Anesthesia News

President's Message

Dear Colleagues,

It is an honour and a privilege to serve as President of the CAS. I must extend thanks to Dr Pierre Fiset and look forward to his counsel during my term. Dr Patricia Houston is Vice President, continuing her association with the CAS. She has been Chair of the CEPD committee and is stepping down as Secretary. Please welcome Dr Salvatore Spadafora who joins the Board as Secretary. Dr Susan O'Leary completes our Executive as Treasurer.

In the near future, the CAS will complete initiatives begun by my predecessor, Dr. Pierre Fiset. The Anesthesia Assistant Task Force, chaired by Dr Fiset, has produced the National Educational Framework for Anesthesia Assistants. The next step is to create a scope of practice for Anesthesia Assistants.

The Stop Smoking for Safer Surgery campaign is both an advocacy initiative and an effort to improve patient outcomes. A working group has been formed to review the available literature on peri-operative smoking cessation and make recommendations on what information should be made available to anesthesiologists to provide to patients prior to surgery.

The RCPSC Maintenance of Certification credit system is to be modified. The new framework will shift some focus away from the Annual Meeting. We will need to provide other opportunities for members to earn credits.

CAS will be undertaking a governance review that will consider Board composition. Governance of CAS Sections is also being considered with the goal of strengthening the Sections.

Informal discussions give the impression that the human resource crisis in Anesthesiology in Canada is not as severe as only a few years ago. The last formal survey of HHR in anesthesia in Canada was done in 2002. The CAS has collaborated with Dr Dale Engen, from Queens, to survey all site chiefs of anesthesia in Canadian hospitals. We want to get some idea of where we are now and will be in five years. The plan is to repeat this survey regularly. I request that any member who receives this survey takes the time to complete and return it. This is the only way we will get a national perspective on what is happening with HHR in anesthesia.

I want to thank all of the individuals who volunteer on the Executive, Board, Committees and Sections of the CAS. The time you give and the work you do are invaluable.

I look forward to serving the CAS during my presidency and to working with you, our members.

Dr Rick Chisholm MD FRCPC
President CAS

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You may contact members, representatives, and invited guests of the Board of Directors through the CAS central office.

Editor-in-Chief	Dr Salvatore Spadafora
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MARK YOUR CALENDAR

CANADIAN PATIENT SAFETY WEEK NOVEMBER 1 – 5, 2010

Good healthcare starts with good communication – this is the message the Canadian Patient Safety Institute (CPSI) is getting out to thousands of healthcare professionals, patients, clients, residents and their families during Canadian Patient Safety Week, (CPSW) November 1 – 5, 2010. With ***Ask.Listen.Talk*** as its theme, this annual national event aims to increase awareness of patient safety issues and share information about best practices in patient safety with healthcare providers, patients and their families.

CPSW is in the process of being proclaimed by every provincial and territorial government across Canada. This is an opportunity to be recognized as committed to patient safety in Canada. To receive further information, including access to several patient safety tools and resources, go to www.asklistentalk.ca.

Course Announcement: 4th Annual CAS IEF/Dalhousie Global Outreach May 21-25, 2011

Faculty

Sarah Hodges (Kampala)	Robert Neighbor (Gloucester, UK)
Jeanne Frossard (London, UK)	Brendon Finucane (Edmonton, AB)
Andrew Hodges (Kampala)	Doug Maguire (Winnipeg, MB)
Adeyemi Olufolabi (Durham NC)	Alison Froese (Kingston ON)
Holly Muir (Durham NC)	Krista Brecht (Montreal, QC)
Peter Daley (Lahore)	Kelly McQueen (Arizona)
Richard Tully (UK)	

Julie Williams, Ron George, Adam Law, Patty Livingston, Shawna O'Hearne, Lynette Reid, Dan Cashen, Steve Williams, Tom Coonan (Halifax, NS)

Course Overview
The course will assist volunteers in preparing for work in conditions that they are unlikely to have encountered in either their training or their normal practice, and to prepare intellectually, technically, psychologically, ethically and attitudinally for what awaits them in the many areas of the globe where health and medical care is a great challenge.

Contact Megan Chipp at Megan.Chipp@dal.ca or Tom Coonan at tjcoonan@gmail.com

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2007 Winner of the Dr R. A. Gordon Patient Safety Research Award

Pamela Angle, MD FRCPC MSc (clin epi), Women's College Hospital and Sunnybrook Health Sciences Centre, Toronto, ON

International RCT: Effect of Small vs Large Epidural Needles on PDPH

Research Project

This report provides findings from our multi-centered randomized controlled trial, which ended data collection in mid-December 2009. The study was co-funded by Physicians Services Incorporated Foundation, the Canadian Anesthesia Research Foundation and in part by participating departments of Anesthesia across Canada. The trial is the first of its kind to explore large-scale use of smaller epidural needles and epidural catheters in laboring women to prevent postdural puncture headache (PPH, primary outcome). Postdural puncture headache is the most significant common morbidity of epidural placement. Two additional studies were embedded in the study. These included a diagnostic study comparing International Headache Society (IHS) criteria for headache diagnosis to our formal study definition as well as a prospective longitudinal study examining the natural history of headaches in women with adjudicated positive PDPH in the trial.

A total of 1,080 women requesting labor epidural pain relief were randomized in four centers across Canada. Of these, 25 women were diagnosed with PDPH by an external blinded adjudicating body (1 headache specialist/neurologist matched to one of three senior obstetrical anaesthesiologist). While rates of PDPH met study expectations, a planned safety and feasibility analysis conducted at 25% recruitment suggested that the feasibility of large-scale use of the smaller epidural catheter was borderline (12% combined failure rate) which when adjusted for in-training effect just made the cut-off to continue the study (10% failure rate). A blinded internal pilot was conducted at 30% recruitment by study statisticians to examine study power to achieve an answer to the primary research question posed. A futility analysis suggested that differences in the incidence of PDPH between groups was on the order of 20%, still clinically important but smaller than the anticipated 40% reduction and that the study was underpowered to demonstrate statistical significance for primary and secondary outcomes without doubling the sample size to >6,000 women. For these reasons, the Safety and Data Monitoring Board advised that study recruitment be halted. Recruitment was halted in August 2009 with final data collection occurring in December 2009.

2007 Winner of the CAS-Abbott Laboratories Career Scientist Award in Anesthesia

Dr Dermot Doherty, University of Ottawa, Ottawa, ON

The Anti-inflammatory Effect of Anti-CD 18 Therapy after Transient Global Ischemic Brain Injury in the Mouse

Research Project

In this final report, I am confident to say that we have answered the experimental question of the grant. We are reporting that anti-CD18 therapy produced three interesting and novel findings.

Firstly, anti-CD18 attenuated the cleavage of casase-8, the phosphorylation of BAD and preserved the phosphorylation of p42/44 and p38 MAPK. This leads to a pro-survival transduction program leading in attenuation of caspase-3 cleavage and less cell death.

Secondly, we will be shortly reporting that the NF-kB pathway, although activated during brain ischemia, does not have a major cytoprotective role. We have a transgenic mouse model for this purpose and are getting better. I have formed a collaboration with Dr Robert Kornaluk for this project.

Thirdly, we will also be reporting that the tyrosine kinase syk and its downstream targets do not undergo significant phosphorylation after brain ischemia.

…AND THE WINNERS ARE….

CAS is pleased to recognize additional 2010 award winners.

Medical Student Prize

To increase awareness among undergraduate medical students of the specialty of anesthesia and the role of anesthesiologists in healthcare

Winner:
1st place: $1,000
Marina Belda
Université de Montréal, Montréal, QC
L'Anesthésie à quatre pattes

2nd place: $500
Jennifer Wilson
University of Ottawa, Ottawa, ON
Anesthetic Simulation: Are We Ready For Take-Off?

3rd place: $250
Sébastien Lachance
Université de Montréal, Montréal, QC
Perspectives du traitement de la douleur en anesthésiologie

Richard Knill Research Oral Competition

In honour of Dr Richard Knill, a special session at the CAS Annual Meeting that highlights the best scientific papers

Winner: Albert Tsui
University of Toronto, Toronto, ON
Methemoglobin as a Potential Biomarker for Anemic Stress: A Role of Neuronal Nitric Oxide Synthase in Mice

Residents' Oral Competition

To encourage scientific excellence in physicians training in the specialty of anesthesia in Canada or France

Winner:
1st place
Dr Pascale Ouellet
Centre Hospitalier Universitaire de Québec, pavillon CHUL, Québec, QC
The Impact of Anesthesia on Glycine Absorption in Operative Hysteroscopy: A Randomized Controlled Study

2nd place
Dr Mélanie Roy
Centre Hospitalier affilié universitaire de Québec, Hopital de l'Enfant-Jésus, Québec, QC
Single Versus Double Injections for US-Guided Supraclavicular Block

3rd place
Dr Harleena Gulati
University of Manitoba, Winnipeg, MB
Variable Ventilation and Pulmonary Edema Clearance in Porcine ARDS

Best Paper Awards

***Ian White Patient Safety Award*: $500**
Dr James Paul
McMaster University, Hamilton, ON
Acute Pain Safety Study: The Impact of Root Cause Analysis

***Award for Best Paper in Ambulatory Anesthesia*: $500**
Dr Gabriele Baldini
McGill University Health Centre, Montreal, QC
Non-Opioid Anesthesia for Laparoscopic Cholecystectomy

***CVT Raymond Martineau Prize*: $1,000**
Dr André Denault
Montreal Heart Institute/Université de Montréal, Montreal, QC
IV Amiodarone and Bi-Ventricular Echocardiographic Function

***Award for Best Paper in Obstetric Anesthesia*: $1,000**
Dr Aleksandra Dlacic
Mt Sinai Hospital, University of Toronto, Toronto, ON
The Epidural Electric Stimulation Test Does not Predict Labor Epidural Analgesia Patterns

***Award for Best Paper in Regional Anesthesia and Acute Pain*: $500**
Dr Geneviève Germain
Université Laval, Québec, QC
Comparison of Two Techniques of US-Guided Popliteal Block

***Award for Best Paper in Anesthesia Education and Simulation*: $500**
Dr Sylvain Boet
St Michael's Hospital, Toronto, ON
Self-Debriefing versus Instructor Debriefing: A Prospective Randomized Trial

2010 MEDICAL STUDENT FIRST PRIZE PAPER

ANESTHESIA ON ALL FOURS

By Marina Belda

To be sick as a dog. To be green around the gills. To play possum. Our idioms are a constant reminder that we are not so different from animals. Nevertheless, notwithstanding the similarities between man and beast, some major distinctions are still to be noted. This obviously leads to anatomical and physiological considerations that are of particular interest to the anesthesiologist. The objective of this trial will, therefore, be to create a parallel between the stages of induction and intubation in human anesthesia and certain features of a lesser-known practice – that is, veterinary anesthesia. This trial is not likely to have an impact on your everyday practice, but I do hope it will entertain you.

Generally speaking, the administration of premedication and induction agents is not overly difficult in man. It is, however, easy to imagine that inducing anesthesia in a lion will not be quite as easy – particularly if that lion happens to live in the bush. In such cases, the most commonly used method is dart-gun anesthesia. With such a technique, the animal's stress is reduced and, more importantly, the operator's safety is ensured. Using such a gun can seem simple at first glance – but in reality, it is quite complex. The speed of the dart must be reduced to a minimum in order to avoid wounding the thigh muscles, or even fracturing a leg. A careful balance should therefore be attained between the speed of the projectile, the shooting distance and accuracy. In the wilderness, more often than not these parameters are difficult to control. In addition, anesthetic doses must be roughly evaluated. For all these reasons, several tries are often necessary.

In veterinary anesthesia, the intravenous and intramuscular routes are the most commonly used to administer induction agents. However, there is another less common route. We are referring to anesthesia by immersion, a technique used in fish. Tricaine methanosulfate (MS-222, a white crystalline powder) is diluted in water. The dose can be adjusted by adding MS-222 or diluting the solution. MS-222 is an acid agent; if large quantities of anesthetics are used, then bicarbonate must be given to buffer the solution. This method is nevertheless very expensive and not very practical when dealing with a large fish such as a shark. An intramuscular injection is then the method of choice. This injection will be administered through a submersible gun or a syringe tied at the end of a stick. Given the fact that fish breathe through gills, intubation is impossible. If an immobile fish stops moving its gills… thus stops breathing… a water flow can be created using a pump directing it toward the gills. Gills are highly vascularized and the locum of gas exchange. Oxygenation can thus be maintained in a fish as long as a water flow is maintained around the gills.

During induction in man, neuromuscular relaxants are used in order to facilitate intubation and prevent laryngospasms. When it comes to animals, however, they are often less prone to such problems – except rabbits, cats and pigs. Consequently, neuromuscular relaxants are rarely used for induction in veterinary anesthesia. In addition, facial masks are ill-suited to the various animal features and leaks are common. Mask ventilation is thus not a valid alternative when an intubation problem occurs in a paralyzed patient. The most commonly used method to reduce the risk of laryngospasm is a 2% lidocaine spray vaporized on the arythenoid cartilages.

Rabbit intubation involves other considerations. The oral cavity is very small and so is the mouth opening. Additionally, teeth growth never stops during the rabbit's whole life, each tooth growing approximately 2 mm every week. Intubation in the tracheal axis is therefore a challenge. Fortunately, there is a toothless space between the incisors and the premolar teeth. The endotracheal tube must consequently be inserted sidewise and, more often than not, without having a clear view.

When it comes to cows, surgeries in recumbent positions, be they lateral or supine, are ill-suited because of its imposing build and complex digestive system. The cow is prone to recumbent myopathies but, more dramatically, presents major regurgitations (the stomach being composed of four compartments). In certain cases, the cow can suffer an uninterrupted flow of regurgitations during the whole anesthesia. In most cases, veterinarians try to do surgery with the cow standing and using a moderate sedation and local anesthesia. However, when surgery is more complex, the cow needs to be anesthetized using an α_2-agonist (medetomidine[1]) and placed in a supine position. As with man, ventilation should be mechanically assisted during general anesthesia. However, a laryngoscope is often useless since its blades are usually too short. Intubation must then be performed by manually palpating the larynx. One has to palpate the glottis with the finger tips and then insert a tube with a diameter of 26-30 mm through the arythenoid cartilages. This technique is also used in tigers and walruses, among others. So yes, in some cases a veterinarian has to put his hand in a tiger's mouth. What is important then is to *not* underestimate induction doses!

Reptiles and birds do not have an epiglottis. Intubation is performed by directly visualizing the glottis, which is usually easily identifiable at the base of the tongue. In addition, birds have complete tracheal rings. The cuff should then not be inflated because it could cause is-

1 Medetomidine is an *S*-enantiomer of dexmedetomidine, i.e., the nonsuperimposable mirror image of this molecule.

chemia by compressing the trachea. Further, a bird can still vocalize despite the presence of an endotracheal tube! In fact, the organ responsible for vocalization in birds is the syrinx – and not the larynx as in mammals. The syrinx is located at the bottom of the trachea, next to the carina. The syrinx is thus not obstructed by the endotracheal tube and it can preserve its function.

The anatomy of a bird's respiratory system has an additional device: air sacs (*Sacci pneumatici*). Their number may vary, but most birds have nine such airs sacs mainly distributed around the thorax and the abdomen. Air sacs participate in pulmonary ventilation, but they play no part in gas exchanges. Their function is that of reservoirs. At the first inhalation, the air first enters the air sacs. At the next inhalation, the air stored there is transferred to the lungs to take part in the gas exchange, before being expelled at exhalation. Air sacs can be used as extratracheal intubation routes. A tube is placed directly through an air sac, generally at the abdominal level. The application of positive pressure ventilation then allows the respiratory system to function properly. Special attention must, however, be given to the oral cavity, which could become a major source of gas leak. In such a case, a closed endotracheal tube can be positioned; another solution is to place a bag over the bird's head and connect it to an anesthesia machine to stop the leak.

Despite the various sizes of human beings, ventilation volumes do not vary much compared to those found for various animal species. An elephant needs imposing ventilation volumes. That volume is measured depending on weight and metabolic rate. An elephant may weigh between two and seven tons according to species, age and gender. For instance, a 5,000 kg elephant will need a tidal volume of 34 litres (i.e., 0.0062 L/kg * $mass^{1,01}$). Ventilators commonly used in horses can provide up to 21 litres. Therefore, to ensure such an elephant's adequate ventilation, two ventilators need to be connected in parallel with a Y-shaped tube. You can no doubt imagine how difficult it may be to use a cuff to perform manual ventilation!

All of the above instances are but a mere overview of the many complexities associated with the induction, intubation and ventilation in veterinary anesthesia. As mentioned at the very beginning, all this information is not very likely to influence your current practices. However, in the surprising possibility that you may decide otherwise, I decline all liability regarding the use of dart-guns in man.

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Impressive Program Results from The Personal

Since it began offering Home and Auto Group Insurance to CAS members last year, The Personal reported an impressive close rate of 50% with the CAS plan. This means that 50% of members who had requested a quote from The Personal opted to switch from other programs. Based on industry experience, "50%" represents a very high close rate and indicates that members find the CAS plan to be competitive with rates elsewhere.

CAS members who may already have home and auto insurance through another group plan could realize additional savings through the low rates offered under this program with The Personal. For more information, go to: www.thepersonal.com/cas or call 1-888-476-8737.

Passport to Toronto Winners

At the CAS 2010 Annual Meeting, exhibitors contributed to a charitable pot, with the goal of dividing the proceeds between the Canadian Anesthesia Research Foundation (CARF) and the CAS International Education Fund (CAS IEF). Delegates were issued either a CARF or a CAS IEF passport and then were required to have it validated by the exhibitors whose booths they visited.

The charity with the most completed passports won 75% of the pot and the other charity received the remaining 25%. Delegates were eligible to win prizes ranging from complimentary full meeting registration at the CAS 2011 Annual Meeting to hotel and restaurant gift certificates.

The Winners

Charitable Foundation: CARF

Draw:

1st *Prize:* Dr Heather O'Brien, Sault Ste Marie, ON

2nd *Prize:* Dr Linda Forgach, Vancouver, BC

3rd *Prize:* Dr Claude Brousseau, Quebec, QC

Charitable Donations Reach $3,000

We are pleased to report that the total donations made to the charitable pot during Passport to Toronto reached $3,000. Included in that is a $500 gift, generously donated by **The Personal**.

A heartfelt "thank you" to all the exhibitors at the CAS 2010 Annual Meeting who contributed to the charity pot!

"CARF is one of my causes, please make it one of yours."

Dr. André Y. Denault
Montreal Heart Institute
University of Montreal

Our profession deserves a firm foundation

CARF
Canadian Anesthesia Research Foundation
www.anesthesia.org/carf

Plan to Attend the WFSA and the World Congress of Anaesthesiologists

David Wilkinson, *Secretary WFSA,*
Chris Stean, *Executive Director of ChoiceLive*
Alfredo Cattaneo, *President, WCA 2012*

Background

The World Federation of Societies of Anaesthesiologists (WFSA) was founded in 1955 in The Netherlands. When it was initiated, there were 28 founding member national societies and today is over 120. There have been a series of World Congress of Anaesthesiologists (WCA) held in the name of WFSA since then (see Table 1).

In recent years, other groups have held "alternative" World Congresses, often focusing on specific sub-specialties, but there is only one WFSA-sponsored WCA. Every four years in a different area of the world, each WCA is organized by a national member society which imparts its own local flavour to the proceedings but there is a specific set of targets that needs to be achieved by each Congress. Many people have discussed what defines a "good Congress". Such debate is outside the scope of this article and there can be no doubt that the perception of a Congress depends very much on one's own circumstances.

There are four main components of a WCA: the delegates who spend their money to attend; the trade exhibitors who invest large sums of money to support the meeting; the WFSA's series of constitutional obligations; and the local Conference Organizing Committee (COC). All of this activity is facilitated by the Professional Congress Organizer (PCO) who is ChoiceLive from the UK.

The Delegates

The majority of delegates attends the WCA to learn new aspects of their professional activities that take place in their own geographical region, which are often highlighted by presentations from the WFSA Regional Sections. Others will be looking for new initiatives that may appear in programmes facilitated by specialist groups, like obstetrics or paediatrics, while others will be searching for answers relating to their professional development and organizational requirements. Many young (and old!) delegates will be presenting their own research or a distillation of their experience either at oral sessions but more commonly at poster sessions. Others will be looking to attend the plethora of workshops that are presented at the WCA.

One of the most important aspects of any WCA is the ability of delegates to meet others from different backgrounds and environments. The exchange of ideas and experiences that takes place within scientific sessions (and over meals and social gatherings) often leads to lasting friendships and facilitation of professional improvements in less affluent areas of the world.

The trade exhibition is a vital aspect of any WCA. It permits the industrial companies operating in our sector to demonstrate their latest innovations and allows them to access anaesthesiologists from all over the world. They provide a huge funding boost to the meeting and their attendance, with the associated financial support, should never be taken for granted. Most delegates recognise the benefits of attending the trade exhibition to familiarise themselves with the latest innovations and, increasingly, they are also attending the growing number of "scientific presentations" that occur within the exhibition

The WFSA has to undertake a series of administrative duties within the time frame of the WCA. All of the WFSA's activities are governed by the General Assemblies (GAs) to which every member society, which has paid its annual membership fees, sends representatives in proportion to their number of announced member anaesthesiologists. These representatives accept the reports of the myriad of permanent and sub-specialty committees of WFSA and determine the organization's future activity, often at the instigation of the elected Executive Committee and Officers. In addition, the GA confirms the appointments of all members of

TABLE 1 World Congress of Anaesthesiologists

WCA	YEAR	CITY	HOST SOCIETY	REGION
1st	1955	Scheveningen	Netherlands	Europe
2nd	1960	Toronto	Canada	North America
3rd	1964	São Paulo	Brazil	South America
4th	1968	London	United Kingdom	Europe
5th	1972	Kyoto	Japan	Asia
6th	1976	Mexico City	Mexico	South America
7th	1980	Hamburg	Germany	Europe
8th	1984	Manila	Philippines	Asia
9th	1988	Washington DC	United States	North America
10th	1992	The Hague	Netherlands	Europe
11th	1996	Sydney	Australia	Australia
12th	2000	Montreal	Canada	North America
13th	2004	Paris	France	Europe
14th	2008	Cape Town	South Africa	Africa
15th	2012	Buenos Aires	Argentina	South America
16th	2016	Hong Kong	China Hong Kong	Asia
17th	2020	To be decided by Venue Committee in Buenos Aires		

all committees and, for the first time in Buenos Aires, will actively elect those standing for the Executive Committee and Officer posts. All WFSA committees have the opportunity to meet at the WCA and plan their activity for the next four years.

Plan to Attend the 2012 Congress in Argentina

The COC, besides wishing to run a memorable meeting, wants to provide for the delegates that attend a flavour of their country and culture. As the 2012 Congress President Alfredo Cattaneo writes:

"By going to the 15th WCA, you will have the world of anaesthesia at your fingertips. Our Scientific Program will cover the latest scientific knowledge in different areas of Anesthesiology, Perioperative Medicine, Intensive Care, Emergency Medicine and Pain Management. Topics will include research, organization, economy and education. The preliminary programme (available shortly) will be comprehensive and diverse, representing the needs of our colleagues from around the world. You will surely be able to find the best level of lectures not just at the cutting-edge of the science of anaesthesiology, but also the "ABC" of the safe practice of our specialty. We hope to have only electronic poster sessions to save delegates having to transport bulky posters. Workshops will have a special priority in this WCA, with simulations and the latest technology designed to improve our access to new skills. Our aim is to improve the skill and knowledge level of all of our colleagues coming to Buenos Aires.

Be sure that there will be a lot of science and also a lot of fun! We are developing a wide variety of social and cultural programmes – tango lessons, parties and our famous cuisine, to name a few. I am confident you will feel very comfortable with our Argentinean culture and it will provide you with a unique opportunity to make new friends in the world of the anaesthesia.

Buenos Aires is Argentina's capital city, with easy access from almost anywhere in the world. Its breadth of attractions makes it an excellent city for hosting the World Congress. Before and after the WCA, you can also enjoy the many interesting tourist possibilities that Argentina can bring you such as Iguazú Falls (one of the wonders of nature), Patagonia and the beaches of Mar del Plata. This is a unique opportunity to mix science and leisure and will be an unforgettable experience and a great pleasure for us to meet you in Buenos Aires!"

I am sure you will all agree he "paints" a very attractive picture.

ChoiceLive is eager to facilitate your attendance at the Buenos Aires WCA. For the "definitive source" for information relating to the Congress, go to: www.wca2012.com. Online, you can register, book workshops and accommodation (to suit all budgets) and select tourist activities. There are full details on the scientific programme, posters, social programmes, exhibitors, sponsors and much

more. Contact ChoiceLive for more information.

Information on the website is constantly updated. Don't miss any important deadlines (such as poster submission dates, closing of early registration) by registering your interest on the website and you will receive timely reminders.

Final Comments

The WCA needs to be a financial as well as a scientific success so that the WFSA can continue to run its extensive programme of educational, publication and safety activity around the world. The member societies' membership dues do not fund this activity, which comes almost entirely from the surpluses generated by the WCA and, in part, determines the delegates' registration fees.

We hope you will attend the WCA in Buenos Aires. It will be a scientific, social and cultural triumph. If you are not there, in future years you will hear from those who were there: "Ah, but you should have been there in 2012 in Buenos Aires; that was a truly great meeting."

Oh, start taking your tango lessons soon!

Mark your calendar: March 25 – 30, 2012

World Congress of Anaesthesiologists in Buenos Aires, Argentina

Start planning NOW.

HIGHLIGHTS FROM 2010 CMA STUDY: PHYSICIAN DISTRIBUTION BY SPECIALTY & SEX

In its 2010 report on the number and percent distribution of physicians by specialty and sex across Canada, the Canadian Medical Association (CMA) includes the numbers for clinical specialists working in anesthesiology. Following is a relevant excerpt:

Number and percent distribution of physicians by specialty and sex, Canada 2010

Specialty	Females		Males		Canada	
	N	%	N	%	N	%
FAMILY PHYSICIANS	*14,351*	*39.8%*	*21,673*	*60.2%*	*36,024*	*100.0%*
General Practice[1]	4,914	28.8%	12,126	71.2%	17,040	100.0%
Family Medicine	9,437	49.7%	9,547	50.3%	18,984	100.0%
MEDICAL SPECIALISTS	*8,144*	*33.3%*	*16,338*	*66.7%*	*24,482*	*100.0%*
Clinical Specialists	*7,561*	*33.0%*	*15,330*	*67.0%*	*22,891*	*100.0%*
Anaesthesia	785	27.6%	2,058	72.4%	2,843	100.0%
Community Medicine	181	41.7%	253	58.3%	434	100.0%

To view the entire report, please go to: http://www.cma.ca/multimedia/CMA/Content_Images/Inside_cma/Statistics/06SpecSex.pdf

CAS ANNOUNCES FUNDING TO THE EARL WYNANDS LECTURE

CAS is pleased to announce that it has signed an agreement with the Society of Cardiovascular Anesthesiologists (SCA) Foundation to provide $3,000 over three years towards the Earl Wynands Lecture. The funding will support a named speaker at the SCA's meetings. The funds were collected through the CAS Cardiovascular and Thoracic (CVT) Section's Earl Wynands Fund.

CAS thanks all who have contributed to the Earl Wynands Fund since its inception in 2009. If you would like to make a contribution to the Earl Wynands Fund, please contact membership@cas.ca or 416-480-0602, ext. 18.

The SCA Foundation will provide annual updates to CAS, which we will publish in future issues of *Anesthesia News.*

The Self Assessment Program from the *Canadian Journal of Anesthesia*

CPD Online

New CPD module:
Management of Sleep Apnea in Adults - Functional Algorithms for the Perioperative Period (September 2010)

Also available

- Anesthetic management for pediatric strabismus surgery (Issue: June 2010)
- Ultrasound guidance for internal jugular vein cannulation (Issue: May 2010)
- Perioperative Pain Management in the Patient Treated with Opiods (Issue: December 2009)
- Management of the anticipated difficult airway-a systematic approach (Issue: September 2009)
- Optimizing preoxygenation in adults (Issue: June 2009)

How to access the modules
Instructions can be found on the Canadian Anesthesiologists' Society website at: http://www.cas.ca/members/cpd

Successful completion of the self-assessment program will entitle readers to claim 4 hours of continuing professional development (CPD) under section 3 of CPD options, for a total of 8 maintenance of certification credits. Section 3 hours are not limited to a maximum number of credits per five-year period.

Publication of this Continuing Professional Development Program is made possible through unrestricted educational grants from the following industry partners.

CAS IEF UPDATE

By Dr Franco Carli

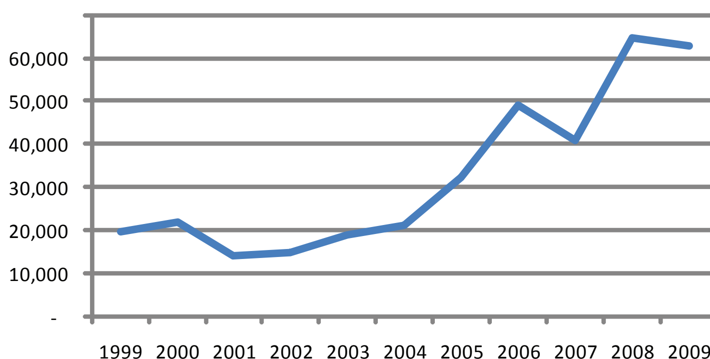
There are still vivid memories of the CAS IEF reunion dinner at the McGill Faculty Club last June when over 100 friends, donors and volunteers came together to celebrate over 40 years of CAS IEF achievements. We were fortunate to have with us **Dr Shestra** from Nepal, **Drs Paulin and Bona** from Rwanda and many illustrious volunteers from all over Canada and the USA who have been involved in the CAS IEF missions. There were a few minutes of silence to commemorate our good friends, Patrick Enright and Dale Morrison. Both of them were part of the CAS IEF family as they have helped so much in assisting and providing technical help.

In the sumptuous ambiance of the McGill Faculty Club, Rwandan popular music entertained the guests. The surprise of the evening was the projection of a film entitled “Ikinya, Canada joins Rwanda for safe anesthesia” where Ikinya means anesthesia in Kinirwanda language. The film was produced in March, thanks to **Dr Patricia Livingston**, our CAS IEF board member and volunteer, her husband Brian Guns and the collaboration of many friends. This film/video was prepared with the intent to show what the CAS IEF volunteers do when they go to Rwanda and help anyone who is interested to join this mission.

The speaker of this memorable evening was Stephanie Nolen, a well-known reporter from The Globe and Mail and several times Award Winner, including the 2009 National Newspaper Award for Explanatory Reporting on child malnutrition in India and the 2008 National Newspaper Award citation of merit for international reporting coverage of Kenya’s post-election violence. Inspired by her book, “28 Stories”, she recounted with compelling clarity examples of resiliency and determination that she witnessed during her time in Africa in direct contact with AIDS victims. Such a powerful talk touched the hearts of many who are involved in humanitarian missions.

Thanks to our generous donors, donations to CAS IEF in 2009-2010 have reached a new record (see below). Please continue to be generous so we can afford to establish a strong group of Rwandan anesthesiologists through clinical and educational fellowships. Drs Bona and Paulin, the two Rwandan residents who spent six months at Dalhousie, are now back in Kigali and soon will be staff working at the Centre Hopitalo Universitaire de Kigali. Next January, we hope to bring to Canada another two residents.

Stephanie Nolen talking to Dr Franco Carli at the dinner



IEF Donations - 1999 to 2009

	Donations
1999	$19,808
2000	$22,034
2001	$14,248
2002	$14,842
2003	$19,073
2004	$21,173
2005	$32,336
2006	$49,235
2007	$41,056
2008	$64,742
2009	$62,975

I am so pleased to say that for the rest of 2010 and the whole 2011 we have volunteers going to Rwanda every month, and for most of the time accompa-

nied by Canadian anesthesia residents. Lately there has been a great interest from this group to join in the educational mission in Rwanda. I have now started to book volunteers for 2012. Please contact me (franco.carli@mcgill.ca) if you wish to go.

Other CAS IEF activities include the Annual Global Outreach Course in Halifax in conjunction with the Dalhousie Department of Anesthesia (May 21-24, 2011), and the educational assistance to the World Federation of Societies of Anaesthesiologists (WFSA) initiative to strengthen anesthesia training in the West Bank and East Jerusalem.

SPARE TIME TO VOLUNTEER?

Live near the CAS office? Have a day to volunteer to CAS IEF?

We have a number of boxes of items that need to be a) established whether they are worthy of being sent to Rwanda and, if so, b) put in priority order.

If you have a free day and are willing to go through the boxes, please contact Joy Brickell at adminservices@cas.ca<mailto:adminservices@cas.ca> or 416-480-0602 x 20.

Thank you.

Dr Franco Carli

2011 CALL FOR NOMINATIONS

Recognizing excellence among CAS members is a long-standing tradition and the October 29, 2010 deadline for submitting nominations to CAS is fast approaching. The awards will be presented at the 2011 annual meeting in Toronto.

The 2011 Call for Nominations was previously communicated to members and is posted on the CAS website under "Awards and Grants". As a reminder, the following award categories are open for nominations:

Gold Medal: The highest award of the Canadian Anesthesiologists' Society and a personal award in recognition of excellence in matters related to anesthesia

Clinical Practitioner Medal: Recognizes excellence in clinical anesthesia practice

Clinical Teacher Award: Recognizes excellence in teaching of clinical anesthesia

Research Recognition Award: Honours a senior investigator who has sustained major contributions in anesthesia research in Canada

Emeritus Membership: Recognizes retired individuals who made a significant contribution to anesthesia during their long-standing practice

John Bradley Young Educator Award: Recognizes excellence and effectiveness in education in anesthesia

MEDICAL STUDENT PRIZE

Another presentation is the Medical Student Prize, which is presented to a Canadian medical student to increase awareness among undergraduate medical students of the specialty of anesthesia and the role of anaesthesiologists in healthcare. The submission date is February 18, 2011. For more information, email Dr Kathryne Faccenda at faccenda@ualberta.ca