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DEPARTMENT OF SURGERY
WAYNE STATE

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THE ANNUAL DETROIT TRAUMA SYMPOSIUM - DAY ONE - 2025

The 73rd annual Detroit Trauma Symposium took place on November 6 – 7 at the MGM ballroom in Detroit Michigan. This is the oldest trauma symposium in the country. Dr. Larry Diebel (WSU/GS 1980/86) was the Guru who put the meeting together. The meeting began with a continental breakfast during which the initial presentations took place.

Thursday, November 6, 2025

7 AM – 7:45 AM:


Dr. Adam Starr

Dr. Adam Starr, from the University of Texas Southwestern in Dallas, Texas, made the first presentation entitled "Minimally Invasive Approach to Pelvic and Acetabular Fractures". Severe pelvic fractures are often due to massive car crashes, pedestrian injuries, and falls. He showed a number of mangled cars which were associated with multiple injuries including severe pelvic fractures. He emphasize that the early treatment includes resuscitation for bleeding from either of the pelvic fracture or other injuries and temporary control of pelvic fractures which have separation of the pelvic structures. This can be temporarily obtained with a sheet, a specially designed strap which goes around the greater trochanters or intraoperative approximation in the stable patient. He emphasized that much of the pelvic fixation is now done percutaneously which can be performed after a previous external fixation has been established. He emphasized the importance of computer tomography guidance and of the critical importance of the radiology technician in working with the surgeon. He showed a number of different types of screws which are used for fixation and the importance of the use of a radiolucent which costs about $80,000. He described in detail the pelvic anatomy including the arteries, veins, and nerves, which must be protected when doing open pelvic fixation. He also described some failures of fixation and the painful task of correcting those failures so that the patients can have appropriate weight-bearing following recovery. Dr. Starr pointed out that some of the worst challenges are in patients with severe posterior pelvic fractures and the increased potential for subsequent infection in patients with those injuries.

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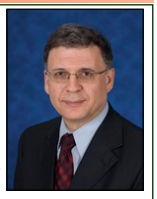
Dr. Wael Sakr

Following his presentation, Dr. Diebel asked him many questions that came from the audience and then introduced the Dean of our Wayne State University School of Medicine, Dr. Wael Sakr, who welcomed all of the registrants. Dr. Sakr congratulated the hard work done by Dr. Diebel and other members of the Department of Surgery who have been very important in maintaining our Level I trauma center, and Dr. Diebel's being a national leader in the care of injured patients and of the teaching of that care.

Thursday, November 6, 2025
7:45 AM – 8:15 AM:


Dr. David Shatz

The next presentation was given by Dr. David Shatz from the University of California at Davis, and was entitled "Current and Updated Management of Blunt Thoracic Aortic Injuries". He described how there have been many advances in the care of this injury which can be very devastating. He emphasized that the mechanism was often due to rapid deceleration from frontal crashes or driver side crashes. Patients often have associated injuries involving the brain, chest wall, and pelvis. The diagnosis of this injury may be suspected by the clinical picture and supported by chest x-ray, angiogram, and CAT scan. The typical imaging findings would include a widened mediastinum, deviation of the nasogastric tube to the right, depression of the aortic knob, and apical cap on the left side, a left hemothorax, and the depression of the left main stem bronchus. He described the four types of injury which included an intimal tear, intra-mural hematoma, aneurysmal dilation, and free rupture. The patients with intimal tear have often been treated with observation; repeat scans show that the injury typically will heal within one month. Patients with aneurysmal dilation or free rupture need prompt repair with either the open technique or the endovascular technique. He described that the first repair for this injury was done by the open technique in 1958 by Dr. Michael DeBakey. The first endovascular repair of this lesion was done in 1997. During the early years of the open repair, emphasis was placed on rapid clamping and repair of the injury in order to minimize the likelihood for spinal cord injury and paraplegia. During these years the incidence of paraplegia decreased from 16% to 2%. The endovascular technique has markedly improved the results of this injury but there is the concern that there may be occlusion of the left subclavian artery by the prosthesis. This has the potential for creating ischemia of the arm which may require amputation at the level of the humerus bone. Technical advances have been made so that now the endovascular technique can incorporate a branch into the left subclavian artery and eliminate the potential for ischemia. Following operation, the patients can be given heparin depending on the presence or absence and severity of an associated dramatic brain injury.

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8:15- 8:45 AM:


Dr. Kenji Inaba

Dr. Kenji Inaba, from the University of Southern California, presented a paper on "Penetrating Neck Injuries". He described how the most urgent problems related to penetrating injury are our airway compromise and bleeding. Often a hematoma associated with bleeding from the anterior portion of the neck can be controlled by Often a hematoma associated with bleeding from the anterior portion of the neck can be controlled by pressure and the most efficient way to stop bleeding is by digital compression. A balloon catheter can be placed into the perforation in order to get proximal control. Those patients with "hard" signs of vascular injury need to be taken directly to the operating room. He emphasized the importance of protecting the airway. The three zones of the neck were described with Zone 2 extending from the manubrium to the angle of the mandible. Whereas, penetration of the platysma muscle in Zone 2 was an indication for operative exploration in the past, this is no longer true in patients who don't have signs of airway or vascular injury. When the patients have soft signs of injury and do not require immediate operation, a CT angiogram may be performed in order to identify any lesions that mandate operative repair. He emphasized that superficial foreign bodies of the neck can be removed but that deep foreign bodies requiring formal exploration do not necessarily have to be removed if they are not causing any problems or not lying next to critical structures.

9:05-9:20 AM:

Dr. Diebel then moderated a panel made up of Dr. Kenji Inaba, Dr. Adam Starr, and Dr. David Shatz.

9:20– 9:50 AM:


Dr. Andrew Kerwin

Dr. Andrew Kerwin, from the University of Tennessee, presented "Critical Decisions in Management of Mangled Extremities". He talked about the Western Trauma Association's classification for injured extremities. He pointed out that this classification involves identifying the severity of injuries to soft tissue, bone, muscle, and vessels. He emphasized the importance of using a tourniquet for active bleeding at the time of the initial examination. He also emphasized that when bleeding cannot be controlled, one must follow the principle of "life over limb" and, when necessary, to perform primary amputation in order to keep the patient alive. Dr. Kerwin pointed out that when the massive extremity injury score is greater than six, the patient almost certainly is going to need a lower limb amputation and when this same score is over eight the patient will likely need upper limb amputation. He described the severity of fractures extending from a flawless fracture with no skin break to an open fracture with soft tissue loss and gross contamination. The minor open fractures are candidates to receive cefazolin within one hour of arrival in the emergency department, whereas, the obviously contaminated fractures should have the addition of an antibiotic to cover gram-

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negative organisms. Besides early operation for hemorrhage control, patients with necrotic tissues need to have early excision or debridement. He emphasized the importance of teamwork in care of the mangled extremity, whereby, the general surgeon, neurosurgeon, orthopedic surgeon, and plastic surgeon may work in harmony in order to achieve the best long-term result.

9:50- 10:20 AM:

Dr. David Shatz, from the University of California Davis, presented a paper entitled "The Spleen: A Simple Organ With A Complicated History." Dr. Shatz summarized the organ injury severity (OIS) classification and provided the most recent update of this classification. He pointed out that a severe injury is now listed as a class 4 and that active extravasation is now listed as a class 5. He described the different types of operation for splenic injury including the role of splenectomy, splenorraphy, and arterial embolization. The spleen is actively involved in immune function and at least 50% of the splenic volume is required to successfully carry out that function. He discussed the role of preserving the spleen following splenectomy by which small segments of spleen are cut up and wrapped within the omentum creating an “omental omelet”. Prior work from Wayne State University (and this author) demonstrated that 15 months following the creation of a splenic replant or “omelet”, all of the follicular centers were fibrotic and these follicular centers are the source of the splenic immunity. Based on these findings, omelets should be reserved for breakfast. He also discussed the role of non-operative management or splenic injury which is appropriate when the patient does not have a severe enough injury to cause change in vital signs. Splenic artery embolization is often helpful in patients with active extravasation but is not without complications. The ischemic portion of the spleen may become a nidus for infection or a splenic abscess and may lead to left upper quadrant infections with extensions into the pleural space. Following such splenectomy he described the importance of splenic vaccines and the most common one being used is "Pneumovax 23".

10:20 – 10:50 AM:

Dr. Kenji Inaba returned to the podium in order to present on "Police First Responders". He pointed out the importance of having police responders trained in emergency medical services since they are the first people on the scene following penetrating and blunt trauma. This is particularly true when there are mass shootings, snipers, or riots. Dr. Inaba had gone through all the training that a police first responder must complete including all of the training in firearms. He is officially listed as a medical police first responder. The police officers who are trained in emergency medical response have a kit within their vehicle in order to provide medical support for their training. The city of Los Angeles always has an emergency medical service police team on call in order to always be available to function as the first response team and bring patients directly to the emergency department rather than having the patient transferred from a police vehicle to the regular

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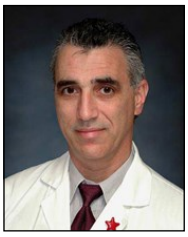
emergency medical service vehicle. They have done prospective analyses of this activity and have demonstrated that the police can get the patient to the emergency department in an average of nine minutes as opposed to 21 minutes when transported by the regular emergency medical vehicles. This allows for the emergency department team and trauma team to more quickly deal with getting control of bleeding and initiating resuscitation.

10:50 – 11:05 AM:

Dr. Larry Diebel then monitored a question-and-answer session which included Dr. Kenji Inaba, Dr. David Shatz, and Dr. Andrew Kerwin.

11:05 – 11:50 AM:


Dr. Thomas Scalea

Dr. Thomas Scalea, from the R. Adams Cowley Shock Trauma Center, presented the Walt Lecture. He highlighted the Scudder Oration that Dr. Alexander J. Walt gave to the American College of Surgeons in 1978. This dealt with the importance of education, particularly to the surgical residents. He discussed the early teachings of Dr. William Halstead who is considered by many to be the father of American surgery. While Dr. Halstead was at Hopkins, he described the importance of a graduated increase in technical knowledge in the surgical residents with them gradually becoming more skillful and more independent in the operating room. He referred to the same contributions made in a military setting by Dr. Edward Churchill and later the definition of inadequacy in American training programs made by Dr. Abraham Flexner. These important pioneers help to develop the strengths of the residency training programs.

Dr. Scalea then discussed the problem that occurred with Mrs. Libby Zion who, in the early hours of the morning, received a phone order for Demerol, which turned out to be detrimental. The resident who made the order without seeing the patient or discussing it with an attending stated that he was too tired because of a lack of sleep. This led to the current restricted hours which have been established by the Residency Review Committee and have emphasized the need for residents to help maintain their skills by various simulation programs, the ASSET program for cadaver dissection, and of the ATOM or participation in porcine dissection with actively bleeding injuries created.

Based upon the potential for decreased exposure to various types of injury, Dr. Scalea has expanded his Trauma/Critical Care Fellowship to two years with a portion of that Fellowship being dedicated to one of the subspecialties such as vascular surgery or neurosurgery. He emphasized that the multiply injured patient being cared for at his institution is seen by a dedicated trauma surgeon who has skills in other areas such as

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vascular surgery. This allows the responding trauma surgeon to resuscitate the patient in a hybrid operating room where the surgeon can resuscitate, insert a REBOA, use angiography to identify bleeding sites, and provide arterial embolization if necessary or to do an open laparotomy. This two-year fellowship is now accepted by the American College of surgeons.

12:50PM – 1:30 PM:

Following the lunch break, Dr. Jamie Coleman, from the University of Louisville, presented "Management of Pelvic Trauma". She emphasized that many patients with pelvic fractures have serious associated injuries to the bladder, urethra, or extensive soft tissue injuries associated with open fractures. Consequently, the physical examination must determine the status of the rectum and imaging studies must determine the status of the urethra and the bladder. Pelvic fractures are often associated with serious bleeding with the result that patients requiring one transfusion of red cells will have a 5% mortality rate while those requiring more than six red cell transfusions have been reported to have a mortality rate over 40%. Besides the physical examination, one can learn much about the abdomen and pelvis by the FAST examination along with the abdominal CAT scan. Pelvic fractures are also frequently associated with intra-thoracic injuries so that a routine chest x-ray is necessary. Patients who have pubic symphysis separation should have a strap going around the greater trochanters applied in order to return the pubic symphysis to its proper position. When a specific binder is not available, a sheet can be used to help bring the rami together. If persistent bleeding occurs, a REBOA can be placed with ablation of flow in Zone 2 to temporarily control the bleeding. This allows some time in order to assess for ongoing bleeding by angiography with possible embolization or to control bleeding with pelvic packing being careful to stay extra peritoneal.


Dr. Jamie Coleman

1:20 – 1:50 PM:

The next presentation was by Dr. Andrew Kerwin from the University of Tennessee and was entitled "Spinal Cord Injury: Role of Diaphragmatic Pacing on Ventilator Independence". He emphasized that the old cliché of "3, 4 and 5 keep me alive". This reflects the importance of the cervical spinal nerves in controlling the muscles of ventilation and chest wall compliance. Inadequate chest wall expansion compromises the clearing of secretions leading to atelectasis and pneumonia and also leading to atrophy of the diaphragmatic muscles because of disuse. He pointed out that this often leads to tracheostomy and the need for tube feeding. Many of these patients spend most of their first year in a rehabilitation institute or some other type of chronic care facility as they have associated paraplegia. This is a terrible burden for the patient and a huge economic challenge to society. He described the use of diaphragmatic pacing in order to restore chest wall function and reversal of the atelectasis which is associated with pneumonitis. This allows for increased activity, more independent

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breathing, and for patients on a ventilator - a decrease in ventilator associated pneumonia. He showed examples of how the pacemaker is applied by laparoscopic technique. He emphasized that this technique should be applied early.

1:50 – 2:20 PM:

The next presentation was made by Dr. Alicia Mangram and was entitled "Geriatrics Trauma in 'G60': We Must Own It". She described how care of the elderly must really be a team project and described how her hospital in Phoenix involves all members of the trauma team. She identified that the average age of American citizens is increasing and that there are many people over the age of 60. This is associated with decreased muscle mass and in many patients frailty. She pointed out that the American College of Surgeons has made this one of the guidelines to be assessed for all trauma centers in 2023. The number one cause or injury in the elderly is a fall usually related to some object being on the floor and sometimes associated with a single drink of alcohol. She emphasized the importance of over triage in these patients who are vulnerable to have serious life-threatening complications due to comorbidities.


Dr. Alicia Mangram

2:40 – 2:55 PM:

Dr. Michael White, (WSU/GS 1990/97) the moderator for the afternoon sessions, hosted a question-and-answer panel which included Drs. Jamie Coleman, Andrew Kerwin, and Alicia Mangram.

2:55 – 3:25 PM:

The next presentation was made by Dr. Jamie Coleman and was entitled "Caring for the Caregiver". Dr. Coleman discussed the tremendous stress that can occur for physicians and nurses who have dedicated their lives to treating the sick and injured. There is tremendous physical and mental stress related to the frequent calls that are made while being involved with seriously injured and sick patients. Because of the stresses, more than 50% of acute care givers identify having some of the symptoms of the post-traumatic stress disorder. Some of the symptoms include impaired sleep, lack of exercise, and procrastinating on such things as getting your car repaired or keeping an appointment with the dentist. She discussed the disruption of normal circadian rhythm due to the many untimely demands on the caregivers time which not only may lead to the above symptoms but may be a stimulus for alcohol abuse or even suicidal ideation.

3:25 – 3:55 PM:

The next presentation was by Dr. Alicia Mangram and was entitled "Compassionate Gift – Wellness While Working in Trauma". This was a philosophical presentation. Dr. Mangram showed eggs being fried and

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suggested that the acute care giver has the potential of having a "fried brain". She emphasized the importance of the "gift of feeling" and the importance of protecting oneself when there is extensive work to do on the front line "in the trenches". She emphasized the importance of talking with ones colleagues and using the term "I need to talk". This is important in preventing suicidal ideation. She also suggested that the "Midas Machine" should be buried and fellow colleagues should emphasize supporting their fellow workers and not tattling on them.

4:30 – 5:30 PM:

Following a break to give the registrants a chance to visit the exhibitors, Dr. Anna Ledgerwood moderated a multidisciplinary "Panel of Experts". This included Dr. Thomas Scalea, Dr. Jamie Coleman, Dr. Alicia Mangram, Dr. Jeremy Cannon, Dr. Kenji Inaba, and Dr. David Shatz. She presented these experts with multiple cases which were very complicated and obtained their opinions regarding types of treatment. As usual, there was some degree of humor which was appreciated by the audience.

THE ANNUAL DETROIT TRAUMA SYMPOSIUM - DAY TWO - 2025

Friday, November 7, 2025

7 AM – 7:30 AM:

Day two of the trauma symposium began with a continental breakfast during which Dr. Christina Colosimo presented a talk entitled "What are the Expectations of Trauma Centers in Regards to Pediatric Readiness?" She talked about the causes of injury in both adults and children and emphasized that the American College of Surgeons Committee On Trauma (COT) has instituted a policy whereby all the emergency departments should be prepared to deal with pediatric injuries. This includes having the appropriate equipment for dealing with children, properly trained staff, and pediatric specific protocols. She emphasized the importance of having resuscitation begin immediately upon arrival. She pointed out that most citizens are not within one hour of a Level I or Level II pediatric trauma center so that the adult trauma centers must be properly prepared. The first step is to make a decision between the physicians and administrative staff to become prepared after which the appropriate policies and protocols can become established. She pointed out that the establishment of pediatric trauma care readiness will save over 2000 children's lives per year. She emphasized that the COT has become a champion of this preparedness and wants 100% of emergency departments to have pediatric preparedness.

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7:30 AM – 8:00 AM:


Dr. Jeremy Cannon

Dr. Al Baylor (WSUGS 2005), the moderator for the next portion of the program introduced the next speaker who was Dr. Jeremy Cannon from the University of Pennsylvania. His presentation was entitled "Changing Zero Preventable Death with AI, REBOA, and ECMO". Dr. Cannon highlighted how continued bleeding inevitably leads to death and that early control of bleeding is essential. He talked about the "Stop the Hemorrhage" campaign, which is especially helpful in the prehospital setting by the appropriate use of tourniquets. He talked about the causes of prehospital death which are overwhelmingly due to hemorrhage, which is many times more likely to cause death than airway compromise or tension pneumothorax. Studies have emphasized that over 20% of these deaths are preventable. He stressed the importance of early and rapid resuscitation in order to restore blood loss, and he identified many factors which may lead to implementation of the MTP. These include a pulse rate greater than 120, a systolic blood pressure less than 90, and lactic acidosis. Various lab works may also identify the need to implement the MTP. Sometimes bleeding can be obscured, such as might occur in the abdomen, but the need to give three blood transfusions within one hour identifies the need to implement the MTP. He identified the role of the REBOA, especially in patients with severe pelvic fractures where rapid placement of the REBOA can allow balloon inflation in the abdominal zone II in order to control bleeding in the pelvis. Finally, he discussed the problems with pulmonary failure and of the role of VVECHO as a rescue measure in patients who have survived the initial insult but are in severe respiratory distress. Dr. Cannon described the classic work by Dr. Robert Bartlett from the University of Michigan, who first began utilizing this technique in 2001 and how this has been expanded beyond cardiopulmonary bypass into the area of trauma. This technique cannot be used in patients with traumatic brain injury who require ongoing anticoagulation. (My camera was not working properly during this symposium but we can get pictures from each of the presentations and each of the panel sessions listed here online. The password for getting online is DTS2025. let me know if there is a problem getting online in order to get these pictures of each of our moderators, each of our presenters, and each of our panel sessions."

8:30 AM – 9 AM:


Dr. Gary Vercruysse

The next presentation was made by Dr. Gary Vercruysse, from the University of Michigan, and was entitled "Inhalation Injury and Burns, Myths, Management, and Treatment". He talked about the cause of burns in both adults and children. He described the rule of nine and gave the percentages of skin in the various parts of the body; this is used to estimate the percent of total body surface area burn. He pointed out that many of the burns in children are caused by spillage of hot liquids causing a scald of the arms and upper trunk. He stated that a surprising number of patients present with burns because they fell asleep while smoking in bed at the same time that

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they are receiving oxygen therapy for respiratory problems. He emphasized the importance of early transfer to the hospital in patients with burns due to house fires in order to deal with both the burn and associated inhalation injury. He emphasized the importance of intubation in patients with inhalation injury and also the role of early endoscopy in order to determine the severity and location of ventilation injury. A CAT scan of the chest will be helpful in determining whether the injury involves the lungs. The utilization of telemedicine, sometimes, is helpful in guiding decision-making regarding the need for intubation at smaller centers.

8:30 AM – 9 AM:

Dr. Jeremy Cannon, from the University of Pennsylvania, presented the next talk entitled "Large-Scale Combat is Coming, Are You Ready?" Dr. Cannon has extensive exposure to the military and is quite knowledgeable about potential military conflict. He described some of the activities that occur at the Hoover Institute as it relates to trying to outsmart a potential future enemy. He pointed out the great concern that our military has for China which he stated wants to buy us out and is on a wartime footing. He stated that our nation has the potential for falling into the "Thucydides Trap", which referred to the Peloponnesian Wars when the military rise of Athens stimulated the Spartans to increase their military preparedness. This led to a total national commitment to prepare for war which eventually was one by Athens. There is great concern that our nation may not be prepared as was evidenced by the lack of a prompt response to the Covid crisis. He emphasized that our nation must be prepared to respond rapidly to a regional crisis such as might occur with a natural disaster, a riot, or to a national disaster such as war. Just as a city must prepare for a riot by having a disaster protocol which focuses on a rapid physician response, nursing response, availability of beds, preparation for dietary needs for the in-house physician and nurses, and available operating rooms to accommodate the sudden rush of inpatients. This preparation must occur at a national level in order to treat an overflow of patients which could be as high as 30,000 per month. He also stressed the new type of weaponry which is currently being used in the Ukraine and in Gaza. His presentation was very sobering.

9:15 AM – 9:30 AM:

Dr. Al Baylor then moderated a panel session which included Drs. Jeremy Canon, Christina Colosimo, and Gary Vercruysse.

9:30 AM – 10 AM:

Dr. Lawrence Diebel, from Wayne State University, gave the next presentation which was entitled "The Endothelial Glycocalyx Following Shock and Trauma: What You Need to Know". Dr. Diebel defined the various elements of the Starling Equation whereby the capillary is active in balancing the contents of the plasma and of the extra cellular matrix. He emphasized of the roles of hydrostatic pressure and oncotic pressures on

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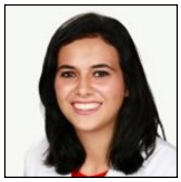
each side of the capillary membrane. He described the individual components of the extracellular matrix and how that acute inflammatory insult causes alterations in the matrix which leads to edema, reduction in coagulation factors, and organ dysfunction. Dr. Diebel emphasized the importance of a balanced OR resuscitation and suggested that the volume of crystalloid infusion correlated with shedding of matrix components. He pointed out that endotheliopathy would lead to edema even though the patient is not in the state of hypervolemia.

10 AM – 10:30 AM:


Dr. Christina Colisomo

The next presentation by Dr. Christina Colosimo, from the University of Arizona, was entitled "What Can You Do To Improve Firearm Culture?" She emphasized that that firearm deaths in our nation were the worst in the civilized world for the past number of years. This includes pediatric and adult deaths. She pointed out that almost 50% of our citizens own guns. Those states that have gun storage laws are troubled by the fact that these laws are often ignored and children often are able to use these weapons for assaults at schools. She also emphasized that the number one cause of suicide was a firearm. Even when parents say that their weapons are secured, most children responded that they know how to get to the weapons. The state of Michigan has over 1000 deaths per year, even though there are state laws mandating that the weapons to be secured. Dr. Colosimo emphasized the importance for states to address these issues and insist that there be training before anybody can purchase a firearm. Many states have such programs but they are not mandatory. It is important to teach firearm prevention in schools and to do prospective analyses to see whether these prevention programs are effective.

10:30 AM – 10:40 AM:

Mrs. Leah Diebel ,a social worker in Detroit, discussed gun violence within our fair city and emphasized that serious injury may result from accidental use of firearms, criminal use, or self-inflicted injury. She emphasized the importance of education and how our citizens are very receptive to education designed to prevent serious injury.

10:40 AM – 11:15 AM:

Dr. John Rozel, from the University of Pittsburgh, gave the next presentation which was entitled "The American Problem: Understanding What the Evidence Really Says about Gun Violence, Mass Shootings, and Mental Illness". He began his presentation by describing a 14-year-old youngster with autism becoming homicidal and injuring several children at his school. He describes the things that have to be done in order to educate our youngsters at school about the importance of firearm protection and he also emphasized that threatening statements made in social media are not part of "just joking". He described one school shooting where 11

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youngsters were killed and many others injured from a firearm that was not protected at home. He pointed out that there are 400 million firearms in our nation and that there are over 27,000 suicides due to the firearms. He showed multiple examples of survivors who have permanent injuries. Our nation leads the world in firearm deaths. The second amendment to the Constitution allows for the American citizens to own firearms. The federal government has decreased the administration of research grants if the grant suggests that decreasing the availability to firearms might be beneficial. Dr. Rozel also pointed out the close relationship between mental illness associated with suicide by firearm or mass shooting. There are different degrees of mental illness with some degrees being quite obvious and other degrees being that the individual is "not well". He encouraged increased legal focus on this terrible national problem.


Dr. John Rozel

11:15 AM – 12 noon:

The scientific program concluded with a panel session moderated by Dr. Larry Diebel. This panel included Dr. John Rozel, Dr. Christina Colosimo, and members of the Detroit Police Department who have to deal with the problem of death and disability due to firearms each day.

This concluded the 2025 Detroit Trauma Symposium. Dr. Larry Diebel thanked the participants and the registrants for their participation and invited them to be present for the 2026 Detroit Trauma Symposium.


Dr. Anna Ledgerwood moderates the "Panel of Experts" which included Drs. Thomas Scalea, Jamie Coleman, Alicia Mangram, Jeremy Cannon, Kenji Inaba, and David Shatz


Dr. Larry Diebel moderating a question-and-answer session which included Drs. Kenji Inaba, Adam Starr, David Shatz, Andrew Kerwin

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The Volunteers who worked the 73rd Detroit Trauma Symposium

Dr. Anna Ledgerwood hosted a dinner for the DTS Volunteers

Dr. Anna Ledgerwood hosted a dinner for the DTS Volunteers

WAYNE STATE UNIVERSITY School of Medicine

2025 Annual WSSS Lectureship

wayne state surgical society

Dr. Thomas Scalea

*The **Surgical Grand Rounds on Wednesday, November 5, 2025** was presented by Dr. Thomas Scalea who had the honor of presenting the **Wayne State Surgical Society Lecture**, which is sponsored each year on the day prior to the Detroit Trauma Symposium. Dr. Bruce McIntosh, the current president of the Wayne State surgical Society, introduced Dr. Scalea who has had an illustrious career in general surgery and trauma. The title of this lecture was "The History over the Management of Vascular Injuries. The Journey continues: Evolution, Revolution, and Resolution."*

Dr. Scalea began by discussing some of the basic principles that must be followed when caring for patients with vascular injury. He described the differences between the hard signs and the soft signs in patients who have injuries that may involve major vessels. Unstable patients with active external bleeding, an expanding hematoma, compression or compromise of adjacent organs due to the hematoma, or patients with compromise vital signs due to the vascular injury, must be taken directly to the operating room. Patients with soft signs such as a small hematoma, minor bleeding, or superficial wounds causing local symptoms may be observed and undergo various diagnostic tests. Patients with no signs are best treated non-operatively even when the injury occurs in the middle zone of the neck.

He pointed out that there have been too many negative explorations in patients who have injuries in certain locations but no positive findings. He described the "Injury Extremity Index," which is used to assess potential vascular injuries to the extremities. One of the major components of this examination would be the ankle/brachial index. He emphasized the role of cognition in examining patients and not immediately ordering a CTA or an arteriogram. He emphasized the increasing role of ultrasonography which has a learning curve.

Dr. Scalea spent some time discussing bleeding from pelvic fractures. He pointed out that one of the early papers emphasizing angiography to assess and treat bleeding from pelvic fractures was published in 1972. One of the co-authors of that paper was Dr. Ernest Ring, a former Wayne State University student. He also stressed the importance of the contributions made by Dr. David Feliciano, a former Wayne State University Trauma Fellow.

The importance of utilizing one's finger to get the direct pressure control of active bleeding from superficial arteries and veins was emphasized. Dr. Scalea gave a number of examples of how digital pressure can be successfully utilized in a desperate situation. He also discussed the role of arterial embolization, particularly, as it relates to splenic and hepatic injuries. He pointed out that splenic embolization which leads to splenic ischemia do not protect the immune function of the spleen. He also pointed out that many of the patients who undergo splenic embolization require splenectomy. He also emphasized that hepatic embolization may be used as part of damage control in addition to providing a more accurate diagnosis.

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WAYNE STATE UNIVERSITY School of Medicine

2025 Annual WSSS Lectureship

wayne state surgical society

The next area of his presentation involved the treatment of blunt aortic injury and he described the different types of proximal aortic injury and how there has been a major shift in treatment from open repair to endovascular repair. He also described how endovascular treatment can be applied in patients who develop a pseudoaneurysm after blunt injury.

Part of the revolution regarding the treatment of vascular injury includes the use of the REBOA which initially was used as a bridge to arterial embolization. Now it is used as part of the initial resuscitation, particularly, in patients with very bad pelvic injuries causing major bleeding and hypotension.

Dr. Scalea emphasized the role of the hybrid"operating room where arterial embolization and open operative repair can be performed in sequence as necessary. He described how resuscitation can be used in conjunction with the REBOA for both arterial and venous injuries. He emphasized how a more rapid control of bleeding can save time and allow for limb salvage in patients who would otherwise have an excessively prolonged ischemic time. He pointed out that the restricted 60 hour duty time has decreased the number of operations performed by residents and they do not have the same exposure to vascular trauma that has occurred in the past. He emphasized that the need to call in a vascular specialist results in a longer ischemic time for patients with serious limb injuries resulting in an increase in amputations. He has addressed this problem by increasing the trauma fellowship at his institution to two years, with part of the second year involving vascular training so that each evening there is a general surgeon with vascular experience on-call who can provide care for both nonvascular injuries and vascular injuries including whatever angiography may be necessary. He pointed out that this approach significantly decreases the time to vascular correction and results in a lower amputation rate. There was an active question-and-answer session to this very comprehensive Wayne State Surgical Society Lecture.

SURGICAL GRAND ROUNDS


Dr. Noah Stern

The Surgical Grand Rounds on Wednesday, November 12, 2025 was presented by Dr. Noah Stern from the Department of Otolaryngology and the title of his presentation was "The Surgical Approach to Thyroid Nodules an Goiter's: A Residents Guide". Dr. Stern discussed some of the history of thyroid surgery. The presence of thyroid goiter disease has been known for almost 5000 years in the written literature. Normal thyroid anatomy was not well-recognized until the 1500s. Dr. Johann Fabricius performed a thyroidectomy for goiter disease in 1774; the patient died eight days later and Dr. Fabricius ended up going to prison. The first of a successful total thyroidectomy was done by Dr. Guillaume Dupuytren in 1808, but the operation still was not fully accepted as evidenced by the statement made by the famous Dr. Samuel Gross in the late 19th century that "no honest surgeon would do a thyroidectomy".

The revolution, in terms of performing thyroid resection, occurred in the late 19th century when Dr. Emil Kocher performed over 500 thyroidectomy's and the mortality rate went from 12% down to less than one percent. Dr. Stern described the pyrimadial lobe which runs along the thyroglossal duct which sometimes contains thyroid tissue. Rarely, the thyroid tissue at the site is the only thyroid tissue that the patient has; so that removing a so-called "thyroglossal cyst results in a total thyroidectomy.

The thyroid capsule is closely adherent to the gland, particularly near the ligament of Berry which is at the site where the recurrent laryngeal nerve passes posterior to the thyroid to enervate the larynx. He described the anatomy of both the superior and inferior laryngeal nerves and described the techniques that are followed in order to prevent injury to either of those nerves. The recurrent laryngeal nerve innervates most of the muscles in the larynx with the posterior branch enervating the vocal cords. He pointed out that there is a "non-recurrent inferior laryngeal nerve" in less than 1% of patients and that this anomaly usually occurs on the right side. Dr. Stern described that although the superior laryngeal nerve helps with cord function, when the nerve is injured the patient describes problems with shouting or control of voice tone. This is usually a temporary defect.

The physiology of thyroid function was discussed in detail as was the endocrine excess of the pituitary secretions of TSH and the normal feedback from the thyroid gland to the pituitary gland. He pointed out that T-3 is the active form and T-4 is the form of thyroid hormone released by the thyroid gland in response to TSH.

Dr. Stern discussed the approach to thyroid nodules and the importance of assessing size, TSH level to determine whether the patient is hyperthyroid or hypothyroid, and various features of the nodules which might suggest malignancy. He emphasized the role of fine needle aspiration and the different interpretations on microscopic examination including non-diagnostic, benign, atypia, suspicious for malignancy, and malignant.

Dr. Stern then discussed Graves' disease and described the changes in the thyroid gland which is often enlarged, the bulging of the eyes, the pre-tibial edema, and acropathy. Non-operative treatment of Graves' disease

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SURGICAL GRAND ROUNDS

was discussed defining all of the different medicines that might be used in order to decrease the production of thyroid hormone, the use of radiation therapy, and the role of thyroidectomy. The different types of anti-thyroid drugs that are used prior to thyroidectomy were discussed at length. Preoperative anti-thyroid drugs are given for a period of 4 to 6 weeks. He described the three different types of hypothyroidism, namely, primary, secondary, and tertiary. Hypothyroidism can usually be treated with thyroid replacement but, when due to Hashimoto's Thyroiditis in the presence of a large thyroid gland causing compression, resection may be needed.

Regarding thyroid nodules, Dr. Stern emphasized the importance of ultrasonography, particularly in the presence of multi-nodular goiter disease and he described a "point system" based upon size, shape, margin, and echogenicity to help determine whether a nodule is malignant. He described the different types of thyroid cancer and the features of follicular cell cancer, papillary cancer, Hurtle cell cancer, and medullary cancer. He also described the types of cancers which are part of the multiple endocrine neoplasia syndrome. Anaplastic thyroid cancer is rare but extremely aggressive and patients often end up with a tracheostomy. He pointed out that the complications of thyroidectomy include hematoma, injury to the superior laryngeal nerve or the recurrent inferior laryngeal nerve, hypocalcemia due to incidental parathyroidectomy and thoracic duct injury. There was an active question-and-answer session to this very comprehensive presentation.


Dr. Amilee Khoury

The Surgical Grand Rounds for Wednesday, November 19, 2025 was presented by Dr. Amilee Khoury and was entitled "Introduction to Life's Lessons". This was a philosophical presentation and she began by describing her early years growing up in the small town of Ionia, Michigan. During her early years she was interested in education and becoming a teacher; this led her to emphasizing science classes during her high school years. She did her premedical and medical training at Michigan State University, after which she did her surgical training at McLaren Hospital, which was followed by her Fellowship at Case Western Reserve University. During her early years she was involved as being a scribe in the emergency department and became interested in both trauma care and critical care. She recalled some patients who had severe multisystem trauma during her residency days and how the care of these patients was very stimulating. She emphasized the love of family and the importance of being truthful, avoiding laziness, and being punctual.

She also emphasized that many of the injuries that were formerly treated with operation are now treated by IR with strategically placed catheters. This has resulted in a marked decrease in the number of operative cases which, in turn, affects the training of surgical residents. She emphasized the importance of communication and

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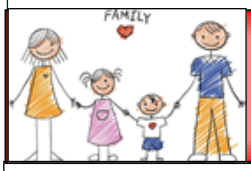
SURGICAL GRAND ROUNDS

discussion with colleagues and patients about the role of an ostomy or a resection in patients with sigmoid diverticulitis. She also discussed the importance of discussing with colleagues and patients when is the best time to close an ostomy in that setting. The frustrations of having complications are helped when one does things for oneself such as walking the dog, enjoying ice cream and cake, and watching reality television.

Dr. Khoury highlighted the importance of monitoring your intravenous fluid therapy and frequently checking electrolytes. She described a 65-year-old patient who had problems with alcohol and who developed respiratory failure with hypoxia following closure of an ostomy. This patient was not getting nutrition for some time and the initiation of nutrition led to development of the refeeding syndrome. She emphasized the importance of following the electrolytes closely in these patients particularly, potassium, magnesium, phosphorus, and sodium. She defined the differences between normal saline and a balanced electrolyte solution.

She also pointed out that sometimes patients develop severe respiratory distress and require an emergency airway. When this can't be done non-surgically, a "crico" as to be performed. She described the anatomy and emphasized that knowledge keeps one out of trouble. She emphasized the old sayings that "better lucky than never" and "luck favors the prepared mind".

Dr. Khoury described a 72-year-old patient who had a peritoneal dialysis catheter for long-term kidney failure. The patient presented with severe constant abdominal pain but had little in the way of physical findings and had normal vital signs. Because of the pain, she operated and found severe adhesions related to the catheter and the patient did well following bowel resection. She emphasized the importance of talking with colleagues, friends, and family. There was a nice question-and-answer session following this philosophical presentation.



PRODUCTIVITY

Dr. Jessica McGee (WSUGS 2017) is not only productive in the operating room and in the intensive care unit but she and her husband, Patrick, are raising two youngsters, William who is five and Abigail who is three; they should be making their applications for the Wayne State University College of medicine in the 2040s.

Dr. Jessica McGee, her husband, Patrick, and their son, William, and daughter, Abigail.

Abby is enjoying preschool and William just started Kindergarten and is excited about all the specials at his new school.

MICHAEL & MARIAN ILITCH DEPARTMENT OF SURGERY

WAYNE STATE

Wayne State Surgical Society

2026 Dues Notice –

RETURN TO: *Charles E. Lucas, M.D*
Detroit Receiving Hospital, Room 2V / Surgery
4201 St. Antoine Street
Detroit, MI 48201

PLEASE COMPLETE ↓↓↓

Name:

Address:

City/State/Zip:

Phone:

Email: _____@_____

MARK YOUR CALENDARS

2026 Critical Care Congress
March 22-24, 2026
McCormick Place, West Building
Chicago, Illinois

146th Meeting of the American Surgical Society
April 23-25, 2026
Hyatt Regency Seattle
Seattle, Washington

72nd Meeting of the Michigan Chapter, ACS
May 20-22, 2026
The Highlands at Harbor Springs
Harbor Springs, Michigan

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

EXCERPTS FROM THE LOG BOOK DOWN MEMORY LANE


Dr. Anna Ledgerwood

8/15/72 - Staff: Dr. Allaben - Chief Resident: Dr. Ali

1. FG: Post stab wound abdomen with respiratory distress, had tracheostomy.
2. BC: Wounds shoulder and AKA, had change of dressing.
3. LM: Appendectomy, which was normal appendix.
4. ML: Acute cholecystitis in a 64yo lady, had cholecystectomy with positive stones.
5. WP: Pedestrian hit by car, had hematoma and contusion of mediastinum with massive laceration of left lobe of lung, had left lobectomy and died in O.R.
6. CN: Laceration extensor tendon with glass, repaired.
7. BS: 1yo female with abscess buttock, had incision and drainage.

8/16/72 - Staff: Dr. Angie Kambouris

1. BC: Change of dressing.
2. SH: Postop GSW right popliteal, had split-thickness skin graft to fasciotomy wounds.
3. VC: Stab wound abdomen, had laparotomy with penetration but no visceral damage.
4. PS: Multiple abdominal GSW, had left thoracotomy with cross clamp of aorta and resection of small bowel and right colon.
5. TD: Incarcerated right inguinal hernia in 11-month-old, repaired.
6. SP: GSW abdomen, had laparotomy and repair of jejunal perforation.

8/17/72 - Staff: Dr. Floyd Lippa

1. BC: Change of dressing.
2. LM: Exploratory laparotomy for GSW in 3yo with closure of liver laceration and removal of bullet from back.
3. JY: Motorcycle crash with cerebral contusion and fracture of jaw, had jaw wiring, bilateral chest tube insertion, tracheostomy, exploratory laparotomy with repair of liver laceration, exploration left groin, and ligation of injured femoral vein and insertion of tibial K-wire for fracture.
4. MC: GSW abdomen with thru-and-thru wound of liver and tangential laceration of colon, which was closed. The vena cava was also explored and was intact.

8/18/72 - Staff: Dr. I.K. Rosenberg

1. BC: Traumatic amputation with change of dressing.
2. WT: Postop hemorrhagic pancreatitis with intra-abdominal bleeding, had exploratory laparotomy, splenectomy, pancreatectomy, omentectomy, vagotomy, and ligation of gastric vessels.
3. HW: Perforated duodenal ulcer which was patched as it was 18 hrs. old.
4. TM: Postop stab wound with splenectomy, had wound dehiscence and repaired with retention sutures.

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WAYNE STATE

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

5. FK: SGW right flank, had exploratory laparotomy with closure of holes in small bowel and then debridement of wound.
6. JC: Shotgun blast chest, abdomen, groin, and thigh, had chest tubes placed, exploratory laparotomy, closure of 20 holes in small bowel, repair of left external iliac artery, and repair of right femoral arterial holes.

8/19/72 - Staff: Dr. G. Baker

1. DH: SGW posterior thigh, treated with debridement.
2. BC: Change of dressing.
3. HR: Stab wound chest with injury to left ventricle and descending coronary artery with coronary artery injury which was repaired; was defibrillated nine times.
4. WB: GSW left upper quadrant and right arm, treated with exploration of right axilla and repair of brachial artery and ligation of axillary vein.
5. DD: Appendicitis treated with appendectomy. Patient has thyrotoxicosis and pregnancy.

8/20/72 - Staff: Dr. J. Kirkpatrick

1. BC: Change of dressing.

8/21/72 - Staff: Dr. W. Harrity

1. BC: Change of dressing.

8/22/72 - Staff: Dr. S. Woods

1. JC: Assault with flail chest, had tracheostomy and insertion of chest tube.
2. EW: Amputation of proximal phalanx of left thumb, treated with flap closure of stump.
3. BC: Change of dressing, debridement and skin grafting.
4. AF: 7yo with GSW left upper quadrant, had closure of stomach, duodenum, and jejunal perforations.
5. PM: GSW abdomen with laceration and resection small bowel. Colon injury was closed and exteriorized, and the laceration of lower pole of left kidney was drained. Of note, patient is six months pregnant.
6. JW: GSW chest, neck, and arm; paraplegic. Patient had laparotomy for perforation of liver and exploration of neck with ligation of internal jugular vein.

MICHAEL & MARIAN ILTCH
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, December 3
Death & Complications Conference
"ABSITE Quest Exam"
David Edelman, MD
Program Director, DMC/WSU School of Medicine Surgical Residency

Wednesday, December 10
Death & Complications Conference
"Management of Liver Trauma in 2025"
Jessica McGee, MD
DMC/WSU School of Medicine

Wednesday, December 17
Death & Complications Conference
"Management of the Axilla in Breast Cancer: The Past, Present, and Future"
Paige Aiello, MD, Breast Surgical Oncologist, Karmanos Cancer Institute
DMC/WSU School of Medicine

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

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. Joseph Sferra (WSUGS 1991) passed the baton of presidency to Dr. Bruce McIntosh (WSU/GS 1989/94) at the WSSS gathering during the American College of Surgeons meeting in October 2025. 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*.