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NEWSLETTER

PAKISTAN SOCIETY OF ANAESTHESIOLOGISTS KARACHI - CHAPTER

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Pakistan Society of Anaesthesiologists Karachi 2009-2010

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8th SAARCAA CONGRESS A MEMORABLE EVENT

The 8th Congress of SAARC Association of Anaesthesiolgists concluded on the 8th of February in Karachi, Pakistan. Theme of the congress was “Expanding Domain of Anaesthesiologists”. It was highlighted in the congress that todays Anaesthesiologist is not the unknown man behind a mask, but plays an important role as a peri-operative physician, in intensive care, as a pain manager and has an extensive involvement in Trauma & Resuscitation.

It was a 4 day event starting on the 5th of Feb. A grand Opening Ceremony & Welcome Reception was held at the PAF museum and was attended by 1600 guests. The Scientific programme of the main congress, spanned over three full days. The congress programme started with the State-of-the-Art Plenary lectures and it was great to see a hall full of an eager to learn audience. An extremely well attended “Meet the Expert at Breakfast” was the highlight of Saturday morning. Discussions were conducted on 10 different issues by giants of the field with post graduates and other anaesthesiologist participating with enthusiasm, sharing experiences and asking questions. Dedicated lectures to our living legends was an absolute innovation. Paying respects and recognizing the efforts of our legendary figures in the field of anaesthesiology was the theme behind this thought. In total, 85 enthusiastic speakers, delivered lectures, 49 amongst them were foreign speakers coming from 18 different countries. Our sincere gratitude goes to all those who contributed, specially our guests from abroad who trusted us and came to Pakistan against travel advice by their respective countries.

A total of 77 Free Paper, oral and poster were presented by juniors or seniors anaesthesiologists. Pre and post congress activity also took place. 8 Pre-congress workshops at 8 major institution / hospitals of the city were conducted and 15 CME lectures were also held in pre-congress period.

SAARCAA celebrations was a festive evening arranged for all delegates. The audience were enthralled by folk music, folk dances and an acrobatic show. Delegates from all over the globe came in groups & represented their country by singing songs. Participants participation gave colour to the evening. Beautiful fireworks and lovely food mela were enjoyed by all attendes.

A concluding ceremony was held on Sunday evening which concluded the session in Karachi.

In the post congress period delegates moved on to Lahore and then to Islamabad for one day session at each place.

This brought an end to a memorable conference. As an Anaesthesiologist from Pakistan I am proud to have been amongst the organizers of such a great event.

Prof. Saeeda Haider,
Chairperson
Scientific Programme Committee
8th SAARCAA Congress

EARLY RESUSCITATION OF TRAUMA PATIENTS

Trauma is defined as anybody wound or shock produced by sudden physical injury, as from accident, injury or impact and so patients suffering from multiple injuries are commonly known as major trauma victims.

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UPCOMING MEETINGS

Annual Conference Association of Anaesthetists in Training. July 1-3, 2009 England
www.aagbi.org/events/gatasm.htm

Regional Anesthesia & Pain Medicine 2009
August 27-30, 2009 Canada
www.uhn.ca

XXVIII Annual Congress of the European Society of Regional Anaesthesia & Pain Therapy (ESRA) Austria
September 9-12, 2009
www.esraeurope.org

Texas Society of Anesthesiologists (TSA) Annual Meeting
September 10-13, 2009
www.tsa.org

The Association of Anaesthetists of Great Britain & Ireland Annual Congress
September 23-25, 2009 England
www.aagbi.org/events/congress.ht

52nd Annual New England Society of Anesthesiologists (NESA) Fall Conference
September 24-27, 2009
www.nesa.net

Society for Airway Management's (SAM) 13th Annual Meeting
September 25-27, 2009
www.samhq.com

American Society of Anesthesiologists Annual Meeting
October 17-21, 2009
www.asahq.org/web/index.asp

3rd Annual NYS Conference for Anesthesiology, Critical Care and Pain Management
November 13-14, 2009
e-mail:
helen.phillips@mountsinai.org

These patients suffer serious and life threatening physical injury and require specialized care within the so called "Golden hour" (first sixty minutes after trauma occurs). In a pre hospital setting, trained staff known as "first responder" use stabilization techniques to improve the chances of trauma patients and then they are transported to the nearest hospital or trauma center. A multidisciplinary approach is required in the management of major trauma.

The patient suffering multiple trauma must be thoroughly assessed on admission so that life threatening injuries can be corrected. The team leader is responsible for assessing the patient and coordinating the work of other members of the team, whose role is to treat the injuries as directed by the leader.

All trauma cases should receive:
- Primary survey (assessment) and resuscitation
- Secondary survey
- Definitive treatment.

Primary survey and resuscitation. The survey is planned as follows:
- Airway control with cervical spine protection.
- Breathing
- Circulation and control of hemorrhage
- Disorders of the central nervous system
- Exposure of the whole body

Air way control with cervical spine protection: Ensure clear and unobstructed airway. If patient can answer questions appropriately then it is unlikely that there is any immediate threat to the airway: Noisy or laboured respiration or paradoxical respiratory movements are evidence of airway obstruction. Vomitus, blood or foreign material in mouth should be removed manually or with a rigid sucker. Simple chin lift or jaw thrust will often open the airway but taking care not to disrupt the cervical spine. Oropharyngeal airway in unconscious patient is inserted with care. Nasopharyngeal airway can be inserted provided there is no suspicion of base of skull fracture. Any patient with possible cervical spine injury should have their neck immobilized in a neutral position to prevent further damage. Endotracheal intubation is indicated if airway patency is inadequate or the patient is in apnea or there is loss of protective upper airway reflexes. Orotracheal intubation with in line immobilization (not traction) of cervical spine and use of gum elastic bougie is unlikely to cause cervical spine movement.

Breathing: Respiratory rate and any obvious injuries must be noted. Routine inspection, palpation, percussion and auscultation are essential. Tension pneumothorax, massive haemothorax, flail chest, open chest wound and disruption of tracheobronchial tree should be treated quickly.

Circulation: Any major haemorrhage that is visible should be controlled by direct pressure. Tourniquet should not be applied as it occludes collateral circulation causing tissue destruction. A rapid assessment of cardiovascular system should be made including pulse rate, skin colors, capillary refill, level of consciousness and blood pressure and immediately two large cannulae (16 G) should be inserted.

Blood should be taken at the time of cannulation for crossmatch and in major trauma with shock eight units should be ordered as a priority. In Class III hypovolaemia (30-40%blood loss) blood is often needed before a full cross match is possible and those with Class IV hypovolaemia(>40%blood loss) un crossmatched O Rhesus negative blood must be used and it is recommended that all accident and emergency departments should have at least 2 units available at all times for immediate use. Commence rapid intravenous infusion immediately. Warm crystalloid or colloid whichever is available should be used. Give warmed blood early in severe shock.

Disorders of the central nervous system: The CNS should be assessed by ascertaining the level of consciousness, spinal cord function and pupillary response to light.

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CEEA course in collaboration with Committee for European Education in Anaesthesiology (CEEA) October 15 October 25, 2009 Contact Regional Course Director.
Rawalpindi Centre
shahab15@hotmail.com
Lahore Centre
anaesthesiaassociates@gmail.com
Karachi Centre
nasim.lirani@aku.edu

29th Annual Academic Activity Report
PAKISTAN SOCIETY OF ANAESTHESIOLOGISTS KARACHI

The 29th Annual Academic Activity of Pakistan Society of Anaesthesiologists (Karachi Chapter) was held at Hotel Pearl Continental Karachi on 10th May, 2009. The activity constituted of two Invited lectures, three interactive sessions and a Business Session.

The activity was started with the Tilawat of Holy Quran followed by welcome address delivered by Dr Nighat Abbas (Ex-President PSA Khi). Next, the General Secretary's Report was delivered by Dr Safia Zafar Siddiqui. She presented the annual report and several reports of CMEs & Workshops at different institutes of the country. Vote of thanks was delivered by Dr Sadia Qureshi (Ex-Treasurer PSA Khi)

The invited lectures were chaired by Dr Akhter Waheed Khan & Prof. Saeeda Haider. Prof. S. Tipu Sultan spoke on the Policy of Disaster Management and Prof. Fauzia Anis Khan on Care of Polytrauma Patients. The Panel of the interactive session comprised of Prof. Fazal H Khan, Dr Shahid Amin and Dr Madiha Hashmi. Three scenarios were discussed in the interactive session. The first scenario was “Anaesthesia for Cesarean Section”. The experts were Dr Fauzia Ali and Dr Sadqa Aftab, and the moderator was Dr Samina Ismail. The second scenario was “Anaesthesia for Respiratory Cripple”. The Experts were Dr Akhter Aziz Khan & Prof. Younis Khatri and was moderated by Dr Hameedullah. The third scenario was “Delayed Recovery”. The Experts were Dr Nighat Abbas & Dr K. U. Shibli, moderated by Dr S. Nur-ul-Haq. Several anaesthesiologists participated in the interactive session.

Exposure: All multiple injured patients should be completely undressed for thorough survey of injuries. Avoid hypothermia.

Secondary Survey: The patient is best examined from head to toe by the team leader. Once the secondary survey has been completed, the primary survey should be repeated to prevent any new complications from occurring during the course of the definitive treatment.

Dr. Syed Nurul Haque
Assistant Professor Anaesthesia
Karachi Medical &Dental College &
Abbasi Shaheed Hospital.

MULTIPLE CASUALTY SITUATIONS: TRIAGE

In **multiple** or **mass casualty situations**, the number of patients and the severity of their injuries exceed the capability of the facility and staff, and patients sustaining major injuries who have the greatest chance of survival with the least expenditure of time, equipment, supplies, and personnel are managed first. **Triage** is a process of prioritizing patients based on the severity of their condition when resources are insufficient for all to be treated immediately. The term comes from the French verb *trier*, meaning to separate, sort, shift or select. Triage has multiple meaning. The term may also refer to the allocation of space on a priority basis for patients arriving at the emergency department.

Simple triage is usually used in a scene of a mass-casualty incident**,** in order to sort patients into those who need critical attention and immediate transport to the hospital. S.T.A.R.T. (Simple Triage and Rapid Treatment) is a simple triage system that can be performed by trained lay and emergency personnel in emergencies. Triage separates the injured into four groups: 1. *deceased 2.* Injured who can be helped by *immediate* transportation 3-injured whose transport can be *delayed 4-* with *minor* injuries, who need help less urgently. In **advanced triage**, doctors may decide that some seriously injured people should not receive advanced care because they are unlikely to survive. The use of advanced triage may become necessary when medical professionals decide that the medical resources available are not sufficient to treat all the people who need help. In these cases some percentage of patients will die regardless of medical care because of the severity of their injuries. Others would live if given immediate medical care, but would die without it.

Reverse triage: There are conditions where sometimes the less wounded are treated in preference to the more severely wounded. After completion of the initial assessment by medical or paramedical personnel, each patient will be labeled with a device called a triage tag. S**econdary** (in-hospital) **triage** is typically implemented by paramedics, medical personnel or by skilled nurses in the emergency departments of hospitals. During disasters, injured people are sorted into five categories:

Black / Expectant: They are so severely injured that they will die of their injuries, possibly in hours or days. They should be taken to a holding area and given painkillers as required to reduce suffering

Red/ Immediate: They require immediate surgery or other life-saving intervention, and have first priority for surgical teams or transport to advanced facilities; they "cannot wait" but are likely to survive with immediate treatment.

Yellow/Observation: Their condition is stable for the moment but requires watching by trained persons and frequent re-triage, will need hospital care.

Green / Wait (walking wounded): They will require a doctor's care in several hours or days but not immediately, may wait for a number of hours or be told to go home and come back the next day.

White / Dismiss (walking wounded): They have minor injuries; first aid and home care are sufficient, a doctor's care is not required.

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Questions/Answers and healthy discussions were carried out throughout the session.

Before Business session the PSA Karachi launched the color coded drug stickers for syringes to avoid injection of wrong drugs

In the business session, the new elected cabinet for the year 2008-2009 was announced by Prof. S. Tipu Sultan.

Dr. Safia Zafar
General Secretary
Pakistan Society of anesthesiologist
Karachi Chapter

POEM

RHYTHM

There is rhythm in heart-beat,
breathing, walking, sleeping,
in every cell of mind and body, art and science, man and nature, sea and sky, plant and creature,

When the breeze blows, insect crawls, a lion roars, an infant cries, water flows, tides fall and rise, the earth moves with a rhythm and the whole solar system.

When a bell tolls, a clock strikes, there is rhythm, and when rain falls, flowers bloom and dew drops, in growth of shrubs and trees, in flight of birds and bees.

There is rhythm in the motion of an acrobat, a dancer, a musician, a car, a plane, a bike, a train, the moment you are out of rhythm, you go off the track and break your neck.

Dr. Khalid Khan
Consultant Anesthesiologist
Liaquat National Hospital Karachi

Thus triage is a process which provides appropriate and speedy medical care and play vital role in multiple casualty situations.

Dr. Muhammad Sirajuddin
Assistant Professor
Liquat National Hospital Karachi

SAFE TRANSFER OF TRAUMA PATIENT

Advanced trauma life support is the standard method for the initial management of severely injured patients. The treatment of the seriously injured patient requires rapid assessment of the injuries and institution of life preserving therapy. Definitive care is started once the patient has been adequately assessed and resuscitated. Definitive care, whether it is supportive and monitoring in an intensive care unit (ICU) or operative intervention, requires the presence and active involvement of a surgeon and the trauma team. If definitive care cannot be rendered at the local hospital, the patient requires transfer to a hospital that has the resources and capabilities to care for the patient. Ideally, this facility should be a verified trauma center. The decision to transfer the patient to another facility depends on the patient's injuries and the local resources. Decisions as to *which* patients should be transferred, and *when*, are matters of medical judgment.

The referring doctor is responsible for the initiation of transfer of the patient to the receiving institution and for the selection of an appropriate mode of transportation and level of care

required for optimal management of the patient en route. The referring doctor should consult the receiving doctor and should be thoroughly familiar with the transporting agencies/resources, their capabilities, and the arrangements for patient management during the transport.

The receiving doctor must assure that the proposed receiving institution is qualified, able, and willing to accept the patient, and is in agreement with the intent to transfer. The receiving doctor should assist the referring doctor in making arrangements for the appropriate mode and level of care during transport. If the proposed receiving doctor and facility are unable to accept the patient, they should assist in finding an alternative placement for the patient.

The major principle of trauma management, is to do no further harm. This should also be remembered when choosing the mode of patient transportation. Ground, water, and air transportation modalities can be safe and effective in fulfilling this principle.

The local doctor wishing to transfer the patient should speak directly to the physician accepting the patient at the receiving hospital and provide this information regarding the identification of patient, brief history of the incident, initial findings and response to initial therapy. A written record of the problem, treatment given, and patient status at the time of transfer must accompany the patient.

The patient should be resuscitated to stabilize the patient's conditions as much as possible. Cleaning and dressing after external hemorrhage control, administration of tetanus prophylaxis/ antibiotics and investigations should not delay the transfer.

The appropriate personnel should transfer the patient, based on the patient's condition and potential problems. Information regarding the patient's condition and needs during transfer should be communicated to the transporting personnel. Key points to remember during transportation include

1. Monitoring vital signs and pulse oximetry.
2. Continued support of cardiorespiratory system.
3. Continued blood volume replacement/resuscitation.
4. Use of appropriate medications as ordered by a doctor or as per written protocol.
5. Maintenance of communication with a doctor or institution during transfer.
6. Maintenance of accurate records during transfer

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