

MARCH 2025

SURGICAL GRAND ROUNDS

J.C. Rosenberg, MD, PhD Endowed Lecture



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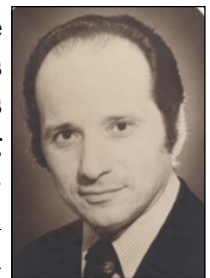
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Dr. Jerry C. Rosenberg grew up in New York where he received his early education, after which he obtained his medical degree from the Chicago Medical School and his surgical residency at the University of Minnesota. During his residency, he was actively involved in research, obtained his Ph.D., and was stimulated to spend one year in research at the Institute of Pathologic Anatomy in Vienna which provided the foundation for his classic later studies on renal cellular changes associated with kidney rejection. After completing his military obligations and spending a period of time under the tutelage of Dr. Ward Griffen at the University of Kentucky, he came to Wayne State University. Dr. Rosenberg was a true surgical scientist and was actively involved as a productive scientific researcher and a clinician with special interest in renal transplantation. He was involved in many of the national societies and served as President of the Transplantation Society of Michigan. He also received many awards for his contribution in renal cell physiology and transplantation.



Dr. Jerry C. Rosenberg

Because of the many contributions that Dr. Rosenberg has made to the University, Dr. Weaver has set up a Rosenberg Lectureship which typically deals with the many challenges related to transplantation. This year, the **Rosenberg Lecture** was presented by **Dr. Jaekeun Kim** on **Wednesday, February 12, 2025** and was entitled **“From Maximally Invasive to Minimally Invasive: The Liver Surgery and Transplant Journey.”**



Dr. Jaekeun Kim

Dr. Kim talked about his earlier experiences with his training, going from pre-medical training through medical school and finally into the area of transplantation. He began his training in South Korea where he worked at the Seveners Hospital at the Yonsei University in South Korea, and he has a special remembrance of the early work of Dr. Horace

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SURGICAL GRAND ROUNDS, cont..

Allen. He philosophically described the battle of survival through his early years and the need to balance all types of activities to survive. This same need extends to the operating room where one wants to be recognized as “Superman,” but sometimes one has to face many hurdles which make it clear to everyone that the surgeon is not “Superman.”



Dr. Miguel Tobon (WSUGS 2021) introduces the Jerry C. Rosenberg Lecturer: Dr. Jaekeun Kim

Preparation is very important. One must study each day and prepare for complicated procedures by having read about technical challenges, reviewed videos of the procedure, and mentally prepared for each operation so that before the operation begins, you know that you could probably do the operation in your sleep.

The early days were discussed when a large incision was made to resect a liver tumor or do a partial liver transplantation. Those days have passed, and now minimally invasive techniques are used to achieve the same end points. Interesting examples were shown regarding the technical aspects of minimally invasive surgery in freeing up liver segments for transplantation. The ligaments being freed up from adjacent attachments to the stomach and diaphragm were shown, as was how the parenchyma is divided using the “burning” coagulator, whereas cross-linking the vessels are individually freed up and divided with appropriate ligature devices. These stapling devices were clearly shown to effectively divide the cross-linking vessels.

From Maximally Invasive to Minimally Invasive:
The liver surgery and transplant Journey

Jaekeun Kim MD, PhD, FACS
Liver Transplantation | Liver Surgery
Department of General Surgery | Digestive Disease and Surgery Institute
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The extended Kocher maneuver was demonstrated, as was how to mobilize the right lobe of the liver anteriorly and medially in order to identify the “short” veins between the inferior vena cava and the mid-hepatic vein. How the capsule of the liver is coagulated was described, thus exposing the underlying parenchyma which is divided with the ligature. It was emphasized that it is very important to know the anatomy in order to avoid having any “surprises” during this resection.

During his early days, Dr. Kim described how he was known as “2 a.m.,” since he was a workaholic and always felt that he needed more preparation before doing another operation. The MELD criteria for selecting patients for liver transplantation was described, as was the differences between living donor liver transplantation (LDLT) vs. diseased donor liver transplantation (DDLT). The combination of the MELD criteria and the success with the perfusion pump providing appropriate oxygenation for as long as possible correlated with the success rate of liver transplantation. The most important factor in determining whether there is going to be a

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SURGICAL GRAND ROUNDS, cont..

successful transplant related to mitochondrial injury to the liver cells is the liver was not optimally protected during the preparation phases. Many people die on the waiting list because there is no liver available. The gender effect was also described, as women have smaller livers than men. Liver transplantation has done quite well in the pediatric age group with a high percentage of patients living beyond the five-year period.

Dr. Kim talked about the future in view of the facility by which laparoscopic technique allows for the left lobe of the liver to be safely harvested from donors. When the harvest is done laparoscopically as opposed to open, there is a decrease in length of stay in the hospital and a decrease in hepatic cellular insult with improved function.

Combined transplants were also discussed, including the liver with lung and the heart with lung and the role of chemotherapy for hepatocellular cancer as a “bridge” for later transplantation. There must be multidisciplinary teamwork in order to continue to improve on the results of liver transplantation.

Finally, this type of surgery is in the early stages of looking at the robotic technique as opposed to the laparoscopic technique. His presentation was followed by an active question-and-answer session.



The WSU Department of Surgery celebrated Dr. Jaekuen Kim as the Annual Jerry C. Rosenberg, MD, PhD, Endowed Lecturer on Tuesday evening, February 11th, at the Detroit Athletic Club.



(L-R) Mrs. Janet Damm, Ms. Jennifer Hart, and Dr. David Edelman (WSU/GS 2002/09)



(L-R) Dr. Anna Ledgerwood (WSUGS 1972), Dr. Andrew Isaacson (WSUGS 2017), Dr. Miguel Tobon (WSUGS 2021), and the JC Rosenberg Endowed Lecturer, Dr. Jaekuen Kim



(L-R) Dr. Madyson Riddell (WSUGDS 2025), Dr. Amanda Dooley Romero (WSUGS 2025), Dr. Benjamin James (WSUGS 2025), Mr. Janet Damm, and Dr. David Edelman (WSU/GS 2002/09)



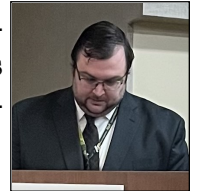
Dr. Isaac Isaacson, Dr. Miguel Tobon, Dr. Jaekuen Kim, and Dr. Jason Pasley from the VA Hospital

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SURGICAL GRAND ROUNDS, cont..

The **Surgical Grand Rounds** on Wednesday, February 5, 2025 was presented by **Dr. Benjamin James (WSUGS 2025)**, one of our senior residents, and was entitled “**Rise of the Machine: Special Topics in Transplant.**” Dr. James discussed the problem with transplantation and the wonderful adjustment that has occurred over many decades regarding organ presentation. Every eight minutes, a patient on the wait list for kidney transplantation dies, whereas patients who are potentially candidates to be organ donors die every 18 minutes. The wait list has decreased a small amount from 2010 when it was over 25,000 to 2022 when it decreased to 20,000. Live organ donations have increased in percentage, but there is a comparable increase in the need for transplantation as exemplified by the fact that more patients receiving a liver transplant are now candidates for this procedure, which has now been extended to patients with liver cirrhosis who have abstained from alcohol or have cirrhosis unrelated to alcohol.



Dr. Benjamin James

Many of the nuances of transplantation were discussed, and there is increased utilization of DCD transplantations. The turn down of potential organ donors because of age has decreased because of increased efficiency of preserving organs which are to be transplanted. Decreasing the ischemic time from the time that the organ is harvested until the organ is transplanted has been a major factor in this improvement. This is a costly procedure, not only as it relates to machines but as it relates to the number of people involved in performing a transplant.

There are many modifications that have occurred in the machines that are used for organ perfusion. It is important to maintain nutrition to the organ during the period of harvest and to maintain the physical condition of the donor and the organ at the time of transplant. Sometimes patients who are brain dead have preoperative treatment in order to preserve organ function, along with attempts to decrease the time from decision to transplant until harvesting and transplantation.

Historically he described how Charles Lindbergh, working with Dr. Alexis Carrel, provided the first cardiopulmonary bypass machine in order to maintain circulation in an experimental animal. This was done in the 1930's. The use of a pump oxygenator was utilized in animal models in the 1960's with short-term survival. The initial orthostatic liver transplants were performed by the famous Dr. Starzl, and by 2013, hypothermic perfusion was successfully utilized. There are different types of machines that are utilized to facilitate this process and different companies that are making machines designed for different objectives in the transplant process.

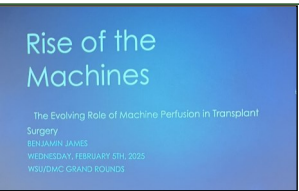
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SURGICAL GRAND ROUNDS, cont..

Typically blood is obtained from the vena cava and then oxygenated in order to perfuse the organ to be donated; for example, perfused through the hepatic artery in order to maintain the health and nutrition of the liver. The different machines are pressure controlled and flow controlled in order to meet specific objectives, and the differences between normothermic vs. hypothermic perfusion were explained. With normothermic perfusion, there is a decrease in injury to the transplanted organ with increased function following transplantation. Utilizing the modern standards of organ perfusion and organ harvest, the survival of liver transplants approaches 100% at one year, 90% at three years, and 80% at five years, which is a tremendous achievement. In addition, maintaining the donor who has been declared brain dead in a proper physiologic state allows for multiple organs to be harvested. This can be done by providing circulation and oxygen to the donor using techniques like ECMO in patients who undergo cardiopulmonary resuscitation followed by appropriate cannulation in order to maintain normothermic regional perfusion.



The importance that the definition of “brain death” has provided to the transplantation world was emphasized. This allows patients to be maintained physiologically in preparation for the transplantation.

The role of xenotransplantation was discussed, whereby porcine heart valves have been utilized to replace dysfunctional human heart valves. This raises all sorts of questions regarding cross species antigenicity, and a great deal of research is going into this topic. Also, there are “genetically modified” porcine models which facilitate successful cardiac and kidney transplantation using the xenograft technique. This has resulted in a great deal of research, identifying “gene edited models” in order to harvest porcine xenografts. The University of Maryland researchers in 2022 described a survival of 61 days in animal models, and ongoing research at the MGH has led to longer term survivals. Recently the FDA has approved xenotransplantation utilizing porcine kidneys. Earlier this month, the FDA had sanctioned a renal xenograft trial in a prospective randomized setting.

Many questions are raised with xenotransplantation. This includes exposure to different pathogens and the potential for viral transmission from the animal to the human. Many studies are taking place now on the effects of immune suppression on bacteriology and the potential for harm to humans. The potential complications of liver, cardiac, and renal transplantation utilizing these techniques were discussed.

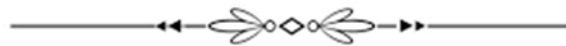
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SURGICAL GRAND ROUNDS, cont..

Some of the ethics involved in xenotransplantation were discussed. Some of the animal lovers objected to an animal being bred in order to become a donor. Each day 250 patients who are receiving renal dialysis die; consequently, there is a real need to improve our efficiency and numbers of organ transplantation, especially kidney transplantation.

The presentation was followed by an active question-and-answer session.



Dr. Matthew Haffner, a graduating Vascular Surgery Fellow, presented at our **Surgical Grand Rounds on Wednesday, February 19, 2025** which was entitled, **“Review of Abdominal Aortic Aneurysms and Endovascular Aneurysm Repair.”** Dr. Haffner began by discussing the anatomy of the thoracic and abdominal aorta. He gave the measurements from the ascending aorta through the arch and on down to the bifurcation. Men are slightly larger than women. The average aortic size just below the renal arteries is 2.4 cm for men and 2.2 cm for women. This decreases slightly at the bifurcation where the average diameter is 2.3 cm for men and 2.1 cm for women. Different types of aneurysmal dilations were described; these would include the suprarenal which involved the aorta above and below the renal vessels, the juxtaaorta, and the infraaortic at the bifurcation. Some of the aneurysms are fusiform, and some of them are more sacular and may not involve all of the circumference of the aorta.



Dr. Matthew Haffner

Dr. Haffner discussed the danger of rupture which is reported as probability per year and is critical when the aneurysm is being observed non-operatively. The likelihood for rupture within one year is greater when the aneurysm is larger and more than 5 cm, and the likelihood of rupture is also greater when there has been significant growth of 0.5 cm in a 12-month period.

The patient with a rupturing or expanding abdominal aneurysm presents with a fairly acute onset of abdominal pain associated with a pulsatile mass just below the umbilicus and a decrease in blood pressure. The risk of this occurring is greater in those patients who have

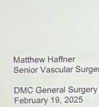
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hypertension and is also greater in men than in women. Other factors which contribute to aneurysmal development and rupture include smoking and age over 65. These patients should be followed annually by means of ultrasound if they have an asymptomatic aneurysm. Again, there is recommendation for annual ultrasound in anyone who has an aneurysm of less than 5 cm before the danger of rupture within 6 to 12 months becomes significant. Again, the recommendation for repair is made when the aneurysm is 5.5 cm in men and 5.0 cm in women or has grown 1 cm in the past year.

Review of Abdominal Aortic Aneurysms and Endovascular Aneurysm Repair

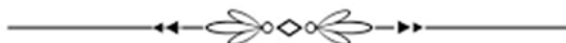


Matthew Haffner
Senior Vascular Surgery Fellow
DMC General Surgery Grand Rounds
February 18, 2025

Elective evaluation is often done by computed tomography (CT) with 2.5 mm slices taken unless there are branches of the aneurysm which must be considered, in which case the slices should be 1.5 mm. The CT scan will give the appropriate diameter of the aneurysm throughout its length and facilitate making appropriate plans for repair.

Endovascular arterial repair (EVAR) has become the new standard, and the prosthetic graft has to be molded to the aneurysm anatomy. These grafts are available commercially with different neck length and neck width in order to adjust to the individual patient. It is important in patients who have a conical aneurysmal neck that the neck be covered for a minimum of 4 mm if it is to be done by the EVAR technique. When the neck is too small, the procedure may have to be done open. The grafts are provided so that the surgeon can deal with altered length, altered extension into the iliac arteries, and can accommodate any branches that have to be included in the procedure.

The commercially available grafts are improving each year and will continue to improve and probably include covering within the graft to prevent or decrease the likelihood of thrombosis. Following his presentation, there was an active question-and-answer period. Dr. Ritz, his mentor, pointed out that the use of open aortic aneurysmectomy has markedly decreased so that the Fellows who go out into practice now are very skillful in the EVAR technique, but many of them have had limited exposure to the open technique. This would be similar to what is seen in General Surgery where the surgeons going out into practice are very skillful with laparoscopic or robotic cholecystectomy but have had less experience with open cholecystectomy.



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The **Surgical Grand Rounds** on **Wednesday, February 26, 2025** was presented by Dr. Samuel Mansour who is completing his Surgical Critical Care Fellowship this Spring. The title of his presentation was “**Acute Kidney Injury and Renal Replacement Therapy.**” Dr. Mansour identified how the presence of acute kidney injury (AKI) is associated with increased morbidity and mortality. He also identified that AKI is a very common entity in the Critical Care Unit and may involve up to half of the patients being treated. This would include some patients who recover spontaneously and many others who need to be treated with renal replacement therapy (RRT).



Dr. Samuel Mansour

The current popular RIFLE criteria describes renal insult; these include Risk, Injury, Failure with impaired function, Loss with short-term renal dysfunction or failure, and End-stage failure beyond three months. The major components which identify the extent of AKI are the serum creatinine which increases beyond 0.3 mg/d, the clearance of creatinine, and urine output to <0.5 ml/h beyond six hours. Besides RIFLE, AKIN and KDIGO are common techniques used to monitor the extent of AKI. All of these techniques are based upon changes in urine output and serum creatinine with the severity of insult reflecting the duration when one has oliguria and elevated serum creatinine.

The general consensus is that the cause of the renal insult in this situation is due to a decrease in renal blood flow. Besides the underlying insult, be it hemorrhage or sepsis, there are a number of co-factors which contribute to the end point of renal dysfunction, including diabetes mellitus, hypertension, associated myocardial compromise, and prior history of renal dysfunction. Severe injury increases the risk for developing AKI in a surgical ICU by at least 25%. Severe sepsis is also a common denominator which leads to the development of AKI.

A number of different therapies are known to contribute to AKI. These include NSAIDs, loop diuretics, ACE inhibitors, intra-abdominal hypertension, positive end expiratory pressure, osmotic diuresis, and different types of antibiotics. Contrast agent induction of AKI is well described in the literature, but more recently, radiologists have had less resistance in utilizing contrast agents in critically ill patients. One must be careful in disassociating the risk of contrast agents on renal dysfunction since often one may see that the serum creatinine only increased from 1.5 to 2.1 mg/dL, not recognizing that this “small” rise in serum creatinine represents a major decrease in the glomerular filtration rate.

The importance of ongoing monitoring vital signs, particularly, mean arterial pressure, sodium concentrations, and the fractional excretion of sodium was discussed. This can be calculated by utilizing the clearance formula (UV/P) for sodium as the numerator and creatinine as the denominator.

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As part of this monitoring, one should recognize that a persistent urine output of $<.3$ ml/hr is significantly associated with death. Once AKI is recognized, all of the above agents which may be nephrotoxic should be discontinued if possible and renal replacement therapy instituted. When there appears to be a conflict between the need to give either vasopressors or crystalloid solution to maintain adequate perfusion pressure, one should monitor the Frank Starling curve of the left ventricular stroke work index in response to a fluid bolus.

ACUTE KIDNEY INJURY AND
RENAL REPLACEMENT THERAPY
SAMUEL MANSOUR, MD
SURGICAL ICU FELLOW
DMC/WSU

The degree of pre-existent compromise can be well estimated by monitoring the APACHE score, which often correlates with an inappropriate rise in serum creatinine and the development of AKI. Part of the monitoring should include looking at electrolyte levels, particularly magnesium and potassium, which may rise in association with AKI.

There is also some controversy about the timing for instituting renal replacement therapy, suggesting that a delay for up to four days may be associated with better outcome. It is possible the better outcome reflects the fact that those who had a delay in the institution of renal replacement therapy had more renal reserve. There is, however, a classic randomized controlled study suggesting that the delay is not harmful.

There are different sites for providing perfusion when giving a patient renal replacement therapy, with the common ones being the jugular vein and the femoral vein. He also discussed the creation of an arterial venous fistula at the wrist in order to develop dilated veins which provide easier access. The continuous veno-venous hemodialysis is the most commonly used technique in the critically ill patient. In addition, different filters are used as part of continuous renal replacement therapy, and there are different pore sizes, ranging from 500 daltons to over 15,000 daltons, which helps get rid of myoglobin. Finally, the role of anti-coagulation with either heparin or citrate was discussed in patients who are on renal replacement therapy. There are also some situations where no anti-coagulation is used. When using citrate, one has to monitor for hypocalcemia. The different solutions that are used for the dialysate were discussed, including a balanced electrolyte solution or a plasmalyte-type solution.

Finally, altered renal function leads to an increase in the half-life of different antibiotics so that one has to be aware of the potential for antibiotic-induced renal failure because of the progressive rise in the serum concentrations of a nephrotoxic antibiotic.

There was an active question-and-answer session following this very comprehensive talk on ICU-related renal dysfunction.



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CORRECTION

Dr. Steven Tennenberg, MD, FACS, FCCM, sent the following email to the Editor regarding an erratum that was made in the February 2025 Monthly Email Report on the Surgical Grand Rounds of Wednesday, January 15, "History of Extracorporeal Membrane Oxygenation (ECMO or ECLS)." The Editor apologizes for the error and thanks Dr. Tennenberg for his critique.

Dr. Lucas,

Thanks for your efforts on the monthly newsletters.

In your review of the recent grand rounds on ECMO, you stated...

"There are a number of contraindications to ECMO, including age under 60, a short period of respiratory failure, absence of a malignancy, absence of an immune deficiency, absence of longterm respiratory failure, severe traumatic brain injury, and tetraplegia."

Most of the conditions listed are in fact favored conditions for ECMO, other than TBI and tetraplegia.

We prefer and favor pts with age under 60, a short period of respiratory failure, absence of a malignancy, absence of an immune deficiency, absence of long-term respiratory failure.

Steve



March 17th

MARCH 2025



REPORTS FROM THE OUTFIELD

Our own, Dr. Molly Belisle (WSUGS 2024) was married to Mr. Nicholas Whalen of Irish descent, from Livonia, Michigan in Cancun on February 7, 2025. They met in Ann Arbor at the University of Michigan. Her husband, Nicholas, currently works in accounting. The extended WSSS Family congratulates Molly and Nicholas on their union and wishes them a beautiful life ahead. Below are some photos from their wedding.



Molly and Nicholas recite their vows



Their first kiss as husband and wife



Signing their marriage certificate



Their first dance as husband and wife



Enjoying their wedding reception

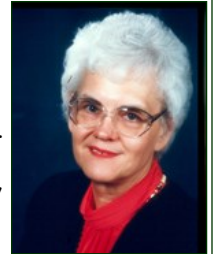




EXCERPTS FROM THE LOG BOOK DOWN MEMORY LANE

6/16/72 - Staff: Dr. T. Grifka; Chief Resident: Dr. S. Sankaren

1. CJ: 62yo with perirectal abscess, treated with I&D.
2. OF: Re-explore laparotomy for control of bleeding from short gastric vessels and left kidney (previous GSW stomach, pancreas, and left kidney with distal pancreatectomy, splenectomy, and partial nephrectomy).
3. EB: Flail chest, treated with tracheostomy.
4. LJ: Diabetic infection right foot, treated with open right BKA.



Dr. Anna Ledgerwood

6/17/72 - Staff: Dr. Baker; Chief Resident: Dr. E. Montales

1. DW: Stab abdomen with injury to liver which was sutured and drained.
2. JR: Left pneumothorax, treated with left chest tube.
3. DW: Small bowel obstruction, treated with lysis of adhesions.
4. BT: GSW abdomen with exploratory laparotomy and exploration of left femoral vessels which was negative.
5. DC: Stab abdomen with injury to inferior epigastric vessels, treated with ligation; laparotomy was negative.

6/18/72 - Staff: Dr. R. Krome; Chief Resident: Dr. S. Sankaren

1. DW: Right hemothorax, treated with chest tube.
2. AH: Motor vehicle crash with seat belt injury and tear of right paracecal parietal peritoneum and adjacent muscles attached to the iliac crest with herniation of cecum; laparotomy was otherwise negative.

6/19/72 - Staff: Dr. N. Thoms

1. RJ: 49yo male in motor vehicle crash, fracture head of pancreas, treated with a Whipple procedure.
2. AB: 43yo with GSW to abdomen with injury to diaphragm and spleen, treated with repair of diaphragm and splenectomy.
3. IO: 80yo with incarcerated right femoral hernia, treated with repair.



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"EXCERPTS FROM LOG BOOK" - DOWN MEMORY LANE, cont...

6/20/72 - Staff: Dr. S. Woods

1. MD: 23yo with large wound right thigh, treated with split-thickness skin graft.
2. EW: 18yo with GSW left leg with wound, treated with split-thickness skin graft.

6/21/72 - Staff: Dr. Joe Bassett

1. GE: 54yo female with flail chest, treated with tracheostomy.
2. HB: Large thigh wound post GSW, treated with split-thickness skin graft.
3. WB: Laceration right wrist, extensor tendon of right ring finger, treated with repair.
4. AJ: 36yo male with stab of abdomen, negative laparotomy.

6/22/72 - Staff: Dr. Y. Silva

1. GS: 26yo female with right subphrenic abscess, treated with drainage (postop GSW with injury to liver, gallbladder, transverse colon, and cecum, developed red rectal bleeding 1.5 days postop, had lysis of adhesions and drainage of pericolic abscess around the transverse colon wounds, and then had resection of the right colon with end cecostomy and mucous fistula).

6/23/72 - Staff: Dr. Walt

1. GJ: 17yo with stab of neck, had laceration of cricothyroid membrane which was repaired with a tracheostomy.

6/24/72 - Staff: Dr. C. Lucas

1. WW: 18yo with SGW left upper arm, had exploration and resection with repair of left brachial artery and noted contusion of left ulnar and radial nerves.
2. WB: Preop diagnosis in 38yo was acute appendicitis, and postop diagnosis was pelvic inflammatory disease, treated with appendectomy.
3. GS: 25yo post drainage of subphrenic abscess, had bleeding from right subphrenic space, had evacuation of blood clots and hemostasis.



March 30th



WSU MONTLY CONFERENCES 2025

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, March 5

Death & Complications Conference

“Debridement, Coverage, and Care of Burn Wounds”

David Springstead, MD

Graduating SICU Fellow
DMC/WSUSOM

Wednesday, March 12

Death & Complications Conference

“Management of Achalasia: A Disease Hard to Swallow”

Molly Belisle, MD

Graduating Minimally Invasive Surgery Resident
DMC/WSUSOM

Wednesday, March 19

Death & Complications Conference

Matthew O’Brien, DO

Graduating Surgical Resident
DMC/WSUSOM

Wednesday, March 26

Death & Complications Conference

“The History of Pediatric Surgery”

Michelle Coughlin, MD

Graduating Surgical Resident
DMC/WSUSOM

**KRESGE AUDITORIUM – SECOND FLOOR WEBBER BLDG
HARPER UNIVERSITY HOSPITAL, 3990 JOHN R.
7:00 Conference: Approved for 1 Hour – Category 1 Credit
8:00 Conference: Approved for 1 Hour – Category 1 Credit
For further information call (313) 993-2745**

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EVALUATIONS

Surgical Death and Complications Rounds #2024321125, Jan-April 2024 CME Reflective Evaluation:

<https://www.surveymonkey.com/r/MJMNIVV>

Surgery Grand Rounds #2024321064, Jan-April 2024 CME Reflective Evaluation:

<https://www.surveymonkey.com/r/MJW12XF>



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

145th Annual Meeting of the American Surgical Association

April 24-26, 2025

Intercontinental San Diego

San Diego, CA

71st Meeting of the Michigan Chapter of the ACS

May 14-16, 2025

Shanty Creek Resort

Bellaire, MI

Midwest Surgical Association Annual Meeting

July 27-29, 2025

Lake Dawn Resort

Delavan, Wisconsin

84th Annual Meeting of ASES & Clinical Congress of Acute Care Surgery

September 10-13, 2025

Boston, Massachusetts



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.



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. Larry Narjkuiewucz (WSU/GS 2004/09) passed the baton of presidency to Dr. Joseph Sferra (WSUGS 1991) at the WSSS gathering during the American College of Surgeons meeting in October 2024. There are hundreds of Charter Life Members who have made contributions of well over \$10,000 to the WSSS and hundreds of regular Dues-paying members of the WSSS, including many of the above who donate the payment for one operation a year to the WSSS. The residents thank all of these former residents for their support of the surgical program and hope that they will have the opportunity to meet these individuals at the annual American College of Surgeons reunion.

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.