See you in San Diego, October 14–16 at the Marriott Mission Valley!

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YOU’VE HEARD IT BEFORE: “Accreditation … it’s on the horizon!” Accreditation WAS on the horizon! Well, ladies and gentlemen, the sun has come up and it is shining on us!

Anesthesia Technology is now a nationally recognized Health Science Discipline!

There has been much talk in recent communications with membership regarding Commission on Accreditation of Allied Health Education Programs (CAAHEP). Well, we have some extremely exciting news to share with all of you. Anesthesia Technology is now a nationally recognized Health Science Discipline! Yes, this statement did need repeating. We have been telling you, and we hope you have been listening. CAAHEP is now in the process of reviewing our Essentials & Guidelines, and the Curriculum Standards. Once these are approved, more information will be on the Website. This information will be vital for schools who are wishing to start a program in Anesthesia Technology. All future schools will need to meet ASATT Curriculum Standards.

CAAHEP has 62 sponsoring organizations and ASATT is one of them.

Accreditation along with certification and licensure is very important to the general public, as it relates to health-related disciplines. Accreditation is a way to help assure that the workforce is well prepared and qualified to provide healthcare services.

For many years you were encouraged to become certified, and to maintain that certification. ASATT is the only organization that offers this certification. NOW is the time become certified! Do not wait any longer. Our profession will start moving at a much faster pace, now. Be a part of it: GET CERTIFIED!!

As I was doing some research, I realized that the Anesthesia Patient Safety Foundation is celebrating its 25th anniversary this year, along with Malignant Hyperthermia Association of United States (MHAUS) who is also celebrating its 25th anniversary. We (ASATT) are celebrating our 21st anniversary; we have come such a long way.

Check out our New Logowear on the Website. Our Logo Committee has done a fine job selecting a very fashionable fleece vest, and a coffee mug. Items are available for purchase check the Website.

Last year at the Annual Meeting when I visited the Regional Meetings it was mentioned at several of them that attendees wanted more education on cell salvage. This year on our agenda is a two-hour Cell Salvage Workshop, along with many other interesting topics. Let us know what you would like to have lectures on, and we will try to accommodate these requests.

During my years on the Board of Directors I have said so many times that we need more members to get involved, for a while I sounded like a broken record. During this year as President, I have really found out what it takes to make all of what we do at ASATT happen. It takes eager, willing, enthusiastic people and lots of them! There are so many things that you can volunteer to do. It does not have to be a position on the Board of Directors, though that would be great to get some new faces and ideas. You can write a Science and Technology article, join one of our many committees, help pick out our newest logowear items; yes, some of what we do is fun.

It has been a rewarding year for me as far as recruiting new volunteers. Someone new has written an S&T article, others have joined committees for the first time, and some are thinking of...
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Your Anesthesia & Respiratory Specialist
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Mary McGavock, LPN, Cer.A.T
President, American Society of Anesthesia Technologists and Technicians
7044 S. 13th Street
Oak Creek, WI 53154-1429

Dear Ms. McGavock:

I am delighted to send this official confirmation that at their Annual Business Meeting on April 19, 2010, the Commission on Accreditation of Allied Health Education Programs (CAAHEP) voted unanimously to add Anesthesia Technologists/Technicians to our system. In addition, they voted unanimously to approve the membership of a new Committee on Accreditation for Anesthesia Technologists/Technician Education (CoA-ATTE) and the American Society of Anesthesia Technologists and Technicians as a sponsor of both CAAHEP and that Committee.

We welcome you to our list of 62 sponsoring organizations and very much appreciate ASATT’s willingness to sponsor the CoA. Sometime in the next two weeks we will be sending the invoices for our 2010-2011 dues (our fiscal year is July 1 through June 30).

Again, congratulations and welcome to CAAHEP!

Sincerely,

Kathleen Megivern
Kathleen Megivern, JD, CAE
Executive Director

cc: Victoria Reyes

Commission on Accreditation of Allied Health Education Programs
Aortic Stenosis (AS) is defined as a narrowing or constriction of the opening of the aortic valve which causes rigidity and leaflet distortion.

In this article, I will address the following questions with hopes my researched explanations will bring an awareness that will help anesthesia technicians better assist their providers.

- What causes AS?
- How does AS affect the left ventricle?
- What are the symptoms that patients experience with AS?
- What might the doctor find in patients with AS?
- How is AS diagnosed?
- How is AS treated?
- How does AS affect the approach an anesthesia tech uses in pre-op and the OR?

Aortic stenosis (AS) occurs in about 5/10,000 people; is more prevalent in men than in women; and is a common congenital defect that occurs in four out of every 1,000 live births in the United States. When symptoms have developed, the mortality rate increases to about 15–20%, with the average survival rate of less than five years, if not treated.

The three causes of AS are: congenital defects, rheumatic fever, and degenerative calcification. Fifty-one percent of aortic stenosis cases are congenital; either the baby’s aortic valve is narrowed or the infant is born with only a two leaflet valve (commonly referred to as a bicuspid valve). A normal valve has three leaflets or cusps. Bicuspid valves don’t open as wide as the normal three-leaflet aortic valves which results in the restriction of blood flow from your heart through the aorta and out to the rest of your body. Envision your thumb over the end of a garden hose; this increases the force of water pressure. The same principle applies here with the bicuspid valve: the increase of force creates turbulence across the valve that increases the wear and tear of the leaflets. Over time scarring and calcification reduces the mobility of the leaflets. Males dominate this condition by 75%.

The second cause of AS is attributed to rheumatic fever (46%). Rheumatic fever is a condition that developed from an untreated infection of group A streptococcal bacteria, otherwise known as strep throat. This causes inflammatory lesions in connective tissue, especially that of the heart, blood vessels and subcutaneous tissue. In time this leads to fibrosis, calcification, and fusion of the leaflets.

Degenerative calcification is the third known cause of AS (3%) and occurs... 

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Senile Aortic Stenosis is shown (bottom right). Note the heavy calcification of the three leaf aortic valve causing it to become restricted.
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A SMART ALTERNATIVE
Aortic Stenosis
continued from page 6

curs most often in adults between the ages of 60 and 70. As we age, the protein collagen in our skin is destroyed and we develop wrinkles. The same holds true with the protein collagen in our valve leaflets. This condition is more common in the elderly patients with diabetes and high cholesterol levels. The calcium deposits begin to eventually stick to the leaflets. Turbulence across the valve increases causing the scarring and thickening and constriction of mobility.

So how does aortic stenosis affect the heart pump? Symptoms develop gradually and often the patient will be asymptomatic until the valve has narrowed to half of its valve area. The heart as a pump must overcome the impedance or resistance in order to perfuse oxygenated blood throughout the body. The pressure in the pump or left ventricle increases. To compensate for the increase in resistance at the aortic valve, the muscles of the left ventricle thicken to maintain pump function and cardiac output. The muscle thickness causes a stiffer heart muscle, which increases the pressures of the left atrium and the pulmonary blood vessels. It’s sort of a vicious cycle — the left atrium pressures must increase to overcome the resistance of the mitral valve to open and fill the left ventricle. Then the same holds true — the pulmonary pressures must increase to overcome the resistance to fill the left atrium. This leads to the symptoms of aortic stenosis. Symptoms of aortic stenosis are chest pain, fainting, dyspnea on exertion and sudden death. Angina is the most common symptom and usually develops during exercise. Rest will usually resolve the chest pain. Dyspnea on exertion follows suit with the angina. Rest once again helps bring the body back to its normal state. Syncope usually occurs during exertion or excitement. The conditions cause relaxation of the body’s blood vessels (vasodilatation), lowering the blood pressure. When this happens, blood flow to the brain is decreased which causes the victim to faint. Fainting can also occur when cardiac output is decreased by an irregular heartbeat. As for sudden death, the exact reason is unknown. Heart rhythm abnormalities or inadequate oxygenated blood flow to the coronary arteries particularly during strenuous exercise, are plausible reasons. Examining the neck area is the first step in diagnosing the patient presenting symptoms. The carotid arteries perfuse the brain and are the closest arteries to the aortic valve. The neck veins may appear distended to the eye. Patients with significant AS have a delayed upstroke and lower intensity or amplitude of the carotid pulse. The physician can hear the turbulence of blood flow during midsystole with the sound decreasing and ending just prior to the second heart sound. This is called a murmur. The patient may present with signs of heart failure and an increase in blood pressure.

How is Aortic Stenosis diagnosed?
Diagnostic tests such as an electrocardiogram (ECG) will show QRS amplitude changes associated with hypertrophy. The ST-T wave changes due to left ventricular strain. Conduction deficits may be the result of a left bundle branch block. Left axis deviation and atrial fibrillation develop in late stages. A chest X-ray will be done and it would show cardiac enlargement. Calcification of the aortic valve and rounding at the apex would be present with slight backward displacement of the heart.

Later in the disease process the left atria would become enlarged, pulmonary hypertension would increase and signs of congestive heart failure would be obvious. A cardiac catheterization will also help define the severity of the stenosis. In this procedure a gradient and valve area would be determined as well as the detection any blockages in the arteries. An echocardiogram would be obtained as well, and would further verify the cardiac catheterization findings. From these studies, the patient’s valve area would be classified into one of four groupings. Normal: 3.0–3.5 cm². Mild AS: 1.0–1.5 cm². Moderate AS: 0.85–1.0cm², Severe AS: less than 0.85 cm².

Based on the criteria of severity, the patient would be treated with medical management accordingly. Mild AS patients usually have no restrictions and are usually monitored with an echocardiogram every two years. Patients with Moderate AS should avoid weightlifting and sprinting. AS can progress over a few years so an echo every 6–12 months and ECG every 1–3 years is recommended. Endocarditis is a common and serious side effect with people having AS. An antibiotic prophylaxis is recommended to be taken before any procedure that may introduce any bacteria into the blood stream, such as dental work, colonoscopies, gynecologic or urologic exams. Some examples of antibiotics prescribed are amoxicillin, erythromycin, and ampicillin, just to
Patients with critical aortic stenosis can temporarily gain relief for about 6–18 months, as the leaflets will eventually become rigid and the valve area will narrow. This procedure is for patients who are not surgical candidates and would benefit with temporary relief. Other types of patients who would benefit from this procedure are those individuals who may need a non-cardiac surgery, such as a hip replacement. Valvuloplasty improves the heart function so the patient would have a greater chance of surviving their non-cardiac surgery. Those who have survived their valvuloplasty procedure and have done well would benefit greatly with aortic valve replacement surgery.

So how does AS affect the anesthesia tech's approach for getting the patient ready for surgery? If the patient has rock or calcification on the aortic valve, one must consider the patient has rock elsewhere in the body. A gradient may be present in one arm from the other. If so, your anesthesiologist should know if the gradient is higher than 20mmHg. The physician may want the radial artery to be placed in the highest pressure of the two arms, as the physician will treat the hypertensive pressures so as not to allow the pressures to exceed a limit systolically that could potentially compromise the sutures of the new valve.

In the presence of a Left Bundle Branch Block (LBBB), the PA catheter placement can precipitate Right Bundle Branch Block (RBBB), and the patient would have an acute onset of Complete Heart Block. Having an external pacemaker unit attached to the patient or available in a moment’s notice would be prudent. If the patient has had a pacemaker placed with a defibrillator lead recently, the PA catheter can dislodge these leads. Again having the external pacemaker unit connected to the patient prior to insertion is strongly suggested.

When the patient arrives in the OR suit, just having the patient slide over onto the OR table under their own power can cause a vagal event. If the pressures fall too low, the valve will not open. Beginning CPR chest compressions will be needed. The patient may be critically severe that orthopenia is present. Placing a ramp on the OR table may help with their breathing as the anesthesia provider proceeds with the intubation process.

These are just some things to think about as an anesthesia technician. Your anesthesia provider will need you, so I hope this article will help increase your knowledge base to better assist in these procedures.

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Technology Changes as Related to Minimally Invasive Procedures

Jamie L. Wagner, Cer.A.T.
Wheaton Franciscan Healthcare
The Wisconsin Heart Hospital Campus
Wauwatosa, WI

As we all know, the world of cardiac surgery has changed drastically in the last couple of years. Not too long ago, common procedure was a sternotomy and pump run for all cardiac surgeries involving coronary artery bypass or valve repair/replacement. The transition from a sternotomy to minimally invasive procedures including thoracic incisions, or mini-sternotomy, only centimeters in length have benefited patients substantially by reducing pain, recovery times and hospital stays! Along with these technically advanced procedures comes additional line placement for the Anesthesiologist. In a traditional heart we see the placement of a Swan-Ganz catheter monitoring CVP and PA pressures, an arterial line (usually radial) monitoring blood pressure, a central line with a manifold and a peripheral IV for medication, blood product and fluid administration. Now, the Anesthesiologist places two catheters, the Coronary Sinus Catheter (EDWARDS LIFESCIENCES) and a Port Access Endovent Catheter (EDWARDS LIFESCIENCES) through the right internal jugular vein (or the left subclavian vein), and two upper extremity bilateral arterial lines in order to properly monitor the patient during these minimally invasive/robotic heart surgeries. Unlike traditional cardiac surgeries, the patient is now intubated prior to insertion of the two neck line catheters. As Anesthesia Techs our role in these cases is critical. We need to know and understand the placement of these lines and their importance for monitoring the patient. Typically there are several different Anesthesiologists that will do these cases, but we (anesthesia techs) are the common denominator. Although the physicians may change on a daily basis, we don't; Physicians depend on us for setting up, opening and prepping these lines and the patient. The purpose of this article is to increase understanding of line placement and intubation procedures for minimally invasive/robotic cardiac cases. In addition to the two catheters mentioned previously (the Coronary Sinus and EndoVent), the article also discusses other monitoring lines that will be displayed on the hemodynamic monitors, some of which are familiar to all of us, such as IV’s and arterial lines.

There are five pressure wave forms on the hemodynamic monitor in addition to ECG, Pulse Oximeter, Foley Temperature, Esophageal Temperature, BIS monitor and EtCO₂. The five pressures are Right and Left Arterial, Coronary Sinus, EndoVent (PA [Pulmonary Artery]) and Aortic Root. Therefore it is important to have five pressure mounts set up and ready to go prior to the start of the case. As far as IV’s, there are three instead of the typical two.

EndoPlege Coronary Sinus Catheter (EDWARDS LIFESCIENCES, model EP)
1. Triple lumen, 9 Fr catheter
2. Large central lumen (green stopcock) delivers cardioplegia
3. White line/lumen allows for coronary sinus pressure monitoring
4. Blue line/lumen allows for balloon inflation

EndoVent Pulmonary Catheter (EDWARDS LIFESCIENCES, model EV)
1. Double lumen catheter used to vent the PA (pulmonary artery)
2. Integrated balloon allows catheter to be flow-directed into the PA
3. Three-way stopcock allows for PA pressure monitoring
One is peripheral with blood tubing through a fluid/blood warmer. One is for the Central Line, with a manifold, also with blood tubing and through a fluid/blood warmer. This line is hooked up to the EndoVent (PA Catheter) catheter that is placed into the right IJ or left Subclavian vein. The third is for the Coronary Sinus Catheter (CS catheter), also placed in the neck via right IJ/left Subclavian. Usually blood tubing is used, but not required, as with the fluid/blood warmer. After all machine checks are complete and the room is set up, anesthesia is ready for patient arrival.

As in a traditional cardiac case, once the patient is brought into the Operating Room, all monitoring devices are attached, specifically ECG’s, Balloon Pump leads, Defibrillator leads, Pulse Oximeter and Blood Pressure Cuff. Once all of this is complete and monitoring is under way, an IV is started either by the Anesthesia Tech, or the Anesthesiologist. Some sedation is provided for the patient prior to the insertion of the bilateral upper extremity arterial lines, radial or brachial. Bilateral arterial lines are required when using the EndoClamp (EDWARDS LIFESCIENCES) (not to be confused with the EndoVent) catheter, which occludes the aorta and is used during some minimally invasive/Robotic cardiac surgeries. The EndoClamp Aortic Catheter, which has been previously set up on the pressure mount at the head of the table, is the catheter that monitors Aortic Root pressures. Arterial lines are often uncomfortable insertions for patients, which is why some IV sedation (typically Versed) is given before these lines are inserted. Once again, these lines will be placed either by the Anesthesia Tech or the Anesthesiologist. Once complete, the patient will be put to sleep and intubated before the placement of the two neck lines. In addition to being two versus one neck line, they often take longer than usual to float and as the Sinus catheter is slightly larger than a traditional Swan-Ganz catheter, it is important for patient comfort that patients are asleep and intubated before placement of these lines. In order to facilitate one-lung ventilation during the surgical procedure, intubations for these cases require the use of either a Left Double Lumen tube or an Endo-Bronchial Blocker Set. Both of these will also require the use of the Fiber Optic Intubation Scope to insure proper tube placement. After preparation of the CS and PV catheters insertion can begin.

Before the lines are placed, there are some catheter preparations that need to be carried out in a vigilant manner while maintaining a sterile environment. There needs to be a dedicated table for the introducers, and another dedicated table for the catheters. Each catheter is removed from its sterile packaging and placed onto the steriley draped table. The CS catheter is a 9 Fr triple lumen catheter that is 60cm in length and has standard depth markings beginning at 10cm. The first and second lumens allow for cardioplegia (a cold solution used to intentionally and temporary arrest or stop the heart so that surgical procedures can be done in a still and bloodless field) to be delivered and coronary sinus pres-
The Sensor

sure to be monitored. The third lumen has an elastomeric balloon (a 2 mL syringe is included for inflation) near the tip used to occlude the coronary sinus. The CS catheter comes with an 11 Fr introducer kit. The CS catheter requires flushing with 0.9% Normal Saline through the Cardioplegia and pressure lumens. The balloon lumen will be primed with a 6:1 solution (0.9% Normal Saline: Omni-paque dye). It is important that all lumens of the CS catheter are de-aired. In addition to flushing of the CS catheter, all stop-cocks on all ports of BOTH catheters need to be tightened. The Port Access EndoVent pulmonary catheter (PV catheter) is a double lumen 8.3 Fr catheter that is 70cm in length. One lumen is for measuring pressure and the other lumen has a balloon on the proximal tip. The PV catheter also comes with a 9Fr introducer kit. The EndoVent catheter assists in decompressing the heart in an operative field by draining the pulmonary artery. Unlike the CS catheter, the PV catheter’s balloon is NOT primed with ANY liquid. Like a Swan-Ganz catheter, the balloon is inflated with air. The pressure lumen is flushed with 0.9% Normal Saline. Although similar to the Swan-Ganz catheter in insertion and pressure monitoring, the PV catheter does not monitor SvO₂ or temperature. Having said this, it is very important that an esophageal AND a Foley temperature probe are placed. In addition to catheter preparation, it is equally important to ensure that the patient is also prepped accordingly. Using a chlorohexadine prep solution, the neck is prepped from the inside out in the appropriate area (right IJ/left subclavian). In order to properly maintain a sterile field, a thyroid drape is used to cover the patient from head to toe, allowing plenty of room for the physician to work while maintaining sterility. The Anesthesiologist and the Anesthesia Tech wear a sterile gown and gloves. Because Fluoroscopy will be used in aiding the insertion of these catheters, it is important that a lead apron be worn underneath the sterile attire, as well as, a lead drape protecting the patient from the waist down. The Anesthesia Tech will now be able to assist the Anesthesiologist with all instrumentation used in order to successfully place the CS and the PV catheters. Both introducers are placed before either catheter is inserted. The placements of these introducers are the same as

Who’s Who

What is your current position?
Anesthesia coordinator.

How many years have you been in the anesthesia field?
20 years.

What do you find the most challenging about your job?
It is always something new and different every day.

What secret vice can you confess?
Can’t think of any.

What has been your proudest accomplishment so far in life?
Being married for almost 30 years and raising two wonderful sons.

What is your favorite food?
Brownies or chocolate chip cookies.

People would be very surprised to know that:
I am a master gardener and in charge of health ministry for my church.

You have just won your dream vacation.
Australia and New Zealand.

If a magic genie could grant you one wish what would it be?
World peace.

It’s your day off: what do you enjoy doing with your time?
Being at my home and working on projects.

What is your favorite type of music?
Rock and roll.

What is your favorite movie?
Rocky.

What would you like to get around to doing one of these days?
Organizing my pictures.

What goals, expectations or changes do you foresee being accomplished by ASATT?
More structured training.

Who has been the greatest influence on your career as an anesthesia technician?
Our MDs and CRNAs.

What was the best seminar you’ve been to as an anesthesia technician?
The Chicago meeting a few years ago.

What was the best presentation?
I enjoyed Dr. Troop's presentation on the intubation pillow.

Dorothy Rippe, Cer.A.T.
placing a regular 9 Fr introducer for a traditional cardiac surgery, with the one difference being that there are two. Usually, the PV catheter introducer will be more proximal than the CS catheter introducer, as the CS catheter is floated before the PV catheter. This sequence avoids having to reach over the open PV catheter introducer; however, it is a sterile field and the introducers can be placed in the opposite manner as well.

The first of the two catheters to be inserted is the Coronary Sinus Catheter. There are two types of CS catheters, Steerable Coronary Sinus Catheter (EDWARDS LIFE SCIENCES) and Endo-Plege Sinus Catheter (EDWARDS LIFE SCIENCES) (nonsteerable). Ironically the nonsteerable CS catheter is more commonly used and easier to place. In other words, it is the preferred catheter. This catheter is placed into the coronary sinus via right IJ or left subclavian vein. Prior to placement Anticoagulant therapy (5,000 units heparin) must be administered to the patient. In order to assure proper placement of this catheter there are a combination of three different methods used.

The first, and most important, of these three is Trans Esophageal Echocardiogram (TEE). TEE gives the Anesthesiologist a visual guide to the insertion of the CS catheter by means of ultrasound of the heart from the Esophagus. A bicaval view is needed on TEE in order to visualize the CS catheter. Once the proximal end of the CS catheter has been introduced about 20cm, the image (a black line) should appear on screen. At this point the physician will be able to guide the CS catheter into the Coronary Sinus by means of TEE. The second method is Fluoroscopy (a live image under x-ray). Similar to TEE, Fluoroscopy gives the physician a visual guide to the placement of the CS catheter on a monitor displaying a live moving image of the patient’s heart. Fluoroscopy reveals the catheter tip position relative to fluoroscopic landmarks. At this time, one can now understand why it is necessary to have the balloon primed with a diluted dye solution. Once the physician feels that the CS catheter is in the Coronary Sinus, the balloon (containing a 6:1 solution of Sodium Chloride 0.9%: Omni-Paque dye) is inflated and 100% Omni-Paque dye is injected through the proper lumen of the catheter. The last method of proper placement is watching the pressure wave form on the hemodynamic monitor. When the CS catheter is placed properly, a wave form will appear on the monitor when the balloon is inflated. Like a traditional Swan-Ganz Catheter, on average, the Right Atrium is at about 25-30cm, and it is important to know that typically proper placement into the Coronary Sinus occurs when the catheter is around 37-42cm. Once proper placement is confirmed, the CS catheter’s sheath is released in order to cover steriley the remaining length of the catheter. The CS can be locked into place. Once locked, the CS catheters’ cardioplegia lumen is flushed with a Heparin (1000 units) NaCl 0.9% (100cc’s) solution in order to prevent crystallization within the lumen by the Omni-Paque dye. Now the PV catheter may be inserted.

The PV catheter is the less complicated catheter of the two to insert. The insertion is very similar to floating a Swan-Ganz catheter. Although not necessary, Fluoroscopy is often used to guide the insertion of the PV catheter. Once the catheter is inserted 20 cm in the balloon is inflated and inserted at 10cm intervals going through the Right Atrium, the Right Ventricle, and subsequently into the Pulmonary Artery. The balloon is dropped when the PV catheter is in place, usually at about 40-50cm. As the CS catheter and PV catheter are required for some minimally invasive/robotic cardiac surgeries, proper placement and function of these catheters is an essential task in order to successfully begin the surgery.

An important thing to keep in mind is this. Although technology has advanced the world of cardiac surgery, complications may occur. Each and every patient’s anatomy, although relatively the same, has some variations that feed into the decision making process. Not every candidate needing cardiac surgery will qualify for minimally invasive/robotic surgery. A patient’s history and physical, current health conditions and many other factors will play a very important role in the decision as to whether or not this type of surgery will benefit the patient more than a traditional surgery. Each and every day there will be new aspects of cardiac surgery, along with new technological advances that we will gain through research and surgical practices. This is what keeps our jobs so exciting! Every day that we learn something new to benefit others ... it is a great day!

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www.edwards.com/products/portaccess/endopchendoclampao.htm
2010. Edwards Lifesciences LLC. 11 February 2010
Hope you all are enjoying the summer. Make sure if there is someone you would like to see get the Regional Educational Award that you nominate that individual. It can be for anyone who has gone above and beyond in the field of lecturing and/or providing education for the Anesthesia Technicians. I want to extend my thanks to Quentin Letson for taking on the task of setting up the Region 1 Meeting in Atlantic City, NJ. It was a huge success and I certainly hope that if you went that your expectations were met. By the time this report is posted the other meeting in Region 1 in Nashua, NH will be done. I also want to thank Kathy Duprey for setting this meeting up; it was a huge help. If you think that you would like to help with meetings for next year, now would be the time to start thinking about it and letting me know. Hope you all are having a wonderful and safe summer.

Also do not forget to start making your travel arrangements for the Annual Meeting in San Diego. We do not want you to miss out on the Annual Meeting. For more details, go to the main page on our Website and look into the hotel and area recreation. Hope to see you there!

Welcome, Region 4 members, to our final “hard copy” of The Sensor.
Our Region 4 Conference was held April 17th at Gunderson Lutheran Medical Center in LaCrosse, WI. We had a good turnout from ASATT members and also some non-members

BYLAWS UPDATE . . . THE VOTING RESULTS ARE IN!

During the business meeting of the 2009 ASATT Annual Educational Conference, proposed revisions of the current ASATT Bylaws were presented to the members in attendance. Not long after, the ASATT website served as the information provider and voting location for all active ASATT members to read about the proposed revisions, then cast a vote as to whether the changes should be accepted or rejected. It is now official with the voting results determining the decision to accept the proposed revisions to the ASATT Bylaws. Please look for the changes to be made to the Bylaws that are posted on the ASATT website link.

The Board of Directors would like to thank the members of ASATT who participated in this important decision making process. The strength of ASATT is ensured by the dedication and perseverance of the members in the society!
who hopefully will be joining us soon after seeing what ASATT has to offer. I want to personally thank everyone who attended and extend a big “thank you” from all the company vendors that were in attendance or contributed to the meeting. They all commented to me how nice it was that attendees really made an effort to visit with them to see what they had and that everyone thanked them for coming and helping to support ASATT. They were so impressed by that. They all asked when and where our meeting for next year will be. They are already planning to exhibit at next year’s meeting.

Make your plans now to attend the National Conference in San Diego in October. There is still time to register and make hotel and transportation arrangements to get the best deals.

One final reminder to everyone: Please consider nominating someone who has made a difference in furthering your education in the field of anesthesia for the Region 4 Educational Award to be presented in San Diego in October. Nomination forms are available on the ASATT Website or use the form included in this issue!

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REGION 5


Director: Joey Herrera, Cer.A.T.T.
Cell: 832/202-7231
E-mail: joeyherrera@rocketmail.com

Dear ASATT Region Five Members,

I would like to take this opportunity to express my heartfelt thanks to you for your very active participation in our recent conference in Houston — the ASATT Region 5 Conference on June 12, 2010. As Region 5 Director, I also want to express my sincere appreciation for the strong support I received from the MD Anderson Cancer Center Anesthesiology Department. Dr. Rahlf, our ASA liaison to the ASATT, served as our Program Director at this conference and with his dedication to the organization of the ASATT Region 5 2010 Education Conference and his strong support to the enhancement of knowledge and skills of the anesthesia technologist and technicians, we were able to have a successful conference.

On a personal level, I really appreciated the time that we had at the Friday Night Dinner for the meet and greet sponsored by Edwards Lifesciences. Thanks to Sharla and Kathleen for supporting this successful event.

I also want to thank all the vendors that participated on Saturday, June 12th. The exhibit show was a success, we had over 12 companies exhibit their products and we were able to spend time and meet with our vendors throughout the day. I cannot say it enough: Thank you all for taking the time on a Saturday to come out and spend it with our organizations.

I look forward to next year, working together with all our sponsors for their continued support in making next year’s conference a success.

Again, thanks so much for your enthusiastic participation in our conference. I have no doubt that it would not have been the success that it was without your presence.

---

REGION 6

AZ–CA–NM–NV–UT

Director: Victoria Reyes, Cer.A.T.
Work: 626/564-3018 • Fax: 626/851-7204
E-mail: victoria.a.reyes@kp.org

I am writing this right after the completion of the Region 6 meeting in Salt Lake City. As before, the site was just beautiful, the weather lovely and the attendees, smart, attentive and enthusiastic. I would like to thank the University of Utah for supporting a great program.

We were lucky enough to have two past-presidents at the meeting. We had some technical glitches and a cancellation during the program, but as always it seems to come together. We had a former speaker in attendance who volunteered to speak and in the end everyone got the CEs and information they came for. Thank you, Tony!

As you probably all know by now the Annual Meeting will be in Region 6 this year, in San Diego. We are working on a great selection of speakers and taking the meeting in some new directions, which should keep everyone interested. San Diego is a beautiful and vibrant place. The meetings are not on the West Coast often, so this is a great opportunity for Region 6 members to attend a national meeting.

Hope to see many of you there!

---

REGION 7


Director: Delbert Macanas, Sr., Cer.A.T.
Work: 808/547-9872 • Fax: 808/547-9247
E-mail: d.macanas@kuakini.org

Howzit Region 7!!

We had a great meeting at Oregon Health Science University Hospital in Portland on Saturday, April 17th. Shannon Sayers-Rana did an outstanding job organizing and...
As the meeting. OHSU is impressively set on the side of the mountain overlooking the river and city. The view is spectacular and the aerial tram ride is fabulous. We must thank the Anesthesia Department at OHSU for being such a gracious host for the meeting.

The 48 members who attended the meeting were treated to a very educational day. We need to thank all the great speakers and supportive vendors. The following was the agenda: Electrical, Fire, and Laser Safety by David Orlando BMET & Greg Nightingale BMET; Central Line Placement by Mary Quinlan Thomas, RN; Hemodynamic Monitoring by Dr. Clayton Horan; Patient Management in High-Risk Surgical Patients by John Frazier, RN; Video Airway Management by Dr. Michael Aziz; Cell Saving by John Rivera; and Ultrasound-Technical Tips for Regional Anesthesia by Mark Gilbert, M.D. Again, thank you vendors for supporting our meeting.

As we begin summer, there are two items to consider: Regional Education Award and the Executive Board Elections (President-elect, Secretary and Treasurer). The deadline for the Education Award is July 30th. I would like to have multiple nominations to select from. As I have said before, look around — there must be a worthy candidate; this person maybe your coworker or a salesperson. This person will be someone who has helped you and your peers learn about our exciting world of Anesthesia. The second is elections; the Region 7 Director position will be open in 2011. Voting is done online. It will not take too much of your time, and you will have your input as to who you want to guide our great association. There are a number of exciting things going on and we want to continue the momentum that we have. ASATT must persevere and move forward.

The Hawaii meeting is set for Sunday, August 8th at Hilton Prince Kuhio Hotel in beautiful Honolulu (one block from world famous Waikiki Beach). I am still finalizing the agenda and may have a slot open. Those who live in Hawaii, please check with your favorite physicians and/or speakers, to see if they would like to share their knowledge by presenting a lecture. Also, please contact your vendors about attending/sponsoring our meetings. As you all know, without their support we would not be able to have these meetings at reasonable rates. Talk to the sponsors now, before they commit their funds to other worthy organizations or efforts. The registration flyer will be posted on the Website shortly … keep an eye out for it. Also, members in Region 7 will receive a blast e-mail as a reminder.

The Anesthesia Technician program at North Seattle Community College has started. Contact Aaron Nelson if you have any questions, at AFNelson@scdc.ctc.edu.

You still have time to plan to attend the Annual Educational Conference and Business Meeting in San Diego. It’s a beautiful city with many different things to do and places to see. The downtown San Diego area has gone through many changes since the ASATT meeting was held there. We may be staying on the outskirts of the city at the Marriott Mission Valley; there will be complimentary public transportation passes for all registered participants. The early bird specials are running out, so the sooner you decide, the cheaper the meeting will be. These rates are for ASATT members only.

Check out the Internet: The Marriott looks like a great place to stay, with good reviews. Make plans to join your peers, make new friends, network, and learn. The Annual Meeting will not be back on the West Coast until 2013 in San Francisco. Look at airfares … they will still be fairly low and will rise as the meeting gets closer. Further, we have a block of rooms at the hotel and once this block is exhausted you will have to look for another place to stay. Traditionally, you have been able to get up to 13 CEs at this meeting. The planning committee is working hard to finalize the program. If you attend one Regional Meeting and the Annual Meeting, you will fulfill all of your requirements to recertify as an Anesthesia Technician in one year. The bonus: You don’t even have to track these ASATT sponsored meetings.

Recertification: Start planning for recertification — it’s only a few months away. Check the database; if you do not have enough CEs, do not wait until December ... it’ll be too late. I would like to see the Recertification Committee have a problem-free recertification period. Desperate people do desperate things. This is when people submit questionable CEs that results in unfavorable decisions.

Adopt the 10% Rule — set a personal goal to improve everything you’re involved in by merely ten percent. Small improvements add up quickly.

— Eric Harvey & Al Lucia

Aloha! ✌

ASATT says goodbye to the hard copy edition of The Sensor!

The 2008 Board of Directors voted to reduce costs and “go green” by reducing the hard copy version of The Sensor to two hard copy issues and two online issues. Following in the footsteps of other professional health organizations, the 2009 Board of Directors agreed that beginning with the Fall 2010 issue, all future editions of The Sensor would be available to ASATT members online, as a PDF file, to read online or download. ASATT has certainly seen its share of “firsts” and while we certainly are excited to make use of the technology available to us, I know we all will miss looking forward to receiving The Sensor in our mailbox.
REGIONAL EDUCATION AWARDS

T HIS YEAR MARKS THE TENTH ANNIVERSARY of the ASATT Regional Education Awards. Regional Directors are soliciting their members to nominate someone in their Region that has genuinely contributed to promoting and furthering the Continuing Education of anesthesia technicians. Has someone . . .

— helped you or a group of technicians gain valuable knowledge in the field of anesthesia technology?
— volunteered their time to provide quality lectures for continuing education credits?

ASATT would like to pay tribute to those individuals who are not required or paid to advance the education of ATs, but whose sincere interest promotes education in our specialty. If you were able to associate a name to either one of those questions, show your appreciation by taking a few minutes of your time to complete and submit the nomination form form below.

The annual plaques will be presented to recipients in each of the ASATT Regions during the business meeting held on Saturday, October 16, 2010. The plaque recognizes the continued dedication in sponsoring, promoting and furthering education programs, thus advancing professionalism among the anesthesia technologists and technologists within each of the ASATT Regions. It also acknowledges continued support of the American Society of Anesthesia Technologists and Technicians.

As a member of the Society, you may nominate a person, facility or company who in your judgment has sponsored, promoted or furthered Continuing Education Programs thus advancing the professionalism among the anesthesia technologists and technicians within your ASATT Region.

• This award is given in recognition of continued dedication in sponsoring, promoting and furthering education for anesthesia technicians.
• Seven awards will be presented each year at the Annual Business Meeting — one award for each Region.
• Recipients will be nominated in each Region by the membership.
• Nominations will be sent to each Regional Director.
• The final selection in each Region will be made by the Regional Director and the President and/or the President-Elect.
• Recipients will be awarded a plaque at the Annual Business Meeting.

CRITERIA FOR NOMINATIONS:

• Nominees must live and work in the Region in which they are nominated.
• Nominees must sponsor, promote or further education for anesthesia technicians in their Region.
• Nominations can be for an individual, a facility or a company.

REGIONAL EDUCATION AWARD

NOMINATION FORM for 2010

I would like to nominate the following person, facility or company located within my ASATT Region:

Name____________________________________________________________________ Region No. ___________
Address _________________________________________________________________________________________
City___________________________________________________________ State______ ZIP Code ______________

Please explain why you feel the above person, facility or company is qualified for this award. Qualifications:
_______________________________________________________________________________________________
_______________________________________________________________________________________________
_______________________________________________________________________________________________
_______________________________________________________________________________________________

Your Name__________________________________________________ ASATT Member Number _______________
Address _________________________________________________________________________________________
City___________________________________________________________ State______ ZIP Code ______________

Nomination forms must be received at ASATT Headquarters no later than Friday, July 30, 2010.
Send your nomination to ASATT Headquarters and it will be forwarded to the Regional Director.
ASATT ~ 7044 South 13th Street ~ Oak Creek, WI 53154-1429
Advancing Patient Safety and excellence in anesthesia is the mission of the AANA. A safe anesthetic environment is basic to promoting patient safety, and a key component of that environment is the anesthesia delivery and monitoring equipment upon which anesthesia providers rely. Anesthesia technologists and technicians provide critical technical support for acquiring and keeping this equipment running safely and efficiently. Their role is described by the American Society of Anesthesia Technologists and Technicians (ASATT) as “assisting licensed anesthesia providers in the acquisition, preparation and application of the equipment and supplies required for the administration of anesthesia. In this role, they contribute to safe, efficient and cost-effective anesthesia care. Anesthesia technicians and technologists provide support in anesthesia for routine and complex surgical cases. They provide this service by preparing and maintaining patient monitoring devices and anesthesia delivery systems before, during and after anesthesia.” (www.asatt.org)

The ASATT is the national professional membership organization for people in the field of anesthesia technology. Founded in 1989 with a charter membership of 100, the ASATT currently has more than 1,000 members. CRNAs can join as associate members. The ASATT has defined scope and standards of practice, a certification/recertification process, and examinations that delineate three levels of practice: anesthesia technician, certified anesthesia technician, and certified anesthesia technologist. These roles are described in detail on the ASATT website at www.asatt.org/sop.html. Through the years many AANA members provided consultation and guidance as the original technician and technologist certification examinations were developed. This is a process that continues to this day with CRNA representation on the ASATT Certification Test Development and Test Writing Committee.

The AANA also provides a liaison representative to the ASATT Board of Directors. Sue Christian, Cer.A.T.T., a past president of the ASATT, has this to say about past and current CRNA liaison representation on the ASATT Board: “We value the support of the CRNA liaison and their time commitment to our organization. They have helped to steer our continued success in unchartered waters.” Pudwill agrees, “Through this process we have been able to assist them as they evolved into a strong and viable association.” The current liaison representative is Jerry Coy, CRNA, PhD, who states that, “the AANAs association with the ASATT is paramount” as they continue to develop this important role.

Future Directions

With the national certification/recertification program established, the ASATT is looking to the future as it addresses the educational needs of the technician and technologist roles. Christian notes that CRNAs have been instrumental in education for the technician and technologist roles. Initially, the AANA helped develop training guidelines that could be used as a reference for both in-house and free-standing programs. Recently, the ASATT has begun examining how it can support structured, formal, community-college-based educational programs. Through the board liaison role, the AANA continues to help the ASATT address issues related to both basic and continuing education. Coy elaborates that, “Our assistance to them as a profession will help them move from mostly OJT (on the job training) to a formal educational model of training.” Christian agrees, “The AANA continues to provide the support and endorsement that will be needed to obtain recognition as a health sciences discipline.”

The AANA influence extends through state associations of nurse anesthetists, many of whom welcome anesthesia technicians and technologists to their meetings and continuing education programs. Past AANA Board action has encouraged state associations to develop policies for nonmem-
ber attendance at state meetings. Information about meeting and continuing education opportunities available through the AANA is posted on the ASATT website with a link to the state associations of nurse anesthetists on the AANA website.

A Winning Relationship

It is apparent that the AANA involvement with the ASATT has fostered a spirit of collegiality that has been a win-win situation for both groups. Christian thinks that CRNAs have helped promote awareness of the role throughout the healthcare field, and she attributes their success to “CRNAs promoting the role.” Pudwill feels that, as a result of the long-term relationship between the two organizations, “Each of us has gained a heightened understanding and respect for the other.” Coy clearly sees the role of technicians and technologists as complementary to that of the CRNA. He states, “They are not there to compete in the healthcare arena; they are there to make our jobs more efficient and enjoyable.”

The ASATT exhibits at the AANA Annual Meeting – please stop by and introduce yourself, learn more about the role, and thank them for the assistance they provide in making anesthesia care safe and reliable for our patients!

The Marriott Mission Valley in San Diego will be the host venue for the 21st Annual ASATT Educational Conference, October 14–16, 2010.
Parker Laryngeal Mask Device

Finally a disposable that feels like a reusable!

The smooth contouring of our 100% medical grade silicone device enables easy insertion, is gentle to the airway, and is designed to produce an effective seal.

The unique color-coded and printed pilot balloon allows for fast and correct size identification.

The clear 15mm connector allows a potential blockage to be seen.

Latex-free & DEHP free

Tracheal Tube Introducer

Curved

Straight

Malleable

This disposable Eschmann-style “bougie” is used to guide the endotracheal tube during difficult intubations. The tube slides over the introducer which helps to guide the way, especially helpful for “blind” intubations.

The purple malleable “bougie” allows you to form it into any shape desired.

Available in adult and pediatric sizes.

SHARN INC. ANESTHESIA

Call for more information 1-800-325-3671
The Anesthesia Tech day cake was presented to the Anesthesia technicians at Memorial Hermann Hospital Texas Medical Center.

On March 31st, the anesthesia technicians at MD Anderson Cancer Center in Houston, TX were recognized by their department with a catered lunch. To show their support of the anesthesia technicians, the providers assembled a display with quotes to show their support of the profession.

The anesthesia techs at Mercy Hospital, Pittsburgh, PA received flowers and were treated to a delicious catered lunch.

Photos by Tonja Thompson, Cer.A.T., Supervisor Anesthesia Services, MD Anderson Cancer Center in Houston.
21st Annual ASATT Educational Conference
Marriott Mission Valley ~ San Diego, California
October 14–16, 2010

SCHEDULE OF EVENTS

Thursday, October 14
1530-1800…..Early Registration
1600-1800…..Exhibits Open
1600-1800…..Welcome Reception and Cash Bar

Friday, October 15
0600–0700…Registration / Continental Breakfast / View Exhibits
0700–0715…Welcome / Announcements
0715–0815…Brainsuite — Thomas Rahlfs, M.D.
0815–0915…Simulation Labs — Jeremy Heiner, CRNA, MSN
0915–0945…Break / View Exhibits
0945–1045…APSF Medication Safety — Shannon Sayers-Rana, Cer.A.T.
1045–1145…CO₂ Absorbers — Mike Holder sponsored by Intersurgical, Inc.
1145–1300…Lunch / View Exhibits
1300–1500…Workshop for Drager Anesthesia Machines
1300–1500…Workshop for GE Anesthesia Machines

Saturday, October 16
0600–0700…Registration / Continental Breakfast / View Exhibits
0700–0715…Welcome / Announcements
0715–0915…Cell Saver Workshop Haemonetics
0715–0915…Cell Saver Workshop Medtronic
0915–0945…Break / View Exhibits
0945–1045…Ultrasound workshop SonoSite
0945–1045…Utrasound workshop GE
1045–1145…Infection Control, TBA
1145–1300…Lunch / Business Meeting
1300–1400…Endovascular Aneurism Repair — Sassoon Elisha, CRNA, Ed.D
1400–1500 …Liver Transplant TBA
1500–1530….Regional Meetings

Program subject to change.
Go online for most current program
www.asatt.org

EXHIBIT DATES CHANGED FOR THE ASA ANNUAL MEETING!
ANESTHESIOLOGY 2010 is being held October 16-20, 2010 at the San Diego Convention Center with new dates for exhibits. The new dates and times are:
Saturday, October 16 ..... 9 a.m. to 4 p.m.
Sunday, October 17 ........ 9 a.m. to 6 p.m.
Monday, October 18 ....... 9 a.m. to 3 p.m.

American Society of Anesthesiologists
Get More Bang for Your Buck in Sunny San Diego!!!

21st Annual ASATT Educational Meeting
San Diego Marriott Mission Valley

ASATT conference registrants who register with Marriott will receive:

- $165.00 single/dbl room rate
- Complimentary 24-hour unlimited trolley pass for each attendee
- “Wired for Business” included with each room
- High Speed Internet and unlimited local calls
- Private Balcony in every room
- Complimentary Health Club
- Hotel Restaurant and Lounge: Cafe Del Sol & Cantina Del Sol
- Heated Outdoor Pool in a Tropical Courtyard Setting
- Sun Bathing Deck – Jacuzzi – Whirlpool – Sauna
- Private Poolside Cabana available for rental
- Adjacent to the San Diego River two-mile Jogging Path
- Self-parking $14/day

10 minutes from Airport: Xpress Shuttle offers a discounted rate of $12.00 per/person, each way

San Diego Trolley stops directly behind hotel, providing easy access to shopping, dining options, movie theaters, downtown San Diego, Seaport Village and just a short ride to Tijuana!

The Marriott is located within one mile of San Diego’s largest outdoor mall, more than 200 stores, specialty shops, restaurants, movie theaters, and Riverwalk Golf Club!

See You in San Diego!

October 14-16, 2010 at the beautiful Marriott Mission Valley
To test your knowledge on this issue’s Science and Technology article on page 6, provide correct answers to the following questions on the form below; follow the instructions carefully. Submissions for this issue’s Quiz expire December 31, 2012. Achieve 100% in this quiz to earn one (1) Continuing Education credit.

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Rheumatoid arthritis is a known cause of aortic stenosis.</td>
<td>□ True □ False</td>
</tr>
<tr>
<td>2. A patient with a valve area measuring 0.85–1.0cm² would be considered to have/be:</td>
<td>A. Mild AS C. Normal B. Severe AS D. Moderate AS</td>
</tr>
<tr>
<td>3. Symptoms of AS include all of the following except:</td>
<td>A. Chest tightness B. Shortness of breath on exertion C. Fainting D. Shortness of breath when resting</td>
</tr>
<tr>
<td>4. The most common cause of AS in patients 60 and older is:</td>
<td>A. Congenital heart defect B. Calcium deposits on the valve C. Rheumatic fever as a child that went untreated D. Endocarditis</td>
</tr>
<tr>
<td>5. The advantage to receiving a mechanical valve is that:</td>
<td>A. It lasts longer B. Does not require the use of anticoagulant medication therapy C. Does require the use of anticoagulant medication therapy D. A &amp; B are correct E. A &amp; C are correct</td>
</tr>
</tbody>
</table>

To apply for Continuing Education/Contact Hours:
1. Provide all the information requested on this form.
2. Provide the correct answers to this issue’s quiz in the box (right)
3. Mail this form along with $5.00 (check or money order, payable to ASATT) to:
   ASATT
   7044 South 13th Street
   Oak Creek, WI 53154-1429
### Continuing Education Quiz

To test your knowledge on this issue’s Science and Technology article on page 10, provide correct answers to the following questions on the form below; follow the instructions carefully. Submissions for this issue’s Quiz expire December 31, 2012. Achieve 100% in this quiz to earn one (1) Continuing Education credit.

<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
<th>Correct Answer(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Of the three methods used to guide proper placement of the Coronary Sinus Catheter, which one is the most effective?</td>
<td>A. X-ray C. TEE B. Fluoroscopy D. Pressure waveform</td>
<td>C. TEE</td>
</tr>
<tr>
<td>2. What does the Coronary Sinus Catheters’ heparin/NaCl 0.9% flush prevent from happening?</td>
<td>A. Blood clots B. Wave form interference C. Crystallization of the Omni-paque dye D. None of the above</td>
<td>B, C</td>
</tr>
<tr>
<td>3. The balloon in the Sinus Catheter contains a contrast solution of 6cc Omni-paque dye: 1cc NaCl 0.9%.</td>
<td>True False</td>
<td>False</td>
</tr>
<tr>
<td>4. When required, what are the five pressure wave forms that are displayed on the hemodynamic monitor?</td>
<td>A. Left Arterial Pressure, Right Arterial Pressure, Aortic Root Pressure, Pulmonary Arterial Pressure, and Coronary Sinus Pressure B. Left Arterial Pressure, Right Arterial Pressure, Aortic Root Pressure, Pulmonary Arterial Pressure, and Central Venous Pressure</td>
<td>B, C</td>
</tr>
<tr>
<td>5. The patient is asleep and intubated prior to the placement of the Coronary Sinus and the EndoVent Catheters for the following reason(s).</td>
<td>A. Length of time it takes to place the catheters B. Comfort level for the patient C. Use of TEE for catheter placement D. All of the above</td>
<td>A, B, C</td>
</tr>
</tbody>
</table>

**To apply for Continuing Education/Contact Hours:**

1. Provide all the information requested on this form.
2. Provide the correct answers to this issue’s quiz in the box (right)
3. Mail this form along with $5.00 (check or money order, payable to ASATT) to:
   ASATT
   7044 South 13th Street
   Oak Creek, WI 53154-1429

The answers to the Summer 2010 “Continuing Education Quiz” are:

1: A B C D
2: A B C D
3: T F
4: A B
5: A B C D
PLEASE PRINT CLEARLY

Name_____________________________________________ E-mail ___________________________________

Street Address _______________________________________________________________________________

City_____________________________________________________ State_______ ZIP Code _______________

Phone  (home)__________________________________ (work) _______________________________________ 

ALL WEARABLES ARE MACHINE-WASHABLE

Fleece Vest: Camel brown with embroidered ASATT logo
   ____ M   ____ L   ____ XL .......................................................... $30.00  $____________
   ____ XXL .................................................................................. $32.00  $____________

Baseball-Style Cap: Blue washed denim-look, embroidered logo on front
   One size, adjustable.......................................................... $16.00  $____________

ASATT Mugs ........................................................................ $10.00  $____________

ASATT Bumper Sticker .......................................................... $ 1.00  $____________

Cer.A.T. Patch ....................................................................... $ 5.00  $____________

Cer.A.T. Pin ........................................................................ $ 8.00  $____________

SUBTOTAL $____________

Postage/Handling:
   on orders $25 or less . . . $ 5.00
   on orders $26-$40 . . . $ 8.00
   on orders $41-$60 . . . $10.00
   on orders $61 or more . . . $15.00 $____________

TOTAL AMOUNT DUE $____________

Credit Card:  □ MasterCard  □ Visa

Card Number___________________________________________ Exp. Date_____/_____  CCV __________

Name/Address for Credit Card (if different from above) ________________________________________________

Signature _________________________________________________________________________________

Rev. 06/10
Anesthesia Roll Labels

Specialty Anesthesia Labels are color-coded and imprinted with the drug name to help prevent medication mixups, and to provide an economical, easy-to-use identification system for anesthesia syringes. As soon as the drug is drawn into the syringe the label is affixed to the syringe barrel. The syringe may then be left in the drug bottle or removed, whichever procedure is normally followed. The labels have pressure-sensitive backing that sticks to the syringe surface for as long as is necessary. Each label names the drug in bold letters and provides space for additional handwritten information.

Specialty Anesthesia Labels are supplied 500 per roll.

Peach Clip

Heavy duty clamp is designed to secure drapes to drape stands, IV poles, etc. Can be used for a variety of clamping needs. Washable, does not rust.

Size: 1-7/8" wide x 2-3/4" long
June 2010
2010-2011 Membership Renewal began ........................................................June 30

July 2010
Online voting for ASATT Board Elections began.............................................July 5
Region 2 meeting, Akron, OH .........................................................................July 24
Deadline for Regional Educational Awards ...................................................July 30
Membership Dues expire ................................................................................July 31

August 2010
Region 7 meeting, Honolulu, HI ...................................................................August 8
Last day for online voting of ASATT Board Elections .................................August 16

October 2010
2010 ASATT Annual Meeting, San Diego, CA ........................................October 14–16
ASA Exhibits .....................................................................................................October 16–18

November 2010
Recertification renewal begins ......................................................................November 15

December 2010
2010 Recertification expires ..........................................................................December 31