SOCIETY FOR AMBULATORY ANESTHESIA

Outpatient • Office Based • Non-Operating Room

6737 West Washington Street, Suite 4210 • Milwaukee, WI 53214
Phone: (414) 488-3915 • Fax: (414) 276-7704 • www.SAMBAhq.org

2022 SAMBA ASC Medical Directors & Leaders Summit Q&A Summary

1) I'm interested in approaches to developing the skills needed by successful medical directors. I lead a group of 150 ASC medical directors and am looking for opportunities to help them be successful.
Answered live: View recording for answer

We are working internally and externally (e.g., with the ASC Association) to provide a 360 degree approach for Medical Directors. WE will continue to have meetings like this, and please encourage your medical directors to join SAMBA!

How effective is a Pyxis machine?

2) Current, near-future, and beyond Covid Testing (or non-testing) protocols
Answered live: view recording for answer

We are having a full session on this at the annual meeting in Phoenix. Is your facility part of the ASC Association? Leo and I gave a lecture on it as well. Please send us your email and we can send it to you.

3) Have an interest in developing a strong total joint program at my ASC?
Answered live: View recording for answer

Today at 1pm EST, Rena Courtay MBA, VP of Duke University Ambulatory ASCs will educate us on developing this line of service.

4) What are thoughts about having succinylcholine available at outpatient GI centers for treatment of laryngospasm? Yeah or Ney? Need dantrolene or not?
The ASA Committee on Ambulatory Surgical care is working on a paper dealing with this very topic. There is a SAMBA position statement that states that Class B facilities that only stock Succinylcholine for emergencies need not stock Dantrolene

There is a current discussion on this very same topic on the SAMBA Forum, and references are provided there , please check it out , you might find it helpful. This will also be discussed at the annual meeting in May.

5) Do ASCs usually pay Medical Directors?
Answered live: View recording for answer
6) How can we get the discount for Niraja Rajan's book? I just looked online,.can you post a link?
https://link.springer.com/book/10.1007/978-3-030-19171-9?sap-outbound-id=00B1DF239EDCB3A1536AA93BA18969672E9D4395&utm_source=hybris-campaign&utm_medium=email&utm_campaign=000_DCO1068_0000018281_AEXS_AWA_CB02_GL_SPR_ABPRone_D&utm_content=EN_internal_34178_20211110&mkt-key=42010A0550671EEC8DE1A12A28EC0B88

7) We have been struggling with multiple cancellations due to COVID-19. Pts are testing positive for several consecutive weeks without symptoms. How are other centers handling this?
Recommendation by APSF for COVID positive patients is to reschedule in 4 weeks if mild symptoms. Do not retest.

https://www.asahq.org/about-asa/newsroom/news-releases/2020/12/asa-and-apsf-joint-statement-on-elective-surgery-and-anesthesia-for-patients-after-covid-19-infection

Unfortunately this has been a common occurrence in the last couple of weeks, thanks to Omicron! I just had a case like that yesterday!

8) If you find diversion, who does this need to be reported to?
After you deal with it locally, I believe you need to report it to the medical board or nursing board, depending on who is diverting.

THE DEA NEEDS TO BE INFOMRED FOR CONTROLLED SUBSTANCES

9) Do each state define the laws on drug testing staff and MDs or is it defined by the hospital system or facility?
Actually both.

10) What to do with patients actively using medical marijuana day of surgery, consent valid?
We will research this topic further. Lots of interests on this!

11) Do you report theft of narcotics during a diversion episode?
Yes to the DEA

12) But not local law enforcement?
Also, local law enforcement. Depends on your policies as well.

In a South Florida ASC, they found vials that had been tampered with during the weekend. The facility called the Police, DEA. They fingerprinted and investigated. An Ex-Employee had entered the facility and knew where things were. So yes, local law enforcement and DEA.

13) Some are using po Tylenol
po tylenol is still a very useful choice and definitely more cost effective

What's the data on po vs IV acetaminophen for pediatric T&A? While there is definitely a cost savings, is there a therapeutic difference in terms of reducing overall opioid use or lower pain scores?

We have IV tylenol and so use it only for the pedi tonsil patients. CNS levels rise much faster and for surgeons who use coblation, the outcomes are great with narcotic sparing

14) Any use of po dexmetotomidene in osa pre op
I mainly use po midazolam preoperatively, and very rarely but difficult cases may add po dex. I am cautious to use dex in the setting of OSA, as it is a drug more difficult to reverse

15) At your ASC, are you doing hip/knee revisions? I assume that there is a potentially higher knee for blood transfusion. Is there a process to donate autologous blood at your free standing ASC? Or can you access blood bank blood for possible transfusion?
We are not doing revisions at this point.

Most people are NOT doing revisions.

16) Questions about urinary retention and spinals for ASC total joints. What local anesthetics being injected? We found less urinary retention with mepivacaine.
We will post this to our forum to see what the wider group of members are doing.

17) Anyone doing unilateral spinals?
Not us. For our total joints, we have had good success with mepivicaine 2% 3 ml for solid 3 hours (sometimes unexpected 5 h!) spinal for at most 2.5 h surgery. Depending on surgeon, we sometimes reduce to 2.5 ml. Rarely have urinary retention - even in older males.

We will post this to our forum to see what the wider group of memebers are doing.

18) Did an informal series and found that unilateral spinals eliminated urinary retention
How many patients?

Around 12 patients

Unilateral spinals?? do tell please. Thanks

19) We use only bupi in spinals

What are the duration of cases typically?

~ 2hrs OR time

20) Anyone using isobaric bupivicaine?
We will post this to our forum to see what the wider group of memebers are doing.

21) Is anyone using bmi percentile limits with pediatric outpatient surgery in an ASC
Answered live: View recording for answer

https://www.cdc.gov/healthyweight/bmi/calculator.html

Marjanovic, V., Budic, I., Golubovic, M. et al. Perioperative respiratory adverse events during ambulatory anesthesia in obese children. Ir J Med Sci (2021).

22) If you have succinylcholine in a center you must have dantrolene. If you decide to do rocuronium instead of sux, are you mandated to have bridion also.
Answered live: View recording for answer

23) Is there an IJ process for non-deemed status AAAHC surveys?
Answered live: View recording for answer

24) Is battery backup for suction a AAAAHB standard?
Answered live: View recording for answer

25) AAAAHC
Answered live: View recording for answer

26) Earlier today there was a post about not needing dantrolene if sux is only used in emergencies - what is the correct standard?
Answered live: View recording for answer

So if your facility is AAAHC, then you do need to have dantrolene if you have a triggering agent. We are writing a paper for Anesthesiology about the business case of sux/dantrolene vs roc/suggamadex.

There was a paper in A&A a few years ago from Joshi. the statement is that Class B facilities (no general anesthesia), he suggests that they should be able to have Sux without dantrolene. Reasoning: laryngospasm needing rescue 1:6,000, Incidence of MH 1:15,000 so the risk of having MH after a colonoscopy 1:6,000*15,000 = 1:90 million cases. However, if a

patient has a laryngospasm, unresponsive to just PPV and Lidocaine or deepening the anesthesia with propofol and there was no sux, they can die.

This paper caused a lot of noise. So AAAASF took that stance (have it in the ACLS cart); AAAHC has stuck with MHaus and continues to have Dantrolene in their manual.

27) AAAASF alows sux for airway rescue without Dantrolene as long as state law allows
Answered live: View recording for answer

28) Does AAAHC still require the preop H and P?
CMS changed their requirement in late 2019 and it now requires a policy identifying patients requiring H&P and a timeframe. However, AAAHC still maintains requirement for all patients to have an H&P within 30 days. (Standards 10.1 D and E)

29) Is ASAs guideline suggesting a 4 week delay for elective surgery for minimally symptomatic COVID infections still the gold standard. Do we need to get a negative antigen test before scheduling? Is a 10 day delay adequate if there is some urgency like in a retina case?