

APRIL 2026

SURGICAL GRAND ROUNDS



April 4th

Inside this issue:

Surgical Grand Rounds	1-8
Dr. David Edelman Named Interim Chair of the WSU Department of Surgery	9-10
Reports From the Outfield	11
"It's Time to Smell the Roses" by Dr. Anna Ledgerwood	11-12
WSSS Dues	13
Down Memory Lane	14-15
WSU Conferences	16
Wayne State Surgical Society	17



2026 WSSS OFFICERS

President:

Bruce McIntosh (WSU/GS 1989/94)

Vice-President:

Michael Malian (WSU/GS 1987/92)

Secretary-Treasurer:

Members-at-Large:

Mallory Williams (WSUGS 2006)

Erin Perrone (WSUGS 2012)

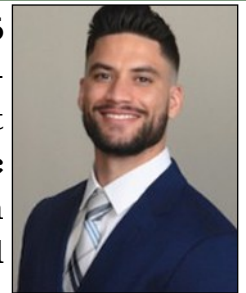
Anita Antonoli (WSUGS 1998)

Resident Member:

Nicholas Calvo (WSUGS 2026)

Jude Jaracki (WSUGS 2006)

The **Surgical Grand Rounds** on **March 4, 2026** were presented by **Dr. Daniel Matienzo** who is completing his Minimum Invasive Surgery Fellowship at WSU. The title of his presentation was "**Bariatric Surgery and Its Future**". He began his presentation by emphasizing that weight loss is reported as total weight loss (TWL) or as a percent of the excess weight loss (% EWL) based upon the patient's calculated ideal weight. He pointed out that about 40% of USA citizens are obese and that about 10% are morbidly obese with a BMI over 40. The cause of obesity may be both familial and environmental with unlikely causes being related to hormone imbalances. He described the physiologic functions of ghrelin and gastrin.



Dr. Daniel Matienzo

Morbid obesity is associated with multiple morbidities including an increased incidence of malignancies. He described how there are multiple studies suggesting that excess weight is associated with an increase in cancers of the breast, thyroid, prostate, pancreas, and uterus. There are also other morbidities related to diabetes, hypertension, and cardiovascular disease.

The treatment of obesity may be provided by either a medical or surgical approach. A prospective study from Sweden suggests that the relapse after medical treatment is very high in comparison to surgical treatment. This is based upon the study of complications of obesity which includes a decrease in the incidence of myocardial infarction and stroke which is associated with a decrease in mortality in patients who undergo surgical therapy. One of the negative aspects of successful surgical therapy is that patients are frustrated by their inability to eat as much as they want resulting in a higher incidence of self harm or suicide.

Continue page 2



APRIL 2026

SURGICAL GRAND ROUNDS, cont..

The indications for surgical therapy include those patients who have a BMI greater than 40 or those patients with a BMI greater than 35, associated with some of the morbidities of obesity. Patients who have a BMI less than 35 are recommended for attempts at medical therapy. The medical therapy has to focus on the importance of motivation in order to alter the habits which have been developed over many years. Some people classify the overeating as being due to "grazing" where there are snacks and goodies all over the house allowing the obese patient to snack all day long. The other category would be patients who are involved in "gorging", whereby they will take two or three helpings at a meal which may last well over an hour. Patients who fall into one or both of these two categories should be encouraged to have no treats outside of the dining room and to confine meals to one helping with a maximum time of 20 minutes.

The lap band was a very popular operation in the early part of this century and peaked in frequency around 2011. This procedure has progressively decreased since that time and is now being used as the operative treatment in less than 3% of patients. He demonstrated the technique for performing this operation and described some of the complications including slippage, erosion, and achalasia. He described how these complications can be diagnosed and appropriately treated.

He described the technique of the sleeve gastrectomy which has gained in popularity and is performed in about 60% of patients since 2017. The advantages of the sleeve gastrectomy are that the pylorus remains intact, there is a reduction in ghrelin which is secreted by the proximal stomach, and a decrease in diabetes associated with weight loss. Complications of all operations related to bariatric surgery include VTE, leak, and inadequate weight loss.

He described the technique for the Roux-en-Y gastric bypass as was originally described by Mason in 1969. He emphasized the importance of having a small proximal gastric pouch which is associated with better weight loss and decreased marginal ulceration. He presented a movie showing many of the aspects of this operation. This procedure is associated with a mortality rate which is less than 0.5% and often will eliminate the symptoms of GERD. The leak rate is approximately 1%. The different weight loss operations are often associated with vitamin deficiencies including Wernicke's encephalopathy due to

Continue page 2



APRIL 2026

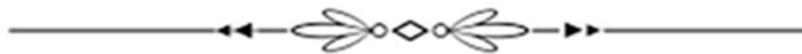
SURGICAL GRAND ROUNDS, cont...

vitamin B1 deficiency. One of the complications of this procedure is narrowing of the anastomosis which can be successfully treated with a balloon dilatation. Marginal ulceration is decreased when protonics are given for the first three months after operation.

He also described the Bilio-Pancreatic Diversion (BPD) which incorporates a distal gastrectomy associated with an anastomosis between the ileum and the stomach. Finally, he discussed the duodenal switch operation which has been associated with internal hernia, hypoproteinemia, and electrolyte imbalance requiring supplemental calcium and magnesium.

Currently, the most frequently performed operation is the sleeve gastrectomy. He also described the single anastomosis duodenal ileum bypass which is not as commonly performed as in the past. Regardless of operation, he emphasized the importance of VTE prophylaxis, slow progression of diet beginning with liquids and including 60g of protein per day and the importance for early protonics.

The future of the approach to obesity now includes an evaluation on a long-term basis of GLP – 1 agonists which are becoming more and more popular. We are in the early stages of their utilization and are still dealing with the problems of high cost and the frequent regaining of weight once these agents are discontinued. There was an active question-and-answer session.



The **Surgical Grand Rounds** on **Wednesday, March 11, 2026** was presented by **Dr. Jason Kurle, DO**, who is a graduating SICU Fellow, and was titled "**Volume Status and Fluid Responsiveness.**" Dr. Kurle talked about the therapeutic conflict that occurs in patients who have marginal blood pressure and how the clinical decision-making is compromised by uncertainty as to whether the patient is hypovolemic suffering from cardiac compromise. He pointed out that a responsive result from fluid administration would include an increase in cardiac output and mean arterial pressure (MAP). Lack of responsiveness to fluid replacement may be associated with multiple organ failure with increased morbidity and mortality.

Continue page 4

APRIL 2026

SURGICAL GRAND ROUNDS

There are many factors which can help determine whether or not there is responsiveness to fluid replacement. These include measurements of right ventricular size, right ventricular output, left ventricular function, and pulmonary accumulation of fluid. Part of the assessment of right ventricular tolerance might include estimates of right ventricular thickness and venous pressures. Left ventricular responsiveness is often determined by the ejection fraction and the status of the interstitial fluid within the pulmonary spaces. Left atrial size is also an important consideration. Many of these estimates can be determined by modern ultrasonography.



Dr. Jason Kurle

Dr. Kurle shared examples of the Frank Starling curve showing the resultant left trabecular stroke work in response to a fluid challenge. Ideally, this would require measurements of cardiac output but there are many surrogates for cardiac output including changes in the inferior vena cava diameter, central pressure such as the wedge pressure or central venous pressure, and changes in mean arterial pressure in response to lifting the legs. He emphasized the importance of looking at the response of a central pressure through a fluid system is better rather than taking a static central pressure. This was the original description of the Frank Starling curve.

Other factors which can be used to assess responsiveness include the stroke volume variation in response to fluid challenge. He showed examples of changes in stroke volume variation representing responsiveness and lack of responsiveness. He also described pulse pressure variation which correlates with arterial stiffness and stroke volume.

There are a number of new monitoring techniques; and the use of ECHO in order to assess chamber sizes is a valuable technique. He showed several examples of how this technique can assess the different heart chambers. Interpretation of many of these parameters is affected by mechanical ventilation particularly when a patient is breathing over the ventilator, has arrhythmia, has right heart failure with low output, an unusually low tidal volume, or has a high ventilatory resistance. He described the technique of end expiratory occlusion and the effects on cardiac output along with end inspiratory occlusion.

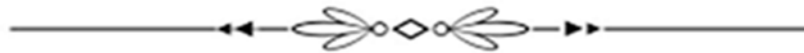
Continue page 5



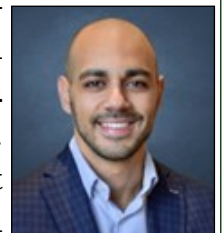
APRIL 2026

SURGICAL GRAND ROUNDS

He demonstrated the ultrasound technique in making various estimates of changes in the inferior vena cava and superior vena cava in response to a fluid challenge when there is a prompt increase in the inferior vena cava diameter by more than 10% which indicates good responsiveness to the bolus. Limitations with the accuracy of this technique relate to pulmonary embolism, abdominal compartment syndrome, and severe chronic obstructive luminary disease. Dr. Kurle finished his presentation by describing the technique of the leg raising test for responsiveness. The legs should be raised 45 degrees for approximately one minute in order to allow the intravascular changes to occur so that they can be reflected in the measurements such as inferior vena cava diameter or mean arterial pressure. When all else fails, patients can have direct measurements of cardiac output and cardiac index by use of the Vigileo/FloTrac system which has replaced the Swan Ganz catheter. There was an active question-and-answer session.



The **Surgical Grand Rounds** for **Wednesday, March 18, 2026**, was presented by **Dr. Michael Romani** who is finishing his fellowship training in vascular surgery. The title of his presentation was "**What It Means to Be an Evidence-Based Physician: Critically Evaluating Our Own Practices.**" Dr. Romani began by discussing the problem of peanut allergy. He pointed out that the incidence of peanut allergies is about 1 to 2% in America and well under 0.5% in Europe. He also pointed out that the incidence of this allergy has been increasing over the past 120 years. There have been different recommendations regarding this malady. One recommendation has been to avoid early eating of peanuts whereas another recommendation has been to start exposure by eating peanuts after 4 to 6 months. He used this as an example of how what we think is evidence-based beliefs are often not true.



Dr. Michael Romani

He talked about the well-established principle that patients who have appendicitis need an appendectomy. This teaching was ingrained in the training of all surgeons over the age of 50. He described a situation where Dr. Leonid Rogongi developed the signs and

Continue page 6



APRIL 2026

SURGICAL GRAND ROUNDS

symptoms of appendicitis when he was far away from civilization and performed an auto appendectomy on himself with his assistants using mirrors so that he could see into his own abdomen. We all suspect that he later wished what we now know to be true: that many patients with acute appendicitis can be treated by nonoperative management. This antibiotic treatment is often successful so that patients never need an appendectomy.

He also discussed the guidelines as it relates to antibiotic therapy for different surgical entities. He pointed out that at one time the antibiotic therapy regimen had to extend for one to two weeks whereas nowadays the recommendation is that antibiotics be given for 24 hours. He discussed the controversy of big fascial bites versus small fascial for closure of the abdomen and how guidelines change from generation to generation. He pointed out that older surgeons were taught to leave the NG tube in place whereas the current recommendation calls for removal of the NG tube and the initiation of diet. These were among some of the many examples he gave, pointing out that "evidence-based" data often becomes rapidly obsolete.

Evidence can be obtained from many sources. The optimal source would be a randomized controlled trial; a large retrospective analysis is another commonly used source; the accumulation of multiple cases is often cited in the literature; sometimes a group of experts will come together and create a consensus about how to deal with a certain problem; and finally, anecdotal evidence is sometimes useful particularly when it comes from a senior physician who has had extensive experience in a certain area.

Dr. Romani emphasized the importance of carefully reading a manuscript and critically analyzing the factors which led to the conclusion. He highlighted the "bad news" that one half of the material that medical schools teach students is no longer true by the time the students' graduate.

He finished his presentation by talking about the world of artificial intelligence and how that is slowly working its way into the guidelines for developing evidence-based recommendations. He pointed out there will be much progress in this area, but that when it comes down to the final decision, the surgeon has to take responsibility for decision-making as to surgical procedures. He ended his presentation by sharing a quote from the famous Dr. William Osler who stated: "**Medicine Is a Science of Uncertainty and An**

Continue page 7

APRIL 2026

SURGICAL GRAND ROUNDS

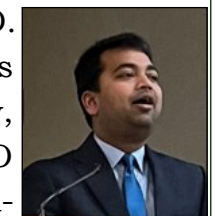
Art of Probability". There was an active question-and-answer session to his stimulating presentation.

The Surgical Grand Rounds for Wednesday, March 25, 2026 was presented by Dr. Nehal Ninad who is completing his Surgical Critical Care Fellowship this spring. The title of his presentation was entitled "Extra - Corporeal Membrane Oxygenation: DMC Experience". Dr. Ninad began his presentation talking about some of the factors that are involved in monitoring patients with ARDS and determining when such patients need to be converted to ECMO. He referred to this decision-making as "when you pull the trigger". He described how patients with an FiO₂ of 100% and a PEEP of 15 are associated with poor oxygenation and hypercarbia and are unlikely to survive. When this occurs in somebody with a stage IV rectal cancer, comfort care is probably appropriate. However, when this occurs in somebody with reversible disease, it is time to "pull the trigger" and convert to ECMO.



Dr. Steven Tennenberg introducing his SCC Fellow, Dr. Nehal Ninad

He described some of the factors that lead to the implementation of ECMO. These included hypoxia, increased CO₂ retention, elevated airway pressures with an inspiratory plateau pressure greater than 30 millimeters mercury, and failure to respond to optimization criteria on the ventilator. The ECMO may be venous-venous (V-V) or arteriovenous (A-V) depending upon the status of myocardial function. The patient who has myocardial failure as part of the multiorgan system failure is not a candidate for the A-V ECMO technique. He pointed out that hypoxia with impaired aeration is associated with reflex pulmonary artery vasoconstriction, both of which contribute to impaired oxygenation. Dr. Ninad showed different case samples where patients had hypoxia, acidosis, and CO₂ retention: all of which were refractory to ventilator manipulation.



Dr. Nehal Ninad



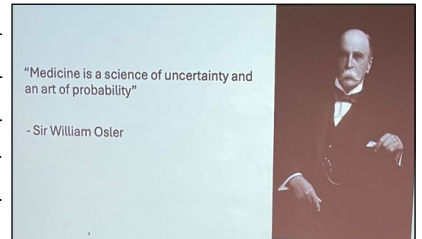
He described how sometimes the ECMO may be applied as a bridge to transplantation. This may be done when the left ventricular assist device is not providing the appropriate cardiac support. This, of course, leads to increased cardiac ischemia. The objective of ECMO

Continue page 8

APRIL 2026

SURGICAL GRAND ROUNDS

in this situation is to improve circulatory flow, increase mean arterial pressure, decrease systemic vascular resistance, and, in this matter, improve organ oxygenation. Hopefully, this would then be associated with increased peripheral arterial oxygen delivery and oxygen consumption. There are a number of complications associated with ECMO. These include thrombosis although the pump, leading related to dissection of the involved vessels, intra-abdominal or retroperitoneal bleeding, and end organ failure due to pump thrombosis and inadequate oxygenation of the peripheral organs. Acute kidney injury and acute liver injury are examples of this phenomenon.



Dr. Ninad then described the DMC experience which included 66 patients with an average age of 50 years and an average BMI of 33. These were very ill patients and had a prolonged length-of-stay due to their problems with multiple organ failure. Ninety percent of these patients underwent V-V ECMO with the most frequent indication being severe ARDS refractory to different treatment modalities. Other etiologies included chest trauma, status asthmaticus, and postoperative lung failure associated with sepsis. ECMO can also be advantageous in patients with multiple organ failure associated with severe burns. The national mortality rate with V-V ECMO is 40% and with A-V ECMO is 60%. The excellent team at DMC has received a "Gold Award" and is working hard to receive the Platinum Award" which only one hospital in Michigan has received.

There was an active question-and-answer session. A decision to place a patient on ECMO is ideally made by the first week of severe lung failure and these patients typically receive large dose steroids during that one week period. The importance of putting a patient in the prone position as part of the treatment for ARDS was emphasized.

Administrative Professional Day



April 22nd



APRIL 2026

David Edelman, M.D., Named Interim Chair of WSU Department of Surgery

David Edelman, M.D., MSHPEd, FACS, Professor of Surgery, has been appointed Interim Chair of the Wayne State University School of Medicine's Michael and Marian Ilitch Department of Surgery.



Dr. David Edelman

Dean Wael Sakr, M.D., announced the appointment March 10.

Dr. Edelman has taught and mentored many dozens of students who have gone on to become successful and recognized surgeons," Dean Sakr said. "His teaching skills have been recognized with the WSU Faculty Teaching Award multiple times, as well as the Department of Surgery Resident Teaching Award and the WSU School of Medicine Distinguished Service Award. He has earned HOUR Magazine's Top Docs honors eight times, and he has served both our school and university in numerous voluntary capacities."

Dr. Edelman replaces longtime chair Donald Weaver, M.D., who stepped down after two decades. He will remain a member of the faculty.

A 2002 graduate of our School of Medicine, Dr. Edelman, joined the Surgery faculty in 2009. He is the chief of Surgery and associate program director of the Minimally Invasive Fellowship at Harper University Hospital, and program director of WSU General Surgery. He is a member of the DMC Medical Executive Committee and formerly served as director of the Surgery Department's Simulation Laboratory. An attending physician at Harper University Hospital, Detroit Receiving Hospital, Hutzel Hospital, Sinai-Grace Hospital and the Barbara Ann Karmanos Cancer Hospital, Dr. Edelman has extensive post-graduate training in both surgery and teaching.

Certified by the American Board of Surgery, he is a member of many professional organizations, including the Society of University Surgeons, the ACS Academy of Master Surgeon Educators, the Association of Program Directors in Surgery, the American College of Surgeons, the American Society for Metabolic & Bariatric Surgery, the Association

Continue page 9



APRIL 2026

David Edelman, M.D., Named Interim Chair of WSU Department of Surgery

for Surgical Education, the Association for Academic Surgery and the Society of American Gastrointestinal Endoscopic Surgeons.

Dr. Edelman graduated from Wayne State University summa cum laude in 1997 with a bachelor's degree in Biological Sciences. After graduating from the WSU School of Medicine, he performed his surgical residency at WSU/Detroit Medical Center, where he was named senior surgical resident and chief administrative resident. In 2014 he attended the MGH Institute of Health Professions in Boston, where he earned a Master of Science in Health Professions Education degree.

Dr. David Edelman is a native Michiganian who received his education locally. He finished his medical education at the WSU School of Medicine in 2002 and did his internship and residency at WSU. After completing his general surgery training, he completed his Minimally Invasive Fellowship and joined the faculty. He rose through the academic ranks and is now a full Professor of Surgery. He has been the Program Director for the Department of Surgery since 2017 and has been the Director of the Simulation Laboratory since 2017. He has been very active in resident teaching and organizing the teaching sessions. He has been a member of the WSU Medical Executive Committee and the Dean's Committee.

APRIL 2026



REPORTS FROM THE OUTFIELD

Dr. Arthur Carlin (WSU/GS 19191998) wanted to share this story in the March newsletter from the tennis club where he plays. It featured a lovely acknowledgment of Dr. Choichi Sugawa, along with a photo of him and with one of the pros.

Dr. Choichi Sugawa has been a valued member of the Troy Racquet Club since 1984 and continues to inspire our community at 91 years old. He has played tennis for more than 60 years, first picking up a racquet in his early twenties. A physician and professor at Wayne State University, he credits tennis for helping him stay active and balanced throughout his life. As he says, "Tennis keeps you healthy, helps you forget stress, and brings you joy. It's good for both your body and your mind."



"IT'S TIME TO SMELL THE ROSES"

Dr. Anna Ledgerwood (WSUGS 1972) recently returned from vacation and shares the following regarding her experience.

Last Fall, I was encouraged to join my two sisters on a cruise to the Panama Canal. This 12-day excursion was longer than I had been away from work, except when I had a broken ankle. My sister Betty from Sacramento, California and my sister Alice from Pomeroy, Washington, departed from Seattle for Fort Lauderdale on Saturday, February 7, 2026. I met them there the morning of Sunday, February 8, and we boarded the Rotterdam, a Holland Cruise Line. We were pampered from the time we boarded the ship. There were 2,600 passengers and about six of them were under the age of 14, and 2,594 were over the age of 65.

The first stop, the following morning, was at Half Moon Cay in the Bahamas. My sister Alice and I did a snorkeling trip prior to relaxing in the sun on the beach with white sand that was about 8" deep. We were at sea for the next two days before docking at Willemstad Curacao where we toured the Curacao Liqueur Factory. After another day at sea, we spent Valentine's Day in Cartagena Colombia where we toured a cocoa factory. We arrived at the Panama Canal

Continue page 7

APRIL 2026



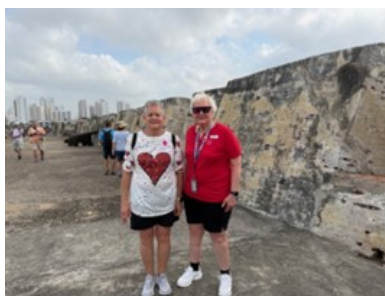
REPORTS FROM THE OUTFIELD

"IT'S TIME TO SMELL THE ROSES"

on February 15 and entered the locks. It was a long day travelling through Panama, partly by sea and partly by bus. While entering the Panama Canal, we had an excellent historian who described the events leading to the creation of the Panama Canal. Our next stop was Puerto Limon in Costa Rica where we toured an aloe vera farm and plant. After a day at sea, we arrived at Georgetown in the Grand Caymans. We toured a rum factory and learned that they do not have any place for storage on the island so they store their rum in kegs at the bottom of the ocean.

There were several educational sessions, including the events surrounding the Covid pandemic. The Holland Cruise Line took four months to get their employees home after the onset of Covid.

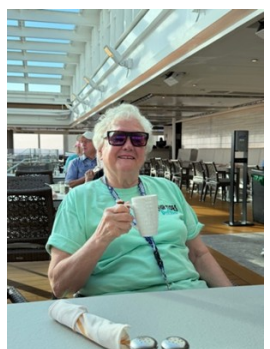
We arrived back in Fort Lauderdale on Friday morning, February 20. The cruise line was very efficient in dealing with luggage. In fact, we placed our luggage outside our cabins, and mine was shipped to Detroit, and my sister's was shipped to Lewiston, Idaho. We departed the ship with our carry-ons only. I highly recommend such a relaxing excursion.



Dr. Ledgerwood with her sister, Alice, on Valentine's Day at a monument



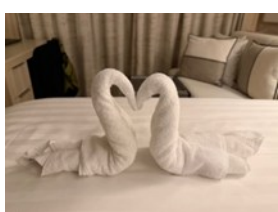
(Left to right) Dr. Ledgerwood's sister, Alice, Dr. Ledgerwood, and her sister, Betty Jane, returning from a short excursion in Curacao their ship is in the background



Dr. Ledgerwood enjoying a relaxing breakfast



Attending a lecture on the harvesting of the cocoa beans



The Cabin Attendant treated the sisters to towel sculptures daily



Entering the locks of the Panama Canal and viewing the ship ahead of us



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

*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.



EXCERPTS FROM THE LOG BOOK DOWN MEMORY LANE

9/21/72 - Staff: Dr. Hartzell

1. CD: Shotgun wound right forearm, no neurological deficit, had debridement and fasciotomy.
2. MD138: Admitted in shock, responded to fluids. Multiple stab wounds scalp with about 80% avulsed, horrible to look at. Stab precordium, no penetration, stab left index finger with lacerated flexor tendon. Multiple stabs face and blunt trauma with multiple facial bone fractures. Stab abdomen x3, all penetrating with gross hematuria; chest x-ray normal. Lacerated stomach x4 that were closed in O.R. Retroperitoneal hematoma left renal area, and plastic surgeons closed lacerations of scalp and face.
3. WS: 61yo female in auto accident, admitted the day before. Persistent upper abdominal pain with guarding and tenderness. Repeat peritoneal tap and lavage was negative, patient stable. Had fracture of ribs right side. Celiac axis angiogram showed questionable subscapular hematoma of spleen with question of splenic infarct. Sickle cell prep was positive. Hemoglobin dropped 2 gm. Patient taken to O.R. with findings of subcapsular hematoma spleen, treated with splenectomy.



Dr. Anna Ledgerwood

9/22/72 - Staff: Dr. Baker

1. AL: Incarcerated left inguinal hernia with postop diagnosis of septic thrombophlebitis of spermatic vein.
2. PM: Acute cholecystitis, treated with cholecystectomy.
3. ER: Lacerated forearm with lacerated flexor tendons to middle and ring fingers and wrist, lacerated median nerve, nerve and tendons repaired.

9/24/72 - Staff: Dr.

1. BF: Acute appendicitis, had appendectomy for perforated appendicitis.
2. JW: 53yo with small bowel obstruction with postoperative diagnosis of acute pancreatitis.
3. LL: Shotgun wound to left arm with fracture of humerus, left femur, and pelvis. Laparotomy showed lacerated spleen treated with splenectomy. Small bowel laceration x6, resection 8", and closed two holes. Thru-and-thru cecum which were closed and wound exteriorized. Patient was shocky on admission and received total of approximately 11 units whole blood.
4. PH: GSW x2 right lower chest. Hemothorax treated with chest tube. Exploratory laparotomy with closure two holes in diaphragm. GSW liver, not bleeding, not sutured, but was drained.

Continue page 10



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

9/25/72 - Staff: Dr. C. Lucas

1. RT: Stab abdomen, hole in small bowel resected with end-to-end anastomosis and hemostasis omentum.
2. AS: 17yo male with acute appendicitis, treated with appendectomy for retrocecal perforated appendix.

9/26/72 - Staff: Dr. S. Woods

1. PA: 22yo with abdominal pain for three days who appeared toxic with diffuse abdominal tenderness, had necrotic and gangrenous retrocecal appendix treated with appendectomy.
2. FM: 52yo male alcoholic with 2.5 days of hematemesis and hemoglobin of 10.6 on admission; given 5 units of blood. Had upper GI with questionable antral ulcer, had exploratory laparotomy with Dr Sugawa doing an EGD; patient had vagotomy and pyloroplasty for gastritis.

9/27/72 - Staff: Dr. Bernys

1. AH: 20yo with stab to bilateral chest from the back, bilateral hemopneumothorax, had bilateral chest tube insertion with 1.1 liters out the right side and 1.2 liters out the left side. Taken to O.R. and had left thoracotomy for bleeding intercostal artery which was ligated. Received 10 units of blood.
2. DT: GSW right arm with no distal pulse, had complete transection of brachial artery, treated with resection and end-to-end anastomosis with good pulse postop.

9/28/72 - Staff: Threlkeld

1. GC: GSW epigastrium; patient shocky on admission. Had laceration of common iliac artery with internal iliac ligated and end-to-end anastomosis of external to common iliac; laceration IVC tangential involving left wall bifurcation repaired with running 5-0 proline. Laceration dome of gallbladder, repaired with cholecystostomy. Laceration duodenum, third part, treated with two-layer repair. GSW colon near hepatic flexure with one hole, treated with loop colostomy. Required 12 units of whole blood. Stable during entire operation.
2. LW (John Doe 455): GSW right shoulder with bullet laying in left upper chest. Gastrografin showed leak at T2-T3 level. Stable after IV fluids, had bilateral chest tubes with right draining 1100 ml and left draining 400 ml. Explored via cervical approach, thru-and-thru hole of esophagus repaired in two layers with interrupted silk and drained. Remained stable.
3. JR: Perforated ulcer with free air. At laparotomy, had 2.5 liters of seropurulent fluid, ulcer patched.
4. RS: 61yo with three-day history of abdominal pain and vomiting with abdominal distention. Preoperative diagnosis was appendiceal abscess; postoperative diagnosis was same. Treated with appendectomy and drainage.



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, April 1

Death & Complications Conference
“The Rise and Fall of the Carotid Endarterectomy?”
Maia Reiley, MD
Graduating Vascular Surgery Resident
DMC/WSUSOM

Wednesday, April 8

Death & Complications Conference
Jude Jaraki, MD
Graduating Surgery Resident
DMC/WSUSOM

Wednesday, April 15

Death & Complications Conference
Farhan Chaudhry, MD
Graduating Surgery Resident
DMC/WSUSOM

Wednesday, April 22

“Annual Program Evaluation”
David Edelman, MD
Director, Surgery Residency
DMC/WSUSOM

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

The Wayne State University School of Medicine is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians. The Wayne State University School of Medicine designates this live activity for a maximum of 2 hours *AMA PRA Category 1 Credit(s)*[™]. Physicians should claim only the credit commensurate with the extent of their participation in the activity.³ 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:



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.