CHAPTER 30

The Role of the American Society of Regional Anesthesia and Pain Medicine

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Introduction

The American Society of Regional Anesthesia was founded by Gaston Labat and his colleagues in New York City in 1923.[1] Subsequently, ASRA joined with another New York society to create the American Society of Anesthesiologists. (The history of the creation of the ASA is well described as: "On October 6, 1905, a small group of nine physician-anesthetists whose particular interests centered on anesthetics met at Long Island College Hospital at the invitation of Dr. A. Frederick Erdmann for the purpose of "promoting the art and science of anesthesia." From this small group came the Long Island Society of Anesthetists and it was this organization that gave rise to organized anesthesia in the United States and its present body, the American Society of Anesthesiologists (ASA) (**www.asahq.org**).

As interest in anesthetics and the scientific sessions of the new society grew throughout those first years so did the need to broaden the scope of membership. On October 28, 1911, at the New York Academy of Medicine, 40 East 41st Street in Manhattan, the name of the society was changed to the New York Society of Anesthetists. On February 7, 1912, its new constitution reiterated the precepts of its founders for "the advancement of the science and art of Anesthesia ..." (**www.nyssa-pga.org/about**).[2]

Reformed in 1975, ASRA has been working closely with the American Society of Anesthesiology in all issues related to regional anesthesia and pain medicine. Today, there are more than 7,400 members in ASRA. The mission of the organization is to address the clinical and professional educational needs of physicians and scientists practicing regional anesthesia and pain medicine; to assure excellence in patient care utilizing regional anesthesia and pain medicine; and to investigate the scientific basis of the specialty.

Regional Anesthesia

Regional anesthesia will be one of the most exciting parts of your anesthesia training. During your CA-1 year you will learn to perform many basic blocks such as axillary blocks to provide anesthesia and analgesia for the forearm and hand, and interscalene block for shoulder, arm and elbow surgeries. You will learn about spinal and lumbar epidural anesthesia, and thoracic epidural analgesia, commonly used to provide postoperative analgesia for thoracic and abdominal procedures. Anesthesia of the lower extremities may be provided by femoral, sciatic and popliteal blocks, while anesthesia for obstetrics may be performed with combined spinal-epidural blocks.

In the past, many patients believed that general anesthesia was the only option for surgery. However, an increased number of studies have demonstrated the benefits of intraoperative and postoperative regional anesthesia, the Internet has made information readily available, and our patients are more aware now of regional anesthesia as an alternative to general anesthesia for many surgical procedures. Regional anesthesia provides anesthesia not only during a surgical procedure but also provides analgesia after the procedure, thus reducing the requirements for opioids and the possible side effects of those medications. For example, for outpatient shoulder surgery, patients may have the option to receive both an interscalene block, which can be performed in the holding area, and general anesthesia for the surgery itself. A patient who receives these two types of anesthetics (a combined technique), will wake up from anesthesia without pain, require less anesthetic during the surgery, and require less opioid after the surgery. The patient can be sent home the same day of the surgery without any discomfort. The only disadvantage is that the shoulder may be numb until the next day.

Increasingly, patients have the option of going home after surgery with a catheter that an anesthesiologist will place when performing the regional anesthetic. This catheter allows patients to get a continuous infusion of a local anesthetic that provides analgesia at home for a few days after the surgery. This procedure reduces the amount of pain medication needed, increases functional status of the patient, and encourages early physical therapy and return to daily activities and work.

The field of regional anesthesia and the number of procedures are becoming so complex that after finishing your anesthesia training you will have the option to acquire more expertise in the field by doing a 12-month fellowship in regional anesthesia. Guidelines have been published for this training. A recent survey among anesthesiologists who completed a regional anesthesia fellowship revealed that 95 percent were pleased with the quality of their education, and 75 percent of them viewed their fellowship credentials as a positive influence on their employability and their relative attractiveness as a candidate for jobs in anesthesia.

Pain Medicine

Pain is considered by some as the "fifth vital sign." Pain medicine is the fastest growing field among the subspecialties of anesthesiology. During your anesthesia training you will learn the basic skills to diagnose and manage some of the common acute and chronic pain conditions, as well as the different treatment options to manage acute postoperative pain.

During your pain management rotation and patient encounters during residency, you will learn that every patient is different. You will learn a variety of approaches to deliver steroids into the epidural space, such as lumbar epidurals, caudal epidurals or transforaminal selective nerve root blocks, and to perform other interventional procedures using fluoroscopic guidance. You will become familiar with normal spine anatomy and will learn how to identify those structures on X-ray.

Patients who in the past had no other option after failing back surgery, or who refused surgery as the first alternative, now have many medical, physical and interventional pain procedures as alternatives.

If you desire additional training in this area, a pain medicine fellowship is an ACGME-accredited fellowship that consists of 12 months of pain medicine training after completing your residency. Anesthesiologists trained as pain physicians can offer many alternatives to their patients such as spinal cord stimulation, intradiscal electrothermal annuloplasty, intrathecal pumps, nucleoplasty, vertebroplasty and more advanced, fluoroscopically-guided blocks.

The ASRA is actively involved with anesthesia pain medicine programs. They have developed the ASRA Pain Medicine Fellowship program to advance training and education within the area of pain medicine. ASRA's goal is to financially support pain medicine training centers dedicated to train Fellows in state of the art pain medicine evaluation and treatment modalities, with three $60,000-fellowship grants per year.

ASRA

As a medical student you have the opportunity to learn more about ASRA and even become a member at no charge. ASRA hosts two meetings each year. The fall meeting is primarily about chronic pain. During these meetings you will meet the experts in the field of pain medicine and you will be exposed to all the new trends in the field. The spring meeting is primarily about regional anesthesia and acute postoperative pain, with experts from the United States and other countries around the world as faculty. Residents and Fellows can attend regional anesthesia workshops in basic procedures as well as advanced procedures such as ultrasound-guided blocks. Every year ASRA sponsors the airfare and hotel fees for a number of residents who submit abstracts to the national meetings.

Residents can opt to become members of the resident section of the ASRA. The resident section is a great forum where you can voice your concerns and ask questions about regional anesthesia, and is a great opportunity to meet other residents interested in regional anesthesia from all parts of the United States. You will also have the opportunity to attend workshops and meet all the experts in this interesting field. This is definitely a unique experience.

Conclusion

Regional anesthesia and pain medicine will be two of the cornerstones of your anesthesia training. ASRA can provide you with the tools you need to become a consultant in these fields during your training and during your professional career as an anesthesiologist.

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CHAPTER 31

Ambulatory Anesthesia

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Ambulatory anesthesia is defined as a formal, organized program for conducting anesthesia for elective surgical procedures, in patients who are admitted and discharged from the facility on the same day. The earliest written reference to an ambulatory surgical facility appeared in the *American Journal of Surgery* in 1919. The legendary United States anesthesiologist, R. M. Waters, M.D., opened the Downtown Anesthesia Clinic in Sioux City, Iowa, where he provided care for dental and minor surgery cases. The next written description of an ambulatory surgery center appeared in Arizona Medicine in 1969. John Ford, M.D., and Wallace Reed, M.D., published an article in which they described their concept of a "Surgicenter." They opened the Phoenix Surgicenter in 1970, the first "free standing surgicenter."

The Society of Ambulatory Anesthesia (SAMBA) was organized in 1984 and was the first subspecialty society to be formed within the American Society of Anesthesiologists.

The primary mission of SAMBA is to encourage specialization in the field of ambulatory anesthesia, to contribute to the growth of the subspecialty and to foster research, education and scientific progress in ambulatory anesthesia and thereby encourage high ethical and professional standards in ambulatory anesthesia.

SAMBA has approximately 1,669 members who practice throughout the United States and 83 international members. The majority of the members devote a significant percentage of their professional activity to the perioperative care of the ambulatory surgery population.

SAMBA is committed to providing high-quality continuing education activities for physicians and other health care professionals. Since 1991 the Society has also had its own annual meeting, which focuses on various aspects of ambulatory anesthesia and in 1997 a mid-year meeting was established that also continues to be held yearly. The Society for Ambulatory Anesthesia held its first educational meeting in April 1986. Since then SAMBA has held an annual and a mid-year meeting each year. The meeting focuses on presentation of scientific abstracts and discussions of practice trends in the field of ambulatory anesthesia. The annual meeting in 2006 presented four days of refresher course lectures, interactive workshops, problem-based learning and lecture sessions on a broad range of topics related to ambulatory anesthesia.