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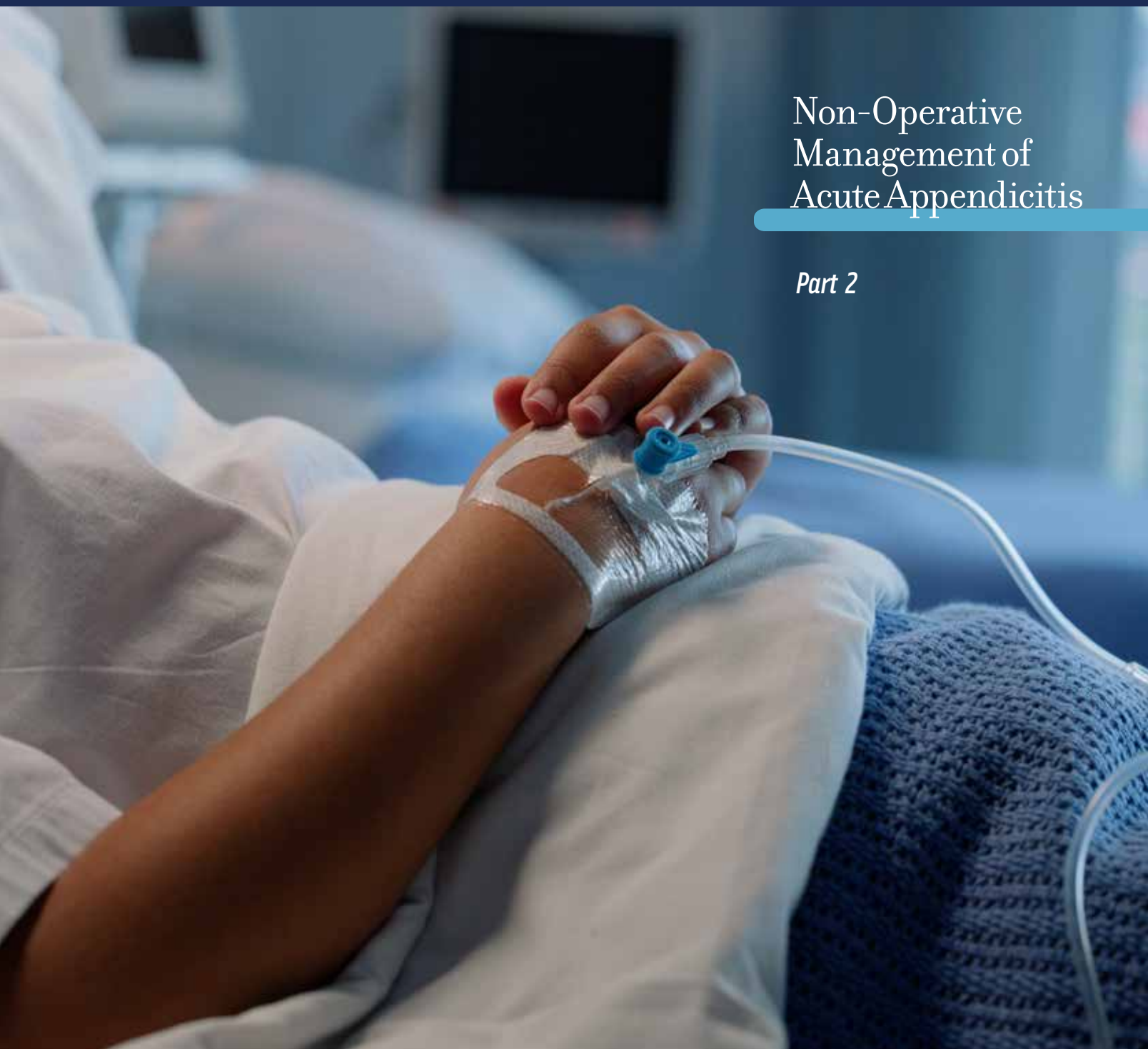
THE SURGICAL TECHNOLOGIST

OFFICIAL JOURNAL OF THE ASSOCIATION OF SURGICAL TECHNOLOGISTS, INC.



Non-Operative Management of Acute Appendicitis

Part 2

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Non-Operative Management of Acute Appendicitis, Part 2

Kevin B. Frey, CST

In the part one article, the anatomy and physiology of the appendix was described as well as the pathophysiology of appendicitis and methods of diagnosis. This article will focus on the somewhat controversial subject of nonoperative management of appendicitis through the administration of antibiotics and aggressive fluid hydration. The results of recent studies will be presented that will provide the reader with pros and cons of what is best for patients.

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Leadership, Accountability, and the Future of AST

DAVE BLEVINS, CST, CSFA, FAST

BOARD MESSAGE

As I conclude my term on the Board of Directors of the Association of Surgical Technologists (AST), I find myself reflecting not only on what we accomplished, but on the responsibility that comes with leadership in a member-driven organization. Serving on the Board reinforced that AST is strongest when its members are *informed, engaged,* and *willing to hold their organization - and leadership - accountable.*

During my time in office, I was consistently reminded that AST exists to serve surgical technologists, educators, and students, and ultimately to protect patient safety. Board members are entrusted with decisions affecting advocacy efforts, educational standards, certification support, and stewardship of member resources. That trust is not automatic or permanent; it must be *earned and maintained* through *transparency, ethical decision-making*, and *open communication.* Meaningful accountability from the membership is essential to that process.

I recognize that there can sometimes be confusion regarding the distinct roles of the Board of Directors and the organization's professional staff. An educated membership is an engaged membership, one that can vote thoughtfully and make decisions in the best interest of the organization as a whole.

The role of the Board is fundamentally strategic. It looks ahead, assesses challenges facing the profession, identifies barriers to advancement, and establishes long-term goals to overcome them. The Board shapes vision, sets policy, ensures fiscal oversight, and guides the organization so that surgical technologists not only participate in healthcare, but also help define and elevate patient care standards. We must continue striving to lead within the operating room, ensuring our expertise, training, and professional voice are recognized, rather than remaining behind a silent mask while others determine what is best for our profession.

In contrast, the professional staff serve as the operational backbone of the organization. They translate the Board's strategic direction into action. Staff manage the day-to-day functions that keep AST running effectively, including implementing programs, coordinating conferences and educational events, overseeing member services, executing communications, managing logistics, maintaining financial and administrative systems, and ensuring continuity and stability. Their work is detail-oriented and essential to maintaining the structure that allows AST to function efficiently and professionally.

Simply put, the Board sets the course, and the staff navigate the daily waters.

Neither can function successfully without the other. Strategic vision without operational execution cannot succeed. Operational excellence without strategic direction lacks purpose. Both are essential. Both are interdependent. Both exist to serve the membership.

As I step away from this role, my hope is that members continue to engage boldly and professionally. Use your voice. Participate in elections and committees. Hold leadership to the high standards our profession demands. AST will remain a strong, credible, and effective advocate for surgical technologists only if its members continue to speak thoughtfully and without hesitation.

As you evaluate leadership and cast your votes, keep these complementary roles in mind. An informed member is an empowered member. When you understand how your organization functions, you are better equipped to select leaders who think strategically, govern responsibly, and collaborate effectively with staff to advance our shared mission.

AST needs engaged members just as members need a strong AST. We stand united for our patients, our profession, our future, and for a safer operating room.

Empower YOURSELF

YOUR VOICE, YOUR POWER

- The Workforce Shortage: A Message from AST
- Turning the Workforce Chute into a Ladder
- CSTs Many Lifesaving Roles
- Education and Certification as an Appropriate Minimum
- Standard for Surgical Technology and Patient Safety
- AST Position Statement on Minimum Education for Surgical Technologists
- AST Position Statement on Accreditation, Certification, Official Title of the Profession, and OJT Training
- ACS Statement Supporting Surgical Technology Accredited Education and the CST
- AORN Job Description Supporting Surgical Technology Accredited Education and the CST
- AST Encourages Healthcare Facility Leaders to Support Local, Accredited Surgical Technology Educational Programs
- AST Recommendations for CSTs, Program Directors, and State Assemblies when Addressing OTH Training with a Healthcare Facility
- Message to Surgical Technology Program Directors Regarding Alternative Certification Credentials from the AST, ARC/STSA, and NBSTSA
- Should Healthcare Facilities Require CST Certification for Surgical Technologists? Yes...Here's Why

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AST News

AT A GLANCE

CALL FOR SPEAKERS

AST is looking for speakers for our 2027 annual Surgical Technology Conference and Educators Conference. Know someone who would be a good fit for either event? Apply or encourage them to complete our speaker form on our website – ast.org – Conference.

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- Package 27 – 6.75 CEs - $12 - Alternative Surgical Approach for Inflatable Penile Prosthesis Removal; Androgen Receptor-Positive Ductal Adenocarcinoma of the Nasolacrimal Duct: A Case Report; Complex Redo Cervical and Vertebral Artery Reconstruction for Takayasu Arteritis; Current Issues in Patient Safety in Surgery: A Review; A Rare Case of Peritonsillar Abscess Resulting in Cervical Necrotizing Fasciitis
- Package 28 – 7.25 CEs - $12 - Eagle's Syndrome; Endoscopically Controlled Surgery with Open Hemilaminectomy; Evidence-Based Surgical Technique for Medial Unicompartmental Knee Arthroplasty; Fluorescent Angiography Used as a Tool to Guide Angiosome-Directed Endovascular Therapy
- Package 29 – 30 CEs - $50 - Association of Anaesthetists guidelines: Cell Salvage for peri-operative blood conservation 2018; AST Guidelines for Best Practices in Intraoperative Cell Salvage; AST Guidelines for Massive

Transfusion of the Surgical Patient; AST Guidelines for the Natural Rubber Latex Allergic Patient; Preparing your intensive care unit for the Covid-19 pandemic: practical considerations and strategies; The impact of the Covid-19 pandemic in an intensive care unit (ICU): Psychiatric symptoms in healthcare professionals; Prone Positioning for Acute Respiratory Distress Syndrome (ARDS); Improving Prone Positioning for Severe Acute Respiratory Distress Syndrome During the COVID-19 Pandemic; What is Proning and How May It Help COVID-19 Patients?; Suicide Assessment in Hospital Emergency Departments: Implications for Patient Satisfaction and Compliance; AST Guidelines for Treatment of Anaphylactic Reaction in the Surgical Patient; AST Guidelines for Treatment of Disseminated Intravascular Coagulation; AST Guidelines for Best Practices in Urinary Catheterization; Vital Signs; Current Surgical Management of Breast Cancer, Dr. Adam Riker; Ophthalmology Updates, Dr. Wesley Ross; What's New in the Transplant OR, Dr. Anil Paramesh; What's New in Hernia Surgery - An Overview of Robotic Repair, Dr. Angelle Gelvin

- Package 30 – 38 CEs - $64 – A-Scope ORIF 14 Yr. old girl; Colonic Crohn's disease; Reconstruction of upper pole artery; Cryoablation for atrial fibrillation; Scapular fractures; Gastric banding; Metatarsal lengthening; Minimal access surgery; Peritoneal bx procedures; Shortening osteotomies for hip replacement; Above-ankle amputations; Extraction broken IM nail; Tommy John surgery; Surgery for stage II uterine cx; Pediatric Cardiac Transplantation; The Role of the First Assistant in Cardiovascular Surgery; Emergent Trauma Surgery: The Crash Laparotomy and Thoracotomy; Robotic Bariatric Surgery; Outpatient Minimally Invasive Anterior Hip and Robotic Knee Replacement Surgery; Cortical Screws: A Gateway Technique to Minimally Invasive TLIF; Treatment Options for Fibroids—What's New; Evolution of Lymphadenectomy;
- Package 31 – 14.5 CEs - $23 – Hepatectomy to Treat Hepatocellular Cancer; Surgery and Von Willebrand Disease; Aortic Valve Replacement; Hypospadias Repair with Bilateral Salpingo-Oophorectomy; Anterior Approach to Total Hip Arthroplasty; Treating Glioblastoma Multiforme; Ulnar Collateral Ligament Reconstruction; Total Abdominal Hysterectomy with Bilateral Salpingo-Oophorectomy; Cervical Laminoplasty; Left Ureteral Reimplantation
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Have you recently served on a medical mission? If so, you may be eligible to apply for a medical mission scholarship.

Eligibility

To be eligible for a mission scholarship you must:

- Be an active AST member with currency.
- Complete and submit the Mission Medical Application and the Medical Mission Verification Form by December 31 of the year of your mission.
- Provide a description of your membership history—join date and any AST involvement.
- Upload official documentation of the mission program you have described.
- Upload official receipts documenting the costs incurred by the individual and all costs must be shown in dollars. All assistance is determined after the medical mission trip has occurred and the appropriate documentation has been provided. Upload supporting documents below.
- Upload two letters of recommendation, along with an article describing your experience for *The Surgical Technologist* journal and related photos.
- Write an article describing your experience for *The Surgical Technologist* and provide related photos before you are reimbursed.

MILESTONES

Happy Anniversary!

Congratulations to the following state assembly as it celebrates its anniversary this month! AST appreciates your hard work, dedication, and all your years of service for making our state assemblies the backbone of this organization.

- Tennessee - 26 years

A Message From AST's CEO

JODI LICALZI, CHIEF EXECUTIVE OFFICER

As the professional organization for surgical technology, it is AST's job to help grow and develop the profession while showcasing the crucial role of a surgical technologist. We consistently hear members say, "no one knows who we are." One of AST's strategic initiatives is to change that – or at least make progress in that area – so that more general public are aware of surgical technologists and how crucial of a role they embody in the operating room and caring for patients.

Although we realize that it will take time to for the general public to recognize this specialized role behind the mask, we decided to focus on early education learners in an effort to influence more students to consider this pathway for entering the workforce. Last year AST entered a partnership agreement with HOSA - Future Healthcare Leaders. As part of this partnership, AST was able to design and implement a surgical technologist skills training program at their international event that sees over 10,000 attendees every year. It also allowed us to encourage states to connect with its local HOSA chapters on partnering on events within their areas. HOSA reported that within the last six months, surgical technology competitions have increased to include over 1,600 competitions with 30 states participating.

That's huge! Impacting local communities within in a relatively short period helps spread awareness of this profession while also allowing practitioners to highlight and feature their skills while encouraging others to join the industry.

We have renewed our partnership with HOSA for 2026 and look forward to even more awareness and involvement to come and we continue to encourage all states to connect with their local chapters to continue providing this pathway for those students who are looking for their next step.

Find your local HOSA chapters: https://hosa.org/chartered-associations/

I had the pleasure of attending the Texas State Assembly meeting at the beginning of March. Alongside AST Vice President Dustin Cain (left), Texas State Assembly President Kristie Cole (second to left) and AST Director and Texas State Assembly Treasurer Jaime Lopez, we engaged with more than 400 AST members in Texas about what lays ahead for the organization and what the most pressing topics are for members and how the organization can best support our members' needs.

This will also be our second year participating in the High School Counselors of America events as we look to continue spreading awareness to instrumental influences who can guide students to explore a career within surgical technology. By connecting to professionals who recommend career tracks to the future of workers, we are providing connections to programs, community and local resources such as you all, and spreading the word about the profession.

Staying relevant and up to date

AST also is prioritizing updated and relevant resources. AST's Education and Professional Standards Committee (EPSC) is currently reviewing all our standards to ensure we are providing up-to-date and relevant guidelines that support your role.

For the last couple of months, we have had guidelines posted on our website for public comment and rely on our membership and other industry experts to provide feedback so that we may make our guidelines industry standards that can be easily assessed within all facilities and for all OR teams. Your comments and feedback help make these resources stronger and we appreciate everyone who has taken the time to submit comments.

Last year we kicked off AST's Compass Survey, a practice we will continue yearly. While last summer's survey focused on general areas our next survey will focus on education and educational resources. It is impertinent that when you receive that survey, you take a few minutes to respond with your feedback so we can ensure we are providing the resources that are needed for you as well as focusing on developing education that you want and need to bolster your career and strengthen your role on the OR team. In addition to the surveys, we will also be kicking off a series of focus groups to gather more data and input on where AST should focus in the next three to five years. If you are interested in participating in AST's focus groups, please watch your email for an invite.

Education is among one of the biggest resources we can provide our membership and the profession. We have committed to expand our educational offerings with relevant education and training, with offering as many hands-on training opportunities as possible. While I recognize these are all hands-on experiences connected with our national events, these experiences are laying the groundwork for us to develop, partner and deliver one-of-the-kind educational trainings that we can offer our members to enhance their role and have access to the latest technologies and techniques.

> "Impacting local communities within in a relatively short period helps spread awareness of this profession while also allowing practitioners to highlight and feature their skills while encouraging others to join the industry."

New this year at conference, and something I am really excited about is our Escape Room: Surgical Style. In small groups, attendees will be able to work together to save the patient and test their skills. A big thanks to Seattle Technology who will build us a mock OR at the conference center, which will allow us to offer attendees an engaging and exciting way to reinforce techniques and training and earn continuing education credit.

Other featured highlights at this year's AST's Surgical Technology Conference in Seattle include:

- Hands-on DaVinci training including one specifically for students provided by Intuitive Surgical. If you're an educator, it's not too late to sign your students up for this golden opportunity of robotics training.
- A CSFA casting workshop
- A career training track
- And the ability to explore career pathways that you may not be aware of as explained by your fellow techs

Our goal soon is to bring these types of experiences to members across the country and provide interactive, engaging content no matter where you are as well as build a database full of engaging, interactive content that reinforces best practices and relevant protocols that assist you in your role. By continuing to partner with industry experts and supportive organizations, we look forward to bringing you the tools and resources you desire.

We hope that you'll join us for an exciting and inspiring conference in Seattle at the end of the month. But if not, we ask you to take a few minutes to complete our surveys when they hit your inbox and even choose to participate in focus groups so that we may deliver more opportunities that assist us in delivering AST's mission as we continue our work on enhancing the profession.

Non-Operative Management of Acute Appendicitis, Part 2

Kevin B. Frey, CST

Nonoperative management (NOM) may be a cost-saving alternative to surgery, but multiple issues surround its use in treating appendicitis, particularly in pediatric patients. The decision to nonoperatively treat the patient is one that must take into consideration the consequences of recurrence and if the better clinical choice is to operate. Before delving further into the subject, a review of the terminology that was presented in "Review of the Appendix and Appendicitis, Part 1," published in March 2026, is appropriate as well as brief reminder of the importance of exploring alternatives to surgery.

The general term that refers to sudden appendicitis is acute appendicitis. It includes the subcategories of complicated appendicitis and uncomplicated appendicitis. A patient diagnosed with complicated appendicitis presents with an abscess, appendiceal rupture, and inflamed mass (phlegmon). Uncomplicated appendicitis, also referred to as acute uncomplicated appendicitis, is characterized by an inflamed appendix without signs of necrosis or rupture. The diagnostic features of these two types of appendicitis must be remembered as they are key to understanding the clinical decision to perform or not to perform surgery.

Appendicitis is the most common surgical diagnosis in children, with an estimated 83 cases per 100,000 children in the US on an annual basis.[1] It is the fifth most common reason for admission to the hospital for children in the US.[2] Children are at a higher risk for perforation as compared to adults, with approximately 30% of pediatric patients admitted to the hospital having experienced perforation.[3]

In 2018, within the age group of 0 – 17, appendectomy was one of the five most costly procedures. The national costs of hospital stays for the procedure in the US were $298 million for men and $194 million for women,

LEARNING OBJECTIVES

- Discuss the factors that must be considered in the decision-making process of nonoperative versus operative management of uncomplicated acute appendicitis
- Review the details of recent studies comparing antibiotic treatment to surgery
- Learn about the advantages of nonoperative treatment versus surgery
- Identify the clinical criteria and contraindications used to determine pediatric patient eligibility for nonoperative management of uncomplicated appendicitis
- Describe the potential risks, recurrence patterns, and long-term outcomes associated with antibiotic-only treatment for uncomplicated appendicitis

KEYWORDS
acute appendicitis, complicated appendicitis, nonoperative management, uncomplicated appendicitis

DEFINITIONS
Appendicolith: A calcified mass that forms inside the appendix. It primarily consists of calcium salts and fecal material. The mass can vary in size. The mass can obstruct the appendix, causing inflammation and resulting appendicitis.

accounting for 23,800 days in the hospital.[4] As evidenced later in the article, controlling costs is one of the motivations for NOM.

RESULTS OF STUDIES

Clinical trials have been conducted for several years to determine the efficacy of NOM, meaning the administration of antibiotics and IV fluid hydration only, in the treatment of uncomplicated appendicitis. A primary issue of this treatment approach has been the recurrence of appendicitis within a short period of time raising the concern if surgery should have been performed in the first place. The following are brief summaries of key studies to highlight the uncertainty within the surgical community regarding balancing what is best for both the patient and contributing towards the control of medical costs.

The results of a study published in 1995 showed that antibiotic treatment in patients with uncomplicated appendicitis was as effective as surgery. Forty patients with abdominal pain of less than 72 hours were divided into two groups of 20.[5] One group underwent surgery, and the second group received antibiotics intravenously (IV) for two days followed by treatment for another eight days.[5] The patients that received antibiotics had a high recurrence rate.

In a study published in 2009, 106 patients were placed in the antibiotics group and 154 underwent an appendectomy.[6] The treatment efficacy for the antibiotic group was 90.8%.[6] Recurrent appendicitis occurred in one-third of the group within ten days and two-thirds between three and 16 months.[6] Major complications, however, were much higher in patients who initially underwent an appendectomy. The conclusion of the research team was that antibiotic treatment "appears to be a safe first-line therapy."[6]

A trial comparing appendectomy to antibiotic therapy in which patients completed a 10-day course of antibiotics was conducted at 25 US centers.[7] The total number of adults included in the study was 1,552 with 414 of those presenting with an appendicolith. The group was evenly divided with 776 that received antibiotics and 776 that underwent an appendectomy. In the antibiotics group, 29% underwent an appendectomy within 90 days.[7] Of that percentage, 41% had an appendicolith and 25% without an appendicolith.[7] Complications were more common in the antibiotic group, but this was attributed to the high percentage of patients with an appendicolith. The researchers concluded, however, that antibiotic treatment was noninferior to appendectomy.[7]

A study published in 2021 was conducted at 97 hospitals in the United Kingdom and Republic of Ireland. The aim of the study included 90-day follow-up of patients.[8] A total of 3,420 patients were included in the study with 1,402 (41%) that were treated with antibiotics and 2,018 (59%) that underwent an appendectomy.[8] At the 90-day follow-up mark, 1,116 patients (80%) of the 1,402 were successfully treated with antibiotics.[8] The researchers also noted the antibiotic group had fewer complications and a shorter length of stay in the hospital. The cost of treating patients with antibiotics was lower by $1,387.48 ($1,665.40 in 2026 accounting for inflation) per patient.[8] The researchers concluded that antibiotics is an alternative first-line treatment and can lead to reduced costs.

> "The question, based on the research, obviously becomes to operate or not to operate."

Another study published in 2021 involved 186 patients who were randomly placed into the antibiotic-group only and the surgery group. Based on the results of the clinical trial the researchers commented, "Patients with acute,

uncomplicated appendicitis treated with antibiotics only experience high recurrence rates and an inferior quality of life. Surgery should remain the mainstay of treatment for this commonly encountered acute surgical condition."[9]

One of the most recent studies was published in 2025 in the *Journal of the American College of Surgeons*. The analysis of data involved 1,068 patients, age 7 – 17, with uncomplicated appendicitis. The study population comprised 370 that received antibiotic treatment and 698 that underwent laparoscopic appendectomy. The data showed that the antibiotics-only patients had less pain and fewer days away from school during the first year after the initial hospital visit.[10] In 2023 dollars, the average cost of a laparoscopic procedure was $9,791, and the cost per patient for NOM was $8,044.[10] The researchers concluded the cost analysis shows that NOM of uncomplicated appendicitis is a cost-effective patient management strategy over one year when compared to surgery.[10]

Two other studies showed that medical costs were much higher. One study showed a higher cost of $1,067 per patient when surgically treating uncomplicated appendicitis.[11,12] The landmark Finnish trial, Appendicitis Acuta (APPAC), conducted from 2009 to 2021, showed the costs for performing surgery were 1.6 and 1.4 time higher in patient follow-ups at 1- and 5-years, respectively.[13]

DISCUSSION

The question, based on the research, obviously becomes to operate or not to operate. The number of extensive studies has generated a mix of contradictory results and conclusions as evidenced by the summaries of clinical studies in the previous section. Although there are studies whose results show the option of using antibiotics alone is a feasible treatment option, clinicians should most likely exercise caution when considering NOM.

Regardless of the advancements that have been made in treating uncomplicated appendicitis with antibiotics, appendectomy has been the primary treatment for more than 120 years.[7,14-16] Though large clinical trials have shown that while NOM might have comparable or better results in the short term, as many as 25% to 40% of antibiotics-only patients wind up requiring an appendectomy within a year.[7,14,16] Other studies have also indicated that 46% of patients underwent an appendectomy at 2 years and increased to 49% at 3 and 4 years.[14] Additionally, for those patients who have a poor clinical response to NOM or experience worsening symptoms or recurrence, the only option is surgery.[17] On the positive side, NOM may be an advantageous treatment for patients situated in a remote medical care environment or locations where resources are scarce, such as U.S. Navy personnel assigned to a submarine.[14,18] Evidence has suggested that antibiotics have been effective in resolving or delaying surgery for individuals in that type of situation or similar if the appendicitis is identified prior to late-stage inflammation.[19,20]

NOM may be considered for selected children who meet specific criteria. The inclusion criteria include[21]:

- being older than 7 years of age,
- a white blood cell count between 5,000 and 18,000 (see Part 1 article published in March 2026 for further information regarding normal leukocyte counts),
- symptoms have been occurring for less than 48 hours,
- imaging results confirm nonperforated appendicitis (see Part 1 for further information regarding methods of imaging for diagnosing appendicitis),
- an appendiceal diameter of less than 1.1 centimeter, and
- the absence of abscess, appendicolith, or phlegmon.

The criteria that are particularly predictive of NOM failure are prolonged symptoms and presence of abscess or an appendicolith.[21] Children whose symptoms fail to improve including persistent pain, fever, or are incapable of tolerating a normal diet should undergo an urgent appendectomy.

Patients that opt for NOM should be advised as to the potential for the progression of the symptoms of appendicitis despite the treatment with antibiotics, the chance of appendicitis reoccurring, and, in rare instances, missed neoplasms of the appendix (see Part 1 article published in March 2026 for further information regarding neoplasms). Furthermore, NOM is contraindicated in immunocompromised patients, pregnant patients, patients with a hemodynamic instability, patients undergoing chemotherapy, and patients with a history of inflammatory bowel disease.[14,17] Based upon the novel approach of NOM, the importance of shared decision-making between the physician and the patient cannot be overemphasized, including patient-centered decision-making to ensure that the appendicitis is identified as uncomplicated, which occurs in approximately 60% to 70% of cases, versus complicated.[14]

NOM involves extensive fluid hydration and the administration of the proper antibiotic therapy, either orally or IV.[17] The treatment generally includes 1 to 2 days of IV antibiotics, followed by the patient taking oral antibiotics for 7- to 10-days as long as the clinical symptoms improve.[21] When a patient is treated by NOM, the treatment involves a combination of antibiotics to eliminate aerobic and anaerobic bacteria.[22,23] A third-generation cephalosporin, such as cefo-

"Appendectomy has been the primary treatment for more than 120 years... whereas NOM, being a fairly novel method of treating uncomplicated appendicitis, does not have documented long-term results."

taxime, or a beta-lactam, such as ampicillin, provides coverage for aerobic gram-negative bacteria.[22] Clindamycin or metronidazole provide coverage for anaerobic bacteria.[22] The decision, however, on the choice of antibiotics will be based on the patient's circumstances including allergies and experience with previous antibiotic administration.

The discussion of cost is another gray area. As presented in the previous section, some studies have shown that NOM may be less expensive as compared to surgery. Other clinicians, however, argue that appendectomy, in the long run, is least expensive for the following reasons:

- Appendectomy has an evidence-based history of a high level of success and efficacy. In other words, it has a low failure rate. Whereas, NOM, being a novel method of treating uncomplicated appendicitis, does not have documented long-term results.
- Other costs should be taken into consideration when treating a patient with antibiotics only, including clinical personnel and the length of patient follow-up that is required for NOM.[14]
- The combined costs also need to be considered. If a patient immediately undergoes an appendectomy, they are paying only for the surgery. Patients that opt for NOM, however, are paying for the costs of that treatment with the strong possibility of then having to pay for surgery in 1 – 5 years.

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Non-Operative Management of Acute Appendicitis, Part 2

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1. **NOM can be effective for patients situated in a remote location who have late-stage inflammation.**
   a. True
   b. False

2. **Which of the following is a contraindication for NOM?**
   a. Patients who underwent previous abdominal surgery
   b. Patients with temperatures above 101 degrees
   c. Dehydrated patient
   d. Pregnant patient

3. **Which of the following medical terms refers to an inflamed mass?**
   a. Appendicolith
   b. Calcinosis
   c. Phlegmon
   d. Ossificans

4. **Which of the following is a false statement regarding NOM inclusion criteria for children?**
   a. WBC of 5,000 – 18,000
   b. < 1.1-centimeter appendiceal diameter
   c. Older than 7 years of age
   d. Symptoms have occurred for less than 72 hours

5. **Which of the following antibiotics are effective against anaerobic bacteria?**
   a. Clindamycin
   b. Ampicillin
   c. Cefotaxime
   d. Aminoglycosides

6. **Multiple studies have shown a significantly lower cost associated in treating patients with antibiotics alone as compared to surgery.**
   a. True
   b. False

7. **How many days will the patient take oral antibiotics after completing the course of IV antibiotics?**
   a. 4 – 7
   b. 5 – 8
   c. 6 – 9
   d. 7 – 10

8. **What is the estimated number of appendicitis cases per 100,000 children per year?**
   a. 83
   b. 73
   c. 63
   d. 53

9. **What percentage of cases are uncomplicated?**
   a. 50% - 60%
   b. 55% - 65%
   c. 60% - 70%
   d. 65% - 75%

10. **What is the estimated percentage of patients that are treated with antibiotics only who undergo an appendectomy within a year?**
    a. 25% - 40%
    b. 30% - 45%
    c. 35% - 50%
    d. 40% - 55%

NON-OPERATIVE MANAGEMENT OF ACUTE APPENDICITIS, PART 2
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SEATTLE

AST SURGICAL TECHNOLOGY CONFERENCE

Sunday, May 31 - Tuesday, June 2, 2026 | Seattle, Washington
The Summit - Seattle Convention Center, 900 Pine St, Seattle, WA 98101

Join us at the AST Surgical Technology Conference in Seattle for an inspiring and energizing experience designed specifically for surgical technology professionals. Conferences like this provide a valuable opportunity to connect with peers from across the country, exchange ideas, and strengthen the professional community that supports excellence in patient care. You'll gain insight into the latest surgical technology techniques, emerging trends, and best practices through expert-led sessions and hands-on learning opportunities that can immediately impact your work in the OR.

Beyond the conference, Seattle offers plenty to explore. Visit the iconic Space Needle for stunning city views, stroll through Pike Place Market to experience local food and culture, or enjoy fresh seafood along the waterfront. Coffee lovers can also take advantage of the city's vibrant café scene. We look forward to welcoming you to a conference experience that combines professional growth with the energy and beauty of The Emerald City.

AST
Association of Surgical Technologists

NEW SETUP THIS YEAR

Sunday, May 31 – Tuesday, June 2, 2026
Seattle, Washington

Conference Location: The Summit - Seattle Convention Center, 900 Pine St, Seattle, WA 98101

Group Hotel: The Westin Seattle, 1900 5th Ave, Seattle, WA 98101
Room block closes on Tuesday, May 5, after which hotel rates will increase. Book today!

Iconic Seattle Experiences

Space Needle – Go up for panoramic views of the city, Mount Rainier, and Puget Sound.

Seattle Great Wheel – A relaxing way to see the waterfront, especially at sunset.

Pike Place Market – Watch the fish toss, explore local shops, and grab fresh seafood or pastries.

Chihuly Garden and Glass – Stunning glass art right next to the Space Needle.

Coffee hopping – Try local favorites like Storyville, Victrola, or Elm Coffee (beyond Starbucks).

Seafood – Don't miss salmon, chowder, or Dungeness crab.

Food tours – Especially around Pike Place or Capitol Hill.

REGISTRATION IS OPEN!

	Regular	After 4/30 - onsite
Member	$425	$500
Student	$150	$200
Student - NM	$195	$245
Non-member	$580	$620
Retired/Disabled	$225	

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$75 OFF regular member registration rate!

Neighborhoods & Culture

Capitol Hill – Lively area with shops, nightlife, and great restaurants.

Fremont – Funky, artsy, and home to the famous Fremont Troll.

Ballard Locks – Watch boats pass through and (seasonally) see salmon swim upstream.

Museum of Pop Culture (MoPOP) – Music, sci-fi, and pop culture in a striking building.

Nature & Outdoor Activities

Capitol Hill – Discovery Park – Forest trails, beaches, and lighthouse views.

Kerry Park – One of the best skyline photo spots.

Waterfront walk or ferry ride – Take a ferry to Bainbridge Island for views and a charming town.

Sports & Entertainment

- Catch a Seahawks, Mariners, or Sounders game.
- Enjoy live music—Seattle's scene is legendary.
- Comedy shows, theater, and concerts are easy to find year-round.

Step into the OR like never before with our Surgical Technologist Escape Room—a fast-paced, immersive experience where precision, teamwork, and critical thinking are the keys to success. Participants must solve clinically inspired puzzles, identify emergent protocol processes, follow sterile technique, and respond to realistic surgical scenarios—all against the clock. Perfect for students, educators, and CST, this interactive challenge turns essential surgical tech skills into an unforgettable, high-energy adventure. Can your team scrub in, think fast, and save the patient?

Local Tips

- Dress in layers—weather can change quickly.
- Public transit and walking work well downtown.
- Don't let light rain stop you—it's part of the Seattle vibe.

SPEAKERS

Sunday, May 31, 2026 | 5 CEs

Joseph Cuschieri, MD, FACS

Chaos to Control: The Art of the Trauma Laparotomy

Chaos to Control: The Art of the Trauma Laparotomy explores how surgical technologists play a pivotal role in transforming high-acuity trauma operations from moments of crisis into coordinated, life-saving care. Using real-world trauma scenarios, this session walks participants through the rapid preparation of the operating room, essential instrumentation for emergent abdominal surgery, and the stepwise progression of a trauma laparotomy from incision to closure.

Chigozirim Ekeke, MD

The SHARP Method™: A Surgeon's Framework for Introducing New Techniques and Managing Intraoperative Emergencies

The SHARP Method™ is a decision-making framework developed from your thoracic oncology and complex chest wall surgery experience. The acronym—Scan, Halt, Assess, Respond, Perfect—translates surgical protocols achieving reliability into a repeatable mental model for high-stakes environments. The session addresses two critical OR scenarios:

- systematically adopting new surgical techniques and
- maintaining clarity during intraoperative emergencies.

Mona Bourbonnais, CST, FAST

Beyond the Back Table: Building a Sustainable Surgical Workforce through Accredited Education, Certification, and Residency Models.

Behind every successful surgery should be a team built on trust, skill, and rigorous training. In this session, we'll explore how formally educated surgical technologists are vital to ensuring patient safety and procedural success. We'll highlight the crucial role of education in aseptic technique, collaboration, and adapting to evolving OR demands—showcasing how investing in strategic alliances with accredited programs and structured onboarding empowers your entire surgical team to put the patient first.

Sunday, May 31, 2026 | 5 CEs

Julie Sosa, MD, MA, FACS, MAMSE, FSSO

Innovation and Change in Endocrine Surgery Operating Rooms

This session will detail the changes in endocrine surgery (parathyroid, adrenal, thyroid) practice that translate into innovation and new approaches in the operating room or different practice settings. Among the topics that will be addressed are minimally invasive parathyroidectomy, parathyroid gland autofluorescence, posterior retroperitoneoscopic adrenalectomy, radiofrequency ablation and evidence-based guidelines for the management of thyroid cancer that were published in 2025. The presentation will also highlight how the national shift toward ambulatory setting endocrine surgery affects the procedure and the OR team.

Nicole Presa, CST, QHMP-CS

Beyond Technique: The Emotional Skills That Prevent OR Mistakes

The Operating Room is one of the most technically demanding environments in healthcare. Yet research consistently shows that a significant portion of surgical errors stem not from a lack of skill but from communication breakdowns, emotional overload, unresolved tension, and momentary lapses in attention. Surgical technologists work at the center of a high-pressure system, where emotional intelligence (EQ) becomes not just a "soft skill," but a critical component of patient safety. This session explores how emotional intelligence directly impacts error rates in the OR, particularly during high-stress cases, unexpected complications, and moments of interpersonal conflict.

Tasce Bongiovanni, MD, MPP, MHS, FACS

Robotics in Acute Care Surgery; The Good, the Bad, the Future

This presentation examines how robotic technology is being used in acute care surgery today, outlining its key advantages, its practical and clinical limitations, and the innovations that may shape its future role. Attendees will gain a balanced view of the opportunities and challenges as robotics continues to evolve in emergency surgical care.

Alyssa Ellis, CST, CSFA

Where Precision Meets Passion: Precepting Technique

Learn about which precepting techniques help change the OR culture in a positive effect while recognizing how to deter and and anticipate while being more efficient with less steps.

SPEAKERS

Monday, June 1, 2026 | 6 CEs

Elina Quiroga, MD, MPH, FACS

Management of Traumatic Vascular Injuries

A focused overview of how traumatic vascular injuries are managed, highlighting key principles in diagnosis and intervention. The summary also examines current treatment approaches for vascular injuries more broadly, including the recognition and management of iatrogenic vascular complications that arise during medical procedures.

Jorge Soledad, MD, MPH

Gynecologic Oncology Surgery 101: What Every Surgical Technologist Should Know

This presentation introduces the essential principles of gynecologic oncology surgery that every surgical technologist should understand. It outlines common procedures, key anatomical considerations, and the technologist's critical role in ensuring safety, efficiency, and optimal patient outcomes in the gynecologic oncology operating room.

Clinton Morrison, MD, FACS

Reengineering the Human Skull: Current Management of Infant Craniosynstosis

Genetics, embryology, diagnosis and management of infant craniosynostosis including the team-based approach to care including multidisciplinary specialists will be presented as discussions include operative interventions from minimally invasive to maximally invasive approaches including preoperative care.

From Scrub Tech to Sales Rep: Industry and Vendor Opportunities

Cortney Hartman, MBA, CST, FAST

BEYOND THE MAYO

You know the instruments, the workflow, and the pressure of a busy operating room. You've seen which devices improve efficiency and which ones fall short. You understand surgeons' preferences better than most sales reps ever could. That's why more and more certified surgical technologists (CSTs®) are finding their next career step in the medical device industry.

Transitioning into industry roles — such as surgical sales representative, product educator, or clinical specialist — offers CSTs the chance to stay close to the OR while taking their careers in an entirely new direction. If you've ever wondered what it's like to trade your scrubs for a business suit, this pathway may be worth exploring.

Why Industry Needs CSTs

The medical device field thrives on innovation, but selling new products in healthcare isn't just about marketing — it's about trust and expertise. Surgeons want to know that the person representing a product understands how it actually works in the OR. CSTs bring credibility because they've lived it:

- **Firsthand Knowledge:** CSTs understand instrumentation and workflow better than most.
- **Credibility in the OR:** Surgeons and nurses respect peers who have real clinical experience.
- **Problem-Solving Ability:** CSTs know how to troubleshoot under pressure — a skill that translates well to supporting new technology.

Industry values CSTs because they bridge the gap between product development and real-world application.

Roles for CSTs in Industry

The medical industry offers a variety of career paths for CSTs:

1. **Surgical Sales Representative**
   - Manages relationships with surgeons and hospitals.
   - Demonstrates products, negotiates contracts, and drives sales.
   - Requires strong communication, persistence, and business acumen.
2. **Clinical Specialist/Product Educator**
   - Provides training and in-case support for new products or devices.
   - Works alongside surgical teams during cases to ensure safe and effective use.
   - Ideal for CSTs who enjoy teaching and troubleshooting.
3. **Medical Device Trainer**
   - Focuses on educating hospital staff on new products and instruments.
   - May design workshops, training materials, and continuing education courses.
4. **Technical Support/Consultant**
   - Offers expertise during product launches or complex cases.
   - Acts as the liaison between the manufacturer and clinical teams.
5. **New Product Introduction**
   - Collaborates with R&D, marketing, and clinical teams to bring new surgical products to market.
   - Conducts hands-on evaluations, gathers clinical feedback, and helps refine device design or workflow integration.
   - Perfect for CSTs with strong technical insight and interest in bridging clinical practice with product innovation.

Each role offers different blends of sales, education, and clinical support, allowing CSTs to choose what fits best with their strengths.

Lifestyle Differences

Moving into industry brings lifestyle changes CSTs should weigh carefully:

- **Travel:** Many sales and clinical roles involve frequent travel, both locally and regionally. Some CSTs enjoy this variety; others may find it draining.
- **Schedule Flexibility:** Unlike predictable shift work, industry schedules are dictated by surgeon availability, case schedules, and travel demands.
- **Compensation:** Salaries in industry often exceed hospital pay, especially when commissions are included. However, income may fluctuate based on sales performance.
- **Independence:** CSTs moving into industry often work more autonomously, which can be freeing but also requires discipline.

The lifestyle can be exciting, but it's not for everyone. Knowing your energy levels, family commitments, and personality is key.

Skills to Build for Success

While CSTs already have clinical credibility, excelling in industry often requires new skills:

- **Sales & Negotiation:** Understanding how to build relationships, pitch products, and close deals.
- **Business Acumen:** Learning about contracts, purchasing processes, and healthcare finance.
- **Public Speaking:** Presenting products confidently to groups of surgeons or administrators.
- **Resilience:** Accepting rejection and continuing to pursue opportunities.

Many companies offer training, but CSTs can give themselves an edge by taking courses in sales, business, or communication before transitioning.

How to Break In

Landing a role in the competitive medical device field requires strategy:

- **Network First:** Reach out to industry reps you know from the OR. Ask about their career paths and whether their companies hire CSTs.
- **Polish Your Résumé:** Highlight your OR expertise, instrumentation knowledge, and any teaching or leadership experience.
- **Start with Clinical Specialist Roles:** Many CSTs use these positions as stepping stones into sales.
- **Show Initiative:** Express interest in product education or in-services at your hospital to build relevant experience.
- **Consider Smaller Companies:** While big-name device makers are appealing, smaller companies often offer more accessible entry points.

Persistence is key. Breaking into industry may take multiple applications, but CSTs who stay committed often succeed.

Challenges of the Transition

Like any career change, moving into industry has challenges:

- **Pressure to Sell:** Some CSTs struggle with the shift from patient care to revenue-driven goals.
- **Surgeon Expectations: S**urgeons may test your knowledge — preparation and confidence are essential.
- **Learning Curve:** Business terminology, contracts, and quotas may be unfamiliar at first. Some companies may require a business degree.

Recognizing these challenges and preparing for them helps CSTs adapt successfully.

Rewards of Industry Work

Despite the challenges, CSTs who move into industry often describe it as energizing and rewarding:

- **Financial Growth:** Many enjoy significantly higher income potential.
- **Professional Respect:** CST expertise earns credibility with surgeons and hospital staff.
- **Variety:** Each day brings new environments, people, and cases.
- **Impact:** Introducing new technology can directly improve patient outcomes.

For CSTs who thrive on challenge, independence, and variety, industry work can be an exciting next step.

Closing Thoughts

Transitioning from scrub tech to sales rep may seem like a leap — but CSTs already have the foundation to succeed. Your hands-on expertise, your credibility in the OR, and your adaptability under pressure make you uniquely qualified to represent surgical products and support innovation.

If you've ever watched a rep in the OR and thought, *I could do that — and do it better,* the industry may be calling your name.

The operating room has prepared you more than you realize. All that's left is the decision to step beyond the Mayo stand and into a career where your expertise shapes not just one surgery, but countless others.

Quick Reflection: Is Industry the Right Fit for You?

Do you enjoy teaching and explaining products to others?

- Are you comfortable with travel and flexible schedules?
- Do you thrive on challenge, independence, and variety?
- Are you motivated by financial growth and professional recognition?

If you answered yes, industry may be your next step.

My Path to Surgical Technology From the Heart of a Practitioner

Tammy Pearson, CST, CSFA, FAST

FINDING MY CALLING

The path we choose in life is often created by moments that leave a footprint on our hearts. For me, the journey toward becoming a surgical technologist began at the age of 16, in a hospital room filled with anxiety and hope. My grandmother was about to undergo open heart surgery. The surgeon came in explaining the procedure with both clarity and compassion, but to my 16-year-old brain, I was hooked! In that tense moment, something in me awakened, and I was overcome by a curiosity about the world of surgery and the people who make healing possible.

As my grandmother's surgery unfolded, I waited nervously, trying to remember all the medical terms the surgeon used to explain the procedure. The next morning in her hospital room, the gratitude I felt toward him was immense, not just for his skill, but for the hope he gave us. I realized then that surgery was not only about technical skills, but it was also about empathy, teamwork, and the chance to change lives. I just didn't understand the lev-

ity of it until I grew older. One day, I would stand alongside someone like him, helping to save lives.

From that moment on, I knew where my heart belonged. My high school counselor gave me a pamphlet for the local community college with the newest program offered as surgical technology, and I knew that would be my path someday. In 2006, I enrolled in the surgical technology program at Rolla Technical Center. I became addicted to the thrill of open heart and vascular procedures and, surprisingly yet contingently hired while a student to join the open heart team during my first clinical rotation. I was eager to master the skills and knowledge necessary to support surgeons in the operating room. Every rotation brought new challenges and revelations. I loved the precision, the attention to detail, and the sense of purpose that came with learning the procedures, instruments, maintaining a sterile environment, and anticipating the needs of the surgeon. My passion deepened, and I was fortunate enough to reconnect with the very heart surgeon who had inspired me years before. The only thing that kept me from my official role on the team was graduation and certification.

The culmination of my journey was both humbling and inspiring. By a twist of fate, I found myself working alongside the heart surgeon who had operated on my grandmother. He remembered me and welcomed my enthusiasm, entrusting me with responsibilities that tested my abilities and strengthened my resolve. The most profound moment came when I assisted him during his final open heart surgery before retirement. Standing by his side in the operating room, I reflected on how far I had come — from a frightened teenager to a confident certified surgical technologist and first assistant, helping the very person who once gave my family hope.

Finding my path to surgical technology has been a journey of gratitude, growth, and fulfillment. I am proud

to carry forward the legacy of compassion and excellence that first inspired me. As I continue my career, I am reminded that every operation is more than a procedure — it is a chance to touch lives, just as mine was indelibly touched years ago.

My story

Are you interested in sharing your story about discovering your passion and becoming a certified surgical technologist? If so, we would love to hear from you! Send your story and any photos to **publications@ast.org** and inspire others by telling us how you found your calling in the surgical technology profession.

Dr. William Wayne Babcock: Educator, Innovator, and Inventor

AST Staff

MEDICAL MARVELS

"We shall not scorn what was done yesterday, because we have something better today any more than our interest in the past will cause us to continue the practice of the past."[1]

Figure 1 *William Wayne Babcock, MD (6/10/1872 – 2/23/1963)*

Dr. Babcock was an American surgeon, educator, and innovator whose contributions to early 20th century surgery included the invention of surgical instruments that are still in use and development of surgical procedures that laid the groundwork for modern day procedures. His method of teaching reflected his own educational upbringing that emphasized not only academics, but that hands-on learning was just as important. His lasting legacy was also cemented by sharing his knowledge through many publications.

Early Years and Entering the Medical Profession

Dr. Babcock was born in East Worcester, a rural town in eastern New York that was a farming community at that time.[2] The limited educational opportunities that were typical of 19th century rural America combined with the life of farm work influenced his practical approach to problem-solving when developing innovative surgical techniques. During this time, he was apprenticed by a local physician while studying medicine and the classical subjects on his own.

In 1893, at the age of 21, he received his first medical degree from the College of Physicians and Surgeons in Baltimore, Maryland.[3] He went on to complete a one-year residency in Salt Lake City, Utah, and moved back to Philadelphia enrolling at the University of Pennsylvania, receiving a second medical degree in 1895.[3]

Academic Appointments

Dr. Babcock held various positions at hospitals in Philadelphia including pathologist and surgeon at the Kensington Hospital for Women and demonstrator of anatomy and pathology* at the Medico-Chirurgical College of Philadelphia, where he later completed training in gynecology and received a third medical degree.[3]

In 1903, Dr. Babcock was appointed as the Chair of Surgery at the Samaritan Hospital, which later became Temple University Hospital.[2,3] He was only 31 years old, indicating how quickly he made a name for himself as a surgeon and educator. He held this position until his retirement in 1943.[2] During this time he mentored many generations of surgeons and furthered the medical school's reputation as a leader in academics.[3] To support the American effort during World War I, he served as a commissioned caption in the U.S. Army Medical Corps but was not sent overseas.[4]

As an Author

Dr. Babcock was a prolific author having written over 100 articles that were published in prominent journals such as the *Annals of Surgery* and the *Journal of the Americal Medical Association*. The subject matter of his articles ranged from trauma management to oncologic surgical procedures and emphasizing that surgical practice should be strongly influenced by data-driven research.[2] He was the author of two of the most significant surgical textbooks of its time, *A Textbook of Surgery for Students and Physicians*, published in 1928, and *Principles and Practice of Surgery*, published in 1944, which was the established textbook for general surgery around the world for many years.[5] The textbook covered operative techniques and postoperative care of the patient, drawing upon his prior medical training and knowledge to provide students and surgeons insights on evidence-based decision-making.

Innovations in Surgery

Dr. Babcock is well-known for pioneering surgical procedures and techniques such as introducing the use of stainless steel as a suture material that he first used during gastrointestinal surgery. However, the four procedures he is most known for are the Babcock procedure, the Babcock – Bacon procedure, the soup bone cranioplasty technique, and the nerve disassociation technique.

Babcock Operation

Dr. Babcock developed the high ligation and stripping technique for treating varicose veins and in the process invented the vein stripping device with the acorn tip. The procedure was essentially one of the first minimally invasive surgical procedures. The simple ligation technique that had been performed for many years had a high recurrence rate where reflux often occurred because of the presence of collateral vessels.[6] Babcock's procedure eliminated pathological reflux and reduced patient's having to undergo additional procedures in the future such as recanalization.[7]

Dr. Babcock described the procedure and the use of the vein stripping device in his 1907 article "A New Operation for the Extirpation of Varicose Veins of the Leg" that was published in the *New York Medical Journal*. He introduced the use of two small, minimally invasive incisions at the ankle and saphenofemoral junction to allow inserting the vein stripper, attaching the acorn tip on the end, and pulling the vein stripper out taking the vein with it. For many years the procedure was the gold standard for treating varicose veins. The techniques established by Dr. Babcock still influence modern day procedures and the end goals of treating varicose veins.

Babcock – Bacon Procedure

In 1938, Drs. Babcock and Harry E. Bacon introduced the procedure they co-developed that was a sphincter-preserving modified proctosigmoidectomy for treating low-lying tumors of the rectal and sigmoid colon. The surgical approach resolved the postoperative complications of the current surgical methods of that time by complete tumor removal that preserved anal sphincter function, thus avoiding patients from having a permanent colostomy.[8] An important advancement was the introduction of the pull-through anastomosis that preserved the anal canal and preservation of continence.

Soup Bone Cranioplasty Technique

The soup bone cranioplasty was first performed by Dr. Babcock in 1915 at the Samaritan Hospital. It represented a step forward in surgically treating large cranial defects using a xenograft. The Samaritan Hospital was comparable to a level II hospital (the designation of level one, two, or three for a hospital was not well-established until the early 1980s) serving as the trauma center in treating the large number of patients who suffered accidents. Frustrated by the materials that were currently being used in repairing craniectomies including autografts, metals, and synthetic materials that lead to "serous secretion in the wound, or tissue irritation, as to necessitate removal," Dr. Babcock came up with the solution of using boiled mutton bones, hence the term "soup bone", as an alternative.[5,9-11]

It can be assumed that Dr. Babcock had a working knowledge of the food that was prepared for patients. A copy of the "Rules and Regulations of the Government of the Samaritan Hospital of Philadelphia" has been preserved and is stored in the archives of the Paley Library of Temple University.[12] Rule 14 may provide a hint as to Dr. Babcock's choice of "mutton bone from the hospital's soup kettle" as a cranial implant.[5]

> Rule 14. The Surgeon and Physician on duty shall constitute an Executive Committee, whose duty it shall be to inspect…and maintain a general supervision over the cleanliness of the wards, water closets, laundry…They shall also enquire into the quality of the food, drugs, and such other matters as may be important to the welfare of the Hospital.[5]

The food served to the patients was donated by volunteers and refrigerated and cooked on-site. A common food preparation for the patients was mutton soup, thus providing Dr. Babcock with the idea to remove mutton bone from the kitchen's soup kettle for use during a cranioplasty procedure. Mutton bone refers to the bone of a sheep over the age of one year.[3] He primarily used the scapula because of its structure and boiling the bone removed the animal tissue.[5,13-15]

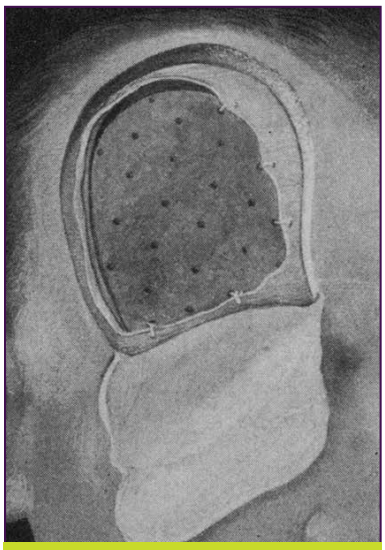

Figure 2 An illustration of a frontotemporal "soup-bone cranioplasty" on the laundryman with previous gunshot wound. *Journal of the American Medical Association* 69:352–355, 1917

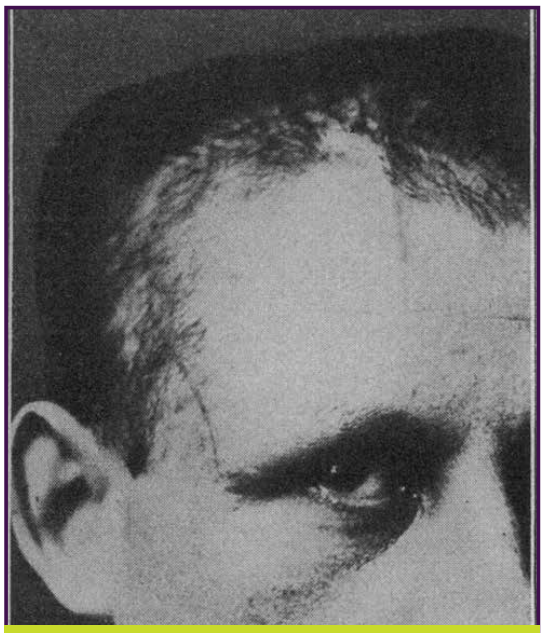

Figure 3 Postoperative photograph of laundrayman. Note that the graft edges are clearly visible beneath the scalp. *Journal of the American Medical Association* 69:352–355, 1917.

Dr. Babcock acknowledged that the use of an autograft did avoid the inflammatory complications that other materials caused and had "the advantage of being well tolerated" by the patient.[5] However, he pointed out the primary drawback of harvesting autogenous bone was the requirement of an additional procedure and the complications that could cause the patient.[5]

After being initially boiled in the kitchen, Dr. Babcock would rinse off the bone and boil it again for one hour. He would then place the bone in a 1:20 phenol solution to soak overnight and boil it a third time the next day for thirty minutes.[3] Dr. Babcock indicated that after boiling "the bone is somewhat softened and can be readily cut into the desired shape."[5] He further prepared the bone by trimming the rough edges and contouring it to match the cranial defect. He also perforated the bone "by many drill holes placed about one-half inch apart" (Figure 2).[5]

The procedure involved Dr. Babcock creating the scalp flap, stripping back the periosteum, and securing the graft to the skull using chromic sutures placed through the drill holes to promote osteogenesis and reduce postoperative complications such as serous secretion, but he did not support the placement of a drain (Figure 3).[5]

Dr. Babcock reported the procedure and results regarding two patients in a 1917 article that was published in the *Journal of the Americal Medical Association*. The first patient involved a 21-year old laundryman who, in 1903, near Bonn, Germany, shot himself accidently while cleaning his service revolver.[3] The bullet entered the right temporal bone, "about two inches in front of the upper lobe of the right ear," taking a "forward and upward" direction.[5] Surgeons at the Bonn hospital excised "part of the temporal and front bones."[5] Two weeks after the surgery, the surgeons performed a second operation by injecting paraffin under a skin flap to repair the cranial defect. Over time the paraffin softened and became "lumpy and irregular."[5] Nine years later, the patient began experiencing epileptic seizures and subsequently the paraffin was removed. However, in April 1915, he arrived at the Samaritan Hospital complaining of continuing seizures and headaches. Dr. Babcock performed his operation implanting the mutton bone and reported the laundryman had "a marked reduction in the volume of convulsions…and had been practically free from headaches."[5] Additionally, after two years, Dr. Babcock indicated "the contour of the front region is well restored and shows no signs of absorption."[5]

The second case involved a 39-year old Irishman who had worked as a cowboy several years previous to his accident. On January 16, 1915, while riding on a trolley car, he experienced a seizure and became unconscious. Fellow passengers took him to Samaritan Hospital where, upon regaining consciousness, related that he had been kicked in the back of the head by a horse and the surgeons performed a right side parietooccipital craniectomy. He could not return to his profession as a cowboy as "horse-back riding, pressure over the depressed area, or nervous excitement incited convulsions."[5] While examining the patient, Dr. Babcock noted "there was a large cup-shaped depression in the right upper occipito-parietal region" and when the patient bent over the brain "bulged through the opening."[5] Dr. Babcock performed the surgery under local anesthesia, and the patient made a full recovery "being able to work and free from symptoms."[5]

Nerve Disassociation Technique

Dr. Babcock introduced the technique in 1907 as a novel procedure to relieve "certain panful and paralytic conditions of nerve trunks."[16] His technique involved separating the adherent nerve fibers to preserve the nerve's conductive function. This "disassociation" restored the normal movement of the nerve within the surrounding tissues by reducing the inflammation and removing the scar tissue. Dr. Babcock reported on four successful cases in which the patients experienced postoperative relief from pain and improved motor function confirming that the nerve conduction pathway had been preserved.[1] He concluded "that the surgical disassociation of nerve fibers may be carried out without producing gross evidence of reduction in the conducting power of the nerve."[16] The technique was a predecessor to modern neurolysis techniques.

Babcock Forceps and Sump Drain

In the early 1900s, Dr. Babcock invented and introduced the atraumatic, fenestrated jaw Babcock forceps that are still in use in modern surgery (Figure 4). In the 1890s, Dr. William Halsted proposed the seven principles of surgery that are still adhered to including gentle tissue handling. The Babcock forceps have contributed to the principle by allowing surgeons to grasp delicate tissue and organs such as the intestines and liver without causing tissue trauma.

Figure 4 Babcock forceps

Dr. Babcock contributed to improving wound management with his invention of the lamp chimney sump drain. His device incorporated a suction mechanism combined with an outer sheath that was shaped after chimney structures for airflow that was effective in irrigating surgical sites and evacuating fluids.[17] His sump drain were particularly popular in treating trauma patients and patients that had undergone an abdominal procedure, improving postoperative recovery in a time prior to antibiotics.[18]

Awards

Throughout his career, Dr. Babcock received multiple awards in recognition of his contributions to advancing the science of surgery. Notably, in 1947, he received the Master Surgeon Award from the International College of Physicians and Surgeons. Seven years later, in 1954, he received the Distinguished Service Medal from the American Medical Association, one of the highest honors a physician can achieve, to specifically recognize his role in introducing the use of spinal anesthesia in the United States and for his "outstanding contributions to medicine and humanity."[19]

Dr. Babcock's legacy has endured through his introduction of innovative surgical techniques that contributed to further advancements such as the endoscopic treatment of varicose veins and improvements in sphincter-preserving colorectal surgical procedures. Of most importance was his emphasis on evidence-based practice and hands-on learning during his time of mentoring and teaching countless students.

***Demonstrator of anatomy:** Junior clinicians who teach anatomy to students through hands-on sessions to include cadaver dissection and may also include teaching histology.

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Advocacy in Action: Strengthening the Future of Surgical Technology

TC Parker, CST, FAST

ADVOCACY IN ACTION

As the Association of Surgical Technologists (AST) continues to advance its mission of supporting the profession through education, credentialing, and legislative engagement, the next phase of advocacy is already taking shape. With the introduction of the AST Ambassador Program and a renewed focus on member involvement, surgical technologists are poised to elevate their influence within healthcare systems and across state and national policy landscapes.

This follow-up article explores how members can build on the momentum of AST's advocacy initiatives and contribute to a stronger, more unified professional community.

Expanding the Impact of Advocacy

The foundation of advocacy begins with awareness, but meaningful progress requires sustained action. As surgical technologists engage in outreach, mentorship, and policy discussions, the profession gains visibility and credibility. The Ambassador Program serves as a catalyst for this work, but its success depends on the collective participation of AST members nationwide.

Advocacy efforts are strengthened when members:

- Promote consistent messaging about the profession
- Support educational and credentialing standards
- Participate in state assembly initiatives
- Engage with healthcare leaders and policymakers
- Share their professional experiences to highlight the value of CSTs

Through coordinated action, surgical technologists can ensure that their contributions to patient care are recognized and respected.

Mentorship: Developing the Next Generation of Leaders

Mentorship remains one of the most effective ways to support the long-term growth of the profession. As Ambassadors begin working with students and early-career CSTs, they help reinforce the importance of accredited education, national certification, and professional engagement.

Mentorship contributes to:

- Higher retention rates within the profession
- Increased participation in certification and continuing education
- Stronger professional identity among new practitioners
- Greater awareness of advocacy opportunities

By investing in future CSTs, members help ensure that the profession continues to advance with skill, integrity, and confidence.

Legislative Engagement: Advancing Professional Standards

AST's advocacy efforts extend beyond the operating room and into state legislatures across the country. Legislative engagement remains essential for protecting the profession, promoting credentialing requirements, and supporting fair and competitive wages.

Members can contribute by:

- Staying informed about state and national legislative priorities
- Participating in state assembly advocacy days
- Communicating with elected officials about the role of CSTs
- Supporting legislation that strengthens patient safety and professional standards

When surgical technologists speak with a unified voice, they help shape policies that reflect the critical nature of their work.

Increasing Public Awareness

Public understanding of surgical technology continues to grow, but there is still work to be done. Ambassadors and members play a vital role in educating communities about the responsibilities and expertise of CSTs.

Effective outreach includes:

- Presenting at schools and career fairs
- Participating in community health events
- Collaborating with local healthcare organizations
- Sharing accurate information about accredited education and certification

Greater visibility leads to stronger recruitment, improved recognition, and increased support for advocacy initiatives.

Building a Culture of Advocacy

The strength of the profession lies in its members. When advocacy becomes part of everyday practice—whether through mentorship, education, or legislative involvement—the profession grows more resilient and more respected.

Members can contribute to this culture by:

- Supporting their state assemblies
- Encouraging colleagues to pursue certification
- Participating in AST events and educational programs
- Sharing their experiences and expertise with others

Advocacy is most effective when it is shared, sustained, and supported by the entire professional community.

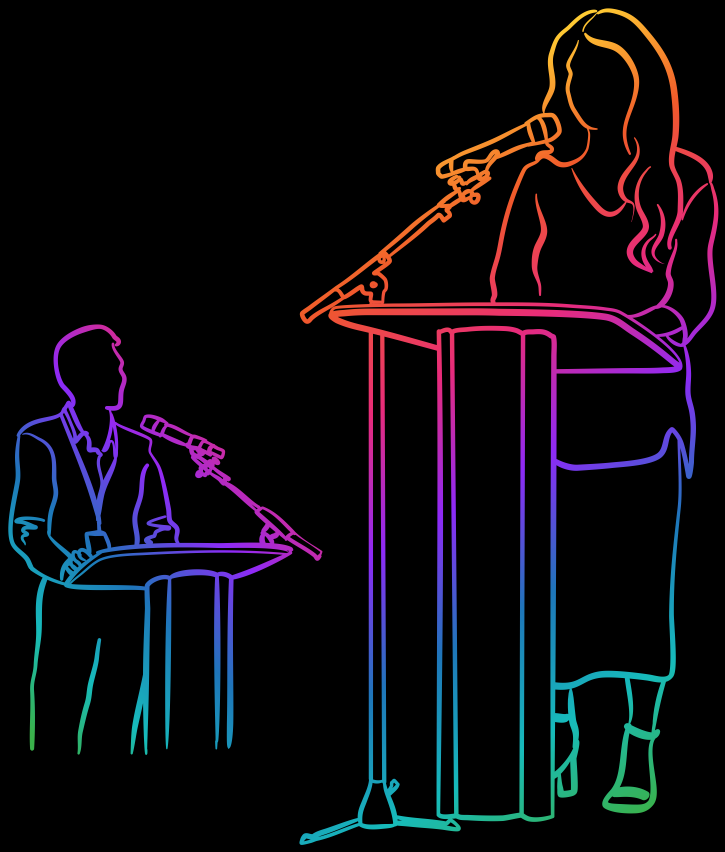
Looking Ahead

As the AST Ambassador Program advances its 2026 launch, the profession stands at an important moment of growth and opportunity. With a nationwide network of trained ambassadors and an engaged membership, AST is well positioned to advance its mission and strengthen the future of surgical technology.

Through continued collaboration, education, and advocacy, surgical technologists can ensure that their role remains visible, valued, and essential to patient care.

SPEAK UP!

Call for speakers.



AST is currently seeking speakers for our clinical webinar series, AST Educators Event and our national conferences. Have a good topic you'd like to see presented or know of a peer or surgeon who would make a good presenter?

Complete our speaker application and help us provide relevant and timely information to surg techs around the nation!

Visit ast.org - Educators - Events to get started.

Surgery May Not Have to be Performed for Select Patients with Breast Cancer

JAMA Oncology

OF INTEREST IN THE MEDICAL ARENA

AST Medical News > Breast Surgery > Single-arm, Prospective Randomized Trial

Media Advisory: To contact corresponding author Henry M. Kuerer, MD, email hkuerer@manderson.org

Topline: Five year results from a Phase II trial showed that for 31 patients who achieved pathologic complete response (PCR)* based on tissue biopsies and imaging, with a median follow-up of 55.4 months, remained disease free.[1] Additionally, the survival rate of the 31 patients was 100% without surgery.[1]

Why the Study is Important: Worldwide, approximately 2.3 million women were diagnosed with breast cancer with 670,000 deaths.[2] It is the most frequently diagnosed cancer among women in 157 of 185 countries worldwide.[2] In 2026, it is estimated 321,910 women will be diagnosed with breast cancer in the US.[2] Because neoadjuvant systemic therapy (NST)** has been linked with PCR in up to 60% of breast cancers, the findings of the trial question the necessity for surgery to be performed.[1]

Methodology and Objectives of the Study: A phase 2 single-arm, prospective randomized clinical trial was conducted at seven US medical centers from March 6, 2017, to November 9, 2021, with data analysis completed from October to December 2024. The objective of the trial was to report preplanned five-year efficacy outcomes evaluating the use of radiotherapy only without performing breast surgery in patients selected with image-guided vacuum assisted core biopsy (VACB).[1]

Patient Population: The trial enrolled 50 women that were 40 years or older with cT1-2NO-1MO *ERBB2*-positive (formerly *HER2*-positive)*** or triple-negative invasive breast cancer**** who presented with residual breast lesions***** of less than two centimeters on imaging after undergoing NST.[1] Patients underwent one image-guided VACB. If no disease was identified by the pathologist upon examining the biopsy, the patient did not undergo surgery and underwent standard whole-breast radiotherapy.[1] The VACB results identified PCR in 31 patients.[1] Those patients whose biopsy was positive after NST underwent surgery as the standard of care.[1]

Results of the Study: For 31 patients who had achieved PCR based on imaging results and tissue biopsies, with a median follow-up of 55.4 months, there were no recurrences of cancer.[1] Additionally, the survival rate of the patient population was 100% without breast surgery having to be performed.[1]

Study Limitations: The primary limitations reported by the research team were the need for further clinical trials that are larger, that is, involving a larger number of patients.[2]

Study Conclusions: The research team stated the results of the clinical trial "suggest that omission of breast surgery in select patients after NST may be feasible, with no recurrences seen."[2]

Funding Support: The trial was supported by the P.H. and Fay Etta Robinson Distinguished Professorship in Cancer Research, the Cancer Center Support Grant (CAO16672) from the National Cancer Institute of the National Institutes of Health, and the MD Anderson Clinical Research Funding Award Program.

Conflict of Interest Disclosure: Multiple disclosures are indicated in the article by Dr. Kuerer, lead author, and collaborating authors. The reader is referred to the article for the list of disclosures.

***Pathologic complete response:** The absence of invasive cancer cells in the breast tissue and sampled lymph nodes.

****Neoadjuvant systemic therapy:** Chemotherapy or hormone therapy given prior to surgery to shrink tumors.

*****cT1-2NO-1MO *ERBB2*-positive:** cT1-2 – small- to medium-sized tumor; NO-1 – cancer has not spread to lymph nodes (NO) or limited spread to adjacent lymph nodes (N1); MO – no metastasis; ERBB2 – cancer cells have an abnormally high number of the human epidermal growth factor receptor 2 (HER2) protein on their surface

that makes them proliferate faster.

****Triple-negative breast cancer:** A fast-growing cancer that tests negative for estrogen receptors, progesterone receptors, and HER2 protein.

*****Residual breast lesions:** Cancerous tissue that remains in the breast or axillary lymph nodes after primary treatment.

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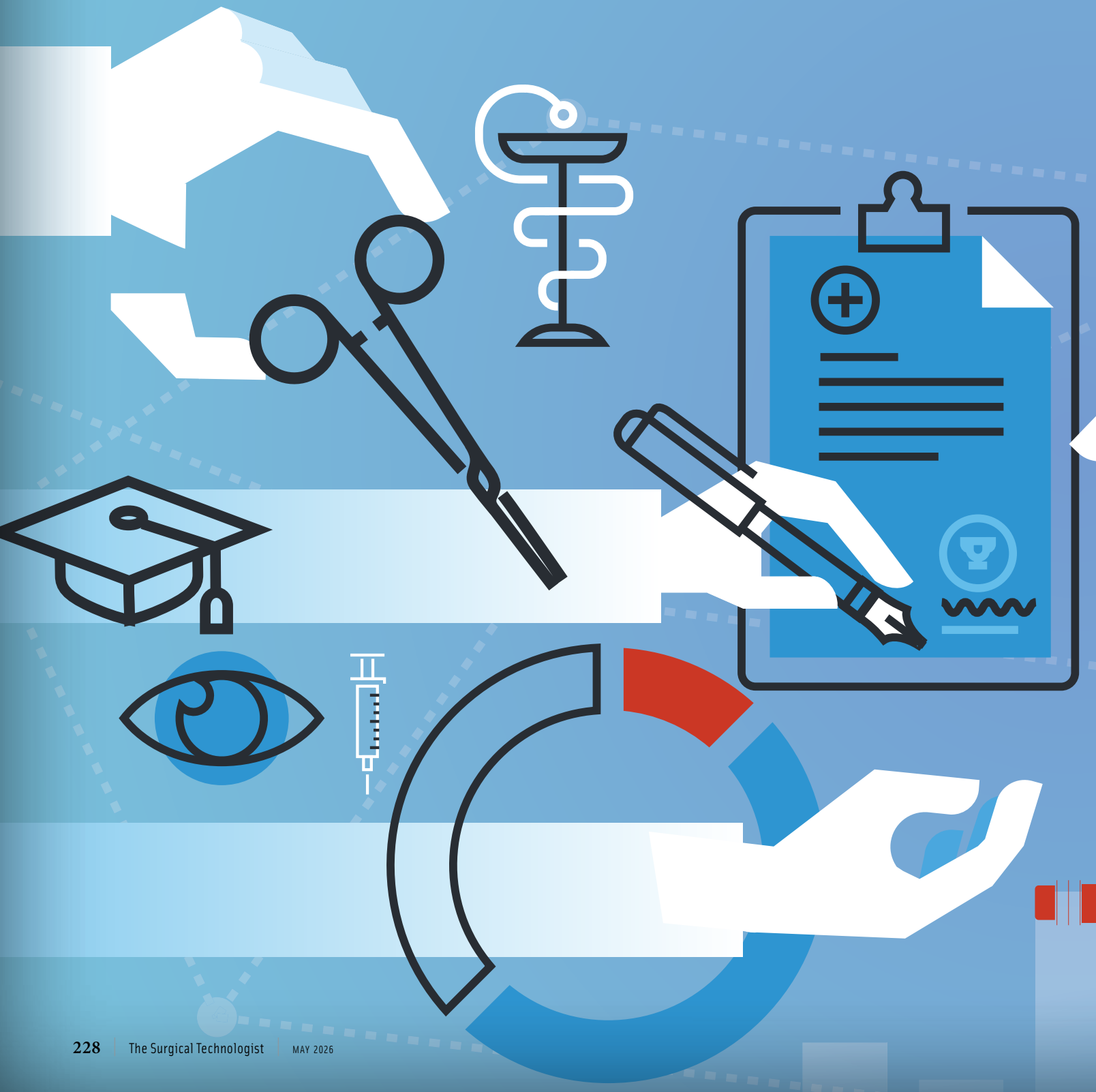
Everything You Need to Know About

EARNING CE CREDITS



The Association of Surgical Technologists (AST) is the national professional organization for surgical technologists. AST's primary purpose is to ensure that surgical technologists have the knowledge and skills to administer patient care of the highest quality by setting standards for education, supporting state and federal legislative efforts, and providing quality continuing education opportunities.

Listed below are all the ways you can earn CE credits to help you maintain your credential and expand your professional exploration.

AST CE ONLINE LIBRARY THREE FREE ONLINE CE CREDITS PER YEAR

Log in to the AST site to complete and earn three free credits per calendar year toward recertification.

AST MEMBER CE PACKAGES

Take advantage of AST's CE packages available on the AST site. The packages are available at a substantial AST member discount.

SUBMITTING ONLINE CE CREDITS

By paying online through your CE shopping cart, the CE credits post to your AST credit history within 24-48 hours after payment.

- You do **NOT** need to submit the certificate of completion or an *AST CE Reporting Form* if you are submitting and paying for online CE credits.
- **No refund** is given for AST online CE tests or packages, and they **cannot** be applied to another certification cycle.
- **Available 24/7 at www.ast.org.**

AST NATIONAL SURGICAL TECHNOLOGY CONFERENCE

Member: CE credits are automatically recorded in your AST CE file. A CE credit conference confirmation letter is mailed four to six weeks post-conference for your personal records.

Nonmember: A CE credit conference confirmation letter is mailed four to six weeks post-conference to maintain in your personal records. Your conference registration fee includes one-year of AST membership.

AST MONTHLY JOURNAL – *The Surgical Technologist*

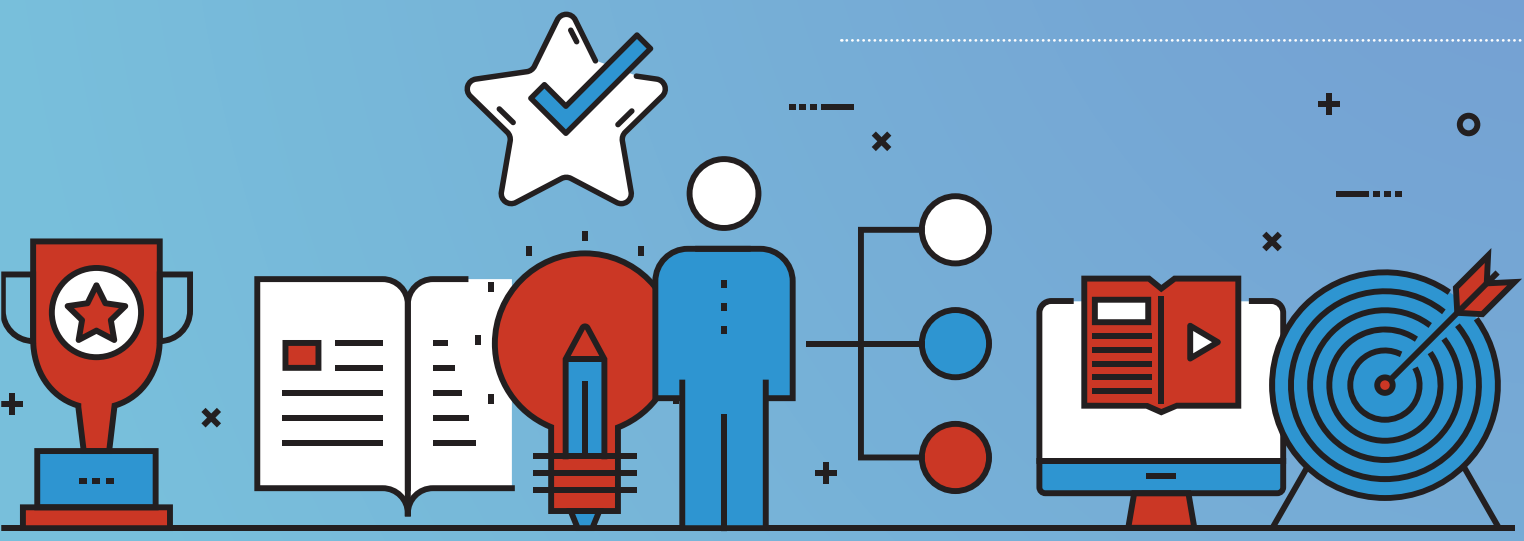
The CE article featured in AST's monthly journal provides up-to-date information concerning a relevant surgical topic, as well as, the ability to earn one or more CE credits. There is no expiration date on the articles.

Submitting Journal CE Credits

- Submit the answer sheets to AST with the appropriate payments. Make a copy of the answer sheets for your records.
  - **Member:** $6 per CE credit, not per test. **NOTE:** If the test is 1.5 CE credits, the fee is $9. If the test is 2 CE credits, the fee is $12. If the test is 3 CE credits, the fee is $18, etc.
  - **Nonmembers:** $10 per CE credit, in addition to the $200 nonmember processing fee.
  - Do **NOT** submit separate checks for each journal test. Multiple journal tests can be submitted and paid with one check or money order.
  - Printed on the journal test answer sheet is the month, year, test number, and number of CE credits the test is worth. For example: 1, 2, or 3 CE credits. If it is an older test that doesn't show the number of CE credits, the test is worth 1 CE credit.
  - You do **NOT** need to submit the *AST CE Reporting Form* with the journal tests.

Reasons Journal Tests are Returned:

- Overpayment
- Payment is not included
- Duplicate: The test(s) were previously submitted and CE credits recorded
- Failed test: A minimum of 70% must be scored on the test. Review the journal article and resubmit a new answer sheet with the appropriate fee.



STATE ASSEMBLY MEETINGS

State assemblies provide CE during meetings, as well as serving as the grassroots organization in regard to state legislative efforts. Announcements of state assembly meetings are published in *The Surgical Technologist,* on the states' websites, and the AST site, www.ast.org, under the State Assembly tab. State assemblies also contact state members of upcoming meetings through email and mailings.

Submitting State Assembly CE Credits

- All state assemblies are required to complete the AST CE program approval prior to the date(s) of the meeting for the CE credits to be approved. The participant should verify that the meeting has been AST approved.
- The state assembly is required to provide a certificate of attendance to the participants even if "auto recorded."
- **Member:** Submit a copy of the certificate to AST for processing. The *AST CE Reporting* Form is not required to be submitted.
- **Nonmember:** Submit a copy of the certificate of attendance with the *AST CE Reporting* Form and $200 nonmember processing fee.

COLLEGE COURSES

College courses that are relevant to the medical-surgical practice of surgical technology or surgical first assisting can be submitted to AST for CE credits.

- College courses **MUST** be completed with a minimum grade of "C."
- The courses **MUST** be completed at an institution that is accredited by an organization recognized by the US Department of Education.
- Surgical first assistant college courses submitted for CE credits **MUST** be completed at a CAAHEP-accredited surgical first assistant program.
- General nursing and physician assistant college courses that are not specifically related to the medical-surgical practice of surgical technology or surgical first assisting **will not be accepted** for CE credits.
- Anatomy & physiology, microbiology, pathophysiology, and pharmacology must be advanced level college courses.

Determining the Number of CE Credits:

- College courses are awarded five CE credits for each semester hour completed. For example, a three-college-credit semester course: 3 x 5 = 15 CE credits.

Submitting College Courses for CE Credits

- **Member and Nonmember:** Submit an unofficial college transcript from the institution where the courses were completed with the *AST CE Reporting Form* – no exceptions.
- **Nonmember:** Include the $200 nonmember processing fee.

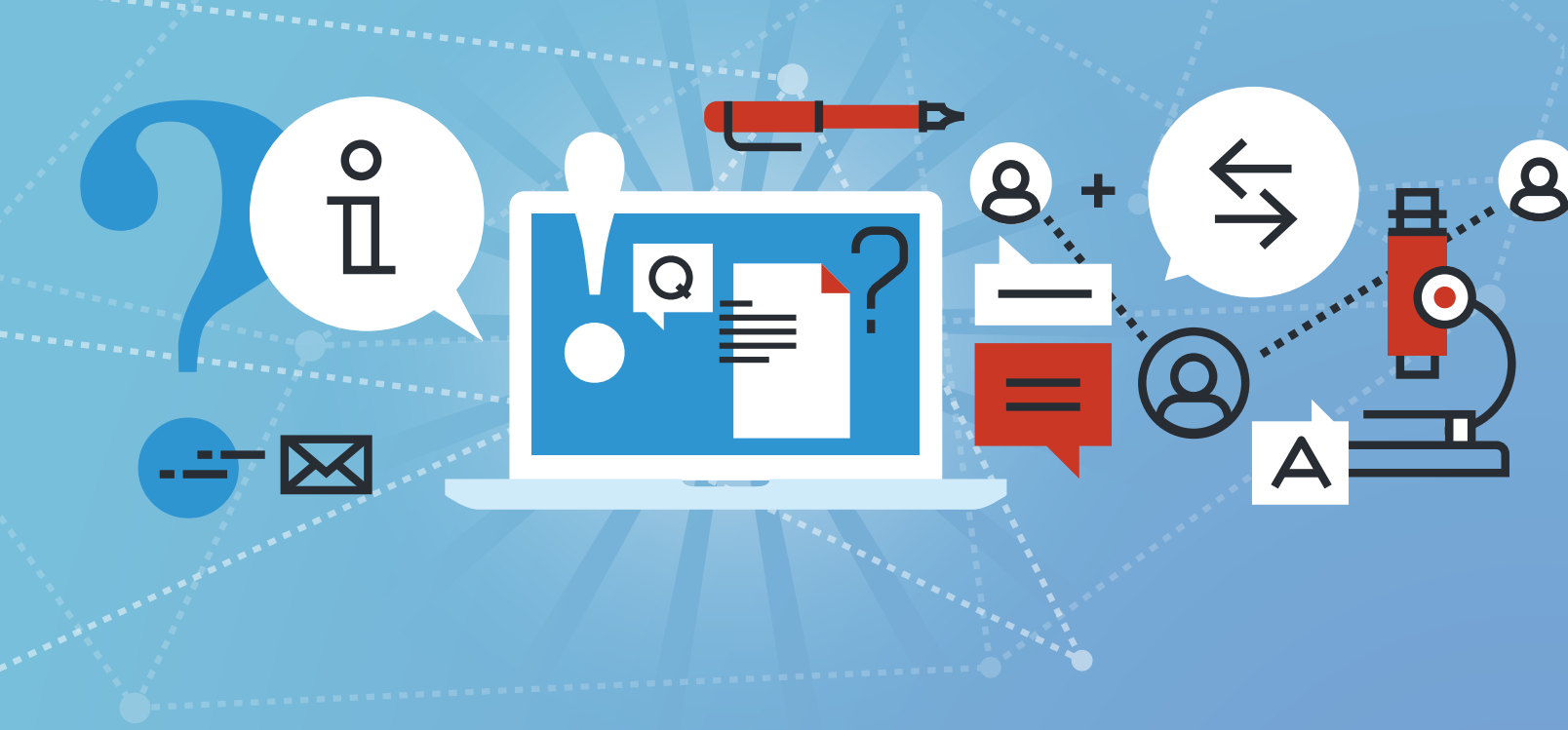
Recommendation

- Provide a copy of the course descriptions from the current edition of the college catalog with the *AST CE Reporting Form* and transcript(s).
- The descriptions assist in determining the relevancy of the course(s) to the medical-surgical practice of surgical technology or surgical first assisting.

HEALTHCARE FACILITY SPONSORED IN-SERVICES

Healthcare facility sponsored in-services can be submitted to AST for CE credits as long as they are relevant to the medical-surgical practice of surgical technology or surgical first assisting. Employers are **NOT** required to submit healthcare facility in-services to AST for approval.

- AST accepts annual mandatory CE in-services relevant to the medical-surgical practice of surgical technology or surgical first assisting. For example, fire safety.
- Healthcare facility orientation is **NOT** accepted for CE credits.
- If the employer sponsors or provides funds for an employee(s) to attend a conference, forum, seminar, symposium, or workshop, or complete any other type of CE activity sponsored by an organization other than the healthcare facility, the program **MUST** be AST approved for the CE credits to count toward certification renewal.
- BLS, ACLS, and PALS are accepted for CE credits. Every 50-60 minutes of activity = 1 CE credit.
  - BLS includes CPR and automated external defibrillator (AED) training.
- CE credits are **NOT** awarded for on-the-job training, healthcare facility orientation, or work



experience that the CST® and CSFA® completed as an employee of the healthcare facility providing the training.

  - Example: A CST is completing on-the-job training in learning the first scrub role to be a member of the healthcare facility's cardiovascular team. This training is distinct from attending healthcare facility sponsored in-services as described above.

SUBMITTING IN-SERVICE CE CREDITS

- A healthcare facility certificate of attendance, official healthcare facility transcript, or sign-in sheet with an authorized signature (for example, a surgery department supervisor, clinical educator, or other individual authorized by the employer).
- The documentation must also include the name of the healthcare facility, indicate it is an in-service, title of in-service, date of in-service, number of CE credits, and signature of the CST or CSFA attendee. The documentation must be submitted with the *AST CE Reporting Form*.

OTHER ENDURING MATERIAL

Enduring material is self-directed learning in which the CST or CSFA independently completes CE activity that is AST approved.

- The enduring material must be AST approved to earn the CE credits. The CST or CSFA is responsible for researching if a CE enduring material offered by a business or organization is AST approved.
- Businesses and organizations that would like to offer CE to the CST and CSFA are required to submit their CE offerings to AST for review and possible approval.
- AST does **NOT** accept enduring material CE offered by healthcare manufacturers.
- Types of enduring materials include CE articles that requires completing the post-article exams that are offered hard-copy or electronically, viewing recorded lectures that includes completing a post-lecture exam that are offered on CD, DVD, online, or other electronic means.

SUBMITTING ENDURING MATERIAL CE CREDITS

Upon completion of an AST approved enduring material offered by another business or organization, the CST and CSFA must submit a copy of the certificate of completion provided by the business or organization with the *AST CE Reporting Form*. The business or organization does **NOT** directly report the CE credits to AST.

For additional information, please see the AST CE Policies for the CST and CSFA at www.ast.org.

PROFESSIONAL ORGANIZATIONS

AST accepts the CE credits offered at live events, (for example: conferences, forums, symposiums, and workshops) that are sponsored by ACCME-accredited organizations and if the event is approved to offer *AMA PRA Category 1 Credit(s)™*, CE credits are accepted if an organization's live event is approved to offer *AMA PRA Category 1 Credit(s)™* by another ACCME accredited organization. Additionally, CE credits are accepted for live events approved by the ADA-CERP and JCAHPO.

Submitting Professional Organization CE Credits

- The professional organization should provide a certificate of attendance that is signed by an individual designated to represent the organization.
- The certificate should include the name of the organization, title of event, date(s) of event, name or signature of the CST or CSFA, and number of CE credits.

Member: Include a copy of the certificate with the *AST CE Reporting Form*.

Nonmember: Include a copy of the certificate with the *AST CE Reporting Form* with the $200 nonmember processing fee.

SURGICAL MISSION

CSTs and CSFAs who perform their job duties as a member of a surgical team that performs surgeries during a surgical mission can earn CE credits.

- One time per certification cycle, the CST or CSFA may submit a surgical mission trip to AST for CE credits.
- One time per certification cycle, 10 CE credits are awarded, no matter the length of the mission
- The *AST Surgical Mission Verification Form* must be completed by the CST or CSFA, including an authorized signature of mission team leader. Incomplete forms will be returned.

WRITING FOR HEALTH-RELATED PUBLICATIONS

The CST or CSFA, who authors a CE article, may be awarded CE credits due to the research that is necessary to write the article.

- When writing a CE article to be published in a journal or magazine, the article must be a health-related publication.
- The publisher must have a peer-review process in place to determine if the article meets the publishing standards of the journal or magazine.
- CE credits will only be awarded for the initial publication of an article.
- Four CE credits are awarded per 2,000 typewritten words. Partial CE credits are awarded in increments of 500 words: for example, 2,500 words equals 1.25 CE credits. The word count does **NOT** include the title of the article, headings, post-article CE exam, reference page, or bibliography.

SUBMITTING PUBLICATIONS FOR CE CREDITS

- *The Surgical Technologist:* The CE credits will be automatically entered for CSTs and CSFAs that write a CE article for the AST journal.
- Other publications: CST or CSFA must submit an official, published copy of the article that has his/her name printed as the author, name of the journal or magazine, date of publication, and volume number with the *AST CE Reporting Form.*

INSTRUCTION OF HEALTH PROFESSIONALS

- CSTs or CSFAs who provide a CE lecture may be awarded CE credits.
- This applies to providing a CE lecture at an AST-sponsored event, such as the National Surgical Technology Conference or Surgical Technology Educators Conference, healthcare facility in-services, or serving as an instructor at an AST-approved CE program or workshop, such as a state assembly meeting or wound closure workshop.
- CE credits are **not** awarded for providing lectures or lab/clinical demonstrations when it is a part of the CST's or CSFA's job duty: ie, educators, medical sales representatives, and preceptors.
- **Awarding CE Credits**
  - The lecture or workshop **MUST** last a minimum of 30 minutes.
  - CST and CSFA presenters and instructors receive 2 CE credits for the initial preparation of a topic.
  - For example: If a lecture lasts 45 minutes, the CST or CSFA presenter would be awarded 2.75 CE credits.
  - However, if the lecture is repeated at a future program, CE credits are only awarded for the length of the lecture.
- **Submitting CE Credits for Presentation or Instruction**
  - **AST sponsored programs,** such as conferences: The CST or CSFA presenter **MUST** be a member of AST to be eligible to present. The CST or CSFA is **NOT** required to submit documentation as proof of giving a CE lecture or serving as a workshop instructor. AST will automatically enter the CE credits in the individual's CE file.
  - **Other programs:** CSTs and CSFAs that present a CE lecture or serve as an instructor at a non-AST sponsored program, such as a state assembly meeting, must submit a copy of the program agenda with the *AST CE Reporting Form.* The program agenda **MUST** include the name of the presenter, title of the presentation or workshop, and length of activity.

WHY CE CREDITS ARE NOT ACCEPTED

CE credits that are not accepted can present a challenge in recertifying if there is not sufficient time left to earn additional CE credits before the expiration date of the credential. **As previously mentioned, it is encouraged to submit CE credits six months prior to the certification expiration date.** This allows time to earn additional CE credits within the certification cycle if CE credits were not accepted and avoid taking the NBSTSA national certification examination to renew the credential. The following are some of the more common reasons for CE credits not being accepted.

CE Credit Value NOT Met

- If a CST or CSFA attends a lecture or program, or views a recorded CE lecture that is less than 30 minutes. (One CE credit equals 50-60 minutes of activity.)
- Partial CE credits are accepted by AST; however, the CE activity must last a minimum of 30 minutes.
- After 30 minutes, CE credits are accepted in 15-minute increments.

CE Credits NOT Earned During Current Certification Cycle

- CE credits **MUST** be earned during the current certification cycle.
- CE credits are accepted based on the date of completing the CE activity, **NOT** when the CE activity was purchased or date submitted to AST.

CE Activity is NOT Approved by AST

- CE credits were earned by completing a CE activity or attending a CE event that is **NOT** AST approved.

CE Reporting Form NOT Submitted with CE Credits

- CE credits were submitted without a completed *CE Reporting Form.* The form is available on the AST site, www.ast.org.

– Each CE activity, with the exception of AST-sponsored CE, must be listed on the reporting form. Forms that state "see other pages" or "see transcript" will be sent back.

Documentation NOT Included with the *CE Reporting Form*

- Documentation verifying completion of CE listed on the *CE Reporting Form* is NOT included when submitted to AST.
- With the exception of AST sponsored activities and state assembly meetings, copies of verification documentation must be included with the *CE Reporting Form.*
- Accepted documentation includes:
  - certificate of attendance or completion
  - attendance sign-in sheet for healthcare facility in-services (see previous information regarding healthcare facility sponsored in-services for details).

Documentation that is **NOT** accepted includes:

- tests
- paid receipts
- announcements of events
- program agenda/brochure

CE Activity is NOT Relevant

- CE credits are returned if it is determined the activity is **NOT** relevant to the medical-surgical practice of surgical technology or surgical first assisting.

Previously Completed CE Submitted Again

- Previously completed CE that was submitted to AST and processed, **CANNOT** be resubmitted for CE credits and will NOT be accepted.
- An exception is made for BLS, ACLS, and PALS. Each time the CST or CSFA renews one of those certifications it can be submitted for CE credits.

Nonmember Fee NOT Included

- The nonmember CE processing fee of $200 is **NOT** included when CE credits are submitted.

UPCOMING PROGRAMS

AST MEMBERS: *Keep your member profile updated to ensure that you receive the latest news and events from your state. As an AST member you can update your profile by using your login information at* ***www.ast.org.*** *You may also live chat at* ***www.ast.org*** *or contact Member Services at* ***memserv@ast.org*** *or call 1-800-637-7433. AST business hours are Mon - Fri, 8 am - 4 pm, MT.*

ARIZONA STATE ASSEMBLY

Program Type: Workshop
Date: September 19, 2026
Title: Bring the Heat
Registration: https://www.azsaofast.org/
Location: HonorHealth NSSC, 2500 W Utopia Road, Phoenix, AZ 85027
Contact: Teresa Sochacki, azsa.assembly@gmail.com
CE Credits: 4 Live Planned

FLORIDA STATE ASSEMBLY

Program Type: Annual Meeting/Elections
Date: September 26, 2026
Title: Florida Surgical Technologists: YOU Matter!
Location: Sheraton Orlando North Hotel, 600 N Lake Destiny Road, Maitland, FL 32751
Contact: Florida State Assembly, flsastateassembly@gmail.com
CE Credits: 6 Live Planned

GEORGIA STATE ASSEMBLY

Program Type: Workshop
Date: September 12, 2026
Title: 25th Anniversary Celebration
Registration: https://www.ast-gasa.com/fall-2026-meeting
Location: Brenau Downtown Center, 301 Main Street SW, Gainesville, GA 30501
Contact: Erin Baggett, PO Box 109, Auburn, GA 30011, 678-226-6943, gasawebmaster@gmail.com
CE Credits: 7 Live Planned

IOWA STATE ASSEMBLY

Program Type: Annual Meeting/Elections
Date: October 10, 2026
Title: Fall 2026 Workshop and Business Meeting
Registration: ia.ast.org/
Location: Mary Greeley Hospital, 1111 Duff Ave, Ames, IA 50010
Contact: Joyce Ortega, 515-954-8332, jaortega@dmacc.edu
CE Credits: 7 Live Planned

NEBRASKA STATE ASSEMBLY

Program Type: Workshop & Webinar (webinar approved only for Nebraska State Assembly members)
Date: August 1, 2026
Title: NESA Summer Workshop 2026
Registration: ne.ast.org
Location: CHI Health Nebraska Heart, 7500 S 91st St, Lincoln, NE 68526
Contact: Castin Martin, PO Box 67034, Lincoln, NE 68506, 402-217-7735, nebraskastateassembly@gmail.com
CE Credits: 6 Live Planned

NEW YORK STATE ASSEMBLY

Program Type: Annual Meeting/Elections
Date: October 2-4, 2026
Title: NYAST Fall Conference, Business Meeting, and Elections
Location: Renaissance Albany Hotel, 144 State St, Albany, NY 12207
Contact: Alisia Pooley, 315-575-0403, boardnyast@gmail.com
CE Credits: 12 Live Planned

TENNESSEE STATE ASSEMBLY

Program Type: Workshop Cruise
Date: October 2-5, 2026
Title: CE's at SEA
Location: Carnival Glory, 1492 Charles M. Rowland Dr, Cape Canaveral, FL 32920
Contact: Ellen Wood, 865-283-5901, ellenwoodtnast@gmail.com
CE Credits: 6 Live Planned

Program Type: Annual Meeting/Elections
Date: March 6-7, 2027
Title: CEs in the Hub City
Location: Jackson-Madison County Hospital, 620 Skyline Dr, Jackson, TN 38301
Contact: Ellen Wood, 865-283-5901, ellenwoodtnast@gmail.com
CE Credits: 12 Live Planned

STATE ASSEMBLY ANNUAL BUSINESS MEETINGS

Members interested in the election of officers & the business issues of their state assembly should ensure their attendance at the following meetings.

FLORIDA
Maitland
September 26, 2026
Annual Meeting
2026 BOD Elections
& 2027 Delegate Elections

IOWA
Ames
October 10, 2026
Annual Meeting
2026 BOD Elections
& 2027 Delegate Elections

NEW YORK
Albany
October 2-4, 2026
Annual Meeting
2026 BOD Elections
& 2027 Delegate Elections

TENNESSEE
Jackson
March 6-7, 2027
Annual Meeting
2027 BOD Elections
& 2027 Delegate Elections

Program Approvals: Submit the State Assembly Program Date Request Form A1 no less than 120 days prior to the date(s) of the program for AST approval. The form must be received prior to the first (1st) of the current month for program publication in the next month of the AST monthly journal ,*The Surgical Technologist.* The Application for State Assembly CE Program Approval A2 must be received at least thirty (30) days prior to the date(s) of the program for continuing education credit approval. An application submitted post-program will not be accepted; no program is granted approval retroactively.

Contact stateassembly@ast.org or 800.637.7433, ext. 2547.

AST
Association of Surgical Technologists

Not All Surgical Teams Are EQUAL

When patient lives are at stake, education and certification **are non-negotiable.**

SAFE SURGERY TOGETHER POWERED BY EDUCATION, EXPERTISE, AND TEAMWORK

The workforce solution already exists - and always has. The Association of Surgical Technologists endorses accredited education and national certification to ensure the highest quality of surgical care.

	(OTJ/NON-CERTIFIED) TECHNICIAN	CERTIFIED SURGICAL TECHNOLOGIST
EDUCATION	No formal education, online only or OTJ	Minimum accredited 2-year degree
CERTIFICATION	None, limited, or not nationally recognized	Nationally recognized certification
COMPETENCY	Variable, no standard	Validated exam & ongoing CE
PATIENT SAFETY	Inconsistent, limited response, higher risk	Expert in asepsis, the sterile field & critical response
WORKFORCE STABILITY	Temporary "fix"	Long-term, career committed

KEY QUESTIONS FOR HEALTHCARE LEADERS

Educational Standards: Why lower the bar when proven standards already exist?

Workforce Sustainability: Are we solving a shortage long-term - or just applying unsustainable patches?

Ethical Responsibility: Unqualified or undertrained staff in surgical roles increase the risk of preventable errors—***endangering patients and those whose licenses oversee them.*** How do we ethically or legally defend that?

Strategic Alignment: Why shift surgical duties to already short-staffed, overextended personnel or non-OR professionals?

Financial Impact: What are the real risks and costs of infections, errors, and turnover?

Protect quality. Protect safety. Protect patients.

Scan for team resources

4TH Edition

The New Edition

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- ✔ insurance discounts
- ✔ education and employment opportunities
- ✔ access to resources that connects you to nearly 60,000 other surgical technology professionals
- ✔ student rate discounts

Apply

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