



OCTOBER 2026



October 12th

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2026 WSSS OFFICERS

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The 85th Annual Meeting of the American Association for the Surgery of Trauma (AAST) took place on September 16-19, 2026, in Dallas, Texas. There were many interesting papers that were presented.

Dr. Jan O. Jansen and co-workers, from the University of Alabama, presented a paper noting that the administration of prothrombin complex concentrate (PCC) in patients with serious injury requiring multiple transfusions was associated with an increased mortality and acute kidney failure in comparison to a placebo, which was normal saline. This has important physiologic implications, which need further study.



Dr. Caroline Ricard and co-workers, from the Grady Memorial Hospital, presented a multi-center review that demonstrated that CT scan angiography provides little additional information in patients with lower extremity vascular injury with hard signs. This specifically focused on pediatric patients and emphasized that these patients are better treated by a direct transfer to the operating room with appropriate reconstruction.

Dr. Marcus Kunzmann and co-workers, from Scripps Mercy Hospital, presented a military paper which showed that the important relationship between civilian trauma centers and military physicians did not always meet the desired thresholds for trauma experiences for military physicians. Part of this might relate to the fact that many of the patients in civilian trauma centers are treated with non-operative management for serious solid organ injuries.

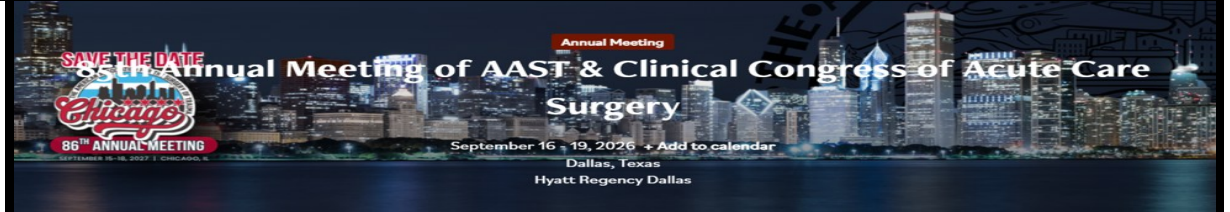
Dr. William Luo and co-workers, from WakeMed, demonstrated that bedside thoracic irrigation in patients receiving decompression for traumatic hemothorax helps remove residual clot and is cost effective. They recommended that there be special kits prepared for this procedure and that it be utilized routinely.



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Dr. Simeng Wang and co-workers from Stanford University presented a paper which demonstrated that serious injuries and the health insurance cost related to those injuries often leads to the injured patients losing their health insurance coverage. They demonstrated that these risk factors are common in the Health Maintenance Organization (HMO) insurance plans and should be considered in discussing job-related perks related to health insurance coverage.



Dr. Luis Llerena and co-workers, from the Sarasota Memorial Hospital, presented a paper which shows that anti-platelet therapy in patients with intracranial hemorrhage is associated with delayed hemorrhage in geriatric patients who are injured in a fall. They pointed out that aspirin carried a 5-fold higher adjusted odds ratio for delayed intracranial hemorrhage in comparison to Warfarin.



Dr. Larry Diebel (WSU/GS 1980/860), along with Dr. Vanessa Anunobi and David Liberati, from Detroit Receiving Hospital and the WSU School of Medicine, presented a paper entitled, "Early but Not Late Tranexamic Acid (TXA) Protects the Microcirculation in Shock: A Microfluidic Study." The authors demonstrated in an endothelial cell model that early TXA protected microcirculation subjected to a hemorrhage/resuscitation/epinephrine insult. They showed that glycocalyx degradation/shedding changes were protected with early TXA but not with late TXA, which explains the late increase in mortality in patients receiving TXA more than three hours after injury.



Dr. Emily Buisson and co-workers, from the University of Cincinnati, demonstrated that whole blood, when it reaches its expiration date, has increased coagulation activity and, therefore, might be good for using as plasma replacement in patients requiring massive transfusion. This would reduce the financial loss when whole blood becomes too old to utilize.



There was a multi-author panel presentation on robotic surgery for both trauma and acute surgical problems. All the authors emphasized the fact that robotic surgery will continue to expand, and ten years from now, it will be routinely used for emergency trauma surgery and acute care surgery.

Dr. Martin Croce, who is a Professor of Surgery at the University of Tennessee in Memphis, presented the Fitts Lecture. This was a very detailed lecture which emphasized the future of health care. He pointed out that House Rule 1 became effective in the 1960's, and Medicaid was expanded in

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1965 to facilitate coverage of expenses for patients with no insurance. This was augmented by the Affordable Care Act (ACA) which was introduced under the Obama Administration. He emphasized that current legislation is interfering with the support of underprivileged patients without insurance. Patients need to be working at least 20 hrs./month, which is sometimes not met, particularly, by patients who have frailty. The reduction in support of the factors in the ACA is going to interfere with the survival of trauma centers within the nation. He pointed out that the decreased support for immigrants, which leads to increased expenses at hospitals who are required by law to take care of emergency patients, is further challenging the ability of trauma centers to stay open. He gave multiple examples, including the expenses associated with traumatic brain injury. He emphasized that the future depends upon education of congressional members so that they understand the downside of not supporting emergency care to people in America.



Dr. Johnathon Beyeler and co-authors, at the University of Cincinnati, presented a paper describing the impact of hypercalcemia on bleeding time after injury in a murine model. He demonstrated that hypercalcemia markedly increases clot formation and may produce a hypercoagulable state, so that when excessive calcium is administered to injured patients, one must follow carefully for coagulation changes and prevent the hypercoagulation state from developing.



Dr. Johnathon Beyeler and co-authors also presented a paper which demonstrated that transfused red blood cells contribute to hemostasis and thrombosis because of storage-induced phosphatidylserine (PS) exposure to the red cell. They demonstrated that stored red cells may induce calcium-driven PS exposure response in aged RBCs. They emphasized the importance of being aware of this phenomenon so that unusual aggregability after injury is avoided.



Dr. Cleo Siderides and co-workers, from Cornell Medical Center, presented a paper on the role of transitioning from laparoscopic to robotic cholecystectomy in an academic acute care surgical service. They showed their data, which represents a tremendous increase in the utilization of robotic cholecystectomy and the rapidly enhancing benefits with reduced time with experience and reduced need for re-operation due to incomplete cholecystectomy.



Dr. Christian Bennett-Grobicki and co-workers, from the R. Adams Crowley Shock Trauma Center in Baltimore, presented a paper which suggests that the combination of whole blood and TXA convey a higher risk for VTE. They pointed out that the improved



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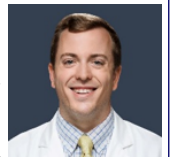


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hemostatic potential of resuscitation with whole blood may limit the potential benefit of simultaneously administering TXA.

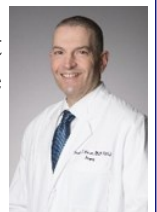
Dr. Jacob Broome and co-workers, from the MedStar Washington Hospital Centers, presented a paper which demonstrates that whole blood replacement outperforms packed RBCs in pre-hospital resuscitation. They suggested that the use of whole blood for resuscitation should be expanded to the pre-hospital setting in patients requiring urgent blood replacement.



Dr. Rishi Purayil and co-workers, from the University of Chicago, presented a paper which shows that conflict of interest statements on published papers is not complete and that approximately half of the authors are receiving significant external funding which is not reported to the editors of the journals to which their papers are published.



Dr. Mark Lieser (WSU/GS 1996) was a co-author on a multi-institutional study that looked at the impact from the time of surgery to death in patients with non-compressible torso hemorrhage. They demonstrated that the median time from E.D. presentation to O.R. was 57 minutes and that the shorter time for surgical hemorrhage control was not associated with increased survival.



The Expert Surgeon Lecture was presented by Dr. Brendan Visser, from the Stanford Cancer Center. His presentation was entitled and dealt with the “Evolving Management of Pancreatitis – Where Does it Leave the Surgeon?” His lecture outlined some of the tremendous advances that have been made with laparoscopic and robotic surgery in the complicated, extensive surgical debridement of the lesser sac in patients with severe pancreatitis and necrotic phlegmon.



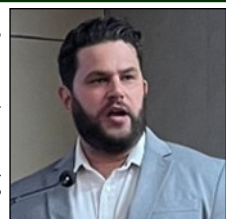
The 85th Annual Meeting of the AAST was quite successful with excellent papers being presented.



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SURGICAL GRAND ROUNDS

The ***Surgical Grand Rounds on Wednesday, September 2, 2026***, was presented by **Dr. Reid Bartholomew** and the title of his presentation was ***"The Surgical Audible: A Look Into The Open Abdomen"***. Dr. Bartholomew did his trauma training at the University of Louisville and is now a full-time and critical care surgeon on the blue/green service at Detroit Receiving Hospital. Dr. Bartholomew discussed many problems that one faces when doing damage control laparotomy (DCL). He described his first exposure to this problem when he was an intern at the University of Louisville. He described a 64-year-old man who had laparotomy for diffuse peritonitis at which time there was extensive physical spill; the patient required extensive resuscitation with balanced electrolyte solution in addition to vasopressures. They were unable to close the abdomen.



Dr. Reid Bartholomew

He illustrated the American College of Surgeons quality improvement data on several thousand patients reported with an open abdomen when primary fascial closure was not possible. These are obviously very sick patients with the result that there is a significant increase in mortality. He described the problems with intra-abdominal hypertension (IAP) which is defined as a pressure greater than 20 mm Hg when DCL is often performed; when the pressure exceeds 25 mmHg, attempts at primary closure are hazardous. Other reasons for doing DCL include the need for massive transfusions with more than 10 units of red blood cells, and massive contamination associated with peritonitis. The more common causes of contamination include peritonitis from bowel viscus perforation, vasculitis with gangrene of the intestines, and hemorrhagic pancreatitis.

Dr. Bartholomew described some of the different techniques that are used to bridge the open abdomen. These included the Whitman Pack with Velcro, the Vacuum (VAC), the Bogotá Bag, and various types of mesh. He summarized the data related to 35 studies on the use of the VAC involving over 1600 patients. He pointed out that these are very sick patients which often require a prolonged intensive care unit stay and have a significant mortality which in some series approaches 25%. Complications include intra-abdominal abscesses and bleeding in addition to enterocutaneous fistulae.

He also discussed the controversial role of nutrition in patients who tend to have adynamic ileus. He pointed out that a delay in starting nutrition for at least four days is associated with better results because of the problems with adynamic ileus and increased abdominal distention. During this early postoperative period, Intravenous nutrition is recommended. He also described the use of direct peritoneal resuscitation with hypertonic saline which was popularized by Dr. Neil Garrison who was one of his mentors.

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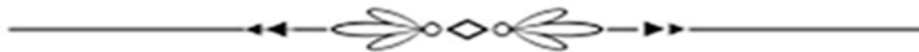
SURGICAL GRAND ROUNDS, cont...

Dr. Garrison is well known as a true surgical physiologist. He finished up the description of his patient who did not receive intraperitoneal resuscitation but later went back to the operating room and had primary closure.

The Surgical Audible: A look into the Open Abdomen

Reid Bartholomew, MD

Dr. Bartholomew described one of the assignments he had during his stay at the University of Louisville, which was to perform a controlled study in a randomized manner of the role of intraperitoneal resuscitation with these very severely ill patients. He highlighted the importance and difficulty with getting IRB approval and the need to get fiscal support by some type of grant. He planned to look at the role of the VAC, direct peritoneal resuscitation, and the open abdomen technique with later closure. The plan was to have 182 patients which would be a large enough group of patients to do statistical analyses. He learned about the difficulties of educating all the people involved, the multiple meetings that are required to provide ongoing monitoring of the study, and in the correction of difficulties encountered during the implementation of this study. After great time and effort, he and his teammates were only able to enroll 28 patients and consequently the study could never be completed. He reported however that many things were learned in this attempt to do a very complicated randomized trial which cost about five years of his life; but that the lessons learned about surgical physiology and the implementation of randomized trials clearly showed that this effort was not in vain. He pointed out that when you look at all of the things that were learned, the inability to complete the study was not a failure. There was an active discussion.



The ***Surgical Grand Rounds on Wednesday, September 9*** were presented by ***Dr. Partha Chamiraju*** who is a professor in the WSU Department of Neurosurgery. The title of his presentation was ***"Traumatic Cervical Spinal Cord Injury"***. Dr. Chamiraju began by discussing some of the epidemiology of Spinal Cord Injury (SCI) including the fact that there are over 100,000 cervical fractures per year in the USA. He also emphasized that there are over 250,000 people who are currently living with some degree of disability following SCI. He discussed both the anatomy and the physiology of the spinal cord and the nerves emanating from this area. He emphasized the differences between the motor branches and the sensory branches over the spinal nerves. He pointed out that the multiple complications of SCI included complete or partial sensory deprivation in addition to complete or partial motor deprivation.

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SURGICAL GRAND ROUNDS, cont...

The grading of the severity of SCI depends upon the degree of both motor and sensory loss. One of the acute life-threatening examples of SCI involves the cervical vertebrae three through five from which the nerves that innervate the diaphragm arise. Thus, the old saying C3–C5 keeps me alive. He also emphasized how the various muscles of the upper thorax and neck also affect pulmonary function; this would include the trapezius, deltoids, and the intercostal muscles.



Dr. Partha Chamiraju

Each of the vertebral bodies can be divided into three columns with the anterior column being the front surface of the vertebral body, the middle column being the posterior portion of the vertebral body, and the posterior column representing the ligaments and spinous process. Imaging patients with SCI must focus on identifying all three columns in order to determine which type of SCI is present.

The treatment of patients with SCIs is multifocal. The mean arterial blood pressure is best maintained at 85–90 torr in order to maintain perfusion. This can often be obtained with balanced electrolyte solution but may require the addition of a vasopressor such as low-dose Levophed. The SCI may affect the urinary bladder so that a Foley catheter is typically recommended. The ICU care must be on the alert for ventilatory compromise, sacral pressure sores, and posterior heel pressure sores. The incidence of these problems is decreased by frequent turning of the patient from side to side.

There are several SCI syndromes. This includes the anterior cord syndrome typically caused by hyperextension and tends to accentuate motor deficit. Other syndromes that Dr. Chamiraju discussed in detail included occipito-cervical dislocation often due to flexion injuries, the Jefferson fracture which is a burst fracture of C1, the hangman's fracture which is due to subluxation of C2 over C3, the teardrop fracture which is due to compression and is quite unstable, the perched facet fracture which involves a displacement of the facet and needs urgent repair, and the Brown-Sequard Syndrome which is typically associated with lateral injury. He described several other SCI presentations.

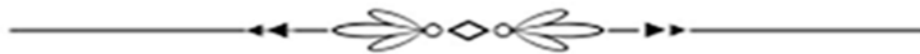
Several of the different types of SCI were presented along with the various images of each of the different types of injury. Besides a careful physical examination, imaging studies would include a posterior anterior view and a lateral view with emphasis placed on identifying the first thoracic vertebra. He pointed out how the classification or the many different CSI examples is based upon whether the sensory changes are partial or complete

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SURGICAL GRAND ROUNDS, cont...

and whether the motor changes are partial or complete. Very few patients with complete sensory and motor loss recover whereas most patients with partial sensory loss and partial motor loss will show tremendous improvement and may return to normal. As part of early treatment, he also discussed the role of steroids which would include 30 mg per kilo as a bolus within six hours and 5.4 g infused over the next 23 hours. During the discussion it was pointed out that the first national acute spinal cord injury study (NASCIS 1) showed no benefit of steroids but a later (NASCIS 2) demonstrated that early steroid therapy showed better improvement involving about one half of one vertebra in the spinal cord. NASCIS 3 supported the use of early steroid replacement. The role of massive steroids in acute SCI from penetrating wounds has not been demonstrated to be of benefit as was reported by Dr. Michael Pendergast (WSUGS 1995) in 1994 (J. Tr 1994;37(4):576-580. This study demonstrated that those patients who received massive steroids had increased infectious complications which compromise their recovery. There was an active question-and answer-session.



The ***Surgical Grand Rounds on Wednesday September 16, 2026*** was presented by **Dr. Chadi Alraies**, Director of the Cardiac Catheterization Laboratory and Cardiac Rehabilitation, Director of Interventional Cardiology Research, and Clinical Associate Professor at Wayne State University. The title of his presentation was ***“Contemporary Management of Cardiogenic Shock”***. In this lecture Dr. Alraies aimed to define cardiogenic shock along with its diagnosis and treatment.



Dr. Chadi Alraies

Dr. Alraies stressed that cardiogenic shock should be classified as a hemo-metabolic syndrome. He pointed out that cardinal signs include a lactate >2 mmol/L and a cardiac index <2 L/min/m². Along with failure to respond to two or more inotropic agents, he introduced the concept of his “rule of 2’s” in early detection of cardiogenic shock. Additionally, he described classic findings of cool, clammy extremities, tachycardia, and a systolic blood pressure of <90 mmHg unresponsive to fluid resuscitation. He described the progression of cardiogenic shock as evidenced by worsening hepatic and renal function, altered mentation, and progression of respiratory failure.

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SURGICAL GRAND ROUNDS, cont...

These principles were applied to a case of a 56-year-old man with several days of chest pain, shortness of breath, and extremity edema. The patient had a prior history of heart failure with reduced ejection fraction <35%, prior percutaneous intervention to the left anterior descending and left circumflex arteries, and an automated implantable cardioverter defibrillator. The patient was given aspirin and ticagrelor, started on norepinephrine, and taken to the catheter lab after a diagnosis of STEMI was made by ECG. The patient underwent angioplasty, thrombectomy, and had an Impella device placed for three days to assist cardiac function.



Cardiogenic shock is a disease spectrum, and treatment can be personalized to the patient depending on right and left ventricular function. Namely, right-sided cardiac dysfunction will require optimization of oxygenation and preload while left-sided cardiac dysfunction requires forward flow support. Dr. Alraies provided a comprehensive review of cardiac physiology and the data provided by a Swan Ganz catheter. Particularly he discussed the utility of the pulmonary artery pulsatility index (PAPI) and cardiac power output. He acknowledged the decreased use of Swan Ganz catheters in modern critical care but demonstrated how PAPI can help delineate between right and left sided ventricular dysfunction (>1 and <1, respectively).

Finally, there was discussion on the modalities of cardiac support. Dr. Alraies showed evidence that increasing the number of inotropes beyond two is correlated with no survival benefit. Using four inotropes simultaneously has been shown to correlate with survival rates as low as 26%. Additionally, trials such as DanGer Shock, ECLS-Shock, and ECMO-CS have shown that ECMO support in select patients can improve outcomes in cardiogenic shock but can carry significant risks such as bleeding, limb ischemia, and acute kidney injury. The Impella device can assist in cases of left heart dysfunction, but Dr. Alraies demonstrated recent evidence that intra-aortic balloon pumps have only minimal effects on cardiogenic shock outcomes.

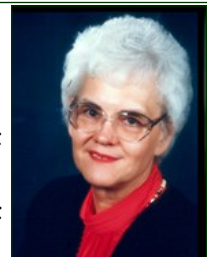




EXCERPTS FROM THE LOG BOOK DOWN MEMORY LANE

11/27/72 - Staff: Dr. J.C. Rosenberg

1. JW: Placement left chest tube for a left hemopneumothorax.
2. EE: GSW abdomen, treated with laparotomy, splenectomy, and insertion of chest tube.
3. GB: GSW back with paraplegia, had exploratory laparotomy and drainage of right retroperitoneal space.



Dr. Anna Ledgerwood

11/28/72 - Staff: Dr. A. Weaver

1. DB: Laceration of right wrist with tendon injury. Operation: Repair of flexor digitorum tendon.
2. HW: GSW right buttock and rectum, treated with pre-sacral drainage and transverse loop colostomy and wound debridement.
3. JF: Small bowel obstruction, treated with laparotomy and lysis of adhesions.
4. RN: GSW abdomen with penetration with negative exploratory laparotomy.
5. CJ: GSW abdomen and right leg, treated with exploratory laparotomy and debridement of right thigh.

11/29/72 - Staff: Dr. Threlkeld

1. FJ: Small bowel obstruction, treated with lysis of adhesions and reduction of internal hernia.
2. DB: GSW abdomen which penetrated the left diaphragm, small bowel and mesentery, and laceration liver, treated with left chest tube and closure of holes.

11/30/72 - Staff: Dr. Thoms

1. EE: GSW chest one week ago, treated with re-insertion of chest tube.
2. DS: Sigmoidoscopy with attempt to remove a foreign body rectally, required exploratory laparotomy, colotomy, and removal of foreign body from descending colon (hairspray can). Had placement of colostomy.
3. RB: GSW abdomen involving liver and gallbladder, treated with exploratory laparotomy, repair of liver laceration, and cholecystostomy.
4. MM: Stab wound abdomen, treated with repair of laceration of sigmoid colon.

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

12/1/72 - Staff: Dr. C. Huang

1. ET: GSW abdomen and chest with negative exploratory laparotomy.
2. DJ: Acute appendicitis, treated with appendectomy.

12/2/72 - Staff: Dr. C. Lucas

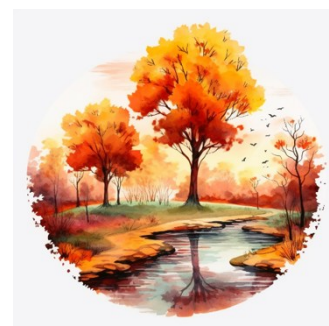
1. CJ: Debridement of abdomen and right thigh wound for SGW, treated with debridement and dressing change with porcine skin graft.
2. BC: Debridement of shoulder wound with skin graft.
3. JC: Debridement and change of dressing of abdominal wound.

12/3/72 - Staff: Dr. V. Gallant

1. JW: SGW anterior abdominal wall, had laparotomy with small bowel resection, repaired dome of bladder and repair of tissue defect of anterior abdominal wall.
2. JH: Blunt trauma to abdomen, treated with exploratory laparotomy with findings of retro-peritoneal hematoma.
3. HW: Debridement of buttock wound for SGW.
4. BK: Perforated duodenal ulcer, treated with exploratory laparotomy and Graham patch.

12/4/72 - Staff: Dr. Ledgerwood

1. JH: Upper GI bleed, treated with exploratory laparotomy, vagotomy, and gastrotomy for suture bleeding duodenal ulcer.
2. LS: GSW left arm with injury to brachial artery, treated with resection and end-to-end anastomosis.
3. BF: Peritoneal abscess, treated with I&D.
4. RR: GSW neck with negative neck exploration.





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, October 7

Death & Complications Conference

Lawrence Diebel, MD, Professor of Surgery

Detroit Medical Center/Wayne State University School of Medicine

Wednesday, October 14

Death & Complications Conference

“What I Learned at the American College of Surgeons Meeting”

**Katie Ciurej, MD; Morgan Jackson, MD; Sana Khan, MD; Sam Mansour, MD; Alfredo Munoz-Laroche, MD;
Megha Patel, MD; Marc Skylsen, MD; Amanda Stevens, MD; Jan Stevens, MD**

Senior Graduating Surgical Residents, DMC/WSUSOM

Wednesday, October 21

Death & Complications Conference

Eliza Beal, MD, Department of Surgery

Detroit Medical Center/Wayne State University School of Medicine

Wednesday, October 28

Death & Complications Conference

John Wallbillich, MD

Department of Obstetrics/Gynecology/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.[®] 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>



Wayne State Surgical Society

2026 Dues Notice —

RETURN TO: Charles E. Lucas, M.D

Detroit Receiving Hospital, Room 2V / Surgery
4201 St. Antoine Street
Detroit, MI 48201

PLEASE COMPLETE ↓↓↓

Name:

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City/State/Zip:

Phone:

Email: _____@_____



MARK YOUR CALENDARS

74th Annual Detroit Trauma Symposium

November 5-6, 2026

MGIM Grand Hotel

Detroit, Michigan

Western Surgical Association 134th Annual Meeting

November 7-10, 2026

El Dorado 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.



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, 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



October 31st