MICHAEL & MARIAN ILTCH DEPARTMENT OF SURGERY

WAYNE STATE

DECEMBER 2021

Allen Silbergleit, MD, PhD Receives His Final Promotion

December 25th

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Dr. Allen Silbergleit
1928-2021

Dr. Allen Silbergleit was born in 1928 in Springfield, Massachusetts, and was promoted to the professorship of everlasting life on October 24, 2021, at the ripe age of 93 years. He grew up being involved in many activities, including excelling in his early school years, participating as a drummer and violinist in his school band, and earning money during his teenage years as a grocery clerk. Following high school, he went to the University of Massachusetts (UMass), where he earned his undergraduate degree and participated in the Reserve Officers Training Corps (ROTC), which allowed him, upon graduation, to receive a special assignment to the United States Military Academy at West Point. Following the completion of his military commitment, he matriculated at the University of Cincinnati Medical School, and while there, he had the privilege of being a student volunteer, working with Albert Sabin, MD, the developer of the oral polio vaccine and, because of his work, he received an honorary membership in the Mitchell Pediatric Society.

After completing his medical training, he was accepted at the University of Minnesota, where he completed his surgical internship and residency, while also meeting his obligations as a U.S. Air Force Officer. After completing his residency training, he was appointed as the chief of the general surgery program at Shepard Air Force Base in Texas. Always one to take advantage of his experiences, Al translated his experience in flight training and low altitude close formation flying to stimulate further physiologic research in high-altitude adaptations.

Following his second military commitment, Dr. Silbergleit was appointed as an Assistant Professor at the WSU Department of Surgery and at the Veterans Administration Hospital in Allen Park. During the next two years, he assisted the surgical residents in the operating room, completed the course activities for obtaining his Doctorate degree in Physiology from WSU, and served as a cardiothoracic surgical resident. Following the completion of all these activities by 1965, he was appointed to the faculty in both the Departments of Surgery and Physiology. Over the years, his productivity was excellent, and he subsequently became a full Professor in both departments. He was also very supportive of administrative activities and was the longest serving member of the WSUSOM Dean's Council. During these years, Dr. Silbergleit was the first author, along with his mentor, Dr. Augustin Arbulu (WSUGS 1961), on the first case report of a patient who survived on acute rupture

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of the aorta caused by tuberculosis aortic arteritis with rupture into the esophagus.

Following the completion of his Doctorate degree and Cardiothoracic residency, Dr. Silbergleit accepted the appointment of Chief of Surgery and Chief of Cardiothoracic Surgery at St. Joseph Mercy Hospital in Pontiac, now known as St. Joseph Mercy Hospital-Oakland. He served as the resident program director at St. Joe's for over four years. He constantly stimulated his residents to be involved in educational activities, and there would always be papers presented by his residents at the Detroit Surgical Association meetings and at the Michigan Chapter of the ACS state meetings. He was a strong supporter of all the local activities and served in all of the officer positions of the Detroit Surgical Association, the Michigan Chapter of the ACS, and other local and regional organizations. During his years at St. Joe's, he organized the Annual Clinic Day, which was subsequently baptized as the Annual Allen Silbergleit Clinic Day. In addition to these time-consuming activities, Dr. Silbergleit used to cover one weekend night a month as the in-house attending for the Emergency Surgical Service at the old Detroit General Hospital. He maintained this contribution to the WSU Surgery program throughout the 20th century. During these years, Al served on the Michigan Committee on Trauma and the Committee on Cancer and provided leadership to many local and regional professional societies. Throughout these years, Dr. Silbergleit had a need to stimulate his surgical residents to publish and, as a result, he was an author on over 100 scientific articles, with special emphasis on articles that paid tribute to well-known American surgeons.

During his many years as the program director at St. Joe's, he was actively involved in the Accreditation Council for Graduate Medical Education (ACGME), which awarded Dr. Silbergleit the Parker Palmer Courage to Teach Award in 2007 because of his many contributions to the ACGME. This is the highest recognition that can be given to a residency program director, and he was one of the first ten in the nation to receive this award. His contributions were recognized by many, and thus, he received many awards, including the Oakland Health Education Program Lifetime Achievement Award for Excellence in Medical Education, the Alexander J. Walt Award of the Michigan Chapter of the ACS, the Wayne State University Surgical Alumnus of the Year Award, the Wayne County Medical Society Humanitarian of the Year Award, and the Wayne State University Distinguished Service Award.

Dr. Silbergleit's energies extended beyond the field of medicine. He enjoyed serving as a judge for the Science and Engineering Fair of Southeast Michigan and the State Science Fair competitions, in conjunction with his son, Robert, who is now a physician. During his early years, Al met and married his wife, Ina, and for 64

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Years, he was a devoted husband to Ina; their offspring and children-in-laws include Dr. Richard and Dr. Alice Silbergleit, Nina Silbergleit, and Dr. Robert Silbergleit and Catherine Zudak. Those who wish to honor Dr. Silbergleit may make a donation to the Holocaust Memorial Center at 25123 Orchard Lake Road, Farmington Hills; St. Joseph Mercy-Oakland Hospital; or Wayne State University School of Medicine.

The Silbergleit Clan (Left to right): Dr. Silbergleit's daughter, Nina Silbergleit; his son, Robert Silbergleit with his bride, Catherine Zudak who is holding their daughter, Marina; Mrs. Ina Silbergleit and Dr. Allen Silbergleit, their grandson, Matthew (Richard and Alice Silbergleit's son, who is a medical student at WSU); Richard and his bride, Alice, Silbergleit, and Dr. Silbergleit's nephew, Paul Silbergleit

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WAYNE STATE UNIVERSITY School of Medicine

2021 Annual WSSS Lectureship

wayne state surgical society

This year's Lecture was provided by Dr. David Spain (WSUSOM 1986), who is the Professor of Surgery and Chief of the Trauma/acute Care Surgery/Surgical Critical Care Division at Stanford University. Dr. Spain is a native Michiganian who did his pre-medical training at Michigan State University and went to medical school at Wayne State University. The seed that grew to become the WSSS was planted in the 1980s by Dr. Alex Walt, our longtime chairman, when he envisioned a large surgical alumni who could work more closely with ongoing activities within the Department of Surgery. During the early years, the concept grew, and the WSSS became an official organization with appropriate bylaws after Bob Allaben (WSUGS 1956) served as president for two years, and subsequently a new president and group of officers have been elected each year. This year's president is Dr. Scott Davidson (WSU/GS 1990/96), and he was able to introduce Dr. Spain for the WSSS Lecture. After attending medical school, Dr. Spain did his surgical residency on the east coast, after which he went to the University of Louisville when Dr. Hiram Polk was chairman of the department, and Dr. David Richardson, the vice-chairman who served as Dr. Spain's mentor for many years. Following a very productive period of time on the faculty at the University of Louisville, Dr. Spain moved west and went to Stanford University, where he has excelled as an academic clinician and has become a leader in the Trauma/Acute Care specialty within North America and beyond. He has just finished his stint as president of the American Association for the Surgery of Trauma and continues to be a leader in the area of trauma and acute care surgery by serving on many committees at the national level.

The lecture provided by Dr. Spain dealt with education. It was a very broad lecture that approached education from the student and resident vantage point, the faculty perspective, and from the publications of many books that deal with education. His lecture was very practical. He dealt with the technique for making patient rounds, highlighting how the nurse would make the original presentation, followed by the resident, who would outline the current and future plans for care of the patient. He pointed out that the rounds are made within the patient room and not in the hallway. Two computers are brought into the patient's room, with one being used to update orders and the other used to look at any images that need to be reviewed during the rounding period. He then spent some time talking about teaching surgical residents technical skills and summarized papers which look at teaching programs in the anatomy lab involving cadavers, as opposed to simulation teaching programs utilizing the most modern of simulation techniques. He pointed out that the technical skills are much more improved with the simulation programs and that teaching programs of the future need to expand this technique of teaching. He further emphasized that there has to be open-mindedness on the part of both the

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student and the faculty member, as newer concepts of physiology are introduced into the teaching program. Dr. Spain pointed out that the resident has a responsibility to stimulate the teacher by working hard, showing an interest, and asking appropriate questions. The teacher then has no option but to go the extra mile in order to teach that desirous and responsive surgical resident. He also discussed the effect that teaching for the faculty is an important aspect of preventing burnout. The need to continue to increase one's knowledge in order to be an effective teacher stimulates the faulty member who no longer has a need to retire and get away from everything. Because of this need by the faculty member to remain current, he or she must continue to read in order to be a source of information for all new things that are coming out in the surgical arena. There was some philosophy in his presentation, but for the most part, this philosophy emphasized the desire by both the faculty member and the resident to increase their knowledge as part of a productive teaching interchange. His presentation was followed by an active question-and-answer sessions. Clearly, the audience was very appreciative of his very productive presentation.

(Left to right) Drs. Renato Albaran, Samantha Tarras, Anna Ledgerwood, David Edelman, and Andrew Isaacson

(Left to right) Drs. Scott Davidson (WSSS President), Bruce Washington, David Spain, Larry Diebel, and Larry Narkiewicz (WSSS President-Elect).

(Back table , left to right) Drs. Michael White, David Springstead, Ashley Malach, Launa Clough, Tom Siegel, and Michael Carge

(Back table, left to right) Drs. Joseph Sferra, Heather Dolman, Jessica McGee, Bruce McIntosh, and Brian Shapiro

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69th ANNUAL DETROIT TRAUMA SYMPOSIUM

This year's Symposium was held both on-site and by virtual technique, as the concerns about the pandemic are gradually reduced. As usual, there were a number of exhibitors present who were well-received by the attendees, and the exhibitors contributed to the success of the DTS.

Dr. Diebel, who organizes the DTS each year, made introductory statements and moderated the Thursday morning session.

The first paper was presented by Dr. Deborah Stein, who is a trauma surgeon and critical care surgeon at the University of Maryland School of Medicine. Dr. Stein presented a paper, "Transfusion and Confusion in Guiding Component Therapy for Massive Transfusion." She talked about the new trends of transfusing with whole blood which, by definition, has all of the blood components, in comparison to initially transfusing with low titer Type O blood (LTOWB). She indicated that this type of resuscitation is safe and provides all of the needed components. She also recommended pre-hospital FFP as a means of decreasing mortality rate in patients who are found later to need massive transfusion. The use of TEG at the patient's bedside then provides a guide as to when further FFP, cryoprecipitate, platelets, or TXA are needed as part of ongoing resuscitation. She pointed out that the 1:1:1 resuscitation ratio is helpful, but there may be other factors that are needed based upon the findings of TEG. She highlighted that balanced electrolyte solution is bad, and blood is good, and that whole blood, given early, is probably best.

Following Dr. Stein's presentation, Dr. Christopher Michetti, a professor of surgery at the University of Virginia and Fairfax Hospital in Virginia, presented a paper, "Contemporary Hemodynamic Monitoring and End Points in Trauma Resuscitation." Dr. Michetti began his dissertation by the comparison of systolic blood pressure (SBP) to mean arterial pressure (MAP) as the best monitor. He suggested that both are good for determining perfusion, but felt that the MAP provided more information. He discussed in detail many different measurements, including CVP and left ventricular end diastolic volume (LVEDV), and emphasized that these measurements should be correlated with the response to fluid resuscitation as emphasized in the Starling curve. Dr. Michetti indicated that the Swan catheter for measuring right heart

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function is no longer popular and, therefore, expertise in passing the Swan catheter has disappeared. He talked about using oxygen dynamics, such as oxygen delivery and oxygen consumption, but suggested that this is impractical nowadays. However, he did point out that the oxygen concentration within a central venous catheter provided important information as to oxygen uptake peripherally. He described that a randomized controlled study looking at the Swan vs. no Swan showed no change in mortality. The Editor believes that this lack of significant difference between the two groups reflected the fact that patients who were not very ill made up the majority of the patients randomized. Dr. Michetti also emphasized that the serum lactate level >2 micromoles is indicative of shock, although lactate can also come from liver disease, vasopressor use, and renal dysfunction. He finally ended up by talking about the leg raising test, which may show an increase in pulse pressure, which would be comparable to an infusion of about 200 ml of crystalloid solution. This test can be used to determine whether an infusion of crystalloid solution would improve the cardiac dynamics.

The next presentation was provided by Dr. Joseph DuBose from the Dell Medical School of the University of Texas at Austin. Dr. DuBose presented, "Utilization of REBOA Technology in the Bleeding Trauma Patient." Dr. DuBose compared the efficacy of an emergency department (ED) thoracotomy vs. REBOA. He explained that REBOA is excellent for an expanding abdominal aortic aneurysm. He also suggested that once the basic skills of REBOA are learned, it provides faster vascular control in hypotensive patients with intraperitoneal bleeding. He described how the best approach is through the common femoral artery, using ultrasound as a guide; this provides much better successful access than does a cut-down onto the femoral artery. He described the different-sized catheters that should be used and the three levels of the abdomen where the REBOA can be inflated. Dr. DuBose stated that inflation of the catheter in Zone 1, proximal to the celiac artery, should have the balloon inflated for no more than 30 minutes, whereas the balloon in Zone 3, just below the inferior mesenteric artery, can be safely inflated for 60 minutes. The use of partial vs. complete occlusion of the aorta by selective inflation of the REBOA balloon is something that is undergoing more study. He suggested that any patient with a heartbeat is better receiving a REBOA placement rather than ED thoracotomy in the acute trauma situation.

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The next presentation was made by Dr. David Spain, entitled, "Cost Effectiveness of Surgical Stabilization of Rib Fractures." Dr. Spain emphasized that about one-third of patients with multiple rib fractures are still not working three months after injury. Prior to 2014, 99% of patients with multiple rib fractures were treated by non-operative therapy. He summarized the non-operative approach, which includes deep breathing, coughing, intercostal nerve block, incentive spirometry, and proper control of pain medicines in order that the patient does not get pneumonia due to inadequate ventilation. In looking at combined series of patients with multiple rib fractures, he recommended that patients over 65 years of age and with flail chest have early surgical fixation, whereas younger patients without flail chest are best treated non-operatively. He then went through and calculated all the costs related to the different types of treatment and concluded that in the subset of patients who are recommended for operative rib fixation, there is a much lower total cost than in those treated non-operatively.

Dr. Diebel then moderated an exciting panel discussion by the above four authors. Some of the recommendations that came out of this panel discussion included the benefit of whole blood in caring for injured patients and the benefit of TXA, although more studies need to be performed. There seemed to be consensus that patients with blunt trauma and hypotension may benefit from REBOA, with the initial inflation made in Zone 1. All the panel members emphasized that ultrasound is helpful with monitoring in terms of looking at inferior vena cava diameter and the potential need for additional resuscitation. When utilizing the REBOA, the sheath should be taken out on the table and not left in place as the patient goes to the ICU because prolonged presence of the sheath may lead to femoral artery thrombosis and threatened limb.

Following a brief break, the second half of the morning session was led by Dr. DuBose, who presented "Management of Traumatic Hemo and Pneumo Thorax." Dr. DuBose presented, "Management of Traumatic Hemo and Pneumo Thorax." He emphasized that acute tension pneumothorax should be rapidly decompressed by needle decompression. He states that many of the military people have extensive muscles in their chest wall, so that a long needle of 7 cm in length should be immediately available in the Emergency Department in order to reach the

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chest cavity. He also supported the use of ultrasound in identifying a pneumothorax in patients with a non-diagnostic chest x-ray. He added that when a pneumothorax is not identified on the initial chest x-ray, there are no complications from the later placement of a catheter or chest tube for the pneumothorax, which is diagnosed in a delayed manner. When the patient has hemothorax and the initial chest tube results in 1,500 ml of rapid blood egress, he suggested that that patient should be taken directly to the operating room, with the likelihood of finding a correctable bleeding source before the patient spends too much time in hypovolemic shock. He supported the use of antibiotics in association with a chest tube in order to decrease the likelihood of subsequent empyema. Interestingly, he taught that there is really no good data as to the incidence of recurrent pneumothorax following chest tube removal when it is done during inspiration or during expiration. When patients have a retained hemothorax following chest tube removal, he recommended non-operative therapy, whereas patient with a larger retained hemopneumothorax may be candidates for thrombolytic therapy, although there are no good data supporting that technique.

The next presentation, "Modern Management of ARDS in Trauma and Acute Care Surgery," was provided by Dr. Matthew Martin, who is a Professor of Trauma and Acute Care Surgery at the Scripps Mercy Hospital with the University of San Diego. Dr. Martin talked about the edematous lung, sometimes referred to as hepatized lung, related to the hemorrhagic shock insult and subsequent aggressive fluid resuscitation. He suggested that the severity of ARDS is decreased when less crystalloid solution is used in resuscitation and that there is also a reduction in the death rate. He described the three categorizations of acute lung injury and talked about lung protective ventilation with 4-6 mL/kg tidal volume, in order to avoid high airway pressures and pulmonary injury. He discussed the role of airway pressure release ventilation (APRV) and the potential role for decreasing acute lung injury, but indicated that there is no good control data to support that principle. He highlighted the value of proning the patient for up to 12 hours a day in order to allow the lung to recruit alveoli in the Zone 3 location. For patients who are not responsive to the above regimens, ECMO can be used as a last resort, and this therapy has shown significant improvement in mortality.

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The next presentation was given by Dr. Spain, entitled "End of Life Decisions: The Difficult Dilemmas." He emphasized that it is nice to know ahead of time, on the basis of previously defined objectives, the life-and-death decisions regarding the critically ill patients. He noted that the surrogate, acting on behalf of his/her relative, usually knows little about the patient's previously made desires. He also emphasized the importance of consulting with Ethics, the Chaplain Service, and the Hospice team. Dr. Spain highlighted the importance of having a good physician-patient relationship and a good nurse-patient relationship throughout the early parts of the patient's hospitalization which, in turn, makes it more productive to have end-of-life discussions with family members later on in the hospital course.

Following the above presentations, Dr. Diebel conducted a very exciting panel session, which addressed many complicated issues related to the presentations.

Following the question-and-answer session, lunch was provided in the auditorium, as visual presentations were shown, including "TEG for Dummies" by Dr. Deborah Stein, "Do's and Don'ts for REBOA Placement," by Dr. DuBose, and "Multimodality Pain Management Following Trauma: My Approach," by Dr. Harvin.

The afternoon session on Thursday began with Dr. Michael White moderating the session. The first presentation was made by Dr. Eileen Bulger from the University of Wisconsin. Dr. Bulger is a famous trauma surgeon and Chair of the American College of Surgeons Committee on Trauma. She presented, "Follow-up to ACS Medical Summit on Firearm Injury Prevention: Where Are We?" Dr. Bulger emphasized how important it is for both the medical community and all of the citizenry to be properly informed about what a terrible problem we have with firearm-related injuries as it relates to physical injury and to cost. She described how the ACS Committees strongly recommend screening of individuals who are trying to purchase fire-arms and that purchasing of a firearm must go along with mandated training as it relates to safe use and locks. She opined that trauma centers should have a firearm prevention program in order to teach all patients who are victims of firearms about the potential dangers. Recent-ly, Congress has passed HR5855, which supports the use of scientific evaluation of the human

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suffering and financial losses associated with firearms. This is a major governmental change since, at the turn of the century, the federal government would not allow for any federal support of any type of science within an institution that was planning to evaluate something about firearms. The statistics that she presented were helpful to everyone.

The next presentation was made by Dr. Martin, entitled, "From Boston to Baghdad: Top 10 MASCAL Lessons." Dr. Martin described the injuries that have been observed in different types of mass casualties (MASCAL). He described the horrible injuries that were created by roadside bombs in the Iraq military campaign and how these bombs lead to multiple injured soldiers presenting to the forward field hospital at one time. He also discussed the large number of severely injured casualties who presented to the Boston trauma centers at the time of the bombings related to the Boston Marathon and the huge number of casualties associated with one of the East coast train crashes. During a MASCAL, there has to be a plan to receive multiple casualties. Successful management of these mass casualty situations requires preparation ahead of time so that everyone knows what job has to be performed, while continuing his/her small part in an overall huge exercise. He emphasized the critical role of triage and how one of the most senior and experienced trauma surgeons should be designated as the triage officer. He pointed out that having the dentist serve as a triage officer, as was once the case in the military, was inappropriate. The triage officer has to make very mature decisions. He gave the example as to how a patient with a severe traumatic brain injury requiring operation would have to go to the back of the line if there is no neurosurgeon available. The use of overtriage is fatal in this situation, in that patients who don't really need much in the way of treatment will take up the time and efforts of the care providers who should be caring for those who need critical treatment in order to survive. The only x-ray allowed in this MASCAL situation would be a chest x-ray. Injured limbs would not be x-rayed because it would take too much time, and the injured limbs could be treated clinically, while other injuries that needed life-saving operations could be performed. He showed how the electronic medical record becomes useless in that a clipboard or actually writing on the patient's dressings was the best way to communicate in this difficult situation.

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This excellent presentation was followed by Dr. Bulger, who presented, "Trauma Systems as the Framework for Disaster and Pandemic Response." Dr. Bulger stated that a mature trauma system is not only helpful for caring for the injured patients, but is also very important when faced with a pandemic such as COVID. When hospitals are overwhelmed by the volume of acutely ill patients, all of the regional hospitals must know that "we are all in this together," and provide available rooms for their neighbors when other hospitals are full and can no longer take patients. Her excellent presentation reminded the editor of the 1967 Detroit riot when certain people were assigned to identify patients who can be discharged home or discharged to a neighboring hospital not involved in the care of riot victims. She emphasized how this relies on good collegiality between the hospitals within a region and that in the future, there needs to be a national trauma and emergency system set up, in order to deal with these catastrophes.

Following a brief coffee break, the next presentation, "Management of the Brain Injured Patient" was presented by Dr. Stein. She taught that TBI is one of the greatest problems challenging the trauma surgeon. She showed a simulation of a T-bone injury, in which a dummy within a vehicle collides with a metal object, causing significant indentation to the vehicle and significant injury to the scalp. These simulation studies reminded the Editor about the major contributions made by WSU Neurosurgery Department and engineering school, looking at head injury crashes in cadavers falling down elevator shafts. These very important WSU studies led to modification of helmets in the NFL. Dr. Stein highlighted how there is an initial impact, followed by a period of ischemia and inflammation due to brain swelling. She emphasized the importance of trying to prevent this secondary injury, which is due to edema and intracranial hypertension. She emphasized the importance of preventing hypertension, as determined by each patient age category; pressure should not exceed 110 torr. She discussed the various techniques used to reduce intracranial hypertension, including Mannitol, hypertonic saline, cerebrospinal fluid decompression, hyperventilation, and sedation. She defined the criteria for operative intervention as based upon shift of an intracranial hematoma or evidence of increased intracerebral pressure, which might show the need for decompressive craniotomy.

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The next presentation "Organ Donation Issues in the ICU Setting" was made by Dr. Michetti. Dr. Michetti emphasized that the trend is for increased donations over the past few years. He encouraged early involvement of the Organ Procurement Organization (OPO) in all patients with critical illness who might subsequently be candidates for donation. Part of the presentation dealt with patient autonomy which, of course, would necessitate that the patient have a previously defined written commitment to be an organ donor. Some states allow for this to be placed on a citizen's driving license. He stated that there are national and uniform guidelines provided by the "National Gift Act." Dr. Michetti repeated over and over again that organ-donation discussions are facilitated by having a good patient family-to-physician and patient family-to-nurse relationship, so that the family members are always aware of the updates in patient status. He also noted that when it becomes obvious that the patient is not going to recover from a brain injury, the treating physician is placed in a dilemma, whereby the natural response would be to provide comfort care, whereas, organ donation requires full patient support to maximize successful donation.

Following this presentation, Dr White moderated a very informative panel discussion with the above speakers.

The last portion of the Thursday afternoon program involved the panel discussion with Dr. Ledgerwood providing many stimulating questions to all of the speakers who presented earlier in the day. She presented a series of cases with pictures of the various injuries. There was a good give-and-take between Dr. Ledgerwood and all of the panel members, which seemed to be enjoyed by everyone in attendance.

The Friday morning session began with Dr. James Tyburski moderating, and Dr. Walter Biffl presented the first paper on the "Diagnosis and Management of Patients with Blunt Cerebral Vascular Injuries." Dr. Biffl reported that, as of 1980, blunt cerebral vascular arterial injuries (BCVA) were associated with over a 20% mortality rate and almost a 50% complication rate. The predisposing factors to BCVA include hyperextension injuries of the neck, blunt trauma to the skull base, and major oral-maxillofacial injuries. Fabian and co-authors in 1996

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described a continuing bad result associated with BCVA in that, in their series, there was a 31% mortality rate and a 37% complication rate. This led to a more aggressive approach with arteriography in patients with specific fractures or dislocations following blunt trauma to the head and neck. Subsequent studies have shown that a CTA provides just as much information in most patients with less risk in comparison to arteriography. A protocol for early diagnosis of BCVA might include a GCS <6, fracture of the petrous bone, LeFort II/III, occipital fractures, and extensor injuries. He described the different levels of severity and stated that Type I injuries with intimal irregularity or Type II injuries with stenosis can be treated non-operatively. Type III injuries are sometimes treated with a stent, Type IV injuries with complete occlusion, or Type V injuries with transection require operative intervention. The non-operative therapy for the minor injuries would usually be anti-platelet treatment, although heparin has been utilized. When the heparin is utilized, the end point should be a PTT of 40-60.

The next presentation was made by Dr. John Harvin from the Hermann Hospital in Houston, Texas. His paper was titled, "Damage Control: Laparotomy: The Pendulum Swings." Dr. Harvin reported that the reason for damage control is to stop the bleeding in a patient with the combination of hypotension, acidosis, and coagulopathy. A review of their own data identified that damage control was being utilized in over 30% of patients, suggesting to everyone that this was an extreme overuse of these procedures. He tended to blame the incidence of damage control rising, claiming it was due to balanced electrolyte solution resuscitation causing an increase in the abdominal compartment syndrome. He speculated that the use of 1:1:1 resuscitation ratio with less balanced electrolyte solution would bring about a decrease in the abdominal compartment syndrome and a decrease in the use of damage control. When they did their later analysis of damage control, they were able to identify a decreased utilization, and subsequent analyses showed that the incidence of damage control was 17%. He suggested that there is still some confusion about when damage control is needed. The Editor notes that when the Detroit Receiving Hospital was receiving huge numbers of patients with bad intra-abdominal injuries following gunshot wounds, the use of damage control was <5% in patients with massive injury who almost uniformly survived.

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The next presentation was made by Dr. Biffl and was entitled, "Critical Decisions for Pancreatic Trauma." Dr. Biffl described the pancreas as being one unforgiving organ, which lies deep in the abdominal cavity and is often difficult to approach. He described the etiology of pancreatic injury in their experience, which was caused by firearms in 37%, MVC in 29%, fall in 8%, and stab in 6%. In patients not requiring immediate operation for an intraperitoneal penetrating wound, the CT provides good, but not perfect, information about determining when to operate. ERCP is still the standard for identifying the status of the pancreatic duct and can be performed in stable patients. The use of MRI has not proven to be as good as was initially thought. For the treatment of minor Type I and Type II pancreatic injuries with small lacerations or hematomas, non-operative therapy is usually successful. A Type III injury with disruption of the distal pancreatic duct is still best treated with distal pancreatectomy, usually including splenectomy. He described the different approaches for a Type IV injury to the head of the pancreas, and these would be diversion with duodenal diverticulization or with pyloric exclusion, resection with the Whipple operation, or extensive drainage. He stated that patients who get extensive drainage require many more operations before the patient is finally fully recovered. The combined destructive injury to the pancreatic head and duodenum is best treated by the Whipple operation.

The next presentation was provided by Dr. Harvin and was entitled, "Opioid Minimizing Acute Pain Management After Trauma." Dr. Harvin emphasized the importance of having a pain protocol in order to prevent excessive opioid use, leading to patient death. He described the frequent types of non-opioid medications which, when used, are associated with a decrease in opioid use when the patient is discharged home and a decrease in opioid use while in the hospital. He stressed that 13% of injured heroin-naïve patients end up on opioids following discharge from the hospital. This high incidence of opioid use after discharge causes significant morbidity, and all efforts should be made to substitute opioid use to prevent this complication. He noted that the risk of being discharged on opioid use is much increased in those who are addicted to alcohol, drugs, or other medicines prior to hospitalization.

Following this presentation, Dr. Tyburski moderated a panel involving all of the above

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speakers, who answered many questions that were asked from members of the audience. This was a very productive panel session.

The last half of the morning session was initiated by Dr. Charles Lucas and Ms. Alita Pitogo, the Trauma Program Manager at Detroit Receiving Hospital. The presentation was entitled, "The Evolution of Trauma Center Verification Process." Dr. Lucas described how the American College of Surgeons (ACS) was established in 1916, with the specific intent to improve patient care for American citizens. The extension of the ACS activities into trauma began in 1922, when Dr. Charles Scudder was instrumental in forming the Committee on Trauma (COT), which led to many teaching efforts designed to improve care of injured patients, especially patients with fractures. Under the leadership of the COT, the ACS had an annual trauma symposium, sponsored trauma lectures, and encouraged the development of a COT within each state. Following the initiation of World War II, there was much greater emphasis placed on penetrating trauma. During the early 1970's, the national COT encouraged the state chairpersons of the state COTs to do individual site visits of hospitals taking care of many injured patients within their own states. These visits identified the need for an on-site review of quality care of different trauma hospitals. The Verification Review Committee (VRC) was established in 1988 and defined specific criteria which must be met for a different level trauma center to be verified by the ACS. This involved two visitors, both members of the national COT, doing on-site visits with the emphasis on education and quality improvement in the care of injured patients. The first hospital to be verified by the VRC was the Detroit Receiving Hospital. The pandemic of 2020 interfered with on-site visits, and the director of the ACS, Dr. David Hoyt, decided to extend current verifications of the different national trauma centers for one additional year. Dr. Lucas reminded Dr. Hoyt that the previous pandemic 100 years ago lasted for over two years and that it would be bad for trauma centers and the ACS to delay visits for over five years because of the pandemic. Dr. Lucas suggested that the visits could be done by virtual technique, and the result is that the Detroit Receiving Hospital was the first hospital to be verified by virtual technique in 2020. Subsequent to that, the ACS has provided an extensive number of virtual verifications, and the process is moving along quite well. The details

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of the verification process as it relates to the communications between the trauma center and the ACS were worked out and presented by Ms. Pitogo. She described the different types of things that have to be placed on a computer stick and made available for transfer to the reviewers who are going to do the virtual site visit. There are many details regarding this process, which were all presented by Ms. Pitogo and were well-received by the audience.

The next presentation was provided by Dr. Rahul Vaidya and was entitled, "Diagnosis and Management of Thoracic and Lumbar Spine Trauma." Dr. Vaidya described the anatomy of the spinal vertebra and demonstrated how each level is associated with subtle changes in the anatomy. He described the differences between a complete vs. incomplete injury as it relates to the sensory and motor changes following acute spinal cord injury. He described how spinal shock due to the injury itself rarely lasts beyond three to five days, after which one can determine what the permanent deficit is and whether it is complete or incomplete. He described the burst fracture associated with falls and how the posterior part of the vertebra intrudes into the spinal canal. When this occurs in the lumbar area, one has injury to the cauda equina, which is associated with bladder or bowel dysfunction. He described how the minor injuries which are stable, can be treated with non-operative management and the use of different types of braces. The seatbelt injury is associated with a flexion injury of L2, which often needs to be corrected. He described how the CT scan usually provides full information, but occasionally, when one needs to determine stability, an MRI may be helpful. Dr. Vaidya described the three columns and how injury to two or more columns is associated with instability requiring operative fixation, whereas stable injuries can often be treated non-operatively.

The next presentation was provided by Dr. Wazim Mohamed, a Professor of Neurology at WSU. Dr. Mohamed's presentation was entitled, "ICU Management of the Severe Head Injured Patient." He emphasized the importance of the secondary injury which occurs after traumatic brain injury (TBI) and how this secondary injury is related to ischemia. He emphasized the importance of maintaining a good cerebral perfusion pressure (CPP) and defined the different types of severity of injury, with severe injury being those patients with a GCS of 8 or less. Dr. Mohamed indicated that intracerebral pressure (ICP) monitoring is important for

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severe injuries, so that one must calculate the CPP, which is equal to the MAP minus the ICP. He emphasized that normally when you increase the mean arterial pressure, auto-regulation within the brain occurs, so that there is vasodilation which prevents intracranial hypertension. One can only be sure that auto-regulation is occurring appropriately if the ICP is monitored simultaneously with the MAP.

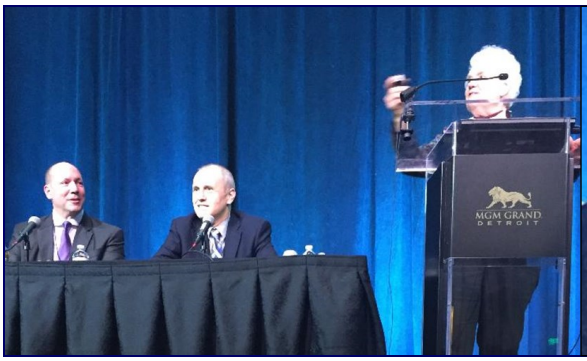
The next presentation was made by Dr. Larry Diebel, the long-term Professor of Surgery at WSU and the Director of the annual DTS. His presentation was entitled, "Venous Trauma: Management of the Blue Man Group." He described how 80% of patients with venous injury have an associated arterial injury; consequently, any patient who has significant bleeding from an extremity in the presence of a good peripheral pulse should be suspected of having a venous injury. The bleeding tends to be worse when the injury is to the lateral vein, so there is no ability for the vein to be contracted or compressed. Duplex is good for identifying venous thrombosis. He emphasized that when a simple repair cannot be made on the injured vein, ligation should be performed. He recommended that complicated venous repairs, including PTFE graft, are inappropriate. He also stated that a compartment syndrome following venous ligation is not as common as the literature suggests. The use of anti-coagulant therapy to prevent VTE after venous injury is not as helpful as was once suspected and that the National Trauma Data Bank shows a very low incidence of pulmonary embolism following venous injury and ligation.

These presentations were followed by a very productive panel session, directed by Dr. Tyburski, and many questions from the audience were answered.

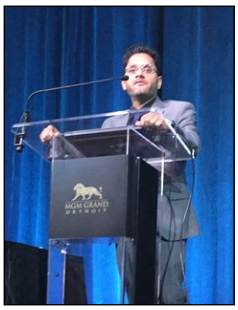
The panel session was followed by a lunch, during which these video presentations were made: "Concepts in Modern Resuscitation for Severe Trauma" by Dr. Martin; "Operative Concepts for Severe Pancreatic Trauma" by Dr. Lucas; and "Tips for Operative Stabilization of Rib Fractures" by Dr. Diebel.

Following the lunch and video sessions, Dr. Diebel wrapped up the 69th Annual Detroit Trauma Symposium and informed the audience that the 70th Annual Detroit Trauma Symposium will occur at the MGM Grand Casino on November 3-4, 2022.

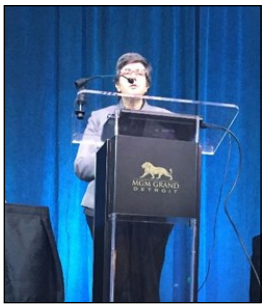
69th ANNUAL DETROIT TRAUMA SYMPOSIUM



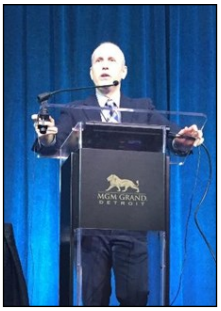

Dr. Anna Ledgerwood moderating her panel while panel members Dr. Walter Biffl and Dr. Matthew Martin listen from the table on the right and Dr. David Spain, Dr. Eileen Bulger and Dr. Joseph DuBose listen from the table on the left



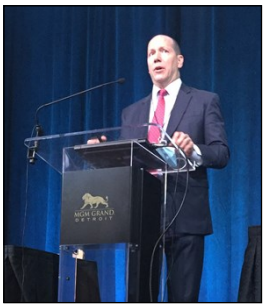
Dr. Wazim Mohamed



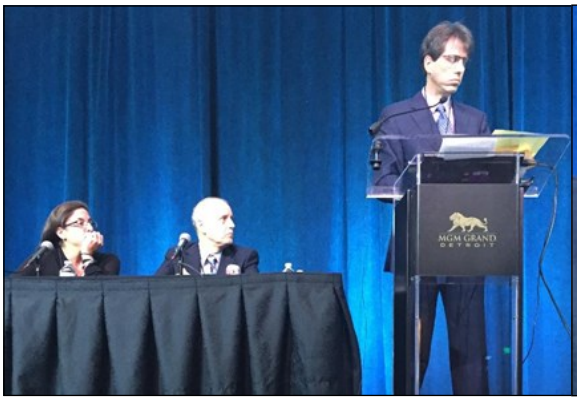
Dr. Eileen Bulger



Dr. Matthew Martin



Dr. Walter Biffl




Dr. Michael White at the podium during his panel while panel members Dr. Deborah Stein and Dr. Matthew Martin listen from the left table and Dr. Eileen Bulger listens to Dr. Christopher Michetti from the right table

69th ANNUAL DETROIT TRAUMA SYMPOSIUM

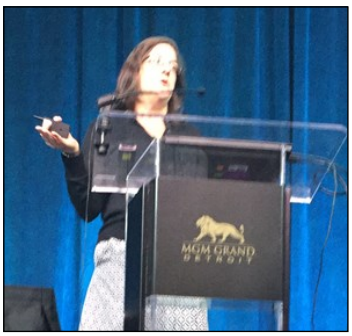
Dr. Rahul Vaidya

Dr. James Tyburski moderating the panel with Dr. Walter Biffl and Dr. John Harvin participating

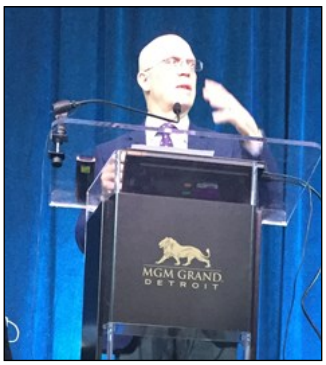
Dr. John Harvin

Dr. Christopher Michetti

Dr. Joseph DuBose

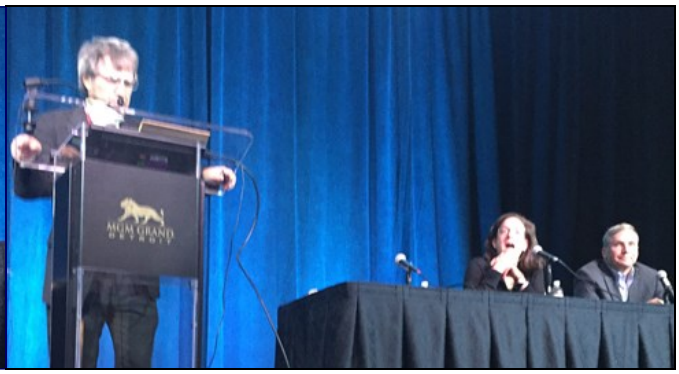


Dr. Deborah Stein



Dr. David Spain

69th ANNUAL DETROIT TRAUMA SYMPOSIUM



Dr. Larry Diebel moderates his panel as panel members Dr. David Spain and Dr. Christopher Michetti listen from the table on the left and Dr. Deborah Stein and Dr. Joseph DuBose listen from the table on the right

MICHAEL & MARIAN ILITCH DEPARTMENT OF SURGERY

WAYNE STATE

"EXCERPTS FROM LOG BOOK" - DOWN MEMORY LANE

Anna M. Ledgerwood, MD

Dr. Anna Ledgerwood

10/6/70: Chief resident, Ali Kafi; staff, Dr. Zwi Steiger

HV: Cecal volvulus. Treated with right hemicolectomy.
RL: Laparotomy for appendicitis (no appendix present due to previous appendectomy).
RK: GSW abdomen. Negative at laparotomy.
TG: MVC. Laceration urinary bladder and serosal tear of transverse colon. Treated with repair.
NW: GSW left upper quadrant abdomen. Treated with laparotomy and splenectomy.
BH: Embolus right femoral artery. Treated with embolectomy.
GJ: GSW neck. Treated with sternal split and ligation of right subclavian vein.

10/7/70: Staff, Dr. Jackson

AF: GSW left flank. Treated with partial nephrectomy and splenectomy with loop colostomy.
AB: Abscess left forearm. Treated with I&D.
RA: Small bowel obstruction. Treated with lysis of adhesions.
AM: Acute appendicitis. Treated with appendectomy.
MB: GSW abdomen with small bowel injury. Treated with resection and end-to-end anastomosis.
CK: Acute appendicitis. Treated with appendectomy.

10/8/70: Staff, Dr. Hershey

FW: GSW right thigh. Treated with exploration of vessels, which was negative.
RH: GSW chest and abdomen with laceration of the liver. Treated with cholecystostomy per the card.
AB: Acute appendicitis. Treated with appendectomy.
MH: GSW left groin. Treated with exploration of femoral vessels, which was negative.
CB: GSW neck. Treated with exploration, which was negative.

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MICHAEL & MARIAN ILITCH DEPARTMENT OF SURGERY
WAYNE STATE

DOWN MEMORY LANE — Anna M. Ledgerwood, MD

10/9/70: Staff, Dr. F. Lippa

TI: Icepick injury to left innominate vein and left common carotid artery. Treated with ligation of vein and carotid subclavian bypass graft using saphenous vein.
JS: Perforated duodenal ulcer. Treated with patch.

10/10/70: Staff, unknown

KK: GSW right leg. Treated with exploration of vessels, which was negative.

10/11/70: Staff, Dr. J. C. Rosenberg

LS: Blunt trauma to abdomen with laceration of proximal jejunum. Treated with repair.
MB: Postop respiratory distress. Treated with tracheostomy.
TH: Lacerations of tendons and median nerve of the left hand at the wrist. Treated with repair of nerve and tendons.
LP: GSW thigh with injury to femoral artery. Treated with resection and saphenous vein graft.

10/12/70: Staff, Dr. LeBlanc

CC: GSW chest. Treated with debridement.
MB: GSW leg with laceration of sciatic nerve. Treated with repair.
LF: Laparotomy for appendicitis with findings of mesenteric adenitis. Treated with appendectomy.

10/13/70: Staff, Dr. Huang

HF: Closure of evisceration (previous right colectomy for cecal volvulus).
MB: Massive large and small bowel infarction. Treated with laparotomy and closure without resection.
EK: Stab chest and abdomen. Treated with repair of left diaphragm and insertion of chest tube.

MICHAEL & MARIAN ILITCH DEPARTMENT OF SURGERY

WAYNE STATE

WSU MONTLY CONFERENCES 2021

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, December 1
Death & Complications Conference
"Portal Hypertension"
Shakir Hussein, MD
Wayne State University Michael & Marian Ilitch Department of Surgery

Wednesday, December 8
Death & Complications Conference
"The Wonderful World of Calcium"
Charles E. Lucas, MD
Wayne State University Michael & Marian Ilitch Department of Surgery

Wednesday, December 15
Death & Complications Conference
"Knowledge is Food for the Soul" (Plato): An Update on Nutrition Management
Lisa Hall Zimmerman, PharmD, BCPS, BCNSP, BCCCP, FCCM, FCCP
Clinical Pharmacist Specialist, Beaumont Hospital, Royal Oak
Adjunct Clinical Assistant Professor, WSU Eugene Applebaum College of Pharmacy & Health Sciences
Adjunct Clinical Assistant Professor, MSU College of Osteopathic Medicine

MICHAEL & MARIAN ILITCH DEPARTMENT OF SURGERY

WAYNE STATE

Wayne State Surgical Society
2022 Donation

Name:

Address:

City/State/Zip:

Service Description		Amount
2021 Dues Payment	$200	_____
My contribution for "An Operation A Year for WSU"		_____
*Charter Life Member	$1000	_____

Total Paid_____

Payment by Credit Card

Include your credit card information below and mail it or fax it to 313-993-7729.

Credit Card Number:_____

Type: MasterCard Visa Expiration Date: (MM/YY)_____ Code____

Name as it appears on card:_____

Signature:_____

Billing address of card (if different from above):

Street Address_____

City_____ State_____ Zip Code_____

*I want to commit to becoming a charter life member with payment of $1000 per year for the next ten (10) years.

Send check made payable to ***Wayne State Surgical Society*** to:

Charles Lucas, MD
Department of Surgery
Detroit Receiving Hospital, Room 2V
4201 St. Antoine Street
Detroit, Michigan 48201

MARK YOUR CALENDARS

American Surgical Association 142nd Annual Meeting
Chicago Mariott Downtown, Magnificent Mile
Chicago, Illinois
April 7-9, 2022

WSU Medical Alumni Reunion Weekend
Detroit, Michigan
May 13-15, 2022

Michigan Chapter of the American College of Surgeons Annual Meeting
Grand Traverse Resort and Spa
Traverse City, Michigan
May 18-20, 2022

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

Missing Emails

Over the years the WSU Department of Surgery has lost touch with many of its alumni. If you know the email, address, or phone number of the following WSU Department of Surgery Residency Program graduates please email us at clucas@med.wayne.edu with their information so that we can get them on the distribution list for the WSU Department of Surgery Alumni Monthly Email Report.

Mohammad Ali (1973)
David B. Allen (1992)
Tayful R. Ayalp (1979)
Juan C. Aletta (1982)
Kuan-Cheng Chen (1976)
Elizabeth Colaiuta (2001)
Fernando I. Colon (1991)
David Davis (1984)
Teoman Demir (1996)
Judy A. Emanuele (1997)
Lawrence J. Goldstein (1993)
David M. Gordon (1993)
Raghuram Gorti (2002)
Karin Haji (1973)
Morteza Hariri (1970)
Harrison, Vincent L. (2009)
Abdul A. Hassan (1971)
Rose L. Jumah (2006)
R. Kambhampati (2003)
Aftab Khan (1973)
Samuel D. Lyons (1988)
Dean R. Marson (1997)
Syed A. Mehmood (2007)
Toby Meltzer (1987)
Roberto Mendez (1997)
Mark D. Morasch (1998)
Daniel J. Olson (1993)
David Packer (1998)
Y. Park (1972)
Bhavik G. Patel (2004)
Ami Raafat (1998)
Kevin Radecki (2001)
Sudarshan R. Reddy (1984)
Renato G. Ruggiero (1994)
Parvid Sadjadi (1971)
Samson P. Samuel (1996)
Knavery D. Scaff (2003)
Steven C. Schueller (1974)
Anand G. Shah (2005)
Anil Shetty (2008)
Chanderdeep Singh (2002)
D. Sukumaran (1972)
David G. Tse (1997)
Christopher N. Vashi (2007)
Larry A. Wolk (1984)
Peter Y. Wong (2002)
Shane Yamane (2005)
Chungie Yang (2005)
Hossein A. Yazdy (1970)
Lawrence S. Zachary (1985)

December 21st

Wayne State Surgical Society

The Wayne State Surgical Society (WSSS) was established during the tenure of Dr. Alexander 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. Scott Davidson (WSU/GS 1990/96) will pass the baton of presidency to Dr. Larry Narkiewicz (WSU/GS 2004/09) at the WSSS Gathering during the American College of Surgeons meeting in October 2022. Members of the WSSS are listed on the next page. Dr. Davidson continues in the hope that all former residents will become lifetime members of the WSSS and participate in the annual sponsored lectureship and the annual reunion at the American College of Surgeons meeting.

MICHAEL & MARIAN ILITCH DEPARTMENT OF SURGERY

WAYNE STATE

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.
Sntoniolli, Anita L.
Auer, George
Babel, James B.
Bassett, Joseph
Baylor, Alfred
Bouwman, David
Bradley, Jennifer
Cirocco, William C.
Clink, Douglas
Colon, Fernando I.
Conway, W. Charles
Davidson, Scott B.
Dujon, Jay
Edelman, David A.
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.
Maxwell, Nicholas
McGuire, Timothy
McIntosh, Bruce
Missavage, Anne
Montenegro, Carlos E.
Narkiewicz, Lawrence
Nicholas, Jeffrey M.
Novakovic, Rachel L.
Perrone, Erin
Porter, Donald
Ramnauth, Subhash
Rector, Frederick
Rose, Alexander
Rosenberg, Jerry C.
Sankaran, Surya
Sarin, Susan
Sferra, Joseph
Shapiro, Brian
Silbergleit, Allen
Smith, Daniel
Smith, Randall W.
Stassinopoulos, Jerry
Sullivan, Daniel M.
Sugawa, Choichi
Tuma, Martin
vonBerg, Vollrad J. (Deceased)
Washington, Bruce C.
Walt, Alexander (Deceased)
Weaver, Donald
Whittle, Thomas J.
Williams, Mallory
Wills, Hale
Wilson, Robert F.
Wood, Michael H.
Zahriya, Karim

Members of the Wayne State Surgical Society—2022 Dues

Alpendre, Cristiano V.
Asfaw, Ingida
Bambach, Gregory A.
Baylor, Alfred
Bucci, Lorenzo
Carlin, Arthur
Dawson, Konrad L.
Dente, Christopher
Dolman, Heather
Dulchavsky, Scott A.
Edwards, Ryan
Fernandez-Gerena, Jose
Gallick, Harold
Goltz, Christopher J.
Hamamdjian, Khatch
Hilu, John
Holmes, Robert
Jeffries, Christopher
Joseph, Anthony
Kaderabek, Douglas J.
Klein, Michael D.
Kosir, Mary Ann
Larson, Sarah
Liebold, Walt
Lopez, Peter
Malian, Michael S.
McGee, Jessica D.
Meade, Peter C.
Mueller, Michael J.
Noorily, Michael
Paley, Daniel S.
Phillips, Linda G.
Schwarz, Karl W.
Shaheen, Kenneth W.
Siegel, Thomas S.
Spencer, Amy
Taylor, Michael G.
Tennenberg, Steven
Thomas, Gregory A.
Thoms, Norman W.
Vasquez, Julio
Ziegler, Daniel W.
Zoellner, Steven M.

December 7th

Operation-A-Year
January 1—December 31, 2022

The WSU department of Surgery has instituted a new group of alumni who are remembering their training by donating the proceeds of one operation a year to the department. Those who join this new effort will be recognized herein as annual contributors. We hope that all of you will remember the department by donating one operation, regardless of difficulty or reimbursement, to the department to help train your replacements. Please send you donation to the Wayne State Surgical Society in care of Dr. Charles E. Lucas at Detroit Receiving Hospital, 4201 St. Antoine Street (Room 2V), Detroit, MI, 48201.

Albaran, Renato G.
Anslow, Richard D.
Antoniolli, Anita L.
Anthony, Joseph
Bambach, Gregory A.
Bradley, Jennifer
Cirocco, William C.
Conway, W. Charles
Davidson, Scott
Dujon, Jay
Edelman, David A.
Francis, Wesley
Gallick, Harold
Gayer, Christopher P.
Gutowski, Tomasz D.
Hamamdjian, Khatch
Herman, Mark A.
Hinshaw, Keith A.
Holmes, Robert J.
Huebel, Hubert C.
Johnson, Jeffrey R.
Johnson, Pamela D.
Joseph, Anthony
Ledgerwood Anna M.
Lim, John J.
Lopez, Peter
Malian, Michael
Maxwell, Nicholas
McGuire, Timothy
McIntosh, Bruce
Missavage, Anne
Nicholas, Jeffrey
Novakovic, Rachel L.
Perrone, Erin
Porter, Donald
Sankaran, Surya
Sferra, Joseph
Siegel, Thomas S.
Silbergleit, Allen
Smith, Randall W.
Sugawa, Choichi
Sullivan, Daniel M.
Tuma, Martin
Whittle, Thomas J.
Williams, Mallory
Wills, Hale
Wood, Michael H.

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*.