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## SSI prevention in gastrointestinal surgery: A surgical technology perspective

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Standards of practice involving aseptic techniques were researched and authored by Association of Surgical Technologists (AST), AST Education and Professional Standards Committee and have been approved by the AST Board of Directors under the American College of Surgeons (ACS) guidelines. These standards were effective in April 13, 2008. The purpose of the standards is to provide an outline that healthcare workers (HCWs) in the perioperative setting can use to develop and implement policies and aseptic procedures during gastrointestinal (GI) surgery. The standards are presented with the understanding that it is the responsibility of the healthcare facility to develop, approve, and establish policies and contamination-free procedures during bowel technique according to established hospital protocols. The standards of practice to prevent surgical site infection (SSI) are related to the use of aseptic techniques during case preparation and intraoperative phase, as well as the use of bowel techniques during surgery. Both techniques are also referred to as isolation techniques utilized to prevent cross-contamination of the surgical abdominal wound by microorganisms that could result in SSI. SSI is the third most frequently reported nosocomial infection. Additionally, SSI is the most common nosocomial infection among surgical patients accounting for 38% (CDC, 2011) of infections and of those, two-thirds involved the incision and one third involved organs or body cavities. SSI results in an increase in postoperative days that the patient spends in the hospital and deep SSI is associated with a greater increase in hospital stays and costs. Even though SSI significantly contributes to the morbidity and mortality rates of surgical patients, improved standards of practice, such as the use of meticulous pre and intraoperative aseptic and bowel techniques aid in reducing the risk of SSI to the surgical patient. Therefore, aseptic and bowel techniques should be practiced on all surgical procedures that involve entry into the GI tract; this includes open and endoscopic procedures. All members of the surgical team should be involved in the process of developing and implementing healthcare facility policies and procedures for establishing the consistent use of appropriate standards of practice.

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## Learning curve in laparoscopic surgery bariatric in the western Amazon: 100 first cases

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Obesity stands as an endemic disease, affecting approximately 502 million adults worldwide. This demand has required a bariatric surgery formation and multidisciplinary teams for the obesity's treatment. We call the learning curve, when we measure the time and number necessary to do the procedure for adaptation and training in new surgical techniques. Aim of this study was to demonstrate the learning curve of a laparoscopic bariatric surgery team in a population of western Amazonia. Between October 2010 to August 2012, 100 bariatric surgeries performed by laparoscopy were analyzed. The sample consisted of 75 female patients and 25 male. Mean age 37.7 [17-62 years]. BMI mean preoperative 41.3 [35-55 kg/m<sup>2</sup>]. The techniques used were Roux-Y gastric bypass in 76 and vertical gastrectomy in 24 patients. Surgery was performed in approximately four hours in the first 30 cases, after that, it was decreased to three hours until the 60 surgeries, fixing the two hours time to complete 100 surgeries. There was little change at the beginning; the hospitalizations were 72 hours in the first 30 cases and it was stabilized in 48 hours after. Among the complications, we quote: it had happened some bleeding in the drain in two, surgical site infection, one case, gastro-jejunal stenosis, one case, inadvertent clipping of the anterior gastric wall, in one case and jejunum of drilling by Fouchet, in one case. All the complications happened in the first 30 cases. Our team reached the learning curve in about 30 cases of bariatric surgery by laparoscopy.

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