

AUGUST 2026

SURGICAL GRAND ROUNDS



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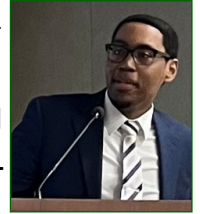
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The **Surgical Grand Rounds on Wednesday, July 8, 2026** was presented by **Dr. Shamon Gumbs** who is currently a Surgical Critical Care/Burn Fellow. The title of his presentation was "**Extracorporeal Membrane Oxygenation (ECMO): Utility in Burn Patients with Severe ARDS**". He began his presentation by describing a patient who was in a drug rehabilitation program and discharged home. There was a house fire and he was severely burned. He suffered smoke inhalation which was initially treated at an outlying hospital. He had severe respiratory distress requiring activation. He had carbon monoxide poisoning. His initial Glasgow Coma Scale was 3. He also had multiple abrasions of the left upper extremity. FAST examination and x-ray confirmed left lower lobe atelectasis and following activation he had to remain on a PEEP level of 8 torr.



Dr. Shamon Gumbs

The patient was very ill and was transferred to the DMC for continued care and possible utilization of ECMO. He had problems with hypotension and was treated with two units of FFP and human serum albumin supplementation every six hours to help maintain circulation. He was maintained on an FiO₂ of 100% and had continued acidosis with a pH of 7.284, for which nitric oxide was added. His P/F ratio was 74. He clearly had life-threatening respiratory failure.

Dr. Gumbs described the initial work with ECMO that was done by Dr. Robert Bartlett at the University of Michigan and showed graphics over the complicated machinery. He described how the initial trials on ECMO were initiated by the NIH in 1975 and how the number of medical centers utilizing this technique has markedly increased, especially following the COVID epidemic. Apparently, there are thousands of ECMO runs that are being done routinely around the country. He pointed out that there are some relative contraindications to the implementation of ECMO including the history of mechanical ventilation, for more than seven days, a peak airway pressure of greater than 30 torr, an FiO₂ requirement of over 90%, and the need for anticoagulation for other problems.

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SURGICAL GRAND ROUNDS, cont...

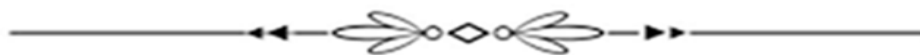
Dr. Gumbs pointed out that the technique for utilization of ECMO varied according to the underlying condition. Patients with cardiac compromise are candidates for A–V ECMO, whereas patients with pulmonary compromise are candidates for V–V ECMO. He described the construction of the membrane oxygenator and pointed out when one would use a single cannula or a double cannula. The use of ECMO on burns is relatively new in comparison to the more traditional indications for ECMO. The major comorbidities which are associated with death despite ECMO include the percent of total body surface area burn, acute renal failure, coagulopathy, sepsis, and severe edema resulting from resuscitative needs.

Extracorporeal Membrane Oxygenation (ECMO): Utility in Burn Patients with Severe ARDS

Department of Surgery
Grand Rounds
July 8th, 2026
Shannon Gumbs, MD
Surgical Critical Care/Burn Fellow



There have been a number of trials which have demonstrated that the use of ECMO reduces the mortality compared to those patients with similar injury randomized to receive no ECMO or standard care. He described some of the results in DMC patients who have been treated since 2020. These patients were treated by V–V ECMO in addition to the standard treatment for ARDS including prone positioning, protective ventilation, and, when needed, renal replacement therapy. Currently, there are many ECMO runs that are being performed internationally with the overall mortality being related primarily to the percent total body surface burn, acute kidney injury, and the number of times that a patient has to be returned to the operating room for excision of his burned skin. Following his presentation, there was an active question-answer-session.



The **Surgical Grand Rounds on Wednesday, July 15, 2026**, were presented by **Dr. Ryan Rosen** who finished his general surgical residency in 2025 and completed his surgical critical care training at the Children's Hospital of Michigan in 2026. He is currently doing surgical research at the Children's Hospital. The title of his presentation was **"Famous Fatalities, Indispensable Lessons: Reviewing Historical Trauma Cases to Inform Modern Surgical Thinking"**. Dr. Rosen emphasized in the first part of his presentation the "race against time" in salvaging severely injured patients who require immediate intervention.



Dr. Ryan Rosen

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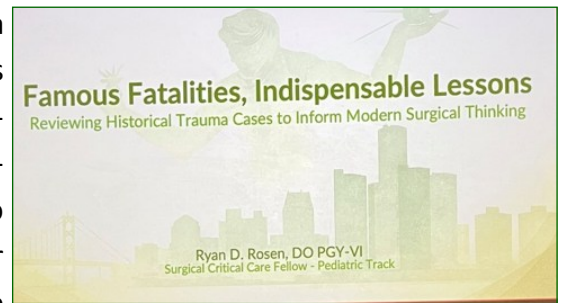
SURGICAL GRAND ROUNDS, cont...

The first case he described was a middle-aged woman who was a backseat passenger in a vehicle that was traveling about 60 miles an hour in a tunnel. Following the crash the patient was very agitated and moved only the left arm and leg. She had obvious injuries to the right chest and while in transit the ambulance had to stop in order to provide CPR. It took 25 minutes to travel four miles to the nearest emergency center. Upon arrival she had the

right chest opened which was then extended as a clamshell incision to identify bleeding coming from the mediastinum. The source of the blood loss was the right pulmonary vasculature which was disrupted and caused death on the table. He was describing the ordeal of Princess Diana who was injured in 1997.

The next case Dr. Rosen described was related to a middle-aged man who sustained a gunshot wound to the right neck. He was quickly resuscitated and taken to the nearest emergency center which was 1.9 miles away; the time of transfer was 14 minutes. He was unconscious during transit and had a weak thready pulse with a gaping wound on the right side of the neck suggesting that the weapon was a rifle. He had a cardiac arrest and received epinephrine and CPR. He had injuries to C7 through T2 with likely spinal cord involvement. He also had transection of the subclavian vessels. The bullet finally lodged in the left scapula. He had immediate exploration of the right neck but died shortly after on the table. Dr. Rose was describing the injuries and treatment of Dr. Martin Luther King Jr. in 1968.

Dr. Rosen described how the French EMS system began in the early 1950s as a means of transferring patients with severe polio causing ventilatory paralysis and the need for artificial ventilation and transfer to emergency facilities capable of caring for this problem. This eventually evolved into the modern French EMS system. The EMS team would often provide care at the scene, which was sometimes facetiously referred to as "stay and play". The proponents of the system emphasized that this is not the same as the injuries that were being treated during the Korean War when rapid transport became the order of the day. He described how the transport times decreased during World War II from 10 hours to 85 minutes during the Korean conflict and then 47 minutes in the Vietnam conflict. It was emphasized that the resultant mortality progressively decreased so that it was less than 2% during the Vietnam conflict. The civilian translation of these data led to the term "load and go" which is how most EMS teams care for patients nowadays.



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Dr. Rosen discussed the innovations made by Dr. R. Adams Cowley from Baltimore as he emphasized the "Golden Hour" which has become an objective for both military and civilian penetrating injuries. His work demonstrated that increased prehospital activities by EMS was associated with an increased mortality rate particularly in patients with severe head injury.

Dr. Rosen next described a 45-year-old man who fell while skiing without a helmet. He was rescued by the ski patrol and taken to the nearest emergency facility. He had evidence of a blown pupil. He also had decrease in his brainstem reflexes. He showed evidence of herniation with intracerebral hematoma and died on day two. Dr. Rosen was describing the death of Richardson in 2009.

Dr. Rosen then described a 44-year-old person who was enjoying the great barrier reef in Australia when he suddenly received a stab wound to the chest from the tail of the stingray. The patient was transferred to the emergency department where he died shortly thereafter. Dr. Rosen was describing the injury of Steve Irwin in 2000.

For both above patients Dr. Rosen emphasized the importance of not overlooking an injury and pointed out that the incidence of a missed injury ranges from 8–15% in different studies. He pointed out that clinicians rely on both the fast instinctive response to any injured patient and the slower more reasoning response with both working in synchrony. He emphasized the importance of relying on the instinctive responses which are often based upon prior experience with this injury. He emphasized, however, that one must not be overconfident and should continue close examination of the patient and keep an open mind for injuries "never seen before".

The ATLS program emphasizes these qualities of combining the instinctive responses followed by a complete assessment including both of the secondary and tertiary surveys in order to reduce the likelihood of missed injuries.

The third part of Dr. Rosen's presentation dealt with the problem of missed injuries. He described a 49-year-old patient who received a gunshot wound to the back and was taken to the nearest facility where the bullet wound was probed. The patient was admitted to the hospital and developed complications which included fever and gastrointestinal difficulties. He was started on diet which was not well tolerated. He had problems with his abdomen for the next several days and later developed gastritis, pneumonia, and a sacral decubitus. He died on postinjury day eight and the postmortem examination demonstrated that there were

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untreated injuries to the liver and the colon. Dr. Rosen was describing the care received by President James Garfield in the early 1880s.

The next patient Dr. Rosen described were the injuries that occurred in a 58-year-old man who received a gunshot wound to the chest and abdomen. He was taken to the closest hospital where his abdominal wound was probed. He eventually went to the operating room where he had a stomach injury that was sutured but the bullet was never found. During the first four days after operation he had fever, decreased urinary output, and abdominal distention. The wound was opened at the bedside on day four and liquid material came out. He had increased fever, tachycardia, and confusion. He eventually died on day eight. The postmortem examination showed a gangrenous repair of the stomach. Clearly the patient did not have full exploration so that all his injuries could be identified and repaired. Dr. Rosen was describing the case of President William McKinley who was assassinated in 1900.

Dr. Rosen described how the approach to penetrating injuries has changed over the past 1½ centuries. Even though Dr. Ian Bauder had successfully explored and treated abdominal gunshot wounds early in the century, nonoperative therapy continued to be widely employed. He quoted one surgeon who stated that "delay in operation is a crime". He described how one of the surgical reports deals with a successful laparotomy for gunshot of the abdomen two days following the injury to President Garfield.

Dr. Rosen described all patients with penetrating abdominal wounds can be observed but this required frequent repeat physical examination in patients who are not compromised by drugs, alcohol, or cerebral injury. He emphasized the importance of serial examination and open-mindedness. He restated the old quote "good judgment reflects experience and experience is related to prior bad judgment". There was an extensive question-and-answer session during which it was emphasized that the surgical team needs to stay with the seriously injured patient throughout all of the various imaging studies in order to meet the mandate of continued serial examinations.



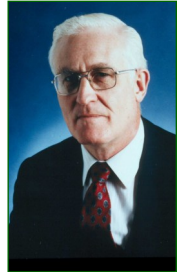
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The **Surgical Grand Rounds for Wednesday, July 22, 2026** was presented by **Dr. Charles E. Lucas (WSU/GS 1962/67)** and was entitled, "The Spleen: From Antiquity to the 21st Century."

Over the millennia, the spleen has attracted many philosophical comments. Aristotle, in the fourth century B.C., taught that the spleen was not important for life. Pliny the Younger, the nephew of Pliny the Older, who died as a result of the eruption of Vesuvius in the first century A.D., taught that the spleen was needed for laughter and speed for runners. The "great Maimonides" in the twelfth century A.D. noted that the spleen was important for laughter, running swiftly, and the purification of blood. One must wonder how this great man knew about the splenic role in the purification of blood eight hundred years before it was later demonstrated. In summary, the romantic contributions of the spleen to life included spirit, courage, mirth, ill humor, and melancholy.



Dr. Charles Lucas

The spleen is about 10 cm in length and weighs about 100 gm. The hilum is transversed by multiple small vessels from the splenic artery and the splenic vein as they course from the posterior superior aspect of the pancreas. The ligamentous attachments which may be vascular and require careful coagulation are between the diaphragm and the upper pole of the spleen, the splenic flexure of the colon and the lower pole of the spleen, and posteriorly between the spleen and the left kidney. At birth, the spleen is histologically immature with no lymph follicles or germ centers. The spleen reaches its maximum weight at puberty when it represents 25% of the total lymphoid mass and receives about 25 ml of blood flow per minute. During maturity, there is leukocyte sequestration in the parafollicular follicles, and these are responsible for immunoglobulin and antibiotic production as part of the spleen's contribution against infection.

Splenectomy was described in the Middle Ages when soldiers who had large slashing wounds with the spleen "hanging out" were, therefore, excised and ligature applied. The real era of splenectomy began in 1897 when Riegner treated a 14-year-old construction worker who had fallen from a scaffold. The patient had evidence of intra-abdominal bleeding and received the standard treatment at that time, which was compression. Following one day of observation, Riegner decided to operate and removed a badly smashed spleen. Postoperatively, the young man developed gangrene of his left leg due to the compression applied and had an above-the-knee amputation. He survived this insult, and it was concluded that the spleen was not necessary for life.

The first serious science regarding splenic function came from a paper that Morris and Bullock published in 1918 showing that splenectomy led to susceptibility to bacterial exposure, concluding that the spleen

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facilitates the immune response. This excellent paper was promptly criticized, first by Lord Moynihan of Leeds who was a president of the Royal College of Surgeons and declared that “. . . resistance to infection is not altered by splenectomy.” He had no data for that conclusion. Dr. Richard Pearce in 1990 maligned Morris and Bullock, declaring that “. . . the spleen can be removed with relative impunity,” even though one of his four animals died from pneumonia. The great

Hamilton Bailey, considered by some to be the English Sabiston, proclaimed “In no instance is there any indication that the asplenic person is more susceptible to infection.” This dramatic conclusion was based upon 13 patients. Another interesting teaching regarding splenic injury came from Dr. Archibald McIndoe, a Scottish surgical pioneer who stated that patients with splenic hematoma need to have splenectomy since 15-30% of such patients will have a delayed splenic rupture. He postulated that this phenomenon occurs because the red cells within the hematoma lyse and create a hyperosmolar state, causing expansion of the hematoma with rupture. The one patient that he had was probably a late diagnosis of early rupture. The author was taught that whenever a splenic hematoma was identified during laparotomy, the spleen had to be removed to prevent late rupture. In reality, the late rupture is very rare, as evidenced by a patient who had a negative diagnostic peritoneal lavage after blunt injury but then later had evidence of bleeding, and at operation, was found to have a rupture of the spleen.

Splenic salvage began in Detroit when Dr. Leo Dredzka, the first Chief of Surgery at the Detroit Receiving Hospital from 1916 to 1929, performed the first splenorrhaphy for pediatric splenic injury. This would be based upon the concept that the spleen was important in fighting infection as described by Morris and Bullock. At that time, the Detroit Receiving Hospital received almost all the injured children in the city of Detroit, with the old Children’s Hospital being north of Warren and not involved in the care of injured children. Dr. Leon Morgenstern from UCLA and Dr. Dredzka identified the important technical aspects of performing splenic repair, including a generous incision, wide exposure, omental division, careful stomach retraction, and suturing the parenchyma of the spleen with absorbable sutures and the intrasplenic vessels with permanent sutures; preserving the capsule often helped with splenorrhaphy.

In 1952, Dr. King and Dr. Shumaker demonstrated the syndrome of overwhelming post splenectomy infection (OPSI) in two children with hereditary spherocytosis, and Smith in 1957 demonstrated OPSI in a child without any congenital abnormality. Later data showed that the incidence of this syndrome was up to 2% in

The Spleen

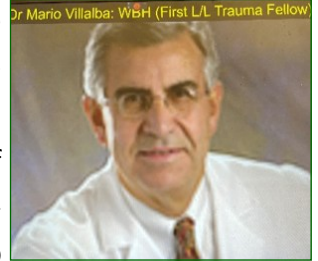
From Antiquity To The
Twenty First Century

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children and <1% in adults, but when it occurred, the mortality rate was 50%. The bacteria involved in most cases were one of the strains of pneumococcus or meningococcus. The current recommendations by the American College of Surgeons calls for immunization for polyvalent pneumococcus and meningococcus at the time of discharge, at eight weeks, and booster doses every five years in patients who undergo splenectomy, Dr. John Gibbon, made the comment, "If the spleen were not so easily removed, fewer splenectomies for rupture would be reported, since the majority of these cases of hemorrhage can be controlled by temporary packing." The first studies on non-operative management of splenic injury began at the William Beaumont Hospital under the supervision of Dr. Mario Villalba, the first Trauma Fellow with Drs. Ledgerwood and Lucas. From 1978 to 1983, 30% of the patients with blunt splenic injury were treated non-operatively, and none required a subsequent splenectomy. This encouraged other surgeons on the Beaumont staff to join the non-operative group so that from 1984 to 1988, 70% were treated non-operatively. The last report was made in the early part of the 21st century, at which time over 80% of their patients with blunt splenic injury were treated non-operatively. They emphasized the importance of a mature surgeon being willing to change his/her mind if the patient developed any symptoms suggesting that there is intra-abdominal bleeding which is not controlled. These authors emphasized that the patients should be walking when there is no longer any pain and should be on diet when bowel function returns.



Many examples of patients treated at the Detroit Receiving Hospital non-operatively were presented and included patients with Grade II, Grade III, and Grade IV splenic injuries. When patients re-bleed while being observed during non-operative treatment, the bleeding usually occurs within 48 hours and essentially always occurs within 96 hours. Different examples of severe splenic injuries being repaired during laparotomy were presented. It was pointed out that when a patient fails non-operative therapy and goes to surgery, the likelihood of being able to do a successful splenorrhaphy is only about 10%. The other 90% require splenectomy. One of the complications of non-operative treatment in patients with splenic hematomas is contamination by bacteria when the patient is an intravenous drug user. Such patients come back with splenic abscess which should be treated with splenectomy.

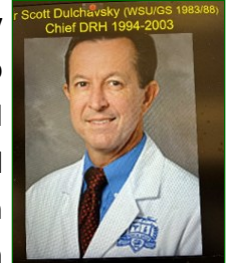
One of the questions that has arisen regarding patients having splenorrhaphy is how long should they be restricted from work, and how long does it take for the spleen, which is observed or sutured, to develop

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enough strength to not have a delayed rupture? This was answered by Dr. Scott Dulchavsky (WSU/GS 1983/88) who was the Chief of Surgery at Detroit Receiving Hospital from 1994 to 2003. He then took the Chairmanship at the Henry Ford Hospital. Dr. Dulchavsky utilized the classic “Levine” methods for measuring wound breaking strength and demonstrated that the injured spleen when sutured or observed almost always obtains excellent strength by three weeks and always by six weeks so that patients did not have to be prohibited from physical activities for more than six weeks at the most. These are the only studies that are published on splenic healing with splenic injuries.



During the early part of the century, it became popular to salvage part of the spleen following splenectomy by cutting up the spleen into 0.5 cm segments and wrapping them within the omentum like “an omelet.” Experience has demonstrated that attempts to do splenectomy after blunt trauma in patients with cirrhosis is almost uniformly fatal. National studies have demonstrated that when the MELD score is >19, the mortality rate from ruptured spleen is close to 100%.

The end of the 20th century saw a new approach to splenic injury, namely non-operative management (NOM). The great Theodor Billroth in the 19th century described the autopsy of a man who had died of head injury and had an incidental splenic rupture with clot around the spleen and made the observation, “From the appearance of the spleen and the blood, we concluded that the injury might have healed completely.”

The recommendation was that 50% of the spleen should be treated and left as an omental omelet within the abdomen. The natural history in man and animals was that there would be coagulative necrosis over the next two weeks, but the matrix cells would survive, and a new spleen would evolve over the next six months. Based upon these recommendations, the Editor treated a judge’s administrative assistant who fell from a two-step ladder onto the corner of a table while retrieving one of his law journals. She had evidence of hemoperitoneum, altered vital signs, and at laparotomy, had a badly injured spleen that was removed. The spleen was diced into small segments and placed within the omentum and left in the peritoneal cavity. By day two, she appeared to be toxic and quite sick and was taken back to the operating room where the “omental omelet” was removed. She was all better by day five and went home by day six. We concluded that this needs to be studied.

The classic studies regarding the function of the “splenic omelet” were done by Dr. Jonathan Saxe (WSU/GS 1980) and Dr. Sharon Hayward (WSU/GS 1985/90). They looked at a canine model which had splenectomy

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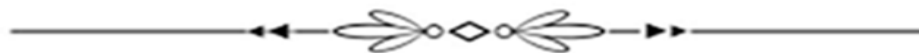
SURGICAL GRAND ROUNDS, cont...

in one group vs. the “omental omelet” in the other group. They looked at hematologic measurements, hepatic function, labelled technetium red blood cell uptake, and the presence of Howell-Jolly bodies and schistocytes in both groups and found them to be identical. When the microscopic sections were studied by the Wayne State pathologist, the splenic omelet tissues had total absence of parafollicular cells, which were all fibrotic and non-functional. This is the only study showing that the splenic omelet is nice in theory but doesn’t work because there are no parafollicular cells.



Splenic salvage can also be performed in patients undergoing distal pancreatectomy. This was first described by Dr. Leon Pachter in 1999 and has been used for both trauma and non-trauma situations. The dissection must be done very tediously as the branches of the splenic artery and splenic vein are separated from the pancreas. Experience at the Detroit Receiving Hospital has demonstrated the unacceptable incidents of lower pole splenic infarction in these patients often necessitating splenectomy. This technique, however, is good for patients who have cystic tumors of the pancreas just lateral to the common bile duct, thereby making them amenable to resection of the tumor, oversewing of the remaining pancreas attached to the duodenum, and attachment of the distal pancreas into a Roux-en-Y jejunal loop.

The last issue discussed was the role of splenic artery embolization (SAE) which in the early 21st century became a panacea for patients with splenic blush. There have been several studies that have come out in the 21st century that show there are many complications of SAE, including splenic infarction and splenic sepsis with associated left pleural effusion and empyema, and unacceptable mortality. The role of SAE should be limited to those patients who are stable and have continued evidence of bleeding, requiring blood and fluids to maintain that stability. The unstable patient must not go to the radiology suite but belongs in the operating room. There was an active question-and-answer period.



The **Surgical Grand Rounds on Wednesday, July 29, 2026** were presented by Dr. **Steve Kim**, a senior oncologic surgeon at the Karmanos Cancer Hospital. The title of his presentation was **"Melanoma 2026"**. Dr. Kim described the various types of skin cancers. These included basal cell carcinoma, dermatofibroma

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protuberans, Merkel cell carcinoma, squamous cell cancer, and melanoma which makes up about 10% of skin cancers. He described some of the early signs of melanoma which might include drainage, itching, turning black, rapid enlargement of a mole, and bleeding. Once suspected, the diagnosis of melanoma is obtained by a punch biopsy or shaving. Regarding the staging of melanoma, he described the importance of the Clark classification and the Breslow classification. One deals with millimeters of thickness, whereas the other describes the anatomic depth of invasion. He emphasized that a depth greater than 0.8 cm was significant as it relates to prognosis and treatment decisions.



Dr. Steve Kim

Dr. Kim described the TNM classification system as it relates to the primary tumor and subsequent regional or distant node metastases. He emphasized the importance of careful physical examination and subsequent imaging studies for patients with the deeper levels of melanoma invasion. He showed examples of melanoma on the toes and foot and also examples of "in transit" melanoma sites between the foot and the groin in patients with positive groin lymph nodes. Patients with advanced disease are candidates to be evaluated by the pet scan and the brain MRI. Patients with very superficial early-stage melanoma are not candidates for imaging studies.

Dr. Kim pointed out that there have been great advances with immune therapy. He emphasized the importance of having clear margins when excising the primary tumor and pointed out that 10–20% of patients will have positive lymph nodes. He highlighted some of the classic studies that have been performed regarding identification of neck anatomy and techniques for doing neck dissections. He also emphasized the importance of the work done by Dr. Morton as it relates to staging melanoma using mapping lymphoscintigraphy. Assessment of regional nodes can be identified by radioactive studies or by blue dyes which are injected distal to the primary lesion and proximal to the lymph node bearing areas. It was pointed out that lesions on the back may have as their primary lymph node bearing area the axilla. Studying the lymphatic system helps identify the lymph node bearing area for that particular lesion.

The identification of melanoma-spread facilitates the logical operative decision-making when trying to access metastatic lymph nodes. The studies also help determine when a patient is a candidate for a radical lymph node dissection (RLND) or simply a sentinel lymph node biopsy. There have also been tremendous strides by the use of gene expression profiling (GEP) in order to provide more specific therapy with lesser toxicity.

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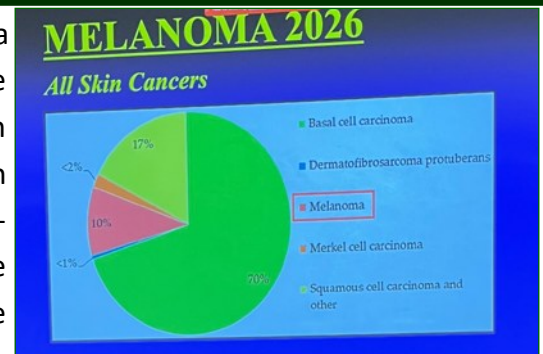
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Dr. Kim described some of the KCC experiences with melanoma and the role that various imaging studies have in determining the best treatment. He describes a large 2017 trial where a comparison of SLND offers similar long-term results as RLND in patients with similar level of nodal involvement. Both groups were followed carefully by physical examination and specialized imaging studies. He also described the more recent immunotherapy studies which are showing survival in patients with stage IV disease. The use of these

agents is not free of complications and has been associated with a small number of organ toxicities as it relates to the pancreas, colon, liver, kidneys, lungs, and heart. Studies in 2022 have demonstrated the elimination of disease in patients with stage III melanoma with the immunotherapy. There are also some studies on neoadjuvant treatment in patients with bulky disease that have shown a decrease in size so that they are potentially respectable. These patients need to be followed closely for new lymph node involvement which might include the skin, breast, or other lymph node bearing areas. Any suspicious lesion needs detailed imaging to rule out recurrence particularly after neoadjuvant therapy which causes the disease to shrink or disappear.

Dr. Kim described the more recent PRADO trial which demonstrated beneficial effect in patients with advanced disease with the result that the neoadjuvant therapy might eliminate the need for axillary lymph node dissection. He described phase 3 trials in which de-escalation of surgery has been possible because of the beneficial effects of neoadjuvant therapy. Dr. Kim summarized his presentation and emphasized that this is a very dynamic time as it relates to enhancing knowledge of both of the 21st-century medical and surgical treatments of melanoma. Many questions remain to be answered. There was an active question-and-answer session during which Dr. Kim pointed out that the use of infusion chemotherapy for the treatment of in-transit metastases has pretty much fallen out of favor and has been replaced by some of the treatment regimens he described during his presentation.



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Dr. Michael S. Dahn Decides to Hang Up the Scalpel

The story of Dr. Michael Dahn (WSUGS 1980) epitomizes the strengths of our great nation and why the United States of America is truly the land of opportunity. Mike was born in 1949 in Kassel Germany. At the young age of six years, the family moved to Brooklyn New York where Dr. Dahn received his early education. He was admitted to the prestigious Rensselaer Polytechnic Institute in Troy, New York where he received his bachelor's degree; after which he began his medical school training at the State University of New York (SUNY) in Buffalo. While at the Rensselaer Polytechnic Institute, Dr. Dahn did research within the Department of Chemistry with work in flash photo kinetics of biomolecular precursors. During this period of research, he became quite familiar with numerical methods, computer programming, and various types of chromatography.



Dr. Michael Dahn

While at the State University of New York in Buffalo, Dr. Dahn was involved in extracurricular studies and received 10 credit hours of graduate work in biophysics. Clearly, he had an inner need to know more than just the clinical practice of medicine. He began his surgical residency at Boston University. Dr. Dahn did well during his surgical residency at Boston University but got caught up in a pyramid program as the number of residents who would be advancing to the later years of the program went from 15 to 9. He then applied to the surgical program at Wayne State University. Sometimes decisions are made in a nonscientific manner. Dr. Peter Decker, at SUNY, wrote to Dr. Anna Ledgerwood (WSUGS 1972), the residency program director at WSU, about Dr. Dahn. "I have had an opportunity over the past six weeks to work with him directly while he was on our surgical oncology service, and I assure you that he is the most capable resident that I have worked with during the past year". Dr. John Byrne, at SUNY, wrote "On the recent examination given to all our surgical residents, Dr. Dahn had the highest mark of the entire group. There is no question that he will be an excellent surgical resident...". The predictions made by the SUNY faculty proved to be true. As would be expected, Mike was an excellent surgical resident and following the completion of his training in 1980, he was appointed as an instructor in surgery and assigned to the VA Hospital in Allen Park. During these years he noted that many of his peers were going into private practice and earning a much greater income than himself. This is sort of the universal truth for all

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Dr. Michael S. Dahn Decides to Hang Up the Scalpel, cont..

people who decide to go into academic surgery where the rewards are more intellectual rather than financial.

While working on the surgical divisions at the VA Hospital, Dr. Dahn convinced the chief of surgery, Dr. Lloyd Jacobs, to provide time for him to pursue the obtainment of his doctorate degree in biochemistry under the tutelage of Dr. Robert Mitchell in the WSU Department of Physiology.

Dr. Dahn has special interest in sepsis and the acute inflammatory response that he had observed in many critically ill patients. One of the observations that he made in caring for these patients was the uniform hypoalbuminemia which began immediately after insult and lasted for a few days. There were some questions at that time as to whether this low albumin concentration might reflect decreased albumin production by the liver. Utilizing extremely complicated methodology, Dr. Dahn looked at the liver production of albumin and various other elements in normal control patients, patients undergoing a major operation without sepsis, and in patients with severe sepsis. Contrary to what many believed at the time, the operated/injured patients and the septic patients had increased liver production of proteins, especially, albumin compared to normal patients. These patients also showed evidence of hypermetabolism as reflected by measurements of various other elements in both the splanchnic system and in the liver venous system. These very important observations have serious ramifications on treatment decisions. He was able to conclude that the low albumin in the serum was a reflection of the rapid movement of albumin out of the vascular system into the interstitial fluid space.

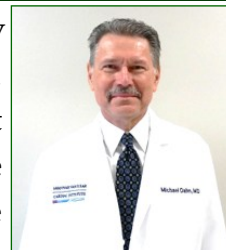
Based upon his interest in this type of metabolism, Dr. Dahn was able to contribute to studies in the Department of Toxicology at WSU as it relates to a hepatocyte which he introduced to the department. During these years he continued to be actively involved in clinical activities. He was responsible for introducing endovascular techniques to the VA Hospital which were not being done by their radiology department at that time. By this time, Dr. Robert Kozol was the chief of surgery at the VA Hospital and supported these important additions. Because of Mike's work, the first endovascular aneurysm repair procedure at WSU was done at the VA Hospital in 1999.

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AUGUST 2026

Dr. Michael S. Dahn Decides to Hang Up the Scalpel, cont..

Subsequently, Dr. Dahn moved to the University of Missouri in Kansas City where he performed the first endovascular procedure at that institution in 2001. Dr. Kozol, meanwhile, had accepted the Chairmanship of the Department of Surgery at the University of Connecticut. He convinced Dr. Dahn to join him there where the first endovascular aneurysm wall repair was first performed by Mike. While at the University of Connecticut, Dr. Dahn introduced a covered stent for exclusion of a popliteal aneurysm before the availability of the Viabahn covered stent. After many scientific and university contributions, Mike decided to enjoy some of the rewards of private practice and he joined the Savanna Vascular Institute in Savannah, Georgia from which he will be retiring later this year. This gave Mike the opportunity to enjoy the relationships with satisfied patients as well as working with surgical colleagues in the private practice of vascular surgery. In retrospect, Dr. Dahn gives great thanks to the WSU surgeons who laid the groundwork for his tremendous success in research and clinical vascular surgery and physiology.



Dr. Dahn's first day in private practice in Savannah, Georgia

An interesting byproduct of his VA exposure was collaboration with University of Pittsburgh personnel to develop a self-guiding visceral catheter which could be used to "seek" the liver and kidney vascular system without the need for x-ray imaging. An optical and electrical metric version was patented but nothing, thus far, has come of it commercially. This sounds like something that could be important in the future. During his last years of practice, 70% of his work has been endovascular, whereas the other 30% has been open vascular surgery.



Dr. Dahn and his bride, Eileen, enjoying Savannah Georgia.

Dr. Dahn and his bride, Eileen, have four children. Their two sons are in the field of Internet Security which will certainly become more complicated as we get into artificial intelligence. Their two daughters are both professional workers with one being an accountant and the other being an attorney. More recently, Mike has confined himself to the endovascular cases and refers the open cases to his colleagues. He is somewhat concerned about retiring from clinical practice since this has been a source of great joy for him over the years, but because of his decrease in clinical activities, Mike and Eileen have been free to do traveling which they could not do in the past. Over the past year the two of them have been to Malta, Spain, Argentina, and the Bahamas. All of us wonder where they will be traveling to next year!

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AUGUST 2026

Dr. Michael S. Dahn Decides to Hang Up the Scalpel, cont..



Enjoying the Summer Theater at Hilton Head Island



Mike and Eileen's daughters and their husbands



Mike and Eileen on their travels to Spain



Two of the Dahn's grandchildren



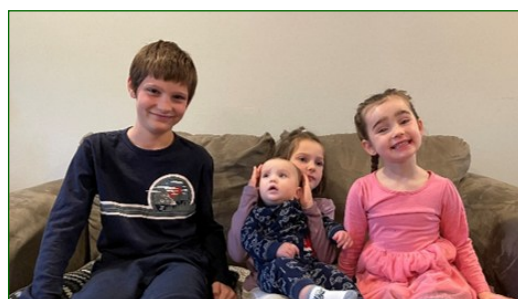
Mike and Eileen in Spain



Mike and Eileen's daughter, her husband, and their children



Two of Mike and Eileen's grandchildren



All four of Mike and Eileen's grandchildren



Mike and Eileen participate in a traditional baking experience in Croatia



AUGUST 2026



The Department of Surgery
cordially invites you and a guest to an

Alumni Reception

**Monday, September 28, 2026
6:00 p.m. – 7:00 p.m.**

The Westin DC Downtown

Hosted by David A. Edelman, M.D.
Interim Chairman, Michael and Marian Ilitch
Department of Surgery

SVP by August 28, 2026 to jdamm@med.wayne.edu or
Call Janet Damm at 313-745-8778





AUGUST 2026

Department of Surgery
6C/UHC, 4201 St. Antoine
Detroit, Michigan 48201
(313) 577-5013
FAX: 577-5310



The Department of Surgery
cordially invites you to the Annual Dinner Meeting
of the Wayne State Surgical Society on

Monday, September 28, 2026

The dinner will begin promptly at 7:00 p.m.
immediately following the WSU Alumni Reception
at the Westin DC Downtown,
999 9th St NW Washington, DC
Potomac Ballroom Salon 1, Ballroom Level

~ **Choice of Entree** ~

- _____ – **Pan Seared Filet Mignon**
Peppercorn merlot, Yukon gold potatoes gratin with smoked gouda, root vegetable medley
- _____ – **Herb Stuffed Chicken Breast**
Sage demi, parm cream butternut squash, asparagus, blistered tomatoes
- _____ – **Herb Gnocchi**
Artichokes, roasted portobello mushrooms, walnuts, gorgonzola cream

RSVP by August 28, 2026 to jdamm@med.wayne.edu or
Call Janet Damm at 313-745-8778



EXCERPTS FROM THE LOG BOOK DOWN MEMORY LANE

11/13/72 - Staff: Dr. Arbulu

1. CJ: SGW right lower quadrant with multiple holes in the cecum, treated with laparotomy, right hemicolectomy, and ileotransverse colostomy.



Dr. Anna Ledgerwood

11/14/72 - Staff: Dr. C. Bernys

1. LC: 64yo with perforated diverticulitis sigmoid colon, treated with loop colostomy and drainage.
2. JD523: GSW to chest and abdomen, had exploratory laparotomy with splenectomy.
3. BM: GSW neck and chest with injury to subclavian vein, treated with ligation subclavian vein, partial right upper lobectomy, and right thoracotomy.

11/15/72 - Staff: Dr. G. Shannon

1. HN: GSW abdomen with injury to mesenteric vessels and serosal tear transverse colon, treated with ligation of bleeding vessels.
2. JD525: Blunt trauma to chest with rupture of thoracic aorta, treated with median sternotomy and cardiac massage; patient expired in the operating room.
3. LB: Upper GI bleeding, treated with vagotomy and pyloroplasty with findings of Mallory-Weiss tear.

11/16/72 - Staff: Dr. Immamaglu

1. JW: 26yo with GSW left chest, had two holes in left diaphragm with laceration of spleen. Treated with closure of holes in diaphragm, chest tube, and splenectomy.
2. LS: 34yo with GSW to abdomen, laceration of left kidney, and thru-and-thru wound of sigmoid colon. Treated with left nephrectomy and sigmoid loop colostomy.

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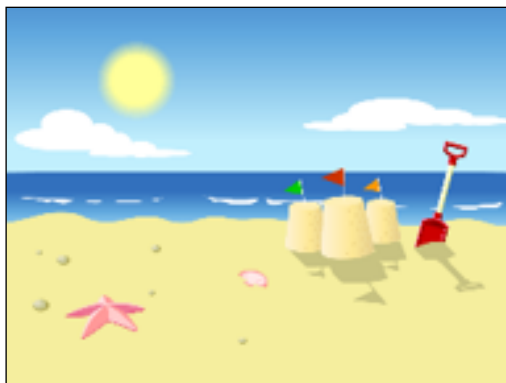
"EXCERPTS FROM LOG BOOK" - DOWN MEMORY LANE, cont...

11/17/72 - Staff: Dr. T. Flake

1. SW: 27yo with abscess of right second finger, treated with I&D.
2. VC: 50yo with GSW left shoulder and chest wall, treated with debridement of wounds.
3. 11/18/72 - Staff: Dr. Allaben
4. SA: Left pneumothorax, treated with chest tube.
5. SD: 27yo female with stab wound to abdomen, had negative exploratory laparotomy.
6. DT: 25yo with stab wound to left groin with lacerated deep femoral vein and artery; had ligation of the deep femoral artery and vein, but repair of femoral vein. Patient received 16 units of whole blood and 4 units of FFP.

11/19/72 - Staff: Dr. O. Tomacdor

1. HS: 29yo with SGW to right lower chest with lacerated liver which was sutured with laparotomy and drained.
2. JA: GSW left shoulder with thru-and-thru right subclavian artery, treated with resection and end-to-end anastomosis.





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, August 5

Death & Complications Conference

“Perioperative Risk Assessment in Patients with Advanced Liver Disease”

Karan Mathur, MD

Assistant Professor of Medicine, Division of Gastroenterology & Hepatology
Wayne State University School of Medicine

Wednesday, August 12

Death & Complications Conference

Gulcin Altinok, MD

Department of Radiology
Detroit Medical Center/Wayne State University School of Medicine

Wednesday, August 19

Death & Complications Conference

“Pneumothorax and Persistent Air Leak”

Khaled Alshabani, MD

Assistant Professor of Medicine, WSUSOM, Director of Interventional Pulmonary Wayne Health,
PCCM Fellowship Director
Detroit Medical Center/Wayne State University School of Medicine

Wednesday, August 26

Death & Complications Conference

“Ocular and Orbital Injuries: Evaluation and Management”

Christopher Cheyer, MD

Clinical Assistant Professor-Ophthalmology
Detroit Medical Center/Wayne State University 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.” The Planning Committee and Presenters have no commercial relationships.

EVALUATIONS

Surgery Grand Rounds #2026321064, May-Sept 2026 CME Reflective Evaluation: <https://www.surveymonkey.com/r/ZXJNLMD>
Surgical Death and Complications Rounds #2026321125, May-Sept 2026 CME Reflective Evaluation: <https://www.surveymonkey.com/r/QKYNCR8P>



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

Midwest Surgical Association 69th Annual Meeting
 August 2-4, 2026
 Grand Hotel
 Mackinac Island, Michigan

85th Annual Meeting of the AET & Clinical
Congress of Otolaryngology
 September 16-19, 2026
 Hyatt Regency Dallas
 Dallas, Texas

American College of Surgeons Clinical Congress 2026
Annual Meeting
 September 26-29, 2026
 Washington, DC



Please Update Your Information

The WSUSOM Department of Surgery wants to stay in touch. Please email Charles Lucas at clucas@med.wayne.edu to update your contact information.



Wayne State Surgical Society

The Wayne State Surgical Society (WSSS) was established during the tenure of Dr. Alexander J. Walt as the Chairman of the Department of Surgery. WSSS was designed to create closer contact between the current faculty and residents with the former resident members in order to create a living family of all of the WSU Department of Surgery. The WSSS also supports department activities. Charter/Life Membership in the WSSS is attained by a donation of \$1,000 per year for ten years or \$10,000 prior to ten years. Annual membership is attained by a donation of \$200 per year. WSSS supports a visiting lecturer each fall and co-sponsors the annual reception of the department at the annual meeting of the American College of Surgeons. Dr. 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.



Lifetime Members of the Wayne State Surgical Society

Charter Life Members

Ahn, Dean
 Albaran, Renato G
 Allaben, Robert D. (Deceased)
 Ames, Elliot L.
 Amirikia, Kathryn C.
 Anslow, Richard D.
 Antonioli, Anita L.
 Auer, George
 Babel, James B.
 Bassett, Joseph (Deceased)
 Baute, Peter
 Baylor, Alfred
 Bouwman, David
 Bradley, Jennifer
 Chmielewski, Gary
 Cirocco, William C.
 Clink, Douglas
 Colon, Fernando I.
 Conway, W. Charles
 Davidson, Scott B.
 Dente, Christopher
 Dittenbir, Mark
 Dujon, Jay
 Edelman, David A.
 Engwell, Sandra
 Evans, Walter
 Francis, Wesley
 Flynn, Lisa M.
 Fromm, Stefan H.
 Fromm, David G
 Galpin, Peter A.
 Gayer, Christopher P.
 Gerrick Stanley
 Grifka Thomas J. (Deceased)
 Gutowski, Tomasz D.
 Herman, Mark A.
 Hinshaw, Keith A.

Holmes, Robert J.
 Huebl, Herbert C.
 Johnson, Jeffrey R.
 Johnson, Pamela D.
 Kovalik, Simon G.
 Lange, William (Deceased)
 Lau, David
 Ledgerwood, Anna M.
 Lim, John J.
 Lucas, Charles E.
 Malian, Michael S.
 Martin, David
 Maxwell, Norman
 McGuire, Timothy
 McIntosh, Bruce
 Mehmood, Syed
 Missavage, Anne
 Montenegro, Carlos E.
 Narkiewicz, Lawrence
 Nicholas, Jeffrey M.
 Novakovic, Rachel L.
 Patel, Bhavik
 Perrone, Erin
 Porter, Donald
 Prendergast, Michael
 Ramnauth, Subhash
 Rector, Frederick
 Rose, Alexander
 Rosenberg, Jerry C.
 Sankaran, Surya
 Sarin, Susan
 Schwarz, Karl
 Sferra, Joseph
 Shanti, Christina
 Shapiro, Brian
 Silbergleit, Allen (Deceased)
 Smith, Daniel

Smith, Randall W.
 Stassinopoulos, Jerry
 Sullivan, Daniel M.
 Sugawa, Choichi (Deceased)
 Taylor, Jamokay
 vonBerg, Vollrad J. (Deceased)
 Washington, Bruce C.
 Walt, Alexander (Deceased)
 Weaver, Donald
 Whittle, Thomas J.
 Williams, Mallory
 Wilson, Robert F.
 Wood, Michael H.
 Zahriya, Karim
 Ziegler, Daniel

