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ASA 9TH ANNUAL MEETING

Image © Carl Purcell, New Orleans CVB

The ASA Advisory Committee has been planning a full agenda for participants of the ASA 9th Annual Meeting that will occur on Wednesday, May 23, in New Orleans from 8 am to 5 pm, one day prior to the official beginning of the 38th AST Annual National Conference.

For the first time, afternoon presentations will incorporate hands-on opportunities for advanced practitioners.

Four companies have been invited to share information, equipment and technologies with the audience of advanced practitioners. The afternoon venue will feature a series of four stations that will offer participants timed sessions for learning and observing. All participants will rotate among the four stations in order to hear all the presentations and share the different learning experiences.

The four invited companies include: Ethicon Endosurgery, Medtronic, Smith & Nephew and Zimmer Spine. The presentations will begin at 1:30 pm after lunch. The program will conclude at 5 pm.

The morning agenda is included below. Please note that a reception will be held on Wednesday evening beginning at 6 pm

Additional changes to the schedule are possible and any alterations will be announced in the next newsletter and in the AST *Journal* and on the ASA website.

Seven continuing education credits will be awarded. Fees for members are $235; fees for nonmembers are $335. *(Registrants must also be registered as conference attendees).*

8-8:50 am	*GYN Updates and the Surgical Assistant* **Jeffrey Marcus,** MD
9-9:50 am	*Minimally Invasive Spine Surgery* **Ron Voorhees,** MD
10-10:50 am	*Unicondylar Knee Replacement, Current Trends and the Robotic Future* **Bill Bresnihan,** CST, CFA
11-11:50 am	*Pancreatic Surgery* **Mark Shikhman,** MD
Noon-1:30 pm	*Lunch (provided)*
1:30-5 pm	*Hands-on presentations*
6-7 pm	*Reception*

HAVE YOU EVER HAD A GREAT IDEA?

Cheryl Shanks, CST, CFA

And then someone else took the time and initiative to make it and patent it. A patent is a property right for an invention granted by a government to the inventor. A United States patent awards inventors the right "to exclude others from making, using, offering for sale, or selling their invention throughout the United States or importing their invention into the United States" for a limited time.

Obtaining a patent can be a daunting experience. An individual can apply personally, seek advice on the internet, or employ the services of a patent attorney. There are also many inventor assistance service resources that advertise in magazines, newspapers and yellow pages.

There are three types of patents:

1) **Utility** patents may be granted to anyone who invents or discovers any new and useful process, machine, article of manufacture, or composition of matter, or any new and useful improvement thereof;
2) **Design** patents may be granted to anyone who invents a new, original, and ornamental design for an article of manufacture; and
3) **Plant** patents may be granted to anyone who invents or discovers and asexually reproduces any distinct and new variety of plant.

Proceeding with a design or utility patent application requires you to initially title your invention. You will be asked to list its objectives and function as well as describe its structure. Technical drawings are also required, showing the size and dimensions from all perspectives. At this time, you will need to conduct a patent search, also known as prior art. This search can be accomplished by an individual or an internet service company but, the services of a registered patent attorney are advisable. The patent search will reveal any other article or process similar in description to your proposed invention. If your idea is truly unique, you may pay the appropriate filing fee and proceed.

Cost is usually a major consideration when applying for a patent. A simple invention or an improvement to existing technology could cost $2,000, using internet or invention service companies. A registered patent attorney's fee varies widely, anywhere from $4,000 – $20,000. And there are no guarantees of patentability.

Once the US Patent Office receives the application and filing fee ($100 - $500), the information is reviewed and a thorough search is conducted to verify any conflicting patents. If any conflict surfaces, the application is delayed and an opportunity is given to you to defend your position of originality. If the outcome of the defense is positive, you will be granted a US Patent. Generally a patent is issued for 20 years from the date of application. Various maintenance fees are required to maintain the patent.

"If a man can make a better mousetrap than his neighbor, though he builds his house in the woods, the world will make a beaten path to his door." Ralph Waldo Emerson

Cheryl Shank, CST, CFA, holds a US Patent on the "Archgrip Positioner," a device that was used to hold the hand and arm intraoperatively for X-rays prior to fluoroscopy. Shank has a second patent pending for a second surgical apparatus, "Total Knee Implant Protector."

REFERENCES

1. inventors.about.com
2. www.uspto.gov
3. www.legalzoom.com

The Georgia State Assembly of AST in conjunction with Northside Hospital of Atlanta is hosting a daVinci robotics seminar on March 2–4. For additional details, please contact Georgia Carter at 770-919-1584 or 404-234-5544 for more information.

Safe Laparoscopic Access

Like any other surgical procedure, safe laparoscopic access begins before the patient enters the operating room. It starts when the patient's history is disclosed and all other previous surgeries are examined. For OB/GYN laparoscopic procedures, other safeguards are involved, including a physical examination to rule out the presence of any pelvic or abdominal masses, (including hepatomegaly or splenomegaly); and even imaging, if questions arise regarding the patient's anatomy. Other considerations include draining the patient's bladder and stomach contents, patient positioning and trocar placement in order to provide a clear operative field and avoid puncturing the bladder and/or bowel.

Frequently, patients undergoing laparoscopic surgery who have a history of surgery may have adhesions at or near the umbilicus. In a 1997 study of 45 patients who underwent laparoscopy, none had adhesions after the procedure. However, 29 had adhesions from earlier surgeries: 17 had adhesions after a midvertical incision, and 11 of 39 had adhesions after a transverse incision.

The site that presents the lowest risk of injury for laparoscopic access is the left upper quadrant at Palmer's point, which is the midclavicular line below the left lowest inferior rib. In most patients, this site will be free of all adhesions, even in patients with previous surgeries.

Bowel injuries from adhesions represent another hazard and have been reported with all known laparoscopic techniques, but significant injuries are not common. Most studies appear to indicate that visceral (predominantly bowel) injuries occur in less than one percent of the procedures performed with either open or closed entry technique.

Vascular injuries occur even less frequently. Proponents of the open technique claim that there are fewer instances of injury but no statistical evidence is available to support that premise.

New trocars that have been recently introduced are targeted to increase safety. Their designs feature optical and radially dilating trocars and trocarless systems that dilate their path into the abdomen. Future studies will examine whether injury rates decline with these advances.

During laparoscopic surgery, the greatest injury usually occurs during entry. This injury can be prevented by three considerations: use of proper techniques, a well-planned point of entry and the safest available equipment. Because patients are often young, any injury can have catastrophic and long-term effects.

According to Duncan Turner, MD, director, Santa Barbara Obstetrics and Gynecology Associates, Santa Barbara, California, safe access for laparoscopic procedures can be categorized into three steps:

- Avoid damage to the interior abdominal wall.
- Avoid intraabdominal structures.
- Avoid retroperitoneal structures.

It is commonly believed that laparoscopic injuries are underreported. However, patterns can be identified. One 1997 medicolegal review reported that the primary port was responsible for half of the study's major vascular injuries in 47 endoscopic cases. In another study that examined 297 laparoscopic cholecystectomies, data indicated that 86% of the major vascular injuries were caused by a primary port, and 75% of gastrointestinal injuries were caused by a trocar.

No method is currently available to prevent or avoid these injuries. However, it is crucial to identify them at the time of surgery or during the postsurgical period when the patient fails to improve.

REFERENCE

1. Palter SF, MD; Turner D, MD; and Miller CE, MD. Ensuring Safe Laparoscopic Access. *Ob Gyn News*. 2005; 40: 61-62.

SURGICAL ASSISTING SURVEY

We need to obtain up-to-date information regarding the profession of surgical assisting and identify trends and issues of importance to practitioners.

The survey is posted on the ASA website, www.surgicalassistant.org. Please take a few minutes to share your insights and experience that will give us the guidelines to determine future directions that will benefit the advanced practitioners. The survey deadline is March 1. Results of the survey will be published in the next issue of *ASA News*.

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REBECCA PIEKNIK—OAKLAND COMMUNITY COLLEGE

Rebecca Pieknik obtained her CST credential in 1997, earned a bachelor of health service administration from Baker College in 2002 and a masters of science in bioethics from Albany Medical College, Graduate College of Union University, in May 2005.

Currently, she is the program director for the surgical technology and surgical assisting programs at Oakland Community College (OCC) and William Beaumont Hospital, in Royal Oak, Michigan.

"There are several reasons the SFA program was started…When the hours were cut for residents, it left Beaumont with a need for assistance at the field. I sent out a survey to surgeons on staff to see if they would support a first assistant program. All surveys came back positive."

The program was developed with the assistance of Jeff Bidwell, CST, CFA, CSA, program director, Madisonville Community College, Madisonville, Kentucky. Staff within the surgical education department assists teaching the didactic courses, and a physician is the surgical A&P instructor. After receiving accreditation, the first class consisted of employees who wanted to advance their careers. "It was a natural transition for them to move from passing to assisting."

Our surgical assisting program was also launched because many Michigan hospitals are starting to recognize the advantage of using surgical assistants as cost-effective alternatives to PAs or RNFAs. Hospitals in others states have also called about education to meet their staff needs.

Soon, the program will switch to Oakland Community College which offers the support of a marketing department to publicize the program. It will be offered along with the surgical technology program.

The program is in the last stages of developing the application and will be sending out packets in response to the 50 requests we have received. We anticipate the first class will consist of approximately 10-12 students and allow us to remedy any gaps that may have occurred during the transition from the jointly sponsored program to its first year under the umbrella of OCC.

The surgical technology students are looking forward to this opportunity for further education once they complete their associate's degree. We anticipate this program will be very successful for many years.