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SPHERE

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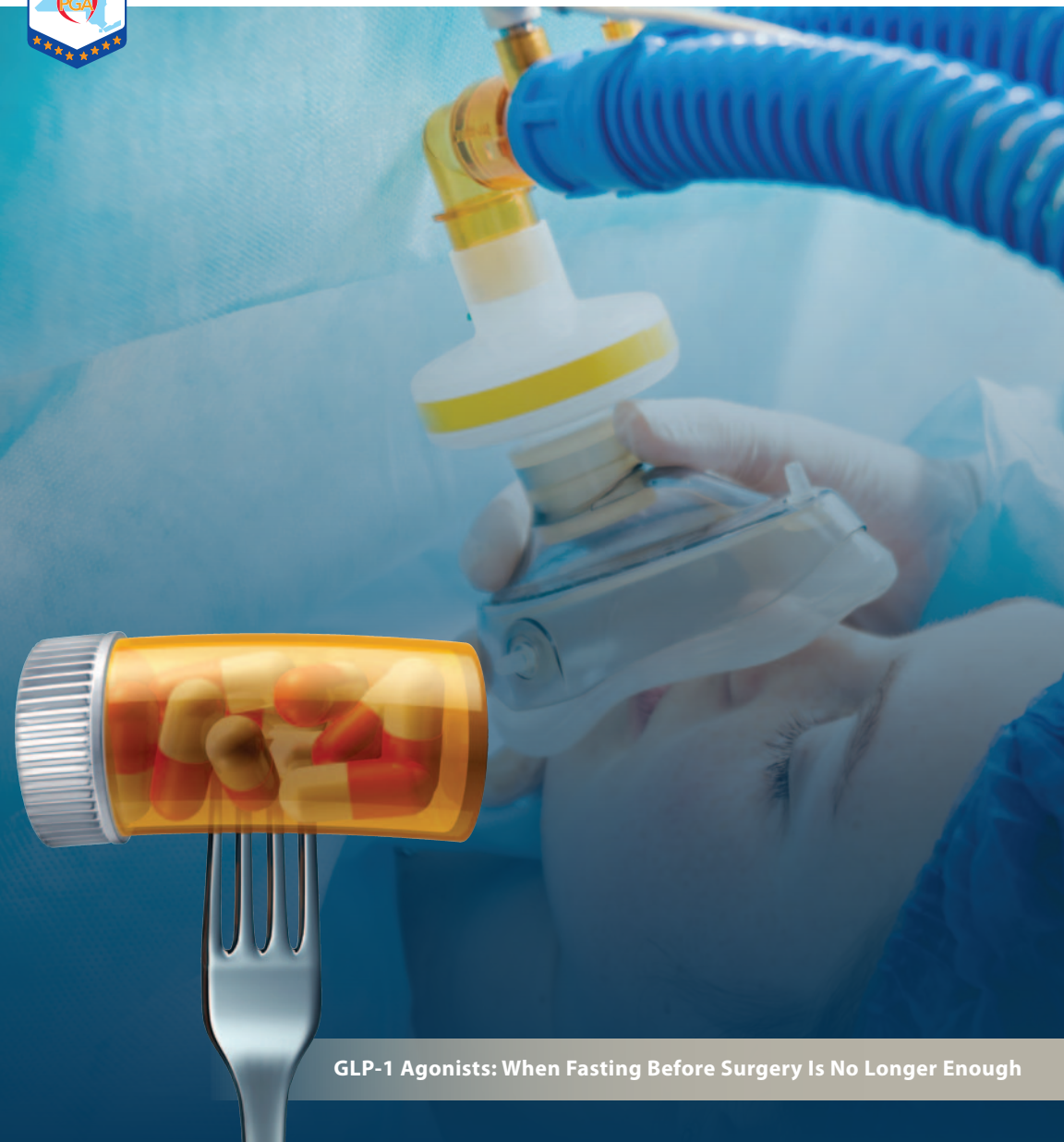

GLP-1 Agonists: When Fasting Before Surgery Is No Longer Enough

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78

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NYSSA
212-867-7140
www.nyssa-pga.org
e-mail: hq@nyssa-pga.org

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Stuart A. Hayman, M.S.

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President's Message

Sustaining Our Mission

JASON LOK, M.D., FASA

The NYSSA was well represented at the ASA House of Delegates meeting in San Francisco in October, with 24 delegates and the NYSSA's ASA director in attendance. We also continued our strong partnership with the California Society of Anesthesiologists by holding a joint reception with our respective executive committees, along with the exchange of society pins between CSA President Dr. Antonio Hernandez Conte and me. This tradition started last year between Dr. Jung T. Kim and Dr. Edward R. Mariano. At the conclusion of the meeting, the NYSSA delegation celebrated Dr. Tracey Straker's election to the position of ASA vice speaker.

As I mentioned in my previous message, we would gain another delegate for every additional 100 active New York members in the ASA. By recruiting new members to the NYSSA, you will help strengthen our advocacy on behalf of our profession, our practices, and our patients. Please take every opportunity to share how the NYSSA has helped you by opening doors to education and advocacy. This is especially pertinent to those who recently joined your staff as well as those who started training at your practice. By integrating these messages with your mentoring activities, you will sustain our mission.

We were fortunate that threats to physician-led anesthesia care in New York were rebuffed this year due to legislative budget issues. We cannot rest on our laurels. We need to remain vigilant and prepared by continuing to educate our legislators on the importance of physician-led anesthesia care and the right of all New Yorkers to receive the highest-quality care. This past May, more than 50 volunteers participated in 76 meetings with New York legislators and their staff members. Our visits with legislators took place while the nurse anesthetists were also present in Albany to lobby against our "safe anesthesia" bill, which was sponsored by Assemblywoman Rodneyse Bichotte Hermelyn (A.1890) and Sen. Andrew Gounardes (S.3000). While participating in our Legislative Day is crucial, we can further help our mission by reversing the declining NYAPAC contributions to build our war chest for any unforeseeable events and by strengthening our ties with local legislators, not just in Albany but in their hometown district offices as well.

Recently, New York Commissioner of Health Dr. James McDonald and Deputy Commissioner Dr. John Morley expressed interest in creating a title for anesthesia assistants in New York state. Certified anesthesiologist assistants (CAAs) are currently authorized to practice in 20 states and the District of Columbia. ASA strongly believes in the anesthesia care team and supports CAA practice authorization across the country. Setting up AA teaching programs in New York would help with workforce shortages, provide an income stream to the state, and create a pipeline for future mid-level anesthesia providers. On July 27, a group of NYSSA leaders and staff participated in a virtual meeting with Drs. McDonald and Morley to discuss the benefits and obstacles associated with creating the CAA title. We were impressed that Dr. McDonald was able to provide a succinct summary of the potential issues he anticipated with the introduction of CAAs in New York state. He understood that the burden to advance an anesthesia assistant program and the licensing of CAAs in New York would fall on hospital and academic administrators. We were steadfast in our position that, while the NYSSA supports CAAs, we were opposed to trading the CAA title for the expanded scope of practice that nurse anesthetists are seeking, as this would threaten patient safety.

In regard to the real estate update, the NYSSA will continue with its annual carrying cost until there is a suitable opportunity to sell. There are seven or eight other properties in the same building that are also not moving, as there is no current market for commercial property. There is always hope that our current commercial zoning may change to dual zoning, enabling a more optimal market.

Congratulations again to Dr. Vilma Joseph on becoming president of the Bronx County Medical Society and alternate delegate to the AMA for MSSNY. Best wishes to Dr. Stacey Watt as she begins serving as president of the Medical Society of Erie County. An article about Dr. Watt in the *Buffalo News* revealed her distinction as a two-time all-American discus thrower at the University of Florida. Last but not least, my heartfelt congratulations to Dr. Tracey Straker for being elected ASA vice speaker. I wish her much success. ■

Editorial

Working Hard on Behalf of Our Profession

SONIA G. PYNE, M.D., M.S., FASA

In October 2023, the American Society of Anesthesiologists (ASA) hosted its annual conference. Held this year in San Francisco, the meeting drew thousands of people from around the world who came to learn, teach and network.

As a delegate representing the NYSSA, I had a front-row seat to the important, and sometimes tedious, work that the ASA does for its membership. The work of the House of Delegates includes reviewing the materials that the ASA publishes to guide standards of clinical practice. This year, the House voted on guidelines dealing with patient discharge from ambulatory surgery, the use of low-flow sevoflurane, and the perioperative management of patients who are on glucagon-like peptide-1 (GLP-1) agonists. As an important side note, this year our very own Dr. Tracey Straker was elected to serve on the ASA's Administrative Council as vice speaker of the House of Delegates. This was a tough election, and Dr. Straker's hard work during her campaign paid off with her well-deserved election to this coveted position. Be sure to check out the ASA meeting photos included in this issue.

Also in this issue of *Sphere*, anesthesiologists from Mount Sinai Hospital review the ASA guidelines regarding the clinical management of GLP-1 agonists. In a separate piece, these authors describe the work done at their hospital to create, disseminate and implement their own more conservative guidelines. This is a timely and important topic given the increased use of these medications in the general patient population, and we hope you find these articles helpful.

Rounding out this issue, you will find a message from our president, the executive director's annual report, the quarterly legislative update, and a case report exploring fire risk in the operating room. Finally, Dr. Elizabeth A. M. Frost provides a summary of the latest New York Academy of Medicine Jeopardy Competition, and we present two creative pieces exploring the authors' thoughts on what it means to be an anesthesiologist.

I look forward to seeing many of you at PGA77, and I wish all of you peace and kindness this holiday season and in 2024. ■

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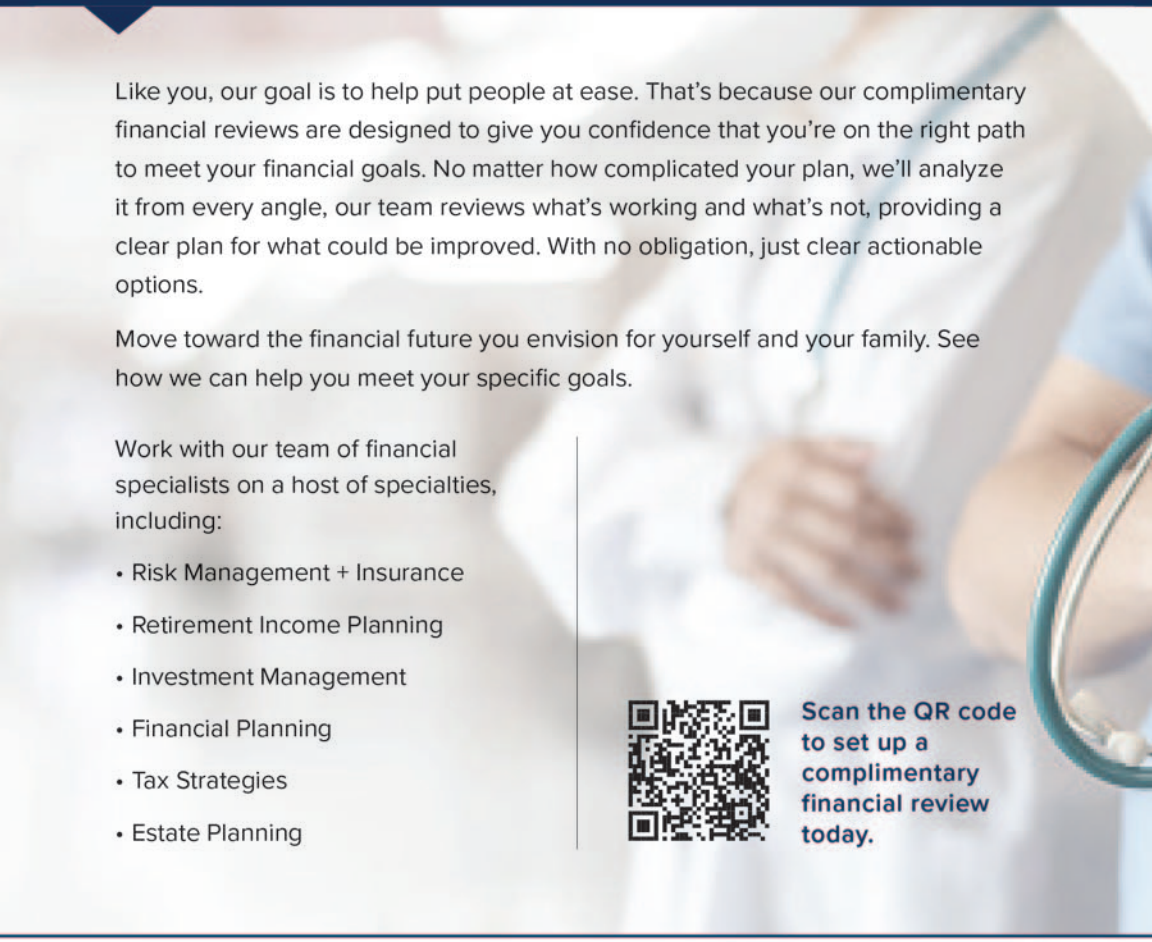

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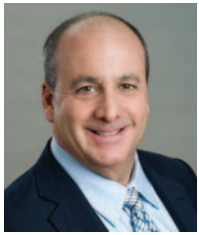

From the Executive Director

The Year in Review

STUART A. HAYMAN, M.S.

I recently began my 16th year with the NYSSA and my 36th year working for professional medical associations. While I started my career as an accountant, switching career tracks early on led to a rewarding professional journey working with physicians, especially the last 15 years working with and for the NYSSA's members.

Professional associations historically have adopted the three-pillar model: advocacy, education, and communication. In the case of the NYSSA (as with the ASA), the educational component primarily occurs via a single live event. As we move forward post-COVID, we are keenly alert to changes in the environment and we stay ready to evolve as necessary.

What follows is a brief synopsis of some of our activities this past year that correlate with the NYSSA's organizational goals as well as the three pillars listed above.

Operations

I believe that the current five-person NYSSA staff team is an outstanding group of dedicated individuals. We run the NYSSA, which is one of the largest ASA component societies, and manage the PGA, which is one of the largest anesthesiology meetings in the world. Additionally, we manage the Anesthesiology Foundation of New York, the New York Anesthesiologists PAC, a perpetually evolving online educational program, a quarterly publication, and multiple social media accounts. The staff also plays an important role in the NYSSA's advocacy efforts and serves a membership of nearly 4,400 physicians. This group of exceptional individuals has been working as an efficient and effective remote team since March 2020. We continually collaborate via phone, text, Zoom and Microsoft OneDrive.

Even with a fantastic staff, this organization's success is rooted in the support of many dedicated physician volunteers. Together we have made the NYSSA one of the strongest ASA component societies. Because of our efforts, we have a financial safety net that buffered the NYSSA from the adverse impact of the pandemic. We also benefited from the 2021 transition to unified billing with the ASA, which helped increase our

membership numbers. I am proud that the NYSSA continues as a stronger and more streamlined professional medical association. With the help of the NYSSA staff and our invaluable volunteers, we will keep the association moving forward and evolving to better meet the needs of our members, both now and in the future.

Property

We would like to sell the commercial condominium that we once used as our headquarters. This office is located at 40th and Park Avenue (approximately two blocks from Grand Central Terminal). Unfortunately, there is very little movement in the commercial market in New York City at this time. The Ad Hoc Committee on Headquarters, formed in 2020 by Dr. Richard Wissler and chaired by Dr. Christopher Campese, continues to monitor market conditions via the NYSSA's real estate vendor.

Advocacy

The NYSSA has strong working relationships with county, state and national medical associations. This is especially the case with the Medical Society of the State of New York and the American Society of Anesthesiologists. These relationships have helped the NYSSA become a stronger presence in Albany and put us in a better position to serve our members.

In January 2023, our lobbyist, Bob Reid, made us aware that NYSANA and the AANA were planning an extensive campaign aimed at removing physician supervision from nurse anesthetists in New York. With this looming threat, staff solicited and obtained a grant from the ASA State Component Society Financial Assistance Program. We wish to thank the ASA physician leadership as well as Manuel Bonilla, Jason Hansen and Paul Pomerantz for their support.

New York Executive Order 4 (EO 4)

Originally issued by the governor in September 2021 and extended continuously until June 22, 2023, Executive Order 4 finally expired this year. The order contained an exemption that suspended long-standing New York state health code provisions requiring physician supervision of nurse anesthetists in Article 28 facilities. The NYSSA opposed EO 4 and advocated for either its repeal or amendment to preserve patient safety in anesthesia care through physician-led care.

Executive Order 4 was introduced with the stated intent to address critical workforce shortages. Proponents of the order erroneously asserted that by removing physician supervision of nurse anesthetists, access to anesthesia care during the pandemic would improve. Based on our internal surveys, the vast majority of care still involved physician anesthesiologists supervising nurse anesthetists. For the most part, preservation of the existing standard of anesthesia care continued.

Anesthesiologist Assistants

A group of NYSSA leaders and staff members participated in a Zoom meeting with Dr. James McDonald, New York state commissioner of health, and his deputy commissioner, Dr. John Morley, regarding the benefits of and obstacles to the creation of a title for anesthesiologist assistants in New York state. Earlier this year, several NYSSA member representatives and I had an opportunity to discuss the AA issue with leaders from the largest healthcare provider in Western New York. This led to the hospital association putting AA licensure in New York on their legislative agenda.

Ultimately, this was another successful year for the NYSSA legislatively. I would like to thank Charles Assini, Esq., the NYSSA's legislative counsel, and Albany-based lobbyist Bob Reid and his firm, Reid, McNally & Savage. I would also like to thank the NYSSA's core group of legislative and PAC volunteer leaders, all of whom dedicate an enormous amount of time and effort to the organization's legislative and regulatory goals: President Dr. Jason Lok and Drs. Ted Kim, Steven Schulman, Jonathan Gal, Tracey Straker, Stacey Watt, Melinda Aquino, Chantal Pyram-Vincent, David Wlody, Ansara Vaz and Farzana Afroze. Additionally, the members of the NYSSA's Executive Committee and the Board of Directors should be recognized for devoting significant time working on behalf of their fellow members, the association and the profession.

Collaboration

We continue to collaborate with other medical associations and not-for-profit organizations that have similar values and core beliefs. Additionally, we strive to ensure that both staff and member volunteers are readily available to educate New York state government officials in order to protect the delivery of safe, high-quality care for all New Yorkers. We also collaborate on educational initiatives with our state, national and international colleagues.

Education

PGA

The PGA is one of the oldest, largest, and most successful anesthesiology meetings in the world. PGA76 was our second consecutive live event after the one-year pandemic interruption, and it was a great success. Registration and overall attendance took a significant step forward. While we are not yet back to our pre-pandemic attendance numbers, the PGA continues to be a source of revenue for the NYSSA. It was another financially positive year as we welcomed more anesthesiologists back to New York City in a safe environment to learn and network.

PGA76 featured: 16 workshops; 50 spotlight sessions; 64 problem-based learning discussions; 30 scientific panels; and 10 "Engaging with the Experts" sessions. In total, we had 384 speakers. Physician attendees could earn up to 26.5 CME credits with their registration and up to 32 credits if they added paid sessions (not including the thoracic symposium). Additionally, attendees could earn up to 22 MOCA patient safety credits. We had two plenary sessions (the Robertazzi on Saturday and the Rovenstine on Sunday). Attendees presented 282 electronic posters, and the Young Investigator Research Contest had six scheduled presenters and eight original submissions. The winner was from Stanford University. PGA76 on Demand includes nine recorded sessions available online, providing up 12.5 hours of CME for members who were unable to attend the live meeting.

Congratulations and thank you to NYSSA staff members Kelly Mancusi, Lisa ONeill, Will Burdett and Christina Gruppuso. I would also like to thank PGA Chair Dr. Linda Shore-Lesserson, incoming PGA Chair Dr. Rose Berkun, Drs. Apolonia Abramowicz and Mark Nunnally, and all the PGA planning volunteers. Without this tremendous group of physician volunteers, this meeting could never happen.

CME

During PGA76, staff received notice that the NYSSA received "Accreditation with Commendation" from the Accreditation Council for Continuing Medical Education (ACCME). This means that the NYSSA and its PGA are accredited to provide CME for the next six years. I would like to express my sincere gratitude to Dr. Francine Yudkowitz and her outstanding team of volunteers throughout this process. Dr. Yudkowitz was assisted by Drs. Sarah Smith, Yan Lai and Cliff Gevirtz as well as members of the NYSSA staff.

Infection Control Program

In July 2023, we received written notification from the New York State Department of Health that the NYSSA has been accredited to provide the state-mandated infection control course for six years! Congratulations to Kelly Mancusi for guiding us through the accreditation process. I also wish to express our sincere gratitude to Drs. Richard Beers and Elliott Greene for creating and updating this outstanding anesthesia-specific infection control educational tool.

MOCA

This year, the PGA MOCA offerings will include credits for multiple educational programs.

Thoracic Symposium

Staff works with Dr. Edmond Cohen on the successful thoracic symposium, which will be offered again at PGA77.

Communication

We continue to expand our social media and email outreach. In the past year, the NYSSA had 68 Instagram posts and an additional 97 Instagram stories, engaging with our followers more than 32,000 times. Between August and October 2023, we reached 1,200 unique individuals through Instagram. On the platform formerly known as Twitter, we have 2,530 followers, and we have posted 1,900 times since creating our account. From January through October, we engaged with these followers nearly 25,000 times. Utilizing our Constant Contact blast emailing system, we have sent more than 218,000 individual emails, and we enjoy an impressive open rate of 51 percent. While we are very happy with the success of our social networking efforts, we will continue striving to do better.

If you are reading this article, you are well aware of the NYSSA's first-class publication, *Sphere*. The editorial board, led by Dr. Sonia Pyne, continues to do a fantastic job with this publication and our other communications initiatives. Two people you may not be aware of, however, are the NYSSA's outside staff editor, Sandy Padwo Rogers, and our graphic designer, Joni Blymire. I brought Sandy on board shortly after I was hired in 2008, and Sandy introduced me to Joni, who began working with us not long after that. These two professionals are integral to our successful messaging and communications, yet they are continually

behind the scenes and out of view of the membership. They are also involved in the NYSSA's and the PGA's social media posts, marketing, advocacy materials, and website work in addition to the publication of *Sphere*. I truly cannot thank them enough for all they do to contribute to our success.

Conclusion

The brief summary above highlights some of the noteworthy activities and initiatives we engaged in on behalf of all NYSSA members and the specialty of anesthesiology this past year. Again, I wish to thank our staff members, who make me look better each and every day. I also wish to thank our many physician volunteers. Without the hard work of all these dedicated individuals, we would not be the preeminent component society of the ASA. We will continue to embrace our organizational goals and to advocate for, educate and communicate with the members of the NYSSA. I thank all of you for the continued support. ■

The NYSSA Ad Hoc Committee on Environmental Sustainability in Anesthesia Presents: Sustainability Tip of the Quarter

INDIVIDUAL	INSTITUTIONAL
Learn to sort OR waste properly. Up to 85% of OR waste can be placed in regular waste bins. Sharps bins and "red bag" regulated medical waste (RMW) must be transported to specialized facilities to be incinerated or autoclaved. Unnecessary use of these waste streams increases both costs and CO2 emissions by a factor of 10.	**Review your waste sorting strategy**. Ensure that your policies follow best practices and guidelines. Formally educate clinicians and provide signage. The size and location of physical receptacles should match their expected use. Small sharps bins and RMW bins will help cue clinicians that these are for specialized waste only.

Want to learn more?
Submit your name and email via the QR code or email Deirdre Kelleher at dck7002@med.cornell.edu to get involved!

Perioperative Management of GLP-1 Receptor Agonists

MARC SHERWIN, M.D., AND SAMUEL DEMARIA JR., M.D.

When was the last time you had anything to eat or drink?

It's a question that anesthesiologists ask every day to guide their anesthetic management and assess the risk of aspiration, but with the surge of GLP-1 receptor agonists, this question alone may no longer be sufficient.

Glucagon-like peptide-1 (GLP-1) receptor agonists are a class of drugs approved by the Food and Drug Administration for treatment of type 2 diabetes mellitus, but they have recently emerged as a common (and even fashionable) drug for weight loss.[1] Their mechanism for weight loss has been attributed to reductions in appetite and an increased sense of fullness due to delayed gastric emptying. Recent emerging evidence has suggested concerns that delayed gastric emptying from GLP-1 receptor agonists may increase the risk of pulmonary aspiration of gastric contents during general anesthesia and deep sedation.[2-4]

Recognizing the potential increased risk of adverse events for patients on GLP-1 receptor agonists, in June 2023 the American Society of Anesthesiologists (ASA) released guidelines for the management of these agents in the perioperative setting. The ASA Task Force on

Preoperative Fasting, which releases the guidelines for managing perioperative fasting,[5,6] reviewed the available evidence on patients taking GLP-1 receptor agonists and advised as follows:

> Given the concerns of GLP-1 agonists-induced delayed gastric emptying and associated high risk of regurgitation and aspiration of gastric contents, the task force suggests the following for elective procedures. For patients requiring urgent or emergent procedures, proceed and treat the patient as 'full stomach' and manage accordingly.
>
> **For patients scheduled for elective procedures consider the following:**
>
> **Day(s) Prior to the Procedure:**
>
> - For patients on daily dosing, consider holding GLP-1 agonists on the day of the procedure/surgery.
> - For patients on weekly dosing, consider holding GLP-1 agonists a week prior to the procedure/surgery.
>
> **Day of the Procedure:**
>
> - If gastrointestinal (GI) symptoms such as severe nausea/vomiting/retching, abdominal bloating, or abdominal pain are present, consider delaying elective procedure, and discuss the concerns of potential risk of regurgitation and pulmonary aspiration of gastric contents with the proceduralist/surgeon and the patient.
> - If the patient has no GI symptoms, and the GLP-1 agonists have been held as advised, proceed as usual.
> - If the patient has no GI symptoms, but the GLP-1 agonists were not held as advised, proceed with 'full stomach' precautions or consider evaluating gastric volume by ultrasound, if possible and if proficient with the technique. If the stomach is empty, proceed as usual. If the stomach is full or if gastric ultrasound inconclusive or not possible, consider delaying the procedure or treat the patient as 'full stomach' and manage accordingly. Discuss the concerns of potential risk of regurgitation and pulmonary aspiration of gastric contents with the proceduralist/surgeon and the patient.
> - There is no evidence to suggest the optimal duration of fasting for patients on GLP-1 agonists. Therefore, until

we have adequate evidence, we suggest following the current ASA fasting guidelines.

There is still not enough evidence to guide the optimal fasting period or the cessation of dosing prior to surgery. This has led anesthesiologists and their institutions to create local guidelines that are in line with, or more stringent than, the ASA's. What is also not clear is whether more stringent guidelines may lead to more patients experiencing hypoglycemia leading up to their planned surgery and/or presenting for surgery in an excessively dehydrated state. For patients with diabetes, it is important to consider an endocrinology consultation so the prescribing physician can offer the best glucose management for the patient while holding their GLP-1 receptor agonist.

When there is uncertainty about a patient's gastric content and airway management and/or sedation will be needed, gastric ultrasound has been recommended to aid in decision-making. Gastric ultrasound is a practical and effective method by which to evaluate residual stomach content volume at the bedside.[7] When there is uncertainty about a patient's risk of aspiration and sedation or airway management will be needed, gastric ultrasound can be used for risk stratification. There is mounting evidence to support the role of bedside gastric ultrasound as a highly sensitive and specific tool to positively identify or rule out a full stomach and guide management.[7] This tool was used in a prospective study of individuals on semaglutide, published in July 2023 in the *Canadian Journal of Anesthesiology*, that found that 90% of semaglutide participants had solids identified on gastric ultrasound even after fasting for more than eight hours (as compared with 10% of patients not taking semaglutide). What was noted with bedside ultrasounds of patients on GLP-1 receptor agonists is that the qualitative consistency of the gastric content is often a homogeneous, hyperechoic solid. This is a finding often seen if a patient has recently ingested yogurt or other thick liquids, but in the stomach of patients on GLP-1 receptor agonists, this likely is well-digested, but not emptied, solid food.[8,9] Still, it is unclear as to whether any of these findings correlate to an increased risk of aspiration.

Another important consideration for anesthesiologists is the timing of the use of these medications. Additionally, because these medications are often acquired by patients for weight loss purposes, they may not be listed on their daily medication list. More at-risk patients may be discovered by regularly asking if a patient has taken this drug, similar to the approach taken for oral anticoagulants. A list of both generic and

brand names for these drugs has been included in the table below to help identify the growing number of available products.

Table: GLP-1 Agonists Generic and Brand Names

Generic	Dulaglutide	Exenatide	Liraglutide	Lixisenatide	Semaglutide
Brand	Trulicity	Bydureon BCise Byetta	Saxenda Victoza	Adlyxin	Ozempic, Wegovy, Rybelsus, and others

It is possible that the institution of the new ASA fasting guidelines or more stringent local guidelines will be met with confusion and even resistance, especially if institutional stakeholders and/or surgeons are concerned about increased cancellations and/or case delays. To bring about sustainable organizational change, it is important to first define the need and create a sense of urgency to fix the problem.[10] This can be done by identifying the problem, understanding its impact, and communicating the need for change to key stakeholders and partners. Anesthesiologists understand the difference between a patient at risk for aspiration and one who is not at risk, and how this may play into the choice of planned anesthetic or planned airway technique. In the complex multidisciplinary healthcare environment, it is often helpful to have a team of champions from different disciplines working together. This creates a critical mass of support for change and can help to overcome resistance from different parts of the organization.

It is also important to ensure that the change is developed by a variety of individuals within the institution rather than being imposed from one department or the other.[11] This will help to ensure that the change is more likely to be accepted and sustained. Finally, it is important to remember that change is not always easy. There may be setbacks and challenges along the way. It is important to be prepared for these challenges and to have a plan for overcoming them. Lewin's 3-step model of change can be helpful in this regard.[12] The model consists of the following steps:

1. Unfreezing: This step involves creating dissatisfaction with the status quo or establishing a clear necessity for change. This can be done by highlighting the problems with the current situation and showing how the benefits of change outweigh the risks.
2. Moving: This step involves implementing the change. This should be done in an iterative way, with ongoing analysis and feedback, changing and rebuilding the guidelines as needed (a recent example would be departmental creation of COVID-19 testing guidelines).
3. Refreezing: This step involves realigning organizational norms and culture to support the change. This can be done by providing training, coaching, and support to the OR team and reinforcing how these changes have led to early successes.

As concerns regarding the risk of aspiration associated with taking GLP-1 receptor agonists continue to develop, it is likely that many will not be aware of these dangers. It is important to discuss the concerns about potential risk of regurgitation and pulmonary aspiration of gastric contents with the proceduralist/surgeon and the patient as part of the anesthesiologist's routine consent. Further studies are needed to offer stronger evidence for the timing of fasting and holding of these medications; as anesthesiologists, we must lead the way in patient safety and remain vigilant until adequate evidence-based guidelines are available. ■

Marc Sherwin, M.D., is an assistant professor of anesthesiology, perioperative and pain medicine, an assistant professor of medical education, associate program director of the Anesthesiology Residency Training Program, and director of the Introduction to Internship course in the Department of Anesthesiology, Perioperative and Pain Medicine at the Icahn School of Medicine at Mount Sinai. Samuel DeMaria Jr., M.D., is a professor of anesthesiology and otolaryngology and vice chairman for research in the Department of Anesthesiology, Perioperative and Pain Medicine at the Mount Sinai Health System.

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One Institution's Response to the Perioperative Risk of GLP-1 Receptor Agonists

MARC SHERWIN, M.D., SAMUEL DEMARIA JR., M.D., AND ANDREW LEIBOWITZ, M.D.

Since approval of glucagon-like peptide-1 (GLP-1) receptor agonists for the treatment of type 2 diabetes mellitus, these drugs have become widely prescribed for the specific purpose of weight loss.[1] A recent study estimated that 2% of all adult residents in the area surrounding Mount Sinai Hospital were prescribed one of these agents.[2] Our practice at Mount Sinai Hospital has seen an increase in patients taking them. GLP-1 receptor agonists cause delayed gastric emptying, and our faculty had an acute concern that many of our surgical patients were at high risk of aspiration. Reconsideration of long-standing preoperative fasting guidelines was in order.

In response to this challenge, Mount Sinai Health System's Department of Anesthesiology formed an emergency task force to determine if we needed to change our routine preoperative NPO policy. We reviewed the relevant available literature,[3-5] including an internally performed gastric residual ultrasound study,[6] and relied extensively on faculty expert opinion.

The task force decided to write very conservative guidelines emphasizing risk mitigation, even at the inconvenience of patients and their proceduralists. While we considered the ASA's recommendations,[7] significant emphasis was given to the pharmacokinetics and pharmacodynamics of this class of drugs as well as the literature, scant as it was. Notably, GLP-1 receptor agonists have very long half-lives, and their effects would likely remain within one half-life of time. We decided that our guidelines would exceed those times published by the ASA.

Our internal study was of particular help in reaching this consensus, so we offer the following brief summary. Gastric ultrasound evaluation of volunteers was undertaken to determine the incidence of significant gastric residual content attributed to semaglutide after the usual recommended NPO guidelines. We compared volunteers who were taking semaglutide for weight loss to those who were not. For reference sake, previous studies have shown that a small proportion (6.2%) of elective surgical patients may present with a full stomach despite the

recommended duration of fasting.[8] Ninety percent of semaglutide participants, compared with 10% of control participants, had solids in their stomachs (RR, 7.36; 95% CI, 1.13 to 47.7; P = 0.005).

Mount Sinai Health System (MSHS) Guidelines for the Management of Patients Taking GLP-1 Receptor Agonists Presenting for Procedures Requiring an Anesthetic

Situation

GLP-1 receptor agonists are widely prescribed to treat diabetes and to promote weight loss. These medications delay gastric emptying and pose an increased risk of a "full stomach," regurgitation and pulmonary aspiration.

Background

The increased risk to patients receiving these medications has only recently been recognized, and the American Society of Anesthesiologists has published "Consensus-Based Guidance." Anecdotally, in the MSHS we have seen several patients on these medications who followed their NPO instructions and had solid food in their stomachs.

Assessment

The Mount Sinai Health System needs guidelines for peri-procedural management of patients taking these medications in order to reduce the risk of serious and life-threatening pulmonary aspiration.

Guidelines

1. Discuss concerns regarding the potential risk of regurgitation and pulmonary aspiration of gastric contents with the proceduralist/surgeon and the patient as part of the routine consent.
2. These medications should not be taken for a minimum of two dosing intervals (e.g., semaglutide and tirzepatide should be held for a minimum of 15 days). While there is no evidence to guide the optimal duration of these medications' cessation, this approach is cautious and practical.
    - Elective cases failing to follow this guidance should be postponed.
    - Diabetic patients should consult their prescribing physician to manage their care without these medications during this time.
3. If the patient has other significant risk factors for aspiration, including obesity, GERD, pregnancy, prior aspiration, partial bowel obstruction, or current GI symptoms (e.g., bloating, sensation of

fullness, abdominal distention, retching, nausea, vomiting), consider scheduling the procedure in a hospital setting, especially if potential tracheal intubation and gastric ultrasound is desired.

4. NPO guidelines (regardless of medication cessation compliance):

   Day prior to the procedure, starting at 8 a.m.:

   i. NPO for all solids and non-clear liquids (normal breakfast consumed before 8:00 a.m. is OK).

   ii. Clear liquids should be consumed for the duration of that day.

   Day of the procedure, starting at midnight:

   iii. Strict NPO: No food including clear liquids should be consumed, except for critical medications with a small quantity of water, or a prescribed bowel preparation.

5. Consider the risks and benefits of alternative anesthetic plans (e.g., "light sedation" with intact airway reflexes vs. deep sedation with blunted airway reflexes vs. GA with ETT/RSI).

6. Consider the use of adjuncts to mitigate the chance and risk of aspiration, including:
   - Metoclopramide 10 mg intravenous over 1-3 minutes
   - Sodium citrate 30 mL orally immediately before the procedure
   - Famotidine 20 mg intravenous > 30 minutes before the procedure, or Pantoprazole 40 mg intravenous > 30 minutes before the procedure

These guidelines were disseminated to more than 3,500 providers in the Mount Sinai Health System using e-mail announcements, a system procedural policy committee, and our preoperative application that is accessible on mobile devices and the intranet. After the policy roll-out, the FAQ page (see below) was immediately created. While time will determine the optimal approach, our policy creation process, stated concerns, and implementation strategy should prove useful to individual anesthesiologists and departments tackling this subject.

Frequently Asked Questions About the GLP-1 Receptor Agonist Guidelines

1. Do the guidelines apply to patients taking these medications for weight loss or diabetes?

   The guidelines apply regardless of indication but suggest that

patients taking GLP-1 agonists for diabetes should consult their provider in case special management of their diabetes in absence of these agents will be required, although we do not anticipate that diabetics who discontinue these agents for a relatively short time will require significant interim management.

2. Do the guidelines apply to patients scheduled to receive mild to moderate sedation by non-anesthesiologists?

   No, the guidelines do not apply to these types of procedures usually performed in non-operating room settings and managed without an anesthesiologist. The main risk for regurgitation and aspiration is loss of airway reflexes. Mild and moderate sedation guidelines are written to avoid the loss of airway reflexes, and providers administering mild to moderate sedation should be extra cognizant of this goal.

3. If a patient stopped taking their GLP-1 agonist a long time ago, do the guidelines apply?

   It is unclear for how long after discontinuation of these medications gastric emptying remains abnormal, with rare patients appearing to have lifelong issues. Given the known half-life of these medications, the current recommendations are as follows, with routine/customary NPO guidelines noted in the last column for patients who have ceased taking these medications for a particularly long time. The two medications most prescribed for weight loss, semaglutide and tirzepatide (highlighted in yellow), likely have the greatest impact on gastric emptying and the longest half-life; thus, they are the greatest concern.

Drugs		Recommended time since last dose	Follow routine NPO guidelines if last dose was
Brand Name(s)	Generic Name		
Byetta, Bydureon	Exenatide	>1 day	>2 days
Adlyxin	Lixisenatide	>1 day	>2 days
Ozempic, Wegovy, Rybelsus	Semaglutide	>14 days	>35 days
Saxenda, Victoza	Liraglutide	>2 days	>3 days
Trulicity	Dulaglutide	>14 days	>21 days
Mounjaro	Tirzepatide	>14 days	>35 days

4. Do these guidelines apply to patients scheduled for MAC anesthesia or procedures scheduled to be performed under a spinal anesthetic or a nerve block?

   Yes. Patients scheduled for MAC anesthetics as well as regional techniques are often sedated to the point of loss of airway reflexes; in a small percentage of cases, these patients are converted to general anesthetics.

5. Will these guidelines affect many patients?

   With type 2 diabetes, metformin is the first line therapy and a GLP-1 agonist is usually added if the HbA1c goal is not met, there is underlying CAD, or when weight loss is desirable. Increasingly we have seen many patients without diabetes who take these medications for weight loss. Asking patients if they take any of these medications prior to a procedure should be as routine as double-checking that they do not take anticoagulants or aspirin. ■

Marc Sherwin, M.D., is an assistant professor of anesthesiology, perioperative and pain medicine, an assistant professor of medical education, associate program director of the Anesthesiology Residency Training Program, and director of the Introduction to Internship course in the Department of Anesthesiology, Perioperative and Pain Medicine at the Icahn School of Medicine at Mount Sinai. Samuel DeMaria Jr., M.D., is a professor of anesthesiology and otolaryngology and vice chairman for research in the Department of Anesthesiology, Perioperative and Pain Medicine at the Mount Sinai Health System. Andrew Leibowitz, M.D., is a professor of anesthesiology, perioperative and pain medicine and system chair for the Department of Anesthesiology, Perioperative and Pain Medicine at the Mount Sinai Health System.

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Scenes From the 2023 ASA Annual Meeting

California Society of Anesthesiologists President Dr. Antonio Hernandez Conte and NYSSA President Dr. Jason Lok

(Back, left to right) Drs. Tracey Straker, Steven Schulman, Stacey Watt, Jonathan Gal, (front, left to right) Melinda Aquino, Vilma Joseph, Linda Shore-Lesserson, Jason Lok, H. Eunice Ko, Chantal Pyram-Vincent, and Lance Wagner

The NYSSA delegation

Dr. Tracey Straker (third from left) visits the state caucuses as she campaigns for the position of ASA vice speaker. Joining Dr. Straker are (left to right) Drs. Lance Wagner, Rose Berkun, Michael Simon, Jeffrey Green and Vilma Joseph.

Drs. Diana Mosquera and Steven Schulman

Will Burdett, Kelly Mancusi and Drs Stacey Watt and Ted Kim

Dr. Stacey Watt

Dr. Tracey Straker addresses the ASA House of Delegates

Drs. Fenghua Li and Jason Lok

Dr. Rose Berkun

The New York delegation at the ASA House of Delegates meeting

The NYSSA and Sociedade Brasileira de Anestesiologia (Brazilian Society of Anesthesiology) Sign a Memorandum of Understanding

(Left to right) Marcel Feldman, Kelly Mancusi, Dr. Linda Shore-Lesserson, Dr. Maria Angela Tardelli, Dr. Jason Lok, Dr. Rose Berkun, Stuart Hayman, and Dr. Luiz Falcão

Stuart Hayman

Dr. Jason Lok

Dr. Luiz Falcão

Mourning

MARJORIE GLOFF, M.D.

Morning. It's a special time of day. In Western New York, mornings generally are dark and chilly. Mornings have the smell of sleep, the sound of silence and safety. For me, mornings have been alone time while my husband and children sleep soundly. I tiptoe around, knowing where not to step as I dance down the stairs so as to avoid any unnecessary creak. The ushering in of a new day. As a student, resident and now as an attending anesthesiologist, morning has always held a special place in my heart. Love it or hate it, my feelings on morning have changed as I've grown older, and I'm sure that my feelings on morning will continue to change: to ebb and flow with each particular day, week and season of my life. The constant, though, is that morning is a new day, a new start, a new opportunity.

I have loved my job as an anesthesiologist from the beginning. I have felt content, satisfied, happy and, believe it or not, I have felt valued. I am an anesthesiologist who spends much of my work life focusing on adding value and safety to our system. I subspecialize in perioperative optimization. I feel like I make a real difference. I've helped people to understand the value of the field of anesthesiology in the healthcare system — from administrators to surgeons to patients. I have worked tirelessly for a decade to lead the creation of a system that is dependable and appreciated. I have fought the fights, stood my ground, weathered many storms. I have been called out and shot down. But I have moved the needle. Now, I am sought out, consulted, depended on, appreciated, and thanked. I decided long ago that making less money so that I can work in academia was the cost of doing what I love. I have colleagues who have become friends who now are my family.

In my line of work, "work" was like an unexplored jungle. It can give you that feeling that must be like what explorers felt when they went on a voyage. You never know what your day will hold, even if you think you do. Slow days give time for catching up with your now-brothers and sisters, your surrogate grandmother, and your adoptive children. The fast days give this rush that is hard to explain, one that only your work family understands. The hard days are made better by hugs, by shared tears, by the kindest words imaginable from people who know and have been there.

Work and home were discreet little fortresses that I had built in my head. Work stays at work, home stays at home. I was the warrior, or maybe the blessed one, or maybe I was the ignorant one who floated back and forth between these two lives. Thirty-minute drives separated these lives. Any work related "to-do" items washed right out of my head when I entered my home. Happiness, vibrance, hugs and kisses from my husband, my babies who then became my toddlers. Gardens, dahlias upon dahlias, walks in the country, helping my husband create amazing things and sitting in awe at what we have made together — this is home. Sunshiny days by the pool. Snow-covered trees and cross-country ski dates in the back forty with my love. Flying kites and blowing bubbles on breezy spring days. Home is safe, and beautiful, and warm, and ours. It was my escape, my solitude.

Then the world fell apart.

Mourning. That terrible time of day when you sit on the edge of a cold, dark bed before having to get up to go to work. Mourning, that 30-minute drive to a place that was once magical and now is petrifying. My friends slowly leaving for family and opportunities in other places. Names of people who float in and out of the walls of my deteriorating fairy-tale castle when contracts end or better opportunities arise. It was about fighting dragons together. Now it seems like it's about hunting for gold — every man and woman for themselves. The family is slowly falling apart, the adoptive children moving on to bigger and better things. Mourning the adoptive child succumbing to terrible cancer. Mourning the colleague who worked magic on broken bones who drops at home, leaving it all behind. Mourning the sparkle in your surrogate grandmother's eyes as she fights for her husband in failing health. Mourning the times when we were invincible together … now we are skeletons of our former selves.

Mourning the carefree attitude of the clinic and the desire to be the best, exuded by everyone within its walls. Mourning the time when I knew everyone's name. Mourning those who now work from home and who I haven't seen in years. Mourning the small centers that gave way to the bigger and better centers. Mourning the time when violence and active-shooter drills to protect your staff weren't always in the back of your mind. Mourning it all.

There is a terrible darkness that seems to be suffocating everything and poisoning the healthcare system. It's happening everywhere. The darkness has forced us all to shift primary focus from safety and quality and outcomes to how we can possibly manage to staff beds and keep operating rooms open. Mourning for those who have lost valuable programs for their communities … or worse yet, had to shutter their doors, unable to stand against the gale-force winds that have given way to the post-pandemic wake. Mourning the rest of us who are hemorrhaging resources to keep the doors open so that people can be treated for things like a heart attack, a stroke, a trauma, a birth. Watching as more systems around us hemorrhage to death. Looking at the person next to me, here on a contract assignment, making so much more money than me, unaware of who I am and what I have done. Clock in and clock out. A ship in the night.

Mourning gives way to fear. How can we keep doing this? How do we help people when we have no one to care for them? Where do we put people within our walls? Why are we getting screamed at by patients more and more often? Why doesn't anyone seem to care that we're slowly dying? This on top of a healthcare delivery crisis that has been brewing for decades in this country and is now endemic: not enough residency spots, not enough doctors being trained, diluting the role of the physician and replacing us slowly. No primary care physicians. People flocking to our doors with fungating cancerous growths encasing their bodies because they could not and cannot get care. In America. In 2023. Mourning the loss of 10 years of advances — or more — so that we can put resources into beds. Mourning our future.

Mourning the drive home. The sanctuary that was vibrant and wonderful is now eerily quiet. The toddlers have grown into teenagers, their faces in their screens. They don't even realize you've come home. Mourning the time you should have spent with them, when they wanted you there. Mourning the separation of home and work … a Zoom meeting reminder, followed by another, and then another. Mourning how life seems to be unraveling, unable to be controlled.

Morning. A fresh start and a new day. Spring is coming, the sun is out. Tears flooding from my eyes as I write this cathartic piece are like raindrops obscuring the morning sky. Then a hug from my husband.

Then a cup of coffee and a kiss from my kids. Mourning giving rise to a new morning, a fresh start, a new perspective. I am changed. All of us are. Yet, there is still so much to give and create and do and grow. And, I want to.

Morning. ■

Marjorie Gloff, M.D., is associate chief medical officer for patient safety and loss prevention, associate chair of perioperative medicine, director of the Center for Perioperative Medicine, and an associate professor of anesthesiology and perioperative medicine in the Department of Anesthesiology at the University of Rochester School of Medicine and Dentistry.

Every Patient Has a Unique Story: The Art of Anesthesiology

SRIDHAR MUSUKU, M.D.

Introduction

Anesthesiologists are often referred to as the "unsung heroes" of the medical world. Their critical role in patient care is undeniable, as they ensure a safe and pain-free surgical experience. However, beyond their technical expertise lies a profound truth: Every patient has a unique story that must be explored and understood.

The Canvas of Health

Imagine each patient as a canvas, waiting for the skilled artist (the anesthesiologist) to paint a masterpiece of safety, comfort, and care. Just as no two paintings are identical, no two patients are the same. They come from diverse backgrounds, present with distinct medical histories, and exhibit a wide range of physical and emotional responses to surgery. Thus, anesthesiologists must approach each patient as a blank canvas, ready to unveil their own narrative.

Personalized Care

Anesthesiology is not a one-size-fits-all field. It thrives on the principle of personalized care. When anesthesiologists take the time to understand a patient's medical history, fears, and concerns, they can tailor their approach to ensure the safest and most comfortable experience possible. Every patient deserves to be treated as an individual with distinct needs, not merely a case on an operating table.

The Art of Assessment

Assessing a patient's unique story begins with a thorough preoperative evaluation. This involves reviewing medical records, conducting interviews, and, in some cases, collaborating with other specialists to gain a comprehensive understanding of the patient's health. Anesthesiologists must be skilled in interpreting this information and translating it into a customized anesthetic plan.

The Precision of Medication

Administering anesthesia is a science. Anesthesiologists must select the appropriate medications and dosages tailored to each patient's specific

requirements. A dosage that is too high or too low can have serious consequences. By treating every patient as a unique story, anesthesiologists can ensure the right balance of medications for a safe and effective procedure.

Navigating Challenges

Every patient's surgical experience may involve unexpected twists and turns. Some may have hidden medical conditions or particular sensitivities. Anesthesiologists must be prepared to adapt to these challenges, making quick and informed decisions to safeguard the patient's well-being.

Conclusion

It is the anesthesiologist's responsibility to recognize and respect each patient's individuality and to approach all patients with care and empathy. By doing so, anesthesiologists can create a safer and more comfortable surgical experience, turning the art of anesthesiology into a masterpiece of personalized care. ■

Sridhar R. (Reddy) Musuku, M.D., is a cardiothoracic anesthesiologist and an associate professor of anesthesiology at Albany Medical Center.

Legislative Update

CHARLES J. ASSINI, JR., ESQ.

NYSANA-Backed Nurse Anesthetist Independent Practice Bill

In my last "Albany Report," which summarized the end of the 2023 legislative session, I briefly highlighted an amendment made to the scope of practice bill (A6958A/S769A – Reyes/Cooney) backed by the New York State Association of Nurse Anesthetists (NYSANA). The amended version of this bill called for a "collaboration" model of care (primarily used to define the relationship between primary care physicians and nurse practitioners) that would, in effect, allow nurse anesthetists to practice independently after they had completed a practice "collaboration" period of 3,600 hours.

This amended bill contains a blatant factual omission. "Physician anesthesiologist" is not included in the bill!

The physician anesthesiologist is the most qualified individual to administer anesthesia, either personally or through medical supervision of the nurse anesthetist, in nearly every surgical case requiring anesthesia. The reasons why physician anesthesiologists must be acknowledged in this bill are clear: (i) the existing standard of anesthesia care includes the physician anesthesiologist; (ii) this long-standing standard of anesthesia care is embedded in the New York state health code; and (iii) this standard of care has proven to save patients' lives.

This amended bill is defective because it fails to acknowledge these fundamental facts and to define the roles of the physician anesthesiologist and nurse anesthetist in the hospital, ambulatory surgery center (ASC), and office-based surgery settings. Despite advances in the delivery of anesthesia, it remains inherently dangerous. Even a routine surgical procedure requiring anesthesia can lead to patient distress and the need for the physical presence of a physician anesthesiologist to make immediate medical decisions.

The amended bill makes no mention of the "physician anesthesiologist." Proponents of this bill make the false claim that the existing standard of care is not adhered to or that it need not be addressed in this scope of

practice bill. We refute both arguments. It is imperative that the existing standard of anesthesia care be preserved to protect patients who undergo anesthesia.

The amended bill proposes that a nurse anesthetist who has practiced more than 3,600 clinical hours would be able to work in an "interdependent role as a member of a healthcare team in which the medical care of a patient is overseen by a physician, dentist or podiatrist." Neither the term "interdependent" nor the term "overseen" are defined in this bill.

This legislation also proposes that a nurse anesthetist who has practiced 3,600 clinical hours or less would work "under the direction" of a physician, dentist or podiatrist. However, the definition of "direction" in the amended bill has no meaning. The amended bill does not require that the physician provide on-site direction, be physically present, or be immediately available. Instead, the amended bill states that "direction" means "coordination" and "communication" between the physician and the nurse anesthetist. Proponents of the bill are being deliberately ambiguous in an effort to allow each provider to interpret "direction" in the way that's most advantageous to the provider.

In the amended bill, the nurse anesthetists' scope of practice remains extremely broad. They would be able to perform all of the anesthesia services provided by physician anesthesiologists. Additionally, the amended bill provides nurse anesthetists with extremely broad prescriptive authority, including the right to (i) prescribe narcotics and develop the anesthesia plan during the "peri-anesthetic period," when the role of a physician anesthesiologist is most critical to assess the patient's tolerance for certain narcotics based on the patient's medical condition; and (ii) make pre-operative assessments (including ordering and evaluating laboratory and diagnostic tests) instead of the physician anesthesiologist, who has the medical training to make critical decisions regarding patient safety and to delay surgery, if necessary, until the patient's medical status is suitable.

What is the intent of this legislation and what would the result be should it become law?

Possible Consequences of This Bill

1. Nurse Anesthetists Will Achieve Independent Practice

The amended bill A6958A/S769A dismantles the existing physician anesthesiologist-led care team standard. This standard of anesthesia care has been embodied in the New York state health code for more than 30 years. It will also render null and void the office-based surgery (OBS) anesthesia accreditation standard. Currently, both standards require the physical presence of a physician anesthesiologist or the operative surgeon. In either case, the physician must assume supervisory responsibility for a nurse anesthetist.

2. Vague and Undefined Terms Will Create Confusion in the Operating Room

As stated above, the vague and undefined terms within this legislation will create confusion in the operating room. The operating room is a critical care environment where there can be no confusion about who is in charge. When the patient is unconscious and there is a possibility that an immediate medical intervention will be necessary, the roles, responsibilities and level of authority of the physician and the nurse anesthetist cannot be in dispute.

The bill authorizes the New York Board of Nursing (BON) to promulgate regulations. The Board of Nursing has a history of demonstrating a strong bias toward independent practice for nurse anesthetists, and authorizing the BON to promulgate regulations to implement this bill will unquestionably lead to this result. **Since the administration of anesthesia is, in fact, the practice of medicine, the Board of Medicine must not abdicate its responsibility with regard to the dissemination of these regulations**.

3. This Legislation Has No Precedent

The amended bill introduces a model of anesthesia care that has never been tested in New York state. In fact, nurse anesthetists who are educated in New York are taught to work under the direction of a physician and not autonomously. The sponsors offer no peer-reviewed studies to support the two models of anesthesia care proposed: one for nurse anesthetists who have worked more than 3,600 clinical hours and the other for nurse anesthetists who have worked 3,600 clinical hours or less.

4. An "Interdependent Role as a Member of a Healthcare Team in Which the Medical Care of a Patient Is Overseen by a Physician, Dentist or Podiatrist" Is Very Problematic

For nurse anesthetists who have worked more than 3,600 clinical hours,

this bill promotes a vague "interdependent" relationship between a physician, dentist or podiatrist and the nurse anesthetist. One practitioner would not be subordinate to the other. This concept, as proposed, cannot be effectively or safely applied in the operating room. The physician anesthesiologist is the patient's primary and most important advocate in this setting, as medical management decisions must be made in seconds. It is the physician anesthesiologist who assumes the responsibility to make the decisions necessary to save a patient's life. This bill authorizes nurse anesthetists to make medical decisions; this authority exceeds their education, training and experience.

5. There Is No Requirement That a Physician Anesthesiologist Direct Care or Be Present or Immediately Available

The amended bill proposes that a nurse anesthetist who has 3,600 clinical hours or less will work "under the direction of a physician, dentist or podiatrist." "Direction" in the amended bill means "the coordination and communication between the physician, dentist or podiatrist" and the nurse anesthetist for the care of the patient. Other states that use the "direction" standard require that the physician direct the care, be present, and assume responsibility for the patient. The amended bill fails to incorporate these essential requirements.

6. Hospitals Will Be Free to Grant Nurse Anesthetists Independent Practice

The amended bill will create an inequitable anesthesia delivery system. Nurse anesthetists in New York are not trained to work as independent practitioners. Clinical training of student nurse anesthetists provides for the direct and personal supervision that the New York state health code requires. There is no training in independent practice and limited training on the use of narcotics. *[10 NYCRR Section 405.13(a)(1)(v): a student enrolled in a school of nurse anesthesia accredited by the Council on Accreditation of Nurse Anesthesia Education Programs may administer anesthesia as related to such course of study under the direct personal supervision of a certified registered nurse anesthetist or an anesthesiologist.]*

7. There Are No Healthcare Cost Savings

Under Medicare and Medicaid, reimbursement for anesthesia services is exactly the same whether it is administered by a physician anesthesiologist or by a nurse anesthetist. Independent studies have shown that the odds of an adverse outcome are 80 percent higher when anesthesia is provided

only by a nurse anesthetist as opposed to a physician anesthesiologist (Memtsoudis SG, Ma Y, Swamidoss CP, Edwards AM, Mazumdar M, Liguori GA. Factors influencing unexpected disposition after orthopedic ambulatory surgery. *J Clin Anesth* 2012 Mar; 24(2):89-95). Adverse outcomes lead to higher costs for patients in both monetary and physical terms when patients require longer hospital stays.

For a more comprehensive analysis of the amended bill and to read the NYSSA's opposition memo, log into **www.nyssa-pga.org/members/legislative-regulatory-issues/**.

The NYSSA leadership team, under the direction of Executive Director Stuart Hayman, President Dr. Jason Lok, the members of the Executive Committee, and newly appointed GLAC Chair Dr. Ansara Vaz and Vice Chair Dr. Farzana Afroze, working with NYSSA lobbyist Bob Reid and me, have been collaborating on our advocacy strategy to oppose enactment of the amended Reyes/Cooney bill (A6958A/S769A).

U. S. Department of Veterans Affairs (VA) Standard of Care Issue

In 2017, the VA updated its "Nursing Handbook" to include a proposal to remove physician anesthesiologists from veterans' care teams. At that time, the ASA and the NYSSA asked all their members to take action on this issue. After more than 200,000 comments from veterans, their families and concerned citizens overwhelmingly directing the VA to ensure our veterans do not receive a lower standard of care, the VA excluded anesthesia from its proposal, maintaining safe, high-quality, physician-led anesthesia care.

Fast forward to October 2023, and safe VA anesthesia care is again at risk. The VA is in the process of undertaking a new federal supremacy initiative. This initiative was announced last November through an interim final rule and requires the VA to "standardize" care through new VA-only "national standards of practice" for all health professionals who work in VA facilities. Under the federal supremacy initiative, the VA will overturn New York's strong anesthesia patient safety laws and those of other states, the vast majority of which represent a higher standard of care.

The Vietnam Veterans of America and the American Legion have both weighed in heavily on this issue. Recently, the American Legion conducted a nationwide survey and found that veterans want the same

level of care that civilians receive. Among the American Legion's survey findings:

- 61% preferred that a physician administer anesthesia care while only 4% chose a nurse. The remainder had no preference.
- 91% expect the same quality of healthcare as the top-rated civilian hospitals.
- 71% believed the VA will have a different standard of care if nurse anesthetists replace physician anesthesiologists.
- 52% said they would seek care outside the VA if their only choice was to have a nurse administer anesthesia.

To safeguard veterans' health and lives and to ensure that veterans continue to receive high-quality anesthesia care in VA facilities, ASA members are urged to advocate for safe anesthesia care in the VA by engaging Congress and VA Secretary Denis McDonough. Our veterans have earned and deserve the same standard of high-quality care, and your engagement is needed to ensure that physician-led anesthesia care is maintained in the VA.

The ASA has put together resources to help make your engagement with your congressional representatives and senators successful. **Go to www.SafeVACare.org to submit a comment on the importance of maintaining physician anesthesiologist involvement in the care of veterans and to contact your lawmaker.** ■

Charles J. Assini, Jr., Esq.
NYSSA Legislative Representative
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1036 Onondaga Road, Niskayuna NY 12309

The New York Academy of Medicine Hosts Jeopardy Competition and Poster Presentations

ELIZABETH A. M. FROST, M.D., AND FARIDA GADALA, M.D.

Continuing with a popular event, the New York Academy of Medicine Section on Anesthesiology hosted the annual Jeopardy Competition and Poster Presentation night on October 4, 2023.The evening began with a wine and beer reception, giving residents a chance to network and catch up with friends.

In all, seven departments participated in the competition. In addition, eight posters were presented.

Some 60 anesthesiologists came out to cheer on their Jeopardy teams, represented by Drs. Brit Zaro and Preet Korani (SUNY Downstate Health Sciences University), Drs. Latha Panchap and Mao "Mike" Yamakawa (Weill Cornell Medical Center), Drs John Choi and Muhammad Khan (Mount Sinai Morningside and Mount Sinai West Hospitals), Drs. Lucas Smith and Douglas Choe (Montefiore Medical

Participants in the New York Academy of Medicine's annual Jeopardy Competition and Poster Presentation event

Center), Drs. Adejuyigbe Adaralegbe and Shivam Patel (Rutgers New Jersey Medical School), Drs. Stacy Joo and Krishna Hegde (NYU Langone Medical Center), and Drs. Darrel Brennen and Sally Ratliff (Westchester Medical Center).

The final winner was Westchester Medical Center, thanks to an astute bet in final Jeopardy after the team clinched the last clue: Which children's character required an appendectomy at the Plaza? The answer was "Madeline." As in the past, the Jeopardy board was expertly managed by Dr. Adam D. Lichtman, professor of clinical anesthesiology at NewYork-Presbyterian/Weill Medical College of Cornell University.

After a lengthy discussion, judges Drs. David Wlody, Jon Samuels, Elisabeth Abramowicz, Meg Rosenblatt and Alex Bekker awarded the first place prize in the poster competition to: Dr. Trong Nyugen and his colleagues in the Department of Anesthesiology, Perioperative and Pain Medicine at Mount Sinai West and Mount Sinai Morningside Hospitals for their work, "Self-isolation and Its Impact on Chronic Pain." The authors followed 65 subjects, their aim being to investigate the impact of the "shelter in place" order on pain severity and level of disability in patients with pre-existing chronic pain. Patients were divided into "during-quarantine" (3/20/2020 through 6/13/2020) and "post-quarantine" periods. The 24-hour worst pain significantly improved in the post-quarantine period, as well as functional scores, general activity, mood, normal work, relations, sleep, and enjoyment of life ($p<0.002$). Nyugen et al. found that self-reported pain severity and analgesic requirements did not significantly differ during and after the "shelter in place" mandate. However, the degree of disability significantly increased during this mandate, attributed to the impact of fear, anxiety, social isolation, and lack of available resources during the pandemic.

We look forward to hosting another Jeopardy Competition and Poster Presentation event in 2024 and hope for even fiercer competition! ■

Elizabeth A. M. Frost, M.D., and Farida Gadala, M.D., are section leaders of the New York Academy of Medicine's Section on Anesthesiology.

Case Report

Fire in the Hole! A Case of Intraoperative Fire Originating in the Thoracic Cavity

AVANTI SURESH, M.D., CARAIN BONNER, M.D., STEVEN POPE, M.D., AND BENJAMIN LANDGRAF, M.D.

Introduction

Operating room (OR) fires are rare but can be catastrophic. OR fires are considered "never events," but even with practice advisories in place and training for OR staff, they continue to be a threat in the perioperative setting.[1] Recent data from the Emergency Care Research Institute estimates that between 200 and 240 surgical fires occur annually in the U.S., with 20 to 30 resulting in severe injury and two to three resulting in mortality.[2]

Case Presentation

A 61-year-old man with recurrent aspiration pneumonia presented to our same day surgery unit for repair of a known tracheoesophageal fistula (TEF). The patient's history included nasopharyngeal cancer, for which he received a total laryngectomy 20 years prior. He received extensive radiation therapy at that time. Shortly thereafter, he was diagnosed with squamous cell lung carcinoma; his right lower lobe was resected, and he was treated with adjuvant chemotherapy and additional radiation therapy. Several recurrences of the patient's lung cancer resulted in additional treatment with radiation therapy.

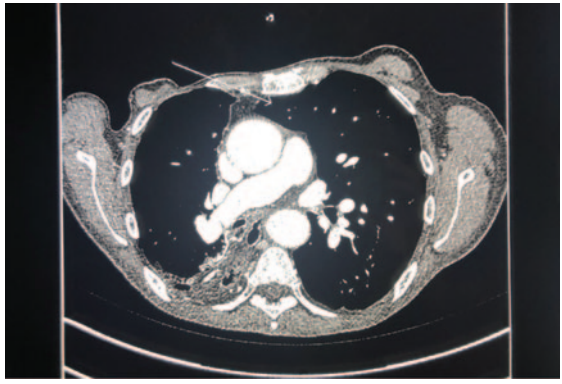

Image: Preoperative CT scan shows the patient's atypical lung anatomy. The arrow points to a portion of the left lung that extends immediately beneath the right sternal border.

A CT scan revealed that the location of the TEF was inferior to the sternal notch. A cardiothoracic surgeon was consulted for exposure through a mini-sternotomy incision. Pre-induction, a time-out was performed that included discussion of the fire risk score.

This was assessed as 3/3 (high) using a three-point assessment tool: one point for surgical location above the xiphoid process, one point for the use of electrocautery, and one point for the potential of an open oxygen source given the location of the TEF.

After the induction of general anesthesia, a cuffed 6.5 mm endoctracheal (ET) tube was placed through the patient's stoma. The FiO2 was maintained at 50% throughout using a mixture of oxygen and air. Prior to sternotomy, during dissection along the right sternal border, the left pleural space was inadvertently violated (Image). The anesthesia team appreciated a gush of air and observed a small fire jet from the chest wall with the next two ventilator breaths. At this point, fresh gas flow was ceased, the ET tube was removed, and the surgical field was doused with normal saline. A fiberoptic evaluation of the airway revealed no airway damage.

Discussion

OR fires related to the thoracic cavity are rare, potentially catastrophic, and described in only a few cases in the current literature. Previous case reports describing intrathoracic surgical fires have involved patients with pulmonary blebs, injuries to previous tracheostomy sites causing oxygen leak, and ignition of surgical sponges located in the thoracic cavity.[3] A case with altered pulmonary anatomy due to previous surgery and radiation has yet to be described.

A fire requires three ingredients: an oxidizer, a fuel, and an ignition source. Anesthesiologists provide the oxidizer in the form of oxygen or nitrous oxide. The surgical team helms the ignition source, often electrocautery, lasers, or drills. The fuel source is often alcohol-based skin preparation agents, tissue, surgical drapes, dressings, or sponges.[4-5]

This case highlights how altered anatomy can bring the three components of the fire triangle together. As noted in the image, the parenchyma of the left lung was located uniquely near the right sternal border. This allowed the surgeon to introduce the electrocautery device into an oxygen-rich environment during dissection. It is often the practice during airway surgery to limit FiO2 to <30% during use of electrocautery.[5] As we had little suspicion that electrocautery would be introduced into the lung during this phase of the procedure, we did not reduce our O2 concentration. To avoid another similar occurrence, we recommend a thorough review of preoperative imaging in any patient who has had previous radiation therapy.

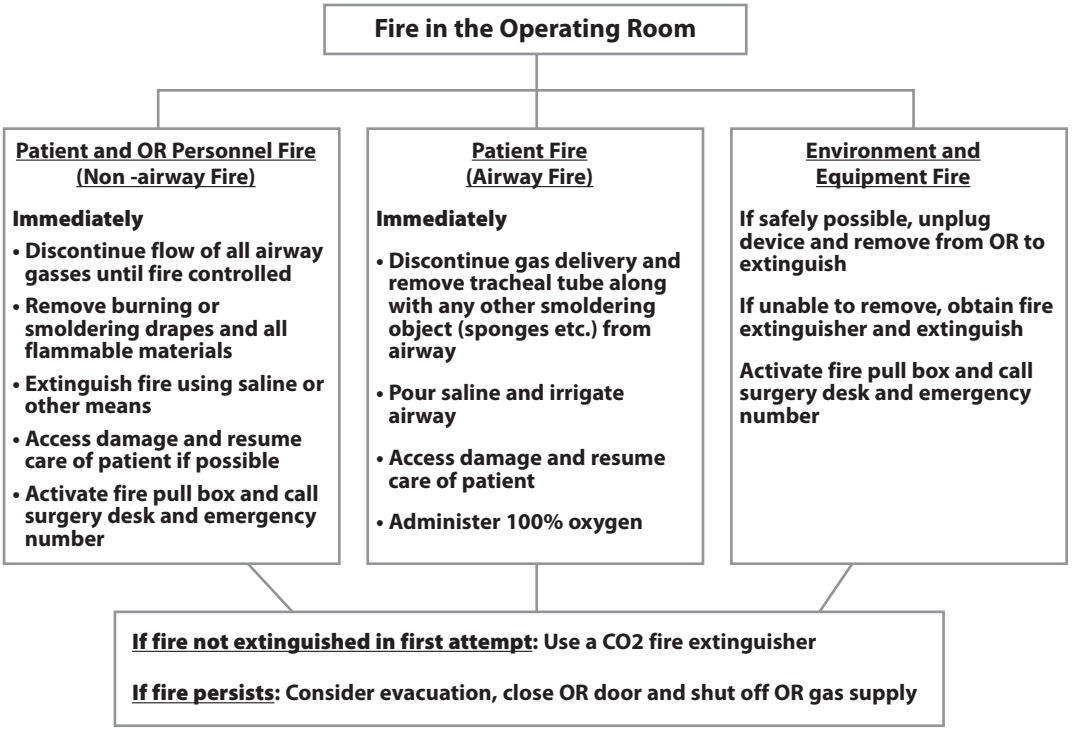

Figure: Guidelines for optimal approach to operating room fires. Source: Saeed M, Swaroop M, Yanagawa F, et al. Avoiding fire in the operating suite: an intersection of prevention and common sense. In: Stawicki SP, Firstenberg MS eds. *Vignettes in Patient Safety - Volume 3*. InTech 2018. doi:10.5772/intechopen.76210.

Conclusion

We describe here a rare case of an OR fire during exposure for the repair of a tracheoesophageal fistula. Our experience highlights the importance of recognizing cases that carry high fire risk, knowing the appropriate management of an OR fire, and conducting a thorough review of imaging to help define a safe anesthetic plan when working near the thoracic cavity. ■

Avanti Suresh, M.D., Carain Bonner, M.D., Steven Pope, M.D., and Benjamin Landgraf, M.D., are with the Rutgers Robert Wood Johnson Medical School Department of Anesthesiology and Perioperative Medicine

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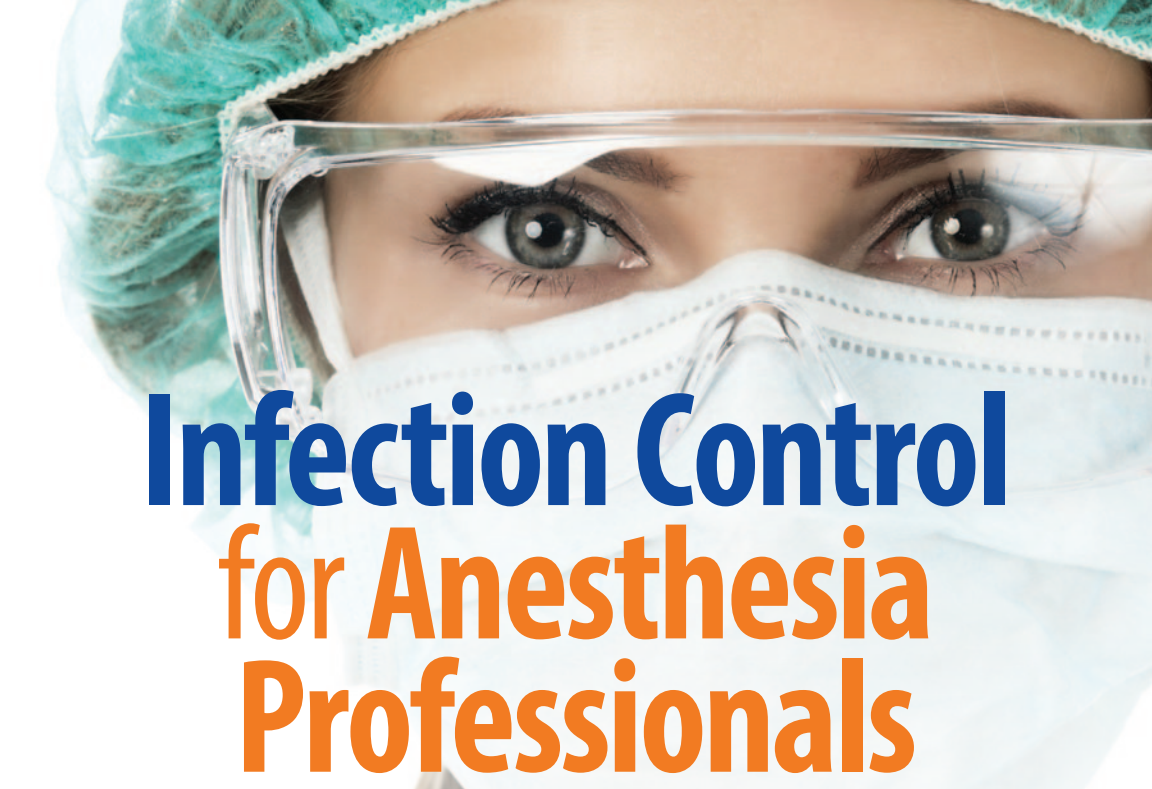

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