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AMERICAN SOCIETY OF ANESTHESIA TECHNOLOGISTS AND TECHNICIANS

PRESIDENT'S MESSAGE...



SECURING THE STEPS TO SUCCESS

by Sheila K. White, CerAT
Mercy Medical Center, Dubuque, IA

If anyone would have told me 4 years ago that I was going to be involved in ASATT and the pursuits and goals of the organization to this extent, I would have laughed at the idea. I was never one to get "caught up" in a cause. But that all changed for me after I attended my first ASATT annual meeting October, 1994, in San Francisco, CA. The idea of traveling halfway across the country to a beautiful city was fascinating enough, but walking into that meeting room surrounded by almost 200 anesthesia technicians was absolutely stimulating! The knowledge that permeated that room was overpowering. The lectures were all so interesting—but it wasn't until Doug Draper came roller skating out onto the floor that the meeting had its full affect on me. He spoke with such fervor about keeping your job-role interesting; making that first impression a great one; making your-

self indispensable; and the list goes on. However, the most noteworthy point he drove home was to get involved. Don't ask me why his presentation affected me in the way it did—destiny perhaps, but I was hooked! I learned that same day that the position of ASATT Region 4 Director was open. I announced my interest to then Vice President Chris Patterson, and as they say—the rest is history!

So much has happened to me, as a person, during these last four years. I would tremble at the thought of having to speak in front of a group of people. (To those of you in attendance in San Diego, I apologize, because you had to witness firsthand the extreme to which the terror of public speaking still affects me!) But this is precisely my point. Four years ago, I wouldn't even have gotten up in front of a group! It takes time and self-esteem, and I am constantly working on this goal which I hope to one day conquer.

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For further information, contact:

The ASATT Sensor
 Dianne Holley, CerAT, Editor
 3810-A Tonkawa Trail
 Austin, TX 78756
 (512) 451-7457

or

ASATT Office
 2000 L. St., NW, Suite 200
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 David G. Mastalski, CerAT
 VA Medical Center
 Portland, OR
 503-642-1537(H)
 nmastalski@aol.com(E)

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Editor: L. Dianne Holley, CerAT 3810-A Tonkawa Tr, Austin, TX 78756. 512-451-7457(H), 512-323-1104(F), ldholley@aol.com(E)

Associate Editor: David G. Mastalski, CerAT VAMC, Portland, OR. 503-642-1537(H), 503-721-7859(F), nmastalski@aol.com(E)

Graphics Assistance: Infinity Design, Houston, TX

All submissions pertinent to the objectives of the ASATT will be considered for publication. Preferred format: micro diskette, (PC or Mac), or email text file. Photographs, preferably black-&-white are also welcome and will be returned.

Deadline for the next issue is February 15, 1998

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THE NEW ASATT OFFICERS:

Chris Patterson, CerAT, Vice President/President-Elect

Joyce Freeman, CerAT, Director, Region 1

Gail Walker, CerAT, Director, Region 3



Chris Patterson, CerAT, Vice President/President-Elect

Chris is one of the original charter members of ASATT, and was instrumental in the formation and growth of our society. She served as ASATT Director, Region 6, from 1989 to 1993. She served as Vice President in 1993-94, and as President in 1994-95. Her continuing involvement in ASATT has included establishing fund-raising for ASATT Certification, forging closer alliances with anesthesia tech societies in other countries, and serving on various committees involving our certification examination.

Chris worked for 18 years at Kaiser Hayward (CA) where she trained as a pharmacy tech, typist, and anesthesia tech. She then moved to Kaiser Redwood City where she has been employed as an anesthesia tech for the past 9 years. She has also worked



Chris Patterson, ASATT Vice President/President-Elect, and Sheila White, ASATT President address the membership at the 8th Annual Meeting and Educational Seminar in San Diego, October 1997

part-time for 7-1/2 years at San Jose Medical Center where she received further experience in trauma, cell-saving, and open heart surgery. She has also trained others in Cell-Saver Blood Recovery and Transesophageal Echocardiography.

Chris currently resides in Union City, CA (in the Bay area) with her husband, Jack. She and Jack have been married for 40 years and have 4 children and 6 grandchildren. Her hobbies are gardening, knitting and crocheting, cooking, home-teaching projects with her church, and of course ASATT.

Joyce Freeman, CerAT, Director, Region 1

Joyce lives in and grew up outside of Syracuse, NY. After graduation from high school, she studied medical assisting and received that diploma in 1974. She started her medical career in 1978 as a nurse's aide at State University Hospital (formerly Upstate Medical Center and now also known as SUNY Health Science Center). Two years later, Joyce returned to school to study surgical technology, which led to 8-1/2 years as a surgical tech.



In 1988, Joyce began on-the-job-training as an anesthesia tech. After several years as a staff anesthesia tech, she became chief anesthesia tech. This promotion was based partly upon her experience as an anesthesia tech, and partly upon her broad OR experience. Joyce studied science for 2 years at a local junior college. She has also taken courses in management.

Joyce describes herself as a simple, easy-to-know person. She is married with 2 children. When she's not busy with family, she also enjoys walking, reading, decorating, and ushering at her church.

Joyce intends to host annual Region 1 meetings in Syracuse.

Gail Walker, CerAT, Director, Region 3

Gail is originally from Chicago, but later moved to Florida. She trained as an anesthesia tech at Southwest Florida Regional Medical Center in Ft. Myers, and worked there for 11 years. Wilmington, NC then became Gail's home for a year, where she was employed as an anesthesia tech at New Hanover Regional Medical Center for one year. Gail continued her career as an anesthesia tech during the past five years at the University of North Carolina-Chapel Hill Medical Center.

Gail became president of the NCSAT in 1995. She also originated and coordinated the NCSAT Job Hotline during her 2 years in that office. She helped plan the past 2 Region 3 Meetings with Linda Cotton, previous Region 3 Director.

Gail has an 18-year-old daughter, and a house full of animals.



Gail has received a lot of on-the-job training, but she is still learning. Her hospital has been very pro-active in conducting in-house training of anesthesia technicians. If anyone would like information on how to set up their own in-house training program, please contact her

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NCSAT JOB "HOTLINE"

The North Carolina Society of Anesthesia Technicians has started a nationwide job referral service for anesthesia technicians looking for employment and hospitals with positions to fill.

A technician seeking a change of employment should send his/her name, address, phone numbers, fax number, and the city or state in which one desires employment. Hospitals should send job opening information and the name of a contact person. NCSAT is asking that technicians send in a one-time-only fee of \$5 to help defray costs. Hospitals can register at no charge.

Hospitals can fax their job listings to (919) 966-4873, ATTN Gail Walker.

Technicians can mail their applications and a check made out to NCSAT to:

Gail Walker, ASATT Director, Region 3
2156 E. Greensboro Chapel Hill Rd
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Phone: (919) 966-5136[W] or
(910) 376-0327[H].

OPEN FORUM...

by David G. Mastalski, CerAT
 ASATT Region 7 Director, SENSOR Associate Editor
 Chief Technician, VA Medical Center, Portland, Oregon

The intent of this page is to provide an "Open Forum" for ASATT members or anyone with an interest in anesthesia technology to exchange information and ideas.

Dear OPEN FORUM:

I have just come from presenting "VRE in a world of merging resistance: approaches for control" at the eighth annual meeting and educational seminar held in San Diego, October 17-19. My presentation was impressively received. After the question and answer session, following the presentation, two certified technologists asked (1) how to handle a patient requiring surgery who is suspected of having TB, and (2) how to handle the HIV-infected patient. In the interest of time, I suggested writing a response for *The ASATT Sensor*, rather than reappear before the group. It just so happened that Mr. Mastalski, one of *The Sensor's* editors, penned a very good response to a similar query from J. Sellars, CerAT, for the October issue, which was available at the registration tables. This enables me to confirm, as well as, expand upon Mr. Mastalski's response.

Bloodborne pathogens: To confirm Mr. Mastalski, you are not going to transmit bloodborne pathogens (HBV, HIV, HCV) through anesthesia equipment. These are bloodborne pathogens, not airborne. There is no requirement or recommendation for the internal routine cleaning of anesthesia machines or culturing them. Evidence is lacking that anesthesia machines are a significant source of respiratory infections. In view of this, they should not be cultured because, even if positive, the data is meaningless and there is no reference for comparison. Demanding sterility of anesthesia machines is probably unrealistic and not clinically significant. Collecting (sterility) data that you cannot interpret will get you into trouble every time.

Anesthesia considerations for tuberculosis: CDC has made some recommendations for "anesthetic considerations" in their famous 132-page book, *Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis in Healthcare Facilities*, 1994, p50. This is available on the internet at www.cdc.gov.

1 Postpone elective procedures until the patient is no longer infectious.

2 Place a bacterial filter on the patient endotracheal tube or at the expiratory side of the breathing circuit of a ventilator or anesthesia machine. "If used, it may help reduce the risk for contaminating anesthesia equipment or discharging tubercle bacilli into the ambient air." (The filter for the patient should be between the Y-piece and the mask or between the Y-piece and the ET tube.)

3 Special masks must be worn by healthcare workers called "N-95 respirators" for cough-inducing procedures such as endotracheal intubation, bronchoscopy, extubation, and suctioning. These masks are similar in appearance to surgical masks. However, they protect HCW from inhaling tubercle bacilli suspended in the air, which is the opposite function of most surgical masks,

which is to protect the sterile field from outgoing respiratory contaminants of HCW's. For surgery upon TB-infected tissue, neither surgical masks nor N-95 respirators will do since the N-95's don't protect the surgical field, and surgical masks don't protect the surgical team. Therefore, other respiratory protection that protects both sides must be used. For reasons that we do not completely understand, cutting into infected tissue is many times more risky than close contact to a person with TB disease who is coughing.

4 During postoperative recovery (when coughing is likely), the patient should be placed in an isolation room meeting all the requirements for TB control including negative air pressure. This means that you will have to do some planning to get your monitoring equipment into position prior to the arrival of the postsurgical TB patient. You should not recover the case in the PACU, and you must wear N-95 respirators while in the patient's room.

Other considerations: Patients who are coughing and must be transported, should be instructed to cough into a tissue if they can cooperate with their care. I feel that this is more effective than putting a surgical mask on the patient to contain TB droplet nuclei. N-95 masks should never be put on the TB patient. Anesthetized patients who cannot cough are not going to be disseminating TB.

Operating rooms have opposite airflow to TB rooms. In TB rooms, the air must flow in. In operating rooms, the air flows out. Therefore, it is desirable for operating rooms to have anterooms. Many operating rooms don't have anterooms. Therefore, keep the doors to the OR shut, reduce traffic to the minimum, and try to do the case at the end of the day when there are no other patients and nonessential staff may have left. Finally, I would like to point out that unless the patient is coughing, TB will not be broadcast.

Judy Gassett, MT, MPH, CIC
 Infection Control Consultant

Dear OPEN FORUM:

I am an anesthesiologist and have had several opportunities to review your national newsletter, *The Sensor*, but I have not seen

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All questions and "Did You Know..." ideas may be addressed to:

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TECHNIQUES OF EXTRACORPOREAL LIFE SUPPORT

by Sally E. Garner, FIOT
Chief ODA, Glenfield Hospital
Leicester, U.K.

Introduction: ECMO (the abbreviation of "extracorporeal membrane oxygenation") has been adopted as a generic term, synonymous with "extracorporeal life support" (ECLS) and includes related techniques such as extracorporeal CO₂ removal (ECCOR). ECMO is currently indicated when potentially reversible pulmonary or cardiopulmonary failure has reached a severity where mortality is expected despite maximal conventional therapy.

The principle of the ECMO circuit is deceptively simple. Life support is provided by draining venous blood to an extracorporeal circuit and oxygenating it artificially before returning it to the patient. In this way the patient's cardiac and pulmonary status can become a function of the circuitry and the patient becomes independent of the functional implications of his or her disease. Unlike other forms of support "when gas exchange fails" [like the intravenous oxygenator (IVOX)], ECMO can completely satisfy gas exchange and cardiac output requirements.

ECMO¹ has now been associated with the successful salvage of the sickest patients. Worldwide experience represents a series of over 6,000 cases (the majority neonates).² Generally speaking, however, understanding of the technique in the UK, is in the most part conceptual. The variety of equipment available and the diversity of circuit designs and methods that have been used on an ad hoc basis may therefore cause (or result from) confusion.³ An atmosphere of innovative experimentation when introducing this technology is best avoided until experienced in the techniques. This article provides an overview of ECMO, as currently practised, with an emphasis on practical considerations.

Background: Historically, attempts to use techniques of cardiopulmonary bypass to provide prolonged life support share a common ancestry with the evolution of perioperative bypass⁴. Extensive haemolysis limited early perfusions but developments in technique and improvements in technology have minimized, although not eliminated, these risks.

The widespread application of extracorporeal life support has been delayed by inconclusive attempts at objective comparison with conventional treatment.^{5,6,7} Consequently, ECMO has been confined to specialist centres and reserved for situations when a potentially reversible disease was anticipated to cause death from cardiopulmonary or pulmonary failure. Selection criteria have been widely employed to restrict treatment to appropriate situations. The apparent success of ECMO is therefore difficult to interpret. There is no frame of reference to allow comparison of results as no such selection is applied to non-ECMO candidates. The results of ECMO are improved by the fact that its use has been confined to experienced centres, performing the techniques on a regular basis. Reliable prospective randomized comparisons between ECMO and conventional treatment are not available and doubts about the validity of criteria used to

predict mortality without ECMO persist.^{8,9,10} This has meant that despite high survival rates and large series of patients, the introduction of ECMO proceeds on a background of conflicting information that provokes active debate.^{11,12,13,14,15}

Clinical application was first found in the treatment of severe neonatal cardiopulmonary failure. ECMO has been accepted as a standard life support technique for mature neonates in the USA since 1985. Survival rates of over 80% reverse the predicted mortality associated with conventional treatment. Following this success further refinement has led to a review of the technique's application in cardiorespiratory failure in older patients. Appreciable survival rates (55%)¹⁶ have again followed. As a result, despite the lack of conclusive trials, interest in extracorporeal life support is increasing. Not least in the UK, where Leicester has been providing a tertiary referral service for ECMO since 1989, and has treated over 75 patients who far exceeded conventional selection criteria, and yet, in whom a cumulative survival rate of 70% has been achieved.

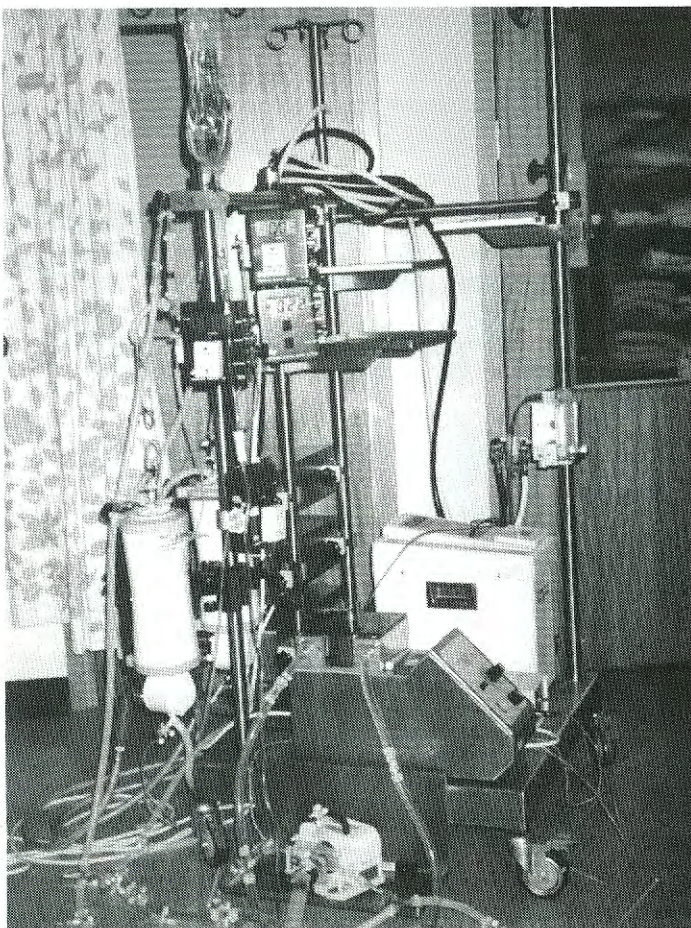
Methods: Although ECMO circuit components are similar to those used for perioperative cardiopulmonary bypass, the processes themselves are very much distinct entities. ECMO circuits function as a closed, continuous flow system in continuity with the patient's circulation. Circuit design for ECMO needs to avoid areas of stasis such as venous reservoirs (necessitating high levels of heparinization that may promote haemorrhage) and promote normothermia (to allow prolonged support). Typical circuit design and the principle is shown in the figure.

Blood is drained by cannulation of a systemic vein(s). Usually the cannula is inserted from the right internal jugular vein to the right atrium. The choice of pulmonary support alone or combined cardiopulmonary support is provided by deciding where to return the blood after it has been drained and oxygenated. Return to a systemic artery (venoarterial ECMO) provides a degree of cardiopulmonary bypass proportional to the extracorporeal blood flow. Return to the same or another systemic vein means that support of gas exchange alone is provided. This may be associated with a degree of recirculation of the oxygenated blood back through the circuit which requires a compensatory higher blood flow.

During ECMO, the emphasis of oxygenation and CO₂ removal is shifted from the patient's lungs to the circuit. Gas exchange takes place within the oxygenator. Current oxygenator designs partition blood and gas phases to minimize haemolysis. The functional principles that apply are common to all types. Membrane oxygenators are so called because they separate blood and gas phases with a silastic membrane that is freely permeable to the respiratory gases. Oxygen and carbon dioxide move across this membrane driven by diffusion gradients which may be maximized by the introduction counter current flow and the use of 100% oxygen as the sweep gas.

Within design (and haemoglobin concentration) limits, oxygen delivery depends upon the blood flow through the oxygenator. Oxygenators have a rated flow beyond which increases in blood flow are not accompanied by changes in oxygenation. It is customary in neonatal perfusions to choose an oxygenator which far exceeds the likely demands to be made upon it during the perfusion. An oxygenator working within its defined blood and gas flow parameters remove CO_2 with much greater efficiency than delivery of oxygen. Bloodborne carbon dioxide is readily accessible for diffusion and CO_2 removal is primarily a function of the minute volume of the oxygenator (and the diffusion gradient). This minute volume is dictated by the rate of gas flow across the oxygenator or "Sweep rate." Because of the remarkable efficiency of oxygenators at removing carbon dioxide, some patients can receive respiratory support from a venovenous cannulation with very low blood flows and high sweep rates. The emphasis is then on CO_2 removal and hence the term "ECCOR."

During ECMO, reliance upon the function of the patient's lungs is reduced and excessive ventilation is avoided. Classically, some degree of lung rest is provided by reduced settings which are designed to minimize atelectasis and counteract any tendency toward pulmonary edema. All infusions are made into the circuit and invasive procedures are wherever possible avoided to reduce any risk of bleeding.



Circuit construction: The choice of circuit components is crucial to the subsequent progress of the perfusion. Cannulae through which to establish an extracorporeal circuit are chosen carefully.¹⁷ The resistance of the drainage cannulae to blood flow imposes a limit to the extracorporeal blood flow (the main variable affecting patient oxygenation during bypass). The resistance of the arterial cannula primarily influences the pressure within the circuit which has implications for the prevention of haemolysis and safety of the circuit. The resistance of cannulae is affected by their length and internal diameter and also the presence of laminar or turbulent flow. The optimal choice of cannula will then depend upon the surgical ease of cannulation which is in turn affected by vessel size and intravascular volume and pressure.

Similar considerations apply to the choice of tubing diameter from which to construct the circuit. Larger flows require larger diameter tubing particularly in the venous drainage line in order to achieve sufficient support. PVC tubing is commonly used for conventional perioperative bypass but prolonged bypass requires components capable of withstanding prolonged use. This is particularly true of the raceway in a roller pump which is currently constructed from supertigon. The venous blood drains through a servo mechanism that is linked to the pump controller. In this way the pump speed can be inhibited in the presence of inadequate or obstructed venous drainage and suction will not be applied to the patient.

Standard ECMO circuits employ a roller pump governed by a controller which in turn is reacting to the volume of a distensible bladder positioned in the venous drainage limb of the circuit. The advantages of this system in minimizing blood trauma have been well proven. Theoretical advantages of constrained vortex or centrifugal impeller pumps, which would not require a bladder have been outweighed by increased haemolysis (primarily from a degree of suction applied to the venous drainage) and the limited life of pump heads which can fail suddenly and catastrophically. More recent designs of self-regulating, pressure sensing, roller pumps have yet to be fully evaluated in ECMO.

A variation of classical ECMO providing tidal flow through a single lumen cannula has been pioneered in France where the technique is known as AREC ("*assistance respiratoire extracorporelle*").¹⁸ The method depends primarily on a specific pump design. This pump is, as yet, not available outside France.

The choice of oxygenator is not limited to its gas exchange or coagulation characteristics, however. Different designs are associated with different flow dynamics and with different degrees of blood trauma, factors which also influence selection. Hollow fibre oxygenators are smaller and may impart less resistance to blood flow. They are also widely available in heparin-bonded form. Widespread adoption however has not followed because of problems with profuse plasma leakage. Heparin-bonded membrane oxygenators are about to undergo preliminary clinical trials in the UK.

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Normothermia during prolonged perfusion is essential. Heat exchangers may be provided as separate components in which case they are positioned post oxygenator to counteract its cooling effects. Some however are integral in the oxygenator design. Stainless steel oxygenators are preferable as aluminium construction has been associated with metallic microembolization.¹⁹

Future Developments: New developments in ECMO technology are continually being promoted. Many improved monitoring systems that have been incorporated into perioperative bypass circuit design such as bubble and particle detectors may have roles to play in long term extracorporeal support. Each must be considered on its individual merits. However, it must be remembered that classical circuit design has probably been so successful *because* of its simplicity. The more adaptations and additional components the more potential for circuit component failure.

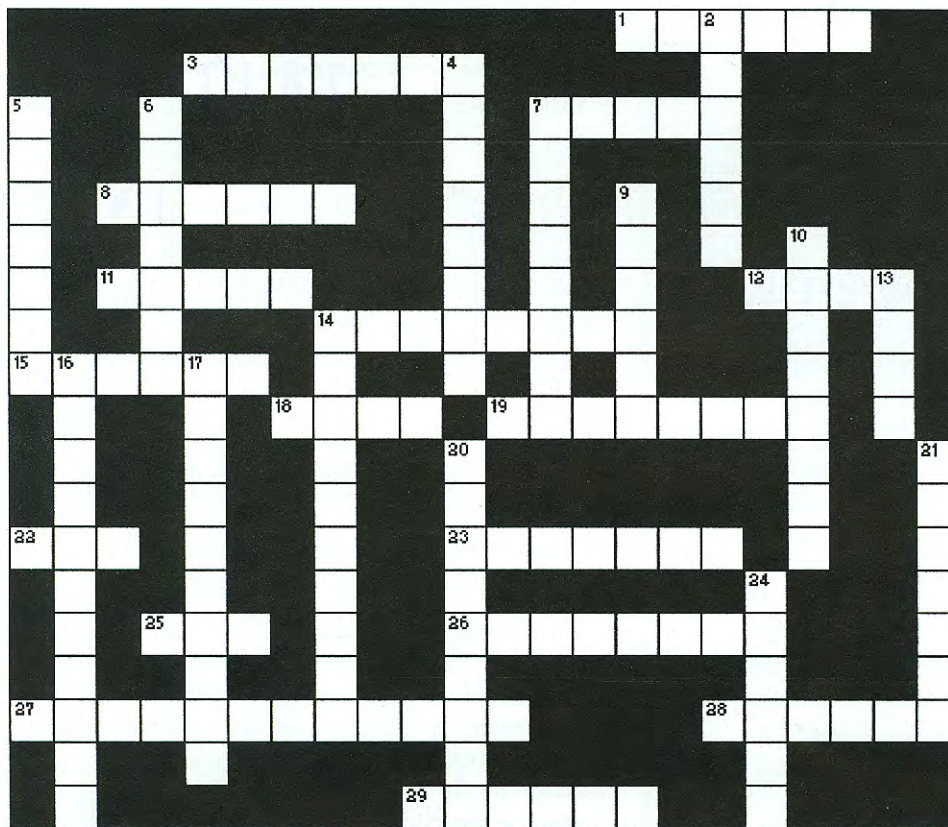
The need for systemic heparinization combined with platelet consumption contribute to the most complications for ECMO-haemorrhage. Efforts to minimize such complications include the administration of drugs designed to increase platelet survival and reduce risks of haemorrhage. The advent of heparin-bonded circuitry and oxygenators may reduce the need for heparinization although this is not yet proven.

Conclusion: The high survival rates of patients treated, at the extremes of illness, with ECMO prove that it is a potent life support technique. It can succeed in clinical situations where other techniques are likely to fail. The continued debate that surrounds ECMO is fueled by difficulties in deciding exactly when the risks of conventional treatment are sufficient to justify a more invasive life support. The lack of reliable comparative data between ECMO and conventional treatment prevents resolution of such issues.

The success of modern ECMO is partly a result of its use being confined to experienced centres and partly because reliable circuit designs and components are adhered to. Although the technology of ECMO is continually evolving, innovations can only be reliably assessed once experience has been gained in established techniques.

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SCIENCE AND TECHNOLOGY POST TEST: Infection Control, Extracorporeal Life Support

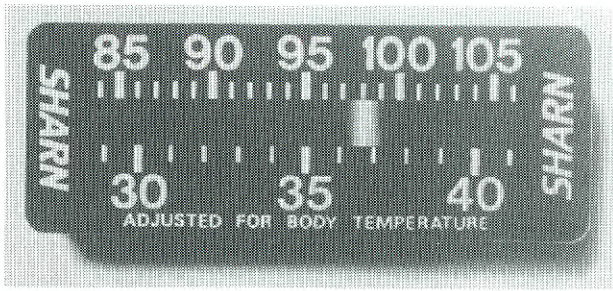
Use this crossword puzzle to test your knowledge on the "Open Forum" and "Science and Technology ..." articles on pages 5-8. Puzzle answers can be found on page 19 of this issue.

Across

- 1 A TB patient should cough into a ___ when possible.
- 3 ECMO can satisfy gas exchange and ___ output requirements.
- 7 Lung rest, as provided by ECMO, helps counteract pulmonary ___.
- 8 A bacterial ___ at the ETT or on the expiratory limb of the breathing circuit may prevent contamination of the ventilator with TB.
- 11 During ECMO, reliance upon the ___ is reduced.
- 12 ECLS stands for extracorporeal ___ support.
- 14 During ECMO, invasive procedures should be avoided to prevent excessive ___.
- 15 Venoarterial ECMO returns blood to an ___.
- 18 Cutting into TB-infected tissue is ___ risky than being near a coughing TB patient.
- 19 Most patients using ECMO are ___.
- 22 An isolation room for TB-control includes negative ___ pressure.
- 23 ECCOR stands for extracorporeal CO₂ ___.
- 25 ___ exchange takes place in an ECMO oxygenator.
- 26 HIV is not an ___ pathogen.
- 27 ___ is provided by heat exchangers.
- 28 Standard ECMO circuits employ a ___ pump.
- 29 ECMO is similar to cardiopulmonary ___ such as is used in heart surgery.

Down

- 2 Circuit design for ECMO avoids areas of ___ such as venous reservoirs.
- 4 Anesthesia machines should not be routinely ___ as the results are meaningless.
- 5 During ECMO, blood is drained via a ___ placed in a vein.
- 6 ECMO is indicated when potentially reversible cardiopulmonary ___ has reached a severity where mortality is expected despite maximal conventional therapy.
- 7 Postpone ___ procedures until a TB patient is not infectious.
- 9 During ECMO, ___ delivery depends upon blood flow through the oxygenator.
- 10 A ___ membrane separates blood and gas phases in an ECMO oxygenator.
- 13 Abbreviation for extracorporeal membrane oxygenation.
- 14 HIV is a ___ pathogen.
- 16 Anesthesia machines are not thought to cause ___ infections.
- 17 An N-95 ___ protects HCW's from TB.
- 20 Survival rates of neonates (using ECMO) reverse the predicted ___ rates associated with conventional treatment.
- 21 A common site for introducing ECMO cannulae is the right internal ___ vein.
- 24 ECMO is provided by draining ___ blood and oxygenating it before returning it to the patient.



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OPEN FORUM (continued from page 5)....

any statistics or information printed on the number of members that are in the ASATT. Can you please provide this information?

New York, N.Y.

At the ASATT 8th Annual Meeting and Education Seminar that was held October 17-19, 1997, in San Diego, CA, the ASATT Executive Director reported to a gathering of state representatives that the ASATT membership as of October 8, 1997 consisted of the following paid and current members: 1,163 Total Members in the following categories; 1,040 Active; 52 Individual; 33 Institutional; 19 Corporate; 12 International; 7 Associate.

Dear OPEN FORUM:

I have received numerous telephone calls regarding the *ASATT Continuing Education and Recertification Guidelines Booklet*. Many of the comments have been critical of the instructions and many technicians seem to view the booklet as "hard to understand."

As a member of the Education/ Continuing Education Committee and a Certified Anesthesia Technician myself, I view the booklet as a thorough picture of these instructions and requirements which ASATT has outlined for the reporting of continuing education/ contact hours. Inclusive of this booklet is the outline for Sponsoring/ Providing (planning) continuing education seminars, inservices, etc.

In my research, I find that the ASATT Continuing Education and Recertification Guidelines Booklet follows the trend of most Allied Health Professional Organizations. As concerned professionals, let us remember that ASATT is our organization, and it is our desire to present ASATT as an organization that strives for professional competency and excellence.

Wilma F. Frisco, CerAT
Euclid, Ohio

DID YOU KNOW....?

Web Sites of Interest:

The **new ASATT web site** is up and running. Look for it at <http://www.asatt.org/>

The AANA: <http://www.aana.com>

The ASA: <http://www.asahq.org/>

Tech Talk Discussion Board: TechTalk@anaes.sickkids.on.ca

ASATT Region 2 Continuing Education
One-Day Seminar/Workshop

Cell Saver/Haemonetics

Saturday, April 4

Radisson Hotel-Cleveland Southwest

Call 216-261-0649

CRASH 98 TECHNICIAN PROGRAM

FACULTY

Howard Miller, M.D.

Assistant Professor of Anesthesiology
CRASH 98 Technician Course Director

Cindy Ackerman, C.C.P.

Clinical Profusionist

Richard Allen, M.D.

Assistant Professor of Anesthesiology

Michael Ochs, D.O.

Assistant Professor of Anesthesiology

John Sedgeley

Marketing Representative, Olympus

Ann Martin, Cer.A.T.

CRASH 98 Technician Course
Assistant Director

Robert Ackerman, M.D.

Assistant Professor of Anesthesiology

Paul Baumgart

Marketing Manager, Ohmeda

W. Clayton Petty, M.D.

Professor & Chief, Madigan Army Med. Ctr.

Kenneth Swank, M.D.

Senior Instructor of Anesthesiology

PROGRAM

SATURDAY - FEBRUARY 28, 1998

- 6:30-7:00 Registration
6:30-7:00 View Exhibits; Continental Breakfast
7:00-7:50 Induction of Anesthesia
Michael Ochs, D.O.
7:50-8:40 Principles of Operations and Preventive
Maintenance of Vaporizers
W. Clayton Petty, M.D.
8:40-9:30 Anesthesia Equipment: Troubleshooting
W. Clayton Petty, M.D.
Paul Baumgart
9:30 View Exhibits; Recess
3:30-4:30 View Exhibits; Refreshments
4:30-5:45 WORKSHOPS
A: Autotransfusion: Methods and
Operation
Robert Ackerman, M.D.
Cindy Ackerman, C.C.P.
B: Hemodynamic Monitoring
Howard Miller, M.D.
Kenneth Swank, M.D.
5:45-7:00 Repeat Workshops A and B

SUNDAY - MARCH 1, 1998

- 6:30-7:00 View Exhibits; Continental Breakfast
7:00-7:50 Preventing Hypothermia
Howard Miller, M.D.

- 7:50-8:40 Intravenous Fluids I: Crystalloids and
Colloids
Kenneth Swank, M.D.
8:40-9:30 Intravenous Fluids II: Blood Products
Robert Ackerman, M.D.
9:30-10:00 ASATT Update
Ann Martin, Cer.A.T.
10:00 View Exhibits; Recess
3:30-4:30 View Exhibits; Refreshments
4:30-5:45 WORKSHOPS
A: Fiberoptic Intubation
Michael Ochs, D.O.
Howard Miller, M.D.
John Sedgeley
B: Positioning for Surgery
Richard Allen, M.D.
Ann Martin, Cer.A.T.
5:45-7:00 Repeat Workshops A and B

MONDAY - MARCH 2, 1998

- 6:30-7:00 View Exhibits; Continental Breakfast
7:00-7:50 Basic Cardiovascular Physiology
Richard Allen, M.D.
7:50-8:40 Carbon Dioxide Absorption
W. Clayton Petty, M.D.
8:40-9:30 Sample Questions and Answers
Howard Miller, M.D.
Richard Allen, M.D.
9:30 Adjourn until February 27, 1999

Vail, Colorado

February 28 - March 2

Contact Phyllis Tuller - Course Coordinator - 303-372-6301

1998 ANESTHESIA TECHNICIAN SURVEY

(ASATT has appointed a committee to review the practice of the anesthesia technician. In as much as there is a diversity of practice, it is most imperative that ASATT establishes "A Standard of Practice for the Anesthesia Technician/Technologist." As a practicing anesthesia technician, you can participate in this endeavor by completing this survey.)

Mail completed survey by February 15, 1998 to:

Wilma F. Frisco, CerAT
24101 Lakeshore Blvd., Suite 314A
Euclid, Ohio, 44123

In what region of the United States do you reside? _____

(eg. north, south, southwest, east, or west)

If you reside outside of the United States, list the country. _____

In what type of facility are you employed? _____

(eg. university, surgery center, medical center, community hospital, pain clinic)

How many OR suites are in your facility? _____

How many anesthetics are administered in a year? _____

Do you work in other areas of the hospital? _____

(eg. MRI, Xray, OB, ER)

How many technical personnel are employed in your department? _____

Are there technicians employed at different levels? _____

Explain: _____

Are you a Certified Anesthesia Technician? Yes___, No___

If "no," will you take the National Certification Examination? Yes___, No___

Where did you receive your technical training? Military___, On-the-Job___, Vocational Program___, College___

Please list the name of the formal program _____

Do you have a license in any medical field? Yes___, No___

Please list all credentials and dates received _____

What is your salary?___ Are the salaries of the other technical personnel higher___ the same___ or lower___

Are you employed by a hospital or anesthesia group? _____

Who supervises the technical personnel in your department? _____

Do certified registered nurse anesthetists work at your institution? Yes___ How many on a given day?_____, No___

How many anesthesiologists are employed at your institution? _____

Does your institution treat pediatric patients? Yes___, No___

Is your facility located in a major city (population greater than 500, 000)? Yes___, No___

Does the technical staff participate in educational programs at your facility? Yes___, No___

Does your department or institution provide funds for educational meetings? Yes___, No___

Does your department or institution provide funds to anesthesia techs for educational meetings? Yes___, No___

TECHNICIAN SURVEY.....

Technical Duties: Please check the box which most accurately describes how often you perform each duty.

Technical Duties	Never	Sometimes	Routinely	Unsure	Technical Duties	Never	Sometimes	Routinely	Unsure
1. Clean machines and other equipment					29. Order supplies/vendors				
2. Stocking supplies					30. Review equipment for purchase				
3. Preparing I.V. setups					31. Propose capital budgets				
4. Assisting with I.V. placement					32. Order bulk drugs				
5. Starting I.V. Lines					33. Order narcotics				
6. Prepare/clean transducers					34. Monitor controlled drugs				
7. Calibrate transducers					35. Repair anesthesia gas machines				
8. Assist with arterial line placement					36. Troubleshoot monitoring equipment				
9. Start arterial lines					37. Set up/sterilize special procedures trays				
10. Assist with CVP line placement					38. Assist with difficult intubations				
11. Start CVP lines					39. Maintain fiber-optic equipment				
12. Assist with PA catheter placements					40. Design special procedure carts/tables				
13. Calibrate monitor for PA Catheter					41. Review patient charts				
14. Assist with regional anesthesia					42. Attach monitors to patients				
15. Mix drugs/Connect drugs to pumps					43. Assist with hemodilutions				
16. Set up rapid infusion devices					44. Assist with trauma patients				
17. Operate blood recovery system					45. Monitor and record vital signs				
18. Operate intra aortic balloon pump					46. Orient other anesthesia technicians				
19. Operate TEE unit					47. Orient other personnel				
20. Teach inservices					48. Work with student anesthetists				
21. Perform administrative duties					49. Work with anesthesia residents				
List the duties:					50. Assist on cardiac arrest team				
					51. Assist with transplant patients				
					52. Obtain/store blood from the blood bank				
					53. Assist in the administration of blood				
22. Assist with intubations					54. Serve on hospital committees				
23. Perform intubations.					55. Supervise other personnel				
24. Assist in the pain clinic					56. Write performance evaluations				
25. Perform blood gas analyses					57. Commute from one hospital to another				
26. Perform other lab studies					58. Transport patients to the OR				
27. Draw samples from arterial line					59. Transport patients to the PACU				
28. Order supplies/in-house					60. Transport patients to the SICU				

Are you employed full-time ___ or part-time ___ How long have you been employed at this institution? _____

The ASATT 9th Annual Meeting and Educational Seminar

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Orlando, Florida

ASA Exhibits

October 18, 19, 20, 1998

COMPETENCY

More information will
follow in the April '98 issue.

KNOWLEDGE

**ASA
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ASATT NATIONAL CERTIFICATION EXAMINATION

Saturday, May 16, 1998, Applied Measurement Professionals, Inc, will administer the 4th ASATT National Certification Examination for Anesthesia Technicians. Six major cities have been chosen as test locations. They are:

Pittsburgh, PA
Charlotte, NC
St. Louis, MO
Dallas, TX
Sacramento, CA
Honolulu, HI

ASATT seeks a volunteer: David Mastalski, CerAT, Director, Region 7 and Associate Editor of the society newsletter, *The ASATT Sensor*, has devoted his expertise in journalism to the newsletter. For several years, David has unselfishly written, edited, and solicited articles that have appeared each quarter.

Because of additional commitments to ASATT, David has resigned as Associate Editor. As much as ASATT regrets that David resigned, ASATT does accept his resignation and realizes that the Editor, Dianne Holley, CerAT, needs an Associate Editor.

If you possess writing, editing, and computer skills and have a desire to share your journalism talents with ASATT, please contact Dianne Holley at 512-451-7457[H], 512-324-1104[F], or ldholley@aol.com [email].

Advertising Rates: New advertising rates will go into effect for ads placed in the January 1998 issue of *The ASATT Sensor*. The new rates are per insertion and are as follows: 1/4 page: \$125, 1/2 page: \$250. Current members will receive a 20% discount.

Remember,

The new ASATT address & phone number is:

ASATT
2000 L. St., NW, Suite 200
Washington, DC 20036
(609) 853-9382

1998 ASATT NATIONAL CERTIFICATION

EXAMINATION APPLICATION DEADLINE:

March 15, 1998

All applications must be sent by Certified Mail to:

ASATT Certification
Attn: Debi Maines
6900 Grove Rd
Thorofare, NJ 08086

If you have not received your application for the May 16, 1998 American Society of Anesthesia Technologists and Technicians Certification Examination return the form below to:

ASATT Certification
6900 Grove Road
Thorofare, NJ 08086-9447
fax 609-848-5274

One request per application. Duplicate form as needed. Request forms must be postmarked no later than January 28, 1998.

ASATT National Certification Examination Request for Application

NAME: _____

ADDRESS: _____

CITY: _____

STATE: _____ ZIP CODE: _____

PHONE: _____

FAX: _____

REGIONAL SOCIETY ACTIVITIES...

Let us announce what's happening in your area. Send a brief report of recent or future activities for the next issue by February 15, 1998 to your ASATT Regional Director or to Dianne Holley (address and numbers on page 2). Send newsletters, if available, a brief write-up, or call with your info. Photos (captioned) are also welcome, and can be returned.

ASATT Region 1:

A Region 1 Meeting is being planned for March 14-15 at the Radisson Hotel, in Syracuse, and is being conducted through the SUNY Health Science Center Continuing Education Dept. For further information:
Joyce Freeman at (315) 464-2825[W].

New York

For information on future events:
George Mann at (315) 471-6077.

ASATT Region 2:

An all-day continuing education seminar is being conducted in Dayton, OH on April 25, in conjunction with the OSATT--contact Charlene Smith (see Ohio, below). In May, Region 2 is cohosting a 1-day seminar in Pittsburgh, PA--contact Vicki Carse (see Pennsylvania, below).
For more information:
Wilma Frisco at (216) 261-0649.

Ohio

Please make plans to attend the following meetings:

- 1/24 and 2/28, 1998 - Calculations and Formulas in Anesthesia - Mt. Sinai Medical Center
- 3/28 - Stress Management
- 4/4 - Blood Recovery/Haemonetics (1-day seminar)
- 4/25 - Region 2/Statewide, 1-day meeting in Dayton

The OSATT welcomes Lesa Cooper, CerAT, from Children's Hospital in Dayton, OH as OSATT Western Division Director.
For further information:
Barbara Powell at (614) 454-4224 or
Charlene Smith (303) 677-3292 or
Wilma Frisco at (216) 261-0649.

Pennsylvania

For further information:
Vicki Carse at (412) 232-5807.

Virginia

For information on future events:
Linda Ferris at (703) 985-8351.

ASATT Region 3:

For information on future events:
Gail Walker at (919) 966-5136[W] or (910) 376-0327[H].

Florida

For further information:
Linda Cotton at (904) 351-7343 or (904) 347-8118.

Georgia

For information on future events:
Marc Dickens at (404) 712-7710.

North Carolina

For information on future events:
Jack Jackson at (910)-424-2868[H]

Tennessee

For information on future events:
Sharon Baskette at (615) 322-4000[W] or (615) 646-1599[H].

ASATT Region 4:

For further information:
Sam Ortiz at (312) 772-7830(H) or (312) 567-2190(W)

Illinois

For information about future events:
Pat Zueck (217) 788-3780.

Iowa

Anyone interested in getting together for a meeting in April '98? Let's put our heads and hands together and organize a "Reunion" meeting! It's been a long time! Give me a call or write: Sheila White, CerAT, 284 Quince St., Dubuque, IA 52003-7539.
For further information:
Sheila White at (319) 589-8665[W] or (319) 556-8234[H].

ASATT Region 5:

See "Crash '98" ad on page 11.
For information about future events:
Ann Martin at (303) 372-6300 [W] or (303) 987-3907 [H].

Colorado

For information on future events:
Teresa Chavez at (303) 320-2440.

Mississippi

For information on future events:
Earl Coleman at (601) 984-5951.

ASATT Region 6:

Region 6 Annual Education Program will be May 2 at Chandler Regional Hospital, Morrison Building, Chandler, AZ.
For information:
Dean Rux at (602) 821-3279[W] or (602) 497-9709 [H].

Arizona

With the assistance of Kimberly Jones, CerAT, LPN, arrangements have been made with the Arizona LPN Association for Anesthesia Technologists/Technicians to attend their monthly meetings to fulfill the required 10 CE/CH. These meetings will be held from 7 - 8:30 PM the THIRD Thursday of EACH MONTH at Carl T. Hayden VA Medical Center, Phoenix, AZ. All topics given by RN/CRNA --- Cost--FREE!!!
November 20 - Psychiatric Issues,
Dec.18-Technical Networking,
Jan.15-Therapy
Feb. 19-Nursing In Desert Storm,
Mar.15-TBA,
April 16-Antidepressants
For further information:
Dean Rux at (602) 821-3279[W] or (602) 497-9709 [H].

California

For further information:
Grainne Senior at (408) 735-1346.

New Mexico

For information on future events:
Chris Urso at (505) 286-1168[H] or (505) 272-0383[W]

Texas

DALLAS/FORT WORTH—mtg held 2nd week of Jan. All other upcoming mtg information contact Bob Reno—214-327-2066 or E-mail--cbyBOB@Aol.com. HOUSTON—Nov. 1, 1997: Malignant Hypothermia Part I, Blood Gas Analysis. Feb. 7, 1998 @ St. Joseph Hospital: Malignant Hypothermia Part II. 1998 schedule of meetings are Apr. 4, May 2, Aug. 1 & Nov. 7— Topics & workshops at these meetings will be in conjunction with training guidelines. Mtg info contact Essie Davis or Emily Jones 713-738-2811.

For further information:
Gerardo Trejo at (713) 793-2898.

Utah

For further information:
Kirk Hanson (801) 625-2700

ASATT Region 7:

Plans are being made for Regional recertification educational workshops/ meetings in Seattle and/or Portland in February and April, 1998

For further information:
Dave Mastalski at (503) 642-1537 or (503) 273-5389

Hawaii

For further information:
Delbert Macanas(808) 547-9872

Oregon

The Oregon Association of Anesthesia Technologists and Technicians presented a Saturday, October 11, 9:00am - 1:00pm meeting at Providence St. Vincents Hospital in Portland.

For further information:
Linda Bewley at (503) 291-2151
Richard White at (503) 273-5389

Washington

For information about future events:
Nora Tiffany at (360) 427-9562.

Finally, a Keyed Agent Adapter that really works, first drop to last.

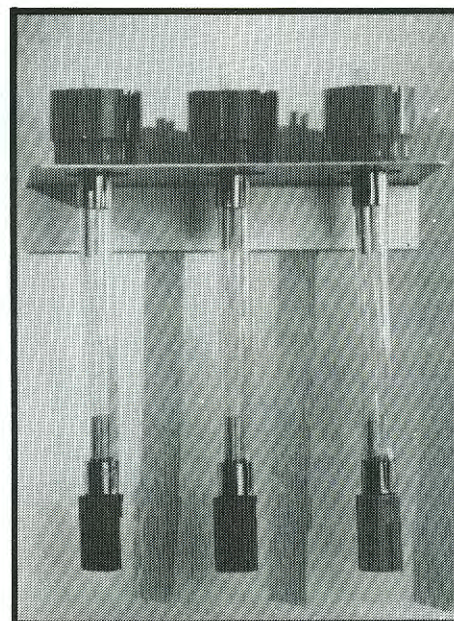
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AUTUMN LEAVES OF EDUCATION

by Wilma F. Frisco, CerAT
Secretary and Director, Region 2, ASATT
Director, OSATT

The Ohio Society of Anesthesia Technicians and Technologists held its Annual Southeastern Educational Seminar on Saturday, September 27, 1997. The beautifully remodeled Holiday Inn and Conference Center, Zanesville, Ohio, was the location for this day of educational bliss.



Charlene Smith, OSATT President, (right) greets Gene Kieffer, Abbott Representative

The technicians who attended this meeting travelled from Pennsylvania, Michigan, West Virginia, and various cities throughout Ohio.

Barbara E. Powell, CerAT, Supervisor, Anesthesia/Surgical Processing, at Bethesda Hospital, Zanesville, Ohio, and Wilma F. Frisco, CerAT, coordinated this great educational experience.

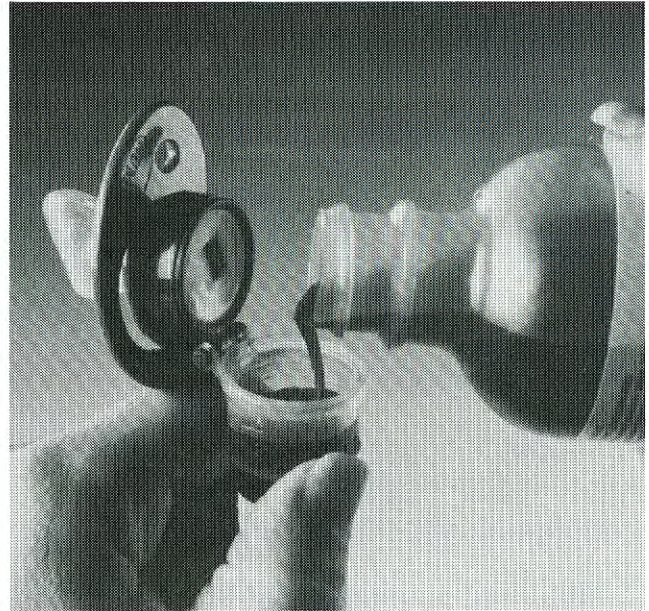


John Gigliotti, Circon Representative, demonstrates intubation techniques to Harriet Milbry

The OSATT extends its thanks and appreciation to the speakers, the coordinators, the attendees, and the vendors. Because of the continued support of the vendors and speakers in the Ohio area, OSATT has a positive attitude and direction that will lead the organization to the "Depths of the Educational Sphere."

As the OSATT Director and ASATT Director, Region #2, I commend all of your efforts and endeavors as you pursue "The Educational Horizon." Look behind you, one day....you will see many footsteps.

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4801 George Road, Tampa FL 33634

ANNUAL MEETING....

ASATT would like to thank the following distinguished faculty at the 1997 Annual Meeting in San Diego:

Phillip O. Bridenbaugh, MD

American Society of Anesthesiologists, President
University of Cincinnati Medical Center
Cincinnati, OH

Denise Martin-Sheridan, CRNA, EdD

American Association of Nurse Anesthetists
Albany Medical College
Albany, NY

Paul Baumgart, B.A., M.B.A.

Director of Marketing N. America System Division
Ohmeda, Inc. Medical Systems Division
Madison, WI

Mindy Bradley, CRTT, Cer.A.T.

Stanford Health Service
Stanford, CA

Harley S. Geller, MD

Attending Cardiac Anesthesiologist
Cedars-Sinai Medical Center
Los Angeles, CA

Sammye Harris, ST, CCA

Manager, Clinical Education Department
Cobe Cardiovascular, Inc.
Arvada, CO

Rosemary Johnson, MD

Script Green Hospital
San Diego, CA

James Marx, RN, MS, CIC

Infection Control and Epidemiology Consultant
Specializing in Long-Term Care Infection Control
San Diego, CA

William Clayton Petty, MD

Capt. MC, USN
Professor and Chairman, Department of Anesthesiology
Madigan Army Medical Center
Tacoma, WA

H.J.C. Swan, MD, M.A.C.P.

Professor of Medicine (Emeritus)
Pasadena, CA

Susheela Sangwan, MD

Associate Clinical Professor of Anesthesiology
Director of Cardiac Anesthesia
Cedars-Sinai Medical Center
Los Angeles, CA

Wava Truscott, PhD

Vice President, Scientific Affairs
Safeskin Corporation
San Diego, CA

Andrea M. Williams, Cer.A.T.

Director, Anesthesia Technologists Program
Western School of Health and Business Careers
Pittsburgh, PA

On behalf of Dean Rux and myself, I would like to publically say THANK YOU to the following companies who supported the ASATT 8th Annual Meeting and Educational Seminar, October 17-19 in San Diego. It was a fantastic meeting. The continued support you provide ASATT is deeply appreciated.

Sincere thanks,

Sheila White, President
97 Program Co-Chairperson

Dean Rux, Director, Region 6
97 Program Co-Chairperson

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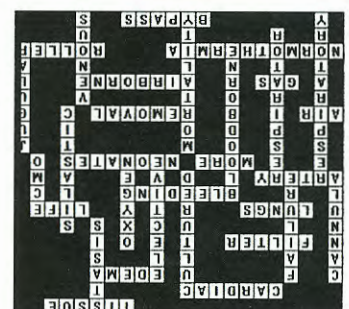
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ANSWERS TO PUZZLE:

(From page 9)



THE EDUCATION HORIZON IS YOURS AT ASATT 8TH ANNUAL MEETING IN SAN DIEGO

by Dean Rux, CerAT, Director, Region 6

As the sun set off the shore of San Diego, over the Pacific Ocean, it gave thought to the 1997 theme "The Education Horizon is Yours." October 17, at the Radisson Hotel Mission Valley/San Diego, anesthesia techs started reaching out to the "horizon of education" at the 8th Annual Meeting and Education Seminar. Since the national meeting in Atlanta, 533 anesthesia techs have gone for the gold. That gold is certification.

Precision by the San Diego Naval Color Guard greeted 253 technologists and technicians from the US, England, Australia, Canada, and Japan. The welcome by Ruth Ochoa, LPNII, CerAT, 1996-97 ASATT President, reflected on the "waste of knowledge"—if people do not conquer the "mountain" to certification and continue the learning base to challenge another "mountain" to obtain CE/CH's.

News came from Dr. Swan, that he had a minor stroke. His physician requested he cancel all speaking engagements. ASATT sends best wishes to Dr. Swan for a speedy recovery.

The lectures to follow were full of educational value for the rookie or seasoned technologist or technician. Support from AANA was recognized as Denise Martin-Sheridan, CRNA, EdD, commended ASATT for achievements with the certification process and commitment to education, continuing education, and desire to provide quality anesthesia technologist and technician services.

Besides the outstanding lectures presented during the 2-1/2-day program, anesthesia techs were given time to interact with 28 vendors. These vendors not only gave financial support toward making this 1997 meeting a success, they showed advances in anesthesia supply and technology.

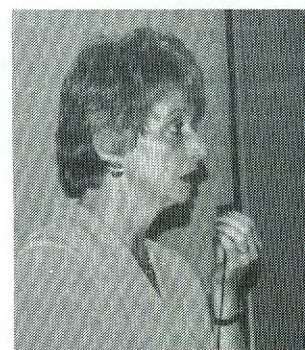
Thank you goes to Datex-Engstrom and B. Braun/McGaw for sponsoring in part the lunches. Relaxing evening wine and cheese reception Friday was sponsored by Ohmeda. Saturday night "Pool Party" was enjoyed by many who "let their hair down" and danced to the music under the stars. This was sponsored by Glaxo-Wellcome and King Systems, Inc.

Before parting as President, Ruth presented special awards. A warm smile and eagerness prevailed as Sheila White, CerAT graciously took the position as President. Sheila, along with Katrina Crist, ASATT Executive Director, answered numerous questions regarding the maintenance of contact hours for recertification. With the process new to all, many concerns and questions were sorted for reassurance. Sheila White stressed the need to learn in order to show competency. She emphasized that for individuals, as well as ASATT, to be successful, they should become involved nationally or with regional and state societies. She encouraged all to "secure the steps to success" for the future.



Newton Palmer, CerAT, Torrance Memorial M.C., CA; and Dave Mastalski, CerAT, Director, Region 7, Associate Editor, The ASATT Sensor, discuss the day's topics

Andrea M Williams, CerAT, Director, Anesthesia Technology Program, Western School of Health and Business Careers prepares her booth at the ASATT Exhibit Hall



Denise Martin-Sheridan, CRNA, EdD, AANA Liaison, addresses the ASATT membership



Samuel Ortiz, CerAT, Director, Region 4 at his laptop, behind the scenes

Enjoying the cookout by the pool (clockwise from left): Bob Reno, CerAT, Baylor, Dallas (in cap); Dave Martin and Ann Martin, CerAT, Director, Region 5; Ruth Ochoa, CerAT, President, 1996-97; Katrina Crist, Executive Director



VICKI CARSE RECEIVES JAMI BLUE AWARD

by Dean Rux, CerAT, Director, Region 6

Jami was one of the founders of ASATT. She had a dream for national certification for the profession she was dedicated to - Anesthesia Technologists and Technicians. Her dream is reality. In memory of this dedicated technician, this year's Jami Blue Lecture Series and Award presentation went to Vicki Carse, CerAT, President PSATT, for her continuing contribution and dedication in the field of anesthesia technology. Vicki works at Mercy Hospital of Pittsburgh. She has supported members with outstanding education programs that have advanced our profession and the knowledge of anesthesia technicians across the country.

As stated in her award acceptance (a quote in likeness to JFK's) "ask what you can do for ASATT, not what ASATT can do for you." With technicians such as Vicki, our society will continue to grow. Thank you for your dedication, hard work and a job well done. Our warmest congratulations!



Vicki Carse, CerAT, proudly displays the plaque naming her the 1997 Annual Jami Blue Award winner

AIME AWARDS \$1,000

by Vilma Young, President, AIME, Inc

AIME, Inc, presented its Award for Outstanding Personal Achievement to Joseph Jaslo, CerAT, of Westchester County Medical Center, Valhalla, NY, at the ASATT Annual Meeting in San Diego. The \$1,000 award was given to the person achieving the highest test score on the AIME Preparatory Exam at a Focus Certification Seminar, 1997 Series.

Joseph is a very quiet family man. He performs his duties on more of a technologist level, but feels he is not always recognized at his facility. He hopes that the plaque will change things when he hangs it in his workroom. His wife says he studied until 3am every night, but that he wasn't aware of the award. She says he just wanted to work very diligently to pass both the AIME Exam, and later the ASATT Certification Exam.



Vilma Young, President, AIME, Inc. (Alliance in Medical Education) announces this year's winner of AIME's Award for Outstanding Personal Achievement, Joseph Jaslo, CerAT

AUGUSTINE MEDICAL HONORS WAYNE GRIFFITH

by Dean Rux, CerAT, Director, Region 6

Wayne Griffith, CerAT, OR Support Service Supervisor at Athens Regional Hospital in GA, was the 1997 recipient of the Annual Augustine Medical/ASATT Clinical Excellence Award. Ruth Ochoa, CerAT, President ASATT, presented the award at the annual ASATT meeting in San Diego. An all-expense-paid (up to \$1,500) trip to the 1998 ASATT Annual Meeting in Orlando, FL accompanied the award, which recognizes excellence in research and writing in the anesthesia technology field. Wayne's article in the April 1997 edition of *The ASATT Sensor*, "Providing Anesthesia in Remote Areas" was chosen from among that year's technical articles appearing in *The Sensor*.

Wayne came up through the ranks: he was first a pharmacy tech in the Air Force. In '84, he went to Duke University where he received his anesthesia tech training. In '90 he became Research Coordinator of the Anesthesia Dept. at Oschner Medical Institution, New Orleans, where he later became Chief Anesthesia Tech. He moved to his present position in GA in Oct. 1997.



Wayne Griffith, CerAT, receives his Augustine Medical Award and a congratulatory handshake from Ruth Ochoa, CerAT, 1996-97 ASATT President

Talking to total strangers, but having that common bond of being an anesthesia technician, was so incredible. I found myself instantly "involved." There was so much to be done (and there still is) that the momentum just grabbed me, and the years have slipped by so quickly.

Now, focusing on the upcoming year and my role as President, and the commitment and motivation it will require of me, my message to each and everyone of you is: **SECURE YOUR STEPS TO SUCCESS.**

Secure your professional role as a qualified, competent anesthesia technician by increasing your knowledge base. Education is vital to our success as an organization and in reaching your personal goals. With national certification present among us, continuing education will be mandatory. But whether you choose to become certified or not, education should be something you want to pursue for YOU!

The next step, I believe, goes hand-in-hand with knowledge. Competency is what you display every minute of every day to your co-workers, the anesthesia providers, your employer, and the other numerous people with whom you come in contact. If you don't constantly strive to increase your knowledge, your competency skills will fail to progress as well. Remember, education is vital to our success.

The final step, and the one about which I feel most passionate, is involvement. There are so many levels in which a person can become involved. The favorite catchall phrase is "I'm too busy." Well, that's probably a very true statement, but so am I, as are the other nine members of the Board of Directors. We all volunteer our time and energies for a cause in which we believe and feel vehemently. I see my involvement as a means to secure my future. Are you really so busy that you are willing to ignore your future?

We, anesthesia technicians, are in an opportune position. Certification is here and JCAHO recognizes us and the role we perform in the OR's across the country. JCAHO is asking: where are your anesthesia technicians and where are their job descriptions and skills performance rosters?

So, involvement could be as simple as paying your membership dues on time, or becoming involved with one of the many committees already established. Consider offering to write an article for the ASATT Sensor, helping your Regional Director or getting more involved with your state society. The list goes on and on. ASATT is YOUR organization! All of us standing united and strong will make known our presence in the OR/Anesthesia environment. It cannot be a one-person show. **WE NEED EACH OTHER!!**

I was lucky enough to witness this bond so many times during my stay in San Diego, CA. Dean Rux and I had a goal in mind when we started planning for the 8th Annual Educational meeting 14 months ago. It was threefold:

1) Present top quality speakers who would deliver interesting, informative, and essential topics to our audience.

2) Feed the masses delicious filling meals and sweet scrumptious desserts!

3) Arrange several opportunities for the people attending to "let their guard down" and meet a great group of colleagues.

After tallying the comment sheets, it appears we were successful in achieving all our goals. We were overjoyed with all the positive comments we received throughout the weekend. We accomplished what we set out to do. Thanks to all of you who participated. It was a tremendous undertaking, and we take pride in the success of the meeting. But, we did not do this to gain recognition or to boast, we did this for you! Knowing how much everyone enjoyed themselves throughout the weekend, especially Friday and Saturday evenings, is heart-warming for both of us. On behalf of the entire ASATT Board of Directors, Dean and I thank you for attending, participating, and taking that first step toward new and lasting friendships and professional involvement.

In closing, I look forward to this year, serving as your President, and visiting with many of you as our paths cross. Remember, my door is always open! I know we have a great deal of work to do, but remember many hands make light the work!!

I hope you had a safe and wonderful holiday season.

Peace and joy!

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White or Navy with the ASATT Crest on the Front

**Prices: Short-sleeve T-shirts-----\$15.50ea
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(Please print clearly or type)

Last Name _____ First Name _____ Initial _____ Degree _____

Home address _____

City _____ State(Province) _____ Zip (Mail Code) _____

Home Phone (_____) _____ May ASATT release your name to other constituents? Yes _____ No _____

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Please check your membership category listed below and send the correct amount of membership dues in U.S. Currency

Active: \$50 _____ This category shall be extended to anyone who is employed in a health care or research facility where his/her duties are comparable or equal to the duties of an anesthesia technician, technologist, assistant or aide. This individual's duties must be supervised by an anesthesiologist, anesthetist or an individual who has been given supervisory responsibilities of anesthesia technical personnel. Active membership is also extended to any retiree who has previously fulfilled the requirements of active membership as described above. This individual must continue to show an interest in, give support to, and actively participate in continuing education in the field of anesthesia technology.

***Associate:** \$60 _____ This category shall extend to Anesthesiologists, C.R.N.A.'s, and Anesthetists.

***Individual:** \$60 _____ This category is open to anyone with an interest in the field of anesthesia technology.

***Institutional:** \$100 _____ This category is limited to academic, medical, hospital, philanthropic, science, governmental and non-profit organizations that express an interest in anesthesiology.

***International:** \$70 _____ This category is limited to any individual who is a member of an International Society of Anesthesia Technology. \$10 of this fee is designated to cover additional postage.

***Student:** \$35 _____ This category is open to students enrolled in anesthesia technology training programs that are recognized by the ASATT.

***Corporate:** \$100 _____ This category is limited to businesses and other profit orientated organizations that manufacture, distribute, provide services or otherwise have an interest in anesthesia technology.

**These categories provide all rights and privileges of active membership except holding office, chairing a committee and voting.*

Applicant's signature here to be valid _____ Date of application _____

ASATT reserves the right to verify employment and/or affiliations appropriate to the membership category requested.

There will be a \$20.00 fee assessed for returned checks.

(for official use only)	
Date application rec'd _____	Region (_____) Membership # _____
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