MICHAEL & MARIAN ILITCH DEPARTMENT OF SURGERY

WAYNE STATE

FEBRUARY 2026

SURGICAL GRAND ROUNDS

February 2nd

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February 16th

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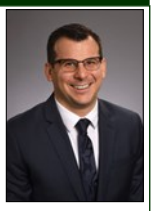

Dr. Andrew Isaacson

The **Surgical Grand Rounds for Wednesday, January 8, 2026** was presented **by Dr. Andrew Isaacson (WSUGS 2017)** who did a fellowship in trauma and critical care surgery following the completion of his general surgery residency. The title of his presentation was **"Trauma and Critical Care: 2025. ABSITE Review: Eighth edition from SCORE".**

Dr. Isaacson's presentation covered the waterfront as it relates to both trauma and critical care. He began by discussing the ABCDEF of approach to the injured patient. He reviewed the Glascow Coma Scale (GCS) and the different level of severity of injury based upon eye movement, verbal ability, and motor function. He described the resuscitation regimen for severely injured patients including the importance of whole blood and a balance resuscitation ratio. Prior to control of bleeding, resuscitation guidelines should include restoration of the systolic blood pressure to 90 torr. He described the five classes of hemorrhagic shock based upon vital signs, **EKG changes**, and kidney function.

The chest x-ray provides much information as part of the physical examination and this allows one to identify fractures, pneumothorax, and changes in the mediastinum. The initial examination should also include a CAT scan of the head on all patients where there is some concern for brain injury. The images showing epidural hematoma, subdural hematoma, intraparenchymal bleeding, and different degrees of midline shift were presented. He also described how the FAST examination will be positive for blood when there is more than 150 ml and will be positive for hollow viscus injury based upon evidence of air outside of the bowel movement. He also emphasized the importance of this examination in identifying pericardial effusion.

All of the features of the TEG examination were discussed, including those findings which suggest inadequate coagulation factors, a deficiency in platelets, and excessive fibrinolysis.. Both blunt and penetrating injuries may be associated with various types of organ injuries in the neck. Dr. Isaacson described the different stages of vascular injury and pointed out which injuries can be treated with antiplatelet therapy, intraluminal stenting, or require open repair. He pointed out that the likelihood for having a stroke secondary to cervical vascular injury relates to the severity of injury and the rapidity of repair.

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SURGICAL GRAND ROUNDS, cont...

A massive hemothorax is defined as containing 1500 ml of blood and pointed out that some of these patients require early thoracotomy. Likewise, patients with lesser degree of hemorrage often have incomplete evacuation with a chest tube so that a second chest tube may be necessary; when a second chest tube fails, the patient is a candidate for a VATS procedure. Other vascular injuries in the chest may require different types of surgical exposure and he described which injuries require a median sternotomy, a right thoracotomy, a left thoracotomy, or the so-called trap door thoracotomy for getting exposure to the left subclavian artery.

There are a number of hollow vicious injuries that occurred following blunt trauma. Dr. Isaacson described how a duodenal hematoma, which is not causing peritonitis, can be treated non-operatively with the expectation that the patient will be able to eat within one week. Prolonged duodenal hematoma requires operative exposure and evacuation of the hematoma. Full thickness duodenal injuries can sometimes be repaired primarily but, on some occasions, the extent of injury is so severe that some type of bypass is indicated. There are a number of pancreatic injuries following penetrating wounds and blunt injury. The treatment depends upon the severity of the pancreatic injury and the location. Severe distal injuries are best treated with pancreatectomy with splenectomy; he did not recommend splenic salvage. The more proximal severe injuries may require extensive diversion or, in very unusual circumstances, the Whipple operation.

Injuries to the large intestine can be treated by primary repair resection with primary anastomosis, or, in the presence of severe hemorrhage and contamination, resectionwith proximal colostomy. Likewise minor rectal injuries can be repaired primarily but require a proximal diversion when the injuries are extensive.

He emphasized the role of an indwelling Foley catheter in patients who have primary repair of a urinary bladder injury . Long bone fractures which are associated with vascular injuries should have the fracture stabilized prior to repair of the vascular injury. When the time from repair of the fracture until the repair of the vascular injury is extensive, a vascular stent may be utilized while the patient is transferred to a trauma center with a higher level of care. He emphasized that when injury occurs in a pregnant patient, treatment of the mother takes priority over treatment of the unborn child. He finished the area of abdominal injuries by describing the three zones of retroperitoneal injury with hematoma and emphasized that patients with zone one injury often require exploration whereas those with zone two and zone three injuries below the renal vasculature can often be observed without operation.

Dr. Isaacson finished his presentation by discussing critical care and summarized some of the features of the Surviving Sepsis Campaign which has had about six editions in the past 20 years. He described the differences between SIRS, sepsis, and septic shock; he included the initial diagnostic tests that are indicated and outlined the treatment recommendations throughout the different phases of treatment. He emphasized the role of early volume resuscitation, antibiotics based upon cultures, and the potential benefit of steroids in patients not immediately responding to fluids. Part of this presentation included the severity of the sepsis based upon the SOFA classification. He described the features of ARDS and at the different types of treatment for this type of lung

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SURGICAL GRAND ROUNDS, cont...

failure. Patients with the worst degree of lung failure may be candidates for ECMO and he described some of the conditions which may benefit from this type of treatment. He emphasized that patients who are on anticoagulants and also have traumatic brain injury are not candidates for ECMO. He finished up by thanking his two infant children for their continued stimulation of his productivity. There was a good question-and-answer session.

The **Surgical Grand Rounds** for **Wednesday, January 14, 2026** were presented by the senior surgical residents with each resident reporting on the most interesting thing they had learned during the October 2025 meeting of the American College of Surgeons.


Dr. Nicholas Calvo

The first presentation was made by **Dr. Nicholas Calvo** who talked about a panel session that dealt with gastrointestinal bleeding. He described how all of the panel members emphasized the importance of balanced resuscitation with blood, crystalloid, plasma and platelets. Once the patient is stabilized, the CT angiogram provides important information regarding the source of bleeding with emphasis being placed on an arterial origin, venous origin, or portal venous origin. He showed examples of the different types or bleeding on CT. He pointed out that the CTA identifies bleeding which is occurring at less than 0.5 ML/minute, whereas the tagged red blood cell with technetium will identify bleeding which is occurring at the rate of 0.04 ML/min. Most of the bleeding distal to the ligament of Treitz will be arising from the colon although malignant melanoma which has metastasized to the small intestine may be a source of bleeding. Once identified, superficial bleeding can be contained by endoscopic techniques but there is about a 15% pre-bleeding rate. When the bleeding is arising from colonic diverticula, the presentation at the meeting suggested that resection of that part of the colon which is the source of the bleeding diverticulum should be performed. This last statement led to some discussion in the question-and-answer session. There is data that suggests that rebleeding from colonic diverticular disease does not always come from the same diverticulum, so that total abdominal colectomy is recommended to prevent rebleeding. The problem with too many loose bowel movements following total abdominal colectomy can be prevented by saving every last millimeter of the terminal ileum which is sutured to the proximal rectum.

The next presentation was made by Dr. Farhan Chaudhry who summarized the Ravdin Lecture which was delivered by Dr. Conn. The presentation emphasized that heart failure is present in over six million Americans and that the expense of caring for these patients runs to over $40 billion per year. He described how Dr. Michael DeBakey and Dr. Domingo Liotta from Argentina worked on the development of an artificial heart.

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Dr. Farhan Chaudhry

Dr. Denton Cooley was also involved in this effort. When Dr. DeBakey was in Washington attempting to get financial support from the National Institutes of Health for this project, Dr. Liotta convinced Dr. Cooley to place their artificial heart in a patient at a time when the only studies had been done in animal models. Dr. Chaudhry reported how this led to a feud between these two surgical giants and he showed a picture on the cover of Time magazine of these two great surgeons being upset with each other when they worked in the same medical center. The first patient in whom this artificial heart was placed developed severe hemolysis and died with multiple organ failure. Subsequently, the artificial heart was improved upon and was inserted in several patients each year. These patients had improved left ventricular function and had significant palliation until they could be transitioned to heart transplantation. Subsequently an indwelling rotary pump has been developed which uses the "screw technique" referred to as the "Archimedes screw". Pictures were shown of this indwelling pump functioning.


Dr. William Dailey

The next presentation was made by Dr. William Dailey and he described some of the current features and challenges with artificial intelligence (AI) and chatbots. He pointed out that artificial intelligence is moving into the medical field and will probably become more useful in providing data to more rapidly make critical decisions. There are many research activities with artificial intelligence and patients seem to accept its utilization in decisions regarding the treatment of their diseases. He presented data suggesting that AI is rapidly improving and leads to improved documentation in an outpatient setting and in the hospital. AI may be beneficial in decreasing office time, increasing accuracy, and reducing the likelihood for "burnout". He presented some examples where the performance of certain office procedures was done in conjunction with AI in order to be certain that the physician was asking all the appropriate questions and making appropriate decisions. He concluded by pointing out that AI is not a panacea but will be used more and more in the future.


Dr. Jude Jaraki

The next presentation was made by Dr. Jude Jaraki and it dealt with different types of arterial injury including bleeding from solid organs. He described the different degrees of severity of arterial injury extending from intimal tear, hematoma, contained hemorrhage, active bleeding, and vascular disruption. Arterial bleeding from liver injury may be treated by arterial embolization using gel foam, coils or stents. He also described how one can have a fistula in the hepatic arterial system to the biliary system resulting in rapid bleeding of blood through the bile duct into the duodenum followed by hematemesis. He emphasized that this type of liver embolization is not without hazard and that a number of patients developed localized liver necrosis. He discussed the different types of splenic injury which may be treated by arterial embolization which, in some reports, results in increased survival. Since the occlusion of any vessel may lead to necrosis of that organ, he emphasized that not every blush needs to be embolized and we should focus on the importance of treating patients and not treating images. Dr. Jaraki also described examples of the successful treatment of renal injuries by arterial embolization although there is a failure rate which is greater than 10% and may be increased in those patients who have an obvious urinary leak or severe hematuria.

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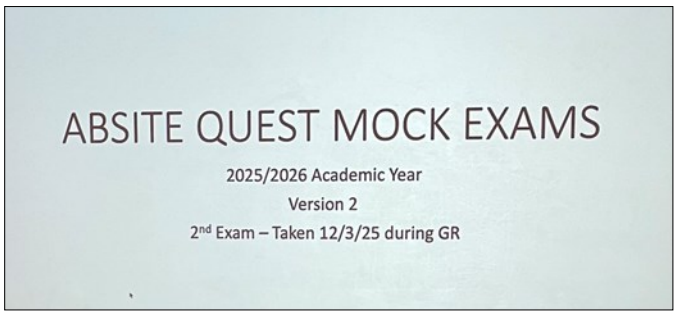
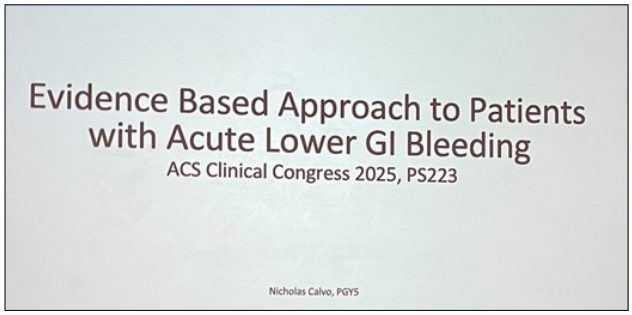
Dr. Stephanie Joseph

The next presentation was made by Dr. Stephanie Joseph and she talked about GLP for obesity. This acts as a hormonal stimulation for decreasing gastric emptying and increasing gastric relaxation. She emphasized how this may interfere with general anesthesia because the patient will have a full stomach even though nothing has been eaten or drunk over eight hours. There have been multiple publications of vomiting and aspiration at the time of induction of general anesthesia. The American Society of Anesthesiology recommends that these agents be stopped one week before scheduled operation in order to prevent this horrible complication. Sometimes a CT of the stomach is performed in order to be sure that the stomach is not full of partially digested food. More recently, emphasis has been placed on using ultrasound to make the same assessment as part of a point-of-care rapidly performed procedure. There was an active question-and-answer session.


Dr. Eliza Beal

The **Surgical Grand Rounds** for **January 21, 2026** was presented by **Dr. Eliza Beal** who is an active and productive member of the Department of Surgery with special interest in tumors. The title of the presentation was **"ABSITE QUEST Mock Exams, 2025/2026 Academic Year, Version 2."** Dr. Beal presented the questions that the residents will face when they do their In-Training examination and their Board examination. She covered approximately 30 different issues. A presentation of the surgical challenge would be given, followed by five possible answers. Each resident would choose their individual choice on their iPhone, and then this would show up on the screen after all of the residents had input their best guess. The correct answer would then be displayed, and there would be a discussion about the case and why the correct answer, indeed, was correct. The presentation was quite good, and the residents were very much involved with the process.





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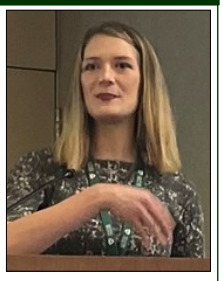
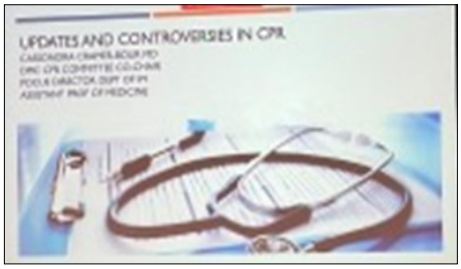

Dr. Cassondra Cramer-Bour

The **Surgical Grand Rounds** on **Wednesday, January 28, 2026** was presented by **Dr. Cassondra Cramer-Bour, M.D.** who is the Co-Chair of the Detroit Medical Center CPR Committee in the Department of Internal Medicine. The title of her presentation was **"Updates and Controversies in CPR"**. She discussed many aspects of the history of CPR and how it has evolved over the years. Her primary objective was to update the current status in the utilization of ultrasound in conjunction with CPR. The use of CPR has been studied for over two centuries and she illustrated the effects that were described with shocking chickens and then performing autopsies to determine the effects on the myocardium.



There are a number of techniques which are used to determine the efficacy of CPR. This would include checking for peripheral pulses which often leads to an error in the interpretation of the CPR effectiveness. This type of error may occur when checking pulses at many different locations including the groin, wrist, and neck. Other techniques for assessing the efficacy of CPR include the measurement of end title CO_2 assuming that restoration to 10-20 mmHg suggests that restoration of spontaneous circulation has occurred. She pointed out that the documentation of successful CPR, performed quickly, is associated with increased survival, especially when performed prior to arrival at the hospital. Arriving at the hospital with spontaneous circulation, in turn, is associated with successful discharge with maintained mental function.

The use of subxiphoid application of ultrasound gives an excellent reading of pulse status which is much more accurate than other techniques. She showed a number of examples of this technique being implemented and the high correlation with successful return of spontaneous pulse. This technique can even be performed when a patient is undergoing external cardiac massage. Utilization of this technique has resulted in increased presentation to the hospital with spontaneous circulation and increased survival compared to when this technique is not used.

The use of ultrasound-guided CPR can be a point-of-care technique in the prehospital setting when the emergency medical technicians are appropriately trained. Even those patients who have had a refractory cardiac standstill, have improved arrival at the hospital with spontaneous circulation which leads to increase in final outcome.

Ultrasound-guided CPR can also be used in patients with large pulmonary emboli who are being treated with fibrinolytic agents or, in selected cases, with anticoagulants. The use of fibrinolytic agents in this setting is associated with an increase in a successful outcome. Ultrasound-guided conversion from atrial fibrillation or atrial flutter is also more likely to be successful. Dr. Cramer-Bour described the different levels of energy which are appropriate to make this electrical conversion. She pointed out that keeping the head elevated is not recommended when applying this technique.

There was an active question-and-answer session following this very interesting presentation.

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Dr. Anthony A. Smith, MD

Dr. Smith and his bride, Sandra, at a Circle the City Fundraiser

Dr. Anthony A. Smith started his Plastic Surgery Residency at Wayne State University (WSU) on July 1st, 1986 after completing his general surgery residency two years earlier at Brooke Army Medical Center in San Antonio, Texas. Between completing general surgery and starting at WSU, he had a two-year military obligation. The first year of his obligation was spent serving as Chief of Surgery at Weed Army Community Hospital at the National Training Center, Fort Irwin, California. He was newly married and he and his bride, Sandra, lived on post. The hospital was only 30 beds and had two ORs staffed by two Army nurse anesthetists. The National Training Center had 5000 active duty Army troopers who engaged in mock warfare 26 days of the month, while wearing Russian uniforms. There were only 11 doctors on post and by default he was also head of the Emergency Department. He started treating traumatic hand injuries out of necessity. It was a great job for someone who did not plan to become a career general surgeon. His oldest son, Matthew, was born while they were at Ft. Irwin and Dr. Smith was able to deliver him. They returned to San Antonio for the second year of his obligation where he served as a staff general surgeon at the U.S. Army Institute of Surgical Research (The Army Burn Unit). The ISR was commanded by Col. Basil Pruitt, a true icon in American surgery and Dr. Smith headed one of the two clinical teams. He was offered an opportunity to train in plastic surgery at Walter Reed but decided to leave the Army after his two year military obligation and it was Col. Pruitt who recommended that he train in plastic surgery with Dr. Martin Robson in Detroit.

Dr. Smith knew very little about the program when he started. In fact, he did not realize the plastic surgery residents took in-house call until the first day of the residency. His first rotation was at Detroit Receiving Hospital with Dr. Jonathan Saxe (WSUGS 1990), a PGY-3 in general surgery who was his junior. He and Jonathan got along great and Dr. Smith staffed him on many cases. Both Dr. Smith and Dr. Saxe also helped out in the burn unit as the burn fellow, Dr. Toby Meltzer, from LSU in New Orleans, had little burn experience and needed help getting through the cases every day. At Detroit Receiving, the attending surgeons, in addition to Dr. Robson, were Dr. David Smith, who was the Chief at Receiving and also head of the burn unit, Dr. Linda Phillips, Dr. Walter Sullivan, and Dr. Eti Gursel (WSUGS/PS 1975/77. Dr. Gursel gave the residents lots of autonomy and always told the circulating nurses that the residents could go ahead and start the case since he was “in the tunnel.” The residents joked that this happened so frequently that they thought Dr. Gursel lived in the tunnel. At Harper, Dr. Smith met Dr. Rick Singer (WSUGS 1980) and they have been friends ever since. The residents in his year were Dr. Mike Busuito (WSUGS 1986), who became a lifelong friend, and Dr. John Anton who,

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Dr. Anthony A. Smith, MD, cont..

unfortunately, was asked to leave the program after only one year in training. They did lots of acute hand trauma at Detroit Receiving which he particularly enjoyed. In Dr. Smith's words, "I will never forget a transmetacarpal amputation of the hand which happened when Dr. Sullivan was on-call and he let Mike Busuito and I replant the hand. We were hot stuff that day. A new attending, Dr. Paul Zidel (WSUGS 1986), who had just completed his hand fellowship at New York University, arrived for his second year of training in Detroit. Dr. Zidel and I did many wonderful cases together including an emergency rectus abdominis free flap at Detroit Receiving for a shotgun wound of the foot. Like Mike Busuito, he became a lifelong friend, and I was able to recruit him to come to Phoenix over 15 years ago."

Dr. Smith and his youngest son, Christopher, researching Bunnell's travels in Yosemite

Hand Surgery became Dr. Smith's chosen area of interest and he was able to obtain a hand fellowship in the Department of Orthopedic Surgery at the University of South Florida in Tampa. This was followed by a year of Reconstructive Microsurgery at the University of Toronto, where he spent much of his time at Toronto General Hospital, the same hospital where his wife Sandra was born. The year in Toronto was truly magical. They were only 90 miles from Sandra's family, their youngest son, Christopher, was born that year, the training was superb, and Dr. Smith made one more lifelong friend, Dr. Steve McCabe.

He completed his training as an AO Fellow in Hand Surgery at the Inselspital in Bern, Switzerland. Matthew was five and Christopher was 6 months of age when they left Canada. They were there for three months. The first month they lived in Bern but the last two months they lived one mile outside of Gstaad, Switzerland. Gstaad was in the middle of the Alps and beautiful in the summer.

After Switzerland, Dr. Smith joined the faculty of Case Western in Cleveland with his practice at Metro Health Medical Center, the Level I Trauma Center for northeast Ohio. Dr. Smith was one of two plastic surgeons assigned to the hospital and his practice was vigorous. He was the only surgeon at the hospital who could do a free flap and he worked closely with the orthopedic trauma service, headed by Dr. Brendan Patterson, now Chief of Orthopedic Surgery at the Cleveland Clinic. He also did an extensive amount of burn reconstructive surgery as Metro had a busy burn center, headed by Dr. Richard Frattiane. Both Dr. Patterson and Dr. Frattiane became lifelong friends.

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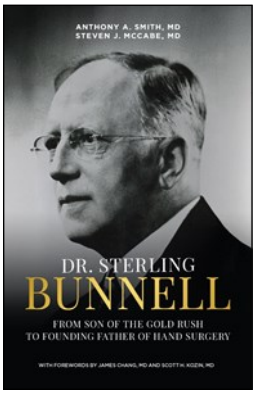
Dr. Anthony A. Smith, MD, cont..

In August 1995 Dr. Smith was recruited to join the Mayo Clinic in Phoenix, Arizona as their first full-time hand surgeon. It was a great move, both professionally and personally. Professionally, he took over as Chair of the Division of Plastic Surgery in 2000 and started the plastic surgery residency in Phoenix in 2008. Dr. Smith recruited Dr. Paul Zidel to join the staff at Maricopa Medical Center, the municipal hospital in Phoenix, in 2008 and they worked together at Maricopa for a number of years. Dr. Smith became active in plastic surgery resident education nationally and in 2019, was selected as President of the American Counsel of Academic Plastic Surgeons.

Personally, Anthony and Sophia's children are now adults with Matthew having an MBA from Thunderbird in Phoenix and he is a successful tech entrepreneur in San Diego; about to publish his first book. Their younger son, Christopher, has begun his senior year at Arizona State University and is studying architecture. Sandra has been a community activist for nearly 20 years and on the board of Circle the City, which provides respite care for the homeless.

Most recently, Dr. Smith recruited Dr. Steve McCabe from Toronto, and they have written the biography of Dr. Sterling Bunnell, considered the Founding Father of Hand Surgery. Our book was published by the American Society for Surgery of the Hand and we have donated all monies to their Foundation. It is available for purchase at:

https://american-society-for-surgery-of-the-hand.myshopify.com/products/dr-sterling-bunnell-from-son-of-the-gold-rush-to-founding-father-of-hand-surgery



This picture (from the January 2026 Monthly Email Report) includes Dr. Erin Perrone and Dr. Bryant Oliphant's 2 younger children - their 15 year old son, Max and their 12 year old daughter, Bella with Dr. Anna Ledgerwood and Dr. Charlie Lucas. Their oldest daughter, Charlie (17 years old), was visiting the Northwestern University campus that day. She is still in the application process and waiting to decide on her college destination!

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:

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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.

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WAYNE STATE

EXCERPTS FROM THE LOG BOOK DOWN MEMORY LANE


Dr. Anna Ledgerwood

9/3/72 - Staff: Dr. Norm Thoms

1. JF: Stab abdomen and left chest, drained 4500 ml out the left chest tube. Taken to O.R., had lacerated diaphragm with bleeding; diaphragm sutured. Also lacerated omentum and a small portion resected.
2. FM: Patient in ICU, taken for intra-abdominal bleeding. Patient had blunt trauma to liver with partial resection of right lobe earlier that day. In O.R. found bleeding from diaphragm and major oozing from liver surface. Minimal diaphragm bleeding which was cauterized. Liver and diaphragm packed with gel foam.
3. EK: Abscess popliteal area in heroin user, treated with I&D.
4. JC: GSW abdomen, appeared to involve abdominal wall. Taken to O.R. and explored under local anesthesia and was non-penetrating.

9/5/72 - Staff: J. Plant

1. HC: Self-inflicted GSW left upper quadrant, had laparotomy with thru-and-thru injury to spleen, treated with splenectomy, and thru-and-thru injury to stomach which was repaired.
2. RL: 60yo male with SGW to left abdomen at close range, came with eviscerated bowel. In O.R. found to have shattered left colon, treated with left colectomy with end colostomy
3. mucous fistula. Perforation spleen treated with splenectomy. Multiple lacerations omentum, treated with subtotal omentectomy. Perforation SB treated with primary closure x13. Injury to left kidney, treated with left nephrectomy with assistance of Urology. Debridement of abdominal wall and closure of large defect with peritoneum.
4. LH: GSW left chest with no BP or pulse on arrival to E.D. but was breathing and restless. Intubated and left thoracotomy in E.R. with 3,000 ml blood, and clot evacuated from left chest. Bleeding lung controlled with fingers and rushed to O.R. In O.R. had wedge resection lingula and lower lobe. Heart and great vessels intact.
5. CB: MVC while on motorcycle. Laparotomy showed hematoma cecum and mesentery with ruptured jejenum which was repaired. A large open right groin wound was debrided and closed.
6. ET: Foreign body rectum, which was a vibrator, removed under general anesthesia.

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

9/5/72 - Staff: Dr. C. Lucas

1. RL: Evisceration from abdominal wall defect packed with Owen cloth and fluffs.
2. MH: Acute appendicitis, treated with appendectomy.
3. LW: Stab abdomen with laceration gastrocolic omentum near the greater curvature, treated with hemostasis.
4. KK. ICU patient treated with tracheostomy.

9/6/72 - Staff: Dr. A. Kambouris

1. JB: Large bowel obstruction treated with transverse loop colostomy.
2. VR: Appendectomy for pelvic inflammatory disease.

9/7/72 - Staff: Dr. Hershey

1. DN: GSW back x2 and could not move right leg. In O.R. had thru-and-thru duodenum on its second part, treated with closure. Laceration upper pole of kidney and serosal tear hepatic flexure of colon, treated with closure.
2. CT: GSW abdomen with gross hematuria. Laparotomy found thru-and-thru bladder injury, treated with primary repair and cystostomy with tangential laceration left ureter, treated with a ureteral stent.
3. HT: 56yo with SB obstruction, exploratory laparotomy and lysis of adhesions, and repair of an internal hernia.

9/8/72 - Staff: Y. Silva

1. NK: Multiple stabs of abdomen, treated with laparotomy and repair of lacerated omentum.
2. ML: Perianal abscess, treated with I&D.
3. DL: Multiple stab wounds chest and abdomen with pneumohemothorax, treated with chest tube. Exploratory laparotomy with control of bleeding of intercostal vessels of 10th and 11th ribs posteriorly.

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WAYNE STATE

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

9/9/72 - Staff: Dr. LeBlanc

1. MG: GSW neck with negative exploration.
2. RL: Postop shotgun wound to abdomen on sixth postop day with large abdominal wall defect, had dressing change in O.R.
3. JD425: GSW chest and abdomen with laceration of heart, lung, stomach, duodenum, pancreas, IVC, and portal vein. Died on table.
4. AR: Dx: Acute appendicitis, but in O.R. had pelvic inflammatory disease.

9/10/72 - Staff: Dr. A. Arbulu

1. IB: Ischiorectal abscess, treated with I&D.
2. CM: Patient on the ward, postop GSW liver and colon from two days ago, had drainage of abscess of flank with removal of bullet.
3. JCK: Shotgun wound left shoulder, chest, and cheek. Had negative exploration of neck and insertion left chest tube. Exploration of axillary vessels with repair of axillary vein x1 and axillary artery x1 and resection 1.5 cm of axillary artery with end-to-end anastomosis and debridement of shoulder wound.
4. EA: GSW right chest and abdomen, had exploratory laparotomy with laceration of dome of liver which was bleeding and sutured and drained. Laceration of diaphragm was repaired, and he had insertion of right chest tube.

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WAYNE STATE

WSU MONTLY CONFERENCES 2026

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, February 11
Death & Complications Conference

J.C. Rosenberg, MD, PhD Endowed Lecture

Sunil K. Geevarghese, MD, MSCI, FACS, MAMSE
Medical Director, Transplant Perioperative Services
Professor of Surgery, Biomedical Engineering, Radiology and Radiological Sciences
Division of Hepatobiliary Surgery and Liver Transplantation
Vanderbilt University Medical Center

Wednesday, February 18
Death & Complications Conference

"This Woman's Work – My Surgical Career and Journey"

Erin E. Perrone, MD
Clinical Associate Professor of Surgery
Associate Chair, Department of Pediatric Surgery and Medical Director
UMMG Medical School
University of Michigan Health/Michigan Medicine

Wednesday, February 25
Death & Complications Conference

"Cutting Edge Surgical Management of Hidradenitis Suppurativa"

Steven D. Daveluy, MD, FAAD
Professor and Program Director, WSU Dermatology

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." The Planning Committee and Presenters have no commercial relationships.

EVALUATIONS
Surgery Grand Rounds #2026321064, Jan-Apr 2026 CME Reflective Evaluation:
Surgical Death and Complications Rounds #2026321125, Jan-Apr 2026 CME Reflective Evaluation:

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*.