DEPARTMENT OF ANESTHESIA AND PERIOPERATIVE MEDICINE

SLEEPY TIMES

VOLUME 19, ISSUE 12 DECEMBER 2025

Inside This Issue:

MESSAGE FROM THE CHAIRMAN: MERRY CHRISTMAS

-Scott T. Reeves, MD, MBA

As we approach the end of the year, December fills our hearts with gratitude and hope. This month, we celebrate not only the Christmas season but also the remarkable impact each of you makes in the lives of our patients. It is a time of a celebration of love with family, generosity, and divine grace. It is a time to reflect on the blessings we have received and to inspire us to extend those blessings to others through our work and service.

Anesthesiology is a field rooted in precision, trust, and care. Behind every successful surgery, there is a team working tirelessly, often in the background, ensuring patient safety and comfort. Your expertise and unwavering commitment transform challenging moments into opportunities for healing. Each patient's anesthesia journey is a testament to your skill and compassionate presence.

December is also a time for reflection — to acknowledge the milestones we've achieved together and to look forward to new opportunities for growth and innovation. Let's remember that our work extends beyond the operating room; it touches the very core of human resilience and the miracle of recovery. Your dedication makes a difference, inspiring colleagues and uplifting patients.

As the lights of the season glow and 2025 comes to a close, take pride in the work you have done. The long days and nights, the teamwork, and your grace under pressure. Take a moment to look around at the colleagues who carried you through the year and remember that our strength comes not only from our individual knowledge and training but more importantly from the community we have built together.

As we gather with family, friends, and colleagues, let us give thanks for the privilege to be part of a profession that touches so many lives. Here's to a joyful, restful December. A month to reflect, celebrate, and renew our commitment to excellence. Thank you for your hard work and for being the heart of our department. I wish you all a season filled with warmth, happiness, and the knowledge that your efforts make the world a better place.

Merry Christmas

ACLS UPDATE BY CATHERINE TOBIN, MD

ACLS October 2025 Update

Dr. Catherine Tobin, AHA ACLS instructor

The American Heart Association (AHA) updates the Guidelines for Cardiopulmonary Resuscitation including the Advanced Cardiac Life Support (ACLS) algorithm approximately every five years. The most recent update occurred in October 2025. I would like to share with you the key changes that are particularly relevant to anesthesia that I find noteworthy.

Name Change Alert:

SVT (Supraventricular Tachycardia) is now called Narrow Complex Tachycardia

Targeted Temperature Management (TTM) now called Temperature Control (in ROSC)

Energy Changes:

For Synchronized cardioversion initial recommended doses are as follows:

Narrow Complex Tachycardia: 100J (in 2020 was 50J)

Monomorphic VT: 100J

Atrial fibrillation/Atrial Flutter: 200J (in 2020 was 120J)

Sustained Polymorphic VT: defibrillation120J to 200J (not synchronized)

"Goodbye" Sotalol: Sotalol is removed from tachycardia algorithm

Hyperkalemia in Cardiac Arrest

2025(Updated): "The effectiveness of IV calcium administration for adults and children in cardiac arrest from suspected hyperkalemia is not well established."

Why: "For adults and children in cardiac arrest from suspected hyperkalemia, human evidence of improved survival or favorable neurologic status following IV calcium administration is limited. Initiating IV calcium must be carefully weighted against the potential for detracting from time-sensitive, guideline-directed resuscitative interventions, including high quality CPR, defibrillation of shockable rhythms, and administration of epinephrine."

Take Home Point: Don't delay CPR or defibrillation in cardiac arrest even if from high potassium. Calcium is useful to stabilize the cardiac membrane if patient still has a pulse and can help prevent cardiac arrest from hyperkalemia.

Asthma Exacerbations (In case you are called to ICU about providing Volatiles or ECLS)

2025 (New): "It may be reasonable to use extracorporeal life support (ECLS) for adults and children with life-threatening asthma refractory to standard therapies."

2025 (New): "Treatment with Volatile anesthetics for adults and children with life-threatening asthma refractory to standard therapies may be considered**."**

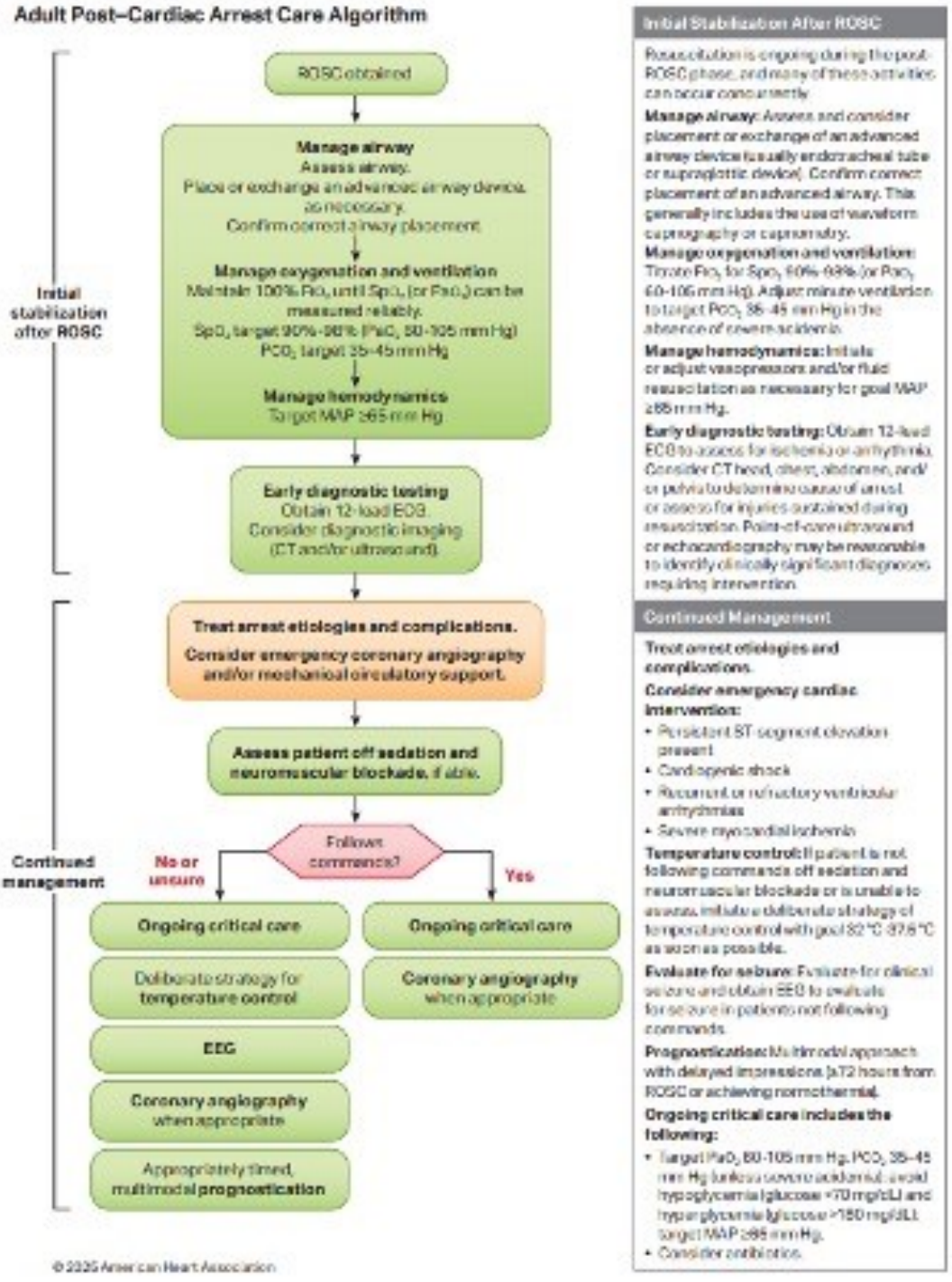
Why:

"Asthma can cause cardiac arrest from lower airway obstruction that leads to hypoxemia, hypercarbia, respiratory acidosis and increased intrathoracic pressure, which leads to decreased cardiac output. Adult and pediatric observational studies of ECLS or volatiles (desflurane, sevoflurane, isoflurane) demonstrate survival rates between 83.5 and 100%. Either venovenous or venoarterial extracorporeal membrane oxygenation can be considered depending on the needs of the particular patient."

ACLS UPDATE BY CATHERINE TOBIN, MD

Return of Spontaneous Circulation (ROSC) Updates

Post–Cardiac Arrest Care	• Targeted temperature management – 32-36 °C – Hold temperature for 24 hours – Do not give OHCA patients with ROSC targeted temperature management • Hypotension: <90 mm Hg • Oxygen saturation: 92%-98%	• Temperature control – 32-37.5 °C – Hold temperature for at least 36 hours – OK to give OHCA patients with ROSC temperature control as long as it is not cold IV fluids • Hypotension: MAP ≥65 mm Hg • Oxygen saturation: 90%-98%



ACLS UPDATE BY CATHERINE TOBIN, MD

Review of New Science References and for a full list and updates:

Science Summary Table

This table compares topics from 2020 with 2025, providing a quick reference to what has changed and what is new in the science of ACLS.

ACLS topic	2020	2025
Tachycardia	• Follow your specific device's recommended energy level to maximize the success of the first shock • Wide QRS complex, irregular rhythm: defibrillation dose (not synchronized)	• Synchronized cardioversion initial recommended doses: – Narrow-complex tachycardia: 100 J – Monomorphic VT: 100 J – Atrial fibrillation: 200 J – Atrial flutter: 200 J – Polymorphic VT: defibrillation dose (not synchronized) • Removed sotalol from the algorithm • Changed supraventricular tachycardia to narrow-complex tachycardia
Post-Cardiac Arrest Care	• Targeted temperature management – 32-36 °C – Hold temperature for 24 hours – Do not give OHCA patients with ROSC targeted temperature management • Hypotension: <90 mm Hg • Oxygen saturation: 92%-98%	• Temperature control – 32-37.5 °C – Hold temperature for at least 36 hours – OK to give OHCA patients with ROSC temperature control as long as it is not cold IV fluids • Hypotension: MAP ≥65 mm Hg • Oxygen saturation: 90%-96%
Cardiac Arrest, Chain of Survival	• 6 links for both chains (IHCA and OHCA): added a Recovery link to the end of both chains	• 6 links for 1 universal chain
ACLS topic	**2025**	
Stroke	• Adding tenecteplase as a thrombolytic agent	
ACS	• Removed LBBB as a definitive diagnosis for STEMI • Removing clopidogrel as primary anticoagulant • Adding fentanyl (opioids) for secondary pain control (in addition to morphine) • Adding enoxaparin or fondaparinux (anticoagulants) • Adding ACE inhibitors	
Airway	• Removed 800-800 mL for ventilations, adding "one third" squeeze and focusing on chest rise. "Squeeze the bag one third and one half, enough to see visible chest rise." • Removed delivering medications down an ET tube	

Part 1: Executive Summary 2025: American Heart Association Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care

From Rios et al, Circulation, Volume 152, Number 16, suppl 2.

New Algorithms can be found here including Pediatric Algorithms, LVAD, and Pregnancy in Cardiac Arrest:

https://cpr.heart.org/en/resuscitation-science/cpr-and-ecc-guidelines/algorithms

PERRINO AND REEVES' PRACTICAL APPROACH TO TRANSESOPHAGEAL ECHOCARDIOGRAPHY 5TH EDITION

In 2000, while at the annual meeting of the American Society of Anesthesiologists in San Francisco, Al Perrino and I came up with the idea of creating a book designed to teach the new technology of transesophageal echocardiography to cardiac anesthesiologists. We would leverage experts within the Society of Cardiovascular Anesthesiologists (SCA) to write the individual chapters. The pitch was "you already have the materials in your individual lectures and syllabus submissions." After years of work and editing, *A Practical Approach to Transesophageal Echocardiography* was published in 2003. The 1st edition consisted of 20 chapters and 356 pages all in black and white. Over the ensuing twenty plus years, the book would go on to include robust color images and drawings, expanded questions and a complete e-book with TEE video files. Individual editions would be translated into Japanese, Chinese, Portuguese and Russian.

A Practical Approach to Transesophageal Echocardiography has made up a significant portion of my carrier as a cardiac anesthesiologist and has established MUSC as a national leader in this field. The preface for the 5th edition is found below.

THE FIFTH EDITION represents a landmark in the publication of *A Practical Approach to Transesophageal Echocardiography*, now titled *Perrino and Reeves' Practical Approach to Transesophageal Echocardiography.* Five editions as editors is a rarity in medical publishing and an achievement beyond our wildest expectations when we began this project in 2000. The longevity serves as a testament to the enduring enthusiasm echocardiography engenders in clinical practice and the intrinsic value this handbook provides. Having witnessed early technology transformations, such as the biplane probe and color Doppler imaging, it is remarkable to witness the advancements imbedded in the current practice of echocardiography covered in this edition. The applications of 3-D imaging, 4-D quantitative analysis, and echocardiography's role expanding from the heart room to critical care and structural heart units are inspiring. For this latest edition to fully capture the state of the art of perioperative echocardiography, we recruited new contributors who are internationally renowned and acknowledged for their independent contributions and teaching ability. They were given the task of presenting a highly readable and clinically relevant survey of the current practice of perioperative echocardiography. Their enthusiasm backed with the strong support of the publisher has produced this volume.

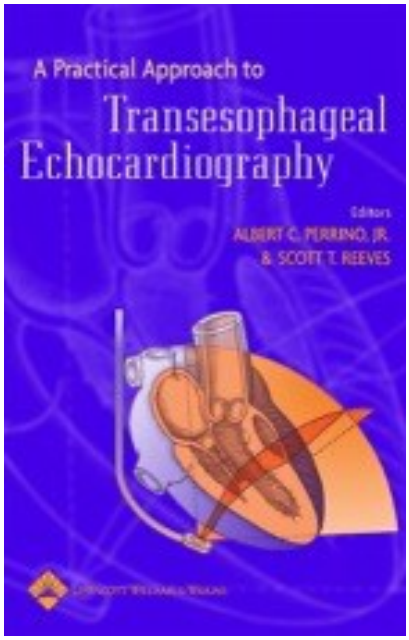
And while perioperative echocardiography endures and expands, we recognize our role as lead editors is term limited. Twenty-five years is a remarkable run, and we look forward to the contributions the next generation of editors and writers will bring. To that effect, Joshua M. Zimmerman and Chirojit Mukherjee enthusiastically agreed to come aboard as associate editors for this latest edition and lead the project forward in upcoming editions. Both are uniquely talented echocardiographers and educators that have enriched this edition both as editors and as authors. They have overseen a Fifth Edition that has been extensively updated, with many chapters rewritten with new images, illustrations, multiple-choice chapter-based questions and answers, as well as videos. Examples include echocardiography's evolving role in structural heart interventions and valve surgeries to the growing impact of artificial intelligence on image acquisition and interpretation.

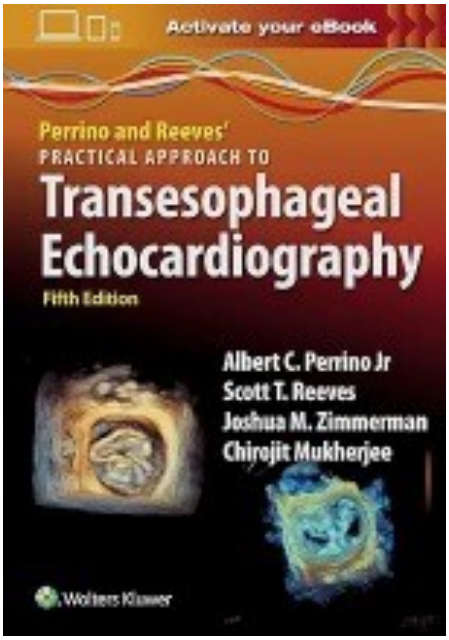
We would especially like to thank the scores of Wolters Kluwer publication team members for their support through these five editions. To the artists, editors, and production team members who took our efforts and visions and embodied them into the finished product you hold today, we truly could not have found better partners for our project.

Lastly, to the readers, this edition further establishes the reputation of *A Practical Approach to Transesophageal Echocardiography* as the practicing clinicians' premier resource to acquire the essential skills of transesophageal (TEE) practice. The presentation, illustrations, and media content create a surprisingly portable and readable text that is conducive to rapid appreciation of the critical elements in the use of TEE for a particular clinical challenge. The associated e-book contains over 400 videos and 300 interactive multiple-choice chapter-based questions and answers to reinforce the reader's knowledge.

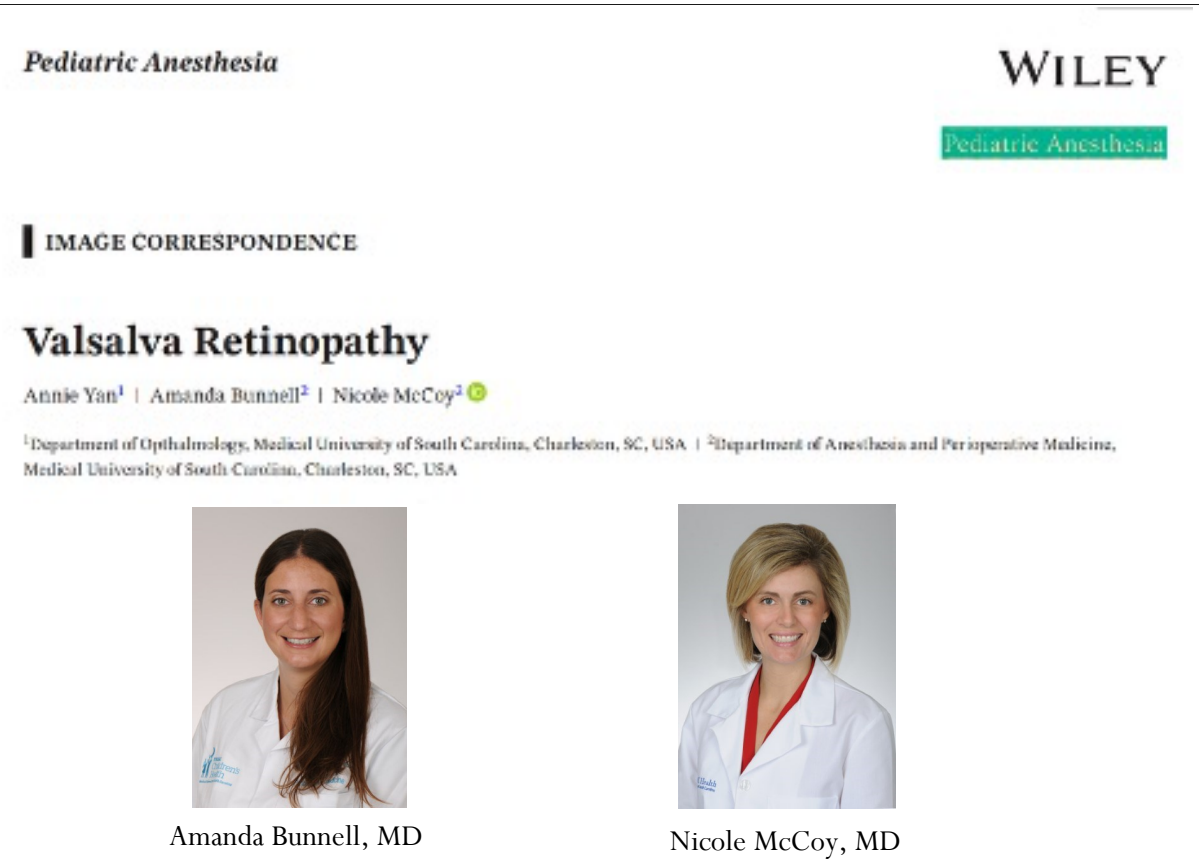
PERRINO AND REEVES' PRACTICAL APPROACH TO TRANSESOPHAGEAL ECHOCARDIOGRAPHY 5TH EDITION

It is our hope that this Fifth Edition textbook will become a well-worn and valued asset to your echocardiography practice.





RESEARCH CORNER



Pediatric Anesthesia

WILEY

Pediatric Anesthesia

IMAGE CORRESPONDENCE

Valsalva Retinopathy

Annie Yan[1] | Amanda Bunnell[2] | Nicole McCoy[2]

[1]Department of Opthalmology, Medical University of South Carolina, Charleston, SC, USA | [2]Department of Anesthesia and Perioperative Medicine, Medical University of South Carolina, Charleston, SC, USA

Amanda Bunnell, MD

Nicole McCoy, MD

TRIAL WITHIN THE TRIAL: MY JOURNEY OF GROWTH AS A FIRST-TIME PRINCIPAL INVESTIGATOR BY CLINTON PILLOW, MD

As a first-time principal investigator, I was completely oblivious to the personally transformative journey I was about to experience. This personal reflection essay narrates my emotional voyage as I guided a clinical trial from thought to patient enrollment to eventual publication.

Taking the leap to principal investigator is an important development in the career of any young resident or attending physician. It starts with a surplus of anticipation and professional pride and leads to a riveting journey filled with elation, uncertainty, sadness at times, and a healthy dose of humbling lessons. At the outset, I envisioned a flawless protocol certain to improve the perioperative care provided to our patients. I expected some logistical and practical obstacles; however, I underestimated the psychological and philosophical impact this experience would have on me. My preconceptions were challenged, and my sense of humility was heightened. It altered my perception of myself as a healthcare provider, a researcher, a husband, a father, and a person.

I started to notice these shifts in perspective almost immediately. Getting a study off the ground requires an exorbitant time commitment: creating a protocol, developing consent forms, and attending the numerous required meetings came with a heavier emotional burden than I had remembered in my previous research experience. Timelines extended, and my clinical responsibilities piled up. While I found it all extremely fulfilling from a professional standpoint, it was putting a strain on my roles as a father and a husband. Even as I'm typing this at my home now, I hear my daughter starting to cry through her baby monitor, and I'm reminded of the blurred line between my personal and professional identities during this busy time. I found myself arriving home from work later than anticipated and more exhausted than usual. My wife and family were always extremely supportive, but too often I had to trade face-to-face dinner time for quick FaceTime calls between my new obligations. I found my initial enthusiasm was slowly shifting to anxiety, burnout, and doubt.

These internal conflicts ignited a change in me. It was a harsh reminder that perfection in all of life's roles is unobtainable. I had to embrace uncertainty and admit that maybe I don't have the perfect answer. I had to remind myself that I deserve grace and forgiveness, while realizing that I have limited control over the world around me. These lessons applied to my research as well. At first, I felt uneasy with each new gap discovered in my investigational knowledge. Now I see this discomfort was imperative for growth. It was key to accept that I can't always be certain of the road ahead. Research encouraged me to disengage from the side of clinical practice focused on rapid decisions and instant gratification. Instead, I explored a slower and less predictable environment where advancements are incremental.

I could not have navigated this time of change and unpredictability without the unrelenting support provided by an exceptional research mentor and a knowledgeable research project manager. Their guidance was invaluable as we worked through the tumultuous times of getting the trial up and running. They demonstrated inspirational leadership, not merely grounded in expertise, but characterized by patience and perspective. Thanks to their influence, I came to understand that in the realm of research, one cannot possibly dictate every outcome. It is more important to cultivate an environment of progress for the study and yourself.

The patient enrollment process brought a plethora of enlightening lessons as well. The perioperative environment moves at a frenetic pace. This is not ideal for conveying the empathy and understanding I sought to communicate during the consent process. I could sense uneasiness at times as patients were asked to comprehend complex study details within a short period of time. The preoperative holding area is extremely anxiety-provoking, even before adding the information overload that can come with a research consent. This tension caused me to question myself and the study. Was I placing unrealistic expectations on my patients? On my research team?

Trial within the Trial: My Journey of Growth as a First-Time Principal Investigator by Clinton Pillow, MD

I can still picture the dejected expression of a patient who became tearful when approached by our research team. I watched as she tried to disguise her anxiety and discomfort. Her puffy eyes and quivering lower lip made it apparent she was overwhelmed by the stressful nature of the surgical experience. My heart knew this patient was not an ideal research candidate, and she was not enrolled. Simultaneously, my brain began to shift. I started to view recruitment not as an obstacle to overcome but rather as a chance to bridge the gap between our scientific goals for the study and the complex human realities involved in clinical care. It became apparent that consenting patients goes far beyond obtaining a signature. It's about having meaningful empathetic interactions, and respecting the patient's needs for autonomy. It is vital to accept no for an answer without questioning the decision. Research is not an honor we bestow on patients. Unequivocally, it's an effort that requires trust and respect to succeed. As the study progressed, I found that I treasured the moments when patients expressed gratitude for the opportunity to participate in the study and assist in refining patient care.

Inevitably, we also encountered scenarios that reinforced the difficulty of controlling outside variables in clinical trials. I realized early in the study that most staff are not as focused on research as myself and my research team. The competing clinical priorities of different services tested the internal validity of our study. Our primary outcome assessments were frequently delayed for multiple reasons: prolonged operative times, imaging studies, nursing assessments, and patient privacy concerns, just to name a few.1 This forced me to take a step back and accept that the hospital was not designed and staffed specifically with research in mind. Secondary endpoints were also affected. For example, time to ambulation following a spinal anesthetic and length of stay were prolonged due to limited availability of physical therapy at my institution. In the beginning, I viewed these disruptions in study flow as shortcomings in my planning or execution. As time passed, I perceived them not as operational hiccups, but as insights into the staffing challenges faced by healthcare facilities nationwide.

This triggered another ideological shift for me. I was no longer solely focused on getting things done accurately and efficiently. I was learning to accept and embrace the research process. A salient realization was understanding it is impossible to control every variable that comes to light in the busy and hectic hospital environment; yes, protocol deviations and protocol amendments are expected in research. I found it more interesting to explore why there were delays and variability in our outcome assessments. While it was challenging to uncover these answers, the search provided me with invaluable insight into how patient care is delivered and caused me to ponder the types of inquiries research should explore.

I recall feeling true elation toward the conclusion of the study, as I reflected on my personal and philosophical renaissance in guiding this study from concept to completion. Success was no longer flawlessly carrying out a study protocol or publishing the results. It became more about my enhanced capacity to navigate uncertainty with grace and adaptability. I focused more on my ability to lead with humility and feel more at ease in the oftentimes uncomfortable space where clinical research lives.

This experience also changed the way I mentor trainees working on their first clinical trial. While research methodologies are important, I now spend more time emphasizing the importance of mindset and tell them to embrace the unforeseen challenges they will encounter. I want my mentees to view research as a realm where personal development often emerges from the setbacks. I speak of the aforementioned feelings of sadness, to those of complete delight. I tell them stories of how research has enhanced my understanding and compassion for patients' feelings and emotions. These are tales we often keep to ourselves, but I find they are the ones that impact our character the most.

As I finally sit back to relax at the end of this journey, I feel a deep sense of gratitude both for the research process and the self-transformation that occurred. I have seen firsthand that it quite literally takes blood, sweat, and tears to conduct a clinical trial, not to mention teamwork, sacrifice, and a great deal of time. For that, I have the utmost respect to fellow physicians, scientists, and researchers who dedicate so much of themselves towards the unbiased advancement of medicine. Personally, I have learned to handle uncertainty with clarity and poise. I have come to realize that research sharpens our thoughts and emotions, while increasing our capacity for leadership. I now inquire not only about what methods are effective, but also seek to understand the underlying reasons for their effectiveness. I take great pride in knowing I have achieved something transformative and meaningful, not just for the well-being of my patients, but for myself.

TIME TO CELEBRATE! WE ARE #1 AGAIN!

Dear Care Team Members,

We are pleased to announce that MUSC Shawn Jenkins Children's Hospital ranked nationally in **six (6)** specialties in the U.S. News & World Report 2025-26 Best Children's Hospitals survey released this morning!

This year's national rankings are an increase from four to six ranked specialties and are as follows:

- **Cardiology & Heart Surgery: #4** in the country, #2 in outcomes. We have ranked as a top four program the past four years and #1 or #2 in outcomes in that same timeframe.
- **Nephrology: #26** in the country
- **Orthopedics: #29** in the country, a significant increase from not ranking last year
- **Cancer: #33** in the country, up five rankings from last year
- **GI & GI Surgery: #42** in the country
- **Neonatology: #49** in the country, a noteworthy improvement from not ranking in 2024
- For the fourth year, U.S. News featured regional rankings, and MUSC Shawn Jenkins Children's Hospital **tied for #11** in the Southeast region, out of 63 surveyed hospitals. An increase from last year and shows our strength in a very competitive region.

Once again, we are the **#1** children's hospital in S.C. and the **only** pediatric hospital ranked in S.C. since the rankings' inception.

These national rankings honor your dedication and commitment to providing unsurpassed pediatric care in the state, region and nation. We are immensely proud of you, the level of care you provide to the sickest children in South Carolina and beyond, and the recognition MUSC Shawn Jenkins Children's Hospital received.

With gratitude and appreciation,

Mark A Scheurer, MD, MSc, FACC

ICCE Chief, Children's and Women's | MUSC Health

Professor of Pediatrics | Medical University of South Carolina

Andrew M. Atz, MD

Chair, The Dr. Charles P. Darby, Jr. Department of Pediatrics

Professor of Pediatric Cardiology

L. Lyndon Key, Jr. Endowed Chair

Medical University of South Carolina

RESIDENT OF THE MONTH NOMINATIONS

My name is Kayla Haley, and I am a nurse on 10 West. I was given your contact by one of the residents on the team hat day because I wanted to reach out about Dr. Naveen Perisetla and Dr. Chamara Gunaratne. I have never been more impressed by residents They are so detail oriented and take time to listen and get to know the patients. They keep a continuous open line of communication with all staff members and respond to all pages faster than any resident we have seen. The majority of the time, they come to the bedside if there are any concerns with the patient. They also come to the unit to check on nursing staff and make sure we do not need anything from them. They are steadfast in efficiency, patient care, decision making, and we all have built a great working relationship on 10W. Recently, we had a young, difficult patient who was hoping out of bed with a chest tube in place. Drs. Perisetla and Gunaratne quickly responded and they were able to calm the patient down in what could have been a very serious situation. Not only did they protect the patient's integrity, but they also made sure the nursing staff was comfortable with the plan of care that was set in place. They were able to build a great rapport with this patient which led to a night without incident. This is one of many situations that have been handled with knowledge, professionalism and empathy. I just wanted you to be aware that they are doing an exceptional job and that everyone appreciated their hard work! Thank you so much for your time!

Dr. Naveen Perisetla

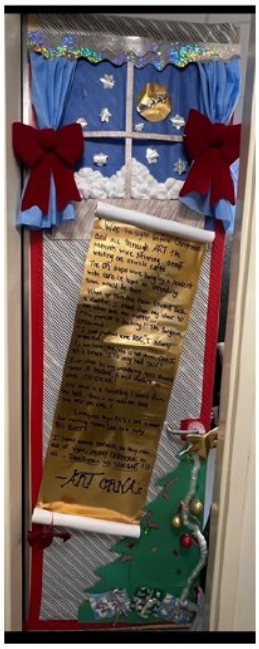
Dr. Chamara Gunaratne

2025 DOOR DECORATING CONTEST

The holiday season is upon us, and we're bringing some cheer to the office with our **Annual Holiday Door Decorating Contest**!

Unleash your creativity and transform your office door into a festive masterpiece. Whether you go for classic, quirky, or something entirely unique, now's your chance to spread joy and show off your holiday spirit! You can decorate your office door or a shared door (ex: resident library door, on-call rooms, etc.) in any fashion you'd like.

We will return to the panel of external judges who will vote for the winners. Additionally, we will continue the virtual voting for the department and award one "Popular" vote. Please send Trey Hiott (hiottg@musc.edu) a picture of your door by **Wednesday, December 17 , 2024**. We'll create the survey and send out for judging and then announce on Friday, December 19th.



There will be a prize for 1st, 2nd, and 3rd place and the popular vote!

As we continue through the holiday season, please review our Decorations Guidelines before decorating patient-facing areas. These guidelines include recommendations for safe and welcoming holiday decorations. Thank you for keeping our environment safe and inclusive for our patients, families, and care team members.
Get your craft supplies ready and let's make the office the most cheerful place to be. We can't wait to see your creations!

NOMINEE PROGRAM COORDINATOR OF THE MONTH: ANGIE MAGUIRE

On behalf of the Program Coordinator Executive Leadership Committee (PCELC) and the Graduate Medical Education (GME) Office, we would like to extend our heartfelt congratulations on your nomination(s). This recognition is a testament to your outstanding contributions and the hard work you put into managing a successful residency/fellowship program.

Being nominated for Coordinator of the Month is a significant achievement which reflects your dedication and commitment. Although you were not selected as Coordinator of the Month this time, we want to emphasize how much this recognition means. It is truly something to be proud of, and we sincerely congratulate you on this well-deserved acknowledgment from your respective nominator(s), as well as, the PCELC and GME.

Department/Division	*Details about the nominee:*
Anesthesiology (Residency, Pediatric Anes Fellowship, Regional Fellowship, CT Anes Fellowship)	Angie is a rockstar coordinator and she deserves special recognition. She is always going above and beyond for our program as well as for the entirety of GME. I was recently out on maternity leave for 3 months, which left her with extra work and responsibilities during a busy season for us. She handled everything so seamlessly and I when I returned I had no "catching up" to do because she had taken care of everything. She is always looking for learning and professional development opportunities for herself. She is a member of several GME committees, and she is always happy to help out her fellow coordinators. Our residents and fellows know they can come to her with any question or problem, and she will have an answer for them. I can't say enough good things about Angie and I'm so thankful she is on my team!

2025 TOYS FOR TOTS DONATION DRIVE

The holiday season is here, and so is our much-anticipated Holiday Party! This year, we're continuing our cherished tradition of supporting **Toys for Tots**! To spread the holiday cheer and make this season special for children in need, we ask that everyone brings an unwrapped toy to the party. Your thoughtful contributions have always made a difference, and we're excited to see that generosity shine once again!

The goal is to collect as many **new, unwrapped toys** as possible for our holiday party on December 6th. You can bring a toy to the holiday party or the week leading up to the party, whichever is easier. There will also be marines at our party to collect the toys!

At the moment, there will be donation boxes at the following locations on campus:

Storm Eye Building- Suite 301

Art- Suite 4200

We were able to collect three boxes last year. Let's see if we can fill four this year!

These toys will be distributed as Christmas gifts to less fortunate children in our community. You can find information on the program at https://charleston-sc.toysfortots.org/local-coordinator-sites/lco-sites/about-local-toys-for-tots.aspx.

Let's make this celebration one for the books – a night of joy, connection, and giving back!

GRAND ROUNDS—DECEMBER 2025

"Stress First Aid: Practical Tools for Supporting Ourselves and Our Teams in Anesthesiology"

Andrew Bacon, MSN, RN, Program Manager

December 2, 2025

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

"TBD"

Meryl William, DO, Assistant Porfessor

December 9, 2025

Dept. of Anesthesiology and Critical Care Medicine
Childrens Hospital of Philidelphia

"M&M "

TBD

December 16, 2025

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

December 23, 2025

December 30, 2025

Happy Holidays!

Department of Anesthesia And Perioperative Medicine

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

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

Check out our website

Future Events/Lectures

CA 1 Lecture Series

12/3—Anesthesia for Patients with Kidney Disease—Tara Kelly

12/10—Hepatic Physiology & Anesthesia for Patients with Liver Disease—Joel Sirianni

Follow us on Facebook, Instagram, and Twitter:

Follow @MUSC_Anesthesia

Holiday Party
Saturday, December 6, 2025
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 January edition will be December 18, 2025.