



ASPS NEWS

AMERICAN SOCIETY OF PLASTIC SURGICAL NURSES, INC.

MAY/JUNE 2010

From the Boardroom

Well, spring is finally here, and we are that much closer to warm summer days and our fall meeting in Toronto. The nominating committee is hard at work to produce a slate of Board of Directors. As LuAnn mentioned in our last ASPSNews, we have two Directors and a President-Elect position becoming vacant. The Director positions are for one two-year term, and the President-Elect is a position which requires a four-year commitment with the last two years as President. Please seriously take the time and commit to make a difference in ASPSN!

I tend to be a bit of a philosophical thinker. When considering the upcoming year and what I want to promote within our organization, several terms come to mind; they not only relate to our professional daily lives, but apply within the very walls of our association.

Excellence: What a great word! What does that term mean to you? It expresses a value that I want to be a part of; it is something greater than me. I want to ensure my actions are consistent with that value. I want to provide care that is safe, reliable, efficient, and patient centered. This word exemplifies a value and a goal to be pursued.

Compassion: This is a value that is not always easy for us when we get caught up in the everyday rat race in which we live. If we encompass the value of compassion, it will help us have a deeper understanding of another's situation and be able to convey empathy.

Integrity: This is a value I hold close to my heart. I know our association is in possession of very firm principles, and we adhere to high moral principles and professional standards. This can set us apart from other organizations. Two words I associate with integrity are completeness and wholeness.

Wholeness: Wholeness is embracing a balanced life that integrates mind, body, and spirit. In our daily lives as professionals, we need to be completely whole as we treat our patients. There is a definition of wholeness that we have all heard: wholeness is an entity or system made up of interrelated parts. I would propose that the value of our association as a whole is greater than the sum of its parts (us as individuals alone).

Teamwork: Teamwork is another word and an effort I support 100%! In our professional lives, it takes a team to fight diseases, and collaboration to achieve a shared purpose. We as an association have a shared purpose, to promote ASPSN as a professional organization. We are going to thrive and grow based on new ideas, innovative technology, and mentoring of our future leaders. By definition, teamwork is a joint action by a group of people in which each person contributes with different skills and has the ability to express his or her individual interests and opinions to the harmony and the effectiveness of the group (ASPSN) in order to achieve common goals. I hope to see many of you adopt my motto for 2010, "I can do it!"

Sharon

Sharon Fritzsche, MSN, RN, FNP-BC, CPSN
ASPSN President-Elect

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The ASPSN National Office sends out frequent e-mail communications with information relevant to your practice needs. Do we have your current e-mail address? If we do, you will have received this newsletter by e-mail from the national office. If you did not receive the newsletter through e-mail, please log onto the ASPSN website and update your profile.

Nurses' Week Message

LuAnn Buchholz, RN, CPSN

ASPSN President

May is such a special time in the life of a nurse. The week of May 6-12, 2010 honors the most famous nurse, Florence Nightingale. I don't know where we would be without "ole Flo." At Vanderbilt Medical Center in Nashville, where I am employed, they make a big deal out of Nurses Week. They encourage clinics to do "extra" things for their nurses. They even have a web page to go to for ideas!

Last year, I treated my 25+ nurses to a 15 minute chair massage given by professional massage therapists who came to our office. Boy, was that a great way to start the week! One day my administrative assistant and I cooked breakfast for them. We brought in a griddle and had French toast, turkey bacon, fruit and juice. At our regularly planned staff meeting that week, we presented them with a label pin with "Healing Hands" on it. To wrap up the week, we had ice cream sundaes with all the fruit and syrups... I was at the top of the Best Boss list!

My message is to embrace your staff, peers, and student nurses. Celebrate what nursing is all about: giving care and receiving long overdue thanks for the "healing hands" you have for your patients. We belong to an elite group, and I am proud to be a member for over 30 years. Pat each other on the back and elevate your spirit. You mean something to someone everyday. What a gift. Happy Nurses Week!

Chapter News

Susan M. Lamp, RN, BSN, CPSN

American Society of Plastic Surgical Nurses and the **Cleveland Clinic** in conjunction with the **Ohio Valley Society of Plastic Surgeons** present "From Laboratory Research to Clinical Reality" on Friday, May 14, 2010, and Saturday, May 15, 2010, at the Ritz Carlton Hotel, 15125 West Third Street, Cleveland, Ohio 44113.

Topics include safe administration of local anesthesia, tattooing techniques, needs of the DIEP patient, new methods of face and neck rejuvenation, face transplantation, advances in fat sculpting, and patient needs for skin care.

For more information, contact Jacqueline Frazee at frazeej@ccf.org or Christine Brajkovich at brajkoc@ccf.org.

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Skin Cancer Awareness

Sue Kunz, BS, RN, CPSN

Director, ASPSN

As an ASPSN member, I suggest that our society warn our patient population about the dangers of sun exposure and tanning booths. An article in my local paper provided the impetus for this commentary. Perhaps, when the media displays a photo of an 18 year old woman sitting in front of a tanning bed showing the scar on her leg from an excision of a melanoma, the public will sit up and take notice. Of course, the bold headline certainly caught my eye: **There's no such thing as safe tan, FDA says.** The young woman in the photo, Katie Donnar, a Miss Indiana contestant, noticed a growth on her leg while preparing for the contest. Katie states that she started using tanning booths as a sixth grade cheerleader. The story goes on to state that she used a tanning booth every other day during most of her high school career, and at one point in time owned one.

On January 26, 2009, the Federal Trade Commission charged the Indoor Tanning Association with making false health and safety claims about indoor tanning. Tanning salons must now display a warning regarding the dangers of tanning booths. I suggest you visit the website for The Skin Cancer Foundation at www.skincancer.org. Tools to advocate for skin cancer awareness are provided. Rather than re-inventing the wheel, I suggest that each one of us find some way to either utilize them in our practice or take it directly to our community.

As practitioners, we should educate all of our patients regarding the dangers of sun exposure. I know that I stress limited sun exposure to all of my postoperative patients and any patient that has been referred by a dermatologist for a lesion excision. However, I am remiss in educating **all** of my patients. Please, let's all take the time and effort to include this important education.

Sources:

www.skincancer.org

Celebrate!

NATIONAL NURSES WEEK

May 6-12, 2010

Nurses: Caring Today for a Healthier Tomorrow

ASPSN Mentorship Program

Georgia Elmassian, M.A., RN CPSN, CFLE

Director, American Society of Plastic Surgical Nurses

Chairperson, ASPSN National Convention Scientific Sessions

Are you looking to find more pride in your nursing specialty? Looking for life to be more fulfilling? Think an exciting and new adventure will bring meaningful change to your life? If you answered "yes" to any or all of those questions, then why not consider becoming an *ASPSN MENTOR*?

According to Dictionary.com (2010), a mentor and mentee are defined respectively as "an influential senior sponsor or supporter, [and] a person who is guided by a mentor." Many of our nursing colleagues and societies have very successful mentor programs which foster growth and professional development for their membership. Therefore, the ASPSN Board thought what better way to cultivate a stronger and more united ASPSN than to integrate our own national curriculum. For that reason and purpose, a primary objective of the ASPSN MENTORSHIP PROGRAM will be to facilitate assurance that the American Society of Plastic Surgical Nurses (ASPSN) will continue to grow and develop by providing role models and helpful pearls of wisdom for its members. This can be accomplished by seeking the voices of certified plastic surgical nurse "experts" at all levels of the organization who desire to further their nursing career by becoming a mentor. Ultimately, mentorship opportunities will ensure efficiency and efficacy by identifying the particularized needs of newer or less experienced nurses just starting out in the plastics field, and then by creating, providing, and supporting interventions for them to reach individual and professional goals in the plastic surgical nursing arena.

The program will be open and inclusive. Members representing a variety of cultural differences, educational qualifications, assorted practice experiences, and divergent generations are invited to participate.

The ASPSN MENTORSHIP PROGRAM will focus on the importance of establishing, developing, and strengthening a mentoring relationship between a "seasoned" plastic surgical nurse and an interested, motivated, and less experienced nurse, who aspires to be a proficient patient advocate and an appropriately diplomatic plastic surgical nurse, whether in an aesthetic, re-constructive, or management environment.

Remember, ASPSN Mentorship cannot be seen or touched; it is simply a powerful, enriching occurrence that can be best described by those who choose to practice it. Will that someone be you? If so, please contact Leslie Long (leslie.long@dancy-amc.com) at the ASPSN National Office or me at missgme@comcast.net for more information.

Learning with Miss Adventures

Dear Miss Adventures,

My hand surgeon called to tell me that she has scheduled a “toe to thumb transfer” on a pediatric patient. I thought she was kidding, I have never seen such a procedure. I have been reading about it and want some advice on what to expect. A toe to thumb transfer seems so dramatic!

Sincerely,
Incredulous

Dear Incredulous,

Yes, it is true. A patient's toe can be transferred to the thumb position when necessary. I am not aware of the circumstance that necessitates this procedure for your particular patient, so let us consider the two most common situations, congenital anomaly and trauma. Radial dysplasia or aplasia are elements of VATER syndrome, which is an acronym used to describe the multiple parts of the body affected with congenital defect. It is important to understand VATER syndrome in the pediatric setting, especially for hand surgery. VATER includes: V for vertebral, A for anal, T for trachea, E for esophagus, and R for radial (and also renal), (<http://www.tefvater.org/vater.html>). The toe to thumb transfer is obviously in response to the radial aplasia. Aplasia is the failure of an organ or tissue to develop normally. In the case of radial aplasia, the missing thumb bone is only one of many considerations. Muscles, nerves, tendons, and ligaments in the shoulder, forearm, wrist and fingers are affected along with the blood supply to the hand and the position of the fingers, hand, wrist, and arm. The surgical goal is to establish function of the hand, focusing on thumb opposition. Transfer of the great toe or index finger to the thumb position is usually done when the patient is between one and two. Moving the index finger to the thumb position is pollicization and is an alternative to transferring the great toe. Whereas the appearance of a thumb through pollicization is closer to normal, the total function of the thumb through toe transfer is greater. (Shibata et al.).

The second instance for toe to thumb transfer involves traumatic tissue loss (Paust and Morris). Although all efforts are made to salvage the native thumb, despite the best surgical intent, the

thumb can be lost due to the extent of the trauma.

In either case, the toe to thumb transfer is a microsurgical thumb reconstruction. The site of injury or the radial aspect of the hand is prepared as any other recipient site. The tendons, nerves, arteries and veins are prepared to accept the donor tissue. The donor toe dissection preserves the digital nerves, vessels, tendons and soft tissue specific to the patient's needs (a traumatic amputation may require more extensive soft tissue coverage than the congenital defect.) The vessels are anastomosed in an end to end fashion and digital nerves are joined; tendons are repaired, and a wire secures the bones. All of this is followed by aggressive rehabilitation and occupational therapy. Nursing considerations of the patient with a toe thumb transfer are consistent with considerations related to all free vascularized flap procedures. Other considerations include attention to other traumatic injuries, or as in the case with VATER syndrome, other anomalies. Whereas toe thumb transfer in VATER patients is done at an early age, the use of a free vascularized metatarsophalangeal joint as traumatic reconstruction can be done at any age if medically appropriate.

Sincerely,

Miss Adventures

References and suggested reading:

Shibata, M., Yoshizu, T., Seki, T., Goto, M., Sailto, H., Tajima T (1998). Reconstruction of a congenital hypoplastic thumb with use of a free vascularized metatarsophalangeal joint. *J Bone Joint Surg Am*, 80 (10), 1469-76.

<http://www.tefvater.org/vater.html>

Paupst, J.M., & Morris, S. F. (2005, August). Digital reconstruction: great toe to thumb transfer. Dalhousie University Medical School - Division of Plastic Surgery

Emerson, E.T., Krizek, T.J., Greenwald, D.P., (1996, Feb). Anatomy, physiology, and functional restoration of the thumb. *Ann of Plastic Surg*, 36 (2), 180-91

The **Special Feature** section will highlight an important field in plastic surgery nursing. For example, the May/June edition highlights hands, wounds/burns. Within the special topic, we will include clinical pearls, new research articles, articles to discuss within journal club, and possibly a great success story. WE NEED YOUR EXPERT HELP to make this a success. Below, you will see the agenda of special topics. I, personally, ask that if you have anything to contribute, please contact me at Haleyjohnstonwood@gmail.com.

2010 Newsletter Special Feature Agenda:

July/Aug: Breast augmentation and reconstruction • **Sept/Oct:** Pediatric issues • **Nov/Dec:** Body contouring

Case Study: A simple dressing change is NEVER a simple dressing change!

Patient JK is a 68 year old man who presented to a large university hospital on April 29, 2010, after being involved in a roll over motor vehicle accident. His initial injuries were evaluated at the outside hospital where a CT scan showed large left hemothorax and closed head injury. While at the outlying hospital, the patient was somnolent and not responding appropriately to questions. Based on his altered mental status, advanced age, left hemothorax, and anticoagulation status, he was transferred to the university hospital for further care as a Level I trauma.

JK's medical history includes prostate cancer, atrial fibrillation, stroke and diabetes. Plavix was the only medication the patient was taking per the family. His social history was significant for alcohol use with no history of drug use or tobacco products. He is retired and a community physician (married).

Physical exam in the emergency room by the trauma attending revealed a stellate laceration 7cm long on the dorsum of the left hand with exposed, uninjured extensor tendons. The hand function was noted to be normal. The right hand was without injury. Radiographic studies were pending and later found to be negative for fracture.

The patient was then transferred in critical condition to the trauma unit. A consultation for hand evaluation was placed, and the patient was seen by the plastic surgery resident on call. The laceration of the left hand was repaired with 4-0 nylons after copious irrigation. A large dressing was applied.

Admission laboratory data was as follows: white blood cell count (WBC) 13.4, hemoglobin (Hgb) 10.8, packed cell volume (PCV) 36, platelet count 232, international normalized ratio (INR) 1.1, sodium 134, potassium 3.6, chloride 106, blood urea nitrogen (BUN) 13, and creatinine 1.14.

In the morning report April 30, 2010, the plastic surgery resident described the repaired laceration, asked that I examine the hand and wanted "just a simple dressing change."

I saw the patient and found him to have the left hand wrapped in gauze as well as a composite dressing of nonstick gauze and tape applied to the dorsum of the hand. Upon removal of the tape, the skin began to tear. I decided to cut the nonstick gauze out of the middle of the dressing and flip it open like a flap to examine the laceration and then reseal the laceration with nonstick gauze and wrap to secure. As I started to trim the dressing, there was

immediate bleeding from the hand. Despite applying pressure to the dorsum of the hand, the bleeding continued and was copious. I pressed harder to no avail. I became concerned knowing the patient's medication history included Plavix, but this seemed to be quite an unusual amount of bleeding for just Plavix (anti-coagulant medication). I thought I had perhaps nicked the laceration with my scissors, but this didn't seem right to me either because I had cut in with the blunt end. The blood now soaked the dressings, the patient's gown and the bed within seconds. This "simple dressing change" was now incredibly complicated and worrisome. I rose the arm up and out of the gauze wrap at the forearm was an intravenous tubing line. I ran my hand down to the hand and cut away the gauze to find the end of an arterial line looped between the index and middle finger gushing bright red blood. I had cut the arterial line that was running directly over the dorsum of the hand and the laceration site. I clipped the suture anchoring the arterial line and pulled the line. I then held pressure at the site for 10 minutes. The bleeding of course stopped once I applied pressure to the radial artery. I then was able to examine the dorsum of the hand which revealed a 7cm well approximated laceration with macerated wound edges, bruising, moderate edema, and minimal serosanguinous exudate. The dorsum of the hand was redressed with antibiotic ointment, nonstick gauze, and a wrap. Daily dressing changes were ordered with ace bandage and elevation.

Arterial lines are catheters inserted into an artery. Most commonly the line is inserted into the radial artery but could also be inserted into the brachial, femoral, or dorsalis pedis artery as well. These lines are used to monitor patient blood pressure in real time continuously. An arterial line can also be used to draw arterial blood gas measurements. Frequently, in emergency situations, consideration for the location of these lines regarding the extremity as well as how the lines are secured is ignored. In this patient's case, the arterial line was placed in the injured left hand with the line running directly over the area of injury. Perhaps further attention could have been paid to avoid insertion of the line into an edematous injured hand by choosing the right hand instead. However, examining the patient further before cutting down the dressings to determine the presence of an arterial line is warranted in this case. Because arterial lines are commonly placed in the radial artery, dressings must be meticulously examined prior to take down.

The patient continued to recover and was discharged to skilled nursing on hospital day 10 with instructions to discontinue the sutures at that time and follow up in plastic surgery clinic in one week.

Amanda Bailey, ACNP-BC, CWS

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Hand Transplantation: Is it worth it?

Robert B. Dybec, RN, MS, CPSN, CNOR

The amputation of a human hand is a devastating injury. The public awareness of this type of injury has increased due to media coverage of ongoing war injuries.

Over the years there have been many new changes in the field of upper limb prosthetics, which enable the patient some form of function. One pioneering surgical technique called TMR, for targeted muscle reinnervation, actually reroutes the nerves that previously supplied the now amputated part to new muscle sites. As a result the new “target muscles” begin to produce electromyogram signals (EMG), which can now be used to control upper limb prostheses (myoelectric prostheses) that afford the upper limb amputee better function.

Hand transplantation continues to be an interest for hand surgeons. Immunotherapy for hand transplantation is improving, and more long term follow up data is becoming available. The first two hand transplants ever performed in the United

States are now seven and nine years post-op. Each patient reports that they are working and are satisfied with the results which gives them fair hand function although each did suffer episodes of rejection.

In a recent article in *Plastic and Reconstructive Surgery Journal*, Dr. Chung and his team investigated the economic impact of hand transplantation in comparison with prosthetics. Based on a hypothetical assumption of forty Quality-adjusted Life years (QALYs), the results indicated that hand transplantation would produce twenty-five QALYs for a unilateral and twenty-two QALYs for bilateral hand transplantation. Amputation with prosthetics in comparison would achieve thirty-four QALYs for unilateral and twenty-nine for bilateral.

Costs estimates per QALY were from \$14,000 to \$27,000 for the amputation/prosthetic and over \$700,000 for the transplantation. The authors offered a perspective based on these costs of hip and knee arthroplasty which is at less than \$10,000.

So is it worth it? It seems that the preferred treatment right now is the adaptation of some type of upper limb prosthetic.

(continued on page 7)

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2010 ASPSN Scientific Sessions Update

Georgia Elmassian, M.A., RN, CPSN, CFLE

Director, American Society of Plastic Surgical Nurses
Chairperson, ASPSN National Convention Scientific Sessions

Spring has finally sprung and new growth surrounds us. In keeping with the theme of new growth, the 2010 Scientific Sessions Planning Committee would like to invite each ASPSN member to consider a new thought of professional development and growth: creating a poster for our ASPSN National Convention this fall in Toronto.

Keeping in mind that authoring a poster does not have to be intimidating, let me pose a few situations for you to ponder. Perhaps, at sometime in your nursing career, you had a patient present with a clinical dilemma that did not quite fit the typical textbook definition. Therefore, you took it upon yourself to think outside the box and problem solve. Possibly, you had an experience where you had to use an innovative dressing technique or pioneer a new set of post-op instructions for a difficult patient. Or maybe you developed a clever public service announcement on the importance of accredited plastic surgery facilities in your community. Well, any or all of these resolutions, explanations, or findings that you came up with provides the working foundation and subject material needed for a "poster."

Simply put, a poster is a form of communication. The material should be visually appealing, informative, and well organized.

The poster should, in basic terms, "show and tell" your clinical dilemma, experience, or technique, as well as the outcome. Therefore, plainly stated, an effective poster is a visual of show and tell nursing care.

In order to help take the mystery out of creating a "convention poster," Amanda Bailey, ACNP-BC, CWS, CRRN, a member of the 2010 Scientific Sessions Planning Committee [and previous poster author herself], has outlined some great ideas for poster illustration and submission. Be certain to look for her practical suggestions in this edition of ASPSNNews.

Lastly, one of the easiest and most effective ways of becoming involved in your nursing specialty organization is through a poster presentation at a professional meeting, a.k.a. the *ASPSN National Convention!* In fact, we want to up the ante a bit, so to speak, and bring a spirited edge to the 2010 Toronto poster submissions. Each poster on display for the fall meeting will be individually judged by a discreet and diverse panel of certified plastic surgical nurses. Votes will be tallied and awards will be given to the first, second, and third place winners. As well, all the posters will remain on display with awards intact for your perusal and viewing preference throughout the convention.

For more information on how to get started, please contact Leslie Long of the Convention Services at leslie.long@dancy-amc.com. Leslie and her staff will be happy to provide you with any of the particulars you may need.

2010 ASPSN Conference Update - Please Read!

We welcome posters that contain all types of educational content including the following:

1. Case Studies
2. Patient Care Ideas
3. Novel Dressing or Garment Application
4. Documentation Development

Our members are knowledgeable and creative. Share your strengths in Toronto in 2010. Don't keep what you know a secret. Maybe you are not ready to lead a session, but you ARE ready for a poster presentation. Keep it simple. If you have an idea and you need help getting this information to our attendees in 2010 (but you are not quite sure how to do it), the poster presentation is the solution, and we can make this happen for you. Remember, "poster" is just a term because we accept power point slides as a form of display as well.

Hand Transplantation: Is it worth it?

(continued from page 6)

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Kuiken T.A., Li G., Lock B.A., Lipschutz R.D., Miller L.A., Stubblefield K.A., Englehart K.B. Targeted muscle reinnervation for real-time myoelectric control of multifunctional artificial arms. *JAMA*. 2009;301:619-28.

Breidenbach W.C., Gonzales N.R., Kaufman C.L., Klapheke M., Tobin G.R., Giorantia V.S. Outcomes of the first two American hand transplants at 8 and 6 years post-transplant. *J Hand Surg Am*. 2008;33:1039-47.

Chung K.C., Oda T., Saddawi-Konefka D., Shauver M.J. An Economic Analysis of Hand Transplantation in the United States. *Plast Reconstr Surg* Feb 2010;125:589-95.

Cherokee Inspired Comfort Award Program Call for Nominations

Program honors healthcare professionals demonstrating exceptional service, sacrifice and innovation

Cherokee Uniforms will now accept nominations through May 31, 2010, for its annual Inspired Comfort Award, a national program to honor healthcare professionals for their exceptional service, sacrifice and innovation.

A panel of nurse leaders, Cherokee professionals and former award recipients will choose winners who best meet the program's criteria of exceptional service, sacrifice and innovation. The grand prize winner in each category will receive an all-expense-paid Caribbean cruise for two. Additional winners in each category will receive all-expense-paid trips to a 2011 U.S. medical conference of each winner's choice, an annual membership to their preferred clinical association and a \$1000 medical wardrobe from Cherokee Uniforms. Additionally, those who nominated the grand prize winner in each category will also receive a \$1000 Cherokee medical wardrobe.

To nominate a healthcare professional, visit www.CherokeeUniforms.com or pick up a nomination form from a Cherokee Uniforms retailer. Candidates may be nominated in two of the following categories but can only win in one: Registered Nurses (RNs); Advanced Practice Nurses (APNs); Licensed Practical Nurses/Licensed Vocational Nurses (LPNs/LVNs); Students enrolled in schools of nursing; and other Non-Physician Healthcare Professionals.

Nominations must contain an accurate description (100 words or more) of the candidate's exceptional performance which must have taken place at least in part in 2009. For every healthcare professional nominated through May 31, 2010, Cherokee Uniforms will make a donation to Nurses House, a national fund that provides short-term financial assistance to registered nurses facing serious hardship.

Nominations are due by May 31, 2010, and winners will be announced in October 2010. For further information on the award, please visit <http://inspiredcomfort.com> or follow the award on Twitter- @InspiredComfort.

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