PANA - NAC (Alberta North)
Members of the Executive: President Angela Winter; Treasurer: Charlette Opper
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There is much excitement and anticipation for Certification amongst PANAnac members. Planning for PeriAnesthesia Nurses Week is in full swing. Events arranged include Cup Cake Monday; Wild Funky Sock Tuesday; Pizza Wednesday; Cookie and Coffee Thursday; Pot luck Friday and as a grand finale to PeriAnesthesia Nurses Week we are hosting our 3rd annual Perianesthesia Symposium with 4 speakers and a lunch on Saturday Feb 9th. The last two symposiums were very well attended and a great recruitment vehicle. PANAnac is also holding a full day Adult Acute Pain Symposium on May 17th. The profits from this event will be used to create bursaries to support members attending ICPAN 2013.

A PANAnac member has been selected as one of the speakers at this event which is very exciting, way to go Pauline Worsfold.

Our membership is holding steady, we hope to increase the membership by creating educational opportunities. We are still holding a recruitment drive for new members of the executive; So far we have been unsuccessful but hope springs eternal

Respectfully submitted

Angela Winter, President PANAnac.

Article:

The Holy Grail of Geriatric Surgery

Mark R. Katlic, MD

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The Holy Grail of Geriatric Surgery is a simple, reliable test to assess perioperative risk. Have the authors found it?

It seems intuitive to most people, even most physicians, that advanced age increases operative risk; but is chronologic age itself really the culprit? We all know octogenarians who play vigorous tennis and others who cannot walk to the mailbox. Most of the possible tests to clarify risk in this highly variable group are surrogates of the standardized cardiopulmonary exercise test (CPET) that the authors studied. These surrogates, utilized because CPET is unavailable in some locales and unappealing in others, all suffer from one or more inadequacies, although some have been correlated with maximal oxygen consumption or surgical risk or even cancer survival: stair climbing, 6-Minute Walk Test, Long-Distance Corridor Walk, gait speed, Shuttle-Walk test, Timed Up-and-Go test, Braden scale, various frailty scales, Surgical Apgar Score, Charlson Comorbidity Index score, American Society of Anesthesiology (ASA) Physical Status Classification, and visceral assessment of an experienced surgeon.

The Charlson Comorbidity Index, ASA Physical Status Classification, Braden scale, and several different frailty scales have all been shown to predict surgical risk but are not true tests of physiological fitness. The Surgical Apgar Score is calculated postoperatively rather than preoperatively. The walking tests and the Timed Up-and-Go test are simple but have not been extensively studied in surgical populations.

Stair climbing, historically used most by thoracic surgeons and with decades of published results and with decades of published results, has consistently come closest to mimicking the CPET.[1,2]

We have known for decades that cardiopulmonary fitness declines with age, even in elite athletes. The authors have shown that this phenomenon, admittedly associated with age, is more important than chronologic age itself in predicting risk.[3] Thereby, they also have struck an indirect blow against "ageism," prejudice based on chronologic age alone.

In nearly 400 patients who underwent major open hepatobiliary and sarcoma operations, anaerobic threshold, at a level of 10 mL/kg/min, proved to be the best predictor, better than chronologic age. Age became important when fitness was poor but was unimportant when fitness was good. The study also shows that CPET is safe and even elderly patients with malignancy can complete the test (96% achieved anaerobic threshold).

So, why not just administer the CPET to all elderly surgical patients? Access to the test and delays in surgery will remain issues. Cost is a major factor and not only cost to the payer. The patients and their caregivers will inevitably bear some cost in time and dollars. The decreased length of stay either in the hospital or in the intensive care unit shown in the present article accrues only to the least fit patients and may not apply to the United States, where one's insurance policy and family issues may prolong stay beyond medical necessity. There is already proven overuse of cardiac stress testing in Medicare patients undergoing elective noncardiac surgery,[4] and we will need to be selective in our use of the CPET.

Parenthetically, the study begs the question, "What do we do when we discover reduced fitness preoperatively?"

Although pulmonary rehabilitation before lung resection has been proven valuable in certain sets of high-risk patients, in general, studies of prehabilitation have shown equivocal results to date.[5] Attempts to improve nutrition, medication use, and postdischarge care are admirable but even more speculative. I suspect that a well-defined patient population (eg, below anaerobic threshold or frail by criteria) given a discrete intervention (eg, brief, evidence-based prehabilitation) would show benefit from that intervention. Given our burgeoning elderly population, most of whom need surgery sometime, this is a ripe area for research.

Many centers have shown excellent results, results equal to a younger population, in septugenarians, octogenarians, and even nonagenarians undergoing major operations such as esophagogastectomy, pancreaticoduodenectomy, and ascending aorta replacement. Better selection of patients may be a factor in their good results, but so may be the great attention to detail perioperatively. Gretschel et al,[6] for example, showed that despite statistically increased comorbidities compared with a younger cohort, their elderly patients suffered no increased morbidity or mortality after gastric resection for cancer. Our Sinai Center for Geriatric Surgery is taking this dual approach: more comprehensive preoperative evaluation of the elderly and excessive attention to perioperative detail.

What should surgeons do in 2013? They should incorporate into their preoperative assessment as many of the Best Practices for Optimal Preoperative Assessment of the Geriatric Surgical Patient, recently promulgated in dual publications by the American College of Surgeons and The American Geriatrics Society.[7] Patients identified to be at risk (frail or depressed or malnourished, patients with delirium or diminished cognition or poor functional status), particularly those for whom a extensive surgical procedure is planned, should then be referred for the CPET.

Have the authors found the Holy Grail of Geriatric Surgery? Not yet. As good as it is, the CPET cannot be conducted easily in a surgeon's office or in a routine preoperative testing suite. However, they have shown CPET to be an excellent option for the assessment of selected patients, and we need every possible tool if we are to improve surgical results in our grandparents, parents, and—soon enough—ourselves.

References:

1. Brunelli A, Refai M, Xiume F, et al. Performance at symptom-limited stairclimbing test is associated with increased cardiopulmonary complications, mortality, and costs after major lung resection. *Ann Thorac Surg*. 2008;86:240–247; discussion 247–248.

2. Pollock M, Roa J,Benditt J, et al. Estimation of ventilatory reserve by stair climbing. A study in patients with chronic airflow obstruction. *Chest*. 1993;104:1378–1383.

3. Snowden CP, Prentis JM, Jacques BC, et al. Cardiorespiratory fitness predicts mortality and hospital length of stay after major elective surgery in older people. *Ann Surg*. 2013;257:999–1004.

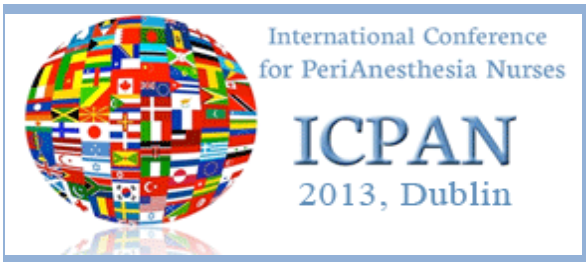
4. Sheffield KM, McAdams PS, Benarroch-Gampel J, et al. Overuse of preoperative cardiac stress testing in Medicare patients undergoing elective noncardiac surgery. *Ann Surg*. 2012;257:73–80.

5. Killewich LA. Strategies to minimize postoperative deconditioning in elderly surgical patients. *J Am Coll Surg*. 2006;203:735–745.

6. Gretschel S, Estevez-Schwarz L, Hunerbein M, et al. Gastric cancer surgery in elderly patients. *World J Surg*. 2006;30:1468–1474.

7. Chow WB, Rosenthal RA, Merkow RP, et al. Optimal preoperative assessment of the geriatric surgical patient: a best practices guideline from the American College of Surgeons National Surgical Quality Improvement Program and the American Geriatrics Society. *J Am Coll Surg*. 2012;215:453–466.

International Conference for PeriAnesthesia Nurses (ICPAN)



In 2008, during an annual meeting of the British Anaesthetic & Recovery Nurses Association (BARNA), several international nurse colleagues socialising in a London pub began to discuss the possibility of hosting a collaborative global conference that would include participation from other associations. The Past President of the American Society of PeriAnaesthesia Nurses (ASPAN) and the BARNA Chairperson agreed to give this idea a try. In early 2009, the ASPAN Past President contacted the President of the National Association of PeriAnesthesia Nurses, Canada (NAPANc) and the Chairperson of the Irish Anaesthetic & Recovery Nurses Association (IARNA) to inquire if each would be interested in creating an International Conference for PeriAnaesthesia Nurses (ICPAN). The response was a resounding "YES!" A first meeting was held during the April 2009 ASPAN National Conference in Washington, D.C., and exploratory planning began.

Amazingly, just a short time later, the first ICPAN was hosted by NAPAN© in Canada's largest city, Toronto. The 2011 organising committee, comprising volunteer chairpersons from the four associations, was eventually augmented by newly found international colleagues through extensive virtual outreach. The enthusiasm and anticipation surrounding this event was incredible! In October 2011, over 500 eager delegates and exhibitors arrived from all corners of the globe to attend. The dream of uniting global perianaesthesia / anaesthetic and recovery nursing practitioners was realised and embodied the inaugural conference slogan, "Many Practices … Just One World." Today, a fledgling ICPAN organisation exists with more professional nursing organisations and colleagues becoming involved, each working toward establishment of an enduring collaborative global networking group.

Converging Practice ~ Celtic Style

It is extremely fitting that the Irish Anaesthetic and Recovery Nurses Association (IARNA) will host the next ICPAN, as 2013 has been named "The Year of the Gathering." Our "gathering" of delegates, from all areas of perianaesthesia/anaesthetic and recovery nursing, will meet at City West venue just outside Dublin City. Following the huge success of the 2011 Inaugural Conference in Toronto, Ontario, Canada, exhibitors and potential delegates are already actively seeking information and are quite excited that we will host in Ireland's capital.

The medieval city of Dublin eagerly extends a warm welcome to delegates from across the globe! As a rising star in the worldwide stage of meeting and conference destinations, Dublin is an exciting, safe and inspirational city that naturally combines contemporary and historic, modern and traditional, and all with a characteristically laid back Irish quality.

A dedicated multinational organising committee is preparing an exciting educational programme which reflects current trends in perianaesthesia nursing. The Irish people are renowned for "having the craic" (having fun), so we are planning a lively social programme to keep you entertained during leisure time. This website will be the central point for information and communication, so please revisit regularly and 'Like' our Facebook page for details of the conference.

Céad Míle Fáilte go hÉirinn (A hundred thousand welcomes to Ireland)!

Ann Hogan,
IARNA Chairperson

To Register: http://www.icpanconference.com

Let's keep the sharing happening internationally by having a great show from Canada.

PeriAnesthesia Nurses Certification:

For Registered Nurses working in PreAdmission, Day of Surgery, Phase I, Phase II or Extended Observation areas. Environments include: PACU, Day Surgery, PreAdmission, Interventional Radiology, Endoscopy, Out of Hospital offices and surgical centres, including Oral Surgery, Plastic Surgery, and any other area where Anesthesia is administered to patients for the purposes of a therapeutic intervention (invasive or non-invasive)

The development of the Certification Examination with the Canadian Nurses Association (CNA) is underway! Over 50 volunteers (PeriAnesthesia Nurses from across Canada) have generously donated their time and have committed to this task.

In the fall of 2012, volunteers travelled to Ottawa to develop competencies over a 5 day period. This not only requires that these generous volunteers give of their time, but they will also have travel and accommodation costs to recover.

There will be many other expenses incurred by our Volunteers. Won't you assist them with their financial obligations so that they may concentrate on developing our Certification Examination?

All donors to this cause will be recognized in the NAPAN© newsletters, on this website (see list below), and in the Certification Study Guide. Receipts for all donations will be issued.

To see information regarding Certification, please go to this link: Certification for PeriAnesthesia Nurses of Canada

To read more about donations for Certification, please read this letter: NAPANc Letter to Donors for Certification.

To donate money or other valuable items (hotel accommodation, travel vouchers i.e. train, bus, airline, gasoline vouchers, food/restaurant vouchers, etc.) please print the following form and mail or fax to the address indicated: NAPANc Certification Donors Pledge Form or purchase a Mountie Bear or T-shirt from our recent Inaugural International Conference (click on the link provided to order yours). Proceeds will go towards Certification expenses. ***Thank you in advance for your generous donation!***

NAPANc would like to thank the following *Donors for Certification of PeriAnesthesia Nurses of Canada* for their generous contributions Most Recent Donations, 2013:

Mariola Brady, Mary Lou Drescher, Sue Kroes, Lya Lamb, Alain Vienneau, Janet Shaughnessy, Laura Van Loon, Paula Ferguson, Thao Le

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Association of Nova Scotia's PeriAnesthesia Nurses (ANSPAN) *and the proceeds from the Silent Auction at the 11th National Conference, 2012*

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"Nurses work 12 hours a day: 4 hours caring for patients and 8 hours washing our hands."