



# ASPS NEWS

AMERICAN SOCIETY OF PLASTIC SURGICAL NURSES, INC.

NOVEMBER 2009

## Editorial

With almost a year behind me as editor of your newsletter, I am excited about the content of information provided by our members, who are the best in their field of expertise. As the newsletters are produced, I am convinced the plethora of knowledge and experience embodied by our membership is rich, relevant, and can be shared in a focused, educational way. As I develop plans for the 2010 newsletter content, I will be contacting members personally to gain a better perspective on the topic at hand. If you have specific plastic surgery topics in which you are interested, contact me. I am always open for ideas and suggestions.

The newsletter this month is brief but pertinent. Within my practice, I hear many patients ask, "Why are you handing me this medication guide with my Botox injections now?" In addition, I find more and more patients come in for "migraine relief" with Botox injections. Within the newsletter, I have addressed the change of environment for Botox these days as well as provided a link to four studies recently completed noting the benefits of Botox for migraine sufferers.

As always, enjoy and learn!

*Haley*

**Haley Wood, MSN, WHNP**  
ASPSN Newsletter Editor  
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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.

# The New Black Box Warning on all Type A Toxins

Haley Wood, MSN, WHNP

With Dysport on the market now as another option in botulinum type A toxins, Botox has had to add a black box warning to its package insert. The black box warning is included in the medication guide Allergan is distributing to all physician offices, which is to be given to all patients who receive Botox injections. Many patients are asking, "Why are you giving me this medication guide now?" Good question!

In the past, the FDA did not require a black box warning on the toxin. However, when Dysport was approved this year, the FDA required all botulinum type A toxins to have a black box warning in its package insert. This black box warning states the rare but potentially life threatening complication when the effects of the toxin spread far beyond the site of injection. This black box warning is also in the PI for Dysport.

*Explaining to patients that the "environment" of toxins has changed, rather than the Botox molecule itself, helps the patients understand they are still receiving the same Botox molecule they have had in the past. As practitioners, it's important to note that with Dysport on the market now, and possibly more to follow in years to come, patients are aware of which toxin they are receiving. Becoming familiar with package inserts is a necessity for practitioners in order to compare and contrast two drugs within the same class, for example time of onset and duration of drug. With the new changes made in the toxin world, it's a good time to become more familiar with the package insert and update informed consents in your practice, if necessary.*

*In the spirit of full disclosure, Haley Wood serves on Allergan's speakers bureau.*

## Hot Topics for ASPSN's Official Journal, Plastic Surgical Nursing

Are you an expert in a hot topic related to plastic surgical nursing? If so, we encourage you to contribute an article to ASPSN's official journal, Plastic Surgical Nursing. Do you know an expert in a hot topic related to plastic surgical nursing? If so, we encourage you to have your contact contribute an article to ASPSN's official journal, Plastic Surgical Nursing.

In either case, please contact Candise Flippin, the Editor of Plastic Surgical Nursing, for more information. Candise can be reached at [psnjournal@att.net](mailto:psnjournal@att.net)

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# Aesthetic Lines

Marilyn Cassetta, BSN, RN, CPSN

## The TRUST Factor and Comprehensive Consultations

Once your non-surgical cosmetic patient has been referred to you by your supervising doctor, had their health and medical histories reviewed, had their initial photos taken, and is ready to proceed with your consultation, do you take the extra few minutes needed to discuss with the patient the full-range of non-surgical to surgical options available to them, *specific to their needs*? I will bet most *successful* Aesthetic Nurse Specialists do.

Many nurses, however, may miss the mark by focusing *only* on discussing those services that *they* provide. Many surgeons do a quick “meet and greet the patient,” just minimally fulfilling the legal requirement to assess and diagnose, and then refers the non-surgical patient on to the Aesthetic Nurse for consultation and treatment.

We all know that patients often float from practice to practice in search of the latest treatments or best bargains but *not necessarily* the best solutions for their needs. As nurses, we are often called upon to be the *primary* educators in the practice: be it pre-op, post-op, or in non-surgical consultation. Patients often confide their thoughts and desires to us first or in greater detail. Perhaps we are perceived to be the less threatening, or the least vested in “selling” a procedure, but we are, most definitely, the most trusted ones.

In the most recent annual Gallup *Honesty and Ethics of Professions* survey (2008), 84% of Americans call nurses’ honesty and ethics standards “high” or “very high”:

*Nurses have topped Gallup's Honesty and Ethics ranking every year but one since they were added to the list in 1999. The exception is 2001, when firefighters were included on the list on a one-time basis, shortly after the Sept. 11 terrorist attacks. (Firefighters earned a record-high 90% honesty and ethics rating in that survey.)*

In essence, your consultation might start low, with a discussion of those solutions that would have the least impact on their time and/or money and work your way up.

Take, for example, a patient who presents with a heavy (and/or heavily-lined) forehead, as well as, low brows. Do you only discuss using a neuro-toxin with that patient?

Kidding aside, the absolute cheapest and quickest way to look fresher would be to cut some bangs. It does not have to be thick, straight bangs; even a few wisps of hair, strategically cut, can bring a youthful, rested presence to a face.

A step up the non-surgical ladder, neuro-toxin injections can be placed at the lateral edges of the eyebrows or from the middle crow’s feet upwards to the brow as well as to the glabella to offer a “chemical brow lift.”

Another step higher on the non-surgical ladder might include such non-surgical techniques as Thermage, or the more recently FDA-approved Ulthera. They employ radio-frequency or ultrasound, respectively, to cosmetically improve the skin by working deep below the surface of the skin to firm, tighten, and lift, without harming the upper layers of the skin. Tightening the skin of the forehead may also reduce the appearance of sagging skin on the eyelids offering a more open, refreshed look in general.

If the forehead/brow heaviness you observe is beyond the scope of the non-surgical treatments you’ve mentioned, then a surgical browlift may be more appropriate choice for your patient.

Of course, we know that the browlifts of the past were of major proportion: a coronal cut from ear-to ear. Today, however, with the popularity of minimal incisions and the “less is more” philosophy, most surgeons favor mini-browlifts: temple/lateral lifts, or even an anterior browlift that will also reduce a high forehead.

Non-surgical, as well as surgical, patients are now more savvy than ever; most have done some research by the time they walk into the clinic or medi-spa. Wouldn’t they like to know *all* the options available to meet their needs in your *initial* consultation? You and your patient should be able to discuss the most appropriate procedure for them based on their budget, lifestyle, and goals, even if the doctor didn’t have enough time. The patient *trusts* that this will happen; so, why not make it so?

<http://www.gallup.com/poll/112264/nurses-shine-while-bankers-slump-ethics-ratings.aspx>



# Wound Consult

**It may be more than it appears or different than what you are told.**

**Marcia Spears, APRN-BC, CPSN, CWS**  
**Amanda Bailey, ACNP-BC, CWS**

A fifty eight-year-old male was seen in the Emergency Department for black toes. He gave a history of an exacerbation of gout followed by foot sprain and subsequently four broken toes. He noticed that all the digits of his left foot turned purple within days. He used a heating pad on the toes for comfort, but within minutes of using the heating pad, he developed blisters. Over the next two weeks, the great and second toe of the right foot turned black and painful, but the pulses remained good in the foot. He reported other symptoms of generalized weakness and anorexia. He also had noticed drainage coming from “boils” on his right buttock that he failed to report to the vascular team during his initial 24 hours in the hospital and only mentioned this incidentally. His past medical history was pertinent for hypertension, peripheral vascular disease, deep vein thrombosis, osteoarthritis, and gout. His past surgical history only included left femoral bypass in 1999. He was admitted to the Vascular Service to address the black toes with consults to Cardiology and Wound. On admission, he was found to have a hemoglobin of 6.9 g/dL.

A wound consult was obtained for the chronically draining right buttock wound. He gave a history of having “boils” in his early to mid-twenties, which would spontaneously drain and heal; however, he says he had not had this problem for years. The current wounds would actually heal to his knowledge but just break back open again. On examination, there were multiple areas of hyper-pigmented scarred epithelium of bilateral buttocks and perineum consistent with the history. On the right lateral buttock, there was a lesion that was a centimeter in diameter, which had an irregular wound edge with no visible sinus, but drainage could be manually expressed. Just medial to right lateral buttock wound, there was a slightly elevated pigmented area, which was only slightly fluctuant. Both areas were extremely tender to palpation. There were no indurations, erythema, or edema associated with the lesions or adjacent tissues. A slight odor was noted when the murky fluid was expressed from the medial wound.

The decision was made that both areas would be anesthetized and drained. Using local anesthetic, both of these areas were opened with incision and drainage. A thick, purulent, yellowish pink and malodorous drainage was expressed. There was also fatty necrosis. While gently probing, a large 6cm pocket

communicating between the two areas was discovered. Cultures were taken. The areas were packed with packing strip. Interestingly, there was little to no bleeding on opening of the pocket except just at the site of I&D.

On correspondence with the primary service, to our surprise and theirs, the CT scan indicated this patient had what appeared to be a large rectal mass, and the cutaneous areas on the right buttock represented cutaneous fistulae from the rectum. There were no abscesses at all.

A cutaneous fistula is an abnormal passage or communication leading from an internal organ to the surface of the body (<http://www.mondofacto.com/facts/dictionary?cutaneous+fistula>). The diagnosis of fistulae should have been of no surprise. The odor of the drainage had a fecal component. There was no erythema or induration noted that would be consistent with abscess and inflammation. The large pocket between the two lesions was not filled with drainage, and the lateral lesion had a mucosal appearance. Also, the minimal amount of bleeding with the incision and drainage could be attributed to his anemia and low hemoglobin.

Currently, this patient is being evaluated for a palpable rectal mass suspicious for carcinoma.

<http://www.mondofacto.com/facts/dictionary?cutaneous+fistula>

## Journal Club Articles

Great articles and current information can be viewed online at [medicalnewstoday.com](http://medicalnewstoday.com), under the cosmetic medicine/plastic surgery news tab. If hosting a journal club is in your future, a few subjects worthy of scientific conversation include the following:

1. Studies find value in Botox treating and preventing migraine headaches. Four studies are mentioned within the column, and it notes the interval in which the Botox treatments are done, which can be very helpful in one's practice to schedule routine appointments.
2. For nurses new to plastic surgery and reconstructive surgery, a very nice article is written discussing cleft lip and palate. It discusses what the condition is, what causes it, and how is it treated.
3. In stem cell research, a fascinating article is written about a 14 year old boy, whose own stem cells were used to grow a cheek bone, when a genetic condition left his facial bone underdeveloped.

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# Surgical Safety in the Office O.R.

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

Statistics from 2008, indicate that of the over 230 million patients, who have surgery every year, approximately seven million suffer some type of disabling complication, and about one million die.

The list of potential complications that can arise in the operating room is lengthy. Complications include everything from retained foreign bodies, wrong site or wrong side surgery, to surgical site infections.

As a result of an increased awareness of these issues, organizations and hospitals have taken strong measures to reduce the risk of these complications and to increase patient safety.

## What about the office O.R.?

The plastic surgery office O.R. and surgical clinics are not exempt from the possibility of having the same complications that are seen in the hospital setting. These surgical settings need to afford their patient population the same level of care that is provided to the hospital based surgical patient.

Research (2007) identified the common causes of patient harm in the perioperative period. This research was instrumental in helping the World Health Organization (WHO) develop their Surgical Safety Checklist. The checklist identifies 19 essential factors for every surgical patient. These items include patient identification and pre-op marking, timely administration of antibiotics, performing a “time-out” before incision, and correct procedure to be performed. The checklist was not intended to be comprehensive, and the WHO recommends that organizations modify and adapt the checklist to fit their individual needs.

Evidence has shown that although the checklist and time-out may add a little time to the procedure, time spent is more than worthwhile when it comes to patient safety.

The office-based surgical team should be following the guidelines set forth by

local and national health care agencies. Adaptation of the WHO checklist is an excellent way to increase patient safety as well as reduce the risk of errors and lawsuits for any surgical patient.

Some important considerations to remember include the following:

- All members of the surgical team must be involved, stop what they are doing and pay attention when the “time-out” is being done.
- All members of the surgical team must respond during the time-out that they agree with all of the parameters.
- Always include the patient in the pre-op site marking.
- Be sure to use “double identifiers” when identifying your patient. The patients name and date of birth are commonly used.

## Resources:

Haynes AB, Weiser TG, Berry WR et al 2009. *A surgical safety checklist to reduce morbidity and mortality in a global population*, New England Journal of Medicine, 360 491-99

World Health Organization 2009 Surgical safety Checklist obtained from [http://whqlibdoc.who.int/publications/2009/9789241598590\\_eng\\_Checklist.pdf](http://whqlibdoc.who.int/publications/2009/9789241598590_eng_Checklist.pdf)

World Health Organization 2008 WHO Guidelines for Safe Surgery obtained from [http://www.who.int/patientsafety/safe-surgery/knowledge\\_base/WHO\\_Guidelines\\_Safe\\_Surgery\\_finalJun08.pdf](http://www.who.int/patientsafety/safe-surgery/knowledge_base/WHO_Guidelines_Safe_Surgery_finalJun08.pdf)

**Surgical Safety Checklist**

World Health Organization | Patient Safety

**Before induction of anaesthesia** (with at least nurse and anaesthetist)

- Has the patient confirmed his/her identity, site, procedure, and consent?  
 Yes
- Is the site marked?  
 Yes  
 Not applicable
- Is the anaesthesia machine and medication check complete?  
 Yes
- Is the pulse oximeter on the patient and functioning?  
 Yes
- Does the patient have a:  
Known allergy?  
 No  
 Yes
- Difficult airway or aspiration risk?  
 No  
 Yes, and equipment/assistance available
- Risk of >500ml blood loss (7ml/kg in children)?  
 No  
 Yes, and two IVs/central access and fluids planned

**Before skin incision** (with nurse, anaesthetist and surgeon)

- Confirm all team members have introduced themselves by name and role.
- Confirm the patient's name, procedure, and where the incision will be made.
- Has antibiotic prophylaxis been given within the last 60 minutes?  
 Yes  
 Not applicable
- Anticipated Critical Events  
To Surgeon:  
 What are the critical or non-routine steps?  
 How long will the case take?  
 What is the anticipated blood loss?  
To Anaesthetist:  
 Are there any patient-specific concerns?  
To Nursing Team:  
 Has sterility (including indicator results) been confirmed?  
 Are there equipment issues or any concerns?
- Is essential imaging displayed?  
 Yes  
 Not applicable

**Before patient leaves operating room** (with nurse, anaesthetist and surgeon)

- Nurse Verbally Confirms:  
 The name of the procedure  
 Completion of instrument, sponge and needle counts  
 Specimen labelling (read specimen labels aloud, including patient name)  
 Whether there are any equipment problems to be addressed
- To Surgeon, Anaesthetist and Nurse:  
 What are the key concerns for recovery and management of this patient?

This checklist is not intended to be comprehensive. Additions and modifications to fit local practice are encouraged. Revised 1 / 2009 © WHO, 2009

## CPSN Corner

### Sue Kunz, BS, RN, CPSN

President, PSNCB

The first CPSN exam was offered twenty years ago! Congratulations to those who sat for that first exam. We have fifteen members in the society, who have maintained their CPSN for the entire time. CONGRATULATIONS to all of you: Phyllis Affeldt, Heidi Bowen, Nancy Baglio, Carla Cole, Ajia Coolbaugh, Barbara Dugas, Beverly Engelsman, Joanne Gladfelter, Claudette Heddens, Kathleen Z. Jones, Benae Potter-Hricko, Claudia Provence, Sandra Thurston, and Barbara Weber.

I remember that day; our meeting was in San Francisco, a few weeks after the earthquake. It was a warm, sunny day, and I was filled with hope, excitement and anxiety as I walked to the convention center to take the exam. I was wrought with distress as I walked back to the hotel after the exam. I am not a good “test taker,” and I was sure that I failed. How could I explain that failure to the surgeons with whom I worked, or to friends who knew I was taking the exam? I spent the remainder of the day touring San Francisco, playing “tour guide” to one of the residents from the University. By the end of

the day, I was able to put aside the feeling of dread, knowing that there was no point in fretting about the exam. I couldn't change anything; I just had to wait for the results.

In 1989, we did not have a review course; the one and only advantage I had was sitting for the “pilot exam” six months prior to the official exam. I don't think the pilot helped; in fact, I came away from the pilot exam with a false reassurance of “that was easy; I can take the exam, no problem.” Well, in my opinion, the pilot exam was very different than the CPSN exam in October.

Twenty years later, we now offer a review course, and we now have our Third Edition of the Core Curriculum. Once again, as in past articles, I encourage any ASPSN member without their CPSN to take that step. Start studying; purchase the “Core” and take the review course. Apply for a scholarship grant to defray the cost of the exam, and take the exam. Maintaining a CPSN is a sign of excellence in our field.

Oh, by the way, I passed the exam. I, too, am one of the fifteen with the CPSN for twenty years. Again, congratulations to those members who have maintained their CPSN for twenty years. Congratulations to all members who have their CPSN.

#### Step 1:

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