

The Sensor



Case Study: Emergent Craniotomy

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The Right Tool for the Job: Introducing the Distal Pharyngeal Airway (DPA)

Discussing a range of airway devices that are specifically designed to address the problem of distal pharyngeal collapse.

Spotlights

Member Highlights:

- Chelsea Moser
- Asonte Summers

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differences



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2. Stannard B, Levin MA, Hung-Mo L, Weiner M. Regional cerebral oximetry is consistent across self-reported racial groups and predicts 30-day mortality in cardiac surgery: a retrospective analysis. *J Clin Monit Comput*. 2021;35(2):413-21.

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Perspective

PRESIDENT'S LETTER



Dear ASATT Members,

I hope this letter finds you in good health and high spirits. I am writing to you today with immense pride and excitement as we reflect upon the recent professional developments and look ahead to a promising future for our organization.

Over the past several months, our dedicated task force has been hard at work refining and improving our Scope of Practice (SOP). Their tireless efforts have resulted in a significant revision to enhance clarity and precision in our language and practice. I am delighted to share the wonderful news that our board has unanimously approved the revised scope of practice this past August. This accomplishment marks a significant milestone in our journey and reinforces our position in the healthcare landscape.

Additionally, ASATT has worked diligently over the past year to expand its reach and collaborative efforts. I am excited to announce that in the new Board year, we will have a liaison from the Society for Technology in Anesthesia (STA) as a member of the ASATT Board. I also want to thank our current ASA Liaison, Dr. Joe Answine; AANA Liaison, Dr. Nancy Sweet-Fitzgibbon; and AAAA Liaison, Ms. Marilyn Archambault, for their support and dedicated service to the board and profession. Thank you!

Now, I want to extend a special invitation to all of you. There is still time to register for the ASATT 2023 Re:EVOLUTION Conference, which will take place from October 18th to 21st in beautiful Pasadena, California, hosted at the Hilton

Pasadena. This conference promises to be an exceptional opportunity for professional growth, networking, and knowledge sharing. I strongly encourage all of you to take advantage of this event, as it will undoubtedly be an unforgettable experience.

At the conference, in addition to sharing all the exciting things happening at ASATT, we will unveil groundbreaking announcements related to further enhancements in our scope of practice. These developments are a testament to the dedication and hard work of our members, and I am eager to witness the positive impact they will have on our profession.

I am also thrilled to introduce our incoming president, Lauren Luna, to you. Lauren is not only a Certified anesthesia technologist but also a Registered Nurse, bringing a wealth of experience and expertise to our organization. She has been a devoted member of our board, having served as both a regional director and president-elect. Lauren is an exemplary leader passionate about advancing our field, and I have every confidence that ASATT will continue to flourish under her guidance.

In closing, I want to express my deepest gratitude to each and every one of you for your unwavering commitment to ASATT and your tireless efforts to improve patient care. Together, we have achieved remarkable progress, and I am confident that the future holds even greater promise for our organization. Let us embark on this journey of innovation and excellence together as we eagerly anticipate the ASATT 2023 RE:EVOLUTION Conference in Pasadena.

Thank you for your continued support and dedication.

Bryan Fulton, M.Ed., Cer.A.T.T.
ASATT President 

From the Executive Director

EXECUTIVE DIRECTOR & COORDINATOR REPORTS



Happy Fall to all of you! We are entering our busy season as recertification will begin on November 1, 2023. Please keep an eye on the website for additional information. As you are aware you **MUST** submit an application for recertification even if you have enough CE's on file with ASATT.

Here are a few ideas on ways to add to your CE's. Have you renewed your BLS, ACLS or PALS, if so send us copies of your cards and we will add those CE's to your records. Check for Sensor quizzes, these are always an easy way to add CE's. Also, we have another webinar scheduled for December 16, 2023, just in time to get those final CE's. Your Certification is important, please do not let it lapse. If you are having difficulties finding CE's feel free to contact the office at 414-295-9220, and we can try to assist you.

It has been a very busy year and we are looking forward to a Great Holiday Season!

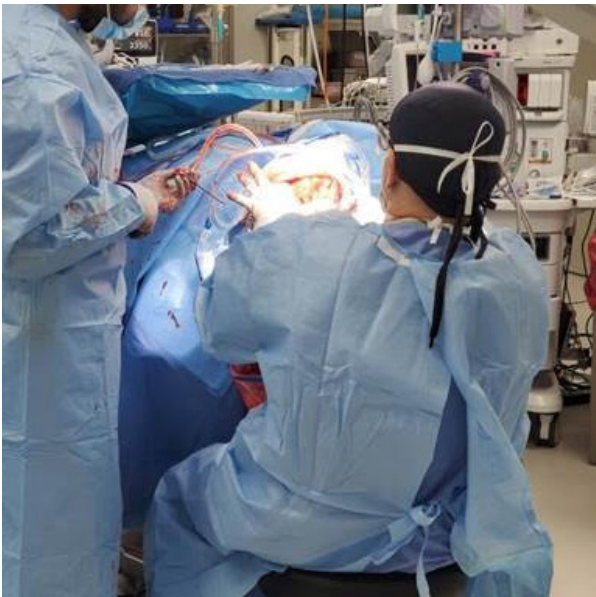
Mike McManus

ASATT Executive Director 

Case Study: Emergent Craniotomy



CHELSEA MOSER
OCCC ANESTHESIA
TECHNOLOGY



ABSTRACT

Malignancy is a term that refers to the existence of cancerous cells that can metastasize (spread to other tissues in the body, occupying local tissues and destroying them (MedlinePlus, n.d.). Malignant tumors can develop new internal blood vessels, which can bleed or become occluded, resulting in necrosis and neurologic dysfunction that can mimic stroke. In this case, a 21-year-old male presented to the hospital with chronic headaches, nausea, and vomiting. A cranial CT scan revealed a large tumor in the patient's Brain. The following morning, the patient underwent a craniotomy for a brain tumor. After surgery, the patient remained intubated and was transported to the intensive care unit (ICU). During nursing rounds, the patient's left pupil was blown (fully dilated and unresponsive to light), and the patient was immediately transported to CT to re-evaluate the patient's head. During the CT examination, the patient went into cardiac arrest. The patient was transported to the operating room for an emergency brain tumor resection.

EMERGENT CRANIOTOMY

In this case, the individual is a twenty-one-year-old (21) male suffering from a massive subdural hematoma and undergoing an emergency craniotomy for resection. Upon evaluation of the medical record by the anesthesia care team, he was designated as an ASA status of V. An ASA V

classification indicates that without surgical intervention, survival is not expected (ASA, 2020). He was approximately seventy-four (74) inches tall and weighed sixty-four (64) kilograms. The patient's systems review includes a history of severe headaches, nausea, vomiting, hypotension, tachycardia, and leukemia. The patient's airway was also secured in the intensive care unit from the previous surgery that morning.

OVERVIEW OF AN EMERGENCY CRANIOTOMY

Craniotomies for tumor resection are typically performed in relation to their location and etiology. The tumor is either supratentorial, meaning the tumor is located above the tentorium in the cerebrum, or it is infratentorial, which indicates the mass is below the tentorium of the Brain in the cerebellum (Sattar, 2018). Second, the tumor will be either intraaxial, located inside the Brain, or extraaxial, located outside of the Brain (Tatco, 2022). For this procedure, the mass was a supratentorial intraaxial tumor requiring the removal of the cranium to access the tumor and the removal of brain matter to excise the mass (Jaffe, 2020). The likely etiology was a primary glioblastoma based on the location of the mass and the patient's age. Glioblastomas are tumors whose origin begins in the brain tissue. These are considered the most aggressive tumors for their growth rate and location in the Brain (Bleeker, 2012). According to Tan et al. (2020), Glioblastomas are most often characterized by location within the astrocyte, a type of glial cell in the Brain. Additionally, these tumors are further characterized by their "proliferation" into the vascular anatomy of the Brain (Tan

et al., p. 300, 2020). This is important as this proliferation into the vascular structures can cause increased blood loss, resulting in a hematoma.

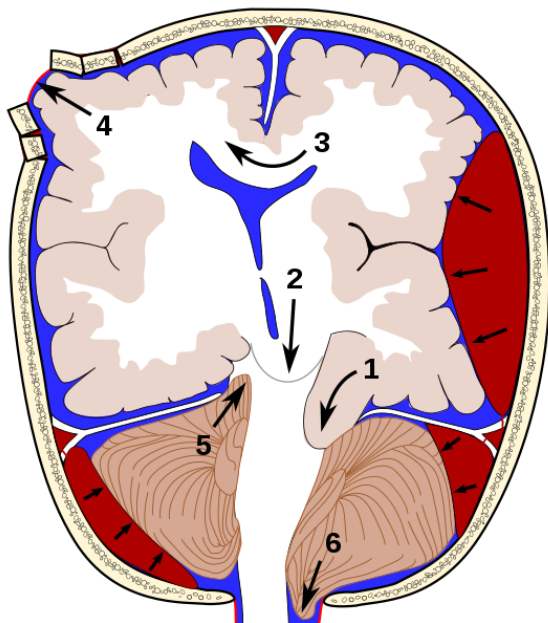
Although rare, hemorrhage is one major complication of removing a large glioblastoma via craniotomy (Jaffe, 2020). Post-operative hemorrhage accounts for between 0.8% and 1.1% of all craniotomies performed; however, the mortality rate of patients who hemorrhage is 32% (Barker, 2008). The main reason for this increased mortality rate is the speed at which the hematoma develops, which warrants emergency surgery to decompress the Brain to restore perfusion and lower ICP (Barker, 2008). For this case report, the focus will not be on the removal of the glioblastoma but on the secondary surgery to respond to the subdermal hematoma that developed post-operatively.

In emergency situations requiring a response to a subdermal hematoma, the main focus of the surgical team is to alleviate pressure on the Brain and correct bleeding (Jaffe, 2020). Patients needing decompression will have elevated intracranial pressures (ICP), which is a value above 20mmHg. ICPs above 20mmHg cause a reduction in blood flow throughout the Brain and cerebral spinal fluid purging from the subarachnoid space (Farkas, 2022). For this reason, the anesthesia team utilizes pharmacological agents that reduce ICP and optimize "surgical exposure and minimize retractor-related edema" while the surgical team performs the intervention (Barash, p.1017, 2017).

PHARMACOLOGY SPECIFIC FOR PATIENTS WITH INCREASED ICP

The anesthesia care team will use several medications and interventions to lower ICP for patients needing surgical intervention of a subdermal hematoma. Mannitol is given as a bolus to rapidly achieve its effect (Barash, 2017). Mannitol is a diuretic used most often to treat acute renal failure, increased intraocular pressure, and cerebral edema (Barash, 2017; Roach, 2005).

Mannitol is referred to as an osmotic diuretic, as it promotes fluid movement from the "intracellular spaces into extracellular spaces" (Pardo & Miller, 2018). The intracellular to extracellular fluid movement makes it ideal for intraoperative treatment of subdermal hematoma as it directly reduces brain size via this movement of fluid out of the cell (Pardo & Miller, 2018). While mannitol is an effective diuretic in reducing brain volume, it is recommended that furosemide be given concurrently with mannitol. One major factor indicating this concurrent use of furosemide with





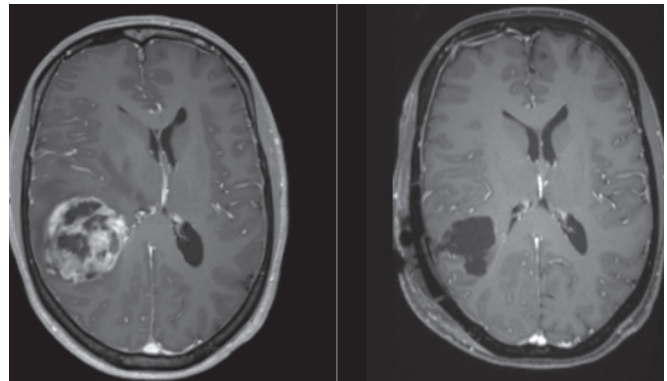
mannitol is the resulting increase in cerebral blood volume and transient increases in ICP associated with the initial fluid movement caused by mannitol (Jaffe, 2020). The furosemide removes excess fluid by preventing sodium reabsorption, which occurs at the loop of Henle (Pardo & Miller, 2018; Jaffe, 2020).

Another medication used to reduce ICP in states of subdural hematoma is the infusion of hypertonic saline solutions. Barash (2017) indicates that the ideal starting concentration is a 3% solution administered continuously at 50-100mL per hour (Barash, 2017). However, Jaffe (2020) indicates that a 7.5% concentration can replace mannitol (Jaffe, 2020). It is understood that the use of hypertonic solutions creates an "osmotic gradient," similar to mannitol producing fluid movement from an area of high pressure to an area of low pressure (Suarez, p.10, 2004).

Additionally, hypertonic solutions decrease blood viscosity, which correlates to an increase in cerebral vasoconstriction. The resulting factor is an increase in cerebral blood flow during these periods of increased ICP (Suarez, 2004). It is important to note that the technologist and anesthesia care team should regularly evaluate sodium levels with arterial blood gases to look for hypernatremia or hyponatremia (Barash, 2017).

SURGICAL APPROACH EVENTS

The planned surgical intervention was a craniotomy for resection of a subdural hematoma. The planned modality of anesthesia was general anesthesia, a medically induced loss of consciousness that renders the patient unarousable with a




combination of intravenous medications and inhaled gases. The decision to utilize general anesthesia was made because the proposed surgery required the patient to be paralyzed, meaning that the patient's muscles would not elicit a response to surgical stimulation. Before the patient entered the operating room, the technologist and anesthesiologist discussed placing an arterial line and a central line. An arterial line is a catheter placed into the radial artery to display a patient's blood pressure continuously. The arterial line also allows the provider to sample the patient's blood without having to draw blood continuously from a different vessel. A central line is a large bore catheter typically placed within a patient's internal jugular vein. The purpose of the central line is to give medications, fluids, monitor a patient's CVP, and can be used to draw blood. However, when the patient entered the operating room, he already had a radial arterial line and a left internal jugular central line. Once the patient was moved onto the operating room table, the technologist placed standard ASA monitors onto the patient, a lower body Bair-hugger to keep the patient's temperature normal, and connected the arterial line to its corresponding monitors.

During the surgical procedure, the patient was maintained by TIVA (total intravenous anesthesia) general anesthesia with low doses of Propofol (which puts the patient to sleep), Rocuronium (which acts as a paralytic to stop any form of muscle reactivity to surgery), and low doses of Sevoflurane (which also is an aid to put the patient to sleep). Once the surgeon began operating on the patient, the patient showed signs of Cushing's Triad. Cushing's triad is a physiological nervous system response to acute elevations of intracranial pressure (ICP) (Dinallo & Waseem, 2021). This presents as a widened pulse pressure (increased systolic and decreased diastolic), bradycardia (slow heartbeat), and irregular respirations (slow and shallow breathing).

The Cushing reaction acts as a "domino effect." Cerebrospinal fluid pressure increases and intracranial tension grows.

As the pressure grows, it causes compression of the Brain and surrounding arteries, cutting off the blood supply to the Brain. The Cushing Triad is; unfortunately, a delayed indication of increasing ICP and evocative that brainstem herniation is forthcoming. During the procedure, the surgeon discussed transferring the patient back to CT to determine the status of the patient's condition but decided against transporting the patient due to the risk of losing the patient on transportation. The surgeon also decided to stop surgery overall. He explained that continuing the surgery would be ineffective for the patient's overall condition. After the surgeon finished closing, the patient was transferred back to the intensive care unit, where ICU staff would continue monitoring him. Several hours later, the patient would pass from the subdermal hematoma.

CONCLUSION

Glioblastomas are primary brain tumors and can present additional complications post- surgical removal. In the case of this surgery, the patient developed a subdermal hematoma, which required emergency surgery to correct. However, as the literature indicates, the mortality rate from these cases remains high at 32%. For the anesthesia technologist, there are several areas of concentration for future exposures to patients presenting for tumor resection. One is a recognition that despite hemorrhagic complications being rare, occurring in 0.8% to 1.1% of all cases performed, emergency surgical intervention is required in events of hematoma. Two, managing patients needing decompression of a subdermal hematoma is complex and requires advanced hemodynamic monitoring, including arterial blood pressure monitoring, central venous pressure monitoring, and, most crucially, intracranial pressure monitoring. Third, the technologist should be cognizant of the patient's pharmacological needs, including diuretics, mannitol and furosemide, and hypertonic solutions to reduce fluid in the Brain, increase cerebral blood flow, and lower ICP. Finally, technologists should be vigilant and stay in the operating room during these procedures to respond to adverse events such as seizures and cardiac arrest. 

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Take the **QUIZ**

[Click here](#) for a copy of the quiz.

The Right Tool for the Job: Introducing the Distal Pharyngeal Airway (DPA)

Patients are more affected from lack of insufficient ventilation than lack of intubation.
– R McMurray

**ROXANNE MCMURRAY,
DNP, CRNA, APRN, FAANA**

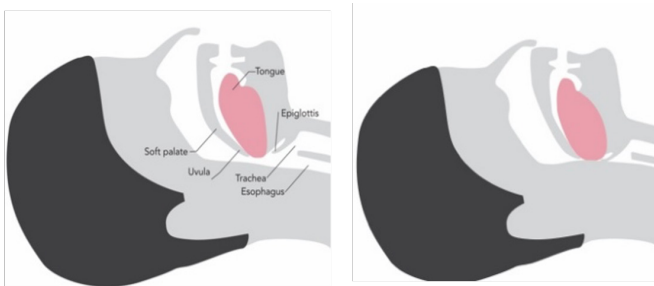
Anesthesia airway management is a crucial component of modern medical practice, enabling the safe and effective administration of anesthesia during surgeries and other medical procedures. In recent years, an aging population with a higher rate of obesity has made patients with a “difficult airway” more common than in the past. While it is possible to address a difficult airway by using external maneuvers, this creates risk for the patient and limits the medical staff. It is far better to have airway devices on hand that are specifically designed to address the problem of distal pharyngeal collapse. A range of such devices is discussed in this paper.

A PATENT AIRWAY IS CRITICAL

The history of airway devices dates back to the 19th century when the first oral airway was introduced to facilitate air passage during anesthesia (Haas et al., 2014). Since then,

many devices have been developed, including face masks, endotracheal tubes, and supraglottic airway devices, with each advancement aiming to improve patient safety and ease of use for healthcare providers.

Maintaining a patent airway during anesthesia is essential to ensure adequate oxygenation and ventilation. It prevents hypoxia and its associated complications, which can lead to brain damage, organ failure, or even death. A patent airway also allows for the delivery of anesthetic gases and efficient removal of carbon dioxide, which is crucial for maintaining a stable and safe anesthetic depth.



Pharyngeal airway anatomy and obstructed airway
Photo: McMurray Medical

Regrettably, some patients possess what is known as a "difficult" airway, a condition that arises when an anesthesiologist trained in conventional methods encounters challenges in providing facemask ventilation to the upper airway or performing tracheal intubation (Apfelbaum et al., 2022). Anatomical, physiological, or pathological factors contribute to this difficulty, heightening the risk of airway compromise and potentially resulting in insufficient oxygenation, ventilation, or both (Heidegger, 2021).

Frequently, airway obstruction triggers this issue, manifesting as the patient's inability to breathe or be ventilated, which significantly elevates the likelihood of negative outcomes (Morris et al., 2017). Swift intervention is crucial to avert hypoxia, hypoxic brain injury, or even death (Bhananker et al., 2006). In the perioperative setting, it can lead to increased morbidity, longer hospital stays, and higher healthcare costs (Weingart & Levitan, 2012).

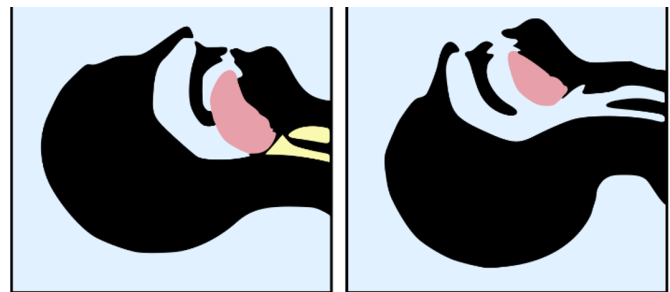
A CHANGING LANDSCAPE

Long-term demographic changes have made difficult airways both more common and harder to treat. The increasing prevalence of obesity, obstructive sleep apnea (OSA), and an aging population have contributed to a rise in difficult airways (Apfelbaum et al., 2022). Obesity can alter the

upper airway anatomy and function, making intubation and mask ventilation more challenging. OSA patients often have airway collapsibility and increased pharyngeal tissue, making airway management difficult. The aging population presents challenges due to reduced muscle tone, decreased respiratory function, and comorbidities that can complicate airway management.

Moreover, there has been a trend toward more patients receiving surgery in outpatient and non-operating room anesthesia (NORA) settings, which also contributes to the rise in difficult airways. The number of ambulatory surgery centers and NORA settings, such as interventional radiology, cardiology, and gastrointestinal suites, has grown significantly (Kuzhively & Pandit, 2019). These facilities often have limited resources, equipment, and personnel compared to traditional operating rooms. Outpatient and inpatient procedures have become longer and more complex, increasing the need for anesthesia technicians to be adept at knowing how to managing difficult airways. In this environment, anesthesia techs often have to cover multiple ORs or procedural rooms simultaneously, which can limit their ability to focus on individual needs and manage difficult airways or a crisis effectively.

The growth of NORA and outpatient surgery has also led to the increased use of deeper sedation, which can increase the risk of airway compromise and make airway management more challenging for anesthesia personnel.



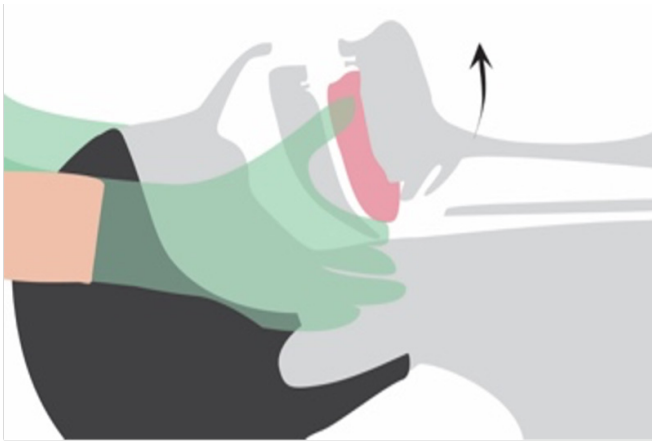
Chin lift maneuver.
Photo: Wikipedia public domain

Not surprisingly, NORA and ambulatory surgery centers have seen an increase in respiratory-related complications during surgery, which are five times higher outside of the traditional OR (Woodward et al., 2017). A recent study of liability claims found that respiratory depression was responsible for 21% of adverse events, with over half of these events being preventable with better monitoring and ventilation (Bhananker et al., 2006). Careful monitoring for apnea allows for early recognition and facilitates quick intervention, if

necessary, with the proper tools. Left untreated, apnea can result in hypoxia, respiratory function decline, asystole, and possibly death, with a mortality rate of almost 40% (Andersen et al., 2016).

HANDLING DIFFICULT AIRWAYS

Anesthesia personnel must be aware of the possibility of difficult airways. This requires a thorough preoperative assessment, including a detailed medical history, physical examination, and identification of risk factors such as obesity, OSA, or anatomic abnormalities.



Jaw thrust maneuver
Photo: McMurray Medical

Continuous monitoring of vital signs, including oxygen saturation, heart rate, blood pressure, and end-tidal carbon dioxide, is crucial for detecting early signs of airway compromise. Providing oxygen with an adequate delivery source is also important to maximize appropriate FiO₂ levels. Anesthesia personnel should be vigilant in recognizing any changes in these parameters, as they may indicate the need for intervention to maintain a patent airway.

The chin lift jaw thrust (CLJT) maneuver is one such initial intervention for managing difficult airways. It involves lifting the chin and pushing the jaw forward to open the airway, allowing for improved oxygenation and ventilation (Davies et al., 2014). The CLJT maneuver should be performed promptly when signs of airway compromise are detected.

While the CLJT maneuver can be effective in managing difficult airways, it also carries several drawbacks:

- *Patient risk:* CLJT may cause discomfort, bruising, or injury to the patient, especially if performed forcefully or for an extended period (McMurray et al., 2020).
- *Distraction:* Performing the CLJT maneuver may distract

anesthesia personnel from other tasks, such as monitoring vital signs or administering medications.

- *Crowding/access:* The need to perform CLJT can contribute to crowding around the patient, limiting access for other healthcare providers.
- *Less efficient use of time:* CLJT may be time-consuming, delaying other aspects of patient care and prolonging the overall procedure.

If a mask is used, certain factors can make positive pressure mask ventilation more challenging. These include facial hair, which can interfere with the seal between the mask and the face, leading to inadequate ventilation. Additionally, a lack of teeth can cause difficulty in maintaining a proper mask seal, resulting in poor ventilation. Lastly, a high STOP-BANG score, indicating a greater risk of OSA, can make mask ventilation more difficult due to increased pharyngeal tissue and airway collapsibility (Chung et al., 2016).

It is important to weigh risk factors before deciding on an airway strategy. A difficult airway is more likely for individuals with obesity, OSA, or challenging head, oral, and neck anatomy. Patients with pre-existing respiratory conditions, such as asthma or COPD, or a history of smoking, may have limited respiratory reserve and are more susceptible to rapid desaturation. Obesity can lead to reduced functional residual capacity and increased oxygen consumption, making these patients more prone to desaturation. A history of smoking can impair pulmonary function and increase the risk of desaturation during intubation. In these cases, apneic oxygenation techniques, such as distal pharyngeal airway (DPA), nasal high-flow oxygen, or continuous positive airway pressure (CPAP), can help maintain oxygenation during intubation attempts.

THE RIGHT TOOLS

Having a range of airway devices readily available is crucial for managing difficult airways in patients with anesthesia (Davies et al., 2014). Anesthesia personnel should be familiar with the use, pros, and cons of each device, and know when to employ them in specific situations.

OPA (Oropharyngeal Airway). The oropharyngeal airway is a simple device used to maintain an open airway by preventing the tongue from obstructing the pharynx. The OPA can be used in unconscious patients without a gag reflex, particularly during bag-mask ventilation or when other airway devices are not available or contraindicated.

Pros:

- Easy to insert and remove
- Can be used in unconscious patients without a gag reflex
- Helps prevent obstruction by pulling the tongue forward
- Provides a better airway than CLJT

Cons:

- Ineffective in conscious or semi-conscious patients with an intact gag reflex, as it may induce vomiting
- Can cause trauma to the oral cavity and teeth if not inserted correctly or left in place for a long duration

NPA (Nasopharyngeal Airway). The nasopharyngeal airway is a soft, flexible tube inserted through the nostril to maintain airway patency. The NPA can be used in unconscious or semi-conscious patients, particularly during bag-mask ventilation or when oral trauma is present.



Airway devices

Photo: McMurray Medical

Pros:

- Can be used in conscious or semi-conscious patients with an intact gag reflex
- Less likely to cause vomiting compared to OPA
- Provides a better airway than CLJT

Cons:

- Risk of nasal trauma or bleeding if not inserted correctly
- May be contraindicated in patients with nasal fractures or coagulopathies
- Stimulating upon insertion

Nasal PAP. The Nasal PAP system, such as the SuperNO2VA (Vyair Medical Inc., Chicago, IL), is a noninvasive device that provides positive airway pressure (PAP) to maintain airway patency and improve oxygenation. The nasal PAP system is used for managing difficult airways in patients requiring analgesia, sedation, or during monitored anesthesia care.

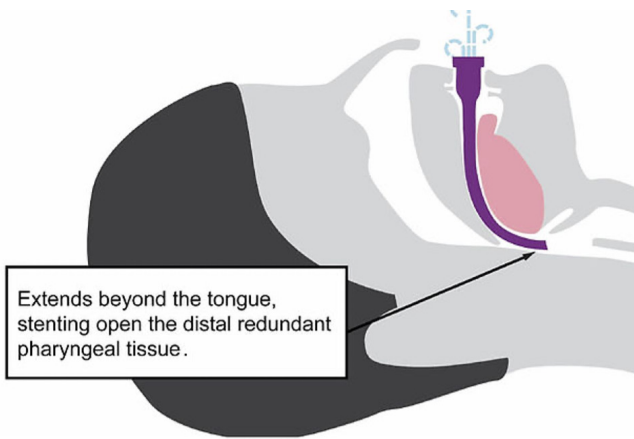
Pros:

- Can be used in conscious or semi-conscious patients
- Provides positive airway pressure to prevent airway collapse
- Allows for spontaneous breathing

Cons:

- May cause discomfort or nasal irritation
- Requires patient cooperation
- Positive pressure limits
- May leak through the mouth
- Requires set-up time

NHFO (Nasal High Flow Oxygen). Nasal high-flow oxygen is a noninvasive oxygen delivery system that provides heated, humidified, high-flow oxygen via nasal cannula. NHFO is beneficial for patients prone to desaturation during intubation attempts, those with respiratory distress, or when apneic oxygenation is needed.



Distal pharyngeal airway cross section
Photo: McMurray Medical

Pros:

- Improves oxygenation and reduces the work of breathing
- Can be used in a wide range of patients, including those with respiratory distress
- Provides apneic oxygenation during intubation attempts

Cons:

- Requires a specialized system and compatible nasal tubing
- May not be suitable for patients with severe nasal obstruction or facial trauma
- Requires set-up time

DPA (Distal Pharyngeal Airway). The distal pharyngeal airway is an oral airway device designed to sit right above the epiglottis, providing an airway passage that bypasses the upper airway structures. A DPA, such as the McMurray Enhanced Airway (McMurray Medical, Minneapolis, MN) can be used in unconscious patients with airway obstruction. It is particularly helpful in situations where intubation or mask ventilation is difficult or not immediately possible, such as in patients with facial trauma, limited mouth opening, or severe upper airway obstruction.

Pros:

- Easy and fast to insert, with minimal training required
- Can be used in patients with difficult airway anatomy
- Directly addresses distal pharyngeal tissue, a common site of obstruction

- Facilitates apneic oxygenation during intubation attempts
- Provides intraoral ventilation to bypass difficult mask ventilation
- Fits alongside an EGD bite block
- Has a cushioned bite block

Cons:

- Not suitable for patients with an intact gag reflex or at risk of aspiration

CONCLUSION


The paramount importance of maintaining a patent airway during anesthesia cannot be overstated. A patent airway ensures adequate oxygenation and ventilation, preventing hypoxia and other complications that could lead to patient harm.

This task is made more difficult with emerging healthcare trends. Changes, such as an aging population, increased obesity rates, and a higher prevalence of obstructive sleep apnea, make managing airways more challenging. The growing trend of NORA and ambulatory surgery further complicate airway management, as anesthesia technicians often need to cover multiple operating rooms and locations

Take-Away Points

- **Maintaining a patent airway is critical for patient health**
- **Demographic trends have increased the number of "difficult airways"**
- **The growth of NORA and outpatient surgery, with changed anesthetic practice, increases the need for additional airway tools**
- **Not having the right tools add to patient risk and reduce efficiency**
- **Anesthesia personnel need the right tools on hand for a range of airway types**

while also handling more complex procedures. As the prevalence of difficult airways increases, anesthesia personnel must be prepared to manage them effectively. This requires vigilance in identifying at-risk patients, close monitoring of vital signs, and having a variety of airway management techniques on-hand.

While the basic airway management techniques such as chin lift jaw thrust (CLJT) maneuver, OPA, and NPA can be useful in managing difficult airways, they also have several limitations. The CLJT can cause patient discomfort, distraction, and inefficiency. The OPA and NPA may not be long enough to reach the distal pharyngeal tissue to open the airway obstruction, especially in older and heavier patients with OSA. As a result, relying solely on CLJT, OPA, and NPA is not a sustainable solution for handling difficult airways. Anesthesia technicians should have access to a range of airway devices, such as distal pharyngeal airways, nasal high-flow oxygen, nasal PAP, and supraglottic airways. Familiarity with the pros, cons, and indications for each device will enable technicians to recommend the most appropriate tool for a given situation, ultimately improving patient outcomes and ensuring a safe and efficient anesthesia experience. 

Take the
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Spotlights

MEMBER HIGHLIGHT




Chelsea Moser

Chelsea Moser, a 2023 graduate of the Oklahoma City Community College (OCCC) Anesthesia Technology Program, is an example of how the development of formalized anesthesia technology education is positively impacting individuals and the profession as a whole. During her time at OCCC, Chelsea received the prestigious OCCC Anesthesia Technology Student of the Year Award in recognition of her exceptional blend of academic prowess and clinical excellence. Chelsea herself emphasizes how the program laid the foundation for her current success, saying, "The anesthesia technology program provided me with essential training in the field and prepared me for the work I am doing today. The faculty was incredible, supportive from day one and sought to have me succeed throughout the entire process."


Chelsea's commitment to excellence also extended beyond the classroom, where she served as the class representative for her fellow anesthesia technology students, showcasing her leadership skills and dedication to her peers. Her involvement with OCCC didn't end with graduation. She continues to give back to her alma mater by serving as a valued member of the OCCC Anesthesia Technology Advisory Committee, contributing her expertise to further enhance the program and to support future graduates.

Chelsea's remarkable journey doesn't end with her accolades. She is making a significant impact in her profession as a Certified Anesthesia Technologist at Integris Baptist Medical Center, where she is an essential member of the award-winning liver transplant team. In her own words, she describes her work as both demanding and profoundly rewarding, stating, "Working on the liver transplant team is demanding but rewarding because I get to be involved in someone's final gift to humanity as well as support someone's new lease on life with a new organ."

Chelsea's story serves as a testament to the transformative power of education and unwavering dedication. We are excited to see what her future holds in store for her as a Certified Anesthesia Technologist. 



Asonte Summers

Ms. Asonte Summers, an Anesthesia Technology graduate of 2022, has a soul as warm and delightful as her last name suggests. Asonte always knew, since high school, that finding a career in anesthesiology was her path to a cherishing and long-lasting profession. Asonte's love and passion for her chosen career led her to full-time employment, being offered a position at Henry Ford Hospital before she graduated. To capstone the result of a phenomenal college experience, Asonte earned a perfect score (125/125) on the National Examination for Anesthesia Technologists, which the American Society of Anesthesia Technologists and Technicians sponsors. To honor the outstanding accomplishments earned, the Anesthesia Technology department at Wayne County Community College District, located in Detroit, Michigan, has awarded Asonte Summers the Graduate of the Year Award for the graduating class of 2022. 



Asonte Summers – ANE Graduate of the Year 2022



Pictured (left to right): Dr. Abby Freeman, Mr. Marc McGaffic, Mr. Marc Phillips, and Asonte Summers.

Notes

REGIONAL UPDATE

REGION 1



Happy Autumn to you all. Getting ready for the white stuff to follow. Thank you to those that chose me to be your Regional Director for Region 1 again. I feel bad, had I known that Jamie DeCaro was going to run, I would not have done it. I hope to see some familiar faces at the meeting in Pasadena.


When you are there and you see an individual who is by themselves, go up and introduce yourself. I have made some amazing friends at meetings. It makes them feel welcome, especially if it is their first meeting.

A couple of items I want to mention. The first being The Practical Experience Pathway. It is an alternate way for Anesthesia Technicians to get certified. Check out the website under Cert. A.T. /Cert. A. T.T. Tab, it says specifically "The Practical Experience Pathway." It will let you download

the brochure and it is very informative. Check it out and let me know what your thoughts are. The second item is, if you want to become more involved, please feel free to volunteer to be on a committee, if the committee you prefer is full, we can always find another committee. It allows you to see how the BOD runs and if you want to become more involved then we will always welcome new participants.

ASATT has a lot of great Webinars scheduled and events that you do not want to miss. Check it out and the price is very pocketbook friendly. In addition, we are always looking for articles for the Sensor. If you want more information on writing an article, please feel free to drop me a line and I can send you the information that you need to do so.

We will be having so much fun, in just a few short weeks. Cannot wait to see you all. Stay safe and healthy, wear your masks by setting an example of what is best for all of us.

Respectfully Submitted and Happy Summer,
Jonnalee Geddis, Cer.A.T. 



Hello members,

I hope this finds everyone safe and healthy!

I can't believe summer is over and our children are back in school already. Wishing everyone a successful school year! I do hope everyone got a chance to get a family vacation

in with making wonderful memories with your family and friends.

Be on the lookout for our **Quarterly Webinar Conferences!** We will be having 2 more webinar Conferences. The next one will be September 9th and the last one will be in December. Watch the ASATT website for more details coming shortly. Remember you can earn up to 4CE's for attending. *If you have any questions or concerns please feel free to reach out to me at region2director@asatt.org.*

Remember being a member has many benefits and discounts. You can get access to the sensor, ASATT updates and discounts to Educational, Regional conferences and many more valuable benefits. So make sure you check out the membership page at ASATT to see the different tiers that are

offered we even have a student membership.

Don't forget to visit our ASATT website it has very useful information and updates about our zoom meetings and articles on healthcare news. And remember to check the quarterly sensor publication, remember you can earn CE's from the quizzes. It's one of many perks for being a ASATT member.

I hope everyone had a chance to vote in our re-election for regional directors. I'm excited to see who won! Let's think about getting more involved as a member. One of the biggest things I always hear when talking to members is how you can be more involved well voting is a great way to get started, Other great ways you can be more involved is join a committee and help better our profession.

There's still time for you to plan on joining us for our National conference don't forget to : **Save the Date:** National Conference will now be held in Pasadena !! The conference dates are 10/18-10/21 at the Hilton. Updates have been posted on the ASATT website. I hope you can join us and I look forward to seeing everyone in person.

Please everyone stay **Safe** and **Healthy!**

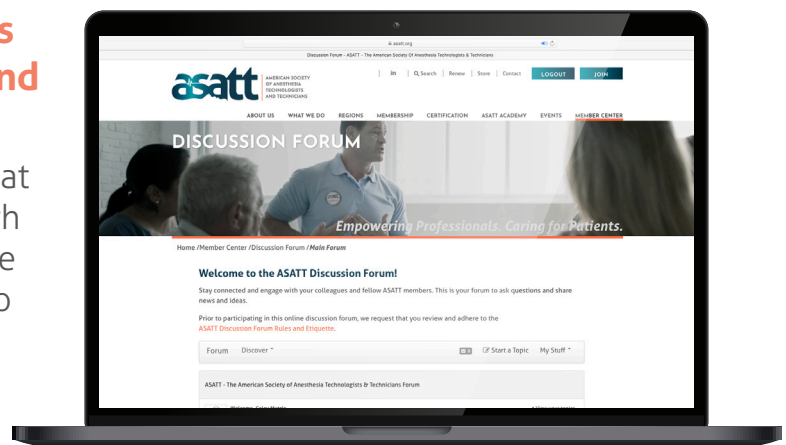
Karen Patrick, Cer.A.T. 

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