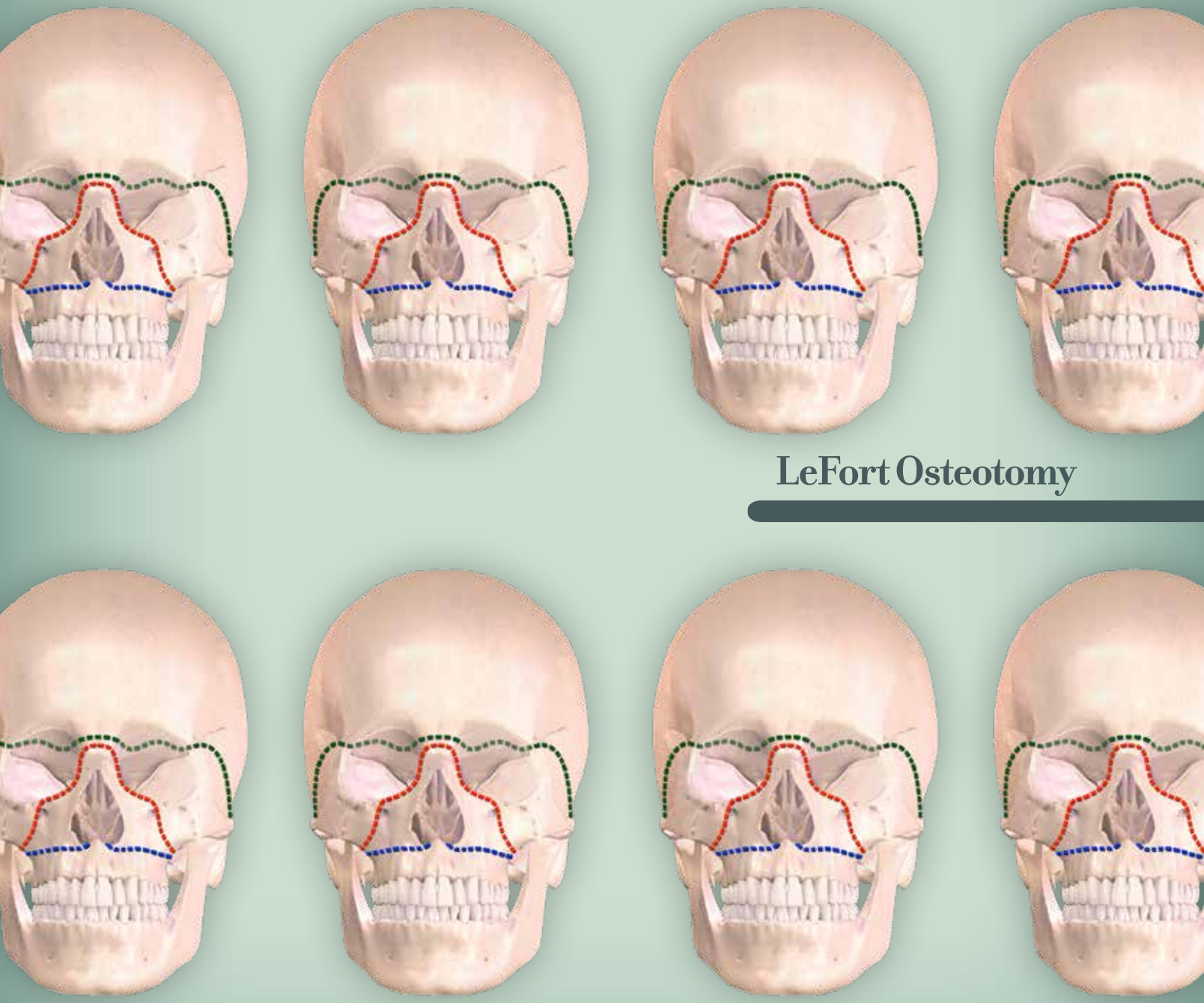
SEPTEMBER 2025 VOLUME 57 NO 9

THE SURGICAL TECHNOLOGIST

OFFICIAL JOURNAL OF THE ASSOCIATION OF SURGICAL TECHNOLOGISTS, INC.



LeFort Osteotomy

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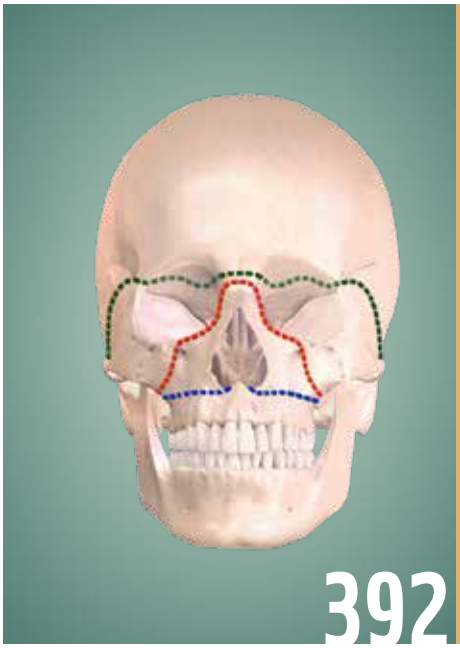

LeFort Osteotomy

Anna Moorhead, Ryan Winters Marc Serra

A LeFort osteotomy is a surgical procedure used to correct misalignments or deformities of the upper jaw (maxilla). It involves cutting and repositioning the bone to improve bite function, facial balance, or breathing. There are three main types—LeFort I, II, and III—each referring to different levels and extents of the bone cuts, depending on the complexity of the condition. This procedure is commonly performed in orthognathic (jaw) surgery and may be done alone or in combination with other facial surgeries.

In This Issue

In Every Issue

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Celebrating the Essential Role of Surgical Technologists

AST Board

BOARD MESSAGE

September 21-27, 2025, is National Surgical Technologists Week. This week is an opportunity to promote the profession and educate the community about the vital role surgical technologists play in the care of patients in the operating room. In addition to celebrating with potlucks and cakes, we challenge you to discover ways you can increase public awareness by highlighting our profession. The AST Board of Directors, AST staff, committee members and state assembly boards all work diligently to promote the profession, however, we cannot accomplish this task alone. By working together to educate the public, we have a better chance at furthering professionals within our facilities about the importance of having a properly educated and Certified Surgical Technologist in the operating room.

You are the face behind the mask, the eyes and ears for the patient. Your role is critical to every surgery, and we want you to take a moment to recognize the greatness that you bring to the OR team. Although AST plays an active role in increasing awareness for this week, if your facility does not recognize you, take time to celebrate yourself. Many of the greatest celebrations are initiated by surgical technologists. Some facilities may not be aware this week exists so make this week known by bringing in a cake to thank the surgical technologists in your facility for the commitment they have to patients and the surgical team.

Since we use this time to celebrate the work we do and our commitment to our patients, what better way to celebrate than to be surrounded by peers who have the same passion for the profession as you. Fall offers many state assembly meetings and provides you with an opportunity to network and meet other professionals who share in both your challenges and your successes.

AST encourages you to share pictures of how you are celebrating yourself, your peers and the important work you do every day. We invite you to participate in our NSTW contest for your chance at winning a 2026 conference registration for AST's Surgical Technology Conference, May 31-June 2, 2026, in Seattle!

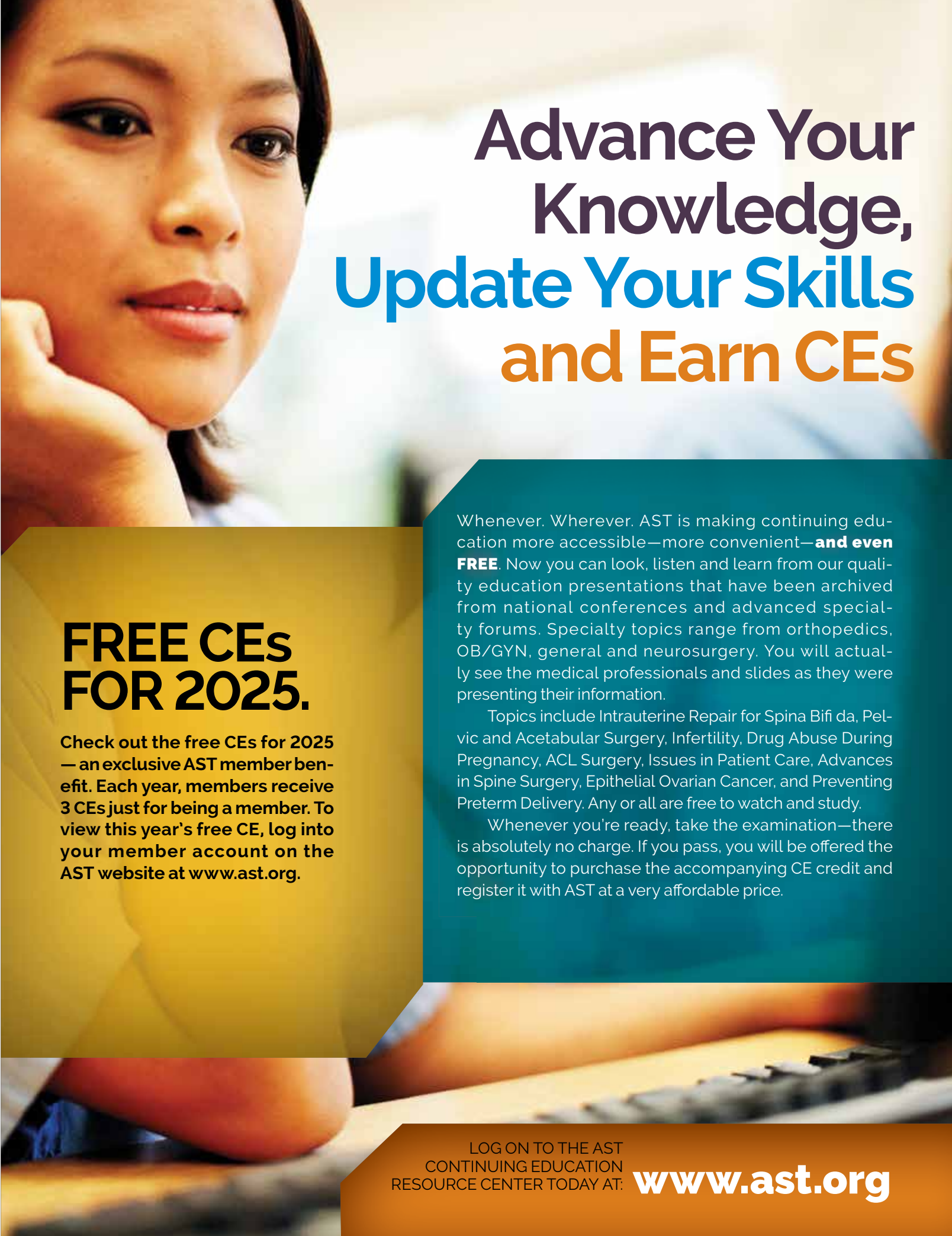
The AST Board of Directors and AST staff wish all of you a Happy National Surgical Technologists Week! While we have more work to do to continue the advancement of the profession and provide all certified surgical technologists the recognition they deserve, we honor you for your commitment to safe patient care and your passion for helping others.

Get ready to celebrate YOU!

National Surgical Technologists Week, September 21–27, 2025!

This year, we're shining a spotlight on the everyday heroes of the OR with our "You Are Essential" Contest—because surgical technologists don't just assist in surgery, they make it possible. Nominate a fellow tech (or yourself!) who brings skill, heart, and dedication to the team. Winners could score a $50 Amazon gift card—or the grand prize: free registration to the 2026 AST National Conference in Seattle!

Don't miss your chance to recognize the essential impact of surgical technologists everywhere. Submit your nomination by September 30, at ast.org!



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AST News

AT A GLANCE

In Memoriam

JEFF FEIX, CST, CSFA, LVN, FAST
1962-2025

Longtime AST member and former board of director, Jeff Feix, passed away July 30, 2025, after a courageous battle with cancer. Jeff was instrumental in paving a way forward for many surgical technologists practicing today. His fierce dedication and passion for students, education and the profession led him to hold many roles to help advance the role of the surgical technologist and the organization.

Jeff became a Certified Surgical Technologist in 1995 and a Certified Surgical First Assistant in 1998. He was awarded the 2004 AST Clinical Educator of the Year and earned his FAST (Fellow of Association of Surgical Technologists) in 2007. He served as Director on the AST Board from 2006-2008, followed by serving as AST's Secretary from 2008-2010.

He was very active in his home state of Texas and served as the Texas State Assembly Board of Directors from 2002-2003, as President from 2003-2008 and as Treasurer from 2015-2019. Jeff was passionate about improving patient care standards and championed legislation mandating credentialing for surgical technologists. His dedication was instrumental in the passage of Texas House Bills HB1748 and HB643, leaving a lasting legacy that will benefit patients and professionals for years to come.

His most recent appointment was with the Accreditation Review Council on Education in Surgical Technology and Surgical Assisting (ARC/STSA) and he served as a Director to its board from 2024 until his passing.

In the early 2000s, he helped to develop a surgical technology program at Vernon College. Jeff's first class began on August 22, 2002, and his last class graduated on August 4, 2022. With Jeff's dedication and the student's willingness to learn he helped 282 graduates complete the program. He was also instrumental in assisting many of his graduates to continue their education in completing their surgical first assistant certifications.

Jeff's passion for surgical technology education and surgical technology profession will be missed by many. AST thanks him for his years of tireless efforts to continue to advance the profession and the organization. May he rest in peace.

Empower YOURSELF

YOUR VOICE, YOUR POWER

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- 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
- CSPS Surgical Team Member Roles - Partner Organizations and Credentials
- 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

AST
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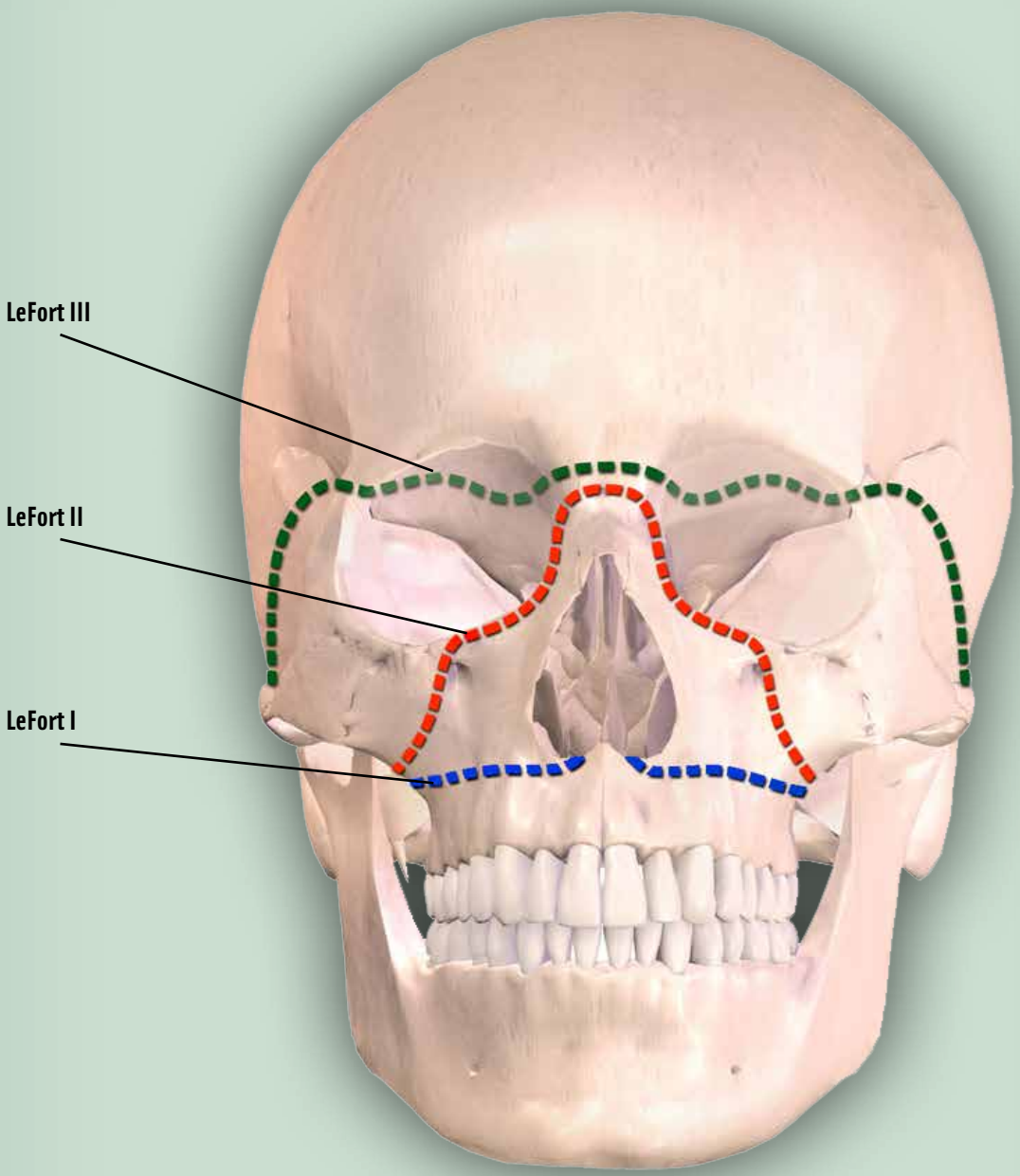
Your Voice IS Your Power
ADVOCATING FOR THE PROFESSION



Three Types of LeFort Osteotomy

LeFort Osteotomy

Anna Moorhead[1]; Ryan Winters[2]; Marc Serra[3]

The LeFort I osteotomy is a procedure utilized extensively within the field of oral and maxillofacial surgery when maxilla repositioning is required to connect dentofacial abnormalities or facilitate surgical access. This procedure facilitates horizontal and vertical movement and allows for transverse expansion when performed as a segmental osteotomy.

This procedure has various applications. The LeFort I osteotomy improves facial harmony and aesthetics by addressing maxillary asymmetry and protrusion. The technique also enhances dental occlusion and chewing function by connecting malocclusion. The LeFort I osteotomy may also alleviate symptoms of obstructive sleep apnea by enlarging the upper airway. Proper technique helps optimize patient outcomes and reduce morbidity.

This activity for healthcare professionals is designed to enhance learners' proficiency in identifying patients with indications for the LeFort I osteotomy and performing the procedure with precision and care. Participants gain a deeper understanding of the procedure's origins, indications, limitations, contraindications, potential complications, and clinical significance. Greater competence equips learners to collaborate more effectively within an interprofessional team caring for patients with dentofacial abnormalities.

LEARNING OBJECTIVES

- Identify pertinent anatomical structures associated with LeFort I osteotomy.
- Describe the different indications for LeFort I osteotomy.
- Implement the proper surgical techniques for LeFort I osteotomy.
- Execute effective collaboration and communication practices among interprofessional team members to improve outcomes and treatment efficacy for patients who might benefit from a LeFort I osteotomy.

INTRODUCTION

The LeFort I osteotomy is a horizontal maxillary osteotomy utilized to connect midface deformities, allowing movement of the dentition-bearing portion of the maxilla anteroposteriorly, vertically, rotationally, and with segmentation or expansion. The procedure may also be used to facilitate surgical access for tumor removal and the reduction of complex midfacial fractures. This surgery is named after the LeFort I horizontal fracture pattern described by Rene LeFort in 1901.[1]

The earliest maxillary osteotomies were utilized to facilitate exposure during nasopharyngeal polyp removal. The first LeFort I osteotomy for dentofacial deformity correction was described by Wassmund in 1921, utilizing orthopedic traction rather than intraoperative mobilization. Auxhausen first described osteotomy with intraoperative mobilization in 1934 to close an open bite.[2] Schuchardt separated the pterygomaxillary junction, allowing anterior repositioning. Bell's research demonstrated the revascularization phenomenon, the ability to sacrifice the descending palatine arteries without compromising blood supply, and the ability for osseous healing from a complete maxillary osteotomy, thus providing the biological basis for a complete down-fracture. The technique has continued to evolve, incorporating and recognizing the roles of hypotensive anesthesia, orthodontics, tension-free stability, and virtual surgical planning. Consequently, the LeFort I osteotomy has become widely accepted as a reliable, predictable, and safe procedure.[3]

ANATOMY AND PHYSIOLOGY

The maxilla is comprised of paired maxillary bones fused at the midline. This bone articulates with the frontal bone superiorly, alveolar process inferiorly, zygomatic bone laterally, palatine bone posteriorly, and pterygoid plate of the sphenoid bone posterolaterally (see image Maxillary Bones.)

Blood supply to the LeFort I segment of the maxilla is provided by the ascending palatine artery, a branch of the facial artery, and the anterior branch of the ascending pharyngeal artery, which arises directly from the external carotid artery. The potential for significant bleeding during LeFort I osteotomy requires in-depth knowledge of the location of various blood vessels pertinent to the procedure. In particular, the descending palatine arteries are posterior to the pyramidal processes of the palatine bone. These blood vessels may be inadvertently damaged from overextension of the lateral nasal osteotomy part of the procedure. Inappropriate superior placement of the osteotome to separate the pterygomaxillary junction can interrupt the pterygopalatine fossa and damage the internal maxillary artery and its branches.[4]

Innervation to the maxilla is via the maxillary division of the trigeminal nerve (2nd division of the 5th cranial nerve or CN V2), which originates from the trigeminal ganglion and exits through the foramen rotundum to enter the pterygopalatine fossa, where it gives off multiple branches. The infraorbital nerve, a terminal extension of CN V2, exits through the infraorbital foramen and provides sensory innervation to the soft tissue of the midface, including the lower lid, cheek or malar region, nose, upper lip, and anterior maxillary dentition. The infraorbital nerve is encountered during dissection for the LeFort I osteotomy and should be identified and protected.[5]

Maxillary Bones. The green-shaded area marks the paired maxillary bones.

Anatomography, Public Domain, via Wikimedia Commons.

> The LeFort I osteotomy improves facial harmony and aesthetics by addressing maxillary asymmetry and protrusion.

PREPARATION

A comprehensive preoperative workup should include a detailed history and physical examination, facial analysis, and meticulous surgical planning via virtual or traditional model surgery. Occlusal splints may be fashioned, depending on the indication for LeFort osteotomy. Orthodontics may be performed before surgery to level, align, and decompensate the dentition if applicable and are frequently required postoperatively to finalize occlusion.[12]

TECHNIQUE OR TREATMENT

The procedure is performed under general anesthesia in the supine position. Nasotracheal intubation facilitates intraoperative assessment of occlusion and placement in maxillomandibular fixation. The endotracheal tube should be placed passively but securely. Landmarks are established preoperatively to provide reference points, which can be checked throughout surgery to confirm the intended maxillary movements. This step may be accomplished utilizing a K-wire or marking pen at the nasion or nasofrontal junction. Preoperative measurements are recorded from the wire to the level of the orthodontic brackets or another stable and reproducible landmark bilaterally. Local anesthetic containing epinephrine is injected along the anticipated surgical incision to assist with hemostasis and postoperative analgesia.

A throat pack is placed. Plastic lip and cheek retractors, "toe-out" Obwegeser, or similar retractors can be utilized to provide better surgical access to the maxillary vestibule.

Careful planning of the surgical incision is necessary to provide an adequate cuff of gingival tissue for soft tissue closure. A minimum of 5 mm above the mucogingival junction should be maintained. The initial mucosal surgical incision is made from the 1st molar to the first molar utilizing either a #15 blade or electrocautery perpendicular to the maxilla. The incision is extended down to the bone. The periosteum is scored to facilitate subperiosteal dissection, performed with a periosteal elevator medially to the piriform rims. Care is taken to dissect the nasal mucosa around the nasal aperture. A curved freer elevator or the blunt end of a Woodson elevator may assist with the dissection of the nasal mucosa.

The nasal mucosal dissection then proceeds posteriorly to the palatine bone. The subperiosteal dissection proceeds superiorly to the infraorbital nerves, which should be identified and protected. The dissection laterally extends to and around the lateral maxillary buttress. Maintaining a subperiosteal plane is of particular importance at this curvature, as failure to do so may inadvertently expose the buccal fat pad, which will compromise and interfere with surgical access. A curved freer elevator may be useful in completing this part of the dissection. The lateral dissection terminates at the pterygomaxillary junction. A raytex sponge or neuro-patties may be placed in the lateral subperiosteal pocket to allow further blunt dissection and assist with hemostasis. Meanwhile, osteotomy is performed on the opposite side.

The planned osteotomy may be marked with a Bovie

INDICATIONS

LeFort I osteotomy is used to reposition the dentition-bearing maxilla and is indicated for the following conditions:

- Maxillomandibular deformities
  - o Maxillary hypoplasia or mandibular hyperplasia
  - o Vertical maxillary excess
  - o Angle's class II and class III malocclusions
  - o Midline discrepancies or asymmetries
  - o Apertognathia or open bite
  - o Absolute transverse arch discrepancy*
  - o Dual or multiplanar occlusion*
  - o Severe maxillary atrophy, in conjunction with bone grafting
- Obstructive sleep apnea
- Access for skull base tumors
- Facilitation of reduction of nonreducible fractures[6, 7, 8]

* May require segmental or multipiece LeFort osteotomy, which is not covered in this article.

CONTRAINDICATIONS

Contraindications to LeFort I osteotomy include the following:

- Incomplete skeletal growth (skeletal immaturity)
- Severe or uncontrolled periodontal disease
- Progressive dentofacial deformities (e.g., condylar hyperplasia and idiopathic condylar resorption)
- Bone or joint diseases (e.g., osteoporosis and osteopenia)
- Medical comorbidities (e.g., uncontrolled diabetes and immunocompromised status)
- Poor nutritional status (e.g., in cases of hypoalbuminemia)[9, 10]

Contraindications should be considered relative in nature and, in certain scenarios, may become indications for surgery. Thus, the surgeon must perform a thorough preoperative evaluation and obtain informed consent from the patient, parent, or legal guardian, explaining the risks, benefits, and potential complications before proceeding with surgery.

EQUIPMENT

The following equipment and materials are needed for LeFort osteotomy:

- 15 blade
- Monopolar or bipolar electrocautery
- Assorted retractors
- Marking pen
- Local anesthetic with epinephrine
- Kirschner or K-wire
- Gauge or caliper
- Assorted periosteal elevators
- Reciprocating saw
- Straight tapered fissure bur (701 or 702)
- U-shaped or double-guarded straight osteotome
- Single guarded osteotome
- Cruciform or large curved osteotome
- Turvey spreaders
- Rowe disimpaction forceps
- Rongeur
- Bone-eating bur or reciprocating rasp
- Small single-pronged skin hook
- Sutures
- Assorted 24- to 28-gauge wires [11]

PERSONNEL

The following personnel are needed:

- Surgeon(s)
- Surgical assistant
- Surgical technologist
- Perioperative nurse
- Anesthesiologist or nurse anesthetist
- Postanesthesia care unit nurse

electrocautery, a bur, or another implement once fully exposed. The osteotomy should proceed apically to the roots of the teeth while terminating below the inferior turbinate. An instrument, such as a Sayre elevator or freer, may be inserted on the nasal aperture's medial aspect to protect the previously dissected nasal mucosa while completing the osteotomy if desired.

The osteotomy is initiated at the lateral maxillary buttress and extended through the piriform rim utilizing a reciprocating saw, straight tapered fissure bur, or bone scalpel under continuous irrigation. The osteotomy is then mirrored on the contralateral side. Care should be taken not to apply force to the cutting implement as the initial bone in the buttress is dense. However, the anterior maxillary sinus wall is very thin once through the buttress, and excessive force can result in loss of control of the implement, iatrogenic damage to the sinus wall, and potentially compromised fixation areas.

Once bilateral osteotomies are completed, the lateral maxillary buttress can be "backcut" by reinserting the cutting implement into the lateral portion of the osteotomy and passing it in a medial-to-lateral direction. Alternatively, small straight osteotomes can recapitulate the cut at the lateral buttresses.

Lateral nasal osteotomies are then completed with a small straight chisel or Neivert-Anderson single-guarded osteotomes with the curved end of the osteotome in contact with the floor. Note that the lateral nasal wall diverges from anterior to posterior. Thus, the osteotome must be oriented accordingly. A hard stop occurs when the osteotome contacts the palatine bone's pyramidal process. The nasal septum is then separated from the maxilla utilizing a thin U shaped or double-guarded V-shaped osteotome seated on either side of the septum with the curved end of the osteotome against the nasal floor. Care should be taken to avoid extending this osteotomy to more than 30 mm in female patients and 35 mm in male patients to avoid damage to the descending palatine arteries.[13]

Afterward, the pterygomaxillary junction is separated utilizing a large curved or Tessier cruciform osteotome directed at the junction in an anterior, inferior, and medial direction. A finger is placed intraorally against the pterygoid hamulus to ensure that the osteotomy is completed at the appropriate level.

Alerting the anesthesia team that the surgical team is preparing to down-fracture the maxilla is prudent before the pterygomaxillary osteotomy. Anesthesia may wish to

maintain mean arterial pressure at around 60 mm Hg to limit excessive bleeding if a hypotensive anesthetic is preferred. Damage to the maxillary artery and its branches, the descending palatine artery, and the sphenopalatine artery can result in significant bleeding during this step if the osteotome is inappropriately positioned. Thus, some authors advocate for separating the maxilla at the tuberosity or achieving down-fracture with digital pressure alone and forgoing an osteotome at the pterygomaxillary junction.[14]

Ultimately, the surgeon's experience, skill, and clinical judgment determine the method for separating the maxilla. Some surgeons prefer to separate the pterygomaxillary junction before completing the nasal osteotomies to expedite visualization and access in the event of vessel damage and brisk bleeding.

Digital pressure should be utilized to down-fracture the maxilla. Excessive force is not required in this step if all osteotomies are properly completed. Using excessive force can result in an unfavorable fracture and other complications and is thus discouraged. If the maxilla does not down-fracture at this point, each previous osteotomy should be carefully examined and revised as necessary until the maxilla down-fractures easily.

Once down-fractured, additional nasal mucosal dissection or repair of torn nasal mucosa may be more easily performed due to improved access. Repair is best performed with a fine, resorbable suture, such as a 5-0 fast absorbing gut.

Down-fracture completion should be followed by careful inspection for any active bleeding, which needs to be controlled at this point before proceeding. Bleeding may be controlled by packing or applying pressure. However, pulsatile bleeds are best controlled with bipolar electrocautery or ligation of identifiable vessels. Depending upon surgeon preference, the descending palatine arteries may be identified, exposed, maintained, or conversely ligated and sacrificed at this stage. Sacrificing the descending palatine arteries generally does not compromise maxillary perfusion.

Depending on the planned surgery, the soft tissue may require stretching at this point to allow for mobilization and tension-free maxillary repositioning to the predetermined postoperative position. This step may be accomplished with digital pressure or Rowe disimpaction forceps. Care should be taken when placing and manipulating the maxilla with the forceps, as improper use may damage the teeth or maxillary bone.

The preoperative surgical plan and osteotomy indications dictate the procedure's next steps. A planned impaction, such as for vertical maxillary excess, usually requires reducing the bone and the nasal septum to enable proper repositioning and prevent nasal septal deviation. Large advancements or down-grafts may require bone grafting for added stability and success. Autogenous and allograft sources are acceptable.

Fabricated surgical splints should be fitted to the dentition. The maxilla should be manipulated into position, and the patient should be placed into maxillomandibular fixation utilizing stainless steel wires. The entire maxillomandibular complex should be rotated, ensuring the mandibular condyles are seated in their respective fossae. Failure to seat the condyles may result in postoperative malocclusion.

> Although oral and maxillofacial surgeons or head and neck surgeons typically perform the LeFort I osteotomy, the crucial role of an interdisciplinary team throughout all stages … cannot be overstated.

Rechecking the preoperatively determined landmarks and anticipated moves against the actual maxillary position is crucial at this point to confirm appropriate positioning, making adjustments as needed. Fixation is then accomplished by utilizing plates and screws. Plates are bent and adapted to the contours of the maxilla's position and secured to the piriform rims and the zygomaticomaxillary buttresses bilaterally, using 4 plates in total. Alternatively, Lindorf-style pre-bent plates may be utilized on each piriform rim, requiring 2 plates in total.

The patient should then be released from maxillomandibular fixation. The mandible should be rotated in and out of the splint, if present, to confirm passive rotation in and out of centric occlusion. Centric relation should also be assessed at this stage, as any occlusal discrepancy may indicate improper condylar seating and necessitate hardware removal and replacement. Dental and skeletal midlines should also be checked to ensure the predetermined positions are achieved.

The surgical site is then irrigated. The mucosa is closed in a watertight fashion utilizing a resorbable suture such as 3-0 or 4-0 chromic gut in a continuous or continuous interlocking fashion.

Before closing the vestibular incision, a nasal or alar cinch suture may be considered to limit alar base widening, as seen with large maxillary advancements. This step is accomplished by everting the vestibular incision and passing a slowly resorbing or nonabsorbable 2-0 to 3-0 suture through the transverse nasalis muscle on either side of the alar base intraorally. The suture is then cinched down in a controlled fashion. Care is taken to ensure that the alar bases are narrowing symmetrically. A nasotracheal tube, which distorts this landmark, can make evaluating this maneuver more difficult.

Consideration should be given to performing a V-to-Y closure if excessive thinning is a possible risk. This technique may also be performed at this point to avoid excessive lip shortening and thinning. A single-prong skin hook is placed in the labial mucosa at the midline and lifted approximately 1 cm to perform a V-to-Y closure. The same suture utilized for mucosal closure is then passed continuously to create a 1-cm vertical limb. Vestibular closure then proceeds on either side.[15]

The decision to perform either procedure should be based on the anticipated soft tissue changes associated with the planned surgery, surgeon experience, and preference. The oral cavity is suctioned free of debris. A nasogastric or orogastric tube may be passed at this point to suction the patient's stomach contents. The throat pack should be removed. Guiding elastics or maxillomandibular fixation is then placed if indicated.

COMPLICATIONS

While a technically simple and versatile procedure, rare but serious complications can occur during or after a LeFort I osteotomy. Complication rates vary, and the incidence has been reported in several studies to be between 6.7% and 8.77%. Complications can broadly be categorized as anatomic, septic, ischemic, vascular, neurologic, and otologic.

In a prospective study of 1,000 patients, Kramer et al found that patients with major anatomic irregularities, such as craniofacial anomalies, cleft palate, and vascular abnormalities, were at increased risk of complications and accounted for a disproportionate number of observed cases. Patients who underwent segmental osteotomies or large advancements were also shown to have an increased risk of complications.[16] A smaller study excluding segmental osteotomies and patients with major anatomic irregularities demonstrated increased complications associated with maxillary setbacks relative to other movements.

The most commonly encountered complications are anatomic and include nasal septal deviation resulting from an inadequate reduction of the cartilaginous septum when performing a maxillary impaction, nonunion of the osteotomy gap, and improper positioning of the maxilla.[17] Common septic complications include abscesses and maxillary sinusitis, both of which are readily controlled by conservative therapies.

The primary vascular complication of concern is hemorrhage, which typically results from damage to branches of the maxillary artery, most often due to an unfavorable fracture of the pterygoid plates.[18] This complication may be avoided by careful surgical technique and osteotome placement or consideration of alternatives to the traditional pterygomaxillary osteotomy. Tranexamic acid at 10 mg/kg 30 minutes before general anesthesia induction is also advocated to reduce blood loss.[19]

Ischemic complications, including avascular necrosis, are associated with large advancements, segmental osteotomies, and major anatomic irregularities. Consideration should be given to 2-jaw surgery if a significant advancement is anticipated, as it can help limit extensive anteroposterior movements within a single jaw.

Damage to teeth or root amputation is another complication that may be encountered but is related to the surgeon's experience and failure to initiate the osteotomy apical to the roots of the teeth. Neurosensory deficits in the infraorbital nerve are frequently seen after surgery secondary to compression or retraction, but symptoms typically resolve. Most patients regain full sensation within 2 months, and all regain sensation within 6 months. Other more serious neurologic complications have been reported, such as unilateral blindness and oculomotor nerve palsy.

However, these complications are exceedingly rare.

CLINICAL SIGNIFICANCE

The relative safety, versatility, and technical simplicity of the LeFort I osteotomy contribute to its position as a workhorse in maxillofacial surgery. With numerous applications, including but not limited to reconstruc-

tion, trauma, pathology, and sleep medicine, the LeFort I osteotomy is useful for surgeons of multiple disciplines. Advancement of the midface can improve the nasal airway and address maxillary hypoplasia while also improving occlusion and aesthetics. The LeFort I may also be used to impact or disimpact the maxilla for aesthetic reasons, managing the degree of incisoral show in the smile.

ENHANCING HEALTHCARE TEAM OUTCOMES

Although oral and maxillofacial surgeons or head and neck surgeons typically perform the LeFort I osteotomy, the crucial role of an interdisciplinary team throughout all stages-preoperatively, perioperatively, intraoperatively, and postoperatively, cannot be overstated. Successful outcomes are contingent upon comprehensive interprofessional care and support. Preoperatively and postoperatively, the orthodontist plays a critical role in preparing the patient for orthognathic surgery and providing input and expertise relative to the surgical treatment plan and the anticipated need for postsurgical orthodontics.

Preoperative optimization is essential for patients with medical comorbidities to have safe and successful surgery. Depending upon the patient's medical conditions, preoperative optimization may involve care coordination and planning by physicians and caregivers from multiple disciplines. Intraoperatively, the anesthesia provider facilitates safe surgery and emergence from general anesthesia. The surgeon and anesthesia provider coordinate and discuss the preferred intubation technique and the risks, benefits, and timing of hypotensive anesthesia. The surgeon and anesthesia provider also plan for potential airway challenges due to maxillomandibular fixation and postoperative edema. Hypotensive anesthesia has been shown to reduce blood loss, provide better surgical field visualization, and shorten the length of hospital stay.[20, 21]

In the immediate postoperative period, the nursing team is vital in educating patients, providing psychosocial support, and ensuring that patients meet immediate postoperative milestones. The pharmacist and pharmacy team determine the appropriate postoperative medications for the patient, balancing adequate pain control with minimizing deleterious side effects. The pharmacist also devises appropriate and effective pain control regimens for patients at risk for over narcotization or respiratory depression, as is the case in patients with obstructive sleep apnea or morbid obesity. Proper nutrition is critical for wound healing. Thus, nutritionists and registered dieticians are pivotal in determining appropriate caloric needs, supporting and facilitating a dietary regimen, ultimately minimizing postoperative complications and decreasing patient morbidity.[22]

AFFILIATIONS

1 Madigan Army Medical Center
2 Ochsner Health System
3 Madigan Army Medical Center
Last Update: August 12, 2024.

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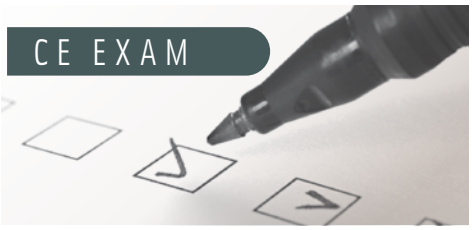

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CORRECTION:

There was a misprint on question #5 of the April 2025 edition of the Surgical Technologist CE exam #499 accompanying the article titled "The Economic Case for Implementing Automated Tissue Removal and Bone Milling Systems in Orthopedic Spine Procedures." The correct answer is A, 25 grams.

LeFort Osteotomy

#505 SEPTEMBER 2025 2 CE CREDITS $12

1. **Which of the following arteries provides blood to the LeFort I segment of the maxilla?**
a. Transverse facial
b. Ascending palatine
c. Inferior labial
d. Maxillary

2. **Which of the following is a contraindication for LeFort I osteotomy?**
a. Periodontal disease
b. Skull base tumors
c. Severe maxillary atrophy
d. Obstructive sleep apnea

3. **Which of the following nerves must be identified and preserved during dissection for a LeFort I osteotomy?**
a. Auriculotemporal
b. Zygomaticofacial
c. Supratrochlear
d. Infraorbital

4. **Which of the following instruments will a surgeon use to dissect the nasal mucosa?**
a. Freer elevator
b. #15 knife blade
c. Rongeur
d. Rasp

5. **What does the surgeon avoid exposing when extending the incision in a curved fashion around the lateral maxillary buttress?**
a. Inferior turbinate
b. Nasal vestibule
c. Buccal fat pad
d. Anterior maxillary sinus

6. **When separating the nasal septum from the maxilla, the surgeon avoids extending the osteotomy in male and females to avoid injuring the:**
a. maxillary artery.
b. superficial temporal artery.
c. ascending pharyngeal artery.
d. descending palantine artery.

7. **What postoperative complication can occur if the mandibular condyles are not properly seated when the maxillomandibular complex is rotated into position?**
a. Abscesses
b. Malocclusion
c. Hemorrhage
d. Nasal septal deviation

8. **What size and type of suture is used to close the mucosa?**
a. 4-0 polydioxanone
b. 2-0 polyglactin 910
c. 3-0 chromic gut
d. 2-0 polyglyconate

9. **Which of the following is the most commonly encountered category of complication?**
a. Anatomic
b. Vascular
c. Neurologic
d. Otologic

10. **What is the reason the surgeon communicates they are preparing to downfracture the maxilla so the anesthesia provider can maintain the mean arterial pressure at 60 mm Hg?**
a. Prevent damage to the nasotracheal tube
b. Prevent excessive hemorrhaging
c. Prevent the patient becoming hypoxic
d. Prevent neurosensory deficits in the patient

LEFORT OSTEOTOMY
 # 505 SEPTEMBER 2025 2 CE CREDITS $12

AST Member No.

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9	☐	☐	☐	☐
10	☐	☐	☐	☐

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FOUNDATION *for* SURGICAL TECHNOLOGY

2025 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 $49,000 in student scholarships. Over the next couple of months, this year's scholars will describe what this award means to them.

JENNIFER LYNN HOVIS, CST
MOBERLY AREA COMMUNITY COLLEGE
ROCHEPORT, MO

$2,500

SPONSORED BY FOUNDATION FOR SURGICAL TECHNOLOGY

Surgical technology has become more than just a career choice for me—it's a calling. From my very first clinical rotation, I knew I had found my place in the operating room. The precision, the intensity, and most importantly, the teamwork all drew me in. Even during challenging or high-pressure cases, I find myself energized by the opportunity to support talented medical professionals and be a part of something that truly changes lives.

I am particularly drawn to cardiothoracic, neurosurgery, orthopedics, and plastic surgery. These specialties are fast-paced, highly detailed, and require a deep understanding of both the technical and human sides of patient care. I enjoy the complex setups, the cadence of the procedures, and the visible impact these surgeries have on improving a patient's quality of life. Of course, all surgical specialties hold value, but I find these especially rewarding and exciting to be a part of.

Throughout my residency and clinical experiences, I've learned that every case is someone's most important day. Whether it's a CABG, laminectomy, or a C-section, I approach each procedure with intention and respect. I am the sterile safety net of the OR, and I take pride in doing my best so my team can perform theirs—ensuring the best possible outcome for the patient. It's easy to slip into the "just another day at work" mindset in any career, but in surgery, I'm constantly reminded that we're making a real, lasting difference.

After graduation, I will be relocating to Denver, Colorado, where I plan to continue gaining knowledge and experience in a wide range of surgical specialties. Long-term, I aspire to be active in Colorado's state assembly for surgical technology, mentor students, and serve as a preceptor who offers both structure and compassion in the OR. I've been fortunate to learn from incredible educators and preceptors, and I hope to pay that forward by supporting and guiding the next generation.

Being a surgical technology student can feel like trying to drink from a fire hose. I'm incredibly grateful for the support I've received from my instructors, residency team, the AST, and the Foundation for Surgical Technology. This scholarship lightens the financial burden and reinforces that I'm on the right path. Thank you for recognizing my passion and commitment—I'm honored to be a part of such a meaningful and impactful profession.

GRACE GLASS, CST
QUINCY COLLEGE
TAUNTON, MA

$1,500

SPONSORED BY FOUNDATION FOR SURGICAL TECHNOLOGY

When I first heard of surgical technologists, I started researching schools right away. I have always had a deep interest in human anatomy and its inner workings. One of the most rewarding parts of this career is getting to witness human anatomy firsthand. On my first day in the operating room, my eyes were wide with wonder, and it became apparent I was meant for this. One thing I truly love about this job is knowing there will always be something new to learn. My favorite procedures are the ones I have not done before as it forces me to take the necessary steps to become a better surgical technologist. Beyond the technical side, I enjoy interacting with people from all walks of life, whether that be my coworkers or patients. Being in the OR makes me feel capable, trusted, and part of something bigger than myself.

I am proud to continue a family legacy by beginning my career at the same local hospital where my parents once worked and met, and where my grandmother's service as a candy striper marked the start of her nursing career. My current goal is to gain hands-on experience, build confidence in the OR, and broaden my knowledge. Looking ahead, I plan to expand my scope of practice, whether that means pursuing CSFA, exploring leadership roles through my AST state assembly or teaching future surgical technologists. I want to grow in this field and make a long-term impact. I hope to inform and encourage others to follow this career path because if someone had not done that for me, I wouldn't have found my dream job.

I am honored to have received the Foundation for Surgical Technology Scholarship; I am especially grateful to all those who made this scholarship possible. Receiving this scholarship reinforces that I'm on the right path. It provides not only financial support but also encouragement to continue working hard and pushing forward. I'm proud to represent the next generation of surgical technologists and thankful to the Foundation for supporting my journey.

ZOE CALABRESE
CABARRUS COLLEGE OF HEALTH SCIENCE
KANNAPOLIS, NC

$1,000

SPONSORED BY FOUNDATION FOR SURGICAL TECHNOLOGY

I am honored and thankful to be a 2025 recipient of a $1,000 scholarship sponsored by the Foundation for Surgical Technology. Surgical technology has been a rewarding program, teaching the importance of sterility and safe surgical practice in the operating room. I chose a career in surgical technology because it offers continuous learning opportunities with exposure to clinical anomalies and their management methods. The various challenges and breakthroughs in my academic journey serve as motivation for my future aspirations as a surgical technologist.

My experience in surgical technology has allowed me to learn continuously, from colleagues and clinical settings. As the career field evolves, I am committed to growing alongside it, embracing innovation and best practices. Surgery can be an overwhelming experience for patients, and I strive to create positive surgical outcomes through maintaining a safe, sterile environment and prioritizing their well-being.

In my career, I aspire to obtain further knowledge and specialize in orthopedic procedures. Orthopedic procedures can often require challenging instrument setups and are a high-risk area for SSI contraction. At the start of my clinical rotations, orthopedic cases posed significant challenges that required fast and effective anticipation. Without appropriate experience or guidance, these cases can quickly become overwhelming. As a CST, my goal is to become a mentor in this field and help students in surgical technology programs navigate the challenges an orthopedic procedure can present.

Investing in students presents ample opportunities to create a skill set that enhances a standard of care. Mentorships, financial aid, and community groups provide resources that can build confidence and professionalism in the future workforce. I hope to sustain the generosity I've received from the committee by offering guidance and sharing my experience with future students in this program. Thank you once again for your consideration and the generous opportunities provided by your foundation to continue my academic pursuits!

DORIS LOPEZ ALLENDE
MALCOLM X CITY COLLEGE OF CHICAGO
CHICAGO, IL

$2,500

SPONSORED BY FOUNDATION FOR SURGICAL TECHNOLOGY

My decision to pursue a career in surgical technology stems from a strong desire to serve others and a deep respect for healthcare professionals who change lives every day (mine included). From an early age, I experienced firsthand the importance of access to medical care, often relying on the generosity of others. Those experiences shaped my values and inspired me to give back through a profession that requires compassion, and teamwork.

I chose surgical technology because it aligns with what I seek in a career. With its constant innovations, dynamic environment, and the opportunity to contribute meaningfully as part of a team, I find myself particularly drawn to it. The operating room demands focus, adaptability, and trust, and I find that challenge both thrilling and fulfilling. What matters most to me is the outcome of knowing that my role helps ensure patients receive the best care possible, which is where my greatest sense of purpose lies.

Now that I am in my second semester of a CST program, I am even more confident that I've found the right path. I enjoy learning new techniques, understanding surgical procedures in depth, and working alongside professionals who are passionate about patient care. Along the way, I've learned so much from mentors who have guided and inspired me. Most notably my professor, Axel Rodriguez. His encouragement pushed me to pursue opportunities like this scholarship and helped shape my long-term goals, including a future role in education.

In the future, I hope to participate in medical mission trips through AST, and volunteer with organizations that support underserved communities. I am especially motivated to give back to programs that once helped me. I believe my background has given me qualities and traits that I can only hope impact others positively.

Receiving this scholarship is a meaningful milestone in my journey. It reinforces my commitment to this field and motivates me to keep pushing forward.

Thank you to the Foundation for Surgical Technology.

ALLYSON GUDEN
MID STATE TECHNICAL COLLEGE
MARSHFIELD, WI

$2,000

SPONSORED BY FOUNDATION FOR SURGICAL TECHNOLOGY

My passion for surgical technology began while working as a Certified Nursing Assistant in the pre-op and post-op areas of an outpatient surgery center in my hometown. There, I witnessed how the surgical team worked together to care for patients with skill, focus, and compassion. Being part of that environment made me realize I wanted to take a more active role in the operating room.

What draws me to surgical technology is the responsibility, precision, and teamwork it requires. I enjoy being detail-oriented and dependable, and I'm excited to build hands-on skills that directly support patient care. I look forward to learning sterile techniques, how to handle surgical instruments, and how to assist during procedures. My goal is to become a skilled surgical technologist and, eventually, take on even more responsibility, possibly as a first assistant or by specializing in areas like plastic surgery, general surgery, or OBGYN.

Though school hasn't always been easy, I've stayed focused and motivated. I know that grades reflect effort, and I've always worked hard to do well. I also believe in learning from challenges and using them to grow stronger.

Receiving this scholarship means the world to me. It will ease the financial burden of school and allow me to focus more on learning and preparing for my future in the operating room. I plan to stay involved in my state's surgical technology community, attend trainings, and keep growing in this career.

Thank you for your support—it brings me closer to reaching my goals and helping others through surgical care.

CAITLIN STURMAN
CONCORDE CAREER COLLEGE
BEAVERTON, OR

$2,000

SPONSORED BY FOUNDATION FOR SURGICAL TECHNOLOGY

My name is Caitlin Sturman, as a recipient of this year's scholarship award I am truly grateful for this opportunity to help assist me in pursuing a surgical technology career starting this fall. Ever since I was a little girl I have been fascinated by medicine. I grew up in Alaska, where very few surgeries were performed. Anyone I knew that was having surgery normally flew out of state to somewhere like Seattle or Texas but spent hours watching shows on Discovery Health such as Trauma; Stories of the ER, Mystery Diagnosis, Medical Miracles at age 5-6, and into my teen years with a passion for learning about medicine. I never quite knew where I would fit into the OR role. I explored careers within imaging, nursing and the lab yet none felt like the perfect fit, yet every time I circled back around to some career in the OR I felt this yearning and instinct that I was meant to be there. I found love for the surgical technology role whilst at my last position before going back to school as a Medical Assistant working alongside Pediatric Surgeons in the clinic and expressed my interest in surgery and was given opportunities to shadow them in the OR. I got to see firsthand the meticulous routine that went into each and every surgery, and saw that while I may not want to be the one responsible for making life altering medical decisions as a lead physician within the OR, I realized I wanted to be the one assisting those making those decisions, by making sure everything was in order for those physicians to be able to make such important decisions. While also getting the chance to be alongside learning all about the intricacies within the human body and the procedures being performed to help save a life. One of my biggest goals is to be able to complete my internship and training at the facility in which I first discovered the love for surgery and be granted the opportunity to help assist the same providers from the Pediatric Surgical Center where I had been their Medical Assistant for three years prior to returning to school. I look forward to all the unique cases and experiences I will encounter and all the information I will gain in learning the routine of each individual provider, specialty and routine surgeries, with the hopes to one day be a traveling Surgical Technologist as well and always be furthering my education and growth within the career while also getting to travel the world. Thank you again for this amazing opportunity, in the ways it helps me to fulfill a lifelong dream.

STACY IANNARONE, CST
TRITON COLLEGE
LISLE, IL

$1,000

SPONSORED BY FOUNDATION FOR SURGICAL TECHNOLOGY

It is an honor to be recognized by the Foundation for Surgical Technology, and receive a scholarship that represents hard work, dedication and perseverance. After my mother and sister passed away from terminal illnesses, it prompted me to put life into perspective. I aspired to extend the kind of compassion they obtained during treatment, especially in moments of uncertainty and vulnerability. Upon reflection and extensive research, surgical technology resonated on multiple levels, which resulted in a shift from a career in marketing to healthcare.

Transitioning professions proved to be a pivotal turning point. From the beginning, I was drawn to the principles of precision, discipline, and efficiency, and yearned to be part of a team who maintained high standards, reinforced safety measures, via aseptic technique, and upheld standard practices. An essential aspect of being in the OR is the sense of unity, characterized by effective interpersonal communication, precision, adaptability and a shared responsibility to deliver successful patient outcomes. I find fulfillment in the structure, pace, and demand for excellence.

This scholarship will help lighten financial responsibilities, as well as enable the opportunity to build on my current skillset, provide mentorship and dedicate time to meaningful volunteer initiatives. I thank my husband, family, close friends and mentors who encouraged me through such a transformative journey -- from long nights of studying, busy days at clinicals and working during the weekends, their support made this achievement possible.

I look forward to giving back to what has blessed me with purpose and will offer the same benevolence my family received. Lastly, I hope my path to rediscovery illustrates that sometimes loss can transcend into a beautiful rebirth, ultimately, making a positive future impact for others.

ALISHA BUDHU
NEW YORK UNIVERSITY
NEW ROCHELLE, NY

$1,000

SPONSORED BY FOUNDATION FOR SURGICAL TECHNOLOGY

From the first time I entered an operating room as an EMT observing a high-acuity trauma case, I felt an undeniable pull toward surgical technology. That intense yet focused environment—the life-and-death stakes, the dynamic teamwork, the precision—ignited a passion I hadn't known existed. Choosing surgical technology wasn't a whim; it was a deliberate decision informed by a deep appreciation for both the art and science of patient care.

My journey began amid the chaos of trauma calls, where I learned to think–fast, stay composed, and act decisively. After entering NYU's Surgical Technology program, I had the opportunity to assist in a variety of operative cases—general, orthopedics, neuro, and minimally invasive surgeries. Each rotated environment taught me how essential preparation, attention to detail, and sterile technique are to patient safety and surgical efficiency. My instructors and preceptors commended my ability to anticipate instruments and maintain seamless workflow—even under pressure. Being a surgical technologist isn't just about passing tools; it's about fostering a partnership of trust with the surgeon, anesthesia team, and nurses.

What I enjoy most about working in the OR is the synergy among all team members. There's a powerful harmony in knowing everyone has been trained to operate at peak performance—yet also trusts others to do the same. Over time, I've found gratification in quietly ensuring the operative field is clear, the instruments are sterile and ready, and that I can step in without hesitation, ever ready to support the patient's outcome. One case springs to mind: during an unexpected hemorrhage in a trauma laparoscopy, I pre-loaded suction and clips before the surgeon completed the instruction—helping reduce the bleeding quickly and stabilize the patient. Moments like that underscore how surgical technologists truly make a difference at calculated critical junctures.

Being awarded the AST scholarship would help me attain certification faster and elevate my skills. Looking toward the future, I aspire to work in Level 1 trauma centers and continuously refine my clinical judgment in high acuity environments. Long-term, I envision stepping into advanced perioperative roles—perhaps in surgical education or leadership—where I can mentor future technologists and promote best practices. I am deeply committed to advancing the profession and elevating standards for patient safety and surgical efficiency.

Receiving support from AST would be more than financial assistance—it would signal faith in my ambition to not only excel as a technologist but to shape the future of surgical care. I hope to embody the AST ideals of professionalism, lifelong learning, and advocacy, while contributing meaningfully to a culture of excellence in every operating room I serve.

KIMBERLY STERLING
SWEDISH INSTITUTE
BRONX, NY

$1,500

SPONSORED BY FOUNDATION FOR SURGICAL TECHNOLOGY

My journey into surgical technology is rooted in personal experience. As someone who was diagnosed with scoliosis at a young age, I spent much of my childhood in doctors' offices, observing how healthcare professionals could completely transform a patient's quality of life. That experience not only made me resilient, but it also gave me a clear purpose: to be part of the surgical team that brings hope, healing, and relief to others.

Currently, I am a Surgical Technology student at the Swedish Institute College of Health Sciences. Every lecture, lab, and hands-on skill session confirms that I've chosen the right path. While I have not yet entered clinical rotations, I am fully immersed in learning the principles of sterile technique, instrumentation, and surgical procedures. I am passionate about the discipline, responsibility, and teamwork required in the operating room, and I am eager to apply my knowledge in real-life scenarios when the time comes.

Receiving this scholarship is an incredible honor and motivation. It reaffirms that my hard work, long nights of studying, and commitment to this field have purpose. It also reminds me that I am part of a broader community of surgical technologists who value precision, empathy, and

excellence. Furthermore, this scholarship is not just a financial relief, it's a symbol of encouragement and belief in my potential. It tells me that I belong in this field, and that I have something valuable to offer. I am sincerely grateful for this support, which brings me one step closer to my ultimate dream of becoming an orthopedic surgeon. I want to be the kind of healthcare provider who helps patients not just heal but feel hopeful.

Looking ahead, my long-term goal is to become an orthopedic surgeon. I want to help patients with conditions like mine feel seen, understood, and empowered through surgical care. This scholarship helps me stay focused on that path and continue my education with greater confidence.

Thank you to the Foundation for Surgical Technology for this opportunity. I am truly honored to be recognized, and I look forward to the day I can give back to the field that has already given me so much.

NATALI CICCONE
CHATTAHOOCHEE TECHNICAL COLLEGE
POWDER SPRINGS, GA

$2,000

SPONSORED BY FOUNDATION FOR SURGICAL TECHNOLOGY

I am honored to have been selected for the Foundation for Surgical Technology scholarship, and I want to share why I chose surgical technology as my career and where I hope this path will lead me.

My interest in surgery started long before I ever stepped into an operating room. Growing up, I was always fascinated by the medical field and the idea that skilled hands and teamwork could help people heal and give them a second chance at life. Early on, I worked in veterinary offices, and assisting during animal surgeries quickly became my favorite part of the job. It was there that I realized how much I loved the environment of the operating room; the precision, the organization, and the sense of purpose that comes with helping patients, even if they couldn't thank me themselves.

That experience inspired me to pursue surgical technology so I could be part of a surgical team dedicated to patient care. I hold an Associate of Applied Science in Biology, and soon I will also hold an Associate of Applied Science in Surgical Technology. I am honored to be a member of the Association of Surgical Technologists and have continued to push myself to learn, adapt, and grow in this field every day. I love that in the OR, no two days are exactly alike, and every procedure is a chance to learn something new and become even better at what I do.

Looking ahead, my goal is to work in a hospital where I can be part of a team that makes a real difference, whether that's in neurosurgery, orthopedics, or pediatric surgery. I'm especially drawn to places like the Shepherd Center, Kennestone Hospital, or the VA Hospital, where I can help vulnerable patients and give back to those who have served our country. My ultimate aspiration is to continue my education and become a first assistant, so I can take an even bigger role in the operating room and support surgeons and patients to the best of my ability.

I am proud to be part of a profession that demands skill, compassion, and constant learning. I am truly grateful for this scholarship, which will help me focus fully on my education so I can achieve my goals and make a difference in the lives of the patients I serve.

Thank you so much for supporting my journey.

MATOV RODRIGUEZ
THE COLLEGE OF HEALTH CARE PROFESSIONS
FARMERS BRANCH, TX

$1,000

TEXAS STATE ASSEMBLY SCHOLARSHIP

The reason I chose to become a surgical technologist is the unique and rewarding experience that healthcare provides. A surgical technologist is not just a helper or an instrument passer, there is more to the field that makes it unique in its way. The curiosity in me always wants to learn more and experience more. I have an exceptional career that not everyone can experience.

My aspiration for the future is to continue my education as a Certified Surgical First Assistant. Continuing my education will motivate me to take on greater responsibility in the operating room and play a more direct role. This field requires precision, focus, and dedication, and as a future certified surgical assistant, I am ready for any challenge that comes my way. I am dedicated to becoming the best I can be. Another aspiration for my future is to be able to teach a future surgical technologist, we all have learned from someone, and still are learning, I hope I can help any student that comes my way to also succeed with their careers, for many this can be a step to something bigger.

The best part of being a surgical technologist is having an important role in surgery. Society may never see what we do in the operating room but the field functions with us, and around us, that is the most rewarding, empowering task to be able to do. The thing I enjoy about working in surgery is the ability to learn about the human body. As a very curious person, surgery gives me the biggest thrill, it motivates me to do better at what I do. Surgery, and being a surgical technologist is the biggest privilege, and I am grateful for being a huge part of it. I stepped into a career I never would imagine being a part of, but I am proud of myself. On to bigger things.

DAVID KIMANI
THE COLLEGE OF HEALTHCARE PROFESSIONS
PRINCETON, TX

$1,000

TEXAS STATE ASSEMBLY SCHOLARSHIP

Choosing surgical technology as my career path has been a deeply fulfilling decision rooted in a family-oriented set up. My wife, who is a registered nurse, has been a close sensational to me. Witnessing the dedication and the profound impact she has on patients' lives inspired me to pursue a role where I can contribute meaningfully. Surgical technology stood out as a perfect blend of hands-on involvement, technical skill, and patient care.

My aspiration for the future is to become a certified surgical technologist, specializing in minimally invasive procedures. I believe that advancements in technology are revolutionizing surgery, and I want to be at the forefront of this change. By acquiring further certifications and training, I hope to enhance my skills and knowledge, allowing me to assist in complex surgeries with precision and confidence. Ultimately, I aim to educate aspiring surgical technologists, fostering a new generation of dedicated professionals in this field.

Moreover, my experiences in surgical technology have taught me the importance of adaptability and attention to detail. In the operating room, every second counts, and I take pride in my ability to remain calm and focused under pressure. I find joy in preparing instruments meticulously and anticipating the needs of the surgical team, which allows for a seamless workflow. This proactive approach not only enhances the efficiency of the procedure but also contributes to better outcomes for patients.

In summary, my choice to pursue a career in surgical technology stems from a desire to make a positive impact in healthcare. With aspirations to specialize further and educate others, I am committed to continuous learning and professional development. The best parts of my job is teamwork, the dynamic environment, and the ability to contribute to patient care, fuel my passion daily, making me eager to embrace the challenges and rewards that lie ahead in this fulfilling career.

LINDSEY JACKSON
FORTIS ORANGE PARK FL
JACKSONVILLE, FL
$1,500
SPONSORED BY FOUNDATION FOR SURGICAL TECHNOLOGY

Receiving this scholarship from the Foundation for Surgical Technology means the world to me. My name is Lindsey Jackson, and before entering this field, I came from a completely different world. I was a professional poker dealer for several years. While I enjoyed the fast-paced energy of the game and interacting with people from all walks of life, deep down I knew I was meant to do something more meaningful and impactful with my life.

Transitioning into the surgical technology field has opened my eyes to a career filled with purpose, structure, and the opportunity to be a part of life-changing work. This journey has introduced me to a brand-new language, a deep sense of discipline, and an even greater sense of responsibility. From scrubbing in for the first time to learning sterile techniques, instrumentation, and anticipating each step of a procedure, I've grown tremendously not just as a student, but as a person.

Attending the AST Conference solidified my passion and confidence in the path I've chosen. Being surrounded by other surgical technologists and future leaders in the field reminded me that I belong here. Their stories, advice, and encouragement fueled my motivation to keep learning and to be someone that others can rely on in the operating room.

Throughout this experience, I've developed strong interests in GYN and orthopedic procedures and surprisingly, podiatry! For someone who never considered herself a "feet person," I now see how fascinating and vital they are to our overall health and movement. I've also always been drawn to the hands and how important they are to so many jobs and daily activities, and how restoring function can restore independence.

This scholarship isn't just financial support, it's recognition. It's belief in my future. I'm deeply honored and excited to give back in the OR, in my community, and to the growing network of peers in this incredible profession.

NOTHANDO NCUBE
TRITON COLLEGE
OAK PARK, IL
$1,000
SPONSORED BY FOUNDATION FOR SURGICAL TECHNOLOGY

I chose surgical technology after watching a "day in the life" video of a surgical technologist on TikTok. It may sound surprising, but that single video introduced me to a career I didn't even know existed—one that has quickly become a central part of my life. Before that moment, I had never considered a role in the operating room, but seeing the teamwork, precision, and impact of the surgical technologist inspired me to learn more. When I enrolled in the surgical technology program, I wasn't sure what to expect, but I was eager to challenge myself and discover where this path could lead.

Now, as I prepare for my clinical rotations, I am learning just how important it is to pay careful attention to detail, always to be aware of my surroundings, and to understand that every second counts in the operating room. The program has been challenging, but each new skill I learn makes me more excited for the future. I have developed a deep respect for the surgical team and the level of coordination and communication required to ensure patient safety and successful outcomes.

While my initial interest was sparked by a TikTok video, I have stayed because I genuinely love the process of working closely with a team and being part of procedures that can change someone's life. My natural curiosity motivates me to keep learning, and I am especially fascinated by neurosurgery—the complexity of the brain and nervous system is truly amazing. I am also interested in plastic and cosmetic surgery, not only because of its presence in the media, but also because it combines technical skill with creativity and artistry.

Looking ahead, I hope to participate in a variety of surgical cases, especially in neurosurgery and plastic surgery, and to continue developing my skills as a surgical technologist. I am committed to lifelong learning, patient safety, and always giving my best in the operating room. I am excited to see where this journey takes me and to make a positive impact on patients' lives through my work.

STELLA LIGHT
MT. HOOD COMMUNITY COLLEGE
PORTLAND, OR

$1,000

SPONSORED BY FOUNDATION FOR SURGICAL TECHNOLOGY

Surgical technology captured my interest because of my passion for the dynamic and fast-paced environment of the operating room, which requires quick thinking, precision, organization, and the ability to remain calm under pressure. The high stakes nature of this setting excites me, as it challenges me to always stay focused and effective. I value the opportunity to collaborate with a diverse, multidisciplinary team and appreciate the collective effort it takes to ensure the patient's safety and providing the best possible care to patients.

My passion for surgical technology is especially fueled by my interest in pediatrics and neonatology. I am drawn to pediatrics from the unique qualities of working with children, specifically their innocence, imagination, and resilience even in challenging circumstances. I find great fulfillment in the opportunity to ease a child's anxiety by offering playful explanations about procedures, comforting them through moments of fear, and helping to transform potentially frightening experiences into manageable ones. I am grateful to have the opportunity to advocate for children, who are unable to advocate for themselves, and provide them with the best care possible. Ultimately, I aim to make a lasting, positive impact on their lives by helping them build resilience and confidence, even in the face of medical challenges.

It is an honor to be part of a team that provides care to patients during their most vulnerable moments, ensuring they receive the highest quality of care. I am committed to delivering care with empathy, integrity, and excellence. Even in the most challenging situations, I believe my work can help turn a patient's difficult moments into temporary setbacks, ultimately making a lasting, positive impact on their futures. Looking ahead, I plan to pursue certification as a Surgical First Assistant which will allow me to grow professionally and expand my ability to contribute, supporting patients and surgical teams alike.

DEVONDRIA NUEBLE (DIAMOND)
FORTIS INSTITUTE (NASHVILLE)
MURFREESBORO, TN

$2,500

SPONSORED BY FOUNDATION FOR SURGICAL TECHNOLOGY

I would like to sincerely thank the Foundation for Surgical Technology Committee and AST organization for this incredible opportunity and for recognizing the hard work and dedication of students like me. Receiving this scholarship means more than financial support-it's a vote of confidence in my future and the path I've chosen, and I'm truly honored and grateful.

I chose surgical technology as my career because I've always been drawn to the fast-paced, hands-on nature of the operating room. As a Medical Assistant, I've worked closely with providers and patients, managing both clinical and administrative responsibilities. While I've grown tremendously in this role, I found myself increasingly inspired by the surgical field and wanted to take a more active part in patient care during critical moments. Surgical technology provides me with the opportunity to contribute to life-saving procedures, maintain sterile environments, and be an integral part of a highly skilled team-something I find both exciting and rewarding.

What I enjoy most about working in surgery is the structure, intensity, and teamwork it requires. Every procedure demands focus, precision, and clear communication. There's nothing more fulfilling than knowing I'll play a part in helping someone heal or even save people's lives. It's behind-the-scenes work that carries real impact, and I take pride in being a part of something so meaningful. My aspirations for the future include becoming a Certified Surgical First Assistant, with a strong interest in cardiovascular and neurosurgery. I want to be even more hands-on in the OR and continue advancing in a field that constantly challenges and inspires me.

Balancing school, work, and motherhood has strengthened my resilience and deepened my commitment to advancing in this field. As I continue my education, I look forward to expanding my technical skills, collaborating with peers in the surgical environment, and engaging in meaningful clinical experiences that will prepare me for more advanced roles. This scholarship opportunity will help lay the foundation for my future as a Surgical First Assistant, and I am excited to build a career rooted in precision, teamwork, and a dedication to patient care in specialized surgical fields such as cardiovascular and neurosurgery.

FOUNDATION *for* SURGICAL TECHNOLOGY

What is The Foundation for Surgical Technology?

The Foundation is a 501c3 organization comprised of representatives from the Association of Surgical Technologists (AST) and the National Board of Surgical Technology and Surgical Assisting (NBSTSA). This type of organization also means any donation you give to the Foundation is tax deductible.

Who does The Foundation support?

The Foundation provides scholarships to the following:

- Students
- Educators
- Military personnel
- and those who have helped others by serving on medical mission trips

When are the annual deadlines for the scholarships?

- Students scholarships - March 1
- Military scholarships - March 1
- Constellation (Educator) Awards - December 1
- Medical mission reimbursement - December 31

Learn more at www.ffst.org and give today!

APIC Publishes 2025 Guide To Preventing *Catheter-Associated Urinary Tract Infection (CAUTI)*

The guide provides information regarding the core components of a CAUTI prevention program as well as best practices and how to measure the outcome and process metrics to reduce the risk of infection in various practice settings.[1] As stated in the guide, it provides "recommendations intended to be achievable and to represent what are believed to be effective strategies to prevent healthcare-associated infections."[1]

The following is a summary of key information presented in the guide. To download and save a copy of the guide go to https://apic.org/implementation_guide/new-guide-to-preventing-catheter-associated-urinary-tract-infections-2025/.

Summary of the Consequences of CAUTIs

Indwelling urinary catheters (IUCs) are placed in up to 16% of hospital patients and each day it remains in place the risk of the patient acquiring an infection increases.[2] According to the Centers for Disease Control and Prevention's National Healthcare Safety Network, 3,774 acute care facilities reported 17,370 CAUTIs that occurred in 2023.[1] This represents a decline of 11% from 2022.[3] However, CAUTIs still account as a major health risk to patients in all patient care settings. CAUTIs are the cause of increased length of patient stay thus increasing the cost of care for the patient, patient discomfort and pain, and increased risk of death. In 2017, the Agency for Healthcare Research and Quality conducted a review of six published studies and based on the information, estimated that for each 1,000 CAUTIs there are 36 deaths.[4]

Some of the risk factors for CAUTI include age related changes to the genitourinary tract, cerebrovascular disease, comorbid conditions that cause neurogenic bladder, female anatomy, illness severity, length of time catheter is left inserted, paraplegia, poor nutrition, and pregnancy.[5] APIC lists the following four methods to reduce the risks.[1]

- Use external urinary catheters when appropriate for the patient.
- Use sterile technique when inserting the catheter and maintenance of the IUC.
- Limit the duration of the IUC by implementing facility-specific removal criteria.
- Not inserting an IUC unless strict criteria are met, for example, obstructive uropathy or neurogenic bladder.

Core Components of an Effective CAUTI Prevention Program

Key Stakeholders

A CAUTI prevention program needs to be tailored to the unique needs of the facility including type of facility and type of patients. To determine those needs, APIC recommends the first step to take is identifying the key stakeholders that are needed to serve on a multidisciplinary team that will work together to conduct a risk assessment to identify the specific risks that will need to be addressed when developing the prevention program. A table listing their recommendations for representatives on a CAUTI prevention program committee does not specifically list CSTs but does indicate "ancillary healthcare personnel not listed above." However, CSTs should insist on being included on the committee being experts in sterile technique as well as the requirement for learning urinary catheterization as a student according to the *Core Curriculum for Surgical Technology* (Physical Preparation of the Patient, IV. Urinary Catheterization).[6]

Risk Assessment

The committee should complete a risk assessment to identify and evaluate existing as well as potential risks that contribute to forming the plan to reduce the risks. APIC provides another table, "CAUTI-Specific Risk Assessment", that lists seven risk factors to consider when completing a risk assessment. A second column provides potential considerations for each factor. Two examples include the following.

- Risk Factor: Current and historical IUC standardized utilization ratios (SUR)[1]
  - Potential Considerations: Is the facility and each unit's SUR higher or lower than expected? Where in the facility are catheters inserted (i.e., emergency

department, surgery, inpatient unit)?[1]

- Risk Factor: Risks that are specific to the patient population served by the facility[1]
  - Potential Considerations: Does the facility routinely care for patients with neurogenic bladder or dementia? Does the facility perform genitourinary surgical procedures? Is the facility located in a geographic area with high incidence of certain multidrug-resistant organisms (MDROs)?[1]

Equipment and Supplies

Healthcare facilities must, obviously, ensure that the equipment and supplies are appropriate to the patient population it serves to support CAUTI prevention practices. The healthcare providers should be trained in the selection and use of the urinary catheter devices based on the needs of each patient. Additionally, any time a healthcare facility acquires a new type of device or changes vendors, the healthcare providers should complete additional training. The next table provided by APIC is "CAUTI Equipment and Supplies" that is divided into three columns – "Type of Supply/Equipment", "Categories", and "Considerations".[1] The following is one example from the table.

- Type of Supply/Equipment: Alternatives to indwelling urinary catheters[1]
  - Categories
    - Incontinence management supplies
      - Considerations: Ensure a wide variety of appropriate incontinence management products are available. Including male and female urinals, diapers/chux, scales for weight, bladder scanners, and skin protectants.
    - External urinary catheters
      - Ensure a wide variety of external male and female urinary catheter options are available to account for different patient acuity, gender, and body habitus.
    - Straight urinary catheters
      - Ensure straight urinary catheters are available in multiple sizes for intermittent catheterization use. Consider purchasing straight catheters as part of a kit.

Training and Education

Upon hiring a healthcare provider, it is recommended that the individual's competency is assessed in regard to their urinary catheterization skills if it is part of the job duties and if necessary, provide the needed education and training. The assessment, education, and training should be documented by the healthcare facility. Additionally, annual training should be completed. APIC provides a recommended list of education topics by activity, such as catheter insertion with the recommended topics appropriate catheter size selection, appropriate kit selection, aseptic insertion technique, and securement and documentation.[1]

Policies and Procedures

A broad CAUTI prevention policy is important toward "communicating expectations for CAUTI prevention practices across the facility."[1] The foundation of the policy should be based on established evidence based guidelines, such as those published by AST and AORN. During accreditation visits, such as by The Joint Commission or Accreditation Association for Ambulatory Health Care will confirm that the healthcare facility is following each section of the policy. APIC provides a list of topics that are recommended to be included in a CAUTI prevention policy and procedure including aseptic insertion, type and frequency of education, and responsibilities for CAUTI catheter insertion and prevention which are organized by position and role.[1]

Information Technology

It is recommended to use electronic information technology as part of a CAUTI prevention program to improve accuracy and efficiency in record keeping. There are multiple software programs available for use by facilities including electronic medical record or infection prevention surveillance software.

Best Practices for a CAUTI Prevention Program

Section 3 of the document summarizes the best practices that are considered essential to preventing CAUTIs. It is divided into "Essential Practices", "Maintenance Elements", and "Advanced Practices." [1] However, APIC states:

> Advanced practices tend to be focused on specific patient populations or specific practices with limited evidence to support their effectiveness. Due to limited published evidence regarding the effectiveness of these advanced practices, key stakeholders at a facility need to review and discuss an advanced practice prior to implementation.[1]

The following is an example of a recommended insertion element.

- Use appropriate insertion practices, including hand

hygiene, aseptic and sterile technique, and sterile supplies.

- Use a documented procedure for IUC insertion.
- Use a checklist in the EMR to improve reliability of insertion protocols.
- Use the appropriate size catheter and insertion experts (e.g., urology) for difficult insertion to limit repeat attempts and reduce traumatic injury.
- Provide a table of ages/weights and recommended catheter sizes.
- Ensure appropriate sterile supplies are available.

Measuring the Prevention Program and Epidemiologic Questions

A last important key component of a prevention program is determining if it is effective to include measuring and recording the outcomes. APIC provides common outcome metrics for CAUTI, five methods of process measurement, and a comprehensive list of metrics for assessing prevention processes in patients with IUCs. Section 4 ends with a list of epidemiological questions to assist in identifying trends in patients with CAUTI. Two examples of the five methods of process measurement include direct observation of inserting a catheter and staff interviews to gather information regarding opportunities for improving the prevention program.[1]

References

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Keeping It Sterile Since 1969

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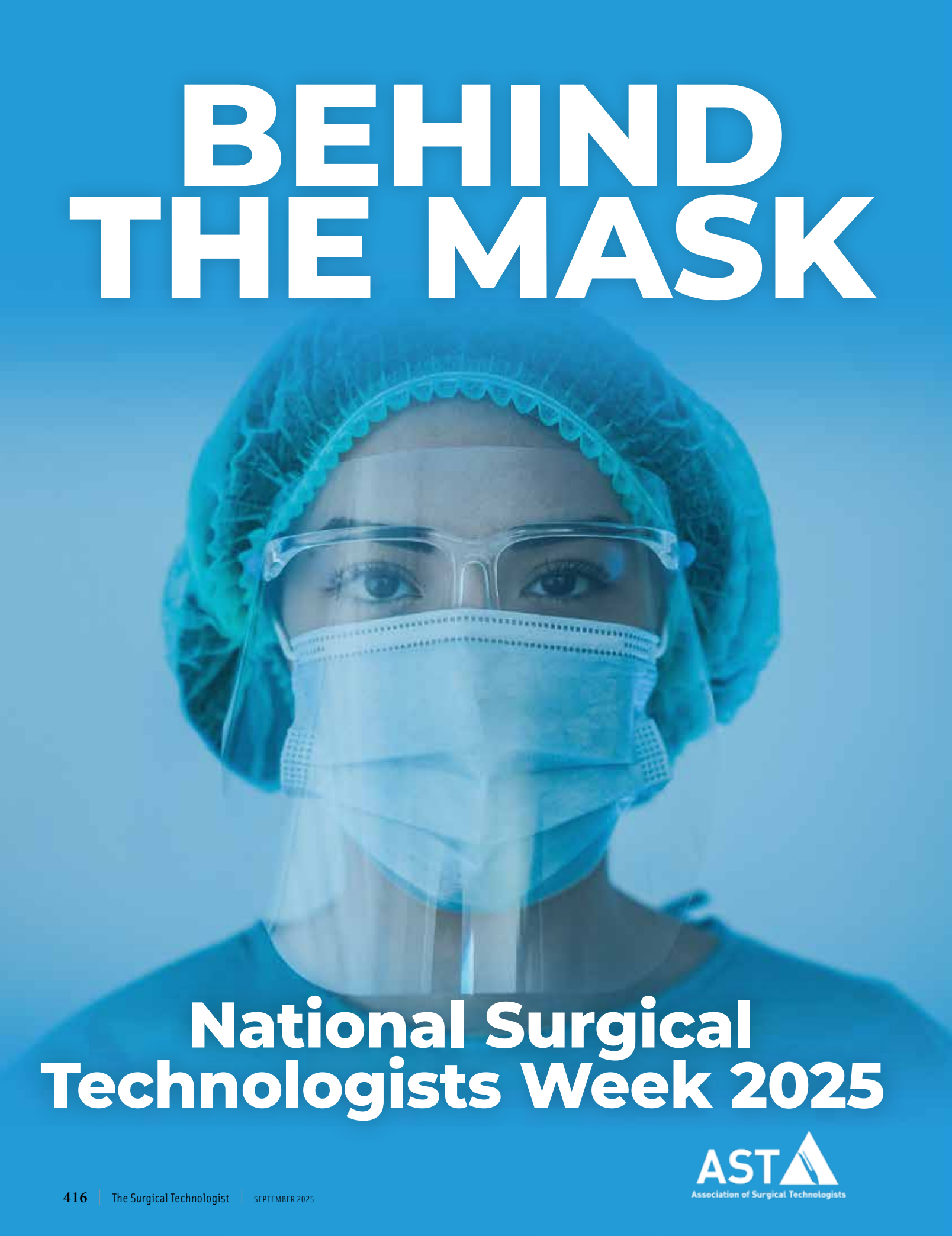
The Association of Surgical Technologists has been fighting for surgical technologists for more than 50 years.

BEHIND THE MASK

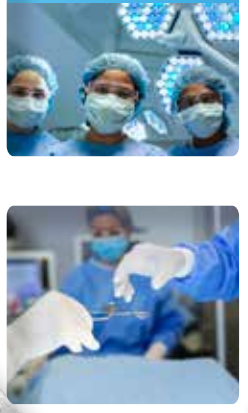


National Surgical Technologists Week 2025

AST
Association of Surgical Technologists

HAPPY NATIONAL SURGICAL TECHNOLOGISTS WEEK!

September 21–27, 2025



Time to CELEBRATE YOU!

What's NSTW All About?

Created in 1984 by the AST Board of Directors, National Surgical Technologists Week honors YOU—the skilled, vital pros behind every successful surgery.

You are skilled. You are the heartbeat of the operating room. You are essential!

"YOU ARE ESSENTIAL" CONTEST

Celebrate Surgical Technologists Who Make a Difference!

Do you know a surgical technologist who is truly essential—not just in the operating room, but in your life, workplace, or community? Now's your chance to shine a spotlight on their incredible impact!

We're inviting coworkers, friends, or anyone who works alongside surgical technologists to nominate someone who inspires them by filling out our "You Are Essential" recognition form. Tell us how they make a difference—big or small—and help us celebrate the heroes behind the mask. Do you primarily work solo—and maybe even travel from site to site? Celebrate yourself by sharing the incredible impact you bring to the surgical team.

Prizes Include:

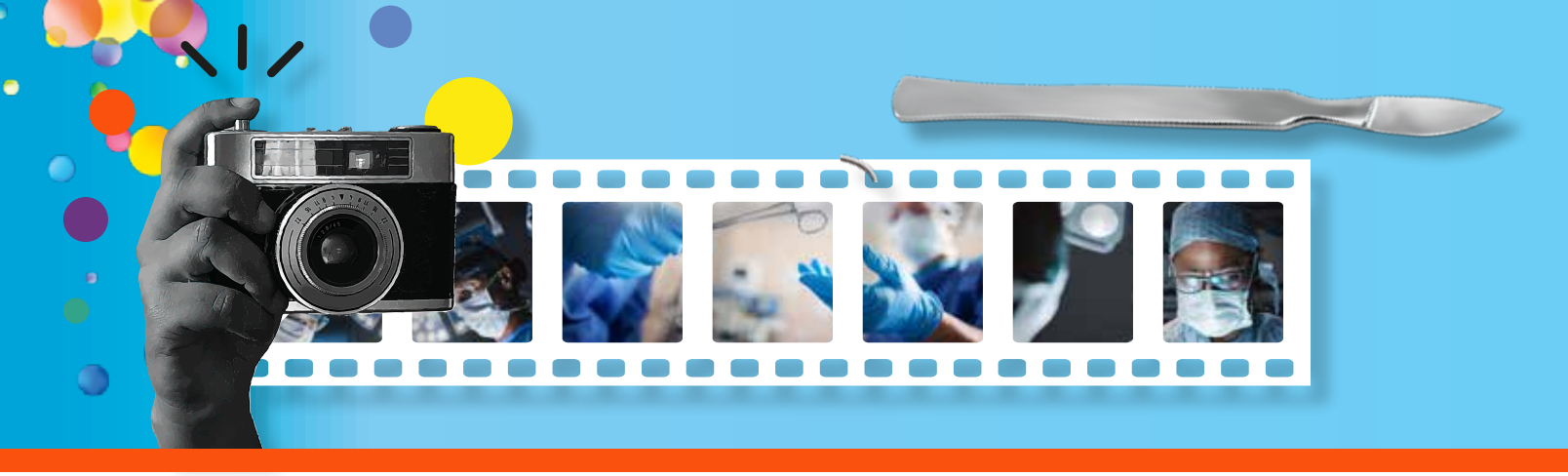
- A chance to win 1 of 3 $50 Amazon gift cards
- Grand Prize: Free registration to the 2026 AST Surgical Technology Conference in Seattle!

Here's the best part: BOTH the person being recognized AND the person who submitted the nomination will win if selected! Winners will be selected at random. Grand prize winners must be AST members to qualify. See all terms and conditions at ast.org or in the September 2025 Surgical Technologist Journal.

How to Enter:

1. Fill out the "You Are Essential" nomination form.
2. Share your story about why your nominee is essential to you or your team.
3. Include a picture of the surgical technologist you're nominating.
4. Submit by September 30, 2025.

Let's celebrate surgical technologists who bring skill, heart, and dedication to everything they do—because SURGICAL TECHNOLOGISTS are essential.



HIPAA Reminder!
Please follow HIPAA and your facility's policies.

Your photos/videos do *not* need to be taken in the OR. Check the contest rules on our website or at the back of this edition.

Not Feeling the Love? Make Your Own Celebration!

No recognition from your OR manager or hospital admin? No problem! Rally your fellow techs and throw your own party!

Ideas to get started:

- Bring in your favorite snacks or plan a potluck lunch
- Happy hour after work? Yes, please!
- Put up banners in the breakroom
- Flip the script: bring snacks for your managers and teammates to show YOUR appreciation

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Grab Your FREE Posters!

Download, print, and display them loud and proud—in your hospital, school, or even at home!

- Visit the AST site to download your free NSTW posters! https://www.ast.org/surgicaltechnologistsareessential/

2025 Surgical Technologists Behind the Mask Contest Rules

- Your photo entry must depict a photo of the surgical technologist you'd like to recognize. The photo DOES NOT NEED to be in the OR.
- Your entry cannot show name badges, boards or screens containing patient names, or any other view that would violate HIPAA regulations. It is your responsibility to know your employer's policy about photography/videography and the use of cell phones in your facility. AST is not liable for any disciplinary action taken against you for failing to know and follow your employer's policy.
- If your photo shows people other than yourself, you must get usage permission from the people in your photo before entering it into this contest. Your entry will appear online and, possibly, in print. By entering, you are verifying that everyone in the photo gave you (and subsequently AST) approval to use their likeness.
- Photos must be submitted through the contest website by September 30. Although entries will continue to be visible online as we post submissions, new entries will not be accepted after September 30. Mailed or emailed entries will not be accepted, nor will photos or videos posted only to AST's Facebook page. If you are having trouble uploading photos from your phone or computer, contact communications@ast.org.
- Only one person can enter a photo (no duplicate entries), and only one entry is allowed per person. The person who submits the photo to the contest and the surgical technologist being recognized will win a prize. Prizes are nontransferable. Prizes are redeemable only within the stated timeframe. Failure to respond during the stated timeframe will forfeit the prize.
- Photo entries may be disqualified and removed at AST's discretion at any time, without notification. Causes for disqualification include a HIPAA violation, lack of permission from subjects in the photo, profanity/obscenities, blatant sales or product pitches, etc.
- Winner selection and notification: Winners of the contest will be selected in a random drawing under the supervision of AST. Winners will be notified via phone or email via the contact information they provide on the registration form. Winners names will be announced on AST's website and Facebook account by November 25, 2025. AST shall have no liability for a winner's failure to receive notices due to winners' spam, junk e-mail or other security settings or for winners' provision of incorrect or otherwise non-functioning contact information. If the selected winner cannot be contacted, is ineligible, fails to claim the prize within 15 days of notification, their prize may be forfeited, and an alternate winner selected. The winner of the grand prize of a 2026 conference registration to AST's national event in Seattle, must be a member of AST to earn their prize. For further rules, visit the AST website.
- Previous grand prize winners of National Surgical Technologists Week contests are not eligible to win the grand prize again but are eligible for other prizes.

REMINDER: The number of likes for a recognition will have NO impact on whether it qualifies for the drawing but will make it eligible for AST promotional prizes. Liking and sharing your entry and others' raises awareness and helps the public understand the profession and the role of the surgical technologist.

Sir Victor Horsley: Neurosurgeon, Scientist, Reformer

AST Staff

MEDICAL MARVELS

Sir Victor Horsley remains one of the most outstanding personalities of his times, at once a pioneering neurosurgeon, effective researcher, inspiring teacher, and principled social reformer, thereby exemplifying the modern ideal of the medical doctor and university professor.[1]

Introduction

Sir Victor Alexander Horsley, FRS, FRCS, (April 14, 1857 – July 16, 1916) was a controversial personality who was a brilliant debater, inventor, neurosurgeon, and neuroscientist who was both admired by some and extremely disliked by others because of his blunt nature. However, his significant contributions to surgery and the understanding of the brain as well as other organs of the body, such as the thyroid, have been recognized as establishing the groundwork for modern surgical techniques.

Medical Education

Sir Horsley grew up in a prosperous family that was filled with artistic and musical family members. His name, Victor Alexander, was given to him by Queen Victoria (1827 – 1901). He was ambidextrous, which contributed to his renowned surgical skills.[2] In 1875 he began his studies in medicine at the University College London (UCL - previously University College Hospital, then University of London, University College and back to its present name of UCL) and in Berlin, Germany.[2] In 1881, he was appointed as the house surgeon at UCL. In 1886, he was appointed as an Assistant Professor of Surgery at the National Hospital for Paralysis and Epilepsy (current name National Hospital for Neurology and Neurosurgery that is affiliated with the UCL Hospitals NHS Foundation Trust).[3] Additionally, appointed respectively as a Professor of Pathology (1887 – 1896) and Professor of Clinical Surgery (1899 – 1902) at UCL.

Life as a Surgeon

Sir Horsley performed his first craniotomy on May 25, 1886, in London.[4] The patient was a 22-year old man who suffered from seizures caused by a cortical scar. Sir Horsley removed the scar with a half centimeter of surrounding brain tissue.[4] The wound healed with no complications and the patient no longer had any seizures. By the end of 1886, Sir Horsley performed 10 craniotomies with outcomes ranging from clinical improvement to complete recovery losing only one patient on the operating room table.[4]

In 1887, Sir Horsley performed the first successful lam-

inectomy to treat a spinal tumor. Sir Horsley was only 30-years old when he performed the surgery on the 42-year old Captain Hubert Grenfell of the Royal Navy who presented with progressive paraplegia.[2] It was reported that the patient had an excellent recovery.[2]

At the 1894 meeting of the British Medical Association (BMA), Sir William Thorburn, English neurosurgeon, reported that surgery for spinal trauma was rarely indicated and the recommended treatment was with plaster jackets.[2] However, in 1895, Sir Horsley presented seven cases of cervical laminectomy at the BMA meeting marking a major turning point in spinal surgery, establishing it as a viable surgical specialty. Three of the patients were operated upon for tuberculosis and the other four for cervical spine trauma with each patient making full recovery.[2] The four cervical spine trauma patients attended the BMA meeting attesting to the improvement in their quadriplegia.[2]

Other firsts by Sir Horsley include the first carotid ligation to treat cerebral aneurysm, the development of the curved skin flap in 1886, the transcranial approach to the pituitary gland, the intradural division of the trigeminal nerve root to treat trigeminal neuralgia using the hook that he invented, and surface marking of the cerebral cortex.[2,4] In 1890, he reported having performed 44 brain surgeries establishing the specialty of neurosurgery.[5]

He was also a pathologist, performing research on bacteria and edema. Subsequently, he founded the *Journal of Pathology*.[2]

Life as an Inventor and Research Scientist

Among many inventions, in 1886, Sir Horsley developed bone wax, first referred to as "antiseptic wax" made of a mixture of beeswax, salicylic acid, and almond oil, of which the current form is still used by orthopedic surgeons.[2,4] However, his best known invention, developed with the British anatomist, physiologist, and surgeon Robert H. Clarke, is the Horsley-Clarke stereotactic device that obviously underwent many transformations because of technology that is still used by neurosurgeons. In an 80-page article published in the journal *Brain* he described the stereotactic device and the use of Cartesian coordinates.[5] The original device was constructed in 1905 and is displayed at the UCL museum (Figure 1).

As a neuroscientist, he completed studies of the functions of the brain. In his book Aminoff emphasizes that Sir Horsley was not only a surgeon with excellent skills, but also a "surgical neurologist who thought deeply about matters of the brain."[1] One focus was on the study of epilepsy and the cerebral cortex in which it was established that seizures originated from the cortex, not the brainstem.[5] The studies lead to his pioneering work on surgically treating epilepsy. From 1884 to 1886 he was the first physician to use an intraoperative electrical simulation device applied to the cortex to localize epileptic foci in humans.[5] On May 25, 1886, he performed the first surgery to relieve epilepsy at the National Hospital for Paralysis and Epilepsy. This surgery and two others, considered successes, were described by him in the article "Brain-Surgery" that was published in the *British Medical Journal*.[6] The first patient had motor paralysis and sensory deficits for two months postoperatively, but the symptoms eventually resolved.[3] The second patient had paralysis of his left side postoperatively, but eventually the only permanent debility was a weak left hand grasp and inadequate independent finger movements.[3] The third patient had a lesion removed from the superior frontal convolution, and postoperatively, had temporary weakness of the right side of the body, and the involuntary movements disappeared.[3]

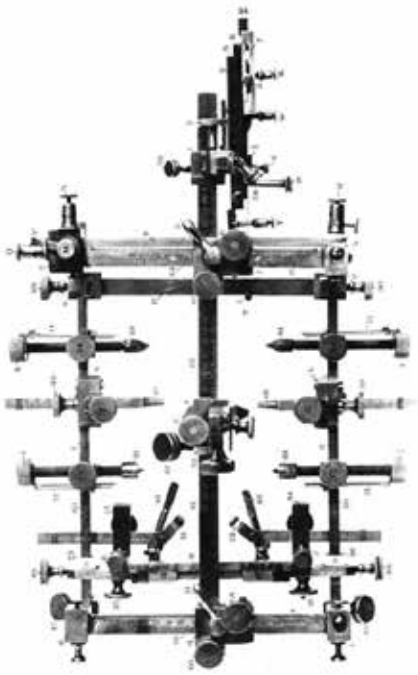

Figure 1 Horsley-Clarke Stereotactic Device

Additionally, he was a leader in the study of the functions of the thyroid including studying cretinism and myxedema. Through experimentation with monkeys, he discovered that hypothyroidism could be treated with extracts of the gland.

In 1886, he was a member of a commission to study the anti-rabies vaccination that had been developed by Louis Pasteur. Pasteur developed the vaccine in 1885 and was used successfully to treat Joseph Meister, a nine year old who had been bitten by a rabid dog. The first of 14 doses started

on July 6, 1885. Sir Horsley, who spoke the French language fluently, traveled to France to study and work with Pasteur and was given a sample of rabid spinal cord for animal studies in England.[7] The commission corroborated the results of the vaccine and Sir Horsley began a nationwide campaign to promote the use of the vaccine, muzzling of dogs, and quarantine of animals which lead to the eradication of rabies in England.[7]

Champion of Many Causes

As Tan and Black stated, "Horsley's kindness, humility, and generous spirit endeared him to patients, colleagues, and students. Born to privilege, he was nonetheless dedicated to improving the lot of the common man and directed his efforts toward the suffrage of women, medical reform, and free health care for the working class."[4]

Sir Horsley had a strong social conscience – gender, race, social status was unimportant to him. What was important is that everyone was treated equally, had the same opportunities in life, and above all, received the medical care they deserved. He is prominent for his support of a young physician, James Risten Russell, who was of mixed race. He sent multiple letters that persuaded the board of the National Hospital to appoint Russell to the next consultant neurologist opening, becoming the first Afro-Caribbean consultant appointment in England.[8]

One of several causes that Sir Horsley supported was the temperance movement. He was an ardent opponent of alcohol and tobacco. He believed that physicians should be advocates for improvement in social conditions and habits that lead to disease.[5] He was confident as to the deleterious effects alcohol and tobacco had on the body, including having observed that many patients were admitted to the hospital with injuries due to the intake of alcohol. He positioned himself as a strong temperance reformer, eventually becoming the President of the British Medical Temperance Association. In 1907, he co-authored with Mary Sturge, MD (1862 – 1925) and Sir Arthur Newsholme (1857 – 1943), a book on alcoholism titled *Alcohol and the Human Body*.[5]

Sir Horsley supported, along with Sir Newsholme, establishing a national health insurance program with the emphasis that it would be particularly beneficial for the underprivileged. The was combined with his interest in child health and welfare, medical inspections, and state registration of nurses.

In between all his other endeavors, Sir Horsley found the time to lead the effort in reforming the BMA, General Medical Council (GMC), and Medical Defence Union (MDU). In 1986, he believed recognition of those qualified to practice should be decided by the GMC, not the MDU. From that point on, the GMC has been the independent register of physicians, physician associates, and anesthesia associates in England.[9] At the BMA he led the effort to reform the organization's constitution that was accepted in 1902 after two years of heated debate.[8] During these times advocating for the causes he believed in he became known as an excellent debater but was often careless in his comments that were considered unprofessional and derogatory, offending opponents.[7]

Honors

Sir Horsley was the first neurosurgeon appointed to the National Hospital for Neurology and Neurosurgery and the Victor Horsely Department of Neurosurgery is named in his honor. Another leading neurosurgical hospital, The Walton Centre (formerly the Walton Centre for Neurology and Neurosurgery) located in Liverpool, dedicated its intensive care unit to him, naming it Horsley Ward.

After graduating from medical school and spending time in Germany, Sir Horsley was given the Fellowship of the Royal College of Surgeons in 1883, a professional qualification to practice as a surgeon in Ireland and the United Kingdom.[7] In June 1886, Sir Horsley was elected and awarded the Fellowship of the Royal Society by the Fellows of the Royal Society of London. In 1894, he was awarded the Royal Medal, also known as the Queen's Medal or King's Medal, depending on the gender of the monarch at the time of the award, for "his investigations relating to the physiology of the nervous system, and of the thyroid gland, and to their applications to the treatment of the disease."[4] During the October 24, 1902, Coronation Honours ceremony, he was knighted by King Edward VII (1841 – 1910) at Buckingham Palace.[4]

Military Career

In 1910, Sir Horsley was commissioned as captain in the Territorial Army of the 3rd London General Hospital, Royal Army Medical Corps.[7] When World War I began, he volunteered for duty on the Western Front where he was initially assigned as a surgeon at a British hospital in Wimereux, France. In May 1915, he was assigned as a colonel and Director of Surgery of the British Army Medical Service in Egypt, based at the 21st General Hospital in Alexandria in

support of the Dardanelles Campaign, a disastrous campaign by the joint forces of the British, France, and Russia against the Ottoman Empire.[7]

The following year, he volunteered for field surgery duty in Mesopotamia where the hospitals were poorly equipped.[7] In a letter to a colleague he described the conditions: "It is very difficult out here some hundred miles up the Tigris on a burning mud flat in the middle of cholera, dysentery, diarrhoea…"[7] He continuously telegraphed the Director of Medical Services at Simla, India, demanding improvements in troop rations, transportation, and water.[4] The British government finally succumbed to public pressure and the changes were made.

Upon his satisfaction with having accomplished his goals, Sir Horsley returned to Amara, Iraq with plans to travel to India. On July 15, 1916, with the temperature hovering at 110˚ F in the shade, he walked several miles to treat a sick officer.[4] Upon returning to camp he complained of a severe headache and developed a fever of 104˚ F and was admitted to the hospital.[4] However, the fever continued to rise, and he lapsed into a coma.[4] The next day, July 16, 1916, he succumbed to heatstroke and severe hyperpyrexia.

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Cataract Surgery May Reduce Falls and Factures in Older Adults

Journal of the American Geriatrics Society

OF INTEREST IN THE MEDICAL ARENA

Topline: Cataract extraction with intraocular lens insertion (CEIOL) was significantly associated with decreased falls, fractures, and intracranial hemorrhage in patients aged 60 years or older.

Why the Study is Important: CEIOL is one of the most frequent procedures performed in the U.S. In 2022, there were 4.6 million cataract procedures performed in the U.S., with an average of 472 cases per ophthalmologist who perform cataract surgery.[1] Cataracts are a leading cause of blindness in the world, and the leading cause of vision loss in the U.S. With life expectancy increasing, it's estimated that the number of cataract procedures will double within the next 15 – 20 years.[2] The connection between CEIOL and falls and hip fractures has been described, but there is a lack of literature describing the association between CEIOL and other age-related traumatic injuries.[3]

Methodology and Objective of the Study: The researchers conducted a retrospective cohort study* using the health database TriNetX to analyze electronic medical records from 64 U.S. healthcare facilities.[3] The objective of the study was to assess the association of CEIOL in decreasing falls and fall-related injuries in patients with age-related cataracts.[3]

Patient Population: 420,907 individuals with a mean age at index** of 70.6 years.[3] The patients were divided into two propensity-score matched*** cohorts. Cohort 1 included patients who underwent CEIOL within 10 years of diagnosis and cohort 2 was patients who did not undergo CEIOL within 10 years of diagnosis.[3]

Study Outcome Measures: The outcomes researchers analyzed included ankle, distal radius, hip, and proximal humerus fractures, falls, and epidural and subdural hemorrhage.

Results of the Study: Patients who underwent CEIOL had a significantly lower risk of falls, fractures, and epidural and subdural hemorrhage as compared to those who did not undergo CEIOL.

Study Limitations: Databases, such as TriNetX, that rely on administrative coding can lead to misclassification. Specific data regarding patient's visual acuity was unavailable. Additionally, the researchers could not determine whether the patients underwent unilateral or bilateral CEIOL because of the limitations in the diagnostic codes.

Study Conclusions: The authors of the study commented, "CEIOL was significantly associated with decreased falls and reductions in major fall-related injuries among patients with age-related cataracts. These findings strongly support improving screen protocols to detect vision loss secondary to age-related cataracts, as this may decrease the incidence of common major fall-related injuries among patients with age-related cataracts."[3]

The authors of the study also wrote, "As the average age of the U.S. population continues to increase, the implications of the present study findings may serve to provide clinical guidance to decrease morbidity and mortality."[3]

Funding/Support: No funding information was published within the article.

Conflict of Interest Disclosure: None reported.

***Retrospective cohort study:** Type of research where a group of people who share a common characteristic or experience, referred to as a cohort, is identified to examine the relationship between a specific research item or factor and the outcome. The study utilizes existing records such as databases or medical charts to analyze and gather information. The study compares the frequency of a specific outcome between the treated and untreated groups to assess the association between the outcome.[4]

****Mean age at index:** Refers to the average age of participants when they were first involved in the research study.[4]

*****Propensity-score match:** Statistical method used in research to reduce bias when comparing the outcomes of

different treatments by creating two cohorts, treated and untreated, based on the probability of receiving a specific treatment that is called the propensity score.[4]

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Microultrasonography-guided Prostate Biopsy May Be an Alternative to MRI

JAMA

Topline: Microultrasonography (microUS)-guided prostate biopsy was confirmed to be "noninferior" to MRI fusion-guided biopsy, according to an article published in the March 2025 issue of *JAMA*.[1]

Importance of Study: Most prostate cancer biopsies are performed using MRI images fused onto conventional ultrasound. This allows urologists to target potential tumors directly to achieve an effective diagnosis. However, there are several limitations to the use of MRI including:

- it is expensive,
- requires the use of gadolinium that has health risks,
- requires radiological expertise to interpret the MRI images and fuse them onto the ultrasound, and
- it is a two-step process, MRI scan followed by an ultrasound-guided biopsy that requires multiple hospital visits.

In comparison:

- there is no toxicity associated with microUS,
- MicroUS is less expensive and more accessible,
- it offers a one-stop healthcare visit for the patient who is scanned and then biopsied immediately afterwards,
- MicroUS has a higher frequency than conventional ultrasound that provides detailed images comparable to MRI, and
- oncologists and urologists can be easily trained to use microUS and interpret the images, particularly if they already have experience with conventional ultrasound.

MicroUS has the potential to offer patients, particularly those that are located in less developed healthcare systems, the opportunity to have better access to a less expensive imaging modality thus contributing to the overall health status of populations.[1]

Methodology and Objective of the Study: The title of the study is OPTIMUM and it is the first multicenter, international, open-label randomized, noninferiority clinical trial* to compare microUS-guided biopsy to MRI fusion-guided biopsy.[1]

Patient Population: The trial included 678 men with a mean age of 65 (59-70) years from 20 centers located in Canada, Europe, and the U.S. (8 countries) with possibility of prostate cancer because of an elevated level of prostate-specific antigen, abnormal digital rectal examination, or combination of both between December 2021 and September 2024.[1] None of the men had previously undergone a biopsy. 121 participants were assigned to receive microUS-guided biopsy, 226 received microUS-guided biopsy followed by MRI fusion-guided biopsy, and 331 received MRI fusion-guided biopsy only.[1]

Study Outcome Measures: The OPTIMUM study found 4.5% more clinically significant tumors in men who underwent microUS-guided biopsy as compared to those that underwent MRI fusion-guided biopsy.

Results of the Study: The use of microUS-guided biopsy was noninferior to MRI/conventional ultrasonography fusion-guided biopsy for detecting Gleason Grade Group 2** or higher prostate cancer in males who had not previously undergone a biopsy.[1] MicroUS-guided biopsy should be considered as a viable alternative to MRI/conventional fusion-guided biopsy for prostate cancer diagnosis.[1]

Funding/Support: The trial was supported by a grant received from the Canadian company Exact Imaging that developed the microUS technology.

Conflict of Interest Disclosure: Dr. Kinnaird reported receiving personal fees from Bayer and Boston Scientific outside the submitted work. Dr. Ghai reported receiving personal speaker fees from Exact Imaging outside the submitted work. Dr. Pavlovich reported stock options in Exact Imaging offered in recompense for consulting done more than 36 months ago. Dr. Harland reported receiving personal fees from EDAP TMS and nonfinancial support from artificial neural network analysis (ANNA) of prostatic transrectal ultrasound and Endomedica outside the submitted work. Dr. George reported receiving personal fees from Koelis and BK Medical outside the submitted work. Dr. Jansen reported receiving personal fees from Exact Imaging for physician training and consulting outside the

submitted work. Dr. Renzulli reported receiving personal fees from Astellas Pharmaceutical, Intuitive Surgical, and Pfizer outside the submitted work.

***Open-label randomized, noninferiority clinical trial:** 1) Open-label – researchers and participants know which treatment each participant receives; 2) Randomized – participants are randomly assigned to different treatment groups; 3) Non-inferiority – new treatment is compared to an established standard treatment, and the objective is to show that the new treatment is not significantly or unacceptably worse than the standard treatment.[2]

****Gleason Grade Group:** The Gleason score is a 1-10 grading system used to evaluate the progression of a prostate cancerous tumor. Gleason Grade Group 2 indicates an intermediate risk of tumor metastasis. It is arrived at by a Gleason score of 7.

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Study Finds Transperineal Prostate Biopsy is Clinically Superior to Transrectal Approach

Lancet Oncology

Media Advisory: To contact corresponding author Professor Richard J. Bryant, MD, email richard.bryant@nds.ox.ac.uk

Topline: In the TRANSLATE randomized control trial (RCT), United Kingdom (UK) researchers showed that local anesthetic ultrasound-guided transperineal biopsy (LATP) is superior to local anesthesia with ultrasound guidance via transrectal approach (TRUS) in detecting Gleason Grade Group (GGG) 2 (see previous article for definition) or higher prostate cancer.[1] According to the research team it is the largest RCT of LATP versus TRUS completed in biopsy-naive (never underwent a biopsy) patients for possible prostate cancer.[1]

Why the Study is Important: Approximately one million prostate biopsies are performed in the U.S. annually with about 240,000 new cases of prostate cancer confirmed each year.[2] For decades, the traditional approach for prostate biopsies has been TRUS. However, it is associated with patient's developing post-operative infections. However, in recent years, LATP has been developed as an alternative approach, but there has been a lack of research to provide evidence to clinicians of its effectiveness as compared to TRUS.

Methodology and Objectives of the Study: The research team conducted a randomized controlled clinical trial involving 10 hospitals in the UK.[1] The study took place between December 3, 2021, and September 26, 2023. The primary objective of the study was to determine the efficacy of LATP versus TRUS in detecting GGG 2 or higher prostate cancer.

Patient Population: A patient was eligible for the study if suspected of prostate cancer because of elevated prostate-specific antigen or abnormal digital rectal examination and biopsy-naive. All patients underwent a pre-biopsy MRI. 1,126 patients aged 18 years or older agreed to participate and were randomly assigned to TRUS or LATP using web-based software. 564 participants were assigned to TRUS and 562 to LATP biopsy.[1] Each patient was immediately followed up postoperatively, and at seven days, 35 days, and four months.[1]

Study Outcome Measures: The primary outcome to be measured was detection of GGG 2 or higher prostate cancer comparing TRUS to LATP.[1] The secondary post-biopsy outcomes to be measured included acute-urinary retention, impact on urinary function, infection, hemorrhaging, and sexual function.[1] Additional measurements included the tolerability of the procedure by patients and overall experience with the procedure itself.

Results of the Study: Biopsy with LATP had a greater rate of detecting GGG 2 or higher prostate cancer as compared to TRUS. Additional secondary findings included 90% of the patients who received LATP had biopsies without antibiotics.[1] Postoperative infection requiring hospitalization within 35 days after the procedure occurred in two (<1%) of the 562 patients in the LATP group and 9 (2%) of the 564 in the TRUS group. The research team commented that this slight trend favored LATP but "no statistically significant difference was observed" in the overall biopsy-related complications.[1] However, men in the trial more commonly reported that LATP was immediately postoperatively painful and more embarrassing as compared with TRUS.[1]

Study Limitations: The research team disclosed the following five limitations.

1. 93% of the participants in the study were Caucasian British, with under-representation of multi-ethnic groups.
2. The individual skills of clinicians were not assessed

versus specialized nurses undertaking trial biopsies.

3. The broad TRANSLATE definition of infection might have included patient-reported symptoms that were not true post-biopsy infections.

Study Conclusions: The research team shared in the article, "To our knowledge, this is the first trial to show the superiority of LATP versus TRUS in detection of GGG 2 or higher prostate cancer. These findings will help to inform patients, clinicians, clinical guidelines, and policy makers regarding the important trade-offs between LATP and TRUS prostate biopsy."[1]

Funding/Support: The study was supported by the Health Technology Assessment Program of the National Institute for Health and Care Research, with the University of Oxford as sponsors. The John Black Charitable Foundation funded the parallel biobanking of clinical samples, with informed consent from TRANSLATE trial participants.

Conflict of Interest Disclosure: Richard Bryant, MD, Tom A. Leslie, MD, and Alastair D. Lamb, MD received support from BST Accelyon to attend LATP biopsy training provided by Guys' Hospital, London, UK.

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UPCOMING PROGRAMS

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ARKANSAS STATE ASSEMBLY

Program Type: Annual Meeting/Elections
Date: October 4, 2025
Title: Harvesting Credits: Reap Knowledge and Refine Skills
Registration: ar.ast.org
Location: Center for Economic Development-University of Arkansas Fort Smith (Bakery District), 70 S 7th St, Suite D, Fort Smith, AR 72901
Contact: Tamara Morgan, 479-414-6720, tamara.morgan@uafs.edu
CE Credits: 6 Live Planned

ALABAMA STATE ASSEMBLY

Program Type: Workshop
Date: September 13, 2025
Title: Sailing into Knowledge
Location: Coastal Community College, 1900 US-31, Bay Minette, AL 36507
Contact: Abigail Jones, 334-389-1250, abigailcarter8614@gmail.com
CE Credits: 6 Live Planned

ARIZONA STATE ASSEMBLY

Program Type: Workshop
Date: September 20, 2025
Title: Advancing Technology in the OR
Registration: azsaofast.org
Location: HonorHealth Network Support Services Center (NSSC), 2500 W Utopia Road, Phoenix, AZ 85027
Contact: Teresa Sochacki, azsa.assembly@gmail.com
CE Credits: 4 Live approved by AST

Program Type: Workshop
Date: November 15, 2025
Title: Tucson Time!
Registration: azsaofast.org
Location: Pima Medical Institute – Tucson, 2121 N Craycroft Road, Building 1, Tucson, AZ 85712
Contact: Teresa Sochacki, azsa.assembly@gmail.com
CE Credits: 4 Live approved by AST

COLORADO/WYOMING STATE ASSEMBLY

Program Type: Annual Meeting/Elections
Date: October 11, 2025
Title: Annual Business Meeting, Elections and Workshop
Location: Intermountain Health Platte Valley Hospital, 1600 Prairie Center Pkwy, Brighton, CO 80601
Contact: Julie Beard, 720-256-5863, jbeard2650@gmail.com
CE Credits: 5 Live Planned

CONNECTICUT STATE ASSEMBLY

Program Type: Workshop
Date: November 1, 2025
Title: My Neck My Back
Location: Norwalk Hospital, 34 Maple St, Norwalk, CT 06856
Contact: Sharkia Bookert, PO Box 581, Monroe, CT 06468, 203-503-7900, bookertsharkia@yahoo.com
CE Credits: 6 Live Planned

FLORIDA STATE ASSEMBLY

Program Type: Annual Meeting/Elections
Date: September 27, 2025
Title: Fall Fest 2025!
Location: Sheraton Orlando North Hotel, 600 N Lake Destiny Road, Maitland, FL 32751
Contact: Stephanie Hurst, 772-538-1230, flsastateassembly@gmail.com
CE Credits: 6 Live Planned

Program Type: Workshop
Date: February 28, 2026
Title: Spring into 2026!
Location: St. Joseph's Hospital, 3001 W Dr Martin Luther King Jr Blvd, Tampa, FL 33607
Contact: Stephanie Hurst, 772-555-1212, flsastateassembly@gmail.com
CE Credits: 8 Live Planned

GEORGIA STATE ASSEMBLY

Program Type: Workshop
Date: September 13, 2025
Title: September in the South
Registration: ast-gasa.com/fall-2025-meeting
Location: Southern Regional Technical College, 52 Tech Dr, Tifton, GA 31794
Contact: Susan Feltmann, PO Box 109, Auburn, GA 30011, 678-226-6676, gasawebmaster@gmail.com
CE Credits: 9 Live Planned

Program Type: Annual Meeting/Elections
Date: March 14, 2026
Title: Spring Forward: Advancing Surgical Technology Education
Registration: ast-gasa.com/spring-2026-meeting
Location: Chattahoochee Technical College - North Metro Campus, 5198 Ross Road SE, Acworth, GA 30102
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 13, 2025
Title: Idaho AST 2025 Annual Business Meeting
Location: St. Luke's Central Plaza, 800 E Park Blvd, Boise, ID 83712
Contact: Dani Hammer, 208-283-3693, daniroesler5@gmail.com
CE Credits: 7 Live Planned

ILLINOIS STATE ASSEMBLY

Program Type: Workshop
Date: October 11, 2025
Registration: https://www.illinoisstateassembly.com/events.html
Title: Honoring the Legacy, Transforming Tomorrow
Location: Malcolm X College, 1900 W Jackson Blvd, Chicago, IL 60612
Contact: Sonya Conton, 5407 North University Cedar Hall C105J, Peoria, IL 61653, 309-690-7568, sonya.conton@icc.edu
CE Credits: 6 Live Planned

INDIANA STATE ASSEMBLY

Program Type: Annual Meeting/Elections
Date: September 20, 2025
Title: ISA Fall Conference 2025
Location: Franciscan Education Center, 421 N Emerson Ave, Greenwood, IN, 46143
Contact: Lora Hofmann, PO Box 421673, Indianapolis, IN, 46242, 812-201-9563, lhofmann1@ivytech.edu
CE Credits: 6 Live Planned

IOWA STATE ASSEMBLY

Program Type: Annual Meeting/Elections
Date: October 18, 2025
Title: IASA Fall Business Meeting and Workshop
Registration: ia.ast.org
Location: Mary Greeley Medical Center, 1111 Duff Ave, Ames, IA 50010
Contact: Tim Danico, 319-540-6008, timothy-danico@uiowa.edu
CE Credits: 7 Live Planned

KANSAS STATE ASSEMBLY

Program Type: Workshop & Webinar (webinar approved only for Kansas State Assembly members)
Date: October 4, 2025
Title: Annual Fall Workshop
Location: WSU Tech, 3821 E Harry St, Wichita, KS 67218
Contact: Melanie Meyer, 785-550-4101, ks.st.assembly@gmail.com
CE Credits: 4 Live Planned

MARYLAND/DELAWARE STATE ASSEMBLY

Program Type: Annual Meeting/Elections
Date: October 11, 2025
Title: Maryland and Delaware Fall Workshop, Business Meeting, and Elections
Location: University of Maryland Medical Center-Midtown Campus, 827 Linden Ave, Baltimore, MD 21201
Contact: Charmaine Miller, 410-818-8208, mddestateassembly@gmail.com
CE Credits: 5 Live approved by AST

MASSACHUSETTS STATE ASSEMBLY

Program Type: Webinar (approved only for Massachusetts State Assembly members)
Date: October 25, 2025
Title: F.A.L.L. 2025
Contact: Kristen Urbanek, 617-257-5384, mastateassembly@gmail.com
CE Credits: 4 Live Planned

MICHIGAN STATE ASSEMBLY

Program Type: Annual Meeting/Elections
Date: September 13, 2025
Title: Cutting Edge in the City: MSA-AST Fall Surgical Tech Conference 2025
Location: Trinity Health Richard J. Lacks Sr. Cancer Center - Conference Center, 250 Cherry SE, Grand Rapids, MI 49503
Contact: Renona Gauthier, PO Box 375, Flat Rock, MI 48134, 248-891-3989, michiganassemblyofast@gmail.com
CE Credits: 5 Live Planned

MINNESOTA STATE ASSEMBLY

Program Type: Annual Meeting/Elections
Date: September 20, 2025
Title: MNSA 2025 Fall Workshop & Annual Business Meeting
Location: LifeSource, 2225 W River Road, Minneapolis, MN 55411
Contact: Lori Molus, PO Box 163, Becker, MN 55308, mnast2016@outlook.com
CE Credits: 6 Live Planned

MISSOURI STATE ASSEMBLY

Program Type: Workshop
Date: September 27, 2025
Title: Fall Workshop - Celebrating National Surgical Technologists Week
Registration: subscribepage.io/gaWgUf
Location: Ozarks Healthcare-Willard Hunter Conference Room, 1211 Porter Wagoner Blvd, West Plains, MO 65775
Contact: Victoria Thompson, PO Box 214, Ashland, MO 65010, 573-836-0637, missouristateassembly@gmail.com
CE Credits: 8 Live approved by AST

MONTANA STATE ASSEMBLY

Program Type: Annual Meeting/Elections
Date: October 4, 2025
Title: Montana State Assembly of AST Fall Conference and Workshop
Registration: mt.ast.org
Location: Intermountain Health St. Vincent Regional Hospital, 1233 N 30th St, Billings, MT 59101
Contact: Megan Ellman, PO Box 1513, Columbia Falls, MT 59912, 406-471-1363, meganrellman@gmail.com
CE Credits: 6 Live Planned

NEVADA STATE ASSEMBLY

Program Type: Annual Meeting/Elections
Date: September 20, 2025
Title: NVSA Annual Meeting 2025
Location: Summerlin Hospital Medical Center, 657 N Town Center Dr, Las Vegas, NV 89144
Contact: Tracy Ellis, 702-769-1520, tracy.s.ellis@gmail.com
CE Credits: 4 Live Planned

NEW HAMPSHIRE/VERMONT STATE ASSEMBLY

Program Type: Annual Meeting/Elections
Date: October 4, 2025
Title: NH/VT AST Fall Conference
Location: Elliot Hospital, 1 Elliot Way, Manchester, NH 03103
Contact: Lynn Jones, 603-370-1489, lmwhitney76@gmail.com
CE Credits: 6 Live Planned

NEW JERSEY STATE ASSEMBLY

Program Type: Annual Meeting/Elections
Date: September 20, 2025
Title: 2025 Fall Workshop & Business Meeting
Location: Morristown Memorial Hospital, 100 Madison Ave, Morristown, NJ 07960
Contact: Janee Flynn, PO Box 218, Ridgefield Park, NJ 07660, 201-658-9922, njast3@icloud.com
CE Credits: 6 Live Planned

NEW MEXICO STATE ASSEMBLY

Program Type: Workshop
Date: September 20, 2025
Title: Fall into Surgery Workshop
Registration: nm.ast.org
Location: UNM Domenici Center for Health Sciences Education, MSC09 5100, 1 University of New Mexico, Albuquerque, NM 87131
Contact: Maggie Mae Sassman, PO Box 66496, Albuquerque, NM 87193, 505-450-1457, maggiesassman@gmail.com
CE Credits: 5 Live Planned

NEW YORK STATE ASSEMBLY

Program Type: Annual Meeting/Elections
Date: October 3-5, 2025
Title: 2025 NYAST 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: October 18, 2025
Title: NDSA 2025 Workshop & Elections
Location: Dakota Medical Foundation, 4321 20th Ave S, Fargo, ND 58103
Contact: Emily White, 701-202-5779, esmallbeck27@gmail.com
CE Credits: 6 Live Planned

OREGON STATE ASSEMBLY

Program Type: Workshop
Date: October 18, 2025
Title: 2025 OAST Fall Conference
Registration: or.ast.org
Location: Doernbecher Children's Hospital, 700 SW Campus Dr, Portland, OR 97239
Contact: Jeffrey Rebo, 406-291-7220, jeffreyrebo.oast@gmail.com
CE Credits: 6 Live Planned

PENNSYLVANIA STATE ASSEMBLY

Program Type: Annual Meeting/Elections
Date: September 13, 2025
Title: PAAST Fall Conference with Business Meeting and Elections
Location: UPMC West Shore, 1995 Technology Pkwy, Mechanicsburg, PA 17050
Contact: Chris Kapp, 717-856-1278, kappcj@upmc.edu
CE Credits: 5 Live approved by AST

RHODE ISLAND STATE ASSEMBLY

Program Type: Reformation Meeting/Elections
Date: October 4, 2025
Title: Advancing Technology in Surgery
Location: New England Institute of Technology, 1 New England Tech Blvd, East Greenwich, RI 02818
Contact: Christine Madeira, 401-474-7892, rhodeislandast@gmail.com
CE Credits: 4 Live approved by AST

SOUTH CAROLINA STATE ASSEMBLY

Program Type: Annual Meeting/Elections
Date: November 1-2, 2025
Title: SCSA Fall Business Meeting and Workshop
Registration: scsaast.org
Location: Southeastern Institute of Manufacturing Technology (SIMT Building), 1951 Pisgah Road, Florence, SC 29501
Contact: Katrina Williams, 843-615-7454, katrinawilliams89@yahoo.com
CE Credits: 12 Live Planned

SOUTH DAKOTA STATE ASSEMBLY

Program Type: Annual Meeting/Elections
Date: October 17-18, 2025
Title: SDSA Fall 2025 Conference & Elections
Location: Western Dakota Technical College, 800 Mickelson Dr, Rapid City, SD 57703
Contact: Krista Hagemann, 605-718-2917, krista.hagemann@wdt.edu
CE Credits: 9 Live Planned

TENNESSEE STATE ASSEMBLY

Program Type: Workshop
Date: October 4, 2025
Title: Wild Wild West Regional
Location: West Tennessee Healthcare Jackson-Madison, 620 Skyline Dr, Jackson, TN 38301
Contact: Ellen Wood, 1344 Copperstone Lane, Knoxville, TN 37922, 865-283-5901, ellenwoodtnast@gmail.com
CE Credits: 6 Live Planned

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, 1344 Copperstone Lane, Knoxville, TN 37922, 865-283-5901, ellenwoodtnast@gmail.com
CE Credits: 6 Live Planned

TEXAS STATE ASSEMBLY

Program Type: Workshop
Date: September 27, 2025
Title: Houston Workshop
Location: Memorial Hermann Texas Medical Center, 6411 Fannin St, Houston, TX 77030
Contact: Joy Taylor, 409-882-4761, joyadalee@gmail.com
CE Credits: 8 Live approved by AST

Program Type: Workshop
Date: October 4, 2025
Title: Odessa Workshop
Registration: texasstateassembly.org
Location: Odessa College Simulation Hospital, 201 University Blvd, Odessa, TX 79764
Contact: Jaime Lopez, 432-638-2269, djjaimelopez@yahoo.com
CE Credits: 8 Live Planned

VIRGINIA STATE ASSEMBLY

Program Type: Workshop
Date: October 25, 2025
Title: VCSA Fall CE Workshop - All About Pediatrics
Location: Children's Hospital of the King Daughters- Children's Pavilion, 401 Gresham Dr, Norfolk, VA 23507
Contact: Rebecca Schultheis, 757-202-9962, virginiastateassemblyofast@gmail.com
CE Credits: 7 Live Planned

WASHINGTON STATE ASSEMBLY

Program Type: Annual Meeting/Elections
Date: October 11-12, 2025
Title: Fall Workshop and Annual Business Meeting
Location: Spokane Community College, 1810 N Greene St, Spokane, WA 99217
Contact: Eugene LeRoy, PO Box 55153, Seattle, WA 98155, 903-453-4738, gene.leroy.wsa@lebbrin.com
CE Credits: 8 Live Planned

WEST VIRGINIA STATE ASSEMBLY

Program Type: Annual Meeting/Elections
Date: October 18, 2025
Title: 2025 West Virginia AST Fall Workshop and Business Meeting
Location: WVU Reynolds Memorial Hospital, 800 Wheeling Ave, Glen Dale, WV 26038
Contact: Erin Carr, 304-214-8930, ecarr@wvncc.edu
CE Credits: 6 Live Planned

WISCONSIN STATE ASSEMBLY

Program Type: Annual Meeting/Elections
Date: September 6, 2025
Title: Rooted in Excellence, Growing the Future
Location: UWSP, 1015 Reserve St, Stevens Point, WI 54418
Contact: Amy Hinz, 920-284-8505, hinz_amy@yahoo.com
CE Credits: 6 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 4, 2025
Annual Meeting
2025 BOD Elections
& 2026 Delegate
Elections

COLORADO/WYOMING
Brighton
October 11, 2025
Annual Meeting
2025 BOD Elections
& 2026 Delegate
Elections

FLORIDA
Maitland
September 27, 2025
Annual Meeting
2025 BOD Elections
& 2026 Delegate
Elections

GEORGIA
Acworth
March 14, 2026
Annual Meeting
2026 BOD Elections
& 2026 Delegate
Elections

IDAHO
Boise
September 13, 2025
Annual Meeting
2025 BOD Elections
& 2026 Delegate
Elections

INDIANA
Greenwood
September 20, 2025
Annual Meeting
2025 BOD Elections
& 2026 Delegate
Elections

IOWA
Ames
October 18, 2025
Annual Meeting
2025 BOD Elections
& 2026 Delegate
Elections

**MARYLAND/
DELAWARE**
Baltimore
October 11, 2025
Annual Meeting
2025 BOD Elections
& 2026 Delegate
Elections

MICHIGAN
Grand Rapids
September 13, 2025
Annual Meeting
2025 BOD Elections
& 2026 Delegate
Elections

MINNESOTA
Minneapolis
September 20, 2025
Annual Meeting
2025 BOD Elections
& 2026 Delegate
Elections

MONTANA
Billings
October 4, 2025
Annual Meeting
2025 BOD Elections
& 2026 Delegate
Elections

NEVADA
Las Vegas
September 20, 2025
Annual Meeting
2025 BOD Elections
& 2026 Delegate
Elections

**NEW HAMPSHIRE/
VERMONT**
Manchester
October 4, 2025
Annual Meeting
2025 BOD Elections
& 2026 Delegate
Elections

NEW JERSEY
Morristown
September 20, 2025
Annual Meeting
2025 BOD Elections
& 2026 Delegate
Elections

NEW YORK
Albany
October 3-5, 2025
Annual Meeting
2025 BOD Elections
& 2026 Delegate
Elections

NORTH DAKOTA
Fargo
October 18, 2025
Annual Meeting
2025 BOD Elections
& 2026 Delegate
Elections

PENNSYLVANIA
Mechanicsburg
September 13, 2025
Annual Meeting
2025 BOD Elections
& 2026 Delegate
Elections

RHODE ISLAND
East Greenwich
October 4, 2025
Reformation Meeting
& Elections
2025 BOD Elections
& 2026 Delegate
Elections

SOUTH CAROLINA
Florence
November 1-2, 2025
Annual Meeting
2025 BOD Elections
& 2026 Delegate
Elections

SOUTH DAKOTA
Rapid City
October 17-18, 2025
Annual Meeting
2025 BOD Elections
& 2026 Delegate
Elections

WASHINGTON
Spokane
October 11-12, 2025
Annual Meeting
2025 BOD Elections
& 2026 Delegate
Elections

WEST VIRGINIA
Glen Dale
October 18, 2025
Annual Meeting
2025 BOD Elections
& 2026 Delegate
Elections

WISCONSIN
Stevens Point
September 6, 2025
Annual Meeting
2025 BOD Elections
& 2026 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 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.

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