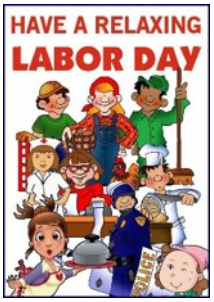
MICHAEL & MARIAN ILITCH DEPARTMENT OF SURGERY

WAYNE STATE

SEPTEMBER 2026



September 7th

Inside this issue:

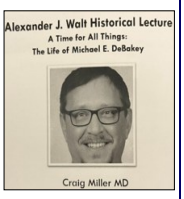
2026 WSSS OFFICERS

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 Antonioli (WSUGS 1998)

Resident Member:
Nicholas Calvo (WSUGS 2026)
Jude Jaracki (WSUGS 2006)

The 2026 Annual Meeting of the Midwest Surgical Association (MSA) was held from Sunday, August 2 through Wednesday, August 4 on the beautiful Mackinac Island at the infamous Grand Hotel. Those actively involved in the planning and organization of the meeting included Dr. Heather Dolman (WSU/GS 2000/06), treasurer of the MSA, and Dr. Jonathan Saxe (WSUGS 1990), the recorder of the MSA.



Following a wonderful reception on the large porch of the Grand Hotel, the membership met to hear the Walt Lecture which is given each year in honor of the former long-term chairman of the WSU Department of Surgery, Dr. Alexander J Walt. The lecture was provided by Dr. Craig Miller, of the United States Veterans Administration. Dr. Miller gave a very comprehensive lecture on the life of Dr. Michael E DeBakey the very creative surgeon who spent most of his career in Houston Texas. Dr. Miller described many of the innovations made by Dr. DeBakey as it relates to vascular surgery and the successful treatment of very complicated aneurysms. This session was followed by a series of lectures which fell under the category of "Spectacular Problems and Surgery". One of these lectures was presented by Dr. Megha Patel and was entitled "An Unusual Radiographic Manifestation of a Common Surgical Condition".

During the early hours of Monday morning, there were multiple posters that were available for review. This was followed by a scientific session which lasted until 9 AM, at which time the Memorial Lecture in honor of Dr. Scott Woods was given. Dr. Woods did his training in surgery at WSU and was a long-term supporter of the department until he died. The lecture this year was provided by Dr. Nancy Gantt who talked about the importance of surgeons being advocates for the surgical profession, the surgical organizations, and oneself. This lecture was followed by more scientific presentations until the early afternoon.


John Langell, MD

The next presentation was the William Harridge Lecture which honored one of the early members of the MSA who was responsible for keeping the MSA alive during times when the membership was small. The lecture was provided by Dr. John Langell who is a national figure as it relates to innovation of new products and the importance of a multidiscipline approach to this type of activity. Dr. Langell's presentation

Continue page 2

was very stimulating. The late afternoon activities were for the membership and their families to enjoy the great Mackinac Island where there were various sporting activities and races.

Tuesday evening was reserved for the annual banquet which was attended by well over 200 people and who enjoyed a wonderful dinner. The banquet room had a central dance floor where the youngsters under the age of eight would dance to the music that was being played. A good time was had by all. There was a good number of the WSU family who attended the banquet.

The Wednesday morning session began with a scientific program where Dr. Heather Dolman (WSU/GS 2000/06) was one of the monitors. One of the papers presented during this session was authored by Dr. Lawrence Diebel (WSU/GS 1980/86) and presented by Dr. Reed Bartholomew and was entitled "Blunt Renal Vascular Injury: A Contemporary Analysis of Management and Outcomes Using the Trauma Quality Improvement Program Registry". Following the morning scientific program, the MSA president, Dr. David Linz, of Broadview Heights, Ohio delivered the Presidential Address entitled "A View From the Front Porch". The morning session was followed by the annual business meeting where plans were made for the 2027 meeting. The new president is Dr. Abdelkader Hawasli of St. John's Hospital in Detroit, the president-elect is Dr. Jonathan Saxe and the secretary is Dr. Heather Dolman.

Dr. Anna Ledgerwood, Dr. Mega Patel (WSUGS 2027) and Dr. Charlie Lucas

(Standing left to right) Dr. Heather Dolman, Dr. James Tyburski, Dr. Mega Patel (WSUGS 2027), and Dr. Alfredo Munoz (WSUGS

SURGICAL GRAND ROUNDS, cont...


Dr. Karan Mathar

The ***Surgical Grand Rounds for Wednesday, August 5, 2026 was presented by Dr. Karan Mathar*** who is an Assistant Professor of Medicine in the Division of Gastroenterology and Hepatology. The title of his presentation was "Operative Risk Assessment in Patients with Advanced Liver Disease". He pointed out that the normal pressure gradient from the portal vein to the hepatic artery and vena cava is no more than 5 mmHg. He described the dual circulation of the liver by the portal vein and hepatic artery with both providing major oxygenation to the liver. The portal pressure is elevated in patients with severe liver disease due to hardening (cirrhosis) of the liver parenchyma. This leads to an increase in portal pressure, and this increase correlates closely with the risk of major operation causing morbidity and mortality. Patients with a pressure gradient of more than 16 mm have a marked increase in morbidity and mortality associated with surgery. The degree of "liver stiffness" may be measured by ultrasound which represents a type of liver utilized elastography. When performing major surgery on patients with severe liver disease, strong recommendations include cessation of drinking, ideally for six months, and preoperative correction of hepatic abnormalities if possible. Cessation of smoking is also strongly recommended and there may be an advantage to minimally invasive procedures over open procedures.

Dr. Mather described the classic risk calculators including the MELD Score and the Child's Classification. A more recent risk which has become quite popular is the VOCAL–Penn Cirrhosis Surgical Risk Score. This has been recently developed and internally validated in a national Veterans Affairs Health System Study. He indicated that when the score is elevated there is over a 15% 90 day mortality rate and that, if possible, a liver transplant is recommended. Cirrhosis of the liver is typically associated with coagulopathy; despite this observation the use of procoagulant transfusions and vitamin K replacement does not have a perfect role in the prevention of bleeding. When some type of portacaval shunt is performed to reduce portal pressure and prevent recurrent bleeding, he recommended that the diameter of the shunt should not be greater than 8 mmHg in order to prevent excessive bypass of perfusion away from the liver, thus, compromising liver oxygenation. Dr. Mather emphasized that the risk of cholecystectomy is markedly increased in patients with Childs Class A and B cirrhosis and prohibitive in Class C cirrhosis.

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MICHAEL & MARIAN ILITCH DEPARTMENT OF SURGERY
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SEPTEMBER 2026

SURGICAL GRAND ROUNDS, cont...

Over the years, there have been a number of contributions made to the understanding of cirrhosis by members of the WSU Department of surgery. One of the factors associated with cirrhosis is hypoalbuminemia which, in the past, led to the recommendation that the administration of serum albumin would increase the intravascular oncotic pressure and thereby decrease the extent of ascites. This led to a study whereby a patient's freshly drawn whole blood was taken to the isotope lab where the serum was separated and the albumin labeled with radioactive iodine. Reinjection of the labeled serum albumin followed by tapping of the ascites showed that the albumin which was reinjected moved quickly into the ascites. Thus, the known observation that 7% of the normal patients serum albumin moves into the interstitial space each hour also applies to the patient with liver cirrhosis and ascites.

Dr. Myron Denney, a long-term faculty member, demonstrated that the high pressure within the venous system after the creation of an arterial venous fistula led to the retrograde movement of red blood cells from the vein into the lymphatic system where it could be demonstrated in the thoracic duct (Arch Surg 1966;92:657-663). He also demonstrated that cannulation of the thoracic duct in cirrhotic patients with bleeding varices led to a cessation of bleeding and that the thoracic duct lymph contained red blood cells. This was referred to as hematochyluria. Later studies demonstrated that in patients who had ongoing measurements of splenic pulp pressure which provided an estimate of pre-hepatic pressure and hepatic wedge pressure which provided an estimate of hepatic venous pressure, there would be an immediate fall in both of these pressures when the thoracic duct cannula was placed to dependent drainage. This clearly demonstrated that the hydraulics within the portal reflected what is known in physics as a parallel system and not a system in series.

This important observation explained why the so-called selective decompression (splenorenal shunt) did not protect the patient from liver failure following operation any more than the side-to-side shunts. Indeed, later studies from the department showed that when several artery catheters were passed through side-to-side shunts into the distal portal vein and a contrast agent was injected, the flow was retrograde from the liver substance through the shunt into the inferior vena cava. Clearly, the side-to-side shunt was "robbing" the liver of oxygenation more than the end-to-side shunt. Continue page 5

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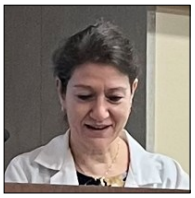
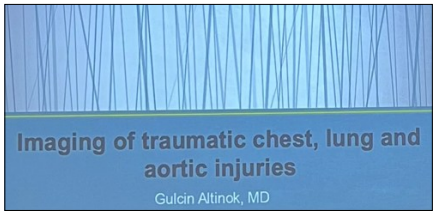
SURGICAL GRAND ROUNDS, cont...


Dr. Gulcin Altinok

The ***Surgical Grand Rounds for Wednesday, August 12, 2026*** was presented by ***Dr. Gulcin Altinok*** who is an Assistant Professor of Radiology at the DMC. The title of her presentation was "Imaging of Traumatic Chest Lung and Aortic Injuries". Dr. Altinok emphasized the importance of understanding how injuries can be identified with appropriate imaging studies. She talked about injury to the thoracic aorta and the different associated signs that are often present. These included three or more rib fractures, isolated first rib fracture, pulmonary contusion, pneumothorax – especially tension pneumothorax, liver or spleen injury, and flail chest. She showed several images including one where the associated injuries were fractures of the left ninth and tenth ribs or stomach rupture.

She showed examples of diaphragmatic injury from blunt trauma. This is often associated with a ruptured hemidiaphragm so that the liver may be in the right chest or the colon and spleen in the left chest. Most of the diaphragmatic injuries from blunt injury are on the left but about 5% are on the right and approximately 7% of such injuries are not identified on a chest x-ray.



Dr. Altinok discussed different types of lung injury including pulmonary contusion which may not be radiographically identified for at least six hours. She showed how the resolution of a pulmonary contusion varies with severity, with some resolving in 48 hours and others lasting several days or weeks. She also showed examples where lung injury is associated with a hematocele or a pneumatocele. One of the hazards with blunt thoracic injury causing injury to the lung is aspiration, which may be gastric use or even a truth which is knocked out by the impact. She also showed multiple examples of pulmonary laceration including GSW pathways with or without hemothorax. Patients who have had prior pulmonary infections are candidates to have adhesive tears at the adhesion sites causing ripping of the parenchyma.

One of the feared complications of blunt thoracic trauma is rupture of the thoracic aorta. The classic finding would be a widening of the mediastinum beyond 8 cm or beyond half the distance from side to side. Other findings for blunt thoracic aortic injury might include the so-called apical cap, associated tracheal injury, or depression of the left main stem bronchus. There are 7% of patients with this injury who present with a normal chest x-ray.

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SURGICAL GRAND ROUNDS, cont...

The Society of Vascular Surgery has a classification for blunt aortic injury with different extents of injury including intimal tear, intramural hematoma, false aneurysm, and free rupture which requires urgent operation. Patients who present with a type I or type II blunt aortic rupture can be treated non-operatively whereas patients with some type II and type III injuries can be treated by endoscopically placed stents. She showed examples of the different types of blunt thoracic aortic injury and pointed out that the very proximal aortic ruptures sometimes bleed into the pericardium and cause rapid death by pericardial tamponade. Dr. Altinok finished up by pointing out that the intramural aortic rupture may dissect distally and cause occlusion of many distal arteries including the renal artery or the iliac arteries. Rarely, the dissection may reenter into the lumen of the distal aorta. There was an active question-and-answer session.


Dr. Khaled Alshabani

The ***Surgical Grand Rounds for Wednesday, August 19, 2026 was presented by Dr. Khaled Alshabani*** who is an Assistant Professor in the Department of Medicine at WSU and is the Medical Director of the Interventional Pulmonary Program. The title of his presentation was ***"Pneumothorax and Persistent Air Leak"***. He started his presentation by presenting a 64-year-old patient with COPD who presented with right chest pain and shortness of breath. The patient had evidence of a spontaneous pneumothorax involving the right upper lobe and the right lower lobe and was treated expectantly until day three when he received a chest tube. He also described an elderly woman with emphysema who presented with sudden onset of chest pain and had a right upper lobe nodule which was associated with a spontaneous pneumothorax. This patient also had subcutaneous air and was treated with a chest tube.

Using these two patients as a starting point, Dr. Alshabani pointed out that a primary spontaneous pneumothorax (PSP) often has no specific cause when there are no associated pulmonary diseases. He emphasized that PSP occurs in about 20 patients per hundred thousand and occasionally is fatal. The risk of PSP is increased in patients who are smokers, males, tall, have prior exposure to tuberculosis, COPD, or any other primary lung disease.

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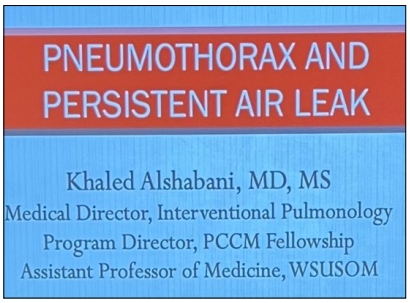
SURGICAL GRAND ROUNDS, cont...



The treatment varies according to the size of the pneumothorax and the symptoms of the patient. Often the patient can be observed and be supported with nasal oxygen if the symptoms do not become worse. More recent data suggests that the size is not the critical factor but that the patient's symptoms provide guidelines for whether some type of intervention should be provided in addition to the oxygen. When nonoperative treatment is provided and the patient does well the pneumothorax typically spontaneously resolves in less than eight weeks. If the PSP does not resolve or the PSP becomes larger, a chest tube placed to a water seal drainage system is recommended. Once the pneumothorax has disappeared, the chest tube is removed. For those patients in whom the PSP resolves within eight weeks, the likelihood of recurrence is quite low.

Intervention for PSP, when needed, can be provided by needle aspiration or by a small "pigtail" catheter. Formal placement of a chest tube is recommended when the above techniques are unsuccessful. Occasionally, repeat aspirations are necessary in order to provide resolution when one or two prior aspirations do not completely bring about resolution.

There have also been some reports of ambulatory treatment which leads to a decrease in the length-of-stay, but one must be careful to have close follow-up. When the pneumothorax is associated with bullae, the likelihood for persistence or recurrence is greater and some of these patients are candidates for a VATs procedure in order to resect the bullae. When all else fails, a pleurodesis may be indicated. This can be done chemically or mechanically. This is also true for patients that have persistent air leak in association with chest tube treatment.

Some patients require more extensive thoracic surgery including wedge resection and a small percentage of patients have formal lobectomy when the pulmonary disease involves the whole lobe. This is more commonly the upper lobe. He also described the use of autologous blood clots for patients with persistent air leaks. The use of a 120 mL autologous clot has been reported with a 90% success rate in different studies.

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SURGICAL GRAND ROUNDS, cont...

Dr. Alshabani also discussed endobronchial valves in patients with refractory pneumothorax. He described that 50% of patients with persistent pneumothorax were cured, but that it takes many days for some patients. There is also a one-way valve that can be passed through the chest wall to the outside but there is not much experience with this technique for persistent pneumothorax. One of the complications of the endobronchial valve that has been reported is hemoptysis. There was an active question-and-answer session.

The ***Surgical Grand Rounds on Wednesday, August 26, 2026,*** was presented ***by Dr. Christopher Cheyer*** who is an Assistant Professor in the WSU Department of Ophthalmology and is the Director of Ophthalmic Trauma at the Kresge Eye Institute. The title of his presentation was ***"Ocular and Orbital Injuries: Evaluation and Management"***. Dr. Cheyer showed the detailed anatomy of the eye and orbit. A common reason for a patient presenting to the emergency department with an eye problem is a potential foreign body. Less common problems dealt with include major blunt injuries which may be associated with proptosis, subconjunctival hemorrhage, orbital bleeding, and severe edema. He emphasized the importance of getting a good history prior to the examination. A good examination is facilitated by topical anesthesia which can allow one to examine carefully for any break in the conjunctiva or cornea. He showed several examples of different superficial injuries.


Dr. Christopher Cheyer

Often a foreign body which is readily apparent in the eye can be removed with topical anesthesia and, following removal, the patient is given topical antibiotics. Chemical injury may be related to exposure to an alkali which causes chemical damage to the conjunctiva and cornea and is sometimes referred to as an "alkali burn".

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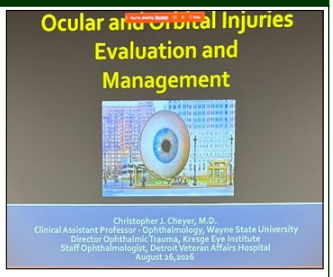
SURGICAL GRAND ROUNDS, cont...



Dr. Cheyer showed pictures of by hyphema which is blood in the anterior chamber. Often the blood will layer; several pictures of this phenomenon were shown. These patients are treated with cycloplegic drops with the expectation that the blood will reabsorb with time. He also showed examples of traumatic iritis which is associated with tearing, pain, photosensitivity, and altered vision. The treatment is topical steroids.

Patients presenting with a perforated globe need to be referred immediately to an ophthalmologist. In the interim prior to being seen, a "Fox Eye Shield" can be applied. A severe corneal laceration may be associated with prolapse of the iris and is an emergency. He showed several severe globe injuries involving various parts of the eye. Surgical repair of these injuries is done with 6-0 sutures which are absorbable. Sutures placed on the eyelids are typically left in place for 5 to 7 days whereas sutures placed on the edge of the eyelid are left in for 10 to 14 days. Repairing the canaliculus may require the placement of probes to identify the two edges after which the repair is with fine sutures. He showed examples of this technique.

The optic nerve is injured in about 4% of severe midface impacts. This usually leads to an abnormal pupillary response to light and may be associated with retinal edema. This requires urgent treatment including topical steroids and may require decompression of the optic nerve although there are no controlled studies as to whether steroids or optic nerve decompression give better results. When steroids are given, Solu-Medrol for 48 hours is recommended.

Dr. Cheyer also showed different pictures of orbital foreign bodies which can be seen on plain x-rays or CAT scan imaging of the orbit. Sometimes foreign bodies made of wood may not be shown on plain films. When foreign bodies are present in the anterior chamber the patient is likely to have diplopia and removal is indicated. The foreign body which is not identified often leads to subsequent abscess and external draining. He showed several examples of orbital injuries. Superficial anterior injuries may be observed in conjunction with topical steroids and frequent lubrication of the surface.

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SURGICAL GRAND ROUNDS, cont...

He emphasized how severe blunt injury may be associated with orbital edema that can be decompressed with a lateral canthotomy. He showed a few pictures identifying the technique for performing this procedure. He also described how retrobulbar hemorrhage leads to proptosis and that these types of complications are seen with blunt injury from a larger object such as a baseball or the dashboard of a vehicle. Patients with large fractures in this area are candidates for operative intervention which may be delayed for one or two weeks when there will be decrease in the amount of swelling. If the extraocular muscles are trapped, operation is to be done earlier.

Dr. Cheyer then described the "white eye blow out" where the rectus muscle becomes trapped at the fracture site and repair is required immediately in order to preserve the blood supply to the rectus muscle. Again, he showed a number of examples of this very bad complication. He also described the transconjunctival approach to repairing this bad injury. There was an active question-and-answer session to this very comprehensive lecture.

September 23rd

WAYNE STATE UNIVERSITY
SCHOOL OF MEDICINE

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

1868

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

wayne state surgical society

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

MICHAEL & MARIAN ILITCH DEPARTMENT OF SURGERY

WAYNE STATE

EXCERPTS FROM THE LOG BOOK DOWN MEMORY LANE


Dr. Anna Ledgerwood

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.

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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MICHAEL & MARIAN ILITCH DEPARTMENT OF SURGERY

WAYNE STATE

"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.
VC: 50yo with GSW left shoulder and chest wall, treated with debridement of wounds.

11/18/72—Staff: Dr. Allaben

1. SA: Left pneumothorax, treated with chest tube.
2. SD: 27yo female with stab wound to abdomen, had negative exploratory laparotomy.
3. 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.

September 11th

MICHAEL & MARIAN ILITCH DEPARTMENT OF SURGERY

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, September 2
Death & Complications Conference
"The Surgical Audible: A Look Into the Open Abdomen"
Reid Bartholomew, MD
Assistant Professor of Surgery
Detroit Medical Center/Wayne State University School of Medicine

Wednesday, September 9
Death & Complications Conference
"Evaluation and Treatment of Traumatic Spinal Injuries"
Parthasarathi Chamiraju, MD
Department of Neurosurgery
Detroit Medical Center/Wayne State University School of Medicine

Wednesday, September 16
Death & Complications Conference
M. Chadi Alraies, MD, MPH
Department of Cardiology
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/QKYNC8P

MICHAEL & MARIAN ILITCH DEPARTMENT OF SURGERY

WAYNE STATE

Wayne State Surgical Society

2026 Dues Notice –

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

PLEASE COMPLETE ↓↓↓

Name:

Address:

City/State/Zip:

Phone:

Email: _____@_____

MARK YOUR CALENDARS

85th Annual Meeting of the AAST & Clinical Congress of Acute Care Surgery
September 16-19, 2026
Hyatt Regency Dallas
Dallas, Texas

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

74th Annual Detroit Trauma Symposium
November 5-6, 2026
MGM Grand Hotel
Detroit, Michigan

Western Surgical Association 134th Annual Meeting
November 7-10, 2026
Eldorado Hotel
Santa Fe, New Mexico

Please Update Your Information

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

MICHAEL & MARIAN ILITCH DEPARTMENT OF SURGERY

WAYNE STATE

Wayne State Surgical Society

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

MICHAEL & MARIAN ILITCH DEPARTMENT OF SURGERY

WAYNE STATE

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.
Antoniolli, 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, Donald
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