MEDICALLY CHALLENGING CASES
AMBULATORY ANESTHESIA

Saturday, October 13, 2012
8:00 AM - 9:30 AM
MC01
Acute Cervical Disk Herniation After Bilateral Thyroplasty
Carlo Alphonso, M.D., Anesthesia, SAMMC, Fort Sam Houston, TX.
65 year-old ASA II male to undergo bilateral thyroplasty for chronic hoarseness. He tolerated the procedure well with propofol sedation. Postoperatively he noted numbness and weakness to bilateral hands and feet. Neurology and neurosurgery were consulted. Resulting cervical MRI noted a ventral epidural collection of fluid most consistent with hemorrhage at the C3-C5 levels with spinal cord edema. Within 24 hours, he returned to the OR for decompression and noted to have a disk herniation at C3-C5 for which an ACDF was performed. Motor and sensory functioned improved postoperatively. The patient was discharged home on the following day.

Saturday, October 13, 2012
8:00 AM - 9:30 AM
MC02
WITHDRAWN

Saturday, October 13, 2012
8:00 AM - 9:30 AM
MC03
Combination Propofol-Remifentanil Anesthesia for a Patient Taking a Monoamine Oxidase Inhibitor
William B. Cederquist, M.D., Anesthesiology, University of Michigan Health System, Ann Arbor, MI.
A 27-year-old ASA 3 man presented for elective septorhinoplasty and turbinate reduction for chronic nasal congestion. He had previously been hospitalized for suicidal ideation and failed standard therapies. His mood disorder was treated with phenelzine 30mg twice a day. The patient and his psychiatrist were reluctant to discontinue phenelzine prior to surgery with concern for recurrent suicidality. Anesthesia was induced with midazolam, remifentanil and propofol. Maintenance anesthesia was with vecuronium, remifentanil and propofol.

Saturday, October 13, 2012
8:00 AM - 9:30 AM
MC04

Perioperative Management of Patient With Antithrombin III Deficiency Presenting for Laproscopic Right Hemicolectomy and Salpingoophorectomy

Praveen Chahar, M.D., Ivan Sanchez Parra, M.D., Hesham Elsharkawy, M.D., Wael Ali Sakr Esa, M.D., Anesthesiology, Cleveland Clinic Foundation, Cleveland, OH.

91 year-old female with history of deep venous thrombosis, antithrombin III deficiency, C5-6 Fusion, anemia presented for laproscopic right hemicolectomy and bilateral salpingoophorectomy for colonic carcinoma with metastasis. Hematology consult was obtained and the patient was admitted preoperatively to transition from warfarin to unfractionated heparin. Preoperatively she was transfused two units of blood for hemoglobin of 7.1 and received 3750 IU antithrombin III concentrate. She was stable intraoperatively and postoperatively. She received 2250 IU antithrombin III concentrate daily with a target trough antithrombin level more than 80 with heparin infusion till she was transitioned back to warfarin.

Saturday, October 13, 2012
8:00 AM - 9:30 AM
MC05

Up With the Legs, Down With the Pulses: A Case of Bradycardia and Asystole With Lithotomy During General Anesthesia

Kallol Chaudhuri, M.D., Ph.D., Sophia Varghese, C.R.N.A., Shiraz Yazdani, M.D., Anesthesiology, Texas Tech University Health Sciences Center, Lubbock, TX.

A 71 yr old patient with history of hypertension and diabetes, scheduled for TVH. History of occasional SOB with moderate exercise. Electrocardiogram showed first degree heart block. GA was induced with fentanyl , etomidate , and vecuronium . Following intubation , when her legs were raised for lithtomy, patient's heart rate began to drop and patient became asystole. Patient's legs were brought down immediately , glycopyrrolate and atropine given , then heart rate restored to mid 70s. Two more attempts were made for lithotomy , which produced similar result of bradycardia and asystole , spontaneously reversed when patient positioned supine.

Saturday, October 13, 2012
8:00 AM - 9:30 AM
MC06

A Potential Challenge in Airway Management - Os Odontoideum

Theodore J. Cios, M.D.,M.P.H., Subramanian Sathishkumar, M.B., B.S., Anesthesiology, The Pennsylvania State University, Hershey, PA.

A 41 year old female with menorrhagia presented for dilation and curettage. Patient had known os odontoideum. Airway exam was unremarkable except previous cervical spine x-rays demonstrated significant retrolisthesis of C1 on C2 during extension. Despite her normal range of motion, we remained concerned about her neurological status throughout the peri-operative period. As part of a neuroprotective strategy, a cervical collar was preemptively applied in the preoperative area with the patient's input regarding fit. An asleep fiberoptic intubation was performed. The collar was removed in the anesthesia recovery unit and a neurological exam performed after removal was normal.

Saturday, October 13, 2012
8:00 AM - 9:30 AM
MC07

Intraoperative Explosion

Brandon Davis, M.D., Neesha Dhanak, D.O., Govind Rajan, M.D., Anesthesiology, St. Louis University, St. Louis, MO.

A 56 year-old male presented for excision of basal cell cancer of the forehead under MAC. A drape was applied just below the eyes and the patients oxygen saturation was maintained with nasal cannula oxygen. During the use of cautery, an explosion occurred igniting the patients face and the overlying drapes. The patient sustained 2nd degree burns and pictures are to be included with this presentation.

Saturday, October 13, 2012
8:00 AM - 9:30 AM
MC08

Tracheal Rupture After an Uncomplicated Outpatient Liposuction Procedure

Kelly U. De Souza, M.D., Albert J. Varon, M.D., Gabriel E. Sarah, M.D., Anesthesiology, JMH/UMH, Miami, FL.

31yo F c/o sore throat, SOB, substernal CP, and swelling of the face, neck, and chest. She had an uncomplicated liposuction procedure under GA at an outpatient center 1.5hrs prior to presentation. She was doing well other than complaints of a sore throat after extubation. She was subsequently given juice by a nurse after which she developed a cough, SOB, and subcutaneous emphysema. She was transferred to JMH with stable vitals, subcutaneous emphysema in her face, neck, and chest. Fiberoptic bronchoscopy revealed a posterior tracheal tear. Esophagram was negative. She was kept NPO, started on IV antibiotics, and admitted.

Saturday, October 13, 2012
8:00 AM - 9:30 AM
MC09

Airway and Anesthetic Management of a Patient With a Known Difficult Airway, Large Laryngeal Tumor, and Thyroid Mass

Christopher Edwards, M.D., Deborah Whelan, M.D., Lauren Hoke, B.S., Joseph May, B.S., Yvon Bryan, M.D., Anesthesiology, Wake Forest School of Medicine, Winston Salem, NC.

A 65-year-old, 103-kg male with neck fixed in fully flexed position presented for laser ablation of a tracheal tumor and thyroidectomy for a thyroid mass. Airway exam revealed Mallampati IV, mouth opening and thyromental distance of 3 FB and 2 FB, respectively. The airway was topicalized with 4% lidocaine nebulizer and later with oxymetazoline hydrochloride/4% lidocaine pledgets placed in the nares. The patient was sedated with dexmedetomidine for transnasal endotracheal laser tumor debulking. Awake intubation was achieved using a flexible fiberoptic bronchoscope with a 6.5 nasal RAE placed in the right nare following the laser ablation and prior to thyroidectomy.

Saturday, October 13, 2012
8:00 AM - 9:30 AM
MC10

Dexmedetomidine-Ketamine for Offsite Ambulatory Procedural Sedation of a Patient With Morbid Obesity and Myasthenia Gravis

Michael F. Esposito, Atul Gupta, M.D., Anesthesia and Critical Care, University of Chicago Medical Center, Chicago, IL.

Providing offsite ambulatory anesthesia can be especially challenging in patients with neuromuscular disorders. An anesthetic regimen should be carefully chosen which, while providing adequate analgesia, amnesia, and sedation, minimizes physiologic perturbations so that patients can be safely discharged from the offsite procedure suite and admission to the hospital can be minimized. We present one such anesthetic technique, utilizing a combination of dexmedetomidine and ketamine, that we employed successfully in our patient with myasthenia gravis and morbid obesity who presented to the GI suite for colonoscopy.

Saturday, October 13, 2012
8:00 AM - 9:30 AM
MC11

Massive Subcutaneous Emphysema During an Upper Endoscopy

Shahram S. Farahvash, M.D., Laurie Easter, M.D., Aisha Ishteeaque, M.D., Kenneth Freese, M.D., Raymond Pesso, M.D., Nassau University Medical Center, East Meadow, NY.

The patient is a 77 year-old male with a significant medical history who presented with dysphagia and was scheduled for an upper endoscopy with balloon dilatation for esophageal stricture under general anesthesia. Few minutes after balloon dilatation had started the patient was noted to have massive subcutaneous emphysema of the head and neck. The procedure was aborted and the patient was sent for emergency esophagogram. Radiographic imaging revealed extensive subcutaneous emphysema, pneumomediastinum and pneumoperitoneum in addition to extraluminal extravasation of contrast at the distal esophagus. Patient was brought to OR for emergency left thoracotomy and repair of esophageal perforation.

Saturday, October 13, 2012
8:00 AM - 9:30 AM
MC12

Anesthesia for Breast Surgery in Patients Who Are Not General Anesthesia Candidates

Farzin Goravanchi, D.O., Linh Nguyen, M.D., Alicia Kowalski, M.D., Elizabeth Rebello, M.D., Spencer Kee, M.D., Anesthesiology, UT MD Anderson Cancer Center, Houston, TX.

General anesthesia (GA) has been the main anesthetic technique for breast surgeries. Patients who are not GA candidates secondary to significant co-morbidities are presented using Paravertebral blocks (PVB). The surgery is performed under the PVB and light sedation. Post operatively, the patient is transferred to the Post Anesthesia Care Unit for recovery; and then discharged when discharge criteria are met. Conclusion: PVB is a safe alternative to GA for ASA 4 patients undergoing outpatient breast surgeries. Their length of stay in the PACU is significantly shortened, and the patients can be discharged safely the same day.

Sunday, October 14, 2012
2:30 PM - 4:00 PM
MC381

Prolonged Paralysis During Neck Dissection

Patrick Hackett, M.D., Teturo Sakai, M.D.,Ph.D., Anesthesia, University of Pittsburgh Medical Center, Pittsburgh, PA.

A 72 year-old male underwent neck dissection and parotidectomy with facial nerve preservation. Endotracheal intubation was facilitated with succinylcholine resulting in prolonged paralysis lasting five hours. Laboratory tests indicated pseudocholinesterase (PChE) deficiency. Propofol was utilized for sedation and he was safely weaned from mechanical ventilation once able to protect his airway. Thyroidectomy was performed, uneventfully one month later using rocuronium as a muscle relaxant. Literature review revealed a total of 40 PChE deficiency cases being reported since 1956.

Sunday, October 14, 2012
2:30 PM - 4:00 PM
MC382

First Experience of Extrapyramidal Symptoms Resulting From a Single Low-Dose of Oral Perphenazine for PONV Prophylaxis

John P. Henao, M.D., Steve Orebaugh, M.D., Shashank Saxena, M.D., Brian A. Williams, M.D., Anesthesiology, University of Pittsburgh Medical Center, Pittsburgh, PA.

As resource constraints are pressuring anesthesiologists to develop opractices tp minimize expenses, PONV prophylaxis for all high-risk surgical patients has the potential to reduce costs and improve “pay for performance.” Recently, a multimodal approach for PONV prophylaxis incorporating routine perphenazine has been recommended as a therapeutic substitution for droperidol. A 42 y.o., ASA 2 female with PMH of chronic LBP and severe PONV presented for L5-S1 microdiscectomy under GA. Post-op, she exhibited profound extrapyramidal system dysfunction. This represents the first case of EPS dysfunction out of 15000 patients when low-dose oral perphenazine was used as PONV prophylaxis at our institution.

Sunday, October 14, 2012
2:30 PM - 4:00 PM
MC383

A Case of Mistaken Identity: Wrong Medication in the Right Syringe

Bommy Hong, Tina Tran, M.D., Anesthesiology and Critical Care, Johns Hopkins University, Baltimore, MD.

60 year-old female with COPD, diabetes, and hypertension presenting for vitrectomy. She required intubation when she became restless after retrobulbar block and sedation. She was fully reversed using a pre-filled neostigmine syringe but remained somnolent, hypercarbic, with minimal respiratory effort. Differential diagnoses included stroke, hypoglycemia, intrathecal injection of ophthalmic analgesia, and narcotic somnolence which were ruled out except for incomplete reversal of muscle relaxant. An additional dose of neostigmine was administered directly from a vial with improved respiratory efforts meeting extubation criteria. The most likely etiology of her post-operative weakness was medication administered from a mislabeled pre-filled syringe.

Sunday, October 14, 2012
2:30 PM - 4:00 PM
MC384

Intra-Operative Takotsubo Cardiomyopathy, Preceded by Atrial Fibrillation

Shuyan Huang, Stewart Lustik, M.D., University of Rochester, Rochester, NY.

Takotsubo cardiomyopathy, or transient left ventricular apical ballooning syndrome (TLVABS), is an under-diagnosed condition of unclear etiology. An 82 year-old woman with obesity and hypertension was admitted for ERCP. Following induction with etomidate, the patient became hypotensive with SBP dropping from 140 to 80 mmHg which responded to phenylephrine. Rapid atrial fibrillation ensued at120 bpm which was controlled with esmolol and then spontaneously converted to NSR. Post-operatively, the patient had hypotension with mild chest discomfort and no ischemic EKG changes. TTE confirmed TLVABS. Troponins were positive, but left heart catheterization (70% mid-RCA stenosis) was not consistent with apical LV dysfunction.

Sunday, October 14, 2012
2:30 PM - 4:00 PM
MC385

Ambulatory Anesthetic Management of Severe Aortic Stenosis

Nathan Thomas Jones, M.D., Fred Shapiro, D.O., Anesthesiology, Beth Israel Deaconess Medical Center, Boston, MA.

This case describes the successful use of a total intravenous anesthetic in the management of an American Society of Anesthesia (ASA) class IV patient undergoing an Esophagogastroduodenoscopy (EGD) in an ambulatory setting. The initial patient is a 74 year old female with severe aortic stenosis and history of cirrhosis with history of variceal bleeds who needs an EGD prior to consideration for a percutaneous aortic valve replacement. The method described in this case has subsequently been successfully performed on several other patients at our institution.

Sunday, October 14, 2012
2:30 PM - 4:00 PM
MC386

Pulmonary Hemorrhage in an Outpatient Ophthalmic Anesthesia Setting– It's Never Just a Cataract

Ashish K. Khanna, M.D., Kenneth Cummings, M.D., M.S., Anesthesiology Institute, Cleveland Clinic Foundation, Cleveland, OH.

A 48-year-old man underwent an uneventful cataract surgery under general endotracheal anesthesia.(Patient refusal of a regional/topical technique because of anxiety).
PMH of note included ESRD, HTN & recreational drug (cocaine) abuse. He was emergently reintubated in the immediate post-extubation period subsequent to a large volume hemoptysis. Chest roentgenograms showed bilateral upper and mid predominant air space consolidation. An emergent bronchoscopy did not show active airway bleeding or obstructive mucous plugs. He was managed on the lines of diffuse alveolar hemorrhage and was gradually weaned off the ventilator. The underlying etiologies of pulmonary hemorrhage in this clinical scenario will be discussed.

Sunday, October 14, 2012
2:30 PM - 4:00 PM
MC387

Ambulatory Anesthesia in an Adult Patient With Corrected Hypoplastic Left Heart Syndrome

Jennifer Knautz, M.D., Yogen Asher, M.D., Mark Kendall, M.D., Robert Doty, M.D., Anesthesiology, McGaw Medical Center at Northwestern University, Chicago, IL.

With recent advancements in clinical science, an increasing number of patients with congenital heart defects are surviving into adulthood and presenting for non-cardiac surgeries. We describe one such example of a 26 year-old patient with corrected hypoplastic left heart syndrome presenting for knee arthroscopy performed under general anesthesia with pre-operative ultrasound guided saphenous nerve block. In this case, we review the anesthetic implications of corrected single ventricle physiology, as well as discuss the technique and role of saphenous nerve block in patients undergoing knee arthroscopy.

Sunday, October 14, 2012
2:30 PM - 4:00 PM
MC388

A Case of Unexpected Post-Operative Seizure

Biao Lei, M.D., Ph.D., Dorothea Markakis, M.D., Anesthesiology, Pediatric Anesthesia, Cleveland Clinic Foundation, Clevland, OH.

A 19 y/o female, with past “seizure reaction” to Phenergan underwent uneventful general anesthesia for hip arthroscopy. Upon closing the surgeon injected 40cc of 0.5% Ropivacaine intracapsularly. The patient was extubated and taken to PACU where she suddenly developed uncontrollable rapid flapping limb movements. Vital signs, blood glucose, electrolytes and EKG were normal. Treatment with benzodiazepines and Intraplid were ineffective. She resumed conversation while shaking persisted. Her guardians provided psychosocial history of physical abuse, PTSD and a brother's recent death. Despite normal EEG, she had two additional episodes. Conversion disorder was suspected. The patient's family refused further psychiatric follow-up.

Sunday, October 14, 2012
2:30 PM - 4:00 PM
MC389

Anesthetic Consideration of Broad Thumb and Hallux Syndrome

Vanetta L. Levesque, M.D., Mohamad Hashim, M.D., Anesthesiology, Maimonides Medical Center, Brooklyn, NY.

A 42 year-old man was scheduled for a laparoscopic cholecystectomy after gallstone pancreatitis. His history was significant for mental retardation, CAD, and generalized anxiety disorder, his preoperative studies an old inferior infarct by EKG, and his previous surgeries included lithotripsy and orchiopexy for an undescended testicle. The patient is small in stature, has broad heavy eyebrows, downward slanting palpebral fissures, low-set angulated ears, and broad thumbs and halluces. He has microstomia, and a mallampati score of four. Due to the potential for a difficult intubation, the decision was made to fiberoptically intubate.

Sunday, October 14, 2012
2:30 PM - 4:00 PM
MC390

The Use of Dexmedetomidine and Remifentanil in a Patient With MELAS Syndrome

Renata Miketic, M.D., Jennifer Adams, M.D., Anesthesiology, University of Nebraska Medical Center, Omaha, NE.

A 27-year-old male, with known MELAS syndrome, presented for elective outpatient septoplasty. MELAS syndrome is a rare genetic disease that affects the mitochondria. It is characterized by mitochondrial encephalomyopathy, lactic acidosis, and stroke-like episodes. Inhaled agents are avoided secondary to the risk of malignant hyperthermia. Propofol can impair mitochondrial activity and thus further contribute to lactic acidosis. Muscle wasting arises concerns for Succinylcholine-induced hyperkalemia. Non-depolarizing neuromuscular blockers are avoided due to the possibility of residual paralysis and/or increased sensitivity. Due to the multiple challenges with this condition, Dexmedetomidine and Remifentanil were used as primary anesthetic agents with no apparent complications.

Sunday, October 14, 2012
2:30 PM - 4:00 PM
MC391

Iatrogenic Coronary Artery Vasospasm During Ambulatory Surgery

Allison Moriarty, M.D., Colin Wilson, M.D., Anesthesiology, West Virginia University, Morgantown, WV.

A healthy 26 year-old female presented to our ambulatory surgery center for septorhinoplasty for nasal deformity. After induction, both nares were injected with lidocaine with epinephrine. The patient became tachycardic followed by precipitous bradycardia treated with glycopyrrolate. The nasal cavity was then topicalized with Afrin and 4% cocaine. Shortly thereafter the patient became hypertensive and tachycardic, then converted to ventricular tachycardia. The patient remained hemodynamically stable and converted to sinus tachycardia after a lidocaine bolus. Conversion to sinus rhythm revealed ST depression in all leads, which persisted for twenty minutes. We discuss iatrogenic coronary artery vasospasm in the ambulatory setting.

Sunday, October 14, 2012
2:30 PM - 4:00 PM
MC392

A Case of Takotsubo Cardiomyopathy in a Healthy Patient Undergoing Outpatient Surgery Under Sedation

Renee A. Myers., Anesthesiology, University of Florida, Gainesville, FL.

A 30 year-old healthy female underwent radiofrequency ablation of varicose veins under propofol sedation. Immediately postoperatively, she was acutely hypertensive and tachycardic. After blood pressure and heart rate control with hydralazine and labetolol, she demonstrated signs of acute heart failure and flash pulmonary edema. Medications administered intraoperatively included propofol and perivascular epinephrine (cumulative dose 0.5mg.) A transthoracic echocardiogram demonstrated an akinetic septal/inferior wall with an ejection fraction of of 45-50% and elevations in troponin. The patient's condition improved with diuresis, CPAP for hypoxia, and long term beta blockade. Repeat transthoracic echocardiogram 6 weeks later showed normal left ventricular function.

Monday, October 15, 2012
2:30 PM - 4:00 PM
MC643

Anesthetic Care of Stiff Person Syndrome in the Outpatient Setting

Lee J. Neubert, D.O., Pamis Green, D.O., Michael Green, D.O., Anesthesiology, Drexel University College of Medicine - Hahnemann University Hospital, Philadelphia, PA.

A 55 year-old male, with diagnosed stiff person syndrome, presented for left ilioinguinal nerve block in the ambulatory surgery center secondary to chronic testicular pain attributed to stiff person syndrome. Stiff person syndrome is characterized as a neurological disease causing fluctuating muscle rigidity escalating to painful spasms. This case reports describes the successful anesthetic management for the procedure without exacerbation of the symptoms.

Monday, October 15, 2012
2:30 PM - 4:00 PM
MC644

Local Anesthetic Toxicity

Lissette Pichardo, M.D., Maimonides Medical Center, New York, NY.

66 year-old female with PMH of HTN, CHF and MVR presented for left carpal tunnel release and cubital tunnel decompression. An ultrasound guided successful axillary nerve block was performed with 30 mls of Ropivacaine 0.5% with Epinephrine 5mcg/ml. Patient was given 2mg of Midazolam and 50mcg of Fentanyl for sedation. She received another 50 mcg of Fentanyl and 60mg of Propofol during the case. The procedure ended uneventfully. In the PACU, the patient reported tingling around her mouth. Shortly, she became unresponsive. ACLS protocol was initiated. TEE revealed EF of 10%. Local anesthetic toxicity was suspected. Patient expired that evening.

Monday, October 15, 2012
2:30 PM - 4:00 PM
MC645

LVAD and General Anesthesia for Non-Cardiac Surgery

Jacob Prine, M.D., Anesthesia, Vanderbilt, Nashville, TN.

48 year old male with a significant past medical history of ischemic cardiomyopathy status post LVAD placement present for emergency laprascopic appendectomy. LVAD therapy is increasingly used as a modality of treatment in end stage heart failure as a bridge to transplantation, as a bridge to myocardial recovery, or as a destination therapy in patients not eligible for cardiac transplantation. Management of general anesthesia poses a challenge in these patients with LVAD. Device malfunction, effects of anticoagulation, right ventricular failure, surgical blood loss and infection are ever present dangers associated with LVAD.

Monday, October 15, 2012
2:30 PM - 4:00 PM
MC646

A Case of Delayed Awakening After General Anesthesia Caused by a Kinked Reinforced Endotracheal Tube

Manish Purohit, M.D., Dmitry Roberman, M.D., Mian Ahmad, M.D., Anesthesiology, Drexel University Hospital, Philadelphia, PA.

A 68 year-old male underwent rotator cuff repair with both general and regional anesthesia. Following successful completion of the surgery, the patient experienced a delayed emergence from anesthesia

secondary to a crushed reinforced endotracheal tube. Differential diagnosis of delayed emergence and complications in use of the reinforced endotracheal tube will be the basis of the discussion

Monday, October 15, 2012
2:30 PM - 4:00 PM
MC647

Hyperbaric Oxygen Therapy in the Treatment of Crohn's Disease

Manish Purohit, M.D., Kesavan Sadacharam, M.D., Michael Green, D.O., Department of Anesthesiology and Perioperative Medicine, Hahnemann Hospital/Drexel University College of Medicine, Philadelphia, PA.

Crohn's disease is an inflammatory bowel disease leading to debilitating symptoms of abdominal pain, diarrhea, and malabsorption. Recently, hyperbaric oxygen therapy has shown promise in the treatment of acute exacerbations of Crohn's disease. We present two cases of pediatric patients with exacerbations of Crohn's disease who had no improvement with conventional medical therapy and underwent hyperbaric oxygen treatment. Both patients showed resolution of the inflammatory lesions and symptoms allowing reduced drug therapy. Although the mechanisms by which hyperbaric oxygen reduces inflammation is poorly understood, this therapy seems to have offer a safe adjunct in the treatment of refractory exacerbations.

Monday, October 15, 2012
2:30 PM - 4:00 PM
MC648

Managing a Patient With Myasthenia Gravis on Pyridostigmine When RSI Is Indicated

Rajesh Reddy, M.D., Anesthesiology, The Mount Sinai Hospital, New York, NY.

58 year old male with Myasthenia Gravis on Pyridostigmine, HIV, Hep B/C presented for a TIPS procedure. As patient with severe ascites, discussed with patient that must do RSI, however the effects of succinylcholine would be unknown as the patient was on pyridostigmine. If resistance to the drug, then must use rocuronium which will last very long. Explained to patient that postoperatively may remain intubated. Patient metabolized succinycholine normally as evidenced by twitch monitor and was maintained at 1.5 MAC for entire case without use of nondepolarizers. Patient successfully extubated at end of case.

Monday, October 15, 2012
2:30 PM - 4:00 PM
MC649

A Patient for an Ankle Fracture Repair With a Giant Mediastinal Mass

Jorge Humberto Rubio, M.D., Ivan D. Quiceno, M.D., Rafael I. Gonzalez, M.D., Gustavo A. Consuegra, M.D., Juan C. Suescun, M.D., Anesthesiology and Perioperative Medicine, Orthopedics, Auditory, Ambulatory Surgical Center/Salud SURA, Medellin, Colombia.

48 year-old. ROS: Dry Cough without dyspnea PMH: HTn: Enalapril 20 mg twice. Metastatic Breast cancer to anterior mediastinum and right lateral neck: Management: Radical mastectomy and Chemotherapy. PE: BP 140/80 HR 80/m RR 22/m Sat O2 92% (FiO2 21%) BMI: 33,73% Thorax: Bilateral respiratory sounds diminished. X thorax: Anterior mediastinum widening In Prone position a motor response from tibial component, plantar flexion and inversion, at current between 0.7 - 0.4 mAmp was observed, "in plane" approach was used Doses: Bupivacaine 0.5% (1:400.000 adrenaline) 50mgr plus Lidocaine 2% (1:400.000 adrenaline) 200 mg. The surgery was done without any complications.

Monday, October 15, 2012
2:30 PM - 4:00 PM
MC650

Mounier Kuhn Syndrome: Anesthetic Experience

Deepu Sasikumaran Ushakumari, M.D., Navneet Grewal, M.D., Anesthesiology, Drexel University College of Medicine, Philadelphia, PA.

58 year-old chronic smoker presented for septoplasty. His imaging revealed dilated trachea and main bronchi, tracheobronchial diverticuli.8.5 cuffed ETT was found to be too big for his glottic aperture and replaced with a 8.0 cuffed ETT and wet gauze packing around the ETT. Anesthetic concerns include grossly enlarged but weakened airways, presence of tracheal diverticuli, post operative tracheal collapse. The anesthetic plan should include finding a balance between too little (air leak, hypercapnea) vs. too much air (mucosal damage) in the cuff, chances of expiratory collapse of the abnormally dilated and thin airways, awake extubation, post operative monitoring.

Monday, October 15, 2012
2:30 PM - 4:00 PM
MC651

There Goes the Airway: Innovative Use of the McGrath Video Laryngoscope

Keith W. Schmidt, M.D., Piotr Al Jindi, M.D., Anesthesiology, Cook County Hospital, Chicago, IL.

46 year-old M w/ BMI of 34 was scheduled for bronchoscopy and RLL resection. His airway exam: Mallimpati class 3, recessed chin, and short neck. An awake fiberoptic intubation was conducted with a bronchial blocker. Patient had successful resection of RLL. The bronchial blocker was deflated and withdrawn. Shortly after, the thoracic fellow stepped on circuit, dislodging the ET tube to the patient's lips. DL with MAC 3 was attempted and unsuccessful. A McGrath video laryngoscope was disarticulated and blade was passed into patient's mouth. The blade was reassembled and reintubation was successful intraoperative with patient remaining stable.

Monday, October 15, 2012
2:30 PM - 4:00 PM
MC652

Unexplained Hypotension in the PACU

Aaron Seller, D.O., Anesthesiology, University of Florida College of Medicine, Gainesville, FL.

We present the case of 51 y/o female with severe hypotension in the PACU after undergoing femoral catheterization for cerebral angiogram. She was later found to have large retroperitoneal hematoma on CT scan and required subsequent blood transfusion. There was no need for surgical intervention as the patient remained hemodynamically stable and her Hct remained stable after transfusion. Hypotension in the PACU can have a number of etiologies and is often directly related to the performed procedure. Many retroperitoneal hematomas can be treated conservatively; however, the traumatic nature of extravasation caused by arterial puncture may increase the need for intervention.

Monday, October 15, 2012
2:30 PM - 4:00 PM
MC653

Anesthetic Implications of Acquired Von Willebrand Disease in Aortic Stenosis

Abhilasha Solanki, M.D., Sheila R. Barnett, M.D., Tyler M. Berzin, M.D., Anesthesia, Critical Care & Pain Medicine, Gastroenterology, Beth Israel Deaconess Medical Center, Boston, MA.

A 92 year-old male with critical aortic stenosis, with recurrent unexplained gastrointestinal bleeding was admitted for a balloon enteroscopy. Preoperatively, a radial arterial catheter was placed. When it was

discontinued at the end of the procedure, there was profuse bleeding that was unrelieved with pressure alone. This caused a drop in hematocrit from 28.5 to 23 for which he received 2 units of PRBC. He ultimately received DDAVP for presumed acquired vWD syndrome and the bleeding resolved.Our patient's clinical picture was consistent with acquired type 2A vWD in the setting of severe aortic stenosis. These patients are highly susceptible to bleeding.

Monday, October 15, 2012
2:30 PM - 4:00 PM
MC654

Blind Nasal Intubation in a Patient With Expanding Tongue Edema Due to Severe Anaphylactic Reaction

Nicholas Sparler, M.D., Michael Olympio, M.D., Joseph May, B.S., Yvon Bryan, M.D., Anesthesiology, Wake Forest School of Medicine, Winston-Salem, NC.

69-year-old male, 117 kg, s/p open incisional hernia repair developed swollen tongue after cleaning with Biotene® mouthwash in PACU. Patient became anxious. Complained of difficulty breathing with increased tongue size and showed signs of upper airway obstruction. Airway exam revealed Mallampati IV, TMD <3 FB, and decreased neck range of motion. A flexible fiberoptic bronchoscope was urgently called for. Oxymetazoline hydrochloride was applied to nares and a nasal trumpet covered in 5% lidocaine ointment inserted. A 7.0 ETT was placed blindly in left nare and advanced until breaths sounds heard and $ETCO_2$ obtained. Patient sedated after confirmation of ETT placement.

Tuesday, October 16, 2012
2:30 PM - 4:00 PM
MC828

Anaesthetic Implications for Endoscopic Removal of an Endometrial Polyp on a Patient With Kartagener's Syndrome

Peter Wicks, M.B., Ch.B., Stephen Cole, M.B., Ch.B., Nazneen Sudhan, M.B., B.S., Emma Birley, 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 65 year old presented for hysteroscopic removal of an endometrial polyp. Suffering Kartagener's syndrome, she was victim to recurrent chest infections; the last only six weeks prior. Previous general anaesthesia was complicated by pneumonia. Bedside test revealed hypoxia and polychythemia. A rare autosomal recessive disorder of ciliary function, patients with Kartagener's have a defect in the dynein protein, manifesting in a classical triad of sinusitis, bronchiectasis and situs invertus. Regional anaesthesia, as employed in our case was the strategy of choice. Nonetheless, diligent consideration to anatomical and functional differences and in particular to respiratory optimisation is required.

Tuesday, October 16, 2012
2:30 PM - 4:00 PM
MC829

Case Series of Conversion Phenomena and Somatoform Events After General Anesthesia

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3 Cases involving conversion disorder, including a subtype called "hysterical paralysis", are presented. These cases all manifested in the post-anesthetic period, specifically after general anesthesia. A review of the disorder is presented. A review of similar cases in the literature is presented.

Tuesday, October 16, 2012
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MC830

Precipitous Bradycardia and Hypotension in an Asleep Patient: The Bezold-Jarisch Reflex

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A 32 year-old, ASA 1, male underwent arthroscopic shoulder surgery in the beach chair position. Interscalene block and induction for general endotracheal anesthesia were both uneventful. One hour into the procedure, he developed precipitous bradycardia indicated by a drop in heart rate from the 70's to the 20's, which was associated with other electrocardiogram changes, followed by hypotension. The bradycardia was unresponsive to glycopylorate and atropine, but quickly improved with administration of ephedrine. The Bezold-Jarisch Reflex was the most likely cause of the bradycardia and may have led to asystole if not treated in an expedient fashion.

Tuesday, October 16, 2012
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MC831

Considerations in Anesthetic Post-Op Management of Refractory Novel Hypertension, With Muscle Rigidity: Is It Malignant Hyperthermia or Is It Pheochromocytoma Crisis?

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A 58 year old male with microscopic hematuria underwent cystoscopy and uretheral dilation of stricture under LMA sevoflurane anesthesia. Intraoperative course was uneventful. Profound hypertension, fever, muscle rigidity developed acutely forty minutes into the post operative course. Symptoms were refractory to fentanyl, IV labetalol and cooling packs. Patient became lethargic, and RSI was performed. Treated with dantrolene for possible malignant hyperthermia. A 24 hourr urine collection later revealed positive normetanephrines. However, diagnosis of pheochromocytoma does not explain intense post-op muscle rigidity. Also, a diagnosis of malignant hyperthermia would not explain positive normetanephrines, trended over five days.

Tuesday, October 16, 2012
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MC832

Airway Fire With Nasal Cannula

Anna Weyand, Gabriella Webster, B.S.N., Lisa Mouzi, M.D., Baylor College of Medicine, Houston, TX.

Healthy 16-year-old male presented for ptosis repair under monitored anesthesia care. Immediately upon initial cautery use, a spark and flame were noted at the site of the cannula. The cannula was immediately disconnected from oxygen source and the site was drenched with sterile water. While the fire was extinguished within five seconds, singed nose hairs and a scorched tongue were noted and the decision was made to intubate the patient. Further exam revealed perioral partial-thickness burns, but no additional airway injury. The patient was extubated in the SICU and was discharged on the third post-operative day with no further complications.

Tuesday, October 16, 2012
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MC833

Monitored Anesthesia Care for a Patient With Advanced Huntington's Chorea

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Huntington's disease (HD), a rare, autosomal dominant disorder of the central nervous system, has been associated at times with unusual responses to anesthetic agents such as thiopental, midazolam, succinylcholine, and nondepolarizing neuromuscular blocking drugs. To our knowledge, only one previous case report has been published describing sedation for a patient with HD. We describe the anesthetic management of a 50 year-old female with advanced HD, complicated by chorea, dementia, dysphagia, and dysarthria, undergoing percutaneous endoscopic gastrostomy (PEG) placement.

Tuesday, October 16, 2012
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MC834

Anesthetic Management of a Patient With Complete Lockjaw in an Ambulatory Surgical Center

Jijun Xu, M.D., Ph.D., Paul Kempen, M.D., Cleveland Clinic, Cleveland, OH.

We report anesthetic management of orbital exploration in an ambulatory ophthalmologic surgical center. The patient has complete fibroplastic mandibular condyles fusion ("lockjaw") syndrome and severe dehydration due to that he is barely able to have oral intake. The airway was secured through an awaking nasal fiberoptic intubation. Anesthesia was maintained using general inhalation and intravenous agents. Fluid resuscitation, vasoactive agents, and blood transfusion were performed to maintain an acceptable hemodynamic stable status. We emphasize that such patients are best served by full preoperative examinations and preparations and care in an inpatient hospital setting rather than a freestanding Surgicenter.

Tuesday, October 16, 2012
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MC835

Anesthetic Management of Morbidly Obese Patient With LVAD for Laparoscopic Gastric Banding

Yuexian G. Xu, Swarup Varaday, M.D., Anesthesiology, Washington University in St. Louis, St. Louis, MO.

41 yo male with severe LV failure on LVAD, RV dysfunction, pulmonary hypertension presented for laparoscopic gastric binding. Comorbidities included BMI 45.4, AICD, OSA, DM, renal insufficiency, TIA's and chronic hypokalemia (K+ 2.2). After identifying the LVAD team,replenishing serum potassium and administering an appropriate preload GETA performed under invasive monitoring including TEE. Preload and afterload maintained with IV fluids and inotropes for optimal LVAD function. Measures taken to avoid worsening pulmonary hypertension and RV failure. Intraoperative course was uneventful. Extubated in the OR and on BIPAP in recovery. Patient was discharged home on POD 2.

Tuesday, October 16, 2012
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MC836

Severe Hypoxemic Hypercarbic Respiratory Failure During Bronchoscopy in a Patient With Tracheobronchomalacia

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27 year-old man with tracheobronchomalacia from relapsing polychondritis, admitted for bilateral stent revision. Exam notable for small mouth opening, Mallampati 4, poor air exchange and wheezes on auscultation. Airway established through existing tracheostomy. Attached to standard ASA monitors and induced with midazolam, fentanyl, propofol. During removal of the left mainstem stent, saturations dropped suddenly to 50% for 2 minutes. Ventilation was impossible through the rigid bronchoscope port. ABG confirmed hypoxemia and hypercapnia (179), and ECMO team called. Pulmonologist found a stent obstructed by granulation tissue, and removed it piecemeal; ventilation was suboptimally recovered. Stents successfully replaced.

Tuesday, October 16, 2012
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MC837

Prone, General Anesthesia for a Patient Undergoing Breast Biopsy in MRI

Diana Zentko, M.D., Nilda Salaman, M.D., Anesthesiology, George Washington University Hospital, Washington, DC.

A 46 year old female with a local anesthetic allergy required general anesthesia for an MRI guided breast biopsy. Due to the location of the lesion, she required prone positioning as well. We were challenged by performing this type of anesthetic in a patient we had limited access to, in an environment without support staff familiar with the potential complications, and without access to the resources we typically have in the OR setting.

Tuesday, October 16, 2012
2:30 PM - 4:00 PM
MC838

A Patient Who Needs Anesthesia, But Would Not Tolerate It

Karin Zuegge, M.D., Christopher Moore, M.D., Anesthesiology, University of Wisconsin Hospitals and Clinics, Madison, WI.

A 50 year-old wheelchair bound patient with severe pulmonary hypertension (peak PA pressures 96 mm Hg), BMI 52.6, sleep apnea (on CPAP and home oxygen), known difficult airway and severe anxiety presented for CT-guided botox injections of her eye muscles for chronic nystagmus. The nystagmus limited the patient's quality of life significantly such that she was unable to read. We were concerned that any interruption of her ventilation could lead to a disastrous increase in pulmonary hypertension and acute cor pulmonale or even death. Dexmedetomidine was successfully used as the sole anesthetic for this case.