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BERITA Anestesiologi

Newsletter of the • Malaysian Society of Anaesthesiologists
• College of Anaesthesiologists, Academy of Medicine of Malaysia

Malaysian Society of Anaesthesiologists

College of Anaesthesiologists, Academy of Medicine of Malaysia

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EDITOR Dr Rafidah Atan

In this Issue...

Message from the President

We have just completed another successful NCIC – the 5th NCIC, held in KL from 22 – 24 June 2007. This time, the response was even more overwhelming than in previous years, with over 1100 delegates, and some had to be turned away. We apologise to those who were turned away, but the place just could not hold more people; we should all realize as well that gone are the days when we can make last-minute decisions to attend a conference – obviously, with the emphasis on continuing professional development (CPD), conferences are getting more popular. It has been a long accepted "fact" that registrations for conferences will only start coming in within the last couple of weeks before the conference itself – attempts to encourage early registration, for example by having "early bird" discounts, have not succeeded. Perhaps now this will change. Planning, after all, makes for better time management, which in turn reduces stress and in the long run improves quality of life!! So let's start planning ahead and booking early from now on. I myself am terribly guilty of poor planning and last minute work, and should be the first to change!

I think that this response from the medical community not only indicates the growing interest in the specialty of intensive care, but also the recognition of the importance of Continuing Professional Development or CPD. Conferences like this give the opportunity for us to update our knowledge of the latest techniques, equipment and drugs available in the management of our patients, and also allows us to exchange experiences with our colleagues from other hospitals, private and public, as well as from other countries. At the NCIC this year, we speakers from Singapore and Hong Kong, as well as from Australia and USA. But I was happy to see that there was an increased number of "home grown" speakers and I think that this augurs well for the future of the MSA.

Compulsory CPD

Regarding CPD, we know that the Ministry of Health has always encouraged CPD for all healthcare providers. However, compulsory CPD is on the horizon, starting with doctors – this means that doctors will be required to collect a minimum number of CPD points before we can renew our Annual Practising Certificate (APC). A pilot project has already started in Penang hospital. For the MSA though, I am proud to note that we have already set up our MOPS (Maintenance of Professional Standards) system two years ago, initiated by our immediate Past president, Dr S H Ng. This is a self monitoring system for our members to track your own CPD activities over the year, and I urge members who have not done so already to make use of this so that you get into the habit of recording all your CPD activities. Members need a log in ID – available from the MSA secretariat at the Academy of Medicine.

I would also encourage all of you to organise CPD activities at your local level – hospital, state, or regional levels. The Society will support you by providing speakers for your activities, if you request for it. The Ministry of Health also has allocated more funds for training purposes and we should make use of this to upgrade our knowledge and skills.

Continued on page 2

Continued from page 1

World Congress of Anaesthesiology 2008

The World Congress of Anaesthesiology in Capetown South Africa, is getting closer. Apart from the MSA subsidy which is available for members who present a paper or a poster at this conference, there are also a very limited number of scholarships available from the WFSA itself – please see this issue of the Berita for the advertisement. Again, a reminder that the closing date for submission of abstracts is early September, so I hope that most of you who are planning to attend the WCA have your abstract almost ready!

Sponsorship for conferences

Perhaps we should think about decreasing our dependence on the healthcare industry for "sponsorship" to attend conferences. When organizing local conferences, seminars and workshops, the registration fee only covers the cost of the conference package; the rest of the costs including bringing speakers from overseas, is funded from other sources of income, for example the rental of exhibition booths. In other countries, most doctors attend conferences on their own expense – indicating how much they value the learning experience.

The MSA has always tried to make our members less dependent on industry sponsorship by providing subsidies for those who present papers or posters at regional and international conferences. I know that there are already a number of doctors who do not take sponsorship from companies to attend conferences; on the other hand, there are still the majority who will not attend a conference unless sponsored! Is it that Malaysian doctors really cannot afford to pay for our own CPD (including attending local conferences? Just a question to ponder upon….

Anaesthetic fee schedule

To change the subject completely – the subject of professional charges for anaesthetists has come up again recently with news that some anaesthetists are being asked to charge 35% of the surgeon's fee (including the discounted fee). The MSA Exco has met up with different parties, including our colleagues in private practice as well as managers of a well-known insurance company in KL to discuss this topic in detail. Although we have already informed members about this in one of the issues of Berita last year, I would like to repeat here that the Private Healthcare Facilities and Services Act 1998 (PHFSA) which was implemented in May 2006 includes a Schedule of fees (Schedule 13 of the Regulations 2006), which stipulates maximum fee chargeable for any procedure or consultation. In this Schedule, which is based on the MMA Schedule of Fees (4th edition) there is a separate fee schedule for anaesthetists i.e. the anaesthetist's fee is NOT a percentage of the surgeon's fee.

I would like to urge all anaesthetists to charge according to the Schedule of fees, and not a percentage of the surgeon's fee. After all, it is clear that anaesthetists are professionals in our own right, not an appendage of the surgeon. There is a risk of breaking the law if we charge 35% of the surgeon's fee across the board, because there are some cases where the anaesthetist's fee in the MMA schedule is less that this. Conversely, there are many cases where the fee is more than 35% and if we maintain this "percentage" practice, we are shortchanging ourselves!

Benefits for members

I would like to end by putting in a plug for the Society – membership of the MSA has grown over the years, but we still do not have 100% of the anaesthetic community as members. We also have many members who do not renew their membership regularly. Members receive many benefits, including discounted registration fees for conferences like this, subsidies to attend overseas conferences, and other benefits like access to the MOPS system, the Berita Anestesiologi, the MSA Yearbook, and access to the virtual library that the MSA is subscribing to. So I would urge all of you reading this (who are obviously members) to firstly, renew your membership if you have not already done so, and secondly, to encourage your colleagues who are not yet members of the MSA to join us – membership forms are available on the MSA website, www.msa.net.my.

Mary Cardosa
July 2007
mary.cardosa@gmail.com

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College of Anaesthesiologists, AMM

President's Ventilation

Dear Fellow Members,

NATIONAL SPECIALIST REGISTER

The registration of specialists for the National Specialists' Register has got on to a good start and the response from anaesthesiologists has been encouraging. In this edition of the Berita I would like to inform all members and other anesthesiologists in the country the process of credentialing and registering of specialists. The intent of the National Specialist Register is described as below:

"The National Specialist Register will ensure that doctors designated as specialists are appropriately trained and fully competent to practise the expected higher level of care in the chosen specialty. With the National Specialist Register in place, doctors will be able to identify fellow specialists in the relevant specialties to whom they can refer either for a second opinion or for further management. Importantly, the National Specialist Register protects the public and will help them to identify the relevant specialist doctors to whom they may wish to be referred or may wish to consult. The National Specialist Register is in fact an exercise in self-regulation by the medical profession, striving to maintain and safeguard the high standards of specialist practice in the country, having the interest and safety of the public at heart." (http://www.nsr.org.my/azhome.jsp)

The process is spear headed by the National Credentialing Committee chaired by the President of the Medical Council and the Director General of Health, Tan Sri Datuk Dr Hj Mohamed Ismail Merican. The members of this Committee are from the public sector hospitals and the Academy of Medicine of Malaysia.

The credentialing and registering of anaesthesiologists is part of the process of registering all specialists in the country in the National Specialist Register. The members of Specialty Sub Committee for anaesthesiology are appointed by the Ministry of Health and represent specialists from the Ministry of Health, Universities and the private sector. For the time being till the Medical Act is amended, the Academy of Medicine and its Colleges have been requested to undertake this enormous task on behalf of the Ministry of Health. This augurs well as the intent of process registration is supposed to be an exercise in self regulation by the medical profession.

This Specialty Sub Committee for anaesthesia was given the responsibility of drawing up the criteria for credentialing and registration of anaesthesiologists. The Sub committee is now headed by Assoc Prof Lim Thiam Aun and has been very busy over the last two years. The document of criteria spells out the academic qualifications that are recognized and the experience required to register one as a specialist anaesthesiologist. The committee has taken great care to ensure that all those who are currently practising as specialists are accorded the due recognition of their contributions to the specialty and the country This document is not static and will certainly see changes and modifications as time goes on. At least for now the document has been finalized and will be available on the National Specialist Register website. (http://www.nsr.org.my/ azhome.jsp)

Specialty Sub Committee for anaesthesiology has received encouraging number of applicants mainly from the private sector. The public sector specialists are taking a wait and see attitude because of the registration fees required. The Sub Committee has vetted all the applications received and will be sending out acknowledgement letters soon. The members must understand that this Sub Committee just vets and recommends registration to the National Credentialing Committee which has the ultimate power to accept or reject our recommendations. The College members and other non-member anaesthesiologists who had applied for registration are kindly requested to be patient as the issuance of the registration certificate is beyond the duties of this Sub Committee or the Academy of Medicine.

At the last AGM of the College held in April 2007, the Council of the College was requested to study the feasibility of registering intensive care practitioners or Intensivist as a separate specialty. In accordance with this resolution the Council set up an adhoc committee chaired by Dr Ng Siew Hian to study this matter and submit their recommendations. The recommendations of this adhoc committee have been received and will be deliberated upon by the Council before it is circulated to the members.

Continued on page 4

Continued from page 3

CONTINUING PROFESSIONAL DEVELOPMENT

Continuing professional development (CPD) is the universal successor to what was previously known as continuing medical education (CME) and maintenance of professional standards (MOPS). CPD embodies both professional learning and personal growth, and extends past maintenance of knowledge and skills, to include improving personal and professional qualities throughout a professional's working life, such as in ethics, management and communication skills (BMJ 2003; 327:33-35).

CPD may thus be defined as

"Any activity to maintain and improve knowledge, skills, and attitudes, and to develop professional and personal attributes required throughout a career as a Specialist Anaesthesiologist."

Many medical professional organizations have now adopted CPD as the way forward to maintain and safeguard standards of practice as well as personal development as enunciated in the definition above. Recently I had the privilege of representing our College at the Australian New Zealand College of Anaesthetists Annual Scientific Meeting held in Melbourne. A half day session was allocated for discussion on CPD and how it can be developed and implemented. Our members, who are also members of ANZCA, would have received information about the ANZCA CPD. Most of the medical regulatory bodies in developed countries require some form of formal documentation of professional development undertaken by the medical professionals. It has also been recognized that CPD can be achieved in many ways and need not be through formal lectures, meetings or conferences as was previously done. Informal case discussions among colleagues, attending mortality and morbidity meetings and presentation of cases at such meetings, participation in risk management and quality assurance activities, public lectures on health care issues are some of the activities that contribute to CPD. While many of the government sector specialists and some of the private specialists especially in larger private hospitals are already involved in such activities, the documentation of these activities is lacking and need to be encouraged. In this respect the College will help the members in providing a framework for annual returns of their CPD activities. It is inevitable that this will be required once the National Specialist Register is in place and maintenance of one's name on the Register will require demonstration of participation in CPD.

All anaesthesiologists will need to start preparing for the changes that will take place and may include the following:

- Planning of activities based on one's needs
- Setting targets (like KPI's in the corporate world) e.g. Learning a new skill or upgrading a skill not commonly used
- Selecting activities most appropriate to ones learning style (e.g. journals, books or internet, etc) and practice (e.g. urban or rural; hospital based or ambulatory care centres)
- Self reflection and evaluation
- Quality of activities should be more important than gaining points

IMPLICATIONS OF THE FEDERAL COURT JUDGEMENT IN FOO FIO NA CASE

As most of you will be aware, the Federal Court of Malaysia in its judgment, delivered on December 30, 2006 regarding the Foo Fio Na vs Hospital Assunta case, decided that Bolam principle does not apply when it involves giving of advice and obtaining consent for medical procedures. What this means to anaesthesiologists is from now on we must spend more time discussing the anaesthetic procedures, the risks and benefits and alternative procedures before obtaining the consent for anaesthesia. Many anaesthesiologists in the private sector do not take a separate consent and rely on the consent embedded in the consent form used by the surgeons. It will now be prudent to take a separate consent befitting us as professionals after full disclosure of the anaesthetic procedures and risks. The patients have a right to know of all material risks involved in an anaesthetic procedure they are about to have performed on them. While some of us may be genuinely worried about patient's ability to comprehend, attempts nevertheless must be made to inform patients adequately.

Most of the government hospitals are now using the new format of Anaesthesia Disclosure and Consent Form in all four languages. If anyone is interested I would be happy to send a soft copy of these to you.

Please email me at namazie@streamyx.com to comment or criticize issues raised above.

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A Page From Malaysian Anaesthetic History

by **Dr Patrick S K Tan**

Anaesthesia has travelled the world for over 160 years. An older generation of anaesthetists used to be terrified by examiners' questions about the first ether anaesthetic by Morton, chloroform for parturition by Liston and cocaine for ophthalmic surgery by Koller. Happily history is not a subject required to pass the Master of Anaesthesiology or M Med Anaes. For those who would be interested in reading the adventure of the first anaesthetics performed in Malaysia, the author has travelled to the Singapore National Library and acknowledges their trustees' contribution in providing facsimiles of the following original accounts. Today's anaesthetists will wonder how it was possible to achieve all that of yesteryear without a pulse oximeter and gas analyzer and also realize that the early anaesthetists were astute clinicians with significant powers of observation, deduction and practical safety.

News of the first anaesthetic performed at the Massachussetts General Hospital in Boston by W T G Morton on October 16, 1846 travelled by the fastest route, the mail steamer from Boston to Liverpool, England. By Christmas 1846 news of the priceless discovery and its first application in England, the first by Francis Boott, and the second by William Squire at University College Hospital London, was published in British newspapers. From then practitioners all over England and Scotland tried their hands. It is the news from England rather than from the country of origin which was widely disseminated and admired throughout the distant colonies of the Empire.

In 1847 a steamer took 47 days to sail from England to Penang. The P&O ship Hindostan left Suez for Ceylon on 15 February carrying January newspapers from London. These were transferred to Braganza which arrived in Penang on 12 March. The introduction of anaesthesia in England is reported in the *Penang Gazette and Straits Chronicle* of 20 March. The first anaesthetic in the Straits Settlements was given on 28 April at Malacca by Dr Ratton and was reported in the Singapore Free Press of 30 April as follows:

"I have the pleasure to forward you the following brief particulars of an operation I performed at this Station on the 28th instant, the patient being previously placed under the influence of sulphuric ether and thereby rendered perfectly insensible to pain or the steps of the operation. I will feel obliged by your giving this communication insertion as it may be of service to some of your professional readers by directing attention to the simple means employed which are at hand in every hospital, and prevent the necessity of waiting for or having any special or complicated apparatus. The present case being perhaps the first serious operation performed in the Straits in connection with the inhalation of ether.

"The man, a Malay, a lascar on board the topay Sri Melaka, had his right hand blown away from a gun on the morning of the 28th instant. The bones of the forearm being also extensively fractured and the parts otherwise injured, circumstances which call for an amputation below the elbow. He was at first put under the influence of ether by inhaling the vapour from a simple Mudges inhaler attached to the hospital (containing small pieves of sponge saturated with the ether), common care only being taken by compressing the nostrils during the act of inspiration and making the mouth piece pass through a piece of sponge to secure its full inhalation into the lungs. This was effected in about 4 minutes when his eyes being closed, his head sank upon his chest in an apparent state of insensibility; the operation was now immediately commenced by the flap operation. The man at the moment of transfixation by the knife merely exclaimed "what are you doing to me?" when he relapsed into his comatosed state and though he moaned twice remained in this state of insensibility and unconsciousness during the operation, and after the steps of tying the arteries, securing the flaps by sutures and removal to bed. And in this quiet somnolent state I left him, breathing naturally with a quiet natural pulse of 80.

"When seen three hours afterwards and questioned relative to the operation, he stated that he was aware of my intention to remove his arm, but of the operation itself,

Continued on page 6

Continued from page 5

pain or of any of the circumstances connected with it, he was perfectly unconscious. The haemorrhage, it may be remarked, was unusually trifling. The man is going on very favourably."

Two months later, the Penang Gazette reported another anaesthetic and surgical success on July 3, 1847:

"The inhalation of the vapour of sulphuric ether combined with atmospheric air was tried on Tuesday last by Mr Smith, surgeon, in the presence of several other persons, upon a patient from whom he removed a fibro-cartilaginous tumour, and proved completely successful in rendering the patient insensible to the pain of the operation. The partly operated upon is a respectable Chinese merchant of this place, about 30 years of age, and of a spare habit of body. The tumour began to make its appearance on the inner side of the upper lip several years ago; it had attained the size of a common walnut, was free from pain, but inconvenient from its bulk and situation, and as latterly it had been growing quickly, the patient was desirous to have it removed. When informed of the effects which have been usually observed from ether administration as above, he said, "that was the sort of medicine for him", and requested that it might be used. Everything being prepared and the patient seated for the operation, a common bladder fitted with an ivory tube, as recommended by Mr Herapath, was the apparatus used. Into this was poured half an ounce of good sulphuric ether, the bladder was then blown up and well agitated so as to saturate the air in it with the vapour, after which the patient was desired to receive the pipe into his mouth, to embrace it with his lips and breathe freely through it. His nostrils were held perfectly closed. After a very few inhalations, and certainly in a space not exceeding a minute and a half, the patient slightly groaned, his lips let go their hold and the pipe fell from his mouth. He appeared in a deep sleep and there was total suspension of motion. The operation was now commenced and completed in about four minutes, during which he continued to groan but never uttered a word or moved a muscle, and his breath was remarked to be extremely cold.

"At the termination of the operation he was still insensible and as he continued in this condition two minutes afterwards with a pulse of 40, extremities cold, geenral pallor, lips and conjunctivae especially pale, some wine was administered and water sprinkled over the face, and these repeated several times before he began to recover his powers of sensations and motions. Altogether, the effects continued fully ten minutes.

The patient's description of his feelings while under the influence of ether:

"The first draught of the vapour produced a sensation of coldness which spread upwards to the different parts of the body; the hands and feet became numb and destitute of feeling, then there were giddiness and a feeling of confusion in the head, noise in the ears, and lastly a total loss of power and feeling in every part, but still a pleasant sensation of most perfect ease and quiet, altogether different from that kind of stupor occasioned from an overdose of spiritous liquors. He could draw no comparison between its effects and those produced by smoking chandoo (opium) never having himself on occasion tried the latter. He was not conscious of having groaned, but he knew when the operation was commenced and when it was completed, during it he was sensible of a scratching in the part, which however, he described not so much as a feeling of pain as a sense of the sound of that, and it was, at all events, not so disagreeable as the slight pain which on recovery he felt in the wound. A tingling sensation was experienced in all the extremities when the influence of the Ether began to subside, and which spread through them to the body before the sense of feeling and power of motion was perfectly restored. He felt a little drowsy afterwards, laid down and had two hours' sleep from which he arose feeling in every respect comfortable and on the same day he followed his usual avocations."

The next article on Malaysian anaesthetic history will describe anaesthesia at Independence. As a contribution to our national celebration of that great event, here is a not-to-be-missed *Berita Anestesiologi* quiz on Malaysian anaesthesia as it used to be in the 'good old days'.

1. What was the most commonly practised method of anaesthesia when Malaysia became independent?
2. Who was the first Malaysian anaesthetist to gain the FFARCS (now called FRCA)?
3. What other singular achievement is this anaesthetist noted for?
4. Where was the Malaysian Society of Anaesthesiologists founded?
5. What is the connection between Hospital Universiti Kebangsaan Malaysia and Field Marshall Gerald Templer?

Prize – to be determined by the Editor for the first, correct and most complete answers. Hint – not all the above answers are to be found in Wikipedia.

Please submit your entries (for the quiz) via email to the Editor at rafidah10@hotmail.com or rafidah.atan@med.monash.edu.my.

The first, correct and most complete answers will receive a copy of **Examination Medicine** by **Talley and O'Connor**.

5th National Conference on Intensive Care

by **Dr Sekar KPK Shanmugam**

The fifth edition of the National Conference on Intensive Care was held from 22 to 24 June 2007 at the Shangri-La hotel, Kuala Lumpur. The conference started on 21 June with pre-conference workshops on bronchoscopy and blood purification techniques.

The opening ceremony this year was kept simple and brief. Dr Ng Siew Hian stressed the importance of increasing quality of nursing in intensive care and the need to start a special interest group for intensive care nursing. The meeting was officiated and opened by Dr Mary Cardosa, President of Malaysian Society of Anesthesiology. Nearly 1100 delegates attended this conference and 65 trade exhibition booths added glamour and festivity to the meeting.

The conference had 5 plenaries and 9 symposia covering various current issues in intensive care. It was encouraging to see greater participation by local speakers. The nursing symposiums were well attended by the nurses-justifying the continuation of nursing related themes for future conferences.

All three interactive sessions were poorly attended. This is unfortunate considering that the sessions would have greatly benefited our medical officers and post graduate trainees. In future, these sessions should probably be held as pre-congress workshops, which may then successfully attract the target group and ensure satisfactory attendance.

With greater number of delegates this year, the success of this conference was never in doubt. The conference also attracted more physicians and paediatricians which augurs well for the development of intensive care in Malaysia. In future years, finding a bigger venue to cater for increasing participation of delegates and trade exhibitors will be an exciting challenge to the organizers.

For the first time, the free paper presentation was won by a foreigner from Aga Khan University, Karachi, Pakistan whose presentation was entitled "Impact of Early Antibiotics on Severe Sepsis-Are We Doing a Good Job?" The poster presentation award went to Dr T C Lim from Melaka Hospital with the poster entitled "Does Feeding Regimen Affect the Incidence of Ventilator Associated Pneumonia? A study in Hospital Melaka"

Running a conference of this magnitude will not be free from complaints. The main grouse was that lunch was served in packs. There were also glitches at the registration counter when some delegates who were industry sponsored did not have their names on the delegates list. At least one had to wait for 24 hours before she was registered in.

The venue was an excellent one. Dining, shopping, clubbing-one was simply spoilt for choice.

The 5th National Conference on Intensive Care has been a huge success. We await anxiously for a bigger and better 6th NCIC!

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This was received from the World Federation of Societies of Anaesthesiologists (WFSA) in July. I urge interested young anaesthetists to apply for this funding. Apologies for the short notice.

~ Mary Cardosa

World Congress of Anaesthesiologists

For the attention of the President:

The World Congress of Anaesthesiologists takes place in Cape Town, South Africa 2 – 7 March 2008. The Global Anesthesia & Critical Care (GACC) Division of Baxter Healthcare Ltd has generously decided to sponsor a number of young anaesthetists on low incomes, who are working in developing countries, to attend the world congress. The learning and friendships gained during the World Congress will prove invaluable in supporting these future leaders in anaesthesia.

We would be grateful if you could circulate the attached application form to all members of your Society. Those interested and able to fulfil all requirements, are requested to return the form to the WFSA headquarters at wfsahq@anaesthesiologists.org by 30 August 2007, in electronic format.

With kind regards.

Dr Angela Enright
Chairman, Education Committee
World Federation of Societies of Anaesthesiologists
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Website: http://www.anaesthesiologists.org
WCA 2008: http://www.wca2008.com

Congratulations

The Malaysian Society of Anaesthesiologists would like to congratulate the following candidates for passing the recent exams. The names are in alphabetical order.

PRIMAR Y EXAMINA TION

1. Dr Asmah bt Mohd Ghazali
2. Dr Azlina Mazzita bt Mohamed Mokhtar
3. Dr Haslinda bt Sulong
4. Dr Mohd Azizan bin Ghazali
5. Dr Norazimah bt Mohd Zain
6. Dr Normah bt Abdullah
7. Dr Ramanesh a/l Mageswaran
8. Dr Saidatinal Azman bt Md Nazri
9. Dr Shazharn bin Muhammad Zain

FINAL EXAMINA TION

1. Dr Amiruddin bin Nik Mohamed Kamil
2. Dr Fadzlon binti Mohd Yatim
3. Dr Muhd Helmi bin Azmi
4. Dr Ina Ismiarti bt Shariffuddin
5. Dr Ismail Tan bin Mohd Ali Tan
6. Dr Jeyanthi a/p Kunadhasan
7. Dr Maszlina bt Mohamad
8. Dr Mohd Shahnaz bin Hasan
9. Dr Nor Hayati bt Mohd Said
10. Dr Sidney Saw Lee Teng
11. Dr Siti Nadzwani bt Mohamad Mahdi
12. Dr Tan Kok Hui
13. Dr Ushananthini Kolandaivel
14. Dr Vineya Rai a/l Hakumat Rai
15. Dr Williemena Ong Hsu Chang
16. Dr Wong Kang Kwong
17. Dr Yogambigai a/p Balasundram

Crisis Management in Orthopaedic Trauma – Orthopaedic Trauma Course (OTC) 2007

Report by Rafidah Atan

DATE	18 & 19 July, 2007
VENUE	University Malaya Medical Centre, Clinical Skill Laboratory, Kuala Lumpur
FACILITATORS	Professor Wang Chew Yin, Dr Anuradha, Assoc Prof Marzida Mansor and Dr Rafidah Atan

The Orthopaedic Trauma Course in annually held by the Orthopaedic Department of University Malaya Medical Centre. One of the practical sessions conducted involved a simulation in crisis management utilising SAM, the high fidelity manikin at the Clinical Skills Lab, UMMC.

A total of six sessions involving four orthopaedic doctors at a time was conducted. During the simulation, the doctors were expected to role play, not always as orthopaedic surgeons but as anaesthetists, emergency physicians and general surgeons as well. The 'patient' will not only have broken limbs but an array of other potentially life threatening conditions which the team must manage as a whole. Facilitators watched from behind one way mirrors, while their colleagues who've escaped the hot seat (until their turn of course!) watched 'live' from the debriefing room. The spectators were then expected to comment on crisis management skills of the participants which included their behavioural, communication and leadership skills. The debriefing session is held in a very friendly, non-threatening manner to maximize reflection and input by all involved. Hostile debriefing sessions are definitely out of style! It only serves the purpose of making everyone involved try to forget the incident as quickly as possible! It was further emphasized that the simulation is not aimed at assessment but for education purposes only.

All in all, the facilitators (all of whom were anaesthetists) were fairly impressed with our orthopaedic colleagues. Not only were they excellent as 'anaesthetists', they handled each crisis well, demonstrated a good amount of knowledge on trauma life support and performed the important act of frequent reevaluation of the trauma 'patient'; all the acts worthy of a trauma surgeon! It was fun and we look forward to having these sessions again next time.

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Advanced Airway Workshop – Penang Hospital

Dr Thomas Ho Wing Nan
Medical Officer, Department of Anaesthesiology and Intensive Care, Hospital Pulau Pinang

Taking control of the airway has long been a forte of the anesthesiologist. Learning to intubate is a skill most pick up early in their training. There is however little formal teaching in this respect. It is something that you learn on the job. Along with this, there are the difficult airways and various ways of securing them with the assortment of devices available in each hospital. Learning to identify and secure a difficult airway is of utmost importance to anesthesiologists as the incidence of difficult intubation have not changed over the years. Although we can't change the population characteristics enough to eliminate difficult airways, we can improve our skills at handling them.... It is with this in mind that the Advanced Airway Workshop for northern peninsular region was held recently at Penang Hospital on the 28 July 2007. The workshop was meant to familiarize anesthesia providers with various available methods of securing the airway. Practising difficult airway in a controlled environment sure beats the enormity of securing the airway in a real live difficult airway patient..... less complications and medicolegal issues.

The workshop was a one day course jointly sponsored by the Malaysian Society of Anesthesiologists and the College of Anesthesiologist. The venue was the spanking new Ambulatory Care Complex of Penang Hospital. The workshop had lectures on fibreoptic intubation and guidelines on difficult airway management, followed by hands-on training and familiarization stations on fibreoptic intubation, use of airway adjuncts, as well as percutaneous cricothyrodotomy and tracheostomy. The lectures were given by Dr Hwang Nian Chih (who is no stranger to Malaysian anesthesiologists!) from Singapore and Dr Lakshmi Thiyagarajan from Penang Hospital.

Sufficient time was given for every participant to have hands on training at each of the practical sessions. Fibreoptic intubation with the now familiar flexible fiberscope was facilitated by Dr Hwang and Dr Khoo Teik Hooi. Participants were also taught the tips of proper use and care for the flexible scopes. There was also a station on using the Bonfils rigid fiberscope to intubate.

The airway adjucts session with Dr Rafidah Atan proved very interesting with tips on the guided technique of Proseal LMA insertion, as popularised by Prof Joseph Brimacombe. There was also this scary looking laryngoscope, called the Upsher scope which is designed to intubate in the neutral head position, as well as for use in patients with limited mouth opening. As Dr Rafidah had said, it's not something you would want to show an awake patient...

Continued on page 11

Continued from page 10

The surgical airway station gave hands on training in percutaneous tracheostomy by Dr Nor'Azim Mohd Yunos and Dr Lim Chew Har. There were two methods demonstrated, the newer single conic dilator method and the open Grigg's method which is more commonly used in Malaysia. Everyone had a go at the available tracheas and came to appreciate that while the techniques appeared simple, the trick is to do it with a minimal amount of collateral damage to the surrounding structures. Well at least no patient was involved…

The workshop drew to a close with a series of case discussions facilitated by Dr Rafidah on real life scenarios of difficult airway, both expected and unexpected which set the participants to thinking and applying their knowledge.

All in all, the workshop was a very useful course for all, familiarizing participants with available difficult airway equipments, as well as formulating plans of action in the event of difficult airways, whether expected or not. And though practice makes perfect, it is not justifiable to practice difficult intubation only in times of crisis. Hopefully for the participants, the anesthetist's nightmare of can't intubate, can't ventilate, remains just that, a nightmare.

E

Multiple Choices Questions

Courtesy of Dr T C Lim from Hospital Melaka

1. Regarding suxamethonium

A. It may be available as a white crystalline solid
B. The pH of the aqueous solution is acidic at 6-6.5
C. Approximately 20% of suxamethonium is metabolized before reaching neuromuscular junction following its administration
D. The action at neuromuscular junction is mainly terminated by hydrolysis
E. About 80% of a dose of suxamethonium is excreted unchanged in urine

2. Regarding suxamethonium

A. The 0.1% solution was previously used for intravenous infusion
B. Fasciculations are more commonly found in children aged 10 and below
C. Myalgia usually occurs within 2-4 hours after the administration of suxamethonium
D. It may cause an elevation in intraocular pressure of 10 cmH_2O for 10 minutes
E. Suxamethonium usually causes increased intracranial pressure via its direct effects

3. Regarding atracurium

A. As recovery from single dose of atracurium is faster than vecuronium, it is preferred in short surgical procedures lasting less than 30 minutes
B. It is available as atracurium besylate with pH adjusted to 5.25-5.65
C. It is metabolized via Hofmann elimination which is a biologic process in human
D. It has the possibility of 16 stereoisomers theoretically
E. The onset is faster than an equipotent dose of vecuronium

4. Regarding atracurium

A. It is a monoquaternary benzylisoquinolinium non-depolarizing neuromuscular relaxant
B. Hofmann elimination produces more laundanosine per molecule of atracurium as compared with ester hydrolysis
C. It is contraindicated in patients with atypical pseudo-cholinesterase
D. The enzymatic degradation of atracurium is accelerated by low pH
E. Tachycardia following atracurium administration is mainly contributed by vagolysis

5. Regarding vecuronium

A. It is a 2-desmethyl analogue of pancuronium
B. It is monoquaternary at physiological pH
C. Commercial preparation consists of vecuronium bromide, citric acid monohydrate, disodium hydrogen phosphate dehydrate and mannitol
D. Reconstitution with water produces a colourless solution with pH of 4.0
E. The recovery index is almost similar to atracurium

MONTHLY QUIZ (April 2007)

Answers provided by Patrick S K Tan

1. Who discovered nitrous oxide? Joseph Priestly, 1775, as phlogiston.

2. i) The person conducting the first public demonstration of anaesthesia: William Thomas Green Morton using diethyl ether in the Ether Dome of the Massachussetts General Hospital. If the question refers to the first (attempted) public demonstration of nitrous oxide as anaesthesia, this would be by Horace Wells around February 1845 in the same Massachussetts General Hospital.

   ii) The date: Same as the Editor's birthday but earlier by 125 years (16 October 1846). This is the 'official birthdate' of anaesthesia.

   However, documentation also supports the claim of William Crawford Long to have performed a public demonstration of the use of diethyl ether to remove a tumour from James Venable's neck on 30 March 1842 (published later in 1848 in Southern Medical and Surgical journal).

   iii) What agent was used: Diethyl ether by both Morton and Long.

Answers

1. TFFFF

The clear solution of suxamethonium has pH of 3-3.5. About 80% of suxamethonium is metabolized before reaching neuromuscular junction. Termination of action is via diffusion away from neuromuscular junction into extracellular fluid. Approximately 2-20% is excreted unchanged in urine.

2. TFFTF

Fasciculations are less commonly seen in patients aged 10 and below. Myalgia occurs usually on second day following anaesthesia and may last for one week although it usually disappears within 2-4 days. The raise in intracranial pressure may be due to an increase in arterial CO_2 produced by fasciculations and direct effect of suxamethonium on intracranial pressure is minimal as there are no changes in intracranial pressure, cerebral blood flow and electroencephalogram observed when suxamethonium is given to patients with neurologic injury receiving mechanical ventilation.

3. FFFTF

Recovery is similar after single dose of equipotent dose of atracurium and vecuronium. The pH of commercial solution of atracurium is adjusted to 3.25-3.65 to minimize likelihood of spontaneous in-vitro degradation. Hofmann elimination is not a biologic process as it is a spontaneous, non-enzymatic degradation at normal body temperature and pH. Atracurium has 4 isomeric centres, and hence there is a theoretical possibility of 16 stereoisomers but only 10 exist in commercial preparation. The onset of atracurium is similar to equipotent dose of vecuronium.

4. FTFTF

Atracurium is a bisquaternary diester benzylisoquinolinium non-depolarizing neuromuscular relaxant. Hofmann elimination produces more laundanosine. Atracurium is not metabolized by plasma cholinesterase and hence it is not contraindicated in patients with atypical pseudocholinesterase. The enzymatic degradation is accelerated by reduction in pH. Tachycardia following atracurium is not related to vagolysis.

5. TFTTT

Vecuronium is the 2-desmethyl analogue of pancuronium. At physiologic pH, tertiary amine is largely protonated and it becomes bisquaternary at pH 7.4.

Multiple Choices Questions