MICHAEL & MARIAN ILITCH DEPARTMENT OF SURGERY

WAYNE STATE

APRIL 2025

SURGICAL GRAND ROUNDS

April 1st

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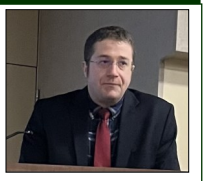
Dr. David Springstead

Dr. David Springstead (WSUGS 2022), a graduating Fellow in Surgical Critical Care, presented the **Surgical Grand Rounds** on **Wednesday, March 5, 2025**, entitled, **"Debridement, Coverage, and Care of Burn Wounds."** Dr. Springstead identified the principles outlined for care of burn wounds by the ATLS program and the ACLS program. The Parkland "Rule of 9s," for example, is universally used to estimate the percent of total body surface area (TBSA). This formula is used to calculate the fluid resuscitation associated with second- and third-degree burns. The anatomy of skin layers was described, including the epidermis, the dermis, the subdermis, and the deeper tissues. First-degree burns involve injury to the epidermis without epidermal death and often manifest as significant redness with pain. Second-degree burns involve epidermal death and blister formation, with serous fluid making up the blister fluid. The different cells within the dermis were described, including how the dermis can be divided into three layers and how the superficial second-degree injuries of the dermis cause injuries to the keratinocytes, but that healing is usually complete and occurs within two weeks with little scarring. Deeper second-degree burns to the reticular dermis may take longer to heal (three weeks) and be associated with some scar formation and decreased sensation. Circulation to the different layers of the dermis was also described. Deeper burns go into the subdermal fat, fascia, and muscle, and a sixth-degree burn would be a deep burn which involves the bone.

Dr. Springstead reported on a number of studies that have discussed the timing of debridement. A delay in debridement of about 48 hours is recommended in order to clearly identify which tissues are survivable as opposed to which tissues are obviously dead and need to be excised. Further delay in debridement is often associated with infectious complications, poorer healing, and increased length of stay.

The debridement objective is to remove dead tissue down to live tissue.

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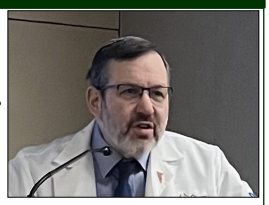

Dr. Steven Tennenberg introducing Dr. David Springstead who is a graduating SICU Fellow

This means there will be some bleeding when the superficial portion of the live tissue is encountered. This may be associated with significant oozing requiring, in some circumstances, blood transfusions and even implementation of the massive transfusion protocol for patients with large areas that need to be debrided. The role of topical thrombin therapy to help with bleeding and the utilization of TXA was discussed. Debridement can be performed in the operating room with various types of instruments designed for different types of debridement, at the bedside with enzymatic agents which break down dead tissue, and biological debridement with the use of maggots. There are a number of debridement knives, including the old-fashioned dermatome. One of the commonly used knives is the "Watson," but there are many others which are designed to control the depth of debridement in different areas. Nexo-Brid was also discussed, noting that it can provide debridement over a period of four hours.

The role of "full-thickness" autogenous grafts was discussed. These may be performed in patients who have an injury to the fingertip where the full-thickness skin is excised from the amputated part, de-fatted, and then sewn back to the uninjured part. Problems with burn wound infections were discussed, as were difficulties with pain management. Patients who have larger burns have an increased tendency for burn wound infection. Silver-containing dressings decrease the likelihood or severity of burn infections. One of these agents that was formerly quite popular was silver nitrate which had the problem of staining everything black so that it was inconvenient for the room floors or walls to be exposed to this material. A number of other dressings which are anti-bacterial in nature were also described.

The use of skin substitutes was fully explained, including xenografts which can be placed over the wound temporarily over a period of three or four days at a time in order that the underlying tissues can heal and become prepared for an autogenous split-thickness skin graft. There are also a number of commercial dressings which provide the same benefit in terms of letting the underlying healthy tissues mature to the point where they are fully granulated and can tolerate an autogenous split-thickness skin graft. Typically the split-thickness skin graft would be measured by the dermatome or grafting knife to be above 11/1,000th of an inch in order to facilitate oxygenation by imbibition from the underlying healthy tissues. The skin graft which is harvested can be meshed in order to permit the egress of tissue fluid to come through the mesh to skin onto the overlying dressing so that no seromas develop between the healthy tissue and the skin graft which would cause deoxygenation of the donor skin graft.

The importance of good nursing care was emphasized, as was how these dressings need to be

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attended to in an organized manner in order to optimize tissue healing and prevent underlying maceration of the live tissue. Some dermal substitutes were described, which may contain substances such as collagen in order to facilitate skin growth into the dermal substitute. These agents are being aggressively studied but have not yet been approved by the FDA.

Finally, some of the cellular suspensions were described; they are currently being studied in order to have individual live skin cells be placed over a larger wound so that lesser sizes of autogenous skin can be utilized to cover a greater surface area. There are currently some randomized controlled trials that suggest that utilization of the cell suspensions may be of greater benefit than the biological dressings.

This presentation was followed by a number of questions which were appropriately discussed.


Dr. Molly Belisle

The **Surgical Grand Rounds on Wednesday, 3/12/25** was presented by **Dr. Molly Belisle (WSUGS 2024)** who is finishing her Fellowship in Minimally Invasive Surgery. The title of her presentation was "**Management of Achalasia: A Disease Hard to Swallow."** Dr. Belisle described how the word achalasia has a Greek stem, referring to "no relaxation." It is a rare disease which occurs in about 2 out of every 100,000 people and has no gender or race preference. The lower esophageal sphincter is about 2-4 cm in length and has inhibitory neurons so that a Type I esophageal peristaltic wave, which begins at the cricopharyngeus, and a Type II esophageal peristaltic wave, which begins in the mid-esophagus, will propagate the bolus into the proximal stomach while the sphincter relaxes. The neurons which are involved in this response are part of the myenteric plexus. The lower half of the esophagus is made up of smooth muscle, so that the Type II peristaltic wave is automatic. The etiology of achalasia is not fully appreciated, but there is a strong suggestion that it may be part of an immune response.

The symptoms of achalasia are insidious and often take years to fully blossom. It may begin with some difficulty with swallowing of liquids, which gradually worsens and involves solids, and is associated with heartburn. The Eckhardt score was described, which gives different

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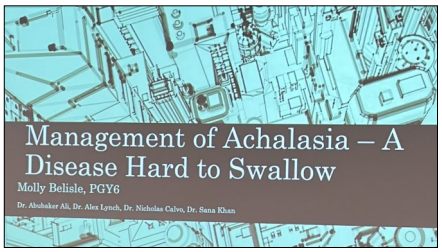

points for the different symptoms, with the worst adding up to a score of 12. This scoring system was first described by Dr. Volker Eckhardt, a German physiologist. Symptomatic patients are candidates to have a barium swallow and an esophagoscopy. During the early phases of achalasia, the endoscope can usually be gently passed beyond the area of narrowing at the lower esophageal sphincter. This approach also allows for manometric studies to be performed. This represents the gold standard in terms of identifying the severity of the achalasia. Patients who have no relaxation of the lower esophageal sphincter will have high pressures on the manometric studies and will have a narrowing of the distal esophagus on the barium study.

Early treatment always consists of gently passing a balloon beyond the lower esophageal sphincter at the time of endoscopy. This is often associated with good temporary relief, and the distensibility index will identify, to some degree, the duration of relief. The use of calcium channel blockers was described, including nifedipine, which decreases the amount of calcium entry into the smooth muscles and is often associated with relief (up to 75%) but typically does not produce long-term relief. Sometimes the relief of symptoms extends beyond one year, and some patients have been conservatively treated with periodic dilations for many years. Some physicians have concluded that dilation and non-operative calcium channel blockade are "non-inferior" to laparoscopic Heller myotomy. Over a period of time, the continued dysfunction of the lower esophageal sphincter leads to increased fibrosis, at which time the calcium channel blockers and dilations are less effective.

One of the more modern treatments is the POEM procedure, which stands for per oral endoscopic myotomy. The endoscope is passed in the submucosal plane through a mucosal incision, down to the area of the involved contracted lower esophageal sphincter, which then has a myotomy performed, after which the scope can be brought back into the esophageal lumen and demonstrate that there is no good distensibility at the area of the spasm of the lower esophageal sphincter. Controlled studies suggest that the POEM procedure is about three times more effective than simple dilation in patients who are followed at one year. The treatment goal is to improve function but not completely cure the underlying process.

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There is an interesting history related to the treatment of achalasia. The first described treatment was in 1674 when a physician used a whale bone in order to dilate the lower esophagus. The members of the audience were conjuring up different pictures of how that could be accomplished! The first cardioplasty was described in 1901 by Gottstein, whereas Heller described his "extramucosal myotomy" in 1914. This became the standard procedure for many years.

One of the complications of doing a myotomy is the potential for increased reflux for which different types of fundoplications have been described in order to counter the tendency towards reflux. Two commonly used anti-reflux procedures were described, namely the Dor, which is a partial anterior fundoplication, as opposed to the Toupet, which is a more extensive fundoplication. Different studies have suggested that the end result of the Dor vs. Toupet fundoplications yields the same result.

The laparoscopic approach to fundoplication was initiated in 1991 by Cushieri, and more recently, Horgan has utilized the robotic approach to the fundoplication. The different techniques for doing the myotomy and fundoplication were described. Examples were shown as to how the robotic technique can be used to achieve a good end result. Part of her presentation on technique dealt with the actual myotomy and the different published reports on how long you make the myotomy above the level of the spasmed lower esophageal sphincter and extending down onto the anterior wall of the stomach. Different distances are reported in the literature. The editor was reminded of the descriptions made by Dr. Yvan Silva, a longtime WSU Surgery faculty member who had special interest in the lower esophagus and achalasia. Dr. Silva described how the myotomy should extend from 1 cm above the spasmed lower esophageal sphincter and then anteriorly down on the anterior wall of the stomach beyond the so-called "rosette." The muscle fibers extending from the esophagogastric junction initially are at an angle, and then gradually become more and more transverse until they are at a 90 degree angle. The distance from the cardioesophageal junction down to this point is known as the rosette, so that the myotomy on the stomach should continue inferiorly until one reaches these transverse gastric fibers.

Occasionally there is a perforation of the esophagus, and the recommended technique was to close the perforation with a figure eight 5-0 PDS suture. There has been some suggestion in the literature that one can do an intentional vagotomy in order to increase the length and make the operation easier. There does not appear to be any difference in the end result whether or not the intentional vagotomy is utilized. Following operation, the patient is kept on liquids for

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the first few days, sometimes extending up to two weeks and then advancing to soft diet and finally regular diet. If there is any pain with institution of diet, the patient is a candidate for a barium swallow.

There was an extensive question-and-answer period following this very comprehensive presentation.


Dr. Matthew O'Brien

The **Surgical Grand Rounds on Wednesday, March 19, 2025** was presented by **Dr. Christopher Matthew O'Brien** who is finishing his General Surgery training this Spring. The title of his presentation was **"First, Do No Harm."** Dr. O'Brien provided a very comprehensive review of the malpractice crisis and emphasized that it has been estimated that there are 98,000 preventable deaths per year related to the practice of medicine. This whole process involves "good people" providing care in a "bad system." The objective of the presentation was to provide an update on the problems with malpractice and how it affects physicians, patients, and the entire medical profession, while placing special emphasis on the four D's.

The problems with bad results in medical care go back to the Code of Hammuradi which was written in 2030 B.C. The Roman Empire instituted a policy dealing with bad results, and at the time that William the Conqueror invaded England in 1066, there are documents related to the bad results of medical treatment. This is a huge problem, and the total costs come to well over 4 billion dollars per year, with the cost in the state of Michigan for 2023 being over 54 million dollars. These costs are related to the damages that the patient receives, the Plaintiff expenses, and the Defense expenses. Because of this high cost, the average expense for malpractice insurance for general surgeons is almost $67,000 per year in order to get coverage of one million per incident and three million for combined incidents. This cost is greater in surgeons who are performing procedures and much less for individuals who do not perform procedures, such as operations or radiographic interventions. The highest malpractice cost for general surgeons is probably in Dade County, Florida where the cost is over $277,000 per year in comparison to Orange County, California where the cost is just over $45,000 per year for general surgeons. Physicians generally buy two different types of malpractice insurance, namely a Claims

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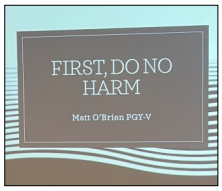

made policy which covers all procedures that were done during the period of time when the policy is in effect; coverage for after that period of time when the insurance is active requires the additional purchase of a tail for any claims that will be made later. The other type is Occurrence insurance, which covers not only for the time of the occurrence but for a long time afterward, which may have a specific number of years included in the contract.

The incidence of malpractice claims is quite high, and 15% of the surgeons will have experienced a claim against them each year. Because of this very high incidence, many physicians practice "defensive medicine," resulting in the ordering of many unnecessary tests in order to avoid being sued for not getting a specific test that the Plaintiff's lawyer later says should have been done. This causes a huge increase in the expense of medical practice which is shared by everyone. From the victim's vantage point, the initiation of a suit by a patient is sometimes instituted in order to prevent this mishap from happening to another patient or to find out why this mishap occurred, or to gain money from the payment for damages, or to punish the surgeon or interventionist who caused the problem.

The Plaintiff's attorney will try to demonstrate that the physician was not in compliance with standards of care. Once the Plaintiff's attorney and the patient have completed the transference of information, the attorney can then file a "Notice of Intent," after which there has to be a six month interim period before the formal malpractice suit can be filed. The advantage for the Plaintiff's attorney is typically related to a contingency fee where the attorney receives anywhere from 25% to 40% of the award, depending upon the difficulty of the litigation and the amount of time supporting the Plaintiff's litigation. It should be emphasized that the physician has some role in decreasing the likelihood of being sued. This primarily revolves around having a good relationship with the patient with very active communication as if the patient is a member of the physician's family, detailed explanation of the intervention, and the potential for bad results should be explained ahead of time. Once a good physician-patient relationship has matured, the patient is more receptive to having a complication of a procedure and less inclined to punish the physician.

From a Plaintiff point of view, the attorney needs to show that the "burden of proof" demonstrates that a "tort" was committed. The word "tort" is an old Norman word which means

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"wrong." This process involves the "four D's," which includes Duty, Dereliction of Duty, Direct cause of the intervention with the bad result, and Damages. The physician has the Duty to do what is right for the patient during the physician-patient relationship. This relationship extends from the time that the physician and patient came together to treat a problem. Termination of that relationship may occur because the patient gives up on the physician to go to another physician, or the physician withdraws from the relationship voluntarily, or there is a resolution of the patient problem which no longer exists. The Duty of the physician is quite clear when the physician and patient meet in the physician's office and discuss a patient problem. The physician then has the Duty to resolve the problem or refer the patient to someone who can resolve the problem. This physician-patient relationship may occur when the physician is making decisions on a telephone conversation with the patient or with the Emergency physician who is giving the physician details about the patient, after which the physician makes specific recommendations. This Duty does not extend to the physician when the physician indicates that he/she is not on call and is unable to accept responsibility for the patient care or referral for a number of reasons, including he/she is not physically available, he/she has been celebrating and is under the influence of alcohol, or some other legitimate reason why the physician cannot accept this new patient and form a specific relationship.

The second element relates to Dereliction of Duty where the Plaintiff's attorney will attempt to show that the lack of compliance with Duty caused damages which are, therefore, a reason for reimbursement. This is where much of the expense for a malpractice suit comes into play as the Plaintiff witnesses and Defense witnesses give depositions regarding the presence or absence of Dereliction of Duty, causing damages. Sometimes there is no debate, such as leaving a sponge in the abdomen, and this is identified legally as "res ipsa loquitor."

The next challenge for the Plaintiff's attorney is to determine that there is a Direct cause for the Dereliction of Duty for the hurt that has occurred to the patient. Again, this is where the expert witnesses on both sides spend much time and earn much money as part of the Plaintiff and Defense depositions.

The final element relates to Damages which can involve time away from work, pain and suffering, and loss of life's pleasures. The extent of Damages will relate to what the patient was doing prior to the medical intervention and involves much investigative work by both the

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Plaintiff and Defense attorneys. Eighty percent of malpractice suits are settled without going to court, and those which do end up in the courtroom are usually settled in favor of the physician. The extent of the Damages of a non-economic variety, such as pain and suffering, is capped in the state of Michigan at $69,000 effective 2024 unless there is a catastrophic result or death, in which case the cap is just slightly over one million dollars.

One of the important aspects of preventing litigation deals with the "informed consent," which is typically obtained by a medical professional and often the attending interventionalist. The Informed Consent protects the interventionalist from civil or criminal litigation because of "battery." The physician is protected against litigation as part of the "Good Samaritan Law," with the extent of that protection ending when the patient reaches the front door of the hospital. The Good Samaritan Law, however, does not protect the physician against willful or wanton activity which causes the patient harm. The Damages against the provider no longer allow the Plaintiff's attorney to access the physician's retirement program or pension. However, the tension related to the malpractice problem causes tremendous stress and often leads to "burnout," with physicians retiring before their expected time of retirement. There are other systems that are available, including the "no fault system" which is utilized in England, Canada, Sweden, Finland, and Australia. This eliminates the huge expense of physicians practicing "defensive medicine," and the specific injuries are defined so that there does not have to be a lengthy discussion about the amount of "Damages" that are to be provided to the patient because of the "tort." Likewise, the Claimant must identify the potential tort within three years of the occurrence. China has a system whereby there is a "voluntary negotiation" between the family and the interventionist in order to deal with damages caused by the intervention.

There is a system to avoid some of this expensive litigation, which includes the institutional and physician identification that a preventable complication occurred. The University of Michigan and the American Medical Association recommend that when such a complication occurs, the victim should be told about the complication, and there would be a reasonable discussion between the physician and hospital team and the patient and patient's family about appropriate compensation, thereby bypassing the expensive legal system. During the discussion period, it was pointed out that when Dr. Anna Ledgerwood provided the Distinguished Scudder Oration for the American College of Surgeons over 30 years ago, she recommended that there be such a system where the physician and institution explain to the patient that a preventable error was made and that there be a reasonable discussion about what the appropriate compensation would be for the injury sustained by the patient.

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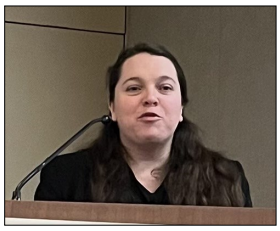

Dr. Michelle Coughlin (WSUGS 2025)

Dr. Michelle Coughlin, a senior Surgical resident graduating this Spring, presented the **Surgical Grand Rounds on Wednesday, March 26, 2025**. During her residency, she spent time on a Research Fellowship at the Children's Hospital of Michigan which allowed her to perform a number of clinical studies that have been presented at various locations. Her presentation was entitled, **"The History of Pediatric Surgery: What Makes Pediatric Patients Different?"**

One of the early reports on record of surgery on children goes back to many years B.C. in Borneo where there are records that a 14-year-old was treated for amputation for leg injury and survived more than 20 years. The first Children's Hospital in America was the Children's Hospital of Philadelphia which opened in 1855, and the first Pediatric Surgical Residency was established in Boston in 1936. Pediatric surgery was recognized as a separate specialty by the American College of Surgeons in 1963, and the first issue of the Journal of Pediatric Surgery was published in 1965. The American Pediatric Surgical Association was established in 1970, and Sabiston provided the leadership for there to be a Board examination for Fellows finishing their pediatric surgical training in 1972.

Dr. Coughlin presented many cases as part of her review of pediatric surgical history. She talked about Dr. William Ladd who was the Chief of Surgery at the Boston Children's Hospital and is considered by many to be the father of pediatric surgery. She showed examples of the Ladd procedure in patients who have malrotation or incomplete rotation, and described the technique of the Ladd procedure. There were many innovative pediatric surgeons who introduced various techniques for unusual problems, including the contributions of Dr. Cole, Dr. Wyatt, Dr. C. Everett Koop- the editor of the Journal of Pediatric Surgery, and Dr. Blalock who performed the classic shunt procedure for infants with the tetralogy of Fallot.

There were many unique challenges related to pediatric surgery, including the severe problem with esophageal atresia and its many variants. Although it was discovered in the mid-19th century, definitive treatment with operative repair done shortly after birth waited until the last half of the 20th century. The problems with omphalocele were first identified in 1633, but it wasn't until more recent years that this could be successfully treated surgically. She also described the many challenges of gastroschisis which was first recognized in 1733 but not routinely successfully treated until the 20th century. Several other unusual pediatric surgical problems were also described which were successfully treated over the past 150 years.

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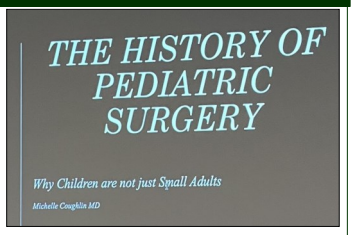


One of the challenges that Dr. Coughlin had during her Research Fellowship was to identify the different diseases which were associated with prolonged length of stay. This is a problem which occurs with all complicated patients, and the Children's Hospital of Michigan has an increased length of stay in somewhere between 15% and 20% based upon the criteria by Medicare and Medicaid recommendations. One of the common problems with causing an increased length of stay relates to the use of narcotics causing urinary retention which prevents discharge in these young patients.

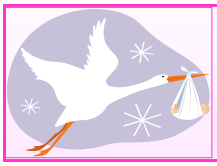
There were a number of patients who had increased length of stay following organ transplantation. Often this was related to the duration of the ischemia time. Other factors that would cause an increase in the length of stay would be co-morbidities which are often present in pediatric patients who have congenital abnormalities. The use of multiple antibiotics and the development of catheter-related infections was also an important factor. This was particularly true in patients who had fungal infections or infections due to multiple organisms.

Regarding patients who need ventilatory support, nasotracheal intubation was better tolerated than oral tracheal intubation and was associated with a decreased number of complications. This is particularly true for patients who suffered burns, and she reported on a series of 134 patients with significant burn injury. Data was also presented on the Stevens-Johnson Syndrome and the severity score (SCORTEN) which helped identify some of the reasons for increased length of stay. The severity score provides better data for adults than it does for pediatric patients with Stevens-Johnson Syndrome.

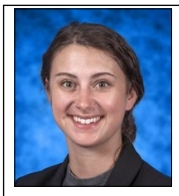
There are certain differences in patients undergoing laparoscopic cholecystectomy in the adult vs. the pediatric patient group. There tended to be a decreased BMI in the pediatric group and a decrease in the female gender in the pediatric patients compared to the adult patients.

There was an informative question-and-answer session to this comprehensive presentation.

April 20th



EXTRA-CURRICULAR PRODUCTIVITY



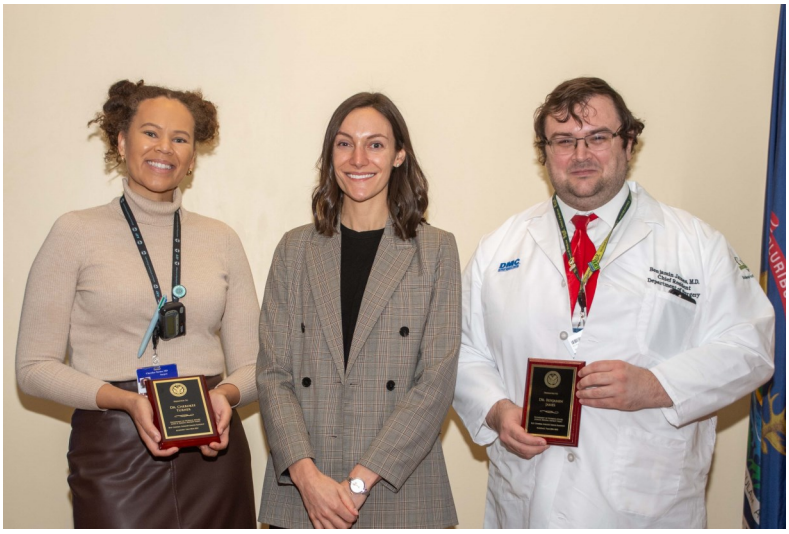
Dr. Amanda Stevens

Dr. Amanda Stevens (WSUGS 2027) and Cody Gilbert welcomed their new born baby girl, Charlotte, on Friday, March 7th at 6:43 p.m. Charlotte entered the world weighing in at 7 lbs., 15 oz. and was 20-1/4" long. The WSSS extended family extends a sincere congratulations to Amanda and Cody and welcomes Charlotte into the family.

Ms. Charlotte

REPORTS FROM THE OUTFIELD

Dr. Bhavana Bhaya, Associate Chief of Staff – Education, Designated Educational Officer (DEO) at the John Dingell VA Hospital in Detroit is pleased to announce that on Tuesday, March 25 2025 the VA Senior Resident of the Year Award was been presented to Dr. Ben James (WSUGS 2025) and the VA Junior Resident of the Year Award was been presented to Dr. Cherokee Turner (WSUGS 2028). Congratulations!!



(Left to right) Dr. Cherokee Turner, Dr. Ashley Malach (WSUGS 2022), and Dr. Ben James

PRODUCTIVITY


Dr. Bryant Oliphant

Dr. Bryant Oliphant, who is actively involved as an orthopedic surgeon at the Detroit Receiving Hospital with Dr. Rahul Vaidya and team and also at the University of Michigan, was the co-author along with many other co-authors on a manuscript presented at the American Association for the Surgery of Trauma; it was published earlier this year in the Journal of Trauma and Acute Care Surgery. The title of the article was **"Association of Pre- and Post-Injury Mental Health with Long-Term Clinical and Financial Outcomes."** These authors looked at a large number of patients from 19 Level I and Level II trauma centers and patients who had been seriously injured and who were followed up to 24 months following discharge. They looked at a total of over 1,000 patients and noted that 32% of patients had pre-injury mental health problems, and 47% had self-reported mental health symptoms following discharge. The patients with pre-injury mental health problems were much more likely to have post discharge symptoms. This had very important financial implications in this group of patients. The authors concluded that addressing post-injury mental health may potentially improve long-term health-related quality of life of trauma survivors, although there is nothing to ensure that these patients can afford the care needed for the attainment of optimal health.

April 22nd

MEET OUR NEW RESIDENTS

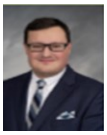
This July there will be 16 PGY-1 residents in the Detroit Medical Center/Wayne State University Program in Surgery who will be joining us. Let's give them a warm welcome when we see them in the halls of the Detroit Medical Center. The New Faces for 2025-2026 are listed below:

Dr. Alexandra Adams comes to us from Wake Forest University School of Medicine

Dr. Melissa Baker hails from St. George's University School of Medicine

Dr. Julia Cochrane graduated from the California University of Science and Medicine School of Medicine

Dr. Lauren Feder is a graduate of Indiana University School of Medicine



Dr. Chayton Fivecoat graduated from our own Wayne State University School of Medicine

Dr. Lauren Haack hails from the Cincinnati University College of Medicine

Dr. Keinnan Hares is also a product from our own Wayne State University School of Medicine

Dr. Sadaf Hashemian also graduated from our Wayne State University School of Medicine

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MEET OUR NEW RESIDENTS

Dr. Anoosha Kishore comes to us from St. George's University School of Medicine

Dr. Zachary Kittrell graduated from the Loyola University Chicago School of Medicine

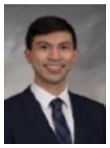
Dr. Kavita Ramnath is a graduate of the Ohio State University School of Medicine

Dr. Mabel Spio hails from the Indiana University School of Medicine

Dr. Heidi Wallour is a product of the St. George's University School of Medicine

Dr. Kristin White graduated from the Chicago Medical School at Rosalind Franklin University of Medicine and Science

Dr. Benjamin Seth Williams comes to us from St. George's University School of Medicine



Dr. Matthew Zabat graduated from our own Wayne State University School of Medicine

MICHAEL & MARIAN ILITCH DEPARTMENT OF SURGERY

WAYNE STATE

EXCERPTS FROM THE LOG BOOK
DOWN MEMORY LANE


Dr. Anna Ledgerwood

6/25/72 - Staff: Dr. J. Kirkpatrick; Chief Resident: Dr. S. Sankaran

1. CH: 21yo with GSW to abdomen involving liver, duodenum, and right ovarian vein. Vein was ligated, liver and duodenum repaired (patient arrested six hours postop and died).
2. HS: 65yo with upper GI bleed, had vagotomy and pyloroplasty with esophagoscopy; diagnosis was alcoholic gastritis.
3. FH: 12yo female with ruptured acute appendicitis with peritonitis, treated with appendectomy.
4. JM: 23yo with preoperative diagnosis of acute appendicitis, found to have a perforated duodenal ulcer, treated with appendectomy, vagotomy, and pyloroplasty.

6/26/72 - Staff: Dr. Tumacder; Chief Resident: Dr.

1. HS: 38yo with laceration tendons right lower leg, treated with repair and splint.
2. JD315: Acute alcohol intoxication with GSW left lower quadrant with injury to cecum, ascending colon, and terminal ileum. All were repaired and cecum exteriorized as a loop colostomy. Patient had fractured ilium.
3. SH: Patient had previous gastrectomy for upper GI bleeding, had a tracheostomy.
4. KN: 35yo with lawn mower injury to left hand, treated with debridement and closure of traumatic amputation and lacerations.

6/27/72 - Staff: Dr. S. Woods; Chief Resident: Dr.

1. 16yo pedestrian struck by a car with bilateral supracondylar femur fractures, good pulse right leg, treated with a cast - no pulse left leg, had arteriogram with injury to popliteal artery, treated with ligation of vein and resection of artery and vein graft and four compartment fasciotomy and fibulectomy.

6/28/72 (No Staff – Dr. Walt available at home.)

2. LV: 3yo with window injury to tips of fingers 3 and 4 right hand, treated with debridement and split-thickness skin grafting.
3. MM: 25yo with SGW left groin and transected left spermatic cord, treated with debridement and hemostasis; exploration of left femoral vessels was negative.

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MICHAEL M & M MARIAN ILITCH DEPARTMENT OF SURGERY

WAYNE STATE

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

6/29/72 - Staff: Dr. Weaver, In-House

1. EH: Blunt abdominal trauma with ruptured spleen, treated with laparotomy and splenectomy.
2. GS: 25yo with previous GSW abdomen with injury to liver, gallbladder, colon, and cecum, had a lysis of adhesions and drainage of paracolic abscess around the transverse colon wounds. In past, treated with resection right colon with end cecostomy and mucous fistula and previous drainage of right subphrenic abscess. Had a tracheostomy.
3. MJ: 22yo with GSW sacral area and rectum x2. Had closure of anterior hole rectum with drainage of pre-sacral space and sigmoid end colostomy with mucous fistula.

6/30/72 - Staff: Dr. Pelok

1. BL: 40yo with GSW abdomen with thru-and-thru wound transverse colon, treated with closure of holes and exteriorization without colostomy.
2. TM: 58yo with stab of abdomen with injury to spleen, transverse colon, and small bowel, treated with splenectomy, closure of holes in colon with exteriorization without colostomy and repair of small bowel x2.
3. Dr. Sankaran's note to Dr. Walt: Thank you for an excellent rotation.

7/1/72 (new year) - Staff: Dr. C. Lucas

1. AU: Postop bilateral supracondylar fractures with left popliteal artery and vein injury, had extensive necrosis of muscle of leg, treated with debridement.
2. EW: 4yo with stab left clavicular area, treated with negative exploration of axillary vessels.
3. WB: GSW arm, right shoulder, and right anterior chest, as well as left flank and buttock. Laparotomy showed laceration lesser curvature of stomach and greater curvature close to the pylorus with abrasion pancreatic head, thru-and-thru stellate laceration of liver, treated with suture left lobe liver and control of hemorrhage from mesocolon and repair of holes in small bowel.
4. CP: 30yo with stab left flank with single hole in colon, closed in two layers.

MICHAEL & MARIAN ILITCH DEPARTMENT OF SURGERY

WAYNE STATE

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, April 2
Death & Complications Conference
"The Surgeon's Role in the Opioid Epidemic"
Amanda (Dooley) Romero, MD
Graduating Surgical Resident
DMC/WSUSOM

Wednesday, April 9
Death & Complications Conference
"Aortic Dissections and More!"
Matthew Georgis, MD
Graduating Vascular Surgery Resident
DMC/WSUSOM

Wednesday, April 16
Death & Complications Conference
Alex Lynch, DO
Graduating Surgical Resident
DMC/WSUSOM

Wednesday, April 25
Death & Complications Conference
"Annual Program Evaluation"
David Edelman, MD
Program Director, Surgical Residency, DMC/WSUSOM

Wednesday, April 30
Death & Complications Conference
"Review of Presentations for the
Michigan Chapter of the American College of Surgeons Meeting - May 2025"
Surgical Residents, 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

The Wayne State University School of Medicine is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians. The Wayne State University School of Medicine designates this live activity for a maximum of 2 hours ***AMA PRA Category 1 Credit(s)***™. Physicians should claim only the credit commensurate with the extent of their participation in the activity."

EVALUATIONS
Surgical Death and Complications Rounds #2024321125, Jan-April 2024 CME Reflective Evaluation:
https://www.surveymonkey.com/r/MJMJNVV
Surgery Grand Rounds #2024321064, Jan-April 2024 CME Reflective Evaluation:
https://www.surveymonkey.com/r/MJWT2XF

MICHAEL & MARIAN ILITCH DEPARTMENT OF SURGERY

WAYNE STATE

Wayne State Surgical Society
2025 Donation

Name:

Address:

City/State/Zip:

Service Description Amount

2024 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

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 AAST & 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.

MICHAEL & MARIAN ILITCH DEPARTMENT OF SURGERY

WAYNE STATE

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 Narkiewicz (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*.