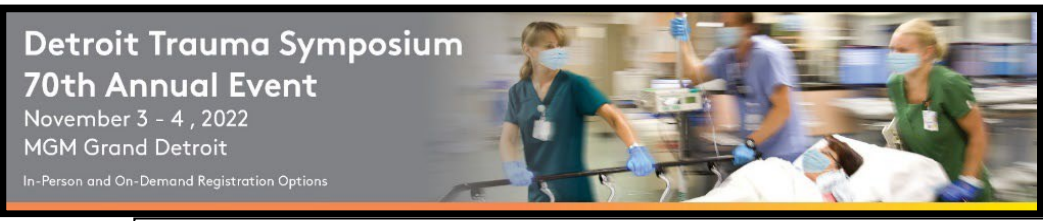
MICHAEL & MARIAN ILITCH DEPARTMENT OF SURGERY

WAYNE STATE

DECEMBER 2022



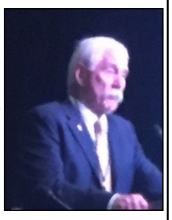
Inside this issue:

2022 WSSS OFFICERS

President:
Larry Narkiewicz (WSU/GS 2004/09)
Vice-President:
Joseph Sferra (WSUGS 1991)
Secretary-Treasurer:
Bruce McIntosh (WSU/GS 1989/94)
Members-at-Large:
Jay Dujon (WSUGS 2011)
Robert Holmes (WSUGS 1983)
Jennifer Bradley (WSUGS 2015)
Resident Member:


Dr. Larry Diebel

The 70th Annual Detroit Trauma Symposium (DTS) occurred on November 3-4, 2022 at the MGM Grand in Detroit. Dr. Larry Diebel (WSU/GS 1980/86) was the guiding light who organized this year's DTS. He defined as the learning objectives of this year's DTS as the current and future use of blood products in trauma resuscitation, the identification of optimal treatment for multiple organ injuries to be the head, chest, and abdomen, an update on pre-hospital care and critical care in the severely injured patient with multiple injuries, and an update on the current problems with obtaining some type of resolution for the effective handling of gun violence from a hospital vantage point. Now that the pandemic has been contained, the DTS had over 700 attendees to participate in these learning efforts.

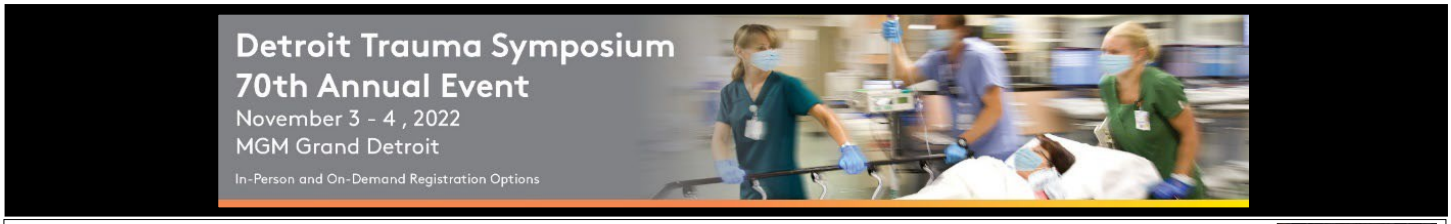

Dr. Ernest E. Moore

Dr. Diebel moderated the opening session on Thursday morning, and Dr. Ernest Eugene Moore made the first presentation entitled, "Trauma -Induced Coagulopathy." He described the physiologic changes of hemorrhagic shock and how the initial approach to active hemorrhage must be to stop the active bleeding while simultaneously correcting the circulatory deficit brought about by the hemorrhagic shock insult. He talked about the triangle of death, including coagulopathy, hypothermia, and acidosis. He added a fourth element to make this the diamond of death, with the fourth element being hypocalcemia. He emphasized how calcium plays an important role in primary hemostasis (formation of a platelet clot) and how this facilitates formation of fibrin. He discussed the paradox regarding the use of whole blood in resuscitation, which provides all of the blood factors rather than giving packed red blood cells which then have to be supplemented with FFP and platelets. He identified randomized controlled trials which show that whole blood provides better restoration of clotting function than does packed red blood cells plus blood components and that early randomized studies show that the administration of whole blood reduces mortality in comparison to the packed red blood cells and blood components that are currently used by most trauma centers.

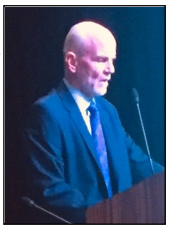
Continue page 2

MICHAEL M & M MARIAN
ILITCH
DEPARTMENT OF SURGERY
WAYNE STATE

DECEMBER 2022



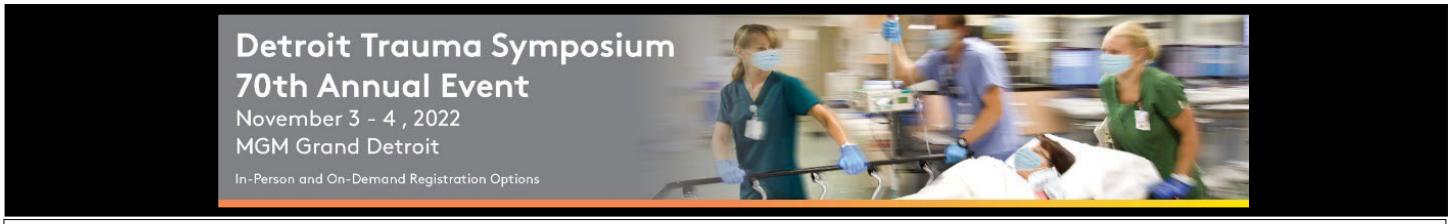

Dr. Rahul Vaidya


Dr. Keith Mayo

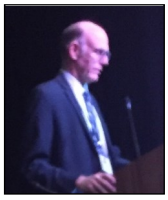
Dr. Rahul Vaidya, the new Chairman of the Wayne State University Department of Orthopaedic Surgery, introduced Dr. Keith Mayo from the Swedish Hip and Pelvis Center in Seattle, Washington. Dr. Mayo is an international expert on the treatment of pelvic fractures with special emphasis on unusual fractures involving the pelvic ring. He emphasized the importance of dealing with the first phase, namely, hemorrhagic shock, in preparation for successfully handling complicated pelvic fractures. He emphasized the importance of early operative intervention for open pelvic fractures. Dr. Mayo discussed some of the historical aspects of fractures and emphasized the important contributions made by Dr. Malgaine in the mid-1980s, including the importance of the pelvic sling and later internal fixation by screws for pubic symphysis fractures. He also emphasized the importance of balanced skeletal traction. The 1940s saw a tremendous shift towards operative reduction and internal fixation (ORIF) and how this has made a big difference in the successful treatment of complicated fractures. He also emphasized that the orthopaedic portion is just part of a multidisciplinary effort in multiply injured patients whose treatment will involve the urologist, neurosurgeons, coagulation experts, and general surgeons, in addition to orthopaedic surgeons. Dr. Mayo pointed out that early treatment with pelvic binders provides temporary support until definitive operative intervention can be performed and the use of external fixators when the patient is too precarious to tolerate a definitive ORIF. He also emphasized the importance of early intervention when there is a degloving injury in association with an open fracture.

Dr. Gene Moore presented the third paper entitled “Resuscitative Thoracotomy.” He went into the historical aspects of Emergency Department thoracotomy for intrathoracic injuries and the use of E.D. thoracotomy in conjunction with cross-clamping the supradiaphragmatic thoracic aorta in order to get control of intra-abdominal hemorrhage prior to emergency laparotomy. He pointed out that these are terribly injured patients and that there is a “high cost with low yield.” He did emphasize, however, that patients who present with acute cardiac tamponade, particularly when they are due to stab wounds, have a high salvage rate with an Emergency Department thoracotomy and pericardiotomy, followed by cardiorrhaphy in patients who are operated upon shortly after arrival. These patients, when stable, can be treated with pericardiocentesis to allow the patient to safely go to the operating room and have definitive repair of the cardiac wound. Dr. Moore then presented some data about patients presenting with cardiac arrest and ongoing CPR. He emphasized that, on the basis of multiple studies, the current recommendation would be that if a patient has a penetrating wound,

Continue page 3

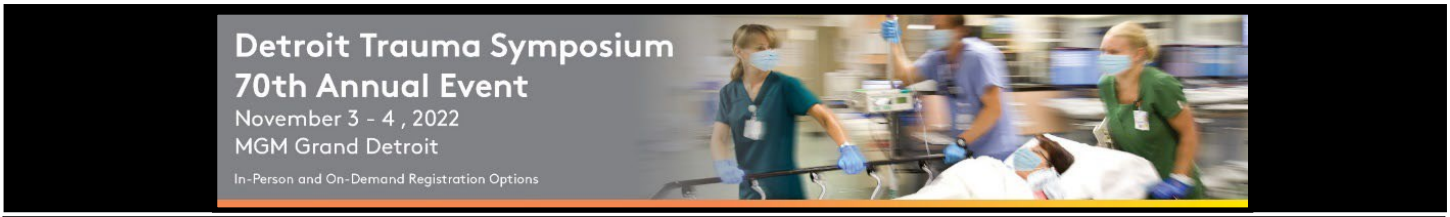


one would proceed with Emergency Department thoracotomy if CPR has been maintained for 15 minutes and, in the patient with blunt injury, if the CPR has been maintained for <10 minutes. Likewise, he emphasized that when a patient is bleeding from severe injuries, the development of bradycardia is a sign that the patient is likely to arrest very soon. He finished by discussing the REBOA as a substitute for emergency thoracotomy in selected patients. Placing the balloon catheter from the groin may allow for the balloon to be inflated in a supradiaphragmatic position and provide the same benefits as an Emergency Department thoracotomy with thoracic aortic cross-clamping without the need for the actual thoracotomy. There is a great interest in the efficacy of REBOA, and the data has not yet shown that REBOA has been used enough in order to demonstrate greater efficacy than the emergency thoracotomy. The editor is convinced that the REBOA technique, over the next ten years, will replace the Emergency Department thoracotomy for patients with intra-abdominal injuries or severe pelvic fractures.


Dr. David Livingston

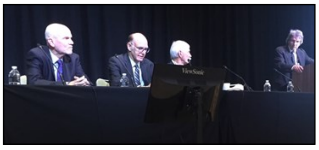
A fourth presentation was presented by Dr. David Livingston entitled, "Penetrating Mediastinal Trauma." Dr. Livingston, who one day earlier had presented the Wayne State Surgical Society Lecture, showed multiple examples of transmediastinal injuries, including bullets and bullet fragments. He showed images of a number of patients with penetrating wounds and emphasized that the unstable patient had to be taken rapidly to the operating room. He emphasized that when patients present with a left-sided precordial wound, the cause of the hypotension is often a pericardial tamponade. From a historical point of view, he pointed out that often this diagnosis was made by way of a pericardial window through a subxyphoid incision or by way of blind pericardiocentesis, whereas now, the diagnosis is more likely to be made by emergency ultrasonography of the pericardium, which is now part of the FAST examination. He discussed different types of incisions and emphasized that a left anterior thoracotomy made through the fifth interspace provides excellent exposure to most penetrating heart wounds. He also discussed the median sternotomy, which can be performed with the sternotomy saw or with the Lebsche knife; he gave examples as to how to utilize the Lebsche knife when doing the sternotomy. Dr. Livingston discussed the role of the clam shell thoracotomy where a left-sided anterior lateral incision is extended transversely across the sternum to the right anterior chest. Dr. Livingston pointed out that sometimes the decision to form a standard posterior lateral thoracotomy as opposed to a clam shell thoracotomy is a best guess, based upon the images as to where the missile or missile fragments travelled. The editor believes that the standard posterior lateral thoracotomy should be performed in patients who are suspected to have posterior injuries in one thorax where

Continue page 4



the thoracotomy is performed and only anterior injuries in the contralateral thorax. A median sternotomy is an excellent incision for patients with bilateral anterior thoracic injuries, as is the clam shell thoracotomy.

Following the above presentations, Dr. Diebel moderated an active panel of the above four speakers, which dealt with many interesting questions from the audience.

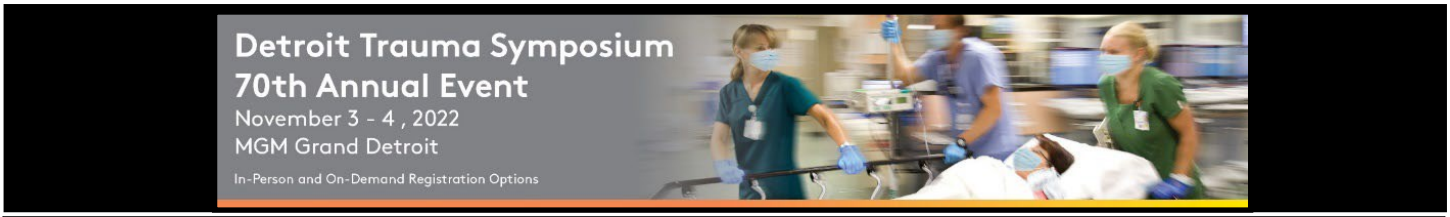


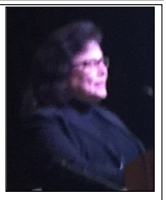
Panel Discussants (left to right) Dr. Mayo, Dr. Livingston, and Dr. Moore await Dr. Diebel's questions.

The second scientific session followed the coffee break and was again moderated by Dr. Diebel. The first lecture was presented by Dr. David Livingston on "Colonic Injury and Damage Control Surgery." Dr. Livingston began with some historical elements regarding the treatment of colon injuries by going back to Tombstone in the days of Wyatt Earp when some of the first descriptions of how visceral injuries were repaired were described. He jumped forward to World War II where operative intervention was more frequently employed for gunshot wounds to the abdomen and, because of the high bacterial count within the colon, a colostomy was the primary procedure. This approach of doing colostomy continued throughout World War II and the Korean conflict. One of the earliest surgeons to challenge this approach was Dr. Michael DeBakey when he was in New Orleans. He, along with his co-author, Dr. Carter Nance, demonstrated that patients with penetrating colonic wounds, which were not extensive injuries to the colon and the patients were stable could be successful treated with primary repair, thereby avoiding the need for a second operation to close a colostomy. He then discussed some of the classic work that came from the Grady Memorial Hospital under the leadership of Dr. Harlan Stone and Dr. Tim Fabian. These authors demonstrated that primary colon repair was safe in patients who were not hypotensive, did not require multiple transfusions, did not have massive spill, and did not have multiple associated injuries. He then discussed the question of what to do with the colon in a patient with extensive injuries necessitating damage control laparotomy. He stressed that the best evidence shows that one should deal with the colon prior to abdominal reconstruction, so that patients should have their ostomy closed before doing a prolonged procedure involving the advancement of abdominal wall flaps in order to close the abdomen following damage control laparotomy.

The next presentation was made by Dr. Lena Napolitano, a Professor of Surgery and leader of the Trauma and Critical Care Division at the University of Michigan. Dr. Napolitano discussed "Pancreas and Duodenal Trauma: 2022." She went into detailed anatomy of the pancreas and duodenum which, of course, like in the

Continued page 5



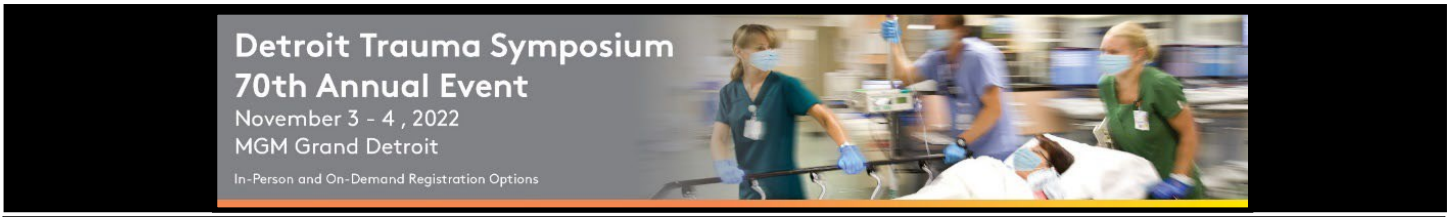

Dr. Lena Napolitano

posterior central part of the abdomen, which necessitates significant knowledge of the retroperitoneum to expose various injuries. She emphasized how pancreatic injuries after blunt trauma, and even after penetrating trauma, are sometimes more difficult to diagnose than duodenal injuries, even in the presence of modern imaging, including computed tomography. In patients with blunt injury, MRCP may be necessary to identify pancreatic ductal injury, whereas ERCP provides better diagnosis but is invasive and more difficult to get. She also emphasized that during laparotomy, if the specific diagnosis of pancreatic ductal injury is in question, cholangiography through the gallbladder may provide access to the pancreatic duct, whereas even intraoperative ERCP has been described when the status of the pancreatic duct is unknown. She emphasized that most mild pancreatic injuries (grades 1/11) can be treated with simple drainage. Complete transection of the pancreatic duct is typically treated with distal pancreatectomy with splenectomy when the transection occurs to the left of the superior mesenteric vein. Thee are some descriptions of primary repair of the pancreatic duct, but this would not be something that most surgeons would attempt. She then described the different types of blunt duodenal injury and how the minor injuries can be repaired simply with sutures placed in a transverse manner, whereas the more severe injuries may require duodenal diverticulization and rarely a Whipple operation when the severe duodenal injury is associated with a severe injury to the head of the pancreas. She also described placement of a feeding tube if there is some concern that the duodenal repair might leak.


Dr. Bellal Joseph

The next presentation entitled "REBOA: Current Practices and Cautions," was presented by Dr. Bellal Joseph. Dr. Joseph reviewed data about how bleeding is the most common cause of death during the initial four hours after injury and that successful care of the severely injured patient requires rapid control of active bleeding while resuscitation efforts are being implemented. He pointed out that in a military setting, 90% of deaths are related to non-compressible bleeding within the chest and abdomen. He showed short segments of movie-like presentations identifying causes of active bleeding and the difficulties with getting control of bleeding when it is non-compressible. He described how previous studies have shown how Emergency Department thoracotomy and aortic cross-clamping can be helpful but that the yield with survival is low. He described how the REBOA can be passed through the femoral artery, up into Zone 1, which is the supradiaphragmatic location and a balloon inflated to occlude the aorta much more rapidly than can be achieved with the E.D. thoracotomy. He also showed how relentless pelvic bleeding can be contained by inflating the REBOA balloon just above the aortic bifurcation.

Continue page 6



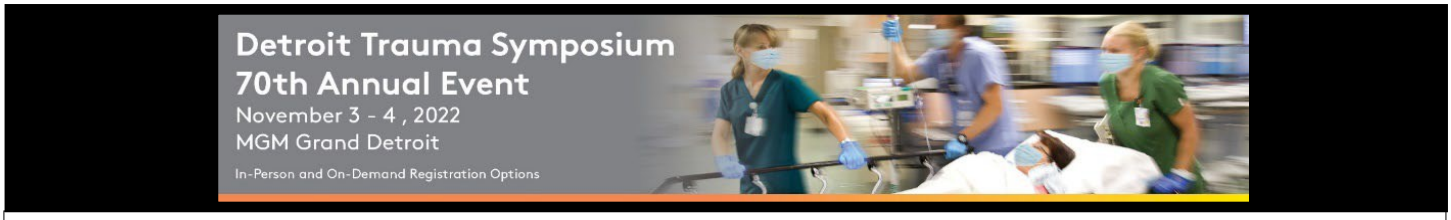
Throughout his presentation, he emphasized how time is essential if the patient is to be salvaged. He presented some of the accumulated data on the use of REBOA. Its success rate in the elderly patient is dismal, whereas its utilization in the badly injured pediatric patient is too early to draw conclusions. The best data that has accumulated is related to early prompt occlusion of Zone 1 to reduce bleeding from an intra-abdominal source and rapid placement of the REBOA balloon in Zone 3 in order to reduce bleeding from bad pelvic injuries and injuries near the junction of the femoral artery and common iliac artery. Following his presentation, there was an active question-and-answer session with many interesting questions arising from the audience.


Dr. Deborah Kuhls

During the luncheon session, Dr. Deborah Kuhls presented an interesting session on "Women in Trauma Surgery." She highlighted the rapidly increasing number of women who have gained fame because of their involvement in care of the injured patient. Of course, the person who received the greatest attention was Dr. Anna Ledgerwood (WSUGS 1972), the current Trauma Director at the Detroit Receiving Hospital, but there were many other very talented women who were recognized due to their many contributions, including a number of women who are part of this year's Detroit Trauma Symposium.

Following the luncheon program, the afternoon session was begun by Dr. Bellal Joseph who presentation was entitled "Use of Full Blood in Trauma." Dr. Joseph went through the history of blood component therapy during the early 1960s. Trauma services were using whole blood, whereas the conversion to component therapy began in the mid-1960s. He emphasized again that death from injury is primarily related to uncontrolled bleeding, and he again emphasized that with component therapy, the 1:1:1 resuscitation ratio give the best results, although in civilian injuries, the 1:1:1 vs 1:1:2 had equal death rates in a large multi-center prospective randomized study. The trauma community is resorting to the use of whole blood, which provides all of the ingredients required for coagulation and has resulted in lower mortality rates in prospective randomized studies. This is especially true when whole blood is used for resuscitation. On the basis of early prospective randomized trials with patients requiring an average of 4 units whole blood, there appears to be no difference in mortality, regardless of whether the blood is Rh positive or Rh negative. Likewise, there is no difference whether cooled blood is used or fresh warm blood is used. The whole blood has a shelf life of approximately four weeks, so it should be available for transfusion without waste. Based upon the current studies that have been completed, the use of whole blood should probably be used universally throughout the country for

Continue page 7



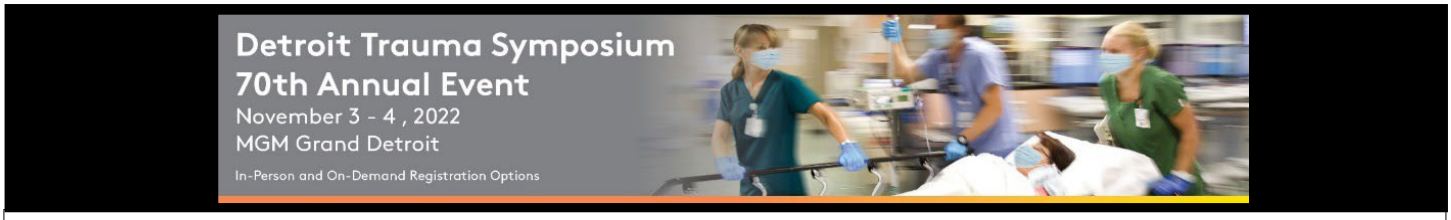
patients with severe trauma. Since the Blood Banks make less money with whole blood transfusions in comparison to component therapy, it will be interesting to see how this process evolves.


Dr. Rosemary Kozar

The next presentation was made by Dr. Rosemary Kozar who discussed "Novel Blood Products in Trauma Research." Dr. Kozar talked about the prior studies that had been performed, comparing 1:1:1 vs 1:1:2, with the mortality rates being similar. She also discussed different types of plasma infusions that are available, namely the FFP and also the liquid plasma, which is thawed in preparation for rapid utilization in acute setting. She pointed out that there are studies on the number of pathogens that are present in thawed plasma. She also highlighted that there is freeze-dried plasma but it is not approved by the FDA at this time, but current studies are being done in the research domain with the freeze-dried plasma. Dr. Kozar discussed the role of plasma and platelets as it relates to endothelial function, with many studies being currently performed to assess this non-clotting benefit of plasma products. She finished by pointing out that there are many studies being performed on fibrinogen, not only for its role in clotting but also for its potential role in protecting the endothelial barrier.

Dr. Lena Napolitano made the next presentation entitled "Zero Preventable Deaths." she pointed out that the ongoing data analyses show that trauma deaths have increased by 20% from the first decade of the 21st century. The causes of this increase are related to motor vehicle collisions and firearms. Likewise, she pointed out that detailed analyses of these mortalities show that there are often opportunities for improvement in the care of these patients in order to prevent death. The American College of Surgeons has defined an objective of having zero preventable deaths which, of course, requires in-depth analysis in order to identify when there are opportunities for improvement in the care of these severely injured patients. Many of the opportunities begin at the scene of injury where important measures must be taken by the pre-hospital providers, followed by the appropriate trauma team activation in order to assure that all trauma team members are present upon patient arrival. She discussed some of the good results that have been obtained in patients with traumatic brain injury with the appropriate use of brain monitoring and judicious use of Propafol. She emphasized that excessive crystalloid solution should not be administered for patients with pulmonary dysfunction and traumatic brain injury. The next lecture in the afternoon session by presented by Dr. Rosemary Kozar and was entitled "Angio-Embolization for Solid Organ Injury - Risks and Benefits." Dr. Kozar presented a great deal of data

Continue page 8



regarding the use of angio-embolization in patients with splenic injury. She pointed out that the minor splenic injuries seldom require a splenectomy or angio-embolization for a splenic aneurysm or bleeding into the peritoneal cavity. Furthermore, patients with Grade V splenic injuries often need to be in the operating room and undergo splenectomy or splenorrhaphy. Selected patient with Grade V injuries who are stable may be candidates for angio-embolization in order to prevent the development of instability requiring operation. Patients most likely to receive angio-embolization are stable patients with an AV fistula or a pseudoaneurysm. Coils are typically used for the embolization. There are complications of angio-embolization, however, with some patients developing splenic necrosis, requiring either splenectomy or else having long-term problems related to sepsis around a necrotic spleen. Dr. Kozar suggested that if there is a contained pesudoaneurysm and the patient is perfectly stable, then angio-embolization should not be performed; such patients would be watched carefully.

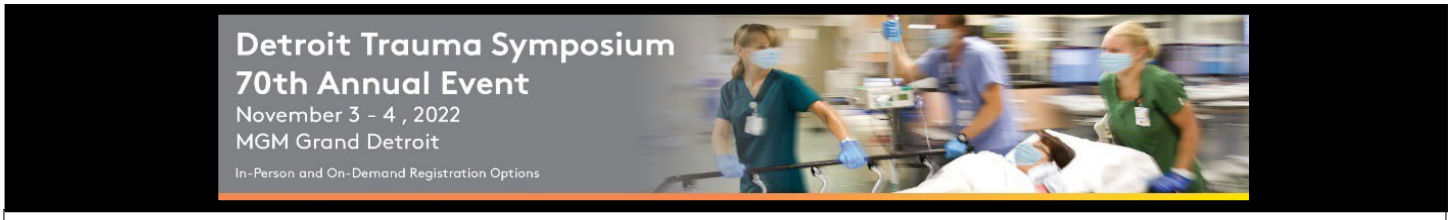

Dr. Anna Ledgerwood

Following Dr. Kozar's presentation, the above speakers and other speakers, including a panel of seven women trauma surgeons, answered interesting questions put forward to them by Dr. Ledgerwood, who presented some of the challenges that she has faced in the past. This was a very exciting panel session as it is every year and the audience enjoyed the presentation. That ended the afternoon session.

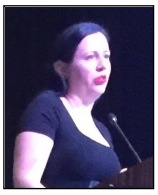

Dr. Kimberly Davis

The Friday morning scientific session was moderated by Dr. James Tyburski (WSUGS 1992), the Chief of Surgery at Detroit Receiving Hospital. The first presentation was made by Dr. Kimberly Davis, who discussed "Disruptive Technologies: What Works, What May Not?" Dr. Davis summarized some of the important technologies that have brought us into the 21st century. She spent some time talking about the advantages of ultrasound and how ultrasound has pretty much replaced diagnostic paracentesis and diagnostic peritoneal lavage, which were routinely performed shortly after admission in patients with primarily blunt trauma in the 20th century. The ultrasound has enough finesse in the results that hemoperitoneum can be readily diagnosed from the multiple etiologies, including solid organ injury and mesenteric injury. Likewise, the ultrasonography allows one to assess the pericardium so that the diagnosis nowadays is based upon ultrasound instead of the old classic technique of Beck's triad of distant heart tones, hypotension, and neck vein distension. Ultrasound has also been of great value in diagnosing pleural effusion from serum or blood and facilitates early placement of a chest catheter or a chest tube.

Continue page 9



She also discussed the current use of CTA and how this has provided tremendous help regarding potential vascular injuries without putting a patient through the ordeal of having invasive angiography. The CTA is valuable for patients sustaining bad blunt trauma to the abdomen and for patients who have potential cervical vascular injury as evidenced by cervical spine fracture, first rib fracture, or fracture of the facial bones, including the maxilla and mandible. The theme of her paper was that the technologies that have evolved during the last 20 years have "disrupted" the procedures which were considered high quality in the 20th century.


Dr. Leah Tatebe

The second presentation for this morning's session was entitled "Trauma Resuscitation in the Pre-Hospital Setting," and was presented by Dr. Leah Tatebe, the Trauma director at Northwestern University in Chicago, Illinois. She discussed the challenges seen by the EMS team when caring for a severely injured patient, including the sequence of the ABCs of the resuscitation effort. She emphasized the importance of appropriate splinting and protection of airway, along with the initiation of correction of volume deficits. She emphasized that skilled EMS teams are quite familiar with endotracheal intubation and nasotracheal intubation. Some specialized teams are cognizant about the performance of a coniotomy. She described how the LMA is useful in someone with an unfriendly intubation. In addition to airway control, she highlighted the urgency of stopping the bleeding simultaneously. She described the "Jump Bag," which contains all of the instruments that are needed for airway control, intravenous therapy, and cervical collar. She emphasized the role of the tourniquet and other pressure devices to obtain stoppage of bleeding while circulation is being re-established. The Jump Bag even has tape in order to facilitate application of the pressure dressings. She also highlighted the different drugs, such as epinephrine that may be given in patients who remain hypotensive, and the use of TXA in patients with active bleeding. Part of resuscitation would be the intraosseous administration of fluids by way of the tibia. The administration of ketamine provides some analgesia, usually without problems with disassociation and disorientation.

The next presentation was given by Dr. Stephanie Bonne, the trauma Director at the Hackensack University in Hackensack, New Jersey. Dr. Bonne described some of the complications of mental trauma as a child and how they extend into adulthood. She taught that about two-thirds of people have at least one very negative episode as a child, which tends to lead to the early use of cigarettes, obesity, different types of eating disorders, diabetes mellitus, and attempted suicide. These negative episodes during childhood lead to a decreased life span and often deficiencies in cognitive skills. She used the term "trauma and epigenetics," which leads to a

Continue page 10

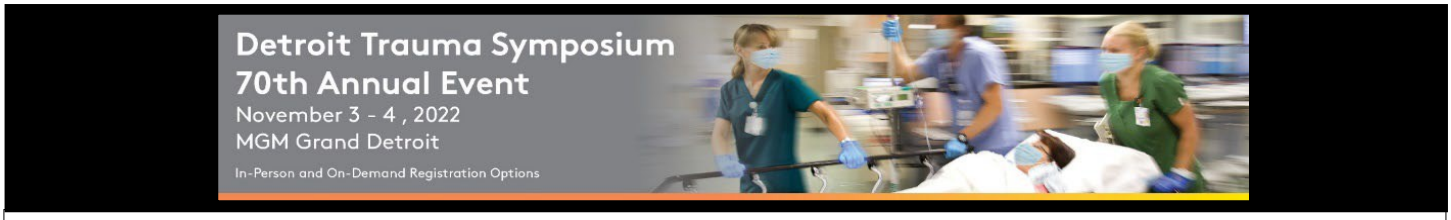

Dr. Rosemary Kozar

toxic stress syndrome in which the individual responds poorly to stress as part of the "fight/flight" syndrome. Post-traumatic stress disorders are more frequent and can expand throughout life. When this stress disorder is passed on to the offspring, it is referred to as epigenetics. When an injured patient arrives in the trauma bay, some of these features related to background may be observed. When facing such a patient, the nurses and physicians must work to build a trusting relationship with the patient so that the patient sees the physician as an advocate. The treatment of such patients includes the 4 Rs, which are realization of the syndrome, recognition when it occurs, appropriate response, and persistence in trying to help the patient through this stressful situation. She suggested that one of the reasons for nurse burnout in the emergency setting relates to the challenges in appropriately responding to this syndrome.

The next presentation was made by Dr. Leah Tatebe entitled "Interaction with Law Enforcement in the Trauma Bay." This was a most interesting presentation which dealt with some of the conflicts that might occur in the trauma bay. She described how the mother of a teenager who had been killed with a firearm was only able to observe her dead son from the doorway because the police officer would not allow her to view the body up close. This is one of the many examples where law enforcement and patient care conflict. There has to be some mutual trust between the treating team and the law enforcement officers. Patients in the community recognize the important role that the police play in stopping bleeding in patients who have been injured and in rapidly transporting them to the emergency department. There is some paranoia in some communities, however, about getting into a police car. The question often arises about discussions between the physicians and the police officers and when such discussions may extend beyond the rights of the patient. A common area of conflict deals with the desire by the police officers to get a blood draw for an alcohol level, particularly when the patient has been involved in a MVC. Dr. Tatebe was able to identify one situation where the nurse refused to let the police officer obtain a blood draw, that there was a $500,000 court settlement against the nurse for interfering with legal matters. She reminded us that we always have to be concerned about patient rights, including such things as autonomy and justice.

The last presentation of the morning session was presented by Dr. Diebel entitled "Beyond 1:1:1 Transfusion: What's Missing?" Dr. Diebel emphasized that 1:1:1 has become accepted as the best way to prevent problems associated with trauma-induced coagulopathy. He emphasized, however, that in his opinion,

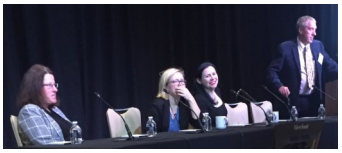
Continue page 11



fibrinogen, which cleaves to form fibrin, is the missing factor that we should be giving more often. This can be provided with the cryoprecipitate. He discussed some of the aspects of fibrinogen converting to fibrin and the subsequent creation of a fibrin clot. Dr. Diebel then announced that the 2023 Detroit Trauma Symposium will occur on November 9-10 at the MGM Casino and expressed his wishes that everyone would attend.

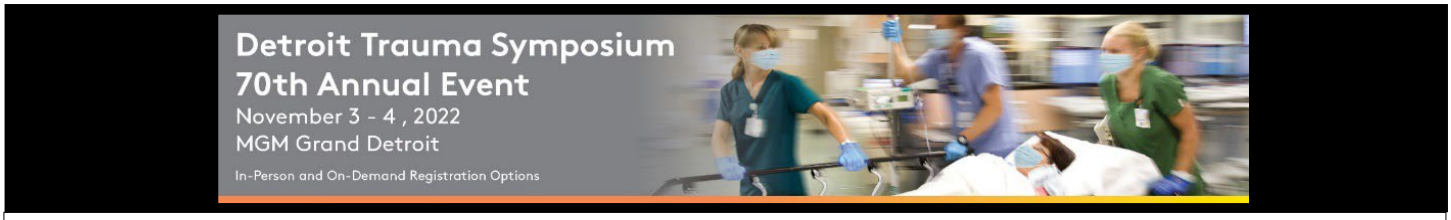
The next presentation in the Friday morning session was presented by Dr. Kimberly Davis entitled "Hyperosmolar Therapy for TBI: What, Where, and How Much?" Dr. Davis discussed some of the techniques that are used to control problems related to intracerebral hypertension in patients with traumatic brain injury. She reminded the audience that an increase in the CO_2 leads to an increase in cerebral blood flow, which is associated with a consequent decrease in cerebrospinal fluid. She emphasized that patients with traumatic brain injury who develop intracerebral pressures >25, have potential for herniation, which leads to rapid death. She also discussed that hypertonic saline (HTS) is associated with a decrease in cerebral water but that the serum sodium should not rise above 155 mEq/L. She reviewed the history of TBI, pointing out that between 1960 and 1990, Mannitol was the most common agent used to reduce intracerebral hypertension because of its osmolar effect. Subsequent to 1990, HTS has been more commonly used. She described that some of the complications related to Mannitol use included hypochloremia, hypokalemia, metabolic alkalosis, and acute kidney injury. She emphasized that the use of HTS has a longer effect on intracerebral pressure than the Mannitol, with the HTS lowering pressure for 18 to 24 hours. The 3% HTS given continuously is the most common form of administration. She pointed out, however, that controlled randomized trials of HTS have not proven its benefit. She cited a 2017 trial in which 20% HTS was compared with balanced electrolyte solution, and there was no difference in patient outcome. When comparing hyperventilation with HS, it appears that the HTS is more effective. She also talked about hypertonic lactate which has been studied as a way of reducing intracerebral pressure. In conjunction with efforts to reduce intracerebral pressure, she highlighted the importance of maintaining a systolic blood pressure of >90 torr in order in order to maintain cerebral blood flow and cerebral oxygenation, thereby decreasing the likelihood of the "second hit" syndrome.

Following these presentations, Dr. Tyburski moderated a panel session during which the above presenters responded to multiple questions from the audience.

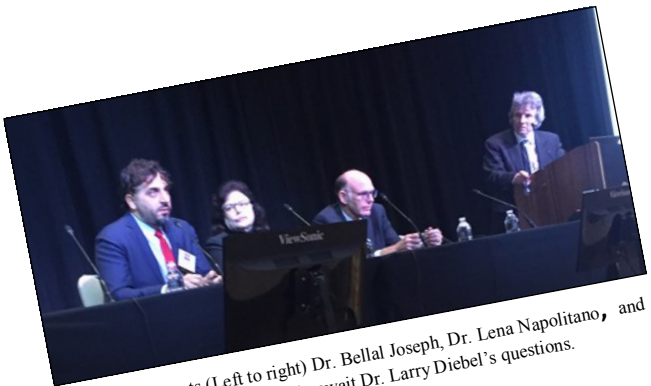


(Left to Right) Panel Discussants Dr. Kimberly Davis, Dr. Rosemary Kozar, and Dr. Leah Tatebe await Dr. James Tyburski's questions.

Continue page 12



The next presentation was given by Dr. Stephanie Bonne entitled "Gun Violence Prevention and Research." Dr. Bonne pointed out that the most common method of suicide is gunshot wound, and many of these patients have had a failed attempt at suicide in the past and were actually seen by a physician within the last ten months but did not receive appropriate guidance. She also emphasized that gun violence has become an increasing problem in the pediatric age group. She indicated that gun violence is one of the most common causes of assault and causes huge financial challenges as it relates to the patient and the healthcare system. The data on gun violence at the CDC is inaccurate, partially related to public health policy. She discussed the congressional restrictions which date back to the 1990s, whereby any organization which is looking at gun violence does not receive federal granting of the various research projects. She also emphasized that the vast majorities of fatalities are caused by handguns and that the United States is far worse than any other civilized nation. Indeed, firearms are now a greater cause of death than motor vehicle collisions. She emphasized that gun education should be mandatory and should include the safety features of gun ownership and the storage of gun ownership so that children do not have access to guns. It was the 1996 Dickey Amendment that caused the restrictions in NIH support to any institution that is looking at gun violence. She also emphasized the problem with recidivism, particularly in the younger population and the increased cost to everyone associated with gun violence. She concluded that these aspects of responding to gun violence should be part of the Department of Health in order to reduce this preventable problem.



Panel Discussants (Left to right) Dr. Bellal Joseph, Dr. Lena Napolitano, and Dr.. David Livingston anxiously await Dr. Larry Diebel's questions.

Women in trauma surgery (Left to Right), Drs. Rosemary Kozar, Dr. Lena Napolitano, Dr. Stephanie Bonne, Leah Tatebe, Deborah Kuhls, Anna Ledgerwood, and Kimberly Davis.

Academy of Surgery of Detroit


Dr. Lena Napolitano

Each year, Dr. Diebel arranges with the officers of the Academy of Surgery of Detroit to have their monthly meeting in November in conjunction with the Detroit Trauma Symposium (DTS). This meeting occurred on Thursday evening after the first day of the DTS, allowing for a number of speakers to attend, in addition to the membership of the Academy of Surgery of Detroit. The visiting speaker was Dr. Lena Napolitano from the University of Michigan who presented a very interesting talk about different diseases which create unusual challenges at times. She presented some of the unusual challenges associated with acute cholecystitis and how some critically ill patients may be decompressed percutaneously or endoscopically by way of a tube passed retrograde up the common bile duct into the gallbladder in order to tie them over from their acute sepsis and permits a later, safer cholecystectomy. She also talked about some of the controversies related to sigmoid colon diverticulitis and when it is in the patient's best interest not to do an open operation, but to do percutaneous drainage and reserve definitive operation until the patient is more stable. She discussed a number of other challenges that surgeons face in caring for patients who are acutely ill, and this was followed by a very active question-and-answer session.

Detroit Trauma Symposium Volunteers

Each year our Detroit Trauma Symposium is blessed to have multiple current and former employees sign up to serve as a volunteer. They assist with registration, direction, collect questions from the audience and are a great resource in the smooth running of the symposium. For the past several years, these volunteers have feasted on lasagna from Giovanni's Ristoranté, while they provide critique of the running of the symposium with Dr. Larry Diebel. Dr. Diebel expresses his gratitude to the volunteers by presenting each with a red rose!




WAYNE STATE UNIVERSITY School of Medicine

2022 Annual WSSS Lectureship

wayne state surgical society

Dr. David Livingston

Dr. David Livingston has spent the last 30 years as a star at the University of New Jersey with special interest in general surgery, trauma surgery, and critical care. He is the recent Past-President of the American Association for the Surgery of Trauma and has been a leader in the North American trauma community for many years.

Dr. Livingston discussed his experience in the world of trauma. He noted the administrative changes that have occurred in his institution, which was called the University of New Jersey Medical School until it was bought out by Rutgers, and then more recently bought out by Robert Wood Johnson. He has served under many Deans and many Chairmen but has always kept his focus on providing the best care for his patients. His trauma center is typical for an urban community with a wide variety of both penetrating wounds and blunt injuries.

One of the important points that he got across to the audience was the principle that "to err is human," after full discussion and teaching, "to forgive is divine." He provided many examples of many challenging cases and emphasized how the patient actually becomes a family member. He described one young lady who had a terrible crush injury requiring amputation and following amputation, was associated with multiple organ failure from which the patient eventually recovered. He described the different stages of that patient's future life and how he became involved as an attendee at her graduation, her marriage, and the baptism of one of her offspring.

Dr. Livingston spent the next part of his presentation defining how the development of trauma systems has been beneficial for care of injured patients. He discussed the classic article by Drs. West, Trunkey, and Lim which compared the complications of severe trauma at the Orange County in California with no trauma system to the L.A. County, which had a mature system. This article identified that the county without an organized trauma system had much worse outcomes in patient with both penetrating and blunt injuries. He also emphasized how part of the trauma system is full discussion of complications and deaths so that the deaths could lead to improvements in care, thereby preventing or reducing the likelihood of future deaths. He emphasized that when you don't have a trauma system in place, "dead men tell no tales."

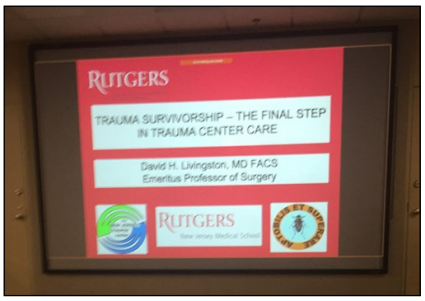
He also discussed the involvement of the National Highway Traffic Safety Administration which has worked with the American College of Surgeons Committee on Trauma to further develop trauma systems. The first trauma system was created by San Diego County under the leadership of the trauma surgeons at the University of San Diego. The second trauma system in the country and the first urban trauma system was Detroit, which organized their trauma system in 1970, one year after San Diego had created their trauma system.

Continue page 15

WAYNE STATE UNIVERSITY School of Medicine

2022 Annual WSSS Lectureship

wayne state surgical society



He finished by pointing out how correction of the injuries is only part of the story. Following successful return to society, many patients have physical problems which interfere with their return to work, resulting in financial difficulties often leading to bankruptcy. He also emphasized that post traumatic stress disorder (PTSD) is present in many of the patients in whom we think we provided wonderful care but have not followed them to identify the terrible problems with PTSD. He spent extra time talking about the long-term effects of Traumatic Brain Injury (TBI). He conveyed to the audience that a patient with severe TBI at a young age is going to be changed forever because certain parts of their brain do not fully recover, even though people who never knew the patient prior to injury think that the patient is normal. Spouses and relatives, however, recognize that the patient with severe TBI is not the same after injury and recovery as he/she was before the injury.

There was an exciting question-and-answer session, and Dr. Livingston was able to demonstrate his widespread knowledge in answering these questions.

A WAYNE GRADUATE RECEIVES PLAUDITS FOR HIS SURGICAL CONTRIBUTIONS


Dr. Vic Velanovich

Dr. Vic Velanovich was born in 1961 in southeast Michigan where he received his early education prior to attending the University of Chicago where he became involved in basic science research regarding bladder infections in a rodent model under the tutelage of Dr. Bagley. At that time, he became involved with John Heggers, Ph.D. and Martin Robson, M.D. at WSU from which he graduated in 1987 and again joined up with the Robson/Heggers team where he became involved in additional research regarding wounds; this was presented at the Surgical Forum of the American College of Surgeons. Following his medical school training, he did his residency at the Letterman Army Medical Center in San Francisco after which he served in the military prior to coming onto the faculty of Henry Ford Hospital. Vic was always a tremendous supporter of the local surgical meetings where the many surgeons from southeast Michigan met and discussed various clinical and research activities. Vic has received many plaudits in the current edition of the American Surgical Association related to his many contributions in the surgical arena related to quality of Care, reflux esophagitis, Barrett's

Continue page 16

A WAYNE GRADUATE RECEIVES PLAUDITS FOR HIS SURGICAL CONTRIBUTIONS

esophagus, achalasia, the Heller myotomy, and paraesophageal hernia. He became a leader in identifying the technical aspects of laparoscopic distal pancreatectomy and the value that pre-laparotomy laparoscopy has in preventing non-therapeutic laparotomies for hepato-biliary disease and foregut cancers. He also focused on developing a scale to assess quality of life for patients who are suffering foregut malignancies. Many of his contributions are summarized by his colleagues at the University of South Florida in Tampa, where he continues to be actively practicing.

PRODUCTIVITY

Dr. Larry Diebel

Dr. Larry Diebel (WSU/GS 1980/86) recently published an article in Surgery entitled "Effect of Albumin Solutions on Endothelial Oxidant Injury: A Microfluidic Study." His co-authors are David Liberati and Dr. Michael Carge (WSUGS 2022).

This study evaluated the beneficial effect of early plasma-based resuscitation in patients following trauma-hemorrhagic shock. The authors pointed out that the mechanisms for this benefit are unknown, but may somehow be related to the protective effects of plasma components on the endothelium and its glycocalyx layer. They point out that albumin is the primary protein in plasma and that it has many anti-oxidant properties when studied in vivo. Sphigosine1-phosphate is a bioactive sphingolipid with many signaling functions, including endothelial barrier protection. They looked at endothelial cell monolayers in a microfluidic perfusion device exposed to shock conditions followed by perfusion with 5% plasma or different albumin solutions with or without exogenous sphingosine1-phosphate. Biomarkers of endothelial and glycocalyx activation, damage, and injury were determined. Using this preparation, they demonstrated that the endothelial cell and the glycocalyx barriers were damaged after shock insult and that the plasma plus sphingosine1-phosphage with added albumin protected against barrier injury. Modest protective effects were noted with albumin alone, so that the efficacy appeared to be related to the added sphingosine1-phosphage within the albumin solution. They concluded that the beneficial effect of albumin on the endothelial-

Continue page 17

PRODUCTIVITY

glycocalyx barrier was dependent upon sphingosine1-phosphage. They speculate that this may help explain the many discrepancies regarding the effectiveness of albumin solutions in shock resuscitation.


Dr. Andrew Kirkpatrick

Dr. Andrew Kirkpatrick, who spent time rotating with the Trauma Service at Detroit Receiving Hospital, continues to be productive. He currently is working at the Foothills Hospital in Calgary, Alberta and is a member of the Canadian Armed Forces. He and his co-authors published a paper, "A Randomized Controlled Pilot Trial of Video-Modelling Versus Telementoring for Improved Hemorrhage Control Wound Packing." These authors pointed out that exsanguination in a pre-hospital setting is still the most feared cause of death in seriously injured patients with soft tissue injury. He emphasized how "stop the bleed" has been very helpful in teaching control of hemorrhage to EMS and private citizens. Likewise, wound packing of compressible wounds is also a critical skill that can save patient lives. They looked at volunteers from their Search and Rescue (SAR-Techs) who were then provided teaching on wound packing by both video-modelling and telementoring techniques. They were broken up into control groups in order to get judgments from these experienced people as to whether either or both of these techniques was important in teaching how to pack wounds. They demonstrated that those experts who were exposed to the two techniques did better wound packing that their control experts who were not exposed to one or both of these techniques. They concluded that teaching of these techniques would be beneficial to EMS personnel and even private citizens in order to augment the "stop the bleed" technique, which has become very popular.

PRODUCTIVITY


Dr. Andrew Isaacson

Dr. Andrew Isaacson (WSUGS 2017) was a co-author on a paper entitled "Severity of Traumatic Adrenal Injury Does Not Meaningfully Affect Clinical Outcomes," which was published in Emergency Radiology earlier this year. The authors pointed out that there is little data on the clinical significance regarding the severity of traumatic adrenal injury (TAI) and the identification as to when patients need some type of intervention. They looked at their experience with TAI from 2009 thru 2017. The severity of injuries was assessed radiographically by a contrast-enhanced abdominal computed tomography (CT) of the abdomen and pelvis. They graded the severity of injury from 1 to 3, based upon the American Association for the Surgery of Trauma grading system. They assessed 149 TAI, which occurred in 129 patients. Eighty-six patients had low-grade injuries and 43 had high-grade injuries with an abbreviated injury score of 3 or greater. The injury Severity Score was not statistically different between the two groups. None of the patients required transfusion or laparotomy for control of adrenal hemorrhage. There was no statistical difference in hospital length-of-stay, ventilator days, morbidity, or mortality between the low-grade injuries and the high-grade injuries. The clinical outcomes were similar for low-grade injuries and high grade injuries. The authors suggest that, regardless of TAI grade, treatment should be based on clinical assessment and not focused specifically on the adrenal injury.

ERRATUM

Dr. Christopher Dente was cited in the November 2022 issue of the Monthly Email Report as having graduated from the WSU Department of Surgery Residency Program in 2022 when in fact he graduated in 2002. Dr. Dente thought this should be rectified since his picture made him look like a very mature 2022 graduate. The editor promises to do better next time.


(Left to right) Dr. Christopher Dente (WSUGS 2002), Dr. Neil Patel (WSUGS 2021) and Dr. David Edelman (WSU/GS 2002/09)

MICHAEL & MARIAN ILITCH DEPARTMENT OF SURGERY
WAYNE STATE
DECEMBER 2022

Dr. Jofrances Marquez Reflects on the Past Eight Years

Dr. Jofrances Marquez graduated from the Wayne State University Department of Surgery General Residency Program in 2014 and attended the WSU/Wayne State Surgical Society Alumni Reception dinner on Tuesday, October 18, 2022. The editor received the message below to share with the extended WSSS family.

Dearest Dr. Charles Lucas,


Dr. Jofrances Marquez

Those eight years have gone by so quickly. I still have fresh memories of my days spent with you, Dr. Ledgerwood, Dr. Donald Weaver, Dr. Tyburski, Dr. Webber, Dr. Baciewicz, and the rest of the Wayne State Surgical Family, as well as with Dr. Duane Ernest Sands before that. I am very delighted to say that it has prepared me well for the challenges that came afterwards.

I had spent almost all of these years in the Mississippi Delta, as a rural surgeon, trying to accomplish major surgeries, in whatever means available in our critical access hospitals, with any help that is available from ancillary staff, and other medical specialties.

I had my share of successes with challenging operations I took up, being a solo surgeon (from 3 Mile's procedures, 6 abdominal wall reconstructions to name a few); as well as managing complications that would make the novice loosen their sphincter and "tap out", looking for the nearest subspecialist to fix that problem (e.g. my one, and hopefully last, case of a transected CBD from doing a laparoscopic cholecystectomy, that I had to fix right away with a Roux en Y cholendochojejuostomy). The mental fortitude and focus in those moments of pressure and self doubt. I attribute a lot to my Detroit "Surgical Forging".

Dr. Donald Weaver, in my isolation in the Delta, had also been a beacon of wisdom. He had really taken "Dialing a Friend" to a new level. He was always available for a discussion on the best course of action to manage challenging cases, during this time. I guess I felt I was cheating a bit because I had one of the best surgical minds in this country on my speed dial, giving me excellent advice. Thank you much, Sir.

Nowadays, I spend most of my time with routine elective and emergency, bread and butter general surgery cases. The allure and challenge of the six to eight hour operations have lost some of its luster on me. One thing is constant, I aim to be a safe, capable surgeon at all times, ready to serve my patient's needs and address any problems that arise. When my patients need a doctor, I am there for them. You had shown me that this is the way doctors

Continue page 20

Dr. Jofrances Marquez Reflects on the Past Eight Years

should be. You have been exemplary examples that I have always tried to emulate. My gratitude and love to you always.

I now have a freshman, Raymond, 18 years old who wants to follow in my footsteps. I would like to say that he did not need much convincing nor brainwashing from me or from his mom. He is attending Miami University in Oxford, Ohio and has already expressed his excitement to "shadow" me in the clinic and the operating room. I was, however, disappointed that he wanted to be eight hours away from me and his mom for his premed. I am praying that he maintains focus and keeps working hard. I would definitely introduce him to my mentors as soon as we get a chance.

Our only daughter, Gaby, who is 16 years old, is attending the Mississippi School of Mathematics and Sciences in Columbus, Mississippi. It is a college prep school with top notch educators among the best in the country. She wants to major in biomedical engineering. It's a "wait and see" with her. She has a strong personality and will insist on going far away from mom and dad, like her big brother. She wants to "Go Blue" and attend the University of Michigan in Ann Arbor. Hmmm….I'll be neutral this time.

Lastly, Nathaniel, our 11 year old, is my Detroit baby and he just started middle school, another worry for another time. Whew!

I am in Crossett, Arkansas close to where Dr. Raymond Read went to, UAMS, as well as Dr. Keiva Bland (WSUGS 2006). I am covering two hospitals, namely, Ashley County Medical Center as well as Bradley County Medical Center. They are both critical access hospitals in two different counties. We also get emergency referrals from as far as Monroe, Louisiana. This is what keeps me on my toes at the moment.

Currently, my beautiful bride, Tanya, keeps busy with ongoing home renovations and updates to the kitchen. I always remind her not to ask me for money, because she has the money. I only get an allowance. She is happy and I want to keep it that way. I have peace of mind in return.

That is all for now Sir. I will definitely give you more updates soon.

Jofrances Marquez (WSUGS 2014)

DE LA SALLE COLLEGIATE

ENEMIES FOR A DAY!

Dr. Charles Lucas (left) and Dr. Larry Diebel (right) duke it out after the DeLaSalle game.

Each year, the Michigan High School Athletic Association schedules the final football State Championship games in their eight divisions to be played at the Ford Field on the Friday and Saturday after Thanksgiving. This year, the Division II State Championship game pitted Warren DeLaSalle Collegiate (Pilots) against the Forest Hills Central (Rangers). The Pilots (Charles Lucas' school) are from Warren, Michigan, and the Rangers (Larry Diebel's school) are from Grand Rapids, Michigan. A major factor in the success of the Rangers was the speed of Diebel, a scatback who was always able to get outside the defensive ends to make many large gains and several touchdowns. Unfortunately for the Rangers and Diebel, the defensive end for the Pilots, Lucas, also ran track and was able to turn Diebel in where the generously-sized tackles and guards threw him to the turf. The Pilot coach out-maneuvered the Rangers coach since, when Diebel was in the left halfback position, he raced around the right end, whereas when he was in the right halfback position, he raced around the left end. The Pilot coach always placed Lucas at the end where everybody knew Diebel was going to run. Besides containing Diebel defensively, the Pilots had a very strong offense led by a future college quarterback and won the game 52-13. Following the game, the young men from the Pilots and the Rangers gathered together and congratulated each other, with the exception of Lucas and Diebel who argued, shoved, and pushed each other. Diebel even managed to get a right cross to the jaw of Lucas but, of course, this had no effect; everybody knows that Diebel's bark is worse than his bite. The day following the championship game, Lucas and Diebel became friends again.

MICHAEL & MARIAN ILITCH DEPARTMENT OF SURGERY

WAYNE STATE

"EXCERPTS FROM LOG BOOK" - DOWN MEMORY LANE

Anna M. Ledgerwood, MD

Dr. Anna Ledgerwood

5/28/71 - Chief Resident: Dr. Asuncion; Staff: Dr. A. Walt

1. KB: GSW left chest, greater curve stomach, right lobe liver, L3-4 spinal cord, and hilum of right kidney, treated with left chest tube, right nephrectomy, closure stomach perforation, and Penrose drain for liver injury. Neurosurgery did laminectomy.
2. LB: Stab left brachial artery, median nerve, and brachial vein. Treated with repair of artery, vein, and nerve, and fasciotomy.

5/29/71 - Staff: Dr. C. Huang

1. BW: GSW right neck with paraplegia, treated with exploration right neck.
2. WW: Lacerated flexor tendon right forearm, treated with repair of tendon.
3. SM: Stab wound left chest with continued hemothorax, treated with left thoracotomy, suture ligation intercostal artery.
4. WT: Stab wound abdomen with transection left inferior epigastric artery, laceration small bowel and sigmoid mesocolon, treated with laparotomy, ligation of inferior epigastric vessel, and repair of small bowel.
5. RW: GSW neck with paraplegia, treated with exploration right neck with no injury to carotids or esophagus.

5/30/71 - Staff: Dr. R. Krome

1. JG: Stab abdomen, treated with laparotomy with findings of small laceration right lobe liver.
2. AG: Stab wound left lower quadrant abdomen and left scrotum, laparotomy revealed small bowel laceration and there was laceration of left scrotum, treated with closure of small bowel and repair of testicle.

5/31/71 - Staff: Dr. Y. Silva

1. MC: Perforated duodenal ulcer treated with closure of perforation.
2. CS: GSW neck with quadriplegia and negative neck exploration.
3. SL: Huge mesenteric cyst with possible hydronephrosis, treated with laparotomy and aspiration and biopsy of cyst.

Continue page 23

MICHAEL & MARIAN ILITCH DEPARTMENT OF SURGERY
WAYNE STATE

"EXCERPTS FROM LOG BOOK" - DOWN MEMORY LANE

Anna M. Ledgerwood, MD

6/1/71 - Staff: Dr. Z. Steiger

No Cases.

6/2/71 - Staff: Dr. A. Kambouris

1. FK: GSW left hand with fracture of head of fourth metacarpal and base of proximal phalanx fourth finger, treated with debridement.

6/3/71 - Staff: Dr. Threlkeld

1. SB: Blunt trauma abdomen and fracture right humerus, right three ribs, and right hip. Laparotomy revealed 3 cm capsular tear of right lobe of liver, and patient had cholecystostomy for liver study.
2. BH: Stab wound right chest with pneumothorax and left lower quadrant abdomen. Laparotomy revealed four perforations of small bowel that were repaired.

6/4/71 - Staff: Dr. L. Pelok

1. MD#97: SGW left chest with cardiac tamponade and multiple rib fractures with severe laceration lower lobe left lung, treated with left thoracotomy, left lower lobectomy of the lung, debridement of chest wall, and tracheostomy.
2. JD: GSW left chest and abdomen with thru-and-thru wound of right ventricle, left lobe of liver, and left diaphragm and gastrohepatic omentum. Treated with open cardiac resuscitation, repair of holes in right ventricle and left diaphragm, and hemostasis with tracheostomy.
3. BJ: Stab wound left supraclavicular region with pneumothorax and stab wound abdomen, treated with laparotomy, closure of thru-and-thru holes of the stomach.
4. JM: GSW abdomen with bullet in retroperitoneum, treated with laparotomy; wound did not penetrate the peritoneal cavity.
5. MC: SGW abdomen with multiple pellet perforations stomach, small bowel, and transverse colon. Treated with laparotomy and repair of perforations.

MICHAEL & MARIAN ILITCH DEPARTMENT OF SURGERY

WAYNE STATE

WSU MONTLY CONFERENCES 2022

Death & Complications Conference
Every Wednesday from 7-8

Didactic Lectures — 8 am
Kresge Auditorium

The weblink for the New WebEx Room:
https://davidedelman.my.webex.com/meet/dedelman

Wednesday, December 7
Death & Complications Conference
"vWF: Not for Dummies"
Lawrence Diebel, MD
WSU Michael & Marian Ilitch Department of Surgery

Wednesday, December 14
Death & Complications Conference
"ABSITE Quest Exam"
David Edelman, MD
Samantha Tarras, MD
WSU Michael & Marian Ilitch Department of Surgery

Wednesday, December 21
Death & Complications Conference
"Trauma Case Review"
Andrew Isaacson, MD
WSU Michael & Marian Ilitch Department of Surgery

NOTE: NEW EVALUATION CODES:
Surgical Death and Complications Rounds #2022321125 Sept-Dec2022 CME Reflective Evaluation,
https://www.surveymonkey.com/r/SQZ9Z9T
Surgery Grand Rounds #2022321064 Sept-Dec2022 CME Reflective Evaluation,
https://www.surveymonkey.com/r/SW&VQNL

MICHAEL & MARIAN ILITCH DEPARTMENT OF SURGERY

WAYNE STATE

Wayne State Surgical Society
2023 Donation

Name:

Address:

City/State/Zip:

Service Description Amount

2021 Dues Payment _____$200 _____

My contribution for "An Operation A Year for WSU" _____

*Charter Life Member _____$1000 _____

Total Paid_____

Payment by Credit Card

Include your credit card information below and mail it or fax it to 313-993-7729.

Credit Card Number:_____

Type: MasterCard Visa Expiration Date: (MM/YY)_____ Code____

Name as it appears on card:_____

Signature:_____

Billing address of card (if different from above):

Street Address_____

City_____ State_____ Zip Code_____

*I want to commit to becoming a charter life member with payment of $1000 per year for the next ten (10) years.

Send check made payable to ***Wayne State Surgical Society*** to:

Charles Lucas, MD
Department of Surgery
Detroit Receiving Hospital, Room 2V
4201 St. Antoine Street
Detroit, Michigan 48201

MARK YOUR CALENDARS

American Surgical Association 143rd Annual Meeting
April 20-22, 2023
Westin Harbour Castle
Ontario, Canada

Please Update Your Information

The WSUSOM Department of Surgery wants to stay in touch. Please email Charles Lucas at clucas@med.wayne.edu to update your contact information.

MICHAEL & MARIAN ILITCH DEPARTMENT OF SURGERY

WAYNE STATE

Missing Emails

Over the years the WSU Department of Surgery has lost touch with many of its alumni. If you know the email, address, or phone number of the following WSU Department of Surgery Residency Program graduates please email us at clucas@med.wayne.edu with their information so that we can get them on the distribution list for the WSU Department of Surgery Alumni Monthly Email Report.

Mohammad Ali (1973)
David B. Allen (1992)
Tayful R. Ayalp (1979)
Juan C. Aletta (1982)
Kuan-Cheng Chen (1976)
Elizabeth Colaiuta (2001)
Fernando I. Colon (1991)
David Davis (1984)
Teoman Demir (1996)
Judy A. Emanuele (1997)
Lawrence J. Goldstein (1993)
Raghuram Gorti (2002)
Karin Haji (1973)
Morteza Hariri (1970)
Harrison, Vincent L. (2009)
Abdul A. Hassan (1971)
Rose L. Jumah (2006)
R. Kambhampati (2003)
Aftab Khan (1973)
Samuel D. Lyons (1988)
Dean R. Marson (1997)
Syed A. Mehmood (2007)
Toby Meltzer (1987)
Roberto Mendez (1997)
Mark D. Morasch (1998)
Daniel J. Olson (1993)
David Packer (1998)
Y. Park (1972)
Bhavik G. Patel (2004)
Ami Raafat (1998)
Kevin Radecki (2001)
Sudarshan R. Reddy (1984)
Renato G. Ruggiero (1994)
Parvid Sadjadi (1971)
Samson P. Samuel (1996)
Knavery D. Scaff (2003)
Steven C. Schueller (1974)
Anand G. Shah (2005)
Anil Shetty (2008)
Chanderdeep Singh (2002)
David G. Tse (1997)
Christopher N. Vashi (2007)
Larry A. Wolk (1984)
Peter Y. Wong (2002)
Shane Yamane (2005)
Chungie Yang (2005)
Hossein A. Yazdy (1970)
Lawrence S. Zachary (1985)

Wayne State Surgical Society

The Wayne State Surgical Society (WSSS) was established during the tenure of Dr. Alexander J. Walt as the Chairman of the Department of Surgery. WSSS was designed to create closer contact between the current faculty and residents with the former resident members in order to create a living family of all of the WSU Department of Surgery. The WSSS also supports department activities. Charter/Life Membership in the WSSS is attained by a donation of $1,000 per year for ten years or $10,000 prior to ten years. Annual membership is attained by a donation of $200 per year. WSSS supports a visiting lecturer each fall and co-sponsors the annual reception of the department at the annual meeting of the American College of Surgeons. Dr. Scott Davidson (WSU/GS 1990/96) passed the baton of presidency to Dr. Larry Narkiewicz (WSU/GS 2004/09) at the WSSS gathering during the American College of Surgeons meeting in October 2022. Members of the WSSS are listed on the next page. Dr. Narkiewiczcontinues in the hope that all former residents will become lifetime members of the WSSS and participate in the annual sponsored lectureship and the annual reunion at the American College of Surgeons meeting.

MICHAEL & MARIAN ILITCH DEPARTMENT OF SURGERY

WAYNE STATE

Members of the Wayne State Surgical Society
Charter Life Members

Ahn, Dean
Albaran, Renato G
Allaben, Robert D. (Deceased)
Ames, Elliot L.
Amirikia, Kathryn C.
Anslow, Richard D.
Antoniolli, Anita L.
Auer, George
Babel, James B.
Bassett, Joseph
Baylor, Alfred
Bouwman, David
Bradley, Jennifer
Cirocco, William C.
Clink, Douglas
Chmielewski, Gary W.
Colon, Fernando I.
Conway, William Charles
Davidson, Scott B.
Dente, Christopher
Dujon, Jay
Edelman, David A.
Francis, Wesley
Flynn, Lisa M.
Fromm, Stefan H.
Fromm, David G
Galpin, Peter A.
Gayer, Christopher P.
Gerrick Stanley
Grifka Thomas J. (Deceased 2022)
Gutowski, Tomasz D.
Herman, Mark A.
Hinshaw, Keith A.
Holmes, Robert J.
Huebl, Herbert C.
Johnson, Jeffrey R.
Johnson, Pamela D.
Kline, Gary
Kovalik, Simon G.
Lange, William (Deceased)
Lau, David
Ledgerwood, Anna M.
Lim, John J.
Lucas, Charles E.
Malian, Michael S.
Martin, Donald J., Jr.
Maxwell, Nicholas
McGuire, Timothy
McIntosh, Bruce
Missavage, Anne
Montenegro, Carlos E.
Narkiewicz, Lawrence
Nicholas, Jeffrey M.
Novakovic, Rachel L.
Perrone, Erin
Porter, Donald
Ramnauth, Subhash
Rector, Frederick
Rose, Alexander
Rosenberg, Jerry C.
Sankaran, Surya
Sarin, Susan
Sferra, Joseph
Shapiro, Brian
Silbergleit, Allen
Smith, Daniel
Smith, Randall W.
Stassinopoulos, Jerry
Sullivan, Daniel M.
Sugawa, Choichi
Tuma, Martin
vonBerg, Vollrad J. (Deceased)
Washington, Bruce C.
Walt, Alexander (Deceased)
Weaver, Donald
Whittle, Thomas J.
Williams, Mallory
Wills, Hale
Wilson, Robert F.
Wood, Michael H.
Zahriya, Karim

Members of the Wayne State Surgical Society—2022 Dues

Alpendre, Cristiano V.
Asfaw, Ingida
Babel, James
Bambach, Gregory A.
Barnwell, John
Baylor, Alfred
Bloch, Robert
Bucci, Lorenzo
Camero, Luis
Carlin, Arthur
Dawson, Konrad L.
Dittinbir, Mark
Dolman, Heather
Dulchavsky, Scott A.
Edwards, Ryan
Fernandez-Gerena, Jose
Field, Erin
Gallick, Harold
Goltz, Christopher J.
Hall, Jeffrey
Hamamdjian, Khatch
Hilu, John
Hollenbeck, Andrew
Holmes, Robert
Jeffries, Christopher
Joseph, Anthony
Kaderabek, Douglas J.
Klein, Michael D.
Kosir, Mary Ann
Larson, Sarah
Liebold, Walter
Lloyd, Larry
Lopez, Peter
Malian, Michael S.
Marquez, Jofrances
Mayuiers, Matt
McGee, Jessica D.
Meade, Peter C.
Mueller, Michael J.
Noorily, Michael
Paley, Daniel S.
Phillips, Linda G.
Porterfield, Lee
Robinson, Steven
Schwarz, Karl W.
Shaheen, Kenneth W.
Shanti, Christina
Siegel, Thomas S.
Spencer, Amy
Taylor, Michael G.
Tennenberg, Steven
Thomas, Gregory A.
Thoms, Norman W.
Vasquez, Julio
Ziegler, Daniel W.
Zoellner, Steven M.

Operation-A-Year
January 1—December 31, 2022

The WSU department of Surgery has instituted a new group of alumni who are remembering their training by donating the proceeds of one operation a year to the department. Those who join this new effort will be recognized herein as annual contributors. We hope that all of you will remember the department by donating one operation, regardless of difficulty or reimbursement, to the department to help train your replacements. Please send you donation to the Wayne State Surgical Society in care of Dr. Charles E. Lucas at Detroit Receiving Hospital, 4201 St. Antoine Street (Room 2V), Detroit, MI, 48201.

Albaran, Renato G.
Anslow, Richard D.
Antoniolli, Anita L.
Anthony, Joseph
Bambach, Gregory A.
Bradley, Jennifer
Cirocco, William C.
Chmielewski, Gary W.
Conway, William Charles
Davidson, Scott
Dente, Christopher
Dujon, Jay
Edelman, David A.
Francis, Wesley
Gallick, Harold
Gayer, Christopher P.
Gutowski, Tomasz D.
Hamamdjian, Khatch
Herman, Mark A.
Hinshaw, Keith A.
Holmes, Robert J.
Huebel, Hubert C.
Johnson, Jeffrey R.
Johnson, Pamela D.
Joseph, Anthony
Ledgerwood Anna M.
Lim, John J.
Lopez, Peter
Malian, Michael
Marquez, Jofrances
Martin, Donald J.
Maxwell, Nicholas
McGuire, Timothy
McIntosh, Bruce
Missavage, Anne
Nicholas, Jeffrey
Novakovic, Rachel L.
Perrone, Erin
Porter, Donald
Sankaran, Surya
Sferra, Joseph
Siegel, Thomas S.
Silbergleit, Allen
Smith, Randall W.
Sugawa, Choichi
Sullivan, Daniel M.
Tuma, Martin
Whittle, Thomas J.
Williams, Mallory
Wills, Hale
Wood, Michael H.
Ziegler, Daniel

WSU SOM ENDOWMENT

The Wayne State University School of Medicine provides an opportunity for alumni to create endowments in support of their institution and also support the WSSS. For example, if Dr. John Smith wished to create the "Dr. John Smith Endowment Fund", he could donate $25,000 to the WSU SOM and those funds would be left untouched but, by their present, help with attracting other donations. The interest at the rate of 4% per year ($1000) could be directed to the WSSS on an annual basis to help the WSSS continue its commitment to improving the education of surgical residents. Anyone who desires to have this type of named endowment established with the interest of that endowment supporting the WSSS should contact Ms. Lori Robitaille at the WSU SOM> She can be reached by email at *lrobitai@med.wayne.edu*.