



n e w s l e t t e r

## European Society of Anaesthesiology Set For 2005

Indications are that last October's announcement, by ESA President Hans-Joachim Priebe, of a possible withdrawal of the Society from the European Federation of Anaesthesiology (EFA) - the umbrella organisation of the ESA, the European Academy of Anaesthesiology (EAA), and the Confederation of European National Societies of Anaesthesiologists (CENSA) - received a frosty reception from the other members of the EFA. Despite the gloom and pessimism surrounding the future of the EFA, secret and reportedly difficult talks over the following two months between the President of the ESA and the incumbent President of the EAA, Prof. Hugo van Aken, have secured an agreement on a merger between the two organisations. No doubt this was aided by the happy coincidence that both Presidents share the same German domicile. The new ESA, the *European Society of Anaesthesiology* (previously *Anaesthesiologists*), will come into existence on 1st January 2005.

The announcement in the EAA Newsletter Extra at the end of last year outlined the history of the merger. The EAA, the ESA and CENSA have competed with specialist societies like the European Society of Regional Anaesthesia for delegates at their annual meetings. Belt tightening amongst the pharmaceutical and equipment companies has forced a rationalisation of trade support to international meetings, and at the same time the international audience has become more discriminating. The annual scientific meetings of the ESA has always attracted thousands of delegates, and last year's Euroanaesthesia meeting in Glasgow saw record support from the trade companies. The ESA Annual

Meeting, at the heart of the Euroanaesthesia, has become established as the major European meeting, and generates a significant income for the Society, which in turn supports prizes, research grants, and is used to encourage education and research in anaesthesia across the continent.

### Merger or takeover?

It has been no secret that the ESA has wished to develop its interest in education and research, and has much admired the work of the Academy in the field of standards, inspections and examinations. The Academy, on the other hand, has had an opportunity to sample joint meetings, through the arrangement



within the EFA. Its journal, the *European Journal of Anaesthesiology*, has seen its position in the impact factor table improve considerably, and its circulation rocket, thanks to its adoption by the ESA. Consequently, both Societies see advantages in a rationalisation of forces within a single organisation.

The similarity in constitutional objectives of the two organisations has facilitated agreement on the new by-laws. Comparison of the stated aims of the Academy and the

### Highlights

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ESA reveals that they are mutually supportive. Professor Priebe announced that the new by-laws have already been agreed. 'The Contract of Agreement has yet to be signed, but there is no going back'.

**What's in a name?**

Where are the sacrifices in the merger? One obvious one is the loss of name. The ESA has less historical baggage than the Academy, and the latter almost certainly will wish to maintain a thread with its past. Loyalty and sentiment are not necessarily obstacles to collaboration and future development, and the new ESA – the European Society of Anaesthesiology - can afford to be accommodating.

The new acronym means no change there, but the new ESA will be recognised by a new logo currently under design. Paolo Pelosi, the ESA Assistant Secretary, has pointed out that while we are all anaesthesiologists, we practice anaesthesiology to different degrees. He reminds us that the term describes an activity that takes place largely in operating rooms, and does not adequately describe the intensivist, the pain specialist, or the perioperative physician.

We should acknowledge the relevance of his comments, but should we worry that our subspecialists are going to feel excluded because the new Society embraces *Anaesthesiology* as opposed to *Anaesthesiologists*. Because the ESA will remain the ESA, many members and delegates might have difficulty in remembering exactly what the 'A' stands for.

**Where next?**

An interim Council and Board of Directors will be established to manage the new Society in 2005. Streamlining two organisations into one can solve problems for some and create difficulties for others. Birth can be a painful business, and opportunities in ego flattening and sensitivity trampling will abound.

The Aims of the Academy	The Aims of the ESA
<ol style="list-style-type: none"> <li>1. To take all measures required to raise the scientific standards of anaesthesiology.</li> <li>2. To concern itself with the training of anaesthesiologists, their programmes of training, their courses of clinical instruction and the means of ensuring their proficiency on completion of training.</li> <li>3. To organise or encourage scientific meetings, lectures, seminars and symposia on matters concerning anaesthesiology.</li> <li>4. To encourage and direct research in anaesthesiology.</li> <li>5. To promote exchanges between anaesthesiologists and those from other disciplines.</li> <li>6. To advise relevant European bodies on all matters and problems relating to anaesthesiology</li> </ol>	<ol style="list-style-type: none"> <li>1. To promote exchange of information between European anaesthesiologists.</li> <li>2. To disseminate information in regard to anaesthesiology.</li> <li>3. To raise the standards of the specialty by fostering and encouraging education, research, scientific progress and exchange of information.</li> <li>4. To promote and protect the interests of its members.</li> <li>5. To promote improvements in safety and quality of care of patients undergoing anaesthesia by facilitating and harmonising the activities of national and international societies of anaesthesiologists in Europe</li> </ol>

In parallel to those with the EAA, intense negotiations took place between the ESA and CENSA with the goal of having CENSA join the ESA and the EAA in one amalgamation process. Although the final outcome of the negotiations is still open, the respective Executives ratified an agreement on the section of the new by-laws dealing with society membership, and on the policy defining the possible future activities of CENSA within the new ESA. The ESA is determined to see unity amongst European anaesthetists and their organizations.

Professor Priebe confessed that allaying concerns in the small as well as the large detail, involved

intense patience and concentration. He said that the ESA would pursue the matter with all the diplomatic and political energies at its disposal, and he hoped that further news would be available soon. Achieving a sweet harmony may take a little time, and patience may be needed in abundance. Most of us are convinced, however, that the gain will be worth the pain. ●

## Profile of the President

**Hans-Joachim Priebe was born in Lübeck, Germany in 1947. His mother practiced as a gynaecologist and obstetrician. 'My mother was in private practice with a lot of obstetrics. I learned very early on about the long working hours in medicine. On the other hand I also experienced that medicine had its rewards, and witnessed how grateful my mother's patients were. This influenced my decision to pursue medicine as a career'. As an undergraduate at the universities of Freiburg, Vienna and Munich, the young Dr. Priebe became interested in cardiology, and set out to train in internal medicine. 'I got the impression that internists could be extremely good in treating chronic disease, but they always needed a considerable amount of time for discussing things, and for coming to a final decision. They weren't particularly good at saving lives in real emergencies. I decided to spend a year in acute medicine'.**

At the same time, Dr. Priebe decided to get some overseas experience that would also improve his English, and applied for numerous rotating internships at hospitals in the USA. In a twelvemonth post, these internships offered six months in anaesthesia and two months each in medicine, surgical intensive care, and another discipline of choice. He was accepted at the University of West Virginia, in Morgantown. 'I had never heard of such a place before'. His rotation started with anaesthesia; 'I quickly began to enjoy the activities involved, and when I subsequently had to rotate through internal medicine I missed the operating room environment'. On finishing the internship, he applied for a training programme in anaesthesia, and was accepted as a Resident at one of the Harvard teaching hospitals in Boston. 'Instead of spending just one year in the US as planned, it was to be six years before my wife and I returned to Europe'.

The opportunity came about by chance. Myron B Laver, a previous professor of anaesthesia at Harvard, who had become Chair of Anaesthesia at the University Hospital in Basle, offered him a senior position. 'It was a difficult decision to make, because I truly enjoyed my work, and had reached a senior position. I liked Boston, which is still my favourite city in the States, but the deliberations turned in favour of returning to Europe'. After eight years in Basle, an opportunity to return to Freiburg arose. 'You can be in the countryside in minutes, and still the centre of this lovely old town is only a 15 to 20 minute walk. The Black Forest is on the doorstep, and Switzerland and the Alsace are not more than an hour's drive. When people complain about the traffic in Freiburg, they have been stop-going for maybe ten minutes'.

Prof. Priebe's involvement with the ESA began in the early 1990s, soon after move to Freiburg. 'One day I got a phone call from Professor Sebastian Reiz, who is one of the founding members of the ESA, and the first Chair of the Scientific Committee. He told me of the intention to found a new European anaesthesia organisation, and asked me whether I would be prepared to put together the first scientific Subcommittee on Experimental Circulation. I said Yes, and I have stayed with the ESA ever since'. He acknowledges that as President he is in a privileged position. 'Hopefully I am in a position to move things along and influence the direction of change. What is definitely positive about being in a position like this is the frequent exposure to colleagues from different countries, with different views and experiences, and this starts within the ESA Board and continues in the Council. It provides a constant challenge to my own opinions and positions'. High office often has little status at home. 'I am responsible – clinically and administratively – for a section of our university hospital anaesthesia department that includes ten operating rooms, and daily clinical work is expected of me'.



I put to Prof. Priebe that obligations spread widely over a number of fronts, invariably meant long hours, and could take a toll. He confessed that for him regeneration came through a love of nature and classical music. 'I used to spend a lot of time playing the hautbois and the piano. Unfortunately, limited time has forced me to cut down on what used to be a very active hobby. I am now a more passive consumer of music – be it live concerts or listening to CDs. And I love nature, particularly mountains and water. We are certainly blessed with natural beauty in this part of the country'.

Lastly, I questioned him about the aspects of office that no one likes to talk about. Inevitably when decisions are made, not every colleague will give universal support, and some decisions will attract personal criticism that could be hurtful. In a demonstration of diplomacy that perhaps illustrates why he is the President, he agreed to answer my enquiry – but not before his term of office was complete! ●

## Council Elections – Term of Office 2004-2005

According to the ESA by-laws, any European country with at least 10 Active Members is entitled to elect a representative to the ESA Council.

In the fourth quarter of last year, Elections were held for the two-year term of office 2004-2005.

Active members from 33 countries were eligible to present themselves as candidates for election.

Candidatures were received from 30 of the eligible countries. No candidatures were received from Luxembourg, Estonia and Slovakia. 9 of the 30 elected members were re-elected for a second term of office.

The ESA Board of Directors welcomes both the new and re-elected members of the 2004-2005 Council. ●

### Council members 2004-2005

Austria	Klaus Hoerauf	Latvia	Peteris Tomins*
Belgium	François Singelyn	Lithuania	Kestutis Rimaitis
Bosnia	Zeljka Knezevic	Norway	Eldar Soreide*
Bulgaria	Snezhana Slavcheva	Poland	Andrzej Kübler*
Croatia	Zdenko Novotny	Portugal	Lucindo Ormonde*
Czech Republic	Ladislav Hess	Romania	Ioana Grintescu*
Denmark	Tom Pedersen*	Russia	Edward Nicolayenko
Finland	Pertti Pere	Slovenia	Neli Vintar
France	Dominique Chassard	Spain	Pablo Monedero*
Germany	Johann Motsch	Sweden	Stefan Lundin*
Greece	Eleni Plessia	Switzerland	Martin Tramèr
Hungary	Akos Csomos	The Netherlands	Robert Steur
Ireland	James Gardiner	Turkey	Neslihan Alkis
Israel	Haim Berkenstadt*	United Kingdom	John Sear
Italy	Maurizio Solca	Yugoslavia	Radmila Kolak*

\* re-elected for a second term of office

### European Journal of Anaesthesiology

## Cambridge University Press Acquire Greenwich Medical Media Ltd

Gavin Jamieson, Journals Publisher

**In December of last year, Cambridge University Press acquired Greenwich Medical Media Limited – the publishers of the *European Journal of Anaesthesiology*. This acquisition is a wholly positive development for the Journal and there will be no disruption, either in the short or the long term, to the Journal's production, publication or distribution. The EJA represents a pivotal medical publication for one of the world's leading academic publishers, and will benefit from Cambridge's enhanced international outreach.**

Cambridge University Press, with headquarters in the historic city of Cambridge, England is the printing and publishing house of the University of Cambridge. It is an integral part of the University and has similar charitable objectives in advancing knowledge, education, learning, and research. For centuries the Press has extended the research and teaching activities of the University by making available worldwide through its printing and publishing a remarkable range of academic and educational books, journals, examination papers and Bibles.

The Press is both very ancient and very modern. It is in fact the oldest printing and publishing house in the world. It was founded on a royal charter granted to the University by King Henry VIII in 1534 and has been operating continuously as a printer and publisher since the first Press book was printed in 1584. Since then, books under Cambridge University's imprint have appeared in each and every year, and the Press has grown to become one of the largest academic and educational publishers in the world, publishing over 2,000 books and 150 journals a year, which are sold to some 200 countries across the globe.

Over the years, the Press has published works by many famous international scholars. Eminent authors before 1800 included the philosopher Henry More, the poet John Milton, the physiologist William Harvey, scientist and philosopher Isaac Newton, and the physician Sir Thomas Browne. Since the late nineteenth century, the volume and range have rapidly expanded.

In the sciences a tradition of popular science publishing was established that leads from Clerk Maxwell, Rutherford, Eddington, Jeans, Einstein, Schrodinger, Dirac, and Bohr, through to such distinguished modern physicists as Hawking, Penrose, Feynman, and Weinberg.

The Press's journal publishing began in 1893 with the *Journal of Physiology*, which remains today one of its largest and most successful journals, alongside some 150 more recent publications such as *Protein Science*, *Brain and Behavioural Sciences*, *The European Review* and the journals of many major learned societies like the Royal Historical Society, the British Sociological Society and the Association for Child Psychology and Psychiatry, all of which are progressively being made available online.

Cambridge University Press has reaffirmed its commitment to the future development of the Journal and to build upon the success achieved with Greenwich Medical Media. A new online peer review system will be integrated to assist both the authors and editors ●

## Greatest Number of abstracts accepted for Lisbon 2004



Gordon Drummond, Chairman of the ESA Scientific Committee

The abstracts for presentation at Euroanaesthesia 2004 have again been submitted entirely electronically this year. In addition the assessment process used a system based on electronic transmission, and all proceeded smoothly. The results were extremely encouraging, and emphasise one of the important aims of the society: to encourage and improve the standard of research in Europe. The number of abstracts submitted was almost exactly the same as last year, at 1169, but the proportion of abstracts accepted for presentation has increased slightly to 73%, the highest it has ever been.

I am very grateful for the invaluable help of the subcommittee chairmen who co-ordinated the assessment of this large number of submissions, and those members of the subcommittees who help with the process. This is not an easy task, and has to be done quickly, but is helped enormously by the careful work of our Secretariat. Each abstract session can accommodate ten presentations, and fitting them all into the general programme can be taxing.

Most of the subcommittee chairmen were very pleased and impressed by the quality of the work submitted. As usual the topics of pharmacology, regional anaesthesia, pain, and the circulation were popular and had impressive acceptance rates. A topic of increasing interest

Table 1 - Accepted abstracts per subcommittee		
Subcommittee	Received	Percentage accepted
Pharmacology	134	67%
Local anaesthesia	132	63%
Monitoring and equipment	128	84%
Acute and chronic pain	116	72%
Circulation	114	68%
Intensive care	97	93%
Respiration	89	76%
Neurosciences	81	91%
Obstetrics	52	38%
Paediatrics	50	70%
Evidence based medicine	45	80%
Ambulatory anaesthesia	41	56%
Transfusion and haemostasis	38	74%
Resuscitation	20	90%
Safety	18	67%
Education and presentation	13	54%
Ethics	1	0%
<b>Total</b>	<b>1169</b>	

Table 1 shows the absolute number of abstracts received by each subcommittee, together with the percentage of each accepted. One abstract session has a maximum of ten abstracts.

is monitoring and equipment, which also had a large number of submissions. (Table 1)

As expected, most of the submissions came from Western Europe and the acceptance rate of abstracts from these countries was high, at 77%. However the number of abstracts received from Eastern Europe increased, and the acceptance rate although not as great, was very creditable. Turkey submitted nearly 12% of the abstracts, and

60% were accepted. As usual, a smattering of abstracts came from other parts of the globe: the middle East, USA, South America, Australasia, and the far East, particularly Japan and Korea. We welcome the authors as "honorary Europeans!" (Table 2)

In the assessment process, the abstracts are judged for their concept, methods, results, and quality of presentation. The system uses a method of grading that has face validity and I hope is reliable. As a result, we shall choose the "best of the bunch" who are invited to give a verbal presentation of their work at the Best Abstract Prize Competition. This special presentation is an event I always enjoy, and will be on Sunday June 6th at 12:15, in time to choose the prize winners to receive their awards at the Gala Dinner in the evening in the Beato Convent! I encourage as many of you as possible to come to this special session, which represents the best of research in Europe. ●

Table 2 - Accepted abstracts / part of the world		
Part of the world	% Received	% Accepted
Western Europe	75	77
Eastern Europe	11	51
Asia	8	68
Middle East & Africa	4	70
North America	2	75
<b>Total</b>	<b>100</b>	<b>73</b>

Table 2 shows the abstracts received from different parts of the world given as a percentage of the total number. The percentage of submitted abstracts that are accepted for publication is shown in the second column.

## News from the Headquarters

John Popovich, Executive Director

**We have now been in the new headquarters building for more than six months, and the Secretariat staff and I can confirm total contentment.**

Meetings of the ESA Board of Directors, the European Federation (EFA), and the Scientific Committee, as well as a number of smaller meetings, have been held at the new headquarters over the past six months and more are planned for the immediate future. Our new building successfully accommodates the requirements of a fast growing international organisation and we have no doubt that it will continue to do so well into the future.

The work in the garden that began in late November has just been completed (photos). With the unseasonably warm weather we have been experiencing, the bushes are already in bud and the tulips are 15 cms out of the ground. The metallic structure in the centre will be covered with climbing blossoms and of course we are all curious to see what the result will be towards the end of the summer as the entire garden matures.

Also late last year the street in front of our building was completely renovated with new cobblestones, wider pavements and spaces intended for planting trees. The entire area around our building is undergoing considerable renovation (buildings, streets, pavements, a new hotel) that will add considerable value to our property. The ESA continues to receive renovation subsidies from the Brussels Regional Government. As of the date of this report, 590,000 € has been received. An additional 80-100,000 € has been requested and, pending final approval, should be allocated within a few weeks.



A book devoted exclusively to our new headquarters has just been published by the editor *Archives d'Architecture Moderne* with financial support from the Brussels Capital Region. The book covers a short history of the original architect, Albert Dumont (1853-1920), and his oeuvre with the remainder devoted exclusively to our building and the renovation of it and includes superb colour photographs. Reference is made to the ESA several times in the book (which was published only in French and Dutch). ESA Members interested to obtain a copy (price 12€ including postage) of the book, please contact the ESA Secretariat ([members.esa@euronet.be](mailto:members.esa@euronet.be)). Purchases are at cost price to the ESA and can be transacted only using a valid credit card.

A few announcements concerning the ESA Secretariat staff merit a mention. Sue Loughlin, our Accounts Administrator, and I both celebrated our five year anniversary of employment with the ESA late last year. Renaud Rollet, Member Services Supervisor, has been promoted to Events Planning Officer and is currently in training to take over the organisation of the ESA Annual Meetings. Anne Dewaegenaere, Member Services Administrator has been promoted to Member Services Supervisor and Cindy Martinez joined the ESA in December 2003 as Member Services Administrator.

Congratulations to Sue, Renaud and Anne and a warm welcome to Cindy. ●

## Lisboa Delights

With thousands of kilometres of coast, the Portuguese have always been intrepid sailors. Long before the colonisation of North America, Portuguese fishermen would visit the rich cod banks off Newfoundland, salting their catch to preserve it for the return voyage. Consequently fish, and especially salt cod, *bacalhao*, features significantly in Portuguese cuisine. *Bacalhao* is available in many different recipes and presentations.

One speciality of the Lisbon region is fish baked in salt, *peixe no sal*. Rock salt is used to completely encase the fish, but somehow the large quantity of salt does not spoil the taste, leaving it full of flavour and very succulent. Portugal is well known for its sardines, and the best time to eat them is in June. They are cooked whole, with head and intestines intact. They lay a sardine on a piece of bread and with their fingers pick the flesh off. The nutritious fish oil soaks into the bread so that is eaten last.

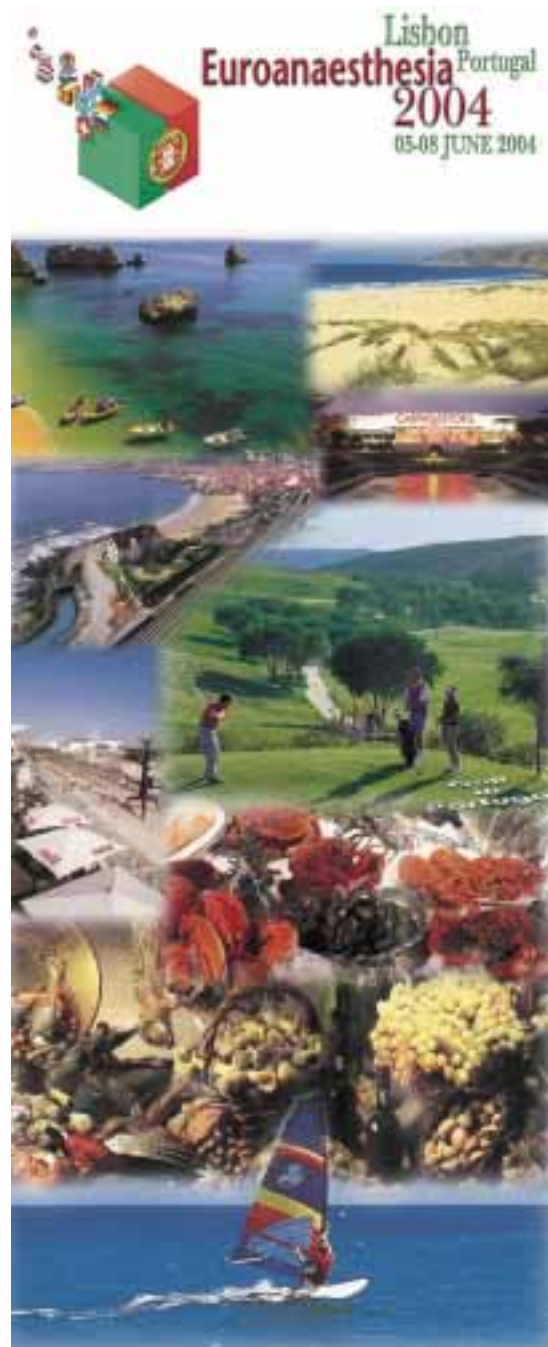
For meat eaters, *presunto*, is similar to the other cured hams of Southern Europe. The Portuguese cure it by burying it in a hole in the ground with a rock on top. As a result, one side is always flat. *Javali* or wild boar is very popular and considered quite a delicacy. As is *leitão* or roast suckling pig.

Euroanaesthesia coincides with the end of the best season for snails. The tiny ones are picked by the bucket load and left in a cage for a couple of days to clean themselves. Then they cook them with butter, garlic and parsley and pick the meat out with a cocktail stick.

To follow you might like to try *pasteis da nata* which are like little custard (sauce anglaise) tarts. *Arroz Doce*, literally sweet rice, is a cold rice pudding that is cooked with eggs and powdered with cinnamon. Chocolate mousse is usually eaten with a tot of something stronger poured on it, commonly vodka or brandy. *Pudim Flan* is creme caramel.

To start the day local style, try a quick swallow of fiery *medronho*, distilled from the arbutus bush or wild strawberry plant, washed down with a *bica*, to "kill the worm" as they say. A *bica* is a small cup of strong black coffee. Connoisseurs of *medronho* will look for a clear, rather than yellow liquid and that will burn silently on a dipped finger!

Portuguese wines have changed much in recent years, though Port from the Douro river region, and Madeira, from the island of the same name, have a long history and are held in high regard. Local taste has led to a reputation for dull and uninspiring table wines, and there are still plenty of these about. Modern tastes, new methods, and an influx of Australian wine makers have brought about a revolution, and crisp dry whites and both light and robust reds can now be found in abundance.



Clearly Euroanaesthesia is going to have a difficult time competing with Lisboa for attention. The delegates are in for a hard time!

## ESA Web Site Gets a Face Lift

**It has been a long time coming but the new design of the ESA website was activated in November last year. The new design should enhance ease of navigation and quicker access to useful information.**

Two new features have been added to the site. The first being a “jobs” section where we hope to post messages from hospitals and clinics with employment opportunities for anaesthesiologists that the ESA Secretariat receives sporadically. In this same section, anaesthesiologists seeking employment are invited to send their profiles and requests to [esa@euronet.be](mailto:esa@euronet.be) for posting.

The second feature is a ‘members only’ area, accessed with a password. Presently we are considering the type of information we would wish to consider ‘member restricted’ and, in the near future, will inform all ESA Members of our plans.

We of course are open to comments and suggestions from our readers as to their appreciation of the new design and ideas for further enhancements. In the meantime, Refresher Courses, complete information about the Annual Meeting, including the scientific programme, registration, hotels, social programme and membership application forms can be easily accessed. Recent postings include the newly elected members of the ESA Council.

On a final note, the American spelling of ‘anesthesia’ must be used to access the ESA web site [www.euroanesthesia.org](http://www.euroanesthesia.org). Several members have tried to access the site using the British spelling of ‘Euroanaesthesia’ that leads to a blank page.

## Editorial Postoperative pain management: a continuing struggle

Francis Bonnet. Anaesthetic Department and Pain Clinic. Hôpital Tenon – Assistance Publique Hôpitaux de Paris. 4, rue de la Chine 75970 Paris cedex 20.  
[francis.bonnet@tnn.ap-hop-paris.fr](mailto:francis.bonnet@tnn.ap-hop-paris.fr)



**Postoperative pain control, once considered an ancillary problem, has witnessed a revolution in the past fifteen years. Advances late in the 20th century have brought greater efficacy in pain control, and this in turn has spurred improvement in its assessment. Simultaneously, the aims of treatment have expanded to embrace not merely a reduction in pain intensity, but the promotion of comfort and rehabilitation. The widening of objectives, together with the insidious elevation of standards and expectations, have placed a burden on an old order that is often ill equipped to serve the new ambitions of anaesthetists.**

The evolution from nurse administered intramuscular morphine to self-administered intravenous bolus did not require revolutionary technology, but did represent a revolution in approach. In recognising that the individual is the best judge

of pain intensity, and that self-administration could produce superior results, anaesthetists placed patient controlled analgesia (PCA) in the vanguard of the new movement. Since PCA required monitoring of efficacy and side effects, it prompted change in the organisation of patient care, through the development of acute pain services (APS) that involved not only anaesthetists, but also nurses and even surgeons. As the concept of the APS gained ground, the means, objectives, and organisation of pain treatment changed.

PCA has now extended beyond the intravenous route of administration of, mainly morphine, to epidural and perineural applications. Similarly the range of agents has grown to include local anaesthetics and their adjuvants. The success of intravenous PCA has resulted in its widespread adoption by the entire surgical community.

The introduction of portable elastomeric pumps connected to perineural catheters, has made PCA a practical option even for ambulatory patients. PCA has evolved into a versatile and flexible form that can be adapted to the needs of almost every individual.

Evidence that standards are improving can be found in the way that pain is assessed. As pain control has improved, its evaluation has become more demanding. Whilst the goal of management remains a reduction in pain intensity, it is no longer sufficient to measure efficacy at rest, but also on mobilisation, and on coughing for abdominal and thoracic surgery. We have learnt that a single analgesic may not give the best results, and multimodal analgesia, the use of a variety of agents and techniques in combination, has become very popular [1]. The use of several analgesics, each targeting a different point in the pain pathway, strengthens efficacy, whilst the modest doses, required to achieve

this, minimises side effects. Commonly the desired objective is a reduction in the side effects of morphine, through the morphine sparing effects of paracetamol, nonsteroidal analgesics, and peripheral nerve blocks. The benefits of morphine sparing have been largely intuitive until recent evidence has pointed to a more rapid resolution of postoperative ileus with a reduced incidence of nausea and vomiting. Anaesthetists who pay close attention to the control of pain reap dividends in patient comfort, with consequent reduction in postoperative fatigue, length of hospital stay and earlier convalescence. Pain management has an important role in the global postoperative care strategy, and it should begin in the operating room.

All surgical procedures are painful and postoperative features are often specific to the procedure. All are amenable to procedure specific analgesic strategies that might, for example, incorporate fast-track anaesthesia and early withdrawal of tubes and catheters together with rapid mobilisation, irrespective of whether the procedures are major resections or minimally invasive techniques, [2]. The development of procedure specific strategies can link with a substantial evidence

basis and choose analgesics with proven efficacy, for examples nonsteroidal analgesics after colectomy or total hip replacement. Useful resources to support such an approach can be found in the Cochrane library, related websites, and the output of the Oxford Pain Relief Unit [3].

Many institutions have seen the combination of interest and expertise give birth to an acute pain service with responsibility for equipment, analgesic protocols and guidelines, and educational programmes for health care professionals. A "low cost model" of acute pain service has been proposed for Europe, intended to accommodate differences in medical culture and organisation of health care [4]. Despite this, recent surveys suggest that in several European countries, acute pain services are facing real difficulties. Stretched surgical nursing services fail to support ward pain relief protocols. Fear of side effects and interaction with thromboprophylaxis, inhibits uptake of the thoracic epidural, the most invasive procedure. Evidence that improvements in postoperative pain control shorten ICU and hospital stay, has failed to convince hospital authorities that investment in acute pain services has an economic justification. From

one hospital to another, anaesthetists continue to struggle to maintain efficient acute pain services. For the sake of the future, this struggle should not be abandoned, Acute pain services have a leading educational role that no one else can assume. Success on the educational front might see other health care providers (surgeons, or general practitioners in case of ambulatory anaesthesia) incorporated into the team. Expanding the multidisciplinary approach could extend the role of acute pain service to all matters obtaining to patient rehabilitation. Such widening of the role might have the double benefit of improving overall patient care, and convincing hospital managers that acute pain service are worthy of support. ●

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## Correspondence

Letters for the Correspondence section are welcomed and should be sent by post to the ESA - addressed to The Editor - or by e-mail to [editor@blocked.org.uk](mailto:editor@blocked.org.uk).

### Dr. Roddie McNicol (UK) writes: about the European Society of Anaesthesiology:

Dear Sir,

Thank you for the recent volume of your newsletter (Volume 16, Autumn 2003) that has now arrived in my department pigeonhole. Unlike the other unsolicited mail that arrived that day, which was quickly despatched to the rubbish bin, I found your slim volume to be very interesting indeed especially the leader article by your president Prof. Priebe.

As someone only slightly interested in the fate of European anaesthesia I was fascinated by Prof

Priebe's account of the evolution and eclipse of the proposed European Society of Anaesthesiology. He gives the impression of the ESA bending over backwards to accommodate the requests and demands of the EAA and CENSA, however, to a complete (impartial) outsider, such as myself, it appears that the ESA is blatantly trying to take over the other two societies and none too subtly either.

Perhaps your society is suffering from a lack of insight. This would not surprise me as one of your committee, Dr Drummond, states in the same volume that the first combined European Scientific Meeting was

held in Glasgow, "Scotland's second city". The same way that New York is the USA's second city and Sydney is Australia's? Perhaps Gordon's tongue was in his cheek as he typed his report or perhaps he shares the same lack of insight as your president? Yours faithfully,

*Roddie McNicol,  
Consultant Anaesthetist  
Royal Hospital for Sick Children  
Glasgow, UK*

*Ed: I am not sure which of these is the bigger crime.*

## Cause for Complaint

**A 50 year old ASA 1 patient was scheduled for ankle surgery. The patient consulted the anaesthetist, 12 days before surgery. He was informed that the anaesthetic technique should be a spinal anaesthesia. He received from the anaesthetist consultant, oral and written information about the procedure, and about the risk of headache and major complications such as cardiac arrest. He gave verbal informed consent to the choice of the anaesthetic technique.**

On the day of surgery, an anaesthetist different from the previous one, performed spinal anaesthesia. The patient was placed in the sitting position; his back was disinfected with chlorhexidine and wrapped with a single-use surgical drape. The anaesthetist washed his hand carefully and wore a facial mask and surgical gloves but not a gown. He was assisted by a nurse who did not wear a mask. A 24 G short bevel needle was introduced at L3-4 and a free CSF backflow was obtained on the first attempt; 4 ml of bupivacaine 0.5 % plain solution were injected; the anaesthetic block extended up to T12 allowing to perform the surgical procedure that was uneventful. After the end of surgery, the patient was placed in the recovery room during 1H1/2 until complete recovery of the block, and then in the surgical ward. The first night was uneventful but on the morning of the first postoperative day he complained of severe headache that persisted all day long, and the following night. He also vomited twice during this period of time. On the second postoperative day, headaches remained very severe, keeping the patient in bed. He was consequently scheduled for a blood patch performed that afternoon. Unfortunately, the epidural injection of 20 ml of autologous blood was absolutely ineffective, and headache persisted all day and night long. Patient's body temperature remained within normal range during those days but an increase in polynuclear cell count (12,000/mm<sup>3</sup>) was documented. On day three, a bilateral facial palsy was noted by the anaes-

thetist in charge of the care of patients in the surgical ward. He decided in the afternoon to transfer the patient to another institution where a lumbar puncture was performed on admission. It documented purulent CSF that contained gram-positive bacterial stains on direct examination, evidenced as streptococcus oralis on culture. He was treated by amoxicillin during 10 days and discharged from hospital after one month with a persisting bilateral facial palsy and urinary and faecal incontinence that persisted 18 months later. Despite active re-education, bilateral facial palsy prevented him from a normal speech. He also lost his job, needed the assistance of his wife for daily life, and suffered from severe depression. The patient in a judiciary procedure namely implicated the institution and the anaesthetist.

*We asked Professor Tony Wildsmith of Dundee to comment. He did so without knowing the outcome of this case, which appears on the next page.*

"Meningitis is rare after spinal anaesthesia and there is evidence that the incidence is no higher than in the general population. However, the risk may be increased by a failure of aseptic technique, or if the patient is bacteraemic at the time of lumbar puncture. I believe that one or two obstetric patients have developed meningitis in association with other, intercurrent source of infection. However, this does not seem to have been the case in this patient so we are left with the possibility that there was a failure of aseptic technique, or that this was just a "happencance" association.

The anaesthetist wore a face mask and surgical gloves, but not a gown. Most authorities would consider these to be acceptable precautions by an experienced practitioner, although I always wear a gown myself. The big concern is that the assistant did not wear a face mask and the bacteria involved were identified as streptococcus oralis. This does imply contamination of the items used by droplets falling from

the assistant onto the sterile field. However, it would be a very hard decision to consider this to be cause and effect, although persuading Judge and Jury of this might be difficult.

However, there is a greater concern. The patient was complaining of persistent headache on the first postoperative day, and it was another two days before a definitive diagnosis was made. In the interval, there was an assumption that the headache was due to CSF leak, but we are not given any information to imply that the headache was postural (the key factor in post-lumbar puncture headache) and clearly the diagnosis was in error. Where I believe there is real blame in this case is that there was an unacceptable delay before the correct diagnosis was made and treatment instituted, with the result that the patient suffered permanent neurological damage. I am concerned that there was not better initial consideration of the alternatives and frankly appalled that other possibilities were not considered when the epidural blood patch was found to be "absolutely ineffective". Prompt diagnosis and treatment would have prevented permanent harm."

### Cause for Complaint: The Outcome

The judge commissioned a medical expert and asked him four questions precisely:

- 1) Was the patient adequately informed of the anaesthetic procedure and the risk of complications?
- 2) Was the patient's care in agreement with established medical standards?
- 3) Was the occurrence of the meningitis related to the anaesthetic technique?
- 4) Was the patient adequately monitored, and was there any delay in the diagnosis and treatment of the complication that resulted in harm for the patient?

1) The medical expert concluded that appropriate information was disclosed to the patient about the anaesthetic technique and the related risk. Indeed, not only was the technique explained, but also complementary written information that listed the major complications of the anaesthetic technique, was provided. This reflected the duty of the anaesthetist to include an account of the risks, including rare and severe complications. The objective is not to scare the patient but to engage in a constructive exchange of information. The patient did not sign any document testifying that he had received the information because there is no legal obligation to do so in the country concerned, provided there is sufficient evidence to show that the patient had received adequate information.

2) Spinal anaesthesia was performed in accordance with current practice. The national anaesthetic society has recommendations con-

cerning asepsis that highlight "surgical" hand-washing, and the use of mask and surgical gloves, but not gown, for spinal anaesthesia. The wearing of a gown is recommended when an epidural catheter is placed. Although the anaesthetist followed these recommendations for himself, the nurse who assisted him did not wear a face-mask and this was criticised.

3) The occurrence of bacterial meningitis was considered to be an iatrogenic complication directly related to the spinal puncture.

Meningitis is an extremely rare complication of spinal anaesthesia. Several case reports have implicated streptococci originating from the oral and pharyngeal cavities (streptococcus salivarius - streptococcus oralis...) as pathogenic agents after spinal puncture, supporting a hypothesis of contamination from the anaesthetist or assistant.

4) Postoperatively the patient complained of headache that could

have been related to the puncture of the dura mater. Nevertheless the persistence of severe headache with vomiting, especially after the performance of the blood patch, was unusual. In addition, although the patient was not feverish, the white blood cell count was increased.

Not all headaches following spinal anaesthesia are related to dural puncture. Other diagnoses must be considered when headache persists, is especially severe, or is associated with other symptoms. Meningitis, pneumocephalus, and cerebral haematoma should not be overlooked as possible causes. In the case under discussion, the diagnosis and treatment of meningitis was delayed for 3 days, until the appearance of a bilateral facial palsy. The medical expert judged that this delay was detrimental to the patient and that careful analysis of the headache could have shortened the time to diagnosis. ●



## Obituary: Peter Safar

**Dr. Peter Safar, widely known as the “father of cardiopulmonary resuscitation”, died at the age of 79 of a pelvic malignancy on August 3rd 2003. With his passing we have undoubtedly lost one of the most far-sighted forerunners of our discipline who not only combined innovative thinking with meticulous research, but also had the moral courage to tackle the ethical problems that accompanied this progress.**

Dr. Safar was born on April 12th 1924, in Vienna. Both his father, an ophthalmologist, and his mother, who was a paediatrician, faced discrimination during the Hitler regime because of the family's distant Jewish ancestry. His father's refusal to join the Nazi party did not help. Nevertheless, he was able to start his medical studies at the University of Vienna in 1943, when an understanding official chose to overlook his Jewish origins. After qualifying in Vienna in 1948, he emigrated to the USA to take up a surgical post at Yale New Haven Hospital, and then went on to train in anaesthesiology at the University of Pennsylvania. Peter Safar next moved to Lima, where he established a department of anaesthesiology at the National Cancer Institute and then went on to found the first interdisciplinary medical-surgical intensive care unit in the United States, at the Baltimore City Hospital in 1958.

Realizing the pivotal role of pre-hospital resuscitation, he pioneered bystander CPR and the training of paramedics, developed and tested CPR techniques, and refined the standard of ambulance equipment. While at the Baltimore City Hospital in the 1950s he described the backward tilt of the head, jaw thrust and mouth opening to open and maintain the airway, a technique now so well etched into our daily practice that we tend to forget the pioneer responsible. Thanks to his research, emergency artificial respiration progressed from the inefficient “Silvester technique” to “mouth-to-mouth” resuscitation. Dr. Safar then combined his innovation with closed chest cardiac massage to create an approach to basic life support now characterized by ‘ABC’. As a founding member of the American Heart

Association's CPR Committee he helped, no doubt with his characteristically lively determination, to formulate the first guidelines for CPR procedure, and initiated recommendations for physician and paramedic training in CPR.

In 1961, Peter Safar joined the University of Pittsburgh where he launched the anaesthesiology department and extended his work to the fields of respiratory therapy, pain control, and critical care medicine. Fate struck with bitter irony in 1966, while he was away from home, when his daughter died in respiratory coma following an asthma attack. Following this he redoubled his efforts to improve the results of resuscitation, turning his attention to cerebral resuscitation. He recognized that without cerebral perfusion, resuscitation efforts were of limited use, and that return of cerebral function was a major determinant of outcome.

Experiments on dogs showed prolongation of cerebral survival time during minimal blood flow conditions when mild hypothermia was applied. The difficulties involved in using this technique in humans have recently been successfully resolved by his former students, and have resulted in improved survival.

Further steps in his career included the establishment of Pittsburgh's first ambulance service with physicians and volunteers trained in CPR in 1967, and a collaboration that resulted in the organization that would later become the World Association for Disaster and Emergency Medicine. Peter Safar stepped aside as head of the Department of Anaesthesiology in 1978 and subsequently launched the International Resuscitation Research Center at the University of Pittsburgh – now known as the Safar Center – which he directed until retiring in 1994. During the course of his career he was received numerous awards and honorary degrees.

After retirement he continued to be active in many areas. His interests and ambitions extended far wider than just cardiopulmonary and cerebral resuscitation. Influenced by what he had seen during the war years of his youth, he was later to recall with horror how many of his



*Peter Safar, M.D., Distinguished Professor of Resuscitation at the University of Pittsburgh, School of Medicine*

generation had been used as “cannon fodder”. Turning this horror into something positive, he became a determined protagonist for world peace and nuclear disarmament, working with organizations such as International Physicians for the Prevention of Nuclear War and the World Federalist Association.

Despite many commitments he always found time to provide encouragement and sympathetic criticism to a younger generation of researchers, and despite his success he was never aloof. He will be remembered not only for his numerous achievements in emergency and critical care medicine, which undoubtedly helped to save thousands of lives, but also for his keen-eyed care of everything that life meant.

He is survived by his wife, Eva, and two sons, Philip, a lawyer and Paul, a musician. ●

*This obituary was kindly provided by Professor Karl Heinz Lindner, Chief of Anaesthesia and Intensive care Medicine at the University Clinic of Innsbruck, and ex chairman of the ESA Resuscitation and Emergency Medicine Subcommittee.*

## ESA Membership Growth Continues

Membership grew 8.6% in 2003 and 62% over the past three years. With over 50,000 anaesthesiologists in Europe today, tremendous potential for growth remains.

If you have not yet renewed your membership for 2004 please do so now.

Members are reminded that a subscription to the European Journal of Anaesthesiology is included in the membership fee and, in addition to other benefits, Members are offered substantial discounts on registration fees for the Euroanaesthesia meetings.

Persuade a colleague to join and earn a free one year membership extension under our Member Sponsorship Programme. Details available on our web site [www.euroanaesthesia.org](http://www.euroanaesthesia.org). ●

Country	Membership Growth				Growth over			2003 Membership by Category		
	2000	2001	2002	2003	1 yr	2 yrs	3 yrs	Active	Trainee	Other*
Albania			6	9	50.0%			9		
Austria	104	106	155	144	-7.1%	35.8%	38.5%	117	19	8
Belgium	276	297	297	323	8.8%	8.8%	17.0%	256	38	22
Bosnia			12	13	8.3%			12		1
Bulgaria	14	14	26	25	-3.8%	78.6%	78.6%	23		2
Croatia	45	62	86	93	8.1%	50.0%	106.7%	84	5	5
Cyprus			6	8	33.3%			7		1
Czech Rep	46	52	80	72	-10.0%	38.5%	56.5%	65	2	5
Denmark	49	50	64	62	-3.1%	24.0%	26.5%	53	4	5
Estonia	15	14	13	11	-15.4%	-21.4%	-26.7%	11		
Finland	39	38	67	70	4.5%	84.2%	79.5%	48	10	12
France	131	144	224	208	-7.1%	44.4%	58.8%	175	7	23
Germany	219	229	316	319	0.9%	39.3%	45.7%	223	67	26
Greece	72	107	143	189	32.2%	76.6%	162.5%	156	32	3
Hungary	97	77	96	106	10.4%	37.7%	9.3%	93	2	11
Iceland			3	10	233.3%			9		1
Ireland	55	54	96	104	8.3%	92.6%	89.1%	64	40	2
Israel	25	26	28	37	32.1%	42.3%	48.0%	23	7	6
Italy	236	164	206	142	-31.1%	-13.4%	-39.8%	125	11	5
Latvia	32	31	34	37	8.8%	19.4%	15.6%	34	1	1
Lithuania			18	27	50.0%			27		
Luxembourg	21	18	17	18	5.9%	0.0%	-14.3%	16		2
Macedonia			5	4	-20.0%			3	1	
Norway	28	46	77	77	0.0%	67.4%	175.0%	64	2	11
Poland	52	70	84	92	9.5%	31.4%	76.9%	84	2	6
Portugal	80	99	117	136	16.2%	37.4%	70.0%	97	39	2
Romania	74	93	128	200	56.3%	115.1%	170.3%	183	13	10
Russia	8	16	23	30	30.4%	87.5%	275.0%	27		3
Slovakia	35	12	8	16	100.0%	33.3%	-54.3%	15		1
Slovenia	30	27	35	35	0.0%	29.6%	16.7%	32	2	1
Spain	77	83	141	145	2.8%	74.7%	88.3%	116	24	6
Sweden	69	141	124	127	2.4%	-9.9%	84.1%	90	5	32
Switzerland	201	214	260	272	4.6%	27.1%	35.3%	251	4	17
The Netherlands	172	193	245	252	2.9%	30.6%	46.5%	204	18	27
Turkey	52	117	166	162	-2.4%	38.5%	211.5%	141	13	8
Ukraine			4	7	75.0%			7		
United Kingdom	245	239	319	366	14.7%	53.1%	49.4%	274	54	38
Yugoslavia	17	18	26	53	103.8%	194.4%	211.8%	52	1	
<b>Other Countries</b>	<b>283</b>	<b>331</b>	<b>580</b>	<b>707</b>				<b>22</b>	<b>23</b>	<b>667</b>
<b>Total Members</b>	<b>2899</b>	<b>3182</b>	<b>4335</b>	<b>4708</b>				<b>3292</b>	<b>446</b>	<b>970</b>

\*(category 'Other' comprised of Honorary, Retired & Affiliate Members)

# The Airway Algorithm

The Airway Algorithm: does it belong in a textbook, or stuck on the wall of the operating room as a reminder for when airway problems arise? A busy but comprehensive progression will suit the textbook, but an aide-mémoire needs something simpler. In this issue of the ESA Newsletter, we have chosen for you an algorithm that we believe represents a useful compromise between fussiness and practicality.

## Laryngoscopy

The upper yellow box deals with insertion of the laryngoscope, and it incorporates a diagnostic approach with practical advice. The obesity epidemic means that limited laryngoscope access due to breasts and adiposity is no longer a problem exclusive to pregnant women. The short handled laryngoscope contains smaller batteries than a standard scope, which allows 5cm to be removed from the handle. It is a practical and versatile option for intubation when faced with anatomical or mechanical obstruction.

### View at laryngoscopy

At laryngoscopy, it is the view of the glottis that determines the approach to intubation (yellow box, left). In 1984, Cormack and Lehane classified view at laryngoscopy into four grades. They argued that grade 3, when only the epiglottis was visible, was the major problem for most patients, because grade 4 is usually associated with anatomical abnormalities that are obvious to any observer, and for which appropriate

preparation can be made in advance. Grade 3, on the other hand, was not generally anticipated, was associated with normal anatomy, and took the anaesthetist by surprise.

The authors suggested that when all (grade 1) or part (grade 2) of the glottis was visible, intubation should not be too difficult. For some grade 2 appearances, and for all grade 3, when only the epiglottis is visible, they recommended intubation over an introducer (see box). They recommended that use of the introducer be taught by simulating difficult intubation during routine surgery. The process of informed consent in the UK today would now require written evidence that the patient understood that he/she was to be used as a teaching aid. It is not surprising that simulation today utilises computer derived images and mannequins.

### Improving the view

Sellick's manoeuvre has always been popular with British anaes-

thetists, but it is not always expertly applied. If the larynx is moved to the left it can disappear behind the laryngoscope blade, mimicking a grade 4 appearance. Manipulating the larynx with the right hand is a good way to improve the view. Everyone has a favourite laryngoscope. The McCoy laryngoscope is described in the box.

### Failure to intubate and ventilate

Tunstall described his failed intubation drill after failing to intubate a colleague's wife. It has since evolved. (pale yellow box, right). One in ten failures to intubate is associated with failure to ventilate. Generally, following preoxygenation and the creation of oxygen stores, the apnoea that follows a single dose of suxamethonium is insufficient to cause hypoxic brain damage, and will revert naturally to spontaneous breathing.

The failed intubation drill brings us to the key decision points. Is it appropriate to abandon the operation altogether, and regroup when better equipped? Should the patient be allowed to wake up and surgery continue but with a regional block? Or is it imperative that surgery continues with general anaesthesia? In the latter event, the laryngeal mask airway increasingly provides the solution. This is incorporated into the failed ventilation drill shown in the bright pink box.

Continued failure to ventilate brings us to the surgical airway, and this algorithm assumes that you know what to do and have the tools to do it. Finally, success is assumed, with appropriate warnings regarding extubation.

## The McCoy Laryngoscope



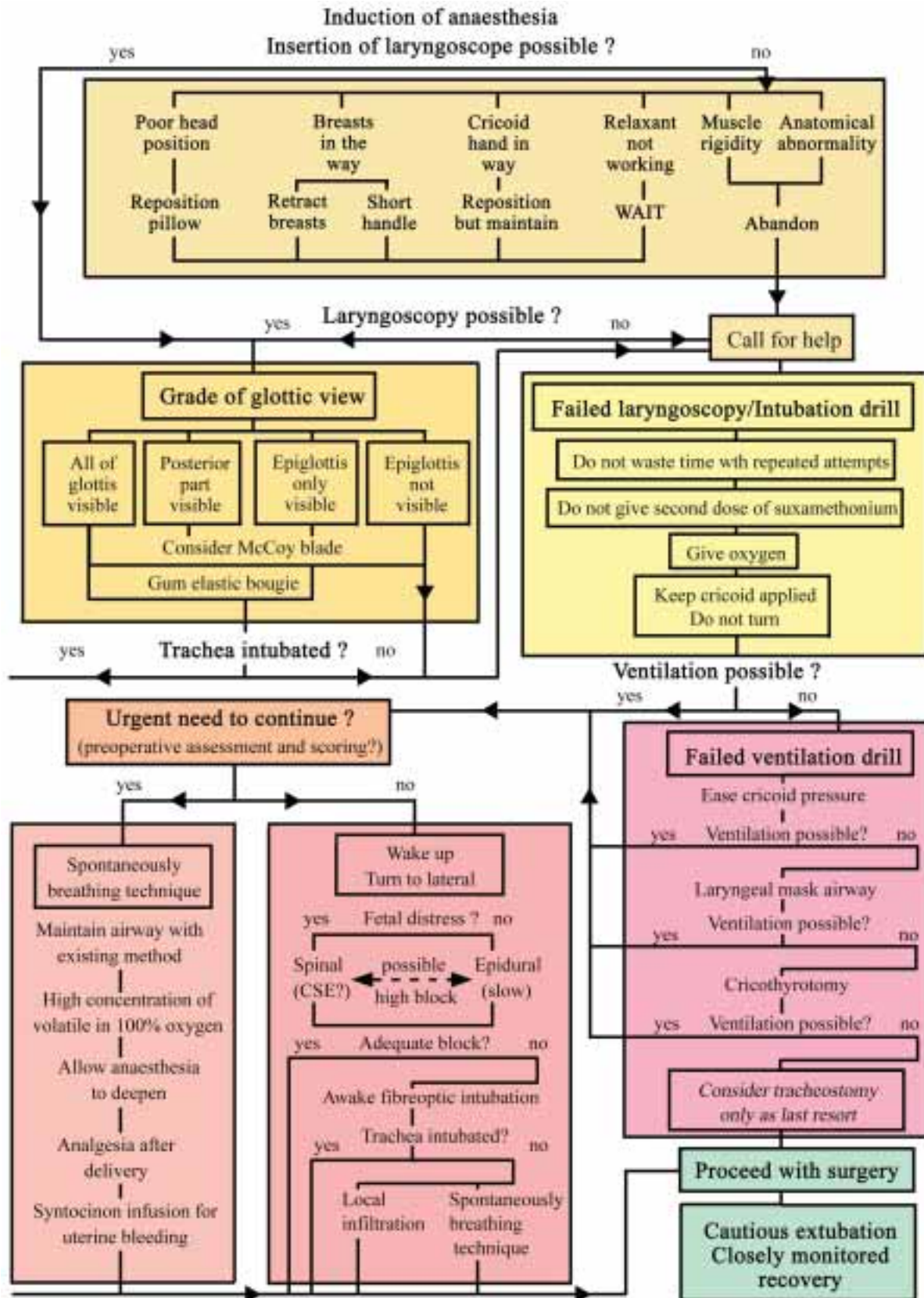
Designed by Dr E P McCoy of Belfast as a modification of the MacIntosh laryngoscope, the aim was to improve control of the epiglottis. Depression of the lever on the handle angled the hinged tip of the blade. This was intended to elevate the epiglottis, improving the view. Such a manoeuvre held promise of changing the grading according to Cormack and Lehane, and simplify the approach to intubation.

## The Gum-Elastic Bougie



This piece of equipment is nothing like a candle, nor is it made of gum. It offers the anaesthetist a Seldinger approach to intubation, being long, slightly stiff, with an angled tip that can lift the epiglottis and slide underneath into the larynx. Perhaps the prototype was a borrowed oesophageal dilator, and this is where the name has come from.

It was probably first used in Prof Robert MacIntosh's Department in the 1940s to assist intubation with the Oxford tube. This was an angled non kink tube with an anterior bevel. The side facing bevel of the McGill tube of today means that the tube must be rotated over the bougie to avoid the tip of the tube becoming caught in the cords.



**Further reading:**

Management of difficult and failed intubation in obstetrics. S Morris. British Journal of Anaesthesia CEPD Reviews 2001; 1: 117-121

Difficult tracheal intubation in obstetrics. R S Cormack and J Lehane. Anaesthesia 1984; 39: 1105-1111

Safe use of cricoid pressure. R G Vanner and T Asai. Anaesthesia 1999; 54: 1-3

Avoiding adverse outcomes when faced with difficulty with ventilation. D Bell. Anaesthesia 2003; 58: 945-948

The laryngeal mask. M O'Meara and G Jones. British Medical Journal 1993; 306: 224-225

*We are grateful to Dr S Morris and the British Journal of Anaesthesia for permission to reproduce the algorithm*

**2004**

- 27-31/3 International Anesthesia Research Society Annual Meeting (IARS)  
Tampa, Florida Contact: iarshq@iars.org
- 30/3-2/4 24th International Symposium on Intensive Care & Emergency Medicine  
Brussels, Belgium Contact: sympicu@ulb.ac.be
- 17-23/4 13th World Congress of Anaesthesiologists  
Paris, France Contact: colloquium@colloquium.fr
- 24-25/4 6th World Congress of Paediatric Anaesthesia  
Bordeaux, France Contact: cecoffey.rennes@invivo.edu
- 5-8/6 **Euroanaesthesia 2004**  
**Lisbon, Portugal** Contact: secretariat.esa@euronet.be
- 9-11/6 European Association of Cardiothoracic Anaesthesiologists (EACTA)  
London, England Contact: www.eacta.org
- 25-27/8 XVIII Edinburgh Anaesthesia Festival  
Edinburgh, Scotland Contact: anaes@ed.ac.uk
- 8-11/9 XXIII Annual ESRA Congress  
Athens, Greece Contact: info@optionsglobal.com
- 16-18/9 15th ESPNIC Medical & Nursing Annual Congress  
London, U.K. Contact: ESPNIC2004@rose-international.com
- 7-9/10 Joint 15th Annual Meeting of the European Society for Computing & Technology in Anaesthesia  
and Intensive Care (ESCTAIC) & 11èmes journées de la Société Francophone pour l'informatique  
et le Monitoring en Anesthésie-Réanimation (SFIMAR)  
Toulouse, France Contact: www.esctaic.org
- 10-13/10 European Society of Intensive Care Medicine (ESICM)  
Berlin, Germany Contact: www.esicm.org
- 23-27/10 American Society of Anesthesiologists Annual Meeting (ASA)  
Las Vegas, United States Contact: www.ASAhq.org
- 10-14/12 58th Post Graduate Assembly in Anesthesiology  
New York- Marriott Marquis Contact: nyssa-pga.org

**2005**

- 11-15/3 IARS – Honolulu, Hawaii Contact: iarshq@iars.org
- 28-31/5 Euroanaesthesia 2005  
Vienna, Austria Contact: secretariat.esa@euronet.be
- 1-3/9 6th European Congress of Paediatric Anaesthesia (ECPA)  
Cologne, Germany Contact: www.free.med.pl/feapa
- 15-18/9 6th International Symposium on the History of Anaesthesia  
Cambridge, United Kingdom Contact: www.histansoc.org.uk
- 22-26/10 American Society of Anesthesiologists Annual Meeting (ASA)  
New Orleans, United States Contact: www.ASAhq.org

*Organisations wishing to advertise their meetings on this page  
should submit their requests to [esa@euronet.be](mailto:esa@euronet.be)*



**European Society of Anaesthesiologists a.i.s.b.l.**  
24 Rue des Comédiens  
1000 Bruxelles, Belgium  
Phone: + 32 (0)2 743 32 90  
Fax: + 32 (0)2 743 32 98  
Email: [secretariat.esa@euronet.be](mailto:secretariat.esa@euronet.be)  
[www.euroanesthesia.org](http://www.euroanesthesia.org)