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Endovascular Stent Insertion

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President's Message

By Margaret Farley, RN, CPN(C)

As we enter the Autumn season I'm reminded of the age-old tradition of *Back to School*. It indicates summer has passed, the holidays are over, and it is time, once again, to focus on education.

It could mean one of many things – preparing children, family members, or yourself to start, continue, or begin again, in the educational arena. In the spirit of learning, many groups, such as perioperative special interest groups, choose to host their annual meetings, workshops and conferences in the fall. This October marks a particularly notable conference as the National Association of Theatre Nurses (NATN), of the United Kingdom, will celebrate its ruby anniversary – 40 years, what a glorious milestone to achieve! Our American counterparts, the American periOperative Registered Nurses (AORN), celebrated its golden jubilee in Chicago last year — imagine 50 years! Operating Room Nurses Association of Canada (ORNAC) is younger by a number of years (we celebrate our 21st anniversary this year) but as an entirely volunteer driven group we take strong pride in each annual milestone. I believe credit must be given to all groups for every year they work together for the benefit of the perioperative practice. I attended the AORN anniversary Congress and plan to be in attendance for the NATN celebrations. It is always an honour to celebrate and learn with colleagues.

I am a truly fortunate student as my most recent classroom has been an international one. My teachers have been international colleagues, industry representatives, and delegates. This group of instructors made learning a pleasure while assisting me in maintaining a high level of competence.

Continuing your perioperative education, and updating your skills, is a daily need in our ever-changing theatres. This makes the goal of continued competence seem very elusive. In order to achieve this goal, be sure your Fall includes some time for learning...however you are able to achieve it. A variety of learning tools are available – on CD and the Internet; via video or audio tape; through journals or equipment

demonstrations; through traditional classes offered at universities or by attending a conference. Consider doing a book review — new perioperative books on the market could be in your health sciences libraries or you can join a professional book club in order to order your own to review. The March 2004 issue of this journal (Volume 22, Issue 1) was dedicated to continuing education and reminded us of the importance of ongoing education in our profession. It also gave hints on how to achieve ongoing education and the role we can play in the ongoing learning of others. It can be fun, as well as challenging, to see our specialty through the eyes of a new recruit. Remember the start of your career in nursing? Can you name a nurse who helped you? I don't think I would have survived without my mentors and I will always remember them!

A commitment to ongoing education within your profession is your responsibility. Remember that an educational process need not be limited to the perioperative specialty. It can provide information that enhances your overall practice – such as discovering the world of bariatric challenges in patient care or learning about rehabilitation post hip and knee joint surgeries.

And remember, don't just pursue your education... take the time to enjoy it! ✨

Margaret Farley, RN, CPN(C) is President of the Operating Room Nurses' Association of Canada. She is the Perioperative Clinical Development Educator at Regina Qu'Appelle Health Region in Regina, SK.

Margaret Farley, inf., CSP(C) est présidente de l'Association des infirmières et infirmiers de salles d'opération du Canada. Elle est éducatrice clinique pour le développement des soins périopératoires au Regina Qu'Appelle Health Region à Regina, SK.



Message de la présidente

Margaret Farley, inf., CSP(C)

L'arrivée de l'automne me rappelle la tradition annuelle de la rentrée scolaire. C'est l'ultime signe que l'été s'achève, que les vacances sont terminées, et que c'est le temps, encore une fois, de tourner son attention vers l'éducation.

Cette attention peut cibler une de plusieurs choses, telle la préparation des enfants, d'autres membres de la famille ou de soi-même lorsque vous commencez, continuez ou recommencez votre formation. Cet esprit d'éducation incite plusieurs groupes d'intérêt spécialisés dans les soins en salle d'opération à tenir leurs assemblées générales annuelles, ateliers et conférences à l'automne. Cet octobre occasionnera une conférence d'importance particulière, celle de la *National Association of Theatre Nurses* (NATN) du Royaume-Uni, qui célébra ses 40 ans d'existence. Quarante ans, quelle belle réussite ! Notre homologue américain, l'*Association of periOperative Registered Nurses* (AORN), a fêté ses 50 ans à Chicago l'année dernière – imaginez, 50 ans ! L'Association des infirmières et infirmiers de salle d'opération du Canada (AISOC) est quelque peu plus jeune (nous célébrons 21 ans cette année) ; toutefois, en tant qu'organisme entièrement dirigé par bénévoles, nous sommes énormément fiers de chacun de nos anniversaires. Je crois qu'il faut reconnaître les efforts de tous les groupes qui travaillent ensemble pour le bien la pratique péri-opératoire. J'ai assisté à la conférence de l'AORN l'année dernière et j'ai l'intention de participer aux célébrations de la NATN. C'est toujours un honneur de célébrer et d'apprendre avec nos collègues.

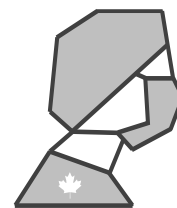
Je suis une étudiante véritablement privilégiée car ma plus récente salle de classe était de caractère international. Je compte parmi mes professeurs des collègues internationaux, des représentants d'industrie et des délégués. Ce groupe d'instructeurs m'a fait un plaisir de l'expérience d'apprentissage tout en s'assurant que je maintiens un haut niveau de compétence.

La poursuite de sa formation en pratique péri-opératoire et la mise à jour de ses compétences sont des besoins quotidiens dans nos salles d'opération toujours changeantes. Cela peut sembler rendre difficile l'objectif de garder à jour ces compétences. Afin d'atteindre ce but, assurez-vous de participer à

des activités de formation cet automne ...de n'importe quelle manière que vous pouvez. Une variété d'outils d'apprentissage sont disponibles : sur CD, Internet, vidéo-cassette ou audiocassette ; dans des journaux ; lors de démonstrations d'équipement ; dans des cours traditionnels à l'université ; ou lors de conférences. Contemplez faire le compte-rendu d'un livre – de nouveaux livres sur la pratique péri-opératoire dans le commerce pourraient se trouver dans votre bibliothèque de sciences de la santé ou vous pouvez vous inscrire dans un club du livre professionnel dans le but de commander un livre à critiquer. Le numéro de mars 2004 de ce journal (Volume 22, numéro 1) a été réservé au sujet de la formation continue et nous rappelle l'importance de celle-ci dans notre profession. Ce numéro donne aussi des idées pour la réalisation de sa propre formation ainsi que des remarques sur le rôle que chacun peut jouer au sien de la formation continue des autres. La perception de notre spécialité à travers les yeux d'une nouvelle infirmière ou un nouvel infirmier peut être plaisante tout en nous lançant le défi. Vous rappelez-vous le début de votre carrière en soins infirmiers ? Vous rappelez-vous du nom d'un infirmier ou une infirmière qui vous a aidé ? Je ne crois pas que j'aurais pu survivre sans mes mentors et je ne les oublierai jamais !

S'engager à la formation continue au sein de sa profession est une responsabilité personnelle. Rappelez-vous que le processus de formation ne doit pas nécessairement se limiter à la spécialité des soins péri-opératoires. Elle peut vous fournir des informations qui peuvent bénéficier votre pratique générale – vous pourriez découvrir toute la gamme des défis présentés par les soins aux patients ayant subi la chirurgie bariatrique ou apprendre au sujet de la réhabilitation suite à la chirurgie de la hanche ou du genou.

Et n'oubliez pas : ne suivez pas tout simplement votre formation, prenez le temps d'en tirer plaisir ! ✨



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Endovascular Stent Insertion for Abdominal Aortic Aneurysm

POSE D'ENDOPROTHÈSE VASCULAIRE POUR ANÉVRYSMÉ DE L'AORTE ABDOMINALE POINT DE VUE DE L'INFIRMIÈRE

Auteure : Carol Skulski, infirmière autorisée à St. Paul's Hospital à Saskatoon, Saskatchewan

Le traitement conventionnel d'un anévrisme de l'aorte abdominale (AAA) comprend une chirurgie abdominale ouverte. La nouvelle alternative à cette intervention chirurgicale est la pose d'endoprothèse vasculaire (*endovascular stent insertion : EVSI*). L'endoprothèse vasculaire est un matériel en forme de tube qui soutient le vaisseau afin de prévenir toute fuite ou rupture de celle-ci et qui ne demande qu'une chirurgie avec effraction minimale. Cette intervention peut être une opération chirurgicale urgente ou non urgente. La chirurgie urgente est indiquée lors de la fuite ou de la rupture de l'anévrisme.

ENDOASCULAR STENT INSERTION FOR ABDOMINAL AORTIC ANEURYSM A NURSING PERSPECTIVE

Author: Carol Skulski, RN, Staff Nurse at St. Paul's Hospital in Saskatoon, SK

The traditional treatment of an Abdominal Aortic Aneurysm (AAA) is an open aortic abdominal repair. The new alternative to the open surgical intervention is endovascular stent insertion (EVSI). An endovascular stent is a minimal access tube like device used to support the vessel to prevent leaking or rupture of the vessel. This intervention is either an elective or an emergency surgery. Emergency surgery is indicated when the aneurysm is either leaking or ruptured.

ANATOMY AND PHYSIOLOGY

The aorta, the largest vessel in the body, extends from the heart to abdominal branches, the renal arteries, mesenteric arteries, lumbar arteries, and divides into the right and left iliac arteries then extends down each leg as the femoral arteries.¹

DEFINITION

An aneurysm is a bulging or ballooning that forms in a weakened area of the vessel.¹ An abdominal aortic aneurysm usually occurs below the renal arteries.^{1,3,4.}

ENDOASCULAR VS. OPEN PROCEDURE

The decision to repair the AAA endovascularly, versus with an open procedure is primarily based upon the patient's health status. Determining this status involves a thorough history and physical as well as establishing the patients cardiac, renal, pulmonary, and vascular status.

A major consideration for endovascular stent insertion is the anatomy of the vessels themselves. If the arterial system is very tortuous it may be exceedingly difficult, if not impossible to pass the required devices up to secure them in position. Those patients with severe medical conditions, who are unable to withstand the effects of an open surgical procedure and/or the effects of a general anaesthetic, and who will live at least two years are candidates for endovascular stent insertion.



AAA Endovascular Graft

Courtesy: Cook (Canada) Inc.

Continued on Page 9

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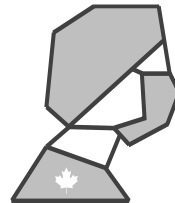
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Endovascular Stent (cont.)

At St. Paul's Hospital in Saskatoon, Saskatchewan, these procedures are carried out in the Angiography Suite, unlike the open aortic abdominal procedures that are performed in the operating room.

ANAESTHETIC CONSIDERATIONS

The anaesthetic considerations are based on the medical status of each patient and his/her anaesthetic wishes. The procedure is performed under a variety of anaesthetics, preferably epidural anaesthesia. The patient has five lead E.C.G., SaO₂ monitor, arterial line, peripheral lines and an indwelling urinary catheter connected to an urimeter as they would with an open approach. Appropriate sedation is also given by the anaesthetist to help reduce the patient stress during the angiographic procedure.

STAFFING REQUIREMENTS

Due to the combined angiographic/surgical requirements the staffing in St. Paul's Hospital comprises perioperative nurses, a radiology nurse, and two medical radiation technologists.

The radiology nurse's duties include the preparation of the table and tray, preparation of Heparinized saline solution (500 mL NS IV with 5,000 units of 1:1000 Heparin), and preparation of various guide wires and catheters. She/he also prepares the endovascular devices (the main body of the graft and limb grafts if they are to be used). The size of the sheath that houses the device is dependent upon the graft size and can range from 16 French to 22 French. The radiology nurse assists the interventional radiologist with the femoral artery punctures, placement of guide wires and catheters into the abdominal aorta, and finally, the endovascular stent.

ENDOASCULAR PROCEDURE

The surgical instrumentation utilized is a Cross-Femoral set-up and includes a minor vascular set (the instruments are used on peripheral areas) as listed in Table 1. A specific supply cart has been set up for use in the Angiography Suite giving the perioperative nurses access to OR related supplies (i.e. packs, ties, sutures) that are not stocked in the Angio Suite.

Table 1

MINOR VASCULAR SET

- 6 Vascular Clamps
- 2 Long Kelly Clamps
- 2 Small Sponge Sticks
- 2 Kockers
- 2 Allis Clamps
- 2 Mosquitos with shods
- 12 Mosquitos Kelly Clamps
- Abdominal Suction
- 4 Tonsils
- 4 Right Angles
- 2 Paediatric Right Angles
- 8 Needle Drivers
- 12 criles
- Irrigating Cannula
- 9 Vessel Dilators
- 2 Mini Iris Tissues
- 2 Toothed Iris Tissues
- Beaver Handle
- Spencer Coronary Artery Tissue Spring Scissor
- 2 Self Retaining Claws
- Small Mastoid Retractor
- 2 Baby Richardsons
- 2 Langenbachs
- 2 Small Langenbachs
- 2 Potts Scissors
- 2 - 7" Metz
- 5" Metz
- Straight Strabismus Scissor
- Curved Strabismus Scissor
- Steven's Tenotomy Scissor
- 2 - #10 Blades
- 2 Toothed Waughs
- 2 Toothed Ramseys
- 2 Toothed Gilles Tissues
- 2 Short Debakey Tissues
- 2 - 8" Debakey Tissues
- 15 Spring Debakey Clamps
- 6 Bulldogs Caliper
- 4 - #3 Scalpel Handles
- 2 Nerve Hooks
- 2 Frazier Suctions with Stilette

Endovascular Stent (cont.)

The perioperative nursing staff set up the back table as if in the operating room. A count, consisting of sharps and sponges is carried out. A weak heparin solution, heparin 1:1000 units / 1 mL in 200 mL of normal saline (IV) is used to help prevent clotting in the vessel.

Prior to the patient being placed on the Angio table a ruler is placed under the mattress to assist with the stent placement. The patient is surgically prepped with a Betadine solution from nipple line to knees and draped as per the surgeon's requirements – usually from umbilicus to knees thereby exposing the groins.

There are usually two vascular surgeons involved in the procedure so the Femoral Arteries are exposed in tandem. Incisions are made in the right and left groins. Dissection is carried out to the femoral artery using cautery to coagulate any bleeding vessels. The common, superficial and deep (profunda) femoral arteries are exposed with the use of vessiloops or umbilical tapes (these are string-like devices that can retract or constrict the arteries, as required, without damaging them). These major vessels may also be occluded with vascular clamps to help decrease blood loss and aid visualization for the stent insertion.

Arteriotomies (incision into the artery) are carried out with a #11 scalpel blade and Potts scissors. The vessel is incised enough to allow the passing of the stent.

The radiologist then passes a guide wire through the femoral arteriotomy, up the external and common iliac arteries, and in to the aorta. The angio catheter-sheath is passed over the guide wire and, with the use of dye the vessels are visualized. The ruler under the mattress, along with the markings on the stent, are used to determine the correct insertion and placement of the stent.

The stent may be either bifurcated or straight. The sheath and stent (that is threaded up over the guide wire with the use of angiography) is positioned approximately 1mm below the lowest renal artery. Once positioned, to the satisfaction of both the vascular surgeon and the interventional radiologist, the stent is deployed. The insertion

device is removed and over the guidewire an angiographic balloon is advanced to the upper portion of the stent. Once in position the balloon is inflated 2 or 3 times until the graft is secure. There may be circumferential rows of small hooks that attach the upper portion of the stent to the intima and media of the vessel, or it may be held in position by radial force alone without the hooks.

The main body of the graft (if bifurcated), once secured in position, looks like a pair of trousers with one long leg and one short leg. The ipsilateral side is the long leg. The contralateral side is the short leg. The second portion of the stent is threaded up the contralateral vessel and positioned so the short section of the main body of the stent overlaps that this, then the graft is secured in position with the angiographic balloon. Once the angiographic sheath and balloon are removed from the artery, the artery is back bled to remove any possible blood clots that may have formed.

The femoral artery is anastomosed by the surgeon using a vascular stitch and the vessiloop and clamps are removed. Protamine is given by the anaesthetist to reverse the effects of the Heparin. The suture line is checked to ensure there is no further bleeding and, if it is satisfactory, primary closure is carried out. Upon finishing the skin closure the vascular surgeon checks the popliteal and posterior tibial pulses as well as color and temperature of the limbs. This is to ensure circulation has not been impaired (i.e. thrombosis).

Mepore dressings are applied to the operative sites and the patient is transferred off the radiology table and onto the patient bed and then transported to PACU.

In the unlikely event of a complication during the procedure (i.e. rupture of aorta) there is a sterile major abdominal aortic aneurysm set up in the operating room. The patient may go to ICU, post-procedure, for an overnight stay but often just goes to an observation unit nearby on the surgical floor.

ADVANTAGES AND DISADVANTAGES

The advantages to the patient of Endovascular Stent Insertion include a decrease in blood loss, lack



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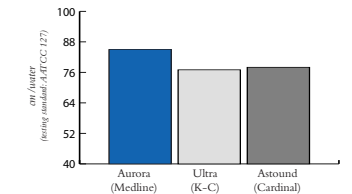
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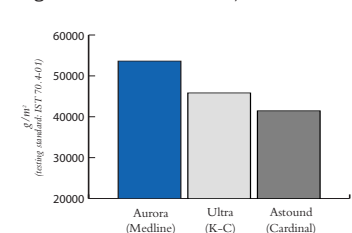
Hydrostatic Head

(A common method of testing protection. Higher numbers are better)



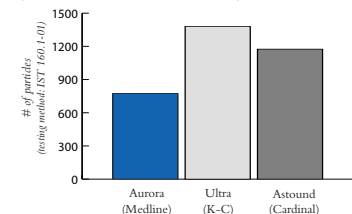
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Endovascular Stent (cont.)

of abdominal incision, and a shortened hospital stay (usually forty-eight to seventy-two hours).²

The potential disadvantages or complications of this procedure are similar to the open abdominal procedure and include emboli, aortic perforation, anaesthetic complications, and higher risk of fatality.

CONCLUSION

In conclusion, the use of Endovascular grafts will only increase in the future. The stent is very expensive but the cost is off-set by the reduction in ICU time and a shortened hospital stay, not to mention the physical and cosmetic benefits to the patient.

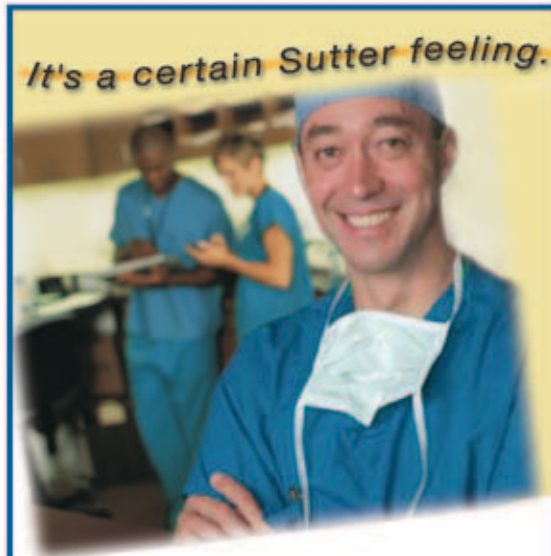
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**Left photo - The darker color in the handprint shows the immediate effect of Hibistat® on staph aureus.

***Right photo - The darker color in the handprint shows the cumulative effect of Hibiclens® on staph aureus the 5th day of use, 6 hours after the final daily hand wash.

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Keeping spirit alive at work: Taking care of the caregiver

L'ESPRIT SAIN AU TRAVAIL : PRENDRE SOIN DU SOIGNANT

Auteure : Catherine Fenwick, M.A., psychologie clinique, est auteure, éducatrice, experte-conseil en milieu de travail, et survivante du cancer.

Une carrière enrichissante est une expression de notre humanité. Elle peut définir en grande partie qui nous sommes ainsi que la contribution que nous faisons à notre communauté. Pour une vie satisfaisante il nous faut tous des activités qui nous semblent importantes, des personnes proches sympathiques et compatissantes et l'habileté de demeurer ouverts aux possibilités de joie, de beauté et d'humour. Il est souvent dit que nous passons autant de temps avec nos collègues qu'avec nos familles; il est donc important de trouver des manières d'apprécier le temps que nous passons ensemble.

KEEPING SPIRIT ALIVE AT WORK: TAKING CARE OF THE CAREGIVER

Author: Catherine Fenwick, M. A. Clinical Psychology, is an author, educator, workplace consultant, and cancer survivor.

Meaningful work is an expression of our humanity. To a large degree, it defines who we are and what contribution we make to our community. To have a satisfying life we all need to have meaningful purposeful activity, be surrounded by caring and compassionate people, and have the ability to remain open to the possibility of joy, beauty and laughter. Many people say that they spend as much time with their colleagues at work as they do with their families. It is important that we find ways to enjoy being together.

Healthy humour is a symptom of mental, emotional, spiritual and organizational well-being for both the care-giver and the care-receiver. Healthy humour helps to reduce stress, create support networks, increase creative energy, build morale and produce healing chemicals in our body^{1,4,11,16}. A joyful attitude helps us strengthen our inner resources and cope

more effectively with things we cannot change^{4,7}. Life does not cease to be serious when we are laughing – indeed, it is during our most trying times that laughter can be most beneficial^{3,6,12,15}.

A healthy sense of humour has long been recognized as an indicator of mental health and maturity. Joy, beauty and laughter build bridges of trust and help us to maintain a sense of hopefulness. This helps to create connections with others^{7,8}. Laughter helps to alleviate fear and protects us against personal vulnerability^{14,15}. The physical benefits include relaxation, better blood circulation and oxygenation, and production of beneficial body chemicals such as endorphins^{1,14,16}. Healthy laughter helps us to feel better and get along with others^{2,9}.

When we enjoy being together, our communications are more likely to have positive outcomes^{7,13}. When we enjoy each other we become more attentive listeners, increase cooperative interaction and build trusting relationships.

While humour and laughter have many benefits, we should not assume that it is always welcome or appropriate¹⁰. During times of medical, emotional or spiritual crises, humour can be harmful. Sensitivity, intuition and rapport are crucial to selecting the appropriate use of humour with patients and colleagues. Receptivity, timing and content are important in deciding when, and if, to encourage laughter. The best humour is both spontaneous and meaningful in the moment. A good rule of thumb is to take cues from the other, watch for opportunities to bring light-heartedness to the situation.

Healthy humour comes from a position of love and support. If we develop our own humour skills we will be ready when the right moment presents itself. If humour is appropriate to the situation, the other will respond to it. If they do not respond, then this is not the right time. Initiate gently and with respect for others.

We should not confuse professionalism with seriousness. A sense of humour is a valuable

component of both self-care and patient care. We can maintain professional behaviour and still find lots of opportunities to share joy and laughter⁵. Humour skills, like any other skills, can be learned and improved. As with everything else we learn, our humour skills become better with practice. Most of us would benefit from laughing more than we do. Joy and humour counteract fear, anger and depression – people under great strain often find things to laugh about.

Humour that heals is compassionate; it brings people closer together and is mutually supportive. For me healthy humour is more about sharing personal stories than it is about telling jokes. In order to share joy, we first need to experience joy. When we focus on the things that cause us to suffer we soon get tired and discouraged and our feelings shut down. When we shift our focus to the positive things that are around us, we notice beauty, experience joy, become receptive to the possibility of laughter, and feel energized.

The ability to laugh, play, and enjoy life are good indicators of a healthy sense of humour. Children are naturals at this but most adults have lost much of their ability to play. What happens to us in the process of growing up – where does our laughter go? As we grow older we are expected to *act our age*, whatever that means. We take on responsibilities, go to school, get a job, and get sick – not necessarily in that order. We suffer losses, big and small. There are many reasons behind our loss of laughter.

To bring more joy in to your life start by making a list of the things that make you laugh. Who are your favorite comedians, clowns, or funny people? If you haven't laughed in a long time, think about the things that brought you joy in the past, then go out and start doing those things again. Your home life probably offers an endless supply of humorous material. Television, movies, books, and songs provide an abundance of laughable material.

You could throw a 'tell only funny stories' party. Invite people you know who love to laugh and



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have everyone come prepared to share their favourite stories. Our stories won't be about laughing at others. We will avoid stories that might be hurtful. Healthy humour invites everyone to laugh and is based on caring and building confidence; we don't get laughs at the expense of someone else. Write them down and add them to your own humour files.

Create a *laughter first-aid kit*. This can include anything that gives you a lift or makes you chuckle. Write a laughter contract with yourself promising "I will do one thing each day to bring more joy and laughter into my life. Today I will _____." Make a conscious decision to find the extra-ordinary in everyday events. Create an atmosphere of caring, support and joy at home and at work. Take ten to fifteen minutes, particularly during the most stressful parts of your day, to read the funnies, play a game, or share something wonderful with someone. Be a clown, liberate your funny bone, and release your playful inner child. Become more childlike (not childish – there is a difference). Spend time with children and let them teach you about healthy laughter and play.

Humour can be a tricky tool. Healthy humour is not used as a defense mechanism, to escape ones responsibilities, or to hurt another person. We do not want to use humour to diminish the seriousness of certain situations. Your patients and clients will toss humour lines so be ready to respond to them.

Continued on Page 34

SURGICAL SMOKE



RISK

Surgical smoke can carry dangerous bacteria and viruses, including HIV. It can produce upper respiratory irritation and may have mutagenic potential.

FACT

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Latex Allergy: Still a Challenge?

ALLERGIE AU LATEX : ENCORE UN DÉFI?

Auteure : Barbara Badger, infirmière autorisée, BSPA CNPR, a plus de 25 années d'expérience en salle d'opération. Elle est actuellement experte-conseil en soins infirmiers cliniques à Regent Medical à Leicester, Massachusetts, États-Unis.

Bien que l'utilisation des produits en latex date d'au-delà d'un siècle, les réactions allergiques aux protéines du latex ne sont reconnues en tant que grave problème de santé que depuis les 15 dernières années.¹ En 1987, quand l'Occupational Health and Safety Administration (OSHA) a instauré ses précautions universelles, le besoin des gants d'examen a vu une augmentation importante. Parce que tout le monde qui venait en contact avec le sang ou d'autres liquides organiques était maintenant obligé de se protéger les mains, le nombre de paires de gants utilisées par année, moins d'un milliard en 1987, a atteint 20 milliards de paires par année en 1996.² La sensibilisation au latex est le résultat de l'exposition aux protéines du latex au fil du temps et, même si les taux de sensibilisation documentés varient, il est estimé que 8 à 12 % des travailleurs de la santé ont une sensibilisation au latex.³

1. Meade, B. J., Weissman, D. N., & Beezhold, D. H. (2002). Latex allergy past and present. *International Immunopharmacology*, 2, 225 – 238.

2. Ibid.

3. U.S. Department of Labor, Occupational Safety and Health Administration. (2002, novembre) Safety and health topics: latex allergy [version électronique]. Consulté le 20 novembre 2002 à <http://www.osha.gov>.

LATEX ALLERGY: STILL A CHALLENGE?

Author: Barbara Badger, RN BSPA CNOR, has over 25 years of perioperative experience. She is currently a Clinical Nurse Consultant with Regent Medical in Leicester, MA, USA.

Although latex products have been in use for over a century, allergic responses to latex proteins have only been recognized as a serious health problem for about the past 15 years.¹ In 1987, when the Occupational Safety and Health Administration (OSHA) introduced Universal Precautions, the demand for examination gloves increased significantly. Since everyone who came in contact with blood or body fluids was then expected to wear hand protection, glove use increased from fewer than 1 billion pairs per year (prior to 1987) to over 20 billion pairs of gloves by 1996.² Latex sensitization is caused by exposure to latex proteins over time, and, although stated sensitization rates vary, it has been estimated that 8 – 12% of healthcare workers are latex sensitive.³




RISK GROUPS

When it comes to latex allergy certain risk groups are examined. Anyone who frequently wears latex gloves in their line of work is potentially at risk of developing this allergy. The major source of workplace exposure is natural rubber latex (NRL) gloves.⁴ The groups at risk include healthcare workers, dental workers, EMS workers, as well as non-healthcare workers such as law enforcement personnel, firefighters, gardeners, and painters. Other groups that may be at risk are people who have spina bifida, those who have had multiple surgeries and those who are atopic (genetically predisposed to allergy).⁵

TYPES OF RESPONSES

The three main potential responses to the use of natural rubber latex gloves are: an irritant response (non-allergic), Type IV allergy (localized response) and Type I allergy (systemic response). Let's look at each response separately.

Irritant response, or irritant contact dermatitis, is the result of mechanical or thermal damage to the skin but is not an allergic reaction. This reaction is caused by skin irritation from using gloves and, possibly, by exposure to other workplace products and chemicals. The reaction can also result from repeated hand washing and drying, incomplete hand drying, or exposure to powders added to the gloves.⁶ Chronic exposure leads to dry, thickened, and cracked

TYPE OF REACTION	MEDICAL TERM	CAUSE	SYMPTOMS
Skin Irritation <i>(non-allergic)</i> 	Irritant or Contact Dermatitis	<ul style="list-style-type: none"> • Repeated washing • Insufficient rinsing • Antiseptic agents • Glove powder 	Dermatitis <ul style="list-style-type: none"> • Redness • Dry, cracked skin • Itching • Hard, red bumps
Type IV Allergy <i>(localized response)</i> 	Delayed Hypersensitivity (T-Cell lymphocytes)	<ul style="list-style-type: none"> • Repeated exposure to processing chemicals 	Skin Symptoms <ul style="list-style-type: none"> • Puffiness • Redness • Inflammation • Peeled/cracked skin <p>Occurs several hours after exposure</p> <p>Can persist for prolonged period if untreated</p>
Type I Allergy <i>(systemic response)</i> 	Immediate Hypersensitivity (IgE mediated)	<ul style="list-style-type: none"> • Repetitive exposures to naturally occurring water-soluble proteins in latex products 	Skin symptoms <ul style="list-style-type: none"> • Inflammation • Redness • Itching • Urticaria Systemic symptoms <ul style="list-style-type: none"> • Watery eyes • Rhinitis • Asthma-like symptoms <p>Can progress to more severe reactions</p> <ul style="list-style-type: none"> • Facial swelling • Breathlessness • Anaphylaxis <p>Can occur within minutes after exposure</p>

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skin. Management of this problem may include identifying and eliminating the irritant, using proper hand hygiene, thoroughly drying hands and changing glove types.⁷

Type IV allergy, or allergic contact dermatitis, is T-cell mediated and is a localized response. This response is an allergic reaction to chemicals that are used in the glove manufacturing process. It is a true allergic response as it involves the immune system.⁸ Many individuals mistake this response for a latex allergy mainly because they have the reaction while wearing latex gloves. Some of the signs and symptoms of a Type IV reaction include but are not limited to erythema, pruritis, and edema. These symptoms can be delayed from 6 to 48 hours. It is important to understand this delay because if one wants to discontinue use of the problem glove they are currently wearing and try a new brand of glove, they should give themselves at least 48 hours without wearing gloves at all. This may allow their body to recuperate somewhat from the offending chemical before they try another brand of glove.⁹

Diagnosis for this allergy is usually a patch test using commercially available chemical reagents. Management for this allergy includes using a latex or non-latex glove without the offending chemical. Be aware that synthetic products can contain the same chemicals as those in latex products. It is important to know exactly *which glove component* one is allergic to, rather than simply assuming that latex is the allergic component.¹⁰

Type I Allergy, or immediate hypersensitivity, is potentially the most serious response to latex products. Between 1989 and 1997, there have been over 2,300 allergic responses to latex products and 28 deaths resulting from latex protein-induced anaphylaxis reported to the US FDA.¹¹ The reaction occurs when a latex-allergic individual comes in direct contact with latex proteins. Reactions usually begin within minutes of exposure. Symptoms run from mild (skin redness, hives, itching) to more severe (cough, hoarse voice, chest tightness, runny nose, itchy or swollen eyes) to life threatening (bronchospasm and shock).¹²

Diagnosis of this allergy requires a careful recording of medical history followed by serologic testing (RAST) and/or skin prick testing. Management of this allergy means that the individual has to avoid contact with latex proteins at all cost. They should use non-latex products and, ideally, should work in a powder-free environment. Starch powder is responsible for aerosolization of the latex proteins that may cause an allergic reaction in sensitized individuals.¹³

POWDER ISSUES

When natural rubber latex gloves were first introduced over 100 years ago, they were sterilized by boiling and donned over wet hands. Later on, when dry sterilization was introduced, it was necessary to use a dusting powder agent to facilitate donning. The first agents used were lycopodium powder, talcum powder or a mixture of the two. Over time, these agents were found to cause peritoneal granulomas.¹⁴ Therefore an absorbable alternative was needed.

“In 1947, the superiority of cornstarch powder treated with epichlorhydrin over talc as a lubricant for surgical gloves was reported. This mixed with 2 percent magnesium oxide as a desiccating agent was later marketed as absorbable dusting powder (ADP) glove powder. It is this material that remains in use today”.¹⁵ When ADP was first introduced, starch peritonitis was not a problem mainly because the cornstarch was broken down during the steam sterilization process, which led to rapid absorption in the body. As gamma irradiation became the sterilization process of choice for surgical gloves, the cornstarch granule was not damaged sufficiently to lead to early absorption.¹⁶ This led to the formation of granulomas and adhesions in some surgical patients.¹⁷ Aerosolization of the latex protein is a hotly discussed issue. Researchers have reported that cornstarch powder on latex gloves serves as a carrier of the latex proteins and may precipitate an allergic reaction in sensitized individuals.¹⁸ Asthma, upper airway, and ocular symptoms are associated with the airborne latex proteins.¹⁹

Powder also acts as a foreign body that can elicit an inflammatory response and may interfere

Latex Allergy: Still a Challenge? (cont.)

with a host's defenses against infection.²⁰ In addition, when cornstarch contaminates soft tissues, it can delay wound healing.²¹ Starch powder can be introduced into wounds by the use of powdered gloves during surgical procedures, despite glove washing and wiping beforehand.²² Powder also has masqueraded as peritoneal carcinomatosis.²³ For at least these reasons, the use of powder-free gloves in any environment simply makes sense. Many hospitals have already made the decision to convert to a powder-free environment and may have also saved money while increasing safety.^{24 25}

LATEX-SAFE ENVIRONMENT

Due to the potential risks associated with latex allergy, and to help avoid further sensitization, healthcare facilities should take steps to create a safe place for both patients and employees.²⁶

One of the first things to do is to form a multidisciplinary latex committee. This committee will be responsible for disseminating information on latex to their various departments so that everyone will be knowledgeable of latex products if questions regarding the allergy arise. Education for this committee is imperative and the group must be committed to seeing that the latex-safe environment is maintained.²⁷

Latex allergy protocols, for both patients and employees, are very important. Each healthcare facility should consider writing protocols that address how to deal with latex-allergic and high-risk patients. A screening questionnaire is an important way to help identify people with the allergy or those who are at risk. Once individuals are identified by the questionnaire, it is a good idea to use a special coloured armband, signs, and other methods to clearly identify the latex-allergic patient.²⁸ A latex-free cart may be readily available outside the patient's room. The latex-allergic person should, ideally, be in a private room. If that is not possible, the other individual(s) in the room must be treated as if they are latex-allergic as well. If the facility does not have a latex-safe procedure or operating room the latex-allergic patient should be the first

case of the day. That is when the level of aerosolized latex protein is at the lowest.²⁹

Also according to Kim, employees who are latex-allergic should be closely monitored on a regular basis.³⁰ Using a screening questionnaire for employees could be part of their annual employee physical (*see page 22*). This would assist the Employee Health Practitioner in keeping accurate records and/or updating the progress of those employees who are either already latex-allergic or are just beginning to exhibit signs of acquiring the allergy. Education programs on latex allergy are very important for all hospital staff. The more knowledgeable the staff, the better they can care for the latex-sensitive patient. Hospitals may want to make this information part of their annual mandatory information sessions.

Many experts advise that all latex-allergic individuals should wear a Medic Alert bracelet or some other form of identification of their allergy.^{31 32 33} It is also suggested that they carry some kind of self-injecting epinephrine with them at all times. Synthetic gloves should be carried on the person for use in case of an accident.

CONCLUSION

Do we have to get rid of latex gloves in order to have a latex-safe environment? According to several researchers already referenced, the use of powder-free, low-allergen latex gloves can provide an adequate latex-safe environment. A powder-free environment would be beneficial to the latex-sensitive employee and patient. It has been shown that if workers wear powder-free, low-allergen gloves, the latex aeroallergens may be reduced by more than 10-fold.³⁴ Because of the advances in the technology of synthetic products, some hospitals have looked at going latex-free.

Besides providing a safe environment for its employees, facilities that decide to go powder-free are able to offer the community a place where individuals can feel that their health is the number one consideration from admission through discharge.



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Screening Questionnaire for Natural Rubber Latex Sensitivity

IMPORTANT CAUTION: This questionnaire is not intended to be all-inclusive. Individuals who are uncertain whether they have sensitivities or allergies to natural rubber latex proteins and/or chemicals should consult a physician.

1. Have you ever been told by a doctor that you have an allergy to any latex product?

Yes No

If yes, to what specifically did the doctor say you were allergic? _____

How were you diagnosed?

Patch test Wear test RAST test Skin Prick test Don't know

2. Have you had a reaction to any of the following personal sources of latex?

	Yes	No		Yes	No		Yes	No
balloons	<input type="checkbox"/>	<input type="checkbox"/>	carpet backing	<input type="checkbox"/>	<input type="checkbox"/>	garden hoses	<input type="checkbox"/>	<input type="checkbox"/>
rubber gloves	<input type="checkbox"/>	<input type="checkbox"/>	clothing	<input type="checkbox"/>	<input type="checkbox"/>	golf grips	<input type="checkbox"/>	<input type="checkbox"/>
hot water bottles	<input type="checkbox"/>	<input type="checkbox"/>	rubber cement	<input type="checkbox"/>	<input type="checkbox"/>	latex cuffs	<input type="checkbox"/>	<input type="checkbox"/>
rubber balls	<input type="checkbox"/>	<input type="checkbox"/>	suspenders	<input type="checkbox"/>	<input type="checkbox"/>	ostomy bags	<input type="checkbox"/>	<input type="checkbox"/>
rubber bands	<input type="checkbox"/>	<input type="checkbox"/>	teething rings	<input type="checkbox"/>	<input type="checkbox"/>	dental masks	<input type="checkbox"/>	<input type="checkbox"/>
adhesive tape	<input type="checkbox"/>	<input type="checkbox"/>	condoms	<input type="checkbox"/>	<input type="checkbox"/>	pacifiers	<input type="checkbox"/>	<input type="checkbox"/>
ace bandages	<input type="checkbox"/>	<input type="checkbox"/>	elastic undergarments	<input type="checkbox"/>	<input type="checkbox"/>	shoewear	<input type="checkbox"/>	<input type="checkbox"/>
dental bite blocks	<input type="checkbox"/>	<input type="checkbox"/>	dental cofferdams	<input type="checkbox"/>	<input type="checkbox"/>	tennis grip	<input type="checkbox"/>	<input type="checkbox"/>
bandages	<input type="checkbox"/>	<input type="checkbox"/>	erasers	<input type="checkbox"/>	<input type="checkbox"/>	weather stripping	<input type="checkbox"/>	<input type="checkbox"/>
belts	<input type="checkbox"/>	<input type="checkbox"/>	face masks	<input type="checkbox"/>	<input type="checkbox"/>	IV tubing	<input type="checkbox"/>	<input type="checkbox"/>
brassieres	<input type="checkbox"/>	<input type="checkbox"/>	foam pillows	<input type="checkbox"/>	<input type="checkbox"/>			

3. Do you have a personal or family history of...

	Yes	No		Yes	No		Yes	No
contact dermatitis	<input type="checkbox"/>	<input type="checkbox"/>	hay fever	<input type="checkbox"/>	<input type="checkbox"/>	autoimmune disease	<input type="checkbox"/>	<input type="checkbox"/>
rhinitis or conjunctivitis	<input type="checkbox"/>	<input type="checkbox"/>	eczema	<input type="checkbox"/>	<input type="checkbox"/>	asthma	<input type="checkbox"/>	<input type="checkbox"/>

4. Do you have any drug allergies?

Yes No

If yes, what drugs are you allergic to? _____

5. Do you have any food allergies?

Yes No

If yes, are you allergic to any of the following?

Onset:	Recent (last 12 mos.)	Long-standing		Recent (last 12 mos.)	Long-standing
banana	<input type="checkbox"/>	<input type="checkbox"/>	milk	<input type="checkbox"/>	<input type="checkbox"/>
avocado	<input type="checkbox"/>	<input type="checkbox"/>	peaches	<input type="checkbox"/>	<input type="checkbox"/>
raw potato	<input type="checkbox"/>	<input type="checkbox"/>	tomato	<input type="checkbox"/>	<input type="checkbox"/>
kiwi	<input type="checkbox"/>	<input type="checkbox"/>	papaya	<input type="checkbox"/>	<input type="checkbox"/>
chestnuts	<input type="checkbox"/>	<input type="checkbox"/>	passion fruit	<input type="checkbox"/>	<input type="checkbox"/>

other _____

6. After handling or wearing latex products, have you experienced:

	Yes	No		Yes	No
chapping or "cracking" of skin	<input type="checkbox"/>	<input type="checkbox"/>	redness	<input type="checkbox"/>	<input type="checkbox"/>
runny nose/congestion	<input type="checkbox"/>	<input type="checkbox"/>	swelling	<input type="checkbox"/>	<input type="checkbox"/>
itching (hands, eyes, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	hives	<input type="checkbox"/>	<input type="checkbox"/>
other _____	<input type="checkbox"/>	<input type="checkbox"/>			

7. Have you ever had surgery?

Yes No

If yes, how many surgeries have you had? _____

At what age did you have your first surgery? _____

Type(s) of surgical procedures _____

Have you ever had an allergic reaction during anesthesia? Yes No Don't know

8. Have you had extensive dental work?

Yes No

Type of work completed _____

9. Do you have any congenital abnormalities (i.e., spina bifida)?

Yes No

What type? _____

10. What is your occupation? _____

Does this occupation involve frequent contact with products containing latex?

Yes No

If yes, which products do you come in contact with? _____

11. Have you ever had an anaphylactic reaction to latex devices?

Yes No

If yes, under what circumstances did it occur? _____

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This document is suggested for use by professional healthcare providers as a diagnostic tool.

CAUTION: Latex protein allergies are cumulative. That is, the more a person is exposed to poorly processed latex, the more likely it is that a potentially irreversible allergy will develop. While sensitization threshold levels vary by individual, it is clear that the best way for healthcare workers to avoid future reactions without sacrificing the protection and performance of latex is to wear only powder-free latex gloves with the lowest possible allergen content. However, once a latex allergy is confirmed, only non-latex gloves should be worn.

REG12197 7/01

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LA RÉALISATION DU RÊVE DE TOUTE UNE VIE

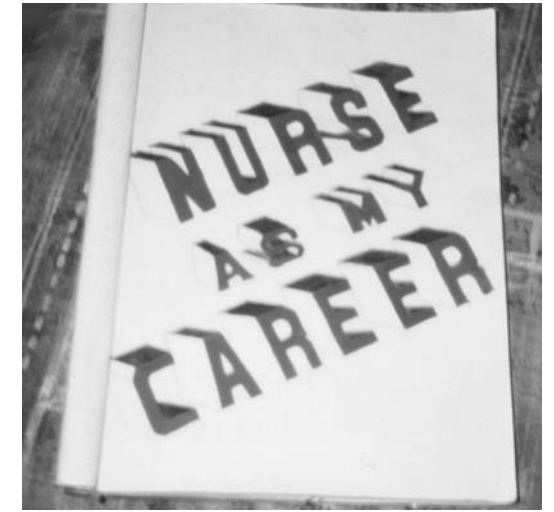
Auteure : Gloria Stephens, après une carrière d'infirmière de 43 ans, est maintenant à la retraite à Halifax, Nouvelle-Écosse. Pendant sa carrière elle a été présidente du BCORNG de 1970 à 1972 et de l'AIISOC de 1990 à 1993. Elle a reçu le RNABC Excellence Award in Nursing Practice en 1987 et a été la toute première récipiendaire du Isabelle Adams Award en 1988.

Au début des années 40, quand j'étais une fille de 14 ans en 9^e année à la Chebucto Road School à Halifax, Nouvelle-Écosse, un conseiller d'orientation nous a enseigné un cours obligatoire nommé CARRIÈRES. Pour réussir le cours, il fallait élaborer un « CAHIER DE CARRIÈRE ». La page titre de mon cahier lisait « Ma carrière comme infirmière ». En fait, j'avais choisi cette carrière bien avant l'âge de quatorze.

LIFE-LONG DREAM FULFILLED

Author: Gloria Stephens is, after a 43-year career in nursing, retired and living in Halifax, NS. Her career included acting as BCORNG President from 1970 to 1972, a term as ORNAC President (90-93), receiving the 1987 RNABC Excellence Award in Nursing Practice; and receiving the first ever Isabelle Adams Award in 1988.

In the early 1940's, when I was a 14 year old in grade 9 at Chebucto Road School, in Halifax, NS, a Guidance Counsellor taught my class a compulsory subject titled CAREERS. The credit criteria for this subject required the development of a 'CAREER BOOK'. The title page for my career book was Nurse As My Career. I had actually chosen this career long before the age of fourteen.



Cover of author's grade 9 career book

Courtesy G. Stephens

Thankfully mothers often save precious momentos. After my mother's passing, in 2001, I found my career book in a trunk. For those days when we wonder why we do what we do, let me share some of the highlights exactly as they appeared in the pages of my career book:

WHY I CHOSE NURSING – “nursing is the practical art of caring for the sick in hospitals, private homes, clinics, institutions, as well as preventing diseases. The work is interesting in all branches, varied and stimulating. The patient who has faith and trust in a nurse has a better chance of recovery than one who feels she is being cared for by a nurse for the financial part alone. I have set nursing as my goal in life and I shall work hard until I have success and achieved this goal.”

WORKING CONDITIONS – “strain of work is severe both mentally and physically therefore it requires an effort to keep oneself healthy.”

QUALIFICATIONS – “nursing is an occupation that has a lasting future, is honourable, profitable, and must be done to the best of one's ability, therefore requires higher education ... start with a High School

Continued on Page 28

ORNAC AWARDS

ORNAC presents several awards every year in recognition of excellence in perioperative nursing. The *ORNAC/J&J Medical Products Drake Thompson Writing Award* honours the top original articles in each year's Canadian Operating Room Nursing Journal. The *Cardinal Health Research Grant* supports perioperative nursing related research projects, and the *ORNAC/J&J Medical Products Bursary* supports continuing education.

In the year of the Biennial National Conference ORNAC also recognizes excellence in perioperative nursing by presenting *The Isabelle Adams Award*. We encourage all ORNAC members to consider applying for, or nominating a peer to receive, one or more of these awards.

Awards are presented at the National Conference or, in a non-conference year, at the Provincial Conference of the recipient. In 2004 the following awards were presented at the Ontario Provincial Conference:

ORNAC/J&J Medical Products Drake Thompson Writing Award

Dawn Atwell and **Grace Groetzsch** each received a \$1,500 award for their articles in the June 2003 CORNJ

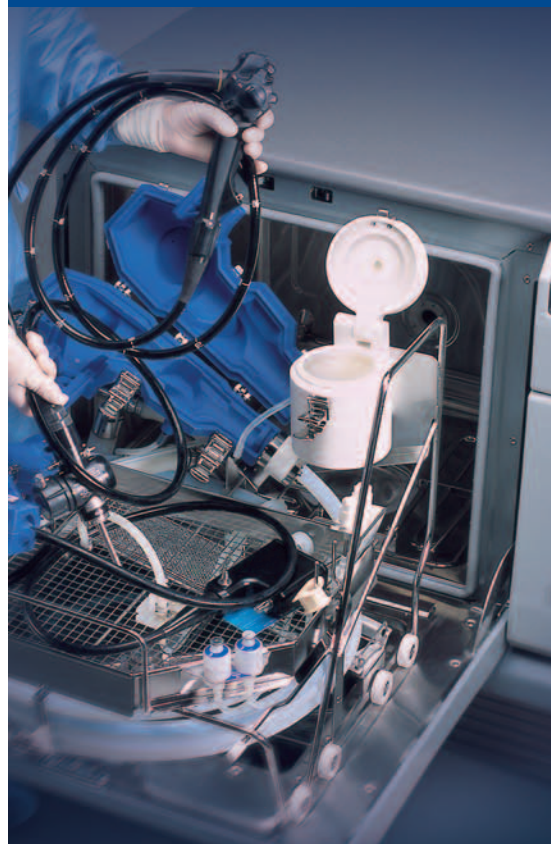
ORNAC /J&J Medical Products Bursary

Mariana Markovics, Perioperative Educator at St. Joseph's Healthcare in Hamilton, ON, received a \$1,000 bursary in support of her Masters Degree studies at the University of Toronto.

For more award information, including application/nomination criteria, visit www.ORNAC.ca.

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UPCOMING EVENTS

For details visit www.ornac.ca

PROVINCIAL CONFERENCES

Alberta	Medicine Hat	October 20-23, 2004
Quebec	Quebec City	December 1-3, 2004
Atlantic Conference	Moncton, NB	October 3-6, 2004
Newfoundland & Labrador	Gander	October 28-30, 2004

ORNAC CONFERENCES

www.ornac.ca

19th National	Montreal, PQ	May 1-6, 2005
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INTERNATIONAL CONFERENCES

NATN (www.natn.org)	Harrogate, UK	October 6-9, 2004
AORN (www.aorn.org)	New Orleans, USA	April 3-7, 2005

ANAESTHESIA CONFERENCES

CAS (www.cas.ca)	Vancouver, BC	June 17-21, 2005
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LIFE-LONG DREAM FULFILLED (cont.)



Courtesy G. Stephens

50th Class Reunion

Left to Right, Back: Marion (Crowell) Hoyland, Hazel (Slocum) Voelker, Jessie (Meikle) Mader, Mora (Clarke) Sallows, Hazel (Taylor) Walker, Gloria (Webb) Stephens, Edie Bogle.
Front: Connie (Gerrard) Stewart, Manny (Schaffner) Thornton, Roma (Preece) Shaw, Edna (George) Clydon, Nancy (Devenny) McInnes, Anne (Laidlaw) Hanrahan.

diploma with university entrance marks. There is the choice of a three year Training School of Nursing in a hospital or preferably a baccalaureate degree and could lead to a Master of Nursing..... above all a spirit of service and a sincere interest in human beings of all classes and kinds are necessary to nursing."

ADVANTAGE – "work is open to anyone regardless of colour, sex, or religion; opportunities for advancement and promotion; professional contracts and the knowledge that one is engaged in the service of mankind; and if one has what it takes – the will to live straight, plus the necessary sense of adventure and the initiative to get out of a rut and into what's happening, the rewards of nursing will be high; you will have a pension all your life after thirty years of service – which is about as much security as you can ask for in this hazardous world."

DISADVANTAGE – "on the whole nursing has not many disadvantages but there are a few – the work is arduous and exacting, making continual and unpredictable calls on the practitioner's time; long hours and one has to keep learning forever."

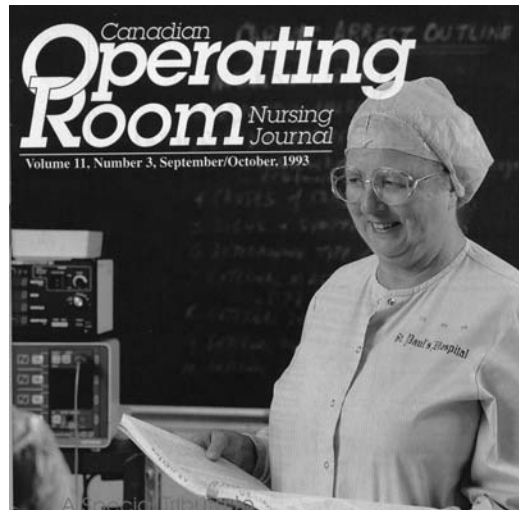
TRENDS – "nursing is advancing socially, professionally and educationally. Nurses will be needed in large numbers as practitioners and health teachers in the general health and welfare field. They will play a large important part, too, in any health insurance plan that is brought into action in the country, – surgery is taking a tremendous stride forward; new drugs are used, new techniques are developed – nursing in the future promises to become a boom profession. To the person suited to the life, nursing has nearly everything."

REWARDS – "the greatest reward of nursing is the satisfaction attained in saving a human life – other rewards – promotion, attractive pay, travel, adventure and above all, a sense of rich achievement and the realization of the importance of your vocation."

HISTORY – (of course Florence Nightingale was mentioned in another passage) "In 1943, the census taken showed that there are in Canada, 50,000 trained professional nurses."

REQUIREMENTS – Physical: good health; strong nerves; good feet. Social: cheerful; intelligent; sincere; have an interest in people."

Finally we were asked to describe a vision of our future. Here is the start of my life-long dream – interesting that it is the operating room...



Courtesy Health Media Inc.

The author as featured on the cover of Sept/Oct 1993 CORNJ

"VISIONARY FUTURE OF 1952"

It was about ten-thirty one stormy December night when the shrilling of the telephone wavered through the night air. I was sitting in an easy chair in front of a crackling fire reading a book, when aroused by the phone. I got up to answer it, "Hello, hello, is that the nurse, Miss Webb, said the voice at the other end, excitedly. Be ready in fifteen minutes and I'll pick you up. There is an emergency call in Brandford". I knew by the voice it was Doctor Welland and was ready in ten minutes. It was a grand feeling to know I was able to help and give my services to someone in need.

In a few minutes the car was outside and as we drove through the blinding snow to Brandford a small village, ninety miles away I took a glance back through the years of preparation for this moment to come, a time when I will be of use to the human race in relieving the suffering.

The Doctor finally broke the silence by telling me about the patient. He said how this boy's father owns a sawmill and how the boy, while playing near the saw, slipped and fell. There will have to be an operation as soon as possible; we will have to make our own operating room. As we rounded the next bend, lights could be seen through the snow. We reached the house in a two-hour drive because of the blizzard.

At about two a.m. the same morning the Doctor and I came out of the make do operating room to be met by the boy's mother and father, "Is he alright? You were in there so long. It was the greatest thing that ever happened to me, to be able to say to them; "Your son will live and to make things still better, we saved his leg."

The storm has died down now so the Doctor left for the city, but I stayed and had a good cup of tea and had a rest after the long night. I'm staying here until Danny has completely recovered. Then after being recommended by the Doctor, because of my surgical ability, I am going to be his assistant in the operating room. "At last after long and continuous years of study, I find myself on the threshold of nursing!"

50TH YEAR REUNION

The 50th year reunion of the Victoria General Hospital Nursing School Class of '53 was held at the home of Gloria (Webb) Stephens, in Halifax, Nova Scotia on September 12th and 13th, 2003.

The house was decorated for the occasion with celebratory balloons, posters featuring old pictures, write-ups, and other sentimental items, along with a banner reminding us "Doesn't Time Fly When You're Having fun?"

Several said it was a homecoming, as well as a reunion, because the house had been a home away from home, under the care of Vida D. Webb, for the entire class during the three years program – Gloria Webb had been the only Haligonian in the class.

Out of a class of 22 students, 14 travelled from BC, Ontario, the US, and other parts of Nova Scotia to attend. Of the eight who were unable to attend five had passed away, after battles with cancer, and three were unable to travel due to illness. Seven husbands also attended.

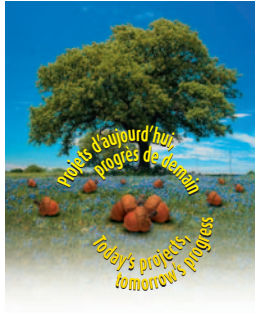
One of our instructors, Sylvia Nott travelled in from Boston for the occasion. Each alumnus received a Victoria General Hospital (VGH) crested china plate, featuring a 50th year rosette, as part of the roast beef dinner on Friday night.

Our entertainment included a Harbour Trip, games with prizes, a comedy skit by classmates portraying Florence Nightingale and the VGH Director of nursing, and a rousing old fashioned sing-song with two members of the Eric Bowers country music group on guitars and piano (note on August 12, 2003, Eric Bowers was inaugurated into Nova Scotia Country Hall of Fame) along with dancing by several energetic folks.

All good things must come to an end – our reunion concluded with the singing of Auld Lang Syne and a promise to meet again in two years.

Here's to MEMORIES!!! 🍁

CALL FOR ABSTRACTS AND POSTERS



Operating Room Nurses Association of Canada **19th National Conference** Montreal, QC • May 1 - 6, 2005

Share your accomplishments in the fields of perioperative clinical practice, education, professional development, research and administration!

The 2005 Conference Program Committee invites you to submit an abstract for presentation or poster at our 19th ORNAC National Conference "Today's Projects, Tomorrow's Progress" Abstracts will be considered for presentation in one of the following forums:

Abstracts will be considered for presentation in one of the following forums:

Paper: A 15-minute presentation by the author plus 5 minutes for questions
Poster: A visual display - Posters will be displayed Monday, Tuesday and Wednesday

Abstract submissions should have a maximum of 150 words on a single-spaced page, typed in a size 12 font. The abstract heading should include title, author(s) name, institution name, city, province, contact information, and the specific field of focus.

Please send three (3) copies of the abstract by November 15, 2004 to:

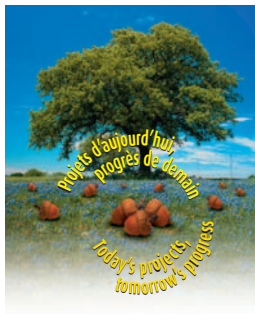


Louise Bilodeau RN, BN, CPN(C)
Chair, Program Committee
8280 Oregon, Brossard, QC J4Y 2J7
Fax: (514) 345-4829 • Email: bilolou@sympatico.ca

The contact person will receive notice of selection after the closing date. Accepted presenters will be asked to complete a biographical data form.

Unsigned, incomplete, or late submissions will not be processed.

APPEL DE RÉSUMÉ ET D’AFFICHE



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Le Comité du programme de la Conférence de 2005, vous invite à soumettre un résumé, pour une présentation orale ou par affiche à la 19ième Conférence de l'AIISOC dont le thème est : « Projets d'aujourd'hui, Progrès de demain »
Les résumés seront considérés pour une présentation à l'un des forums suivants:

Les résumés seront considérés pour une présentation à l'un des forums suivants :

Présentation orale : 15 minutes de présentation par auteur plus une période de questions de 5 minutes
Affiche : Les affiches seront exposées lundi, mardi et mercredi

Les résumés soumis devront avoir un maximum de 150 mots dactylographiés à simple interligne dans une police à 12 points. L'entête du résumé devrait inclure le titre, nom de l'auteur/des auteurs, nom de l'institution, ville, province, coordonnées et le domaine précis d'intérêt.

Envoyez trois (3) copies de votre résumé avant le 15 novembre 2004 à:



Louise Bilodeau inf BSc, CPN(c),
Responsable du Comité Programme
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Télécopieur: (514) 345-4829 • Courriel: bilolou@sympatico.ca

La personne-ressource recevra la liste des résumés acceptés après la date limite. Les conférenciers choisis seront demandés de remplir un formulaire de données biographiques. Aucune soumission non-signée, incomplète ou en retard ne sera considérée.

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ORNAC and its President, Margaret Farley, would like to thank Acart for its generous support through the 2004 *Acart President's Bursary*.

This bursary has been in existence since 2002 and has allowed ORNAC to be represented at conferences both within Canada and Internationally.



This year's bursary allowed ORNAC President Margaret Farley to travel to Toronto, Ontario, for the Canadian OR Leaders (CORL) national conference on May 2 to 4, 2004.



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Taking Care of the Caregiver (cont.)



Courtesy Jupiter Images

I lost my laughter during cancer treatments. To get it back I took up clowning and started a *thanks-giving journal*, as ways to get it back. Clowning, while not for everyone, is an excellent technique for creating joy and laughter. We will be healthier and happier if we hang on to our sense of humour and have some fun every day. “A merry heart doeth good like a medicine” (Proverbs 17:22). From my thanks-giving journal I composed a poem, which I dedicated to all OR staff:

*Thank you, Great Spirit, for the gift of laughter; for the people who bring me joy, for the comedy that makes me forget, if only for a moment. Thank you for the gift of creativity; for artists, whose work takes me out of the sadness and into a kinder place. Thank you for the ability to find great joy in simple things; for the peace of long walks in the country, for a cool lake on a hot day, for snow in winter, for music, meditation and prayer. Thank you for the gift of compassion, and the joy of forgiveness. And please, let me be at peace with whatever happens today.*⁷

I was about to sign the permission for surgical removal of my right breast when I noticed that the consent form read, “removal of left breast”. I called attention to the error and was assured, with sincere apologies, that the correction would be made. The next morning, before going into surgery, I put a note over my left breast that said, “This is not the one!” I heard later that the operating room and recovery room staff had a good laugh. As I grow older more and more of my friends are learning to live with physical disabilities, chronic illness, and difficult life events. They are determined, courageous, and honest about their feelings. In between the times of tears we spend a lot of time laughing together.

There are many ways to connect with colleagues or patients. Smile, laugh, or share hugs (when it is appropriate). Introduce creative ways to greet one another, instead of shaking hands with each other, try shaking elbows, shoulders, knees, etc. Initiate conversation about topics of interest to the other. Use open-ended questions such as, “If you had loads of time and money what would you do?” or “What’s the funniest thing that happened to you today?” or even “When are you happiest?” Play *happy* music. I remember the music that was playing in the operating room while I waited for the anaesthesia. It was Stevie Wonder singing “I just called to say I love you.” My eyes still well up with tears when I hear that song and remember the kindness of the OR staff.

I believe that meaningful work, caring people, beauty, joy, and laughter are the best stress busters. They help us to keep things in perspective and to face each day with renewed hope. Look for balance in life, strive for excellence (not perfection), and take time to stop and smell the roses. Keep physically fit, eat healthy food, get enough sleep, and make time for family and friends. Concentrate on taking care of yourself and taking care of each other. Give yourself rewards for small successes, pay attention to all the wonderful things you do, and try not to worry so much about what can’t be done. Tap into your healthy humour attitude, build healthy relationships, focus on the things that really matter, be the best that you can be, and fill your life with beauty and joy. All of these things will help you to keep your spirit alive... at home and at work.

For more information on this topic please contact the author at www.healingwithhumour.com or cfenwick@sasktel.net.

ISABELLE ADAMS AWARD FOR EXCELLENCE IN PERIOPERATIVE NURSING



This award is presented at the ORNAC National Conference, if there is a suitable candidate, to an outstanding nurse who through major commitment has made a significant contribution to perioperative nursing in Canada. The Award winner will reflect the practice and ideals of Mrs. Isabelle Adams of Montreal. The Award was established on the initiative of the Operating Room nurses of Quebec, in 1987, and is one of high-profile recognition with no monetary award.

More details can be found at

www.ORNAC.ca

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One Child With Hope for the Future

UN ENFANT AVEC DE L'ESPOIR POUR L'AVENIR

MISSION CAMTA 2003

Auteure : Eileen Guilfoyle, infirmière autorisée, unité chirurgicale niveau 1 (pédiatrie), et niveau 3 (adultes), University of Alberta Hospital, Edmonton, Alberta. Elle est membre fondatrice de la CAMTA et a participé à 5 missions depuis le début de son implication dans l'organisme en 2000.

CAMTA, la *Canadian Association of Medical Teams Abroad*, est un groupe d'individus, avec ou sans formation médicale, qui se sont engagés à aider les personnes démunies souffrant de problèmes orthopédiques en Équateur. Le groupe a entrepris deux missions avant d'incorporer en 2001; depuis sa fondation officielle, 3 autres missions ont été entreprises en Équateur. Pendant leurs missions chirurgicales, l'équipe de la CAMTA vise également le partage de l'information et l'enseignement aux infirmières, infirmiers et médecins locaux.

ONE CHILD WITH HOPE FOR THE FUTURE

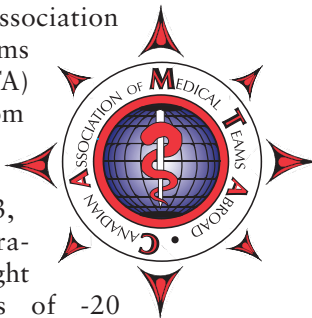
2003 CAMTA MISSION

Author: Eileen Guilfoyle, RN, is Registered Nurse, Level 1 (Paediatrics) and Level 3 (Adult) Surgical Suite, University of Alberta Hospital, Edmonton, AB. She is a founding member of CAMTA and has participated in five missions since getting involved with the organization in 2000.

CAMTA, the Canadian Association of Medical Teams Abroad, is a group of medical and lay individuals dedicated to helping underprivileged people suffering from orthopedic problems in Ecuador. The informal group conducted two missions prior to officially incorporating in 2001 and has, since its official founding, conducted 3 more missions in Ecuador. During their surgical missions the CAMTA team also aims to share information and provide teaching to local nurses and physicians.

The Canadian Association of Medical Teams Abroad (CAMTA) team's departure from Edmonton in the wee hours of January 24, 2003, was on an extraordinarily cold night with temperatures of -20 degrees. The bus departed from the Royal Alexandra Hospital at 12:30 AM and arrived at the Calgary airport at 3:30 AM. There were fifty 70-pound hockey bags of equipment carried by the 25 team members. The team included nurses, surgeons, anaesthetists, a family doctor, a physio-therapist, an anaesthetic technician, three lay people (two travel agents and one CAMTA representative).

We traveled from Calgary, through Houston, and arrived in Quito, Ecuador late in the evening on Friday, January 24th, 2003, after almost 24 hours enroute. Children selling flowers greeted us at the airport. They scurried around us and under our feet as we loaded the bags onto the truck for transport to the clinic where we would spend the next 10 days. Once the bags were safely stored we proceeded to our hotel.



Courtesy CAMTA

L to R Francie Martin RN, Eileen Guilfoyle RN, Dr. Boris Petriw, Anaesthesiologist, in the OR with Dustin



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One Child With Hope for the Future (cont.)



Courtesy CAMTA

The twins in the arms of author Eileen (L) and their mother (R)

I was filled with great anticipation of this, my fourth, medical mission. This team had traveled together to Ecuador on three previous missions, but on those occasions we had traveled to the city of Cuenca in the south of Ecuador. This time we were entering the unknown – the city of Quito. The city of Quito is the capital of the country and it is located at 9,500 feet above sea level in the volcanoes of central northern Ecuador. The Tierra Nueva Clinic, our final destination, is located in a poor area in the south end of the city.

On Saturday morning we were oriented to the clinic and had a chance to meet some of the local people with whom we would be working side by side over the next 10 days. By noon all of us embarked in vans to visit the market at Otavala about two hours north of the city. It was an opportunity to relax a little before the heavy work of our mission began.

On Sunday morning the pre-admission clinic commenced early — there were already 130 people waiting when we arrived at the hospital at 8:00 AM. We exchanged greetings with both patients and their parents as we entered the hospital.

Later in the day I was able to take my camera in search of photo opportunities at the pre-admission clinic. My eyes caught sight of a young mother with two children

about 7 months of age. She smiled as I passed. When I returned from the clinic to where she waited with her children in the hallway I noticed that one of the children had bilateral clubfeet I asked the mother – through my husband as interpreter – about her children. I learned they were twins and this delighted me because I am a twin. But I was saddened that, while one of the twins was completely healthy, the other, Dustin, had abnormal feet. I expressed my hope that her child would be able to receive surgery. Later my heart leapt when I learned that her child was one of our patients.

Clubfoot is a congenital disorder that occurs in about 1 per 1000 births.

It develops early in the pregnancy and results in a downward and inward pointing foot. The Achilles tendon, as well as the tendons on the inward side of the foot, is shortened and some bony abnormality also occurs.

On the day of surgery, I hugged the young 19-year-old mother when she arrived, with Dustin, at the operating room. I was so happy for her. Her eyes were glistening with anxiety and trepidation about the impending anaesthesia for, and surgery on, her baby. But her large



Courtesy CAMTA

Dustin's surgery

Continued on Page 45

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“Backing down wasn’t even an option.”

In touch: with Peggy Doyle, Director of Perioperative Nursing

It was bizarre. Out of the norm. Just plain unheard of. Why would a healthcare facility abandon the long-held tradition of powdered latex surgical gloves just because of something that appeared to be as miniscule as air particulates? These were some common responses Peggy Doyle, Director of Perioperative Nursing received as she lobbied to change her OR over to powder-free surgical gloves.

But she wouldn’t back down. It was 1991, and she was listening to a great number of OR and PACU nurses who were experiencing unexplained allergic reactions. Inhaler usage was increasing among the nurses, and soon, there were other workers throughout the facility who were complaining of similar symptoms. Starch powder from latex medical gloves had found its way into the air, creating an environment that Peggy believed prevented some of the staff from returning to work.

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ORNAC would like to congratulate the Registered Nurse First Assistant Network of Canada (RNFANC) on their approved status as an affiliate group with ORNAC. At the present time, there is only one other group that has affiliate status with ORNAC.



Some of the requirements for a national perioperative nursing organization, representing a special interest, to receive ORNAC affiliate status include:

- the organizations’ members are perioperative registered nurses the applicant organization requires its members to be active members in their respective provincial perioperative nursing organization and shall encourage participants to be active members within their provincial perioperative nursing organization.
- the applicant organization has a statement of its goals or objectives, identification of its membership base, and a described structure of its organization base.

ORNAC welcomes the Registered Nurses First Assistant Network of Canada and looks forward to working together to enhance and expand perioperative nursing. For more information about the RNFANC, please visit ORNAC’s newly updated website at www.ornac.ca and click on the “affiliate” link.

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ORNAC in a Nutshell — Spring 2004

Author: Lynn Anderson, ORNAC Secretary

The Spring meeting of the Board & Executive was held in Toronto April 30, May 1, and May 2, 2004.

- ✓ ORNAC President, Margaret Farley, welcomed new Board members: Francine Cloutier, QC and Kim Reese, NB and Observers: Donna Marin SK, Sue Styles AB and Thelma MacNeil NS. Thank You and farewell was expressed to Peggy Ziegler AB, Laura Ellsworth NL, Lucette McLean MB, and Theresa Thomas PE.
- ✓ Guests included: Mr. Stephane Delorme Accountant, Pat Pocock and Muriel Shewchuk CORL, and Pam Rialton representing the RNFANC (RN First Assist Network of Canada).
- ✓ Congratulations to RNFANC who applied for and have been granted ORNAC affiliate status at this Board meeting.
- ✓ CORL held it's Spring meeting in Toronto in conjunction with the Board & Executive meeting.
- ✓ Past President, Mary Knight attended the 1st IFPN study day at ACORN in April. She presented two sessions Infection Control – SARS in Canada and Issues in Sterilization and Decontamination. Approximately 150 Nurses attended. Mary also stayed on to attend the ACORN National Congress. We look forward to her reports.
- ✓ Since our last Board meeting the Recommended Standards, Guidelines and Position Statements for Perioperative Registered Nursing Practice 5th Edition has been released. It is available through Canadian Standards Association at 1-800-463-6727. French translation of the Standards was delayed but we are endeavoring to have the French version released as soon as possible. ORNAC apologizes for the delay. There have been a lot of positive comments about the new module format and we will begin review

immediately. Chair of the Standards Committee is Alaine Young.

- ✓ ORNAC has several major reviews underway. We are in the process of reviewing the Board structure, rules and regulations manual, national conference planning manual, and ORNAC bylaws. More news to follow after our November meeting!
- ✓ We are moving closer to the reality of a Virtual Office and are working with Keynote Networks on a major restructuring of our website (www.ORNAC.ca). Stay Tuned!
- ✓ At our November 2003 meeting it was decided that ORNAC would like to become more involved at the International level. We contacted IFPN and will be sponsoring a three-year membership for Kenya. This sponsorship will allow Kenya to become a member of IFPN.
- ✓ The Awards Committee presents several ORNAC Awards every year. Chair of the Committee, Peggy Ziegler, will travel to Ontario in June to present several Awards at the ORNAO Provincial Conference. 🍁



In the OR

Courtesy Jupiter Images

L'AIISOC en Bref — Printemps 2004

Auteure: Lynn Anderson, AIISOC

La réunion du conseil d'administration a eu lieu à Toronto du 30 avril au 2 mai 2004.

- ✓ La présidente de l'AIISOC, Margaret Farley, a accueilli les nouveaux membres du conseil : Francine Cloutier, QC ; et Kim Reese, NB, ainsi que les nouvelles observatrices : Donna Marin, SK ; Sue Styles, AB; et Thelma MacNeil, NS. Nous avons remercié et dit au revoir à : Peggy Ziegler, AB ; Laura Ellsworth, NL ; Lucette McLean, MB ; et Theresa Thomas, PE.
- ✓ Parmi les invités figurent : M. Stephane Delorme, comptable ; Pat Pocock et Muriel Shewchuk, CORL ; et Pam Rialton, représentante de l'RNFANC (RN First Assist Network of Canada).
- ✓ Félicitations à l'RNFANC, qui a fait demande et a été accepté en tant que membre affilié à l'AIISOC pendant la réunion du conseil.
- ✓ CORL a coordonné sa réunion de printemps avec celle du conseil de l'AIISOC à Toronto.
- ✓ La présidente sortante, Mary Knight, a assisté à la première journée de formation professionnelle de l'IFPN lors de la conférence de l'ACORN au mois d'avril. Elle a présenté deux discours : Infection Control – SARS in Canada (La prévention de l'infection – SRAS au Canada) et Issues in Sterilization and Decontamination (Enjeux de stérilisation et de décontamination). Approximativement 150 infirmiers et infirmières ont assisté. Mary est restée et a assisté elle-même à la conférence nationale de l'ACORN. Nous attendons avec impatience ses rapports.
- ✓ Depuis la dernière rencontre du conseil, la cinquième édition de Recommended Standards, Guidelines and Position Statements for Perioperative Registered Nursing Practice a paru. Pour en procurer une copie, contacter l'Association canadienne de normalisation (CSA) au 1-800-463-6727.



Courtesy Jupiter Images

Scrub Nurse

- La traduction française des normes a été retardée mais nous travaillons assidûment pour faire en sorte que la version française puisse être publiée aussitôt que possible. L'AIISOC vous demande pardon du délai. Nous avons reçu un grand nombre de commentaires positifs en ce qui concerne le nouveau format modulaire et la révision sera immédiatement commencée. Alaine Young est la chaire du Comité des normes.
- ✓ L'AIISOC effectue actuellement plusieurs révisions majeures. La structure du conseil, le manuel de règlements, le manuel de planification de la conférence nationale et les règlements administratifs de l'AIISOC sont en processus de révision. Plus de renseignements seront disponibles suite à la réunion de novembre !
- ✓ La réalité d'un bureau virtuel s'approche. Une réorganisation importante de notre site web (www.ORNAC.ca) se fait avec l'aide de Keynote Networks. Restez à l'écoute!
- ✓ À la réunion de novembre 2003 la décision a été prise d'augmenter la participation de l'AIISOC au niveau international. Nous avons communiqué avec l'IFPN et allons parrainer la participation de Kenya pendant trois ans. Ce parrainage permettra au Kenya de devenir membre de l'IFPN.
- ✓ Chaque année le Comité des prix accorde plusieurs Prix de l'AIISOC. La chaire du comité, Peggy Ziegler, ira en Ontario en juin afin de présenter plusieurs prix à la conférence provinciale de l'ORNAO. 🍁

ORNAC ANNOUNCES . . .

The 2005 CARDINAL HEALTH RESEARCH GRANT
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WHO

Available to researchers who meet the criteria as outlined in the Cardinal Health Research Grant Guidelines for Applicants (see HOW).

WHAT

An annual grant of up to \$5,000 sponsored by Cardinal Health and administered by the ORNAC Research Committee.

WHY

To promote perioperative nursing research activities and to encourage the integration of research findings into perioperative nursing practice, in order to improve perioperative patient care.

WHEN

Letters of Intent are required by November 15, 2004. Application deadline is March 15, 2005. Grant recipients will be selected at the May 2005 ORNAC Board meeting.

HOW

Guidelines for Applicants and Application Forms are available from Karen Frenette, Chair of ORNAC Research Committee, at kfrenett@health.nb.ca or through the ORNAC Website: www.ornac.ca



L'AIISOC ANNONCE . . .

LA BOURSE DE RECHERCHE CARDINAL HEALTH
2005 VALEUR: jusqu'à 5000 \$

QUI

Chercheuses et chercheurs satisfaisant aux exigences mentionnées dans le guide d'admission à la bourse de recherche Cardinal Health (voir COMMENT).

QUOI

Bourse annuelle pouvant atteindre 5000 \$, parrainée par Cardinal Health et administrée par le comité de recherche de l'AIISOC.

POURQUOI

Promouvoir des activités de recherche et intégrer leurs résultats dans nos pratiques de soins périopératoires dans le but d'améliorer ou de valider ces soins auprès des patients.

QUAND

Soumettre votre lettre d'intention par le 15 novembre 2004. La date limite pour soumettre votre demande est le 15 mars 2005. La sélection des gagnant(es) de la bourse se fera lors de la réunion du conseil d'administration de l'AIISOC de mai 2005.

COMMENT

Le guide d'admission et les formulaires d'application sont disponibles auprès de la présidente du comité de recherche, Karen Frenette, par kfrenett@health.nb.ca, ou par le biais du site web de l'AIISOC : www.ornac.ca



One Child With Hope for the Future (cont.)



Courtesy CAMTA

L to R Author Eileen Guilfoyle, Dr. John McIvor, and Francie Martin cast Dustin at the end of the surgery.

Ecuadorian eyes also conveyed hope and anticipation.

The surgery went well and after ninety minutes Dustin was in the recovery room with his mother at his side. Later I visited them on the ward and took some photographs. The mother was so grateful for the fact that she could see that her son's feet were straight in his leg casts. She was given a backpack containing toys and a soccer ball for each boy. Football (soccer) is very popular in Ecuador and now Dustin would some day be able to



Courtesy CAMTA

Dustin, post-operatively, with his mother

compete with his twin brother on an even playing field.

I was unable to see Dustin and his mother before they were discharged from the hospital. However, my colleague Mark, a physiotherapist, said that the young mother was overwhelmed with gratitude.

The child's casts would remain on for another six weeks and follow-up care would be provided by a local physician.

It is heart-wrenching to see the many families who are in need of our help and to know that we do not have the time to help all of them. In January 2003 we performed 32 surgeries on 14



Courtesy CAMTA

Casts complete

children and 18 adults. Some of the people who we were unable to help in 2003 did receive surgery in 2004. We hope that still others will be helped at future clinics.

CAMTA believes that it is vital for us to leave knowledge and skills behind after each clinic. We make the most of every teaching opportunity when we work side by side with our Ecuadorian partners. In 2003 formal lectures were given about the "Care of the Patient with a Total Hip Replacement and plastic models were used to show a new non-surgical way to treat clubfeet.

We also provided information about the

One Child With Hope for the Future (cont.)



Courtesy CAMTA

With mother in the recovery room

importance of examining children at birth and in early childhood in order to spot Developmental Dysplasia of the Hip (DDH). When DDH is detected early it can be treated with splinting before an abnormality in the acetabulum develops. If it isn't treated the child will limp and as an adult will develop osteoarthritis at a very early age.



Courtesy CAMTA

One foot is straight, but the other will require more surgery

In Ecuador there are so many children with orthopaedic problems who have no access to the care that we take for granted. We saw many hopeful faces at the pre-admission clinic – some that were transformed into pictures of delight, following surgery, and others who still wait for the chance to have the surgery that will completely change their life.

For more information on this topic please visit www.camta.com or contact the author at eileenguilfoyle@shaw.ca.

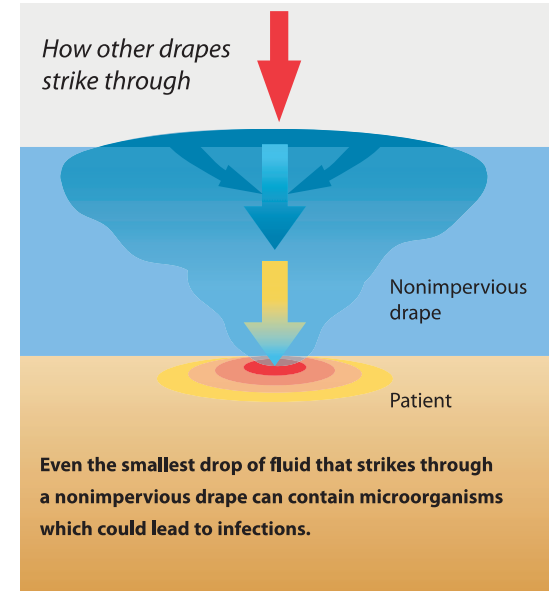
UPDATE:

Following our return trip in January 2004 CAMTA is pleased to report even more success. An additional 12 children and 19 adults received surgery. All the adults received total joint replacements. The majority of children had unilateral or bilateral femoral or pelvic osteotomies for DDH (developmental dysplasia of the hip) and some received club-foot release surgery.

CAMTA representatives were also able to see a number of the 2003 patients. The child who I followed in the above story (Dustin) visited us with his mother and his twin brother. He is now 19 months old and, with some coaxing, he walked for us! One foot will require a minor revision when he is four years old, because it still is slightly inward turning, but the other foot is fine.

The other patients who returned for assessment were adults. They all were interviewed using a Spanish version of a questionnaire tool that assesses function. All patients had received the questionnaire before surgery to give us a baseline about their ability to function at home and the levels of pain experienced during various activities. In general, all of the returning adult patients were doing well as of the January 2004 assessment. There had been no infections and all patients had seen an improvement in function along with a reduction in pain. As of 2004 the Tierra Nueva clinic has an electronic patient database that records all pre-op, intra-op and post-operative recovery details. This will greatly improve CAMTA's ability to do follow-up work. 🌱

Is your drape impervious? Ours is.

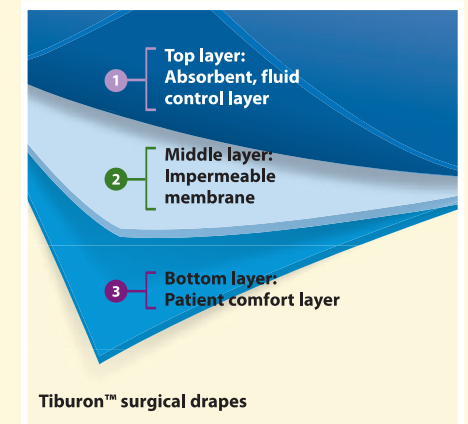


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