

10105 Park Rowe Circle

Baton Rouge, Louisiana 70810

(Inside The NeuroMedical Center)

**Clinical Coordinator:** Joshua Todd DNAP, CRNA (318)564-3599

**Chief Anesthesiologist:** Salim Sukkar, MD (225)408-9214

**Orientation to Clinical Site**

* **General Hospital information**
* **Pain Management Preferences for Anesthesia Services**
* **Operative Preferences for Anesthesia Services**

**General Hospital information**

**\*\*Please contact Joshua Todd DNAP, CRNA (318)564-3599 as soon as you receive your schedule. He will talk with you about paperwork and obtaining Pyxis Access. You will need to arrive early on the first day to get badge and scrubs.**

Parking:

• Please park on the 4th floor of the parking garage or above

• May enter building with badge directly to OR from the parking garage

o Go to ground floor and locate the elevator (easily seen on walk to front of hospital)

o To the left of the elevator there is a stairwell, behind the door to the stairwell is a badge

access door that will let you in

o Walk to the end of the hallway and you will come to the OR area

COVID Policy:

• Vaccination is currently not mandatory

o If not vaccinated, please be mindful of masking as it is their policy to remain masked if unvaccinated

• Upon entry, temperature check will be requested if entering through the front door

o If entering through the parking garage, there will be a kiosk to scan your wrist for a temperature

• Patients and their visitor are screened within 72 hours of procedure

Scrubs:

• Scrubs are provided

o We wear the light blue. The rust colored scrubs at the facility are only for reps

• Cloth scrub caps are allowed

• Please wear a jacket (also provided)

Breakroom:

• There is a general staff breakroom – located to the left if entering from the parking garage

• Can store lunch here but here is also a small bistro downstairs with some items

• Microwaves and a toaster oven are in the breakroom

Restrooms:

• Appropriately marked and located throughout perioperative area

**Pain Management Preferences for Anesthesia Services**

General Information:

• Communicate with Cody Fletcher, RN he will have the list of cases we will be covering

* + Cody’s contact information is 225-978-5180
	+ Cases may be added to the list as patients arrive

• The mornings will typically be the busiest times in Pain

o Dr. Patel is the highest volume producer; his block time is usually from 0745-1130

o Occasionally, pain management services will begin at 0700

• CERVICAL Procedures

o Midazolam and Fentanyl ONLY

o Proceduralists want to be able to communicate with these patients

▪ Dr. Patel will give up to 8mg midazolam at times

▪ Just bring enough to keep patient comfortable while still allowing them to communicate

• TRANSFORAMINAL Procedures

o Drs. Graugnard and Trahan have requested Midazolam and Fentanyl ONLY

▪ Due to location of injection, they want to monitor for paresthesia

▪ Dr. Patel seems to be fine with Propofol – but best to ask

**Epidural Steroid Injection (LESI):**

• Propofol if appropriate for patient

• Quick procedure just like placing an epidural

**Medial Branch Block (MBB):**

• Propofol is preferable and desired

• Patients will have two of these procedures as a trial of pain control prior to having an RFA

o Proceduralist will inject local anesthetic and essentially perform a selective nerve root block to assess if ablating the nerve will give pain relief

• Preference is to avoid Midazolam/Fentanyl as to give the physician the clearest diagnostic picture because if fentanyl is given, pain relief may be contributed to narcotic, not block

**Radiofrequency Ablation (RFA):**

• Propofol if appropriate for patient

• Proceduralist will place multiple introducer needles at sites for ablation at desired site

o Once introducers in place, will test motors to ensure appropriate location

o Ablation will begin at last 90 seconds

▪ Ablation is stimulating

• May need an additional small dose of propofol when preparing to perform ablation

**Operative Preferences for Anesthesia Services**

**General Information:**

• Communicate, communicate, communicate with the neuro-monitoring techs

o They will tell you what they need and want for the optimal assessment of the patient during the procedure

o It is our responsibility to the patient and our colleagues to perform the most optimal anesthetic we are able

• **Drs. Scrantz and Corsten** very rarely utilize monitoring

o Dr. Waguespack often does not utilize monitoring, but will from time to time

• Decadron dosing - Please write this somewhere clearly visible with the time given for re-dosing purposes

• When bringing patients to PACU, if a second PIV was placed in OR and you hooked the PIV directly to your IV tubing for flow purposes, please attach a pigtail to the PIV prior to leaving the OR

• Controlled Medication Wastage

o Please be sure we are wasting all controlled medications on the appropriate line for pharmacy

▪ They have taken the time to put the anesthesia record together as they have to make it easy for us, we can do our part to be sure we are wasting correctly

• Charge Sheets

o Please be sure we are charging for all medications and supplies on the charge sheets for each patient

▪ Chart everything you use accurately

• Contraindications to monitoring MEPs

o Pacemaker / AICD o Bladder stimulator o Seizures

o Recent MI or stroke

o Cochlear implant

o Atrial fibrillation or other abnormal cardiac rhythm

**Dr. Oberlander:**

Lumbar Microdiscectomy

• Monitoring - SSEPs and EMGs

o Up to 1 MAC of anesthesia gas acceptable for SSEPs

o Maintain MAPs 60-90

TLIF / PLIF / Lumbar fusions or Extension of Lumbar Fusion

• Monitoring - SSEPs and EMGs

o Up to 1 MAC of anesthesia gas acceptable for SSEPs

• EMG:

o Muscle relaxant for exposure

▪ Plan for approx. 45 min of relaxation from induction

o Will place screws 1st and decompress after screws are placed

o Monitoring tech should communicate regarding how relaxed the patient is at this point

▪ May require reversal to test screws

▪ Keep this in mind when relaxing patient early in case

▪ Need TOF 4/4 for testing screws

ACDF or any Anterior Cervical Disc

• Monitoring - SSEPs, MEPs, and Motors

o NO NIM tube

o DECADRON 10mg

▪ Verify this with Dr. Oberlander, but he typically likes all his cervical cases to

receive Decadron

o Intubate with muscle relaxation that will allow neuromonitoring tech to test motors once patient intubated and positioned

▪ May be succinylcholine or small dose of muscle relaxant that will allow testing

o TIVA anesthetic

▪ If using Ketamine, please notify monitoring tech as it can alter their signals and

they would like to know where they are starting

• Also notify with subsequent Ketamine dosing

o If absolutely necessary, may give small dose muscle relaxant for exposure

▪ Will request second set of motors to be done following interbody placement -

Make sure patient is 4/4 and motors can be tested at this time

o Vital Signs Monitoring

▪ Blood Pressure

• Maintain MAP 60-90mmHg for entirety of case

o Want good cord perfusion

▪ EKG Leads

• To back as to not interfere with X-ray imaging

o Glidescope

▪ Patient with moderate to severe myelopathy or canal stenosis, use it to protect the

patient and yourself

▪ Maintain head in neutral position

▪ May tell monitoring tech to ask us to use Glidescope for these patients

▪ Take it upon yourself to ask patient about the degree of their myelopathy during preoperative interview

o Utilize most appropriate bite block for patient

o Preferable not to use Christmas tree

▪ May utilize tape or tourniquet to secure tubing, circuit, etc to head piece

extension

o 5 to 10 lb. weight to head - Will be done for traction by Dr. Oberlander or his PA

▪ After final interbody spacer placed, anesthesia provider will be asked to remove

the weight

o Arms will be burrito’d

▪ Be sure elbows are padded at the ulnar nerve

Posterior Cervical Discectomy or Fusion

• Monitoring - SSEPs, EMGs, and Motors

o NO NIM tube

o DECADRON 10mg

▪ Verify this with Dr. Oberlander, but he typically likes all his cervical cases to

receive Decadron

o Intubate with muscle relaxation that will allow neuromonitoring tech to test motors once patient intubated and positioned

▪ May be succinylcholine or small dose of muscle relaxant that will allow testing

▪ Positioning will require Dr. Oberlander placing the head in pins and turning the

patient prone

**Dr. Bowie:**

Lumbar Microdiscectomy

• Monitoring - SSEPs and EMGs

o Up to 1 MAC of anesthesia gas acceptable for SSEPs

• EMG:

o Dr. Bowie likes muscle relaxant for exposure and as an aid to keep dilator (retractors)

from moving

o Not uncommon for Dr. Bowie to ask for more muscle relaxant, even with 0/4 twitches

▪ Do not ask monitoring tech if patient has twitches in this case

• Deepen patient or give more relaxant

TLIF / PLIF / Lumbar fusions or Extension of Lumbar Fusion

• Monitoring - SSEPs and EMGs

o Up to 1 MAC of anesthesia gas acceptable for SSEPs

• EMG:

o Muscle relaxant for exposure

o Will place screws 1st and decompress after screws are placed

o Monitoring tech should communicate regarding how relaxed the patient is at this point

▪ May require reversal to test screws

▪ Keep this in mind when relaxing patient early in case

▪ Need TOF 4/4 for testing screws

ACDF or any Anterior Cervical Disc

• Monitoring - SSEPs, MEPs, and Motors

o NO NIM tube

o Intubate with muscle relaxation that will allow neuromonitoring tech to test motors once patient intubated and positioned

▪ May be succinylcholine or small dose of muscle relaxant that will allow testing

o TIVA anesthetic

▪ If using Ketamine, please notify monitoring tech as it can alter their signals and

they would like to know where they are starting

• Also notify with subsequent Ketamine dosing

o If absolutely necessary, may give small dose muscle relaxant for exposure

▪ Will request second set of motors to be done following interbody placement -

Make sure patient is 4/4 and motors can be tested at this time

o Vital Signs Monitoring

▪ Blood Pressure

• Maintain SBP greater than 100 mmHg for entirety of case

o Dr. Bowie wants good cord perfusion

▪ EKG Leads

• To back as to not interfere with X-ray imaging

o Glidescope

▪ Patient with severe myelopathy, use it to protect the patient and yourself

▪ Maintain head in neutral position

▪ Dr. Bowie may tell monitoring tech to ask us to use Glidescope for these patients

▪ Take it upon yourself to ask patient about the degree of their myelopathy during preoperative interview

o SOFT GREEN BITE BLOCK to right side of mouth

▪ Do not forget as motors will be tested

• Patient may bite their tongue and/or chip their teeth during motors being tested

▪ Do not use broken off tongue depressor with Bowie

o Preferable not to use Christmas tree

▪ May utilize tape or tourniquet to secure tubing, circuit, etc to head piece

extension

o 10 lb. weight to head - Will be done for traction by Bowie or his PA

▪ After final interbody spacer placed, anesthesia provider will be asked to remove

the weight

o Arms will be burrito’d

▪ Be sure elbows are padded at the ulnar nerve

Posterior Cervical Discectomy or Fusion

• Monitoring - SSEPs, EMGs, and Motors

o NO NIM tube

o Intubate with muscle relaxation that will allow neuromonitoring tech to test motors once

patient intubated and positioned

▪ May be succinylcholine or small dose of muscle relaxant that will allow testing

▪ Positioning will require Dr. Bowie placing the head in pins and turning the

patient prone

**Dr. Fautheree:**

Lumbar Microdiscectomy

• Monitoring - SSEPs and EMGs

o Up to 1 MAC of anesthesia gas acceptable for SSEPs

o Maintain MAPs 60-90

• EMG:

o Dr. Fautheree is indifferent in regard to paralytics for minimally invasive disks

TLIF / PLIF / Lumbar fusions or Extension of Lumbar Fusion

• Monitoring - SSEPs and EMGs

o Up to 1 MAC of anesthesia gas acceptable for SSEPs

• EMG:

o Muscle relaxant for exposure

▪ Plan for approx. 45 min of relaxation from induction

o Will place screws 1st and decompress after screws are placed

o Monitoring tech should communicate regarding how relaxed the patient is at this point

▪ May require reversal to test screws

▪ Keep this in mind when relaxing patient early in case

▪ Need TOF 4/4 for testing screws

ACDF or any Anterior Cervical Disc

• Monitoring - SSEPs, MEPs, and Motors

o NO NIM tube

o Intubate with muscle relaxation that will allow neuromonitoring tech to test motors once patient intubated and positioned

▪ May be succinylcholine or small dose of muscle relaxant that will allow testing

o TIVA anesthetic

▪ If using Ketamine, please notify monitoring tech as it can alter their signals and

they would like to know where they are starting

• Also notify with subsequent Ketamine dosing

o If absolutely necessary, may give small dose muscle relaxant for exposure

▪ Will request second set of motors to be done following interbody placement -

Make sure patient is 4/4 and motors can be tested at this time

o Vital Signs Monitoring

▪ Blood Pressure

• Maintain MAP 60-80 for entirety of case

o Want good cord perfusion

▪ EKG Leads

• To back as to not interfere with X-ray imaging

o Glidescope

▪ Patient with moderate to severe myelopathy or canal stenosis, use it to protect the

patient and yourself

▪ Maintain head in neutral position

▪ Dr. Stanger may tell monitoring tech to ask us to use Glidescope for these patients

▪ Take it upon yourself to ask patient about the degree of their myelopathy during

preoperative interview

o Dr. Stanger is indifferent on which bite block

▪ Use your best judgement based on patient dentition

o Preferable not to use Christmas tree

▪ May utilize tape or tourniquet to secure tubing, circuit, etc to head piece

extension

o 5 lb. weight to head - Will be done for traction by Stanger or his PA

▪ After final interbody spacer placed, anesthesia provider will be asked to remove

the weight

o Arms will be burrito’d

▪ Be sure elbows are padded at the ulnar nerve

Posterior Cervical Discectomy or Fusion

• Monitoring - SSEPs, EMGs, and Motors

o NO NIM tube

o Intubate with muscle relaxation that will allow neuromonitoring tech to test motors once

patient intubated and positioned

▪ May be succinylcholine or small dose of muscle relaxant that will allow testing

▪ Positioning will require Dr. Bowie placing the head in pins and turning the patient prone

**Dr. Stanger:**

Lumbar Laminectomies and Micro-discectomies

• Often Dr. Stanger does not monitor for these

• Again, communicate regarding this and implications/considerations same as Drs. Fautheree and

Bowie

TLIF / PLIF / Lumbar fusions or Extension of Lumbar Fusion

• Monitoring - SSEPs and EMGs

o Up to 1 MAC of anesthesia gas acceptable for SSEPs

• EMG:

o Muscle relaxant for exposure

▪ Plan for approx. 45 min of relaxation from induction

o Will place screws 1st and decompress after screws are placed

o Monitoring tech should communicate regarding how relaxed the patient is at this point

▪ May require reversal to test screws

▪ Keep this in mind when relaxing patient early in case

▪ Need TOF 4/4 for testing screws

ACDF or any Anterior Cervical Disc

• Monitoring - SSEPs, MEPs, and Motors

o NO NIM tube

o Intubate with muscle relaxation that will allow neuromonitoring tech to test motors once

patient intubated and positioned

▪ May be succinylcholine or small dose of muscle relaxant that will allow testing

o TIVA anesthetic

▪ If using Ketamine, please notify monitoring tech as it can alter their signals and

they would like to know where they are starting

• Also notify with subsequent Ketamine dosing

o If absolutely necessary, may give small dose muscle relaxant for exposure

▪ Will request second set of motors to be done following interbody placement -

Make sure patient is 4/4 and motors can be tested at this time

o Vital Signs Monitoring

▪ Blood Pressure

• Maintain SBP MAP 60-80mmHg for entirety of case

o Want good cord perfusion

▪ EKG Leads

• To back as to not interfere with Xray imaging

o Glidescope

▪ Patient with moderate to severe myelopathy or canal stenosis, use it to protect the

patient and yourself

▪ Maintain head in neutral position

▪ May tell monitoring tech to ask us to use Glidescope for these patients

▪ Take it upon yourself to ask patient about the degree of their myelopathy during preoperative interview

o Utilize the most appropriate bite block for the patient’s dentition for Dr. Stanger

o Preferable not to use Christmas tree

▪ May utilize tape or tourniquet to secure tubing, circuit, etc to head piece

extension

o 5 lb. weight to head - Will be done for traction by Fautheree or his PA

▪ After final interbody spacer placed, anesthesia provider will be asked to remove the weight

o Arms will be burrito’d

▪ Be sure elbows are padded at the ulnar nerve

Posterior Cervical Discectomy or Fusion

• Monitoring - SSEPs, EMGs, and Motors

o NO NIM tube

o Intubate with muscle relaxation that will allow neuromonitoring tech to test motors once

patient intubated and positioned

▪ May be succinylcholine or small dose of muscle relaxant that will allow testing

▪ Positioning will require Dr. Bowie placing the head in pins and turning the

patient prone

o TIVA anesthetic

▪ If using Ketamine, please notify monitoring tech as it can alter their signals and

they would like to know where they are starting

• Also notify with subsequent Ketamine dosing

o If absolutely necessary, may give small dose muscle relaxant for exposure

▪ Will request second set of motors to be done following interbody placement -

Make sure patient is 4/4 and motors can be tested at this time

o Vital Signs Monitoring

▪ Blood Pressure

• Maintain SBP greater than 100 mmHg for entirety of case

o Dr. Bowie wants good cord perfusion

▪ EKG Leads

• To back as to not interfere with X-ray imaging

o Glidescope

▪ Patient with severe myelopathy, use it to protect the patient and yourself

▪ Maintain head in neutral position

▪ Dr. Bowie may tell monitoring tech to ask us to use Glidescope for these patients

▪ Take it upon yourself to ask patient about the degree of their myelopathy during

preoperative interview

o SOFT GREEN BITE BLOCK to right side of mouth

▪ Do not forget as motors will be tested

• Patient may bite their tongue and/or chip their teeth during motors being tested

▪ Do not use broken off tongue depressor with Bowie

o Preferable not to use Christmas tree

▪ May utilize tape or tourniquet to secure tubing, circuit, etc to head piece

extension

o 10 lb. weight to head - Will be done for traction by Bowie or his PA

▪ After final interbody spacer placed, anesthesia provider will be asked to remove

the weight

o Arms will be burrito’d

▪ Be sure elbows are padded at the ulnar nerve

**Drs. McCarthy & Harrod**

▪ NIM Tube for cervical cases

o All other implications the same as for Bowie and Fautheree

▪ Dr. McCarthy will want a nasal RAE for anything where he is working at the C2 level