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Hybrid Posterior
Decompression
in Cervical
Myelopathy:

Laminoplasty-
Laminectomy
Technique



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Hybrid Posterior Decompression: Laminoplasty-Laminectomy Technique

CHRISTY SMITH, BAS, CST, CSFA

Hybrid cervical laminoplasty combines selective laminectomy with laminoplasty to decompress the spinal cord while preserving cervical spine stability and motion. The article explains how this approach addresses multiple sources of compression, including hypertrophic ligamentum flavum, while using the Globus Canopy laminoplasty system to secure the expanded lamina. It also emphasizes the CST's critical role in preparing instrumentation, maintaining the sterile field, supporting OR workflow, and anticipating the surgical team's needs throughout this complex posterior cervical spine procedure.

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The Modern Preceptor: Shaping Clinical Excellence Through Mentorship

CHRIS BLEVINS, MBA, AAS-ST, CST, FAST, AST DIRECTOR

BOARD MESSAGE

There is a moment in every surgical technologist's career that never quite fades. For some, it was the first time they independently prepared a sterile field without hesitation. For others, it was the first surgeon who acknowledged them by name or trusted them to assist, or maybe the first life they knew was saved with their assistance. Often, however, what remains most vivid is not the procedure itself. It is the person standing beside them.

Nearly every experienced surgical technologist can identify a preceptor who fundamentally changed the trajectory of their career. Rarely was that individual remembered because they possessed the greatest technical ability in the department. They are remembered because they demonstrated patience when a mistake occurred, gave encouragement when confidence was lacking, and created an environment where learning could happen without fear. Those moments often become the foundation upon which professional identity is built.

Workforce Challenges

In today's healthcare environment, surgical services face unprecedented workforce challenges. Staffing shortages, increasing surgical volumes, burnout from clinicians of all areas, and an aging workforce have transformed recruitment and retention into strategic priorities. Organizations continue searching for innovative solutions, which at times steers away from excellent patient care provided by surgical technologists who have graduated from NCCA accredited programs. Yet one of the most powerful workforce development tools already exists within every operating room: the clinical preceptor.

The modern preceptor does far more than teach students how to pass instruments or maintain aseptic technique. They influence confidence, resilience, communication, critical thinking, and professionalism. More importantly,

"Long after students forget the specifics of a procedure, they will remember who believed in them. That may be the greatest responsibility, and the greatest privilege, of being a preceptor."

they shape how future surgical technologists perceive the profession itself. Every interaction between a student and a preceptor contributes to whether that student develops a lasting sense of belonging within the surgical team.

Clinical rotations have traditionally been viewed as a programmatic responsibility. In reality, it represents one of the profession's greatest investments in workforce sustainability. Every student entering the operating room is a potential future colleague, mentor, educator, team lead, and advocate for the profession. The clinical experience often determines not only what students learn, but whether they remain in surgical technology long enough to mentor the next generation.

Beyond Technical Skills

Asepsis and technical skills will always remain fundamental to the profession. Students must learn instrumentation, surgical procedures, positioning, and countless other details that ensure safe patient care. Yet technical knowledge alone has never defined an exceptional surgical technologist.

The OR demands emotional intelligence alongside precision. Students must learn to communicate under pressure, adapt through unexpected changes, accept constructive feedback, and maintain cool under fire regardless of the circumstances. These qualities cannot be mastered through

textbooks alone. They develop through time, trials, reflections, and meaningful relationships with experienced professionals who intentionally model excellence.

This is where preceptors become transformational leaders because whether intentionally or not, preceptors teach culture every day.

Students Rarely Remember Lessons – Always Remember Leaders

Years after graduating, most surgical technologists will not recall every chapter read or every exam taken. What they remember are the people who influenced their confidence. They remember the preceptor who quietly corrected contamination without embarrassment. They remember the ones who invited them into difficult cases instead of sending them to observe from across the room. They remember being treated as a future colleague rather than an inconvenience. These are the moments that shape professional identity.

Professional identity is the process through which students begin seeing themselves not simply as a learner but

as a valued member of the surgical team. When students experience belonging, engagement, and mentorship, they are more likely to remain within the profession and mentor others.

In many ways, mentorship creates a cycle of stewardship. Today's student becomes tomorrow's preceptor.

The Legacy We Leave

Every surgery eventually ends. Every clinical rotation concludes. Students will graduate. What remains is the culture we create. The future of our profession will not be determined solely by advances in technology, certification requirements, or educational standards. It will be determined by the willingness of experienced professionals to invest in those who follow them.

Long after students forget the specifics of a procedure, they will remember who believed in them. That may be the greatest responsibility, and the greatest privilege, of being a preceptor.

They are shaping the future of surgical technology, one student at a time.



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AST News

AT A GLANCE

GET READY TO CELEBRATE SURG TECHS EVERYWHERE!

**NATIONAL SURGICAL
TECHNOLOGISTS WEEK IS
SEPTEMBER 20-26, 2026**

Get ready to celebrate National Surgical Technologists Week in style!

Join us in celebrating healthcare's bravest guardians: Surgical Technologists!

Watch for more communication in the weeks leading up to NSTW regarding AST's 2026 campaign as we portray surgical technologists as guardians of the operating room, recognizing their essential role in providing quality patient care. Stay tuned for polls, stories, trivia, and contests!



CONFERENCE ROUNDUP AWARDS

Multiple awards are handed out at AST's national conference each year. Congratulations to the following recipients:

2025 State Assembly Leadership Achievement Award

Presented through a competitive application process, the State Assembly Leadership Achievement Award recognizes state assemblies that demonstrate outstanding leadership and make significant contributions to their members, communities, and the advancement of the profession.

Arkansas State Assembly

Tamara Morgan, CST, FAST, Arkansas State Assembly President, and Joe Charleman, DBA, CST, CSFA, FAST, AST President



Illinois State Assembly

Sonya Tyson, CST, FAST, Illinois State Assembly President, and Joe Charleman, DBA, CST, CSFA, FAST, AST President



Tennessee State Assembly

Stephanie Austin, EdD, CST, FAST, Tennessee State Assembly President, and Joe Charleman, DBA, CST, CSFA, FAST, AST President



Washington State Assembly

Joe Charleman, DBA, CST, CSFA, FAST, AST President, and Mark Martin, CST, Washington State Assembly President



Congratulations to these state assemblies for their dedication, service, and commitment to excellence.

2025 State Assembly Membership Awards

Each year, AST recognizes state assemblies with the Membership Growth Award for their outstanding contributions in fostering member engagement and expanding membership within their states. Established in 2014, this award honors the state assemblies that have achieved the highest percentage of membership growth and recognizes their dedication to recruiting, retaining, and supporting AST members.

2025 Top-performing states by active membership category:

- States with 0-250 active members – Rhode Island 11.69%
- States with 251-500 active members – Utah 10.46%
- States with 501-1000 active members – Massachusetts 5.17%
- States with 1001- and higher active members – Tennessee 4.25%

Congratulations on your achievements!

View award winners on page 370.

Legacy Award



Each year, the former AST presidents honor an individual in the profession who has made significant contributions to the profession and created a lasting mark on the organization. This year the former presidents represented by Roy Zacharias, Sherri Alexander and Margaret Rodriguez, awarded two outstanding individuals.

Congratulations to the 2026 recipients: Jeff Feix, CST, CSFA, FAST, posthumously; and David Alfaro, CST, FAST



President's Award

Each year, the AST president awards someone who has showcased their dedication and commitment to advancing the profession.

Congratulations to the 2026 recipient: Roy Zacharias, CST, FAST

SAVE THE DATES!

UPCOMING EVENTS



2027 AST Educators Conference – Austin, TX

February 19-20, 2027, with preconference February 18

Plan to join us for our next two AST Surgical Technology Conferences. We want to see you there!



2027 AST Surgical Technology Conference – Milwaukee

- June 3-5, 2027

2028 AST Surgical Technology Conference – Phoenix

- June 8-10, 2028

CALL FOR SPEAKERS

Interested in giving a clinical presentation or know someone who would? AST is actively accepting applications to present in webinars or at our national events. Interested? Complete our speaker package by visiting our website – ast.org – Educators – Speaker Application.

WRITE FOR US

CALLING ALL WRITERS!

We are always looking for new CE authors and surgical procedures that detail the latest advancements in the surgical arena. We'll also help you every step of the way, AND you'll earn CE credits by writing a CE article that gets published! Here are some guidelines to kick start your way on becoming an author:

- An article submitted for CE must have a unique thesis or angle and be relevant to the surgical technology profession.
- The article must have a clear message and be accurate, thorough, and concise.
- It must be in a format that maintains the journal's integrity of style.
- It must be an original topic (one that hasn't been published in the journal recently).

Ready to get started? Email us at publications@ast.org.

APPLY FOR A MEDICAL MISSION SCHOLARSHIP

Did you serve on a medical mission during the first couple months of this year? 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.

MILESTONES



Congratulations to the following state assemblies as they celebrate an 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.

- Georgia – 25 years
- Mississippi – 26 years
- Oklahoma – 26 years

2026 Scholarship Recipients

The Foundation for Surgical Technology funds various awards during the year, but it is best known for the academic scholarships that assist students entering the field. This year we awarded \$47,500 in student scholarships. Over the next couple of months, this year's scholars will describe what this award means to them. Congratulations to the following students:

Aaliyah Amanda Lackhan, Swedish Institute College of Health Sciences, New York, NY - \$1,000
Adrianna Cheyanne Brumley, Rasmussen University, Bloomington, MN - \$500
Alexa C Davis, Bob Caruthers Scholarship, The College of Health Care Professions, Houston, TX - \$1,000, sponsored by the Texas State Assembly
Allyson A Guden, Mid State Technical College, Marshfield, WI - \$1,000
Amanda June Thompson, South College, Knoxville, TN - \$2,500
Brittany Nicole Sablan, Mt. Hood Community College, Portland, OR - \$500
Carlie D Bautista, Swedish Institute College of Health Sciences, New Milford, CT - \$1,000
Cassandra Gianne Rhind, Pima Medical Institute, Seattle, WA - \$500, sponsored by the Washington State Assembly
Chelsea Phoebe Calahan, Dalton Gay Memorial Scholarship, Reynolds Community College, Midlothian, VA - \$3,000
David Daniel Munoz, Don Brazier Scholarship, Texas State Technical College, Mcallen, TX - \$2,500, sponsored by the Texas State Assembly
Emily Alexis Cupo, Bergen Community College, Wood-Ridge, NJ - \$500
Golubina Stefanova, Passaic County Community College, Lodi, NJ - \$1,000
Hannah Grace Kiffer, Carlow University, Freeport, PA - \$500
Jasmine L McMiller, Southern Technical College, Thonotosassa, FL - \$500
Jessica Dawn Palmer, Reynolds Community College, Richmond, VA - \$2,500
Kathryn Noelle Davis, Pima Medical Institute, Tucson, AZ - \$2,500
Kelsy Dyshell Rogers, South College, Maryville, TN - \$1,000
Kylee Sharon Nolan, Rasmussen University, Clearwater, FL - \$1,000
Mactaysia L Hoots, Carlow University, Braddock, PA - \$500
Madalyn Jean Schnettler, St. Cloud Technical Community College, Sartell, MN - \$1,000
Madisyn Kylie Hohimer, St. Louis Community College, Saint Charles, MO - \$1,000
Maijoy Andrea Wooten, Owens Community College, Toledo, OH - \$1,000
Makayla M Reese, Carrington College, Placerville, CA - \$1,000
McKenna Lynn Morse, Quincy College, Norton, MA - \$2,500
Mylari Davila Colon, South College, Mount Dora, FL - \$1,000
Natalie Cooper, Concorde Career College, Adelanto, CA - \$2,500
Nikkolette Josephine Kriegel, Greenville Technical College, Greenville, SC - \$1,000
Olivia Goze, Ivy Tech Community College Valparaiso, South Bend, IN - \$1,000
Preston DiVali, Southwest Tech, Montfort, WI - \$500
Reagan Michelle Waller, Cabarrus College of Health Sciences, Concord, NC - \$1,000
Sandy Orozco, Mount Aloysius College, Kersey, PA - \$2,500
Sasha Khan, San Jacinto College Central, La Porte, TX - \$1,000
Skylar Madison Cox, Santa Fe Community College, Gainesville, FL - \$2,500
Trisha Danielle Drobny, Mount Hood Community College, Portland, OR - \$2,500, sponsored by AST Educators
Vanessa Vargas, North-West College Riverside, Riverside, CA - \$1,000
Yasmine M Firdous, Owens Community College, Toledo, OH - \$1,000

Are You Standing Up for the Surgical Technology Profession?

ROY G. ZACHARIAS, JR., CST, FAST, FORMER AST PRESIDENT

ADVOCACY IN ACTION



Scroll through Facebook or any other social media platform where surgical technologists gather, and you will inevitably find a familiar chorus of frustrations. Posts flash across the feed daily with declarations like "I want licensure," "I want mandatory certification and better pay" or "AST should be doing more to help me." It is completely understandable to feel this impatience.

When patients are at their most vulnerable, we become a vital guardian for safe patient care even though it seems that the profession is still fighting an uphill battle regarding formal recognition. These digital demands reveal a critical misunderstanding about how professional advancement works. These questions, complaints, and aspirations are the reason why every member must actively participate as advocates for the profession and understand what advocacy requires. The Association of Surgical Technologists (AST) cannot do it without the tireless help of every member.

During my tenure as President of AST (2013 – 2017), I tried to travel to as many state assembly meetings as possible to support ongoing efforts for recognition and mentor key members in ways to traverse the dynamics of communicating with OR managers, hospital administrators, and legislators. Fortunately, during this time, we were able to establish state assemblies in all 50 states. I dealt with some of the same questions that you have today. This is why the Advocacy Committee is identifying members that are willing to become ambassadors to navigate the pathway to successful advancement of the profession.

"The future of surgical technology belongs to those who are willing to stand up and claim it."

The Complex Dynamics of Legislation

As we move beyond social media venting, practitioners must grasp the complex legislative dynamics required to achieve certification and licensure laws. While the terms are often used interchangeably online, they represent entirely different legal frameworks. Pushing for mandatory certification sets a baseline credentialing requirement for employment, but pursuing true state licensure requires establishing a formal state board, defining a legal scope of practice, and enforcing strict regulatory oversight.

This introduces a massive hurdle: cost. Setting up and maintaining a licensing infrastructure creates a substantial financial and administrative burden. State legislators are notoriously hesitant to implement new regulatory burdens unless they are convinced it is necessary for public safety. Furthermore, someone must pay for it—whether through increased individual fee burdens on the technologists themselves or through state funding. When advocates understand these financial realities, they can shift their messaging from simple demands to structured arguments focused on patient outcomes, cost-mitigation through reduced surgical site infections, and public safety. This is where your specific ambassador will be able to support the leadership of their state to identify the pathway that will successfully strengthen the profession.

Advocacy Has No Expiration Date or Prerequisites

One of the greatest misconceptions about advocacy is that it is reserved only for politicians or seasoned organizational leaders. The anatomy of advocacy embraces every single person within the professional spectrum. A first-year Certified Surgical Technologist (CST®) fresh out of school and learning the rhythms of the operating room as well as the tenured CST are powerful advocates simply by explaining the rigor of their education to curious colleagues or hospital administrators. This is the avenue that can lead to successful identification of the CST credential and making it the initial requirement for employment. The same goes for improved pay scales. This takes time and effort on everyone's part.

On the other end of that spectrum are legends like Stuart Robinson. As a dedicated CST and a respected past president of AST, Stewart embodies the lifelong commitment our profession needs. At 95 years old, he remains an active member of AST and continues to carry his CST credential with pride. If a 95-year-old leader can maintain his dedication and stand up for the profession, then every working technologist scrubbing in today has the capacity to contribute their voice.

Moving from Venting to Action

AST provides the structural blueprint and legislative tracking tools, but grassroots momentum requires individual faces and local stories. Standing up for the profession means writing to state representatives, participating in local state assembly meetings, and educating hospital leadership. It is time to transform online complaints into real-world advocacy. The future of surgical technology belongs to those who are willing to stand up and claim it.

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Calling All Writers!

We are always looking for new CE authors and surgical procedures that detail the latest advancements in the surgical arena. We'll also help you every step of the way, AND you'll earn CE credits by writing a CE article that gets published! Here are some guidelines to kick start your way on becoming an author:

- An article submitted for CE must have a unique thesis or angle and be relevant to the surgical technology profession.
- The article must have a clear message and be accurate, thorough, and concise.
- It must be in a format that maintains the journal's integrity of style.
- It must be an original topic (one that hasn't been published in the journal recently).

Ready to get started or have questions?
Email us at publications@ast.org.



Hybrid Posterior Decompression in Cervical Myelopathy: Laminoplasty-Laminectomy Technique

CHRISTY SMITH, BAS, CST, CSFA

OVERVIEW OF CERVICAL SPINE DECOMPRESSION PROCEDURES

Posterior cervical decompression procedures are commonly performed to relieve pressure on the spinal cord caused by conditions such as cervical spinal stenosis and cervical spondylotic myelopathy. These conditions occur when degenerative changes narrow the spinal canal, compressing the spinal cord and nerve roots. Patients may experience symptoms such as neck pain, numbness, weakness in the upper extremities, loss of coordination, or difficulty walking. When conservative treatments fail, surgical decompression may be required to prevent further neurological decline.

Two commonly performed posterior decompression procedures are laminectomy and laminoplasty. Although both techniques aim to relieve pressure on the spinal cord, they differ in how the lamina is managed and how spinal stability is preserved. A laminectomy involves the surgical removal of the lamina, the posterior portion of the vertebra that forms the roof of the spinal canal. By removing the lamina, the surgeon creates additional space for the spinal cord and nerve roots, relieving compression.

Laminectomy has historically been considered a reliable method of decompression because it allows for wide exposure of the spinal canal. However, removal of the posterior bony structures can compromise the stability of the cervical spine. In many cases, this requires spinal fusion to maintain alignment and prevent postoperative deformity. Fusion can limit motion and increase surgical time and recovery.

Laminoplasty was developed as an alternative to laminectomy to preserve spinal stability and maintain motion. The expansive open-door lami-

LEARNING OBJECTIVES

- ▲ Differentiate between laminectomy, laminoplasty, and hybrid cervical decompression techniques used to treat cervical spinal cord compression
- ▲ Explain the purpose of hybrid cervical laminoplasty in decompressing the spinal cord while preserving cervical spine stability and motion
- ▲ Identify key instrumentation, implants, and supplies used during hybrid cervical laminoplasty, including the Canopy Laminoplasty System
- ▲ Describe the role of the CST during hybrid posterior cervical decompression
- ▲ Recognize postoperative considerations and potential complications associated with cervical decompression procedures

noplasty technique was originally described by Hirabayashi and Satomi.¹ Instead of removing the lamina entirely, the surgeon reshapes and repositions it to expand the spinal canal. The lamina is typically opened on one side, like a door, allowing more room for the spinal cord while keeping the bone intact.

Modern laminoplasty procedures often utilize plates or spacers to hold the lamina in the expanded position. Instrumentation systems such as the Canopy Laminoplasty System from Globus Medical allow surgeons to secure the lamina with small plates and screws, maintaining the new canal diameter while promoting stability.² Laminoplasty preserves motion and avoids the need for fusion in many patients. However, it may not fully address all sources of compression, particularly when thickened ligament tissue is present within the spinal canal.

HYBRID DECOMPRESSION

To address the limitations of each technique, some surgeons have adopted a hybrid decompression approach that combines laminoplasty with selective laminectomy. This allows the surgeon to remove structures that are directly compressing the spinal cord while still preserving the stabilizing structures of the spine.

Ding et al examined the effectiveness of a hybrid decompression technique that combines laminoplasty with selective laminectomy in patients with cervical spinal cord compression associated with hypertrophic ligamentum flavum.³ In this approach, selective laminectomy is used to remove compressive ligament tissue while laminoplasty is performed at adjacent levels to expand the spinal canal thus preserving the posterior spinal elements.

The study demonstrated that hybrid decompression provided significant enlargement of the spinal canal while maintaining structural stability of the cervical spine. Post-operative imaging confirmed adequate decompression of the spinal cord and reconstruction of a stable laminar arch. Patients in the study also demonstrated neurological improvement following the procedure. These findings suggest that combining laminoplasty with selective laminectomy can effectively address multiple sources of spinal cord compression while preserving important anatomical structures.

Additional research comparing laminoplasty techniques with traditional laminectomy and fusion procedures has supported the use of motion-preserving approaches

"Hybrid cervical laminoplasty combining laminoplasty with selective laminectomy provides an effective surgical approach for decompressing the spinal cord while preserving stability of the cervical spine."

when appropriate. In a comparative study evaluating modified laminoplasty versus laminectomy with fusion, investigators found that laminoplasty produced similar neurological recovery while offering advantages such as shorter operative times, reduced blood loss, and improved preservation of the cervical range of motion.⁴

These findings highlight the growing interest in hybrid and motion-preserving posterior cervical decompression techniques. By selectively removing compressive structures while maintaining spinal stability, surgeons may be able to achieve effective decompression while minimizing some of the limitations associated with traditional procedures.

For the Certified Surgical Technologist (CST®), understanding the differences between these procedures is essential. Hybrid decompression requires familiarity with both laminectomy and laminoplasty techniques, as well as the specialized instrumentation used during the procedure.

ROLE OF THE CST DURING HYBRID CERVICAL LAMINOPLASTY

The role the CST plays in a hybrid cervical laminoplasty is crucial. Knowledge of instrumentation and surgical setup, along with a clear understanding of the procedural steps, helps ensure that the surgical team maintains efficiency and patient safety throughout the procedure. Proper preparation and anticipation of the surgeon's needs allow the procedure to progress smoothly and minimize delays in the operating room.

Preparation for this procedure begins before the patient enters the operating room. The CST is responsible for ensuring that all necessary instrumentation, implants, and supplies are available and properly organized on the



sterile field. For hybrid cervical decompression procedures, this typically includes standard spine instruments, high-speed drills and burrs, Kerrison rongeurs, curettes, and the laminoplasty instrumentation system. When using the Canopy Laminoplasty System, the CST must verify that the appropriate plates, spacers, and screws are available and that the implant system is open and ready for use. Hemostatic agents such as Floseal and small surgical patties should be available, along with bone wax to control bleeding from bone surfaces. Irrigation should be prepared in a 20 mL syringe with an angiocath attached, which allows for controlled irrigation while drilling. Continuous irrigation is important because high-speed drills can generate significant heat, and irrigation helps cool the drill tip and surrounding bone during the procedure.

OPERATING ROOM SETUP AND PATIENT POSITIONING

Proper operating room setup is essential for maintaining efficiency and patient safety during posterior cervical spine procedures. For hybrid cervical laminoplasty, the patient is typically positioned prone on a radiolucent spine table, such as a Jackson table, which allows for proper spinal alignment and unobstructed imaging during the procedure. The patient's head is secured in a Mayfield head holder to maintain stability and prevent movement while the surgeon is working near the spinal cord. Careful positioning of the head and neck helps maintain neutral cervical alignment and allows optimal surgical exposure of the posterior cervical spine.

Fluoroscopy using the C-arm is used to confirm the correct spinal level prior to the incision. The CST should ensure that the C-arm can be brought into position easily without contaminating the sterile field and that there is adequate space in the operating room for imaging equipment and the surgical team.

Many surgeons utilize an operating microscope during

posterior cervical decompression procedures to improve visualization of the spinal cord and surrounding structures. The microscope should be draped prior to the start of the procedure so that it can be moved into position when needed without interrupting surgical flow.

Intraoperative neuromonitoring is commonly used during cervical spine procedures to monitor the function of the spinal cord and nerve pathways throughout the surgery. Neuromonitoring equipment is set up in the operating room prior to the start of the procedure, and baseline signals are typically obtained before surgical decompression begins. This monitoring helps the surgical team detect any potential changes in neurological function during the procedure.

Careful attention to the operating room setup, patient positioning, and equipment placement allows the surgical team to work efficiently and safely throughout the procedure. Draping both the operating microscope and the C-arm is performed by the CST with the assistance of the circulating nurse using sterile technique. Proper draping is critical to maintaining the sterile field while allowing the equipment to be safely maneuvered during the procedure. If the equipment is not draped correctly, contamination of the sterile field can occur, potentially increasing the risk of surgical site infection. For this reason, careful attention must be given to proper sterile handling and placement of these drapes to ensure patient safety and maintain the integrity of the sterile environment.

HYBRID LAMINOPLASTY-LAMINECTOMY SURGICAL TECHNIQUE

Once the patient has been properly positioned, the surgical site is prepped according to the surgeon's preference using an appropriate antiseptic solution. The required dry time for the prep solution is observed to ensure effectiveness and reduce the risk of surgical site infection. The surgical field is then

draped using sterile towels followed by placement of a universal spine drape to establish and maintain a sterile operative field.

A midline incision is made over the affected cervical levels. The surgeon begins the dissection through the subcutaneous tissue and muscle layers to expose the posterior elements of the cervical spine. Electrocautery is commonly used during this portion of the procedure to control bleeding and aid in tissue dissection.

Once the posterior cervical spine is reached, the paraspinal muscles are carefully elevated from the lamina using periosteal elevators. Self-retaining retractors are placed to maintain exposure and allow clear visualization of the surgical field. At this stage, the lamina and spinous processes of the affected vertebral levels are exposed.

After adequate exposure has been achieved, fluoroscopy using the C-arm may again be used to confirm the correct spinal level before decompression begins. A spinal needle is often placed into the surgical field and visualized under fluoroscopy to accurately identify the appropriate vertebral level. Accurate level confirmation is essential in spine surgery to ensure the correct anatomical site is treated and to prevent wrong-level surgery.

The hybrid decompression technique involves a combination of selective laminectomy and laminoplasty. During the laminectomy portion of the procedure, Kerrison rongeurs, curettes, and high-speed drills are used to remove portions of the lamina and other compressive structures that are contributing to spinal cord compression. Careful removal of these structures helps create additional space within the spinal canal.

Following decompression at the necessary levels, the laminoplasty portion of the procedure is performed. Using a high-speed drill, the surgeon creates a hinge on one side of the lamina while opening the opposite side to expand the spinal canal. Continuous irrigation is used during drilling to prevent exces-

sive heat generation, that can occur when high-speed drills are used on bone.

Once the lamina has been opened to the desired position, laminoplasty plates and spacers from the Canopy Laminoplasty System are placed to secure the lamina in the expanded position. Screws are inserted to stabilize the plates and maintain the newly enlarged spinal canal. During this stage of the procedure, the CST plays an important role in implant management. The CST should organize the Mayo stand with the various plate sizes and screws that are required, allowing the surgeon to easily select the appropriate implant. The CST must also verify the correct screw length prior to passing it to the surgeon to ensure proper fixation and prevent complications associated with implanting the incorrect size of screw.

After instrumentation is secured and adequate decompression has been confirmed, the surgical site is irrigated and hemostasis is achieved. The retractors are removed, and the wound is closed in layers according to the surgeon's preference.

POSTOPERATIVE CONSIDERATIONS AND POTENTIAL COMPLICATIONS

Once the surgical procedure is completed, dressings are applied and the patient begins the process of emerging from anesthesia. The surgical technologist must continue to maintain the sterile field and ensure that sterile technique is preserved until the patient leaves the operating room. Maintaining sterility throughout the entire procedure helps reduce the risk of surgical site infection.

As the patient begins to awaken from anesthesia, the surgeon may perform a brief neurological assessment. The patient may be asked to move or wiggle their feet and squeeze the surgeon's hands to help confirm that motor function remains intact following the decompression procedure. These early neurological checks provide reassurance that the spinal cord and nerve structures are functioning appropriately.

Following hybrid cervical laminoplasty, patients are closely monitored for neurological status, pain control, and signs of complications. Frequent neurological assessments are performed to evaluate motor strength, sensation, and overall spinal cord function. Early detection of neurological changes is important to ensure prompt intervention if complications arise.

Although hybrid decompression procedures are generally safe, potential complications can occur. These include postoperative bleeding, infection, cerebrospinal fluid leak, nerve root injury, or C5 nerve palsy. Kaptain et al identified C5 nerve palsy has been identified as a recognized com-

"By selectively removing compressive structures while maintaining spinal stability, surgeons may be able to achieve effective decompression while minimizing some of the limitations associated with traditional procedures."

plication following posterior cervical decompression procedures.⁵ Careful surgical technique, proper instrumentation handling, and adherence to sterile technique by the surgical team help reduce the risk of these complications.

CONCLUSION

Hybrid cervical laminoplasty combining laminoplasty with selective laminectomy provides an effective surgical approach for decompressing the spinal cord while preserving stability of the cervical spine. By addressing multiple sources of spinal cord compression and maintaining important anatomical structures, this technique offers an alternative to more extensive procedures that can limit spinal motion.

Advancements in spinal instrumentation, such as the Canopy Laminoplasty System, have improved the ability to secure the lamina in an expanded position and maintain adequate decompression of the spinal canal. These technological developments have contributed to increased efficiency and improved surgical outcomes in posterior cervical spine procedures.

The CST plays a vital role throughout the procedure, from initial operating room setup to assisting with instrumentation and maintaining the sterile field. Knowledge of surgical anatomy, instrumentation, implant management, and sterile technique allows the CST to anticipate the needs of the surgical team and contribute to the overall success of the operation.



ABOUT THE AUTHOR

Christy Smith, BAS, CST, CSFA, is a Certified Surgical First Assistant with extensive experience in multiple surgical specialties including orthopedic,

spine, and robotic procedures. She has worked in the operating room for more than two decades and currently practices as a surgical assistant supporting complex surgical cases. Smith is passionate about surgical education and advancing the role of the Certified Surgical Technologist in the operating room. She is dedicated to promoting patient safety, teamwork, and excellence in perioperative care.

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Hybrid Posterior Decompression in Cervical Myelopathy: Laminoplasty-Laminectomy Technique

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1. **The primary purpose of hybrid cervical laminoplasty is to:**
 - a. Fuse the cervical vertebrae together.
 - b. Decompress the spinal cord while preserving spinal stability.
 - c. Remove the spinal cord.
 - d. Replace damaged vertebrae.
2. **Which of the following best describes the difference between laminectomy and laminoplasty?**
 - a. Laminectomy reshapes the lamina while laminoplasty removes it.
 - b. Laminectomy removes the lamina while laminoplasty expands and preserves it.
 - c. Laminoplasty fuses the vertebrae while laminectomy replaces bone.
 - d. Laminoplasty removes nerve roots.
3. **Why is fluoroscopy used with a spinal needle before decompression begins during posterior cervical laminoplasty?**
 - a. Measure spinal cord pressure
 - b. Confirm the correct vertebral level prior to surgery
 - c. Monitor blood flow to the spinal cord
 - d. Guide screw insertion
4. **Why is irrigation used during drilling of bone in cervical spine surgery?**
 - a. Improve bone healing
 - b. Cool the drill and surrounding bone to prevent thermal injury
 - c. Increase visibility of the lamina
 - d. Sterilize the bone surface
5. **What device is commonly used to stabilize the patient's head during posterior cervical spine procedures?**
 - a. Halo brace
 - b. Mayfield head holder
 - c. Gel head ring
 - d. Cervical collar
6. **Which piece of equipment may be used intraoperatively to monitor spinal cord function during cervical spine surgery?**
 - a. Cardiac monitor
 - b. Ultrasound
 - c. Intraoperative neuromonitoring
 - d. Endoscopy
7. **What responsibility does the CST have regarding implants during laminoplasty instrumentation?**
 - a. Determining surgical indications
 - b. Organizing plate sizes and verifying screw length before passing
 - c. Inserting the screws
 - d. Selecting the surgical approach
8. **What is one advantage of laminoplasty compared with traditional laminectomy with fusion?**
 - a. Increased removal of vertebral bone
 - b. Preservation of spinal motion
 - c. Shorter incision length
 - d. Elimination of decompression
9. **Which of the following helps maintain a sterile environment during procedures involving a microscope or C-arm?**
 - a. Covering equipment with sterile towels only
 - b. Draping the equipment using sterile technique by the CST
 - c. Limiting movement of equipment
 - d. Avoiding use of imaging devices
10. **The neurological assessment that may be performed as the patient awakens from anesthesia following cervical decompression is asking the patient to:**
 - a. Cough
 - b. Wiggle feet and squeeze hands
 - c. To sit upright
 - d. Turn their head

HYBRID POSTERIOR DECOMPRESSION IN CERVICAL MYELOPATHY: LAMINOPLASTY-LAMINECTOMY TECHNIQUE

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Travel CST: Adventures, Flexibility, and Career Expansion

Cortney Hartman, MBA, CST, FAST

BEYOND THE MAYO



What if your surgical technology career could also be your ticket to adventure? What if you could explore new cities, earn higher pay, and build a network of colleagues across the country — all while staying in the operating room?

For many certified surgical technologists (CSTs), becoming a travel CST® offers exactly that.

Travel work has grown in popularity across all healthcare professions, and CSTs are no exception. The model is simple: hospitals across the country face staffing shortages and rely on travelers to fill gaps. In return, CSTs who are willing to relocate temporarily can enjoy flexible assignments, competitive pay, and experiences that expand both career and personal horizons.

Why Travel CSTs Are in Demand

The demand for travel CSTs is driven by multiple factors:

- **Staffing Shortages:** Hospitals often struggle to recruit enough full-time surgical staff.
- **Specialty Needs:** Certain service lines (like ortho, neuro, or cardiac) require expertise that travelers can bring.
- **Seasonal Surges:** Elective surgery schedules often peak in certain regions or times of year.
- **Flexibility:** Travelers allow hospitals to keep ORs running smoothly during turnover or leaves of absence.

This demand creates consistent opportunities for CSTs willing to take assignments away from home.

Lifestyle Benefits of Travel

Travel CSTs often cite lifestyle as the biggest draw:

- **Adventure & Exploration:** Assignments can take you to big cities, small towns, or even tourist destinations. Weekends off can feel like mini vacations.

- **Flexibility:** Most assignments last 8–13 weeks, giving you control over when and where you work. You can take breaks between contracts for family, rest, or travel.
- **Networking:** Each assignment expands your circle of professional contacts.
- **Skill Development:** Exposure to new surgeons, techniques, and systems sharpen your adaptability and expertise.

For CSTs with a sense of curiosity and flexibility, travel can be life-changing.

Financial Rewards

Compensation is another significant benefit:

- **Higher Pay Rates:** Travel contracts often pay more than staff positions, especially during high-demand periods.
- **Tax-Free Stipends:** Housing and meal stipends can increase take-home pay.
- **Bonuses:** Some contracts include sign-on or completion bonuses.

However, it's important to factor in the costs: traveling frequently means budgeting for temporary housing, transportation, and healthcare benefits if not provided by your agency.

Challenges to Consider

Travel work isn't for everyone. Potential challenges include:

- **Constant Transition:** New hospitals mean new policies, coworkers, and surgeon preferences every few months.
- **Homesickness:** Time away from family or friends can be difficult.
- **Uncertainty:** Contracts can be canceled or altered, leaving you to adjust quickly.
- **Adaptation Stress:** Some travelers thrive on constant change; others find it exhausting.

Understanding your own personality, support system, and resilience level are essential before committing.

How to Get Started

If you're interested in becoming a travel CST, here are the steps to take:

1. **Research Agencies:** Work with reputable travel staffing companies that have experience placing CSTs.
2. **Update Credentials:** Make sure your CST certification and BLS are current. Some states require an additional registry for CSTs.
3. **Polish Your Résumé:** Highlight specialties and adaptability. Travel hospitals value CSTs who can "hit the ground running."
4. **Set Priorities:** Decide what matters most — pay, location, schedule, or specialty experience.
5. **Be Flexible:** Being open to different regions or shifts increases opportunities.

Skills That Make Travel CSTs Successful

Certain qualities make travel CSTs especially effective:

- **Adaptability:** The ability to adjust quickly to new work-flows and personalities.
- **Confidence:** Surgeons and staff expect you to integrate smoothly.
- **Strong Clinical Base:** Travel CSTs must be competent without extensive orientation.
- **Communication Skills:** Building quick rapport with new teams is crucial.

If you already thrive in diverse or high-pressure OR environments, you're well prepared for travel.

Family and Lifestyle Considerations

For CSTs with families, travel can be more complex — but it isn't impossible. Some travel CSTs bring partners or children along, treating each contract like a temporary relocation adventure. Others choose assignments close enough to commute home on weekends.

Single CSTs or those with fewer obligations may find the lifestyle easier to navigate, but anyone considering travel should weigh how it fits into personal commitments.

Professional Growth

Beyond lifestyle and pay, travel experience can accelerate career growth:

- **Resume Strength:** Demonstrates adaptability, specialty expertise, and broad exposure.
- **Pathway to Leadership:** Travel CSTs often gain experience that prepares them for educator or manager roles.
- **Expanded Perspective:** Seeing how different hospitals

run their ORs can spark ideas for process improvement.

Many CSTs later leverage travel experience into permanent leadership, education, or specialty roles.

Closing Thoughts

Becoming a travel CST isn't just about changing jobs — it's about changing perspective. It's about trading routine for adventure, predictability for possibility. It's about expanding not only your professional skills but also your personal horizons.

For those who crave flexibility, variety, and growth, travel work can be the perfect next chapter.

So, the next time you find yourself daydreaming about new places or wondering what's beyond the walls of your current OR, ask yourself: *Could the road ahead be my new Mayo stand?*

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Future of Treating Long-Gap Esophageal Atresia May Rely on Tissue Engineering

OF INTEREST IN THE MEDICAL ARENA

Hollow organ tissue engineering (TE) has had several successful clinical applications including arteries, urethra, and vagina. TE is now becoming a reality for treating esophageal pathologies. Adult and pediatric esophageal pathologies, both acquired and congenital, usually require surgery. Esophageal atresia (EA) is one type of serious congenital condition that affects 1 in 3,500 newborns. Immediate surgery by primary anastomosis is required to provide the newborn esophageal continuity.

In a single-arm pilot study involving minipigs, the implantation of autologous tissue-engineered esophageal grafts supported all the minipigs for 30 days and in the process restored normal function including motility, normal growth, and oral feeding without the need for immunosuppressants. Strictures were the most common complication that were managed endoscopically and most of the minipigs survived for six months.

In approximately 8% - 10% of EA cases, however, newborns suffer from long-gap esophageal atresia (LGEA).¹ LGEA is characterized by a long, interrupted gap between the upper and lower segments, defined as a gap that is the length of three or more vertebrae (Figure 1).² Surgery is not an option for the newborn because the gap is too long to close immediately after birth, the lack

of appropriately sized grafts, and the complexity of the vascular supply.^{1,2} Initial treatment is a gastrostomy to insert a feeding tube to provide adequate nutrition. Eventually, the child is eligible for surgery with the common approach of repositioning (transpositioning) the colon, jejunum, or stomach to fill in the gap.^{1,2} The procedures, however, are accompanied by several postoperative complications that contribute to the morbidity and mortality rates including

anastomotic leak, graft necrosis, loss of motility, respiratory complications, reflux, and unknown long-term cancer risk depending on the organ that is used.^{1,2} There is, obviously, the clinical need for better options to be developed that present with fewer life-threatening complications.



Figure 1 Gap study under general endotracheal anesthesia in a 1-month-old infant with long-gap esophageal atresia. In this anteroposterior fluoroscopic spot image, there is a transoral bougie dilator in the upper esophageal pouch. A small, flexible endoscope was placed through the gastrostomy site and advanced into the lower esophageal pouch. The esophageal gap was over 4 vertebral bodies.

Recognizing this need, researchers from the Great Ormond Street Hospital (GOSH) and the University College London (UCL) created the first lab-grown esophagus relacing a 2.5 centimeter section of the organ in a minipig model. The transplanted esophagus functioned normally, including peristalsis and swallowing. The study, published in *Nature Biotechnology*, showed that a pig donor esophagus can be decellularized, implanted with the recipient mini-

pig's own cells, and transplanted into the minipig to restore esophageal function. The need for immunosuppression was not needed because the implant was grown using the recipient's cells and the implant itself grew within the recipient.¹

How the Technology Works

The first step of the process involved creating a tube-based scaffold using a donor pig's esophagus. As with porcine heart valves and skin, the pig's esophagus is closest to human anatomy and physiology. Because the human esophagus does not have an internal blood supply from its own vessels and relies on external sources for blood, it was important for the research team to identify an animal model that was similar to human tissue. To create the scaffold, the tissue was stripped of its pig's cells, referred to as decellularization, while preserving the rest of the underlying support tissue.¹

Next, the scaffold was repopulated with the recipient minipig's cells that were removed by performing biopsies. The cells had been multiplied in the lab and injected directly into the scaffold.¹ The scaffold was then placed into a bioreactor container that pumped vital growth fluids through the tissue for one week to allow the cells to further multiply and infiltrate the tissue.¹

After transplantation, all eight minipigs survived the vital first outcome of 30 days. Five of the minipigs reached the six-month outcome, of which the minipigs could eat and swallow normally and grew at a normal rate. The transplanted esophagus showed a regeneration of normal anatomical structures, with a mucosa, submucosa, muscularis propria, adventitia, muscle, and muscularis mucosae, allowing the bioengineered esophagus to exhibit peristalsis with enough strength to provide the minipigs with normal swallowing movement comparable to a native esophagus.¹

Adverse events included stricture formation that were successfully treated endoscopically, which is the same as how a human patient would be treated, and development of hyperplastic epithelial polyps, treated with steroids or endoscopic excision.¹ None of the minipigs developed anastomotic leaks, infections, or pneumothorax.¹

Another first by the research team, led by Natalie Durkin, Stem Cell and Regenerative Medicine Section, Zayed Centre for Research into Rare Disease in Children, UCL Great Ormond Street Institute for Child Health in London, England, was mapping the genes in the bioengineered esophagus to show that the activated tissue genes were the same as in a native esophagus.¹

Ongoing Research

The research team is continuing their efforts by refining the scaffolding process to produce longer grafts, reduce the steps for producing a graft, and complete further safety testing.² The team is focusing on improving the blood supply and preparing for human trials. The goal of the team is to begin the research trial within the next five years.²

Summary

"Graft implantation was safe and effective, supporting oral feeding, maintaining structural integrity, and facilitating animal growth and survival," the research team wrote.¹ The team further commented, "In summary, we demonstrated that autologous, full-thickness, cell-seeded esophageal grafts can be generated within 2 months and are a feasible, safe alternative to repair thoracic esophageal defects in a growing large-animal model. This method addresses key translational barriers to circumferential esophageal repair."¹

Limitations

The study focused on using short grafts that would be used in treating pediatric patients with LGEA. Studies focusing on the use of longer grafts for adult patients to treat conditions such as cancer, need to be completed.

Disclosures

The research study was supported by the National Institute for Health and Care Research (NIHR) GOSH Biomedical Research Centre, GOSH Charity, the LifeArc Translational Research Accelerator, and a Rosetree Trust Major Project Award. Dr. Paolo De Coppi, MD, disclosed being a named inventor on two patents. The other authors declared no competing interests.

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AST STUDENT ASSOCIATION FORUM & SCRUB BOWL



OUTREACH

The Association of Surgical Technologists Board and CEO teamed up with representatives from the Accreditation Review Council on Education in Surgical Technology and Surgical Assisting (ARC/STSA) and the National Board of Surgical Technology and Surgical Assisting (NBSTSA) to help sort and repack food for those experiencing food insecurity throughout Western Washington through Food Lifeline.

The team sorted and repacked more than 2,400 pounds of crackers that would then be distributed to those in need.

In addition to sorting and repacking packing, all organizations made monetary contributions so Food Lifeline can continue to provide much-needed nutrition to its communities.



Left to Right: Antionette Trujillo-Fergus, ARC/STSA President; Monica Thulon, AST Director; Brooke Oliver, AST Director; Jaime Lopez, AST Director

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DO GOOD GIVE BACK

This year we also supported Seattle Children's Hospital, acknowledging their efforts to provide kids, teens, and their families with essential items. Attendees graciously donated gift cards to provide for the families and we are proud to say we raised over \$380. Thank you to everyone who contributed!

SNAPSHOTS FROM THE AST 2026 CONFERENCE



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Francesco Durante, MD: Advancing the Surgical Specialty of Neurosurgery

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MEDICAL MARVELS



“Francesco, what have you done?” And he proudly replied, “Dad, nothing you should be ashamed of.”¹ (During the Franco-Prussian War, Dr. Durante entered no-man’s land to stop the bleeding and attach the severed ends of a frontline soldier’s subclavian vein, while under opposing fire. Word of the act reached the Prussian ambassador in Paris who wanted to award him an honor on behalf of the King of Prussia but could not find Dr. Durante. The ambassador found Dr. Durante’s father, Domenico who, unaware of the situation, asked the above question).

Beginnings

Dr. Durante was born in Letojanni, Sicily, a small coastal town located in the northern part of the island. He was the son of Domenico and Giovanna (Galeano) Durante. His father was a construction foreman who oversaw the building of the main road in Letojanni. Dr. Durante was first introduced to medicine when a friend of his father brought him to the University of Messina to assist in a surgical procedure.² At the age of 20, he attended the University of Messina School of Medicine and after moving to Naples, Italy, he graduated on January 7, 1868.²

To further his medical knowledge after graduation, he traveled to multiple countries to study under prominent physicians. During the Franco-Prussian War, Dr. Durante received a fellowship in Berlin, Germany, as an assistant to Rudolf Ludwig Karl Virchow, the well-known German physician known as the “father of modern pathology.” After the war, he moved to Vienna, Austria, and studied under the already well-known physician Theodor Billroth, who is still recognized for the two types of partial gastrectomy procedures he developed, the Billroth I and II.² Dr. Durante next moved to London, England, to serve as an assistant to Joseph Lister that influenced his belief in and adoption of sterile technique.²

In 1872, he moved to Rome, Italy, to teach surgical pathology at the Sapienza University of Rome, also called La Sapi-



Figure 1 Francesco Durante, MD (6/29/1844 – 10/2/1934)

enza, the largest university in Europe. He remained in Rome for the rest of his 34-year professional career until retirement. In 1873, at the age of 29, he was appointed as the Chair of Surgical Pathology.² The next few years saw additional significant appointments including full professor of General and Human Pathology at the University of Catania in 1875 and full professor of Surgical Pathology at the University of Padua and La Sapienza in 1881.² In 1885, he was appointed as the Chair of Clinical Surgery at La Sapienza.

During this time, Dr. Durante was instrumental in the construction of a new hospital in Rome, the Policlinico Umberto I, so named to honor King Umberto I, who had granted 10,000,000 Lira (\$219,364 U.S. dollars in 2026) for the construction. The construction began on January 19, 1888, and finished in 1902 (during construction, King Umberto I was assassinated on July 29, 1900).² Applying Lister's concepts, Dr. Durante had tunnels built between the

49 buildings to separate patients according to their disease to prevent cross-contamination among the patients.³

Durante's Pioneering Neurosurgical Procedure

On June 1, 1884, Dr. Durante performed the procedure for which he is most well-known, consisting of the successful removal of a left olfactory groove meningioma that resulted in long-term survival for the patient. The procedure was a first of its kind in the world. The patient was a 35-year-old woman from Narni, Italy. She was referred to Dr. Durante by an ophthalmologist, presenting with a one-year history of loss of olfactory function, loss of memory, and left eye exophthalmos.² Dr. Durante diagnosed the patient with a left intracranial tumor that had destroyed the olfactory nerves, compressed the frontal lobe of the brain, and infiltrated the orbital cavity (see Box 1).²

Box 1: Surgical Steps of the Procedure⁴

1. Upon anesthetizing the patient with chloroform, Dr. Durante made an incision extending from the inner angle of the left orbit nearly to the hairline of the temporal region.
2. Implementing the concept that he developed prior to the procedure, Dr. Durante performed an osteoplastic flap consisting of discontinuous pieces of bone.
3. Using a bone chisel, a fronto-orbital bone opening of 5 cm in width and length was made.
4. The dura mater had been perforated by the tumor. The tumor was lobular and about the size of an apple. It occupied the anterior fossa at the base of the cranium and spread to the right. Posteriorly, the tumor extended to the glenoid tubercles. The orbital roof was depressed, but intact. The left frontal lobe had been invaded by the tumor.
5. The dural attachment was identified and the tumor was excised.
6. A drainage tube was inserted in the cavity, which descended to the left nasal fossa through the opening made in the ethmoid bone by the lesion.
7. The operation lasted one hour.
8. On the fourth postoperative day, a stop in the drainage from the nasal tube coincided with a tendency for the patient to sleep and experience mental confusion. The tube was repositioned and the patient's symptoms subsided.
9. On the 15th postoperative day, the patient was released from the hospital and went home.
10. After three months, the patient's loss of memory resolved as well as her olfactory functions returned. The displacement of the left eye was partially reduced.
11. Microscopic examination of the tumor showed that it was a fusio-cellular sarcoma that had originated in the dura mater.

When describing the procedure, Dr. Durante stated “... the progress of experimental pathology and of studies of cerebral localization every day now smooths our way to the diagnosis of cerebral diseases, so that the cranial cavity may, in the future, justly enter into the dominion of surgery.”⁴

In March 1896, the patient underwent surgery to treat a recurrence of the tumor, a fibrosarcoma of the dura mater. The patient recovered and lived a fulfilling life for another 12 years.⁵

Author, Forceps, and Politics

Dr. Durante was a prolific author who wrote of his many contributions to various surgical specialties including general surgery, gynecological surgery, orthopedic surgery, otorhinology, and urogenital surgery. His articles were constantly published in the *Bulletin of the Royal Medical Academy* that include examples such as “A New Operative Approach for Removal of the Tongue” (1880), “Extirpation of a Neoplastic Larynx” (1883), “New Operative Approach for the Resection of the Knee” (1886), “Cases of Abdominal Hysterectomy” (1889), “Resection of the Pylorus” (1892), “Pyloroplasty” (1892), and “Cholecystectomy for Calculi” (1902).

In 1895, Dr. Durante’s three volume *Master Book of General Surgery* was published, in which second and third editions were published in 1895 and 1905. The volumes addressed all surgical specialties including neurosurgery and was the definitive textbook for students and surgeons.⁵

Another reminder of Dr. Durante for all surgery personnel is the Durante forceps (Figure 2). He invented the forceps with the intent of having an instrument that would not injure vessels and tissues including tumor tissue.



Figure 2 Durante forceps

Dr. Durante did not limit his professional life to surgery alone. On January 29, 1889, at the age of 45, he was elected as a Senator of the Kingdom of Italy. Because he was elected at such a young age, he served for several decades and was considered a Senior of the Italian Senate.² His focus as a politician was on social reform for the poor, particularly disabled and poor veterans. He led the efforts in reforming the laws “Protection and assistance for disabled veterans”

and “Protection and assistance for the war orphans.”² During his time as a senator he founded the National Order of Disabled Veterans. His commitment to politics has had a lasting effect with many of the reform bills that he introduced and subsequently approved, still in effect.

Retirement and Remembrance

On June 19, 1919, Dr. Durante retired from practice. After the many years of living in Rome, he returned to his birth town of Letojanni. After his return, the town dedicated a monument to him that is located in what is now called Piazza Durante (Figure 3). It is a bronze bust that was created by the famous Italian sculptor, Ettore Ximenes. Beneath the likeness of Dr. Durante, surrounding the base, are four portraits of Charity, Medicine, Science, and Surgery.

On November 15, 1984, on the 50th anniversary of Dr. Durante’s passing, his collection of surgical instruments and memoirs were displayed for the first time in Letojanni, which are now housed in the Museo Durante. The museum is filled with over 362 surgical instruments as well as charts of his patients, books, photos, and paintings.²

In honor of his lasting legacy and contributions, the International Prize Francesco Durante is awarded to recognize surgeons who have made significant contributions. The town of Letojanni along with the Universities of Catania and Messina give the award. In March 2002, Mahmut Gazi Yasargil, MD, received the recognition, and as part of the award was given a reproduction of the Durante forceps made of gold – a fitting tribute to the genius of Dr. Francesco Durante.



Figure 3 Francesco's bronze bust sculpture in the Piazza Durante in Letojanni, Italy

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1. Garrozzo A. Francesco Durante. *Ursini Edizioni*. 2013. p. 23.
2. Tomasello F, Germanó A. Francesco Durante: the history of intracranial meningiomas and beyond. *Neurosurgery*. 2006; 59(2): 389-396.
3. Garrozzo, A. Francesco Durante. *Ursini Edizioni*. 2013. Pp. 71-85.
4. Durante F. Contribution to endocranial surgery. *Lancet*. 1887; 2: 654-655.
5. Durante F. Trattato di Patologia E Terapia Chirurgica Generale E Speciale. Vol. III: Chirurgia del Sistema Nervoso Centrale. Rome, Dante Alighieri. 1895. 2nd ed.

Basic Anterior Approach Instrument Set

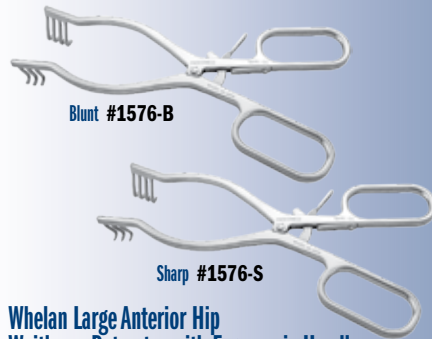
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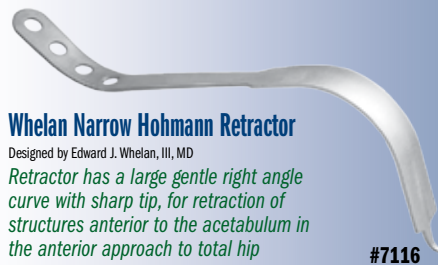
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Designed by Edward J. Whelan, III, MD

Designed for self-retaining exposure
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Designed by Edward J. Whelan, III, MD

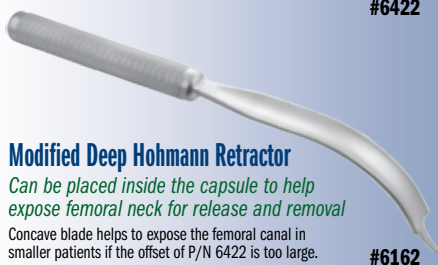
Retractor has a large gentle right angle
curve with sharp tip, for retraction of
structures anterior to the acetabulum in
the anterior approach to total hip



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Modified Anterior Hip Retractor

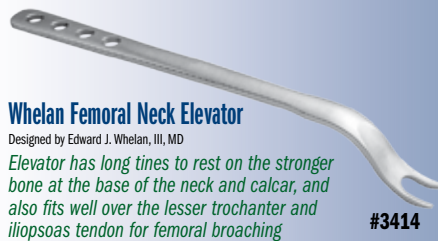
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Optional Radiolucent Tapered Blades

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Winged Modified
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Optional
Radiolucent
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#7425-03R

Optional
Radiolucent
4" Tapered Blade
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help to protect the soft tissue during THA,
reducing intraoperative muscle lesions



US Patent No.
11,744,757



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ARIZONA STATE ASSEMBLY

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

ARKANSAS STATE ASSEMBLY

Program Type: Annual Meeting/Elections
Date: October 3, 2026
Title: Fall Workshop/Business Meeting
Location: TBA, Fort Smith, AR
Contact: Tamara Morgan, PO Box 10301, Fort Smith, AR 72917, 479-414-6720, arkstateassembly@gmail.com
CE Credits: 6 Live Planned

COLORADO/WYOMING STATE ASSEMBLY

Program Type: Webinar (approved only for Colorado/Wyoming State Assembly members)
Date: August 4, 2026
Title: Summer School
Contact: Julie Beard, 720-256-5863, information@coloradoast.com
CE Credits: 2 Live Planned

Program Type: Annual Meeting/Elections
Date: October 10, 2026
Title: Annual Business Meeting
Registration: coloradowyomingast.org/events
Location: Concorde Career College, 4300 Kittredge St, Denver, CO 80239
Contact: Lori McGregor, 406-781-3973, gfmtgirl@yahoo.com
CE Credits: 5 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 approved by AST

GEORGIA STATE ASSEMBLY

Program Type: Workshop
Date: September 12, 2026
Title: 25th Anniversary Celebration
Registration: 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

IDAHO STATE ASSEMBLY

Program Type: Annual Meeting/Elections
Date: September 26, 2026
Title: Harvesting Innovation in Neuro Surgery
Location: St. Luke's Plaza, 800 E Park Blvd, Boise, ID 83712
Contact: Keri McKenney, 208-941-2457, IDSAST@gmail.com
CE Credits: 6 Live Planned

INDIANA STATE ASSEMBLY

Program Type: Annual Meeting/Elections
Date: September 19, 2026
Title: INSA Fall Workshop and Business Meeting 2026
Registration: indianastateassembly.org
Location: Conference Center & Culinary Institute at Ivy Tech College, 2820 North Meridian St, Indianapolis, IN 46208
Contact: Sara Velligan, 219-808-8240, svelligan@hotmail.com
CE Credits: 6 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

MAINE STATE ASSEMBLY

Program Type: Annual Meeting/Elections
Date: October 10, 2026
Title: Fall Workshop and Annual Meeting With Elections
Location: Northern Light Mercy Hospital, 175 Fore River Pkwy, Portland, ME 04102
Contact: Lorraine Swenson, 207-329-8402, lorrainekimball@yahoo.com
CE Credits: 5 Live Planned

MINNESOTA STATE ASSEMBLY

Program Type: Annual Meeting/Elections
Date: September 19, 2026
Title: MNSA Fall 26 Workshop and Business Meeting
Registration: mnast.mn
Location: TBD
Contact: Jolianne Mohler, 763-458-2764, mnast2016@outlook.com
CE Credits: 6 Live Planned

MISSOURI STATE ASSEMBLY

Program Type: Workshop
Date: September 19, 2026
Title: Missouri State Assembly Fall Workshop
Location: State Fair Community College, 1701 N 2nd St, Clinton, MO 64735
Contact: Victoria Thompson, PO Box 1740, Camdenton, MO 65020, 573-836-0637, missouriassemblyast@gmail.com
CE Credits: 8 Live approved by AST

MONTANA STATE ASSEMBLY

Program Type: Annual Meeting/Elections
Date: October 16-18, 2026
Title: Montana CSTs & CSFAs ROCK!
Registration: mt.ast.org
Location: St. Peter's Health, 2475 E Broadway St, Helena, MT 59601
Contact: Kristen Stone, 406-407-1595, mtast.president@gmail.com
CE Credits: 12 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 HAMPSHIRE / VERMONT STATE ASSEMBLY

Program Type: Annual Meeting/Elections
Date: October 3, 2026
Title: NH/VT Fall Conference
Location: Dartmouth Hitchcock Medical Center, 1 Medical Center Dr, Lebanon, NH 03766
Contact: Jennifer Fleury, 603-817-3039, jenniferfleury08@gmail.com
CE Credits: 6 Live approved by AST

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

NORTH DAKOTA STATE ASSEMBLY

Program Type: Annual Meeting/Elections
Date: September 12, 2026
Title: 2026 NDSA Workshop & Elections
Location: Boniface Auditorium, 900 E Broadway Ave, Bismarck, ND 58501
Contact: Emily White, 701-202-5779, esmallbeck27@gmail.com
CE Credits: 6 Live Planned

OREGON STATE ASSEMBLY

Program Type: Annual Meeting/Elections
Date: October 17, 2026
Title: OAST Fall Business Meeting/Workshop
Registration: or.ast.org
Location: Providence Willamette Falls Community Center, 519 15th St, Oregon City, OR 97045
Contact: Jeffrey Rebo, 406-291-7220, jeffreyrebo.oast@gmail.com
CE Credits: 8 Live Planned

PENNSYLVANIA STATE ASSEMBLY

Program Type: Annual Meeting/Elections
Date: September 19, 2026
Title: Shaping Tomorrow's OR
Location: Central Penn College, 600 Valley Road, Enola, PA 17025
Contact: Chris Kapp, 717-728-2230, christopherkapp@centralpenn.edu
CE Credits: 5 Live Planned

SOUTH CAROLINA STATE ASSEMBLY

Program Type: Annual Meeting/Elections
Date: September 26-27, 2026
Title: SCSA 25th Fall Business Meeting and Workshop
Registration: scsaast.org
Location: Southeastern Institute of Manufacturing Technology, 1951 Pisgah Road, Florence, SC 29501
Contact: Katrina Williams, 843-615-7454, katrinawilliams89@yahoo.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

TEXAS STATE ASSEMBLY

Program Type: Workshop
Date: September 12, 2026
Title: West TX Workshop
Registration: texasstateassembly.org
Location: Knipling Education and Conference Center, 21st St & Louisville Ave (6th Floor), Lubbock, TX 79410
Contact: Kristie Cole, PO Box 152982, Arlington, TX 76015, 806-787-8298, kcole@southplainscollege.edu
CE Credits: 8 Live Planned

Program Type: Workshop
Date: September 26, 2026
Title: South Texas CEs
Registration: texasstateassembly.org
Location: Texas State Technical College - Cultural Arts Center, 2425 Boxwood St, Harlingen, TX 78550
Contact: Kristie Cole, PO Box 152982, Arlington, TX 76015, 806-787-8298, kcole@southplainscollege.edu
CE Credits: 8 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.

ARKANSAS

Fort Smith
October 3, 2026
Annual Meeting
2026 BOD Elections
& 2027 Delegate Elections

FLORIDA

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

COLORADO / WYOMING

Denver
October 10, 2026
Annual Meeting
2026 BOD Elections
& 2027 Delegate Elections

IDAHO

Boise
September 26, 2026
Annual Meeting
2026 BOD Elections
& 2027 Delegate Elections

INDIANA

Indianapolis
September 19, 2026
Annual Meeting
2026 BOD Elections
& 2027 Delegate Elections

IOWA

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

MAINE

Portland
October 10, 2026
Annual Meeting
2026 BOD Elections
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MINNESOTA

TBD
September 19, 2026
Annual Meeting
2026 BOD Elections
& 2027 Delegate Elections

MONTANA

Helena
October 16-18, 2026
Annual Meeting
2026 BOD Elections
& 2027 Delegate Elections

NEW HAMPSHIRE / VERMONT

Lebanon
October 3, 2026
Annual Meeting
2026 BOD Elections
& 2027 Delegate Elections

NEW YORK

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

NORTH DAKOTA

Bismarck
September 12, 2026
Annual Meeting
2026 BOD Elections
& 2027 Delegate Elections

OREGON

Oregon City
October 17, 2026
Annual Meeting
2026 BOD Elections
& 2027 Delegate Elections

PENNSYLVANIA

Enola
September 19, 2026
Annual Meeting
2026 BOD Elections
& 2027 Delegate Elections

SOUTH CAROLINA

Florence
September 26-27, 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.

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