From the 7th Floor – A Sepsis Retrospective

by Nicholas Sadovnikoff, M.D.

I remember fairly vividly getting a call at 2 AM or so. The year was 1987 and I was the senior admitting resident for the MICU at Beth Israel Medical Center in New York City. On the other end of the line was Jeff, a sharp fellow third-year resident who would be starting a cardiology fellowship in a few months. He was transferring to my unit a patient who’d developed gram-negative sepsis on the floor. He said, not without some pride at his efficiency and wisdom, “He’s already gotten his gram of Solu-Medrol.” I remember being pleased that Jeff had already carried out this intervention that we all believed at the time would benefit patients afflicted with sepsis. Of course, we now know that high-dose steroids are not beneficial, and are in fact probably harmful in this population. What we knew at the time was that steroids suppressed the immune response, and sepsis was a manifestation of an immune system gone awry. As Lewis Thomas so eloquently wrote in A Parting Shot...

A Parting Shot... or Two

by Alessia Pedoto, M.D.

Fellowship at an institution different from the one you train at is quite an interesting experience. For sure, it is no joke. I was very excited at coming to Boston, from New York, and looked to Harvard to put its finishing touches on my training.

For the first two months of my new job I felt like a glorified first-year resident. You have the basic knowledge to go through a case, but have no clue about the location of supplies; and nobody knows you (in my case, I was the one with the weird Boston-incompatible accent). More irritating still, you’ve been trained not as “they do it in Boston!” For me, it was the reverse of what I’d expected. I was used to a fast pace and ran my life by countdowns. Here, the “Boston way” dictated that everything slowww dowwwn—the nurse has to come in the PACU, usually after you, and give report, usually before you...

After a brief warm-up, I had the pleasure of interacting with Dr. David Sugarbaker. I had kind of figured out his impressive “stature” when, quite by mistake, I put on one of his gowns…but the encounter in person was an amazing experience. After investigating where Phil was, we settled down to the business of transfusing, and stopped at the end of the case. It seemed that no matter what the problem, Phil was the miracle treatment. It seems to me every surgeon has his or her own “Valium anesthesiologist” and Dr. Hartigan would understandably be one—comforting, mildly sedating, very long lasting...

As time went by, the competition with my co-fellows became tougher, almost like going to war. I became the bronch/C-med, VATS expert! I also did a Bueno fellowship! My skills in oro/nasogastric tubes placement reached a level previously unknown to man—I could place that device in the most adverse of conditions. I discovered that a Malooney and a Boogie are the same thing! By the end of the year, ABBA became my favorite musical group—a single CD for the entire day, no matter how long the day. By month #10, I could give anesthesia, place NGT and sing and dance ABBA all at once. The only break came when

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stood to reason, we could abort the triggering of the septic state. Animal models of sepsis provided “proof of concept,” and by the time I entered my critical care fellowship in 1991, great enthusiasm was generated with the publication of an article in the *New England Journal of Medicine* that appeared to show that HA-1A, a recombinant human antibody directed against endotoxin, provided clinical benefit in a subpopulation of septic patients who had documented gram-negative bacteremia. The FDA, however, perhaps alarmed by the expense of the new therapy, pointed out that the drug did not show a benefit in the overall population studied. They reasoned that since one could not prospectively identify patients who would later prove to have gram-negative bacteremia (the benefited subgroup), further study would be needed before the drug could be approved. To our dismay, a second trial of the drug had to be halted before completion due to evidence of harm in the treatment group. E5, a murine anti-endotoxin antibody met the same fate, with a promising initial study showing subgroup benefit, but a subsequent study finding none. Other inflammatory cytokine targets were targeted with the monoclonal antibody strategy, to no avail; a trial of anti-TNF antibody met the same fate, and IL-1ra, an interleukin-1 receptor antagonist, also proved ineffective.

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**“It was intuitively attractive to believe that, by smothering our immune system with steroids, we could reverse the course of this inflammatory response.”**

well-designed study led by Roger Bone put to rest the validity of the practice. In a meticulously designed and executed prospective, randomized, placebo-controlled, double-blind study of 382 septic patients, no benefit was found for high-dose steroids. A trend towards harm was noted, particularly in patients with renal insufficiency. This was, at least for me, the dawn of evidence-based medicine.

The loss of steroids from the anti-sepsis armamentarium left us feeling bereft, weaponless. The research community realized that a more finely-tailored approach to treating the inflammatory cascade would be necessary—steroids were too blunt a club. Gram-negative sepsis, the reasoning went, is an inflammatory event that starts with release of endotoxin. If we could selectively block endotoxin, it

In response to this theory, three new anticoagulant agents were developed and put to use in a subpopulation of septic patients who had documented gram-negative bacteremia. The FDA, however, perhaps alarmed by the expense of the new therapy, pointed out that the drug did not show a benefit in the overall population studied. They reasoned that since one could not prospectively identify patients who would later prove to have gram-negative bacteremia (the benefited subgroup), further study would be needed before the drug could be approved. To our dismay, a second trial of the drug had to be halted before completion due to evidence of harm in the treatment group. E5, a murine anti-endotoxin antibody met the same fate, with a promising initial study showing subgroup benefit, but a subsequent study finding none. Other inflammatory cytokine targets were targeted with the monoclonal antibody strategy, to no avail; a trial of anti-TNF antibody met the same fate, and IL-1ra, an interleukin-1 receptor antagonist, also proved ineffective.

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Attention turned from blocking the inflammatory cytokines to attempting to modify the resultant milieu. It was hypothesized that septic pathophysiology is characterized, at least in part, by uncontrolled intravascular activation of the coagulation cascade resulting in obstruction of the microcirculation. This could occur in many different organs’ vascular beds, explaining in part the phenomenon of multiple organ dysfunction. In response to this theory, three new anticoagulant agents were developed and put to use in a subpopulation of septic patients who had documented gram-negative bacteremia. The FDA, however, perhaps alarmed by the expense of the new therapy, pointed out that the drug did not show a benefit in the overall population studied. They reasoned that since one could not prospectively identify patients who would later prove to have gram-negative bacteremia (the benefited subgroup), further study would be needed before the drug could be approved. To our dismay, a second trial of the drug had to be halted before completion due to evidence of harm in the treatment group. E5, a murine anti-endotoxin antibody met the same fate, with a promising initial study showing subgroup benefit, but a subsequent study finding none. Other inflammatory cytokine targets were targeted with the monoclonal antibody strategy, to no avail; a trial of anti-TNF antibody met the same fate, and IL-1ra, an interleukin-1 receptor antagonist, also proved ineffective.

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clinical trials. The first two, antithrombin III and tissue-factor-pathway inhibitor (tifacogin), showed no benefit in preliminary trials. The third agent, however, broke the skein of failures. A randomized placebo-controlled trial of the natural anticoagulant activated protein C (drotrecogin alfa [activated]) was published in March 2001 in the New England Journal of Medicine. Known as the PROWESS trial (Protein C Worldwide Evaluation in Severe Sepsis), the study of 1,670 patients randomly assigned to receive activated protein C or placebo, demonstrated a mortality of 24.7% compared to 30.8% in the placebo arm. Finally, we had cause to celebrate a new weapon in the treatment of sepsis. Eli Lilly, Inc., also declared a mass celebration, naming the drug Xigris, and launching an intensive marketing campaign to intensivists that included a free George Benson concert at the subsequent convention of the Society for Critical Care Medicine.

There were, however—and still are—a few “flies in the ointment.” First, the drug has the major side effect of causing major bleeding, which occurred in 3.5% of the patients in the treatment arm, compared to 2% of the placebo recipients. Second, there was no benefit in the less sick 50% of patients, with a trend towards harm in the lowest quartile. Third, the incidence of intracranial hemorrhage, 0.5% in the study, rose to 2.5% in open label use after the trial. Finally, the drug is quite expensive, costing on the order of $8,000 for a 96-hour course.

At BWH, use of the drug is restricted to patients with an APACHE II severity of illness score of 25 or higher. This was the score above which patients in the PROWESS study benefited, they being the more ill 50%. In the SICU, we use this drug with moderate frequency, especially in the sicker septic patients. As it is an anticoagulant, anesthesiologists should know that it must be turned off for one hour before surgical or percutaneous procedures. It may be resumed one hour after percutaneous procedures and 12 hours after major surgery.

As much as the discovery of an effective drug is a cause for rejoicing, it is sobering to consider that even with the use of this drug, one patient in four dies of severe sepsis. Studies since PROWESS have revealed the drug to be ineffective in septic children, and a planned 11,444 patient trial of “less sick” patients (APACHE < 25) with severe sepsis was stopped by Eli Lilly after interim analysis indicated it unlikely any benefit would be detected. We do not have a perfect method of identifying those patients who are most likely to benefit from this expensive intervention.

In short, we’ve come a long way since the era of high-dose steroids in sepsis, but this disease process remains a major cause of death worldwide. It is likely to become yet more prominent given our graying population, and we will need better, but hopefully less expensive, effective pharmacologic agents than activated protein C in the future.

Nicholas Sadovnikoff is Instructor in Anesthesia at HMS, Co-Director, Surgical Intensive Care Unit, and Director, Critical Care Anesthesia at BWH

Early 20th century gauze.
Dear Friends,

After seven exciting and enriching years at BWH, it is with a heavy heart that I leave academic medicine and return to private practice. Life is, as the saying goes, indeed a journey. My family and I have been blessed in many ways. We’ve enjoyed opportunities and experiences that have added immeasurably to the richness of our lives. The growth that occurs as a result of meeting new challenges and exploring new horizons is something we’ll always celebrate. And yet, when one distills the totality of life’s experience, an inescapable conclusion is reached—it is the people we meet who attach meaning, value, and joy to life.

Indeed, of everything I shall miss about Brigham and Women’s Hospital, nothing will surpass the people. As I reflect upon the past 7 years, my greatest sense of fulfillment derives from the many deep and enduring friendships I’ve formed with so many of you. It is this gift for which I am most grateful and extend my sincerest thanks. While Harvard has always been known for its vibrant academic environment and world-class scholars of insatiable intellectual curiosity, I shall always maintain that its best-kept secret is the humanism of its people.

Once again, I want to say what a genuine privilege and honor it’s been for me to work with you. While one always strives to contribute to the mission, to share knowledge and exchange ideas with colleagues, these efforts are never tantamount to what is received in return—I, for one, doubt I could ever give back half of what I’ve gained from my association with you. With affection and appreciation, I thank you for your friendship, the many wonderful moments, and the treasure-trove of memories I carry within me. I will always cherish these most precious gifts.

~Matt Posner

surgical fellow Sidhu tried (unsuccessfully) to trade ABBA for Techno-Hindi—plenty of Tylenol needed, not to mention Ondansetron!

During my spare time, I started running what seemed like my very own thoracic surgi-center, obviously under the supervision of my master-and-commander, Dr. Hartigan. The average age of the clientele was usually in the 70s, everyone was ASA grade 3 if not higher, and had a medication list longer than my grocery list on a day I’m having guests for dinner. Most of them were friendly, especially after drugs—the more drugs, the friendlier. That’s when I discovered that Bostonians are quite pleasant and sociable, at least until my accent becomes too much to bear, at which point the quest for my mysterious roots begins. Creativity is not unique to Boston though, particularly when it comes to geography—often they went for the Middle Eastern option! I also learnt, belatedly, that drugs are one way of getting asked out, though you mustn’t be finicky, of course, on age or medical issues.

Calls were another facet of training. It seemed that 4 PM was the magic demarcator of ability. I was to work under “strict supervision” until then, but, at the stroke of 4, would transform into Superwoman, and, in my XXXL-size gown, fly out the pod and go save lives!

The rhythm of the pod, comparable at times to the pace of a hurricane, helps keep you in shape. The running is so much that after a couple of months you’re fit for the Boston marathon, and after a year can qualify for the NYC one without extra training; you just need very good shoes. If stress becomes a concern, Dr. Mentzer recommends scotch! If that is not enough, yoga’s a thought—just make sure you awaken early enough to do that, shower and arrive here in time to talk to the patient, place all the lines you need and simultaneously page all the fellows you can think of for consents and site-verifications, and still be able to get into the room by 7:15 in a mad race to evade that evil pager, and with it, Dr. Flanagan, of course.

Anyway, time to cut it short and run, as that pager continues to summon. At this time of the year the thoracic-surgical pod looks forward to the Sug’s Booze Cruise—sailing in the harbor and quickly getting tipsy (all the better to socialize?), on a boat as rocky as a thoracic operating room.

Have a merry time all, and thank you for a fantastic experience.

Parting Shots… (from page 1)

Upon completion of a thoracic anesthesia fellowship, Alessia Pedoto joined our staff, and has now accepted a staff appointment at Memorial Sloan-Kettering in New York. She remains very Italian.
For a while it seemed prophets of doom had come to claim what had been stuff of quiet whispers only: what started with a self-assertive bang would go out into ignominious oblivion with barely a whimper! But friends, may I suggest that, like all of you who muster the requisite zeal, day after sweltering day, to bring your unsullied selves to tasks that lie in wait, I too am bitten by a tenacious bug. This issue of our newsletter may be awfully late, but in the process of gathering unto itself, it seems also to have undergone somewhat of a transformation and a broadening of context. It is for this reason, as much as for reasons more mundane—formal printing, print out-sourcing, experimentation with color, etc., not to mention the tremendous pickup in the volume of work that all of us typically experience at this time of year—there has been a necessary delay in bringing this Summer 2005 issue to you.

Please indulge the presumption on my part in imagining that relevance exists between all of us who gather to work together everyday. Any forays made into lives that surround ours and determine, to a significant degree, the quality of our mornings and evenings, are cultivated to lend value and worth to individual and collective effort. It is with this hope that I welcome my surgical friends and colleagues to partake of this venture; may the alliances strengthen and grow!

On this note, our existing feature, A Conversation... is now extended to our friends in the Department of Surgery. In the service of momentous beginnings, you will meet the delightful Esther Rhei, with whom I hope to have built not simply a conversation but a unique friendship.

The inception of a new feature under the title Get-to-Know, did not work out this time, though I shall not name names (Jeff Strickland, please take note!). What did work out, and beautifully so, is the addition of a second personality to Profile: in addition to the ever-dependable Pat Tape, in it is featured Hancy Jean-Simon, the anesthesia tech with the ubiquitous smile who so magically appears at the side at the first symptom of trouble! Words of farewell from my dear friend Matt Posner appear in this issue; ditto from Alessia Pedoto, a former thoracic anesthesia fellow, who redefined humor as a survival tool. Pankaj Sarin may have refused us his photograph, but it’s not like we need one to recognize him! Nick Sadovnikoff, on the other hand, has given us one too wonderful to consign to forgetfulness.

After a brief siesta, when it re-emerges at the end of this long and frolicky summer, the Anesthesia Record will be published every second month, in the interest of economy of labor, pursuit, incubation of ideas and fruition of plans, not to mention conservation of my own sanity. In the realm of sanity, however, it is Jamie Bell who must continue to guard his; were it not for his enthusiastic, candid and intensely productive collaboration—ever mindful of the outcome—there would be not a smidgen to hold or preserve; the entire enterprise would be as a fanciful summer cloudburst: fast, furious, but ultimately fickle.

Best Wishes,

Naila Moghul, M.D.
Esther Rhei

Refreshing in her candor, utterly dependable and forthright; a gracious colleague, a lovely friend—meet Esther Rhei, the surgeon so many of us have come to admire and love.

—Naila Moghul

Esther, where did you grow up?

My father was a minister; we moved from city to city based on his work in the church, but lived mostly in New York and New Jersey. I attended medical school at Robert Wood Johnson in New Jersey, and then on to residency at SUNY-Downstate in Brooklyn, followed by a fellowship at Memorial Sloane-Kettering; I have been here ever since…my life is far from glamorous, though.

Not many of us are children of ministers…It’s like living life in a fishbowl.

Sounds like it should make for a pretty strong ethical core—is that really the case?

I think each of us would like to think that about ourselves. My parents were political science majors in college: my father graduated from Yonsei University, my mother graduated Ewha University. My father emigrated here as an adult and matriculated in a seminary in North Carolina when he decided to become a minister. My mother was not permitted to join him immediately due to strict immigration laws, so she raised my brother in Korea for roughly nine years before coming to the United States. My parents also created an Asian food store/service based in our home. I was born and my three sisters followed, so we grew up in a crowded household. My parents worked very hard and were strict, but also very loving—they provided immense guidance ethically and personally. My sisters and I were each about a year apart, we were very close and we grew to become the best of friends.

What about the proverbial Asian stereotype—thou shalt not partake of frivolity! Not to mention the one about success—that it comes from four essential ingredients: academics, academics, academics, and…ah well…the fourth doesn’t count.

My parents allowed us to enjoy life, but I do agree that they were very strict; they were typical Korean parents. They stressed academics and a strong moral fiber. I skipped two grades as a child because they instilled in me the importance of studying and doing well in school. I knew I wanted to be a physician since I was four years old, though I never thought I would be a surgeon. I originally aspired to be a pediatrician but changed my mind after completing my surgical clerkship in medical school. My parents fostered (the idea), embraced it and were very happy when it happened.
What was your childhood like?
I consider myself very fortunate in that I was raised in a loving home. I did not come from a wealthy background. My parents are very educated, very intelligent people, but when they came to America, they did not have the wealth of resources that they had in Korea. They worked very hard and eventually elevated themselves to the point where they were able to send us all to college. We are all doing well for ourselves now, so I think they are the ultimate example of people who come to America and use the opportunity to make the best of their lives. My parents were always very proud of us and we were very fortunate to have parents who loved us so much.

Can affluence be counterproductive?
I think that affluence can be counterproductive if you choose to use it that way. You can take any kind of opportunity and make the best of it. I see it in some of the children around me, that they take a lot for granted. I think it is parents’ responsibility to keep their children grounded. I do not have children, but I would hope that if someday I did I would instill in them to not take anything for granted.

Tell me about your husband.
His name is Paul Tornetta and he is my heart. He is an orthopedic trauma surgeon at Boston Medical Center. Although I would like to spend more time with him, he’s extremely busy both clinically and academically, traveling around the world to give lectures, advance resident education, and change the way that trauma is being approached. He is someone who makes a difference in lives. In life there are observers and there are participants—he’s definitely one who participates, and actively. He is a visionary.
I am very lucky in many, many ways. I have a fulfilling job, I work with quality people, I have a wonderful family, and a loving and supportive husband. I am very blessed.

Do you enjoy your work?
Yes, very much. When patients do well I’m elated; when patients don’t do well, it can be devastating…

These days with breast cancer there are so many survivors; for the first time ever we are making a difference in mortality where breast cancer is concerned. So you know, when people tell me, “I don’t know how you do your job,” I say, it’s because everyday I have patients who not only survive but do well and that helps me to move forward, to do what I do, because it will make a difference. I am also proud to say that all my colleagues here are very skilled, intelligent, sympathetic, and kind. They make a difference in people’s lives—not only in treating them, but in helping them along the way, expanding beyond just the necessary skills. I am very lucky to work with such high caliber individuals.

Would you agree, dealing with an illness as catastrophic as cancer, that tragedy could bring in its wake something elementally humanizing? Or is that not your experience?
There are always patients you marvel at. You try to help and support as much as you can. But I am always amazed at some individuals who
really draw on their inner selves (for courage) and are able to move on, to think “I can beat this!” To (have this diagnosis) and go on with a positive attitude, to try to make the best of what they have, to rise above their diagnosis…

A brush with death affirming life itself…
I do think a brush with death is always a wake up call. It impacts lives in different ways, both positive and negative. From a physician’s point of view, I think that one definitely appreciates life more when we work with people who are battling it, winning over it. I now try to make sure everyone around me takes care of themselves. I often will check up on my colleagues and make sure they have their mammograms and followup.

Enough grimness! Let’s talk about music.
Sure. You know I love all music—maybe excluding heavy country! Just kidding. I love all music. I think that it comes from being in church (at any early age) and always being involved with music. You talked to me about parents forcing me into playing an instrument; well, I played piano as a child. I actually regret that I do not play it well. But as for music, you cannot walk into my operating room without having music playing, unless the patient does not want it. The patient comes first, of course.

What do you play at home?
It depends on the mood; late at night we play a lot of jazz; during the day we will play contemporary music, even groups that are not considered popular but ones Paul will discover and play for me. And when I want to relax I listen to classical music.

Finally, given your upbringing, has religion been integral in your life?
It has been a very important part of my life and has definitely contributed to making me who I am today. I may place my faith and optimism in something higher, but as a physician, I base my decisions and treatment on science and medicine.

Esther Rhei is an Associate Surgeon at BWH and at Dana Farber Cancer Institute
An Introduction to the OR Resource Management System (ORRMS)

by Pankaj Sarin, M.D.

As many of you know, since the beginning of the year we’ve been testing an electronic system that aims to help the floor leader and OC1 with their daily tasks. Currently, ORRMS can help keep track of the progress of OR cases, on-call versus non-call staff, and the departure times of both paid and non-paid staff. ORRMS is divided into two components: one that deals with case progress and staff location, and another that deals with staff time tracking. We began testing the second component on June 1, for eventual integration with the paid call system. This integration will eventually allow paid call information to be electronically sent to the accounting office while minimizing errors and staff work load.

This month, I’ll provide an overview of how to use the staff time entry component of ORRMS. Please note that this component can be used independently of the case progress and staff location component. If you use paper (or some other system!) to track cases and staff during the day or while on call, you will still need to enter paid call staff times. In the next issue, I’ll delve into how to use the case progress and staff location aspects of the system, as well as point out some tips and tricks that may help make your day easier.

In order to access ORRMS, go to https://etherweb.bwh.harvard.edu/orrmsv2 (you may wish to add this website to your “Favorites” list), and log in using your Partners username and password. After a successful login and after the OR schedule appears, you can access the staff time entry system by selecting any of the options in the Staff Lists drop-down menu (see Figure 1). A screen similar to Figure 2 should appear. You will note that all staff is categorized into 4 groups: Day Staff (e.g. floor leader, extra staff (ES), TBA, Faulkner); Overnight Call Staff (e.g. OC1, OC2, TC, CC); Late Call Staff (e.g. OC3A/OC3B); and Non-Call Staff (also designated as NC). These lists are automatically generated from the Excel call sheets and the daily OR schedule.

Any changes in staff can be made by simply replacing the old staff name with the new one on the above page. Time In and Time Out for each staff member can be entered on these pages. You can move through all the above groups to enter the times for each staff member. After you’re finished entering all staff times you must hit Save Changes before closing the web page or moving to the case and staff tracking system (note that you don’t have to hit Save Changes for each individual change, but rather, only after you’ve finished making all of your changes).

Thoracic and cardiac call backs can also be entered into the system. In order to enter call backs, first select the appropriate group (e.g. Overnight Call Staff). You’ll notice a drop-down box located below all the call types (Figure 3); this drop-down box contains all of the valid call types for this group. You can select the appropriate call type, and then enter the person’s Name, Time In, and Time Out. Be sure to hit Save Changes after you’re finished!

Once staff and times have been entered, a copy of the report can be printed by going to the Reports menu and selecting Paid Staff Sheet. Note that you cannot edit the times on the report itself. During the test period, we ask that you hand in a signed printout to the scheduling office instead of the usual paper form; after the evaluation period is over you will only be required to verify times via a digital signature.

Please let me know of any questions, concerns or issues you may have with the program as it is still in the development phase. If there’s an error with the system, please page me so I can check the error message; otherwise, feel free to e-mail me with comments.

Pankaj Sarin is Instructor in Anesthesia at HMS and Fellow in Medical Informatics at Harvard-MIT Division of Health Sciences and Technology
News & Updates

Appointment

Stephen B. Corn, M.D. has been appointed Director of Clinical Innovation in our department. In this capacity, Dr. Corn will organize didactic lectures concerning clinical innovation, as well as serve as a mentor for faculty and residents wishing to develop and present their ideas to the Ventures Office at Brigham and Women’s Hospital.

Dan Dedrick, M.D., has been re-appointed to the Committee on Residents and Medical Students of the American Society of Anesthesiologists for 2005 by ASA President-Elect Orin F. Guidry.

Brian J. Gelfand, M.D., F.A.C.S., a second-year resident in our program, was appointed by Orin F. Guidry, M.D., President-Elect, American Society of Anesthesiologists, to serve on the ASA Committee on Academic Anesthesiology. The committee is charged with representing the interests of academic anesthesiology to the society and making recommendations pertaining to the present and future challenges to academic anesthesiology and the specialty in general.

Brian has also been appointed as a member of the Massachusetts Medical Society Universal Care Taskforce, by Alan M. Harvey, M.D., M.B.A., President, Massachusetts Medical Society. To provide a basic safety net of coverage for every citizen of the Commonwealth is an important initiative of the Medical Society, the Governor, and the State Legislature.

Lawrence Tsen, M.D., has been appointed to the ASA 2006 Annual Meeting Subcommittee on Obstetric Anesthesia and Perinatology.

William Camann, M.D., assumes the role of President of the Society for Obstetric Anesthesia and Perinatology (SOAP) for the upcoming year.

The BWH Division of Obstetric Anesthesia was well-represented at the recent 37th Annual Meeting of the Society for Obstetric Anesthesia and Perinatology (SOAP), held on May 4–7 in Palm Desert, California, and on the scientific program:

- William Camann, M.D., moderated the panel on International Aspects of Obstetric Anesthesia.
- Miriam Harnett, M.D. and Lawrence Tsen, M.D., hosted Breakfast with the Experts tables.
- Bhavani Kodali, M.D., moderated the debate Cell Salvage Use in Obstetrics.
- Scott Segal, M.D., presented the Best Case Reports of the Year poster review session.

Academic Activities & Achievements

The abstract submitted by William Camann, M.D., Moeen Panni, M.D., and Lawrence Tsen, M.D. at the 37th Annual Meeting of the Society for Obstetric Anesthesia and Perinatology (SOAP) was selected as the winner of the Research in Education Award.

Yandong Jiang, M.D., Ph.D., was awarded the Massachusetts General Hospital Anesthesia Department 2004 Beecher Clinical Teaching Award.

Publications


Memtsoudis SG. (Comment) Bariatric surgery for pediatric patients. Anesthesiology News, June 2005; 31(6):60. This was an excerpt from an interview with Anesthesiology News.


Cho JH, Fraser IP, Fukase K, Kusumoto S, Stahl GL, Ezekowitz RAB. Binding specificity and activity of human Peptidoglycan...


**Lectures**

Massimo Ferrigno, M.D., gave a presentation entitled *Neurological and Hemodynamic Aspects in Competitive Breath-Holders*, at the Annual Scientific Meeting of the Undersea and Hyperbaric Medical Society in Las Vegas, Nevada on June 19. Coauthors of this work were: Carlo Pancaro, M.D., Luigi Magno, M.D., Massimo Del Sette, M.D., and Scott Kelley, M.D.

Simon Gelman, M.D., Ph.D., Peter Gerner, M.D. and Annette Mizuguchi, M.D., visited the Department of Anesthesiology at the University of Innsbruck, Austria, where they presented the following talks during their Grand Rounds on May 25:

**Simon Gelman**: Pathophysiology of Aortic Cross-Clamping and Un-clamping

**Peter Gerner**: Prevention of Local Anesthetic Toxicity

**Annette Mizuguchi**: TEE and the Thoracic Aorta.

Beverly Philip, M.D., attended the VI International Congress on Ambulatory Surgery, in Seville, Spain on April 24–27. She spoke on *Office-Based Surgery: Choice of Patients, Anesthesia, and Procedures*. Dr. Philip is co-Editor-in-Chief of the organization’s journal *Ambulatory Surgery*; the journal’s Editorial Board also met in Seville.

Beverly Philip, M.D. and James Philip, M.D., with the assistance of Robert Knapp, M.D., held a Leaders’ Course for Ambulatory Anesthesia on May 5 for anesthesiologists from Hong Kong and Macao. The course taught the physicians how to give state-of-the-art ambulatory anesthesia, how to organize an ambulatory surgery service, and how to then teach this to others. Nicole Georgi, M.D. and Johanna Higgins, M.D., provided excellent clinical demonstrations of ambulatory anesthesia.

Beverly Philip, M.D., participated in the Society for Ambulatory Anesthesia (SAMBA) meeting in Scottsdale, Arizona on May 12–15. She presented the 2005 SAMBA Distinguished Service Award and also participated in the Board of Directors meeting and several committee meetings.

Beverly Philip, M.D., gave Grand Rounds at Indiana University in Indianapolis on May 19. She spoke on *Fast Track Recovery*. She also lectured to community physicians on *Advances in Inhalation Anesthesia* in Indianapolis on May 18.

Beverly Philip, M.D., gave Grand Rounds at Concord Hospital, NH on June 2. Her topic was *Advances in Inhalation Anesthesia*.

Beverly Philip, M.D., gave Grand Rounds at University of Nebraska Medical Center in Omaha on June 15. The presentation was on *New Horizons in Ambulatory Anesthesia*, and it was simulcast to Creighton University and the Omaha Veterans Administration Hospital. Dr. Philip also spoke on *Advances in Inhalation Anesthesia* to community practitioners in Omaha on June 14. Alum Tuc Tranh says hello to everyone.

Beverly Philip, M.D., lectured to University of Colorado anesthesiologists, residents and pharmacists as well as community physicians on *Advances in Inhalation Anesthesia*, on June 22 in Denver, Colorado. She also spoke on *Ambulatory Anesthesia Update*, at Denver Health Medical Center in Denver, Colorado on June 23.

James Philip, M.D., was visiting speaker at Boston University Medical Center on May 16. Dr. Philip presented a Grand Rounds lecture entitled, *Understanding Inhalation Kinetics using Computer Simulation*. He followed Grand Rounds with the inaugural presentation in the BUMC Anesthesia AV Learning Center; *Using Gas Man to Learn Inhalation Kinetics through Exploration and Simulation*. Several BWH-trained faculty were in attendance.

James Philip, M.D., was Grand Rounds speaker at Beth Israel Deaconess Medical Center (BIDMC Boston) on June 1. His Grand Rounds lecture was entitled *Inhalation Anesthesia Kinetics*.

James Philip, M.D., lectured at Philadelphia-area hospitals June 21–22. He lectured at Crozer Medical Center. Dr. Philip presented Grand Rounds on *Inhalation Anesthetics*, performed an OR Visit with digital photography, and presented a lunch lecture on *Lessons Learned at Crozer ORs Today*. Dr. Philip presented a dinner lecture on *Clinical and Economic Impact of Low Blood/Gas Solubility*, at Yardley Inn, speaking to area anesthesia providers. On June 22, Dr. Philip presented Grand Rounds at Albert Einstein Hospital on *Clinical and Economic Impact of Low Blood/Gas Solubility*.

Charles Serhan, Ph.D., gave the keynote lecture entitled *Endogenous Anti-inflammatory Lipid Mediators, Resolvins and Docosatrienes: LC-UV-MS-MS Based Lipidomic Analysis, Databases, and Searching Algorithms* to the American Society of Mass Spectrometry (ASMS) at a San Antonio, Texas symposium on lipidomics.

Charles Serhan, Ph.D., gave the opening lecture at the Hot Topics Symposium on lipidomics for the National Biotechnology Conference of the American Association of Pharmaceutical Sciences in San Francisco. His lecture was entitled *Novel Bioactive lipid Mediators, Resolvins, and Protectins profiling: LM-Lipidomics*.

Stanton Shernan, M.D., presented a lecture entitled *Diastolic Heart Failure: Myth or Reality?* during Grand Rounds for the Department of Anesthesiology at New England Medical Center on June 6.

Gregory L. Stahl, Ph.D., presented a seminar entitled, *Lectin Complement Pathway Activation in Sterile Injury* to the Department of Immunology at Fukushima Medical University in Fukushima, Japan on July 11.
**Profile**

**Patricia Tape...** was raised in Dorchester and graduated from the University of Massachusetts, Boston, where she received a Bachelor’s degree in Management. She has been happily married to her husband, Jim, for 37 years. They have three grown children, two girls and a boy, two young grandchildren and twins due in November.

Pat loves spending time with her grandchildren, reading, shopping and traveling. She hopes to return to Ireland and France in the near future.

Pat has held various positions in the department since 1989. Currently she’s the department’s Office Manager. For the past 18 years, Pat has been honored to work with the members of her support group, the physicians and nurses. She especially enjoys sharing fun-loving antics with her co-workers.

**Hancy Jean-Simon...** My life began in Port-au-Prince, Haiti, where I grew up in less than ideal circumstances. Even though I had worked hard and managed to earn a Bachelor’s degree in Accounting, I was looking to better my life in a more substantial way. I emigrated to America, this land of freedom and opportunity, in 1976. Here, I attended Cambridge Latin High School, and then earned an Associate’s degree in Management from Bunker Hill Community College, settling down finally at Mt Auburn Hospital, which became my home in so many ways—I have now worked as an anesthesia tech there for twenty-seven years.

It has been a pleasure being a part of the anesthesia tech team here at Brigham & Woman’s hospital. I have been here for seven years already, but these seven years seem like seven weeks sometimes, so pleasant it has been! I have been made to feel like a team member, with understanding, patience and respect. I, for my part, have tried to be diligent in my duty, and helpful in every way I can. Reflecting on my life, I believe I have worked hard to achieve what I have in life, with the help of my wife of twenty-five years and my two beautiful daughters. At the same time, I know I have benefited tremendously from the compassion I have experienced from my colleagues, my co-workers, my friends and my family. I am proud to belong to this family! ♦

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