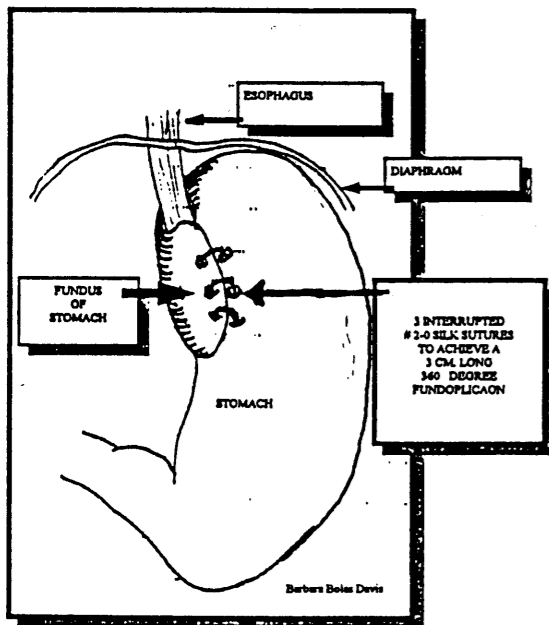


Figure 2



anaesthesia the nurse remains in attendance to respond to emergent situations and provide safety and comfort measures to the patient as necessary. The patient is assessed, extubated, stabilized and transferred to the Post Anaesthetic Recovery Room where standard postoperative assessments are performed, with an estimated length of stay of one hour. Once discharge criteria have been met the patient is transported to the nursing unit.

The morning after surgery, the patient undergoes a gastrographin swallow to confirm a secure anastomosis exists. If the X-ray is negative (no apparent leaks), the patient starts on a fluid diet and is discharged on the second postoperative day. The patient is educated to remain on a fluid or semi-solid diet for approximately one week, and gradually resumes eating solid foods. All patients are followed up regularly with 24 hour pH and esophageal manometry studies at six months, two and five years, unless otherwise determined.

Results

Over a seventeen month period (Aug. 1992-Apr. 1994) at St. Joseph's Hospital in Hamilton Ontario, 105 LNF's have been performed. Of this number only one case required conversion to the conventional open Nissen Fundoplication. Dr. Anvari states, "all patients that have undergone this procedure have reported complete or partial relief of their symptoms". Post operative complications have been minimal and zero mortality reported.

Conclusion

Laparoscopic repair of gastroesophageal reflux has been demonstrated as an efficacious alternative to traditional radical laparotomy and thoracotomy approaches. Low morbidity, high patient satisfaction, less pain, shorter recovery and subsequently a quick return to activities of daily living are just a few of the benefits to minimal access surgery (Geagea, 1991).

Technologies and health care are rapidly advancing towards the minimally invasive approach. Continued research and development of equipment, techniques and surgeon expertise are required in order to empirically demonstrate the success of new laparoscopic approaches. Successful advanced minimal access surgery now being performed by our expert staff include: laparoscopic bowel resection, gastrectomies, hernia repair, appendectomies, liver biopsies and thorascopic surgery. St. Joseph's Hospital and its team of health professionals have embraced this challenging new field of minimal access surgery with enthusiasm. As a team we endeavour to remain on the cutting edge of knowledge and practices in our continuous striving for excellence in the provision of health care.

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Laparoscopic Assisted Vaginal Hysterectomy

By Pam Railton, RN, Lynn Kurylko, RN and Dr. C.M. Shah

Laparoscopic assisted vaginal hysterectomy (LAVH) is the latest advancement in gynecological surgery. Laparoscopy is a medical term used to describe insertion of a telescope into a sleeve into the abdominal cavity. In the past few years, technological advancements have made it possible to do extensive surgeries utilizing laparoscopy.

It is now possible to do a vaginal hysterectomy by doing a laparoscopy - surveying the pelvic contents, separating the uterine attachments, fallopian tubes, ovaries, and main arteries.

As the uterus is too large to remove through a small cannula, it is removed through the vagina. Therefore, a patient who wouldn't normally be a candidate for vaginal hysterectomy can have an LAVH, thus avoiding a large abdominal incision and benefiting from a more rapid recovery.

In the following article, the indications, instrumentation, procedure and early clinical experiences comparing LAVH and abdominal hysterectomy will be covered. Complications, restrictions, benefits, costs and postoperative care for patients undergoing LAVH will also be discussed.

Indications

Dr. J. Arneja and Dr. C. M. Shah have been performing LAVH at the Victoria General Hospital since January 1992. After completing 50 cases they undertook a review of their clinical experiences. They found that indications for doing hysterectomies were almost identical between the two techniques - LAVH and abdominal hysterectomy. The most common indication being fibroids. (See Tables 1A and 1B).

Authors

Pam Railton, RN, is Staff Nurse, Operating Room, Lynn Kurylko, RN, is Staff Nurse, Operating Room, Victoria General Hospital, Winnipeg, Manitoba. Dr. C.M. Shah is Head of Obstetrics and Gynecology, Victoria General Hospital, Winnipeg, Manitoba.

Abstract

Laparoscopic Assisted Vaginal Hysterectomy (LAVH) is the latest advancement in gynecological surgery. It is proving to be a viable alternative to abdominal hysterectomy.

Dr. J. Arneja and Dr. C. M. Shah have been doing LAVH since 1992. After completing 50 cases, a review of clinical experiences was undertaken. Indications for doing the procedures are almost identical, with fibroids being the most common indicator.

A list of instruments required for doing LAVH, along with a diagram of the room set-up are included to help those nurses who are in the preliminary stages of doing LAVH.

The procedure is described at length, beginning with positioning, prepping, and draping of the patient.

A telephone audit with 25 patients who had a LAVH or Abdominal Hysterectomy is also reported.

Complications, benefits, restrictions, and a cost comparison are discussed, including charts to show our results. The article concludes with an overview of the postoperative management of patients having LAVH.

Instrumentation

1. Equipment and theatre set up:

- i) anaesthetic machine
- ii) electric table made ready for the lithotomy position with knee support stirrups
- iii) high straddle table, low back table, and other basic furniture
- iv) two video monitors, (TV screens) - the main video monitor opposite the surgeon has the camera attachment, video recorder and CO₂ insufflator
- v) cautery with bi-polar and monopolar capabilities with the foot pedal to the surgeon
- vi) a hydro-dissection machine on a stand with 1 litre bottles of sterile distilled water

2. Instrumentation:

Gyne Operative Laparoscopy Instruments

- 1 10 cm verres needle (regular)
- 1 15 cm verres needle (long)
- 2 5 mm trocars
- 1 storz 11 mm trocar and key
- 1 hook scissors - monopolar
- 1 hook scissors - long - monopolar
- 1 Metzenbaum scissors - monopolar
- 1 grasping forcep with ratchet
- 1 grasping forcep with teeth and ratchet
- 1 oviduct forcep
- 1 Babcock forcep 5 mm
- 1 Bipolar cautery forcep
- 1 Bipolar cautery cord-grey
- 1 J-hook cautery electrode
- 1 monopolar cautery cord-black
- 1 suction irrigator
- 1 probe with stopcock
- 1 Hulka tenaculum
- 1 extension for laparoscope
- 2 round grey seals
- 2 flat round grey seals
- 2 hourglass grey seals
- 2 clear seals
- 2 luer-lock plugs
- 1 white plastic tube
- 1 metal adaptor for monopolar forcep
- 1 0 degree telescope (soak)
- 1 30 degree telescope (soak)
- 1 laparoscope (soak)
- 1 5 mm light cable (soak)
- 1 insufflator tubing

Laparoscopically Assisted Vaginal Hysterectomy (LAVH)

- 1 Vaginal Hysterectomy instrument set
- 1 set gyne operative laparoscopy instruments
- 1 Valtchev uterine mobilizer
- 1 Nezhat-Dorsey pump/cannulae and tubing
- 1 laparoscopy pack
- 1 1/2 sheet
- 1 table cover large
- 1 vaginal pouch
- 1 double basin
- 1 single gown
- 1 double gown pack
- 1 prep tray
- 1 8 x 4 R-10's
- 1 LAVH kit
- 2 #12 surgigrips
- 1 #10 surgigrip
- 2 universal downsizers
- 1 sterile foley bag
- 1 camera drape
- 1 set light handles
- 1 CO₂ insufflator tubing
- 1 sterile suction tubing
- 1 plastic tonsil suction
- 1 IV luer-lock extension
- 1 IV decanter
- 1 #14 red rubber catheter
- 2 20 ml syringes
- 1 50 ml syringe
- 1 5 ml syringe
- 1 fir tree adapter
- 1 small airstrip dressing
- 2 bandaids
- 1 Peri pad
- 1 Benefits pants
- 1 set gloves - surgeon, assistant, scrub nurse, circulating nurse
- 1 IV 1000 ml lactated ringers
- 1 IV tubing 3-way stopcock
- 1 specimen jar with formalin (med)
- 1 1000 ml bottles water
- 2 white stirrups
- 1 doctor's preference card & extras from card.

An LAVH kit prepared by *Autosuture* is also utilized. It contains the following instruments:
 3 12 mm trocars with surgical grips,
 2 universal downsizers,
 endoshears with monopolar cautery capabilities,
 and endo-gia 30 v with cartridges, 6-8 cartridges.

Dr. Shah and Dr. Arneja use a 0° telescope draped with a sterile camera drape. A Nezhat-Dorsey hydrodissection pump, which comes with a sterile package of disposable tubings, is also used. The actual dissectors are non-disposable and come in a sterile box. All laparoscopic instruments are set up on the high table. The vaginal hysterectomy instruments are set up on a low mayo table. If at any point the LAVH becomes an open abdominal case, a sterile abdominal retractor set is added to the vaginal hysterectomy setup. The transition from laparoscopic to open abdominal procedure is done with a minimal disturbance or delay to the surgery.

The drugs used during the procedure are: warm Ringers Lactate with 5000u of heparin in a pressure bag for irrigation during the procedure, Ringers Lac-

Table 1A
Indications for LAVH
50 cases Jan.'92 - Nov. '93

27	Leiomyoma	54%
15	Menorrhagia / dysfunctional uterine bleeding	30%
3	Adenomyosis	6%
2	Endometriosis	4%
1	Post menopausal bleeding	2%
2	Cervical dysplasia	4%

Table 1B
Indications for Abdominal Hysterectomy
25 cases - Jan.'92 - Nov. '93

12	Leiomyoma	48%
5	Menorrhagia/dysfunctional uterine bleeding	20%
2	Adenomyosis	8%
2	Ovarian tumor	8%
1	Severe cervical dysplasia	4%
1	insitu CA of cervix	4%
1	Endometrial CA	4%
1	Adenomatous hyperplasia of endometrium	4%

Table 2A
Comparing Techniques -
Abdominal Hysterectomy

average blood loss	300cc
average O.R. time	1 hr. 18 min.
blood transfusion	2 patients , 2 units ea
complications	nil
average length of stay	6 days

Table 2B
Comparing Techniques - Laparoscopic
Assisted Vaginal Hysterectomy

	Stapling & Cautery	Bipolar Cautery	Laparotomy Converted
No. of Cases	44 cases	1 case	5 cases
O.R. time	1 hr. 52 min	4 hr. 15min (1st case)	2 hr. 10 min
est. blood loss	175 ml	550 ml	250 ml
transfusions	1-2 units	1-2 units	0
hospital stay	3 days	7 days	6 days

Table 3

Complications Associated with LAVH			
Technique	Ptn.	%	Specific Complication
Cautery	1	2	Post-op bleeding requiring laparotomy - cuff cellulitis
Automatic Stapling	2	4	Bladder perforation requiring laparotomy
Device & Cautery	2	4	Rectus hematoma
Converted failed	5	10	Bladder adhesions, large fibroids, obesity

Table 4
Results of Phone Survey

		LAVH	AbHyst
A	Return to normal activity	3-4 wks	5-6 wks
B	Return to work	5-6 wks	8-9 wks
C	Return to sexual activity	4 wks	7-8 wks

tate 500mls with 250mg ampicillin for abdominal instillation at the end of the procedure, xylocaine 1% with epinephrine 1:100,000 20 mls used in the vaginal area.

The sutures used:

- Laparoscopic puncture sites
- O Dexon TT3 deep for fascia
- 2-0 plain CE-6 for skin
- Vaginal:
- 2 - 0 chromic holding ties
- 1 T-12 Dexon x 5 - (used for remaining pedicles that are not stapled)
- 0 T-12 Dexon x 2

LAVH: The Procedure

The patient is anaesthetized and placed in the low dorsolithotomy position. A bean bag is used to support the arms at the sides, and folded around the shoulders to keep the patient from sliding down the table when placed in the trendelenburg position. Special attention is paid to padding the elbows, fingers and knees. The perineum, abdomen and vagina are prepped with povidone solution. The patient is draped with sterile, disposable drapes. The instrument tables, video screens, cautery and hydrodissector are brought into position and connected.

The hulka or valtchev tenaculum is placed on the cervix to antivert the uterus. A # 14 foley catheter is inserted and attached to a sterile foley bag.

A verres needle is inserted into the umbilicus and the abdomen is insufflated with CO₂. A # 12 mm trocar with a surgigrip is inserted after removing the verres needle and placement is checked with the telescope. A surveillance is done of the abdomen for adhesions; the uterus, ovaries, tubes, and cul de sac are examined. If the gynecologists decide to go ahead with the procedure laparoscopically, trocar placement is continued. A 5mm trocar with a surgigrip is placed in the

suprapubic area. Two 12 mm trocars with surgigrips are placed bilaterally about 3" from the umbilicus.

The hysterectomy is begun by ligating the infundibular pelvic ligaments and round ligaments. (The ligation is done using an endo GIA stapling device from Autosuture.) The endo gauge is used to determine the appropriate reloading unit. The instrument is opened and placed on the ligament and fired. An inspection is done of the cut and stapled edges for hemostasis. If everything is satisfactory, the same procedure is performed on the opposite side.

The next step is to take down the bladder flap. The peritoneum is lifted at the vesico-uterine fold. The dissection is done with cherry dissectors (which are much like a long Q-tip) and/or a hydrodissection pump. The bladder is dissected off the lower uterine segment and cervix. Upon completion of the bladder flap, both ureters are identified. If the ovaries are to be removed, they are ligated next. The uterine pedicles are removed using a GIA stapler. The broad ligaments and the uterosacral ligaments are ligated with bipolar cautery.

In most cases the endoscopic portion of the surgery is completed after ligation and division of the uterine arteries. The level of the bladder and vagina prevents further downward application of staples. In some cases, however, if the bladder is adequately dissected and displaced, the upper aspect of the cardinal ligaments may be staple ligated using the same methods discussed earlier.

It is extremely important to visualize and avoid the ureter during this step. The vagina is not entered during the laparoscopic portion of the operation, although this can be accomplished. When the endoscopic dissection is complete, the vaginal approach is begun.

The hulka or valtchev tenaculum is removed. The CO₂ is turned off. The video equipment is turned off, and the room and operating lights are turned on. A suitable tenaculum is applied to the cervix and a standard vaginal hysterectomy is begun. After entering the posterior cul de sac, the anterior vaginal mucosa is dissected upwards. Usually the anterior cul de sac is easily entered through thin areolar tissue. The uterus is removed and the last pedicles are tied. The vaginal cuff is closed, the peritoneum and vagina are closed in one layer.

The room and operating lights are again turned off, and the video equipment is turned on. The pneumoperitoneum is recreated. The peritoneal cavity is irrigated with a solution of Ringers Lactate 500 ml/

with 250 mg of ampicillin 200-300 mls. Inspection for hemostasis is done with the laparoscope. If all is satisfactory, some of the CO₂ gas is removed from the abdomen. The equipment is removed, the incisions are closed with subcuticular stitches. Dressings and a peri-pad are applied, the foley is taped and the patient is transferred to the Recovery Room.

Early Clinical Experience

Tables 2A and 2B compare O.R. time, blood loss, transfusions and length of hospital stay. Patients who have an LAVH using cautery/stapling are discharged within 3 days. The average operating time is 1 hour and 52 mins versus 1 hour and 18 minutes for the abdominal approach. As the surgical team becomes more skilled, this time may be less. The case using Bipolar cautery was the first case done at the Victoria General Hospital, hence the lengthy O.R. time.

Table 3 shows the complications associated with LAVH when the first cases were reviewed. The first case developed postop bleeding at the base of the bladder which required a laparotomy, the cuff cellulitis was treated with antibiotics and the patient required two units of packed cells. There were two cases of bladder perforation, one required a mini-laparotomy and the other was sutured laparoscopically. There were two case of rectus hematoma. There were five cases that had to be converted to abdominal hysterectomy due to bladder adhesions, a large fibroid and obesity.

As part of the review, a telephone survey was done by the audit personnel at VGH. The patients were asked the following questions:

1. How did you feel about the procedure?
2. When did you start normal activities?

3. When did you return to work?
 4. When did you resume sexual activity?
- Table 4 shows the results of this phone survey. Patient satisfaction with the procedure is high, as reflected by their comments:
- "Recovery was fast and almost painless."
 - "I felt it was very successful, felt good after the operation. I could have gone home the next day."
 - "I would definitely recommend it."
 - "Great! I wouldn't have it any other way."
 - "I couldn't believe it would be so easy."
 - "Hardly any pain."

The Benefits of LAVH

There are several benefits to this procedure:

1. Less invasive procedure - 3-4 puncture sites.
2. Shorter hospital stay. Three days vs. six for abdominal hysterectomy.
3. Fast recovery.
4. Less painful - needing less narcotics.
5. Early return to normal activity and work.
6. System wide cost benefits.

Restrictions of Laparoscopic Surgery

With laparoscopic surgery there are some restrictions.

1. Three dimensional vision is impossible, (unless you have a 3-dimensional camera) and the team has to get used to working with cameras.
2. The actual organ size is distorted.
3. Operation mobility is restricted - once the trocars are placed, you have to work with the instrument in those positions.
4. Increased skills are required by the surgeons and the O.R. staff.

Table 5
Comparison of Coast and Hospital Stay

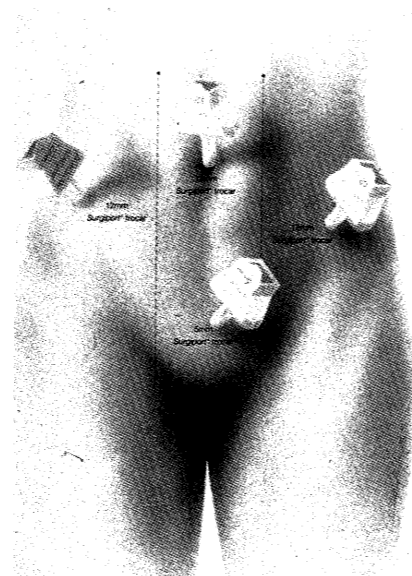
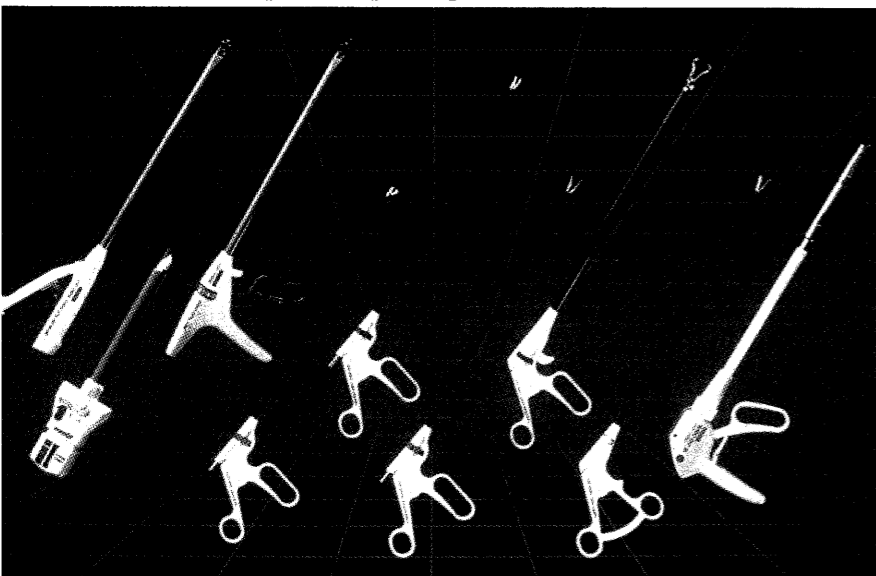
	LAVH with Stapling	LAVH with Bipolar cautery	Abdominal Hyst	Vaginal Hyst without repair
average days in hospital	3	3	6	5
av. VGH cost (per day \$466 + Taxes)	\$1398	\$1398	\$2796	\$2330
OR Costs	\$1100	\$284	\$284	\$284
Anaesthesia and surgeon cost	same	same	same	same
TOTAL:	\$2498	\$1682	\$3070	\$2614



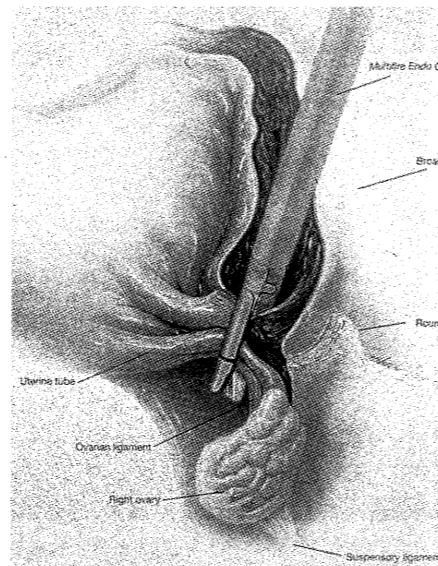
Photo Above: Vaginal Instruments on a low table.



Photo Above: Laparoscopic Instruments on a high straddle table
Lower Photo: Disposable Laparoscopic Instruments.



Sample of Trocar Placement



Above: Stapling Instrument . Below: Hydrodissection Pump Accessories

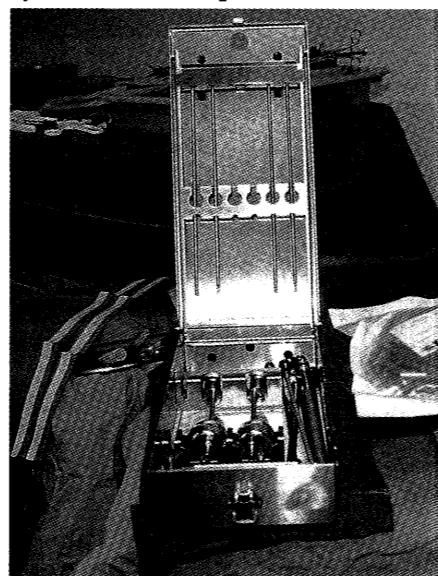


Table 5 is a comparison of costs between conventional hysterectomies and laparoscopic assisted hysterectomies. The average hospital cost at the VGH per day is \$466 plus GST and PST. Anaesthesia and surgeon costs remain the same for each procedure. Although the O.R. cost for LAVH is much more due to the stapling devices, the overall savings come from the decreased length of stay in hospital. LAVH with combination stapling and cautery seems to be the technique of choice among our gynecologists.

Postoperative Care

The postoperative care for patients who have had an LAVH is somewhat different. As in any laparoscopic surgery, bowel peristalsis is only minimally affected. There is little to no postoperative gas pain, and patients ambulate sooner, which minimizes complications.

Patients who have had an LAVH are put on liquids to diet as tolerated immediately postoperative as you don't have the concerns with Ileus that you have with the abdominal technique. The foley catheter is removed approximately 4-6 hours postoperatively; with the abdominal technique the foley usually remains in for a day or two. Pain is managed for both techniques

by PCA (Patient Controlled Analgesia), but requirements for analgesia following LAVH are much less. Patients having abdominal hysterectomy require more nursing care and their hospital stay and recovery are longer. When patients are discharged following LAVH, they are given a postoperative instruction sheet with the following guidelines.

Pain

If you are given a prescription for pain - take medication as instructed by pharmacists. If you are not given a prescription, take 1-2 Tylenol every 4 hours when you have discomfort.

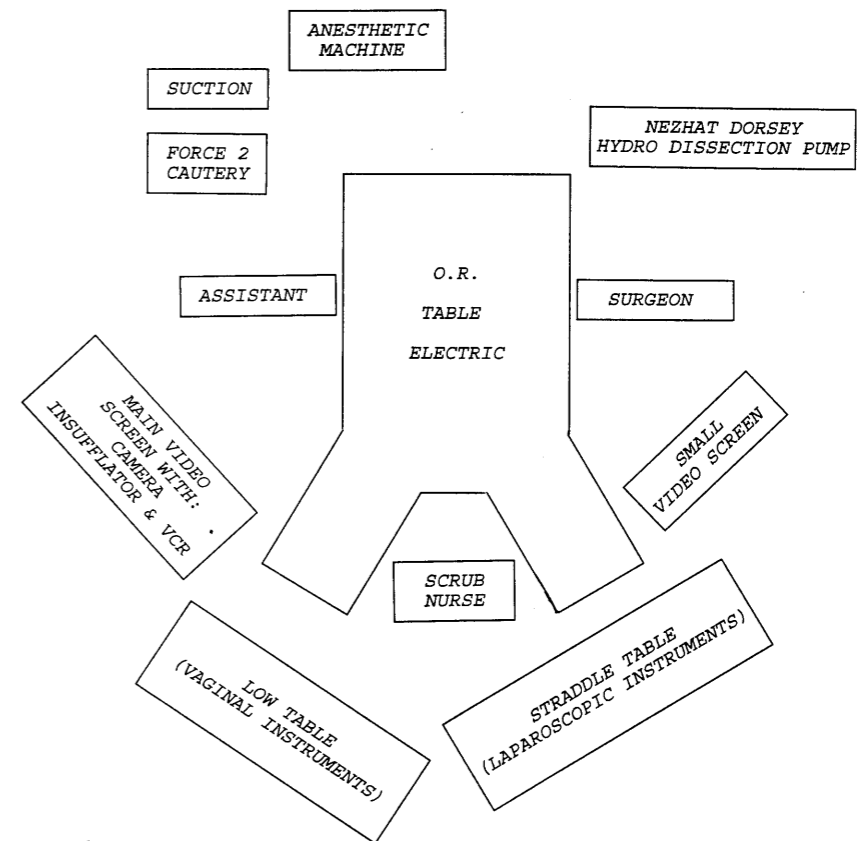
Activity

You may tire quickly for a few weeks following surgery. Your energy level will return as you recover. For 2-3 weeks avoid heavy lifting, and vigorous activities, i.e. vacuuming, laundry, shopping. Exercise such as going for walks and climbing short flights of stairs are encouraged. You may return to work 3 weeks following surgery.

Sexual Relations

You may usually resume sexual relations 4-6 weeks following your surgery.

Diagram 1 - Victoria General Hospital Theatre Set-Up - LAVH



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Bathing and Pericare

It is preferable to take a shower rather than a tub bath for two weeks following surgery. Patient continues pericare at home with warm water and a squirt bottle, and instructed not to douche or use tampons. The patient is also informed that vaginal discharge will gradually decrease, and that since the uterus has been removed, she will no longer have a period, and will no longer have to take birth control precautions.

Incisions/Dressings

You will either have paper tapes or bandaids over your abdominal incisions. Remove the bandaids before you shower and replace them with clean ones after you shower. Wash gently around the paper tapes, being careful not to rub. The paper tapes will dry on their own

Diet

You may resume your normal diet once you are at home. You can help the healing process by eating foods which are high in protein, such as lean meat, eggs, fish, poultry, beans, peas, and milk. To help prevent constipation, eat foods which are high in fiber such as bran, whole grains, fresh fruits, and vegetables. Drink at least 4 glasses of water every day.

Additional Instructions

Notify your doctor if you have any of the following:

- vaginal discharge becomes foul smelling
- vaginal bleeding increases in amount or you start to pass clots
- a fever 38°C or chills
- internal lower abdominal pain
- symptoms of bladder infection: a feeling of an urgent need to empty your bladder, having to empty your bladder frequently, pain when you empty your bladder

Conclusion

The laparoscopic approach provides patients with a more viable alternative to abdominal hysterectomy. Their hospital stay is shorter, recovery is faster, and they are able to return to their normal activities and work sooner.

As the potential of operative endoscopy is realized, techniques and instrumentation will change to meet with our needs. A highly skilled and knowledgeable surgical team that keeps in touch with changing technologies will improve the quality of care for patients, and in the long run provide cost savings to the health care system. ■

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