DEPARTMENT OF ANESTHESIA AND PERIOPERATIVE MEDICINE

SLEEPY TIMES

VOLUME 20, ISSUE 3 MARCH 2026

Inside This Issue:

OPENING STATEMENT: NEW MITOCHONDRIAL DISEASE AND ANESTHESIA

-Carlee Clark, MD

I'd like to bring your attention to a few important Department updates based on the recent jointly communicated safety concern from the ASA and SPA regarding a newly recognized risk of severe neurologic complications following anesthesia in patients with maternal Venezuelan ancestry.

As a reminder, recent case reports have identified catastrophic neurologic injuries—including basal ganglia infarcts and death—in otherwise healthy adult and pediatric patients exposed to general anesthesia. A mitochondrial ND4 gene mutation (mtND4 m.11232T>C) has been implicated in several cases, suggesting a mitochondrial vulnerability to anesthetic-induced inhibition. Most reported events involved sevoflurane exposure.

Although the overall incidence remains unknown, this information is important for our preoperative screening and case planning—particularly in ambulatory settings, where patients may appear entirely healthy and mitochondrial phenotypes may be silent until anesthetic exposure.

We have already had a patient at SMP with Venezuelan ancestry who was cancelled until further discussion. Pediatric patients with mitochondrial diseases pose potential additional risks with propofol infusions.

As a department, we are currently discussing how best to operationalize screening, counseling, and anesthetic planning. Dr. Bridges is working with our PAT clinic teams to identify at-risk patients as the preoperative evaluation may help guide testing, risk stratification, and anesthetic choice. Drs. McCoy and Bridges have been in touch with our genetics team, and we are working with them to figure out who should be tested and what that workflow will be (ie. who should order the testing and how long it will take). We are also trying to partner with our pediatric and adult surgeons for early identification of patients at risk. We are meeting soon as a large group and will follow up with everyone afterwards.

In the interim, please familiarize yourself with the statements from ASA and SPA. We do not think cancelling all procedures is warranted at this time, but we should consider whether elective cases requiring volatile anesthesia should be postponed or modified for these patients until more data are available. We should ALL be asking about Venezuelan ancestry as part of our preop exam. Dr. Bridges has worked on language to help us add this to our interview

OPENING STATEMENT CONTINUED

Pediatric suggestion

"To help us provide the safest care, we ask about family history with anesthesia. Some medicines can affect patients differently depending on genetics or family background. All of the questions we ask are confidential and used only for medical purposes. In some recent cases, certain anesthesia reactions have been reported more often in families with Venezuelan ancestry. On your child's mother's side of the family, is there any Venezuelan ancestry, or family originally from Venezuela?"

Alternative for adults:

"Due to recent findings about genetic risk related to anesthesia medicines, we ask about maternal heritage. All of the questions we ask are confidential and used only for medical purposes. Are you or your mother of Venezuelan descent?

The optimal and safest anesthetic for patients with this ND4 mutation has not been established, but these cases will be treated very similarly to patients at risk for MH.

Key considerations for optimal patient care for patients with maternal Venezuelan lineage:

- Avoid volatile anesthetics, when possible, along with Machine flush, charcoal filters, possible first case of the day
- Regional anesthesia is encouraged when appropriate.
- Consider TIVA-based anesthetics, with thoughtful and cautious use of propofol.
- Utilize EEG-based depth-of-anesthesia monitoring to avoid burst suppression.
- Provide close neurologic observation in the postoperative period.
- No point-of-care test exists; genetic sequencing can identify the mutation, but labs must be asked specifically to report mtND4 m.11232T>C.

Thank you all for your attention to this emerging issue.

Warm regards,

Carlee Clark, MD

The following is a translation of the Updated Statement from the Venezuelan Society of Anesthesiology (February 2026). ChatGPT was used for this translation.

Informational statement from the Venezuelan Society of Anesthesiology regarding susceptibility to general anesthetics in patients of Venezuelan origin

Caracas, February 4, 2026
Social media and the news media shape the narrative used by a large part of the community. Many times, this wave of messages generates considerable concern within the medical community and among the general population. Our intention with this statement is to promote calm among the public and to invite an attitude of healthy expectation within the medical community while awaiting further scientific evidence to understand an infrequent and new phenomenon that requires appropriate explanations.

What do we know about this problem?
In July 2025, the Chilean Society of Anesthesiology reported six clinical cases of pediatric patients who, after elective surgical procedures without incidents, developed severe neurological impairment or failed to awaken.

OPENING STATEMENT CONTINUED

Fifteen days later, the Spanish Society of Anesthesiology, Resuscitation, and Pain Therapy acknowledged an international cohort of patients with similar involvement: Chile (6), Guyana (1), the United States (2), Germany (2), and Spain (3).

The American Society of Anesthesiologists and the Society for Pediatric Anesthesia published a joint communication in January of the current year in which they issued a clinical alert regarding cases of patients with severe neurological sequelae after routine anesthetics. In their official statement, the ASA and the SPA did not specify an exact numerical figure. They limited themselves to qualitatively confirming that, following the initial reports in South America, "additional cases have been identified in Europe and the United States."

The scientific societies emphasize that detailed clinical information is limited because much of it has been shared through personal communications and non–peer-reviewed publications, and access to complete records is restricted by health information protection laws. However, the report from the Spanish Society of Anesthesiology noted four cases in the United States, two of them genetically confirmed.

And in Venezuela?
In a 2025 statement, the SVA reported that there were no formally documented or reported cases. Some specialists, through personal communications, are aware of patients with similar outcomes. Additionally, in a research study presented as a keynote lecture at the Venezuelan Congress of Anesthesiology in November 2025, the authors presented a series of eight patients, five of whom underwent surgery in Venezuela between 2003 and 2025. This study will soon be published in an indexed anesthesiology journal.

This discrepancy between the figures recognized by the SVA in July 2025 and the events reported by the authors of the research study highlights the complexity of underreporting and the importance of this work in making visible a clinical reality that has gone unnoticed or has not been officially reported.

Do we know the cause of this situation?
The conference presented at the Congress describes a variant of mitochondrial DNA (mtND4 m.11232T>C) that causes instability of this protein, which is involved in energy production—especially in cells with high energy demand, such as neurons of the central nervous system—when exposed to inhaled anesthetics; in this conference, sevoflurane was discussed in particular.

In this *in vitro* study, exposure to sevoflurane in cells with the mutation caused a 90% decrease in oxygen consumption, leading to immediate energy collapse. Although propofol can also affect mitochondrial bioenergetics, it does so through pathways that do not interact destructively with this specific structural defect. In the same laboratory study in which sevoflurane was lethal to the mutant cells, propofol behaved in a benign manner. At clinical concentrations (<0.06 mM), propofol did not cause a significant decrease in oxygen consumption and showed no differences between healthy cells and those carrying the mutation

The inheritance of mitochondrial DNA is maternal, although mitochondrial DNA is modulated by nuclear DNA, which may explain why some individuals with the mutation may not manifest susceptibility even when exposed to the triggering factor.

In the general world population (outside the specific Venezuelan lineage of origin), this variant is virtually unknown. The variant has not been reported in any of the 285,539 sequences analyzed in MITOMAP (the reference database for the human mitochondrial genome) nor in more than 250,000 additional controls from around the world. This confirms that it is not a common polymorphism, but rather a very specific private mutation that is not circulating in the general European, Asian, or North American population.

Even within Venezuela, the variant does not appear to be ubiquitous, which makes its detection difficult without a targeted search. The variant was not found in a review of 414 Venezuelan individuals from the existing medical literature, nor in the 71 Venezuelan population controls specifically analyzed by the research team.

OPENING STATEMENT CONTINUED

Of the eight patients presented in the main cohort of the study (which includes cases in Venezuela, the United States, Germany, and Spain), five (5) were able to trace their direct maternal lineage to the state of Carabobo. It is estimated that the specific mitochondrial haplotype containing the mutation is 15 times more common in Carabobo than in the rest of Venezuela. The epidemiological importance of this geographic location lies in the fact that if the variant were random or uniformly distributed, the mathematical probability of randomly finding eight affected patients who share exactly the same mitochondrial haplotype would be one in (a number with 21 zeros).

We must state that we are very likely dealing with an extremely infrequent condition. Sevoflurane is the most widely used inhalational anesthetic in the world due to its safety profile and rapid recovery. According to data submitted to the World Health Organization (WHO) for inclusion in the Essential Medicines List, it is estimated that from its introduction through January 2022, more than 1.194 billion patients (nearly 1.2 billion) have received anesthesia with sevoflurane worldwide. This figure of more than one billion successful uses contrasts with the rarity of severe adverse events, underscoring that the recently discovered mitochondrial toxicity is a very low-frequency pharmacogenetic phenomenon

Is it possible to detect this mutation before surgery?
A targeted medical history must be taken. This is the highest-yield preoperative screening tool. Since the child's physical phenotype is irrelevant (they may be blond, dark-haired, or of mixed ancestry due to nuclear DNA admixture), the mitochondrial origin must be traced.

The question is not only the child's nationality, but rather: **"Where are the mother and the maternal grandmother from?"** Mitochondrial DNA is inherited exclusively through the maternal line.

If the maternal line originates from the state of Carabobo, the pretest risk increases exponentially (it is estimated to be 15 times more frequent in this area due to a founder effect).

The traditional clinical history question of "allergies to anesthesia?" is insufficient. We must actively question patients in search of the clinical expression of mitochondrial dysfunction in the maternal family, which is often subtle or misinterpreted.

The "Delayed Awakening" sign: Ask specifically: *"Did any relative on the mother's side take a long time to wake up, remain very weak, or require admission to intensive care 'as a precaution' after surgery?"* This delayed awakening is often the clinical manifestation of a mitochondrial energy crisis in patients who survived the exposure.

Sudden death or unexplained events: Ask about deaths of maternal cousins or uncles in childhood following minor procedures.

Although affected children are usually healthy (a silent phenotype), look in the mother or siblings for a history of chronic fatigue, palpebral ptosis (drooping eyelids), severe migraines, or exercise intolerance, which may suggest an underlying mitochondrial disorder.

Currently, there is no rapid point-of-care test that provides immediate results in the operating room. However, there are specific laboratory methods to identify the m.11232T>C variant in the MT-ND4 gene. According to the current evidence:

1. Confirmatory Genetic Testing
There are two main methods to identify the mutation, which can be performed using blood samples or, in a less invasive manner, via a buccal swab (saliva sample).

PCR-RFLP (Restriction Fragment Length Polymorphism): This is an option that can be performed in many standard molecular biology laboratories. It is a targeted test designed specifically to detect this point mutation. Its limitation is that it does not allow hundreds of samples to be processed simultaneously as quickly as with high-throughput sequencing, but it is very effective for individual diagnosis.

OPENING STATEMENT CONTINUED

Sequencing (Sanger or NGS): This is the definitive method. It allows reading of the entire mitochondrial genetic code or specifically the ND4 gene. Massively parallel sequencing makes it possible to study many patients daily, although it requires laboratories with more advanced technological equipment.

2. Metabolic Biomarkers (Indirect Screening):
If there is no time for genetic testing (for example, in emergency surgery), indirect signs of mitochondrial dysfunction can be sought, although these are not diagnostic of the specific mutation:

Serum lactate: Baseline lactate levels > 3 mmol/L or a lactate-to-pyruvate ratio > 20 may suggest an underlying mitochondrial abnormality.

Limitation: Many patients with this specific mutation have normal lactate levels at rest and decompensate only under anesthetic stress; therefore, a normal lactate level does not rule out risk.

Can intraoperative screening for this problem be performed?
If you decide to proceed with general anesthesia in a suspected patient (due to urgency or lack of testing), a depth-of-anesthesia monitor (BIS or SedLine) becomes a real-time diagnostic tool. Patients with Complex I defects (such as this mutation) show an abrupt drop in the bispectral index (BIS < 60) at very low concentrations of sevoflurane (0.5%–1%) during induction.

What are we doing from the Venezuelan Society of Anesthesiology?
The Venezuelan Society of Anesthesiology (SVA) is facing a unique epidemiological challenge: defining the true magnitude of a genetic "founder effect" that has transformed a routine practice into a life-threatening risk for a specific subgroup.

To study the prevalence of the m.11232T>C variant and mitigate risk without stigmatizing the general population or paralyzing operating rooms, the SVA must propose a phased strategy based on four fundamental pillars, supported by its alliance with the Institute of Advanced Studies (IDEA) and the Ministry of Science and Technology:

1. "Ground Zero" Study (Targeted Genetic Screening)
It is neither feasible nor cost-effective to sequence the entire Venezuelan population. The SVA should propose a stratified sampling focused on the state of Carabobo.

Justification: Current evidence suggests that the risk haplotype is 15 times more frequent in Carabobo than in the rest of the country, indicating a founder effect in this region.

Proposed Methodology: Implement PCR-RFLP testing (Restriction Fragment Length Polymorphism) instead of initial full sequencing. This technique is inexpensive, rapid, and can specifically detect the m.11232T>C mutation in saliva samples (buccal swab) or blood.

Target Population: Neonates or pediatric patients scheduled for elective surgery in major hospitals in Valencia and surrounding areas, compared with a control group from another region (e.g., Caracas or Zulia).

2. Creation of the "National Delayed Awakening Registry"
Clinical prevalence is often just the tip of the iceberg. Many patients with Complex I dysfunction do not die but exhibit hypersensitivity to halogenated anesthetics.

Proposal: The SVA should establish a mandatory (non-punitive) reporting protocol for any pediatric patient who presents unexplained delayed awakening or an abrupt drop in the bispectral index (BIS < 40) with low doses of sevoflurane (< 1 MAC).

Scientific Value: These patients ("intermediate phenotypes") are ideal candidates for confirmatory genetic testing, which would allow identification of carrier families before a fatal event occurs.

OPENING STATEMENT CONTINUED

3. Retrospective Audit of "Cold Cases" (Neuroimaging)
It is likely that there are previous undiagnosed cases, mistakenly labeled as cerebral palsy, hypoxic encephalopathy, or "idiosyncratic reactions."

Proposal: Request that the Neurology and Radiology departments of reference pediatric hospitals (e.g., J.M. de los Ríos Hospital, Dr. Enrique Tejera University Hospital) review their databases from the past 10–15 years.

Search Criteria: Patients who were admitted healthy and were left with postoperative neurological damage showing a distinctive radiological pattern: bilateral necrosis of the basal ganglia (striatum) and cerebellar lesions, without evidence of intraoperative systemic hypoxia. This would help estimate the true historical penetrance of the disease.

Possibility: If any of these patients are still alive, genetic testing could be performed to determine whether they carry the variant

4. Standardization of Genealogical History Taking (Clinical Screening)
While genetic data are being generated, the SVA should propose the immediate modification of the national preanesthetic evaluation form to include a **"Mitochondrial Risk"** section.

Key questioning: Not only ask about the patient's personal history, but also trace the maternal lineage (geographic origin of the mother and maternal grandmother) and inquire about family history of fatigue, palpebral ptosis, or sudden infant death along the maternal line.

Action: If the patient has a maternal lineage from the state of Carabobo along with suggestive family history, they should be classified as having **"Theoretical Mitochondrial Risk"** and managed under a TIVA protocol (Propofol/Remifentanil/Dexmedetomidine), without exposure to inhalational anesthetics, regardless of the lack of genetic confirmation.

The Venezuelan Society of Anesthesiology (SVA) is not only remaining vigilant, but has activated a high-level scientific and professional surveillance structure to address this patient safety crisis.

The SVA has deployed a team of professionals operating under principles of scientific rigor and epidemiological prudence, structured as follows:

1. Activation of the Board of Directors and Scientific Committees
The SVA Board of Directors has assumed an active leadership role, and its institutional position rejects speculation and rumors, focusing instead on genomic and clinical evidence to define safe management protocols.

2. National Strategic Alliances:
The SVA is not working in isolation. It has established direct working groups with Venezuela's governing bodies in science and health to ensure serious, methodologically sound research.

Governmental and Academic Collaboration:
High-level meetings have been held with the Ministry of People's Power for Science and Technology (Mincyt), the Ministry of Health, and experts in bioethics.

Genetic Research:
The Society is working jointly with reference institutions such as the Venezuelan Institute for Scientific Research (IVIC) and the Institute of Advanced Studies (IDEA). The objective is to move beyond anecdotal data and initiate mitochondrial DNA sequencing studies in the local population to determine the true prevalence of the m.11232T>C mutation.

3. Connection with Global and Regional Experts:
The SVA team has served as an international academic bridge to bring the most up-to-date information to the Venezuelan anesthesiology community.

OPENING STATEMENT CONTINUED

Network of Experts:
They have convened leading global authorities on the subject, including Dr. Eduardo Ruiz-Pesini (principal investigator of the genetic study in Spain), Dr. Irene Paradisi (human geneticist at IVIC), and Dr. Philip Morgan (expert in mitochondrial anesthetic sensitivity from the United States), organizing symposia to analyze the pathophysiology of the problem directly with the researchers.

Latin American Coordination:
They have actively participated in joint commissions with the Chilean Society of Anesthesiology (SACH), the Colombian Society of Anesthesiology and Resuscitation (S.C.A.R.E.), and the Latin American Confederation of Anesthesiology Societies (CLASA), seeking a regional consensus that protects patients without stigmatizing nationality.

In summary, the SVA has a multidisciplinary, vigilant team that prioritizes anesthesia safety grounded in science, acting as the governing body responsible for filtering, analyzing, and disseminating any critical developments related to this mitochondrial disorder to anesthesiologists across the country.

Atentamente,
Junta Directiva de la Sociedad Venezolana de Anestesiología

Dr. Miguel Silva
Presidente SVA

Dr. Alfredo Vetencourt
Vice-Presidente

Dra. Soryddalia Rodríguez
Secretario SVA

Dr. Adrián Márquez
Tesorería

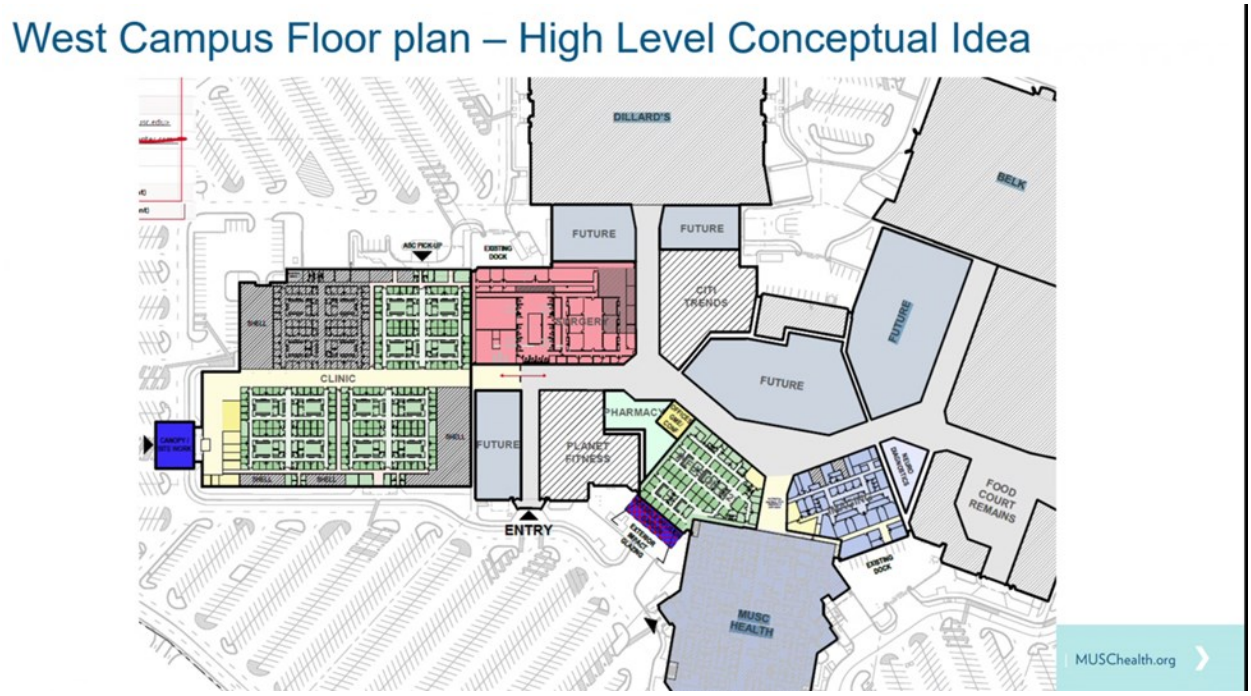
Dra. Carmen A. Rangel
Vocal

Dr. Juan C. Núñez
Vocal

Dr. Carlos Lanz
Secretario de Doctrina

MUSC HEALTH CITADEL MALL OPPORTUNITIES

In January, the MUSC Board of Trustees approved the purchase of Citadel Mall. This purchase included most of the mall with the exception of Belk's, Dillard's and Target. The floor plan below shows early planning for MUSC Health development. The area in pink which is just outside the current Sear's building is being proposed to have 4-6 operating rooms. This acquisition will be critical as we start to decant from the Rutledge Tower building.



ANNUAL MANDATORIES

The 2026 annual mandatory online lessons for all members of the MUSC workforce (including contractors/ contingent workers) were assigned on January 1, 2026.

All annual mandatory training modules and requirements must be completed no later than 11:59 p.m. on June 30, 2026, after which disciplinary action will be taken.

Link to - Learning - OurDay

2026 MUSC General Mandatories for everyone

(Enterprise-wide for all MUSC and MUSC-related entity employees, contractors, and others with access to MUSC resources unless otherwise designated.)

Computing and Privacy Requirements
- Information Security Awareness
- HIPAA Privacy
- Family Educational Rights and Privacy Act (FERPA)

Standards of behavior
- Organizational Engagement
- Title IX and Prohibited Discrimination and Harassment
- Conflict of Interest
- Code of Conduct

Workplace Safety
- Annual Tuberculosis Training
- Active Shooter Training
- Crime Prevention and the Jeanne Clery Act
- Workplace Health and Safety General Compliance (OSHA)
- Annual Bloodborne Pathogen Training

Overview of Research at MUSC (University only)
- Role-based only

2026 MUSC Health Mandatories for Health only

(**MUSC Health** care team members, contractors, and others with access to MUSC Health resources in all divisions)

MUSC Health Compliance in Action and Fraud, Waste and Abuse
- MUSC Health Compliance in Action
- Fraud, Waste and Abuse

MUSC Health Safety
- Infection Prevention and Control for All Employees
- Antimicrobial Stewardship
- MR Safety for Healthcare Workers
- Emergency Management & Campus Security
- Acute Stroke Recognition and Emergency Team Activation
- Early Warning Signs of Heart Attack
- What is Diabetes
- Suicide Awareness and Care
- MUSC Workplace Violence Prevention and Safety Program

MUSC Health Patient Safety, Care and Engagement
- Patient Safety
- Patient- and Family-Centered Care and Patient Engagement

2026 Annual Clinical Education (MUSC Health clinical care team members only)
- Lessons vary depending on your clinical role
- Completion date varies based on clinical requirements

2026 Medical Staff Mandatories (Credentialed providers only)
- 2025 MS Module 1: Health Information Services
- 2025 MS Module 2: Patient Safety Initiatives
- 2025 MS Module 3: Sleep and Fatigue/Clinical Handoffs
- 2025 MS Module 4: Diabetes Symptom Care and Management

RESEARCH CORNER

Patient Blood Management

SPECIAL ARTICLE

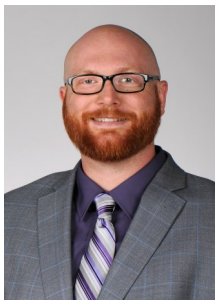
Management of Direct Oral Anticoagulants in Adult Patients Undergoing Cardiac Surgery: A Joint Consensus Statement by the Society of Cardiovascular Anesthesiologists and the Society of Thoracic Surgeons

Ashley N. Budd, MD,[1] Miklos D. Kertai, MD, PhD,[2] Moritz C. Wyler von Ballmoos, MD, PhD,[3] Jacob Raphael, MD,[4] Kamrouz Ghadimi, MD,[5] Jerrold H. Levy, MD,[5] Linda J. Shore-Lesserson, MD,[6] Michael A. Mazzeffi, MD,[7] Roman M. Sniecinski, MD,[8] Kenichi A. Tanaka, MD,[9] Daniel Bolliger, MD,[10] Mohamed Abdalla, MD,[11] Kelly G. Ural, MD,[12] Patrick A. Upchurch, MD,[13] Olga Rozental, MD, PhD,[14] Caroline B. Hunter, MD,[15] Adam R. Seibert, MD,[16] John C. Klick, MD,[17] David Carroll, DO,[18] Katie Lobner, MLIS,[19] and Nadia B. Hensley, MD[20]

David Carroll, DO

eLife

RESEARCH ARTICLE



Michael Scofield, PhD

Adolescent alcohol exposure promotes mechanical allodynia and alters synaptic function at inputs from the basolateral amygdala to the prelimbic cortex

J Daniel Obray[1], Erik T Wilkes[1], Mike Scofield[1,2], L Judson Chandler[1]*

[1]Department of Neuroscience, Medical University of South Carolina, Charleston, United States; [2]Department of Anesthesia and Perioperative Medicine, Medical University of South Carolina, Charleston, United States

RESEARCH CORNER

Journal of Cardiothoracic and Vascular Anesthesia
Available online 29 January 2026
In Press, Corrected Proof What's this?

Case Report

Successful Implementation of Biventricular HeartMate 3 Ventricular Assist Devices as Destination Therapy

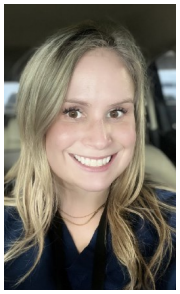
Rachel Liedberg DO, Loren Francis MD, Robert Bowen MD, Matthew Hulse MD, Jeffrey McMurray MD, Callah West DO, Carlee Clark MD

Loren Francis, MD

Rob Bowen, MD

Matt Hulse, MD

Jeff McMurray, MD



Callah West, DO

Carlee Clark, MD

Archival Report

Biological Psychiatry

Histone Deacetylase 5 in Prelimbic Prefrontal Cortex Limits Context-Associated Cocaine Seeking

Sarah M. Barry, Jessica L. Huebschman, Derek M. Devries, Lauren M. McCue, Evgeny Tsvetkov, Rose Marie Akiki, Caroline Limbaker, Ethan M. Anderson, Daniel J. Wood, Benjamin M. Siemsen, Stefano Berto, Michael D. Scofield, Makoto Taniguchi, Rachel D. Penrod, and Christopher W. Cowan

Michael Scofield, PhD

WELCOME TO THE DEPARTMENT

Kinnon White, MD
Pediatric Faculty

Hey y'all, my name is William, but I go by Kinnon which is part of my middle name. I am originally from Charleston. I grew up near Shem Creek in Bayview Acres. I went to the College of Charleston for undergrad, then MUSC for medical school. I graduated in 2015 and moved to New Orleans for my residency training at Ochsner. After completing my residency, I went to Emory for my fellowship in pediatric anesthesia. After completing that I returned to Ochsner in New Orleans and worked for two years, before moving to Nashville to Pursue my fellowship in Pediatric Cardiac Anesthesia at Vanderbilt. Following that, I returned again to New Orleans to join their peds cardiac team, where I worked for a little over two and a half years. I loved my time in New Orleans, but it was time to come home. I am very excited to be back in Charleston and to be joining y'all at MUSC. Fun fact, my mother is Callie of Callie's Hot Little Biscuit if anyone has ever been there.

LOWCOUNTRY HEART WALK—FEBRUARY 28, 2026

Thank you to everyone who donated to our Anesthesia Sleepwalkers Team! Our team raised over $300 and at the time of the walk, the AHA had raised over 1 million dollars this year!

GRAND ROUNDS—MARCH 2026

"Pediatric ERAS: Past, Present, and Future "

Megan Brockel, MD, Associate Professor

March 3, 2026

Dept. of Pediatric Anesthesiology
Children's Hospital Colorado

"MUSC Heart & Vascular: Then. Now. Next. "

Arman Kilic, MD, Professor

March 10, 2026

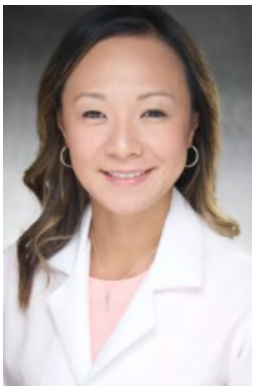
Dept. of Surgery
Medical University of South Carolina

"The Right Ventricle"
Stephanie DeFord, MD, Fellow

"Heparin Induced Thrombocytopenia"
Nolwenn Phan, MD, Fellow

March 17, 2026

Dept. of Anesthesia & Perioperative Medicine
Medical University of South Carolina



"Heart and Soul: The Ethics of Heart Transplantation "

Dionne Peacher, MD, Associate Professor

March 24, 2026

Dept. of Anesthesia & Perioperative Medicine
Medical University of South Carolina

"MAC vs. General Anesthesia for TAVR (…and other procedures) "

George Whitener, MD, Professor

March 31, 2026

Dept. of Anesthesia & Perioperative Medicine
Medical University of South Carolina

Department of Anesthesia And Perioperative Medicine

Email: hameedi@musc.edu
Phone: 843-792-9369
Fax: 843-792-9314

Check out our website

Future Events/Lectures

CA 1 Lecture Series

3/4—Maternal/Fetal Physiology—Jessi Stockinger

3/11—Impaired Physician/Medical Legal Issues—Jenny Matos

3/18—Free Time for Reading

3/25—Resident Career Day—SC Society of Anesthesiologists

4/1—Geriatric Anesthesia—Jenny Matos

Follow us on Facebook, Instagram, and Twitter:

Follow @MUSC_Anesthesia

I HUNG THE MOON

Please don't forget to nominate your co-workers for going 'Beyond the Call of Duty.' I Hung The Moon slips are available at the 3rd floor front desk and may

Hercules Brown—Thank you for picking up a late notice call shift on the weekend. Greatly appreciate it! - Jennifer Jones

Graduation
June 19th at 6:00pm
Trinity Hall

Holiday Party
Saturday, December 5th
Carolina Yacht Club

ONE MUSC Strategic Plan

We Would Love to Hear From You!

If you have ideas or would like to contribute to *Sleepy Times,* the deadline for the April edition will be March 18, 2026.