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PRESIDENT'S MESSAGE

Gary D. Cass MD
Tampa Eye and Specialty Surgery Center
4302 N. Gomez Ave
Tampa FL 33607

The curriculum for our Annual Meeting has been completed. The topics promise to be very informative and address the comments and suggestions made by our membership at our last meeting. The speakers include faculty members from many of the most prestigious medical schools in the nation as well as very well respected and experienced clinicians, administrators and consultants from around the country.

Medical topics pertinent to ophthalmic anesthesia to be presented will include the pre-operative work up, the peri-operative use of anti-thrombotics and anti-coagulants, allergic reactions, pacemakers, and an ACLS/PALS update. An update of anterior segment surgery, as well as anesthesia for ophthalmologist will be offered. A discussion of pediatric ophthalmic anesthesia as well as an interesting talk on veterinary ophthalmic anesthesia will broaden our horizons. Risk management and administrative issues in our field will also be covered. As always our "how to" workshops on peribulbar and sub-Tenon's anesthesia and management of complications will be available.

Recently, I have received numerous questions from anesthesia providers and ophthalmologists in both my community and around the country about topics pertinent to our specialty. These questions have all been about topics that will be discussed at our meeting. I always answer the questions to the best of my ability but then I urge clinicians who are working in this field to attend our meeting. I urge our membership to do the same. We have become very subspecialized so for the safety of our patients, and frankly the future of our Society, we need to share our knowledge with an increase number of clinicians practicing in our field.

I look forward to seeing in September!

Gary D. Cass MD
Tampa Eye & Specialty Surgery Center

INR Survey Results

We recently sent out a survey request to OAS Members. Of the 66 respondents, the following are the responses:

1. Does your facility use a CLIA-waived instrument to check INR?

Yes	10.6%	(7)
No	89.4%	(59)

2. If so, how much labor is required to calibrate, maintain, and use the machine?

Negligible - (calibrate just prior to use; simple to use)	37.5%	(3)

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Diplopia Study – Phase II

Dan Simonson CRNA MHPA
Spokane Eye Surgery Center
Spokane, WA

In the last issue of OASIS, I described the process of creating a study to assess the incidence of diplopia after ophthalmic regional anesthesia. My hope was to conduct a pilot study of approximately 100 patients and use the experience and results to guide us in developing a larger "multi-center" study of Ophthalmic Anesthesia Society members. The ensuing months have been spent developing documents, obtaining Institutional Review Board (IRB) approval, and finally, figuring out how to implement the study in a very busy ophthalmic surgical practice involving eleven ophthalmologists and all of the ophthalmic sub-specialties.

Developing documents: Before I could apply for IRB approval, I had to create the various documents for the study. These included a description of the data collection methods we would use, rationale for the study, the questionnaire, the methods of managing patient privacy and data security, and a description of the informed consent process and documentation. I then contacted the IRB and completed the application forms. Spokane has a community-wide IRB set up by several of the hospitals and housed in offices of Washington State University.

The IRB was helpful, although they have definite hoops to be jumped through. In particular, my rather rudimentary consent was expanded to four single-space pages, the last two of which addressed HIPPA concerns about how we would share the data and results. Once I had submitted the application and the documents to our IRB officer, she determined that the study could be more narrowly defined as a "registry", in that we were simply following patients more closely than usual and that we were subjecting them to no specific experimental treatment. For that reason we did not have to submit to a full IRB review and were able to begin.

I emailed all of my surgeons and CRNAs and everyone was very cooperative. However, translating that cooperation into patients ready to be admitted to the study was more difficult. My ophthalmologists and their assistants are very busy and find themselves extremely pressed for time as they try to process ever-larger volumes of patients in a quality manner. I tried out my patient recruitment procedures on one of my surgeons first, and pretty quickly found out that if I was going to meet my deadline of next October for my results and presentation, I was going to have to figure out another way.

I turned to my staff at the Surgery Center. Since I am the manager as well as the Chief CRNA, I was able to recruit two of the nursing staff to assist me as "Research Nurses." They loved the opportunity to participate, and once I described the process, they have quickly adapted that to fit our particular scenario.

Patients are recruited by our receptionist who, when the patients present at the front desk for sign-in, offers the lengthy consent and asks them to review the paperwork that they will then be able to discuss the study with the RN. The RN then goes over the consent, has the patient sign it, and attaches it along with a study questionnaire (to be filled out by the anesthetist) to the chart.

At this point we have completed about 30 patients, with a goal of at least 100 by the end of May. That will allow us to begin calling patients in three months to determine if they have experienced any permanent diplopia. Patients who are found to describe symptoms of diplopia will then be asked to come in to be evaluated by one of our strabismologists. By the beginning of August we should be able to declare an incidence of diplopia among our 100 patients.

My next step will be to write up the experience and present it at our September 26th Meeting in Chicago. I will be in communication with Dr. David Guyton of Johns Hopkins and a number of OAS members who have expressed interest in developing the multi-center study. Please consider joining us in Chicago and signing up for the study!

Review of the Second World Congress of Ophthalmic Anaesthesia

Cairo proudly hosted the second World Congress of Ophthalmic Anaesthesia (WCOA) February, 2008. While attending the First World Congress in London 2004, I felt first-hand how useful it was for ophthalmic anaesthetists to attend such a meeting. Coming from Egypt, I realized that due to limited study leave time and budgets, anaesthetists from developing

and third-world countries would have great difficulty traveling to such distant places as the UK and USA. As the 14th World Congress of Anesthesiologists was to be held in Cape Town (WCA2008), I thought it would be wonderful if I could arrange and host the WCOA congress around the same time and make 2008 the "African Year for Anesthesia!" Thanks to the BOAS organizing committee, it was decided to have my dream recognized.

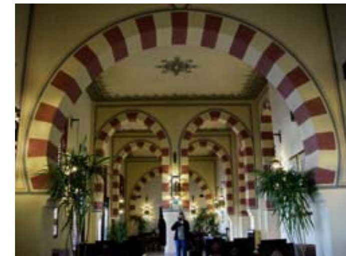
The attendance of the congress was above expectations. The number of delegates from around the world was well above one hundred, and the number of local delegates was above 150. That was no surprise to me, as we had managed to attract the best international lecturers and experts in the field of ophthalmic anaesthesia. Lectures covered different aspects of ophthalmic anaesthesia and there were two workshops on ophthalmic regional block techniques. The feedback was excellent, and I am still receiving abundant phone calls to congratulate me on the job well done.

Apart from the scientific meeting, the social activities were intense. We started with a cruise up the Nile. The mighty Nile is a lifetime must-see for every one! We were lucky to have the cruise prior to the the meeting, as the entire faculty and the delegates got to know each other well and thus make the actual meeting extremely friendly and collegial. On behalf of the organizing committee, I would like to thank the speakers who came at their own expense to willingly teach and transfer their knowledge to our many delegates. Also I would like to express my deep gratitude to the British Ophthalmic Anaesthesia Society for their generous financial and scientific support.

I hope that everyone enjoyed the Congress and I trust that we can arrange another meeting in Cairo again in the near future.

Ezzat Samy Aziz MBBCh MD FRCA FCARCSI MSc DA(UK)
Organizing Secretary, 2nd World Congress Of Ophthalmic Anaesthesia
Professor of Anaesthesia,Cairo University

World Congress


Aswan Cataract Hotel

Drs. Gayer and Aziz

Audience

World Congress Faculty

Drs. Gayer Kumar Dodds Aziz

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Minimal - (brief daily calibration; just a few minutes)	50.0%	(4)
Moderate - (at least 1/2 hour daily to calibrate & maintain)	0.0%	(0)
Excessive - (nursing staff wants to throw it away!)	12.5%	(1)

Employment Opportunities

Certified Registered Nurse Anesthetist, Flying Eye Hospital
ORBIS International

Nearly 37 million people worldwide are blind, and 28 million of them do not need to be. As a nonprofit organization, ORBIS International strives to eliminate avoidable blindness and restore sight in the developing world, where 90% of the world's blind live. ORBIS is a founding member of Vision 2020, a global initiative led by the World Health Organization and the International Agency for the Prevention of Blindness, which aims to end avoidable blindness by the year 2020.

An exciting opportunity exists to join the ORBIS team as Certified Registered Nurse Anesthetist (CRNA) on its unique Flying Eye Hospital, a DC-10 wide-body aircraft converted into an innovative teaching facility and ophthalmic surgical center. The ORBIS Flying Eye Hospital and its international medical team have conducted treatment and training programs in more than 70 countries since 1982. Many of the world's leading surgeons donate their time to perform surgery and teach aboard the aircraft, in programs specifically designed to suit the needs of host countries.

ORBIS International is looking for a Certified Registered Nurse Anesthetist to be responsible for administering anesthesia to patients and teaching anesthesia practices and protocols to other health care professionals who participate in the Flying Eye Hospital programs. For this opportunity, we are seeking an experienced CRNA (minimum 4 years) who is a graduate from an accredited school of nursing and has a current RN license and Nurse Anesthetist certification. The ability to interact with people of diverse cultural backgrounds and to work effectively in a team-driven environment is a must. The candidate must have a willingness and ability to travel internationally up to 75% of the time, and excellent communications skills.

For further information, visit our website at www.orbis.org. To apply, forward your resume to CRNA@ORBIS.org.

Bangladesh: Your Skills Needed!

http://news.bbc.co.uk/2/hi/programmes/from_our_own_correspondent/7257347.stm

Dear OAS Colleagues:

This could be our next mission trip! I don't think many of us would mistake this vessel for a cruise ship! It still looks better than the conditions I worked in with Surgical Eye Expeditions in British Guyana or with Pat Roberts and his mission to India!

But have a look and consider your own volunteer mission.

Lesa Morby CRNA ND
Wichita, KS

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ICD Management Update

Editor's Note: The entire Society gives thanks to Joe Bayes for his continued dedication to establish perioperative eye-surgery management guidelines for these devices. Every member of OAS is keenly aware that ophthalmic surgery procedures/patients have unique attributes that make them outliers from the "routine."

ICD Management Update

Joseph Bayes MD, Clinical Director of Anesthesia
Massachusetts Eye & Ear Infirmary

Dr. Gayer asked me to write a summary of a Letter to the Editor I recently wrote regarding new information on managing ICDs during ophthalmic surgery, and a response and additional recommendations from Dr. Marc Rozner, an expert on implanted cardiac defibrillators (ICDs). These letters were published together in ***Anesthesia & Analgesia*** Feb 2008.

I wrote:

1. From discussions I had last year with the technical support departments of the five current manufacturers of ICDs (Medtronic, Guidant/Boston Scientific, St. Jude, Biotronik, and ELA/Sorin) I learned that the time from onset of ventricular arrhythmia to delivery of shock could be a short as 6-12 seconds for four of the five manufacturers. ELA/Sorin reported this time interval to be 12-15 seconds. (Older generations of ICDs required 15-30 seconds to detect arrhythmias and discharge.)
2. Although ICDs rarely discharge during ophthalmic surgery, clinicians who choose to leave these devices active for tachyarrhythmia treatment during surgery should warn the surgeon that the time from the appearance of a ventricular rhythm on the ECG to delivery of a shock and subsequent patient movement may be as little as 6 seconds. Therefore if the ICD remains active, we must carefully monitor the ECG monitor during these cases in order to warn the surgeon that patient movement may occur quickly after onset of a ventricular (or possible supraventricular) arrhythmia.

Dr. Rozner responded and made several points:

1. Appropriate preoperative care of patients with ICDs also requires a recent in-office (not telephone) interrogation of the device.

   My opinion (J.B.) is that this preoperative ICD evaluation (and documentation) should ideally include: the manufacturer and model, date of implantation, name of person interrogating device, supervising physician, telephone number for patient's ICD clinic, date of most recent interrogation, documentation of proper functioning of the ICD, dates of device discharges (if any), adequacy of battery life, any special precautions such as a lead malfunction alert (which increases the possibility of an inappropriate discharge of the ICD), how the device will respond to a magnet placement, and recommendations for intraoperative and post operative management.
2. The decision of where patients should be permitted to have elective surgery, and how to manage the device perioperatively, should be made after reviewing the preoperative interrogation data (and obtaining a history from the patient). For example, if a patient is having frequent discharges of their ICD, or the device has a lead malfunction alert, it is probably best to have surgery in a medical facility with immediate access to ICD interrogation devices, inactivate the device immediately before surgery (after placing the patient on an ECG monitor, and having a working external defibrillator in the room) and reactivate and interrogate the ICD postoperatively.
3. NOT ALL ICDS RESPOND TO A MAGNET BY TRANSIENTLY DISABLING SHOCK THERAPY. Some models of Guidant/Boston Scientific and St. Jude can be programmed not to respond to a magnet, and there are at least 46,000 Guidant/Boston Scientific ICDs with a defective magnet switch now programmed to ignore magnet placement. Even more concerning, some Guidant/Boston Scientific models can be programmed so that they can be "permanently" disabled by placing a magnet, unless they are reactivated in a specific sequence.
4. It is also important to note that ICDs sometimes discharge inappropriately because of arrhythmias other than VT/VF (e.g. misinterpretation of SVT or atrial fibrillation as VT) and other device malfunctions.
5. Dr. Rozner believes that intraoperative disabling of an ICD is not *REQUIRED* if monopolar electrosurgery is not used, regardless of the type and duration of anesthesia, if all of the following 3 conditions are met:

1. The ICD undergoes an in-office comprehensive evaluation (not a phone check) shortly (i.e., 1–2 weeks) before the procedure.

However I, (J.B.) have some concerns that at our institution (and I suspect other institutions), obtaining this evaluation 1-2 weeks before surgery might be difficult for many patients to accomplish without delaying scheduled surgery. At our institution (MEEI) we require patients who are clinically stable to have this evaluation within 3 months of surgery.

2. The ICD lead system has no leads on alerts. For example, the Medtronic Fidelis leads can create spurious signals resulting in a shock without ECG evidence of a problem.

3. There is no history of any arrhythmia that will predispose to shock (VT, VF, supraventricular tachycardia, or paroxysmal atrial fibrillation).

Thanks to Dr. Marc Rozner for his review and thoughtful comments regarding this summary. For further information on this subject I would suggest reviewing the following articles and the references contained within them.

1. Bayes J. Management of implanted cardiac defibrillators during eye surgery. Anesth Analg 2008;106:671
2. Rozner M. http://www.sambahq.org/enewsletter/enews-Apr-2007-part2.html Accessed 4/20/08
3. Rasmussen MJ, Friedman PA, Hammill SC, Rea RF. Unintentional deactivation of implantable cardioverter-defibrillators inhealth care settings. Mayo Clin Proc 2002;77:855-9
4. Ellenbogen KA, Wood MA, Shepard RK, Clemo HF, Vaughn T, Holloman K, Dow M, Leffler J, Abeyratne A, Verness D.Detection and management of an implantable cardioverter defibrillator lead failure: incidence and clinical implications. J Am Coll Cardiol 2003;41:73-80
5. Fleisher LA, Beckman JA, Brown KA, Calkins H, et al ACC/AHA 2007 guidelines on perioperative cardiovascular evaluation and care for noncardiac surgery. A report of the American College of Cardiology/American Heart Association Task Force on practice guidelines (writing committee to revise the 2002 guidelines on perioperative cardiovascular evaluation for noncardiac surgery). Circulation 2007;23;116(17):418- 99
6. Practice advisory for the perioperative management of patients with cardiac rhythm management devices: pacemakers and implantable cardioverterdefibrillators: a report by the American Society of Anesthesiologists Task Force on Perioperative Management of Patients with Cardiac Rhythm Management Devices. Anesthesiology 2005;103:186-98

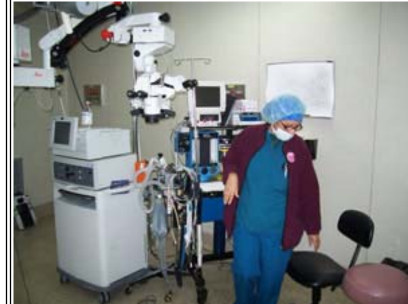
Member Spotlight

OJOS, Eye Surgery Specialists of Puerto Rico
Santurce, Puerto Rico

Maria de los A. Tirado MHSA, Executive Director
Gustavo Hernandez MD, Medical Director
Diplomate ABO, Glaucoma Specialist

The idea of starting an ASC for ophthalmologic procedures became a reality in April 1987. The idea came from a group of ophthalmologists and one anesthesiologist. As a forward-thinking group in Puerto Rico they obtained state-of-the-art equipment—including microscopes, anesthesia machines and medications. The center started with three ORs rented to a community hospital whose own facility was quite old. The goal was to have an institution with the best services in ophthalmic surgical procedures for the people of Puerto Rico; every day was a learning experience.

Dr. Torres	Dr. Lopez

Induction Area	Operating Room
Operating Room	 Operating Room

The first year, approximately 900 surgeries were performed. Today, we are close to 100,000 procedures. The center now has six operating rooms, two recovery areas and two preparation areas, where the majority of blocks are performed. Typically, we have 35 ophthalmologists, 4 full time anesthesiologists, 7 anesthetic nurses, technicians and graduated nurses on staff.

The center has seven floors. A laser suite is located on the first level with the reception area. Second and third floors house the ORs, each with preparation area and a recovery area. The fifth floor is the record room and waiting room for family. The sixth floor is pre-admission, including anesthesia office and internal medicine evaluation office. The seventh floor is administrative offices and Executive Director's Office. Two new ORs will soon be finished in the fourth floor as well as a new and remodeled laser suite. Our center receives referrals from all of Puerto Rico because of our high standard equipment, and the personnel who specialize in complex eye procedures.

Dr. Ivan Lopez became a member of OAS in 1998 so that he could share important knowledge and experience in ophthalmic anesthesia. Dr. Lopez emphasizes that prior to performing any block it is important to evaluate the orbit and check the axial length. One important change in our practice is to use needles 27 sharp less than 1.25", and inject the infero-lateral temporal area, per Dr. Gary Fanning's recommendation. As a junior partner, Dr. Francisco Torres learned from Dr. Guillermo Fernandez and Dr. Lopez how to perform intra- and extra-conal blocks, and how to manage ill patients in a free-standing ASC. In June 2000, Dr. Torres was taking an ophthalmologic block course and explained to the audience the importance of avoiding pivoting during eye blocks, as he learned from Dr. Lopez and later published in several anesthesia books. Since the beginning, we have been using a color-coded circle over the eyebrow of the eye to be operated to avoid wrong-site surgery.

Ojos, Inc., is accredited by Medicare and the State Department of Health and has had an average of more than 550 surgeries per month over the past five years.

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