# Looking Back to the Future

**By Donna Farid, RN, PGOR, CPN(C)**

During World War II, Army and Navy nurses taught theory "including not only how to function in the scrub and circulating roles, but also how to serve as an anesthetist and first assistant" (Groah, 1990).

The above quotation refers to an historical perspective of the perioperative role and was excerpted from a text written on periopertive practice. The time frame refers to the period between 1941 and 1945, when Registered Nurses joined the armed forces and those assigned to surgery needed additional training to meet the demands of the field and evacuation hospitals.

Isn't it interesting that some fifty years later, we are once again identifying a need to realize these advanced roles and are developing programs to implement them.

The expanding role of Registered nurse (Advanced Practice) was the second key issue identified by the perioperative nursing audience at the National Conference last April in Ottawa. I will attempt to address this issue, although numerous excellent articles have been written by Grace Groetch, entitled RN First Assisting - 1997 Update. (*See Canadian Operating Room Nursing Journal.* Vol. 14, No.3, March/April, 1997).

To avoid redundancy, it will suffice to say that the surgical assist role is in varying stages of development in most provinces. I would like to add that Nova Scotia has also come on stream with a hospital-based pilot [project for the surgical assist role in Cardiovascular surgery at the QE II Health Sciences Centre in Halifax. The first student started in October, 1997.

The Anesthetist's Assistant role is moving more slowly. A joint project by the Operating Room Nurses Association of Canada, the Canadian Anaesthetists Society and the Canadian Society of Respiratory Therapists has been to develop a national analysis and competency profile for Anethestist's Assistants. Co-funding has been sought through Human Resources Development Canada, and has been refused. A second proposal to lobby the IIRDC is in progress.

ORNAC has been instrumental in supporting these roles, and in 1995, developed a *Blueprint for Curricula Development for the Role of Perioperative Nurse Anesthesia (PNA) and Surgery (PNS)*. Copies of this blueprint have been sent to colleges and universities around the country.

It has been a long hard struggle at times, and there have been pioneers - nurses who at great expense and commitment, enrolled in recognized RNFA programs in the U.S., only to to meet with obstacles on returning to Canada, either to compete their internship components, or to find employment as RNFA/PNS. However, at present, recognition of both roles is improving and will continue to do so as programs progress. I agree with Groetch when she stated..."ORNAC needs to continue to not only promote the role, but also influence the manner in which the role is being implemented." Since each curriculum is different, and many of the programs are hospital and specialty

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based, it is important to endeavor to move toward offering these programs through recognized educational facilities and coordinating more standardized curriculae to allow to unity, compensation and movement.

I would like to add that not every perioperative nurse is interested in these advanced roles, nor will there be sufficiently large numbers of opportunities to everyone to fill them. However, each perioperative nurse should be committed to enhancing their curent practice as much as possible. As acuity of hospitalized patients increases, advanced knowledge is necessary to provide them with the safest care possible. As CNA's study predicts, a severe nursing shortage is looming in the future, (See page 13). Take this opportunity to be the expert in your speciality. Add to your credentials by furthering your education through certification, post-basic courses, degree programs and self-learning. Determine your own destiny and the destiny of your patients.

While we must show gratitude to those pioneers, both in the 40's and in the 90's, we must also determine the future of perioperative nursing, and ensure that it is valued and promoted. ■

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# Endovascular Repair of Abdominal Aortic Aneurysm:

## An Alternative to Conventional Surgery

By Shari Jones, RN, BScN, CPN(C) & Regina Ludwa, RN, CPN(C)

New technology has been developed to allow the vascular surgeon to insert a vascular graft into the abdominal aortic aneurysm (AAA) sac via a femoral arteriotomy, much the same as an angioplasty is performed. The endovascular prosthesis is an alternative to the traditional vascular graft, which requires major abdominal surgery.

Aneurysms may occur in any section of the aorta with approximately 80% occurring in the abdominal segment (Fellows, 1995). The majority of AAA's are infra-renal, and may extend into the common iliac arteries (Meeker & Rothrock, 1995.

The most common cause of AAA's is atherosclerosis. Other causes are classified as inflammatory, mechanical, pseudoaneurysms, and congenital. The incidence of AAA is reported at approximately 2% of elderly persons in North America, occurring more often in men (Hatswell, 1994). The majority of patients will have medical conditions such a hyperlipidemia, hypertension and arteriosclerosis, which will compromise the cardiovascular system.


### Abstract

The majority of aortic aneurysms occur in the abdominal segment. Aneurysms above 5 cm are at higher risk for rupture, and have traditionally been treated with surgical intervention. Conventional surgical treatment involves major abdominal surgery with associated complications. The endovascular prosthesis is a newly developed vascular graft which is inserted into the abdominal aortic aneurysm sac via a femoral arteriotomy. The procedure is less invasive for the patient, which is a significant benefit considering many patients with an abdominal aortic aneurysm are medically compromised. Thorough preoperative planning by the surgical and radiological teams is critical to ensure a successful patient outcome.


Abdominal aortic aneurysms may be managed medically or surgically. The average abdominal aorta is approximately 2cm in diameter. Aneurysms under 5 cm, with low risk of rupture, may be treated medically. This includes life-style changes, antihypertensive medications, and frequent follow up with ultrasound to detect further growth of the aneurysm. Aneurysms above 5cm are considered at a higher risk for rupture and will generally be considered for surgical intervention, particularly in the presence of symptoms (Hatswell, 1994).

Abdominal aortic aneurysms have traditionally been surgically repaired using a knitted or woven double velour vascular graft. The repair involves major abdominal surgery, associated complications, and a length of stay of 8 -10 days. The mortality rate for surgical intervention is reported at 4% (Blum et al., 1997).

## Endovascular Prosthesis

The endovascular prosthesis was developed in Germany, with the first reported use in a patient in


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