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尊敬的读者：

感谢您正在阅读本期CASA协会的刊物。鉴于本刊并未设定同行评审（peer review）机制，于本刊所投及发表的学术文章可仍于今后发于Peer Review刊物。已正式发表的文章亦可于本刊物转载。本编辑部鼓励专业同行积极投稿，为我们麻醉事业的发展努力。

We appreciate your attention to this issue of CASA's publication. As this journal does not employ a peer review process, academic articles submitted and published in this journal retain the potential for future publication in peer-reviewed journals. Additionally, officially published articles may be reprinted in this journal. The editorial board strongly encourages our colleagues to actively submit articles and contribute to the advancement of anesthesiology.

本期导读

本期的CASA会员访谈我们有幸邀请到了资深会员蒋延东教授介绍他主编的杂志Anesthesiology Open的办刊宗旨及投稿要求，并且分享他的麻醉学执业经历和对麻醉学的未来以及年轻麻醉医生的期许。

本期的会员风采首先特别介绍前会长黄佳鹏教授(University of Kentuky)荣任 American Board of Anesthesiology Board of Directors, 成为首位担任此职位的华人。此外特别征集了多位杰出会员参与美国(ASA)以及中国(CSA)麻醉学年会的合影。

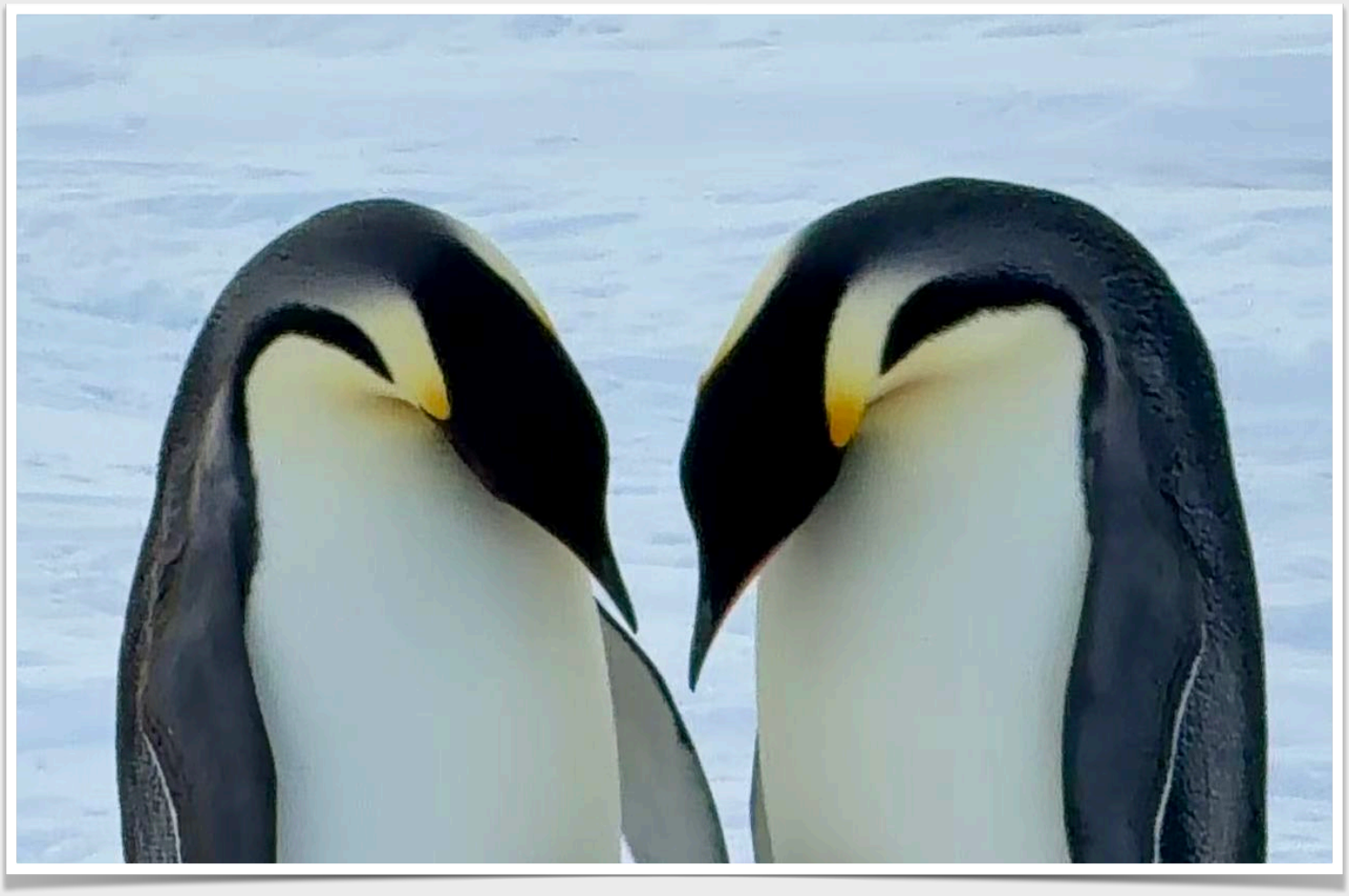
本期的特别报道介绍了今年11月8日与9日周末，CASA成功举办了两场面向今年申请麻醉科 Residency 的中国医学毕业生的线上模拟面试。

文献速递向大家带来了CASA会员李娟，方壮霆教授 (UCLA) 和前会长彭勇刚教授 (Unvieristy of Florida)近期发表的三篇学术文章。分别探讨了心脏外科术后即刻拔管，术中精准镇静以及重度肥胖患者房颤复率的麻醉管理。

本期的原创文章来自于纽约医学院Winchester Medical Center的Jeff Xu，介绍超声引导下颈肌平面阻滞在颈椎后路手术中的阵痛应用。

本期的最后依然是我们敬爱的CASA创始人之一王海明医生的回忆录 （最终章）。带领我们回忆CASA成立初期与中国麻醉学界的交流，以及很多前辈对CASA的成长做出的卓越贡献。

本期封面及插图均是来自于我们CASA bulletin 的资深编辑张珊在南极的摄影作品。



(张 珊 摄影作品， 南极风采)

会员访谈 （陈轶男 撰稿）

蒋延东 Yandong Jiang, MD PhD

Professor, Anesthesiology, Critical care and Pain Medicine at McGovern Medical School

蒋医生您好，首先祝贺您成为 Anesthesiology Open Executive Editor！能否请您简要介绍一下这份期刊的创办宗旨、文章方向以及投稿要求呢?

I am very glad to have this opportunity to share information about Anesthesiology Open with CASA members. This journal has been in planning for several years, and only recently have we been able to turn the vision into reality. I want to sincerely thank Ms. Kim Jensen, Ms. Rebecca Brand, our Editor-in-Chief Dr. Jim Rathmell, and the ASA leadership for their dedication, hard work, and selfless support. For those interested in learning more about the journal, please visit our website:

https://www.editorialmanager.com/alno/

Anesthesiology Open is an online, peer-reviewed, open-access journal that complements and expands the reach of Anesthesiology. Our mission is to promote scientific discovery and knowledge in perioperative, critical care, pain, palliative care, and sleep medicine — ultimately advancing patient care.

The journal accepts a wide range of article types, including:

• Original Investigations

• Research Letters

• Reviews

• Innovation in Practice

• Focal Point

• Letters to the Editor

• Editorials

A unique new feature is the Innovation in Practice section. These brief articles describe novel solutions to clinical problems in anesthesia, perioperative medicine, critical care, or pain management. Submissions might introduce a new technology, demonstrate an innovative use of existing technology, or propose an organizational or workflow change. The focus is on feasibility, creativity, and clinical relevance — not case reports or series. Articles are limited to 2,000 words with a 150-word unstructured abstract. The goal is to inspire discussion and creative thinking that can refine, support, or challenge new ideas and practices in anesthesiology.

Importantly, Anesthesiology Open shares the same high editorial standards and reviewer pool as Anesthesiology. Our editorial board consists of internationally recognized experts, many of whom have extensive experience as editors. We also share the same technical editorial team and office infrastructure, supported by ASA leadership.

We plan to publish our inaugural issue in February 2026, and we warmly welcome submissions from colleagues worldwide — including all CASA members. As the inaugural Executive Editor, I take a very hands-on approach and look forward to working closely with authors to disseminate impactful work that advances our field.

Photo courtesy of Dr. Jiang. From left to right: Dr. Jamie Sleigh, University of Auckland, New Zealand; Dr. Kane O. Pryor, Weill Cornell Medicine, New York, NY, USA; and Dr. Yandong Jiang, University of Texas Health Science Center at Houston, Houston, TX, USA, during a strategy discussion at ASA 2024

您是哪一年加入 CASA 的？您认为协会的价值和文化是否符合预期？对未来发展有何建议?

I joined CASA many years ago and worked closely with our founding president, Dr. Haiming Wang. I still vividly remember when he called me and recited his poem 留学生之歌. I was honored to receive a CASA award from Dr. Wang in 2014.

I deeply believe CASA's mission reflects the values of its members. It bridges anesthesiologists across the Pacific, fostering communication and collaboration between the U.S. and China. Science and patient care are the same language we speak.

CASA plays a crucial role in promoting this dialogue and partnership. Looking ahead, I hope CASA continues to grow as a vibrant society. China has made tremendous progress in clinical care, education, and research over the past decades, and the gap in practice standards has significantly narrowed. We must remain open-minded and willing to learn from our Chinese colleagues, while also strengthening our own research and scholarly contributions.

I also support greater unity between CASA and ICCA. I believe both organizations share the wisdom and will to unite into a stronger, single society. Union brings strength.

您认为近二十年来麻醉学最大的改变是什么？未来发展趋势如何?

The progress in Anesthesiology over the past 20 years has been astonishing — particularly in science, technology, and outcome research. Previously, our focus was largely on intraoperative mortality, which is now extremely low (less than 1%). Today, our attention has shifted toward longitudinal outcomes such as long-term survival, cognitive recovery, and quality of life. Artificial intelligence (AI) is empowering anesthesiologists with greater efficiency, precision, and decision support. Because anesthesia is inherently digital and data-rich, AI's impact on our specialty will likely be profound and transformative.

.

如果可以重新选择职业，您还会选择麻醉吗?

This is a philosophical question. Honestly, I am one of those who did not begin with a clear career goal. I simply followed curiosity and passion. After medical school in China, I trained in internal medicine. Later in the U.S., I earned a Ph.D. in cell physiology. My mentor at Harvard Medical School, Dr. Fred Julian, an anesthesiologist, encouraged me to enter this field — and I'm forever grateful. I love being an anesthesiologist and would choose it again.

您印象最深刻的病例是什么?

Last year, during a night on call, I was called urgently to the OR for a patient vomiting blood due to a ruptured gastric tumor. The patient had terminal cancer and was not a surgical candidate, but his wife begged us to do everything possible so he could live long enough to say goodbye to his family. We stabilized him just long enough for that final conversation. We could not save his life, but we were able to give him and his family peace. It reminded me that the smallest medical act can carry deep humane meaning.

您曾在中国从事麻醉工作或访问教学吗？您认为中美麻醉的最大区别是什么?

I visited China once or twice each year in the past, but not this year. I hope that traveling will get easier soon.

Our colleagues in China have made tremendous progress, as reflected in the steadily increasing number of publications. However, the production of high-impact articles that influence clinical practice still has room for improvement. I sincerely hope that more Chinese anesthesiologist colleagues will join us in advancing patient care, research, and education.

If one wishes to identify the main difference between the two countries, it lies in the number of truly high-impact research papers. In addition, review articles that integrate physiological reasoning and conceptual thinking represent another area where our Chinese colleagues can make significant contributions.

Recently, a group of colleagues from the United States, New Zealand, and Europe came together to examine which aspects of anesthesia could be further optimized. This collaboration has already led to several major review articles, for example: Consciousness and General Anesthesia: Challenges for Measuring the Depth of Anesthesia (Anesthesiology, 2024); Anesthetic Amnesia: The Forgotten Importance of Forgetting? (2025); Beyond Unconsciousness: Optimizing Antinociception Under General Anesthesia (invited review, under submission); and The Era of Sugammadex: A Paradigm Shift in Airway Management (accepted). Together, these works represent an ongoing dialogue about the fundamental mechanisms and outcomes of anesthesia—an area full of opportunities for collaboration between U.S. and Chinese anesthesiologists.

您目前的科研方向是什么?

Although most of my time is devoted to editorial work, I continue to collaborate on clinical research at UT Health. One of our recent studies — published in Anesthesia & Analgesia — explored new strategies for the "cannot intubate, cannot ventilate" emergency. We examined a simple rescue method using a "tracheal tube in pharynx" (TTIP) approach — inserting an endotracheal tube into the pharynx without cuff inflation. Even without perfect alignment to the glottis, this can allow effective ventilation with minimal mouth opening. The concept may help shape future airway management guidelines.

工作之外，您的爱好与梦想旅行地是什么?

Outside of work, I enjoy playing basketball — it keeps me energetic and connected with friends. My dream vacation is space travel. My two daughters strongly disapprove of this idea, but it remains on my bucket list!

您最自豪的成就是什么？想对年轻人说些什么?

The greatest pride of my life is being a physician. My family has a long history in Chinese medicine, and I still remember my grandfather's joy when he cured patients. That same fulfilment drives me today.

We may not be the richest profession materially, but spiritually we are, because we can bring healing and hope.

To young people, I often share the advice from my mentor and friend, Dr. Warren Zapol:

"Do what you have passion for, and opportunity will find you."

The photo of Dr. Yandong Jiang was taken during a break between the basketball games, October 2024

2025 CASA 麻醉Residency申请者线上模拟面试活动（张 扬 撰稿）

2025年11月8日与9日周末，CASA成功举办了两场面向今年申请麻醉科 Residency 的中国医学毕业生的 线上模拟面试（Mock Interviews）。本次活动旨在帮助申请者进行全面的面试准备，获得个体化指导，提高临床面试表现与沟通自信。参会的申请者纷纷表示 收获颇丰，不仅获得全面、实用的面试指导，也对未来正式 Residency 面试更加信心十足。

活动形式：高度还原真实面试流程

每场活动均由三位申请者参加，进行三轮、每轮20分钟的一对一模拟面试。每轮结束后，面试官都会提供 5–10分钟即时反馈与答疑，指出亮点与改进方向。最终，面试官与所有申请者还会进行集体讨论分享，交流不同视角下的经验体会。

Residency 面试关注的核心能力：

麻醉科 Residency 的正式面试并不只是对纸面成绩或发表文章数量的考察，也很重视面试者的沟通能力、个性气质、临床团队中的可塑性、对麻醉事业的热情与长期投入。

本次模拟面试发现了申请者中最常见的几类挑战，并整理出如下关键建议：

面试中常见问题与改进建议

1）如何有效地自我介绍（How to introduce yourself）：申请者需在 30秒至1分钟 内完成精炼介绍，清晰呈现个人特点与职业发展时间轴，避免冗长细节。

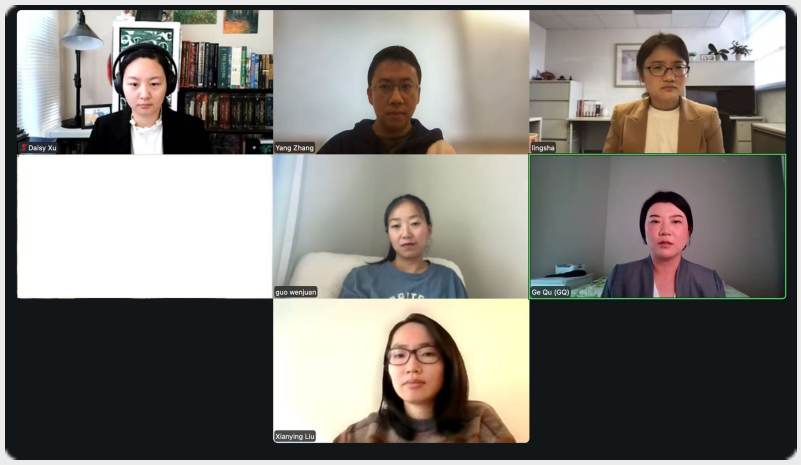
2）了解你的听众（Know your audience）：许多面试官是 临床麻醉科医生，对于具有科研背景的申请者，应将重点放在如何将研究成果转化为临床价值（translational research），而非罗列论文与数据。

3）突出自身特色与故事：无论是过去的经历、克服的困难、兴趣爱好，或个人动机，都应让对话体现出独特性与人格魅力。

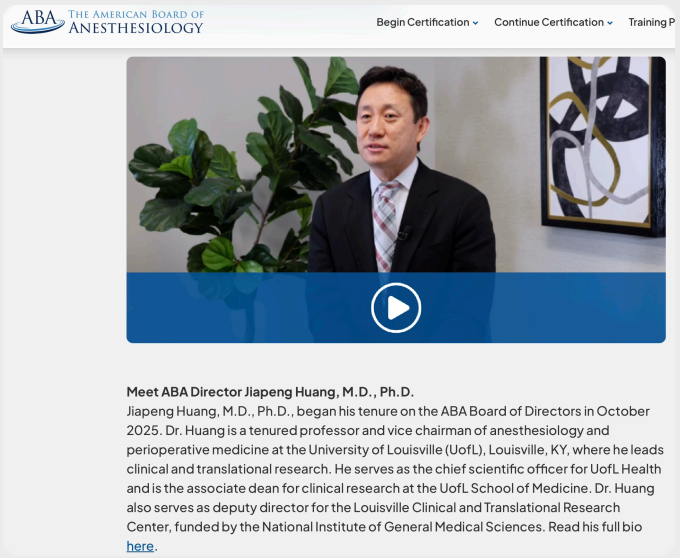
4）重视线上面试的形象与技术细节：包括摄像头角度、光线、背景、衣着选择等，确保在虚拟环境中展现最佳专业度。

5）反复练习可提前准备的问题：熟悉常见面试题，让表达更加自然流畅，提高整体交流效果。

最后特别鸣谢本次担任面试官的医生：曲歌、刘显英、郭文娟、张扬、李娟、徐思超、吴非、赵雪纯、封小美。 欢迎更多医生加入CASA Residency 教育项目包括：Residency 模拟面试、Mock Oral Board和Match 经验分享会，让我们共同助力更多申请者迈向成功！



CASA 会员风采

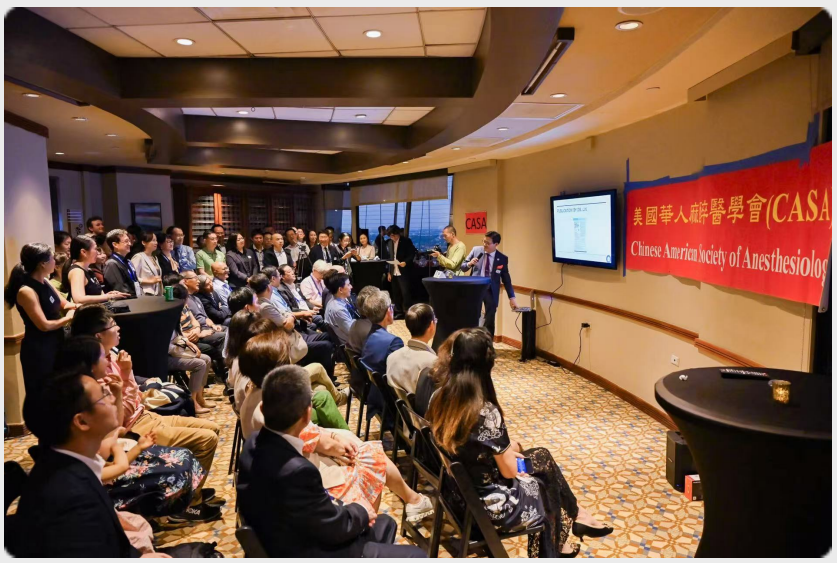


CASA前会长黄佳鹏教授(University of Kentucky)于2025年10月荣任ABA Board of Directors

CASA会长仲巍及多位会员参加2025年中国麻醉学术(CSA)年会

CASA会长仲巍和多位会员参加2025年ASA年会

CASA会长仲巍参加2025年中国麻醉学术(CSA)年会



CASA会长仲巍和多位会员参加2025年ASA年会

CASA 候任会长王景平参加2025中国麻醉学术(CSA)年会

文献速递 (李 娟 撰稿)

Pro On-Table Extubation After Cardiopulmonary Bypass Surgery: Key Considerations and Evidences

Juan Li MD, Litty John MBBS, M. Haseeb Zubair MD, FASE

This content was originally published on August 1st 2025 in the newsletter for the Society of Cardiovascular Anesthesiologists. (https://scahq.org/education/publications/sca-newsletter/) 原文作者为CASA board member 李娟。

On-Table Extubation

The history and development Ultra-fast track anesthesia—used synonymously with on-table extubation (OTE) in the operating room—refers to intraoperative or immediate postoperative extubation. This approach has gained momentum in cardiac anesthesia recently. The first reports of OTE date back to the 1980s in pediatric cardiac surgery. This practice was often driven by physiological considerations rather than logistical ones. The 2000s saw critical advancements that enabled OTE to transition from anecdotal reports to a feasible strategy. By the 2010s, OTE had gained traction in the field of adult cardiac surgery.

OTE Safety and Clinical Outcomes

Volume-Outcome Relationship: Centers performing more than 40% of OTE cases demonstrate comparable mortality and morbidity rates to those of early extubation (within 6 hours), suggesting that institutional experience is a critical factor. In contrast, low-volume centers may report marginally higher complications (e.g., reoperation for bleeding, pneumonia), which is likely due to selection bias or suboptimal protocols.
Morbidity and mortality: OTE does not increase mortality or major complications when applied to suitable patients. Avoidance of prolonged ventilation decreases ICU-acquired infections, fluid overload, and ventilator-induced lung injury.

Pediatric Populations: OTE has been safely implemented in 85% of pediatric cases, including neonates and complex congenital repairs, with reintubation rates of 5% and no mortality linked to extubation timing.

Adult Populations: In minimally invasive valve surgery, OTE reduced ICU stays by 50% (median 7.76 vs 13 hours) without increasing reintubation rates (1.7% vs 7.9%). For coronary artery bypass grafting (CABG), OTE was associated with a 1.24-day reduction in hospital stay ($p<0.001$) and lower postoperative glycemic peaks.

Decreased time for extubation: OTE bypasses ICU hand-offs and allows immediate decision-making by the surgical/anesthesia team familiar with the patient's intraoperative course. In addition, in busy ICUs, clinicians prioritize unstable patients, often delaying "simple" tasks like sedation weans or extubation assessments. OTE occurs before sedation is fully weaned, leveraging residual anesthesia for a smooth transition to spontaneous breathing.

Ventilator-Associated Pneumonia (VAP): OTE decreases ventilator exposure, reducing VAP incidence. ERAS protocols incorporating OTE lowered nosocomial infections from 40% to 24%. Fluid Overload and Delirium: Opioid-sparing regimens and early mobilization in ERAS pathways reduced delirium (6.9% vs. 13.4%) and nausea/vomiting (14.9% vs. 32.8%). OTE avoids even brief periods of postoperative mechanical ventilation, which can worsen lung injury caused by cardiopulmonary bypass, blood transfusions, and ischemia-reperfusion.

Improved hemodynamics: On-table extubation avoids the adverse effects of positive pressure ventilation (PPV) on right ventricular (RV) function. PPV, particularly with PEEP, elevates

transpulmonary pressure, which can compress pulmonary microvasculature, increase pulmonary vascular resistance (PVR), and raise RV afterload—a critical concern in patients with preexisting RV dysfunction or pulmonary hypertension.
Alleviating Perioperative Anxiety: OTE protocols can mitigate perioperative stress and enhance patient-centered outcomes. For instance, ERAS protocols emphasize reducing sedation exposure and promoting early mobilization, which aligns with patient preferences for minimal sedation and rapid recovery.
Additionally, studies report high patient satisfaction with early extubation, attributing it to reduced opioid use, faster return to normal activities, and avoidance of prolonged mechanical ventilation.

OTE Contraindications

Absolute Contraindications
While many patients benefit from early extubation, in some subsets of patients, early extubation is contraindicated. Open sternum, significant residual defects, severe pulmonary hypertension or need for inhaled pulmonary vasodilating agents, hemodynamic instability requiring high-dose inotropes.

Relative Contraindications
Patient factors: older age, chronic obstructive pulmonary disease, severe obstructive sleep apnea (OSA), New York Heart Association functional class IV, preoperative renal failure, lower arterial oxygen tension.
Procedure-related factors: Complex surgeries (e.g., Norwood procedure, aortic arch repairs). Redo surgery, surgical procedures involving the thoracic aorta, intraoperative transfusion of blood products of>10 units, and cardiopulmonary bypass time of>120 minutes, hypothermia.

Conclusion

OTE is a safe, resource-efficient strategy that aligns with ERAS principles. Success hinges on patient selection, opioid-sparing analgesia, and institutional commitment. Future research should refine risk stratification and promote protocol standardization to maximize benefits while minimizing risks.

(张 珊 摄影作品， 南极风采）

文献速递 (蒋天宇 撰稿)

Precision sedation with novel single syringe multimodal opioid or non-opioid 6–2-2 mixtures,

Zhuang T. Fang, Christine Nguyen-Buckley, Tristan Grogan, Alan Zamora, Natalia MacDougall, Theodora Wingert,
Journal of Clinical Anesthesia, Volume 107, 2025, https://doi.org/10.1016/j.jclinane.2025.112013.

(本文原作者为CASA 会员 UCLA 麻醉科教授 方壮霆)

Introduction

Monitored anesthesia care (MAC) is widely used in OR and non-OR settings, but sedation techniques vary greatly between providers, leading to inconsistent outcomes and MAC-related complications, especially during the induction phase for ophthalmic surgery where rapid, profound yet safe block conditions are critical. The 6-2-2 technique refers to the pre-mixing of anesthetic agents in a single syringe using a 6:2:2 volume ratio prior to administration. The anesthetic agents include different mixture of propofol, opioid, ketamine, and etomidate. We report here the efficacy and safety profiles of this novel method, with a focus on induction of MAC.

Methods

We performed a single-center retrospective study of adults undergoing ophthalmic surgery with MAC at the UCLA Stein Eye Surgical Center. Data were examined for 1376 patients from 13 groups receiving different combination of the 6-2-2 mixture placed in a 10ml syringe (please refer to actual paper for different composition of mixtures). Some were opioid based and some were opiod free. A bolus dose for all mixtures was calculated based on the patient's age and weight. After the bolus dose, most patients received a continuous infusion of the 6:2:2 mixture at a rate of 12–24 mL/h to achieve a moderate level of sedation. Primary outcome was the efficacy of analgesia with the standardized bolus dose with any of the 6-2-2 mixture and prevention of head movement during ocular blocks. Efficacy of analgesia was defined as a binary variable based on the patient's report of pain and their physical reaction to needle insertion. Secondary outcomes include incidences of apnea, desaturation, n/v, loss of consciousness, recall of block, need for airway maneuver (chin lift, mask ventilation, or intubation), and hemodynamic stability.

Results

The efficacy of analgesia was 91-98%. In the 2–9 % of patients who felt pain, most of them stated it was tolerable. 98 to 100 % had no head movement during ocular blocks across all 8 groups. Patient readiness for ocular blocks were less than 1 minute (46-51s) for the opioid based group. The non-opioid group were even shorter (36-43s). Incidence of LOC and recall were lower in the ketamine mixture group compared to opioid based. Rest of the secondary outcomes were similar for all groups.

Discussion

In this study, we demonstrated the efficacy and safety of induction of MAC with the 6-2-2 sedation method with agent combinations that can be tailored for diverse populations, including elderly and morbidly obese "high-risk" patients. The mixtures achieved predictable, moderate sedation (patients breathing and following commands but comfortable and still for blocks), with very low rates of oxygen desaturation that were easily managed and no cases requiring intubation over more than two decades of use. Both opioid-based and ketamine-based regimens were effective, with KE6–2-2 particularly useful in opioid-sensitive or OSA patients but less suitable for those with uncontrolled hypertension or tachyarrhythmias. patients reported high satisfaction, minimal recall of block injection, and low postoperative opioid and antiemetic requirements. Overall, we believe that the 6–2-2 approach offers a scalable framework to standardize MAC for ophthalmology and potentially other NORA and specialty procedures

文献速递 (曲 歌 撰稿)

病态肥胖患者房颤复律的独特挑战和方案

Unique Treatment of Atrial Fibrillation: Simultaneous Dual Direct-Current Cardioversion in Morbidly Obese Patient

Peng B, Sommerville S, Tragesser A, et al. (N/A) Unique Treatment of Atrial Fibrillation: Simultaneous Dual Direct-Current Cardioversion in Morbidly Obese Patient. Cureus (): e. doi:10.7759/cureus.

原文作者为CASA原会长 University of Florida 彭勇刚教授

Introduction

The management of atrial fibrillation (AFib) is profoundly complicated by morbid obesity. A high body mass index (BMI) not only increases AFib risk but also diminishes the efficacy of standard treatments like pharmacotherapy and catheter ablation. Direct-current cardioversion (DCCV) can fail due to adipose tissue attenuating electrical current, while the required procedural sedation carries a high risk of airway complications. This case report details a successful strategy for a patient with a BMI of 87 kg/m², combining simultaneous dual DCCV to overcome biophysical barriers with an advanced anesthetic protocol designed to preserve spontaneous ventilation.

Case Presentation

A 43-year-old male with a significant history of hypertension, diabetes, chronic kidney disease, heart failure with preserved ejection fraction (HFpEF), and obstructive sleep apnea (OSA) was admitted with sepsis. His most prominent comorbidity was extreme morbid obesity, with a recorded weight of 257.5 kg (567 lb) and a BMI of 87 kg/m². During his admission for sepsis treatment, he developed new-onset AFib with a rapid ventricular response. Initial management with escalating doses of metoprolol was ineffective, as was a prior trial of amiodarone. Given his HFpEF and a CHA_2DS_2-VASc score of 3, restoring sinus rhythm was imperative to optimize cardiac output and mitigate thromboembolic risk. After successful treatment of his sepsis, the AFib persisted, prompting an interdisciplinary decision to pursue electrical cardioversion.

Anesthesia Evaluation and Plan

Given the patient's extreme BMI, Mallampati score of 4, and history of OSA—all signaling high risk airway—the procedure was scheduled in the operating room to ensure immediate access to advanced equipment and specialized personnel. The primary anesthetic objective was to achieve a depth of sedation sufficient for patient comfort and transesophageal echocardiogram (TEE) tolerance while rigorously preserving spontaneous ventilation and avoiding instrumentation of the airway.

The meticulously crafted anesthetic protocol included Standard ASA monitoring and a Bispectral Index (BIS) monitor to titrate sedation to a target range of 40-60. A SuperNO2VA™ device was placed to provide nasal continuous positive airway pressure (CPAP), a critical intervention to stent the upper airway open and prevent obstruction. Pharmacologically, a dexmedetomidine infusion was initiated at 3 mcg/kg/hour (based on an estimated lean body weight of 100 kg) for its sedative and analgesic properties without significant respiratory depression. After a loading period, a propofol infusion started at 200 mcg/kg/minute, also dosed on lean body weight. This conservative dosing strategy was essential to prevent overdose, apnea, and hemodynamic instability in the context of massively altered volume of distribution.

Procedural Sequence

After achieving adequate sedation (BIS ~40), a TEE was performed, successfully ruling out a left atrial appendage thrombus. To maximize the chance of successful cardioversion, two sets of defibrillation pads were placed in complementary positions: one in the standard anterior-posterior configuration and a second in a right-posterior to left-lateral configuration. An initial synchronized biphasic DCCV at 200 J was unsuccessful.

Immediately following, a rescue attempt was made using simultaneous dual biphasic DCCV, whereby both defibrillators were charged to 200 J and discharged synchronously. This intervention successfully converted the rhythm to normal sinus rhythm. The patient maintained spontaneous respirations and oxygen saturation above 99% throughout the procedure, emerging from sedation uneventfully.

Patient's Outcome

The patient remained hemodynamically stable post-operatively with minimal vasopressor support and experienced no airway complications, respiratory distress, or recall. Sinus rhythm was maintained throughout hospitalization and at the two-month follow-up.

Discussion

This case highlights two pivotal advances for high-risk cardioversion. First, the efficacy of simultaneous dual DCCV as a rescue therapy underscores its value when single shocks fail in morbid obesity. The "critical mass" theory—which states that terminating fibrillation requires depolarizing a sufficient myocardial volume—explains this success. Excessive adipose tissue dissipates electrical energy; dual DCCV overcomes this by delivering higher cumulative energy through two vectors, a finding consistent with studies like that of Aymond et al.
Second, the anesthetic strategy was crucial for safety. The combination of dexmedetomidine (preserving respiratory drive) and lean-body-weight-dosed propofol achieved deep sedation without apnea. Proactive nasal CPAP via the SuperNO2VA™ device was essential in preventing airway obstruction. This multidisciplinary, pre-emptively planned approach, leveraging OR resources, ensured significant risks were mitigated.

Conclusion

Managing AFib in morbidly obese patients with multiple comorbidities necessitates a specialized, multidisciplinary strategy, particularly when conventional pharmacologic therapy fails. This case demonstrates a novel approach of the successful use of simultaneous dual DCCV, supported by a respiratory-sparing anesthetic protocol using dexmedetomidine, propofol, and nasal CPAP, effectively mitigated the high procedural risks.

(张 珊 摄影作品， 南极风采）

Original Article （原创文章）

超声引导下颈肌平面（CCeP）阻滞在颈椎后路手术中的镇痛应用

Jeff L. Xu

Division of Regional Anesthesia & Acute Pain Management,

Westchester Medical Center/ New York Medical College, Valhalla, NY

颈椎后路脊柱椎体融合术及椎板切除术术后常伴随显著疼痛，尤其在慢性疼痛患者中更具挑战。[1] 针对颈脊神经背支的区域阻滞能够有效缓解术后疼痛。超声引导下颈肌平面（Cervical Cervicis Plane, CCeP）阻滞是一种通过向颈半棘肌（Semispinalis Cervicis）后方与头半棘肌（Semispinalis Capitis）前方的筋膜间隙注射局麻药，从而阻滞颈椎后方肌群神经支配的技术。[2]

CCeP 是一个连续的筋膜层，[3] 从枕骨延伸至 C7 节段。颈脊神经背支穿行于该平面中，并发出分支支配后颈肌肉及皮肤（见图A）。该平面位于颈半棘肌与头半棘肌之间，在超声下呈高回声特征（见图C），被命名为“颈肌平面（CCeP）”。在上颈段（约 C2 水平），该平面位于头下斜肌（Obliquus Capitis Inferior Muscle）与头半棘肌之间。颈深动脉（肋颈干分支）亦走行于此平面，可在关节突水平在超声下连续显示（见图B）。颈深静脉通常伴行，被超声探头压迫时不易显像，因此在注射局麻药前需确认无回血，避免血管内注射。

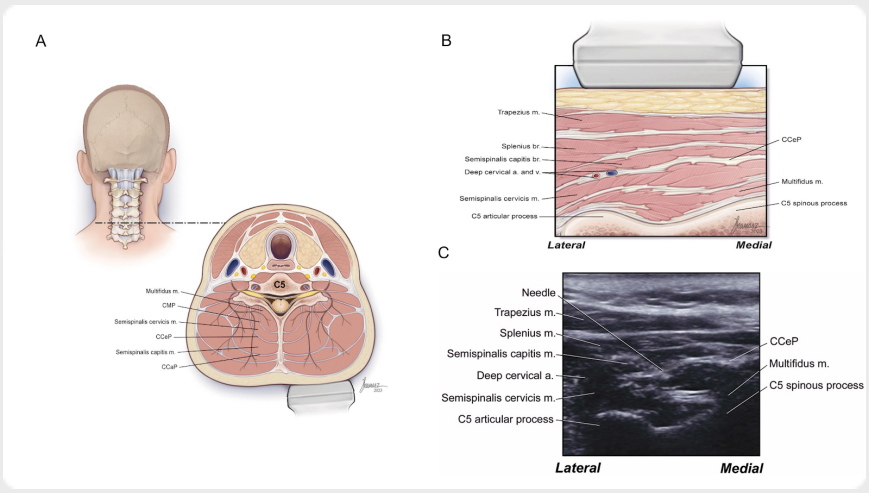


Figure 1 Anatomical relationships and ultrasound-guided approach for the CCeP block. (A) Axial cross-section at the C5 level demonstrating the relevant muscular and neural structures targeted by CCeP block. (B) View of the CCeP block approach under ultrasound guidance. (C) Anatomical relationships and sonographic landmarks essential for the administration of CCeP block. （This figure was adapted with permission from Rahimi M, Xu JL. Chapter 43. Cervical Paraspinal Interfascial Plane Block, Brown's Atlas of Regional Anesthesia 7th Edition. Elsevier.2025;289-294.）

CCaP, cervical capitis plane, the fascial plane posterior to the semispinalis capitis muscle; **CCeP**, cervical cervicis plane, the fascial plane between the semispinalis cervicis and semispinalis capitis muscles; **CMP**, cervical multifidus plane, the fascial plane posterior to the multifidus muscle.

CCeP 阻滞的具体技术已在既往文献中描述。[2] 简要而言，患者在全麻后、术中神经监测导线放置完成后取俯卧位。于切开皮肤前，在无菌条件下使用高频超声探头识别颈椎横突、颈深筋膜及相关肌肉。在实时平面超声引导下，使用 G20、2 英寸超声可视针进针到颈半棘肌与头半棘肌之间筋膜间隙。于双侧分别注射 10–15 mL 的 0.5% 布比卡因，并可加入辅助药（如 地塞米松 2 mg 及 右美托咪定 20microgram，或使用其中一种）。注射部位通常选择在拟手术节段的中点位置。

目前已有三项小型随机临床试验评估了 CCeP 阻滞在颈椎后路手术中的效果。[4, 5, 6] 其中两项研究显示其可降低术后疼痛评分，其中一项可持续至术后 12 小时，另一项可持续至 48 小时。同时均观察到术中及术后阿片类药物使用减少、术后恶心呕吐发生率降低、瘙痒减轻以及首次补救镇痛时间延长。另一项随机对照试验发现，CCeP 阻滞可显著减少术中阿片类药物使用量、降低术后 48 小时疼痛评分，并能使患者更早下床活动，缩短住院时间。

最新解剖研究提示，[7] 在 C2 水平可能存在潜在屏障限制染料扩散，但该屏障并非完全，增加注射容量可克服此问题。根据该研究的发现，在临床上，提出CCeP分区的新概念尤具意义——上颈区（C2–C3）与下颈区（C2–C3 以下）可能存在不同的扩散特性。CCeP 阻滞为颈椎后路手术提供了一种不涉及臂丛、前支或硬膜外扩散的区域麻醉方式，因此可避免膈神经麻痹、上肢无力及术中干扰心电生理监测信号等风险。

与横突水平实施的竖脊肌平面（ESP）阻滞不同，CCeP 阻滞选择性作用于颈脊神经背支，不会造成前支阻滞，也不会影响术中运动和感觉诱发电位监测。因此，其引发臂丛神经阻滞或膈神经麻痹的风险极低，尤其在双侧阻滞时更具安全优势，而颈部 ESP 阻滞则可能增加这些并发症风险。[8]

总之在超声引导下的CCeP 阻滞技术简便，能够有效阻滞颈脊神经背支。该高回声筋膜平面在各颈椎节段均可识别，颈深动脉是重要的超声定位标志。CCeP 阻滞在颈椎后路手术中应用安全，不干扰术中腹侧神经监测，对术后镇痛具有显著价值。

References:

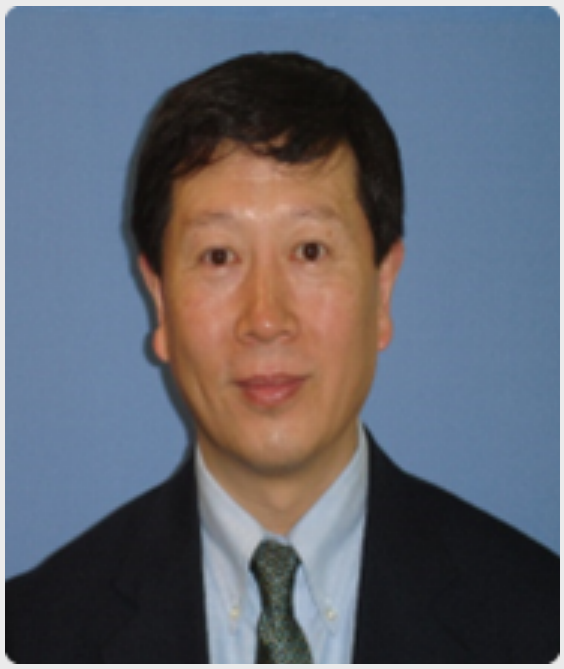
1. Koda M, Yoshii T, Egawa S, et al. Factors Significantly Associated with Postoperative Neck Pain Deterioration after Surgery for Cervical Ossification of the Posterior Longitudinal Ligament: Study of a Cohort Using a Prospective Registry. J Clin Med. 2021;10.
2. Xu JL, Pisapia JM, Shabsigh M. Ultrasound-Guided Cervical Cervicis Plane Block for Postoperative Pain Control in Cervical Spine Surgery: A Technical Note. World Neurosurg. 2023;171:5-7.
3. Rahimi M, Xu JL. Chapter 43. In: Cervical paraspinal interfascial plane block, Brown's Atlas of Regional Anesthesia. Elsevier, 2025: 289–94.
4. Ramachandran K, Chandramohan M, Shetty AP, et al. Efficacy and Safety of Ultrasound Guided Inter-semispinal Plane Block for Postoperative Analgesia in Posterior Cervical Laminectomy - A Prospective Randomised Controlled Study. Global Spine J 2025;15:1625–34.
5. Abdelhaleem NF, Youssef EM, Hegab AS, et al. Analgesic efficacy of inter-semispinal fascial plane block in Patients undergoing Cervical Spine Surgery through Posterior Approach: a randomized controlled trial. Anaesth Crit Care Pain Med 2023;42:101213.
6. Mahmoud AM, Alsaied MA, Ragab SG, et al. Inter-Semispinalis Plane Block Versus General Anesthesia for Postoperative Analgesia in Posterior Cervical Spine Surgery: A Randomized Controlled Trial. Anesth Pain Med 2024;14:e143369.
7. Leurcharusmee P, Thunyacharoen S, Inchai C, et al. Ultrasound-guided cervical cervicis plane (CCeP) block: a cadaver study. Reg Anesth Pain Med. 2025 Aug 11:rapm-2025-106962. Online ahead of print.
8. Kwon AH, Xu JL. Cervical erector spinae plane block: is it feasible for cervical spine surgeries? Reg Anesth Pain Med 2021;46:552–3

(张 珊 摄影作品，南极风采)

王海明医生回忆录 （终章）

19.莘莘学子诚奉献 拳拳赤子众人赞

1991 - 2006年期间，我多次回国讲学。先后到访过北医、北京协和医学院、北京阜外医院、首都医大、301总院（空军总院，海军总院）。难忘那次所有在京军队医院麻醉科主任们，齐聚301对面的长风假日酒店，大厅坐满了军队麻醉精英的场景。张宏将军和米卫东大校主持讲座，我先介绍了美国华人麻醉医学会 (Chinese American Society of Anesthesiology, CASA），接着讲了《American Anesthesiologists and Medical Malpractice》。我边打幻灯边解释，讲了三小时。我参观了数家在京医院手术室，刚去时看到条件较差，但各科主任们均知中美差距，诚学力赶。



王海明 (10/1/1959 -08/23/2019) 1983年毕业于北京医学院，1985年赴美。1994年从Boston Elizabeth and MGH完成麻醉科培训。于2002年创立CASA 并出任首任会长，也曾任CASA Bulletin责任编辑。为CASA和中美麻醉医学的交流作出了杰出贡献。

2006年时，北京的大医院均翻新或新建了手术室，麻醉药品和设备已与欧美相近。麻醉科主任们和骨干团队在理论及临床已接近欧美较大的教学医院，那时中国麻醉科研正在努力与欧美接轨。近十年来，中国麻醉科研进步很大。一方面，国内老师和同学们朝夕奋斗；另一方面，CASA 和 ICAA （ International Chinese Academy of Anesthesiology 国际华人麻醉学院 ）等欧美同仁回国交流，贡献。吴新民教授任中华医学会麻醉学会会长时，褒赞：“ 美国华人麻醉医学会（ CASA）为中国麻醉现代化贡献巨大！”

如今，CASA，ICAA，SCAPE（ The Society of Chinese American Physician Entrepreneurs，2015创立于加州斯坦福 ），ACAP (The Association of Chinese American Physicians 1995 创立于纽约市) 均为祖国麻醉现代化争先恐后地奉献着。经北大医院吴新民主任介绍，我联系了在英国研究麻醉的马大青教授，我们曾互相鼓励，如今的马教授研究水准可谓世界级，每次看到他的新刊文，我总说：大青真棒！

1991年，经罗爱伦主任介绍，我有幸结识了在美国犹他州医学院研究麻醉的黄宇光教授。该院麻醉科主任 K . C . Wong （ 黄光中教授）还培养了武汉的姚尚龙教授、湖南的郭曲练教授 ，美国的刘恒意教授 …… ; 还为台湾麻醉培养了许多领军人物。K. C. Wong （ MD，PhD）教授生前曾受我聘为CASA荣誉会员，那时，他是国际麻醉研究协会 （ IARS)主席，我俩曾在IARS年会，新奥尔良畅谈人生；他为CASA的发展提了许多好建议。他有自传《缘分》，北京协和医院周游、于琁译，黄宇光和罗爱伦审。中国协和医科大学出版社 2005出版。

同是1991年，经北京阜外医院麻醉科胡小琴主任介绍，我结识了在美国研究麻醉的刘进教授，刘教授抱负大，很有使命感！那时，我在波士顿圣伊丽莎白医院做麻醉住院医（1990 - 1993；哈佛 Pain Management Fellowship： 1993 - 1994；1994 ABA Board Certified)。当时，刘进教授与我讨论：如何在中国推广美国一样的住院医师规培（这是中国麻醉现代化梦之一 ），如今祖国各地终于开始规培了。CASA的骨干有：张晓燕(LA)、汪宏教授 (西佛吉尼亚 ）、黄建宏教授 （佛罗里达 ）、曹锡清（DC）、冯鸿辉（康州）、李金蕾教授（康州）、刘恒意教授（费城）、唐越（加州）、刘虹教授（加州）、王清（加州）、林永健教授（LA）、胡宗元 （费城) 、陶为科教授（德州）、林佳（克利夫兰）、胡灵群教授（芝加哥）、谢仲淙（波士顿）、刘仁玉教授（费城）、李韵平教授（波士顿）、刘立新教授（纽约）、黄佳鹏（肯塔基）、赵培山教授（波士顿）、孙建中（费城）、邵燕夫（费城）、彭勇刚教授（ 佛罗里达）、田惠荣（纽约）、夏云教授（俄亥俄）、周捷教授（波士顿）、熊明教授（新泽西）、巢卫教授（马里兰）、纪如荣教授（北卡）、高卫东教授（马里

兰）、蒋延东教授（田纳西）、左志义教授（佛吉尼亚）、郑刚教授（德州）、屈振生教授（波士顿）、李锋华教授（纽约）、王景平教授（波士顿）、邹圣平教授（纽约）、谢宏（纽约）、魏华锋教授（费城）、李成付教授（圣路易斯）、周海峰（新泽西）、李迺曦（纽约）、陈国纲（新泽西）、王长征（新泽西）、谢燎阳（纽约）、苗宁（马里兰）、王萌教授（纽约）、游若旭（新泽西）、夏伍一（LA）、陆晓薇（马里兰）、张均奎（纽约）、李戈（伊利诺）、唐军（加州）、徐龙（加州）、梁小民、Yan Lai（ 黎恩海，纽约）、楼燕勤（加州）、汤革新（加州）、钱湘（加州）、李刚（加州）、李赞红（加州）、裘卫（华盛顿州）、雷思正和钟为民（俄勒冈州）、苻铁波（纽约）、章利铭（宾州）、王海龙（威斯康星），刘家彬（纽约）、杭键；均在呕心沥血编译，办班，网教。

回顾CASA成立十五余年的历程，对我们厚爱最多的前辈中当推Fun Sun Yao （姚繁盛）教授。首先是在我们学会的成立大会上，姚教授热情地致辞祝贺。此后，我们年年见面，CASA许多会员昔日学习姚教授的书，通过各种考试，解决了许多临床问题；今日有些会员已成为姚教授麻醉教科书部分章节的编者。姚教授的书越编越好，中国麻醉教授王天龙已组织团队将姚教授的书第五版译成中文，千万中国麻醉医护获益。2017年，Fun Sun Yao教授和夫人（胡报治 Baw-chi Peggy Yao）还为美国华人麻醉医学会（ CASA）捐款，以示坚定不移地支持和鼓励，使我们备受感动！姚教授夫妇治家有方，三个孩子中，两个入读哈佛大学，一位毕业于麻省理工。姚教授言传身教，不愧为楷模，世界因有姚繁盛教授夫妇而更美好！

Tong J Gan MD (颜东裕教授，纽约州立大学石溪分校医学院麻醉科主任）和夫人蓝玉（Audrey）均讲流利的国语。对CASA一直鼓励有加。我们年年见面。他年轻，机敏，勤奋。在杜克大学工作多年，曾任美国门诊外科麻醉医师协会会长，又创建了《American Society of Enhanced Recovery After Surgery , ERAS 》加速术后康复学会，是Founding President，很令人钦佩。

2003年， 我和女儿 Margaret Meiling Wang (王美玲 ） 为 CASA 设计了会徽 （ Logo ）。2016年，哈佛大学医学院李韵平教授请冯如壁 （ Ms. Ruby Feng， 冯鸿辉医师和曾赛环的女儿，毕业于 Wellsley College) 又为会徽增加了密度，更清晰漂亮了。

2004，我参与了美国西北大学医学院胡灵群教授主译宾大Lee A. Fleisher 著作《Evidence-Based Practice of Anesthesiology 循证临床麻醉学》。

2005年秋，上午在北大医院手术室参观麻醉，下午去人民医院参观，又返回北大医院讲座，晚上要去北京友谊医院见李树人教授。可下午工作一结束。吴新民教授说：你不能马上去友谊医院，全科人员在医院对面餐厅为感谢你要聚餐呢！ 啊？ 我那时不谙国内的套路：白天一起工作，晚上一起吃饭交流！ 我说：友谊医院田鸣教授和司机已在等我。吴教授坚持要田鸣和司机一起参加北大医院麻醉科聚餐。餐桌上，田鸣对我耳语：李树人老师等着咱们呢！ 我赶紧起身频频招呼。

我盼将来可再去参观及拜访：中国医大（沈阳）王俊科，马虹教授；大连医学院（安刚教授：悼念可敬的学长），大连市医院（王多友主任），大连麻醉委员会；北京市麻委叶铁虎，任洪智，岳云，田鸣，王保国， 许幸，左明章，范志毅，薛富善，金清尘，倪家骧，张利萍，王天龙，王东信众教授等；天津总医院副院长麻醉科主任王国林教授；齐鲁医学院主任-山东麻委（类维富教授）；青岛医学院（王世端教授）；徐州中国第一麻醉系创始人：曾因明教授；杭州：钟泰迪教授；上海：薛张纲，蒋豪，于布为，邓小明，俞卫锋众教授，学习交流。

遗憾的是，2006年患病，暂停回国。

今后，我希望能去哈尔滨拜访李文志，李恩有教授；西安：熊利泽教授和景桂霞教授；银川：施伟忠教授。我在北大医院实习时，施老师正读谢荣教授的研究生。我要进四川拜访我的学长刘进教授，回国报效前，“ 准备克服千万艰难”（他的来信，1994-1-24）。我还盼去武汉，拜访姚尚龙和田玉科教授；去长沙拜见：郭曲练教授，我拜读了徐启明教授的回忆录《惊回首》；参观南京鼓楼医院麻醉科和南大医学院；昆明：况铣、衡新华；广州：黄文起，陈秉学和黄国杰教授；深圳大学；香港：Tony Gin教

授；台湾：王志中教授； 英国：马大青教授；杭州：浙大医学院，西湖大学。

再有时间就考虑去做义工：心情好的人是世界上最幸福的人！

我建议：中国麻醉住院医师规培教材或参考书中“麻醉意外风险妥善处理部分”可否考虑综合编译：1. ASA Closed Claims Analysis 好的案例；2. MLMIC (Risk Management Letter)和 PPM (Anesthesia & Law); 3. CASA 黄建宏教授等主译的《美国斯坦福大学医学院麻醉应急手册》；4. ASA、欧洲等麻醉学会/协会 Guidelines。 我盼有机会协助中国医师协会创立象美国纽约州的保险公司MLMIC（保险内外妇儿等多学科）那样医师们发起，请好律师和保险专家护航的非盈利公司。这样可能解决“医闹“。麻醉意外多属“民事诉讼”，好的保险公司可帮两头：1. 让意外受害者及家属得到应有的经济赔偿；2. 配合专业学会/协会责罚医者中的违规！美国罕见”医闹”，今后中国与世界接轨成功之时，就是“医闹”消失之际！ 我珍藏的信呢：将捐献给不久会有的《中国麻醉科学博物馆》： 1. 罗艾伦教授为我写给胡小琴教授的（1992-7-6）； 2. 胡小琴教授写给我的（ 1992-8-9）；刘进教授写给我的两封信（1992-10-6，1994-1-24）3. 一些我与同仁们的email和微信联系；4. 一些珍贵的照片；5. 一首歌词（简谱，五线谱 ）《留学生之歌》！ 感谢彭云水教授十几年来一直寄给我《中华麻醉学杂志》；感谢白雪先生的帮助；感谢祖国麻醉同仁们的支持和鼓励；感恩我再生一次，我将继续贡献，携手与大家同行！

20. 世上风水轮流转　明日好运到你家

纽约上州虽然山清水秀，可我们因为工作忙，与外界接触较少。偶遇国人就觉得亲切。而长年居住大城市者见我们如此，觉得好笑。山中仅数日，世上已多年！

2002年底，创建美国华人麻醉医学会时，我的活动陡然增加。去新奥尔良参加了IARS （美国麻醉和诊治疼痛年会）见到 K C Wong （黄光中教授） 。那次会议期间，他的学生，刘恒意教授，在家热情地招待了我们。SARS在中国大陆刚开始，黄光中教授提醒我们应警惕可能的巨大风险！我很快向中华医学会麻醉分会主任委员（北京协和医院麻醉科主任）罗爱伦教授汇报了我们的努力。联系到台湾王志中教授，香港Tony Jin教授。

2003年， SARS已在中国肆虐，北京曾见千街空巷！ 美国各地的中国留学生、学者、华侨们在大使馆和各地领事馆纷纷集会、捐款、捐物，支援祖国人民抗击非典。我代表CASA，与ACAP 、药学联盟、工程师协会等多次参加活动，大家献计献策，同仇敌忾！

我参加了纽约总领馆教育组和科技组的活动。总领事、付总领事、教育参赞、科技参赞和众领事们给我许多鼓励。通过领事馆与祖国大陆人民紧密地团结起来。那是一段激情澎湃的时光。

国务院总理温家宝访问纽约市时，我持请柬到曼哈顿第五大道沃道夫旅馆，聆听了温总理的讲话。他引用泰戈尔的话：“ 一颗大树，无论它是如何高大，其影子总是连着它的根！ ”与会者分批与总理合影留念。

许多领事和参赞成为我们的朋友。于长学、刘强、房东波、艾方琳等。领事馆任职通常 3 - 5 年一换，到期回国，或到其它国家、地区去工作。认识了张宏喜、刘碧伟，彭克玉等总领事，副总领事黄惠康。纽约总领馆曾与中国常驻联合国代表团团长王光亚每年多次举办节日聚会，我和张丽曾在纽约总领馆聚会大厅外（多层楼顶上），向西眺望哈德逊河，在迎风飘扬的国旗下合影留念。

2004年，我去北京协和医学院讲学。黄宇光教授主持，罗艾伦教授特去鼓励。我一鼓作气连讲三个小时，喝了几杯冰水。讲座结束后，回答了协和师生们的提问。忽见，美国哈佛大学麻省总院屈振生 （Jason Qu MD ）教授也在悄悄旁听。我当时心情格外激动，仿佛是站在世界屋脊演讲。当晚，我高烧。幸亏父亲嘱我服药，长眠一夜。次日，神清气爽！最近，加州一律师，Victor，告知我当年他是北京协和医学院学生，在我讲座时负责供应冰水。我对他说：如果那次我的讲座，对他学业略有启发则不胜欣慰。

2005年秋，下午电话铃响。波士顿哈佛大学医学院 Beth Israel Deaconess 医学中心麻醉科主任，Carol Warfield 教授，来电话说要去北京，请我介绍中国麻醉同仁。问清：她计划何时启程、旅行时间、愿讲演什么题目 、有何特别要求等。我立即电话到北京北大医院吴新民教授。吴教授欢迎她。安排北医三院麻醉科张

利萍教授负责具体招待。那次北京之行，Carol Warfield 教授很愉快。吴新民教授和张利萍教授提出希望：2006年在北京举办《北医—哈佛麻醉与疼痛治疗论坛》。哈佛大学医学院副院长 Nancy Oriol 和 Carol Warfield 教授热情响应。我于2005年秋，2006春两次去北京参与组织。在美国，我与李韵平教授 （ 我们均是Carol Warfield 的学生）日夜翻译、整理论坛讲义。《北医—哈佛麻醉与疼痛治疗论坛 》如期在北京京西宾馆举办，与会者挤满了大礼堂，学员们很满意。时值北医校领导，北大医院普外科教授，昔日我同班同学，刘玉村特来致辞祝贺。我陪哈佛团队下榻北京饭店，又结识了新朋友。令我印象深刻的是：北大医院、人民医院、北医三院和北京医院（北医教学医院）各麻醉科年轻一代医师们的敬业精神和良好的英语水平！ 能参与此次活动实为我之大幸。

我在论坛的汇报是：《 American Anesthesia Malpractice and Litigation 》，王天龙教授诚挚地建议：“讲一案例最好。” 为准备此交流：1. 我联系了ASA Closed Claims Analysis 二专家：Karen B. Domino 教授和 Karen L. Posner, PhD （西雅图）；2. 纽约州医师们建立的 非盈利保险公司 - MLMIC (medical Liability Mutual Insurance Company,），可上网查询许多 “Case Review “... 自1994年来纽约工作，我一直参加MLMIC 的《 Risk Management 》学习班（入班学习可提高业务；降低从业风险；还可降低买麻醉意外保险费；定期得股息｛买它的保险立即成为股东｝）多好的公司：有最好的律师，最好的服务态度和效率，医师们多么幸运！那么好的公司教育我，为我从业护航！3. 另一麻醉意外保险公司也几乎同样好：Preferred Physicians Medical (PPM)是盈利保险，只做麻醉意外保险，也有大数据库；有《 Anesthesia & the Law : A Risk Management Newsletter 》这期刊也是到手必读。 4. ASA Newsletter （月刊），每月均有” Case Report “ - 真人真事，我每期必看且分析，获益良多。 5. 我曾请教一位纽约州高院法官（病人）关于麻醉与法律和特案分析。

数年前，刘立新教授来电话说：纽约州立大学石溪分校医学院麻醉科主任 Peter Glass 教授希望访华，而且提出 “ 要去中国最穷的地区去支援！ ”我说：好办！ 一个电话去了北京。北医三院麻醉科新主任郭向阳教授（北京协和医院麻醉科罗爱伦教授的博士生），曾到过美国北卡，久仰此教授大名。郭教授对我说：欢迎！ 结果石溪团队中国西北行一切顺利。

过去的岁月充满美好回忆。2002年组创美国华人医学会时，唐越还是爱因斯坦医学院的麻醉住院医师。毕业后，他去哈佛医学院麻省总院专修心血管外科麻醉。Fellow毕业就有了好工作。临行前，全家来敝舍聚会。我送他一瓶红酒祝贺。我仿佛看到我的兄弟在茁壮成长！如今，唐越已是加州首府一私立医院麻醉科副主任了，还参与组织领导北加州华人医师会，鞠躬尽瘁，奉献爱心！

2002年底创会的另一女住院医师陶青，如今已是华盛顿特区经验丰富的主治大夫了。

李迺曦从2002年时的助理教授已升至一私立医院麻醉科主任了！

2003年，我一人去旧金山参加美国麻醉医师协会（ASA）年会。组织美国华人麻醉医学会与中国大陆、台湾、香港等地医师聚会。资金虽微量，可我们热情很高，因为是史无前例。加州，王清医师提出要周末去加班 ，用她的 血汗钱来支援聚会 (那时他们还住在出租公寓内），令我感动至极！在王清和其丈夫李鸥（二人均毕业于北京协和医学院八年制）的帮助下，向一制药公司募得千元。订制了CASA会旗（今日仍在使用）。我们还得到楼燕勤医师（加州尔湾）和汤革新医师（加州尔湾）的大力支持。尤其要感谢谢宏医师（纽约）帮助邀请到了ASA主席 James Cottrell 教授；特别感谢黄宇光教授和中华医学会麻醉学会（CSA）的支持；感谢台湾王志中教授；感谢Philip Liu教授；感谢加拿大Davy Cheng MD 郑仲煊教授；感谢中国住旧金山领馆王勉烁科技参赞；感谢岳云教授代表CSA致辞；感谢王清和李鸥预定 “ 羊城茶室 ” 作为聚会厅；感谢《世界日报》、《星岛日报》等媒体的报道！聚会后，我参观了旧金山中国城华人医院。曾有人问：王海明何许人也？李鸥骄傲的回答：海外赤子！李鸥和王清陪我参观了加州大学伯克利分校、斯坦福大学医学院和硅谷。

多年来，参与美国华人麻醉医学会活动，极大地拓宽了我的视野。2002 - 2003年，发展会员时，周末在家，我电话美国五十个州，上午联系东部、中西部；下午呼唤西部；清晨和傍晚友情联络中国大陆与台湾。三个电话轮流使用。其实 ，我今日已明白：

美国华人麻醉医学会的创立是时代的呼唤，众人之努力，水到渠成！我为自己有机会参与而倍觉幸运！

专业交流平台的作用实不可低估。一方面使许多有识之士人尽其才，大展宏图；而当某会员急需求助时，如果及时联系到学会，有时会有意想不到的惊喜。而对那些强者，助人为乐，有时甚至就是举手之劳 。能与人分享，是快乐！

资源再丰富，如果不知会用，岂不令人扼腕！

21.写在感恩节之际　朝夕勿忘省吾心

我们能有今天的生活是多么的幸运！ 我们有些天分，也比较勤奋，而令我们杰出的很重要因素却是我们或多或少曾得贵人相助！在我们的征途上曾巧遇贵人指引方向；坎坷艰难时曾获及时的鼓励和关爱，我们则不放弃理想，继续变通着向上，贵人的托举或牵手上提，可能只是轻轻一下，我们抓住了机遇飞跃闪亮了！ 若有幸，多遇贵人和伟人，经过畅叙，交流，我常觉自己突然会在情感境界升华了！ 当我们兴高采烈地向亲友们报捷时，那智者（或言：我们的贵人）正欣慰地微笑：我们的成功令贵人享受成就感！ 这种成就感也会是如痴如醉，贵人一边为我们的成功欢呼，称颂；一边陶醉于本人境界的升华！ 这是一种双赢：莽撞年轻人的进步，正反馈给那些历经世事 ，洞若观火的智者无限的欢乐！ 我们中年人本应：穷者独善其身，达则兼济天下。或三级跳：修身，齐家，治国平天下！ 我是凡者，从身边做起。

不久前，我到泳池健身。泳厅内竟然只有我俩，一泳者，一救生员。我见他友善地看我游得高兴，便暂停泳上前主动交流。几分钟获知：他名汤姆，高三，成绩一般但有志当麻醉科医师 。因为他已上网调研，认为麻醉医生待遇好。我立即为他着急了！我说：你高考成绩和高中成绩均一般，又无惊人特长，怎可只申请四所大学（他申请的四所大学，我竟前所未闻。当然，可能是我孤陋寡闻）。我俩对视，我问他如果四所大学均不录取他怎么办，他竟尴尬无语。我说那将很可怕啊！ 他点点头，目光迷惑。我建议他至少要申请十二所大学，一定要包括州立大学中最易被录取者。再聊几句，知他亲友中无涉医者。我想：这汤姆还远未上通向理想之轨道。我告诉他我的联系方式，叮嘱他：一定要与任州警察的父亲，和教小学的母亲再研讨如何改进大学的报考！如果进了大学，一定要保持好成绩！大学成绩差很难入医学院。大三时一定要联系我，我辅导你如何申请医学院。医学院三年级时再咨询我如何申请住院医师。在中国，医学生多远避麻醉科和皮肤病科，而在美国恰是收入较好的专业。汤姆你不应只向钱看，而要选自己喜欢的专业，那样你就会当别人抱怨苦和累时，你却干得其乐无穷！ 汤姆真诚地感谢王医生，我答：你以后别忘了我这个王叔叔。如果你真有志献身麻醉科学，我乐当你的引路人。 数日之后，我与一对七十年代台湾来美留学，以高级工程师退休的前辈谈起 “ 汤姆的麻醉医生梦 ”，二老称颂我做的好。我说：我来美国后得几位贵人相助方有今日。来美国前，我在北京曾得几位贵人及时相助，毕生难忘！ 我曾万分感激地问美国教授罗伯特：“ 老师，今后我怎样才能报达您呢？ ” 他沉思片刻，微笑地说：“ 当你学有所成后，就像我一样去帮助别人 ”！ 多少年来，恩师的教诲常在我耳边回响！ 我竟情不自禁地去助人为乐，而且陶醉于中。我的确又升华了！

如果有人问我人生体验，我将会坦诚相告：

1. 我有了更多的自知之明，我以前曾以为自己是名栋梁之才；今日，我明白自己就似沧海一粟！

2. 我是非常幸运者。世界上，千万万人比我更聪明（智商和情商均在我之上），我能有今日之幸福，很大程度是运气好。我时常想，如果我的父母是农民或蓝领工人，我可能不会有如此之多好机遇。我感恩父母和全家！ 父母虽已过世，可二老的音容笑貌常伴我而行，而思。

3. 我更注重试着与对方换位思考。与人换位思考使我待人处事睿智许多！

4. 2006年，倘若我不是医者，很可能忽视心绞痛，可能英年早逝。我既然再生一次，则应对社会再做贡献。让我的亲友见我如沐春风，欢乐愉快，每次离别均是依依不舍！ 我要热拥生活，尽情享受有限的宝贵时光，要努力去做，让我的周围因我而更美好。

5. 我要继续努力学习，让自己对人有益；而尽可能少的成为社会负担。我将科学地健身和健心，期盼今后的生活有意义、高质量。

6. 今后，当再遇新生（年轻医师），我虽能力有限，但愿做其成功之路的铺路石，愿竭尽全力将有为青年（ 智商和情商均高者 ）奋力擎起！

亦盼新生：要想方设法把握好自己的命运（ 天赋，勤奋和机遇 =>成功）！ 祝福你，为你加油！ 多少年后，当你暮然回首，你可以自豪地说：无怨无悔！ 那我将欣慰。

7. 我感恩有幸生活在这个时代：真善美、科学幻想一一实现、社会发生着巨变、继续向前！ 战争、邪恶和灾难也知道了一些。

我仍是乐观主义者!

《留学生之歌》

祖国啊 请听我们的歌，
为理想 我们赴远方，
去学友邦之长，
去把中华弘扬。

那一年 初学到异乡，
朋友们 热情又善良，
爱情花儿多芬芳，
青春之歌多么悠扬。

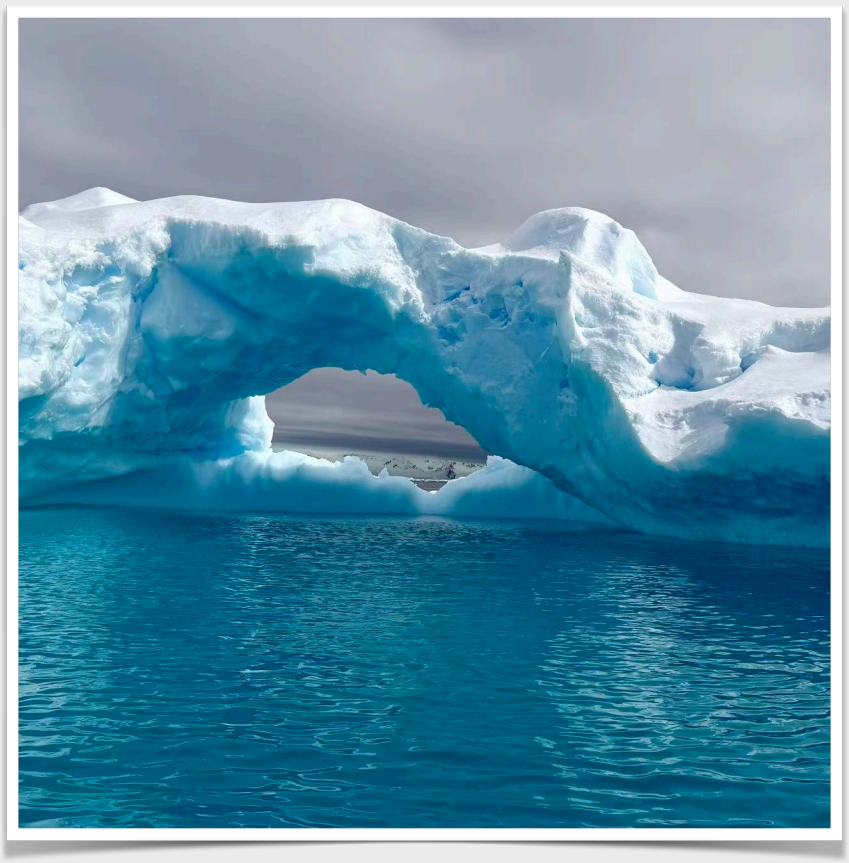
先驱们啊 克难留洋，
代代英豪 血谱希望，
唯盼那 民富国强，
唯盼那 民富国强。

孜孜求学 拼搏向上，
珍怀乡愁 勇挺胸膛，
朝朝夕夕 奋创辉煌，
朝朝夕夕 再创辉煌。

我们的歌 高亢嘹亮，
来自五洲 多语齐唱：
祖国 故乡 我们的向往，
中国 祖国 未来的希望！

王海明 （ Haiming Wang MD ）

美国纽约哈德逊河畔
10 - 1 - 2018



(张 珊 摄影作品，南极风采)

招聘信息

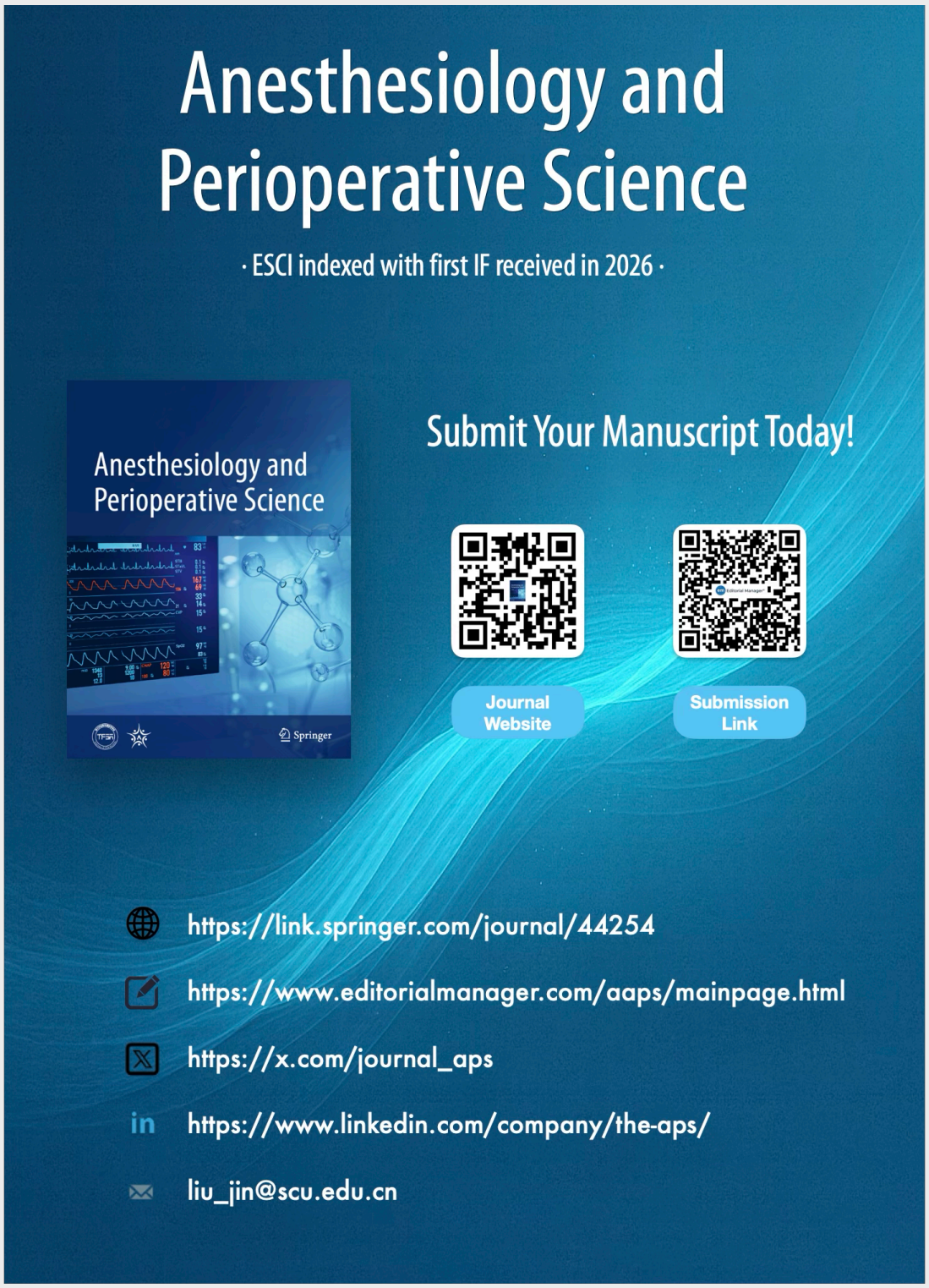
Disclaimer: This is just a projection and final $$ and terms will vary on individual basis

Senior Associate Professor/Full Professor
70% Clinical, 30% Research Admin
50K signing bonus
1580 clinical hours for 1 FTE (so 70% of this – 1106 hours) and the remaining 30% (474 hours for Research/Admin)
Discretionary Compensation per Chair
Call shifts
Base of 500K+
Could get to 700K+ total compensation with additional call and late work past 3pm
Excellent retirement and health benefits.
More details during interview/hiring process.
Hope this is helpful.

Contact Information：

Patrick N. Olomu, MD, FRCA (UK), FMCA (*Honoris Causa*)
Division Chief of Pediatric Anesthesia
Professor of Anesthesiology
Interim Vice-Chair of Research
Children's Hospital of Richmond at Virginia Commonwealth University
West Hospital, 7th Floor, North Wing, Room 7-105
1200 East Broad Street
Richmond, VA 23219
Telephone (804) 828-2207

Anesthesiology and Perioperative Science (APS) 征稿信息



APS作为金色开放获取期刊，2025年继续对作者完全免费投稿，所发表论文均可被全球读者免费访问。诚挚邀请广大专家选择APS提交发表您的最新研究成果，同时积极关注、阅读和转发APS已发表文章，共同为推动APS更快地被SCIE收录并跻身麻醉学期刊Top行列助力！

在国内麻醉同道们大力支持下，APS取得极大成功。据现在的数据计算，今年IF将为7.5～8.5；明年争取达10+。目前APS高度欢迎海外单位积极投稿，现在是给APS投送高质量稿件，特别是高质量的综述，荟萃分析和系统评价，原创研究等的大好时机。投稿链接：https://www.editorialmanager.com/aaps/default2.aspx

从2026年开始，我们收到投稿后，平均将在两个月内做出接收或拒稿的决定，接受稿件在收到投稿的四个月内上线发表。

主编 刘 进 教授

WISONIC公司简介

华声医疗，成立于2013年，总部位于中国深圳；是一家拥有完全自主知识产权，集研发、制造、营销为一体的中国国家高新技术企业。 华声是全球POC专科应用领域一线品牌，以临床专业专科精准诊疗为基础，提供“专科专用”的产品和服务。 华声拥有“一核两翼”—— 其核心是云端医疗服务，两翼是生命信息支持、智能超声影像。 目前，华声与全球顶级医院共同建成培训基地，与多所院校建立技术前沿的联合实验室。华声致力于服务全球，聚焦全球中高端医疗用户；进口替代，走进国内400多家三级医院；出口升级，产品出口100多个国家和地区。 华声用智慧科技，呵护更多生命健康需求，让更多人分享专属生命关怀。

产品介绍：
针对麻醉科室，华声目前有2款核心麻醉专用超声，信息如下：

指南针 (英文型号名： Navi S)： 秉承着“专科专用”的理念，经过大量的市场调研，了解了一线客户的痛点和需求，华声医疗于2016年推出了业内首款麻醉疼痛专用彩超——指南针。指南针以其19寸超大的全触屏设计、全面的穿刺解决方案，很好地克服了传统超声操作复杂、穿刺针显影不清等问题。通过近几年的市场推广、专家体验、学术合作等，在麻醉疼痛领域，目前在中国市场占有率稳居第一，在国际上也逐渐树立口碑。打破了进口品牌在相关领域的传统垄断局面。

北斗 （英文型号名：Labat SP）：2019年，华声医疗推出了首款麻醉专科AI智能超声——北斗。作为一款高端彩超，北斗采用了HOLO BEAM 全息平台，无需调节焦点，图像更清晰。同时，基于强大的硬件平台，北斗智能识别神经、血管及各类组织，配合专业的教学软件，使得超声下组织识别更为快速、简单，也极大地缩短了入门医生的学习曲线。此外，北斗的激光导航功能更是产学研合作的成果之一，创新地解决临床穿刺定位困难的问题。

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