Arthur Leitzke, for his excellent work on *Isoflurane Pretreatment Ameliorated Germinal Matrix Hemorrhage-induced Brain Injury by Activating the Sphingosine Kinase/AKT Pathway in Neonatal Rats*. Arthur is a third year medical student at Loma Linda University and has been invited to present a summary of his research at the 41st SNACC Annual Meeting in October.

The Board of Directors has made good progress with many of the issues that I highlighted in the Spring Newsletter and I am pleased to be able to report on some of these now. Following discussion with interested parties, it has been agreed that the Scientific Affairs Committee will coordinate a trial of selected clinical practice surveys. Further details will be available shortly via the website and a call for proposals will also be made via a broadcast email to members. The *SNACC Consensus Guideline on the Anesthetic Management of Endovascular Treatment of Acute Ischemic Stroke* has completed a public consultation and will be published online during the summer. This has been a huge amount of work and I am most grateful to Dr. Pekka Talke and his group for bringing this project to completion. The Board of Directors has decided to open the successful *SNACC Bibliography* to non-members for a limited time period as a way of attracting more traffic to the website and we will review this in six months. This short trial that will allow non-members a time limited log-in to this section of the website only. SNACC members will continue to have unlimited access to the bibliography as well as new educational content that is being developed by the Education Committee. Some of you will already have reviewed the most recent *Chat with the Author on the Role of Hypotension in Perioperative Stroke* presented by Dr. Adrian Gelb from the University of California, San Francisco.

Following the report from the Membership Taskforce, the Board of Directors has agreed to establish a Membership Committee to take forward several ideas to add value to SNACC membership, and to increase our membership base. This committee will be chaired on an interim basis by Dr. Deb Culley, and co-chaired by Dr. Deepak Sharma, and its terms of reference and membership will be reviewed in October.

You may remember that last year it was agreed that consideration should be given to revision of the Society’s Bylaws. These have not been reviewed for many years and are no longer a fit for our purpose. We aim to simplify the bylaws to allow our Society to conduct its business in a more responsive manner and to facilitate day-to-day Society business. The Board of Directors, in association with Stewart Hinckley, our Executive Director, have been working on this during the last few months and it is anticipated that the revised Bylaws will be available for review on the website by the summer, and for adoption at the business meeting in October.

Finally, and most importantly, I urge you to consider attending this year’s Annual Meeting which will be held in San Francisco on October 10-11, 2013 at the Hilton Union Square. Dr. Deb Culley and colleagues have developed an impressive program which will begin at lunchtime on Thursday, October 10. During a Mentoring Workshop, distinguished SNACC members will discuss the challenges of starting, maintaining and developing an academic career. Although this workshop is primarily aimed at residents, fellows and junior faculty, all SNACC members are welcome to attend; pre-registration is required. The popular Transcranial Doppler Ultrasonography Workshops will be comprised this year of a beginner and an advanced session. Early registration is recommended as these events have previously been very popular. For the first time, we are hosting a Research Symposium - CNS Inflammation: Friend or Foe? - on the Thursday afternoon. This event will

*Continued on page 11*
Best Abstract Award in Neuroscience and Perioperative Medicine Presented

Jeffrey Pasternak, MD
Mayo Clinic College of Medicine
Rochester, MN

For the first time, SNACC sponsored an award for Best Abstract in Neuroscience and Perioperative Medicine at the International Anesthesia Research Society meeting held in San Diego, California on May 4-7, 2013. Selection of the winner was conducted by a subset of members of the Scientific Affairs committee from among 26 eligible and blinded abstracts. Eligible abstracts consisted of both basic neuroscience topics and clinical topics pertaining to perioperative neuroanesthesiology.

The winning abstract was submitted by Arthur Leitzke, a third year medical student at Loma Linda University in Loma Linda, California. The title of his abstract was *Isoflurane Pretreatment Ameliorated Germinal Matrix Hemorrhage-induced Brain Injury by Activating the Sphingosine Kinase/AKT Pathway in Neonatal Rats*. Mr. Leitzke’s advisors for this project were Richard Applegate, MD and John H. Zhang, MD, PhD. Prior to the presentation of the award, Arthur shared his strategies for finding time to complete his project during his major third year clerkships. Mr. Leitzke plans to continue his career in neurosciences research and complete his residency training in anesthesiology.

As the winner of this award, Mr. Leitzke received a $500 cash prize, a complementary one-year membership to SNACC, complementary registration to the SNACC Annual Meeting in San Francisco in October, and a plaque to commemorate his award. SNACC would like to congratulate Mr. Leitzke and offer our best wishes for a successful career.

Editor’s Corner

Reza Gorji, MD
SNACC Newsletter Editor

In this issue of the newsletter, we have contributions from the community at large. A Letter to the Editor from Tumul Chowdhury, MD, a neuroanesthesiologist in Canada, writes about the *Management of Cardiac Arrest with Skull Pin Fixation in Neurosurgical Patient*. A contribution from Shobana Raja, MD gives perspective of trainees in neuroanesthesia. The Education Committee has also been very active the past few months. These physicians are dedicated to SNACC as well as neuroanesthesia. The committee gives us a glimpse of their activity in a report.

I took a break from my usual interviewing neuroanesthesia resident, neuroanesthesia fellows and program directors for this issue.

Please feel free to contact me should you have any questions or suggestions. Contributions to the newsletter are welcomed by all including residents and fellows interested in neuroanesthesia.

SNACC 41st Annual Meeting Preliminary Exhibitors

October 10-11, 2013 • San Francisco, CA

BRONZE LEVEL

HOSPIRA

Integra

Lippincott, Williams & Wilkins

NeurOptics

SmartTots
Neuroanesthesia Fellowships from the Perspective of Trainees

Shoban Rajan, MD
Previous Fellow in Neuroanesthesia
Current Resident in Anesthesia (CA-2)
Cleveland Clinic
Cleveland, OH

An expert is someone who knows more and more about less and less (Butler, Nicholas). After training as a neuroanesthesia fellow at the Cleveland Clinic, I continue to be actively interested and involved in this sub-specialty. Although the field of neuroanesthesia is still relatively young, it is growing at a rapid pace due to the work of eminent scientists in this field. However, the number of residents who pursue a fellowship in this field still seems relatively small. With this in mind and encouragement from the program director of the neuroanesthesiology fellowship at the Cleveland Clinic, I decided to investigate the trainees’ views on neuroanesthesia education. If neuroanesthesia is to thrive and grow as a specialty, we should increase resident interest as well as investigate what could be done now to motivate them to pursue a career focus in the specialty.

The neuroanesthesiology rotation at the Cleveland Clinic is a part of the CA-2 year and CA-3 year. Residents participate in a two block module during the CA-2 year and a minimum of one module during the CA-3 year. During their rotations, residents provide care for patients with a variety of unusual and challenging neurosurgical problems undergoing intracranial, spinal, and interventional neuroradiological procedures. Emergencies are usually in the form of neurointerventional procedures for acute stroke or intracranial hemorrhage. In addition to the clinical training, there are regular weekly didactics that focus on neurophysiology, pathology, and surgical interventions.

In assessing the current state of neuroanesthesiology training, five residents and five current and previous fellows were interviewed. Questions were focused on identifying current perceptions of the specialty, expectations for clinical experience and training, whether trainees felt they were adequately prepared after residency training, and the perceived value of fellowship.

The residents and fellows alike expressed their expectations of receiving a good mix of cases, cranial and spinal alike. The variety of cases was also an important factor in maintaining interest in the specialty. As trainees, the case variety justified the presence of neuroanesthesia as one of the core rotations prescribed by the ACGME and the commitment to three rotations during their 36 months of training at the Cleveland Clinic. In terms of long term practice, the trainees mentioned that their future practice was less likely to become boring or routine.

The other aspect of the rotations that both residents and fellows appreciated was the didactic education sessions. During the neuroanesthesia rotations the didactics are presented as problem based learning discussions (PBLD) every Monday morning between 6:30 am and 7:00 am. In addition, there are monthly journal clubs with two articles presented, usually from the Journal of Neurosurgical Anesthesia. The residents and fellows felt that the PBLD sessions were extremely useful, not only because these were the core cases of neuroanesthesia, but also because this gave them a chance to interact with neuroanesthesia staff, including the section head of neuroanesthesia, in a less formal, non-clinical setting.

On inquiring how they would feel about neuroanesthesia as a career focus, response varied somewhat between residents and fellows. The residents felt well trained and had no objection to doing neuroanesthesia in the future, but at the same time, they did not feel that fellowship was necessary. The perception was that if one were able to safely intubate the patient, maintain hemodynamics and extubate smoothly, one could do neuroanesthesia. They questioned the added value of an additional year of training in neuroanesthesia when they do get adequate exposure during residency. When compared to other subspecialty areas, where there is the perception of added value in the form of skills, techniques, or certifications, neuroanesthesia did not hold the same appeal. Fellows, on the other hand, had felt that their fellowship was time well spent developing in-depth knowledge and understanding of neurological pathology and surgical interventions. Why was there a disconnection between the perceptions of the two groups? The explanation might lie in the saying, “What the mind does not know the eyes do not see.” Perhaps the residents, feeling that residency training alone provided...
the full scope of understanding of neuroanesthesia, showed a lack of awareness of the depth of understanding required to care for the full breadth and depth of neuroanesthesia cases.

What then is the future of fellowships in neuroanesthesia if residents share this misperception? How can we generate more interest in neuroanesthesia and make it a specialty that merits additional study? How do we help residents to appreciate the impact of anesthesia on neurologic outcomes and to realize that there is much more in neuroanesthesia than just doing more cases? How should we alert them to various cerebral perfusion issues, to aspects of brain protection, and management of hemodynamics and the science behind it? In discussing these questions with neuroanesthesia staff and educational leaders in our department, their suggestions focused on experiences outside of the OR that would broaden the resident's base of knowledge and expose them to the clinical questions that merit further research and study. These included rotations in the neurosurgical ICU, and as part of the neuro monitoring team focusing on intra-operative monitoring and cerebral protection.

These suggestions are consistent with, and would give residents a glimpse of, the rotations around which we have developed our fellowship in neuroanesthesia. The fellowship at the Cleveland Clinic is designed such that each fellow spends at least six months in the neurosurgical operating rooms providing anesthesia. One month is spent in neurocritical care, one month of training in EEG and evoked potentials, two weeks of training in the use and assessment of transcranial Doppler and two weeks of training in applications of Echocardiography for neurosurgical patients are mandatory rotations of the curriculum. Emphasis is also placed on research and active involvement in resident education. There are electives available in subspecialty areas such as pediatric neuroanesthesia and neurocritical care.

What is the future of the specialty for neuroanesthesiologists as compared to cardiac anesthesiology or pediatrics where one is definitely required to do a year before being able to practice it, especially in an academic environment? Transesophageal echocardiography in the cardiac operating room is now being handled mostly by cardiology anesthesiologists who are becoming as proficient as cardiologists. Cardiovascular ICUs are being managed by anesthesiologists. It seems, as neuroanesthesiologists, we may have to bring more to the table than what is currently happening in order to show our value. Neurologists are mainly in charge of the neurophysiologic monitoring. Neurointensivists are managing the neuro ICUs. Would it help if, as anesthesiologists, we, too, participated more in all these areas?

An underlying theme is that the current resident focus is on the technical skills and protocols that surround neurosurgical procedures, rather than fully understanding their role as "physician consultants" in neurophysiology and pharmacology. This suggests that the lack of perceived value in fellowship training is tied to the fact that most of the psychomotor skills are attained with ease during residency. What this perspective fails to recognize is that as long as we continue to define ourselves by psychomotor tasks we are replaceable by any other primate with an opposable thumb. One solution to this is to ensure that the skill set provided by the anesthesiologist provides for more than "lines, drains, and intubations," and instead focuses on perioperative management of patients with neurologic disease. Training and certification in the assessment and diagnosis of neurological disease would create value added resources to the team. Transcranial Doppler, EEG, and Evoked Potential Interpretation would contribute to care across the continuum of neurological disease. These could be essential components of fellowship training or additional credentials for fellowship trained intensivists. A societal move in this direction would broaden the scope of practice for the neuro anesthesiologist while making fellowship training a valuable adjunct to residency.

In conclusion, our assessment of the environment for neuroanesthesia is that it is a challenging and upcoming field with the potential for broadening the perioperative scope of practice of anesthesiologists, providing added value to our institutions, and improved outcomes for our patients. Incorporation of multiple facets to neuroanesthesia like neuromonitoring, transcranial Doppler, etc., would add further value to our specialty and create a reason for residents to pursue fellowship. Establishing a national curriculum at the residency level which is dynamic, interactive and problem based would simulate resident involvement and encourage further study and research.

Continued on page 7
Opening Minds and Eyes to Neuroanesthesiology

George Mashour, MD, PhD
University of Michigan
Ann Arbor, MI

I very much enjoyed the comments of Dr. Rajan and appreciate the invitation by Dr. Gorji to reflect upon them. As Dr. Rajan aptly notes, what the mind does not know, the eyes do not see. It is often not appreciated that the scientific and clinical questions within the purview of neuroanesthesiology are also central to anesthesiology in general. In fact, neuroanesthesiology should legitimately be regarded as the core of anesthesiology, because anesthesiology is a fundamentally neuroscientific field. The nervous system is the primary target for the therapeutic effects of anesthetics and analgesics, yet it is the least understood by anesthesiologists and thus least assessed. How, precisely, do general anesthetics suppress consciousness, memory, and mobility? How do we best monitor these effects in the operating room? How do we protect the brain in the perioperative period? Are there neurologic sequelae to anesthetic exposure? Can we detect neural injury in real-time? We, as 21st century neuroanesthesiologists, are poised to address the most pressing questions of anesthesiology. The 20th century was, primarily, focused on cardiorespiratory systems – given the improved monitoring and increased safety with respect to cardiovascular and pulmonary outcomes, perioperative medicine in the 21st century is shifting its focus to the frontiers of neuroscience. Neurotoxicity, neurodegeneration, postoperative cognitive dysfunction and other neuro-related outcomes are important patient safety concerns across the spectrum of perioperative medicine. Who best to serve as a consultant on these issues than a fellowship-trained neuroanesthesiologist?

We need to help trainees and colleagues recognize that neuroanesthesiology extends beyond the neurosurgical operating room to neurocritical care, neuroradiology, neuromonitoring, and more. Just as importantly, we need to emphasize the relevance of neuroanesthesiology to the field of perioperative medicine in general, especially with respect to neurologic outcomes of all types of surgery. Finally, we need to highlight that clinical, translational, and basic neuroscience scholarship provides some of the most exciting research directions available in anesthesia and beyond. Helping to open the minds and eyes of residents to the dynamic future of neuroanesthesiology requires us first to clarify our own vision and then develop systematic ways to transmit it.

SNACC Newsletter Schedule

<table>
<thead>
<tr>
<th>Submission Deadline</th>
<th>Publication Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>August 15, 2013</td>
<td>Fall and Pre-meeting Issue,</td>
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<tr>
<td></td>
<td>September 15, 2013</td>
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<tr>
<td>November 15, 2013</td>
<td>Winter Issue, December 15,</td>
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<td>March 15, 2014</td>
<td>Spring Issue, April 15,</td>
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<td></td>
<td>2014</td>
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<td>May 15, 2014</td>
<td>Summer Issue, June 15,</td>
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SNACC’s newsletter is open to submissions by members of SNACC. Please adhere to the following schedule. Submissions do not guarantee publication. We are interested in news and articles of interest from the membership at large. In addition, if you have a question to ask any of the officers of SNACC, you can submit them as well. Due to time limitations and the volume of issues anticipated, not all questions can be answered.
“What do you expect from us?” This is the main question that the Education Committee would like to ask from the society members. In fact, we would like to know what would prompt the membership to visit the Education tab of the SNACC website. In defining the role of the Education Committee we find that our responsibility is to provide the membership with educational material to improve their knowledge as well as to retain this material for their trainees. Though the definition is not that difficult to make, in practice it is not easy to find what would be interesting for such a multidisciplinary society, where we have members ranging from neuroscientist researchers to patient focused clinicians. What makes it more difficult is that by now most of the members have already found their so called “best, go to reference” making them reluctant to visit just another website to find (or not) what they need. Thus, instead of being a reference, we thought we can change it to a “what’s new” format. For those who don’t have enough time to read all articles, we came up with the “Chat with the Author” idea where the interview with an author of a paper can give information about the article in 15-20 minutes. In fact, it gives an opportunity to the author to even tell beyond what is printed. Another cumbersome task of the committee was to provide a bibliography for main topics in neuroscience in anesthesia and critical care for the most up-to-date articles. Our hope was to provide a reference to those who would like to have an answer to “What’s the best article for….?” or “What should I read if I want to know about…..?”

But how successful have we been? Since many of us dislike and usually delete the multiple surveys and questionnaires we receive on a daily basis, we did not think this was the way to go. The only valid metric that we have now is the number of hits on the Education portion of the SNACC website. The results have not been discouraging, but certainly not as high as we wanted them to be. What we really want is feedback. Especially for future projects, including adding CME content on the website, or creating a blog for members to ask questions and make comments, we really need to have a high interest level before proceeding. So, please let us know your ideas, visit the website under the Education Committee, see what we have and send us your feedback. You can forward all remarks to snacc@snacc.org and mention “Education Committee” in the subject line.

In the aviation community it is said that “a superior pilot is one who uses his superior judgment to prevent having to use his superior skills.” Could advancing the clinical judgement, research, and fellowship interest in neuroanesthesia create a model for anesthesiology leadership in perioperative care and position us as “captain of the ship?”
SNACC Board of Directors 2013-2014

The SNACC Nominations Committee is seeking nominations for open positions on the SNACC Board of Directors for 2013-14. The vacancies open for nomination are one Secretary-Treasurer and four Directors-at-Large. The statements and short CVs of the nominated applicants will be published by August 2013 on the SNACC website. This will also be announced to the members by an e-blast. The election will take place at the SNACC 41st Annual Meeting on Friday, October 11, 2013 and new members will take office at the conclusion of the Business Meeting.

Secretary-Treasurer (one vacancy)

The Secretary-Treasurer shall serve to oversee the finances of the Society, keep records of the biannual Board of Directors meeting, aid the Director of Communications in keeping open communications with the members and to perform such other duties as may be prescribed by the Board of Directors or President. The Secretary-Treasurer will serve a one-year term, but members seeking nomination to this post should be able to commit to a five-year period because it is usual for the Secretary-Treasurer to progress through the other Officer positions on the Executive Committee.

Directors-at-Large (four vacancies)

Directors-at-Large should promote the activities of SNACC and provide advice to the Executive Committee. Individuals will be required to lead one specific task within their areas of interest. They should attend the Board of Directors meetings (twice a year) and participate on the telephone conferences (twice a year). They will serve staggered three-year terms. Individuals serving as Directors-at-Large may serve only two successive full terms in these positions.

Eligibility

Any SNACC member in good standing is eligible to self-nominate for these posts.

Nominations

Candidates need to have demonstrated a commitment to SNACC over time and preferably have already served on a SNACC committee. Experience in the work of SNACC and the individual's effectiveness in performing their duties are crucial to the success of their nomination.

Application via self-nomination in form of a brief statement (maximum 400 words) should include the candidate's experience, suitability for election to the position and their vision for their future contribution to SNACC. This should be accompanied by a short CV of the applicant.

Nominations should be forwarded to Kristin Engelhard, Chair of the 2013 Nominations Committee, at engelhak@uni-mainz.de by July 20, 2013 and cc'd to Sandra Peterson at sandra@societyhq.com.

Distinguished Service Award

2013 Guidelines:

The award is presented to an individual who has made outstanding contributions to the field of neuroanesthesia and neurocritical care, and for his or her distinguished service to the Society. The award will be presented at the SNACC 41st Annual Meeting in San Francisco on October 11, 2013.

Nominations Accepted Through August 15, 2013

What to Submit?

1. Nominator's name, title and contact information
2. Name, title and contact information of the nominee
3. A minimum of two paragraphs outlining the nominee's contributions to the field of neuroanesthesia and/or service to SNACC
4. Brief biographical sketch or summary CV of the nominee
5. Two letters of recommendation

Recipients of these Awards will Receive:

• A plaque of recognition presented at the SNACC 41st Annual meeting on Friday, October 11, 2013
• Recognition on the SNACC website with a citation and picture
• Recognition in the SNACC Annual Meeting Reports published in the SNACC newsletter and the Journal of Neurosurgical Anesthesiology
Call for Nominations

Nominations for the Distinguished Service Award should be sent to Kristin Engelhard, Chair of the 2013 Nomination Committee, at engelhak@uni-mainz.de and cc’d to Sandra Peterson at the SNACC Administrative Office at sandra@societyhq.com. The closing date is August 15, 2013.

Teacher of the Year Award

This award recognizes SNACC members who exemplify outstanding teaching of health care professionals and basic scientists in the areas of neuroscience, neuroanesthesiology and neurocritical care. The award will be presented at the SNACC 41st Annual Meeting in San Francisco on October 11, 2013.

Nominations Accepted Through August 15, 2013

What to Submit?
1. Nominator's name, title and contact information
2. Name, title and contact information of the nominee
3. A supporting letter of nomination from the nominee’s current departmental chair
4. Summary of the nominee's teaching credentials:
   • Evidence of expertise and innovation in education, invited lectureships, review course presentations at national/international meetings and participation in educational activities of national/international societies.
   • Summary of relevant publications of the contribution of new knowledge to the field and publication record of review articles and book chapters relevant to neuroscience, neuroanesthesiology and neurocritical care.
   • Administrative positions held in areas relevant to education.
   • Evidence of innovations in education, including the development of relevant course syllabi and/or development of methods for evaluation of effectiveness of teaching methods.
   • Evidence of mentorship of medical students, anesthesia/critical care residents/fellows and any other relevant groups.
   • Evaluations supporting the nominee’s effectiveness as a teacher, quality of mentorship, impact on the development of the students’ career and impact on the productivity of the student, including evaluations from previous students.
   • Evaluations from chair/colleagues (past or present) regarding demonstration of a passion for teaching, verification of contributions to education, research and administration, and demonstration of respect for advisees.
   • Evaluations from international colleagues as above.

Note: Nominees will not be expected to have achieved excellence in all these categories.

The Recipient of this Award will Receive:
• A plaque of recognition presented at the SNACC 41st Annual Meeting on Friday, October 11, 2013
• Recognition on the SNACC website with a citation and picture
• Recognition in the SNACC Annual Meeting Reports published in the SNACC newsletter and the Journal of Neurosurgical Anesthesiology

Nominations for the Distinguished Service Award should be sent to Kristin Engelhard, Chair of the 2013 Nomination Committee, at engelhak@uni-mainz.de and cc’d to Sandra Peterson at the SNACC Administrative Office at sandra@societyhq.com. The closing date is August 15, 2013.
Management of Cardiac Arrest with Skull Pin Fixation in Neurosurgical Patient - Time for Guidelines

Tumul Chowdhury MD, DM  
Fellow Neuroanesthesia  
University of Manitoba  
Winnipeg, Manitoba, Canada

Dear Colleagues,

I am always fascinated with absurd ideas and one day, I thought about the possibility of cardiac arrest in patients with skull pin fixation. Though, there are very few evidences of intraoperative cardiac arrest during neurosurgical procedures; none of those address this issue.¹

There are few points to be considered.

1. What is the cause of cardiac arrest (fibrillation versus asystole)?
2. What is the position of the patient [supine/prone/lateral/sitting]?
3. Stage of surgery (tumor manipulation or predisection phase).

In case of asystole or ventricular fibrillation, cardiopulmonary resuscitation (CPR) and defibrillation is the management of choice; however, these methods may have serious implications with skull pins in situ.

First, during CPR, the neck position would be a major concern. In spite of muscle relaxant, there could be serious threats to cervical spine injuries. On the other hand, defibrillation attempts may have potential to cause surgical site injury and cervical spine injury due to body jerks. After an extensive search on the internet, I found an online survey conducted through the Neuroanaesthesia Society of Great Britain and Ireland (NASGBI). This survey indicated that events requiring CPR/DC cardioversion in such scenarios were not uncommon (10% of respondents). However, a large proportion of respondents (64%) had never considered how to manage such a scenario. The survey suggests that pulseless asystole and VF should be promptly managed if there are no concerns for cervical injury. However, skull pins should be removed first in cases with unstable cervical injuries or when body jerks may cause these injuries. Gloved hands can be used to stabilize the head and neck if bi-phasic shock is to be given. Prone patients should be turned supine. In cases of prone positioning, few evidences advocate placing the pads on the infrascapular area for the rapid management of VF. The CPR may be instituted by placing a fist beneath the sternum in such position and continue CPR from the back.² However, prompt arrangement should be aimed to make the patient supine as soon as possible. CPR has been successfully applied in cases of lateral and sitting positions; however, there is lack of standard guidelines related to management of patients in these positions.³

In conclusion, intraoperative cardiac arrests in neurosurgical patients are not uncommon, so proper awareness of the situation and management goals could potentially direct a favorable outcome. There is a need for our society to conduct a well-designed survey and make firm guidelines for the management of such cases.

References:

Disclaimer: The views expressed are those of the author(s) and not of SNACC or the newsletter editor. The content of the letter has not been peer reviewed.
A Message from the Neurocritical Care Society

The 11th Annual Neurocritical Care Society Meeting will be held October 1 - 4, 2013, at the Philadelphia Marriott Downtown in Philadelphia, Pennsylvania.

The Neurocritical Care Society’s mission is to improve outcomes for patients with life-threatening neurological illnesses by promoting quality patient care, professional collaboration, research, training and advocacy. Over 900 medical professionals were in attendance at the 2012 Neurocritical Care Society meeting. An equally substantial turnout is expected this year thanks to an innovative program with topics such as:

- Practice Update
- When I Grow Up, I Want to be an Astronaut: Cerebral Physiology in Space
- Special Member Submitted Session – Weathering the Storm: Brain Injury and the Autonomic Nervous System
- Full Update on NCS Guidelines
- Debates on topics such as: Neurointensivists Should See Outpatients Electronic Medical Records Improve Care in the NeuroICU

While the official 2013 program is currently in development, we ask that you please click on the following link to view the 2012 NCS Annual Meeting Program.

CLICK HERE FOR THE PROGRAM

President’s Report
Continued from page 2

include lectures from experts on the physiology and pathophysiology of brain inflammation, the role of inflammation in POCD and Alzheimer’s disease, in the development of chronic pain syndromes and in stroke. An open poster discussion session will follow the lectures. This symposium is open to both SNACC members and non-members, and again, pre-registration is required. Blood Products and Fluids in Perioperative Neuroscience is the theme for the Thursday evening Dinner Symposium, which has been sponsored by a generous educational grant from Masimo.

There will be the usual whole-day program on Friday, October 11 and full details are available on the SNACC website. In brief, the keynote speaker will be Dr. Robert T. Knight, Professor of Psychology and Neuroscience from UC Berkeley, who will discuss Lessons from Direct Cortical Recording – Can We Hear What you Think? This year’s mini-symposia are on Psychoneuroanesthesia: Myths and Fads in Neuroanesthesia, and include speakers who are new to SNACC as well as more established faculty. During the two poster sessions, more than 120 colleagues from around the world will present their most recent research on perioperative neuroscience. The day will conclude with a Pro/Con Debate in which Dr. William Lanier, Jr. will argue for the utility and validity of database research whilst Dr. John Drummond will take the “con” position and consider whether ice cream really does cause boating accidents!

As well as the educational activities, there will be ample opportunity to network with friends and colleagues during the meeting. A series of Special Interest Groups will also meet at different times during the two days. Detailed information about all aspects of the 2013 Annual Meeting is available on the SNACC website at www.snacc.org.

This year’s diverse program will have something for everyone, and I hope that you will be able to join us in San Francisco. In the meantime, I wish you a pleasant summer and, to those of you who will have time away from work, happy vacation!
41st Annual Meeting
October 10-11, 2013
Hilton at Union Square • San Francisco, CA

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