Volume 3, Number 2

THE ASATT SENSOR

April 1993

THE QUARTERLY NEWSLETTER OF THE

AMERICAN SOCIETY OF ANESTHESIA TECHNOLOGISTS AND TECHNICIANS

President's Message ...

by George Mann

ASATT Fourth Annual Meeting-October 9,10, and 11, 1993. Please check your dates for this meeting...it was listed wrong in our last news letter and I don't want anyone to miss it! This is the Fourth Annual Meeting of the ASATT and the Planning Committees are looking forward to one of the largest turn-outs in our young program's history. Our Program Director is currently Ricki Kallish from Children's Hospital in Philadelphia, PA. The exhibit for this year is being coordinated by Joretta Huffman and Linda Nester from Charleston, WV. Both of the programs are in their final stages of completion and will be reviewed by the ASATT of Directors at the Spring Meeting which is to be held on April 16, 1993 in Syracuse, NY. It is my hope that this meeting will set the pace in the right direction for our organization for the rest of the year. The Board will also be taking part in a seminar to be held on April 17 at the SUNY Health Science Center in Syracuse.

Good News and Bad News. It is always good news when someone receives a promotion or salary increase. It is also good news when someone takes on a new job to better themselves. However, the bad news is that since the organization has brought so much attention to our specialty, some of our members are leaving for various career advancements. Good for them, bad for us. I wish those individuals the best in all that they endeavor.

Region 2 - you will feel the first pinch. Ricki Kallish, your Regional Director, has informed the Board of Directors that she will be leaving the ASATT after its Annual Meeting. Ricki has asked to be relieved of her duties as Director as soon as possible. I have therefore asked Wilma Frisco in Cleveland to become the Interim Director until there is an election for Region 2. Good luck to you Ricki, we'll miss you; and to you, Wilma...thanks for taking on the job.

Although Paul Faupel from the Washington, D.C. area left our organization last year, he has not forgotten us. Paul assisted me in a successful site visit while choosing the hotel for our Annual Meeting. Thanks to Paul for taking the time.

Just a Reminder! Our meeting will be running during the same weekend as the ASA and they have first choice of hotels and meeting space. Our meeting space must be able to hold a general session in classroom style for approximately 200-300 people. Not many hotels can do that, therefore we had to go shopping. This year's meeting will be held at the Sheraton Crystal City Hotel in Arlington, VA, located just 10 minutes from downtown Washington by Metro, and within walking distance of a 200-store underground shopping mall.

More information on the meeting later!

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THE VIEW FROM...

Community Hospital of Roanoke Valley
(An Affiliate of Carilion Health System)
Roanoke, Virginia
by Linda K. Ferris, LPN,
President, VSATT

The Roanoke Valley of Virginia stands tall as the star of the Blue Ridge. The valley is the largest metropolitan area in Southwest Virginia. A quarter million people enjoy its unique combination of small town charm and big city appeal. The area is also the region's cultural hub with the Center in the Square - a home for art, history, science, and theater, overlooking the historic City Market. Roanoke Valley provides medical services for all of Southwest Virginia.

Community Hospital of Roanoke Valley, with 400 beds, has been serving this community in the scenic Blue Ridge since 1967. Our excellent facilities include the Center for Women and Infants, the Western Virginia Laser Center, a Level-II trauma center, the Sleep Disorders Laboratory, Ophthalmology, and the Children's Medical Center of the Virginias.

Our Surgical Services Department includes the Pre-Anesthesia Preparation Area, the Main Surgical Suite which consists of nine major operating rooms, one cysto room, one ophthalmology room, and one local room; Post-Anesthesia Recovery; Outpatient Surgery; and the Laser Center. Adjacent to the main surgical suite, the Endoscopy Suite has four procedure rooms; and the obstetrical suite consists of three major rooms.

Our Anesthesia Support Team is made up of four LPN's and three Anesthesia Technicians. Staffing is provided seven days a week from 6:30am to 11:30pm. We oversee the 18 anesthetizing locations, as well as procedures involving anesthesia in the Radiology Department. Job duties range from room turn-over to assisting with invasive monitoring, from budgeting to submitting annual reports, and from providing emotional support to our patients to lending a helping hand to the surgical team.

Our basic philosophy includes a combination of teamwork, professionalism, and the encouragement of continuing education to achieve the ultimate goal of quality patient care.

The anesthesiologists at the Department of Anesthesia at Community Hospital feel that anesthesia technicians make significant contributions to the welfare of the patients that they care for. It has been with their support, as well as the support of the anesthesia clinicians throughout the "Old Dominion", that our state technician society celebrated its second birthday last April 13th. As society president, I would like to personally thank Roger W. Litwiller, M.D., ASA Liaison to the ASATT, for his continued interest and encouragement in the VSATT as well as the ASATT. It is this vision of the future that calls all anesthesia technicians to prepare for the increasing challenges in a changing healthcare industry.

THE SENSOR, Quarterly newsletter of the ASATT. *The opinions expressed herein are those of individual authors, and do not necessarily reflect the views or positions of the ASATT.* **EDITOR:** Diane Holley, 3810-A Tonkawa Trail, Austin, TX 78756. (512)451-7457(Home) (512)323-1104(Fax). **ASSOCIATE EDITOR:** Dennis McMahon, Virginia Mason Medical Center, Seattle, WA 98101. (206)223-6980(Work) (206)223-6982(Fax). All Submissions pertinent to the objectives of the ASATT will be considered for publications. Photographs(preferably black & white) are also welcome, and will be returned. **Deadline for the next issue is May, 1993.**

NEW TECHNOLOGY -

The Laryngeal Mask Airway: A New Device for Airway Management

by Lee Amorin, ASATT Vice-President
Technical Services Supervisor,
Harborview Medical Center, Seattle

In spite of its odd appearance and the comments it evokes from OR personnel, the laryngeal mask airway has steadily won converts to its use in our department. Since general availability in late 1992, we have increasingly used the laryngeal mask (LM) in patients who can be managed with a spontaneous breathing technique. Invented by Dr Archie Brain of the United Kingdom in 1981, the original idea behind the LM was to find a device that is easier to use than the face mask, and provides greater security of the airway.

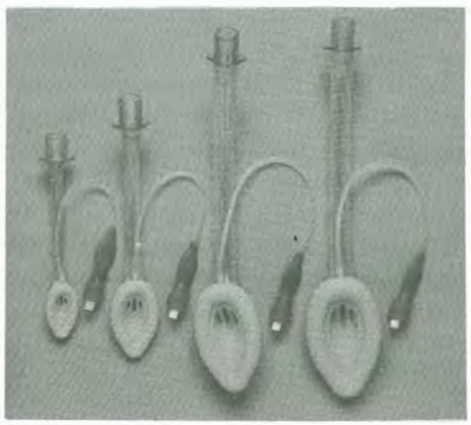
The masks first surfaced in our department when imported by visiting professors from Britain and Canada. While at first skeptical of its use, our staff members soon recognized the benefit of having their hands free, not holding a mask, and the added comfort of the patient. The device became widely used in our department, and we had difficulty keeping an adequate supply. With FDA approval last year and marketing in the U.S., the mask is now readily available. One of the main advantages of the LM is certainly its use for ambulatory patients. Using propofol as the induction agent, insertion of the LM can be accomplished within 30 seconds once adequate oxygenation has been achieved, thus saving the time and expense of additional equipment.

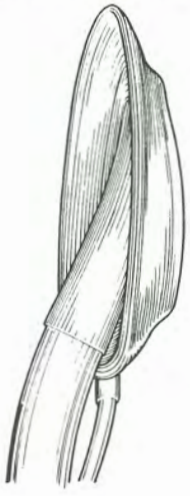
Learning how to use the LM is relatively easy. The LM is supplied from the vendor with a demonstration videotape and instruction manual. Clinical users should refer to these for specifics on use and complications. A brief description is provided here for the technical community. Prior to insertion, the LM needs to be inspected after inflating the cuff. The cuff is then deflated completely deflated, with care given to removing any wrinkles, then lubricated. It is then inserted "blindly" into the pharynx and advanced, using the index finger as a guide, until resistance is is felt at the hypopharynx. The cuff is then inflated with the appropriate volume for its size, the gas supply is connected, and a clear airway is verified. Once positioned, the mask tip rests against the upper esophageal sphincter and forms a seal around the laryngeal perimeter (Figure 2). While the trachea and lungs are protected by secretions from the oropharynx, it is important to remember that they are not protected from regurgitated stomach contents.

Most of the problems we have seen in using the LM are associated with maintaining an adequate level of anesthesia, and with inexperience with placement. The anesthetist must also take care not to stimulate the patient during the recovery phase. This is difficult for some clinicians to remember since they are used to arousing the patient into recovery. Instead, the patient should be allowed to awaken quietly to the point where he can open his mouth on command. Then, and only then, is the cuff deflated while simultaneously withdrawing the LM. Suctioning prior to removal should be done with care to avoid stimulating the patient. Most secretions will adhere to the mask and be withdrawn with it.

The "care and feeding" of the LM is not difficult, although I must admit the technicians in our department moaned a little when they learned that it is not a disposable item. It is purchased unsterile, and must be checked and steam autoclaved before each use. After each use, it is soaked in any detergent recommended for use on rubber or latex items. It is then thoroughly scrubbed with a 4x4 gauze and cleaned internally with a tube brush, taking care not to damage the two bars in the bowl of the mask. We find that partially inflating the cuff facilitates cleaning. It is then rinsed with tap water and towel-dried. The cuff is then fully inflated and a visual inspection is performed to determine if there is any damage or if the cuff leaks under pressure.

Prior to packaging for sterilization, the cuff is fully deflated, taking care to remove all air and wrinkles (Figure 3). Placing the mask on a flat surface and gently pushing down on the tube helps with this process. It is important to keep the cuff deflated during sterilization; air expansion during autoclaving can rupture the cuff. Also, a deflated cuff assures that the valve is working properly. We sterilize our LMs in a peel pack at 270° F for 4 minutes.





TECHNICALLY SPEAKING

RECENT LITERATURE ..

by Wes Simpson II, San Diego, CA

This edition of *Technically Speaking* concentrates on literature relative to the Laryngeal Mask Airway (LMA). Although only recently introduced in the United States, the LMA has been commercially available since its development by Dr. Archie Brain of England in 1983 throughout most of the British medical system. It was introduced commercially in Australasia in 1988 and Canada in 1989. A North American manufacturer has been selected to produce the LMA in our market, so it is timely to survey the most recent literature on this topic.

The articles cited represent only a small portion of the published literature. As the LMA has only recently become commercially available in the U.S., the largest body of literature exists in foreign English language journals. Despite this fact, most of the sources referenced should be readily obtainable, either through direct subscription by your hospital library, or through the inter-library sources they have available.

Brimacombe J, Berry A: Insertion of the laryngeal mask airway - a prospective study of four techniques. Anaesth Intens Care 21:89-92, 1993

Compares the recommended insertion technique for the LMA with three proposed alternatives; with the cuff fully inflated, with the cuff partially inflated, and with the cuff deflated and using a back-to-front technique (similar to the insertion of a Guedel airway). Results indicate that the standard insertion technique is superior, with the Guedel technique a close second. Fully or partially inflated cuff techniques are not recommended.

Blake DW, Dawson P, Donnan G, Bjorksten A: Propofol induction for laryngeal mask airway insertion: dose requirement and cardiorespiratory effects. Anaesth Intens Care 20:479-483, 1992

Dosage, hemodynamic, and respiratory effects of propofol for LMA insertion were studied. Patients were randomly assigned to one of four dosage regimens. A success rate of 94% for LMA insertion on first try was achieved by using a two minute pre-oxygenation period followed by a bolus dose of 2.0mg/kg injected over 30 seconds. No other drugs were needed during intubation. Significant arterial desaturation (<90% SpO_2) was avoided in all patients, and the apneic period before return of spontaneous respiration was brief.

McCrirrick A, Ramage DTO, Pracilio JA, Hickman JA: Experience with the laryngeal mask airway in two hundred patients. Anaesth Intens Care 19:256-260, 1991

Observations were recorded from two hundred insertions of the LMA. They were undertaken by 27 anesthetists, most of whom had no previous experience of its use. A clinically patent airway was achieved in 94% of patients and in the majority of cases the LMA was positioned at first attempt. Success with the LMA was related to experience: anesthetists who had used the LMA over 15 times had no failures in 67 insertions. Incidence of postoperative sore throat was 8%.

Briscombe JR: LMA in awake fiberoptic bronchoscopy. Letter, Anaesth Intens Care 19:472, 1991

This letter describes use of the LMA for awake fiberoptic bronchoscopy. The experiences of the author indicate that while the LMA does not provide the security of an endotracheal tube, it may offer distinct advantages during bronchoscopy including visualization of the vocal cords, and the ability of the patient to speak if needed.

Tuck M, Phillips R, Corbett J: LMA for fiberoptic bronchoscopy. Letter, Anaesth Intens Care 19:472-3, 1991

This letter describes use of the LMA for fiberoptic bronchoscopy under general anesthesia. Advantages are listed as: the endoscopist is provided with optimal conditions for examination of the entire airway including the larynx, the LMA offers an airway with a larger internal diameter than would be available using an endotracheal tube, the anesthetic circuit can be reliably scavenged, it avoids intubation, it avoids the use of succinylcholine, and it is well tolerated by patients.

Sellers WFS, Edwards RJ: Awake intubation with Brain laryngeal airway. Letter, Anaesth Intens Care 19:473, 1991

continued on page 9

EDUCATION -

Education and the Anesthesia Tech: An Editorial View

by Dianne Holley
Austin, TX

Education is one of the most important issues facing anesthesia techs, both individually and as part of the ASATT. While there is no doubt that many of our colleagues are very well educated and hold various degrees and certifications, there are currently no programs open to the general public that are designed to completely prepare a person for the role of anesthesia technician or technologist. On-the-job training, though generally effective, is increasingly difficult, especially since the basic knowledge requirements for techs have become so specialized. Most anesthesia techs recognize this inadequacy and seek educational resources outside their places of employment; the motivations are job security, job advancement, and naturally the satisfaction of job expertise.

ASATT, with cooperation from the ASA, AANA, and several allied healthcare organizations has established and published educational guidelines intended to help trainers plan and implement their programs. The guidelines consist of modules, each focusing on a specific area of anesthesia technology. They also differentiate between the educational requirements of the anesthesia technician and the technologist, those of the technologist being more extensive. Ricki Kallish, chairman of ASATT's Education Committee and Director of Region 2, has been instrumental in writing the guidelines and surveying anesthesia techs across the country to determine the prevailing status of our community. She has also been working closely with the various available educational programs to ensure adherence to ASATT requirements.

The most obvious educational opportunities are available from the various anesthesia tech societies - local, regional, and national. These societies provide many lectures and seminars for any who wish to attend; most at little or no cost. Those who do not have easy access to these meetings can organize their own meeting and/or societies. While this route places the burden of education on the anesthesia techs to choose topics, speakers, locations, and times, it is often the most flexible route and can be tailored to meet the specific needs of the attendees.

Many manufacturers and service companies recognize the growing educational requirements of anesthesia techs and are offering short courses that range from very specialized training (*eg* anesthesia machine maintenance or cell-saver operation) to broad overviews of anesthesia technology. These courses usually include a registration fee and a certificate of successful completion, and last from one to several days. Some companies are also taking their courses "on the road" to reach technicians in various parts of the country.

Other brief courses are being offered by medical/educational institutions. Baylor University in Dallas offered an intense three-day training course for techs last September, and has plans to present others. The Association for the Advancement of Medical Instrumentation (AAMI) offers several courses geared toward both anesthesia techs and bio-medical techs. The AAMI courses are held at several cities and times each year to reach more technicians. Both the Baylor and the AAMI programs require a registration fee.

While these short courses, lectures, and seminars will continue to be important educational resources for the anesthesia tech, the need still exists for comprehensive college-level programs to fully train new technicians. Several university-based hospitals are working toward that goal. The University of Texas Medical Branch in Galveston has begun a pilot program for the in-house training of anesthesia techs. This program, initiated last fall, accepts only their current personnel and lasts one year. Educational coordinator Dale Meyer has set up weekly lectures, quizzes, and quarterly exams. Other institutions such as Loyola University in Chicago and Kentucky Tech Jefferson State Vocational School in Louisville are reportedly working on similar programs to be offered as regular college courses.

Most, if not all, allied healthcare professions began with on-the-job training as the only educational resource, and eventually evolved to college-based to supply professional-trained people for their ranks. The profession of anesthesia technical support is also moving in that direction. The British-based medical systems already have two-year training and certification programs for their anesthesia techs. Those techs in the U.S. who are already trained on-the-job will require some supplemental education to fill any gaps in their knowledge; for the most part, this is already available. At the very least, comprehensive college programs will ensure the viability of our profession by providing anesthesia techs with a standardized educational background, and providing hospitals with professionally trained allied healthcare professionals.

Next issue:
The Road to National Certification

Contributed by D J McMahon, Seattle

If holding the two 1 mL vials in Figure 1 at arm's length, how readable is the labeling to you? If one were misplaced in a storage container in a typical anesthesia cart, how distinguishable would it be from the other? Just such a misplacement contributed to a near incident recently, in which an anesthesiologist mistook a vial of phenylephrine for one of metoclopramide. Intending to administer metoclopramide for its antiemetic effect, an anesthesiologist recently picked up the vial of phenylephrine and drew it up into a syringe in preparation for delivery before becoming aware of his error. The vascular effect of phenylephrine could have created a clinical disaster. While there is no excuse for failure to deliberately read the labeling on any pharmaceutical, the indistinct, similar markings on these two products clearly contributed to the likelihood of the error (Figure 2).

The problem of distinct labeling of drugs has been discussed within the clinical anesthesia community for some years, occasionally in the literature[1-4], more often in anecdotes. It was with this problem in mind that a committee formulated a standard for the clear marking of small amounts (less than 100 mL) of drugs. The American Society for Testing and Materials (ASTM) published its standard D-4267 almost ten years ago[5]. It specifies that the label should include the generic name of the drug, its strength, and the volume. Proprietary drug names and conventional abbreviations are encouraged. More importantly, it specifies the size of the lettering, and that there is contrast between the lettering and the background against which is placed. It also specifies that the lettering is either parallel to the axis of the container, or "wrapped around" the circumference of the container no more than 180 degrees. (Figures 3 & 4.) The standard includes a legibility test under specific lighting conditions and distance. Regrettably, manufacturer compliance with ASTM D-4267 is essentially voluntary, and many drug companies still provide their products with non-standard, easily confused labeling, as the incident above demonstrates. Ultimately, compliance with the standard may be most effectively encouraged by hospital pharmacies, by specifying only the purchase of pharmaceuticals that are labeled in accordance with ASTM D-4267.

By its nature, the practice of anesthesia involves the use of a large number of medications whose physiologic effects can be rapid and profound. Errors in medication can be serious, if not disastrous. As support personnel, anesthesia technicians/technologists do not administer medications; the

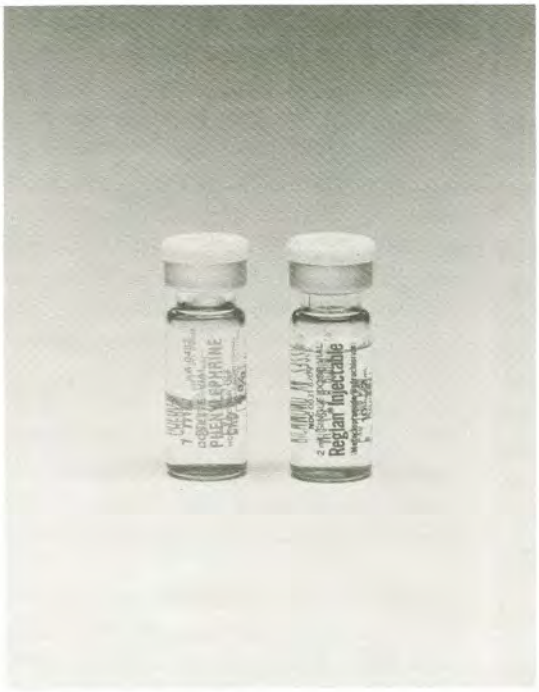


Figure 1. Two vials with non-standard markings at arm's length.

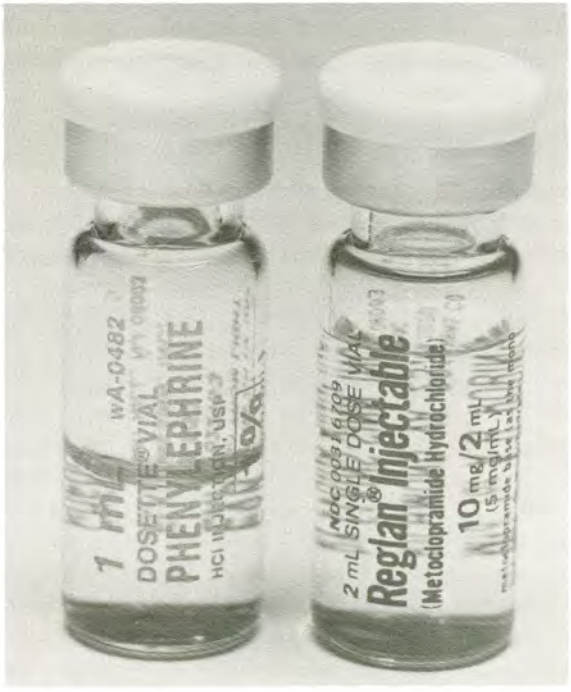


Figure 2. Same vials relatively close; note added confusion of markings of the vial on the left by use of lighter shade of ink.

responsibility for consistently safe delivery of any pharmaceuticals falls to the anesthesiologist or anesthetist. But technical personnel who order drugs, stock drugs in anesthesia supply cabinets or carts, and who are asked to deliver or prepare specific medications during procedures should be aware of the possibility of mistaking vials and ampules of drugs. When stocking or delivering any drug, *read the label.* Read the drug name *and its strength*; many pharmaceuticals come in a variety of strengths. Be aware of similarities between two or more medications in the array of drugs available in the drawers of supply carts. Where possible, keep similar items separated, or suggest that one is changed to a alternative vendor whose labeling is different.

Competent anesthesia technical personnel should serve as one of several "safety nets" in patient care; don't be an inadvertent contributor to a critical incident.

References:

1. Rendell-Baker, L:
Better Labels Will Cut Drug Errors.
APSF Newsletter, 2:4 p29, Dec 1987.

2. Lees, E:
Drug Accident Shows Need for Label Standards.
APSF Newsletter, 4:3 p28, Sep 1989.

3. Hasche-Kluender, H:
Look-Alikes Cause Drug Administration Mistakes.
APSF Newsletter, 5:2 p17, Summer 1990.

4. Kettler RE & Dhamee MS:
Similarity Between Ampules.
Regional Anesthesia, 15:6 p311, Nov-Dec 1990

5. *Standard Specification for Labels for Small-Volume (less than 100mL) Parenteral Drug Containers.*
American Soc for Testing & Materials #D-4267-83. ASTM, Philadelphia, PA.

captions:

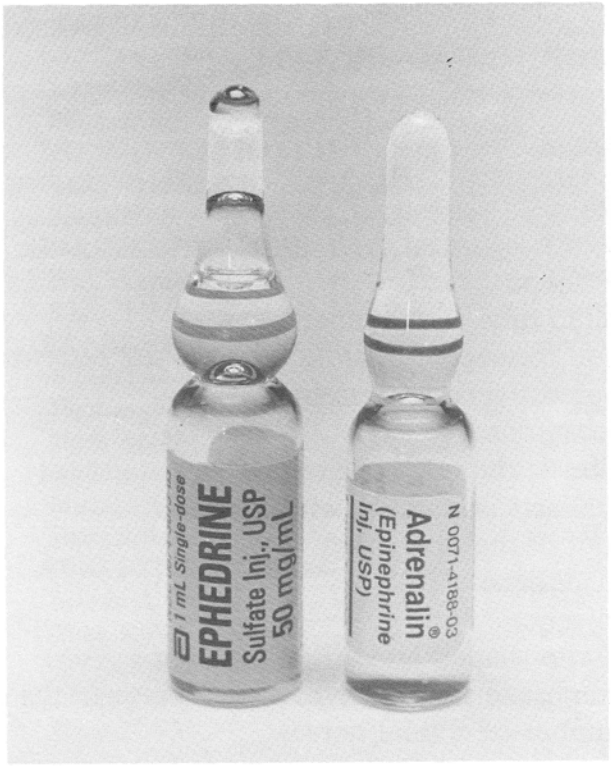


Figure 3. Two ampules with ASTM standard axial labeling; orientation of markings of the vial on right is non-ASTM specification, in that the marking is inverted when held in the right hand.

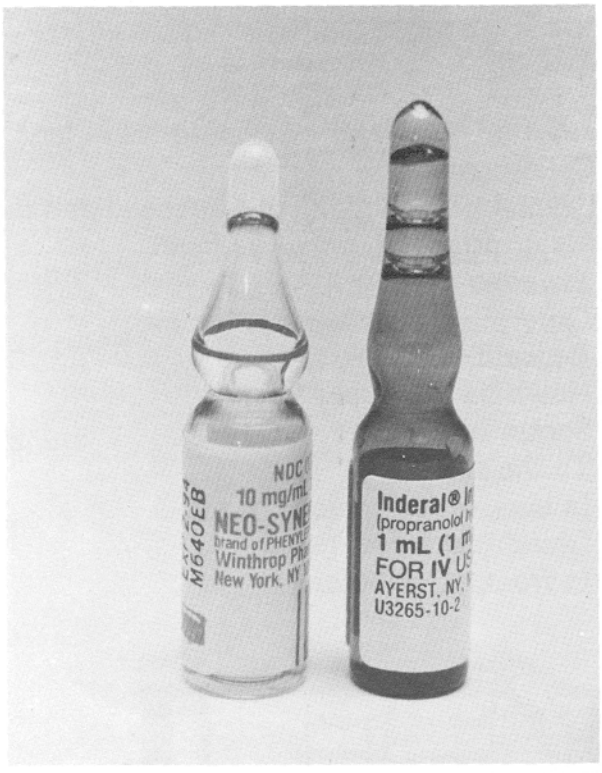
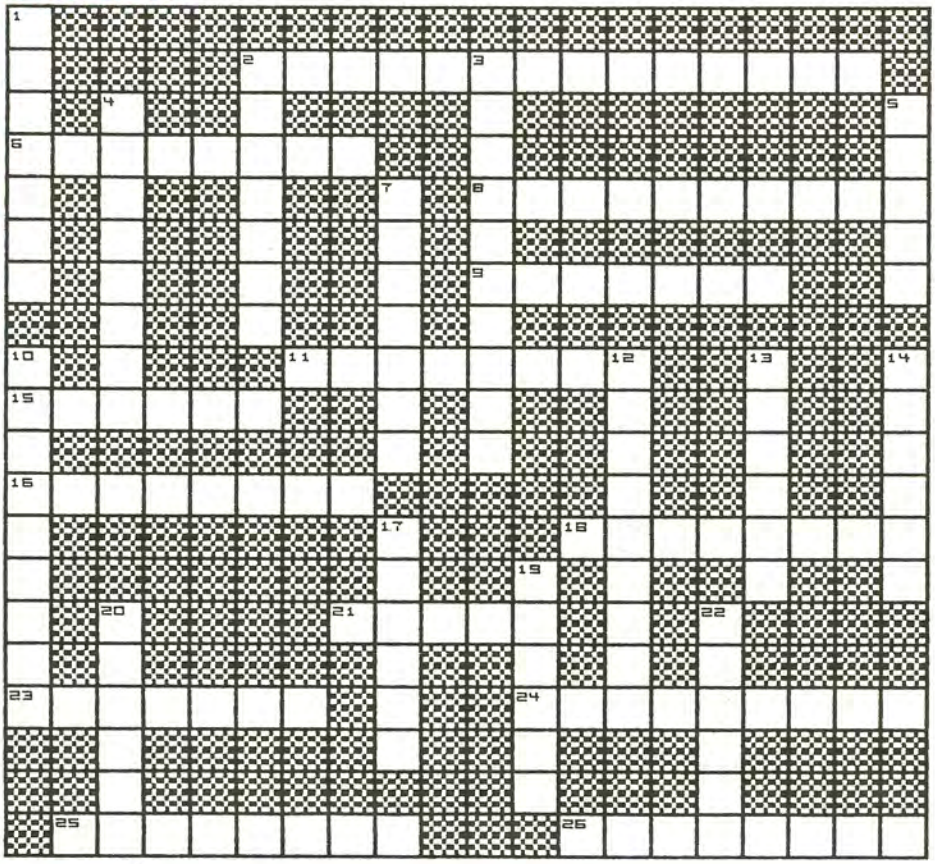


Figure 4. Two ampules with ASTM standard "wrap-around" labeling.

TECHNICIAN

CROSSWORD



Answers to previous puzzle:

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R     P       C C
U  AERATED    H L
B     E      SAFETY
B FISSION     N A
I     S    OXYGEN
N  S U        E   O
GLUTERALDEHYDE    S
   E E          X  H
   R        HOSPITAL
ANTISEPTIC     I      F
   L       STERILE    E
RADIATION      A A    C
   Z  N        T T    E
   E  D        I HANDS
 BODY I        O E
      C    F   N R
    GRAM   I
      T    V
      OXIDE
      R
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HOW'S YOUR ANATOMY? 1: Head & Neck

ACROSS:

2 Junction of several major arteries at base of the brain
6 Collarbone
8 Cranial nerve serving the forehead and face
9 Major arteries serving the head
11 Jawbone
15 Outermost clear layer of the eye
16 Beneath, or below
18 Notch on the upper lip
21 Socket holding the eyeball
23 To the side
24 In back of, or behind
25 Gland that forms tears
26 In front of, or before

DOWN:

1 Windpipe
2 Coiled tube in the inner ear
3 Tube connecting middle ear with the pharynx
5 Topmost cervical vertebra
7 Breastbone
10 Lobe at the back of the brain
12 Connects oral cavity with stomach
13 Roof of the oral cavity
14 Cheekbone
17 Voicebox
19 Stirrup-shaped bone in middle ear
20 Membrane that receives visual image in the eye
22 Number of cranial nerves

Reference: F. H. Netter, M.D.: *Atlas of Human Anatomy*.
CIBA-GEIGY Corporation, 1989.

continued from page 4

Briefly describes how the laryngeal mask can be utilized to provide a patent airway and guide the introduction of a flexible fiberoptic scope or a bougie dilator, even in a patient who had eaten three hours earlier.

Fisher JA, Ananthanarayan C, Edelist G: Role of the laryngeal mask in airway management. Editorial, Can J Anaesth 39:1-3, 1992

Describes conditions for which the LMA may be suitable or unsuitable. Cautions against considering the LMA as a panacea for airway management. Affirms the unique role that the LMA fulfills in airway management, and provides a useful balance to the discussion at hand.

Nanji GM, Maltby JR: Vomiting and aspiration pneumonitis with the laryngeal mask airway. Can J Anaesth 39:69-70, 1992

Reports a case of severe aspiration pneumonia after anesthesia became 'too light' during an Austin-Moore arthroplasty. Discusses potential limitations of the LMA and concludes that in appropriate cases the LMA should still be considered a valuable tool for the anesthetist.

Dubreuil M, Janvier G, Dugrais G, Berthoud MC: Uncommon laryngeal mask obstruction. Letter, Can J Anaesth 39:517-8, 1992

Discusses a case which resulted in obstruction despite adequate chest expansion, normal auscultation, and $ETCO_2$ and SpO_2 monitoring. Encourages the use of fiberoptic laryngoscopy via the lumen of the LMA to diagnose airway difficulty with the laryngeal mask.

MEMBERSHIP UPDATE

CORPORATE AND INSTITUTIONAL ASATT MEMBERS . . .

INSTITUTIONAL:

DUKE UNIVERSITY MEDICAL CENTER
Durham, NC
Since 10/90

GOOD SAMARITAN HOSPITAL
Portland, OR
Since 2/91

GOOD SAMARITAN HOSPITAL
W. Islip, NJ
Since 12/91

LANCASTER GENERAL HOSPITAL
Lancaster, PA
Since 9/90

MONMOUTH MEDICAL CENTER
Long Branch, NJ
Since 2/91

PARKVIEW MEMORIAL HOSPITAL
Fort Wayne, IN
Since 2/91

PRESBYTERIAN UNIVERSITY HOSPITAL
Pittsburgh, PA
Since 10/91

RIVERSIDE MEDICAL CENTER
Minneapolis, MN
Since 1/91

ST ALEXIUS MEDICAL CENTER
Bismarck, ND
Since 12/92

SUTTER GENERAL HOSPITAL
Sacramento, CA
Since 10/91

UNITED STATES NAVAL HOSPITAL
San Diego, CA
Since 3/90

UNIVERSITY OF MARYLAND MEDICAL CENTER
Baltimore, MD
Since 4/91

UNIVERSITY OF TEXAS MEDICAL BRANCH
Galveston, TX
Since 11/92

CORPORATE:

ABBOTT LABORATORIES
Abbott Park, IL
Since 1/93

ARC MEDICAL, INC
Clarkston, GA
Since 1/93

BAXTER HEALTHCARE CORP
Valencia, CA
Since 9/92

CRITICARE SYSTEMS, INC
Waukesha, WI
Since 8/91

DATEX MEDICAL
Tewsbury, MA
Since 3/91

ELECTROMEDICS, INC
Englewood, CO
Since 8/92

KING SYSTEMS CORP
Noblesville, IN
Since 12/91

LIFE SUPPORT SYSTEMS, INC
Phoenix, AZ
Since 5/91

MEDIREPS, INC
Glendale, AZ
Since 10/92

OHMEDA CORP, Div of BOC
Louisville, CO
Since 9/92

SPECTRUM ANESTHESIA SERVICE, INC
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Since 3/93

TRADEMARK MEDICAL
Fenton, MO
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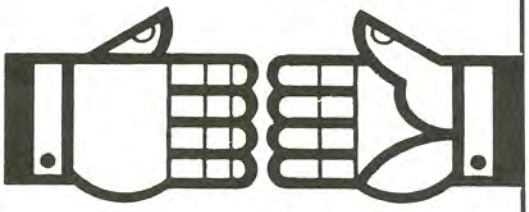

REGIONAL SOCIETY ACTIVITIES... by Dianne Holley ...Let us announce what's happening in your area. Send a brief report of recent or future activities for the next issue by May 31 to Dianne Holley. Send newsletters, if available, or give your info on my answering machine if I'm not home (512-451-7457). Captioned photos are also welcome.

California

Don't miss the *9th Annual Meeting and Seminar* of the **California Association of Anesthesia Technologists and Technicians** at the Marriott Hotel in Monterey, May 21-23. In addition to the beautiful bay scenery, attendees can look forward to educational lectures Friday-Sunday and a business meeting, luncheon, and evening reception on Saturday. The new **CAATT** permanent address is: 2530 Berryessa Rd., #826; San Jose, CA 95132.
For further information:
Ron Turner at (510) 674-2241.

Colorado

See *"Colorado Hosts Ski Meeting"* pg 11.
For further information:
Judy Drakiotes at (303) 270-8399.

Tampa is the site of the *Annual Statewide Seminar and Business Meeting* of the **Florida Society of Anesthesia Technicians**, next September 26. Several important society business issues will be dealt with at the meeting, including the election of officers and the presentation of new by-laws.
For further information:
Jerry Guttery at (904) 374-6051 [work] or (905) 472-3925 [home].

Illinois

In addition to several Board of Directors meetings this spring, the **Illinois Society of Anesthesia Technology** will present an educational meeting May 22 focusing on Swan-Ganz Catheters at the Columbus Hospital in Chicago. ISA has invited **ILSAT** members to attend their Midwest Anesthesia Conference, May 6-8, in Chicago, and the *2nd Annual ILSAT State Meeting* will also be held in conjunction with the ISA next November at Oakbrook Hills in Oakbrook.
For further information:
Jim Underwood at (309) 968-6998.

Maryland/DC

A new statewide organization is being formed in the Maryland/Washington, DC area.
For further information:
Richard Harrison at (410) 225-8176.

Michigan

The **Michigan Society of Anesthesia Technologists and Technicians** held their statewide meeting in Detroit, last November.
For further information:
Louise Martin at (313) 593-7696 or Jim McEvoy at (313) 343-4766.

New York

Syracuse will be the site of the ***ASATT*** *Board of Directors Meeting* as well as the *Anesthesia Technician Seminar* sponsored by the SUNY Health Science Center this April 17. Besides their bimonthly meetings (the next will be in May), the **New York State Anesthesia Technology Association** has been busy getting March 31 proclaimed as their statewide Anesthesia Technician Appreciation Day. **NYSATA** has also taken steps to have this date proclaimed by the U.S. Congress as National Anesthesia Tech Day. They will keep you posted. The new address of **NYSATA** is P.O. Box 23073; Rochester, NY 14692.
For further information:
John Armstrong at (716) 336-3377.

Ohio

The **Ohio Society of Anesthesia Technologists and Technicians** is offering a wide variety of educational meetings over the next few months. On April 24, a one-day seminar is being held in Cleveland. Other meetings occur on the 4th Saturday of each month; topics include a follow-up film on malignant hyperthermia and anesthesia safety in May, a pediatric anesthesia review in June, and trouble-shooting arterial lines in August. No meeting will be held in July.
For further information:
Wilma Frisco at (216) 541-5710.

Pennsylvania

The Children's Hospital in Philadelphia is the location of a business and educational conference sponsored by the **Pennsylvania Society of Anesthesia Technicians**. Acting-President Norman Holst announced that **PSAT**'s T-shirts are a popular item and have been selling very well.
For further information:
Norman Holst at (215) 590-2798 [work] or (215) 927-4958 [home].

Tri-State Anesthesia Tech Meeting

This meeting co-sponsored by the Pennsylvania, Virginia, and Maryland anesthesia tech societies has been canceled. Instead, each state will hold its own meeting.

Tennessee

The newly-formed **Association of Tennessee Anesthesia Technicians and Technologists** will hold an organizational meeting at the Lowe's Vanderbilt Plaza in Nashville at the end of May. If anyone is interested in becoming a member or attending this meeting, please contact Sharon Baskette, Vanderbilt University Hospital, Nashville, TN 37232.
For further information:
Sharon Baskette at (615) 322-4000 [work] or (615) 646-1599 [home].

Texas

Besides preparing for the *Fall 1993 Meeting* of the **Texas Society of Anesthesia Technology**, in September, **TSAT** is meeting on a regular basis in different cities. San Antonio [Raul Sanchez at (210) 675-1564] and Dallas [Susan Guthrie at (817) 485-5963] both host monthly meetings, and Austin hosts bimonthly meetings.
For further information:
Dianne Holley at (512) 451-7457.

Virginia

The **Virginia Society of Anesthesia Technologists and Technicians** has tentatively scheduled a one-day educational seminar on June 12 in Richmond. More information will be available at a later date.
For further information:
Linda Ferris at (703) 985-8351.

Washington

The **Northwest Society of Anesthesia Technology** held its January meeting at Harborview Hospital in Seattle. An Anaquest representative spoke on the new anesthetic agent desflurane (Suprane™) and the North American Drager company presented their new technology in medical information systems. The March meeting was bypassed in lieu of the Region 7

meeting in Vancouver; our May meeting will be announced soon.
For further information:
Dwight Shields at (206) 548-6538 or -6510.

Wisconsin

The annual meeting of the **Wisconsin Great Lakes Society of Anesthesia Technicians** will take place September 10-12 at the Abby in Lake Geneva, coinciding with the WGLSA annual meeting. Besides the educational meeting held in Wassau on March 20, **WGLSAT** is tentatively planning an educational/business meeting in Milwaukee.
For further information:
Noreen Soeller at (715) 387-7179 [work] or (715) 387-4792 [home].

REGION 7 TECHS MEET IN VANCOUVER, WASHINGTON

The first regional meeting for anesthesia techs in the northwest was held at the Red Lion Inn in Vancouver, Washington last March 13th. About 45 attendees heard speakers on PA catheters, hemodynamic drugs in anesthesia, the history of anesthetic gases, the rapid infusion system, and troubleshooting pulse-oximeters and capnographs. Lee Amorin, ASATT Vice-President, made introductory comments on the evolution of anesthesia technologists, and a product exhibit was on display during the afternoon break.

The meeting set a precedent for enabling techs from Region 7 to meet and share their mutual experiences, as well as providing an enhancement to ASATT membership. Many thanks to Ruth Ochoa, Director of Region 7, for her efforts coordinating the meeting, as well as to John Spaulding, ASATT Executive Director, for his support with registration, and to all the speakers who sent us home better technicians.

COLORADO HOSTS SKI MEETING

by Ann Martin

The University of Colorado Department of Anesthesiology held its CRASH '93 for Anesthesia Technologists and Technicians at Vail on March 27. The session opened with a reception on Friday evening with 28 registrants representing nine states. The Colorado Society of Anesthesia Technicians hosted the ASATT booth in the anesthesiologist's exhibit hall. It was a great opportunity to meet other members in our region as well as out-of-state ASATT members and non-members to exchange information.

The Jami Blue Lecture was presented by Christopher A. Mills, MD on the past roles of the Anesthesia Technician, and more importantly, the current and future roles of our a rapidly growing support profession. The lecture was well received by all. Other lectures, workshops, and hands-on experience with equipment proved to be very educational and fun.

One subject that kept recurring was "tough times" and motivation. It is a constant challenge of adult life to remain clear about what we want to accomplish and to stay directed toward important goals. Some days it seems as though keeping ourselves on track and motivated is a full-time job. People who thrive, who keep themselves moving in the direction of their goals and dreams, have certain characteristics and they use particular techniques to determine where they want to go and how to stay on track getting there. If we assess our strengths, set goals, learn self-motivation, and create a personal plan for moving ahead, we can make it through tough times.

Thanks to the University of Colorado School of Medicine and the Colorado Society of Anesthesia Technologists and Technicians for hosting the ASATT exhibit.

Ann Martin (left), Director of Region #5 with Judith Drakiotes (right), President of the Colorado Society.

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ASATT Annual Meeting

& Educational Program

Washington, D.C.

October 9 - 11, 1993

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