Military Advanced Regional Anesthesia & Analgesia
Fall 2005 Meeting
Minutes &White Paper Decisions*

*MARAA decisions and recommendations to service Anesthesiology Consultants to the Surgeons General can be found under the heading: **Service anesthesiology consultant recommendation.**

I.

Meeting Date: 29 November 2005, 1800-2100
Meeting Location: Army Navy Club, Washington DC

Voting Members in attendance:

1. COL John Chiles – Army[1]	john.chiles@na.amedd.army.mil
2. LTC Chester Buckenmaier – Army[2]	chester.buckenmaier@na.amedd.army.mil
3. Lt Col Todd Carter – USAF[1]	todd.carter@andrews.af.mil
4. CPT Ivan Lesnik – Navy[1]	ilesnik@usuhs.mil
5. CDR Dean Giacobbe – Navy[2]	dtgiacobbe@mar.med.navy.mil

Voting Members absent:

1. MAJ Peter Baek – USAF[2]	peter.baek@andrews.af.mil

[1]Service Consultant
[2]Service Consultant's Designee

II. REVIEW OF PREVIOUS MINUTES

The original fall meeting of MARAA was scheduled to occur at the annual ASA meeting which was canceled due to the effects of hurricane Katrina. A brief mention of the successful MARAA update at the Uniformed Services Society of Anesthesiology during the Atlanta, Georgia (alternative site) ASA was discussed. No MARAA business was undertaken at that update.

III. IDENTIFICATION VOTING MEMBERS AND ELECTION OF MARAA PRESIDENT FOR 2006

As outlined in the MARAA charter. Voting members of MARAA for 2006 were identified by the service consultants and are as follows:

1. MAJ Scott Croll – Army[2]	scott.croll@na.amedd.army.mil
2. LTC Chester Buckenmaier – Army[2]	chester.buckenmaier@na.amedd.army.mil
3. Lt Col Todd Carter – USAF[1]	todd.carter@andrews.af.mil
4. MAJ Peter Baek – USAF[2]	peter.baek@andrews.af.mil
5. CPT Ivan Lesnik – Navy[1]	ilesnik@usuhs.mil
6. CDR Dean Giacobbe – Navy[2]	dtgiacobbe@mar.med.navy.mil

Selection of a MARAA president for the 2005-2006 fiscal year was voted on by the Members. LTC Chester Buckenmaier was selected president by unanimous vote.

IV. OLD BUSINESS

a. Continuous Peripheral Nerve Block (CPNB): CPNB remains a success story on the battlefield and in the air evacuation system. There was discussion regarding how to determine if a CPNB was analgesic or a surgical block before a patient could enter the evacuation system. This issue was raised by some orthopedic surgeons (in Iraq) who had concerns that CPNB could mask of compartment syndrome. It was decided that if the patient retained some motor function then the block would be considered analgesic and the patient could fly. Experience with analgesic blocks suggests compartment syndrome can be recognized with this pain management modality.

Service anesthesiology consultant recommendation: CPNB patients should have motor function in the blocked extremity prior to air evacuation.

b. Patient Controlled Analgesia (PCA) pumps: The Ambit™ military PCA pump recommended by MARAA is now certified for flight on US military aircraft. The first PCA pumps have flown with patients in the air evacuation system. MARAA had recommended the Sorenson ambIT pump as an interim solution while the Defense Medical Standardization Board (DMSB) conducted air worthiness testing and competitive bidding for a joint PCA device. 40 MARAA system pumps are on order and will be distributed between Landstuhl, Germany, Iraq and Afghanistan. This is a

significant advancement in battlefield pain control that all involved with MARAA can take pride in.

Service anesthesiology consultant recommendation: Service consultants should support the MARAA Ambit™ PCA system as an interim solution to battlefield PCA pending a final decision on PCA by the DMSB.

c. **Regional Anesthesia Tracking System (RATS):** The RATS went online the first week of August 2005. Since then the use of RATS by anesthesia providers has exceeded all expectations. RATS statistics:

	RATS Statistics				
Date	9-27-05	10-18-05	3-11-05	11-15-05	2-12-05
Number of patients	41	65	89	104	119
Registered users	34	39	47	51	54
Notes --					
Clinical	42	93	141	172	193
Procedure	49	84	110	128	149
Transfer	32	50	68	83	94
E-mails generated	138	301	423	622	816

RATS is being used by some personnel in the Global Patient Tracking System (GPMC) and there is interest in incorporating it into the Joint Patient Tracking System (JPTA). However, we need a point of contact in JPTA.

Service anesthesiology consultant recommendation: MARAA recommends each service consultant adopt RATS as the tri-service internet tracking system for CPNB and PCA in patients coming from OIF/OEF using these advanced pain management techniques.

IV. NEW BUSINESS

a. Addition of CRNA voting members to MARAA: The possible role of CRNAs in the MARAA organization was discussed. LTC Chester Buckenmaier and COL Jack Chiles recommended an amendment to the MARAA charter that would allow each service anesthesiology consultant to select one CRNA to serve as a voting MARAA member. Considerable discussion, both in support and against this proposal ensued. It was decided that the issue would be addressed at the next MARAA 2006 spring meeting. In preparation for this debate, each voting MARAA member is asked to provide a short paragraph outlining their reasons to support or reject this proposal prior to the spring meeting. Additionally, each service consultant will select one CRNA to provide CRNA representation in this discussion.

Service anesthesiology consultant recommendation: A final recommendation on this issue will occur in the spring meeting. Consultants are asked to select a CRNA to represent their service during this discussion.

b. Epidural Catheters on Military Aircraft: It was proposed that MARAA move to support epidural catheter infusions on military aircraft. Lt Col Todd Carter noted that the USAF Air Mobility Command Surgeon General desired recommendations from MARAA on this issue. Some casualties have already flown with epidurals in place without appropriate visibility by air evacuation staff. It was decided that epidurals should NOT fly pending establishment of guidelines (unanimous vote). The following guidelines (see Appendix A) are recommended to the voting members for review and suggestion. An electronic vote on these guidelines will be completed the first week on January 2006.

Service anesthesiology consultant recommendation: A final recommendation will be provided after voting members have reviewed Appendix A, and made comments. An email vote will occur the first week of January 2006.

c. USSA affiliation: A proposal was made by LTC Buckenmaier to affiliate MARAA under the Uniformed Service Society of Anesthesiology (the military component society of the ASA). Concern was expressed by COL Chiles that MARAA, as a military organization, should not be subordinate to a civilian organization (the ASA). This issue had been discussed at the last fall meeting. Following a discussion with the USSA president, COL Paul Mongan, the Members agreed that MARAA should become a committee of the USSA and this affiliation was in the best interest of MARAA. This affiliation will not subordinate MARAA to the ASA since all authority for action of MARAA decisions rests with the service anesthesiology consultants. The vote was unanimous in favor of this affiliation.

Service anesthesiology consultant recommendation: MARAA is now a committee of the USSA. This affiliation should provide better exposure of MARAA to anesthesiologists who are interested in military anesthesiology through their membership with the USAA.

d. Non-voting membership in MARAA: COL Jack Chiles suggested MARAA formalize its membership to include dues and non-voting members. The general consensus was this was not the time for such a move. It was agreed that the MARAA meeting remain open to anyone with an interest in military anesthesiology and battlefield pain management. To encourage participation by interested parties, MARAA scheduled meetings and meeting minutes will be made available to the USSA membership at large.

V. NEXT MEETING:

The next MARAA meeting will be held in conjunction with the spring American Society of Regional Anesthesia and Pain Medicine meeting 6-9 April, 2006 at the Marriott Rancho Las Palmas Resort in Rancho Mirage, California. The meeting is planned for the evening of 6 April. Location for this meeting will be announced. There is a possibility

of funding for voting members through TATRC, this is currently being explored. A meeting agenda will be emailed to voting members a week prior to the meeting.

Appendix A

Epidural Infusion Recommendations for Air Evacuation

December 2005

Note: Guidance for these recommendations was provided by BG Thomas Loftus, USAF of the Air-Mobility Command.

1. Epidural infusions must be in place and running without incident for a minimum of four (4) hours prior to transport to the aircraft for air evacuation.

2. Only local anesthetics will be infused through epidural catheters on air evacuation flights. Narcotics (or any other medication) will NOT be added to epidural infusions. Other pain medications or narcotics administered orally, IV or by PCA can still be administered by established protocols or in conjunction with written physician orders.

3. Only the Styker PainPump II can be used for epidural infusions and the pump must be clearly marked as "Epidural Infusion".

4. Epidural infusions will only be allowed on flights that have a Critical Care Air Transport (CCAT) team accompanying the flight. The patients do not need to be specifically assigned as CCAT patients, however the patients will have CCAT oversight and will be followed by the CCAT and AE team during the flight.

5. CCAT teams will be educated in epidural infusions, specifically complications related to this therapy. The common answer for any and all problems related to epidural infusions during flight will be to terminate the infusion (turn off the Stryker pump) and resort to other established pain management techniques. Catheters will <u>not</u> be removed until re-evaluated by an anesthesia provider at the next scheduled air evacuation stop, or by phone patch consultation.

6. MARAA will be responsible for developing educational programs relating to epidural infusions in flight for CCAT personnel.

7. Epidural infusions must be documented fully on the patient movement record (AF Form 3899). In addition, the epidural infusion must be noted on the AF Form 3899 prior to manifestation onto the flight. The theater Validating Flight Surgeon must be aware of the presents of the epidural infusion and the planned presents of a CCAT team prior to clearing the patient for flight.

8. Epidural infusions will be regulated by the Global Patient Movement Command. The Regional Anesthesia Tracking System (RATS) can also be used to track epidural patients through the evacuation system.