

MARCH 2024

# SURGICAL GRAND ROUNDS



March 10<sup>th</sup>

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March 20<sup>th</sup>

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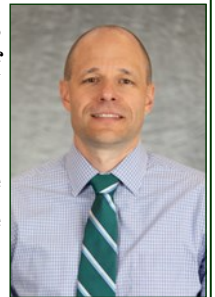
Anita Antoniolu (WSUGS 1998)

### Resident Member:

Paige Aiello

Molly Belisle

The Surgical Grand Rounds on February 7, 2024 was presented by Dr. Jeffrey Janowicz from the Department of Emergency Medicine. The title was “Transitions: Protecting Assets.” Dr. Janowicz talked about his choice to go into Emergency Medicine during his medical school years. He commented that one could assume that this would provide a minimum income of \$200,000/year, and he listened to various “sales pitches” from different insurance agents about how he had to protect his assets for now and for the future. He learned since going into Emergency Medicine that there are many administrative chores that have to be performed in order to ensure that financial assets are brought in. This includes providing proper coding and billing, and he needed to get an education on these topics in order to be financially secure.



Dr. Jeffrey Janowicz

For example, a physician in his/her early 30’s who is about to enter into private practice in an office setting or within a hospital setting needs to give serious consideration to generating income and dealing with the debts which are often over \$1,000,000. Data from current studies suggests that there is currently a shortage of 16,000 physicians, and this will increase to 32,000 by 2036.

There are different types of insurance that must be considered. These different types include car, boat, home, or an overall uniform insurance which includes all of these items; one has to define the cash value which is needed to maintain the lifestyle of one’s spouse and children in case of premature illness, disability or death. He discussed the expense of long-term care when a physician is no longer able to work and may have additional expenses because he/she is unable to perform the duties of daily living. Rehabilitation programs, nursing homes, and home care are very expensive if one has not been properly insured to cover all of these things.

Physicians also need to anticipate disability or illness and be able to provide support for family members, which would include the paying off of all debts and loans and providing funds for education of children. He

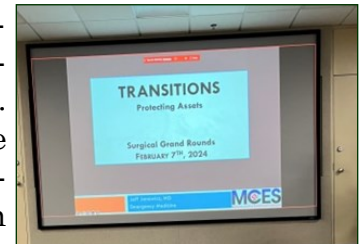
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raised the question as to how much is enough to meet these commitments and that there should be a death plan which incorporates coverage which keeps the surviving family members financially healthy. There also has to be a financial plan in case of disability to allow for the children to have a college education. An insurance plan that covers almost \$1,000,000 over a 17-year period can be broken down to less than \$5,000/month in order to support all these obligations.



When discussing insurance with an agent, it is important to be upfront with any past medical illnesses, smoking, and any other habits that might compromise one's longevity. Otherwise, the insurance company will forfeit the policy when they identify things that were untrue in the application. For a ten-year term policy, one can get a policy for \$3,000,000 which would cost about \$600 per year. This might be altered on a yearly basis depending upon the circumstances.

Although there are many causes for disability, illness is the most frequent cause. Therefore, one should have a rider on the insurance policy which provides benefits for life to the incapacitated physician or the surviving family members. He stressed the importance of shopping around with different companies to determine what is best.

Short-term policies which might commonly be used for pregnancy were discussed. One should look for an employer to provide a short-term (12 weeks) leave of absence following a newborn's birth. Disability insurance is important and should be sufficient to cover all loans and debts in addition to maintaining the lifestyle to which one has become accustomed. Different insurance companies may have different options, including features that deal with disability. One should look at the tax returns and pay scales in order to provide disability insurance which can usually be obtained up to the age of 67. The most common disability from illness is related to cancer, and there should be riders on the policy which deal with partial disability when the physician is able to work part-time. There should also be a mechanism to deal with cost of living adjustments as a rider on the policy.

The Emergency Medicine Department residents around the country get some type of insurance about 30% of the time during the first two years, whereas the others will usually wait until their third or fourth year before completing attainment of appropriate insurance.

Wills and Last Testaments are also important in order to avoid Probate. Trusts can deal with children, mental problems, and any spend thrift who might be able to inappropriately waste monies. He finished by discussing the estate tax, which varies from state-to-state; this should be looked into during discussions with an insurance agent.

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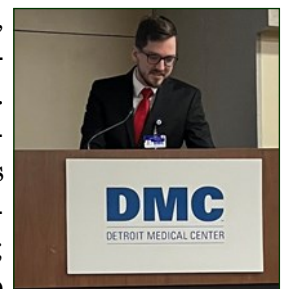
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There was an ongoing question-and-answer session following his unique presentation.



The Surgical Grand Rounds on 2/14/24 was presented by Dominic Suma, M.D. who is a PGY-7 Vascular Fellow. The title was “Thoracoabdominal Aneurysm: Maximally Invasive Surgery and Endovascular Techniques.” Dr. Suma began by discussing the different types of thoracic abdominal aneurysms, including type I which begins at the subclavian artery and extends distally; type II which is located in the proximal abdomen; type III which extends distally from the subclavian aneurysm into the abdominal structures; type IV which is only the abdomen; and type V which is distal involving the thoracic, abdominal, and renal vasculatures. He described the zones of the aorta, beginning with the ascending aorta which is zone 0 and extending down into the iliac arteries which represent zone 11. The typical abdominal aortic aneurysm would be zone 8. The different causes of these aneurysms can be related to degeneration, which is seen with hypertension, atherosclerosis, and smoking; the inherited, such as might be seen in patients with Marfan’s syndrome; and the traumatic, which would also include the mycotic aneurysms.



Dr. Dominic Suma

There are also different types of dissecting aneurysms with the type I being the intimal tear, type II being the extension into the intimal plane, type III extending down into the media, and type IV being dissection down the medial plane which may be associated with rupture or re-entry into the aorta.

The danger of rupture of these aneurysms is related primarily to size with the diameter of greater than 8.2 cm being associated with a risk of rupture of 7%. Other risk factors that are associated with rupture include age over 75, COPD, and acute kidney injury. Aneurysms which are less than 5 cm in diameter have a less than 1% probability of rupture, whereas aneurysms greater than 6 cm have a risk of rupture of 45%, and aneurysms greater than 8 cm have an 80% risk of rupture within one year. Evaluation of the thoracic aortic aneurysm is best made by CTA after the diagnosis is made. The decision to operate is based upon the prediction of rupture based on size and other factors vs. the mortality of an elective operation. The pseudoaneurysms are candidates for excision when they are greater than 5.5 cm; when they are greater than 7 cm, there is a 43% probability of rupture. When the aneurysms are related to a connective tissue disorder, the recommendation for resection is 6 cm in diameter or greater. Dr. Suma described some of the open, complicated repairs which are done for aneurysms involving branch

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vessels of the aorta. He described the importance of spinal cord protection when doing these aneurysms since the vessels that feed the anterior spinal artery are the lumbar aortic vessels. It is also important to protect the kidneys so that the patient does not get acute renal failure following operation. This is done by performing the operation with hypothermia and cardiopulmonary bypass. Spinal drainage is also provided in order that the spinal capillaries have less resistance in getting the capillary flow to the cord itself. Likewise, it is important to avoid vasodilation which might be associated with decreased flow through the capillaries to the spinal cord.

Dominic Suma, MD Vascular Fellow PGY7  
Thoracoabdominal Aneurysm:  
Maximally Invasive Surgery  
and Endovascular Techniques

Also described was the different levels of the thoracic aortic aneurysm, beginning with a type I lesion which involves the ascending aorta and extending to a type IV lesion which extends from the ascending aorta down to the iliacs.

The open surgical approach to these extensive aneurysms begins with a left thoracotomy in the sixth interspace and then extending the incision through the diaphragm down into the abdomen. He emphasized the importance of protecting the left phrenic nerve and the left inferior pulmonary vein which is the most inferior structure of the left pulmonary hilum. He also described the mobilization of the left abdominal viscera in order to expose the full extent of one of these huge extensive aneurysms. The intraoperative pictures and the graphics were excellent in demonstrating this exposure.

Different techniques for re-perfusing the celiac axis, SMA, and renal vessels were discussed, using grafts coming off the main graft or doing separate grafts from the iliacs to the renals. Clearly, there have been extensive advancements in the skills of vascular surgeons and the development of grafts by American industry.

Dr. Suma spent considerable time on the endovascular techniques for approaching these aneurysms. He described how re-perfusion done by grafts through the branches of the aorta is being accomplished. There were a number of different techniques described, including Dacron branches on the Dacron graft, parallel stents, scallops, fenestrated windows on the grafts, and iliac side branches.

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There has been great innovation by the vascular surgeons who are able to make custom grafts in order to accommodate unusual circumstances. When the vascular surgeon has time, he can arrange for industry to prepare the custom graft with an interval of about 3-6 weeks.

This excellent presentation provided much information to the General Surgery audience and demonstrated the imaginative skills of vascular surgeons and American industry. There was a good question-and-answer session to this excellent presentation.



The Grand Rounds for Wednesday, February 21 was presented by Dr. Charles E. Lucas (WSU/GS 1962/67). The title of his presentation was “Surgical Management of Cutaneous Neuralgia in the 21<sup>st</sup> Century” and he began by stating Garnet, in 1926, described cutaneous neuralgia (CN) as a pinpoint pain within a 2 cm area, which is exacerbated by gentle pressure or digital stroking of that area. Although most literature has focused on postoperative abdominal pain or groin CN, this entity may occur in many different situations, including post chest trauma, rib fractures, long bone fractures, and cranial fracture. The duration of CN may vary widely from several months to many years; in general, all patients diagnosed with CN have had symptoms for more than six months. CN is suspected on history and physical examination, which demonstrates pain along a specific dermatome and is confirmed when a percutaneous neural blockade performed proximal eliminates all symptoms. This successful diagnostic blockade helps avoid all unnecessary imaging and unnecessary operations looking for another source of the pain.



Dr. Charles Lucas

CN typically results from prior operation with resultant nerve entrapment and scar tissue and/or surgically placed mesh. More recent literature regarding CN has focused on groin pain after inguinal hernia repair, especially following the use of mesh. CN, however, occurs in all anatomic areas and often is associated with delayed diagnosis, unnecessary imaging, or non-therapeutic operations. Definitive elimination of CN has been provided by proximal neurectomy, typically resecting the nerve trunk leading to the CN. One frequently used technique for relief of groin CN or inguinodynia is triple neurectomy of the ilioinguinal, genitofemoral, and iliohypogastric nerves, with or without removal of associated groin mesh.

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A preliminary report from this unit suggested that a lesser procedure, directed cutaneous neurectomy (DCN), would eliminate CN in the groin or lower abdomen. CN, however, also occurs with other conditions, such as osteoarthritis, different types of trauma, and other operations. This follow-up report describes the results of DCN in a much larger group of patients, including patients with long-bone fracture, blunt thoracic injury, vertebral osteoarthritis (VOA), post-cranium fracture, and after many operations. This project was approved by the Institutional Review Board.

The role of DCN for CN was assessed in 100 patients who underwent a total of 112 DCN procedures from September 2011 through November 2022; this includes the 28 patients from the prior report and four second DCN procedures for recurrent CN in these 28 patients. All patients presented with typical CN, which was completely eliminated in an outpatient setting by a proximal neural blockade. When pain recurred after the local anesthetic wore off, the patient was offered DCN. The duration of CN prior to DCN was not recorded, but none of the patients had CN for less than six months, and some of the patients had CN for over five years. The duration of CN did not appear to affect the clinical presentation.

The outpatient neural blockade was performed with 0.5% bupivacaine (maximum 3ml). The injection was made 3-5 inches proximal to the site of CN in the same dermatome as judged clinically; no imaging was used to facilitate the injection. Once complete relief was obtained with a small injection (usually <0.5 mL), the total 3 mL injectate was placed around the nerve with the hope that long-term relief beyond the expected six hours could be obtained. When pain recurred and the patient opted for DCN, 0.5 mL of Evans Blue dye was added to the bupivacaine before the patient had any operative sedation in the operating room; a minimum amount of combined mixture of anesthetic and blue dye was injected to completely remove the pain, thus minimizing the extent of blue-stained tissue that had to be excised; no imaging was used. The previous injection in the office helped localize the fibers that were causing the CN, thus minimizing the volume of blue-stained tissue that had to be excised. About 0.2 mL of blue-stained injectate was injected near the dermis in order to identify where the subsequent incision would be made, since the inked margins for the injection would often be washed off by the subsequent skin prep. Following the successful injection, anesthesia was administered and a small incision was made in the natural skin lines over the injection site, and all of the blue-stained tissues were removed. Sharp dissection was used to excise the injection site down to the blue-stained tissues; electrocoagulation was used to excise all blue-stained tissues, which sometimes involved the superficial fascia. The total specimen was sent for pathological examination. During

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operation, specific nerve fibers were seldom seen. Two of the patients who had mesh in place had partial removal of the mesh because that portion of the mesh was stained blue. The patients were followed postoperatively, and a registry of DCN was created to facilitate data analysis. Follow-up examination was facilitated by patients who routinely use the authors as their physicians and by patients who adopted the authors as their caregivers because of the success of DCN, even when a new medical problem was not surgically correctable. The follow-up information was obtained by office visits, a review of the patient's total medical records, and in six patients who lived far from Detroit, by phone contact. Parameters measured included patient age, gender, type of operation that led to CN, and result of DCN as subdivided into continuous (C) relief, no (N) relief, and temporary (T) relief, including the duration of documented C and T relief in months. C relief and T relief times were defined in months according to the last follow-up evaluation. They are reported as mean  $\pm$  SD in months following operation. There were 100 patients who underwent 112 procedures during this 11-year interval; six patients had two operations, and two patients had three operations. There were 55 men and 45 women with an average age of  $56 \pm 12$  years. The specific sites of DCN included the groin (49 patients), right upper abdomen, including gallbladder area (10 patients), status post component separation (12 patients), intercostal nerve of the lower ribcage (5 patients), osteochondritis (1 patient), drain site (3 patients), abdominal wall hernia (13 patients), long bone fracture (4 patients), skull fracture (2 patients), and chest radiation (1 patient). There were 42 patients who had mesh placed at prior operation, including 32 of 49 patients who had DCN of the ilioinguinal nerve or the genitofemoral nerve, 5 of 12 patients after abdominal component separation, 4 of 13 patients after abdominal wall hernia repairs, and 1 of 10 patients after upper quadrant surgery.

Based on prior history and preoperative examination by the authors, etiologic factors leading to CN along the distribution of the ilioinguinal nerve in 27 patients included prior herniorrhaphy in 24 patients, including 22 patients with mesh and three patients with vertebral osteoarthritis (VOA). The 22 patients with CN along the distribution of the genitofemoral nerve included 18 after hernia (10 with mesh). All 7 patients with CN along the distribution of the iliohypogastric nerve had a prior lower abdominal wall hernia or component separation. The CN in five patients was associated with VOA involving the distribution of the ilioinguinal nerve (2 patients), a mid-abdominal nerve (2 patients), and a lower chest wall nerve (1 patient).

There were 82 patients who had long-term continuous relief of CN at an average of  $27 \pm 20$  SD months after operation, which was the time of their last follow-up visit. Six patients had no benefit from DCN at one month, and 12 patients had long-term temporary relief of CN at an average of  $22 \pm 19$  SD months prior to return of pain in the same dermatome.

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operation, specific nerve fibers were seldom seen. Two of the patients who had mesh in place had partial removal of the mesh because that portion of the mesh was stained blue. The patients were followed postoperatively, and a registry of DCN was created to facilitate data analysis. Follow-up examination was facilitated by patients who routinely use the authors as their physicians and by patients who adopted the authors as their caregivers because of the success of DCN, even when a new medical problem was not surgically correctable. The follow-up information was obtained by office visits, a review of the patient's total medical records, and in six patients who lived far from Detroit, by phone contact. Parameters measured included patient age, gender, type of operation that led to CN, and result of DCN as subdivided into continuous (C) relief, no (N) relief, and temporary (T) relief, including the duration of documented C and T relief in months. C relief and T relief times were defined in months according to the last follow-up evaluation. They are reported as mean  $\pm$  SD in months following operation when the benefit of DCN can no longer be seen. A larger segment of soft tissue, which incorporated the external oblique fascia, was performed in the patients having second DCN procedures after initial long-term relief.

There was no apparent relationship between the identification of nerve fibers or filaments and the subsequent relief of pain. Nerve fibers were seen histologically in 42 patients, including 34 who had C relief for an average of  $28.1 \pm 19.6$  months, 3 patients who had N relief, and 5 patients who had T relief for an average of  $16.8 \pm 12.5$  months. In contrast, there were 58 patients in whom no nerve fibers were seen histologically, and they had C relief in 47 instances for a mean of  $26.8 \pm 20.7$  months, N relief in 3 patients, and T relief in 8 patients for an average of  $24.6 \pm 24.5$  months. The comparison of the duration of C relief had a p value of 0.9, and the comparison of the T relief had a p value of 0.4 when the group with histologic nerve fibers were compared with the group without histologic nerve fibers.

The presence or absence of mesh did not appear to affect outcome. For the 42 patients with mesh, 33 had a C relief, 3 had N relief, and 5 had a T relief, compared to the 47 patients without mesh of whom 47 had a C relief, 3 had N relief, and 8 had a T relief. The mean duration of the C relief in the 33 patients with mesh was  $28.1 \pm 19.6$  SD months, compared to the 47 patients without mesh who had a C relief, which was  $26.8 \pm 20.7$  SD months (the p value calculated by paired t-test for this difference was 0.79). Five of the 42 patients with mesh had a T relief of  $16.8 \pm 12.5$  SD months, whereas the 8 patients without mesh who had a T relief had a mean relief of  $24.6 \pm 24$  SD months (p value = 0.33 by paired t-test).

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The wound healed normally after 102 DCN procedures, had a seroma in nine instances, and had a superficial infection in three patients. All seromas occurred at abdominal site incisions, and the one superficial infection occurred in a third DCN performed in the groin.

DCN appears to have many benefits for treatment of patients with persistent cutaneous neuropathy related to many different etiologies as are summarized in this report. Many descriptions of truncal neurectomy with or without removal of associated mesh have been described. DCN seems to be a simpler procedure. Huynh and co-workers reported that truncal neurectomy with mesh removal averaged 162 minutes when performed laparoscopically and 217 minutes when performed robotically; the average operating time for the DCN was 36 minutes.

The concept of a limited neurectomy (DCN) evolved because of the invasiveness of triple neurectomy and mesh removal. Our preliminary report on 28 patients in 2013 described the techniques used herein. This early report dealt primarily with lower abdomen pain in the inguinal area and demonstrated good long-term results. The current report includes patients with CN involving the scalp, chest wall, upper and lower abdomen, groin, and extremities. Based upon the results herein, the advantages of DCN include simplicity, reliability, and effectiveness. The procedure is minor and does not sacrifice the entire nerve but removes only the cutaneous branches. Likewise, the operative times are short. Postoperative numbness in the area of prior CN is a common finding but does not appear to bother the patients. The surgeon has to inquire about this numbness since the patient almost never complains about the small skin segment with no feeling. The lack of identified nerve fibers in many patients with complete permanent relief suggests that there is a lack of microscopic appreciation of very small nerve fibers. The pathologist was asked to re-examine excised specimens in two C relief patients without nerve fibers; small nerve fibers were identified in one patient. Similar findings would likely be true if all of the pathology samples were re-examined.

The reason for no benefit after 6 of the 100 procedures is not known. All blue-stained tissues were removed. One patient had a pre-anesthetic given prior to the block and, in retrospect, this procedure should have been cancelled. Repeat DCN in two of these six patients resulting in continuous long-term relief suggests some type of unknown surgical error.

There are a number of limitations to this study. First, all procedures were performed by the authors; the surgical technique, however, is quite simple and should provide reproducible results in the hands of all surgeons. Second, not all patients had at least temporary relief after

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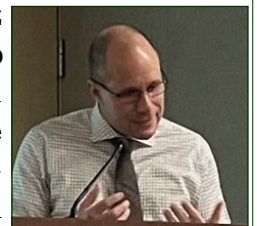
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DCN despite good relief on the preoperative blockade. This raises the question as to whether there might be some other unrecognized factor contributing to the pain in this subset of patients. Third, some of the patients defined as C relief might have converted to T relief if followed longer. Fourth, this was a registry-dependent report, so there may have been some inconsistencies of data entered retrospectively into the registry, although all of the elements in the registry were complete.

In conclusion, these findings show that CN can be relieved by DCN without resecting nerve trunks or full excision of mesh. However, the results herein cannot be compared to traditional truncal neurectomy with mesh removal, since this is not a randomized controlled trial. However, DCN is a simple and effective means for treating CN due to multiple etiologies. This includes CN along the lower thoracic and upper abdominal regions and CN related to trauma, causing rib fractures, skull fractures, and long bone fractures.



The Surgical Grand Rounds on 2/28/24 was provided by Dr. Jeffrey Janowicz and was entitled “Transitions: Building Wealth.” This was actually a follow-up presentation from the Grand Rounds that he delivered earlier this month when he discussed different aspects of expenses and financial principles of which the young house officer must be aware. He described the things that should be considered as you move through your working years in order to accumulate wealth commensurate with what you plan to do during your retirement years.



Dr. Jeffrey Janowicz

He talked about the typical salary for residents within different specialties and the various debts that occur related to repayment of loans, disability and life insurance, and how one should prepare for the future. When it comes to financial expertise, he noted that most physicians are inadequately prepared. He described the “pseudo” knowledge that the young physician accumulates and that this often has nothing to do with the real world. Likewise, sometimes the finishing resident may think that he/she is wealthy and spend foolishly at a time when they are extraordinarily ignorant about taxes, savings, and the burden of long-term debt. He presented many numbers about the above issues.

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Dr. Janowicz also discussed the concept of net worth which follows the principle that net worth is equal to assets minus debt. There are different types of retirement plans which should be considered, including the IRA, work-related retirement plans, the Roth IRA, and others. He emphasized that the Health Savings Account (HSA) is the “perfect investment” in that it avoids taxes. He also talked about the value of a 401K as it relates to retirement and how the guidelines for investment vary with age. He also talked about the “Back Door” Roth IRA and how it relates to the normal IRA, particularly as it relates to taxation with withdrawal of funds. Clearly, these are very complex issues, and the ignorant physician probably should work with a professional to get guidance.

Various college savings plans were also discussed, and he pointed out that tuition and college fees are going to continue to increase. He praised the Michigan Education Trust (MET) as it relates to preparing one’s children for the financial burden of a college education. He pointed out the strengths and weaknesses of the TIAA/CREF in terms of planning for retirement. He praised the Michigan 529 which is also a valuable asset when planning for retirement. Additional investing with a financial broker should be taking place after all the above methods of preparing for retirement have been implemented.

The total presentation was somewhat complex. The editor felt somewhat ignorant about many of his teachings but took solace in the fact that Dr. Janowicz probably knows essentially nothing about the physiology of the interstitial fluid space.



# CORRECTION

A number of the WSSS members are trying to help the Editor and have pointed out that the location of the NFC Championship game this year was in Santa Clara's Levi's Stadium. The Editor promises to try to do better in the future.





## EXCERPTS FROM THE LOG BOOK DOWN MEMORY LANE

2/23/72 - Staff: Dr. Tom Grifka: Chief Resident: Dr. Anna Ledgerwood

1. CC: 91-yo with upper GI bleeding. Gastroscopy showed gastric erosions and duodenal ulcer with continued bleeding, treated with exploratory laparotomy, over sewing bleeding duodenal ulcer, vagotomy, and pyloroplasty.
2. AW: 17-yo with GSW abdomen, four holes hepatic flexure colon, and tip right lobe of liver. Treated with resection colon with end colostomy and mucous fistula.



Dr. Anna Ledgerwood

2/24/72 - Staff: Dr. P. LeBlanc;

1. OW: 30-yo with GSW abdomen with small hole in duodenum, treated with closure.

2/25/72 - Staff: Dr. Norman Thoms

1. OH: 21-yo with GSW right thigh and fracture neck right femur, GSW right arm with radial nerve palsy, GSW abdomen with injury to diaphragm and both lobes of liver and two holes in stomach. Treated with exploratory laparotomy, closure stomach and diaphragm, and bilateral chest tubes. Femoral vessels explored and were intact.

2/26/72 - Staff: Dr. J.C. Rosenberg (Senior Resident: Dr. E. Montales)

1. CL: GSW abdomen with two holes in stomach and colon, treated with exploratory laparotomy, closure holes in colon, exteriorization of injury, closure of stomach, and gastrostomy.
2. CT: GSW neck with paraplegia at T4 level. Esophogram showed extravasation, treated with exploration of neck, closure anterior hole of trachea and posterior holes trachea, and holes in esophagus not found.
3. CB: 28-yo with SGW left thigh and groin with no pulse. Massive injury to left thigh and superficial femoral artery and vein, treated with exploration, debridement muscles, and massive saphenous vein bypass graft and ligation of vein.

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

2/27/72 - Staff: Dr. J. Kirkpatrick

1. EM: 60-yo with SGW left arm and chest, self-inflicted. Treated with amputation of left arm at shoulder, debridement of axilla, and placement of left chest tube. Had fracture left 3,4,5 ribs and pulmonary contusion.
2. LS: 71-yo with perforated pre-pyloric ulcer, treated with biopsy of wall, vagotomy, and pyloroplasty.
3. EW: 26-yo with previous GSW abdomen, treated with evacuation of clots, left chest tube, gastrostomy, jejunostomy, and exteriorization of colon repair.
4. RA: 28-yo with GSW abdomen with injury of left common iliac vein and two holes in small bowel. Initially presented with BP 80/0, given 800 cc of fluid, and BP improved to 120/60. Stable in E.R. but had increased abdominal distension. In O.R., BP 160/100 but dropped to 0 after induction of anesthesia. EKG not working, left anterior thoracotomy, heart was beating, aorta cross-clamped. Abdomen opened, 3 liters of blood evacuated, left common iliac vein was injured and ligated. Aorta unclamped and small bowel resected with anastomosis.

2/28/72 - Staff: Dr. A. Weaver

1. GK: GSW abdomen, exploratory laparotomy, closure six holes ilium. Repair iatrogenic hole in urinary bladder.

2/29/72 - Staff: Dr. Tumacador

1. EM: Flail chest, tracheostomy.
2. LL: 18-yo with GSW abdomen with hemopneumothorax, had re-insertion of right chest tube.
3. CB: SGW left thigh with prior debridement. had partial closure of wound.
4. CB: Ligation muscle bleeders, SGW right groin and thigh.
5. BS: 18-yo with acute abdomen, had acute appendicitis treated with appendectomy.
6. NS: 39-yo with blunt trauma from auto accident with fracture L4-11 ribs and L3-4 transverse processes and positive peritoneal lavage. Exploratory laparotomy revealed ruptured spleen, treated with splenectomy and placement of left chest tube.



## WSU MONTLY CONFERENCES 2024

Death & Complications Conference    Didactic  
Every Wednesday from 7-8 Kresge Audi-



Lectures — 8 am  
torium

*The weblink for the New WebEx Room:  
<https://davidedelman.my.webex.com/meet/dedelman>*

### Wednesday, March 6

Death & Complications Conference  
“Strategies of Hemodialysis Access”  
Sidra Bhuller, DO  
Graduating Vascular Surgery Resident  
WSU Michael & Marian Ilitch Department of Surgery

### Wednesday, March 13

Death & Complications Conference  
“Intra-thoracic Pathologies in the Neonatal and Pediatric Population”  
Hollis Hutchings, MD  
Graduating Surgical Critical Care Resident  
WSU Michael & Marian Ilitch Department of Surgery

### Wednesday, March 20

Death & Complications Conference  
Anastasya Chuchulo, MD  
Graduating Surgery Resident  
WSU Michael & Marian Ilitch Department of Surgery

### Wednesday, March 27

Death & Complications Conference  
“Time to Say Goodbye: The Quest of Dying with Dignity”  
Yuchen Zhang, MD  
Graduating Surgical Critical Care Resident  
WSU Michael & Marian Ilitch Department of Surgery

**RESGE 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)*<sup>™</sup>. Physicians should claim only the credit commensurate with the extent of their participation in the activity.<sup>7</sup>

#### EVALUATIONS

Surgical Death and Complications Rounds #2024321125, Jan-April 2024 CME Reflective Evaluation:

<https://www.surveymonkey.com/r/MJM1NVV>

Surgery Grand Rounds #2024321064, Jan-April 2024 CME Reflective Evaluation:

<https://www.surveymonkey.com/r/MJW12XF>



**Wayne State Surgical Society  
2024 Donation**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Service Description	Amount
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2024 Dues Payment _____	\$200	_____
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My contribution for "An Operation A Year for WSU" _____		_____
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*Charter Life Member _____	\$1000	_____
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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 144<sup>th</sup> Annual Meeting  
April 4-6, 2024*

*Grand Hyatt Hotel  
Washington DC*

*Michigan Chapter of the American College of Surgeons*

*May 1-3, 2024  
Radisson Plaza Hotel  
Kalamazoo, Michigan*

*Midwest Surgical Association Annual Meeting  
August 4-6, 2024*

*Grand Hotel  
Mackinac Island, Michigan*

*88<sup>th</sup> Annual Meeting of the American Association for the Surgery of Trauma/ Clinical Congress of Acute Care Surgery*

*September 11-24, 2024  
Las Vegas, Nevada*

*American College of Surgeons Clinical Congress Annual Meeting*

*October 19-22, 2024  
San Francisco, California*



**Please Update Your Information**

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



## 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](mailto: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)

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)

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)

## 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. Scott Davidson (WSU/GS 1990/96) passed 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. Narkiewicz 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.*





*Members of the Wayne State Surgical Society  
Charter Life Members*

Ahn, Dean	Clink, Douglas	Gerrick Stanley	Lucas, Charles E.	Ramnauth, Subhash	vonBerg, Vollrad J. (Deceased)
Albaran, Renato G	Chmielewski, Gary W.	Grifka Thomas J. (Deceased 2022)	Malian, Michael S.	Rector, Frederick	Washington, Bruce C.
Allaben, Robert D. (Deceased)	Colon, Fernando I.	Gutowski, Tomasz D.	Marquez, JoFrances	Rose, Alexander	Walt, Alexander (Deceased)
Ames, Elliot L.	Conway, William Charles	Herman, Mark A.	Martin, Donald J., Jr.	Rosenberg, Jerry C.	Weaver, Donald
Amirikia, Kathryn C.	Davidson, Scott B.	Hinshaw, Keith A.	Maxwell, Nicholas	Sankaran, Surya	Whittle, Thomas J.
Anslow, Richard D.	Dente, Christopher	Holmes, Robert J.	McGuire, Timothy	Sarin, Susan	Williams, Mallory
Antonioli, Anita L.	Dujon, Jay	Huebl, Herbert C.	McIntosh, Bruce	Sferra, Joseph	Wills, Hale
Auer, George	Edelman, David A.	Johnson, Jeffrey R.	Missavage, Anne	Shapiro, Brian	Wilson, Robert F.
Babel, James B.	Engwall, Sandra	Johnson, Pamela D.	Montenegro, Carlos E.	Silbergleit, Allen (Deceased)	Wood, Michael H.
Basset, Joseph (Deceased)	Francis, Wesley	Kline, Gary	Narkiewicz, Lawrence	Smith, Daniel	Zahriya, Karim
Baylor, Alfred	Flynn, Lisa M.	Kovalik, Simon G.	Nicholas, Jeffrey M.	Smith, Randall W.	
Bouwman, David	Fromm, Stefan H.	Lange, William (Deceased)	Novakovic, Rachel L.	Stassinopoulos, Jerry	
Bradley, Jennifer	Fromm, David G	Lau, David	Perrone, Erin	Sullivan, Daniel M.	
Busuito, Christina	Galpin, Peter A.	Ledgerwood, Anna M.	Porter, Donald	Sugawa, Choichi	
Crocco, William C.	Gayer, Christopher P.	Lim, John J.	Prendergast, Michael	Tuma, Martin	



*Members of the Wayne State Surgical Society—2023-24 Dues*

Alpendre, Cristiano V.	Goltz, Christopher J.	Marquez, JoFrances	Siegel, Thomas S.
Bambach, Gregory A.	Gutowski, Tomasz	Martin, Jonathon	Tarras, Samantha
Carlin, Arthur	Hall, Jeffrey	McGee, Jessica D.	Taylor, Michael G.
Chmielewski, Gary	Hollenbeck, Andrew	Mostafa, Gamal	Tennenberg, Steven
Dawson, Konrad L.	Joseph, Anthony	Nevonen, Marvin G.	Thoms, Norman W.
Dolman, Heather	Klein, Michael D.	Paley, Daniel S.	Vasquez, Julio
Dulchavsky, Scott A.	Kline, Gary	Park, David	Ziegler, Daniel W.
Fernandez-Gerena, Jose	Kosir, Mary Ann	Porterfield, Lee	
Field, Erin	Lloyd, Larry	Shanti, Christina	



*Operation-A-Year  
January 1—December 31, 2024*



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.	Dittinbir, Mark	Holmes, Robert J.	McGuire, Timothy	Sullivan, Daniel M.
Antonioli, Anita L.	Engwall, Sandra	Johnson, Jeffrey R.	McIntosh, Bruce	Wood, Michael H.
Bambach, Gregory A.	Fernandez-Gerena, Jose	Johnson, Pamela D.	Porter, Donald	Ziegler, Daniel
Bradley, Jennifer	Gutowski, Tomasz	Joseph, Anthony	Prendergast, Michael	
Busuito, Christina	Gayer, Christopher P.	Lim, John J.	Siegel, Thomas S.	
Chmielewski, Gary W.	Herman, Mark A.	Malian, Michael	Smith, Daniel	
Dente, Christopher	Hinshaw, Keith A.	Marquez, JoFrances	Smith, Randall	



**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](mailto:lrobitai@med.wayne.edu).