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I recall a recent conversation with a colleague about whether it was more important to be good at what we do or to look good at what we do. In the end, we agreed that they are equally important. Today, it is not enough just to be a good anesthesiologist; our patients and our communities need to see and hear about the important role we play in healthcare. Many people, including our own patients and lawmakers, are not even aware that anesthesiologists have medical degrees. Several times a month, our departmental receptionist will get a call from someone inquiring about a job as an anesthesiologist. When asked where the individual went to medical school, it is revealed that they were unaware that anesthesiologists were physicians. We must advocate for ourselves by educating the public, including our patients, about the fact that we are physician members of the healthcare team.

I am writing this during the last few days of June. The New York Legislature has adjourned, and this past legislative session resulted in mostly favorable results for our members. That said, we continue to be concerned about the details regarding the arbitration process in the No Surprises Act. The governor’s budget included language that added average in-network physician fees as one of the criteria to be used to determine out-of-network physician fees. Because insurance companies can manipulate this value, the use of this information is concerning. For example, to lower median in-network rates, some health insurance companies in New York will utilize what are known as “dummy contracts,” whereby they put anesthesiology codes with dramatically lower rates into primary care contracts. We will continue to advocate for a fair arbitration process that favors both patients and physicians.

For this past NYSSA legislative day, we saw the largest turnout of young members that I can recall. While this is very encouraging, we believe we can do better. The NYSSA membership cannot rely on just a few to
advocate for more than four thousand. If you are asked by the NYSSA or the ASA to contact your local legislative representative about a specific issue, please do. We will not request your help in this way unless it is an urgent matter. If you cannot spare the time, you can always participate by making additional donations to our PACs. The healthcare environment is constantly changing, and we all need to participate in educating our legislators and our communities about the vital role we play for our patients.

During the summer you should have received a survey from NYSSA President-elect Dr. Jason Lok asking you to volunteer for a committee. Committee assignments will be sent to members in the fall. NYSSA committees are vital to our future planning as well as the day-to-day running of our organization. Volunteering your time not only helps the NYSSA, it may also allow for your professional growth, including progression to participating in your national specialty society, the ASA. Whether you want to use your voice locally or you aspire to be heard on a national level, your professional society needs to hear from you.
Researchers at JAMA Internal Medicine recently published a retrospective cohort study comparing medical school attrition rates for more than 33,000 allopathic doctor of medicine students matriculating within a two-year period. According to the authors, students who were underrepresented in medicine “(Hispanic, non-Hispanic American Indian/Alaska Native/Native Hawaiian/Pacific Islander, and non-Hispanic Black/African American),” low-income students, and students from under-resourced communities were more likely to experience attrition from medical school. The rate of attrition was actually highest among students who reported all three marginalized identities (underrepresented minority, low income and under-resourced community), at 3.7 times higher than those students who did not report any marginalized identity. The authors go on to discuss opportunities to help seal this “leak in the pipeline.” Considering the challenges these students may face even securing admission to a medical school due to their lack of resources and marginalized status, the authors conclude that it behooves medical schools and society at large to implement interventions that help prevent their attrition from medical school and that focus on retention efforts in addition to recruitment.

Our feature article in this issue, solicited by NYSSA Committee on Professional Diversity Chair Chantal Pyram-Vincent, M.D., and written by Ben Toure, M.D., offers a unique perspective on an important topic: Black men in medicine. (Don’t miss Dr. Pyram-Vincent’s call to action immediately following Dr. Toure’s personal story.) By now many of you may be aware of the “Black Men in White Coats” movement, which went viral when the documentary of the same name was released in 2021. The film explores why only 2% of American doctors are Black men and what that means for society. The movement has since been supported by the American Medical Association (AMA).
You Can Make a Difference

AFNY provides PGA-related scholarships to anesthesiologists from the developing world who wish to refine their delivery of safe, modern anesthetic care. Since 1993, more than 400 anesthesiologists representing 62 countries have enhanced their education and training thanks to the generosity of the NYSSA and its members.

You can help AFNY fund the education and research that will improve patient care around the world. Contributions are tax deductible and 100 percent of every donation will be used to fund the programs that fulfill AFNY’s mission.

Visit www.afny.nyc and make your donation today.

One may still question why this topic is relevant to members of the NYSSA or to any of us as individual anesthesiologists. The answer begins with a simple realization: Representation matters. Diversity in healthcare helps ensure that all backgrounds, beliefs, ethnicities and perspectives are adequately represented in the medical field. Ultimately, providing the best possible care for ALL patients is the goal. Having diversified healthcare teams has been shown to improve outcomes. For recruitment and retention purposes, having a diverse workforce that represents the population at large ensures that the best and brightest see themselves in that workforce.

We hope this issue stimulates some thought and discussions about this topic in your individual practices and, if applicable, leads to dedicated efforts toward a more representative workforce.

REFERENCES
From the Executive Director

The Evil Empire Undermines Surprise Billing Laws

STUART A. HAYMAN, M.S.

Throughout my career in medical association management, I have spent a substantial amount of time fighting for-profit health insurance companies on behalf of physician members. These companies have a history of obstructing patients’ access to quality care while striving to drive physician payments lower. The goal of the industry isn’t to pay for healthcare; it is to make money for shareholders. Consolidation of the health insurance market has created an oligopoly, giving insurers significant influence with the government at both the state and federal level and far too much authority over physicians and patients.

Most recently, health insurance companies have been covertly undermining the surprise billing regulations that were put in place for the state of New York as well as those passed by Congress. The health insurance lobby has spent years looking for openings to manipulate the data and change the way these laws are implemented. The result is a reduction in payments to physicians and increased profits for insurers.

Federal No Surprises Act

The federal No Surprises Act was written to provide patients with protection against surprise medical bills and to disallow balance billing for specified out-of-network (OON) services. The No Surprises Act created an independent dispute resolution (IDR) entity that would consider six factors when determining the payment amount for OON bills. Somewhere between the passage of this law and its enactment, however, the insurance lobby persuaded the administration to reduce the six diverse factors to one: “median in-network reimbursement rates.” On the surface this may not seem like a big deal, but it’s important for all NYSSA members to understand that it is, in fact, a VERY big deal. This change distorted and corrupted years of congressional work and the entire law. The net result puts more profits into the insurers’ pockets and further decreases physician payments. Clearly this was not the intent of Congress when this law was passed.
Insurers have been working to further undermine the new law by concocting a way to manipulate the median in-network reimbursement rates, thereby deceitfully driving the median rates lower. They have accomplished this by getting physicians to sign in-network contracts that include billing codes related to other specialties. These contracts are referred to as “dummy contracts.” As an example, a health insurance company sends a lengthy contract to a primary care physician that contains multiple pages of billing codes for anesthesia (and for other specialties) with an extremely reduced conversion factor. The primary care physician is not concerned with the pages in the contract that pertain to anesthesia procedures, so these pages are overlooked and the contract is signed. Unfortunately, these unrelated in-network conversion factors are then used to lower the median in-network rates for all anesthesiologists in the geographic area.

On the federal level, the ASA has been taking a very proactive approach to this battle. On February 9, the ASA, the American College of Radiology and the American College of Emergency Physicians filed a motion for summary judgment asking the court to vacate the changes made to the No Surprises Act and to reverse the enormous concessions given to private health insurers. The Texas Medical Association (TMA) has also acted on behalf of physicians by filing a lawsuit against the federal government pertaining to the changes enacted to the No Surprises Act. Additionally, as one of his first acts as NYSSA president, Dr. Jung Kim submitted paperwork for the NYSSA to join the Physician Advocacy Institute (PAI) in its amicus brief supporting the TMA action.

Another ASA initiative has involved collecting data via the conversion factor survey, which accumulates data on commercial payers (not Medicare, Medicaid or other government payers) annually. The ASA looks at the contracted (not paid) conversion factor (rate per unit) for commercial payers and compares that to the skewed in-network median rates.

**Surprise Billing Arbitration Rules Finalized**

In late August, the Biden administration finalized regulations on the arbitration of surprise billing disputes. While arbitrators will still take into account the median in-network payment rate for a service, they may also consider other factors, including a provider’s training and experience, how many services the provider offers, the market share of a medical facility or
insurance plan in that geographic area, and whether the medical facility is a teaching facility.

While better than the previous rules put forward by the Biden administration, the revised rules still run counter to the original intent of Congress in that they continue to favor insurance companies. However, the new rules do require greater transparency by the arbitrators.

At this time, it is not clear if the newly released arbitration rules will impact the legal actions brought forward by the TMA and ASA or if both lawsuits will be allowed to proceed.

**The ASA Releases Results From the Avalere Health Study**

Recently released data from the Avalere study exposed the insurance industry's use of phantom rates aimed at driving down median in-network rates. Specifically, the authors of the study supported the belief that phantom rates are being used by insurers to drive down the median in-network rates for specialized services, including anesthesia services.

**New York State’s Surprise Billing Law**

In 2014, New York passed a surprise billing law that provided transparency and protection for patients from excessive bills if they unknowingly went out of network. The law was broadly recognized as the best surprise billing law in the country. One reason for this was the fact that the law created an independent dispute resolution process that was touted as a fair and balanced method to resolve payment disputes between insurers and physicians. Despite the successful implementation of New York's surprise billing law, in 2022 Gov. Kathy Hochul was persuaded to put language in her annual budget to dilute the law in favor of health insurers.

**Changes to New York’s Surprise Billing Law**

Last January, the New York State Health Insurance Program (NYSHIP) began dramatic and unexpected cuts in payments for anesthesia services. NYSHIP is the self-funded health insurance carrier for approximately 1.2 million state and local government employees. NYSHIP falls under the umbrella of the New York State Department of Civil Service. NYSSA representatives reached out to Acting Commissioner Rebecca Corso and were told that as of January 2022, NYSHIP is following the guidelines of the federal No Surprises Act and reimbursing at the median in-network rate. Under normal circumstances, Ms. Corso would have been correct.
that, as a self-insured plan, NYSHIP falls under the federal law; however, when New York state was setting up NYSHIP in 2010, the Legislature directed NYSHIP to provide benefits mandated by state insurance law, rule, or regulation. This meant that NYSHIP had to follow New York state insurance regulations.

When the state Department of Civil Service acting commissioner realized that they were governed by state law rather than federal law, there was a push to persuade Gov. Kathy Hochul to weaken New York's regulations so that the state could pay lower reimbursement rates. This change was accomplished by adding median in-network rates as one of the criteria to be considered on all disputed surprise bills. On April 1, 2022, Crain's New York Business published an article with the headline, “Physician payments plummet after state health plan upends surprise-billing process.” The article states, “Local physician groups say the New York State Health Insurance Program has slashed payments for out-of-network services more than 80% by attempting to sidestep the state's surprise billing law.”

This change to New York's surprise billing law undermined what had proven to be one of the most common sense and successful state surprise billing regulations in the country. While the state may save money as a result of this change, the impact on New York's physicians does not appear to have been considered. Troy Oechsner, executive vice president of the Medical Society of the State of New York, spoke for all the state's physicians when he said, “If the insurer has the ability to stick you with whatever the median in-network rate is, they have every incentive to keep driving that rate down.”

The NYSSA has been working with our lobbyist, legislative counsel, MSSNY and other specialty societies to repeal this change to New York's surprise billing law. To that end, we participated in a call with the deputy counsel to the governor; the deputy director of state operations; the acting commissioner, general counsel and director of employee insurance programs for the Department of Civil Service; and the executive vice president of MSSNY to discuss a resolution. Unfortunately, that call was not successful. We then worked with MSSNY and other specialty societies to send a letter to the governor asking her to reverse this action but have not yet received a response. MSSNY has also reached out to some of the state's largest public sector unions (AFSCME, CSEA) to advise them that their members could be facing physician shortages due to recent NYSHIP
actions. Additionally, a private group of physicians joined together to file an action against the state regarding this change. For more information on this issue, see the Albany Report on page 29.

At both the state and federal level, surprise billing legislation was intended to help patients avoid unexpected medical bills and to create a level playing field for physicians who had payment disputes with insurers. It is unfortunate that the insurance industry has once again found a way to corrupt these noble efforts. We will continue to fight these battles on your behalf and will keep you posted on our progress.
Help the NYSSA Maintain Patient Safety: Support Physician Supervision of Anesthesia

Patient-Centered, Physician-Led Care
Recognizing the Challenges for Black Men in Medicine: One Man’s Perspective

BEN TOURE, M.D.

Recent events have accelerated the focus on racial tensions and the need for continued change in this country. The racial reckoning following the tragic murder of George Floyd and the appalling evidence of dramatic health disparities that we have witnessed during COVID-19 have brought racial relations in medicine to the social forefront. As a consequence of these challenging times, we have all had to do some self-reflection. As a Black/African American man, this self-evaluation was deeply pertinent.

I have been an attending physician for approximately 15 years, and it has generally been an incredibly satisfying, quite positive journey. I’ve wanted to be a doctor since I was a small child growing up in Africa. Graduating from medical school in New York wasn’t just a dream realized, it was also a tremendous honor. To serve as an anesthesiologist has been an amazing privilege. I am profoundly grateful to be trusted with my patients’ lives and to care for them when they are most vulnerable.

I work in a tertiary care, academic institution in New York City, which affords me the opportunity to work with great colleagues as well as to teach and train medical students, residents, and fellows from all over the world. The institution is acclaimed internationally for its excellence in clinical care, and tremendous research opportunities are always accessible. In short, the actual work of medicine is satisfyingly challenging and incredibly rewarding at the same time, so my race as a Black person is only minimally, if at all, relevant to my work as a physician … or so I thought.

Dealing With Microaggressions

During residency training, I encountered episodes of both subtle and overt racism and prejudice from patients and colleagues of all racial backgrounds, but my modus operandi at the time was (and, to some degree, still is) to ignore the obscure insults, disrespect, and semi-humiliating interactions and focus on the task at hand. I have learned that these daily incidents are called microaggressions.

A few years ago, I casually mentioned to a friend and colleague my experiences working with a certain ENT surgeon for six years. The surgeon has never once acknowledged me or even said hello, despite my efforts. I do not think he is intrinsically prejudiced or malicious. I first thought he
mistook me for the man who cleaned the operating rooms in between cases, who is also an African American man deserving of a hello and thank you. My friend countered that humans use pattern recognition to make sense of the world and to make the complex manageable, explaining this is generally why folks stereotype and that there is nothing inherently wrong with it. I am not sure that is entirely accurate but, even if partially true, it provides another rationale for encouraging a more robust effort at responsibly elevating the number of African American physicians and establishing a more humane pattern recognition.

After contemplating these and other microaggressions, I decided that I had bigger fish to fry, so I chose not to waste time and mental energy on ignorant stereotypes and foolish banalities. I frequently tell myself that I need to rise above such nonsense and move on with the clinical tasks at hand. After all, isn't my entire family, both here and in Africa, counting on me to excel? Isn't medicine a once-in-a-lifetime career opportunity? Didn't Dr. Martin Luther King Jr. take a fatal bullet for me to be here? I told myself to refuse to let microaggressions derail or obstruct my path, as clinical excellence and, ultimately, providing great care for my patients was — and still is — the only outcome that mattered. This was generally a successful stress reliever, motivating me along the way countless times over the years. Microaggressions are real and significant stressors, but my coping system is good, even if far from perfect. Admittedly, however, it has failed me at times in a spectacular and disastrous fashion.

**When Coping Mechanisms Fail**

Recently, a Senegalese patient insisted that I call the chief of my neuroanesthesiology department to take care of her during a spine operation. The chief happened to be me. Although I explained this to her and even volunteered to speak in French, which she was more comfortable with, she was even more incredulous that a “Noir” was going to be administering her anesthetic for this dangerous operation. It was a humiliating and sickening experience that I would not wish on anyone. My resident, who happened to be Asian American, understood and had tears in his eyes. The entire operating room staff couldn’t believe it and empathized when I translated our conversation. Racism negatively impacts all — those directly involved as well as bystanders.

For context, the routine scenario is that I approach a patient, physician colleague or new anesthesia resident in the hospital and I am often mistaken for the janitorial, transport or other ancillary staff — despite wearing an
identification badge that not only says M.D. but also has “PHYSICIAN” printed in large caps. In these situations, I simply brush aside the microaggressions and proceed with my clinical questions or engagement. Unfortunately I have become accustomed to these negative stereotypes. I’ve come to expect masked and seemingly benign questions about my place of training, nationality, experience and ability. I’ve experienced the audacity of some patients who will Google my name on their phones as I am obtaining their histories. My failure to cope with these stressors is rare, fortunately, but occurs when I am least prepared or not expecting racism at all, as with the Senegalese patient above. It is the most hurtful and intense when coming from people of color, especially other Africans or African Americans.

A similar yet even more jarringly hurtful example was experienced on a charity medical mission to Africa, where I was met with overt racism and ignorance. In 2018, my institution arranged a global health medical mission to the West African nation of Liberia. I jumped at the opportunity to partake since I am from that part of the world, and helping “our people” is only logical. I was the sole anesthesiologist volunteer from my department but was able to recruit a couple of medical students and an excellent resident for the trip. During introductions in the local hospital in Monrovia, I noticed that the Liberian students and medical staff were only interested in talking to my students and resident, who were white. Their almost total avoidance and dismissal of me persisted for our entire trip, and my trainees were considered the experts solely based on the color of their skin. It was such an abrasive experience that it really broke me down. I was embarrassed, angry, and sad at the same time but couldn’t do much about it. Emotionally, my trusted coping mechanism failed me. I thought about all I had gone through in college, medical school, and residency training, about Dr. King and his sacrifice, and I still couldn’t understand how to deal with the pain I felt.

This incident was most surprising and difficult because I have participated in other humanitarian missions to Haiti and Colombia and had excellent experiences. I was treated with utmost respect and genuine human kindness. In Colombia, I was treated like a king despite my protests, so the notion that this hurtful behavior would occur in my own backyard and from people who looked just like me was shocking. In Liberia I was so traumatized that I couldn’t sleep at night. It bothered me so much that I’ve vowed never to participate in another medical mission to Africa. That said, I realize there are indeed good people in those countries and those who avoided me may not have been
representative of their population. My rational conclusion regarding this episode was that this may be the unfortunate remnant of a colonial inferiority mindset.

**Where Do We Go From Here?**

One of the primary factors leading to health disparities is the underrepresentation of minorities in the physician workforce. According to the AAMC, 5% of physicians in the United States are African American despite African Americans making up 13% of the population.\(^2\) In my own institution, despite being in diverse New York City, until recently I was the only African American male anesthesiologist on the faculty out of a staff of 145 physicians. I dug deeper and found that African American physicians make up only about 2% of the total number of faculty members in our anesthesiology department system-wide. This is an unfathomable statistic in such a diverse city and state and should, in fact, be an urgent call to action. Sadly, the statistics around the country have not changed much in the past 40 years. Black men comprised only 3.1% of the medical student body in 1978 and just 2.9% in 2019.\(^3\) How do we as a society remedy this? Do we wish to improve? At my institution, there is an active diversity and inclusion office within the medical school and they are trying to do great things, but I suspect the *pièce de résistance* requires a more universal approach at the national level. Perhaps having more African American physicians will blunt the sad but real stereotypical attitudes within medicine and society at large. I believe this may even lead to better healthcare outcomes and, indeed, more caring and symbiotic doctor-patient relationships.

Ben Toure, M.D., is chief of the neuroanesthesiology department at Mount Sinai Hospital and an assistant professor in the Department of Anesthesiology, Perioperative and Pain Medicine at the Icahn School of Medicine at Mount Sinai.

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A Call to Action
CHANTAL M. PYRAM-VINCENT, M.D., M.P.H., FASA

In 2019, the life expectancy at birth for Black and American Indian/Alaska Native men was the lowest in the country, at 71 and 69 respectively.¹ Studies on patient-physician racial concordance have illustrated how communication is improved and treatment recommendations more readily accepted when both physician and patient are from racially minoritized communities,² illustrating the need to increase physician numbers to better represent the national population. Until the healthcare needs of the most vulnerable populations are addressed, health equity will not be achieved for all.

In the previous article, we heard the perspective of one Black anesthesiologist who was brave enough to share his story. Dr. Ben Toure is chief of the neuroanesthesiology department at Mount Sinai Hospital. His personal account should be seen as an urgent call to action to address recruitment, retention and inclusion of these underrepresented groups in medicine.

Dr. Toure’s story illustrated the various forms of microaggressions faced by minority physicians on a daily basis. These included microinvalidations from his colleague who excluded him or dismissed his personal feelings about being overlooked as well as microinsults, which were the subtle snubs and humiliation he experienced regularly that may be unintentional, such as daily instances of mistaken identity.³ His most touching example was from his experience in Liberia, which exemplified the constant reminders of prejudice and bias that exist on a systemic level.

Methods to address microaggressions have been developed, including: “Open The Front Door” (Observe, Think, Feel, Desire),⁴ “XYZ” (I feel X when you do Y because of Z)⁵ and the “ACTION” framework (Ask clarifying questions, Come from curiosity, Tell what was observed using facts, Impact exploration, Own your own thoughts, and Next steps).⁶ The reality remains, however, that for those who have been facing these challenges since before these frameworks were developed, utilizing them in real time is challenging and does not always heal existing wounds and trauma.

In 2015, the Association of American Medical Colleges (AAMC); the American Medical Association (AMA); the National Medical Association (NMA), an organization of African American physicians who were
previously refused enrollment in the AMA; and the Student National Medical Association (SNMA) put out a clarion call to action to recruit underrepresented minorities in medicine, specifically Black/African American men. The solution is not a sheer increase in numbers, however. Retention and inclusion efforts, as well as identifying and dismantling existing toxic environments, are paramount. Racial fatigue, from managing and working through bias and stereotypes, has been associated with decisions to change training and working environments. That is relevant to any form of discrimination in the workplace and can be amplified with increasing physician burnout overall and a stressful operative environment in which immediate decisions must be made.

Institutional inclusion efforts in medicine can aid retention. At the Icahn School of Medicine at Mount Sinai, there are ongoing departmental efforts to address these challenges. In addition to formalizing a position to address diversity, equity and inclusion, existing high school, college and medical student pipeline programs have been strengthened. A specific example is the increase in the number of students who are supported financially by the department. Additionally, an institutional zero-tolerance policy was developed to promote inclusion and protect house staff and faculty and support staff from racism or any form of discrimination by patients or their families. Other efforts include collaborating with our medical school, as they are far more advanced than clinical specialties in antiracist policies and education since the AAMC began confronting these challenges earlier, with the Accreditation Council for Graduate Medical Education (ACGME) following in 2019 and other specialty organizations thereafter. Our department is also working on partnering relationships with the City University of New York School of Medicine and Meharry Medical College, both of which have increasingly diverse student bodies.

We cannot accomplish our goals alone, but collectively as physicians we can make a difference in this world. As former President Barack Obama once said, “Change will not come if we wait for some other person, or if we wait for some other time. We are the ones we’ve been waiting for. We are the change that we seek.”

Chantal M. Pyram-Vincent, M.D., M.P.H., FASA, is chair of the NYSSA’s Committee on Professional Diversity and director of District 3. She is the departmental chief of diversity, equity and inclusion as well as a clinical assistant professor in the Department of Anesthesiology, Perioperative and Pain Medicine at the Icahn School of Medicine at Mount Sinai.
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After a three-year hiatus, the New York Academy of Medicine Section on Anesthesiology was pleased to present the Jeopardy Competition and Poster Presentation night on May 26, 2022. The evening commenced with a lively reception that included excellent food and drink, and then the fun began!

Eight departments sent teams of two each to participate in the challenge. Dr. Adam Lichtman, chief of vascular anesthesiology at Weill Medical College of Cornell University, once again served as the Jeopardy Competition host. During the first round, SUNY (Drs. Matthew Gao and David Kim) squared off against Weill Cornell (Drs. Erin Adams and Nick Govea), Icahn School of Medicine (Drs. Zachery Douglas and Alex Domanski), and Montefiore Medical Center (Drs. Ross Scott-Miller and Yifel Zheng). Round two followed with Rutgers New Jersey (Drs. Shivani Patel and Stephen Van Beek) paired against Columbia (Drs. Casey Drubin and Chris Folgueras), NYU Langone (Drs. Andrew Fleming and
Andrew Ghaly) and Westchester Medical Center (Drs. Jenna Littmann and Jeanne Tong). The winners of these rounds, Weill Cornell and Westchester Medical Center, battled in the championship round, with Westchester Medical Center emerging as the winner, receiving cash prizes and bragging rights.

Poster presentations included entries from Westchester Medical Center, SUNY Downstate and Columbia, all of which were considered by the judges to be of such high quality that two first-place prizes were awarded: to Dr. Liana Grosinger from Westchester Medical Center and Dr. Casey Drubin from Columbia.

The Section on Anesthesiology plans to hold another poster presentation evening in October, allowing residents and fellows to show their work before a discriminating audience prior to the annual meeting of the American Society of Anesthesiologists and the NYSSA's PostGraduate Assembly.

Elizabeth A. M. Frost, M.D., is the chair of the New York Academy of Medicine Section on Anesthesiology.
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American Society of Anesthesiologists
Euroanaesthesia 2022

Drs. Linda Shore-Lesserson, Jung T. Kim and Meg Rosenblatt

Dr. Jung T. Kim places an apple sticker on an attendee’s badge.
Dr. Meg Rosenblatt helps attendees at the PGA exhibit booth.

Drs. Linda Shore-Lesserson, Meg Rosenblatt, Jung T. Kim and Christopher Campese with NYSSA staff member Kelly Mancusi
The NYSSA booth at Euroanaesthesia 2022

Dr. Christopher Campese

Informed Surgical Consent
A fundamental expression of patient autonomy

Drs. Linda Shore-Lesserson and Jung T. Kim with SAESP International Affairs Director Dr. Claudia Simões (far left), SAESP Scientific Director Dr. Marcio Matsumoto, SAESP President Dr. Maria Carmona, and Dr. Joana Berger-Estilita (far back) from Bern University Hospital
Drs. Meg Rosenblatt, Christopher Campese and Linda Shore-Lesserson

Drs. Christopher Campese and Jung T. Kim spend some time at the NYSSA exhibit booth.

Dr. Meg Rosenblatt

The NYSSA panel at Euroanaesthesia 2022
Infection Control for Anesthesia Professionals

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Infection control training is mandatory for anesthesiologists and other healthcare providers in the state of New York. This course satisfies the NYS licensure requirement for infection control education. This course was developed and updated by NYSSA, in conjunction with Elliott S. Greene, M.D.; Richard A. Beers, M.D.; and Medcom, Inc., thanks to an unrestricted educational grant from New York state. This activity is designated for 3 AMA PRA Category 1 Credits™ of which 3 are MOCA® Safety Credits.
New York State Health Insurance (NYSHIP) Empire Plan

The Empire Plan, a major payer for providers, covers more than 1.2 million lives and is subject to the New York state surprise billing law. At least all providers thought so until it was discovered that after January 1, 2022, the New York State Department of Civil Service (DCS) and United Health Care (which administers the medical arm of the Empire Plan) made the decision to apply the federal No Surprises Act (NSA) independent dispute resolution (IDR) rules. Please keep in mind that although the American Society of Anesthesiologists (ASA) and other specialty associations are engaged in an ongoing lawsuit challenging the implementation of part of the federal IDR regulations, the lawsuit does not affect the application of the federal IDR rules. The lawsuit only impacts the weight that will be given to the qualifying payment amount (QPA). QPA is defined as the median of the contracted rates recognized by the plan for the same or similar item or service that is provided by a provider in the same or similar specialty and provided in the same geographic region in which the item or service under dispute was furnished, increased by inflation. The question is, will the QPA be the dominant factor in the federal IDR or will it be considered equally with other stated factors?

In the immediate aftermath of the DCS's decision to apply the federal IDR rules, it was clear that the federal process was more favorable to insurers than the New York state surprise billing law.

MSSNY/NYSSA Response

On or about February 14, 2022, the Medical Society of the State of New York (MSSNY) facilitated a meeting among New York state government officials representing the DCS, Department of Financial Services (DFS), and the governor's office in order to express concerns about reductions in payments to providers. The NYSSA was represented by Executive Director Stuart Hayman; the NYSSA's Albany lobbyist, Bob Reid; a New York state anesthesiologist with direct evidence of the impact of this decision; and me. At this meeting, DCS officials announced that it was their opinion that they had the legal authority to apply the federal IDR rules.
On March 14, 2022, MSSNY prepared a detailed letter (which the NYSSA co-signed) to the governor’s office setting forth the legal position why the DCS opinion should be reversed. The letter also identified the negative consequences of the decision, which resulted in a drop of reimbursements of more than 80% for some physicians.

**Legal Action**

On March 29, 2022, a legal action to obtain a declaratory judgment was filed with the Albany County clerk and the New York state Supreme Court by 18 out-of-network physician providers and four Empire Plan enrolled clients to challenge Empire Plan’s contention that since January 1, 2022, it was no longer subject to the New York State Department of Financial Services (DFS) independent dispute resolution regulation.

NOTE: Updates to be provided about the status of the legal challenge as more information becomes available.

**New York State’s No Surprise Law’s Independent Dispute Resolution — Additional Criteria**

The New York state budget for fiscal year 2022-2023 included additional criteria for the New York state surprise billing law IDR. A part of the New York state budget regarding a comprehensive proposal to update New York state’s surprise billing law was to incorporate mandatory provisions of the federal NSA, including median in-network payment data, as one of the express criteria to be considered by the state IDR in addition to the physician’s usual and customary charge and the particular expertise of that physician.

MSSNY and the NYSSA lobbied against the inclusion of the median in-network payment data in the state budget. Both houses of the Legislature excluded this requirement. However, during the final budget negotiations, it was included by the governor. The NYSSA continues to work with MSSNY to assess the impact of this change in the state IDR.

**Summary of Criteria**

Summarized below is the criteria (see highlighted provisions), as amended, in the budget bill as signed by the governor.

[Current through 2022 NY Law Chapter 200]

**Section 604 - Criteria for determining a reasonable fee**

In determining the appropriate amount to pay for a healthcare service, an
independent dispute resolution entity shall consider all relevant factors, including:

(a) whether there is a gross disparity between the fee charged by the provider for services rendered as compared to:

(1) fees paid to the involved provider for the same services rendered by the provider to other patients in healthcare plans in which the provider is not participating, and

(2) in the case of a dispute involving a healthcare plan, fees paid by the healthcare plan to reimburse similarly qualified providers for the same services in the same region who are not participating with the healthcare plan;

(b) the level of training, education and experience of the healthcare professional, and, in the case of a hospital, the teaching staff, scope of services and case mix;

(c) the provider's usual charge for comparable services with regard to patients in healthcare plans in which the provider is not participating;

(d) the circumstances and complexity of the particular case, including time and place of the service;

(e) individual patient characteristics;

(f) the median of the rate recognized by the healthcare plan to reimburse similarly qualified providers for the same or similar services in the same region that are participating with the healthcare plan; and

(g) with regard to physician services, the usual and customary cost of the service.

Grieving Families Act (Wrongful Death Legislation)

Even though the NYSSA worked closely with MSSNY in opposition to the Grieving Families Act promoted by the New York State Trial Lawyers Association, the bill passed at the end of the legislative session. As this article is being written, the bill awaits Gov. Hochul's action.

This Act will greatly expand the type of damages that could be awarded in wrongful death cases, increase the eligible close family members who can bring a wrongful death case, and increase the statute of limitations for bringing such an action. According to the Medical Liability Mutual Insurance Company (MLMIC), a well-respected actuarial firm estimates that these provisions will result in a roughly 40% increase in New York medical professional liability premiums.
The NYSSA is a co-signatory of a letter (reprinted below) authored by MSSNY recommending that the governor veto this legislation. Other medical specialty societies have also joined in co-signing the letter. (For publication in *Sphere*, this letter has been edited for clarity and style.)

Elizabeth Fine, Esq.  
Counsel to the Governor  
State Capitol, Executive Chamber  
Albany, NY 12224  

RE: S.74-A (HOYLMAN)/A.6770 (WEINSTEIN) - AN ACT to amend the estates, powers and trusts law, in relation to payment and distribution of damages in wrongful death actions  

Dear Ms. Fine:  

Our respective associations, which together represent tens of thousands of physicians across the state of New York providing care to hundreds of thousands of New Yorkers each year, urge you to recommend a veto of the above-referenced legislation that would exponentially expand damages and lawsuits for “wrongful death” by including compensation for grief or anguish. The explosive increase in liability costs that expansions like this bill would necessitate would cause significant damage to our healthcare safety net, driving physicians out of state, and exacerbate the already challenging patient access to care issues we face.  

One recent actuarial study has estimated that this legislation could increase New York’s already outrageously high medical liability premiums by nearly 40%. This extraordinary increase would be on top of the already exorbitant premium costs New York’s physicians and hospitals continue to incur, with many specialties across the New York City and Long Island region of the state already paying hundreds of thousands of dollars per year for their liability coverage. If that were not problematic already, these costs are likely to rise for many physicians across the state for the 2022-23 policy year based upon a determination by the New York Department of Financial Services. If the actuarial assessment provided is accurate, S.74-A/A.6770 would necessitate a premium increase of over $76,000...
for a Long Island OB-GYN and over $61,000 for a Long Island surgeon.

These costs are simply not assumable by most physician practices.

New York already has a notorious history as being one of the worst states in the country to deliver patient care (https://wallethub.com/edu/best-and-worst-states-for-doctors/11376), in large part because its liability costs and risks far exceed all other states. While some advocates have claimed that New York’s existing wrongful death law is an outlier compared to other states’ laws, what they do not mention is that most of these other states also have comprehensive provisions to contain excessive medical liability insurance costs, including limits on damages. New York has no such law, which is why our medical liability insurance and payout costs far exceed every other state in the country.

A recent report from Diederich Healthcare showed that in 2019, New York once again had the highest cumulative medical liability payouts of any state in the country, 68% more than the state with the second highest amount (Pennsylvania). It also had the highest per capita liability payment, 10% more than the second highest state (Massachusetts). It also far exceeds other large states regularly competing for physicians such as California and Texas.

Even under ordinary circumstances, this bill would have an absolutely devastating impact on our healthcare system and jeopardize patient access to care as physicians simply retire or move to other states. But the myriad challenges thrust upon physicians and other providers of healthcare arising from the pandemic make this legislation absolutely unconscionable. Many physicians continue to face significant financial challenges in recovering from the huge drop in patient visits that arose from the need for social distancing. An AMA survey reported that during the height of the pandemic the average number of in-person visits to physician offices fell from 97 per week to 57. As a result, physicians averaged a 32% drop in revenue for most of 2020, with about one in five doctors seeing revenue drop by
50% or more, while nearly one-third saw a 25%-49% decrease. Even as we emerge from the pandemic, physicians face greatly increased overhead costs to increase safety for themselves, their staff and their patients, including excessive personal protective equipment (PPE) costs. Enacting this legislation threatens access to care to countless numbers of New Yorkers who depend on their physicians for their care.

We appreciate that last year Gov. Hochul recognized these concerns [by] vetoing another trial lawyer-backed bill (S.473/A.2199) to permit the awarding of pre-judgment interest in certain instances, because of concerns of imposing [a] premium increase on healthcare providers and municipalities at a time when their budgets are under severe constraint due to managing the COVID pandemic. Specifically, the veto message noted:

“\textit{This bill would have a significant negative impact on defendants in litigation including hospitals, State government and local governments, all of which are already under a great amount of strain due to COVID-19} … I cannot impose this burden on local municipalities and health care providers at this time. Accordingly, I am constrained to veto this bill.”

As noted above, S.74-A/A.6770 will have an exponentially larger adverse impact on insurance premiums than what would have been triggered by the provisions of S.473/A.2199. Accordingly, we believe that Gov. Hochul’s words from the December 2021 veto message are even more relevant now. Our hospitals, community physicians, clinics, counties and cities — all of whom also oppose this bill — cannot afford the extraordinary new liability premiums and costs this legislation would necessitate. It is simply untenable.

In sum, this bill would do nothing to address the problems facing our healthcare system and would instead make these problems worse by adding substantial new costs at a time when [healthcare providers] can least afford to incur them. It would make it even more difficult for our healthcare system to recover from the pandemic.
To preserve access to our healthcare safety net, the governor must veto this legislation and bring together various parties to discuss how our liability laws can be equitably reformed while preserving access to New York’s magnificent but overburdened healthcare system.

Clinical Peer Reviewer Legislation
This legislation, which is supported by the NYSSA, would assure that those who make “medical necessity” determinations on behalf of a health insurance company are appropriately qualified. This passed both houses of the Legislature and now awaits Gov. Hochul’s action. The NYSSA, together with other medical specialty societies, co-signed the following letter authored by MSSNY. This letter urges the governor to sign this measure into law. (For publication in Sphere, this letter has been edited for clarity and style.)

Elizabeth Fine, Esq.
Counsel to the Governor
State Capitol, Executive Chamber
Albany, NY 12224

RE: A.879 (GOTTFRIED)/S.8113 (CLEARE) – AN ACT to amend the public health and insurance law, in relation to definition of clinical peer reviewer

Dear Ms. Fine:

Our respective associations, which together represent tens of thousands of physicians across the state of New York providing care to hundreds of thousands of New Yorkers each year, are writing to you regarding the above-referenced legislation that would establish necessary qualifications for a person with whom a health plan must consult before deciding to deny a treatment or needed prescription medication for a patient that has been requested by the patient’s treating physicians. We respectfully request that you recommend that Governor Hochul sign this bill into law.

This bill seeks to assure that those who make “medical necessity” determinations on behalf of a health insurance company are appropriately qualified to make those decisions. Under current law, the only qualification required for a person who, on behalf of a
health plan, may contradict the treatment recommendation of the patient’s treating physician is that such reviewer be a licensed physician. The physician does not even need to be licensed to practice in New York state. Moreover, there is no requirement that the reviewing physician have the same qualifications as a physician who would typically render or facilitate the treatment that is being recommended for the patient. Therefore, the person reviewing the treatment request may not have the sufficient training or experience necessary to decide whether the treatment or prescription medication that has been recommended is appropriate. As a result, care that may be needed for our patients may be unnecessarily delayed or denied while the patient has to resort to taking an internal and, if necessary, external appeal, to attempt to receive the care that has been recommended, which risks putting the patient’s health in jeopardy while these appeals are processed.

For example, we note that, according to the [2021] NYDFS Consumer Guide to Health Insurers, there were nearly 52,000 internal appeals made by patients against New York-regulated health insurers for claim or pre-authorization denials in 2020, with nearly 50% of these appeals reversed. In 2019, according to the [2020] DFS Guide, there were nearly 60,000 internal appeals filed against New York-regulated health insurers for claim or pre-authorization denials, with over 50% of these appeals reversed.

The same NYDFS annual guides noted that there were also 1,400 external (independent) appeals filed against health insurers in 2020, and 1,500 external (independent) appeals filed in 2019, with a full or partial reversal nearly 40% of the time for both years. Tens of thousands of patients are impacted by these unnecessary care delays prompting either or both internal and external appeals, caused by initial unjustified denials. It is essential for health insurers to use appropriately trained physicians to provide reviews of claims or pre-authorization requests submitted by patients and their physicians to protect patients from needless delays in accessing necessary care.

This bill would do just that. It would ensure that a health plan may not deny a request for needed patient care unless the reviewing physician is adequately qualified to review the treatment requested
or provided, by requiring that such reviewing physician be board certified or board eligible in the same or similar specialty as the physician who typically recommends the treatment or manage[s] the condition that is under review. It would also require that such physician have a New York license to practice medicine. Overall, this bill would provide much-needed additional protections to ensure that our patients will have coverage for the care they are expecting and entitled to receive. Therefore, our groups respectfully request that this legislation be enacted into law.

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Perioperative Management of a Patient With C1 Deficient Hereditary Angioedema

MAKSIM MERAKHOVICH, M.D., ANNETTE LUO, M.D., AND DIVYA CHERUKUPALLI, M.D.

Abstract
A 40-year-old female with a known history of GERD and C1 deficient hereditary angioedema (HAE) presented with eight hours of right upper quadrant abdominal pain and was subsequently admitted for urgent cholecystectomy. Her HAE is controlled with Firazyr as needed for angioedema exacerbations, which are characterized by neck swelling, hand swelling, and abdominal cramping. Preoperative evaluation and consultation by allergy and immunology yielded a perioperative plan that included short-term prophylaxis of Berinert with Kalbitor (ecallantide) as needed for acute episodes. There were no intraoperative complications and the patient was discharged after two days of SICU monitoring.

Introduction
Hereditary angioedema (HAE) is a rare autosomal dominant disease characterized by deficiency in or dysfunction of C1-esterase inhibitor (C1-INH), a protein in the complement cascade that regulates vascular permeability. Presenting symptoms of an angioedema exacerbation include sudden edema of the subcutaneous tissues of the face, larynx, and extremities. While most HAE attacks are spontaneous, events like trauma or surgery may be significant triggers that can lead to asphyxiation and other fatal complications. Proper management of HAE during the perioperative period is imperative in preventing life-threatening airway compromise, as these emergencies affect up to two-thirds of HAE patients and are responsible for a high mortality rate of 15%-33%.1 This case describes a patient with C1 deficient HAE who required cholecystectomy. We delineate the treatment modalities used during the perioperative period for HAE prophylaxis, rescue and management. The patient’s consent for publication of this report was obtained prior to anesthesia intervention via written HIPAA authorization.
Case Report

The patient is a 40-year-old female with a notable past medical history of GERD and previously diagnosed C1 deficient hereditary angioedema (HAE) who presented with eight hours of right upper quadrant abdominal pain. She reported that the pain was associated with eating. Additionally, she had nausea and vomiting but denied fever and chills.

The patient’s hereditary angioedema was diagnosed at 14 years old, with manifestations presenting as neck swelling, hand swelling, voice change due to mild throat swelling, and abdominal cramping, all of which are controlled with Firazyr (icatibant injections) as needed, which the patient carries with her at all times. It is notable that she did not have a history of prior intubations due to the condition. The patient had no known drug allergies and did not take oral contraceptives or use tobacco products. She takes famotidine 20 mg twice daily. Her only prior surgical history included dental work, which would lead to angioedema exacerbations with neck swelling.

Preoperative evaluation for laparoscopic cholecystectomy revealed normal vital signs and a BMI of 39 kg/m². The physical examination revealed no relevant findings except for right upper abdominal tenderness and discomfort. A COVID-19 PCR test was negative and preoperative CBC, PT/INR, PTT, and CMP were normal. Repeat testing to confirm C1 deficient HAE revealed a C1 esterase level of 5 mg/dL (reference range: 21-39), C1 esterase inhibitor function of 32% (abnormal <41%), C4 levels <8 mg/dL (reference range: 19-52), and no detectable mutations of 86 mutant variants analyzed. Ultimately, the patient was assessed to be ASA III due to her history of HAE and symptomatic gallstones.

Consultation with allergy and immunology led to a plan of short-term prophylaxis of Berinert 20 units/kg intravenously (human C1 esterase inhibitor) given 30 minutes to one hour prior to surgery. Additionally, acute episodes were to be managed with Kalbitor (ecallantide) 30 mg SQ, with administration of another 30 mg within 24 hours if required for recurrent exacerbation. Furthermore, immunology recommended a plan for careful intubation and extubation to avoid laryngospasm or a traumatic extubation. Since the patient was high risk for airway collapse, the trauma team was on standby for a potential surgical airway during intubation and extubation.
The procedure was uneventful and intubation was performed without trauma using a video laryngoscope. Postoperative management involved 48-hour monitoring for angioedema in the surgical intensive care unit. During the monitoring period, the patient experienced no postoperative adverse events. She was subsequently discharged after two days with a one- to two-week follow-up with the surgical team.

Discussion
C1 deficient hereditary angioedema results from increases in vascular permeability and swelling of soft tissues because of dysregulation of C1-INH, which regulates the complement, coagulation, and fibrinolytic pathways. The plasma contact system, which is a group of proteases that line the vessel wall, generates bradykinin, which subsequently activates a series of G protein-coupled receptors that increase vascular permeability. The role of a C1 inhibitor is to inactivate kallikrein, factor XIIa, and factor XIII, stopping the contact cascade and preventing downstream vascular permeability changes. Deficiency in C1-INH results in an imbalance of increased vascular permeability that can lead to HAE exacerbations with clinical features as described.

Perioperative management of patients with HAE includes prophylaxis, identification of pre-existing symptoms or risk factors, and creation of a patient-specific anesthetic plan that delineates rescue treatment for acute events. This case demonstrates successful management of a patient with HAE and outlines perioperative recommendations for this patient. In the pre-operative period, a comprehensive patient history should be obtained and include current medications, a thorough physical exam, and pre-op labs, including CBC, PT/INR, PTT, CMP, as well as current C1-esterase levels. A CBC and CMP can provide baseline counts in case of a proinflammatory and metabolic event. Abnormalities in PT/INR and PTT may predict excess bleeding in the event of a surgical airway. Optimal perioperative management of patients with HAE benefits from a comprehensive plan tailored by an interdisciplinary team of anesthesiologists, surgeons, immunologists, allergists, and pharmacists. (See Figure 1 for schematic planning.)

There are two FDA-approved medications that are used for HAE prophylaxis: Cinryze and Haegarda, both of which are human-pooled C1 esterase inhibitors. Berinert is categorized as an on-demand treatment and is also a human-pooled C1 esterase inhibitor like Cinryze and Haegarda,
Patient presenting with previously diagnosed C1-def HAE requiring non-emergent abdominal surgery.

Obtain relevant preoperative lab studies with allergy/immunology consult for collaborative pre/peri/post-surgical plan.

Berinert 20 units/kg given IV 30 min - 1 hr before operation.

Video laryngoscope-guided intubation to minimize trauma.

Kalbitor 30 mg available for exacerbation

48 hr postoperative monitoring in surgical ICU.

Trauma team on standby for surgical airway, if needed.

Kalbitor 30 mg available for exacerbation

Uncomplicated postoperative course and discharge after 48 hrs.

Figure 1. Schematic representation of patient’s perioperative course from admission to discharge.
except with a shorter half-life (Half-lives: Cinryze – 56 hrs; Haegarda – 69 hrs; Berinert – 18.4 hrs). The half-life of Berinert was sufficient for a shorter procedure such as the laparoscopic cholecystectomy, which lasted a total of 107 minutes (1.8 hrs). While Berinert is not currently widely established for use as a prophylactic, prior studies as well as our case help demonstrate its effective usage as a short-term surgical prophylaxis for HAE exacerbations, especially when administered within a one- to six-hour window prior to the surgical procedure.

It should be noted that Cinryze, Haegarda, and Berinert have the potential to cause venous thromboembolisms (VTE), as well as hypersensitization, because they are biologics, imparting the potential for allergic reactions upon repeat use. This identifies a potential risk, especially in a surgical patient, who will be at an increased risk for VTEs. The hypersensitization would have to be a consideration for current or future surgeries due to the concern for anaphylaxis. That risk can be assessed during preoperative evaluation via patient interview for past usage of the human-pooled C1 esterase inhibitors or a history of past anaphylaxis with those agents. Side effects of the agents include nausea, vomiting, diarrhea, and headache, which are also associated with HAE. Given this procedure was abdominal in nature, it is certainly possible that the operative location could confound the presentation of medication side effects versus presentation of an HAE exacerbation. Particular care should be placed on determining the etiology of symptoms, as they can portend a more serious postoperative HAE exacerbation requiring intervention with a rescue agent.

The human-derived C1 esterase inhibitors are easily available at our facility, a tertiary care center, but their high cost prevents them from being widely available. Prior established pre-surgical prophylaxis with the use of danazol (promoter of C1 inhibitor synthesis) and FFP (C1 inhibitor replenishment) exists, but danazol carries the risk of virilization, obesity and transaminitis. Additionally, danazol and FFP do not meet the same efficacy and carry increased side effects when compared to human-pooled C1 esterase inhibitors. Danazol dosage schemes require administration five to seven days before surgery, which is not always feasible, especially when urgent or emergent operations are required. In contrast, the benefit of using Berinert is that it can be administered within a short window prior to surgery. Short-term prophylaxis using danazol has been recommended in children and during the third trimester of pregnancy in gravid patients, which bolsters it as an alternative option.
Particular attention in this case was given to the necessity of a smooth intubation, as any minor physical insult carries a substantial risk of airway edema. Avoiding the need for a surgically accessed airway is preferable. Regardless of patient anatomy, a video-guided laryngoscope can promote establishment of an atraumatic airway, as with our case.

The availability of rescue medications for acute HAE exacerbations is particularly vital. Kalbitor (ecallantide) is a plasma kallikrein inhibitor that is indicated for acute attacks in patients that are ≥12 years old.\(^2\) Risks of Kalbitor include a falsely elevated PTT (not associated with increased bleeding), anaphylaxis and auto-drug antibodies. Additionally, Firazyr (icatibant) is a bradykinin B2-receptor antagonist that is indicated for acute attacks in patients ≥18 years old, with the most common side effect being injection site discomfort.\(^2\) As standardization of acute HAE prophylaxis with human-pooled C1 esterase inhibitors becomes more prevalent, it is still crucial to tailor the prophylaxis to the patient’s surgical duration and to be aware of past use of these agents to anticipate hypersensitization reactions.

Maksim Merakhovich, M.D., and Annette Luo, M.D., were medical students at Albany Medical College at the time of this case report’s submission. Divya Cherukupalli, M.D., is an attending anesthesiologist at Albany Medical Center.

REFERENCES

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