At the end of April, Don Marion will take over as chairman of the AANS/CNS Section on Neurotrauma and Critical Care. I would like to offer my sincere thanks to all those many individuals who have worked tirelessly for the Trauma Section, particularly Alex Valadka, Michael Fehlings, Don Marion, Jamie Ullman, and Katie Orrico. Sylvia Melendez and Sylvia White have provided exceptional secretarial support for the section.

Through these efforts, the Trauma Section has achieved many of its aims over the last two years. The following sets of guidelines have been produced, updated, or are in preparation: management of severe traumatic brain injury (TBI), prognosis of severe TBI, surgical management of TBI, pediatric severe TBI, and mild head injury. In addition, Trauma Section members have been associated with the Guidelines for the Management of Acute Cervical Spine and Spinal Cord Injuries and Guidelines for the Management and Prognosis of Penetrating Brain Injury.

The section has produced and disseminated the document “Emergency Room Coverage: What Every Neurosurgeon Should Know,” and it is in an advanced stage of developing position statements on the topics of maximum hours of emergency room coverage and the role of midlevel practitioners in intracranial pressure monitoring. Through the efforts of Alex Valadka and others, the section has continued to offer highly successful and well attended critical care courses at each of the major meetings and has contributed to the cerebrovascular and pediatric critical care courses also.

Through the efforts of Jamie Ullman, the membership of the Trauma Section is at its highest level to date—around 1,200 members—making it second only to the Spine Section in size of membership. The financial status of the section is secure, and sufficient funds are available for development projects, such as a combined meeting with other trauma societies, a proposal which has, however, been extremely difficult to realize.

Through the efforts of Michael Fehlings, the section has been able to offer the Codman Fellowship in Neurotrauma and Critical Care, which provides one year of full academic support for an individual to pursue research in neurotrauma. Our thanks again go to David Habel of Codman, who has generously agreed to provide support for this award through 2002. In addition, at each AANS and CNS meeting, the section presents two Synthes Resident Research Awards: one for Brain and Craniofacial Injury, and one for Spinal Cord and Spinal Column Injury.

In addition, the Trauma Section has also created a traveling fellowship, the Douglas Miller Traveling Fellowship, to extend our international outreach and to celebrate the achievements within neurotrauma of a more senior individual outside the United States. This fellowship will be awarded for the first time in 2002. The first awardee is Ivan Ng, MD, of Singapore.

In response to the devastating and tragic events of Sept. 11 and their aftermath, the Trauma Section has been co-organizing a special seminar, “The Role of the Neurosurgeon in Mass Disasters,” to be held on Thursday, April 11, during the AANS meeting in Chicago. Although there were almost no significant neurosurgical injuries sustained in the tragedies of Sept. 11 and the Oklahoma City bombing, the role of the neurosurgeon in such disasters remains important. Neurosurgeons, in common with other surgical specialists, need to develop contingency plans for disaster management within their geographically defined region. Neurosurgeons can often have a major role to play as managers and triage organizers in such situations.

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SUNDAY, APRIL 7, 2002

Practical Clinic 1–5 PM
32 Head Trauma: Current Treatments and Controversies
Co-Directors: Alex B. Valadka, Geoffrey T. Manley
Faculty: Raj K. Narayan, Donald W. Marion, Claudia S. Robertson, Jeffrey Lobosky, Domenic Esposito
Clinic Fee: $350 Material Fee: $0 Total: $350
This course will review the current status of several controversial treatments for traumatic brain injury, including hypothermia, CPP-based management, and decompressive craniectomy.

MONDAY, APRIL 8, 2002

Breakfast Seminar 7:30–9:30 AM
105 Management and Treatment of Traumatic Cervical Spinal Cord Injury
Moderator: Charles H. Tator
Panelists: Fred H. Geisler, Christopher G. Paramore, Barth A. Green, Michael G. Fehlings, Paul R. Cooper
This seminar will teach diagnosis, non-surgical treatment, and surgical treatment of acute cervical spinal cord injury based on the principles of evidence-based medicine.

2002 Poster Session 2:15–2:45 PM
Neurotrauma and Critical Care Posters

Scientific Session IV 2:45–5:15 PM
747 Anterior Plating for Cervical Trauma: The Effect of Plate Design on Graft Subsidence and the Preservation of Segmental Lordosis
Larry T. Khoo, Anthony Kim, Daniel T. Laich, Fred Geisler, Srinath Samudrala
Discussant: Regis William Haid, Jr.

TUESDAY, APRIL 9, 2002

Breakfast Seminars 7:30–9:30 AM
202 Current Options in Cerebral Neuromonitoring
Moderator: Jeffrey R. Kirsch
Panelists: Gary K. Steinberg, Donald W. Marion, Jamie S. Ullman, Pirjo Manninen
The seminar will serve to educate the audience in the use of neuromonitoring in neurovascular surgery, head trauma and spine injury. The seminar will be used to discuss advantages and disadvantages for using electrophysiologic monitoring as well as monitoring of intracranial hemodynamics and invasive and noninvasive assessment of parenchymal viability.

211 Pediatric Head Injury: Avoid Common Pitfalls
Moderator: Thomas G. Luerssen
Panelists: Ann-Christine Duhaime, Lorenzo F. Munoz, P. David Adelson
This session will review specific age related aspects of traumatic brain injury. Special attention will be placed on early diagnosis and management of injuries that might be missed or easily misdiagnosed.
Neurotrauma Symposium 3–4 PM
Speakers: Shelly D. Timmons, Domenic P. Esposito, Raj K. Narayan, Alex B. Valadka

Timing Issues in Decompressive Craniectomy for Trauma – Domenic P. Esposito

Trauma Practice Guidelines: Their Impact in the Real World – Raj K. Narayan

Socioeconomic Aspects of Neurotrauma: Position Statements, Contracts, EMTALA and On Call Obligations – Alex B. Valadka

Scientific Session 4–5 PM
Moderators: Shelly D. Timmons, Julian E. Bailes, Jr.

Synthes Award for Resident Research on Brain and Craniofacial Injury
808 Limited Head Trauma: A New Criteria for Management of Patients with Minor Head Injury
Joseph S. Neimat, Sepideh Amin-Hanjani

Synthes Award for Resident Research on Spinal Cord and Spinal Column Injury
809 Increased Frequency of Cells Expressing a Neuronal Phenotype in the Injured Spinal Cord after Intravascular Transplantation with Bone Marrow Cells
Edward R. Smith, Tao Cheng, David Scadden, E. Antonio Chiocca

810 Intravenous Administration of Marrow Stromal Cells (MSCs) Increases the Expression of Growth Factors in Rat Brain after Traumatic Brain Injury (TBI)
Asim Mahmood, Danyue Lu, Yi Li, Michael Chopp

811 Relationship between Local Cerebral Blood Flow and Metabolism after Severe Human TBI
Oscar L. Alves, Egon R.M. Doppenberg, Tobias Clausen, Michael Reinert, Alois Zauner, Harold F. Young, Ross Bullock

812 Metabolic Blood Flow Effects of High Dose Propofol in Head Injured Patients
Matthias F. Oertel, Daniel F. Kelly, Thomas C. Glenn, Neil A. Martin

813 The Protective Role of Cerebrospinal Fluid in Traumatic Brain Injury
Yung-Hua Chu, Michael Bottlang

WEDNESDAY, APRIL 10, 2002

Breakfast Seminars 7:30–9:30 AM
303 Cerebral Trauma: Evidence Based Approaches in Your Practice
Moderator: Jack E. Wilberger, Jr.
Panelists: Brian T. Andrews, Beverly C. Walters, Jamshid Ghajar
A full discussion of the currently available guidelines in neurotrauma (critical care of severe head injury, penetrating head injury, surgical treatment and severe head injury) and their pertinence for clinical practice.

313 Spinal Cord Injury: Contemporary Management Including Post-Traumatic Syrinx
Moderator: Barth A. Green
Panelists: Dennis Jay Maiman, Michael G. Fehlings, Fred H. Geisler, Emmanuel Gay
This seminar will provide the audience with the latest information on the medical and surgical management of spinal cord injury, including delayed consequences and posttraumatic syringomyelia.

Frank Z. Bagan Special Symposium 11:45 AM–1 PM
Moderator: David F. Jimenez
EMTALA Regulations: Clarification and Discussion of How They Affect Your Practice and Your Life
Thomas Scully, CMS Administrator (Invited)
EMTALA rules are causing significant pressure on neurosurgery to provide 24/7 on-call trauma coverage. Failure to comply with these rules places neurosurgeons at great risk. This program will clarify and describe the responsibility neurosurgeons have in complying with these rules.

THURSDAY, APRIL 11, 2002

Special Courses 9:45 AM–12 PM
Special Course I - Spinal Cord Injury: What’s New in 2002
Moderator: Mark N. Hadley
Panelists: Beverly C. Walters, Paul A. Grabb, Richard G. Fessler, Daniel K. Resnick, Paul C. McCormick
Spinal cord injuries occur approximately 14,000 times per year in North America. Management can affect outcome in these patients. This course is designed to provide assessment and management strategies based on evidence-based medicine. Recently developed guidelines will be reviewed, and promising future treatments will be discussed.

Special Course III - The Neurosurgeon’s Role in the Management of Mass Casualties
Moderator: M. Ross Bullock
Panelists: James M. Ecklund, Jamshid Ghajar, Randall R. McCaffery
We will review the organization of mass disaster medical care in the U.S., review the role of neurosurgeons in such disaster scenarios and also draw upon military neurosurgical experience.
By the end of May 2001, the ground in and around Houston was "supersaturated" by the usual spring rains. No one paid particular attention to the squall line that formed off the coast of Galveston the first week of June. A Gulf of Mexico weather buoy that was damaged by a passing ship in April had not been repaired, and the severity of the storm was underestimated. By June 5 and 6, newly reclassified Tropical Storm Allison had stalled south of Houston and added 12 inches of water to Houston’s already wet turf. By Friday, June 8, Allison was stalled directly over Houston and dropped up to 36 inches of rain in 24 hours in some areas of the city.

The medical community of Houston was completing another typical week of patient care, research, education, and operations. The 7,000 beds of the Texas Medical Center were filled with patients, many in critical condition. The two regional trauma centers (located one block apart in the Texas Medical Center) were extremely busy, and each had already been on “ambulance drive-by” for three to four days during the first eight days of June.

On Friday, June 8, 2001, primarily during the evening hours, the torrential rains came down. By 6 a.m. on June 9, when the rains slowed, the entire city was flooded, with freeways becoming rivers and lakes, downtown tunnel systems becoming underground rivers, and all drainage bayous over their banks. Tens of thousands of homes were flooded, and many citizens awoke to water creeping into their homes at an alarming rate. Their calls to 911 were met with a busy signal. Many had to leave their homes, trudging through waist-high water in the dark predawn hours with only the clothes on their backs, devoid of possessions, including necessary medications. Although no area was spared, three areas of Houston were hardest hit—downtown, northeast residential sections, and the Texas Medical Center.

Twenty-two deaths were attributed to the “Great Flood of 2001.” With the extensive, rapid flooding and ensuing damage, it is amazing that the death toll was not higher. Damages were ultimately calculated as being in excess of $5 billion, about $2 billion of which was in the Texas Medical Center. The research facilities and laboratories of the University of Texas Health Science Center at Houston and Baylor College of Medicine were devastated by loss of power and rising floodwaters. The impact on medical research was, and will continue to be for years to come, catastrophic. Over 30,000 laboratory animals were lost. Major loss of cell lines, some produced over a lifetime, occurred.

All clinical activities of the city were severely impaired, with major flooding and loss of power in most downtown and Texas Medical Center hospitals. Floodwaters crashed through the basements of Medical Center hospitals, knocking out power, and, in some cases, disabling backup power sources. Hermann Hospital lost both municipal and back-up generator power and evacuated the entire hospital for approximately six weeks. At the peak of the crisis, nurses manually ventilated patients on electric ventilators, and some patients had to be carried down many flights of stairs with only flashlights to provide illumination. The usual routines at The Methodist Hospital and St. Luke’s Episcopal Hospital ground to a halt, especially for the first few days after the flood. Ben Taub General Hospital remained the only Level I trauma center for the greater Houston area. Although all emergency care was impaired and strained, two areas were recognized as creating the greatest challenges: identification of available nurses and neurosurgery resources.

Neurosurgery challenges existed from before loss of power until the regional hospitals were fully functional. These challenges included an initial increase in head injuries, isolation of the Texas Medical Center from access by ambulance for eight hours, power surges requiring ventilators to need “resetting,” blowing out the motherboard on the trauma center’s CT scanners, overcrowding of the neurosurgery ICU, and a paucity of regional locations where neurosurgery capabilities existed.

Because of the street flooding on early Friday evening, Ben Taub General Hospital had more than the average number of car wreck victims during that time. The last surgery performed prior to loss of municipal power was on a patient with an acute subdural hematoma. The neurosurgery intensive care unit was full. By 12:30 a.m. Saturday, no ambulance could enter or egress the Texas Medical Center. By 3:30 a.m., Ben Taub General Hospital began receiving calls from outlying hospitals and individuals requesting transfer or advice, including one from a person who had fallen at home, had a seizure, and was seeking advice on how to obtain medical attention. Other calls were from patients with obstetrical problems, myocardial infarctions, diabetic ketoacidosis, and various types of trauma. At Ben Taub General Hospital, during the initial power outage and subsequent powering up of generators, all ventilators stopped functioning. Nurses assured that all affected patients were manually ventilated until ventilators could be reset.

(continued on page 5)
After publication of my article “Who Wants to Be an EMTALA Surveyor?” in the last issue of Neurotrauma and Critical Care News, I have been overwhelmed with electronic and conventional mail. The prevailing question concerning the article has to do with the minimum number of neurosurgeons needed to satisfy the 24/7 call requirement. By reporting that the presence of four or more neurosurgeons on staff at a given hospital obligates the provision of 24/7 emergency room coverage, I was guilty of perpetuating a myth. Those of us working on the EMTALA issue had been led to believe in the “Rule of Three.” We were told that a Centers for Medicare and Medicaid Services (CMS) guideline instructs surveyors to require hospitals with more than three specialists in a given field to provide uninterrupted coverage of the emergency room. Supposedly, if three or fewer neurosurgeons are on staff, gaps are allowed in the schedule.

In November 2001 I contacted the CMS to see if this rule could be verified. There is not now, and there has never been, such a guideline or statute. As the EMTALA coordinator from CMS explained to me, this “urban legend” originated with a lawyer whose goal was to compel specialists in his hospital to take ER call by suggesting that a federal regulation mandates 24/7 coverage if mean that three specialists on staff are sufficient to provide 24/7 coverage if

The “Rule of Three” is an Urban Legend

Thomas E. Hoyt, MD

Unfortunately, the surge protector on the CT scanners did not protect the motherboard, and CT scanners were nonfunctional for 18 hours. Neurosurgeons were prepared to resort to arteriograms to evaluate patients presenting with head injuries during this time.

At 7:00 a.m., a vehicle arrived with the first patient to be transported to Ben Taub General Hospital since the flood began. This “ambulance” was a large 18-wheeler—the only type of vehicle able to negotiate the high waters. The patient had sustained a head trauma. Fortunately, the patient did not require extensive diagnostic testing or surgery.

During the first 18-24 hours after the power outage, numerous challenges faced the teams that found themselves “trapped” in the hospitals at midnight on Friday. At least 50 percent of hospital personnel for the night and day shifts were unable to get into the hospitals. The hospitals had no air conditioning, and many of the elevators would not function. Initially, Saturday morning breakfast for the patients and (tired) personnel was in question. A cook and limited dietary personnel managed to prepare a meal that was somewhat delayed, but very appreciated. Limited inventories of needed drugs and supplies became a concern to the hospitals that were still functional. The city water pressure remained normal, and any concern about contaminated municipal water was unfounded.

For almost three months after the flood, the normal flow of neurosurgery patients, especially head trauma patients, was interrupted. Houston’s EMS attempted to bring to Ben Taub General Hospital only the most severely ill and injured, but this did not keep the intensive care units from being full. Hermann Hospital personnel set up a temporary trauma unit at one of the peripheral hospitals.

Space does not permit identification of the numerous individual heroes who performed far beyond the call of duty during this time of disaster. Many physicians, nurses, engineers, and personnel from virtually every hospital support area worked more than 36 hours straight during the initial time of crisis. Innovations occurred in every hospital to provide needed healthcare to the patients of the greater Houston region.

One major lesson learned related to disaster drills and planning. Drills are beneficial to at least train and facilitate communication, which, indeed, is key to successfully managing any situation. However, many “paper plans” have no practical application in an actual disaster situation. It is imperative to realize that no one document is the end-all, be-all “plan,” and there is no substitute for a reasoned approach—tempered with sound judgment—to the many unexpected, unanticipated problems that inevitably accompany any disaster or catastrophic event. Recommendations have been made to JCAHO (Joint Commission on Accreditation of Healthcare Organizations) and FEMA (Federal Emergency Management Agency) to alter their approaches to disaster planning.
Fellowships and Resident Awards

Michael G. Fehlings, MD, PhD

Codman Fellowship
The 2001-2002 Codman Neurotrauma Fellowship has been awarded to John Boockvar, MD, of the University of Pennsylvania for his proposal “EGFR Signaling and Human Neural Stem Cell Phenotype,” presented at the 2001 Annual Meeting of the Congress of Neurological Surgeons in San Diego.

Synthes Awards
Two Synthes Resident Research Awards were presented at the CNS 2001 Annual Meeting in San Diego. The Synthes Award for Resident Research on Spinal Cord and Spinal Column Injury was presented to Nicolas Phan, MD, of the University of Toronto for his paper “Role of the mGluR1 Receptor in Diffuse Axonal Injury after Brain and Spinal Cord Trauma: Potential for a Novel, Clinically Relevant Neuroprotective Strategy.” The Synthes Award for Resident Research on Brain and Craniofacial Injury was presented to Ketan Bulsara, MD, of Duke University for his paper “Progressive Lesions Accelerate Functional Axonal Reorganization.”

Douglas Miller Traveling Fellowship
Ivan Ng, MD, FRCS, director, Neurosurgical Intensive Care Unit, Department of Neurosurgery, National Neuroscience Institute in Singapore, was awarded the Douglas Miller Traveling Fellowship for 2002. He will be visiting Ross Bullock, MD, PhD, at the Medical College of Virginia/Virginia Commonwealth University, Richmond, Va., and Donald Marion, MD, at the University of Pittsburgh.

Winners of the Synthes Awards for Resident Research are selected from among the abstracts submitted to the AANS and CNS. Through the support of Synthes, the Trauma Section is able to award two prizes (one cranial and one spinal) at both the AANS and CNS annual meetings.

The Codman Fellowship in Neurotrauma and Critical Care has been generously funded by Codman to support young neurosurgeons in obtaining additional clinical and research training in neurotrauma and related fields. Fellowship Award winners are chosen through a formal peer review process based on their curriculum vitae, the training environment, and the research and/or training proposal.

Information about these awards is available at the AANS/CNS Web site, www.neurosurgery.org. For further information, please contact Michael G. Fehlings, MD, PhD, chair, Fellowships and Awards Committee of the AANS/CNS Section on Neurotrauma and Critical Care (e-mail: michael.fehlings@uhn.on.ca).

Chairman’s Message (continued from front page)

The Case for Designating Specialized Head and Spinal Cord Injury Centers in the United States
The trauma designation system has now been in existence for a number of years and has had a major impact on improving the quality of trauma care. Evolution in the patterns of care for patients with severe head and spinal cord injuries over the last 10 years or so now means that centers that manage high volumes of such patients are those that have the best outcomes, a correlation which has been shown in several surveys of outcome following severe head injury. Factors such as the increasing use of helicopter and fixed-wing air transfer make distances between centers a less important factor in the management of head- and spinal cord-injured patients, except in those very few head-injured patients who are rapidly deteriorating from acute epidural or subdural hematomas. The increasing demands of managing such head- and spinal cord-injured patients in terms of ICP care, adjunctive pharmacological therapy, management of other systemic injuries, and surgical interventions means that outcome is generally better for such patients in centers that have residents in training.

Accordingly, the Trauma Section has proposed that “supraregional” centers with a declared interest and special expertise in the management of severe head and spinal cord injury be established. The state of Florida has already designated centers in this way. We envision a system in which centers could initially self-select and volunteer themselves to be so designated. The Trauma Section could then ratify and support their designation in the same way the American College of Surgeons designates Level I, Level II, and Level III trauma centers. For those centers which do not meet the criteria, the Trauma Section could assist the center in developing the required expertise.

Clearly, third-party payers and insurers would have a strong interest in ensuring that these extremely “expensive” patients be cared for in the best possible environment to achieve the best outcomes and to contain costs. Specific, designated centers could then provide specialized training, either at “fellowship level” or at chief resident level, to facilitate the dissemination of the best knowledge of neurotrauma care throughout the country.

A major challenge for the Trauma Section over the next two years will be to develop specific details for this scheme.
CPT Coding and Reimbursement Committee
Sam Hassenbusch, MD, PhD

The AANS/CNS Coding and Reimbursement Committee, in conjunction with the Trauma Section, has been working on new codes (and better wording of codes) to cover all of the Trauma Section’s procedures and also to try to keep reimbursement values (based on relative value units, or RVUs) as high as possible for our members.

In response to requests from various societies through the AMA House of Delegates, the Current Procedural Technology (CPT) Editorial Panel has passed a new code for 2003 that allows reporting for “mandated on-call physician services” for the emergency room: “Hospital-mandated on-call service; in-hospital, each hour” and “out-of-hospital, each hour.” How these codes will be valued remains to be seen. It seems unlikely that many payers will reimburse for this work, but documenting and submitting such codes might be useful for contracting with hospitals.

A new neurosurgical trauma code proposal (to take effect, it is hoped, on Jan. 1, 2003) has been proposed and is working its way through the CPT and RVU Update Committee (RUC) process. Tentatively, the first of these codes would be “Craniotomy/craniectomy, decompressive, with duralplasty, without lobectomy, for treatment of intracranial hypertension, without evacuation of associated intraparenchymal hematoma.” This code is intended for the treatment of increased intracranial pressure by removal of bone and dura only.

The second of these new trauma codes would be “Craniotomy/craniectomy, decompressive, with lobectomy, with or without duralplasty, for treatment of intracranial hypertension, without evacuation of associated intraparenchymal hematoma.” This code is intended primarily for the resection of a focal area of brain swelling that does not have an intracerebral hematoma. For purposes of CPT approval and RUC valuation, this code covers either a supratentorial lobectomy or a cerebellar lobectomy. If needed in the future, the code can be split into two new codes.

To avoid any overlap with these two new codes, a rewording of the present code 61340 was necessitated. The new wording would be “61340–Subtemporal cranial decompression (pseudotumor cerebri, slit ventricle syndrome).”

It should be remembered that the removal of an intracerebral hematoma (with or without associated surrounding edematous brain) is coded by 61313/61315 (supratentorial/infratentorial, respectively), and the removal of an epidural or subdural hematoma is coded by 61312/61314 (supratentorial/infratentorial, respectively).

Another code pair is also on track for Jan. 1, 2003: “Incision and subcutaneous placement of cranial bone graft” and “Incision and retrieval of subcutaneous cranial bone graft for cranioplasty.”

As always, the AANS/CNS Coding and Reimbursement Committee is eager to hear from any Trauma Section member about new code needs, problems with existing codes, and/or reimbursement problems. Please feel free to contact at any time either Samuel Hassenbusch (samuel@neosoft.com, fax 713.794.4950) or Greg Przybylski (gprzybylski@nmff.org, fax 312.695.3141). While we’re always available by phone, it generally is more effective to use either e-mail or fax so we can have time to research the issue, look up alternative options, and then discuss best answers with the entire committee, although we can almost always have an answer within three to five days.

Pediatric Neurotrauma Committee
P. David Adelson, MD

Members of the Pediatric Neurotrauma Committee remain active in multiple areas and have made excellent progress on a number of projects:

The Pediatric Severe Traumatic Brain Injury (TBI) Guidelines.
Excellent progress continues to be made on the Pediatric Severe TBI Guidelines. Drafts of each of the chapters were being completed and compiled at the time of the 2001 CNS meeting in San Diego. A compact disc of the Guidelines draft has been distributed to the AANS and CNS for initial review and comments. Finalization of different revisions and completion of the final product is imminent. The Guidelines will then be submitted for publication, the venue of which remains to be decided.

Multicenter Trial: Phase II Study of Hypothermia for Severe TBI in Children and Evaluation of Initial Outcome Assessments in Children Following Severe TBI.
The Multicenter Trial continues and will likely finish up accrual by June 2002. Most of the aims and goals of the study are being met, and the study is likely to be completed as originally projected. Once the data are analyzed, abstracts will be submitted to the different national meetings in order to disseminate information.

The edited versions of the finished chapters are near completion. April 2002 is the planned date for publication and distribution of this book. Chapters will discuss identification, evaluation, and treatment of these children, as well as some interesting aspects of the unique pathophysiology of injuries in this age group, outcomes, and possible future efforts in the areas of prevention and education. There is also an important chapter on medicolegal aspects, particularly with regard to the treating physician.

continued on page 8
Cervical Spine Clearance Recommendations for Young Children.
A new working group of pediatric neurosurgeons and members of the Pediatric Neurotrauma Committee met at the 2001 CNS meeting in San Diego to discuss issues surrounding cervical spine clearance of the comatose or young child where there is a question of radiologic versus clinical clearance. This group is considering a multicenter prospective study to look at best practices in these situations.

It is obvious from the number of major projects that are near completion that members of the Pediatric Neurotrauma Committee remain active and productive. I wish to publicly thank the members of the Pediatric Neurotrauma Committee and recognize their contributions to these different programs and projects.

Spinal Cord Injury Committee
Michael G. Fehlings, MD, PhD
A special “Focus Issue” devoted entirely to a state-of-the-art review of basic and clinical aspects of spinal cord injury appeared as a supplement to the Dec. 15, 2001, issue of 'Spine. The issue, which I guest-edited, is available on the Web at www.spinejournal.com. Highlights of this comprehensive review include a pro-con debate regarding the use of steroids in spinal cord injury, and the presentation of the results of the GM-1 ganglioside trial in acute spinal cord injury.

The articles are grouped under the following sections: Basic Science; Nonoperative Management of Acute Spinal Cord Injury; The Role of Methylprednisolone in Acute Spinal Cord Injury; The Role of GM-1 Ganglioside in Acute Spinal Cord Injury: Results of the Sygen-Multicenter Trial; Surgical Treatment of Acute and Chronic Spinal Cord Injury; and Rehabilitation and Chronic Issues after Spinal Cord Injury.

Membership Committee
Jamie S. Ullman, MD
As of February 2002, the Trauma Section has nearly 1,200 members. This number reflects a steady increase over the past several years. The Trauma Section is second only to the Spine Section in membership. Recent initiatives have been responsible for the current increase, including extending free membership to residents. Letters of invitation to join the section have been mailed to all first-year residents and to all graduating chief residents. Plans are underway to send an AANS News E-Blast and written letters of invitation to member neurosurgeons who have listed trauma as an area of activity but who are not section members. It is also our hope to increase the number of Associate Members in the near future. All persons interested in joining the AANS/CNS Section on Neurotrauma and Critical Care are encouraged to submit the application in this newsletter.

Washington Committee
Donald W. Marion, MD
The Washington Committee met Nov. 29-30, 2001, and discussed several issues related to neurotrauma. Domenic Esposito, MD, sent a letter to John Popp, MD, chair of the Washington Committee, raising concerns that the Food and Drug Administration is making it increasingly difficult for pharmaceutical companies to get approval for Phase I and Phase II clinical trials in brain injury. According to Dr. Esposito, this issue was originally raised at the Executive Committee meeting of the American Brain Injury Consortium in San Diego, and both he and Anthony Marmarou, PhD, were requesting assistance from the Washington Committee to convince the FDA to relax its restrictions. The issue was discussed at length, and the recommendation of the Washington Committee was that it should be discussed at the next Executive Committee meeting of the AANS/CNS Section on Neurotrauma and Critical Care. Before it decides to take action, the Washington Committee would like more information about specific instances where the FDA blocked Phase I and Phase II trials, other possible reasons for pharmaceutical companies to not want to proceed with these trials, and general information about how widespread this problem is. The issue will be on the agenda of the next Executive Committee meeting of the Trauma Section, and the results will be reported to the Washington Committee at its next meeting in the spring.

Currently, the AANS and CNS, in an effort led by Katie Orrico, JD, are working with the AMA to draft legislation to revise EMTALA laws to make it easier for neurosurgeons to comply. Rep. John Shadegg and Sen. John Kyle, both of Arizona, are primary sponsors of this legislation; action is expected in early 2002. The primary changes that are sought relate to the Centers for Medicare and Medicaid Services and their interpretation of the bill. The new legislation asks for clarification of EMTALA’s requirements for physicians and hospitals, improvement of the enforcement process of EMTALA regulations, Medicare and Medicaid support payments for EMTALA-mandated services, and involvement of the provider community in evaluating EMTALA policy.

Ms. Orrico also provided the Committee with a review of Congress’ recommended appropriations for trauma and trauma-related programs for next year. For the Trauma Care Systems Act, the U.S. House has recommended $3 million for fiscal year 2001, and the Senate has recommended $4 million. Last year’s appropriation was $3 million. For the Traumatic Brain Injury Act, the House again has recommended the same appropriation as last year, $5 million, and the Senate has recommended doubling this amount. This particular bill provides funding for community service programs, advocacy and protection services, and money for planning grants for community-based traumatic brain injury programs. Finally, the House has recommended a slight increase, and the Senate a larger increase, in the appropriations for the National Center for Injury Prevention and Control. The Senate versions of all of these bills are strongly supported by the AANS and CNS, as well as by the American Association for the Surgery of Trauma and the Orthopaedic Trauma Association.

Congresswoman Jamie S. Ullman, MD is the chair of the Membership Committee. She has been instrumental in increasing membership numbers in the AANS/CNS Section on Neurotrauma and Critical Care. She will also present a special “Focus Issue” on traumatic brain injury in the April 2002 issue of Spine, which will be available on the Web at www.spinejournal.com. Highlights of this comprehensive review include a pro-con debate regarding the use of steroids in traumatic brain injury, and the presentation of the results of the GM-1 ganglioside trial in acute traumatic brain injury.
Application for Membership
AANS/CNS Section on Neurotrauma and Critical Care

Eligibility: Members of the AANS and/or CNS who are actively interested in Neurotrauma.

Note: Adjunct Membership is available to non-neurosurgeons who are not members of the AANS or CNS. Please contact 847-378-0500 for an Adjunct Membership application.

I. Biographical:
(A) Name: ______________________________________________________________________________
(B) Home Address: ______________________________________________________________________
(C) Office Address: ______________________________________________________________________
____________________________________________________________________________________
Phone:_______________________________________ Fax: __________________________________
(D) E-Mail:______________________________________________________________________________

II. Category of Membership Requested:
❏ Active    ❏ Associate    ❏ International    ❏ Resident*

III. Membership, Certification and Practice:
(A) Are you certified by the American Board of Neurological Surgery?    ❏ Yes    ❏ No
(B) For Resident Applicants-Expected Residency Completion Date (month/year) ____________
(C) Are you a member of:
1. The American Medical Association?    ❏ Yes    ❏ No
2. A Local or Regional Medical Society?    ❏ Yes    ❏ No
3. A State or Provincial Medical Society?
   Name: ________________________________    ❏ Yes    ❏ No
4. American Association of Neurological Surgeons?    ❏ Yes    ❏ No
5. Congress of Neurological Surgeons?    ❏ Yes    ❏ No

_________________________    ________________________
Signature of Applicant    Date

* Membership dues are waived for applicants currently enrolled in a neurosurgical residency program.

Please return completed application with your membership fee of $50 to:
AANS/CNS Section on Neurotrauma and Critical Care
Dept. 77-7550
Chicago, Illinois 60678-7550
2002 AANS Education and Practice Management Course Schedule

**Beyond Residency: The Real World**
October 26, 2002  Chicago, Illinois

**Innovations in Spinal Fixation: An Advanced Course**
July 27-28, 2002  Memphis, Tennessee

**Managing Coding & Reimbursement**

**Challenges in Neurosurgery**
May 10-11, 2002  Anaheim, California
August 23-24, 2002  Boston, Massachusetts
September 6-7, 2002  Chicago, Illinois
November 15-16, 2002  Washington, D.C.

**Neurosurgical Practice Management:**

**Managing Your Practice by the Numbers**
May 12, 2002  Anaheim, California

**Neurosurgical Review by Case Management:**

**Oral Board Preparation**
May 26-28, 2002  Hartford, Connecticut
November 10-12, 2002  Houston, Texas

For more information or to register call (888) 566-AANS or visit www.neurosurgery.org/aans/meetings/epm/epmcourses.html.

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