**MEDICALLY CHALLENGING CASES**
**FUNDAMENTALS OF ANESTHESIOLOGY**

Saturday, October 13, 2012
11:00 AM - 12:30 PM
MC110
**Airway Management for an Unusual Cause of Supraglottic Stenosis**
*Christopher Cropsey, M.D., Roy Neeley, M.D., Vanderbilt University, Nashville, TN.*
A 34 year-old male with a history of sickle cell disease, myasthenia gravis, and deep vein thrombosis presented to the emergency department with a complaint of lower extremity pain and throat tightening. Following initial treatment for suspected vaso-occlusive crisis, the patient had decreasing oxygen saturation and obtundation with the onset of stridor. Plain films of the neck revealed soft tissue edema and anesthesia was consulted urgently to secure the airway. Flexible fiberoptic bronchoscopy revealed significant supraglottic edema without erythema. Following intubation, CT of the neck revealed acute vasogenic edema due to thrombosis of his bilateral internal jugular veins.

Saturday, October 13, 2012
11:00 AM - 12:30 PM
MC111
**Orthotopic Liver Transplant Complicated by Massive Blood Loss and Tachyarrhythmia**
*Christopher Cropsey, M.D., Amy Robertson, M.D., Vanderbilt University, Nashville, TN.*
A 58 year-old male with a history of orthotopic liver transplant, cryptogenic cirrhosis, and cyclosporine-induced renal failure presented for kidney and repeated liver transplant. The dissection phase of the case was complicated by hyperkalemia-induced tachyarrhythmia and extreme blood loss. Veno-venous bypass was urgently initiated. Following reperfusion, the patient continued to have tremendous blood loss and hemodynamic instability which could only be ameliorated by sustained massive transfusion. The patient received a combined total of greater than 100 liters of blood products including both allogenic and autogenous transfusion. He expired on post-operative day 16.

Saturday, October 13, 2012
11:00 AM - 12:30 PM
MC112
**Re-do Sternotomy for Resection of Malignant Mediastinal Nerve Sheath Tumor**
*Major Cunningham, M.D., David Wild, M.D., Anesthesiology, Saint Louis University, Saint Louis, MO.*
Patient is a 59 year-old man with a history of neurofibromatosis type I and worsening stridor diagnosed with recurrent mediastinal nerve-sheath tumor. The patient was taken to the operating room and underwent awake-fiberoptic endotracheal intubation. The surgeons were able to dissect around most of the tumor; however, the left border of the mass completely encompassed the left subclavian artery and


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was intimately attached to the left carotid artery. The surgeons determined it was not safe to attempt a complete resection and instead chose to debulk the majority of the tumor. The operation was completed without complications.

Saturday, October 13, 2012
11:00 AM - 12:30 PM
MC113

**Anesthetic Management of a Patient With Concurrent Mediastinal Masses and Increased Intracrainal Pressure**

*Nishita S. Dalal, Dominika James, M.D., Anesthesiology, University of North Carolina, Chapel Hill, NC.*

53 year-old female presented to OSH with AMS and increased ICP. Brain and body CT showed multiple brain lesions, lung mass involving entire LUL, and mediastinal mass. She was transferred to UNC for bone lesion biopsy and IM nailing of femur fracture. Our challenge was to determine the safest method of airway management in the setting of concurrent mediastinal mass presence and increased ICP. We also considered whether the risks of neuraxial anesthesia in the setting of increased ICP outweighed the risks general anesthesia in a patient with a mediastinal mass.

Saturday, October 13, 2012
11:00 AM - 12:30 PM
MC114

**Methemoglobinemia After an Awake Fiberoptic Intubation**

*Jennifer Danielsson, Eric J. Heyer, M.D.,Ph.D., Anesthesiology, Columbia University Medical Center, New York, NY.*

67 year-old female presented for anterior cervical decompression and fusion. An awake fiberoptic intubation was performed with cetacaine spray bilateral to posterior pharynx for 2 seconds, lidocaine 2% jelly on posterior pharynx with tongue depressor, and transtracheal block with 3ml 4% lidocaine. Patient intubated and placed on 100% oxygen, but oxygen saturation remained 85-90% despite bilateral clear breath sounds and confirmation of ETT placement. Blood gas revealed a pO2 216 and an oxygen saturation of 95%. Diagnosis of methemoglobinemia suspected and co-oximeter profile revealed methemoglobin level of 18.2%. Patient was treated with methylene blue with no further complications.

Saturday, October 13, 2012
11:00 AM - 12:30 PM
MC115

**Left Double Lumen in the Right Place**

*Tiffany Denepitiya-Balicki, M.D., Anesthesiology, Yale, Hamden, CT.*

An 80 year-old female s/p left lobectomy with 80% perfusion to the right lung presented for right upper lobectomy. A L-DLT was placed to purposefully occlude the RUL and thereby ventilating remaining lobes. Lung isolation was achieved and right upper lobectomy was performed. The case was uneventful, however at emergence the patient failed extubation. She was reintubated and later extubated in the SICU. While this unique approach to one lung ventilation worked well, it is not used often. Subsequent echocardiography revealed pulmonary hypertension which was unknown at the time of presentation and partially explains this patient's post-operative respiratory failure.



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Saturday, October 13, 2012
11:00 AM - 12:30 PM
MC116

**Hypoperfusion-Induced Tracheal Sloughing Complicated by Post Intubation Tracheal Stenosis in a Post-Partum Cardiomyopathy Patient**

*Armin F. Deroee, M.D., Basem Abdelmalak, M.D., Thomas Gildea, M.D., Michael Machuzak, M.D., John Doyle, M.D., Ph.D., Anesthesiology Institute, Cleveland Clinic Foundation, Cleveland, OH.*

38 year-old female whose pregnancy was complicated by severe pre-eclampsia and HELLP syndrome. After discharge , she developed orthopnea, dyspnea and edema and presented to the ED with severe hypoxemia. Post-partum cardiomyopathy was diagnosed and she was intubated for about 72 hours. A few days after extubation she developed worsening of dyspnea and finally stridor. Bronchoscopy revealed subglottic stenosis. During general anesthesia,ventilation was achieved through attaching the breathing circuit to the bronchoscope's side port. The necrotic area was debrided via cryotherapy and a flexible bronchoscope. The procedure lead to a patent trachea and improvement of the patient.

Saturday, October 13, 2012
11:00 AM - 12:30 PM
MC117

**Difficult Mask Ventilation Secondary to Epiglottic Mass**

*Neesha B. Dhanak, D.O., Hui Yuan, M.D., Robert Buchmann, M.D.,*
*Anesthesiology and Critical Care, Saint Louis University Hospital, Saint Louis, MO, Saint Louis University Hospital, Saint Louis, MO.*

A 57 year-old presented with an epiglottic mass which on bronchoscopy was significantly compromising the glottic opening. Clinically the patient showed no signs of respiratory distress. We proceeded with a conventional general anesthetic approach. After induction, mask ventilation proved difficult. Intubation however was successful on first attempt after succinylcholine. Here we examine the nature of our case and various independent predictors of impossible mask ventilation as well as clinical responses, recognizing that the anesthesiologist must be knowledgeable to respond appropriately no matter the pathway he or she chooses.

Saturday, October 13, 2012
11:00 AM - 12:30 PM
MC118

**The Anesthetic Management of a Patient With an Acute MI for Nonelective Orthopedic Surgery**

*Michael B. DiGiacomo, Steve Neustein, M.D., Anesthesiology, The Mount Sinai Medical Center, New York, NY.*

A 76 year-old woman with a history of multiple myeloma presented for repair of a pathologic fracture of the left femur. Her past medical history was significant for CAD with a documented NSTEMI 20 days ago. Cardiac catheterization revealed 100% occlusion of the mid LAD yet revascuralization was deferred based on the presence of collaterals. The patient's operative course included placement of a preinduction arterial line and utilization of both a pulmonary artery catheter and TEE for close hemodynamic monitoring. Surgery proceeded relatively uneventfully, and the patient was extubated the following day.



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Saturday, October 13, 2012
11:00 AM - 12:30 PM
MC119

**Anesthetic Challenges in a Jehovah's Witness Patient With Hemorrhagic Shock**

*Cora Dong, M.D., Duraiyah Thangathurai, M.D., Rodney McKeever, M.D., Department of Anesthesiology, University of Southern California, Keck School of Medicine, Los Angeles, CA.*

We present the case of a 21 year-old man who underwent emergent ex lap for multiple abdominal and orthopedic injuries after a motor vehicle collision. He was a Jehovah's Witness who refused blood products, even at the risk of death. Initial blood gas showed a hematocrit less than 15. Nitroglycerin drip and judicious infusion of crystalloids was exercised to minimize hemodilution and further drop in hematocrit. Controlled hypotension technique with SBP between 75-85 mmHg minimized further hemorrhage. We discuss the role of nitroglycerin to minimize bleeding, while also maintaining perfusion. The patient was transferred to ICU in stable condition.

Saturday, October 13, 2012
11:00 AM - 12:30 PM
MC120

**Anesthetic Management of a Large Substernal Goiter**

*Cora Dong, M.D., Tim O'Shaughnessey, M.D., Mary M. Joseph, M.D., Anesthesiology, LAC & USC Medical Center, Los Angeles, CA.*

A 58 year-old, 100Kg, 60 inch woman presented for a transcervical total thyroidectomy and possible sternotomy. She had a large substernal thyroid mass extending into the anterior mediastinum. The neck computerized tomography showed a large neck mass impinging on major vessels. The trachea was shifted to the right with 50-70% narrowing. The patient complained of shortness of breath when climbing stairs or while sleeping supine. An awake fiberoptic intubation was performed using size 7mm armored endotracheal tube. General anesthesia with ASA monitors and arterial line was uneventful. The patient was extubated in the OR and recovered satisfactorily.

Saturday, October 13, 2012
11:00 AM - 12:30 PM
MC121

**The Unexpected in Anesthesia: Complications Versus Error? Ischemic Wound Secondary to IV Infiltration**

*Alexander F. Bautista, Grant Doornbos, M.D., Aurel Neamtu, M.D.,Ph.D., Rana Latif, University of Louisville, Louisville, KY.*

Anesthesia involves some risks. However, major side effects and complications are uncommon. Unintentional injection or leakage of fluid in the perivascular space accounts for 10-30% of patients receiving IV therapy. We are presenting a 43 year-old male who underwent an 8-hour spine surgery with blood loss amounting to 2.3L. Intraoperative course required aggressive fluid and phenylephrine boluses which continued on in PACU where norepinephrine drip was infused through peripheral IV. A few hours after, patient complained of pain in the arm and notable discoloration was noted unresponsive to conservative management and subsequently requiring debridement and skin grafting.



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Saturday, October 13, 2012
11:00 AM - 12:30 PM
MC122

**Ischemic Optic Neuropathy: A Contraindication to Robotic Cases?**

*Nirali Doshi, Dalia Elmofty, University of Chicago, Chicago, IL.*

Ischemic optic neuropathy (ION) is the most common cause of postoperative visual loss (POVL) among cases with perioperative venous congestion. Surgeries that have shown to have POVL are spine, cardiac, trauma, and more recently prostatectomies. This case report describes a patient with anterior ION whose robotic-assisted laparoscopic prostatectomy (RALP) was cancelled for further perioperative work-up of the patient's ION. The patient instead had an open prostatectomy to avoid further vision loss. Given an increase in frequency and elevated risk of ION in robotic cases with steep trendelenberg positioning, a thorough preoperative evaluation is essential to minimize POVL.

Saturday, October 13, 2012
11:00 AM - 12:30 PM
MC123

**Anesthetic Challenges for Patient With Advanced Amyotrophic Lateral Sclerosis**

*Danielle Doyle, M.D., Ranita Donald, M.B.,B.S., John Blackburn, Anesthesiology, Georgia Health Sciences University, Augusta, GA.*

A 67 year-old male with history of amyotrophic lateral sclerosis (ALS or also known as Lou Gehrig's disease) with diffuse neuropathic abnormalities involving bulbar muscles on electromyogram and severe restrictive disease pattern on pulmonary function test, was scheduled for therapeutic esophagogastroduodenoscopy and laparoscopic gastrostomy tube placement under general anesthesia. Patient also had dysarthria, dysphagia, and shortness of breath at rest for which patient used C-PAP. Patient was managed successfully with general anesthesia. This case will highlight the problems associated with ALS patients and the challenges of this patient's anesthetic management.

Saturday, October 13, 2012
11:00 AM - 12:30 PM
MC124

**Aspiration in a Patient With Bowel Obstruction Status Postgastric Bypass Surgery**

*Jared Riehl, D.O., Stanlies D'Souza, Anesthesiology, Baystate Medical Center, Tufts University School of Medicine, Springfield, MA.*

50 year-old female who had Roux-en-Y gastric bypass ten years ago, presented for emergent exploratory laparotomy for acute small bowel obstruction. As per the surgeon's request a nasogastric tube was not placed prior to induction due to concerns about injury to the anastomosis and about not being able to effectively decompress the bowel secondary to the prior Roux-en-Y procedure. Patient aspirated during rapid sequence induction with cricoid pressure. Airway was secured with endotracheal tube, cricoid pressure was maintained and aspirate suctioned from the oropharynx and endotracheal tube prior to ventilation using fiberoptic bronchoscope. Patient subsequently developed aspiration pneumonitis and ARDS.



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Saturday, October 13, 2012
11:00 AM - 12:30 PM
MC125

**ACDF to ABCs: Airway Management in Expanding Neck Hematoma**

*Allison Dulaney, M.D., Melissa Laxton, M.D., Wake Forest University, Winston-Salem, NC.*

A 34 year-old male presented to the emergency department complaining of acute shortness of breath and neck fullness five days after undergoing an anterior cervical diskectomy and fusion. CT imaging showed a large retropharyngeal cervical hematoma with active extravasation, and displacement of the oropharyngeal structures. Anesthesia was consulted, and the patient was taken emergently to the OR for definitive airway management. An awake fiberoptic intubation was performed after gag and cough reflexes were ablated with nerve blockade. Anesthesia was induced, and the hematoma was removed. The patient was transported in stable condition to the ICU and was extubated the following day.

Saturday, October 13, 2012
11:00 AM - 12:30 PM
MC126

**Anesthetic Considerations for Endo-Bronchial Valves (Ebvs) Placement to Treat Broncho-Pleural Fistula: How Do You Coordinate With the Pulmonogist for a Successful Outcome?**

*Ahmad Elsharydah, M.D., Bettina Barr, M.D., Department of Anesthesiology and Pain Management, UT Southwestern Medical Center, Dallas, TX.*

A 70 year-old M with lung CA, CAD, DM and Emphysema, admitted for a robotic assisted thoracotomy for RUL mass. His surgery with complicated with PA bleeding lead to conversion to open thoracotomy to complete the lobectomy and control the bleeding. Post-op course was complicated with broncho-pleural fistula. He was referred for one way endobronchial valve (EBV) placement. Full coordination between the anesthesiologist and the pulmonogist required for successful placement of these valves. Three valves were placed using flexible bronchoscope. This led to significant decrease in the leak. On his first post-operative visit, patient was feeling good with some DOE.

Saturday, October 13, 2012
11:00 AM - 12:30 PM
MC127

**Perioperative Transient Left Bundle Branch Block**

*Kelly Elterman, M.D., Richard Urman, M.D.,M.B.A., Anesthesiology, Perioperative and Pain Medicine, Brigham and Women's Hospital, Boston, MA.*

Transient LBBB in the setting of physical exertion is a known phenomenon in patients with and without CAD. 64 year-old woman without CAD underwent Nissen fundoplication. Preoperatively, an exercise-tolerance test revealed LBBB without EKG changes or ischemic symptoms. Intra-operatively, patient remained in NSR, without LBBB. In PACU, LBBB appeared suddenly in a previously-normal EKG. Patient denied ischemic symptoms, and described previous similar episodes. Cardiac enzymes were negative. Subsequent EKGs revealed persistence of LBBB. Remainder of hospital course was uneventful. Anesthesiologists should be aware of the possibility of transient LBBB in the absence of cardiac ischemia in the perioperative period.



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Saturday, October 13, 2012
11:00 AM - 12:30 PM
MC128

**Use of Proseal Laryngeal Mask Airway in a High Risk Patient for Urgent Vascular Surgery**

*Obinna C. Emechebe, M.D., M. Iqbal Ahmed, M.D., Anesthesiology, Tufts Medical Center, Boston, MA.*

The risk of perioperative re-infarction with general anesthesia in patients with myocardial infarction (MI) has been shown to be reduced when surgery is delayed for at least eight weeks and the patient is medically optimized on beta blocker therapy, HMG-CoA reductase inhibitor and glucose control. Previous studies have reported re-infarction rates of 32.8% within a month, 18.7% within two months and 8.4% within three months of an MI. We present a case report of the use of a Proseal laryngeal mask airway (LMA) in a patient with a history of MI six weeks prior to urgent vascular surgery.

Saturday, October 13, 2012
11:00 AM - 12:30 PM
MC129

**Perioperative Management of a Patient With Von Willebrand's Disease and Anaphylaxis to Factor VIII-vWF Concentrate**

*Mark Erickson, M.D., Naeem Bhatti, M.D., Anesthesiology, Wake Forest University, Winston Salem, NC.*

An 80 year-old man presented for repair of a right hypogastric artery aneurysm. His past medical history was significant for several comorbidities including von Willebrand's disease 2N subtype and a prior history of anaphylaxis to Factor VIII-vWF concentrate. A hematology consult was obtained and on the evening prior to surgery and the patient received 2 units of cryoprecipitate in the hours preceding surgery. Intraoperatively, adequate hemostasis was achieved with administration of DDAVP and an additional 3 units of cryoprecipitate. The patient required several additional doses of DDAVP for continued postoperative bleeding, but no additional cryoprecipitate was administered.

Saturday, October 13, 2012
11:00 AM - 12:30 PM
MC130

**Combined Glidescope and Fiberoptic Scope Technique in Intraoperative Emergency Airway Management in Patient Undergoing LeFort I Procedure**

*Michael F. Esposito, M.D., Stephen Small, M.D., Anesthesia and Critical Care, University of Chicago Medical Center, Chicago, IL.*

Intraoperative airway emergency is a concern for any patient, but especially for the patient with a known difficult airway and surgery of the head and neck. This presentation highlights the case of a 52-year-old female undergoing general anesthesia for a LeFort I osteotomy. When clinical signs were highly suspicious for a compromised endotracheal tube, the anesthesia team utilized a combined Glidescope video laryngoscope and flexible fiberoptic bronchoscope technique to re-secure the airway.

Saturday, October 13, 2012
11:00 AM - 12:30 PM
**MC131**

**Airway Management in a Morbidly Obese Subject With a Large Goiter With Intrathoracic Extension and Tracheal Compression**

*Daria F. Flores, Suman Rajagopalan, M.D., Anesthesiology, Baylor College of Medicine, Houston, TX.*

Large thyroid masses causing compression and deviation of the trachea are known causes of difficult intubation. We report a 67 year-old morbidly obese female with hyperthyroid goiter and dyspnea in supine position who presented for total thyroidectomy. She had a massive goiter 13.5 x 8x 14.2



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centimeters extending from the level of hyoid to the anterior mediastinum causing tracheal compression, deviation, and tracheomalacia. Surgical airway was not an option given the size and extent of the tumor. Awake fiberoptic intubation was the only viable option. Fiberoptic intubation was successfully performed despite of the distorted anatomy of the larynx and upper trachea.

Saturday, October 13, 2012
11:00 AM - 12:30 PM
MC132

**Intubating LMA Exchange With Eschmann Stylet Bougie for Standard TT in Trendelenburg Position**

*Daria F. Flores, M.D., Ashutosh Wali, M.D., Anesthesiology, Baylor College of Medicine, Houston, TX.*

Intraoperative endotracheal tube (ETT) exchanges can pose difficulties, especially if patients are in Trendelenburg position. We report a healthy 20-year-old female who presented for ovarian laparoscopic cystectomy. An intubating LMA (Fastrach) was introduced into oropharynx and exchanged for a 7.0 millimeter wire-reinforced ETT. With the patient in Trendelenburg position for surgical facilitation, tidal volumes decreased and a leak was heard around the ETT cuff. Eschmann stylet bougie with coude tip was passed though the ETT to facilitate a successful exchange for a new 7.0 cuffed ETT. The exchange was achieved without complication and did not require disturbance of surgical positioning.

Saturday, October 13, 2012
11:00 AM - 12:30 PM
MC133

**Difficult Airway Following Penetrating Trauma to Posterior Cervical Spine**

*Marc D. Galland, D.O., Tilak Raj, M.D., Roxie M. Albrecht, M.D., Anesthesiology, Surgery, University of Oklahoma Health Sciences Center, Oklahoma City, OK.*

We present a 70 year-old patient brought to the ER with a penetrating wound to the posterior neck resulting from a 12 inch knife. Patient had a Philadelphia C collar placed in the field by EMSA, and was receiving supplemental oxygen via a simple facemask. Securing the patient's airway was a challenge with the C collar in place and the knife still being embedded in his posterior neck interfering with optimizing the 'sniffing' position for intubation. We discuss with pictures the traumas that can interfere with the airway and the means available to manage them.

Saturday, October 13, 2012
11:00 AM - 12:30 PM
MC134

**A Case of Prolonged Apnea Following Prosratectomy Surgery**

*Andrew Fine, M.D., John Young, M.D., Raghuvender Ganta, M.D., Anesthesiology, OU Medical Center/VAMC, Oklahoma City, OK.*

An 80 year-old male was scheduled for elective prostatectomy. His present history iincluded of hypertension and hiatal henia. He was on Lisinopril for control of Hypertension. Induction of anesthesia was uneventful. He had rapid sequence induction and paralysed with succinyl choline 80 mg and intubated uneventfully.He was paralysed with 6mg of cisatracurium for further management. Post-operatively he was apneic for 10 hrs and ventilated electively and sedated with propofol.. His pseudocholine-esterase levels were low and also Dibucaine no. was 28.This patient was not only homozygous (qualitative) type but also quantitative. Post-operatively he was extubated and recovered safely.



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Saturday, October 13, 2012
11:00 AM - 12:30 PM
MC135

**Management of Three Patients With Severe Aortic Stenosis and Acute Femoral Neck Fracture**

*Chandrika Garner, Sivasenthil Arumugam, M.D., Anesthesiology, University of Connecticut, Farmington, CT, Anesthesiology, St. Francis Hospital, Hartford, CT.*

Severe aortic stenosis carries a significant risk for patients undergoing non-cardiac surgery. We describe three patients with severe aortic stenosis presenting with acute femoral neck fracture. Each patient had different comorbidities and was therefore managed differently in preparation for femoral neck repair. One patient had aortic valve replacement prior to orthopedic surgery. The other patients had ORIF of the femur with medical management of valvular disease. All three patients were discharged from the hospital within a week of the procedure.

Saturday, October 13, 2012
11:00 AM - 12:30 PM
MC136

**Vocal Cord Neoplasm: Management of an Unanticipated Difficult Airway for Emergent Surgery**

*Jeffrey Gerritsen, Amanda Burden, M.D., Keyur C. Trivedi, M.D., Dean A. Drezner, M.D., Department of Anesthesiology, Department of Otolaryngology, Cooper University Hospital, Camden, NJ.*

A 63 year-old male smoker with mild hoarseness presented for an emergent exploration and arteriogram following a gunshot wound to the right arm. General anesthesia was induced with a rapid sequence technique. Despite a grade 2 view, intubation attempts failed and ventilation by mask and LMA could not be achieved. A surgical airway was established via cricothyroidotomy. Subsequent evaluation by the otolaryngologist revealed laryngeal edema, vocal cord leukoplakia, and a vocal cord neoplasm consistent with granular cell tumor. The patient was later decannulated successfully. This case demonstrates successful use of the difficult airway algorithm.

Saturday, October 13, 2012
11:00 AM - 12:30 PM
MC137

**Unexpected Malignant Hyperthermia in a Trauma Patient**

*Ramsis F. Ghaly, M.D., Scott Klier, D.O., N. Nick Knezevic, Kenneth D. Candido, M.D., Anesthesiology, Advocate Illinois Masonic Medical Center, Chicago, IL.*

A healthy 20 year-old male presented for exploratory laparotomy after an automobile accident. Anesthesia was induced with lidocaine 80mg, fentanyl 100mcg, propofol 180mg, and succinylcholine 100mg and maintained with desflurane and rocuronium. One-hour later, the patient developed a rapid increase in end-tidal$CO_2$ to 60mmHg that did not improve with increasing RR and TV. Patient's temperature increased to 38.8°C despite discontinuation of external-heating devices. ABG revealed a pH of 7.29. Desflurane was discontinued, infusions of propofol and remifentanyl were started, and 2mg/kg of dantrolene was given, along with 100% oxygen. Rapid recognition and initiation of appropriate treatment is essential in these patients.



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Saturday, October 13, 2012
11:00 AM - 12:30 PM
MC138

**Management of Anaphylaxis Prior to Emergent Surgery**

*Sheryl Glassman, D.O., Mario Gonzalez, D.O., Hahnemann University Hospital, Philadelphia, PA.*

Neuromuscular blocking drugs are well known causes of intraoperative anaphylaxis.1 When faced with a potentially life threatening event, such as anaphylaxis, the anesthesiologist must make a critical decision in a short period of time. This case discusses a practical approach to anaphylaxis in the operating room in a patient who received an emergent orthotopic liver transplantation and his successful outcome.

Saturday, October 13, 2012
11:00 AM - 12:30 PM
MC139

**Cerebral Fat Embolism Syndrome Following a Gun Shot Wound to the Foot**

*Stephen J. Gleich, M.D., James D. Hannon, M.D., Department of Anesthesiology, Mayo Clinic, Rochester, MN.*

A 42 year-old male sustained an accidental rifle gunshot wound to his left foot, resulting in fracture deformities of the calcaneus, navicular, cuneiform, 1 and 2 metatarsal bases, and talus. As he was transported to our trauma center, he developed progressive encephalopathy. Urgent external fixator placement under general anesthesia was postponed due to his encephalopathy of unknown etiology. Brain magnetic resonance imaging demonstrated a “starfield” pattern of infarcts, consistent with cerebral fat embolism syndrome. Subsequently, he underwent uneventful general anesthesia. The patient was managed supportively and continued to have persistent neurologic dysfunction two months after injury.

Saturday, October 13, 2012
11:00 AM - 12:30 PM
MC140

**Quadriplegia Secondary to Epidural Abscess in a Morbidly Obese Patient**

Caron Hong, Nicholas Goehner, M.D., Anesthesiology and Critical Care Medicine, University of Maryland School of Medicine, Baltimore, MD.

A 34 year-old male with morbid obesity (210kg), hypertension, poorly controlled diabetes, coronary artery disease and chronic decubitus ulcers. Presented with bilateral lower extremity weakness progressing to paraplegia and burning pain from the nipple line to his feet for over 24 hours. There was a delay in diagnosis and surgical treatment secondary to transfer to radiology facility for open MRI to accommodate body habitus. He was transfer to tertiary medical center. MRI demonstrated a large thoracolumbar epidural abscess with spinal cord edema. After an emergent multilevel thoracolumbar decompressive laminectomy, he remains paraplegic.

Saturday, October 13, 2012
11:00 AM - 12:30 PM
MC141

**Why Me? The Case of the Patient With BMI of 60+, a Small Tracheostomy Tube, Severe Asthma, and a Leaky Esophagus in an Off-Site Location Late in the Afternoon**

*Tammara S. Goldschmidt, M.D., Anil Ladhani, M.D., Pilar Mercado, M.D., Anesthesiology, University of Illinois, Chicago, IL.*

A 39 year-old woman with a BMI of 62 is scheduled for esophageal stent exchange in the GI suite. She has h/o recent gastric sleeve procedure complicated by an esophageal leak and heparin drip for LE DVT,



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PMH of asthma (multiple intubations resulting in severe tracheomalacia and tracheostomy tube placement), h/o heroin abuse, NIDDM, super morbid obesity, anxiety and chronic pain condition requiring a ketamine drip and other modalities. During the gastric sleeve procedure, she was noted to be "difficult to ventilate." On physical exam she has a capped size 4 flexible tracheostomy tube, is wheezing, and exclaims, "Why me?"

Saturday, October 13, 2012
11:00 AM - 12:30 PM
MC142
**Anesthetic Management of the Difficult Airway Requiring One Lung Ventilation and Post Extubation Stridor**
*Emily Goodwin, University of Connecticut, Farmington, CT.*
31 year-old female with PMH thyroid goiter s/p subtotal thyroidectomy, presented for right thoractomy for removal of 7.7x8.6x12.1cm mass involving thoracic cavity, extending into base of neck, compressing trachea to 6 mm. Surgical resection requires one-lung ventilation. Management included awake fiberoptic intubation with 35F left DLT after airway topicalization and versed/fentanyl. Perioperative course involved significant post-extubation stridor without respiratory distress, improved with racemic epinephrine/steroids but persisted while sleeping. Patient was discharged POD#7, but had persistent change in voice and upper-airway obstruction with sleep. EMG diagnosed unilateral superior and recurrent laryngeal nerve paresis. Poster will include CT and gross/histopathology images.

Saturday, October 13, 2012
2:30 PM - 4:00 PM
MC182
Anesthetic Considerations for Retrieval of Tracheoesophageal Prosthesis Following Aspiration
**Adam W. Green, M.D., Daniel C. Sizemore, M.D., Anesthesiology, West Virginia University, Morgantown, WV.**
A 58 year-old male with a history of laryngeal cancer and total laryngectomy presented with increasing respiratory distress. After evaluation with flexible laryngoscopy, a foreign body was identified in the right lower bronchus. The patient was taken to the operating room for removal of a foreign body which was identified as a tracheoesophageal prosthesis. Foreign body aspiration can present with a multitude of symptoms with varying degrees of severity. We will discuss the anesthetic concerns for all patients with foreign body aspiration and the unique presentation and treatment plan for aspiration in this patient with a history of laryngectomy.

Saturday, October 13, 2012
2:30 PM - 4:00 PM
MC183
**Anesthetic Management for an Intratracheal Mass With Severe Airway Obstruction**
*Adam W. Green, M.D., Arpan Kohli, M.D., Lance Parks, D.O., Anesthesiology, West Virginia University, Morgantown, WV.*
An intratracheal mass not only presents challenges to the anesthesiologist but also can quickly become life-threatening. We present the case of a 25-yo morbidly obese female with a near complete obstruction of the trachea from tumor recurrence. She had a past medical history significant for granulosa tumor of the lung, previously treated with chemotherapy, YAG-laser, and tracheal stent placement due to stricture. The patient was urgently taken to the operating room for laser photocoagulation, at which point it was also noticed that the tracheal stent was mobile. We will discuss the anesthetic management and unique challenges posed by this case.


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Saturday, October 13, 2012
2:30 PM - 4:00 PM
MC184

**Heat and Moisture Exchanger (HME) Occlusion: A Rare Cause of Sudden Increased Airway Pressures and Difficulties in Ventilation**

*Shaun E. Gruenbaum, M.D., Kristin L. Richards, M.D., Jeffrey J. Schwartz, M.D., Department of Anesthesiology, Yale University School of Medicine, New Haven, CT.*

A 56 year-old lady presented for lower extremity bypass graft surgery under general anesthesia. 12 hours after incision, the patient experienced a sudden increase in peak airway pressures from 27 to 41mmHg, decreased tidal volumes from 500 to 70cc, and a desaturation from 100 to 85%. The patient was immediately taken off the ventilator, aggressively suctioned, and a bronchodilator was administered without improvement. The endotracheal tube was then disconnected, and a large amount of moisture was expelled from the HME upon squeezing the reservoir bag. The patient was easily ventilated thereafter and her saturation increased to 100%.

Saturday, October 13, 2012
2:30 PM - 4:00 PM
MC185

**Successful Use of Combination Therapy With Factor VIII Bypassing Agents in a Hemophiliac Patient With Inhibitors Undergoing Surgery**

*Jayakar Guruswamy, M.D., Christina Fidkowski, M.D., Anesthesiology, Henry Ford Hospital, Detroit, MI.*

Development of inhibitors is one of the most serious complications of haemophilia. Bleeding episodes in patients with inhibitors are refractory to Factor VIII (FVIII) replacement necessitating the administration of FVIII bypassing agents, which include recombinant activated Factor VII (Novoseven) and activated prothrombin complex concentrates (FEIBA). While individual therapy with these agents is common in the management of bleeding episodes, their combined use is uncommon. We report a case of 44 year-old male with severe haemophilia with inhibitors, who underwent left shoulder hemiarthroplasty. Combined therapy with both Novoseven and FEIBA was used perioperatively with minimal bleeding and no adverse effects.

Saturday, October 13, 2012
2:30 PM - 4:00 PM
MC186

**Perioperative Supine Hypotension Syndrome Secondary to Intraabdominal Mass**

*Roger K. Haddad, D.O., Murali S. Patri, M.D.,F.R.C.A, Dragos Galusca, M.D., Anesthesia, Henry Ford Health System, Detroit, MI.*

55 year-old lady with history of coronary artery disease, hypertension, emphysema, deep vein thrombosis who presented for resection of a large intra-abdominal mass. On two separate perioperative occasions, patient experienced hemodynamic instability including symptomatic bradycardia and nonsustained ventricular tachycardia. Management included antiarrhythmics and cardiology evaluation which did not reveal any cardiac abnormality. Upon return to operating room the third time, the patient was hypotensive and bradycardic requiring vasoactive agents, fluids, and electrolyte replacement until mass was resected. Once the tumor was removed, patient regained hemodynamic stability. The hemodynamics were probably attributable to aortocaval compression and resulting supine hypotension syndrome.



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Saturday, October 13, 2012
2:30 PM - 4:00 PM
MC187

**Unanticipated Laryngeal Papillomatosis Obstructing the Airway**

*Keith Haller, D.O., Franco Resta-Flarer, M.D., Anesthesiology, St. Lukes Roosevelt, New York, NY.*

44 year-old female with hoarseness scheduled for Hysterectomy. Fiberoptic bronchoscopy revealed a large pedunculated mass in the airway. Surgery postponed pending ENT evaluation. Nasopharyngeal endoscopy revealed papillomatosis obstructing the glottis. Case rescheduled for laryngeal debridement and hysterectomy. Glidescope intubation performed with 4.5 ETT. Following debridement and under laryngeal suspension, a Cook catheter was placed adjacent to the 4.5 ETT. 6 ETT was placed over tube exchanger and advanced into airway after removal of 4.5 ETT. ETCO2 confirmed with exchanger in place by feeding proximal portion of exchanger into breathing circuit. Patient underwent uneventful hysterectomy and extubated in the OR.

Saturday, October 13, 2012
2:30 PM - 4:00 PM
MC188

**Case Presentation: Takotsubo's Cardiomyopathy**

*Ashley Hambright, M.D., Robert Craft, M.D., Anesthesiology, University of Tennessee- Knoxville, Knoxville, TN.*

67 year-old male with history of coronary artery disease, atrial fibrillation, and obstructive sleep apnea presented for multilevel anterior cervical discectomy and fusion. Ten minutes after IV induction ACLS protocol initiated for pulseless electrical activiy. ECG revealed atrial flutter, septal infarct, ST elevations in anterior leads. After cardiac catheterization, Takotsubo's cardiomyopathy was believed to be the cause of his decline. Echocardiogram the following day revealed systolic function returned to baseline and he was discharged on hospital day 4. He represented 1 week later with an uneventful anesthetic course, monitored in ICU overnight, and discharged the following day.

Saturday, October 13, 2012
2:30 PM - 4:00 PM
MC189

**Hyperoxalosis in Orthotopic Liver Transplant**

*Malik Hamid, M.D., Kim Reetz, M.D., Anesthesiology, University of Kansas Medical Center, Kansas City, KS.*

We present a case of a patient with primary hyperoxaluria presenting for combined liver/kidney transplant. Primary hyperoxaluria is an autosomal recessive disorder characterized by oxalate accumulation in the body leading to cardiac, renal and hepatic morbidity. Patients may present for combined kidney and liver transplant. The other manifestations of hyperoxaluria may complicate their perioperative course. Cardiac complications can lead to significant morbidity and death, as occurred in this case.

Saturday, October 13, 2012
2:30 PM - 4:00 PM
MC190

**Hereditary Angioedema--Prophylaxis Can Help Prevent Acute Attacks With Intubation**

*Lisa Hammond, M.D., Richard Urman, M.D., Brigham and Women's Hospital, Boston, MA.*

Avoidance of acute attacks can be life-saving in patients with hereditary angioedema (HAE) who may experience angioedema refractory to traditional antihistamine and steroid rescue therapies.



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Prophylactic cinryze can prevent acute attacks from airway manipulation in these patients. A 30F with prior attacks of HAE underwent diagnostic laparoscopy. She was premedicated with 1000U of cinryze one hour prior to intubation. A 7.0 ETT was placed with direct laryngoscopy and cricoid pressure. The patient was extubated at the conclusion of surgery with a positive cuff leak. Post-operative course was uneventful. Anesthesiologists should understand the potential benefit of prophylactic cinryze in HAE patients.

Saturday, October 13, 2012
2:30 PM - 4:00 PM
MC191

**Managing Difficult Airway in Patients With Postburn Mentosternal and Circumoral Scar Contractures**

*Anthony T. Han, Joshua Gaines, Quynh Nguyen, Department of Anesthesiology, Paul L. Foster School of Medicine, Texas Tech University Health Sciences Center, El Paso, TX.*

Many airway techniques have been effectively used in burn patients, but the role of awake blind or fiberoptic bronchoscopy, although well established in the non-burn population, has yet to be evaluated in burn patients. We report a case series of successful management of difficult airways with fiberoptic bronchoscopy in patients with varying degrees of postburn head and neck scar contractures.

Saturday, October 13, 2012
2:30 PM - 4:00 PM
MC192

**The Impact of Nitroglycerine and Perfusion on Oxymetry During a Major Urologic Surgery**

*Mark W. Haney, M.D., M.S., Mariana Mogos, M.D., Peter Roffey, M.D., Duraiyah Thangathurai, M.D., Anesthesiology, University of Southern California, Los Angeles, CA.*

A 55 year-old male with a level II inferior vena cava (IVC) thrombosis was managed with high dose nitroglycerine to provide an improved surgical field. With this management perfusion, as determined by central venous saturations, was measured against a four channel Equanox™ 7600 regional oxymeter for continuous monitoring of tissue perfusion. As a result, the surgical field was optimized and the patient remained hemodynamically stable and did not require blood transfusions.

Saturday, October 13, 2012
2:30 PM - 4:00 PM
MC193

**Odontectomy in a Patient With Stone Man Syndrome**

*Jeffrey W. Hanson, M.D., Brian A. Hall, M.D., Anesthesiology, Mayo Clinic, Rochester, MN.*

Fibrodysplasia ossificans progressiva (FOP) is a very rare genetic disorder leading to heterotopic bone formation and progressive ossification of connective tissue. These patients present unique challenges to the anesthesiologist which include: difficult airway due to limited cervical neck extension and limited mouth opening, positioning issues due to joint immobility, and need for limitation of tissue trauma from venous or arterial cannulation or local anesthetic infiltration. We describe the anesthetic management of a 54 year-old male with FOP undergoing odontectomy of remaining teeth.



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Saturday, October 13, 2012
2:30 PM - 4:00 PM
MC194

**Encountering Sudden Increased Airway Pressures Intraoperatively**

*Ziyad M. Haque, Anesthesiology, St. Luke's-Roosevelt Hospital, New York, NY.*

A 61 year-old man with GERD and mild asthma presented for revision ventral herniorrhaphy. Prior anesthetics were unremarkable. Ten minutes following induction of general anesthesia and LMA placement, increased airway pressures, wheezing and desaturation suddenly occurred. A small amount of gastric secretions were noted in the LMA bowl, suggesting aspiration. However, following endotracheal intubation, flexible bronchoscopy was normal. Due to associated hypotension refractory to phenylephrine, anaphylaxis was considered, and after repeated epinephrine boluses, cardiopulmonary status improved. A serum tryptase of 90 ng/mL drawn immediately after resuscitation confirmed the diagnosis. The patient was extubated 15 hours later, recovering uneventfully.

Saturday, October 13, 2012
2:30 PM - 4:00 PM
MC195

**Anesthetic Considerations for a Transoral Robotic Tonsillectomy**

*Nazish K. Hashmi, Esamelden S. Abdelnaem, M.D., Mohamed Ismaeil, M.D., Anesthesiology, University of Arkansas for Medical Sciences, Little Rock, AR.*

A 64 year-old woman underwent a robotic tonsillectomy for carcinoma of the right tonsil. General anesthesia was induced using propofol. Her airway was secured with an oral endotracheal tube placed under direct laryngoscopy. Eyes were covered with plastic goggles and the table was rotated 180 degrees. Paralysis was maintained using rocuronium prior to insertion of a mouth gag. Anesthesia was maintained with sevoflurane. The operation proceeded without any complications. Dexamthasone was given at the outset. At the end, she had minimal airway edema and was successfully extubated. We present the anesthetic challenges for a transoral robotic surgery.

Saturday, October 13, 2012
2:30 PM - 4:00 PM
MC196

**Postoperative Myocardial Infarction in a Patient With Known Multivessel Coronary Artery Disease Undergoing Hepatic Segmental Resection for Metastatic Colorectal Cancer: Should Revascularization Have Preceeded Resection?**

*Nazish K. Hashmi, M.D., Sabina A. Khan, M.D., Victor Mandoff, M.D., Anesthesiology, University of Arkansas for Medical Sciences, Little Rock, AR.*

A 79 year-old female with metastatic colorectal adenocarcinoma presented for hepatic resection of metastases to the liver. She was recently diagnosed with three vessel coronary artery disease (CAD) on left heart catheterization. Cardiology recommended a three vessel CABG. The patient elected to proceed with hepatic resection prior to revascularization due to poor six month survival from her malignancy. Her intraoperative course was unremarkable. Postoperatively, she developed hypotension and tachycardia, which precipitated an MI. She developed cardiogenic shock and died within 36 hours. The decision to proceed with non cardiac surgery in the presence of three vessel CAD was debated.



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Saturday, October 13, 2012
2:30 PM - 4:00 PM
MC197

**Use of Inhaled Nitric Oxide for One Lung Ventilation on a Patient With Severe Pulmonary Hypertension**

*Rachel L. Helle, D.O., Melanie B. McMurry, M.D., Anesthesiology, University of Missouri-Columbia, Columbia, MO.*

A 71 year-old Caucasian male with severe pulmonary hypertension, RA pressures 94/33, presented for resection of primary pulmonary malignancy. General Anesthesia was induced, inhaled NO initiated and one lung ventilation was established. Fi02 was maintained at 1.0, hemodynamic support was provided with norepinephrine. Judicious fluid administration allowed maintenance of euvolemia. Acidosis was treated with hyperventilation and THAM. Upon emergence from general anesthesia, our patient was extubated, however, required reintubation for hypoxia prior to leaving the OR. Post-operative pain was controlled through a thoracic epidural. He underwent an otherwise uneventful post-operative course and was discharged on POD 10.

Saturday, October 13, 2012
2:30 PM - 4:00 PM
MC198

**Airway Management in the Setting of a Traumatic Cricoid Fracture With Exposed Arytenoid Cartilage and Neck Hematoma**

*Jenna Helmer Sobey, M.D., Amy Robertson, M.D., Anesthesiology, Vanderbilt University Hospital, Nashville, TN.*

21 year-old s/p ATV accident with laceration of anterior neck from clothesline injury. Presented w/ hoarseness, displaced cricoid fracture, compromised airway, neck hematoma, exposed right arytenoid cartilage, C4-5 ligamentum flavum injury requiring c-collar and junctional escape rhythm with prolonged QT syndrome. Taken for emergent stabilization of airway, tracheostomy, repair of cricoid fracture, hematoma evacuation, laryngoscopy. Required awake intubation utilizing topical lidocaine to oropharynx and nebulized lidocaine preoperatively. Zoll pads placed preoperatively. Dexmetatomodine bolus and infusion used for awake intubation utilizing fiberoptic scope. Severe cord edema required 5.0 ETT. Tracheostomy then placed by ENT team and further repair of injuries performed.

Saturday, October 13, 2012
2:30 PM - 4:00 PM
MC199

**Case Report: Anterior Mediastinal Mass Complicated by Airway Obstruction and Severe Superior Vena Cava Syndrome**

*Jeremy L. Hensley, M.D., Colin Wilson, M.D., Department of Anesthesiology, West Virginia University Hospitals, Morgantown, WV.*

A 60 year-old female was referred to our center for evaluation of a paratracheal mass. She described swelling of her face, neck, and right upper extremity associated with increased dyspnea. CT scan revealed 5 cm rounded right paratracheal and pretracheal mass lesion. She was taken to the operating room for mediastinoscopy. In the operating room the patient was unable to tolerate lying flat due to airway obstruction and need for venous drainage. She was intubated with an awake fiberoptic technique in the sitting position. Here, we will discuss the anesthetic implications, including airway management, of anterior mediastinal mass and SVC syndrome.



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Saturday, October 13, 2012
2:30 PM - 4:00 PM
MC200

**Difficult Ventilation After Pneumonectomy**

*Kellie Park, M.D.,Ph.D., Sarah Herbst, M.D., Jeffrey Schwartz, M.D., Anesthesiology, Yale University, New Haven, CT.*

A 57 year-old male with history of small cell lung cancer, POD 11 from pneumonectomy complicated post-operatively by small bowel ischemia, went to the OR for exploratory laparotomy with a double-lumen tube (DLT) *in situ* to avoid stump damage. Intraoperatively, he became difficult to ventilate and oxygenate. Peak airway pressures and end-tidal $CO_2$ rose and $O_2$ saturation dropped. Suctioning the DLT temporarily improved these parameters, but bronchoscopy was required for further assessment after difficulty resumed. Bronchoscopy revealed intraoperative mucus plugging. Ultimately, we exchanged the DLT for a single-lumen endotracheal tube and altered ventilator setting to ensure stump protection.

Saturday, October 13, 2012
2:30 PM - 4:00 PM
MC201

**Intra-Operative MI Following Discontinuation of Anti-Platelet Therapy in a Patient Presenting for Partial Nephrectomy**

*Anna Katharine Hindle, M.D., Brian Kim, M.D., Neil Lee, M.D., George Washington University, Washington, DC.*

Anti-platelet therapy following percutaneous interventions (PCI), has been shown to be beneficial in preventing stent rethrombosis. For patients undergoing elective surgery following PCI, ACC/AHA guidelines assist the anesthesiologist with recommendations regarding timing of procedures and interruption of antiplatelet therapy. Difficulties arise when surgical considerations require a short cessation of antiplatelet therapy. We present the case of a patient scheduled for partial nephrectomy, with drug eluting stents who had halted his antiplatelet therapy. The patient survived a turbulent intra-operative course including an ST elevation myocardial infarction progressing to cardiac arrest requiring emergent cardiac catheterization, stent placement and an intra-aortic balloon pump.

Saturday, October 13, 2012
2:30 PM - 4:00 PM
MC202

**Competing Hemodynamic Goals in Advanced Hepatocellular Carcinoma Resection**

*Chelsea Hinkle, M.D., Lev Deriy, M.D., Anesthesiology, UNMH, Albuquerque, NM.*

62 year-old male with hepatocellular carcinoma invading the pericardium causing RV compression scheduled for pericardioscopy,pericardial/diaphragmatic resection, and left hepatectomy. History: cirrhosis, HCV, HTN, smoker, and IVDU. Perfusion scan normal systolic function, no ischemia. Induction with midazolam, fentanyl, ketamine, cisatricurium after awake a-line/R IJ.d TEE exam concerning for vena cava thrombus, no compression. Goal CVP was 2 to 3 and was toleratedx5 hours. 6 hours into case increased surgical bleeding required resuscitation. CVP goals abandoned and patient was successfully resuscitated with 8 units PRBC, 2 units FFP, and 5 liters of crystalloid.Total EBL was 3600 cc.



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Saturday, October 13, 2012
2:30 PM - 4:00 PM
MC203

**Anesthetic Management and Considerations for a Patient With SVC Syndrome and Mediastinal Mass Presenting for Mediastinoscopy**

*Jeffrey T. Hopcian, M.D., Richa Dhawan, M.D., Department of Anesthesiology and Critical Care, University of Chicago, Chicago, IL.*

We present a management algorithm for perioperative anesthetic management of mediastinal masses. Anesthesia for patients with mediastinal mass is associated with high morbidity and mortality stemming from severe airway obstruction and hemodynamic compromise. We present the case of a 40 year-old female with right paratracheal mediastinal mass presenting for mediastinoscopy with presenting symptoms consistent with both her mediastinal mass and associated SVC syndrome. We review risk stratification based on symptoms and imaging as well as appropriate strategies for airway management and anesthetic technique. Our presentation demonstrates effective implementation of a medical-decision-making algorithm for anesthetic management of mediastinal masses.

Saturday, October 13, 2012
2:30 PM - 4:00 PM
MC204

**One Lung Ventilation in a Patient With Seckel Syndrome**

*Aimen Houni, M.D., Stanlies D'Souza, Toni Chahla, M.D., Matthew Harris, D.O., Anesthesiology, Baystate Medical Center, Tufts University School of Medicine, Springfield, MA.*

A 58 year-old female with past medical history of Seckel syndrome presented with a persistent cough refractory to antibiotic therapy. Workup showed bilateral pulmonary nodules and patient was scheduled for right video-assisted thoracoscopic lung biopsy. Pertinent physical exam findings included: a nonverbal patient with low-set ears and dwarfism, a narrow and receding mandible, prominent nose and eyes. Face mask induction was performed maintaining spontaneous ventilation and a 28 french double lumen tube was placed using a glide scope and position was confirmed with a flexible fiberoptic bronchoscope. Surgery was performed with an uneventful postoperative course.

Saturday, October 13, 2012
2:30 PM - 4:00 PM
MC205

**Airway Management for Bronchopleural Fistula With Spontaneous Ventilation**

*Marcos A. Izquierdo, M.D., Maureen Harders, M.D., Kelly Lebak, M.D., Anesthesiology, MetroHealth Medical Center, Cleveland, OH.*

Twenty year-old male who sustained a GSW to right upper chest five days prior with a persistent hemopneumothorax presented for a bronchoscopy, thoracotomy and lobectomy. General anesthesia was induced while maintaining spontaneous ventilation with Nitrous 50%, Sevo 0.5 MAC and Propofol 30 mg. While spontaneous, the surgeon performed fiberoptic bronchoscopy through an LMA to evaluate the injury. The patient was intubated with a fiberoptic bronchoscope through the bronchial lumen of a 39 French double lumen tube and the patient was immediately started on one lung ventilation. Positive pressure to the right lung was avoided until the lobectomy was complete.



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Saturday, October 13, 2012
2:30 PM - 4:00 PM
MC206

**Laparoscopic Cholecystectomy in an Adult Patient With Congenitally Corrected Transposition of Great Arteries (TGA): A Case Report**

*Pankaj Jain, M.D., Hesham Elsharkawy, M.D., Allen Keebler, D.O., Anesthesiology, Cleveland Clinic, Cleveland, OH.*

A 43 year-old man enlisted for cardiac transplant for congenitally corrected transposition of great arteries with systemic ventricular dysfunction and pulmonary hypertension underwent elective laparoscopic cholecystectomy for biliary dyskinesia. His home intravenous milrinone therapy was continued intraoperatively. Following placement of invasive lines and anesthetic induction with etomidate and tracheal intubation, anesthesia was maintained with sevoflurane. After gently insufflating the peritoneum, normocapnia, acceptable airway pressure and stable hemodynamics were maintained throughout the procedure. The anatomy of this rare congenital heart disease and the deleterious effect of laparoscopic surgery and anesthesia on the cardiopulmonary physiology of these patients will be discussed.

Sunday, October 14, 2012
8:00 AM - 9:30 AM
MC232

**A Case of Postoperative Cardiac Tamponade After Kidney Transplant: A Possible Consequence of Alemtuzumab (Campath)-Induced Cytokine Release Syndrome**

*Phillip S. Adams, D.O., Ibtesam A. Hilmi, M.B., Ch.B., Anesthesiology, University of Pittsburgh Medical Center, Pittsburgh, PA.*

A 55 year-old female with non-hemodialysis dependent end-stage renal disease underwent living related kidney transplantation. Immunosuppression induction was accomplished with alemtuzumab 30 mg IV intraoperatively. The procedure was uneventful with immediate allograft function. Five hours postoperatively, the patient developed cardiovascular collapse due to massive pericardial effusion with tamponade, as observed by TEE during emergent surgery. All possible etiologies for pericardial effusion were ruled out. Alemtuzumab is associated with cytokine release syndrome and reports exist of cytokine-induced pericardial effusions leading to cardiac tamponade. This patient lacked other reasons for developing a pericardial effusion and alemtuzumab-induced cytokine release is a plausible etiology.

Sunday, October 14, 2012
8:00 AM - 9:30 AM
MC233

**Securing the Airway of a Man With a Large Posterior Neck Mass**

*Oludayo A. Adeyefa, M.D., Omonele O. Nwokolo, M.D., Anesthesiology, University of Texas Health Science Center at Houston, Houston, TX.*

42 year-old man (Height- 153cm, Weight- 83 kg) who presented with a 4 kg mass growing at the back of his neck for the last 10 years. On examination of his airway, he was found to have a Mallampati Grade of 2. Prior to induction, the patient was positioned with multiple blankets under his head to even his head with the mass; a sniffing position was established. After induction, a GlideScope was used and a Grade 2 laryngoscopic view was seen after which the ETT was placed. Capnography and auscultation of the chest confirmed the correct ETT position.



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Sunday, October 14, 2012
8:00 AM - 9:30 AM
MC234

**Recurrent Pheochromocytoma Resection Including Pulmonary Metastases in a Patient With a Known Difficulty Airway**

*Junaid Nizamuddin, M.D., Meredith A. Albrecht, Department of Anesthesia, Critical Care, and Pain Medicine, Massachusetts General Hospital, Boston, MA.*

A 57 year-old male initially presented with hypertensive urgency in 2008 and underwent a right adrenalectomy notable for a difficult intubation. Five months prior to admission he presented with recurrent headaches and hypertensive episodes. Imagining revealed recurrent pheochromocytoma with metastases in the right upper and lower lung lobes and in the retroperitoneum. His pertinent past medical history includes hypertension, diabetes, and obesity (BMI=38). His intraoperative course was notable for a difficult videolaryngoscopic intubation and hypoxia with one lung ventilation. Hemodynamically after resection, he required norepinephrine to maintain perfusion. Postoperatively his catecholamine levels remain elevated but are markedly reduced.

Sunday, October 14, 2012
8:00 AM - 9:30 AM
MC235

**Super Obese Patient and Endotracheal Intubation: Friend or Foe?**

*Anna M. Allred, M.D., Brian Farrel, C.R.N.A., Irina Gasanova, M.D., Ph.D., Department of Anesthesiology, Parkland Health and Hospital System, Dallas, TX, Department of Anesthesiology, UT Southwestern, Dallas, TX.*

A 44 year-old female, ASA 4 with BMI 96.5 kg/m2, history of hypertension, Pickwickian Syndrome and lower extremity deep venous thrombosis, underwent incision and drainage of labia and buttock abscess. General anesthesia without intubation was maintained with dexmedetomidine infusion (0.2-0.7mcg/kg/h), ketamine boluses (20-30 mg) and nitrous oxide in oxygen ( 50%). Nasal airway was placed and CPAP via anesthesia circuit was provided with occasional respiratory support via nasal airway. Intraoperative and immediate postoperative course was uneventful. On subsequent incision and drainage a general endotracheal anesthesia was performed and the patient was unable to be extubated postoperatively and later required a tracheostomy.

Sunday, October 14, 2012
8:00 AM - 9:30 AM
MC236

**Tracheostomy Displacement and the Creation of a False Passage: Emergency Airway Management**

*Walid Alrayashi, M.D., Levon Capan, M.D., Thor Lidasan, M.D., Anesthesiology, New York University Medical Center, New York, NY.*

58 year-old female with ITP, GERD, and obesity presented to the ER with weakness after she was found on the floor for >36hours. She became ventilator dependent with failure to wean, ultimately requiring a tracheostomy. On POD #14, an airway was called for a dislodged tracheostomy tube. Upon arrival, the patient was becoming more hypoxic as the ENT staff was unsuccessfully attempting to replace the tracheostomy tube over a fiberoptic scope. Subcutaneous crepitous was noted around the neck. Direct laryngoscopy with MAC 3 failed because the tube passed into the trachea then out through the stoma into a false lumen.



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Sunday, October 14, 2012
8:00 AM - 9:30 AM
MC237

**The Hyperthyroid Patient for ECT**

*Zirka H. Anastasian, M.D., Eric J. Heyer, M.D., Joshua Berman, M.D., Ph.D., Anesthesiology, Psychiatry, Columbia University, New York, NY.*

A 36 year-old male with a history of bipolar disorder and essential tremor, presents for electroconvulsive therapy (ECT) for severe depression. Laboratory results were significant for high FT4 levels and suppressed TSH. Review of systems is significant for a recent weight loss of 10 lbs in 2 weeks that the patient attributed to anxiety and was negative for eye symptoms, palpitations, hair and skin changes and difficulty with memory or concentration. The patient denied history of thyroid disease or autoimmune disorders. He denies recent contrast or amiodarone exposure. His medications include lithium, zyprexa, effexor, and clonazepam, and propranolol.

Sunday, October 14, 2012
8:00 AM - 9:30 AM
MC238

**Anesthetic Challenges During Management of Mastectomy in Rural Dominican Republic**

*Jeffrey Anderson, M.D., Seth Christian, M.D., Stephanie Wang, M.D., Jeffrey Freed, M.D., Kalyan Latchamsetty, M.D., Tulane University School of Medicine, New Orleans, LA, Rush University Medical Center, Chicago, IL, Mount Sinai School of Medicine, New York, NY.*

37 year-old male presents with unilateral gynecomastia presumably secondary to filariasis during surgical mission to rural Dominican Republic. Due to findings of cellulitis, surgery team proposes mastectomy. Although patient is otherwise healthy, resources including equipment and medications are limited. During general anesthesia, challenges include losing power and monitors, ineffective medications, and providing pain control with few pharmacologic options.

Sunday, October 14, 2012
8:00 AM - 9:30 AM
MC239

**Anesthetic Considerations for Patients With Tracheal Stenosis**

*Nicole Ansell, M.D., Edmond Cohen, M.D., Mount Sinai Hospital, New York, NY.*

A 23 year-old female with history of postintubation tracheal stenosis presented with stridor and worsening oxygen saturations. Medical history included Beckwith-Wiedermann syndrome, IDDM secondary to pancreatic resection for nesidioblastosis, adrenal insufficiency secondary to adrenalectomies for pheochromocytoma, and bipolar disorder. A bronchoscopy with tracheal dilation was scheduled. The patient was pre-oxygenated with 100% oxygen while sitting up and leaning slightly forward. Induction and maintenance was accomplished with a propofol infusion. An LMA was placed and the patient was kept spontaneously breathing throughout the case. This case demonstrates the complications associated with tracheal stenosis and management of a potentially difficult airway.



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Sunday, October 14, 2012
8:00 AM - 9:30 AM
MC240

**Preoperative Assessment and Anesthetic Management of Patient With Recent Myocardial Infarction and PCI on Antiplatelet Medications**

*Romana Baig, M.D., Davide Cattano, M.D., Ph.D., Anesthesiology, UT Houston, Houston, TX.*

An 81 year-old with history of gout presented to ER with a presyncopal episode. Patient was found to have an acute STEMI, pneumonia and femoral neck fracture. He received PCI with bare metal stents and was started on aspirin and plavix. Patient was taken for hip arthroplasty, monitored by TEE. Thromboelastograph revealed a hypercoaguable state. EKG showed an acute STEMI and patient had in-stent thrombosis of the LAD. Verify now assays revealed patient to be an aspirin and plavix nonresponder. Topics to be discussed include current recommendations following recent myocardial infarction and use of thromboelastograph to determine Plavix and ASA efficacy.

Sunday, October 14, 2012
8:00 AM - 9:30 AM
MC241

**Anesthesia Related or Surgically Mediated Perforation of the Trachea?**

*Amit Bardia, Joan E. Spiegel, M.D., Anesthesia and Critical Care, Beth Israel Deaconess Medical Center, Boston, MA*

30 year-old woman with papillary thyroid carcinoma presented for total thyroidectomy. Following propofol-succinylcholine induction, DL (performed twice) with a MAC3 revealed a Grade2(b) view and a 6.5 endotracheal tube was passed. The patient underwent an uneventful total thyroidectomy course. By day 14 post-op, she had developed gradual voice changes, swelling, odynophagia and neck pain. CT scan showed extensive anterior-posterior pneumomediastinum from the thoracic inlet to the esophagogastric junction with subcutaneous emphysema. Flexible bronchoscopy showed 3 to 4-mm tracheal defect at the 1st to 2nd tracheal ring level. She underwent repair and incision and drainage of the tracheal tear without difficulty.

Sunday, October 14, 2012
8:00 AM - 9:30 AM
MC242

**Successful (Rescue) Use of the Glidescope® in a Patient With an Obstructing Nasopharyngeal Mass**

*Amit Bardia, M.D., Joan E. Spiegel, M.D., Anesthesia and Critical Care, Beth Israel Deaconess Medical Center, Boston, MA.*

A 94 year-old female (BMI 20) was s/f biopsy of a nasopharyngeal mass. She denied swallowing or voice changes. CT scan identified a 4cmx5x3 mass from the lateral nasopharyngeal wall to the base of the tongue with obliteration of the valleculae and normal larynx. Airway was Mallampatti 3 revealing no obvious mass. Following propofol-succinylcholine induction MAC3 DL revealed a large, friable mass at the base of tongue with completely obscured vocal cords. Bag-mask was adequate. DL using a Miller 2 was unsuccessful. Using a Glidescope® vocal cords were visualized and a 6.5ETT was passed successfully. Biopsy revealed poorly differentiated B-cell lymphoma.



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Sunday, October 14, 2012
8:00 AM - 9:30 AM
MC243

**High Altitude Pulmonary Edema and New Diagnosis of a Neuroendocrine Tumor**

*Sean Barnes, M.D., Sean Owens, M.D., Tracey L. Stierer, M.D., Anesthesiology and Critical Care Medicine, Johns Hopkins, Baltimore, MD.*

24 year-old female presented to Pre-Operative clinic for upcoming whipple. Paroxysmal tachycardia: Intermittent, with no pathology identified by Holter-monitor. HAPE: 6 months ago while visiting Denver, Colorado patient developed respiratory insufficiency requiring 4 days of mechanical ventilation. - Neuroendocrine tumor: During this hospitalization, a cystic mass in the porta hepatis was incidentally diagnosed. On day of surgery, after induction and incision, surgeons realized the lesion was a peri-pancreatic paraganglioma. Manipulation correlated with large elevation of BP (280/150). The Anesthesia Team initiated both alpha- and beta-blockade. Thereafter, even with tumor manipulation, the patient was exceedingly stable throughout the case.

Sunday, October 14, 2012
8:00 AM - 9:30 AM
MC244

**Ondansetron (Zofran): To Give or Not to Give**

*Alexander F. Bautista, M.D., Mary Tyler Burkhart, M.D., Department of Anesthesiology and Perioperative Medicine, University of Louisville, Louisville, KY.*

It has been estimated that postoperative nausea and vomiting occurs in 35% patients undergoing general anesthesia, hence prevention and active treatment have been advocated to prevent extended postoperative stays or unplanned admission and accompanying expense. The judicious use of anti-emetics have been the standard of care for most anesthesia providers, giving it like “water” to all patients, discounting the fact that some of them, especially the serotonin antagonists, are associated with adverse reaction such as prolonged QT syndrome. Here presented is a patient who underwent video-assisted thoracoscopy who manifested with prolonged QT after surgery after being given Zofran.

Sunday, October 14, 2012
8:00 AM - 9:30 AM
MC245

**Anesthetic Management of a Patient With a Bleeding Tracheostomy Stoma and Granulation Tissue Causing a Saddle Bronchial Obstruction**

*Talia K. Ben-Jacob, M.D., Keyur Trivedi, M.D., Amanda Burden, M.D., Department of Anesthesia, Cooper University Hospital, Camden, NJ*

A 76 year-old male with extensive past medical history including large traumatic subdural hematoma after anticoagulation presented to the operating room emergently because of large amounts of hemoptysis from his tracheostomy tube. Previous CT angiography and bedside bronchoscopy had not identified the source of the bleed. In the operating room, an oral endotracheal tube was placed and a fiberoptic bronchoscope was used to identify the source of bleeding and retrieve the granulation tissue causing an obstruction. We discuss the anesthetic and airway management of patient with an intermittent “ball-valve” obstruction requiring urgent operation for his complicated surgical airway.



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Sunday, October 14, 2012
8:00 AM - 9:30 AM
MC246

**Case Report: Unanticipated Sympathetic Paraganglioma Postoperative Pulmonary and Cerebral Edema**

*John Berry, VII, M.D., Anthony Passanannte, M.D., Anesthesiology, University of North Carolina at Chapel Hill, Chapel Hill, NC.*

We present a case of a woman with worsening right flank pain. Workup included a CT Abdomen/Pelvis showing a 4.3 cm x 4.2 cm Retroperitoneal Mass medial to the IVC, Lateral to Aorta, and Posterior to the main portal vein. Intraoperatively, she experienced extreme hypertension upon manipulation of the tumor consistent with a neuroendocrine tumor. Postoperatively she experienced altered mental status and respiratory distress. She was able to be extubated on post operative day 1 with no neurologic sequelae. Pathology later confirmed Sympathetic Ganglioma with Malignant Features.

Sunday, October 14, 2012
8:00 AM - 9:30 AM
MC247

**Mitochondrial Encephalopathy, Lactic Acidosis, and Stroke-Like (MELAS) Syndrome**

*Mark Bicket, Melissa Freck, Tina Tran, Johns Hopkins Medical Institutions, Baltimore, MD.*

Mitochondrial encephalopathy, lactic acidosis, and stroke-like syndrome (MELAS) is a rare disorder with significant consequences for anesthetic management. A 47 year-old female with medical history significant for MELAS presented for repair of symptomatic ventral hernia. After review of patient history and physical exam, an anesthetic plan was implemented which successfully avoided operative and post-operative complications associated with this disorder.

Sunday, October 14, 2012
8:00 AM - 9:30 AM
MC248

**Sacral Chordoma: A Multidisciplinary, Multi-Staged Approach**

*Cheryl Bline, M.D., Susan Vassallo, M.D., Anesthesia, Critical Care and Pain Medicine, Massachusetts General Hospital, Boston, MA.*

A 36 year-old man developed cauda equine syndrome; evaluation revealed a S2 and S3 vertebral body chordoma. He presented to the Massachusetts General Hospital for multidisciplinary care with a unique team of specialist: medical oncology, radiation oncology, general surgery, plastic surgery, orthopedic surgery, anesthesiology and rehabilitation medicine. In a staged fashion he underwent pre-operative radiation; ligation of internal iliac vessels, sacral osteotomies and creation of a vertical rectus muscle flap. Three days post-operatively he suffered hemorrhage from a superior epigastric artery. The final stage was a prolonged en-bloc resection and reconstruction in prone position notable for large blood loss.

Sunday, October 14, 2012
8:00 AM - 9:30 AM
MC249

**Anesthetic Management of an Unknown Large Tracheoesophageal Fistula**

*Nathaniel M. Bolli, M.D., Michael Bassett, M.D., Anesthesia, MetroHealth Medical Center, Cleveland, OH.*

39 year-old male with a history of G6PD deficiency, hyperlipidemia, 20 pack years of tobacco use, and recently diagnosed lung cancer with metastasis was admitted for worsening odynophagia and planned PEG tube placement. Standard ASA monitors were applied and he was induced with midazolam,



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fentanyl, propofol, rocuronium and intubated through direct laryngoscopy. A large circuit leak was immediately noted that resolved with advancement of the ETT and returned with withdrawal. Fiberoptic bronchoscopy revealed a large posterior wall tracheal defect. The patient was kept intubated and transferred to the ICU where he was declared comfort care and shortly expired.

Sunday, October 14, 2012
8:00 AM - 9:30 AM
MC250

**Pacemaker Mediated Tachycardia During Carotid Endarterectomy**

*Nathaniel M. Bolli, M.D., Samuel DeJoy, M.D., Anesthesia, MetroHealth Medical Center, Cleveland, OH.*

86 year-old male with a history of CAD s/p CABG, HTN, COPD, PVD, DM, bilateral Carotid stenosis, and pacemaker presents for L CEA. Standard ASA monitors applied, left radial arterial line placed, induced with midazolam, fentanyl, propofol, rocuronium, and tracheal intubation was performed without complication. EKG showed fluctuation between paced narrow complex rhythm, paced wide complex rhythm, and paced wide complex tachyarrythmia resulting in hemodynamic compromise believed to be pacemaker mediated tachycardia. Pacemaker set to DOO. Postoperatively patient extubated, developed acute onset chest pain, dyspnea and required reintubation. New LBBB and increased Troponin-I developed. Patient is being medically managed.

Sunday, October 14, 2012
8:00 AM - 9:30 AM
MC251

**Tracheal Injury Following Blunt Trauma**

*Naga Boyapati, M.D., Toni Chahla, M.D., Stanlies D'Souza, M.D., Anesthesiology, Baystate Medical Center, Tufts University School of Medicine, Springfield, MA.*

A 20 year-old male presented to the emergency room following a blunt trauma to the chest. Radiographic imaging showed subcutaneous emphysema, pneumomediastinum and a right posterior tracheal injury. Flexible Fiberoptic bronchoscopy was performed under general anesthesia through a Laryngeal Mask Airway (LMA) maintaining spontaneous ventilation (SV) and revealed a 2 centimeter laceration proximal to carina. Patient underwent a right sided thoracotomy with a left sided double lumen tube (DLT) that was placed and advanced under direct fiberoptic guidance. Laceration was repaired and the DLT was changed to a LMA maintaining SV for final fiberoptic inspection and smooth emergence.

Sunday, October 14, 2012
8:00 AM - 9:30 AM
MC252

**Anesthetic Management of an Insulinoma Patient Undergoing Pancreatectomy Surgery**

*Guilherme Moraes Ancora Braga Netto, M.D., M.D., Elizabeth Fernandez Vaz Silva, M.D., M.D., Thaísa M. Queiroz, M.D., M.D., Marco Antonio Carvalho Resende, M.D., M.D., Ismar Lima Cavalcanti, M.D., M.D.,Ph.D., Anesthesiology, Universidade Federal Fluminense, Niterói, Brazil.*

Male, 33yrs, 170 cm, ASA III, in use of phenytoin 200 mg daily. Symptomatic with blood glucose levels < 40mg/dL. The patient was kept with a 10% dextrose IV infusion pump preoperatively. No pre-anesthetic drug was given. Monitoring: SpO2, cardioscope in DII, EtCO2 and right radial invasive blood pressure. Anesthetic technique consisted of an epidural with continuous infusion of levobupivacaine (enantiomeric excess bupivacaine 75/25%) and balanced general anesthesia (induction with fentanyl, thiopental and vecuronium and maintained with isoflurane). Arterial blood gas and capillary blood



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glucose levels were analyzed regularly during the perioperative period. There were no complications during surgery.

Sunday, October 14, 2012
8:00 AM - 9:30 AM
MC253

**Challenging Awake Nasal Fiberoptic Intubation for Traumatic Submandibular Hematoma**

*Robert Buchmann, M.D., David Wild, M.D., Anesthesiology, SLU, St. Louis, MO.*

A 32 year-old male presented with a penetrating submental wound. Anesthesia was called to secure a difficult airway due to an expanding submandibular hematoma. Because of his respiratory stability, we transported the patient to the controlled setting of the OR for procurement of the airway. Several attempts for an awake nasal fiberoptic intubation were unsuccessful due to an uncooperative patient. The decision was made to attempt an asleep nasal fiberoptic intubation as the glottic opening was easily visualized previously. Otolaryngologist was available bedside for emergency tracheotomy. Nasal endotracheal airway was secured and surgery was completed.

Sunday, October 14, 2012
8:00 AM - 9:30 AM
MC254

**The Utility of Preoperative Transthoracic Ultrasound in a Patient With Pericardial Effusion and Impending Tamponade**

*Kenneth Burckardt, M.D., Cornelia Atherton, M.D., University of Louisville, Louisville, KY.*

While the pericardium can accommodate up to two liters of chronic effusion, as little as 100 cc accumulating acutely can lead to impaired cardiac function, tamponade and death. Knowing how severe cardiac impairment is in a patient with pericardial effusion can be difficult. We report a case of elective pericardial effusion drainage and the use of transthoracic ultrasound to assess cardiac function preoperatively. With the information gained from ultrasound the surgical and anesthetic plans were altered and the case became emergent and resulted in a good outcome. We also review the pertinent anesthetic considerations for pericardial effusions.

Sunday, October 14, 2012
8:00 AM - 9:30 AM
MC255

**Bed of Poison? Cases of Unrecognized Anaphylaxis During Repeat Spinal Surgery**

*Bridget Bush, Ryan Pong, M.D., Anesthesiology, Virginia Mason Medical Center, Seattle, WA.*

A 24 year-old woman presenting for revison of L4-5 laminectomy beomes hypotensive upon prone postioning, refractory to phenylephrine, ephedrine and vasopressin. She develops left ventricular outflow tract obstruction with adminstration of epinephrine. Perioral edema is appreciated and treatment of anaphylaxis is initiated. She becomes hemodynamically stable after histamine blockers and steroids. Of interest, she had experienced a similar episode 10 months prior attributed to intravascular depletion and IVC compression with successful surgery the following day. The same medications were used in all three cases. Triptase levels confirm the diagnosis.



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Sunday, October 14, 2012
8:00 AM - 9:30 AM
MC256

**Complications and Management of Video Assisted Thoracotomy**

*Muriel Cajuste, Tracey Straker, Montefiore Medical Center, Bronx, NY.*

33 year-old woman with no significant past medical history underwent a right video assisted thoracotomy for resection of a 24x24 cm esophageal cyst .After intubation with a double lumen tube and well into the surgical procedure, the patient developed new onset rapid atrial fibrillation with accompanying hypotension .After differential diagnosis , ultimately the arrhythmia was controlled and the patient did well.Post operative pain management consisted intercostal blocks and intravenous medications.

Sunday, October 14, 2012
8:00 AM - 9:30 AM
MC257

**Postoperative Rigidity: A Diagnostic Dilemma**

*Ashley Caplan, D.O., Michael Duggan, M.D., Carlos Wilkerson, M.D., Anesthesiology, Thomas Jefferson University, Philadelphia, PA.*

A 64 year-old female with Grave's disease experienced rigidity in the PACU after uneventful total thyroidectomy. We review perioperative rigidity, predisposing factors, and potentially responsible pharmacologic agents. Differential diagnosis included hypocalcemia, malignant hyperthermia(MH), neuroleptic malignant syndrome(NMS), serotonin syndrome(SS), and adverse medication effect. Laboratory results were unremarkable. Acute hypocalcemia due to postsurgical hypoparathyroidism was ruled out. She received odansetron, which has been associated with extrapyramidal reactions. The timely use of Dantrolene in cases suggestive of MH, SS, or NMS may be warranted. Although this patient did not fit into a clearly defined syndrome, treatment with dantrolene proved successful.

Sunday, October 14, 2012
8:00 AM - 9:30 AM
MC258

**Off-Site Anesthesia for EGD to Evaluate Food Impaction and Achalasia**

*Christine L. Carqueville, M.D., Justin DaGraca, M.D., Allen N. Gustin, Jr, M.D., Department of Anesthesia & Critical Care, University of Chicago Medical Center, Chicago, IL.*

81 year-old female with history of esophageal dysmotility disorder, achalasia, rheumatoid arthritis and interstitial lung disease presented to ED with progressively worsening nausea and vomiting with any food intake for 3 days. Chest xray demonstrated significant mediastinal widening and CT showed widened esophagus. The patient came to GI suite for EGD under anesthesia. Awake fiberoptic intubation was performed with patient in sitting position. Keeping head of bed elevated at 45 degrees, EGD was attempted several times without success until assisted with direct laryngoscopy. Upon visualization, the esophagus was extremely dilated with a large, well-formed food impaction.

Sunday, October 14, 2012
8:00 AM - 9:30 AM
MC259

**Unusual Usage of Double Lumen Endotracheal Tube**

*Cameron C. Cartier, D.O., Anesthesiology, Riverside County Regional Medical Center, Costa Mesa, CA.*

A 37F double lumen ETT was placed in a 66 year-old, 5'6'' and 72kg male for right thoracotomy. DL-ETT position was confirmed by auscultation/fiberoptiscope, but a noise was heard from the patient's mouth



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(oral pharyngeal visualization appeared normal). After positioning, gurgling was prominent. When the DL-ETT was advanced the noise subsided, but the bronchial cuff disappeared. Correct positioning of the DL-ETT without noise from the mouth could not be achieved simultaneously. We then suctioned the right lung (14F catheter) and advanced the DL-ETT to achieve one lung ventilation.

Sunday, October 14, 2012
8:00 AM - 9:30 AM
MC260

**Identifying Intraoperative and Post-Anesthetic Pulmonary Embolisms**

*Helen A. Chang, Norma Dominguez, D.O., Anesthesiology, Riverside County Regional Medical Center, Moreno Valley, CA.*

In the postoperative scenario, a 94 year-old female with past medical history of hypertension and osteoarthritis underwent a left femur closed reduction after sustaining a mechanical fall. In the intraoperative scenario, a 56 year-old male with history of diabetes, hypertension, obstructive sleep apnea, and morbid obesity presented for a right femur open reduction following a motorcycle accident. The former became hemodynamically unstable and resuscitated with re-intubation, establishing invasive access, and vasopressors; the latter remained intubated upon conclusion of surgery. Both patients exhibited signs conclusive for the diagnosis of a significant pulmonary embolism in which immediate action was necessary.

Sunday, October 14, 2012
8:00 AM - 9:30 AM
MC261

**Patient With Severe Rheumatoid Arthritis for Cardiac Surgery With Subsequent Vocal Cord Paralysis**

*Judy Chang, M.D., Rachel Androphy, M.D., Anesthesiology, NYU Medical Center, New York, NY.*

We describe a 48 year-old female, with rheumatoid arthritis and rheumatic heart disease, who presented for re-op MVR and TVR. Patient had long-standing severe RA, for which she took daily prednisone. Patient denied neck pain, decreased range of motion, nor hoarse voice. Patient was gently intubated with lubricated 7.0 ETT with in-line stabilization. Surgery proceeded uneventfully and patient was brought to PACU intubated. After extubation on POD 1, she developed stridor and increasing difficulty breathing. ENT examination showed paralysis of bilateral vocal cords and patient was re-intubated. Several days later, the patient failed another extubation attempt. Patient ultimately received tracheostomy.

Sunday, October 14, 2012
8:00 AM - 9:30 AM
MC262

**Myasthenia Gravis - To Roc or Not to Roc: Two Patients, Two Surgeries and Two Anesthetics, Two Different Outcomes**

*Destiny Chau, M.D., University of Kentucky Medical Center, Lexington, KY.*

A 32 year-old male presents for laparoscopic cholecystectomy. A 35 year-old male presents for thymectomy. Both have myasthenia gravis. The first patient underwent the laparoscopic procedure uneventfully, was extubated in the operating room and recovered to baseline in the post- anesthesia care unit. He was discharged to home on the same day. The second patient underwent the thymectomy uneventfully, was extubated in the operating room and recovered to baseline in the post- anesthesia care unit. He was alert, oriented and sipping on ice water comfortably until he developed the sudden onset of apnea requiring intubation and ICU admission.



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Sunday, October 14, 2012
8:00 AM - 9:30 AM
MC263

**Desmin Storage Myopathy in a Super-Morbidly Obese Patient: Making a Sensible Anesthetic Plan for a Rare Disease**

*Nicholas Cirac, M.D., Karin Zuegge, M.D., Anesthesiology, University of Wisconsin Hospital & Clinics, Madison, WI.*

A wheelchair-bound 65 year-old female with desmin-related myopathy, left bundle branch block, endometrial cancer, severe sleep apnea and body mass index of 67 kg/m² presented for a 10 hour total abdominal hysterectomy, salpingo-oophorectomy, and panniculectomy. She had previously received a volatile agent for a brief procedure at an outside hospital. Despite this uneventful prior anesthetic, we elected to use a non-triggering technique including a preoperative thoracic epidural and propofol infusion for maintenance. Our major concerns included severe postoperative respiratory muscle weakness, cardiomyopathy, malignant hyperthermia and propofol infusion syndrome. She was extubated successfully on day 2 and discharged on day 11.

Sunday, October 14, 2012
8:00 AM - 9:30 AM
MC264

**Trisomy 15 Patient With Subglottic Tracheal Granuloma: Anesthetic Management for Emergency Rigid Bronchoscopy**

*Vincent A. Cordero, M.D., Sergey Pisklakov, M.D., Anesthesiology, UMDNJ-NJMS, Newark, NJ.*

Trisomy 15 is a rare genetic disorder presenting unique problems and concerns. Patients may present with multiple craniofacial, cardiac, and skeletal abnormalities, affecting anesthetic management. A 16 year-old female with Trisomy 15 was diagnosed with a subglottic tracheal granuloma, and underwent emergency rigid bronchoscopy for granuloma removal to relieve dyspnea. With the granuloma being subglottic, intubation or jet ventilation was not feasible for possibility of pushing the granulomatous tissue further distal, so the anesthetic plan was to keep the patient spontaneously breathing through her tracheostomy while under anesthesia.

Sunday, October 14, 2012
11:00 AM - 12:30 PM
MC309

**Anesthetic Challenges in a Patient With Rubinstein-Taybi Syndrome**

*Terry Brandon Thacker, M.D., Michael T. Drake, M.D., Aurel Neamtu, M.D., Department of Anesthesiology and Perioperative Medicine, University of Louisville School of Medicine, Louisville, KY.*

Rubinstein-Taybi syndrome (RTS) is an autosomal dominant condition characterized by short stature, moderate to severe learning disabilities, distinctive facial features, and broad thumbs and first toes. Associated skeletal, airway, and cardiac anomalies can complicate administration of anesthesia. We report the case of a 33-year-old obese, bipolar female with RTS and obstructive sleep apnea (OSA), who underwent open reduction and internal fixation (ORIF) of a right femur fracture under general anesthesia. Discussion of the case and a review of the literature are presented.



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Sunday, October 14, 2012
11:00 AM - 12:30 PM
MC310

**Anesthetic Considerations for Patients With Goldenhar Syndrome**

*Antony Tharian, M.D., Omar Raja, M.D., N. Nick Knezevic, Anesthesiology, Advocate Illinois Masonic Medical Center, Chicago, IL.*

A 24 year-old G1P0 female presented to the Labor and Delivery unit in passive labor. The patient had no significant past medical or surgical history except for congenital Goldenhar Syndrome. Epidural anesthesia was chosen to control labor pain and she went through normal vaginal delivery without complications. Airway management in these patients can be very difficult due to the congenital abnormalities of head, spine and internal organ system. If general anesthesia is required, video fiberoptic laryngo- or bronchoscopy should be strongly considered. Also these patients tend to have increased incidence of obstructive sleep apnea, the post operative safety should be considered.

Sunday, October 14, 2012
11:00 AM - 12:30 PM
MC311

**Carcinoid Crisis Requiring Massive Doses of Somatostatin Analogues**

*Kathryn M. Thompson, M.D., Maria D. Fritock, M.D., David W. Barbara, M.D., Anesthesiology, Mayo Clinic, Rochester, MN.*

A 53 year-old female with a 12 cm symptomatic metastatic carcinoid of the liver presented for ileocecectomy and right hepatectomy. After awake radial artery cannulation, general anesthesia was induced with midazolam, fentanyl, lidocaine, propofol, and vecuronium. Shortly after successful intubation, she experienced severe hypotension (52/34 mmHg) refractory to 20 units of vasopressin and 1,000 mcg of octreotide. After epinephrine administration, the hypotension resolved. 11,000 mcg of octreotide boluses and continuous infusions were required throughout the 8 hour anesthetic. Intraoperative carcinoid crises can be fatal, and the anesthetic management requires avoidance of further mediator release and treatment with somatostatin analogues.

Sunday, October 14, 2012
11:00 AM - 12:30 PM
MC312

**Anesthetic Management of Carotid Body Paraganglioma Excision**

*Nicholas Tinkham, M.D., Harendra Arora, M.D., Priya Kumar, M.D., Anesthesiology, The University of North Carolina at Chapel Hill, Chapel Hill, NC.*

Carotid body tumors are a relatively rare neoplasm of neuroendocrine origin. The tumors are called paragangliomas, chemodectomas, or glomous tumors, depending on their location. These may be successfully managed with careful preparation for the challenges posed during the administration of anesthesia. Catecholamine secreting paragangliomas can behave much like pheochromocytomas. It may be worthwhile screening these patients for elevated urine or serum catecholamines. We discuss the perioperative considerations and preparation in patients presenting for paraganglioma resections and present the successful management of a 45 year-old female with a mass in the right carotid space and carotid body with elevated dopamine levels.



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Sunday, October 14, 2012
11:00 AM - 12:30 PM
MC313

**Acromegaly: A Big Problem in the O.R.**

*Katie Tuler, Department of Anesthesiology, Medical College of Wisconsin, Wauwatosa, WI.*

Acromegaly is a rare medical condition but can pose a considerable challenge to anesthesiologists in the perioperative period. Some manifestations of acromegaly include overgrowth of soft tissues of the upper airway (enlargement of the tongue and epiglottis) and increased length of the mandible. Polypoid masses reflect overgrowth of soft tissues of the pharyngeal tissues, making the patient's upper airway susceptible to obstruction. The subglottic diameter may be decreased in acromegalic patients. Case Report: This presentation is a case of a 56yo white female with acromegaly and gigantism who presented for transphenoidal resection of her growth hormone-producing anterior pituitary gland tumor.

Sunday, October 14, 2012
11:00 AM - 12:30 PM
MC314

**Airway Management of an Intratracheal Mass**

*Suzanne VanValkenburgh, M.D., New York University Langone Medical Center, New York, NY.*

A 29-year-old male with no medical history was admitted after 3 months of worsening dyspnea. He was found to have multiple intratracheal nodules, the largest measuring 1.4 x 1.3 x 1.3cm. He was booked urgently for rigid bronchoscopy and resection of the masses. After discussions with the patient and surgical team, we proceeded with an awake fiberoptic intubation. Remifentanil and dexmedetomidine infusions were used for sedation while maintaining spontaneous ventilation, and after topicalization with lidocaine, the patient was successfully intubated with a 6.0 ETT proximal to the mass. Adequate ventilation was ensured before the patient was induced for the procedure.

Sunday, October 14, 2012
11:00 AM - 12:30 PM
MC315

**Complications During Emergency Vascular Access in a Traumatic Hemorrhage**

*Eric T. Vessels, Detlef Obal, M.D., Anesthesiology, University of Louisville, Louisville, KY.*

A 65 year-old patient returned emergently to the operating room after initial spleenectomy for re-evaluation. The coagulopathic patient required massive blood transfusion. The anesthesia team was challenged by inadequate intravenous access (only 20G catheter left upper extremity). During rescuscitation efforts (pulseless electrical activity, CPR) the anesthesia team repeatedly tried to place large bore catheters for blood transfusion. Subsequently, the subclavian vein was injured resulting in right hemothorax and additionally a 9F catheter was placed in the right carotid artery. The poster will discuss aspects of emergency volume replacement, documentation, and state-of-the-art management of vascular injury repair.



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Sunday, October 14, 2012
11:00 AM - 12:30 PM
MC316

**Refractory Intra-Operative Bradycardia in Patient Undergoing Trachostomy Placement**

*Robert C. Vietor, III, Christopher Maani, M.D., San Antonio Uniformed Services Health Education Consortium, San Antonio, TX.*

Patient is a 48 year-old male ASA IV for history of ischemic cardiomyopathy (EF of 20%), anoxic brain injury s/p intra-op bradycardia/PEA requiring ACLS presenting for Tracheosotomy, PEG tube placement and RLE amputation for necrotizing fasciitis. Given patient's history of prior ACLS event under general anesthesia, plan for this case was TIVA with fentanyl and ketamine. After 1 hour in the OR, the patient again developed bradycardia which was refractory to atropine and glycopyrollate and required transcutaneous pacing. The case was aborted and patient transferred to the ICU. The case represents a unique case of refractory intra-operative bradycardia.

Sunday, October 14, 2012
11:00 AM - 12:30 PM
MC317

**Intra-Operative Red Blood Cell Salvage: Is it Safe in Patients With Lead Poisoning?**

*Eugene Vovchuk, M.D., Samuel Perov, M.D., Anesthesiology, Detroit Medical Center/Wayne State University, Detroit, MI.*

A 56 year-old female who was diagnosed with lead poisoning, and transferred to Detroit Receiving Hospital for chelation therapy and removal of bullets from her pelvis. During the pre-surgical evaluation she was noted to have a hemoglobin level of 8.2g/dL, a type and cross match was ordered, however, matching blood wasn't available and surgery was canceled. Given the urgent nature, prior to canceling, consideration was made to use an RBC salvage machine. Since there is no data available for this situation, an RBC salvage machine wasn't used and surgery was rescheduled once blood was available.

Sunday, October 14, 2012
11:00 AM - 12:30 PM
MC318

**Anesthetic Management of a Patient With Multiple Myeloma Using Stroke Volume Variation**

*Zen'ichiro Wajima, M.D., Ph.D., Toshiya Shiga, M.D., Ph.D., Kazuyuki Imanaga, M.D., Ph.D., Department of Anesthesiology, Shioya Hospital, International University of Health and Welfare, Tochigi, Japan, Department of Anesthesiology, Kaken Hospital, Chiba, Japan, Department of Anesthesia, New Tokyo Hospital, Chiba, Japan.*

Multiple myeloma is a malignant neoplasm characterized by the poorly controlled growth of a single clone of plasma cells that produces a monoclonal immunoglobulin. Excessive production of monoclonal immunoglobulins can lead to hyperviscosity, which may result in stroke; thus, it is essential to provide adequate hydration to avoid precipitating hyperviscosity syndrome and renal failure. Stroke volume variation (SVV) is indicative of the patient's volume status and can be used to assess cardiac preload. The author will discuss the anesthetic management of an 84-year-old woman focusing on the use of SVV to provide adequate hydration.



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Sunday, October 14, 2012
11:00 AM - 12:30 PM
MC319

**General Anesthesia for Thyroidectomy for a Patient With Uncontrolled Hyperthyroidism**

*Christian M. Walker, M.D., Michelle C. Santiago, M.D., Richard Bryant, M.D., Anesthesiology, The Ohio State University, Columbus, OH.*

Patient is a 27 year-old female with uncontrolled hyperthyroidism who presented with new onset atrial fibrillation with rapid ventricular response and IUFD at 21 weeks gestation. During her Dilation and Curettage she developed thyroid storm and DIC and was transferred to the ICU for post-operative care where she was treated for respiratory failure, sepsis, acute renal failure, and biventricular heart failure. She failed maximum medical therapy for her hyperthyroidism and underwent total thyroidectomy for with PA catheter monitoring several weeks later. Post-operatively she developed hypokalemic cardiac arrest and expired on post-operative day three.

Sunday, October 14, 2012
11:00 AM - 12:30 PM
MC320

**Optimization of Compromised Cerebral Circulation in the Setting of Extreme Trendelenburg Position During Robotic Assisted Hysterectomy**

*Jeremie Walker, M.D., M.B.A., Colin Wilson, M.D., Anesthesiology, West Virginia University, Morgantown, WV.*

A 64 year-old female with endometrial adenocarcinoma, morbid obesity, and diabetes presented for robotic assisted total hysterectomy. She had persistent global encephalomalacia after suffering left ICA occlusion, right ICA stenosis, and a right MCA stroke. Despite this, the patient retained significant functional capacity from tenuous collateral flow in the vertebral arteries and Circle of Willis. The patient was to be placed in steep Trendelenburg position for operative exposure. Cerebral oximetry and an arterial line supplemented our ASA standard monitors. We discuss the challenge of optimizing compromised cerebral blood flow during steep Trendelenburg position.

Sunday, October 14, 2012
11:00 AM - 12:30 PM
MC321

**Bilateral Total Mastectomy, Pacemaker and Unipolar Bovie, Pacemaker in Close Proximity of Surgical Site**

*Erikka L. Washington, M.D., Anesthesiology, University of Texas Health Science Center School of Medicine Houston, Houston, TX.*

The patient is a 49 year-old AAF who has a past medical history of invasive breast cancer, bilateral acquired breast deformity, chronic atrial fibrillation, pacemaker dependent, hypertension, asthma, rheumatoid arthritis, morbid obeisity, presenting for bilateral total mastectomy, right sentinel lymph node biopsy, bilateral placement of silicone implants and acellular dermal matrix and possible tissue expander.



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Sunday, October 14, 2012
11:00 AM - 12:30 PM
MC322

**Successful Anesthetic Management of Rigid Bronchoscopy-Guided Percutaneous Tracheostomy in a Morbidly Obese Patient**

*Nicholas R. Wasson, Stephanie Jones, M.D., Department of Anesthesia, Critical Care, and Pain Medicine, Beth Israel Deaconess Medical Center, Boston, MA.*

We discuss a medically challenging case involving the anesthetic management of a 66 year-old morbidly obese female (148 kg, BMI 60 kg/m) with obesity hypoventilation syndrome and respiratory failure undergoing rigid bronchoscopic guidance for percutaneous tracheostomy. Past medical history was significant for severe obstructive sleep apnea, heavy smoking history, COPD on 3 liters home oxygen, pulmonary hypertension, and atrial fibrillation on warfarin. Topics for discussion include the anesthestic management of rigid bronchoscopy in the morbidly obese patient, options for jet ventilation, and safe and efficient transport.

Sunday, October 14, 2012
11:00 AM - 12:30 PM
MC323

**Anesthetic Considerations and Perioperative Management for Hyperthermic Intraperitoneal Chemoperfusion: A Case Report**

*Christopher A. Webb, M.D., Paul D. Weyker, M.D., Vivek K. Moitra, M.D., Richard K. Raker, M.D., Anesthesiology, Columbia University College of Physicians & Surgeons, New York, NY.*

Anesthesiologists face several perioperative challenges when patients need CRS and HIPEC because patients may experience metabolic derangements, fluid shifts, and chemotherapeutic toxicities. Optimal anesthetic management of patients being treated with CRS and HIPEC requires control of a complex interplay of physiologic mechanisms, including hyperthermia, abdominal hypertension, electrolyte abnormalities, coagulopathies, increased cardiac index, oxygen consumption, and decreased systemic vascular resistance. As this surgery continues to gain popularity among oncologic surgeons, further studies that clearly define the chemistry, pharmacokinetics, pharmacodynamics, and endpoints of efficacy need to be performed to elucidate optimal perioperative management.

Sunday, October 14, 2012
11:00 AM - 12:30 PM
MC324

**Reperfusion Injury Following Orthotopic Liver Transplant**

*Andrea L. Westman, M.D., Anesthesiology, Vanderbilt University, Nashville, TN.*

60 year-old male with a history of hepatitis C and hepatocellular carcinoma (MELD-22) who presented for orthotopic liver transplant. Liver disease complicated by ascites and encephalopathy. The pre-anhepatic and anhepatic stages of transplant were uneventful. The donor liver was noted to have 30% steatosis but decision made to proceed with case. After reperfusion, the patient acutely developed severe hemodynamic disturbances including hypotension, arrhythmias with significant T wave inversions and ST depressions, and coagulopathy requiring large amounts of blood products. Nearing the end of the case, patient developed acute pulmonary edema and ARDS.



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Sunday, October 14, 2012
11:00 AM - 12:30 PM
MC325

**Fiberoptic Tracheal Intubation via Laryngeal Tube**

*Anna Weyand, M.D., Ashutosh Wali, M.D., Baylor College of Medicine, Houston, TX.*

King LTS-D, a paraglottic airway, has gained popularity in out-of-hospital emergency airway management. Patients frequently present to our institution's emergency room with this device in place. Despite King LTS-D's value in rescue ventilation, it is frequently necessary to replace the device with a tracheal tube (TT). We describe four cases in which the device was successfully replaced. A fiberscope was used to visualize vocal cords via the ventilating lumen of King LTS-D, and an Aintree catheter (AC) was then inserted over the fiberscope through the cords. Fiberscope and King LTS-D were withdrawn and a TT was passed over the AC.

Sunday, October 14, 2012
11:00 AM - 12:30 PM
MC326

**ECT in a Patient With Neuroleptic Malignant Syndrome**

*Jordan Wicker, Meg Rosenblatt, M.D., Anesthesiology, The Mount Sinai Hospital, New York, NY.*

The patient was a 14 year-old male with paranoid schizophrenia and past medical history significant for a recent ICU admission for neuroleptic malignant syndrome (NMS) associated with aripiprazole administration. He was scheduled to undergo electroconvulsive therapy (ECT) for treatment of medically-refractory schizophrenia. Succinylcholine use is controversial in patients with NMS, but succinylcholine is frequently used to limit tonic-clonic contractions and skeletal muscle injury during ECT, thus patients with NMS pose unique challenges. This case highlights the anesthetic course, discusses considerations necessary to provide safe and comfortable anesthesia, and presents current research regarding proper care for patients with NMS undergoing ECT.

Sunday, October 14, 2012
11:00 AM - 12:30 PM
MC327

**Refractory Hypotension Following GETA and Utility of Vasopressin Rescue in a Patient on Combination Antihypertensive Therapy**

*Rodney C. Smart, M.D., Casey M. Windrix, M.D., Abhinava S. Madamangalam, M.D., Thomas D. Tinker, M.D., Department of Anesthesiology, University of Oklahoma College of Medicine, Oklahoma City, OK.*

We describe the occurrence of serious refractory hypotension and management in our patient with long standing hypertension on combination drug therapy with Angiotensin II antagonist and Alpha blocker. Hypotension occurred soon after the induction of general anesthesia for a relatively minor day surgery. Hypotension was significant enough to cause marked reduction in ETCO2. The hypotension was unresponsive to routine hypotension reversal measures including repeated intravenous low dose epinephrine boluses. A single IV Vasopressin bolus promptly corrected the severe hypotension and the ETCO2 normalized.



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Sunday, October 14, 2012
11:00 AM - 12:30 PM
MC328

**Transfusion in Trauma Patient With ESRD**

*Nic Winters, M.D., Jim Jackson, M.D., Anesthesia, University of Louisville, Louisville, KY.*

Our patient is a 43 year-old male with a medical history of ESRD secondary to DM and hypertension. After an emergent CT, he was found to have a sub arachnoid hemorrhage and a ruptured spleen. The patient sustained poly-trauma injuries and required emergent surgery. The gentleman was found to have rare antibodies in his blood, secondary to multiple transfusions. This created a more complicated environment for maintaining his hemodynamic stability, as his hemoglobin at the time was 4.6. He continued to have neurological issues until day 5. His course was further complicated by infection.

Sunday, October 14, 2012
11:00 AM - 12:30 PM
MC329

**Simpson-Golabi-Behmel Syndrome: A Congenital Difficult Airway and Its Management**

*Waylan Wong, M.D., M.S., Nathaniel W. Parker, M.D., Roya Yumul, M.D.,P h.D., Anesthesiology, Cedars Sinai Medical Center, Los Angeles, CA.*

A 45 year-old male with Simspson-Golabi-Behmel Syndrome (SGBS) presented for right tibial incision and drainage with hardware replacement. He was Mallampati class 4, no visible neck, and mouth opening <3 cm. Awake nasal fiberoptic intubation (FOI) in a semi-sitting position failed from redundant pharyngeal tissue. However, oral FOI succeeded with patient phonation. He represented two years later for the same surgery. We attempted awake Supreme LMA placement, but failed from redundant pharyngeal tissue obstruction. The patient was woken up and awake FOI was done uneventfully. SGBS syndrome presents a difficult airway challenge that almost always requires awake FOI with phonation.

Sunday, October 14, 2012
11:00 AM - 12:30 PM
MC330

**Airway Management for Acute Respiratory Failure in a Patient With Severe Tracheal Stenosis**

*Hui Yang, M.D.,Ph.D., Stacy Ritzman, M.D., Cleveland Clinic, Cleveland, OH.*

A 59 year-old male with remote history of tracheostomy for facial burn developed acute respiratory failure after atrial fibrillation ablation. Experienced anesthesiologist could only pass size 4 MLT tube distal to vocal cords under direct laryngoscopy. Patient had poor minute ventilation, leading to escalating PaCO2 and declining pH. Patient was emergently transferred to OR. A severe tracheal stenosis was found under rigid bronchoscope and ventilation improved after tracheal dilation. A size 8.0 endotracheal tube was advanced over the tube exchanger beyond the stenosis and the rigid bronchoscope was removed with ease. Patient eventually had tracheotomy four days later after failed extubation.



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Sunday, October 14, 2012
11:00 AM - 12:30 PM
MC331

**Management of Unexpected Monomorphic Ventricular Tachycardia**

*Shiraz Yazdani, M.D., Bryan Skulpoonkitti, D.O., Bettina U. Schmitz, M.D., Ph.D., Anesthesiology, Texas Tech University, Lubbock, TX.*

A 26 year-old male underwent laparascopic appendectomy. His medical history was negative. Intraoperatively, he had frequent PVCs. He was asymptomatic and hemodynamically stable. Cardioversion/defibrillation pads were placed as a precaution. General endotracheal anesthesia was induced. PVC frequency increased, with ventricular bigeminy, trigeminy, and NSVT; blood pressure was stable. Lidocaine did not decrease PVCs. The procedure was completed uneventfully. He emerged from anesthesia without issue and was placed on telemetry. Drug screen was negative. Post-operative ECG displayed PVCs as seen intraoperatively. His echocardiogram was negative. A beta-blocker was started without further intervention. He was discharged home and remained asymptomatic on follow-up.

Sunday, October 14, 2012
11:00 AM - 12:30 PM
MC332

**Anesthetic Management During a Case of Sudden Increase in EtCO2**

*Gregory Yoshikawa, M.D., Rebecca E. Lee, M.D., Davinder Ramsingh, M.D., Department of Anesthesiology and Perioperative Care, UC Irvine, Orange, CA.*

This case examines the intraoperative management of a 74 year-old male undergoing a robot-assisted laparoscopic distal pancreatectomy and splenectomy for pancreatic cancer. Thirty minutes into the surgery, a sudden increase in EtCO2 occurred which did not respond to increasing minute ventilation. A subsequent arterial blood gas showed hypercapnia and respiratory acidosis. The patient's other vital signs remained stable throughout; the cause was later attributed to subcutaneous insufflation of carbon dioxide by the surgeon. This cases focuses on the diagnosis and management of subcutaneous emphysema intraoperatively.

Sunday, October 14, 2012
11:00 AM - 12:30 PM
MC333

**Acute Abdominal Compartment Syndrome During Right Total Hip Arthroplasty**

*Remone Yousif, M.D., Zhong-Jin Yang, M.D., Syed Ali, M.D., Reza Gorji, M.D., Anesthesiology, SUNY Upstate Medical University, Syracuse, NY.*

82 year-old female patient with hypertrophic obstructive cardiomyopathy, atrial fibrillation and lymphoma underwent right hip arthroplasty under general anesthesia with standard monitoring plus a left radial arterial line. Anesthesia was maintained with sevoflurane and fentanyl. Patient was positioned on the pegboard table in a left lateral decubitus position. Sudden hemodynamic instablility (hypotension) occurred at surgical conclusion. Aggressive resuscitation included fluids and vasopressors. Patient was found to have distended abdomen and emergent exploratory laparotomy was performed revealing elevated abdomen pressure >30 mmHg and ascites . Patient's hemodynamics improved after the opening of abdomen. A diagnosis of acute abdomen compartment syndrome was made.



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Sunday, October 14, 2012
11:00 AM - 12:30 PM
MC334

**Hyponatremia-Induced Muscle Weakness Leading to a Difficult and Challenging Extubation in the OR**

*John Zaki, M.D., Cosmin Guta, M.D., Anesthesiology, Texas Tech Health Science Center-El Paso, El Paso, TX.*

Transurethral fulguration of the bladder(TUFB) is a conservative form of treatment for bladder related issues.These procedures may require irrigation solution similar to that found in cases of TURP and are a recognized cause of hyponatremia which occurs by intravascular absorption of irrigation solutions that dilutes the serum sodium. We present an unusual case of muscle weakness and respiratory failure after emergence and extubation from anesthesia, attributed to hyponatremia, which developed after a TUFB procedure.After adequate fluid restriction,symptoms of hyponatremia eventually resolved and she was discharged home.

Sunday, October 14, 2012
11:00 AM - 12:30 PM
MC335

**Difficult Airway Management Squared**

*Zebo Zakir, M.D., Jason Mitchell, M.D., Eric Matten, M.D., Anesthesiology, Rush University Medical Center, Chicago, IL, Anesthesiology, North Shore University Health System, Chicago, IL, Anesthesiology, Evanston Northwestern Hospital ANS, Evanston, IL.*

79 year-old female presented to Emergency Department for new onset wheezing, shortness of breath and cough. She was diagnosed with community acquired pneumonia, adrenal insufficiency and multinodular goiter with mass effect causing tracheal deviation and upper airway obstruction. Patient underwent thyroidectomy with awake fiberoptic intubation. In the PACU patient developed enlarging hematoma and was taken emergently to OR for wound exploration. Induction drugs were administered concurrently with surgical removal of the sutures and evacuation of hematoma. The airway was secured with RSI and GlydeScope. The source of active bleeding was found to be the left middle thyroid vein.

Sunday, October 14, 2012
11:00 AM - 12:30 PM
MC336

**Anesthetic Management of a Large Mediastinal Mass for Tracheal Stent Placement**

*Sonal N. Zambare, M.B.,B.S., Suman Rajagopalan, M.D., Anesthesiology, Baylor College of Medicine, Houston, TX.*

64 year-old woman with history of sarcomatoid mediastinal tumor previously treated with chemotherapy and radiotherapy presented with progressively worsening dyspnea. CT scan showed a large mediastinal mass 10.3x10.4x12.7 cms with encroachment on the great vessels, tracheal stenosis and marked right deviation of the trachea. She was scheduled for tracheal stent placement to relieve the compression. General anesthesia with spontaneous ventilation was successfully achieved with a classic LMA, propofol infusion and lower than a MAC of sevoflurane. Our case demonstrates that spontaneous ventilation with LMA will facilitate stent placement in patients with large mediastinal tumor and prevent airway obstruction.



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Sunday, October 14, 2012
11:00 AM - 12:30 PM
MC337

**Anesthetic Considerations in the Resection of Giant Thrombosed Internal Jugular Venous Aneurysm: Risk of Two Major Complications**

*Angela Zauner Cuervo, M.D., William Fernando Amaya Zuñiga, M.D., David Rodriguez Lima, M.D., Daniel Benitez Avila, M.D., Departamento de Anestesia, Departamento de Cuidados Intensivos, Hospital Universitario Fundación Santa Fe de Bogotá, Bogotá, Colombia.*

A 22 year-old woman, with history of congenital left internal jugular venous aneurysm of progressive growth, recent thrombosis, was admitted with neck pain. Ultrasound and CT scan showed an aneurysm of 87x47x61mm with thrombus inside of 50x22x22mm. Pre-anesthetic tests included blood work. An intraoperative rupture of 3,5L with life threatening massive bleeding, occurred within 25 minutes. Crisis management included arterial line, femoral vein access, 3 RBC units, 6 FFP units, 1 platelet afferesis, 720mL from
cell saver, Phenilefrine and Dopamine infusions as needed. After 2 hours of reanimation, acid-base status control and hemodynamic stability allowed extubation in operation room.

Sunday, October 14, 2012
11:00 AM - 12:30 PM
MC338

**Unilateral Post-Operative Visual Loss After Endoscopic Retrograde Cholangiopancreatography in the Prone With Left Lateral Tilt Position**

*Jon Y. Zhou, M.D., James Heitz, M.D., Elaine Kilmartin, M.D., Anesthesiology, Thomas Jefferson University, Philadelphia, PA.*

A 55 year-old man with cholelithiasis presented for endoscopic retrograde cholangiopancreatography with general anesthesia. Although patients at this institution are typically placed in prone position with the head turned to the side, prior complete cervical fusion with no neck mobility required positioning midway between left lateral and prone. The procedure lasted 44 minutes. Postoperatively, the patient had light perception only in the dependent eye due to posterior ischemic optic neuropathy. Postoperative visual loss has rarely been reported from procedures in the lateral position. Asymmetric ocular outcome in lateral position may provide clues as to the etiology of this devastating complication.

Sunday, October 14, 2012
11:00 AM - 12:30 PM
MC339

**Ooops It Happened Again - Two Cardiorespiratory Arrests Prior to AV Fistula Placement**

*Allison Goldfarb, C.R.N.A., Patrick Ziemann-Gimmel, Coastal Anesthesiology Consultants, St. Augustine, FL.*

This 59 year-old patient, with an uneventful past surgical history, suffered a cardio-respiratory arrest and cardiovascular collapse during consecutive attempts to revise an existing AV-fistula: first shortly after uneventful regional anesthesia and second, one month later, shortly after induction of general endotracheal anesthesia (GET) with a constant heart rate. The intraoperative transesephageal echocardiogram showed a “kissing ventricle”. The coronary angiogram showed mild non-obstructive coronary artery disease with preserved ventricular function. The patient recovered fully and was discharged home. Few weeks later the surgery could finally be completed under GET with extremely labile blood pressure.



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Sunday, October 14, 2012
11:00 AM - 12:30 PM
MC340

**A Case of Delayed Emergence**

*Jamie M. Zorn, M.D., Thomas C. Mort, M.D., Anesthesiology, University of Connecticut, Farmington, CT.*

This is the case of a 28 year-old woman who presented for diagnostic laparoscopy for pelvic pain. Her intra-operative course was essentially uneventful but her emergence was extremely prolonged. She met extubation criteria in the OR after an extended wait and was unarousable in the PACU. Therapeutic/Diagnostic management included Narcan, Flumazenil, CT, MRI, and EEG in the PACU. There was no apparent organic cause on imaging and she remained somnolent. Later in the evening (in the Neuro ICU) she spontaneously awakened without knowledge of what had transpired. Underlying cause is inconclusive and diagnosis from neurology at discharge was "psychogenic pseudoseizure."

Sunday, October 14, 2012
11:00 AM - 12:30 PM
MC341

**Anesthesia for a Malignant Hyperthemia-Susceptible Patient Presenting for Liver Transplantation**

*Sarena Teng, M.D., Sara Cheng, M.D., University of Colorado, Aurora, CO.*

A patient with end-stage liver disease, hepatitis C, hepatocellular carcinoma and a history of malignant hyperthermia presented for liver transplantation. A non-triggering anesthetic was administered. An arterial line and central venous lines were placed. Maintenance of anesthesia was achieved with maximum rates of 100 mcg/kg/hr and 0.2 mcg/kg/min of propofol and remifentanil, respectively. Intraoperative events included sudden and profound metabolic acidosis and hyperkalemia during the anhepatic phase. The differential diagnosis and management of these events is discussed.

Monday, October 15, 2012
11:00 AM - 12:30 PM
MC531

**Anesthetic Management of a Bull Rider With a Fractured Right Main Bronchus**

*McNeil L. Cronin, M.D., Debra R. McCutcheon, M.D., Ruth B. Hyde, M.D., Wake Forest School of Medicine, Winston Salem, NC.*

31 year-old male thrown from a bull, presented to the ED with chest pain and dyspnea. CT scan showed a fractured right main bronchus. Pt was breathing spontaneously, completely dependent on negative pressure for ventilation. Upon arrival to OR, the patient's right sided CT's were placed to suction. A 16g PIV and radial a-line placed. With minimal sedation airway blocks were performed. The fiberoptic scope and ETT were advanced into the trachea, with visualization of airway edema and bloody secretions. An 8.0 ETT was passed into the left main bronchus and spontaneous ventilation maintained throughout induction.

Monday, October 15, 2012
11:00 AM - 12:30 PM
MC532

**Successful Treatment of Methemoglobinemia Refractory to Multiple Doses of Methylene Blue: A Case Report**

*Greesh John, M.D., Mohammad Hosseinian, M.D., Ramsis Ghaly, M.D., John H. Stroger Hospital of Cook County, Chicago, IL.*

Methemoglobinemia secondary to benzocaine spray is successfully treated with IV methylene blue 1 mg/kg x 3. Unexplained low oxygen saturation and central cyanosis after benzocaine spray for awake



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fiberoptic in a patient with recent excision of ameloblastoma was suspicious for methemoglobinemia. Chocolate brown blood sample with PaO2 450 while co-oximetry displayed 58% methemoglobin. After 2 unsuccessful doses of IV methylene blue, the oral cavity was rinsed with saline to rid possible residual benzocaine and followed by the third dose. Appropriate decrease in methemoglobin level was seen. The patient was extubated with stable vitals and no neurologic sequela.

Monday, October 15, 2012
11:00 AM - 12:30 PM
MC533
**Cardiac Arrest and Tension Pneumothorax Resulting From a Difficult Airway**
*Lydia Josephs, M.D., Carl Adkins, M.D., Megan K. Way, M.D., UT Southwestern, Dallas, TX.*
A 45 year-old woman with history of stage IV Sinonasal Undiffrentiated Carcinoma presented to the emergency department with severe dyspnea . She was noted to have a very large mass that encompassed the entire oral cavity. She had been 6 weeks status post near complete resection of the mass, however this aggressive tumor fully recurred in this short time period. The mass encompassed the entire oral cavity and prevented her from closing her mouth or laying flat. Her symptoms prompted an emergent, awake tracheostomy. The procedure was complicated by obstruction, tension pneumothorax and cardiac arrest in the operating room.

Monday, October 15, 2012
11:00 AM - 12:30 PM
MC534
**True Allergy to Propofol? You Make the Call**
*Aruna M. Kamath, M.D., M.P.H., Paul G. Barash, M.D., Anesthesiology, Yale University School of Medicine, New Haven, CT.*
A 66 year-old male, who states allergy to propofol, scheduled for T10-L4 revision fusion with neurophysiologic monitoring. Possible allergic reaction (lingual swelling) to propofol noted during treatment of status epilepticus, per patient's wife (witness and nurse by profession). In the context of a hospital shortage of other IV induction agents, propofol was preferred for proposed anesthetic plan, induction, and TIVA maintenance. Anesthetic challenge was to discern true allergy based on limited history, to weigh rarity of propofol reactions and shortage of IV induction agents against emerging literature of adverse outcomes to propofol, and to then create a safe anesthetic plan.

Monday, October 15, 2012
11:00 AM - 12:30 PM
MC535
**Lymphangiomyomatosis: A Case of a Pneumothorax During One Lung Ventilation**
*Megha Karkera, M.D., Anesthesiology, University of Arkansas for Medical Sciences, Little Rock, AR.*
Pt is a 32 year-old female with history significant for dyspnea on exertion, anxiety, and spontaneous pneumothoraces. She was scheduled for a VATS with wedge resection and thorascopic pleurodesis with the preoperative diagnosis of Lymphangiomyomatosis (LAM). Intraoperatively, the patient had a pneumothorax during one lung ventilation. This poster will discuss the signs and symptoms of LAM, perioperative considerations, and intraoperative management.


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Monday, October 15, 2012
11:00 AM - 12:30 PM
MC536

**Hypercarbia and Ventilator Failure: Compounding Difficulties in the Diagnosis of Malignant Hyperthermia**

*Emily J. Kaser, Ruth Hyde, M.D., Anesthesiology, Wake Forest University, Winston-Salem, NC.*

29 year-old female with a history of mental retardation and six prior, uneventful general anesthetics was scheduled for dental surgery under anesthesia. Three hours into the procedure, increasing end-tidal CO2 was noted. During investigation into the rising ETCO2, the Drager Apollo ventilator malfunctioned. Ventilation through a self-inflating bag was started with variable minute ventilation and no ETCO2 monitoring. Hyperventilation was started and an ETCO2 monitor was attached to the self-inflating bag. Hypercarbia was still noted along with a slight increase in temperature. Malignant hyperthermia was suspected and immediately treated with a successful outcome. MH was confirmed with muscle biopsy.

Monday, October 15, 2012
11:00 AM - 12:30 PM
MC537

**C-Mac's D-Blade and Schroeder's Directional Stylet Aided Nasotracheal Intubation in Patient With Restricted Mouth Opening**

*Rashid M. Khan, Sr., M.D., Naresh Kaul, Sr., M.D., Abdullah M. Al-Jadidi, Jr., M.D., Anaesthesia and ICU, Khoula Hospital, Al Harthy Complex, Oman.*

A mouth opening of less than 25 mm is usually associated with failed conventional rigid Macintosh laryngoscopy. [1] Recently, we were faced with a situation of failed fiberoptic intubation (FOI) in a patient with restricted mouth opening secondary to neglected faciomaxillary trauma. In the absence of lightwand availability, expertise in blind nasotracheal intubation, and reluctance to adopt retrograde tracheal intubation as an initial strategy, we successfully intubated this patient using a combination of C-Mac videolaryngoscopy and dynamic alteration in endotracheal tube (ETT) shape using Schroeder's stylet via the right nostril.

Monday, October 15, 2012
11:00 AM - 12:30 PM
MC538

**Cola-Induced Hypokalemia**

*Suzanne Kellman, M.D., Barbara Scavone, M.D., Department of Anesthesia and Critical Care, The University of Chicago, Chicago, IL.*

A pregnant 36F presented with decreased appetite and diarrhea due to severe hypokalemia. History revealed 12 liters of cola consumption per day. Chronic massive cola consumption causes hypokalemia and increases risk for MI and CKD. Glucose leads to insulin secretion and intracellular potassium shift; Fructose causes osmotic diarrhea and potassium loss (Tsimihodimos et al, Int J Clin Pract, 2009). Caffeine's structural similarity to adenosine blocks its activation of K+ATP channels and its inhibition of catecholamine release, both increasing intracellular potassium, leading to hypokalemia (Alasami, Q J Med, 2005). Massive consumption overwhelms caffeine's metabolism, leading to increased effect.



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Monday, October 15, 2012
11:00 AM - 12:30 PM
MC539

**Use of Bronchial Blocker in the Prone Position During CT Guided Abscess Drainage**

*Dost M. Khan, M.D., Paul Kempen, M.D., Anesthesiology, Cleveland Clinic, Cleveland, OH.*

A 43 year-old female with history of stage IV sarcoidosis, prior deep vein thrombosis, and right upper lobe aspergilloma with worsening hemoptysis presented for CT guided abscess drainage and intracavitary amphotericin infusion. Following induction of anesthesia a 7.0 french Arndt endobronchial blocker was placed in the right upper lobe using fiberoptic bronchoscopy and patient positioned prone in the CT scanner with CT confirmation of maintained placement prior to drainage of abscess under CT guidance. Case illustrates use of complex airway equipment in a tight space involving significant patient repositioning.

Monday, October 15, 2012
11:00 AM - 12:30 PM
MC540

**Cardiovascular Compromise After Ethanol Sclerotherapy: A Case Report and Review of Literature**

*Sabina Ali Khan, M.D., Nazish Khalid Hashmi, M.D., Joshua Cain Chance, M.D., Jucelle Occidental, M.D., Resident, Department of Anesthesiology, University of Arkansas for Medical Sciences, Little Rock, AR.*

A 37 year-old female with generalized venous malformations presented for ethanol sclerotherapy under general anesthesia. A total of 30 ml of ethanol was injected during the procedure. The patient became hemodynamically unstable near the completion of the procedure and was treated with epinephrine and atropine. Nitroglycerin was given in anticipation of elevated pulmonary artery pressures. This led to immediate improvement in blood pressure, heart rate, oxygen saturation and end tidal CO2. Prompt diagnosis and rapid treatment allowed this patient to fully recover. It is important to be aware of possible pulmonary hypertension as a consequence of systemic ethanol absorption.

Monday, October 15, 2012
11:00 AM - 12:30 PM
MC541

**Intraoperative Management of Undiagnosed Metastatic Pheochromocytoma**

*Adam B. King, M.D., Anesthesiology, Vanderbilt University, Nashville, TN.*

24 year-old presented for biopsy of 15cm by 9cm iliac crest mass. The patient underwent uneventful induction of anesthesia. Upon biopsy of the mass, the patient developed hypertension and tachycardia. The systolic blood pressure reached 200 up from 130, and heart rate increased from to 120. Anesthetic was deeped without improvement. Metoprolol was given which caused an increase in systolic blood pressure to 220. The blood pressure was then treated with labetalol and hydralizine with a return to baseline. Pathology revealed a pheochromocytoma. The patient was started on alpha blockade and returned later for unremarkable resection of his tumor.

Monday, October 15, 2012
11:00 AM - 12:30 PM
MC542

**Malignant Hyperthermia in a Chinese Female Pediatric Patient During GA for a Dental Procedure at a Large Urban Hospital**

*Igor Kirzhner, M.D., Corey Scher, M.D., Anesthesiology, NYU, New York, NY.*

The above episode occurred in a 2 year Chinese girl with no previous medical history. Preoperative evaluation was conducted using an interpreter and revealed no risk factors for MH. During the case the



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patient developed hypercapnia, tachycardia and fever of 39.4C that failed to respond to cooling with ice packs. After confirming the diagnosis with ABG analysis Dantrolene was administered and MH protocol initiated. The patient's condition rapidly improved and she was transferred to PICU. Further investigation revealed a similar episode in the patient's half-sister 20 years ago.

Monday, October 15, 2012
11:00 AM - 12:30 PM
MC543

**Perioperative Management of an Untreated Pheochromocytoma in a Patient Presenting With Acute Bowel Ischemia**

*Brian P. Kornrumpf, M.D., Deborah M. Whelan, M.D., Daniel J. Forest, M.D., Anesthesiology, Wake Forest University School of Medicine, Winston Salem, NC.*

63 year-old female with hypertension and PVD with a small bowel obstruction conservatively managed at an outside facility due to the presence of a 3cm adrenal pheochromocytoma. She was transferred to our hospital where CT scanning showed ischemic bowel and an aortic thrombus. She presented for urgent exploratory laparotomy without preoperative alpha blockade. Initial anesthetic management focused on sympathetic ablation during induction and laryngoscopy. Upon entry of the abdomen she had necrotic bowel with frank stool contamination. Her clinical status deteriorated due to florid septicemia and her anesthetic management changed from pheochromocytoma management to major fluid resuscitation with vasopressor administration.

Monday, October 15, 2012
11:00 AM - 12:30 PM
MC544

**Securing a Difficult Airway for an Elective Coronoidectomy in a Patient With Ankylosing Spondylitis and History of Emergent Tracheostomy**

*Edward Kosik, D.O., Nathan Putnam, M.D., Anesthesiology, University of Oklahoma HSC, Oklahoma City, OK.*

A case of a 33 year-old male scheduled for coronoidectomy with a history of ankylosing spondylitis and previous emergent tracheostomy. The patient had a history of severe anxiety and drug abuse and refused an awake intubation unless absolutely necessary. The surgeon requested a nasal intubation. A bilateral glossopharyngeal nerve block was performed and antisialalogue administered. The patient was sedated with small doses of propofol and volatile agent. An nasoendotracheal tube was inserted and glidescope visualization of the glottis and endotracheal tube introducer placement were unsuccessful. After surgeon approval, an LMA with fiberoptic guidance of endotracheal tube was successful.

Monday, October 15, 2012
11:00 AM - 12:30 PM
MC545

**Acute Hyperammonemia in a Young Adult With Previously Unrecognized Ornithine Transcarbamylase Deficiency and Hepatocellular Carcinoma: A Case Report**

*James Krakowski, M.D., Ibtesam Hilmi, M.D., Anesthesiology, UPMC, Pittsburgh, PA.*

An 18 year-old female presented with vomiting and progressive confusion. Her laboratory and imaging workup revealed positive HCV antibody, ammonia level of 322 mmol/L, mildly elevated liver transaminases, left lung nodule, and large intrahepatic mass. Percutaneous biopsy revealed hepatocellular carcinoma. She underwent hemodialysis for hyperammonemia and fasciotomy for Ileofemoral DVT with compartment syndrome. Consideration of portosystemic shunt and inborn error of metabolism were entertained, leading to hepatic artery embolization and metabolic panel for urea cycle



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disorder. Results were consistent with ornithine transcarbamylase deficiency. After successful ammonia reduction, the patient underwent hepatic trisegmentectomy and lung wedge resection with later discharge to home.

Monday, October 15, 2012
11:00 AM - 12:30 PM
MC546

**The Heart Doesn't Lie: Management of Symptomatic Intraoperative New Onset Atrial Fibrillation**

*Sachin Kulkarni, M.D., Tina Tran, M.D., Anesthesiology and Critical Care Medicine, The Johns Hopkins Hospital, Baltimore, MD.*

79 year-old healthy male status-post recent cervical decompression presented for spinal fusion. Upon arrival, he complained of nausea. He was discovered to be in atrial fibrillation with rapid ventricular response. Esmolol boluses transiently altered his cardiac rhythm to sinus tachycardia. Hypotension was also noted. Additional IV access and arterial cannulation was obtained to optimize management and treatment of cardiac instability. He was transported to the ICU for work up of etiology of new onset arrhythmia including hypovolemia, anemia, myocardial ischemia, cardiomyopathy, infection and electrolyte imbalances. Detailed clinical evaluation and diligent monitoring are critical to managing cardiopulmonary instability.

Monday, October 15, 2012
11:00 AM - 12:30 PM
MC547

**Anterior Mediastinal Mass With SVC Syndrome and Difficult Airway: Anesthetic Management in a Remote Location**

*Catherine Kuo, M.D., Timothy Olund, M.D., Anesthesiology, Medical College of Wisconsin, Milwaukee, WI.*

53 year-old female arrives on New Year's Eve with a large anterior mediastinal mass causing both tracheal compression and superior vena cava (SVC) syndrome. The surgeons wish to urgently place an SVC stent in a remote location, the interventional radiology suite. The patient is dyspneic at rest on a 100% oxygen facemask, sitting upright, and is morbidly obese with a history of difficult airway including past failed awake fiberoptic intubation. This is further complicated by a nosebleed and a swollen face, likely from the SVC syndrome. We further elaborate on the anesthetic considerations and management for this patient and syndrome.

Monday, October 15, 2012
11:00 AM - 12:30 PM
MC548

**A Surprising Cause of Wheezing in an Obese Patient - A Case Report**

*Lakshmi N. Kurnutala, M.D., Sangeetha Kamath, M.D., Joel M. Yarmush, M.D., Joseph SchianodiCola, M.D., Anesthesiology, New York Methodist Hospital, Brooklyn, NY.*

A 54 year-old, 168 kg man with a "known history" of asthmatic COPD was scheduled for an emergent debridement of Fournier's gangrene. Physical examination revealed tachypnea and diffuse bilateral wheezing. In the sitting position, his SpO2 was 99% on 50% oxygen. When supine, he became cyanotic with a SpO2 of ~ 85%. He was treated with bronchodilating nebulizers.
An awake fiberoptic intubation was performed in the semi-Fowler's position (45°). Tracheomalacia was observed and the wheezing was completely resolved after insertion of an endotracheal tube. The endotracheal tube stented the airway open and improved air entry. Surgery then proceeded uneventfully.



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Monday, October 15, 2012
11:00 AM - 12:30 PM
MC549

**Aspiration During Electroconvulsive Therapy (ECT) Under General Anesthesia - A Case Report**

*Lakshmi N. Kurnutala, M.D., Sangeetha Kamath, M.D., Joel M. Yarmush, M.D., Joseph SchianodiCola, M.D., Anesthesiology, New York Methodist Hospital, Brooklyn, NY.*

An otherwise healthy man was scheduled for an ECT for major depression. His medications were quetiapine and venlafaxine. He was NPO for greater than 14 hours. The patient was easily ventilated after induction of anesthesia with methohexital and succinylcholine. After two electrical stimulations, the patient had an adequate seizure. However, the patient then vomited copious amounts of semi-solid food. He was quickly intubated, sedated and transferred to the ICU (FiO2 100%, SpO2 88-90%). Bronchoscopy revealed partially digested rice and beans, eaten the day before. The patient had gastroparesis, which was previously undiagnosed. This was attributed to his medications and depression.

Monday, October 15, 2012
11:00 AM - 12:30 PM
MC550

**Difficult and Failed Airway Management in a Neck Hematoma Patient - A Case Report**

*Lakshmi N. Kurnutala, M.D., Sangeetha Kamath, M.D., Joel M. Yarmush, M.D., Joseph SchianodiCola, M.D., Anesthesiology, New York Methodist Hospital, Brooklyn, NY.*

Neck swelling was noted the morning after an uneventful left carotid endarterectomy in an elderly man. The surgeon felt that any possible hematoma was limited and not increasing in size. That evening, the patient suffered a sudden respiratory arrest, which led to bradycardia and asystole. Bag mask ventilation was ineffective. The vocal cords were unable to be visualized on laryngoscopy. Insertion of an Air-Q® allowed adequate ventilation (O2 Sat ~ 96%) Fiberoptic bronchoscopy revealed edema and near-complete obstruction of the tracheal opening. Emergency tracheostomy was followed by exploration and evacuation of a hematoma. Airway edema subsided only after three days.

Monday, October 15, 2012
11:00 AM - 12:30 PM
MC551

**Case Report of a Novel Hybrid Approach to Endovascular TAAA Repair and Anesthetic Concerns**

*Audrie M. Lasater, Robert S. Isaak, D.O., Anesthesiology, University of North Carolina at Chapel Hill, Chapel Hill, NC.*

Case report of a 67 year-old male with 7.5 cm TAAA and also with ischemic myopathy and EF of 25%, chronic kidney disease, severe PVD and end stage COPD on chronic oxygen therapy with DLCO of 39% to undergo hybrid approach for endovascular repair. Hepatorenal bypass was performed followed by an endovascular aneurysm repair two days later. The perioperative course was complicated by spinal cord ischemia, renal failure, and ischemic bowel. Report discusses the surgical techniques involved in this novel hybrid approach as well as anesthetic concerns, management, and monitoring in the preop, intraop, and post op period.



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Monday, October 15, 2012
11:00 AM - 12:30 PM
MC552

**Challenging Airway in a Patient With Crouzon's Syndrome**

*Diana H. Lee, D.O., Alice Tsao, D.O., Anesthesia, Riverside County Regional Medical Center, Moreno Valley, CA.*

33 year-old female with a history of Crouzon's syndrome, seizure disorder, osteoporosis, mental retardation, morbid obesity presented for right tympanomastoidectomy with facial nerve monitoring and left ear myringotomy tube insertion. She was 4'10", 90.8kg (BMI 41.8) with dental crowding, high arch, Mallampati 3, large tongue, and thick neck. There was difficulty in masking the patient due to craniofacial abnormalities and her body habitus. Endotracheal tube placement was successful with few attempts after Dexmedetomidine sedation, Ketamine/Propofol supplementation, and with the video laryngoscope and cricoid manipulation.

Monday, October 15, 2012
11:00 AM - 12:30 PM
MC553

**One-Lung Ventilation for Resection of Right Mainstem Bronchial Tumor With Tracheal Extension: Bedside Modification for a Short Cuff-to-Tip Length Endobronchial Tube**

*Jiwon Lee, M.D., Jae-Hyon Bahk, M.D.,Ph.D., Yunseok Jeon, M.D.,Ph.D., Jeong-Hwa Seo, M.D.,Ph.D., Hyun Joo Kim, M.D., Anesthesiology and Pain Medicine, Seoul National University Hospital, Seoul, Korea, Republic of.*

For OLV during resection of right bronchial tumor with tracheal extension, we needed a tube with short cuff-to-tip length for placing into LMB. Although a nasal RAE tube has the shortest cuff length, its cuff-to-tip length was even longer than the length of LMB, so we cut off the tube distal to the cuff. Because the distal inflating tube became opened after cutting, we cauterized the end of the opened inflating tube to seal. Afterwards, the tube was lengthened by end-to-end connection with the proximal part of a plain tube that was cut in the middle.

Monday, October 15, 2012
11:00 AM - 12:30 PM
MC554

**Intraoperative Opioid-Free Anesthesia for a 68 Year-Old Morbidly Obese Male With Ischemic Cardiomyopahty Using Simultaneous Intravenous Lidocaine and Dexmedetomidine Infusions**

*Agnieszka Lesicka, M.D., T. Anthony Anderson, M.D., Ph.D., Department of Anesthesia, Critical Care and Pain Medicine, Massachusetts General Hospital, Boston, MA.*

We present the case of a 68 year-old man with morbid obesity, obstructive sleep apnea, coronary artery disease, and ischemic cardiomyopathy with significantly reduced ejection fraction who presented for open reduction and internal fixation of zygomatic maxillary complex fracture. The patient was induced with etomidate, lidocaine, dexmedetomidine, and succinylcholine. He was maintained on nitrous oxide, dexmedetomidine, lidocaine infusions and required no opioids intraoperatively. He remained hemodynamically stable, without episodes of tachycardia or hypertension on intubation, incision, surgical stimulation, nor extubation. Upon emergence and after extubation, the patient was hemodynamically stable, alert, pain free, without respiratory depression or airway obstruction.



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Monday, October 15, 2012
11:00 AM - 12:30 PM
MC555

**Postoperative Thyroid Hematoma Management in Parallel With the Surgical Team**

*Vanetta L. Levesque, M.D., Andrew Kroh, M.D., Anesthesiology, Maimonides Medical Center, Brooklyn, NY.*

An 87 year-old woman with a history of chronic right vocal cord paralysis from right thyroidectomy was scheduled for resection of a left substernal thyroid goiter. The patient had a history of tracheomalacia, CHF with orthopnea, HTN, and Afib. She underwent an awake fiberoptic nasal intubation. She had mild stridor upon extubation, but adequate oxygenation/ventilation, and no respiratory muscle fatigue. In the PACU, one hour postoperatively, the patient went into respiratory then cardiac arrests. During CPR the neck wound was reopened and a compressive hematoma evacuated. The patient was then taken back to the OR for a emergent tracheostomy.

Monday, October 15, 2012
11:00 AM - 12:30 PM
MC556

**Cardiovascular Collapse Following the Administration of Intravenous Cefazolin for Elective Total Abdominal Hysterectomy**

*Joan Spiegel, M.D., Alexandra Lewis, M.D., Anesthesia And Critical Care Medicine, BIDMC/Harvard Medical School, Boston, MA.*

A 54 year-old woman presented for total abdominal hysterectomy. She was induced with propofol, hydromorphone, and rocuronium without difficulty. She then received cefazolin 2gm. Three minutes later, ETCO2 was 18mmHg. SBP was 70/40 and HR 120BPM. On exam, no wheezing or rash was noted. EKG revealed ST depressions laterally. TEE revealed hyperdynamic ventricles, poor filling and inferior wall hypokinesis. Pulseless V-Tach ensued and CPR was initiated with success. A diffuse erythematous rash emerged. The patient was extubated w/in 24hrs. Serum tryptase within 1hr of cardiovascular collapse was 45ng/mL. Follow-up studies revealed a reactive pinprick test to cefazolin, but not penicillin.

Monday, October 15, 2012
11:00 AM - 12:30 PM
MC557

**A Case Report: Venous Air Embolism During Colonoscopy in a Crohn's Disease Patient**

*Jia Liu, M.D., Tatyana Kopyeva, M.D., Anesthesiology, Cleveland Clinic Foundation, Cleveland, OH.*

Colonoscopy is a widely used and minimally invasive diagnostic and therapeutic modality. Commonly reported complications are perforation and bleeding. Venous air embolism from the procedure, however, is rarely reported. This article reports a challenging case that we encountered in the operating room where a patient with Crohn’s disease developed pulseless electrical activity (PEA) likely caused by venous air embolism while undergoing colonoscopy. The article also discusses the possible route of entry of the air. VAE is a rare event, especially in colonoscopy, but the consequence can be serious, even life-threatening. Anesthesiologist should be aware.



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Monday, October 15, 2012
11:00 AM - 12:30 PM
MC558

**Large Mandibular Mass in a 14 year-old Afghan Female Requiring Use of Awake Fiberoptic Nasal Approach to Intubation**

*Mark Liu, Victor Rivera, M.D., Eric Kent, M.D., Megan Lehr, M.D., Anesthesiology, SAUSHEC, Colorado Springs, CO, Flight Medicine, Quantico Clinic, Quantico, VA, USA, Anesthesiology, Portsmouth Naval Hospital, Portsmouth, VA, Anesthesiology, Keesler Medical Center, Biloxi, MS.*

A 14 year-old ASA 3 Dari speaking Afghan female presented with a large right mandibular mass (8.3cm x 8.3cm x 7.5cm) destroying the right mandibular condyle and ramus, with partial destruction of the mandibular body. The mass significantly limited her interincisor gap to 1.5cm. Mass effect resulted in leftward pharyngeal deviation. Distortion of the mandible, size, and location of the mass presented anticipated difficulty with mask ventilation. Anatomic abnormalities resulting from the mass necessitated an awake nasal approach for intubation.

Monday, October 15, 2012
11:00 AM - 12:30 PM
MC559

**Large Thyroid Mass With Severe Impingement of Trachea Requiring Awake Fiberoptic Intubation and Use of Armored ETT**

*Mark Liu, M.D., Christopher Nagy, M.D., Eric Kent, Richard Barnett, M.D., Anesthesiology, SAUSHEC, San Antonio, TX, Naval Medical Center Portsmouth, Portsmouth, VA, Otolaryngology, Eglin Air Force Base, Eglin AAFB, FL.*

A 55 year-old ASA 4 Dari speaking Afghan female presented with a large left thyroid mass (9cmx 13cmx 7cm) extending from the posterior oropharynx to the aortic arch. The mass compressed her trachea to 3mm in diameter 2cm below the vocal cords. Due to the size, vascularity, and distorted tracheal anatomy, ENT anticipated difficulty with an awake tracheostomy. Diagnostic FNA was the planned alternative to thyroidectomy if a definitive airway could not be obtained. Mediastinal involvement and tracheal deviation necessitated awake fiberoptic intubation with a reinforced ETT.

Monday, October 15, 2012
11:00 AM - 12:30 PM
MC560

**Chlorhexidine Impregnated Central Venous Catheter Inducing Life Threatening Anaphylaxis**

*Dustin Lloyd, University of Arizona, Tucson, AZ.*

Chlorhexidine is a synthetic bis-biguanide antiseptic that is commonly used in both medical and non-medical fields. Central venous catheters coated with chlorhexidine have been shown to significantly reduce catheter associated blood stream infections. Unfortunately, adverse reactions to chlorhexidine do occur. We report a case of a 79 year-old female who had two separate episodes of life threatening anaphylaxis shortly after placement of a chlorhexidine coated central line. She was successfully resuscitated and was ultimately found to have positive intradermal and skin prick testing to chlorhexidine.



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Monday, October 15, 2012
11:00 AM - 12:30 PM
MC561

**Coronary Artery Stents and Non-Cardiac Surgery in a Patient With a Recent Myocardial Infarction**

*Jeff Longnion, M.D., H. David Hardman, M.D., M.B.A., Anesthesiology, University of North Carolina at Chapel Hill, Chapel Hill, NC.*

A 68 year-old male with DM, ESRD, and CAD, was scheduled for surgery to create an AV fistula. His medical history was significant for a NSTEMI 8 days previously, with a DES placed in his LAD. Medications included Prasugrel and ASA. We will discuss the anesthetic challenges associated with this case.

Monday, October 15, 2012
11:00 AM - 12:30 PM
MC562

When Two Tools Are Better Than One: Securing a Difficult Airway With the Combined Use of a Fiberoptic Bronchoscope and Glidescope

*Jeff Longnion, M.D., H. David Hardman, M.D.,M.B.A., Robert Silvers, C.R.N.A., Robert Matthews, C.R.N.A., Anesthesiology, University of North Carolina at Chapel Hill, Chapel Hill, NC.*

A 68 year-old black male with small cell metastatic lung cancer presented with stridor, secondary to a large left sided neck mass with extreme right lateral laryngeal deviation. He was brought to the operating room for a planned awake nasal fiberoptic intubation, followed by tracheostomy. A bronchoscope was positioned in the mid-trachea, but we were unable to advance the endotracheal tube due to resistance. A Glidescope was inserted in the oral pharynx, revealing a 90 degree anterior rotation of the glottis. Under direct vision, we were then able to exert sufficient mechanical pressure to redirect the tube into the trachea.

Monday, October 15, 2012
11:00 AM - 12:30 PM
MC563

**Perioperative Discovery and Management of HCM in the Setting of Emergency Laparoscopic Surgery**

*Jack Louro, M.D., Jessica Brodt, M.D., Roman Dudaryk, M.D., Anesthesiology, UM/Jackson Memorial Hospital, Miami, FL.*

We will present the case of a young patient with undiagnosed hypertrophic cardiomyopathy undergoing emergent laparoscopic appendectomy. We will discuss the red flags that can alert anesthesia providers of the condition in the preoperative setting, including ECG changes and imaging modalities targeted at abdominal pathology. We will review the pathophysiology of hypertrophic cardiomyopathy along with the impact of open versus laparoscopic procedures on the anesthetic management. Special attention will be given to the intraoperative diagnostic modalities available to the anesthesiologist and the intraoperative management of such patients including the use of TEE for diagnosis confirmation and maintenance of optimal hemodynamics.

Monday, October 15, 2012
2:30 PM - 4:00 PM
MC608

**A Case of Intraoperative Extubation Secondary to Maloney Esophageal Dilator Placement**

*Gary S. Okum, M.D., Gregory Turner Simmons, M.D., Anesthesiology, Drexel University College of Medicine, Philadelphia, PA.*

The Maloney Esophageal Dilator is one of several devices employed by surgeons during gastric bypass surgery with which anesthesia providers may be unfamiliar. We report a case of inadvertant tracheal



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extubation during positioning of a Maloney Dilator. As gastric bypass surgical volume grows exponentially, so too grows the risk of encountering this complication. Given the airway challenges already posed by these patients, extreme caution is advised when manipulating these devices.

Monday, October 15, 2012
2:30 PM - 4:00 PM
MC609

**Anesthetic Management of Simultaneous Emergent Decompressive Craniectomy and Splenectomy: A Case Report**

*Shannon Ong, M.D., Department of Anesthesiology, University of Arkansas for Medical Sciences, Little Rock, AR.*

Many trauma patients sustain multiple injuries that require surgical interventions often by more than one surgical service, and in rare cases, have multiple emergent diagnoses where simultaneous emergency surgeries must be performed. There are few, if any, documented cases on the anesthetic management of these types of patients. Thus, we describe the perioperative anesthetic management and post-operative course of a 64-year-old male with hypertension and diabetes mellitus II, who sustained multiple traumatic injuries after a motor vehicle accident, most significant for bilateral subdural hematomas with midline shift and a grade III splenic laceration, undergoing simultaneous emergent splenectomy and decompressive hemicraniectomy.

Monday, October 15, 2012
2:30 PM - 4:00 PM
MC610

**Management of a Patient with perioperative saddle embolus after IMN of tibia fracture**

*Jaime Ortiz, M.D., Austin Lee, M.D., Baylor College of Medicine, Houston, TX.*

45 year-old African-American male with no past medical history s/p auto-ped accident came to the OR for intramedullary nailing of left tibia fracture. Patient had an uneventful surgery until emergence, when patient had persistent hypoxemia after extubation even though he was awake and ventilating well. After no improvement noted in PACU, CT scan was ordered and found a saddle embolus involving multiple segments of the lung. In addition, a left leg DVT was found. An echocardiogram showed right ventricle dilatation and decreased function. Treatment with heparin was begun and the patient began a slow recovery until eventual dicharge home.

Monday, October 15, 2012
2:30 PM - 4:00 PM
MC611

**Isolated Hyperthermia or Something Else?**

*Sean Owens, D.O., Tina Tran, M.D., Emmett Whitaker, M.D., Shawn Sumida, M.D., Jai Lee, M.D., Anesthesiology and Critical Care Medicine, Johns Hopkins University School of Medicine, Baltimore, MD.*

A previously healthy 29 year-old patient presented for laparoscopic donor nephrectomy. After preoperative evaluation, general anesthesia was induced with propofol 200 mg, vecuronium 10 mg, and hydromorphone 1.6mg. Access to the peritoneum and insufflation with $CO_2$ were carried out uneventfully. Core temperature as measured by esophageal probe increased from 36.4 C to 44.6 C over several minutes. Probe was repositioned and replaced without change in reading. TIVA was initiated. Laboratory studies were unrevealing. No other signs of malignant hyperthermia were noted, thus dantrolene was not given. Shivering and prolonged weakness following subsequent anesthetic several days later, despite TIVA.



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Monday, October 15, 2012
2:30 PM - 4:00 PM
MC612

**Reviewing the Anesthetic Implications of Kartagener's Syndrome**

*Raj M. Parekh, M.D., Meg Rosenblatt, M.D., Anesthesiology, Mount Sinai Medical Center, NYC, NY.*

A 19 year-old, 62 kg male with Kartagener's Syndrome (triad of sinusitis, bronchiectasis, and situs inversus) presented with epigastric pain and elevated lipase for a laparoscopic cholecystectomy following an episode of gallstone pancreatitis. His chronic sinusitis and bronchiectasis secondary to his primary ciliary dysfunction (PCD) posed anesthetic challenges and his anatomic anomalies posed surgical ones. An anesthetic plan was developed that included minimizing 1) airway secretions, 2) airway manipulations and 3) postoperative mucocilliary dysfunction, while appreciating the need for a rapid induction of anesthesia. After the surgery, his trachea was extubated and he had an uneventful postoperative course.

Monday, October 15, 2012
2:30 PM - 4:00 PM
MC613

**Two Suspected Cases of Halogenated Volatile Anesthetics Induced Hepatitis May Not Actually be Caused by Volatile Anesthetics**

*Shahmohammed F. Parves, M.D., Barbara Gold, M.D., Ann Chinnakotla, M.S.N., Kumar Belani, M.D., Department of Anesthesiology, Preoperative Assessment Center, University of Minnesota, Minneapolis, MN.*

Two very challenging cases of hepatitis after general anesthesia with desflurane and isoflurane were diagnosed by the Pathologist and Hepatologist. A detailed review revealed that both were women and had identical procedure performed by the same surgeon with a similar clinical postoperative course and changes leading to clinical hepatitis. Isosulfan blue was used in both of these two cases, which has a high risk of allergy and immune response. Hepatitis is rare with isoflurane and even rarer following desflurane. Therefore, we believe that these patients most likely developed isosulfan blue related hepatitis.

Monday, October 15, 2012
2:30 PM - 4:00 PM
MC614

**Serotonin Syndrome in the Postoperative Period**

*Kunal Patel, M.D., Anesthesiology, Boston Medical Center, Boston, MA.*

This case report involves a 44 year-old male with a history of depression being treated with duloxetine 60 mg per day who underwent a mandibular osteotomy with a sagital split under general anesthesia. The intraoperative period was uneventful. One hour after arrival to the post anesthesia care unit the patient became agitated, confused and diaphoretic accompanied by shivering and tremors. A differential diagnosis was developed headlined by serotonin syndrome given the patient's history, symptoms and preoperative assessment. The patient received supportive treatment, symptoms resolved in less than 24 hours and patient was discharged home on hospital day 2.



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Monday, October 15, 2012
2:30 PM - 4:00 PM
MC615

**Blind Oral Intubation of Patient With Large Supraglotic Mass**

Mayur B. Patel, M.D., Mohamed Ismaeil, M.D., Anesthesiology, University of Arkansas for Medical Sciences, Little Rock, AR.

A 56 year-old man with presented to the ENT outpatient clinic of our hospital, with a six month history of > 25lbs weight loss and worsening dysphagia with solids and liquids. Patient had sleep apnea secondary to obstructing pharyngeal mass. CT of neck with contrast showed a large enhancing mass along the epiglottis measuring 2.6 x 3.6 by 3.1 cm in size. There was extension into the vallecula, especially on the right side. There is involvement of the pre-epiglottic fat space extending into the supraglottic larynx. There was thickening of the right greater than left aryepiglottic folds.

Monday, October 15, 2012
2:30 PM - 4:00 PM
MC616

**Perioperative Management of a Patient With Hyperkalemic Periodic Paralysis**

*Ravi Pathak, M.D., Thomas A. Anderson, M.D., Ph.D., Department of Anesthesia, Critical Care, and Pain Medicine, Massachusetts General Hospital/Harvard Medical School, Boston, MA.*

57 year-old man with hyperkalemic periodic paralysis (HPP) for total thyroidectomy. Prior to surgery, patient was being treated with dichlorphenamide and albuterol but experiencing frequent episodes of paralysis affecting his extremities and tongue. Malignant-hyperthermia precautions were taken: volatile vaporizers were removed and the anesthesia machine was changed and flushed. Prior to induction two hot-air warmers and fluid warmers were utilized to maintain normothermia. Fluids and drugs that may increase serum potassium were avoided. Patient was induced with propofol and remifentanil. General anesthesia was maintained with nitrous oxide, propofol infusion, and fentanyl infusion. The patient remained asymptomatic through the perioperative period.

Monday, October 15, 2012
2:30 PM - 4:00 PM
MC617

**Pulmonary Cement Embolism During Reconstructive Spine Surgery**

*Murali S. Patri, M.D.,F.R.C.A, Arturo Suarez, M.D., Zachary Price, M.D., Anaesthesia, Henry Ford Health System, Detroit, MI.*

Pulmonary cement embolism is a known and serious complication of procedures like vertebroplasty. We would like to present a case of a incidental finding of pulmonary cement embolism in a 71-year-old lady, who underwent reconstructive spine surgery for scoliosis. Following surgery, the patient had a chest x-ray demonstrating a right-sided pulmonary embolism from a cement migration. CTscan showed a large central right lower lobe pulmonary artery cement emboli with numerous additional smaller and more peripheral bilateral upper lobe and right middle lobe cement emboli. The patient was entirely asymptomatic and made an uneventful postoperative recovery.



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Monday, October 15, 2012
2:30 PM - 4:00 PM
MC618

**The Elderly Patient With a Mediastinal Mass Causing Tracheal Compromise**

*Leroy Phillips, M.D., Franco Resta-Flarer, M.D., Jonathan B. Lesser, M.D., Anesthesiology, St. Luke's - Roosevelt Hospital Center, New York, NY.*

93 year-old female with hypothyroidism, mitral regurgitation, pulmonary hypertension, and recent pneumonia with productive cough and worsening dyspnea presented with a mediastinal mass causing significant tracheal deviation. Chest CT demonstrated a large substernal goiter. The patient was initially referred to cardiothoracic surgery for endotracheal stenting; however, total thyroidectomy was deemed the best option to alleviate tracheal compressive symptoms. Using videolaryngoscopy (Glidescope) a 6.0 NIM ETT could not be advanced due to resistance. A regular 6.0 ID ETT was advanced beyond the tracheal obstruction and the patient was successfully ventilated and extubated at the end of the procedure.

Monday, October 15, 2012
2:30 PM - 4:00 PM
MC619

**Difficult Airway in a Carotid Artery Transection With Questionable Acute Stroke**

*Sudheer Potru, D.O., Richard McNeer, M.D., Ph.D., Anesthesiology, University of Miami, Miami, FL.*

A 58-year-old female sustained a single gunshot wound to Zone II of the right neck, and was found with profuse bleeding, agonal respirations, and movement of only her right lower extremities. After multiple failed intubation attempts in the field, cricothyroidotomy (ETT6.0) was performed.
With no blood pressure reading upon arrival, the patient was reintubated (ETT8.0) and massive transfusion was initiated. She underwent an emergent neck exploration, which with extension to median sternotomy revealed injury to the right internal jugular vein necessitating ligation, as well as significant transection of the right common carotid artery requiring extensive resection and primary repair.

Monday, October 15, 2012
2:30 PM - 4:00 PM
MC620

**Airway Management in an Adult With a 5.6mm Tracheal Stenosis**

*Alison S. Powell, M.D., Ryan C. Gardner, M.D., Priya A. Kumar, M.D., Harendra Arora, M.B., B.S., Anesthesiology, University of North Carolina Hospitals, Chapel Hill, NC.*

A 46 year-old female was transferred from an outside hospital for management of possible tracheal compression and respiratory compromise. She presented to the OR for planned tracheostomy and biopsy of a large mass severely compressing and invading the trachea, causing tracheal deviation, with a stenotic area near the glottis. The patient reported a history of difficult intubation. An awake fiberoptic intubation was performed with Heliox on standby in case of respiratory compromise. The procedure was complicated by excessive tissue, large tumor, and distorted anatomy. The trach was positioned successfully in the tracheal lumen after four encounters with a false passage.



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Monday, October 15, 2012
2:30 PM - 4:00 PM
MC621

**Calamity in the OR: Severe Anaphylaxis Following Induction of General Anesthesia**

*Scott G. Pritzlaff, M.D., Mazen A. Maktabi, M.B., B.Ch., Anesthesia, Critical Care, and Pain Medicine, Massachusetts General Hospital, Boston, MA.*

A 59 year-old male with an abdominal mucinous neoplasm presented for planned cytoreductive surgery with hyperthermic intraperitoneal chemotherapy. Following induction of general anesthesia, preoperative antibiotics were administered. During subsequent placement of a central venous catheter, the patient developed hypotension that escalated to cardiovascular collapse with diffuse urticaria. Immediate resuscitation was initiated with epinephrine and crystalloid. The patient survived anaphylaxis because of the heightened vigilance of a second anesthesiologist present during a period of task saturation. A high index of suspicion, closed loop communication, teamwork, and rapid recognition of this potentially lethal event were essential for successful treatment of this patient.

Monday, October 15, 2012
2:30 PM - 4:00 PM
MC622

**The Management of Severe Pulmonary Hypertension in a Renal Transplant Recipient**

*Peter Pryzbylkowski, M.D., Cobin Soelberg, M.D., Linda Chen, M.D., Department of Anesthesiology and Critical Care, Hospital of the University of Pennsylvania, Philadelphia, PA.*

This case report describes the anesthetic management of a ESRD (end stage renal disease) patient on HD (hemodialysis) with severe PAH (pulmonary arterial hypertension) who underwent orthotopic kidney transplant. The prevalence of pulmonary hypertension in the ESRD patient population is well established. The development of PAH in ESRD patients is created by a multitude of physiologic factors. It is important when evaluating patients who are undergoing kidney transplantation that previous cardiac studies are reviewed and a cohesive plan is formulated to treat PAH intraoperatively.

Monday, October 15, 2012
2:30 PM - 4:00 PM
MC623

**Perioperative Conversion Disorder (Non-Epileptic Seizure)**

*Nathan G. Putnam, Anesthesiology, University of Oklahoma Health Sciences Center, Oklahoma City, OK.*

During emergence from routine general anesthesia after a benign gynecologic procedure, a 50 year-old female developed seizure-like activity. The patient was known to have multiple drug allergies and be taking herbal medicines, including black cohosh. Organic causes were ruled out through laboratory testing. Neurology was consulted and an EEG was performed that ruled out an epileptic seizure or status-epilepticus. The patient was diagnosed with Conversion Disorder and was managed appropriately.

Monday, October 15, 2012
2:30 PM - 4:00 PM
MC624

**Routine Chest X-Ray: A Not so Routine Left Internal Jugular Line Position**

*Shahbaz Qavi, M.D., Natasha Malackany, M.D., Antonio Ramirez, M.D., Anesthesiology, Cleveland Clinic Foundation, Cleveland, OH.*

59 year-old female S/P robotic right partial nephrectomy with left IJ central line, placed intraoperatively for venous access, had routine chest x-ray to verify line placement (Fig1) The left IJ failed to cross



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midline and ended at the level of the aortic arch. A ventriculocaval shunt was seen in right SVC. CVP was transduced with appropriate waveform & pressure. Radiology report suggested a left SVC which has an incidence of 0.3%. Presence of partial anomalous pulmonary venous drainage cannot be excluded. There is possibility of erosion in such a vessel. Recognition of anatomical variants by anesthesiologists is extremely important.

Monday, October 15, 2012
2:30 PM - 4:00 PM
MC625
**An Overenthusiastic Pacemaker**
*Shobana Rajan, M.D., Jiang Wu, M.D., Reem Khatib, M.D., Robert Helfand, M.D., Department of Anesthesiology, Cleveland Clinic, Cleveland, OH.*
48 year-old male with a DDD pacemaker presented for lumbar laminectomy.Shortly after incision, use of electrocautery triggered ventricular tachycardia and low blood pressure. The abnormal rhythm subsided with medications and surgery was resumed. Use of the bovie again led to wide complex tachycardia. The pacemaker spike detection showed that the pacemaker was the culprit.
Pacemaker mediated tachycardia can occur with dual chamber pacemakers with atrial sensing (Cross Talk). It happens due to retrograde activation of the atrium and can be terminated by interrupting the retrograde loop. The pacemaker should be reprogrammed to prolong the post ventricular AV conduction delay.

Monday, October 15, 2012
2:30 PM - 4:00 PM
MC626
**Early Recognition and Management of Intraoperative Pulmonary Embolism**
*Saima Rashid, Jonathan Gal, M.D., James Eisenkraft, M.D., Anesthesiology, Mount Sinai Medical Center, New York, NY.*
An 81 year-old with no significant medical history presented for total hip arthroplasty to treat a hip fracture. An epidural catheter was placed for postoperative pain management, followed by induction of general endotracheal anesthesia. Immediately following left lateral decubitus positioning, end-tidal CO2 decreased despite presence of breathsounds bilaterally. Simultaneously, hypotension occurred, minimally responsive to vasopressors, but began improving with intravenous fluid boluses. An arterial blood gas demonstrated increased PCO2 and significant A-a gradient. The patient was returned to supine position. Transesophageal echocardiogram revealed dilated right atrium and ventricle. The patient was transported to an intensive care unit for further management.

Monday, October 15, 2012
2:30 PM - 4:00 PM
MC627
**Successful Intubation and 45 Min Into Surgery Sao2 Dropping and no Etco2**
*Shamantha G. Reddy, M.D., Anesthesiology, Montefiore Medical Center, New Hyde Park, NY.*
24yrM obese for mandibularosteotomy has sleep apnea, asthma, Mallampati3 airway. With emergency airway equipment available, patient was induced, intubated nasally with Mac3. 45min into surgery Sao2, etco2 started dropping. Tidalvolumes decreased. Nasalrae was cut by the drill accidentally. Airway was bloody. Tube exchanger was available. 2assistants maintained suction. As the intubation was not difficult, pt was kept ventilated through original tube by an assistant and DL done and under direct visualisation the original tube withdrawn while new nasalrae was passed through other nostril.


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Monday, October 15, 2012
2:30 PM - 4:00 PM
MC628

**Unrecognized Liver Failure in a Healthy Young Man Booked for Laparoscopic Appendectomy Caused by Red Bush Tea**

**Shamantha G. Reddy, Anesthesiology, Montefiore Medical Center, New Hyde Park, NY.**

37 year-old healthy male for lap appendectomy LFTs were elevated. No smoking, alcohol, drug abuse, herbal supplements, jaundice, hepatitis, travel outside the states. Was placed on IV antibiotics. Hepatologist consulted. Pt has been having Red Bush tea for a year every day. He didn't think it was worth mentioning as it is just tea. Hepatologist ordered a stat ultrasound of liver r/o liver abnormalities. Open appendectomy was done under a spinal anesthetic. There were 3 fatal liver failures in that area with the tea. Postponing the case, hepatologist's consult helped treat the patient safely.

Monday, October 15, 2012
2:30 PM - 4:00 PM
MC629

**Utilization of iPad FaceTime Application to Facilitate Intra-Operative Patient Cooperation**

*Benjamin F. Redmon, M.D., Claude McFarlane, M.D., Nishita Dalal, M.D., Anesthesiology, University of North Carolina, Chapel Hill, NC.*

We describe the use of iPads and FaceTime to facilitate cooperation in a non-communicative combatant patient: A 67 year-old male with bilateral hearing loss, morbid obesity and extremely difficult intra-operative bag-mask ventilation underwent cochlear device implantation. He communicated via gestures and lip-reading with his wife who relayed communication to care providers. Post-extubation, the patient became combative, requiring physical restraint; further sedation was avoided by connecting the patient with his wife via FaceTime and two iPads, which quickly calmed the patient. This MCC illustrates the utility and benefits of intra-operative video-conference to connect patients with family or other care team members.

Monday, October 15, 2012
2:30 PM - 4:00 PM
MC630

**Acute Persistent Brachial Plexopathy After Robot-Assisted Transaxillaryright Thyroid Lobe Resection**

*Mark C. Reiner, Mojca Konia, M.D., Ioanna Apostolido, M.D., Anesthesiology, University of Minnesota, Minneapolis, MN.*

This presentation will demonstrate the case of a young female who developed significant transient motor and persistent sensory deficits of the right upper extremity after robotic transaxillary thyroid nodule resection.

Monday, October 15, 2012
2:30 PM - 4:00 PM
MC631

**Comparison of Pleth Variability Index and Stroke Volume Variability During Open Abdominal Aortic Aneurysm Repair**

*Ben Ekstrom, M.D., Darren Nabor, B.S., Paul S. Pagel, M.D.,Ph.D., Matthias L. Riess, M.D., Ph.D., Anesthesiology and Physiology, Medical College of Wisconsin, Milwaukee, WI, Anesthesiology, Clement J. Zablocki VA Medical Center, Milwaukee, WI.*

New technologies allow intravascular volume status assessment by using dynamic waveform analysis of arterial blood pressure or pulse oximetry produced by intermittent positive pressure ventilation. In



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three patients undergoing open abdominal aortic aneurysms repair we concurrently measured *S*troke *V*olume *V*ariability (SVV, FloTrac, Edwards Lifesciences) and *P*leth *V*ariability *I*ndex (PVI, Radical 7, Masimo). Although SVV and PVI responded appropriately to changes in volume status and aortic cross clamping and unclamping, they correlated well to each other only in one patient (R0.85), but not in the other two (R0.10, 0.03). Thus, their individual clinical utility and limitation warrants further investigation.

Monday, October 15, 2012
2:30 PM - 4:00 PM
MC632

**Bariatric Surgery in Patients With Cardiomyopathy**

*Rania Rifaey, M.D., Sivasenthil Arumugam, M.D., Anesthesiology, University of Connecticut, Farmington, CT.*

59 year-old female with PMH of non-ischemic cardiomyopathy (NYHA class IV), EF of 10%, DM, HTN, BMI=53, OSA, AICD for non-sustained V-tach, CKD presented for bariatric surgery as recommended by her cardiologist based on case reports of cardiomyopathy reversal by bariatric surgery induced weight loss. Patient was admitted prior to surgery for Swan placement and started on a lasix drip for optimization. Post op course was complicated by apnea in the PACU. She was discharged POD5 and over the last 4 months, lost 60lbs, symptoms are improved, diuretics dose halved, and renal function improved.

Monday, October 15, 2012
2:30 PM - 4:00 PM
MC633

**Post-Induction Resuscitation of Patient With Pulseless Electrical Activity and Transient Left Ventricular Apical Ballooning Syndrome**

*David Roberts, D.O., Michael Goldberg, M.D., Marc C. Torjman, Ph.D., Anesthesiology, Cooper University Hospital, Camden, NJ, Rowan University, Camden, NJ.*

A 72 year-old Vietnamese male with gallstone pancreatitis presented for laparoscopic cholecystectomy. The patient's past medical history included hypertension, malnutrition, failure to thrive, and cerebrovascular accident. A preoperative echocardiogram showed an ejection fraction of 55-60%. Shortly after induction, the SPO2 was lost and hypotension was refractory to vasoactive agents. He became pulseless, CPR was initiated, and was treated for PEA/cardiac arrest. After resuscitation, EKG precordial leads showed ST-T segment elevations, and the patient underwent cardiac catheterization. No significant coronary artery disease was found. Transient left ventricular apical ballooning syndrome was diagnosed and successfully treated.

Monday, October 15, 2012
2:30 PM - 4:00 PM
MC634

**Acute Treatment of Restless Legs Syndrome in PACU With Physostigmine**

*Jeff Peacock, M.D., Raymond C. Roy, M.D., Ph.D., Anesthesiology, Wake Forest School of Medicine, Winston-Salem, NC.*

Restless legs syndrome (RLS) is a common neurologic disorder characterized by dysthesias of the legs accompanied by involuntary leg movement, partially or totally relieved by walking. However, it is rare for anesthesiologists to encounter its acute manifestations. Five recent case reports discuss the acute treatment of RLS in the perioperative setting, 2 with oral pramipexole, and 1 each with oral ketamine, iv magnesium sulfate, and iv physostigmine. We present the second case where the iv administration of



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physostigmine 2 mg provided more than 6 hours of relief from an RLS exacerbation following a gastroendoscopy procedure.

Monday, October 15, 2012
2:30 PM - 4:00 PM
MC635
**Post Operative Atrial Fibrillation Following Elective Septoplasty**
*Najmeh P. Sadoughi, M.D., Mary M. Joseph, M.D., Department of Anesthesiology, LAC & USC Medical Center, Los Angeles, CA.*
A 47 year-old female with no significant past medical history was scheduled for a septoplasty. Patient had normal EKG, labs, and history on exam. Patient was extubated without any problems and transferred to post-anesthesia care unit. In discharge area, patient's pulse was in 160's bpm and blood pressure unattainable. Patient was asymptomatic. 12-lead EKG showed a-fib with rapid ventricular response (RVR).

Monday, October 15, 2012
2:30 PM - 4:00 PM
MC636
**Off-Pump Management of Nephrectomy/Thrombectomy for Renal Cell Carcinoma with High Level III IVC Thrombus**
*Joseph Sanford, Jr., M.D., Esamelden Abdelnaem, M.D., Mohamed Ismaeil, M.D., Yasser Salem, M.D., Anesthesiology, University of Arkansas for Medical Sciences, Little Rock, AR.*
Renal cell carcinoma (RCC) can present with vascular invasion. Thrombus can extend into the vena cava and, rarely, intra-atrial. Embolization, though rare, frequently results in patient mortality. Multiple options for thrombus removal exsist including inferior vena cava (IVC) isolation, veno-venous bypass (VVB) and cardiopulmonary bypass (CBP). We present an anesthetic provided for a 63 year-old gentlemen with renal cell carcinoma and thrombus extending to the level of the right atrium who underwent a sternotomy, right radical nephrectomy, IVC thrombectomy, and IVC filter placement with IVC isolation.

Monday, October 15, 2012
2:30 PM - 4:00 PM
MC637
**Crisis Management During an Operating Room Flood**
*Jacob H. Schauer, M.D., Jonathan Gal, M.D., Anesthesiology, Mount Sinai Medical Center, New York, NY.*
A 48 year-old male undergoing right frontal craniotomy was 3 hours intra-operative. In the adjacent operating room a 55 year-old woman was being placed under general anesthesia for anterior cervical discectomy and fusion. Suddenly, both operating rooms began actively flooding with contaminated water from an adjacent utility room. Crisis management was implemented, immediate safety of patients and operative teams was confirmed, and a barricade stopping influx of water was constructed. The craniotomy team rapidly concluded surgery, while the discectomy team opted to transport to an alternate operating room where the surgery was performed without complication.


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Monday, October 15, 2012
2:30 PM - 4:00 PM
MC638

**Decision Making With the Physician Patient Within One Year of Drug Eluting Stent Placement**

*Jacob H. Schauer, M.D., Steven Neustein, M.D., Jonathan Gal, M.D., Anesthesiology, Mount Sinai Medical Center, New York, NY.*

A 72 year-old cardiologist traveled cross country for elective Kock pouch revision due to constant stool leakage. First seen pre-operatively in the holding area, he was found to have a history of myocardial infarction, five vessel coronary artery bypass grafting, and two drug eluting stents (DES) placed four months prior. Aspirin and clopidogrel were discontinued eight days before presentation. Risks of perioperative discontinuation of anticoagulation following DES placement were discussed with the patient. Postponement of surgery was recommended. The patient insisted on proceeding. He then signed a Refusal of Medical Recommendations Consent form, was given 325mg of aspirin, and surgery commenced.

Monday, October 15, 2012
2:30 PM - 4:00 PM
MC639

**A Disturbing New Abnormal Neurological Exam After General Anesthesia**

*Corey Scher, M.D., Anesthesiology, New York University School of Medicine, New York, NY.*

A 19 year-old is scheduled for a lap. ovarian cystectomy. Her PMH is unremarkable except for 2 "psych meds. A general anesthetic and immediate post- operative course were uneventful. At discharge, numerous neurological complaints appeared. She said she could barely hear, speak, and felt numbness up to her knees. The anesthesiologist's exam showed no response to an 18 gauge needle stuck into both calves A neurologist exam followed. The consult led to the conclusion that her CNS was normal with but the software that runs the CNS was damaged. The patient had a Conversion Disorder whereby the symptoms are real but psychiatrically based.

Monday, October 15, 2012
2:30 PM - 4:00 PM
MC640

**Difficult Airway Secondary to Unanticipated Subglottic Stenosis**

*Troy Seelhammer, M.D., Anesthesiology, University of Michigan, Ann Arbor, MI.*

Unanticipated subglottic stenosis was encountered in a patient presenting for left carotid-subclavian bypass in preparation for a staged endovascular descending aortic aneurysm repair. Failure to advance multiple oral ETT tubes and a bougie was encountered post induction despite a Cormack-Lehane grade 1 view. Successful airway instrumentation via a pediatric fiberoptic bronchoscope facilitated passage of a 6.0 mm tube. Intraoperative Otolaryngology consultation identified clinically significant subglottic stenosis at the site of previous percutaneous tracheostomy. The patient was extubated over an exchange catheter with uneventful recovery. Subsequent induction for stage 2 of the procedure encountered multiple failed asleep fiberoptic and Glidescope intubations.



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Monday, October 15, 2012
2:30 PM - 4:00 PM
MC641

**Challenges of Interpreting Pulse Oximetry in a Patient With Raynaud's Phenomenon**

*Amit A. Shah, M.D., Thomas Halaszynski, M.D., Anesthesiology, Yale University, New Haven, CT.*

The pulse oximeter is an invaluable monitoring tool in perioperative patient care. Despite its high predictive value and known limitations in detecting underlying hypoxemia, decreases in SpO2 can be a source of stress and diagnostic dilemma for the anesthesiologist. This case report presents a rather uncommon source of transiently decreased SpO2 likely secondary to Raynaud phenomenon that complicated the typical clinical picture of evaluation of decreased SpO2. While treatment and diagnostic algorithms can often help guide management, this case presents an uncommon situation where patient observation maybe have been the best course for the patient.

Monday, October 15, 2012
2:30 PM - 4:00 PM
MC642

**Intraoperative Acute Severe Hypotensive Transfusion Reaction**

*Waleed Shah, Elia S. Elia, M.D., Anesthesia, Thomas Jefferson University Hospital, Philadelphia, PA.*

A 68 year-old female on ACE inhibitors for Hypertension underwent a lumbar decompression/fusion for symptomatic spinal stenosis. Blood was transfused intraoperatively, within minutes of starting the transfusion the patient had an severe and acute hypotensive episode (systolic 40's) refractory to iv fluids or large phenylephrine boluses with no other change in vitals (ekg, heart rate). The transfusion was immediately stopped and 100 mcg epinephrine was required to stabilize the patient. Due to the isolated and acute hypotensive episode related to blood transfusion and history of ACE -inhibitor use, Acute Hypotensive Transfusion Reaction (AHTR) was diagnosed.

Tuesday, October 16, 2012
8:00 AM - 9:30 AM
MC685

**Aberrant Conduction (Wolff Parkinson White) in the Perioperative Period Mimicking Cardiac Ischemia**

*Derek H. Lowe, M.D., Jay Roby, M.D., Peter Roffey, M.D., Mariana Mogos, M.D., Duraiyah Thangathurai, M.D., Anesthesiology, University of Southern California, Los Angeles, CA.*

An otherwise healthy 30 year-old male presented for a right foot osteotomy following traumatic injury. Preoperative ECG showed a normal sinus rhythm. Anesthesia was induced with propofol and maintained with sevoflurane with an uneventful course. In recovery, the patient was noted to have tachycardia with ST segment depression. ECG revealed a Wolf Parkinson White (WPW) pattern. However, the patient was without angina. The ST segment changes can be attributed to abnormal ventricular repolarization seen in WPW syndrome, which can resemble myocardial ischemia. However, myocardial infarction was excluded after performing biochemical tests (negative serial troponins).

Tuesday, October 16, 2012
8:00 AM - 9:30 AM
MC686

**Anesthetic Considerations and Management of Intra-Heptatically Placed Right Thoracostomy Tube**

*Jun Luo, M.D., Kenneth Eichenbaum, M.D., Anesthesiology, Maimonides Medical Center, Brooklyn, NY.*

A 78 year-old male post operative day 1 status post mitral valve replacement with right sided pleural effusion that required placement of right thoracostomy tube. The thoracostomy tube was malposition into the liver. The patient was brought down to interventional radiology suite to assess the position and



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further management. Active blood transfusions were needed to maintain hemodynamics. The patient acutely developed shortness of breath, chest pain and desaturation into low 80's. Acute pneumothorax was suspected and a new right sided had to be placed emergently. Intra-hepatic balloon catheter was inserted to tamponade ongoing bleeding.

Tuesday, October 16, 2012
8:00 AM - 9:30 AM
MC687
**Aortic Stenosis and Hip Surgery in the Geriatric Population**
*Marissa Lyttle, M.D., Jason Yu, M.D., Bryan Noorda, M.D., Piyush Gupta, M.D., Jack Choueka, M.D., Department of Anesthesiology, Department of Orthopedic Surgery, Maimonides Medical Center, Brooklyn, NY.*
In patients with severe aortic stenosis, surgery can be performed with a mortality risk of approximately 10%. In 2010 we studied 22 patients with aortic stenosis who underwent surgery for hip fracture. Patients with mild, moderate, and severe AS had an average length of stay (LOS) of 5, 10, and 10 days, respectively. Post-operative complications in 2 of the patients in the severe AS group occurred secondary to CHF exacerbation while 1 patient with moderate AS suffered an intra-operative cardiac arrest. With strict hemodynamic monitoring and appropriate attention to fluid management, both LOS and rate of complications can be reduced.

Tuesday, October 16, 2012
8:00 AM - 9:30 AM
MC688
Drug Shortage!: Is the Alternative as Effective and Safe?
*Laila Makary, M.D., Anesthesia and Pain Management, University of Texas South Western/ Veterans Affair Hospital, Irving, TX.*
Case: 63 year-old male for partial gastrectomy , history of HTN, COPD, GERD, uneventful anesthetic induction and maintenance and surgical course, cisatracurium was used, total of 12 mg , at the end of surgery 4/4 TOF, reversal with edrophonium and atropine was given 50 mg, we experienced delayed recovery for 25 minutes secondary to muscle weakness after ruling out other reasons for delayed recovery. Conclusion: Alternative medication of neuromuscular reversal are available but they are not as effective, yet can be used with caution, the pharmacokinetics and dynamics is not widely recognized and partially forgotten.

Tuesday, October 16, 2012
8:00 AM - 9:30 AM
MC689
**A Novel Airway Rescue Technique Utilizing the Yankour Suction Catheter**
*Elizabeth B. Malinzak, Brian Ohlendorf, M.D., Kelli Brooks, M.D., Stephen Parrillo, M.D., Department of Anesthesiology, Department of Surgery, Duke University Medical Center, Durham, NC.*
A 28 year-old male with Duchenne's Muscular Dystrophy, restrictive lung disease, and known difficult anterior airway was accidentally extubated during upper endoscopy. Attempts to reintubate with direct laryngoscopy, fiberoptic bronchoscopy, fast track laryngeal mask airway, and glidescope with Frova and bougie were unsuccessful. Intubation was achieved using glidescope visualization, placing a large Yankour suction tip through the vocal cords, inserting an 11 French Cook airway exchange catheter through the Yankour as a guide, and an endotracheal tube placed over the exchange catheter. Since this technique was initially used, it has been successful in four additional difficult airways at our institution.


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Tuesday, October 16, 2012
8:00 AM - 9:30 AM
MC690

**Methohexital Interview in the Diagnosis and Treatment of Conversion Disorder**

*Deepinder S. Mann, D.O., Jeffrey B. Gross, M.D., Anesthesiology, University of Connecticut, Farmington, CT.*

Previously ambulating 22 year-old woman with a 6 month history of bilateral lower extremity motor and sensory paralysis. Medical history includes high-dose corticosteroid use for interstitial nephritis, L2-3 compression fracture, depression, anxiety and morbid obesity. Full medical work-up shows no source of neurological issues. Suspicion of conversion disorder; however, no inciting stressor found during psychiatric evaluation. Patient undergoes psychiatric interview under methohexital. Based on information gathered during interview, patient's cognitive treatment is adjusted with slight improvement in symptoms. Later, after undergoing ECT, patient was able to move both lower extremities, establishing the psychiatric basis of her neurologic symptoms.

Tuesday, October 16, 2012
8:00 AM - 9:30 AM
MC691

**Urgent Exploratory Laparotomy in a Patient With an LVAD**

*Jordan R. Martin, M.D., Anesthesiology, Yale University, New Haven, CT.*

This case discusses a patient who presented for an urgent exploratory laparotomy, however, earlier during the same admission he had an LVAD placed with the conduit traversing through the abdomen. We review the course of the case, including preparation for the surgery with a meeting between the anesthesia, general surgery and cardiothoracic surgery teams. Important caveats to caring for a patient with an LVAD in the operating room are also discussed.

Tuesday, October 16, 2012
8:00 AM - 9:30 AM
MC692

**Contralateral Tension Pneumothorax Amidst Single Lung Ventilation**

*Eapen Mathew, Leonard Contois, M.D., Sivasenthil Arumugam, M.D., University of Connecticut, West Hartford, CT, Anesthesiology, St. Francis Hospital, Hartford, CT.*

68 year-old man presents left thoracoscopic lobectomy. Anticipating difficult intubation, after thoracic epidural and GA, videolaryngoscopy used to introduce single lumen tube; flex-tipped exchanger inserted to appropriate depth, DLT passed. After initiation of SLV hypoxemia noted but hemodynamics stable. since standard maneuvers failed to correct hypoxemia, bronchoscopy revealed inward bulge of right tracheal wall, absent right breathsounds, creating pneumothonax suspicion. surgery was halted and right chesttube inserted, with air gush noted. post-op diagnostic battery revealed no clear etiology. Most likely cause was flexible exchanger, in spite of precautions. Other causes: bleb rupture, traumatic / lobar DLT, lung puncture during epidural placement.



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Tuesday, October 16, 2012
8:00 AM - 9:30 AM
MC693

**Submental Intubation as an Alternative to Tracheostomy**

*Morgan Mathie, D.O., Anesthesiology, University of Florida, Gainesville, FL.*

33 year-old female involved in a MVC who sustained C7-T1 fracture, an unstable C2 fracture. She presented for repair of multiple facial fractures including bilateral type 2 naso-orbito-ethmoid fractures, bilateral LeFort III fractures, and comminuted left angle and ramus fractures. Due to her unstable C2 fracture and facial fractures she was intubated via oral FOB which was converted to submental intubation given the extensive facial reconstruction. She was taken to the SICU where she was extubated 1 day later avoiding a tracheostomy.

Tuesday, October 16, 2012
8:00 AM - 9:30 AM
MC694

**Malignant Hyperthermia in a 32 year-old Male Upon Emergence From General Anesthesia**

*Neil Matthey, M.D., James W. Chapin, M.D., David Faust, M.D., Scott Hofmann, M.D., Jim Trammel, C.R.N.A., University of Nebraska Medical Center, Omaha, NE, VA Hospital, Omaha, NE.*

A 32 year-old male underwent I&D of a submandibular abscess under sevoflurane general anesthesia, propofol and succinylcholine. After induction the patient developed masseter spasm. Upon emergence, spontaneous ventilation returned and $EtCO_2$ rose from 42 to 75 despite a minute ventilation of 15 liters/minute. The temperature increased from 37.5 to 39.4 Celsius and rigidity noted. Malignant hyperthermia was suggested and dantrolene 2 mg/kg initiated. An arterial line and active cooling were started. Blood gases revealed $pCO_2$ of 42 and pH 7.36. The Malignant Hyperthermia hotline consultant recommended 1 mg/kg dantrolene every six hours and trending CPK levels.

Tuesday, October 16, 2012
8:00 AM - 9:30 AM
MC695

**Abnormal Positioning of Left Sided Central Venous Catheters: A Series of Two Cases**

*Cory Maxwell, M.D., Kelli Brooks, M.D., Kerri Wahl, M.D., Anesthesiology, Surgery, Duke University, Durham, NC.*

Placement of central venous catheters (CVC) may be complicated by arterial puncture, pneumothorax, thrombosis, and infection. An uncommon complication is malposition in a minor vein of the chest (e.g. internal thoracic vein). Two CVCs were identified as “concerning for aortic placement” by radiology, but likely in the internal thoracic vein. The diagnosis was supported by chest radiographs and simultaneous ABG and VBG. Each was removed without complication. If left in place, previous morbidity reported in the literature includes thrombosis, pleural effusion, pulmonary edema, chest wall abscess, necrosis, and hemorrhage. Previous reports include sternotomy to facilitate removal.



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Tuesday, October 16, 2012
8:00 AM - 9:30 AM
MC696

**Laparoscopic Approach Safe in Patients with Pulmonary Arterial Hypertension: Two Cases of laparoscopic Cholecystectomy**

*Cory D. Maxwell, M.D., John Nardiello, M.D., Cathleen Peterson-Layne, M.D., Ph.D., Anesthesiology, Duke University, Durham, NC.*

Two patients with PAH, undergoing cholecystectomy laparoscopically. A) 25 year-old female, 14 month h/o PAH, PA pressures "greater than 60 mmHg", treated with epoprostenol, sildenafil. B) 39 year-old female, 10 year h/o PAH, PA pressure 58/28 mmHg, treated with trepostinil. Each evaluated preoperatively with consultation between surgical and anesthesia teams. Laparoscopic approach preferred by patient and surgeon acknowledging concerns of hypercarbia on PA and prompt conversion to open approach. Management included a-line before sedation, ABG guided ventilation, and empiric nitric oxide. Post-op telemetry during 23-hour observation. Uneventful perioperative course. First reports of successful laparoscopic surgery in patients with significant PAH.

Tuesday, October 16, 2012
8:00 AM - 9:30 AM
MC697

**Acute Aortic Occlusion Presenting as Paraplegia; A Catastrophic Complication to Elective Laparoscopy : A Case Report**

*Robert L. McClain, Sher Lu Pai, M.D., Anesthesiology, Mayo Clinic, Jacksonville, FL.*

Paraplegia is a rare complication after non vascular or neurological surgery and can be associated with significant morbidity and mortality if not addressed immediately, however and its eitiology can often be somewhat elusive. We present the case of a 72 year-old female who underwent a laparoscopic cholecystectomy that was complicated significant lower extremity paraplegia discovered in the post anesthesia care unit. This was found to be secondary to acute aortic thromboembolic occlusion. Our case points out the importance of accurate neurological and cardiovascular history and examination along with appropriate diagnostic studies to arrive at an expedient diagnosis.

Tuesday, October 16, 2012
8:00 AM - 9:30 AM
MC698

**Perioperative Carcinoid Crisis**

*Theresa McClung, M.D., Anesthesiology, WFU BMC, Winston Salem, NC.*

56 year-old female with metastatic carcinoid tumor of the colon causing obstruction of the right ureter. She presented for right ureteroscopy, cystoscopy, RPG with possible biopsy/stents. At home, her carcinoid syndrome was controlled with increasing doses of depot octreotide. Premedication included midazolam, fentanyl, ranitidine, diphenhydramine, and octreotide. Volume loading was initiated in the holding area and a-line was placed. Anesthesia was induced with remifentanyl, propofol, rocuronium and sevoflurane. Flushing was noted prior to intubation. Bronchospasm and extreme hemodynamic fluctuations ensued. Treatment included IV fluids, octreotide bolus and infusion, and avoidance of sympathomimetics.



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Tuesday, October 16, 2012
8:00 AM - 9:30 AM
MC699

**Continuous Oxygen Delivery During Fiberoptic Intubation Through an Intubating LMA**

*Melanie Beth McMurry, M.D., University of Missouri Department of Anesthesiology, Columbia, MO.*

A 68 year-old, 128 kg male for laparoscopic cholecystectomy reported no known history of difficult intubation. Airway exam revealed a MP3 airway, thick neck and thyromental distance of 5 cm. After an unsuccessful intubation attempt, an intubating LMA was inserted. LMA disconnection from the circuit for the fiberoptic scope led to oxygen desaturation. To provide continuous oxygen, the endotracheal tube was inserted into the LMA shaft and a bronchoscopy elbow was placed between the ETT and circuit. The fiberoptic scope passed through the port in the elbow and into the trachea. The ETT was advanced and the LMA removed.

Tuesday, October 16, 2012
8:00 AM - 9:30 AM
MC700

**Superior Laryngeal Nerve Block to Facilitate Awake Intubation of a Patient With Recurrent Spontaneous Laryngospasm**

*Erin McNicholas, M.D., Laura Hemmer, M.D., Department of Anesthesiology, Northwestern University Feinberg School of Medicine, Chicago, IL.*

Laryngospam is a common perioperative complication caused by an exaggeration of the glottic closure reflex produced by stimulation of the superior laryngeal nerve. Superior laryngeal nerve blockade results in anesthesia of the supraglottic mucosa and paralysis of the cricothyroid muscle, and has been described in the management of severe postoperative laryngospasm. Bilateral superior laryngeal nerve blocks facilitated awake fiberoptic intubation of a 65 year-old female with recurrent spontaneous laryngospasm and a difficult airway. This may be a preferable method of topicalization in a patient with a significant history of laryngospasm who necessitates an awake fiberoptic intubation.

Tuesday, October 16, 2012
8:00 AM - 9:30 AM
MC701

**Pain Control Options in an Opiate-Addicted Trauma Patient: An Argument for Methadone for Acute Pain Control**

*Barbara J. Meinecke, M.D., Suneeta Gollapudy, M.D., Harvey Woehlck, M.D., Anesthesiology, Medical College of Wisconsin and Affiliated Hospitals, Milwaukee, WI, Anesthesiology, Froedtert Hospital, Milwaukee, WI.*

29 year old male presented to the ED. A 30-foot fall resulted in multiple fractures requiring surgical fixation. The patient tested positive for heroin and cocaine. During surgery, he had symptoms of acute opioid withdrawal (hypertension and tachycardia). Hydromorphone was administered until vital signs normalized and spontaneous respiratory rate was reduced. Goals for therapy were acute pain control and prevent withdrawal during admission. He was loaded with 250mg of methadone over 16 hours, and monitored in the ICU. Additional surgery proceeded the following day, where he remained hemodynamically stable. His post-operative pain was controlled with morphine PCA (90mg over 4 days).



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Tuesday, October 16, 2012
8:00 AM - 9:30 AM
MC702

**PEA Again?**

*Maria L. Mendoza, M.D., Miguel A. Cruz, M.D., Anesthesiology, Cleveland Clinic, Cleveland, OH.*

A 69 year-old female scheduled for RTK revision after an aborted procedure 4 months before due to PEA arrest secondary to septic shock. Patient was evaluated and cleared by cardiology and infectious disease. Her medical history was significant for rheumatoid arthritis and bilateral septic knees. Case was done under general anesthesia with pre-induction arterial line and invasive monitoring. One hour after surgery started, during reaming of the femoral canal, a PEA arrest happened, CPR and epinephrine were successful. TEE was advanced, demonstrating pulmonary embolus floating in the RA. Procedure was terminated; patient was transferred to SICU for further management.

Tuesday, October 16, 2012
8:00 AM - 9:30 AM
MC703

**A Case of Upper Airway Obstruction Caused By Granulation Tissue and Post-Trcheostomy Tracheal Stenosis: An Interesting Finding on Direct Laryngoscopy**

*Andrew Messiha, M.D., Anesthesiology, Case Western Reserve University/MetroHealth Medical Center, Cleveland, OH.*

48 year-old male with multiple medical problems including history of tracheostomy presents with stridor. Patient was taken to the OR for direct laryngoscopy by ENT, and found to have difficulty with advancing endotracheal tube during intubation. Direct laryngoscopy was performed by surgeon followed by fiberoptic bronchoscopy, which revealed the development of a column of scar tissue at the prior tracheostomy site, and surgeon was able to intubate using size 4 endotracheal tube.

Tuesday, October 16, 2012
8:00 AM - 9:30 AM
MC704

**The Role of Cerebral Oximetry in Providing Controlled Hypotension for the Removal of Extensive Retroperitneal Tumor in a Jehovah's Witness**

*Rahul H. Modi, M.D., Kim Ngo, M.D., Navid Alem, M.D., Mariana Mogos, M.D., Duraiyah Thangathurai, M.D., Anesthesiology, LAC & USC Medical Center, Los Angeles, CA.*

28 year-old Jehovah's Witness with extensive retroperitoneal spread of testicular cancer undergoing dissection of metastases. He previously underwent 3 cycles of bleomycin/cisplatin. Pre-operative SpO2=92-95%, hematocrit=34. Anesthetic plan included controlled hypotension and low FIO2 to minimize EBL and bleomycin related pulmonary complications, respectively. Anesthesia course was uneventful. MAP maintained in range of 55-65 with nitroglycerin (80-667mcg/min) and esmolol during critical stages of dissection. Surgery lasted 10 hours with EBL=250mL and UOP=1500mL requiring 8L crystaloid. Post-operative hematocrit=30. Cerebral oxygenation and echocardiography were useful for monitoring cerebral oxygenation and cardiac function. With nitroglycerin, cerebral oxygenation remained 15-20% above baseline during surgery.



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Tuesday, October 16, 2012
8:00 AM - 9:30 AM
MC705

**Patient With CAD, Stents on Antiplatelets Therapy for Liver Transplantation**

*Marina Moguilevitch, James Widyn, M.D., Anesthesiology, Montefiore Medical Center, Bronx, NY.*

58 year-old man with primary sclerosing cholangitis, CAD with stents, had living donor liver transplantation. He has been taking Aspirin and Clopidogrel until last day before surgery. Platelets function testing showed 100% suppression from Aspirin and Clopidogrel. Patient underwent liver transplantation without excessive bleeding and required only 1.5 units PRBC transfusion. Patients with coronary stents can continue their antiplatelet therapy and safely undergo liver transplantation without additional risk of bleeding. Chronic liver disease patients can avoid abnormal bleeding due to multiple compensative balancing mechanisms. Often, stopping antiplatelet therapy poses much higher risk of stent thrombosis and subsequent development of ischemia.

Tuesday, October 16, 2012
8:00 AM - 9:30 AM
MC706

**Airway Management in a patient With a Supraglottic Mass**

*Jonathan W. Moresco, M.D., M.S., Raymond Pesso, M.D., Kenneth Freese, M.D., Anesthesiology, Nassau University Medical Center, East Meadow, NY.*

We present a case of a 59 year-old male with PMHX of severe Emphysema and alcohol abuse who arrived to our ED with SOB, new onset horseness and difficulty swallowing. He was noted to have a right sided neck mass. CT examination revealed an irregular, infiltrating right supraglottic and glotic lesion with epiglottic involvement. The lesion extended laterally involving the right aryepiglottic fold, posterior larynx and superior hypopharynx. ENT's surgical plan was to proceed to the OR for excisional biopsy and tracheostomy. Discussed will be the anesthetic airway management and approach to a patient with a supraglottic and glottic mass.

Tuesday, October 16, 2012
8:00 AM - 9:30 AM
MC707

**Penetrating Craniofacial Trauma From Trimming Sheers: A Case Report and Discussion**

*John Mortensen, M.D., Patrick Boyle, M.D., University of Arizona, Tucson, AZ.*

Penetrating craniofacial trauma is an atypical trauma presentation. Potential challenges with in situ craniofacial foreign bodies include safe removal, airway management, bleeding, injury to neurovascular structures, and potential elevated intracranial pressures. I am presenting the case of an 86 year-old man who fell on trimming sheers. The handle entered his right orbit, penetrated his inferior orbital wall, maxillary sinus and terminated at the bifurcation of his carotid artery. On exam, he could only open his mouth 1cm. We elected to perform an RSI using a GlideScope, given the risk of potential difficult airway. The sheers were removed without significant complications.

Tuesday, October 16, 2012
8:00 AM - 9:30 AM
MC708

**Accounting for Direct Muscle Stimulation During Train of Four Monitoring**

*Arvind Murthy, M.D., Mark Shulman, M.D., Anesthesiology, St. Elizabeth's Medical Center, Brighton, MA.*

A 60 year-old 136 Kg male presented for CT guided irreversible electroporation in the prone position. Because the electrical discharge from electroporation can produce massive upper body muscle



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contractions, the radiologist requested total relaxation. The patient was given Rocuronium 150mg IV, but after 5 minutes train of four monitoring at the ulnar nerve and the facial nerve bilaterally were 4/4 and tetanus showed no fade. Subsequent doses of Succinylcholine 200mg IV and Cisatracurium 30 mg IV yielded the same results. After EMG testing revealed a visual twitch but no neuromuscular transmission, the case proceeded without incident.

Tuesday, October 16, 2012
8:00 AM - 9:30 AM
MC709

**Domino Liver Transplant - Challenges for the Anesthesiologist**

*Bindu Muthu, M.D., Jeoffery Plotkin, Anesthesiology, Georgetown University Hospital, Washington D.C.*

Domino Transplant, where 2 patients each receive a transplanted organ simultaneously, is taking the complexity of transplant surgery even further.The case involved one patient with history of amyloidosis presenting with symptomatic disease and a second patient with endstage liver disease secondary to hepatocellular carcinoma. The plan was to transplant a cadaver liver to the amyloidosis patient and then transplant his liver which was functionally good, to the patient with endstage liver disease. The challenges faced were, staff availability,timing ,resource utilization required for perfoming two simultaneous transplant and an alternative plan if one of the organs is unsuitable.

Tuesday, October 16, 2012
8:00 AM - 9:30 AM
MC710

**Establishing Vascular Access in a Hypercoaguable Patient Undergoing Renal Transplantation With History of Multiple Failed Renal Transplantations**

*Sharanya Nama, M.D., Ibtesam A. Hilmi, M.B., Ch.B., Anesthesiology, University of Pittsburgh Medical Center, Pittsburgh, PA.*

Forty-eight year-old male with ESRD and hypercoaguability (lupus anticoagulant) presented for allograft nephrectomy and repeat renal transplant. He has failed transplantation three times, developed heparin-induced thrombocytopenia, and has multiple failed AV fistulas. Additionally, he has bilateral thrombosed IJ and subclavian veins, dialysis catheter in the right groin and left femoral artery/vein reserved for future dialysis access. He also underwent left brachial AV-graft repair nine days prior to transplantation thereby precluding cannulation of the left radial artery. From previous fistulas, he lacked right-sided pulses. Though central access was desirable, ultimately, left axillary arterial line with multiple large peripheral IVs were placed.

Tuesday, October 16, 2012
8:00 AM - 9:30 AM
MC711

**70 Year-Old Female With Prior Nasopharyngeal Carcinoma Now for Urgent/Elective Total Glossectomy and Left Muscle Flap. AM EKG Documented Acute Ant MI New Since EKG 2 Days Prior to Surgery: When to Proceed?**

*Bahram Namdari, David Jury, M.D., Paul Kempen, M.D., Cleveland Clinic, Cleveland, OH.*

Preop evaluation disclosed: 1:Sinus tachycardia, EKG depicts new recent anterior MI AM of surgery (troponins pending) 2: ICU transfer 2 days prior for hypercapneic respiratory failure, desaturated to the 40's 3: Hyopkalemia 4: Anemia (corrected). 5: Glossal tumor with growth into the airway-awake fiberoptic needed. 6: S/p bronchoscopy, cystoscopy, peg tube in past week Due to her second cancer and urgent need for intervention, cardiac consultation was deferred. With past medical history of COPD,



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severe right sided carotid stenosis s/p carotid stent in 2002, hypothyroidism, and nasopharyngeal carcinoma s/p radiation that resulted in difficulty speaking and swallowing.

Tuesday, October 16, 2012
8:00 AM - 9:30 AM
MC712

**Chest Trauma Management: A Case of Open Chest With Lung Herniation**

*Sachin Narain, Sripad Rao, M.D., Anesthesiology, University of Miami, Miami, FL.*

A 31 year-old female came with a stab wound to the right chest with right upper lobe herniation. She was spontaneously breathing, vocalizing and hemodynamically stable despite ongoing hemorrhage. Airway and access were secured in the operating room where she underwent wound exploration and chest wall reconstruction before an uneventful recovery. The lung herniation may appear to be her major injury; however, it was actually the hemorrhage that warranted emergent surgery. This case illustrates that an isolated unilateral lung herniation may indeed be benign since the functional hemithorax that remains will still be able to generate a negative intrathoracic pressure.

Tuesday, October 16, 2012
8:00 AM - 9:30 AM
MC713

**Unexpected Delayed Emergence From General Anesthesia: A Case Report**

*Tariq Naseem, Pei-Shan Zao, M.D., Anesthesiology, Tufts University Medical Center, Boston, MA.*

A 43 year-old female with NIDDM, CKD, CAD, HTN and morbid obesity, underwent bilateral breast reduction surgery. She denied taking oral hypoglycemic agents or insulin. Her pre-operative BS was 106 mg/dL. Intra-operatively the patient remained stable, however towards the end of procedure, patient failed to emerge from anesthesia. A VBG indicated a glucose level of 40 mg/DL. 100 ml of D50 and 200 ugm of Naloxone were given with no response. Detailed workup failed to show any acute insult.
This case raises the question of intra-operative glucose monitoring in patients potentially at risk of hypo or hyperglycemia during prolonged cases.

Tuesday, October 16, 2012
8:00 AM - 9:30 AM
MC714

**Anesthetic Considerations for a New Treatment of an Ancient Disease**

*Faiz Nasser, M.D., Christopher Hogan, C.R.N.A., Brent Brown, M.D., Gozde Demiralp, Department of Anesthesiology, University of Oklahoma, Oklahoma City, OK.*

Bronchial Thermoplasty (BT) is an application of controlled radiofrequency heat via catheter inserted through a flexible bronchoscope. Upon contacting the bronchial walls, the catheter treatment ultimately reduces the smooth muscle mass which results in decreased contractility and reactivity. BT has been performed under sedation with complications, such as apnea and cough. We would like to present a patient who was given general anesthesia for his BT session. We inserted an endotracheal tube vs. LMA, to not only secure the airway, but also to provide positive pressure controlled ventilation. We observed better stabilization of the probe with increased proceduralist satisfaction.



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Tuesday, October 16, 2012
8:00 AM - 9:30 AM
MC715

**Tracheal Resection for Invasion of Thyroid Cancer**

*Stephanie Nessmann, M.D., Angus Christie, M.D., Anesthesiology, Maine Medical Center, Portland, ME.*

78 year-old presented for tracheal resection due to invasion of thyroid cancer. Patient was induced with propofol and an LMA inserted for bronchoscopy. The patient was intubated with a NIM tube. Maintenance of anesthesia was a combination of inhalational and intravenous. Once the anterior tracheal incision was completed, the NIM tube was pulled back into the oropharynx. The surgeons intubated distal to their resection. Once the posterior tracheal anastomosis was completed, the NIM tube was repositioned with the cuff distal to the anastomosis site. A restraining suture was placed from chin to chest. The patient was extubated without issues.

Tuesday, October 16, 2012
8:00 AM - 9:30 AM
MC717

**Anesthetic Management of an Adult Undergoing Acquired Tracheoesophageal Fistula Repair**

*Tom Nguyen, M.D., Catherine Kuo, M.D., MCW, Milwaukee, WI.*

Tracheoesophageal fistulas (TEF) are primarily encountered in the pediatric population; however, adults may develop this defect as a result of malignancy such as esophageal cancer. We report on a 59 year-old male who underwent TEF repair for a lesion he developed following esophagectomy. Multiple esophageal stents had been placed, but the patient still had persistent cough with possible chronic aspiration. The fistula was located just above carina and the trachea was further compromised by moderate compression. The surgical approach was via thoracotomy requiring one-lung ventilation. We discuss the anesthetic considerations, management, and peri-operative issues related to acquired TEF repair.

Tuesday, October 16, 2012
8:00 AM - 9:30 AM
MC718

**Epidermolysis Bullosa: A Review of an Increasingly Challenging Anesthetic**

*Alexandria Nickless, Megan Freestone-Bernd, M.D., Patrick McQuillan, M.D., Anesthesiology, Penn State Milton S. Hershey Medical Center, Hershey, PA.*

Epidermolysis bullosa (EB) is a disorder that results in blistering of the skin with minor trauma as a result of defective keratin cells in the basal epithelium. This results in severe alterations of the airway as well as other anatomical changes that present a unique challenge to anesthesiologists. A 13 year-old male with a known diagnosis of EB was scheduled for EGD for dilation of strictures. Examination of his medical record revealed an escalation in the difficulty of airway management. This case reviews anesthetic management of EB in a complex patient.

Tuesday, October 16, 2012
8:00 AM - 9:30 AM
MC719

**Partial Transection of Right Main Bronchus Following Placement of a Silicone Y-Stent for Chronic Trachebronchomalacia**

*Olga Nin, M.D., Melissa Vu, M.D., Anesthesia, Shands Hospital, Gainesville, FL.*

57 year-old Caucasian male with history of chronic tracheobronchomalacia, morbid obesity, DM, HTN, OSA, and tobacco abuse was admitted for outpatient rigid bronchoscopy with silicone Y-stent placement



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after failing PAP therapy. Intraoperatively, placement of stent caused a 3cm laceration to the right main bronchus 2cm from carina, which caused worsening oxygenation and airway pressures. Emergent right chest tube was placed. Patient was transferred to the MICU where he developed severe hypercapnea, hypoxia, extensive subcutaneous emphysema, and pneumomediastinum. The patient was emergently intubated and bronchoscopy revealed the right side of the stent had migrated and was terminating in the mediastinum.

Tuesday, October 16, 2012
11:00 AM - 12:30 PM
MC785
**Severe Intraoperative Anemia, Hemodynamically Stable: To Transfuse or Not to Transfuse?**
*Omair Shakil, M.D., Feroze Mahmood, M.D., Robina Matyal, M.D., Anesthesia, Critical Care and Pain Medicine, Beth Israel Deaconess Medical Center, Boston, MA.*
A healthy 44 year-old male rock-climber suffered a left open tibial plateau fracture. He underwent staged reconstruction and multiple wound debridements. There was a significant skin defect for which he was scheduled to undergo a left free flap reconstruction under general anesthesia. Intraoperative blood specimen results demonstrated severe anemia (Hemoglobin 3.9 g/dL, calculated Hematocrit 12%) without hemodynamic instability. The challenge faced by the team was whether to transfuse the patient at that point in anticipation of more blood loss or to wait till hemodynamic instability set in.

Tuesday, October 16, 2012
11:00 AM - 12:30 PM
MC786
**It's Never Just a Tracheostomy Tube Exchange**
*Surangama Sharma, M.D., Lovkesh Arora, M.D., Shekar Bhavani, M.D., Anesthesiology, Cleveland Clinic Foundation, Cleveland, OH.*
A 73 year-old female s/p thyroidectomy, laryngopharyngectomy, B/L neck dissection for malignant paraganglioma, scheduled for tracheal stoma revision. Given stomal stenosis and difficulty in passing ETT, had to downsize but finally able to pass #4 MLT. Spontaneous ventilation was maintained. FOB revealed granulation tissue at the distal end of the tracheostomy. After unsuccessful attempts by surgeons to dilate using ETT, radial cuts were made and a shorter length tracheostomy tube was customized to fit above the granulation tissue. Challenges faced in terms of maintaining a patent airway in such situations will be discussed with some images pertinent to this case.

Tuesday, October 16, 2012
11:00 AM - 12:30 PM
MC787
**Pregnancy Ending in Heart Lung Transplant**
*Surangama Sharma, M.D., Gohar Dar, M.D., Anesthesiology, Cleveland Clinic Foundation, Cleveland, OH.*
39 year-old 22 weeks pregnant female, presented with worsening pedal edema, dyspnea, bleeding PV. CT angiography of chest and lower extremity Doppler ruled out PE but CTA showed dilated RA. TTE revealed RVSP>70 mm Hg, PAH confirmed by a PA catheter. New onset RUQ pain and further investigations suggested HELLP syndrome and independently associated DIC. Immediate dilatation and evacuation performed with invasive monitoring and balanced anesthetic technique, helped maintain an uneventful intraoperative course. Discussion will include anesthetic management of IPAH in setting of HELLP Syndrome and DIC with a brief mention of patient's complicated post-operative course, which involves heart-lung transplant.


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Tuesday, October 16, 2012
11:00 AM - 12:30 PM
MC788

**Anesthetic Management for Resection of Obstructing Tracheal Mass**

*Vikram Shenoy, Crystal C. Wright, M.D., Sally R. Raty, M.D., Sandeep Markan, M.D., Anesthesiology, Baylor College of Medicine, Houston, TX.*

52 year-old female with history of worsening dyspnea. CT scan revealed 2.1cm endobronchial mass arising from the posterior/lateral wall narrowing the mid/distal trachea. Patient was scheduled to undergo rigid bronchoscopy for debulking of the mass in the OR. The location and dynamic nature of obstruction by the mass caused concern for perioperative airway management. Another challenge was for circulatory support during the procedure if anesthesiology was unable to maintain oxygentation and ventilation. A multidisciplinary team approach with anesthesiology, ENT, pulmonary and cardiothoracic surgery collaborated to develop an anesthetic plan for airway management and circulatory support with cardiopulmonary bypass standby.

Tuesday, October 16, 2012
11:00 AM - 12:30 PM
MC789

**Anesthetic Evaluation and Perioperative Management in a Patient With New Onset Mediastinal Mass Syndrome Presenting for Emergency Surgery**

*David Shi, New York Presbyterian Hospital - Columbia University Medical Center, New York, NY.*

A 23 year-old, previously healthy, woman presented with new onset bilateral lower extremity weakness along with several months of worsening chest, left upper quadrant abdominal pain and intermittent back pain. CT chest with intravenous contrast showed a 4.9 x 7.6 x 5.8 cm anterior mediastinal mass and a 2.6 x 3.7cm mass above the right pulmonary artery. Compression of the proximal or distal airways was not noted. MRI confirmed vertebral involvement and extension of the soft tissue mass into the epidural space with corresponding spinal cord compression. Neurosurgery and Anesthesiology were consulted for emergency surgical decompression of the thoracic spine.

Tuesday, October 16, 2012
11:00 AM - 12:30 PM
MC790

**Perioperative Management of a Patient With Cold Urticaria**

*Lance Shilliam, Kenneth Moran, M.D., Anesthesiology, Wexner Medical Center at The Ohio State University, Columbus, OH.*

This case describes a 45 year-old female presenting for laparascopic Nissen fundoplification. She has a fourteen year history of cold urticaria, which includes anaphylaxis with stimuli as minor as an ice cube in her mouth. In order to help prevent anaphylaxis, normothermia was maintained with multiple blanket warmers, fluid warmers, and measurement of central and peripheral temperature. Histamine releasing drugs were avoided. Histamine blockers and steroids were given as premedication, and epinephrine was readily available. The operation was performed successfully. She developed delirium in the PACU, but was successfully treated and had no anaphylaxis.



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Tuesday, October 16, 2012
11:00 AM - 12:30 PM
MC791

**A Case of Intraoperative Hypermetabolic Syndrome With Early Dantrolene Intervention Without a Rise in Creatinine Kinase: Is This Malignant Hyperthermia?**

*Alicia Shook, M.D., Michael R. Shaughnessy, M.D., Abimbola Opanuga, M.D., Haley M. DiGiacomo, M.D., Anesthesiology, Duke University Medical Center, Durham, NC.*

A 49 year-old male with six previous anesthetics presented for cervical fusion. He reported a history of remote cocaine abuse. Induction and maintenance of anesthesia was achieved with fentanyl, propofol, succinylcholine and isoflurane. His esophageal temperature increased to 43.1 within twenty minutes without tachycardia or rigidity and with minimal hypercarbia. Surgery was aborted and dantrolene was administered. Creatinine kinase levels remained normal in the ICU. Four days later, the patient received an uneventful total intravenous anesthetic. Genetic testing was performed. We will present a review of the diagnosis, management and follow up of Malignant Hyperthermia susceptible patients.

Tuesday, October 16, 2012
11:00 AM - 12:30 PM
MC792

**Understanding the Differential Diagnosis of Altered Mental Status and Ensuing Management Strategies Immediately Following Postoperative Extubation**

*Mandeep Singh, M.D., Obianuju Okocha, M.D., Anesthesiology, Northwestern University - Feinberg School of Medicine, Chicago, IL.*

41 year-old female with uncontrolled hypertension and uterine fibroids underwent abdominal myomectomy. After surgical closure, EBL was 2L and hemoglobin 9.6. The patient was breathing spontaneously with TV 500cc, RR 15, following commands appropriately, and demonstrating a 5-second head lift. She was extubated but became obtunded and apneic approximately one minute later requiring re-intubation (remained hemodynamically stable). Abdomen was markedly distended which prompted surgical re-exploration. Stat labs included hemoglobin 6.5, INR 2.3, thrombocytopenia, and low fibrinogen consistent with DIC. There was uncontrollable bleeding which required hysterectomy. Transportation of products to the OR was impeded by a malfunctioning pneumatic tube system.

Tuesday, October 16, 2012
11:00 AM - 12:30 PM
MC793

**Undiagnosed Hypercoagable State in Postpartum Patient Leading to Compartment Syndrome**

*Craig Malk, M.D., Sumit Singh, M.D., Ramsis F. Ghaly, M.D., Feodor Gloss, M.D., Anesthesia, John H. Stroger Jr. Hospital of Cook County, Chicago, IL.*

24 year-old female who, after delivery of her baby, her hospital course was complicated by volvulus. She was taken emergently to the OR. A IV was obtained in the right hand. After the procedure she had significant swelling on the right hand and arm. Compartment syndrome was diagnosed and she was taken to the OR for forearm fasciotomies when it was noticed her left hand was starting to swell and become mottled. An urgent bilateral upper extremity ultrasound showed venous thrombi. A hypercoaguability workup was positive. This case presents an unforeseen complication leading to a diagnosis of hypercoaguable state. 



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Tuesday, October 16, 2012
11:00 AM - 12:30 PM
MC794

**Aspirated Thumbtack Extraction: Applying the Lessons Learned - A Simple and Elegant Adjunct**

*Marcos Gomes, M.D., Pramod Chetty, M.D., Daniel Skelly, M.D., Katherine Biernat, Marvin Peyton, M.D., University of Oklahoma Health Sciences Center, Oklahoma City, OK.*

Trachealbronchial foreign body aspiration is a problem that can result in distinct complications. Often, bronchoscopy forceps cannot successfully extract the object from the bronchial tree, and alternate methods, sometimes invasive, lengthy, and traumatic (laser-assisted breakage) are attempted. First, we describe a case in which a technically difficult, lengthy procedure resulted in successful retrieval only after the topical application of a vasoactive solution. Next, we describe a second similar case in which this technique was applied earlier in the procedure promoting faster extraction and positive outcomes. We believe airway topicalization could be a valuable adjunct during these challenging procedures.

Tuesday, October 16, 2012
11:00 AM - 12:30 PM
MC795

**Methemoglobinemia Following General Anesthesia and Prior to a 14-Hour Surgery: A Case Report**

*Ben Sloop, M.D., Eric Ashford, M.D., Paul Sloan, M.D., Anesthesiology, University of Kentucky, Lexington, KY.*

This case report will discuss the management of local anesthetic induced methemoglobinemia occurring after induction and line placement, in a patient with a 14-hour planned cancer surgery. A 62-year old male presented for major neck tumor resection. Awake fiberoptic intubation was completed for a difficult airway using 3 sprays of benzocaine and 2cc of translaryngeal lidocaine. 20 minutes following induction, the SaO2 decreased to 90% and central cyanosis was observed. Methemoglobinemia was diagnosed. Treatment with IV methylene blue was successful. When methemoglobinemia is diagnosed post-induction, incision for extensive surgery should be delayed until SaO2 has returned to normal and stabilized.

Tuesday, October 16, 2012
11:00 AM - 12:30 PM
MC796

**Awake Glidescope Technique in a Patient With Rheumatoid Arthritis and Atlantoaxial Subluxation**

*Elizabeth Smith, M.D., Laura Clark, M.D., Anesthesia, University of Louisville, Louisville, KY.*

39 year-old female, originally from Eastern Europe with untreated debilitating juvenile rheumatoid arthritis. Cervical spine imaging revealed atlantoaxial subluxation, a prior c1-c2 fusion and anterior subluxation of c4-c5. Airway exam revealed micrognathia, severe overbite, mandibular deterioration, mallampati IV, and limited range of motion of her neck. Multiple past surgeries all required awake fiberoptic intubation. The patient pleaded to be asleep prior to intubation due to her traumatic memories, which was not a safe option. We report a case of a successful awake glidescope technique in this difficult patient.



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Tuesday, October 16, 2012
11:00 AM - 12:30 PM
MC797

**Knotted Pulmonary Artery Catheter in a Coagulopathic Patient Undergoing Orthotopic Liver Transplantation**

*Mark M. Smith, M.D., Christopher J. Jankowski, M.D., Laurence C. Torsher, M.D., Anesthesiology, Mayo Clinic, Rochester, MN.*

Multiple attempts at pulmonary artery catheter (PAC) flotation in a coagulopathic patient undergoing liver and kidney transplantation were unsuccessful. Upon attempted PAC removal, resistance was encountered, and fluoroscopy revealed a knotted PAC that could not be unraveled. Under fluoroscopy, PAC traction was applied so that the knot abutted the introducer, minimizing knot size. After passage of a guide wire down another lumen of the introducer, both the introducer and PAC were removed *en bloc.* A new introducer and PAC were placed uneventfully. Knotting of a PAC is a rare but serious complication for which anesthesiologists should have familiarity.

Tuesday, October 16, 2012
11:00 AM - 12:30 PM
MC798

**A Case of Carcinoid Tumor**

*Sarah Smith, D.O., Stanlies D'Souza, M.D., Toni Chahla, M.D., Anesthesiology, Baystate Medical Center, Springfield, MA.*

A 58 year-old male with asymptomatic carcinoid tumor of the ileocecal junction, diagnosed with positive octreotide scan, presented for laparoscopic tumor resection. The patient was given mineralocorticoids, anti-histamines and an octreotide infusion prior to induction with non-histamine releasing agents. Blood pressure and volume status were monitored using an arterial line. Hypotension during tumor manipulation was managed with octreotide and phenylephrine. Octreotide infusion was discontinued before transfer to recovery and the patient had an uneventful post-operative course.

Tuesday, October 16, 2012
11:00 AM - 12:30 PM
MC799

**Anesthetic Management of Laproscopic Adrenalectomy for a Large Pheochromocytoma in the Setting of a National Shortage of Phentolamine**

*Jamey J. Snell, M.D., Shawn Sikka, M.D., Richard Novack, M.D., Ken Sutin, M.D., Department. of Anesthesiology, New York University Medical Center, New York, NY, College of Medicine, Drexel University, Philadelphia, PA, Department of Anesthesiology, New York University Medical Center/Bellevue Hospital Center, New York, NY.*

A 47 year-old man experienced HTN, several episodes of nausea, vomiting, diarrhea, and abdominal pain for a year prior to admission. CT scan showed a hypervascular, heterogeneous 11x8x9cm tumor located anterior to and distinct from the left kidney. Plasma and urine catecholamine and metanephrine levels confirmed the suspected diagnosis of pheochromocytoma and the patient was started on phenoxybenzamine and scheduled for laproscopic adrenalectomy. Pre-op preparation led to the discovery of a hospital-wide and national shortage of the intravenous alpha-blocker phentolamine--commonly used for intra-op management of hypertension. Review of the literature revealed alternative therapeutics for intraoperative management of anesthesia and hemodynamics.



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Tuesday, October 16, 2012
11:00 AM - 12:30 PM
MC800

**Iatrogenic Complications of Multiple Reintubations Resulting in Awake Tracheostomy**

*Chris M. Sobey, M.D., Michael A. Pilla, M.D., Anesthesiology, Vanderbilt University, Nashville, TN.*

65 year-old female with hydrocephalus and basilar subarachnoid hemorrhage requiring embolization of supraclinoid aneurysm. Patient with grade 3 airway, reduced oral opening, neck flexion and extension requiring 2 intubation attempts. ICU course complicated by episodes of hypoxic respiratory failure/stridor requiring multiple reintubations (4 total intubations with >2 attempts each). On postop day 10, otolaryngologic examination revealed posterior glottis stenosis. Tracheostomy performed the following day under local anesthetic and mild sedation using dexmedetomidine infusion. Laryngoscopy following tracheostomy revealed severe edema of false and true vocal cords, mucosal ulcerations, scarred and immobile arytenoid cartillages, tracheomalacia, and tracheal stenosis proximal to tracheostomy insertion.

Tuesday, October 16, 2012
2:30 PM - 4:00 PM
MC839

**Glidescope Assisted FOI for a Bloody Airway With Small Mouth Opening**

*Samy M. Soliman, M.D., Anesthesia, New York University, New York, NY.*

75 year-old female w metastatic melanoma presented for a craniotomy and resection of a metastatic hemorrhagic tumor. Patient was 2 weeks s/p a partial maxillectomy, and as a result had a 1.5cm mouth opening. An asleep, oral FOI resulted in difficulty with passing the ETT and was unsuccessful. A subsequent nasal FOI was c/b a bloody airway and an inability to visualize laryngeal structures. A Glidescope was introduced into the mouth and the FOB and ETT were advanced into the trachea under direct vision on the glidescope monitor. The discussion will focus on using a combined Glidescope/fiberoptic technique.

Tuesday, October 16, 2012
2:30 PM - 4:00 PM
MC840

**Hypotensive Event Following Autologous Cell Saver Blood Transfusion**

*Che Antonio Solla, M.D., Byron Edmond, M.D., Anesthesiology, Walter Reed National Military Medical Center, Bethesda, MD.*

63 year-old male ASA-II for hypertension on lisinopril (taken morning of surgery) with prostate cancer presented for radical prostatectomy. Autologous cell saver blood used during case. Immediately following initiation of transfusion, precipitous hypotensive event noted refractory to all vasopressors but epinephrine. It is hypothesized that accumulation of bradykinin in cell saver blood may have been the source. Interaction of factor XII with the negatively charged surface in cell saver filter can initiate cascade leading to production of bradykinin. Bradykinin, which is broken down in the body primarily by ACE was hindered by the fact that the patient was on lisinopril.



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Tuesday, October 16, 2012
2:30 PM - 4:00 PM
MC841

**Disaster Anesthesia for Orthopedic Procedures Using TIVA**

*Aleeta A. Somers-Dehaney, M.D., Joan Christie, M.D., Anesthesiology, Fremont Memorial Hospital, Fremont, OH, Anesthesiology/Critical Care/Pain, University of South Florida, Tampa, FL.*

01/12/2010 earthquake struck Haiti. Anesthesiologists faced with surgery for a 24 year-old male s/p MVA with hip fracture. He was bleeding in shock & coagulopathic. Limited access to O2, anesthesia machine, lab, monitoring devices & blood-products. Monitors used: BP machine & pulse-oximeter. Regional/general anesthesia not ideal given coagulopathy & no machine. TIVA employing propofol, ketamine , 2% lidocaine was used. Spontaneous respirations. Sao2 normal. Intraoperatively: unconscious with no movement & muscle relaxation. Postoperative pain control good. BP improved with additional hydration. There maybe utility for this technique in unstable/high risk patients who cannot tolerate general/regional anesthesia.

Tuesday, October 16, 2012
2:30 PM - 4:00 PM
MC842

**Mediastinal Mass Associated With Unanticipated Difficult Airway Management and Cardiovascular Collapse**

*Joan Spiegel, M.D., Anesthesia and Critical Care Medicine, BIDMC/Harvard Medical School, Boston, MA.*

A 27 year-old obese (BMI 40) male was s/f axillary lymph node bx. Hx was significant for mild asthma. CT scan revealed 7x5cm anterior mediastinal mass w/o tracheal-vascular compression. Induction was performed with propofol, succinylcholine with Grade II view. A 6.5ETT was placed but no end-tidal CO2 seen. After albuterol was administered via ETT, CO2 was seen. LN biopsy completed but with marginal ventilation. On extubation, oxygen saturation decreased and patient was re-intubated with extreme difficulty. On transfer to the ICU, patient had respiratory and cardiovascular collapse, but successfully resuscitated and extubated without deficits on POD#2. Hodgkin's Lymphoma was diagnosed.

Tuesday, October 16, 2012
2:30 PM - 4:00 PM
MC843

**Psychogenic Vocal Cord Dysfunction Treated by the Injection of Botulinum Toxin**

*Jared Spilka, Steve Barnes, M.D., Anesthesiology, Rush University Medical Center, Chicago, IL.*

Psychogenic vocal cord dysfunction is a well described yet often wrongly diagnosed clinical entity that can create a challenging airway scenario for clinicians. Diagnosis is often clouded by the more common diagnosis of asthma and ineffective, costly treatments are initiated after misdiagnosis. Studies suggest a certain set of symptoms and tests can be used to distinguish the two. We present a classic case of VCD in a healthy female that was successfully treated by injection of botulinum toxin into the thyroarytenoid muscles under general anesthesia with an endotracheal tube, with subsequent intense psychosocial and speech language therapy.



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Tuesday, October 16, 2012
2:30 PM - 4:00 PM
MC844

**Airway Management in Patient With Large Circumferencial Neck Mass With Tracheal Deviation and Mediastinal Extension**

*Dennis G. Sprockel, M.D., Oleg Gusakov, M.D., Anesthesiology, Boston Medical Center, Boston, MA.*

A 56 year-old male with an aggressive diffuse large B cell lymphoma presents with large neck mass encapsulating the airway and extending into mediastinum with mainstem involvement. Presented with dyspnea, worsening stridor, tracheal deviation, difficulty clearing secretions and swallowing. CT scan demonstrated large right-sided neck mass encapsulating airway, diffusely infiltrating with mediastinal shift and compression of mediastinal structures including the trachea, esophagus and major vessels. Patient brought to the operating theatre with ENT and Cardiothoracic Surgery on standby for possible awake tracheostomy and possible bypass since we were not sure how the mainstem obstruction would behave under general anesthesia.

Tuesday, October 16, 2012
2:30 PM - 4:00 PM
MC845

**Anesthetic Considerations and Airway Management Techniques for Gigantiform Cementoma**

*James W. Stephens, D.O., Edward Kosik, D.O., Vaidy Rao, M.D., Department of Anesthesiology, University of Oklahoma, Oklahoma City, OK.*

A 25 year-old Native American female presents for maxillary osseous recontouring and removal of intranasal mass secondary Gigantiform Cementoma. The patient has had multiple anesthetics administered in the past with the airway ranging from routine to difficult. The expansile cementoma involves the mandible, maxilla, sphenoid, and frontal bones resulting in gross abnormaility with nasal and maxillary projection several centimeters past the mental process. The patient was slowly sedated with propofol and ventilation was taken over using nasal mask ventilation with a toddler mask as anesthetic was deepened. The patient was intubated using video laryngoscopy without difficulty.

Tuesday, October 16, 2012
2:30 PM - 4:00 PM
MC846

**Cherubism in a 22-Year-Old Male**

*Peter Stiles, M.D., Anesthesiology, University of Michigan, Ann Arbor, MI.*

A 22 year-old patient with severe cherubism (hereditary, massive bony and soft tissue overgrowth of the mandible) presented for debulking of tumors of the bilateral mandible and giant cell granuloma intralesional dexamethasone injection. This was a challenging case secondary to obligate intubation and the patient's unique anatomy posing a potentially difficult airway; though the patient had prior anesthetics, previous airway experiences could not be applied due to the dynamic nature of the disease. The case will review how the patient was masked, induced and, ultimately, intubated via video fiberoptic laryngoscope, as well as what extra safety measures were observed.



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Tuesday, October 16, 2012
2:30 PM - 4:00 PM
MC847

**Acute Hypoxia After Administration of Factor VII for Massive Hepatic Hemorrhage**

*Andrea J. Strathman, M.D., Matthew Benshoff, M.D., Anesthesiology, Wake Forest University, Winston-Salem, NC.*

33 year-old female presented emergently for laparotomy for ruptured hepatic hemangioma, which had been embolized at an outside facility. Upon opening of the abdomen, the patient was found to have 2 liters of blood in the abdominal cavity and was coagulopathic. The massive transfusion protocol was initiated. The liver was packed for hemostasis and the patient was taken to Interventional Radiology for embolization of selected hepatic arteries. Factor VII was given for coagulopathy. During the procedure, the patient acutely developed significant, refractory hypoxia. This slowly resolved over the next several hours without further intervention. Most likely etiology was Gelfoam embolization.

Tuesday, October 16, 2012
2:30 PM - 4:00 PM
MC848

**Pneumothorax After Failed Intubation**

*Gopakumar Sudhakaran Nair, M.D., Hesham Elsharkawy, M.D., Anesthesia, Cleveland Clinic Foundation, Cleveland, OH.*

A 44 year-old obese female patient with COPD and Alpha-1-antitrypsin deficiency was scheduled for MRI of the spine. Intubation attempts failed with both direct laryngoscopy and glidoscope, requiring hand mask ventilation (HMV) to be reinitiated. However, high airway pressures were needed to achieve adequate ventilation. Patient was woken up, and found to be hypoxemic. Chest x-ray revealed right sided pneumothorax, needing chest tube insertion. The purpose of this report is to increase awareness among anesthesiologists, that regulating airway pressure during HMV is important not only to prevent gastric insufflation, but also to prevent barotrauma.

Tuesday, October 16, 2012
2:30 PM - 4:00 PM
MC849

**Anaesthetic Management for Esophagoscopy on a Post Pneumonectomy Nonagenarian With an Interesting Chest Radiograph**

*James Hardwick, M.B., B.S., Namita Arora, M.D., F.R.C.A, Nazneen Sudhan, M.B., B.S., Ruth Harrison, M.B., Ch.B., Watson Gomez, M.D.,F.R.C.A., Anaesthetic and Intensive care, Norfolk and Norwich University Hospital, Norwich, United Kingdom, Anaesthesia, Bedford Hospital, Bedford, United Kingdom.*

A 95 year-old woman presented after choking on a piece of bacon. Auscultatory findings revealed breath sounds in the right lung fields and bowel sounds with muffled heart sounds on the left. It was understood that she underwent a left pneumonectomy and the chest radiograph revealed migration of the left hemidiaphragm to where the apex of left lung would have been. On surgical consult it was suggested that the left hemithorax was occupied by colonic structures. Following rapid sequence induction spontaneous ventilation with remifentanil and sevoflurane was maintained to avoid excessive airway pressures on the left bronchial stump.



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Tuesday, October 16, 2012
2:30 PM - 4:00 PM
MC850

**FastTrack Geriatric Trauma Anaesthesia in a Medically Complex Scenario Following a Risk-Benefit Guage**

*Vijeta Mahinthan, M.B., Ch.B., Krzysztof Kurzatkowski, M.B.,B.S., Nazneen Sudhan, M.B., B.S., Ben Linton-Willoughby, M.B., B.S., Watson Gomez, M.D.,F.R.C.A. Anaesthesia, Bedford Hospital, Bedford, United Kingdom, Anaesthetic and Intensive care, Norfolk and Norwich University Hospital,UK, Norwich, United Kingdom.*

Days following the evolution of a pulmonary embolus, an independent and warfarinised ASA3 nonagenarian suffered a subtrochanteric fracture. Pleural effusions resulted as sequelae of congestive heart failure. The tenability of offering a dynamic hip screw against conservative approaches favoured the former. Fluid was tapped in excess of a litre from each hemithoraces. The anticoagulation was switched to heparin. The absence of residual emboli on CTPA and moderately deranged coagulation led to administration of fresh frozen plasma to facilitate spinal anaesthesia and minimise intra operative blood loss. This rapidly orchestrated multi-disciplinary approach resulted in exemplary trauma fast tracking in our case.

Tuesday, October 16, 2012
2:30 PM - 4:00 PM
MC851

**Retrograde Oral to Nasal Tracheal Tube With an Endotracheal Tube Exchanger**

*Jessica Sumski, M.D., Seth Akst, M.D., Anesthesiology, George Washington University Medical Center, Washington, DC.*

A 25 year-old male presented for mandibular fracture fixation requiring nasotracheal intubation. There was difficulty passing a nasotracheal tube through the arytenoids. Patient was intubated through an LMA and tube secured orally. We placed an airway exchange catheter through the left nares, and brought the sital end out the patient's mouth. We then bent the exchange catheter upon itself, and advanced the distal end through the orotracheal tube. Using forceps we advanced the orotracheal tube into the hypopharynx. The endotracheal tube was then moved with forceps in a retrograde direction along the exchange catheter and out the patient's left nares.

Tuesday, October 16, 2012
2:30 PM - 4:00 PM
MC852

**Malignant Hyperthermia: A Case Report**

*Benjamin Sutlive, M.D., Promil Kukreja, M.D., Gwendolyn Boyd, M.D., Somsak Sittitavornwong, D.D.S., Seth Richardson, C.R.N.A., Anesthesiology, University of Alabama Birmingham, Birmingham, AL.*

This case is a 46 year-old renal failure patient undergoing resection of a mandibular tumor. The patient underwent several previous uneventful surgeries prior to this. After nearly eight hours under general anesthesia the patient began showing signs of MH. However, complicating the matter was the patient's renal failure and the development of hyperkalemia prior to recognizing possible MH. The hyperkalemia was treated but did not correct until MH treatment was started. After being treated for several days it was discovered through further investigation that there was a family history very suspicious for MH that was never mentioned/ascertained prior to surgery.



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Tuesday, October 16, 2012
2:30 PM - 4:00 PM
MC853

**Life-Threatening Bronchospasm During Open Nephrectomy of Congenital Horseshoe Kidney in an Obese Patient With Asthma and ESRD**

*Michael A. Tahir, M.D., Lindsay Higgins, M.D., Henry Liu, M.D., Brian McClure, M.D., Frank Rosinia, M.D., Department of Anesthesiology, Tulane University School of Medicine, New Orleans, LA.*

Severe bronchospasm represents a critical intraoperative emergency. We report a case of life-threatening bronchospasm during open bilateral nephrectomy in a 36 year-old obese patient with asthma, GERD and end stage renal disease, under general endotracheal anesthesia. Soon after induction and intubation, there was mild desaturation and wheezing. Later, ventilation became difficult. Peak airway pressure increased, rapid desaturation followed. ETCO2 was lost, and oxygen saturation dropped into the low teens. Intravenous epinephrine, terbutaline and other aggressive therapies gradually stabilized the condition, and a decision was made to continue the case. Outcome was good with no sequelae.

Tuesday, October 16, 2012
2:30 PM - 4:00 PM
MC854

**Bradycardic Arrest After Induction of Anesthesia in a Patient With a Recent Subarachnoid Hemorrhage**

*Ngano Takawira, M.B.,Ch.B., Cosmin Guta, M.D., Anesthesiology, Texas Tech University Health Sciences Center, El Paso, TX.*

We present a case of a 47 year-old male who into bradycardic arrest after induction of anesthesia. He had a complex recent medical history of a ruptured cerebral aneurysm , ventilator dependency with a tracheostomy as well as an empyema which was scheduled for a thoracoscopy. The patient was succesfully revived but experienced another episode of bradycardia when a second direct laryngoscopy to replace the double lumen tube with a single lumen tube was performed ,this resolved after atropine administration. One week later the patient had an uneventful induction after pretreatment with atropine and avoidance of direct laryngoscopy .

Tuesday, October 16, 2012
2:30 PM - 4:00 PM
MC855

**Severe Hyperkalemia in a Dialysis Patient During Massive Transfusion**

*Cara B. Tang, M.D., Kalyani Karandikar, M.D., Peter Roffey, M.D., Mariana Mogos, M.D., Duraiyah Thangathurai, M.D., Anesthesiology, LAC & USC Medical Center, Los Angeles, CA.*

A 52 year-old female with chronic renal failure was scheduled for resection of a retroperitoneal mass. An arterial line was placed and she was induced in a standard fashion. A blood gas shortly after induction revealed potassium of 5.9mEq/L. A low-dose epinephrine infusion (2mcg/min) was instituted. The potassium was rechecked and within one hour was 3.5mEq/L. During tumor resection, the patient required massive blood transfusion of 12 units PRBC. The epinephrine infusion was continued. Subsequently the potassium never rose above 3.5mEq/L. The epinephreine alone was able to lower the patient's potassium acutely and maintain it at an acceptable level.



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Tuesday, October 16, 2012
2:30 PM - 4:00 PM
MC856

**Airway Management of a 54 Year-Old Male With Acute Onset Severe Laryngeal Edema and an Incidentally Found Sub-Glottic Mass**

*Vahe S. Tateosian, M.D., Raymond Pesso, M.D., Kenneth Freese, M.D., Nassau University Medical Center, East Meadow, NY.*

54 year-old male with a tracheal stoma from previous tracheostomy tube placement arrived to the SICU in severe respiratory distress. Laryngoscopy revealed a severely edematous epiglottis and arytenoids; false cords were appreciated without a visible glottic opening. A 5.0mm-ETT was inserted through the stoma to establish airway control. The patient came to the OR for revision of the stoma, where both video and fiberoptic laryngoscopy were performed. In addition to larygneal edema, a subglottic mass was found obstructing the tracheal lumen. Our management, possible alternative approaches, and general considerations for emergency airway management in patients with previous tracheostomies are discussed.



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