From the Boardroom...

COLLABORATION ACROSS ORGANIZATIONS

In July, Sharon Fritzsche, President-elect, and I were invited to attend the summer board meeting of ASPS in Chicago. Although it was a short trip, we found the time spent invaluable for ASPSN. We were graciously recognized as invited guests and encouraged to participate in their strategic planning sessions. We participated in the Intra-Specialty Relations small group session. Much to my surprise they were intent on collaborating with several physician specialties* within the plastics world to strengthen opportunities and communication. I was so happy to learn that they too loved my new favorite word, collaboration! In this session all parties voiced interest in integrating more educational opportunities at shared meetings and to have each organization represented at planning sessions in the future. We also agreed to allow a member of both organizations to audit one another's board meetings. Plans for Seattle include a Presidents Meet & Greet to introduce the leaders in this collaboration plan.

As auditors of their board meeting, we realized we share some of the same problems: decrease in sponsorship & exhibitors, increasing food & beverage costs, membership stability, increasing overhead, convention attendance, etc.

Everyone felt the time has come, now more than ever, to eliminate the silo mentality among healthcare organizations. The future of healthcare is on everyone's radar as President Obama seeks to reform it. Now is the time for us to unify, not fragment ourselves.

I have shared with you just a short synopsis of our meeting in Chicago, but I encourage your comments and suggestions. Please email me at luannrncpsn@comcast.net.

LuAnn Buchholz, RN, CPSN
ASPSN President 2009-2010

* European Society of Plastic Reconstructive & Aesthetic Surgeons
International Society of Aesthetic Plastic Surgeons
American Society of Peripheral Nerve
American Society of Maxillofacial Surgeons
American College of Surgeons
American Society of Aesthetic Plastic Surgeons
Editorial

Haley Wood, MSN, WHNP
ASPSN Newsletter Editor

ASPSN had an impressive presence at a recent Speaker’s Bureau meeting for cosmetic injectors. Thirty five non-physician injectors attended the meeting, three of whom were distinguished faculty members who led round table discussions. All three faculty members are certified plastic surgery nurses! Not only was I honored to be among the attendees of this meeting, I was equally honored to see our organization so well represented and led by our very own nurses!

While meeting other attendees, I donned my cheerleader pom-poms and shouted a big cheer for ASPSN and our annual conference in Seattle! I am pleased to note that we have at least two new members added to our organization and two new participants going to our conference!

Rocket City Gala 2009

Robbi Stephens, RN, CPSN

The annual meeting of the ASPSN Tennessee/Alabama Chapter was recently held in Huntsville, Alabama, on Saturday, August 1st. The all-day conference was well attended by over fifty health care professionals from the southeast area. Eight presenters spoke on informative and timely topics, including MRSA & HIV updates, melanoma, nutrition, electrocautery safety, botox/fraxel/fillers, and breast reconstruction. Attendees were treated to breakfast and lunch, as well as many exciting door prizes!

One important thing I learned from this educational event was the importance of our office having a post-exposure plan in place before a “needle stick” injury occurs. This type of injury should be treated as an urgent medical situation, as blood testing for the health care professional should be done immediately (within two hours if possible) after the exposure.
Aesthetic Lines

Marilyn Cassetta, RN, BSN, CPSN

As previously mentioned in the July 2009 ASPSN News, the US Food and Drug Administration (FDA) identified the need to change the generic name of Dysport from botulinum toxin A to abobotulinumtoxinA to assist in the differentiation of Dysport from Botox and Myobloc. In fact, all three derivatives of the botulinum toxins have undergone name changes to reinforce individual potencies and prevent medication errors:

Botox/Botox Cosmetic: onabotulinumtoxinA
Dysport: abobotulinumtoxinA
Myobloc: rimabotulinumtoxinB

In addition, the toxins ALL now come with a boxed warning, highlighting “the possibility of experiencing potentially life-threatening distant spread of toxin effect from the injection site after local injection.” A risk evaluation and mitigation strategy that includes a patient-directed medication guide has also been issued.

According to the FDA press release, symptoms associated with distant spread of toxin effect from the injection site have been reported mostly in children with cerebral palsy being treated for muscle spasticity. No serious adverse event reports have been associated with dermatologic use in the glabellar lines or with hyperhydrosis.

More information is available at http://www.fda.gov/medwatch

Additionally, on July 30, 2009, the FDA approved the cosmetic use of poly-L-lactic acid (Sculptra Aesthetic) for the correction of deep naso-labial fold deficiencies and other facial wrinkles in which a deep dermal grid-pattern injection technique would be appropriate.

Many Aesthetic Nurse Specialists have learned through experience, when to choose Sculptra over other injectables, but a few guidelines may be worth mentioning:

• Sculptra is NOT a filler: it is a dermal stimulator
• It requires pre-mixing: at least 2 hours prior to use
• Patient participation is critical: 5/5/5 is an easy way to teach your patients how to participate: massage for 5min x 5 times a day x 5 days

• Unwanted side effects such as lump or bump formation can often be avoided by steering clear of both obicularis oculi and oris muscular regions.

• Most patients require 1-4 treatment sessions, approximately 3 weeks apart.

For more information go to:


http://products.sanofi-aventis.us/sculptra_aesthetic/sculptra_aesthetic.pdf

Report from Treasurer

Debby L. Booth, RN, CPSN

As you know, we must have members to make up a Society, and we rely on our new membership and renewals for a big part of our revenue. The Board members have been brainstorming for ways to keep members and attract new ones. The ASPSN members are the greatest asset of this organization. We anticipated some drop in numbers with the economy, but we don’t want to lose any of our current members. The Board commissions each member to encourage colleagues to remain a part of the ASPSN or become a new member of this exciting Society.

Let’s continue to get the word out about the great things that ASPSN is accomplishing for its members and ultimately the patients.

The membership to date is 1029, and we have 214 members out there that haven’t renewed this year. We have 87 new members thus far compared to 270 last year. See graph below:
The Natrelle® Pre-Consultation Kit is offered right where women research their breast augmentation options — on the web. It delivers the answers they look for, all in one place. All with the Surgeon in mind.

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Includes $170 in Rebates!
Imagine for a moment that you are a survivor of domestic violence. After many attempts at leaving your abusive environment, you finally have succeeded. Whether you live in an apartment, home, or have found safety in a women’s shelter, you now on your own. You and your children are no longer in harm’s way. Or so you think...

Envision you and your young children are out for a walk, perhaps on your way to the neighborhood park. Possibly you are in your car driving to the grocery store. You have arrived at your destination. You look up and suddenly see your husband/boyfriend/abuser/stalker making his way towards you and your kids. You begin to sense a feeling of panic because you feel trapped. What will you do? Your first thoughts are to alert someone to the situation, but how can you do that when there is no phone or person in sight to help you.

In 2006, Motorola, a large cell phone company, donated 16,000 used cell phones to various domestic violence shelters across America (www.motorola.com). Motorola’s recycling effort provided 16,000 victims of domestic violence access to safe harbor through used cell phones. Other phone companies such as AT&T, Verizon, and Nextel currently have similar donation programs which redistribute unwanted cell phones to domestic violence shelters.

The 2009 ASPSN Scientific Sessions Committee along with the ASPSN Western Washington Chapter would like to participate in providing used cell phones to New Beginnings domestic violence shelter in Seattle. Therefore, we are asking all members who are planning on attending the Seattle meeting to please bring your unwanted cellular phones and drop them off at the convention registration area. The leadership of the Western Washington Chapter will then take the collected phones to the shelter on behalf of the entire ASPSN organization.

Recently, I randomly interviewed several people about cellular phones. I inquired if they had any old, unused cell phones at home stuffed in a drawer. I also queried them: if they were to upgrade their current cell phone, would they consider donating the older model for the use of victims and survivors of domestic violence. “Yes” was the response of 98.7% of those questioned. Their only concern was the needed assurance that the information stored on their phones would not be misused or “fall into the wrong hands.”

With those statistics and comments in mind, I contacted my local AT&T store for reference and direction. According to the customer service representative, AT&T suggests the following to help ensure privacy and protect personal data of a wireless phone donation:

- Turn off the power.
- Remove your phone’s SIM card, if it has one.
- Erase your address book, photos, messages and other stored information.

We truly hope those who are attending the 2009 ASPSN Convention; Plastic, Reconstructive, and Aesthetic Nursing: Collaborating Through ASPSN in Seattle will contemplate an old cell phone contribution to New Beginnings. This small act will have the potential to support a much larger need in the lives of survivors and victims of domestic violence.
Post Operative Nausea, Tips, and Warnings

Sue Kunz, BS, RN, CPSN
Regional Director

Post operative nausea and vomiting can impact an office surgical setting in numerous ways. First and foremost it is a horrible feeling for a patient. It also can have adverse effects on some surgical procedures, such as a hematoma in a facelift patient, excessive swelling in a blepharoplasty patient or “popped” sutures in an abdominoplasty patient. It can also increase the time spent in recovery room, which in turn can delay other procedures due to lack of recovery space, or extend the hours that the recovery room must be staffed.

It is important to identify patients who are considered high risk. High risk patients tend to be young, female, thin, non-smokers; those with a history of motion sickness or PONV, patients that are given opioids during or after surgery. Obviously, length of the procedure is considered. The type of surgery can also be a factor; high risk procedures that our office would be involved in are breast and abdominal surgery. For the past few years, our staff has made a concerted effort to ask specific questions such as “Do you have problems with motion sickness?” or “Have you had problems with N/V in the past after a surgery?” This information along with the other known risk factors dictates the medications used pre, intra, and post-operatively.

Over a number of years, we have tried several different antiemetics. We used Droperidol until the 2001 “Black Box” warning. Reglan was our next choice; when Zofran became available as a generic medication, we switched to Zofran due to its selective 5-HT3 receptor antagonist property.

Zofran IV seemed to be most effective. For those with immediate PONV problems in the recovery room, we use a medication from a local compounding pharmacy: ABHR gel. This is a combination of lorazepam, diphenhydramine, haloperidol and/or metoclopramide. The medication comes in a prefilled syringe; 1cc is applied to the patient’s wrist, and they are then asked to rub it into the skin. The medication takes effect within minutes. It quickly eliminates or reduces the nausea.

In November and December of 2008, we had three incidents which we attributed to the administration of Zofran. All three patients were healthy; each developed cardiac symptoms immediately after the Zofran was given. Each patient reported feeling as if they couldn’t breathe and tightness of the chest; all three became pale and diaphoretic, followed with EKG changes. The only other IV medication given was the pre-op antibiotic. One surgery was cancelled due to the reaction. Research into the possible complications with Zofran led us to discontinue the use of Zofran IV as our pre-operative antiemetic.

Information found at www.rxlist.com/zofran-drug

Cardiovascular side-effects from zofran reported post-approval use: Arrhythmias (including ventricular and supraventricular tachyrdardia) premature ventricular contractions and atrial fibrillation, bradycardia, electrocardiographic alterations including 2nd degree heart block, QT interval prolongation and ST segment depression, palpitations and syncope.

Presently we are using ZOFRAN ODT (orally digested tablet). We have found this to be very effective. Patients who are identified as high risk, i.e. motion sickness or previous PONV are given a scopolamine patch placed post auricular 1 hour prior to surgery. Our incidence of PONV in the recovery room is greatly decreased. However, for the occasional complaint of nausea, we immediately administer the ABHR gel.

A report in Outpatient Surgery June 2008 quotes, “Studies conducted over the past five years make it clear that this is sound both in theory (to use multiple agents from different pharmacological lasses to cover different receptor sites.) and in practice when treating patients at a moderate to high risk of PONV.” Combination therapy may be particularly beneficial not only for the higher risk patients but also for cases where vomiting poses a particular medical risk.
Effective Communication and Patient Safety

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

Since 1996, in a study of sentinel events reported to The Joint Commission in their database, communication breakdown has been identified as the root cause in a majority of the cases.

In the healthcare setting, the appropriate and timely sharing of information between members of the healthcare team is crucial. In the absence of effective communication, patient safety becomes an issue as patient care could be compromised.

The importance of teamwork cannot be stressed enough in developing a culture of good and open communication. Whether it is a hospital setting or a physician’s office, staff must work together to create this environment. Providing team training, eliminating hierarchy, delineating roles/responsibilities and having a zero-tolerance policy for disruptive behavior are excellent strategies that can be utilized in developing this environment.

When dealing with patient communication, especially in the office setting, a patient centered approach is the most effective. There are many communication models available. One that is very popular was developed by the Studer Group and is known as AIDET for acknowledge-introduce-duration-explanation-thank you.

1. Acknowledge the patient. Smile, make eye contact and call the patient by name.
2. Introduce yourself. Give your name, role and what you are qualified to do, and what you are going to do.
3. Clarify duration of task at hand. Provide the patient with the length of time expectancy for whatever procedure, process, evaluation, consultation, or waiting.
4. Provide an explanation. Discuss what comes next: what you are doing and why, tools and who else may be coming.
5. Thank the patient. Let the patient know that you are appreciative for choosing your hospital or practice. Be sure to listen and allow time for questions.

Liability
The American College of Surgeons in a study of 460 claims discovered that 19.8% were filed largely, if not entirely, because of failures to communicate. Failed communication leads to anger, mistrust and litigation, and in many cases adverse events that could have been prevented as well as impact on morbidity and mortality rates. Nurses are not exempt from litigation and must be aware of their method of communication as well as documentation.

By providing open and effective communication, we can realize positive outcomes for our patients.

ASPS / ASPSN Joint Safety Panel – Seattle, WA.
On Monday, October 26, 2009 at the National Convention in Seattle, the topic of the joint panel will be “Effective Communication – A Key to Patient Safety and Prevention of Malpractice Claims.” Anyone wishing to learn more about this important topic is encouraged to attend.

NOTE: This event will be held at the Sheraton Hotel, 1:15 – 2:15 p.m.

E-mail: rdybec@winthrop.org

RESOURCES:
Learning with Miss Adventures

Dear Miss Adventures,

The other day, after positioning my patient for a breast reconstruction, prepping and draping and completing the Universal Protocol for a “hard stop time out,” the surgeon asked that the electric OR bed be placed into a slight reverse Trendelenberg position. What a surprise when the power failed on the bed. We were fortunate to have another bed available and transferred our anesthetized, intubated patient to the new bed. The bed was working fine up until that moment, and the biomedical engineers said it was a blown fuse!

I was not comfortable that my patient was safely positioned in the haste of the move. I felt rushed and pressured. Later, my instrument count was incorrect. After searching through six bags of discarded linens and trash, I found a towel clip in the discarded drapes! How can a situation such as this be avoided in the future?

Stressed-out Circulator

Dear Stressed-out Circulator,

Sometimes, bad things happen to good nurses! It actually sounds fortunate that the mechanical failure of the bed was noticed before the incision was made (although it sounds like a close call). A recommended practice is to check the biomedical inspection dates on equipment in the room. If any equipment is near the inspection date or has no inspection sticker, biomedical engineering (or the equivalent in your facility) should be immediately notified. Equipment that is approved for use should be powered on before the patient is brought into the room, and the power cords distributed evenly to circuits so that major circuit failures do not occur. Still, as in this case, electrical equipment can fail at any time. Maintaining a reciprocal relationship of respect with biomedical engineering helps to get the assistance you may need in a timely fashion.

When re-positioning this patient, the most important factor to consider is patient safety. It would not be possible to position the patient any faster than the first time without taking shortcuts. Here the role of patient advocate is first and foremost as the circulating nurse communicates the need for safety over speed. Nursing, anesthesia, and surgery work together to meet the safety goals of patient care. It is crucial that a calm demeanor prevail. De-escalating and de-fusing any frustration that might be vented at the OR staff for the disruption often falls to the nursing team. A supervisor may be needed to quell the situation or lend a hand. In addition to airway management and positioning safety, attention should be paid to maintaining the sterile field (the instrument tables must be carefully observed) and reconfirmation of a correct count is necessary. Because this patient was already draped, those drapes were discarded between the laundry and trash. It was entirely possible that drape clamps and sponges on the field ready for incision could be lost, which is exactly what happened here. Once the patient is evaluated to be safely positioned and the instrument and sponge counts are confirmed as correct, the patient can be re-prepped and draped and a new time out should be initiated. Only then can the procedure begin. Documentation should include the repositioning and confirmation of optimal patient care in spite of the disruption. Safety reporting protocol for the individual institution should be followed.

Sincerely,

Miss Adventures
Flu season is almost upon us once again, but this upcoming season promises to be a little rocky. With so much news in the media, the H1N1 virus or “swine flu” appears to be on the brink of making this one of the most memorable seasons in many years. The World Health Organization has signaled that a global pandemic of novel influenza A (H1N1) exists and has signaled a worldwide pandemic alert level Phase 6 as of June of this year. Phase 6 level clearly signals the need for response and mitigation efforts. The Phase 6 alert was in response to the spread of the new H1N1 virus in more than 70 countries and continuing community level outbreaks. In the United States, significant novel H1N1 illness has continued into the summer, with localized and in some cases intense outbreaks occurring. The United States continues to report the largest number of novel H1N1 cases of any country worldwide; however, most people who have become ill have recovered without requiring medical treatment.

Given ongoing novel H1N1 activity to date, CDC anticipates that there will be more cases, more hospitalizations and more deaths associated with this pandemic in the United States over the summer and into the fall and winter. The novel H1N1 virus, in conjunction with regular seasonal influenza viruses, poses the potential to cause significant illness with associated hospitalizations and deaths during the U.S. influenza season.

What is the H1N1 flu virus? The H1N1 is a new flu virus of swine origin that first caused illness in Mexico and the United States in March and April of this year. It’s thought that novel influenza A (H1N1) flu spreads in the same way that regular seasonal influenza viruses spread, mainly through the coughs and sneezes of people who are sick with the virus, but it may also be spread by touching infected objects and then touching your nose or mouth. Novel H1N1 infection has been reported to cause a wide range of flu-like symptoms, including fever, cough, sore throat, body aches, headache, chills and fatigue. In addition, many people also have reported nausea, vomiting and/or diarrhea (http://www.cdc.gov/h1n1flu).

The symptoms of novel H1N1 flu virus in people are similar to the symptoms of seasonal flu and include fever, cough, sore throat, runny or stuffy nose, body aches, headache, chills and fatigue (http://www.cdc.gov/h1n1flu). A significant number of people who have been infected with novel H1N1 flu virus also have reported diarrhea and vomiting. High risk groups are not currently known, but it’s possible they may be the same as for seasonal influenza. Each of us can do our part to prevent the spread of the virus. Stay home when you are sick and keep away from others as much as possible. Continue to stay home for at least 24 hours after the fever is gone. Wear a facemask if you leave home to seek medical care. Cover your mouth when you sneeze or cough with a tissue and discard. Practice good hand hygiene. With seasonal flu, people may be contagious from one day before they develop symptoms to up to seven days after they get sick. Children, especially younger children, might potentially be contagious for longer periods. People infected with the novel H1N1 are likely to have similar patterns of infectiousness as with seasonal flu. There are symptoms that are in need of urgent medical attention. In children they include fast breathing or trouble breathing, bluish or gray skin color, not drinking enough fluids, severe or persistent vomiting, irritability to the point the child cannot be held; symptoms improve but then return with fever and worse cough and difficult to arouse or interact with others. In adults, warning signs that need urgent medical attention include difficulty breathing or shortness of breath, pain or pressure in the chest or abdomen, sudden dizziness, confusion, severe or persistent vomiting; flu-like symptoms improve but then return with fever and worse cough.

With the new H1N1 virus continuing to cause illness, hospitalizations and deaths in the US during the normally flu-free summer months and some uncertainty about what the upcoming flu season might bring, CDC’s Advisory Committee on Immunization Practices has taken an important step in preparations for a voluntary novel H1N1 vaccination effort to counter a possibly severe upcoming flu season. On July 29, ACIP met to consider who should receive novel H1N1 vaccine when it becomes available (http://www.cdc.gov/h1n1flu). Clinical trials are underway at eight hospital and medical organizations that have been used since 1962 to test seasonal flu shots and other experimental vaccines. They include the Baylor College of Medicine in Houston, Children’s Hospital Medical Center in Cincinnati, Emory University in Atlanta, Group Health Cooperative in Seattle, the University of Iowa in Iowa City, the University of Maryland medical school in Baltimore, St. Louis University and Vanderbilt University in Nashville. After all, the best defense is a vaccine.

Novel H1N1 Flu “Swine Flu”; http://www.cdc.gov/h1n1flu
Call for Papers for *Plastic Surgical Nursing*

*Plastic Surgical Nursing (PSN)*, the official journal of the American Society of Plastic and Reconstructive Surgical Nurses, is currently soliciting articles for 2009. *PSN*, published by Lippincott Williams & Wilkins (LWW), is a quarterly journal that has been published continuously since 1980. *PSN* presents the latest advances in plastic and reconstructive surgical as well as nonsurgical nursing practice. Written by and for plastic surgical nurses, *PSN* features clinical articles covering a wide variety of surgical and nonsurgical procedures. Patient education techniques and research findings are also included, as well as articles discussing the ethical issues and trends in this expanding clinical nursing specialty. The journal also contains continuing education for the entire scope of plastic surgical nursing practice. *PSN* is interested in receiving papers on a variety of topics that would be of interest to the readership but not limited to plastic surgery topics. Our readers pride themselves in having broad nursing knowledge, so general interest topics are welcome as well. Authors from other healthcare professions also are encouraged to submit manuscripts.

**Some Suggested Topics**

- Ambulatory Surgery Settings
- Evidenced-Based Practice
- Pain Management
- Age-Specific Considerations
- Plastic Surgical Nursing Outcomes
- Assessment of the Plastic Surgery Patient
- Intraoperative Considerations
- Patient Education
- Prosthetic Implants
- Tissue Expansion
- Endoscopic Surgery
- Cleft Lip/Plate Reconstruction
- Anesthesia Techniques
- Updates on Nursing Care for Burn Patients
- Evaluation of Hand Injuries and Disorders
- Psychosocial Care
- Craniofacial Reconstruction
- Basic How-to articles for Plastic Surgery Nurses

& (for a Nursing 101 series)

- Legal Topics
- Flaps and Grafts for Reconstruction
- Aesthetic Surgery of the Head and Neck
- Traumatic Facial Fractures
- Skin Lesions and Tumors
- Breast Surgery
- Surgical Excision of Redundant Tissue
- Suction-Assisted Lipectomy
- Nonsurgical Treatments
- Pharmacology
- Injectables
- Lasers
- Dermapigmentation
- Hair Transplantation
- Interventions for Patients Who Are Addicted to Tobacco, Sunbathing, Alcohol, Surgical Procedures, etc.
- The Noncompliant Patient
- Nursing Research
- New Products

Easily submit and review manuscripts online with LWW's Editorial Manager. This automated, Web-based tool simplifies the manuscript submission and review processes and enables users to electronically submit, review, and track manuscripts and artwork online in a few easy steps. The journal invites contributors and reviewers to begin using the Editorial Manager interface today at https://www.editorialmanager.com/psn/.

*PSN* journal staff are willing to work with novice writers and walk them through the writing process. All you have to do is ask. The most important thing is that you share your knowledge with other nurses. We all will appreciate it.

Please feel free to e-mail me at psnjournal@att.net with any questions.

Thank you

Candise Flippin, RN, MS, CNOR
Editor-in-Chief
ASPSN National Office
7794 Grow Drive, Pensacola, FL 32514
Phone: 760 917-0111; Fax: 760 945-7568
American Society of Plastic Surgical Nurses, Inc.
7794 Grow Drive
Pensacola, FL 32514

LuAnn Buchholz, RN, CPSN
President

Elizabeth Bennett Bailey
Executive Director

Haley Wood, MSN, WHNP
ASPSNews Editor

LOOKING FOR A CHAPTER NEAR YOU?

CALIFORNIA
Southern California Chapter
Judy Akin Palmer
San Juan Capistrano, CA
judyakin@mac.com

INDIANA
Greater Indianapolis Chapter
Diane Horner
Fishers, IN
dianekhorner@comcast.net

KANSAS/MISSOURI
KS/NO Chapter
Karen K. Harman-McGowan
Lawrence, KS
Karen1of2@sunflower.com

MASSACHUSETTS
New England Chapter
Brenda White
Danvers, MA
bswhite@shrinenet.org

NORTH CAROLINA
Piedmont Chapter
Melba Edwards
Pfafftown, NC
cmelbae@yahoo.com

OHIO
Ohio Valley Society of Plastic Surgical Nurses
Susan Lamp
Hillard, OH
susan.lamp@osumc.edu

PHILADELPHIA/DELAWARE
Philadelphia-Delaware Valley Chapter
Sheri Levin
Sewell, NJ
sheriblevin@comcast.net

TENNESSEE/ALABAMA
Tennessee/Alabama Chapter
LuAnn Buchholz
Franklin, TN
luannrncpsn@comcast.net

WASHINGTON
Western Washington Chapter
April Thomas
jamesthomasclan51238@msn.com

WISCONSIN
Wisconsin Chapter
Cynthia Leu
Iron Ridge, WI
Cindyl@plasticsurgerydoc.org

If you would like information on starting a local ASPSN chapter, please contact Amanda Crisler, Chapter Services Specialist, at amanda.crisler@dancyamc.com