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D-770265-A1 November 29, 2005
Biogel Eclipse is the new surgical glove from the makers of Biogel, the world’s leading glove manufacturer – it’s innovation that will create a standard that eclipses all others.

Biogel Eclipse is made from an entirely new form of natural latex that’s deproteinised to minimise extractable protein content, helping reduce allergenic potential.1

And in terms of fit and feel it’s the most comfortable experience in surgical space, providing a level of sensitivity that's a significant step forward.

New Theatre Tagging System in use at Heartlands

Heart of England NHS Foundation Trust has recently decided to expand the use of a new system using wristbands fitted with smart technology for use on patients undergoing day surgery. The Safe Surgery System™ improves patient safety by mistake-proofing the surgical journey and reducing the opportunity for wrong side/site surgery. The system provides major financial benefits by allowing for more operations per day and reducing exposure to litigation costs.

On admission each patient is photographed and given a single-use, smart tagged wrist band. The digital photograph is saved to the electronic patient record which is available to all staff on the wards, operating theatres and recovery rooms to view and update the record and operating list. The surgeon, anaesthetist and preoperative nurse have wireless Personal Digital Assistants (PDAs) with which they can view the same operating list and patient records. When the clinician approaches the patient, the PDA recognises the patient from their smart tag and selects the appropriate patient record and displays the photograph to ensure positive patient identification.

The system is used to manage the patient pre-operative checks which immediately update the operating list, thus improving theatre efficiency by avoiding delays. A series of 'traffic lights' in the record indicate which checks have been done and only when all the necessary checks are completed, and the ‘traffic lights’ are green, can the patient be moved to theatre.

This system which is being deployed in both ENT and Thoracic Surgery theatre. The system was tested against five representative strains of epidemic methicillin resistant Staphylococcus aureus (EMRSA) and human Norovirus. Tristel Duo comprises disinfectant-impregnated wipes used with a chlorine dioxide foam dispensed immediately before use. A surface test methodology was used to evaluate the efficacy of the system against five common strains of epidemic methicillin resistant Staphylococcus aureus (EMRSA) and human Norovirus. A study conducted at the School of Life Sciences, Glasgow Caledonian University has confirmed the efficacy of the Tristel Duo sporicidal surface disinfection system against two opportunistic pathogens in the hospital environment. The system was tested against five representative strains of epidemic methicillin resistant Staphylococcus aureus (EMRSA) and human Norovirus. Test data indicate that Tristel Duo effectively reduces each of the five global EMSRA strains by at least 5 log10, following the recommended contact time of 30 seconds. For the Norovirus surrogate, infectivity was completely removed to the level of sensitivity of the assay used.

New Medical Video from Brandon Medical

Brandon Medical have announced the launch of new theatre camera suite to complement their new flat-screen monitors and medical video cameras.

This software allows the entire theatre camera system to operate over a hospitals existing communications network removing the need for expensive stand-alone equipment. The video feed uses video-over-IP technology (the same protocols used to transfer information over the internet) combined with advanced MPEG4 compression to provide high quality images.

The software itself is designed to run on any standard Windows PC. The split-screen view option allows a surgeon to monitor video feeds from every camera in the theatre simultaneously as well as re-winding certain feeds and playing them back in real-time. This allows you to monitor the live feed whilst also looking at what has happened previously.

The feeds from this software can all be made available over the hospital intranet. Senior surgeons can monitor procedures from anywhere using this system, they can even dial into the intranet from an external location if necessary. These surgeons can communicate with the operating team using the latest in-theatre microphones.

The new system also includes medical-grade dome cameras mounted in the theatre ceiling. This allows the movements of the entire operating team to be monitored and recorded alongside the other camera feeds.

As well as improving clinical monitoring and review this new system benefits teaching hospitals. The software is easily installable on a lecture theatre’s PC, allowing the lecturer to show live procedures and to retrieve archived surgical procedures. All this can be done over standard IT networks using standard computer equipment.

This new approach to medical video makes it cost effective to provide medical video to all who want it.

For further information Tel: 0113 2777393 or Email: enquiries@brandon-medical.com Web: www.brandon-medical.com

Independent evaluation confirms efficacy of Tristel Duo sporicidal wipes

A study conducted at the School of Life Sciences, Glasgow Caledonian University has confirmed the efficacy of the Tristel Duo sporicidal surface disinfection system against two opportunistic pathogens in the hospital environment. The system was tested against five representative strains of epidemic methicillin resistant Staphylococcus aureus (EMRSA) and human Norovirus.

Tristel Duo comprises disinfectant-impregnated wipes used with a chlorine dioxide foam dispensed immediately before use. A surface test methodology was used to evaluate the efficacy of the system against five common strains of EMSRA and the accepted Norovirus surrogate, feline calicivirus. Test data indicate that Tristel Duo effectively reduces each of the five global EMSRA strains by at least 5 log10, following the recommended contact time of 30 seconds. For the Norovirus surrogate, infectivity was completely removed to the level of sensitivity of the assay used.

Now in a new cost-effective packaging format that allows users to purchase a starter pack followed by refills as needed, Tristel Duo is proving highly effective and convenient for deep cleaning of near-patient equipment. As well as MRSA and Norovirus, it is active against a wide range of organisms, including Clostridium difficile, Bacillus subtilis, Mycobacterium tuberculosis and Acinetobacter baumannii.

Further information available from: Polly Oates, Tristel Solutions Limited, Lynx Business Park, Fordham Road, Snallwell, Cambbs UK CB8 7NY Tel: +44 (0) 1638 721500 Fax: +44 (0) 1638 721911 E-mail: mail@tristel.com www.tristel.com
**New Fabric Can Stem MRSA Deaths Increase**

The number of deaths linked to the hospital superbug MRSA has risen by nearly a quarter, according to figures released today by the Office for National Statistics.

Official data shows that, between 2003 and 2004, the mentions of MRSA on death certificates increased by 22% to 1,168. Worse still, it was cited as the underlying cause on 360 death certificates during the year, up from 195 in 2000.

Commenting on the statistics, Patients Association chairman Michael Summers said, ‘We are disappointed by these new figures. It is clear that MRSA and hospital infections are winning the war in many of our wards.’

The results of the report come amid evidence that rates of the MRSA superbug can be slashed through an intensive hospital cleanliness programme. According to the results of a 2003 study by the University College London Hospital, MRSA rates can be dramatically cut by introducing universal cleanliness standards.

More significantly, a Healthcare Commission report published last December estimated that MRSA is killing up to 5,000 people a year in England.

**MRSA Killing Fabric Can Help**

However, a new fabric devised by Midlands-based Toray Textiles Europe Limited can kill MRSA and other hospital bugs within one hour of contact.

The new ‘See it Safe’ fabric contains woven silver thread, and is being deployed in bedding, sheeting, surgical gowns and drapes.

The fabric does not require any special process or procedures to maintain its MRSA killing properties.

**Eliminates Microbial Activity**

Three years of continuous R&D lie behind See it Safe, which has been proven to eradicate 99.9% of over 800 micro-organisms in analyses conducted in accordance with recognised standards and testing procedures.

Tory See it Safe is proactive not reactive and, through ionisation of the silver atoms, eliminates microbial activity and destroys all harmful bacteria.

Cross-contamination through airborne, nurse-to-patient and patient-to-patient, mechanisms can therefore be effectively and simply managed.

More information is available at www.seeitsafe.info, or by telephoning Toray on 01623 415 000.

**Over 90 Per Cent of Patients Undergoing Surgery Fail to Benefit From a “Standard Clinical Practice” in the NHS - Inexpensive and Simple Monitoring System Could Dramatically Improve Care for Surgery Patients and Save the NHS Millions of Pounds**

The National Institute for Health and Clinical Excellence (NICE) has ruled that a simple monitoring technology which can be used during surgery with a proven track record in significantly reducing post-operative death and infections falls outside its remit for assessment as it is “considered a standard clinical practice with risks and benefits that are well known.”

Yet over 90 per cent of UK hospital patients undergoing surgery are currently failing to benefit from this technology.

Haemodynamic monitoring of blood flow during and after surgery allows doctors to detect and deal with problems through accurate administration of fluid and drugs. In one NHS funded study, haemodynamic fluid optimisation was associated with a 1.5 day median reduction in post operative hospital stay and patients recovered faster and with fewer side effects.

In another NHS Trust - Medway Maritime NHS Trust - the average length of stay after surgery was reduced by three days. This equated to an approximate saving of GBP800 per patient. Phase one introduction of the technology saved the Trust in excess of GBP1million in a year.

Professor Monty Mythen, Professor of Anaesthesia and Critical Care, University College of London, said today on behalf of the Improving Surgical Outcomes Group (ISOG): “We welcome confirmation by NICE that improving patients’ post-operative prospects with haemodynamic monitoring during surgery should indeed be standard practice for patients undergoing surgery but we bitterly regret that this just isn’t being implemented in many UK hospitals at the moment. NICE may think this is a standard practice but the figures show that this is in actual fact far from the case.

“Over 90% of patients undergoing surgery are not benefiting from a technology that is absolutely in line with Department of Health policy to implement the modernisation of care and improve surgical outcomes for patients. The NHS Confederation has also been urging Trusts to make the new NHS a reality by using new practices and technologies that can save lives, time and money.”

The Improving Surgical Outcomes Group (ISOG) aims to improve the understanding of interventions that contribute to better patient outcomes and reduce the number and severity of complications following surgery.

**Clinical Waste Discussion Forum**

Dear Reader,

We are pleased to announce the recent launch of a new web-based Clinical Waste Discussion Forum, accessible at www.ianblenkhn.com. The Forum offers a focal point for the dissemination of information concerning every aspect of clinical waste management, a soapbox from which to share news, views and opinion, and an exchange for practical knowledge in the hope of promoting best practice. Primary themes for discussion include:

- Health & Safety issues
- News & Information
- Ask a Question
- Waste Policy & Regulations
- Disposal technologies

An addition “Miscellaneous” theme can accommodate any other topic; other themes will be added as necessary.

We hope to provide a unique interface between producers of clinical wastes, scientific, nursing and other special interest groups, equipment manufacturers, waste management companies, representatives of government and government agencies, and all others with an interest in this field. The Discussion Forum is an open book - presently with blank pages! - and is there to receive your input.

This forum is free, independent, non-commercial, and non-political. It is open to anyone interested in, involved with, or affected by the management of clinical wastes or other healthcare wastes, from their generation to final disposal. No prior registration is required, and although we accept anonymous posts we do ask that you leave your name and email address. Email addresses will NOT be used for any other purpose.

We hope to produce an occasional newsletter digest of posts made to the Clinical Waste Discussion Forum. Users wishing to receive this monthly summary of messages may register their email addresses. However, please do not visit the Discussion Forum - success depends on the number of people visiting the Forum, and returning to it regularly, to share their thoughts and experiences with others.

Please visit the Clinical Waste Discussion Forum. We want to encourage everyone to visit, and to keep on visiting the Forum. Create a bookmark to the site. Please take an active part in the forum - post a message; read the comments posted by others. Share your experiences with others. The more who are willing to take part in the exchange of information, to post items of news, or simply to voice their opinions, the more successful the Discussion Forum will be.

Feel free to ask a question, or to post an answer that may be of help to others. The editorial policy is for open and unrestricted communication, and will only restrict blatant advertising.

www.ianblenkhn.com

References
UK SHARPS DISPOSAL SYSTEM GOES TO TSUNAMI-HIT REGION

Hypodermic Needle and Syringe Destructors from Lincolnshire company Balcan Engineering have been sent out to the tsunami-hit town of Banda Aceh in Indonesia by the World Health Organisation.

The patented devices are the only ‘defangers’ listed in the WHO-UNICEF product information sheets and are supplied widely to government and aid organisations around the world, including thousands for USAID, the charity supported by Microsoft founder Bill Gates.

The manually operated Destructor chops the whole needles into several pieces and in the same action cleanly cuts both the hub and nib from the syringe so it can’t be used again and can be disposed of as a ‘non-sharp’ item. This results in considerable saving of space in sharps boxes and the subsequent cost of disposal as the syringes can be put into much cheaper clinical waste bags.

“Our device has become increasingly popular in the third world and with relief organisations where health budgets are tighter than in the UK,” explained Balcan’s Managing Director, John Rinfret. “It’s a highly efficient and cost effective solution for safe sharps disposal but is also particularly hard wearing, easy to operate and can be used anywhere without needing a power supply.”

The Destructor reduces the likelihood of accidental needlestick injury from sharps boxes that are overloaded or where storage near warm radiators means whole needles can pierce the casing. As the needles and syringes can’t be used again, they are no longer susceptible to theft or misuse, which is particularly useful in preventing them being used as weapons in police stations and prisons.

The mechanical devices require minimal servicing, apart from occasional cleaning. Made from tough stainless steel, Destructors are designed to be easy to clean and maintain and are fast to operate with a simple lever. The waste is safely stored in pots underneath (holding around 250 destroyed needles) which are capped when full and easily disposed of.

More information is available from Balcan Engineering Ltd, Banovallum Court, Boston Road Industrial Estate, Horncastle, Lincs LN9 6JR. Tel:01507 528 500 Fax: 01507 528 528 E-mail: balcan@balcan.co.uk Website: www.balcan.co.uk

C’est Magnifique .......

When a unique solution was required for the Anticoagulant Clinic of Outpatients at Ealing Hospital, Michael Milne, its scientist and lecturer in special testing methods, found the answer in the Magnifique II magnifier from Luxo.

Nurses and pleibotomists at the Anticoagulant Clinic carry out routine blood tests on patients taking the anticoagulant drug Warfarin, which involves approximately 1% of the UK population, and local residents will access the clinic every three to four weeks.

The test involves a capillary sample technique at ‘point of care’, a process now widely used to allow immediate treatment of the patient. The procedure involves a capillary blood sample being drawn from the finger of the patient and transferred by hand pipette into a testing chamber. The process could allow blood to be in contact with the work surfaces or the operators clothing. It was found that Magnifique II not only offers a large viewing lens with good flicker free light for the test, with no stroboscopic effects but also provides for a barrier of protection between the operator and the blood sample reducing the danger of contamination to the health worker.

Michael Milne commented: “With its large lens and almost invisible lens frame, Magnifique II is an ideal visual aid and a useful tool in such medical applications, its design and ergonomics provide for an easy clean of the sealed light unit and removable lens, which is consistent with good practice.”

Further information please contact: Romana Berzolla LUXO (UK) LTD 21 Willow Lane, Mitcham, Surrey, CR4 4NA Tel: 0208 2743500 E-mail office@luxo.co.uk

When responding please quote ‘OTJ’
Norma Brook announces her decision not to stand for re-election as President of the Health Professions Council

HPC President and President of Council, Professor Norma Brook has announced that she will not stand for re-election at this Spring’s elections.

“I have thoroughly enjoyed my time since my appointment as the first President of HPC in 2001. It was a great stride forward for health professionals to have one of their number appointed to lead the development of the new regulatory body, the Health Professions Council (HPC). The last 5 years has seen the emergence of HPC as an effective and efficient regulator of health professionals due to the hard work and energy of members of Council, Partners, the Executive Team and the employees at Park House. I am really grateful for all the support that these people have given to me personally as well as that which they have given to the organisation.

“It is now time for ‘new blood’ to be in the leadership position and I am sure that there will be a very able person ready to take over the roll and that HPC will go from strength to strength as it consolidates current developments and introduces new ones. It is an interesting and exciting time for healthcare regulators as this year will see changes in Government policy on regulation of healthcare professionals, the introduction of new professions and extended scope of practice for existing professions in the delivery of care.”

Elections will be held in May for the physiotherapy, radiography and occupational therapy members of Council, and a by-election will be held for the alternate radiography member of Council. Nomination forms were sent out on Monday 13th February and the deadline for nominations is Noon on Thursday 30th March. A new President will be selected by the Council after the new Council members have been appointed in July. The President of Council may be a lay member or a Health Professional.

PUBLICATION OF REPORT ON CARDIOVASCULAR DISEASE AND AIR POLLUTION

A new report recognising the link between air pollution and heart disease, was published recently by the Committee on the Medical Effects of Air Pollution.

The report considers the possibility that cardiovascular related deaths, or the worsening of cardiovascular diseases, are directly linked to the breathing in of small concentrations of pollutants that are usually found in outdoor air. It is the first time that this link has been investigated in the UK.

The main findings of the report are: Outdoor air pollutants are likely to associated with increased deaths and hospital admissions for cardiovascular related disease. This association is not as large as factors such as family history, smoking and hypertension. A precautionary principle should be adopted in future planning and policy development.

Professor Jon Ayres, Chairman of COMEAP, said: “The evidence that exposure to air pollutants has important effects on the cardiovascular system is of public health concern and calls for greater research. Results from studies should feed into policy-making decision processes across different sectors of Government.”

Although the Committee could no identify the exact mechanisms by which air pollution affects the cardiovascular system, they suggest two possible mechanisms:

That the inhalation of particles found in the air causes chemical reactions in the body which increase the likelihood of blood clot and/or atheromatous plaque to rupture, leading to heart attack. That particles subtly affect the control of the heart’s rhythm.

An information pack on air pollution and health is available from the Department of Health (HPC). The last 5 years has seen the development of the new regulatory body to strength as it consolidates current developments and introduces new ones. It is an interesting and exciting time for healthcare regulators as this year will see changes in Government policy on regulation of healthcare professionals, the introduction of new professions and extended scope of practice for existing professions in the delivery of care.”

The UK ODP Message Group and Website

www.theatrepractitioner.org.uk

Joining is easy, just send an e-mail, stating your name, e-mail address, position and Hospital to:

ODPGroup-subscribe@theatrepractitioner.org.uk

(please quote “otj-online” somewhere within the message)

And that’s it, you are a member!

You can also join the group by visiting:

www.theatrepractitioner.org.uk and clicking on “message group” link

The Electrode Company celebrate 20 years in medical technology

The Electrode Company Ltd specialises in non-invasive monitoring, optical sensors and high performance pulse oximetry. The company is celebrating its 20th anniversary in 2006.

Initially founded in 1986 to fill a niche in the market for repair and refurbishment of oxygen monitoring equipment, their work highlighted the issues arising from inaccurate sensors. The magnitude of this problem is now increasing as a result of the appearance on the market of cheaper sensors, facilitated by the expiry of a major American owned patent on sensor technology, and increased pressure on OEMs to reduce costs.

A decision was thus made to develop a cost effective, portable and user-friendly device, which meant miniaturising a large bench interface that would convert the wavelength error into an output of clinical relevance.

The Lightman® spectrometer has now changed this uncertainty. The unique instrument can determine inaccuracies, either negative or positive, which can be picked up and indicated immediately.

Over the past 20 years, The Electrode Company has achieved the SMART & SPUR awards for Innovation in UK companies, and have been recognised by IP Wales as one of the top five most innovative companies in Wales.

For more information on The Electrode Company, visit www.electro.co.uk, or for details of the Lightman®, please telephone 01633 861772.

The Electrode Company: Ensuring accurate data for better clinical outcomes.

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Anniversary in 2006.

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When it comes to infection control in the operating theatre, we don't leave anything to chance. So, why should you?

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To find out more, visit www.molnlycke.com or call Mölnlycke Health Care on 0870 6060766.

Mölnlycke Health Care Limited, The Arenson Centre, Arenson Way, Dunstable, Bedfordshire LU5 5UL. Fax: 0870 6081888
First Fully Digital Mobile Fluoroscopy System Launched in UK

Ziehm Vision FD offers distortion free imaging & insensitivity to magnetic fields

Xograph Imaging Systems, the UK’s leading independent radiology equipment supplier, has announced the launch of the Ziehm Vision FD mobile digital C-arm fluoroscopy system to the UK hospital marketplace. It is the first fully digital C-arm currently available.

The Ziehm Vision FD is built to the same high standards, compact dimensions and mobile design as the other systems in the Ziehm Imaging range of mobile C-arms but features distortion free images from a digital flat panel detector. The integrated a-Si flat panel detector is insensitive to magnetic fields, which makes it possible to work close to MRI sites or places where other strong magnetic fields are present such as radiotherapy units.

The system offers surgeons an unmatched dynamic range perfect for soft tissue and skeleton imaging in the same picture. This is particularly useful in interventional radiography, vascular, neuro, trauma and specialised orthopaedic surgery. The combination of fully-digital images in advanced applications such as in neurosurgery with navigation systems or Computer Aided Surgery (CAS) opens new horizons and possibilities with higher accuracy and image quality.

The Ziehm Vision FD was showcased in late 2005 at RSNA in Chicago and has already received its first international order. University Hospital in Leiden (LUMC) in Netherlands has ordered one unit that will be used for different interventional radiology procedures.

Neil Staff, Technical Director at Xograph Imaging Systems states, “The new Ziehm Vision FD is an exciting evolution for mobile C-arm imaging in the UK. Not only can the system be used in magnetic field affected environments traditionally incompatible with mobile image intensifiers, but the digital features offer higher accuracy and superior image quality aiding advanced clinical applications such as neurosurgery.”

The compact design and small footprint of the system provides outstanding mobility and can be easily manoeuvred by staff into position at the patient’s side. It features a touch screen user interface on the monitor cart and mobile C-arm to guide clinical staff logically and effortlessly through each imaging procedure. The system is fully compatible with digital network integration including wireless LAN connectivity to HIS/RIS/PACS.

www.xograph.com

OCULUS INNOVATIVE SCIENCES INTRODUCES NEW 500 ML PACKAGING OF DERMACYN® WOUND CARE

Formulated with patented Microcyn® Technology—World’s First Non-Toxic and Stable Super-Oxidized Water

Oculus Innovative Sciences Netherlands B.V. (www.oculusis.com/europe/index.html) announced that the company’s notified body, KEMA, has granted a CE Mark for the 500 mL configuration of the company’s Dermacyn® Wound Care (formulated with the patented Microcyn® Technology). While previously available only in a five-liter presentation, both sizes will now be offered.

Dermacyn® Wound Care is a super-oxidized solution intended for use in the debridement, irrigation and moistening of acute and chronic wounds, ulcers, cuts, abrasions and burns. Through reducing the microbial load and assisting in creating a moist environment, it enables the body to perform its own healing process. Dermacyn® Wound Care can be broadly applied within a comprehensive wound treatment.

In October of last year, the company announced the results of an Italian clinical study that assessed the safety and performance of Microcyn® Technology in treating diabetic foot ulcers as compared to povidone iodine (10%) antiseptic, which is often used as the “standard care” in treatment of open wounds.

In the study, the Microcyn® Technology proved superior to the iodine relative to the reduction of the number of bacterial strains, local adverse effects, surgical dehiscence (incidence of not healing after surgery due to infection or ischemia) and healing time.

The company is currently sponsoring several human clinical studies to assess the safety and performance of the Microcyn® Technology in treating various wounds and burns as well as a pre-operative skin preparation.

Information about Dermacyn® Wound Care

Health Care workers in the European Union can gather more information about Dermacyn® Wound Care by phoning +31 (46) 4572 300. The new 500 mL bottle is available immediately.

About Oculus

Oculus Innovative Sciences is a medical technology company focused on the development, manufacture and marketing of Microcyn® Technology, which is used to eliminate a wide range of bacteria, viruses, fungi and spores in a non-toxic manner without creating resistant strains of pathogens. Microcyn® Technology is a non-toxic and shelf-stable antimicrobial, which has been proven effective in safely and quickly killing bacteria (including antibiotic-resistant strains such as MRSA, Methicillin-Resistant Staphylococcus; and VRE, Vancomycin-resistant Enterococcus, in vitro), viruses, spores, and fungi.

Microcyn®-based products are currently being used in the treatment of both chronic and acute wounds in the European Union, United States, Mexico and Southeast Asia. The Microcyn® Technology received CE approval according to the European Medical Devices Directive (93/42/EEC) for Dermacyn® Wound Care in November 2004. It also received two FDA 510K clearances in May 2005 to be marketed under the brand name of Dermacyn® Wound Care in the United States as a medical device to lubricate, moisten, cleanse and debride wounds and burns. Statements regarding approved uses only apply to specified locations and should not be construed as approvals in other jurisdictions. Oculus’ principal operations are in Petaluma, California, and it conducts operations in Europe and Latin America through its wholly owned subsidiaries, Oculus Innovative Sciences Netherlands B.V. and Oculus Technologies of Mexico, S.A. de C.V. Please visit us at www.oculusis.com

Now Sam & Tina have recruited for themselves!

Having settled into brand new offices, Kirkham Young is delighted to announce the recruitment of its first additional consultant, Katie Ainsworth.

Katie started her career working within care services before moving into health and social care recruitment where she has spent the last 3 years. During this time Katie has gained experience of recruiting in both the UK and Australia, and formal qualifications with the REC.

With this strong professional background, Katie is perfectly suited to developing her own specialist area within the medical equipment arena and continuing the high level of service offered to candidates and customers alike.

For more information contact Sam Kirkham on 0870 7873134

www.oculusis.com

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Regent Medical continues to support many charities through its Regent Foundation. Recently a large consignment of Biogel® surgical gloves was donated and delivered to Mercy Ships, an international charity operating hospital ships around the globe including Africa, Nicaragua, Central America and the Caribbean.

Over 43,000 Biogel gloves were donated to the charity in September. These gloves will be of enormous benefit to the dedicated surgical teams operating on these ships all over the world. Judy Polkinhorn, Chief Executive Mercy Ships UK said ‘This generous donation will provide our teams with a safe and trustworthy supply of surgical gloves that will last throughout the coming year.”

The highly skilled surgeons onboard Mercy Ships are committed to performing life changing procedures that would otherwise not be available. They work to correct cleft lips and palates, remove tumours, rectify disfigurements and repair fistulas following childbirth or trauma. The volunteers, otherwise known as shipmates, aim to help those people from poor communities that have little, if no access to medical facilities. Mercy Ships also provide medical and dental teams that regularly visit prearranged sites or field clinics and additionally, work hard to educate and support the local communities.

This is just one of many projects that Regent Medical has supported in 2005 and demonstrates the Foundation’s ongoing commitment to charitable aid, which will no doubt bring more exciting opportunities in 2006.

For more information on Biogel, please visit www.regentmedical.com or for more information on these vital services provided by Mercy Ships, please visit www.mercyships.org.uk

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Resuscitation

“And he went up and lay upon the child, and put his mouth upon his mouth and his eyes upon his eyes, and his hands upon his hands, and he stretched himself upon the child and the flesh of the child waxed warm” Bible: Kings, IV, 34

The above passage is a quote extracted from the Old Testament attributed to the testimony of Elisha.

Elisha’s text was describing the most basic technique of resuscitation, that of mouth to mouth.

The child mentioned within the biblical text may be a suitable, if not futile, subject for both theoretical and theological debate on whether he survived or not.

Techniques of basic resuscitation are by no means new as the above quotation hopefully illustrates.

There are many differing accounts of various resuscitation methods throughout history. The Egyptian dynasties describe the inversion method, whereby the afflicted person is hanged by the feet and pressure is applied to the chest, the pressure is then released to aid respiration.

This ancient technique has some credibility, being inverted would definitely aid cerebral blood flow, the chest compression should allow a reasonable gaseous exchange and indeed the position should allow good postural drainage empowering the resuscitator to expel any gastric contents without the complication of aspiration.

However some of the other methods described in early attempts at resuscitation are not so credible, and are at the very least may appear quite bizarre.

They include flogging, bouncing on a trotting horse, being rolled over a barrel, and there is more than the occasional reference to divine intervention.

It may appear that the effort in finding either a horse to trot or a barrel to roll over at the point of your patient needing resuscitation you may as well have left your fate to the option of divine intervention.

In 1767 the Dutch humane society published resuscitation guidelines for the drowning person that included Mouth to mouth ventilation.

“Good move” Keep the victim warm. “Second good move”

But the third action encourages performing insufflation of the smoke from burning tobacco into the rectum.

Well, I am sure we are always open to abstract ideas and new techniques, but the third stage described does not seem like a good move.

On reflection though, perhaps a cigarette may have been easier to find than a horse or a barrel.

On a more serious note resuscitation has progressed and evolved since those early examples, practising efficient C.P.R can actually save an individual’s life, a life that may otherwise have been lost.

In the 18th century John Howard described external chest compression, followed by Chile who documented chest compression, artificial respiration and the use of adrenaline. These practices at the time were upon animals and were proven to be successful.

Things really started to progress in the mid 1950s when many papers were being published describing successful attempts at defibrillation, notably by Zoll in 1956. Mouth to mouth ventilation was described as a successful method for assisting respiration and in 1960 Kouwenhoven, Jude and Knickerbocker described both defibrillation and external cardiac compression.

These events and the subsequent publications that followed are widely regarded to be the forerunner for modern cardiopulmonary resuscitation [C.P.R.] guidelines.

Coming right up to date the techniques for CPR have been continually reassessed and new improvements have been introduced into the medical arena.

As a result the techniques have diversified into many different areas and fields, including, of course the obvious being the hospital environment, the ambulance and fire service, the police and the R.N.I.I.

Other areas are underground in mines, sports and activity centres. Defibrillators can even be found on certain street corners, particularly in the USA and as man further explores the deep oceans and probes deeper into space, resuscitation techniques will no doubt be required and further refined as it prepares to eventually go out of this world.

Resuscitation courses

Because of the diversity in the areas of resuscitation there are a host of specialist courses available for all grades in varying professions and aiming at differing abilities.

Basic Life Support [BLS]

If you are working in a health care environment your employer should be facilitating these courses in house with yearly updates as part of your mandatory training days. The BLS should be regarded as the basic requisite before advancing onto more complicated resuscitation techniques.

Newborn Life support [NLS]

The Newborn life support course is aimed at any health care professional regardless of “discipline or status” who may find themselves in the unenviable position of having to be involved in the resuscitation of the newborn or infant.

The course content aims at both a practical and theoretical approach and may be run over either one or two days. If an individual shows a particular talent in this field they may be offered an invitation to attend the councils three day instructor course.

Immediate Life Support

The Immediate Life Support course is a natural progression from the BLS.

The one day course requires some pre reading and preparation, and a manual is supplied up to a month prior to the course start date.

I.L.S. aims, through a theoretical approach that includes recognising when a patient is deteriorating and heading towards a cardiac arrest. The course includes a basic introduction into recognising cardiac rhythms, to the practical side of basic airway management, using an artificial airway, Guedel, L.M.A. and sometimes the option of the Combitube.

The course aims to enable the individual to maintain life signs until the resuscitation team arrives, and then continue to be an active member of that team. I personally believe that it is this course that O.D.P’s should be aiming their sights on in their continued involvement with resuscitation.

A.T.L.S

Advanced Trauma Life Support [A.T.L.S] has evolved from an interesting and fateful turn of events.

In 1976 an orthopaedic surgeon was flying his family in their light aircraft over Nebraska when disaster struck.

The plane lost altitude and crashed in a remote field, whereupon the surgeon’s wife was killed on impact and three of their four children received life-threatening injuries.

Eventually the surviving family members were rescued from the scattered wreckage of the light aircraft and transported to the nearest local medical facility.

Such was the disorganised charade of care that the injured surgeon experienced around him, he vowed that if he should survive this horrendous ordeal, the plane crash and the awful treatment that he and his family were being subjected to he would address the standards of care during resuscitation, and that’s exactly what he did.

All of the aforementioned modern resuscitation courses stem from this one unfortunate incident, and the techniques are now practised throughout the world.

Some useful contact points

Resuscitation Council [UK]

5th Floor
Tavistock House
North Tavistock Square
London
WC1H 9HR

Telephone: 020 7388 4678
Fax: 020 7383 0773
Email: enquiries@resus.org.uk

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MRSA deaths up by nearly quarter

The number of deaths linked to the hospital superbug MRSA has risen by nearly a quarter, statistics show. The Office for National Statistics data revealed that between 2003 and 2004 the mentions of MRSA on death certificates increased by 22% to 1,168.

It does not necessarily mean the superbug was the cause of death, just that it contributed to it. Most of the deaths were in the older age groups and rates were higher among men than women. MRSA was mentioned on two out of every 1,000 death certificates in England and Wales, the statistics showed.

Despite the rise, Chief Nursing Officer Christine Beasley said: “It is important to put this in to context. “These figures show that out of the 12m people that go in to hospital in a year about 360 of them probably die directly of MRSA, but it is unacceptable for anyone to die unnecessarily from infections.

“Many people who have MRSA are very, very sick people prone to infection and not all infections are avoidable, but we are ensuring that the NHS has good hand hygiene and clinical procedures to prevent the ones that are.

“We are now legislating to put a hygiene code and a tougher inspection regime into law, to drive up standards of hygiene and infection control, with ultimate sanctions for trusts who fail to deliver.”

But Patients Association chairman Michael Summers said: “We are disappointed by these new figures. “It is clear that MRSA and hospital infections are winning the war in many of our wards.”

He added simple hygiene measures, such as washing hands, could have a huge impact and should be taken by everyone in hospitals.

Source: BBC  www.bbc.co.uk

CAOSUK - First Annual Congress on Computer Aided Orthopaedic Surgery (CAOS)

CAOSUK 2006 presents some of the latest research which is taking orthopaedic surgery in a new direction. CAOS represents the merger of advanced 3D computer modelling software with powerful computers and sophisticated electronic and optical devices applied to orthopaedic surgery.

The conference aimed to increase public and professional awareness of emergent technologies that have already proved promising in delivering better outcomes for patients. It demonstrated that the UK is not behind the rest of the world but at the forefront of the development and implementation of these technologies.

The conference brought together a number of eminent surgeons and scientists from the UK and international CAOS community. Every aspect of orthopaedic clinical practice was critically examined and the basic, underlying scientific and engineering principles explored. Topics covered included trauma, joint replacement, and deformity correction and how CAOS works in conjunction with minimally invasive surgery (MIS) to reduce surgical trauma and speed recovery.

Other highlights of CAOSUK 2006 included a special spine session in association with WENMSS (World Society for Endoscopic Navigated & Minimal Invasive Spine Surgery) (http://www.wenmss.org) and practical workshops and demonstrations. One of the sponsors recreated an entire operating theatre to demonstrate its vision of the future of orthopaedic practice.

Marc Maheson, president of CAOS-UK, commented: “Computer technology can improve surgical precision which, in turn, can lead to higher success rates than conventional techniques when applied on their own. The speed, power and resolution of modern devices make this accuracy available for a large number of orthopaedic surgical procedures. Ultimately this benefits patients by improving function, speeding recovery and reducing surgical failure rates.

CAOSUK 2006 aims to accelerate the uptake of this technology in a scientific manner, ensuring that the UK stays ahead.”

CAOSUK 2006 took place at London Heathrow Marriott, Bath Road, Hayes Middlesex, UB3 5AN on Saturday 11 February.

New Datasheet accompanies launch of Fukuda Denshi’s PetiTelemo multi-parameter monitor

Fukuda Denshi is a leading supplier of advanced patient monitoring and user-configurable clinical information management systems, including the very recently launched DS-7100 PetiTelemo multi-parameter monitor, with an integrated telemetry transmitter facility. It has published a new 2-page colour datasheet to coincide with this introduction to the patient monitoring market.

The DS-7100 PetiTelemo is a compact and lightweight monitor, ideal for transport duties. It is able to monitor ECG, Respiration, NiBP and SpO2. The new datasheet illustrates the PetiTelemo and describes the major features of this handy monitor, which can store waveforms for later reviewing:

• Full specification including weight, dimensions and power consumption.
• Standard and optional accessories.
• Parameters measured and displayed on the LCD.
• Details of the battery operation.
• Associated equipment, such as receivers, transmitters and central station monitors.
• Details of the trending and recording abilities.
• Safety standards complied with.

For a copy of the Fukuda Denshi DS-7100 PetiTelemo compact monitor datasheet, or for more information, please telephone the company on: 01483 728065, Fukuda Denshi.
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Creating Greater Awareness of the Risks of Sudden Cardiac Arrests to Spur Demand for External Cardiovascular Defibrillators in Western and Eastern Europe

Growing Deployment of Automatic External Defibrillators in the Public Access End-User Market Segment to Fuel Market Revenues

The decentralisation of healthcare systems and the mounting pressure to provide high-quality service despite stringent budgets are creating enormous cost pressures in the external cardiovascular defibrillators market across eastern and western Europe. However, affordable and ergonomically convenient automatic external defibrillators (AEDs) will drive uptake in the public access market, thereby boosting market revenues. Here, governments across Europe will need to take a more proactive role in stimulating the interest of private stakeholders in order to support the development and implementation of AED programmes.

Market penetration for external cardiovascular defibrillators will not be easily achievable due to low levels of awareness, lack of regulations pertaining to the use of AED and lengthy regulatory and industry approval processes. However, in response to this, governments are currently striving to implement healthcare reforms to promote awareness of the need for early defibrillation.

Reports indicate that due to the growing incidence of sudden cardiac arrests (SCAs) in public places, the lack of access to early defibrillation can prove to be fatal. Hence, AEDs are being deployed in public access areas including train/railway stations, airports and ferry boats to improve accessibility to victims, which will reduce the number of deaths associated with SCAs.

The uptake of AEDs, particularly in the public access market segment, is likely to witness an annual growth of 20.0 per cent. As a result, the total European external cardiovascular defibrillators market is anticipated to reach revenues of $319.0 million by 2011 from $226.0 million in 2004.

For companies to leverage the full growth potential of AEDs, governments need to implement community and school programmes which will augment public awareness of the incidence of (SCA).” remarks Ms. Eleni Grammenou, Research Analyst at Frost & Sullivan (http://healthcare.frost.com).

“Manufacturers would do well to work in tandem with the government to establish such programmes to create awareness of SCA and the benefits of easy access to resuscitation equipment for SCA victims.”

Market growth will receive a boost from technological advancements and the implementation of biphasic technology, which offers higher efficacy to SCA patients in out-of-hospital emergency conditions. Moreover, defibrillators with dual and multi-mode functionalities will increasingly be used in the pre-hospital and hospital markets, due to their enhanced ease of use. This trend, combined with improvements in data transmission in the pre-hospital setting, will improve the continuum of patient care leading to an increase in defibrillators sales.

Sustaining market expansion will also depend on the ability of manufacturers to offer affordable products, which can be achieved through economies of scale, foreign outsourcing or through technological innovations. Reducing prices of AEDs and engineering easy-to-use devices will enable vendors to promote the uptake of defibrillators. In addition, reviewing product ergonomics to meet the growing demand for small-sized, user-friendly defibrillators will allow manufacturers to effectively target potential applications.

“Lastly, with the market growing more competitive, mergers or joint alliances with larger companies will enable smaller manufacturers to gain leverage in product development, manufacturing or marketing competencies”, advises Ms. Grammenou. “Investing in R&D to develop built-in data management programmes of defibrillators for enhanced data communication will become crucial.”

If you are interested in a virtual brochure, which provides manufacturers, end-users, and other industry participants an overview of the latest analysis of the Western and Eastern European Markets for External Cardiovascular Defibrillators (B674-54), then send an e-mail to Radhika Menon Theodore, Corporate Communications, at rmtheodore@frost.com with the following information: your full name, company name, title, telephone number, fax number and e-mail address. Upon receipt of the above information, an overview will be sent to you via e-mail.

Hygiene forces cancellation of ops

A hospital is having to reschedule operations because its equipment has not been properly sterilised, it has emerged.

NHS Grampian said theatre staff at Aberdeen Royal Infirmary sent back equipment “from time to time” because it was not clean.

The problem is worst in the hospital’s Ear Nose and Throat (ENT) department, and has delayed some patients’ operations. An NHS Grampian spokesman said: “There was an operation cancelled last week and it does happen from time to time because equipment has not been properly sterilised and just slips through the net.

“It does happen more often with ENT because of the type of equipment they use.

“This is something that we and other boards are aware of and discussions are taking place with the manufacturers of the equipment.”

The spokesman said he did not have details of how many operations had been cancelled. “We are on the case, we are aware of the issue and we are continuing to monitor the situation,” he said.

One patient, Betsy Cassie, 57, from Aberdeen, had a nose operation cancelled because the equipment was not clean. “It must be very frustrating for doctors and nurses in the operating theatre,” she told the Evening Express. Source: Scotsman.com

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Western and Eastern European Markets for External Cardiovascular Defibrillators B674-54

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Recent ‘Resus’ Changes

I remember during my training, finding a faded piece of paper stuck to the back of a drug cupboard listing the action to take in case of cardiac arrest it listed various steps including “taking the casualty to the defibrillator”, one can imagine a device standing in the corner of a room probably about the size of a modern CT scanner!

So resuscitation procedures have changed and obviously have to keep up with technology, latest research, best practice and a more thorough understanding of the patho-physiological processes involved.

Last November the Resuscitation Council (UK) issued its latest guidelines for Resuscitation in the UK both in hospital and pre-hospital as well for adults, infants and newborn patients. See www.resus.org.uk for the full guidelines.

The main bulk of the recommendations follow the publication of the European Resuscitation Council (ERC) Guidelines which themselves stemmed from the 2005 International Consensus on CPR and emergency cardiovascular care science with treatment recommendations (CoSTR).

The changes are numerous although a lot are fairly subtle obviously to get the full picture the full Resuscitation Council guidelines should be read, I’ve summarised the main changes below, the rational behind all of these changes can be found in the guidelines.

Adult Basic Life Support

For out of hospital, single rescuer

- make diagnosis of cardiac arrest if a victim is unresponsive and not breathing normally
- location of hands for chest compression are at the centre of the chest, not now found by going up the rib margin
- ratio of compressions to ventilations of 30:2 for adults and children

the rationale behind these changes are the inability of the lay rescuer to accurately find a carotid pulse, time spent looking for the xiphoid process, and the realisation that the air loading step is normally effective whereas the circulation of the oxygen around the body using chest compressions is much less effective.

AEDs (Automated External Defibrils)

Out of hospital guidelines for lay responders, first responders and health care professionals

- Place the axillary electrode pad vertically to improve efficiency
- Continue CPR if possible whilst applying pads
- AED provides one shock then pauses for 2 minutes before re-analysing
- energy levels given (machine determined) are changed

Adult Advanced Life Support

- out of hospital do two minutes CPR before defibrillation for an unwitnessed arrest attended by health care professionals
- in hospital defibrillate immediately
- energy setting changed initial shock is now 360 J (monophasic), 150 – 200 J (biphasic)
- don’t attempt to shock fine VF
- Give adrenaline if VF/VT persists after second shock, repeat every 3-5 minutes. It is now recommended the adrenaline is given immediately before defibrillation
- Therapeutic deliberate hypothermia is suggested for out of hospital VF arrest with an unconscious adult who has had a return of circulation (32-34 degrees centigrade for 12-24hr) and mild deliberate hypothermia for out of hospital arrest from a non shockable rhythm or an in hospital arrest
- Once intubated it is suggested that continuous chest compressions are given, with the person doing this changed every two minutes.

Paediatric BLS

- lay rescuers compression to ventilation rate 30:2
- 2 or more rescuers rate of 15:2
- if no paediatric BLS training use adult sequence

Paediatric ALS

- where possible give drugs via IV /IO route
- it is acceptable to use cuffed / uncuffed tubes in hospital for infants and children
- one defibrillation shock as per adult sequence
- initial shock 4 J/kg
- Dose of adrenaline is 10 mcg / kg on each occasion

Newborn Life Support

- use of food grade plastic wrapping to insulate newborn babies
- attempts to aspirate meconium from nose and mouth no longer recommended when the babies head is still on the perineum
- Ventillatory resuscitation initially started with air, progressing to supplemental oxygen only if there isn’t a rapid improvement
- Adrenaline should be given via IV/ IO route
- If there are no signs of life after 10 minutes of adequate resuscitation then discontinuation maybe justified

Implications of these changes on the NHS

The Resuscitation council actually goes to lengths to explain that there guidelines are only that, however one does wonder what the legal ramifications would be for a trust not deciding to adopt the accepted global “best practice” guidelines.

The obvious cost implication on the NHS is a training one, the logistics involved in retraining an entire trust, at all resuscitation levels, is a large one. Obviously some of this retraining can be accomplished during the next mandatory training event.

It is for this reason that a lot of trusts have chosen to defer the latest guidelines for six months or so to allow training to be accomplished, posters to be re-written and a co-ordinated change over to occur.

Obviously this enormous retraining is not limited to the NHS alone and has implications for voluntary aid societies, publishers of manuals, commercial organisations employing first aiders, people who write courses etc.

Another knock on effect is that all AED’s need to be reprogrammed to be compliant, there are over 700 AEDs alone in the public access defibrillation scheme and a lot of NHS trusts use AEDs in outlying areas, again this is another cost that will have to be covered and will take time to do.

The final recommendation is that mono-phasic defibrillators are phased out and replaced by the newer lighter, more portable and more effective bi-phasic versions. Some of this will be a case of replacing faulty and defunct mono-phasic defibrillators however the cost implications of replacing functioning monophasic units is a very large burden for the NHS.

It is obviously difficult to estimate the number of monophasic defibrillators in service within the 159 NHS trusts and 31 Ambulance service trusts, but if each trust averages 200 monophasic defibrillators needing to be replaced then the cost could be somewhere in the region of 72 million pounds (this is an estimate).

So what of the future… obviously resuscitation will continue to evolve, cerebral protection techniques seem to be the new trend, with companies manufacturing hypothermia jackets and suits. External compression machines are being trialled around the country with some very positive results especially for non shockable arrests. And the resuscitation council has recognised in the latest guidelines the need for arrest prevention with amongst other suggestions the introduction of METs (medical emergency teams) for pre arrest stabilisation.

Changes are always met with distain but it does seem difficult to question these changes from what is a global consensus of opinion on the management of cardiac arrest.

Mark Hellaby ODP, Bsc(Hons)
www.trauma-resus.com

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OrthoView to preview new Trauma Module based on Company’s unique Wizplate™ technology at forthcoming AAOS Meeting

OrthoView – providers of orthopaedic digital planning and templating solutions, will preview the Company’s latest product at the forthcoming AAOS meeting in Chicago, USA.

The OrthoView Trauma Module offers new functionality to meet the needs of orthopaedic surgeons working in trauma. By means of an easy-to-use package, trauma surgeons will have at their fingertips everything they require for all routine 2-D planning procedures. OrthoView’s intuitive Wizplates™ have been introduced for each class of prosthesis, enabling rapid sizing and positioning of templates.

The new Module will support the following classes of trauma prosthesis from all the major manufacturers: plates, screws, nails and prostheses for fractured neck of femur.

A major new addition to the image processing toolset includes ‘on-screen fracture reduction’ providing the surgeon with the ability to visually re-assemble a fracture.

Within the Module, attention has also been given to the widely adopted ‘AO Method’ so that its planning techniques, currently done with film, can now be performed on screen.

The Trauma Module is part of OrthoView 4.0, which includes the market leading joint replacement surgery functionality of earlier versions of OrthoView, plus the unique Paediatric Assessment toolset.

OrthoView is the world’s most widely used digital orthopaedic planning solution, used in hospitals and clinics throughout the globe. For a demonstration of the new package, visit the Company’s booth, No. 2952, at AAOS Annual Meeting in Chicago (22-24th March 2006). www.orthoview.com

Release for sale of this product will be 1st June, 2006.

Surgeon played opera video while operating

SHOULD a surgeon be able to watch opera on video while performing a major operation?

It’s already happening in Australia.

In a letter to the Medical Journal of Australia, West Australian anaesthetist Richard Riley outlines his concerns about how developments in entertainment technology have entered the operating theatre.

He witnessed one case in which a surgeon requested nursing staff to move a video-cassette player and monitor into the operating suite before a major operation. Once the operation had started, the surgeon directed an opera video be taken from his briefcase and played.

“The anaesthetic team were concerned about this, and the video player was turned off when the operation became more difficult,” Dr Riley wrote.

In another case, a surgeon operated while listening to music through ear phones from his digital music player.

“Before the operation began, the anaesthetist questioned the surgeon about the wisdom of this practice and asked several times if it might interfere with communication or concentration,” Dr Riley said. “The operation proceeded without incident with the surgeon listening to his music.”

Music is often played in operating theatres. Sydney neurosurgeon Charles Teo says without the “pleasant background” of Abba or Elvis love songs while he operates, his stress levels would be compounded by other audible distractions, such as the beeping of the monitors or the chatter of a nurse.

In a comment piece about Dr Riley’s concerns, Dr Teo said he could accept a person would be distracted by watching a video while operating. “Even if the surgeon was simply listening to the music, the video playing on the monitor would be a distraction to other theatre personnel,” he wrote in the journal.

Dr Teo said technology in the workplace must be continually re-evaluated.
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