niques, the majority of them knew what the basic life support and automated external defibrillation is. Half of them would not apply mouth to mouth ventilation in unfamiliar person, but most of them would apply mouth to mouth ventilation to children or familiar adult. Regarding the management of the airway, the majority of them showed an inability to put the victim in recovery position while half of them failed to ventilate with a laryngeal mask.
Conclusion: The results of our study suggest the need for continuous and intensive training of Gastroenterology doctors and nurses who provide sedation in resuscitation and airway management techniques.

17AP3-5

Intraocular pressure changes during robotic assisted radical prostatectomy with total intravenous anaesthesia

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Background and Goal of Study: Robotic assisted radical prostatectomy (RARP) is one of the newest and most advanced surgical treatment of prostate cancer with advantages of decreased blood loss and faster surgical recovery. But the procedure requires specific positioning; steep Trendelenburg position. Laparoscopic surgery with head-down position is associated with nonphysiologic effects as increase in the intraocular pressure (IOP). However, IOP changes during RARP with steep Trendelenburg position are not certain, and the effects of anaesthesia, head-down tilt, pneumoperitoneum have not been clearly separated. The aim of this ongoing study was to investigate IOP changes during RARP performed under TIVA.
Materials and Methods: Following approval by the institutional review board, informed consent was obtained from 20 patients (ASA I-III) scheduled for elective prostatectomy. Patients with preexisting eye disease, history of eye surgery, elevated IOP (>30 mmHg), age older than 80yr were excluded. Anaesthesia was induced with propofol (2-3 mg/kg), remifentanil (1 μg/kg), rocuronium (0.6 mg/kg) and maintained with propofol (6-10 mg/kg/hr) and remifentanil (0.05-0.2 μg/kg/hr), infusions were adjusted to keep mean arterial blood pressure within 20% of its preinduction value. The IOP (Tono-pen XL® tonometer) was measured at defined intervals during the procedure; before induction-supine (T1), entubated-supine (T2), after insufflation-supine (T3), in steep Trendelenburg (T4), after desufflation-steep Trendelenburg (T5), repositioning supine (T6), and 1hr after awakening in supine position (T7).
Results and Discussion: For both eyes a significant decrease was observed in IOP after anaesthesia induction (T2) compared with baseline measurements (T1) ($p < 0.05$). Following CO_2 insufflation and Trendelenburg positioning IOP increased consequent with literature findings but this increase was not statistically significant. At the end of the procedure repositioning the patients to supine position resulted with a significant decrease in IOP, probably as a result of desufflation and ceasing pneumoperitoneum.
Conclusion(s): In this ongoing study, we examined the effects of TIVA, steep Trendelenburg position during laparoscopy with CO_2 insufflation on IOP changes in patients undergoing RARP. Total intravenous anaesthesia seems to be protective against increases in intraocular pressure with pneumoperitoneum and steep Trendelenburg position.

17AP3-6

Does the transportation of patients from the operating room to the post-anesthetic care unit should be done with supplemental oxygen?

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Background: After a surgery, the transportation of patients from the operating room (OR) to the post-anesthetic care unit (PACU) is normally done without supplemental oxygen. Unless the patient is at a high risk of developing hypoxemia, the oxygen supplementation is not used. The goal of this study was to compare the changes in oxygen saturation when patients leave the OR and when they arrive in the PACU, and to identify the risk factors associated to the development of hypoxemia.
Methods: We prospectively observed 50 patients of both genders, 38 men and 12 women, between 19 and 82 years old (mean 62), physical status ASA I, II and III, who underwent vascular and general surgeries, and were submitted to balanced general anesthesia. Oxygen saturation was measured just before the patient left the OR and as soon as they arrived in the PACU. The time of the transportation was also recorded. The hemoglobin saturation was classified as normal (≥ 95%), mild hypoxemia (between 91% and 95%), moderate (between 86% and 90%), and severe (< 85%).
Results: Moderate and severe hypoxemia occurred in 8% and 4% respectively. The mean of the transport duration was 6 minutes. There was a greater incidence of this occurrence during the transport of female patients (16,6%), and patients with physical status ASA III (29%). The mean of ages was 64 years old. All of the patients that presented moderate and severe hypoxemia, were smokers (42,9%), or obese (75%), and in two cases the duration of surgery was superior to 4 hours.
Conclusions: Although the small number of patients observed in this study, we can conclude that there are factors that could be associated with the development of hypoxia during the transportation of patients from the OR to the PACU. The option of using supplemental oxygen during the transportation to the PACU should be considered separately, patient by patient, and should be guided by the presence of these risk factors in order to reduce the morbidity, mortality, and the incidence of hypoxemia in the early post-operatory period.

17AP3-7

Reducing the number of cancelling surgery, increasing the patient safety

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Background and Goal of Study: Cancelling or delay surgery brings time consumption, patients and families' unpleasantness, resource wasting, and even poor prognosis caused by extended starvation and progression of disease. All these factors make the decision of anesthesiologist being difficult. Some factors could be avoided. In order to reduce the unnecessary/avoidable cancellations, we investigated cases in our institution from January, 2009 to December, 2010.
Materials and Methods: During a period of 23 months, we recorded 123 cases(over 57451 cases) retrospectively which were cancelled or delayed at the first scheduled time. We collected the data from medical chart and the coordinator of quality assurance in our anesthesiology department. The reasons, postponed duration, surgical departments, outcome, the ration of transferring anesthetic methods, outcome with disease progression, and patient's characteristics were analyzed.
Results and Discussion: The overall incidence was 0.2% and there were seven categories of reasons for cancellation: change of medical condition, surgical plan, insufficient fasting duration, systemic error, airway problems, incomplete pre-operative evaluation, and family relative factors.
The higher proportion of cancelling cases were found in orthopedic **(0.16% in orthopedic surgery, 0.03% in all),** genitourinary **(0.3% in GU surgery, 0.04% in all)** and endoscopic examination **(0.2% in endoscopic)**.
From categories of reasons, the incidence of unexpected change of medical status **(59.3%)** (such as malignant hypertension, severe arrhythmia, etc) was significant higher than other factors. The following reasons were families relative factors including change of decision and absent from discussion about illness condition. Interestingly, 20 cases were cancelled after anesthesia induction, and 75**%** could be preventable for cancellation.
Conclusion(s): This results may help us improving the quality of operation room and the safety of patient care. Although some causes seem to be an uncontrollable factor, but we still could reinforce communication between branch departments.
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17AP3-8

Wrong side peripheral nerve blocks; a ten year review

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Background and Goal of Study: As the use of peripheral nerve blocks is becoming more frequent, the number of blocks performed on the wrong side has become a serious concern, warranting closer attention. In the state of Pennsylvania alone, it is estimated that "wrong-site" blocks represent 29% of all reports of wrong-site procedures in the surgical suites, the largest cohort of wrong-site procedures within a single specialty. Over time, wrong-site blocks have increased significantly from less than 20% of all reported cases to more than 40%, suggesting that the implementation of best-practice strategies to prevent wrong-site blocks lags behind other efforts to prevent wrong-site surgery.
Materials and Methods: We reviewed the number of peripheral nerve blocks performed by the division of Acute Interventional Perioperative Pain and regional anesthesia at the University of Pittsburgh Department of Anesthesiology between the time period of July 1, 2002 - June 30, 2011.