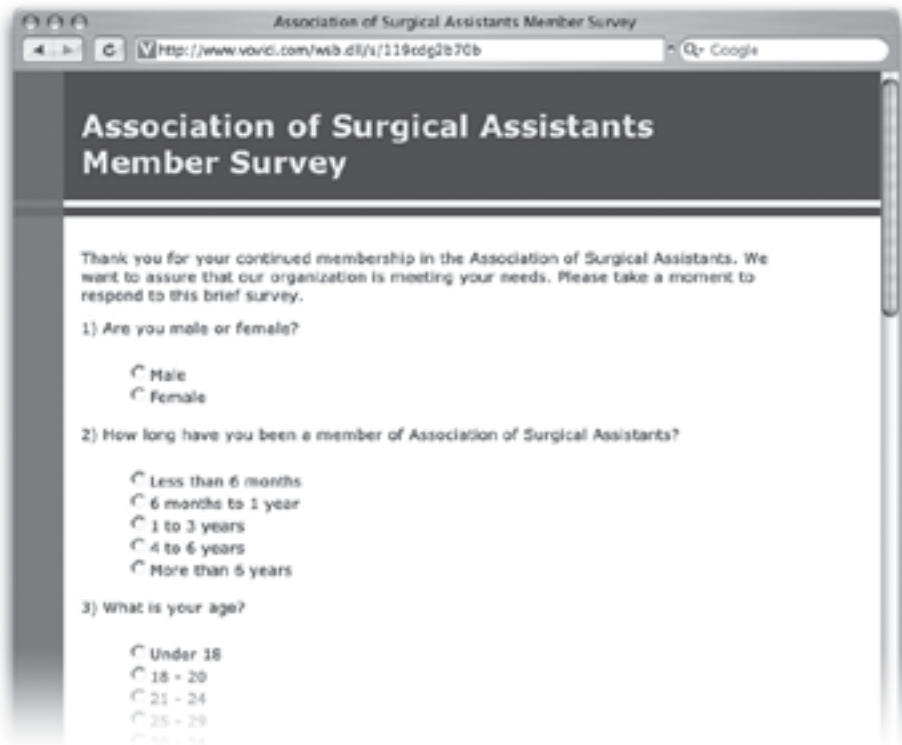


ASA NEEDS YOUR HELP

As a service to ASA members, we are attempting to gather statistical data on the profession of surgical assisting. Recently, ASA announced a survey online for surgical assistants in the hopes of releasing information to the membership about the surgical assisting field overall.

On the first go-round, the response level was not high enough to provide significant data to draw from. We need your help! We'll be running the survey again starting the first week of August 2007. Your response to the survey will help us provide you with information pertinent to your career. Please join in and give us your thoughts through the survey at www.surgicalassistant.org.



www.vovici.com/wsb.dll/s/119cdg2b70b The ASA Survey is completely anonymous. No names or member numbers are required to submit your feedback. Please help us obtain information that will benefit the advanced practitioners.

NATURAL ORIFICE TRANSLUMENAL ENDOSCOPIC SURGERY—NOTES™

Tom Lescarbeau, CST, CFA

Natural Orifice Transluminal Endoscopic Surgery (NOTES™) technique is a new approach using minimally invasive surgery that could conceivably replace some of the laparoscopic techniques that exist today. These innovative surgical procedures resulted in response to the need for reducing patient recovery time, decreased physical discomfort and elimination of the scarring associated with traditional methods.

NOTES™ techniques are still in the experimental stages and have primarily been confined to porcine models. Examples of the types of experimental procedures include appendectomy and cholecystectomy (human models—India / USA), porcine models: ligation of fallopian tubes, transgastric gastrojejunostomy, gastroplasty and gastric bypass for obesity.¹

Until now, most of the research has been focused on entering the abdominal cavity through the anterior wall of the stomach. The lower microbial count in the gastric region compared to other areas in the gastrointestinal region theoretically decreases the incidence of postop-

erative infections. Additional steps have been taken to further reduce the risk of postoperative infection, including copiously irrigating the anterior wall and gastric lavage prior to gastrotomy. Traditional gastrotomies have the same risks associated with them as NOTES™. However, one additional concern that can potentially affect the outcome is the introduction of organisms from the oropharynx onto the endoscope and then further into the gastric region.

While in the early stages of technical development, some surgeons are adopting a hybrid approach. The laparoscopic method, in conjunction with an endoluminal approach, provides an element of comfort for the surgeon while gaining confidence. Developing the technical skills is crucial to reach an appropriate outcome. The end result in adequate training would be total endoluminal procedures.³

Other routes utilizing the NOTES™ technique include transvaginal and transcolonic. In India, surgeons have been able to successfully perform appendectomies via transcolonic approaches. However,

this procedure has a new set of complications attributed to it. Infection and complications for incomplete closure are of particular importance. Devices are being developed and improvements on existing devices are being made to ensure adequate closure of the appendiceal orifice.

On April 20, 2007, at New York Presbyterian Hospital, Columbia University Medical Center, Mark Bessler, MD, FACS, and his team were the first in the United States to successfully remove a gallbladder transvaginally. The procedure took 3.5 hours.

“Internal incisions, such as in the vaginal wall, are less painful and may allow for quicker recovery than incisions in the abdominal wall... the advances are decreased scars—and eventually no scars—decreased pain and quicker recovery... this is *deja vu* of 1988. At a meeting a doctor presented his first laparoscopic removal, and surgeons were aghast as to how terrible this was and people asked what the benefits are. Now most gallbladders—more than 90 percent—are removed laparoscopically.” Bessler said.²

The transvaginal cholecystectomy also caused some skepticism within the medical community.

“To put something like that through the vagina—I just think it is crude, and there aren't many things that should be going in and out of the vagina... I don't think a gallbladder should be, or those instruments... Everyone that has heard about this that I have talked to, they are taken aback. They say it is very distasteful... A man wouldn't want to have an organ removed out of his penis. It is the same with the vagina.” said Christine Ren, MD,

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NUCC ISSUES NEW CODE FOR CERTIFIED FIRST ASSISTANT FOR USE WITH NPI NUMBER

As most surgical assistants are aware, the National Provider Identification (NPI) number is a 10-digit numeric identifier that is

issued to health care providers and organizations defined as covered entities under HIPAA.

Beginning May 23, 2007, all health care providers who utilize HIPAA standard electronic transactions were required to hold an NPI, and other providers who do not use HIPAA electronic transactions are allowed to hold an NPI. All major third party health payers were required to have the capability to utilize the NPI number in their standard electronic transactions.

On July 1, 2007, the NUCC announced the approval of a code for the Certified First Assistant, effective October 1, 2007.

Under the **Technologists, Technicians & Other Technical Service Providers Type, Specialist/Technologist, Other Classification the Certified First Assistant Specialization** was added:

Status:

*New Since 7/1/2007,
Effective 10/1/2007*

Code:

246ZC0007X

Type:

*Level III Area of
Specialization
Certified First Assistant
As defined by the American College of Surgeons (ACS), the surgical first assistant provides aid in exposure, hemostasis, and other technical functions that will help the sur-*

geon carry out a safe operation with optimal results for the patient. These functions include, but are not limited to, positioning of the patient, suturing, and closure of body planes and skin, and the application of wound dressings.

Source: <http://www.wpc-edi.com/content/view/515/229>

The NPI number and/or use of the code does not guarantee reimbursement by health plans, but it does establish a national standard and a single code for use in billing by Certified First Assistants. Further information will be available at www.surgicalassistant.org.

FRCS, assistant professor, New York University School of Medicine.²

As with any developing technology, there are a number of challenges to overcome. Most importantly, the equipment must be able to provide the advantages sought after. Olympus has developed an endolumenal device called the "Claw" with a camera and capabilities for performing the procedures. Currently, others are in development. Another question relates to which specialty group should perform these techniques—gastroenterology surgeons or endoscopists? The operative environment may dictate the answer. Many of the minimally invasive endoscopic procedures are done under surgically clean conditions. However, due to the potential for

visceral perforations, some facilities are electing to perform these procedures under sterile conditions in the operating room. Of course, there are also issues surrounding the costs of the procedures and reimbursement. The initial costs of laparoscopic procedures are often accepted when the long-term expenditures of treating the disease are greater.³

Natural Orifice Transluminal Endoscopic Surgery will provide an interesting addition to today's range of surgical interventions. Its concepts are indicative of our natural ability to push the envelope and stretch beyond our imagination.

"The NOTES™ initiative is a joint effort of the American Society for Gastrointestinal Endoscopy (ASGE) and the Society for American Gas-

trointestinal Endoscopic Surgeons (SAGES). Together, these societies have formed the Natural Orifice Surgery Consortium for Assessment and Research™ (NOSCAR™), a group that provides guidance and oversight and evaluation of NOTES techniques and the related research required."³

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1. Hockberger J, Lamade W. Transgastric surgery in the abdomen: the dawn of a new era. *Gastrointestinal Endoscopy*. 2005. Vol 62: 293-296.
2. <http://abcnews.go.com/Health/WomensHealth> (Accessed 7-17-2007)
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EASTERN VIRGINIA MEDICAL SCHOOL

R Clinton Crews, MPH, has enjoyed a long relationship with Eastern Virginia Medical School (EVMS). Over 20 years ago, he donated the contents of his piggy bank to the medical school during a fundraising effort. During subsequent years, he has been substantially involved in patient advocacy projects, and two years ago became the director of the surgical assistant program at EVMS.

The surgical assistant education program traces its roots back to 1964 when medical professionals recognized “that the ever increasing complexity of modern surgery demands more technically qualified operating assistance.” For the next 17 years, the surgical assistant education program was housed at a local hospital. In 1981, the medical school’s department of surgery agreed to sponsor the program, and it is now located in the EVMS Office of Planning and Health Professions.

Since assuming the responsibilities of program director, Crews has observed a dramatic shift in the education backgrounds of program applicants. Increasingly, more applicants with four-year degrees or higher are interested in becoming advanced practitioners. For the class that entered the program in July 2007, 60% had a minimum of

a two-year degree, and 25% had earned master’s degrees. The program now offers a graduate certificate for students enrolling with a four-year undergraduate degree.

Most students choose EVMS because of the program’s superior reputation. The 22-month curriculum includes 12 months of supervised clinical training and didactic classes with other health professions and medical students. Nearly 80% of EVMS graduates obtain employment in Virginia hospitals, and all graduates are hired within 90 days.

During the 26 years of the program’s history, the average class size has gradually increased to 12 students. From Crews’s perspective, two key challenges confront the surgical assistant profession: the pathways by which individuals enter the profession and the absence of minimum education admission requirements

The program is exploring several dynamic directions, including utilizing distance learning technology to deliver portions of the didactic curriculum, partnerships with four-year colleges and universities to offer a joint program, and accelerated/self-paced education delivery models.