



WESTERN SURGICAL ASSOCIATION

# **2014 Annual Scientific Session**

Saturday through Tuesday

November 8–11, 2014

Miramonte Resort and Spa

Indian Wells, California

*Final Program*





**Western Surgical Association**

**2014 ANNUAL  
SCIENTIFIC  
SESSION**

**Saturday through Tuesday  
November 8–11, 2014  
Miramonte Resort and Spa  
Indian Wells, California**

# WESTERN SURGICAL ASSOCIATION MISSION STATEMENT

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The Western Surgical Association is dedicated to the cultivation, promotion, and diffusion of the art and science of surgery, to the sponsorship and maintenance of the highest standards of practice and to the delivery of the best possible care for the public. The goal of our continuing medical education effort is to provide information to the practicing surgeon that will enhance his/her knowledge regarding new diagnostic modalities and therapeutic maneuvers. The scope of our activities is meant to encompass the breadth of general surgery, including the primary and secondary components and is intended for our members and guests who are surgeons in academic and private practice. Our activities will focus on recent advances in basic science applicable to surgical practice, new developments in technology, issues in pre- and post-operative care; assessment of diagnostic accuracy and surgical outcomes; and critical analysis of the information provided.

## FUTURE MEETINGS

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- |                       |  |
|-----------------------|--|
| <b>Nov 7–10, 2015</b> | <b>Meritage Resort and Spa</b><br>Napa Valley, California    |
| <b>Nov 5–8, 2016</b>  | <b>Lowes Coronado Bay Resort</b><br>Coronado, California     |
| <b>Nov 4–7, 2017</b>  | <b>Montelucia Resort and Spa</b><br>Paradise Valley, Arizona |

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# LOCATION

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**Miramonte Resort and Spa**  
Indian Wells, California

# REGISTRATION

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Sat, Nov 8	3:00pm – 6:00pm
Sun, Nov 9	7:00am – 12 Noon
Mon, Nov 10	7:00am – 5:00pm
Tue, Nov 11	7:30am – 12 Noon

# SCIENTIFIC SESSIONS

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Sun, Nov 9	7:30am – 12 Noon
Mon, Nov 10	7:30am – 12 Noon 1:30pm – 4:00pm
Tues, Nov 11	8:00am – 12 Noon

## LEARNING OBJECTIVES

*At the end of this activity, participants will be able to:*

Participants at the annual scientific meeting are expected to become more knowledgeable about the most current clinical and research topics in the broad field of general surgery.

1. Delineate the importance of new diagnostic and therapeutic modalities in surgery.
2. Prioritize treatment of surgical diseases with new operative and non-operative technologies and treatment options.
3. Elucidate the outcome of new surgical procedures and novel adjuvant therapies.

## ACCREDITATION STATEMENT

This activity has been planned and implemented in accordance with the Essential Areas and Policies of the Accreditation Council for Continuing Medical Education through the joint sponsorship of the American College of Surgeons and the Western Surgical Association. The American College Surgeons is accredited by the ACCME to provide continuing medical education for physicians.

## ***AMA PRA CATEGORY 1 CREDITS™***

*The American College of Surgeons designates this live activity for a maximum of 13.50 AMA PRA Category 1 Credits™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.*

Of the *AMA PRA Category 1 Credits™* listed above, a maximum of 9.5 credits meet the requirements for Self-Assessment.



## **American College of Surgeons Division of Education**

### **DISCLOSURE INFORMATION**

In compliance with ACCME Accreditation Criteria, the American College of Surgeons, as the accredited provider of this activity, must ensure that anyone in a position to control the content of the educational activity has disclosed all relevant financial relationships with any commercial interest. All reported conflicts are managed by a designated official to ensure a bias-free presentation. Please see the insert to this program for the complete disclosure list.

#### **Your CME @ your Convenience**

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- Available 24/7
- Exclusive to ACS Members
- Print duplicate CME certificates
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# ELECTED TO MEMBERSHIP AT THE ANNUAL MEETING NOVEMBER 2013

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## *The Western Surgical Association Welcomes its New Members and their Spouses*

**Brian Badgwell**  
*Houston, TX*

**Mary Kwaan**  
*Minneapolis, MN*

**Marshall Baker**  
*Evanston, IL*

**Rifat Latifi**  
*Tucson, AZ*

**James Boffa**  
*Skokie, IL*

**Stephen Lu**  
*Albuquerque, NM*

**Jayer Chung**  
*Dallas, TX*

**Katherine Morris**  
*Albuquerque, NM*

**Tina Desai**  
*Skokie, IL*

**John M. Morton**  
*Stanford, CA*

**Brian Eastridge**  
*San Antonio, TX*

**Fredric Pieracci**  
*Denver, CO*

**John Garry**  
*Fresno, CA*

**Marc Singer**  
*Highland Park, IL*

**Julie Heimbach**  
*Rochester, MN*

**Ronald Stewart**  
*San Antonio, TX*

**W. Scott Helton**  
*Seattle, WA*

**Carlos Timaran**  
*Dallas, TX*

**Joseph Kambe**  
*Albuquerque, NM*

**Sonlee West**  
*Albuquerque, NM*

# OFFICERS – 2014

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**PRESIDENT**

Steven C. Stain  
Albany, New York

**SECRETARY**

R. James Valentine  
Dallas, Texas

**1<sup>ST</sup> VICE PRESIDENT**

Alden Harken  
Oakland, California

**TREASURER**

Mark Talamonti  
Evanston, Illinois

**2<sup>ND</sup> VICE PRESIDENT**

Kenneth Sirinek  
San Antonio, Texas

**RECORDER**

Kelly McMasters  
Louisville, Kentucky

## EXECUTIVE COMMITTEE

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**PRESIDENT**

Steven C. Stain  
Albany, New York

**PAST PRESIDENT**

Raymond Joehl  
Phoenix, Arizona

**SECRETARY**

R. James Valentine  
Dallas, Texas

**DISTRICT REPRESENTATIVE**

Randall Smith  
Temple, Texas

**TREASURER**

Mark Talamonti  
Evanston, Illinois

**DISTRICT REPRESENTATIVE**

Karen Borman  
Washington DC

**RECORDER**

Kelly McMasters  
Louisville, Kentucky

**DISTRICT REPRESENTATIVE**

Margo Shoup  
Warrenville, Illinois

**IMMEDIATE PAST PRESIDENT**

Clive Grant  
Colorado Springs, Colorado

**DISTRICT REPRESENTATIVE**

Daniel Margulies  
Los Angeles, California

# OTHER REPRESENTATIVES

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## **BOARD OF GOVERNORS, AMERICAN COLLEGE OF SURGEONS**

Karen J. Brasel  
Portland, Oregon

## **AMERICAN BOARD OF SURGERY**

Gregory J. Jurkovich  
Denver, Colorado

## **ADVISORY COUNCIL ON SURGERY, AMERICAN COLLEGE OF SURGEONS**

Thomas A. Broughan  
Falls Church, Virginia

## **MEMBERSHIP COMMITTEE – 2014**

Katherine Liu – *Chair*  
Anees Chagpar  
Steven De Jong  
Mark Faries  
Randall Smith  
Karen Borman  
Steven C. Stain, *Ex-Officio*  
R. James Valentine, *Ex-Officio*  
Mark Talamonti, *Ex-Officio*  
Jason Fleming, *Ex-Officio*

## **PROGRAM COMMITTEE – 2014**

Mark Talamini – *Chair*  
Peter Rhee  
Charles Scoggins  
Margo Shoup  
Daniel Margulies  
Steven C. Stain, *Ex-Officio*  
R. James Valentine, *Ex-Officio*  
Kelly McMasters, *Ex-Officio*

## **LOCAL ARRANGEMENTS CHAIRMAN – 2014**

Anton Bilchik  
Santa Monica, California





# **Schedule of Events**

# SCHEDULE OF EVENTS

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## FRIDAY, NOVEMBER 7

6:00pm – 9:30pm      **Executive Committee Dinner** *(invitation only)*  
Piazza

## SATURDAY, NOVEMBER 8

8:00am – 12Noon      **Executive Committee Meeting**  
Venetian Ballroom

3:00pm – 6:00pm      **WSA Registration Open**  
Mediterranean Foyer

3:00pm – 5:00pm      **Exhibitor Setup**  
Mediterranean III and IV

5:30pm – 6:30pm      **New Member Reception**  
Piazza

6:30pm – 8:30pm      **Welcome Reception**  
Olive Grove/Mira Pool

# SCHEDULE OF EVENTS CONTINUED

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## SUNDAY, NOVEMBER 9

<i>7:00am – 8:00am</i>	<b>Continental Breakfast for Physicians</b> Mediterranean III and IV
<i>7:00am – 12noon</i>	<b>WSA Registration Open</b> Mediterranean Foyer
<i>7:00am – 12noon</i>	<b>Exhibits Open</b> Mediterranean III and IV
<i>7:30am – 10:00am</i>	<b>Scientific Session I</b> Mediterranean I and II
<i>8:00am – 10:00am</i>	<b>Spouse/Guest Hospitality and Breakfast</b> Florentine 1
<i>10:00am – 10:15am</i>	<b>Beverage Break</b> Mediterranean III and IV
<i>10:15am – 11:15am</i>	<b>Scientific Session I continued</b> Mediterranean I and II
<i>11:15am – 12:15pm</i>	<b>Presidential Address: Steven C. Stain</b> Mediterranean I and II
<i>12:45pm</i>	<b>Golf Tournament – Shotgun Start</b> Indian Wells Golf Course
<i>1:00pm – 4:00pm</i>	<b>Tennis Tournament</b> Indian Wells Tennis Garden
<i>1:00pm – 5:00pm</i>	<b>Optional Tour: Palm Springs Aerial Tram</b>
<i>Afternoon</i>	<b>Open</b>

# SCHEDULE OF EVENTS CONTINUED

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## MONDAY, NOVEMBER 10

7:00am – 8:00am	<b>Continental Breakfast for Physicians</b> Mediterranean III and IV
7:00am – 5:00pm	<b>WSA Registration Open</b> Mediterranean Foyer
7:30am – 1:30pm	<b>Exhibits Open</b> Mediterranean III and IV
7:30am – 12noon	<b>Scientific Session II</b> Mediterranean I and II
8:00am – 10:00am	<b>Spouse/Guest Hospitality and Breakfast</b> Florentine 1
10:00am – 10:15am	<b>Beverage Break</b> Mediterranean III and IV
12noon – 1:30pm	<b>NEW Poster Session</b> Mediterranean III and IV
12:15pm – 1:15pm	<b>Women in Surgery Lunch</b> Grove Artisan Kitchen
1:30pm – 4:00pm	<b>Scientific Session III</b> Mediterranean I and II
1:30pm- 3:30pm	<b>Special Discussions</b> Mediterranean I&II  <i>“Surgery 2025: Who Will I Work for, What Will Surgical Practice Be, HowWill We Train?” and “General Surgery Residency Training Should be Contracted to a Period of Basic Training Followed by Subspecialty Training for all Residents”</i>



# SCHEDULE OF EVENTS CONTINUED

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<i>3:30pm – 3:45pm</i>	<b>Beverage Break</b> Mediterranean Foyer
<i>4:15pm – 5:15pm</i>	<b>Annual Business Meeting</b> Mediterranean I and II
<i>7:00pm – 8:00pm</i>	<b>President’s Reception</b> Mediterranean Foyer
<i>8:00pm – 11:00pm</i>	<b>President’s Dinner Dance</b> <i>(Black tie optional)</i> Mediterranean Ballroom

## TUESDAY, NOVEMBER 11

<i>7:00am – 8:00am</i>	<b>Continental Breakfast for Physicians and Spouses</b> Mediterranean Foyer
<i>7:00am – 12noon</i>	<b>WSA Registration Open</b> Mediterranean Foyer
<i>8:00am – 12noon</i>	<b>Scientific Session IV</b> Mediterranean I and II
<i>10:10am</i>	<b>Beverage Break</b> Mediterranean Foyer
<i>11:25am</i>	<b>Meeting Concludes</b>





# Scientific Program

# SCIENTIFIC PROGRAM

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**SUNDAY, NOVEMBER 9, 2014**

*7:30am – 12Noon*

**FIRST SCIENTIFIC SESSION – Moderator:** Steven C. Stain

## **Quick Shots:**

### **Thermal Ablation Of Single Foci Of Hepatic Pancreatic Adenocarcinoma Metastases To The Liver Is Of Dubious Health Care Value**

W Scott Helton, Flavio Rocha, Adnan Alseidi, Thomas Biehl, Mehran Footohi, Bert Crane, Ellen Hauptman  
*Virginia Mason Medical Center*

### **Endovascular Repair Of Ruptured Aortic Aneurysms**

Shruthi Thiagarajasubramanian, Timothy Liao, Ashraf Mansour  
*Michigan State University College*

### **Correlation Between Twitter Metrics And Impact Factor Of Surgical Journals**

Anees Chagpar  
*Yale University*

### **Safety and Efficacy of PerOral Endoscopic Myotomy after Prior Interventions for Achalasia**

Yalini Vigneswaran, Matthew Gitelis, Joann Carbray, Michael Ujiki  
*NorthShore University HealthSystem*

## **1. Cost Effectiveness of a Fast Track Protocol for Urgent Cholecystectomies and Appendectomies**

Karina Katchko, Colleen M. Trevino, Amy Verhaalen, Marie Bruce, Travis P. Webb  
*Medical College of Wisconsin*

**Invited Discussant:** Richard C. Frazee, Temple, Texas

## **2. Small Bowel Obstruction Is a Surgical Disease: Patients with Adhesive Small Bowel Obstruction Requiring Operation Have More Cost-Effective Care When Admitted to a Surgical Service**

Phillip A. Bilderback, Danielle La Selva, Ryan K Smith, Dan Satchell, W. Scott Helton  
*Virginia Mason Medical Center*

**Invited Discussant:** Robert V. Rege, Dallas, Texas

# SCIENTIFIC PROGRAM CONTINUED

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## **3. Abdominal Injuries in the “Found Down”: Is Imaging Justified?**

Ara Ko, Galinos Barmparas, Andrea Zaw, Debora Lee, Nicole Fierro, Tri Tran,  
Daniel Margulies, Eric J. Ley  
*Cedars Sinai Medical Center*

**Invited Discussant: Peter Rhee, Tucson, Arizona**

## **4. The Protective Effect Of Remote Ischemic Conditioning In A Septic Mice Model**

Mazhar Khalil, Bellal Joseph, Irada Ibrahim-zada, Ammar Hashmi,  
Narong Kulvatunyou, Andrew Tang, Terence O’keeffe, Lynn Griesse,  
Donald J. Green, Randall S. Friese, Peter Rhee  
*The University of Arizona*

**Invited Discussant: Ashwani Rajput, Albuquerque, New Mexico**

## **INTRODUCTION OF NEW MEMBERS**

## **PRESENTATION OF “J. BRADLEY AUST AWARD” FOR BEST PAPER BY A NEW MEMBER**

## **RECIPIENT OF “J. BRADLEY AUST AWARD” 2013 – James W. Jakub, MD**

*10:00am – 10:15am*      **Beverage Break**

*10:15am – 12noon*      **Scientific Session I *continued* – Moderator: Alden Harken**

## **5. Long-term Survival with Long-Acting Somatostatin Analogues Plus Aggressive Cytoablative Surgery in Patients with Metastatic Neuroendocrine Carcinoma**

Gary B. Deutsch, Manabu Fujita, Ji Hey Lee, Myung Sim-Shin, Anton Bilchik  
*John Wayne Cancer Institute*

**Invited Discussant: David M. Nagorney, Rochester, Minnesota**

## **6. Definition of Readmission in 3041 Patients Undergoing Hepatectomy**

Kristoffer W. Brudvik, Yoshihiro Mise, Claudius Conrad, Giuseppe Zimmiti,  
Thomas A. Aloia, Jean-Nicolas Vauthey  
*The University of Texas MD Anderson Cancer Center*

**Invited Discussant: W. Scott Helton, Seattle, Washington**

# SCIENTIFIC PROGRAM CONTINUED

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## **7. Does Positron Emission Tomography Have Clinical Utility In The Management Of Patients With Intraductal Papillary Mucinous Neoplasm?**

Alexandra M Roch, Morgan R Barron, Richard Barnes, Mark Tann, Oscar W Cummings, Kumar Sandreswaran, Kathryn N Hannaford, John M DeWitt, Mohammad A Al-Haddad, Eugene P Ceppa, Michael G House, Nicholas J Zyromski, Attila Nakeeb, C Max Schmidt

*Indiana University School of Medicine*

**Invited Discussant: John C. Mansour, Dallas, Texas**

*11:15am – 12:15pm*

**Introduction of President – Alden Harken**

**Presidential Address**

***“Contributions of Public Hospitals to American Surgery”***

**Steven C. Stain**

*12:15pm – 5:00pm*

**Open**

## **MONDAY, NOVEMBER 10**

*7:00am – 8:00am*

**Continental Breakfast for Physicians**

*7:00am – 5:00pm*

**WSA Registration Open**

*7:30am – 1:30pm*

**Exhibits Open**

*7:30am – 10:00am*

**SCIENTIFIC SESSION II – Moderator: Steven C. Stain**

## **8. Donor Age-Based Analysis of Liver Transplant(OLT) Outcomes: Short and Long-Term Results are Similar Regardless of Donor Age**

William C Chapman, Neeta Vachharajani, Jason R Wellen, Ying Lin, Surendra Shenoy, Jeffery A Lowell, M B Majella Doyle

*Washington University*

**Invited Discussant: Patrick G. Dean, Rochester, Minnesota**

## **9. Is There an Objective and Fair Method to Assess General Surgery Resident Performance? Yes!**

Jad Abdelsattar, Phillip Rowse, Raaj Ruparel, Yazan AlJamal, David Farley

*Mayo Clinic-Rochester*

**Invited Discussant: Paul Nelson, Indianapolis, Indiana**

# SCIENTIFIC PROGRAM CONTINUED

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**10. Impact of the ACSOGO Z0011 Randomized Trial on the Number of Axillary Nodes Removed for Early Stage Breast Cancer**

Katharine Yao\*, Erik Liederbach, Chi Wang, Catherine Pesce, David J Winchester  
*NorthShore University HealthSystem*

**Invited Discussant: Nora Hansen, Chicago, Illinois**

**11. Does CT Chest Provide Clinically Meaningful Information in Patients with Suspected Rib Fractures?**

Brandon C. Chapman, Feven Tesfalidet, Kristofer Schramm, Robert T. Stovall,  
Gregory J. Jurkovich, Fredric M. Pieracci  
*University of Colorado Denver*

**Invited Discussant: John M. Santaniello, Hines, Illinois**

**12. A Multi-Institution Prospective Observational Study of Small Bowel Obstruction: Clinical and Computerized Tomography Predictors of Which Patients May Require Early Surgery**

Narong Kulvatunyou, Viraj Pandit, Sadoun Moutam, Kenji Inaba, Konstantinos Chouliaras, Marc A. DeMoya, Naraghi Leily, Bobby T. Kalb, Hina Tiwari, Sindhu Kumar, Bellal Joseph, Donald J Green, Lynn Gries, Terence O’Keeffe, Andrew L Tang, Peter Rhee  
*University of Arizona*

**Invited Discussant: David R. Farley, Rochester, Minnesota**

**13. Predictors of Survival in Patients with Resectable Gastric Cancer Treated with Neoadjuvant Chemoradiation Therapy and Gastrectomy**

Brian Badgwell\*, Mariela Blum, Jeannelyn Estrella, Yi-Ju Chiang, Prajnan Das, Paul Mansfield, Keith Fournier, Jaffer Ajani  
*The University of Texas MD Anderson Cancer Center*

**Invited Discussant: Mark Talamonti, Evanston, Illinois**

**14. A Change in MELD Score is Associated with Improved Mortality in Trauma Patients with Chronic Liver Disease**

Allan Peetz, Reza Askari, Marc De Moya, Tracey G. Simon, Fiona K. Gibbons, Ali Salim, Kenneth B. Christopher  
*Brigham and Woman’s Hospital*

**Invited Discussant: Daniel Margulies, Los Angeles, California**

8:00am – 10:00am

**Spouse/Guest Hospitality and Breakfast**

10:00am – 10:15am

**Beverage Break**

# SCIENTIFIC PROGRAM CONTINUED

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10:15am - 12:00noon      **Scientific Session II *continued* – Moderator:** Kenneth Sirinek

**15. Outcomes of Thoracic Endovascular Aortic Repair and Subclavian Revascularization Techniques**

Kimberly Zamor.; Mark Eskandari; Heron Rodriguez; Mark Morasch; Andrew W. Hoel  
*Northwestern University*

**Invited Discussant:** William Fry, Columbia, South Carolina

**16. Comparative Evaluation of Extended Hospital Length of Stay After Bariatric Surgery** ■

John Morton\*, Ulysses S. Rosas, Trit Garg, Homero Rivas  
*Stanford*

**Invited Discussant:** Jonathan Myers, Chicago, Illinois

**17. Composite Measurement of Outcomes in Laparoscopic Cholecystectomy**

Donald E. Fry, Michael Pine, David Locke, Gregory Pine  
*Michael Pine and Associates*

**Invited Discussant:** Charles Scoggins, Louisville, Kentucky

**18. A Double Blinded Randomized Trial To Compare Minimally Invasive Procedures Using Patient Reported Outcomes**

Juliane Bingener, Pam Skaran, Andrea McConico, Paul Novotny, Peter Wettstein, Jeff Sloan  
*Mayo Clinic - Rochester*

**Invited Discussant:** Carlos V.R. Brown, Austin, Texas

**19. Laparoscopic Linx Procedure vs Laparoscopic Nissen Fundoplication: A matched-pair Analysis of 100 Patients**

Jessica L. Reynolds, Joerg Zehetner, Phil Wu, Peter Crookes, Nikolai Bildzukewicz, Namir Katkhouda, Kulmeet Sandhu, John C Lipham  
*University of Southern California Keck Medical Center*

**Invited Discussant:** Michael Ujiki, Evanston, Illinois



# SCIENTIFIC PROGRAM CONTINUED

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12noon – 1:30pm

## NEW POSTER SESSION

*Please join us for a new featured poster session. A best poster award will be given at the conclusion of the meeting.*

### **Poster 1. Same Day Discharge After Appendectomy for Acute, Non-Perforated Appendicitis**

Armen Aboulian, Vikram Attaluri, Letitia Bridges, Dean T. Nora, Thomas F. Wood, Tracy Heisler, Steven Weinstein, Justin S. Kang, Nora Rosario, Steven R. Crain  
*Kaiser Permanente Medical Center*

### **Poster 2. Acid Suppressive Therapy and C. Difficile Infection: Beyond Gastric Ph Effects?**

Lawrence N. Diebel, David M. Liberati  
*Wayne State University*

### **Poster 3. The Protective Effect of Estrogen in an In Vitro Model of Necrotizing Enterocolitis**

Alexander P. Stoffan, David M. Liberati, Lawrence N. Diebel  
*Wayne State University*

### **Poster 4. Melatonin Attenuates Lipopolysaccharide-Induced Microvascular Endothelial Derangements**

Wiggins-Dohlvik K, Stagg HW, Han MS, Alluri H, Anasooya Shaji C, Smith RW, Davis ML, Tharakan B  
*Baylor Scott and White Health*

### **Poster 5. Predictors of Hospital Readmission Following Bariatric Surgery**

Christopher Werter, Christa R. Abraham, Yusef M. Hazimeh, Ashar Ata, Ujas S. Shah, Avinash Bhakta, Marcel Tafen, Paul T. Singh, Todd D. Beyer, Steven C. Stain  
*Albany Medical College*

### **Poster 6. Surgical Site Infection Impact of Hyperthermic Intraperitoneal Chemotherapy after Colorectal Resections**

Zhobin Moghadamyeghaneh, Joseph C. Carmichael, Steven D. Mills, Alessio Pigazzi, Michael J. Stamos  
*University of California, Irvine*

### **Poster 7. Pain After Tep-Ihr: Is it Caused by Surgical Factors?**

Keith H. Paley, Daniel S. Paley  
*Mayo Clinic Health System in Owatonna*

# SCIENTIFIC PROGRAM CONTINUED

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## **Poster 8. Preoperative Leukocytosis in Colorectal Cancer Patients**

Zhobin Moghadamyeghaneh, Joseph C. Carmichael, Steven D. Mills,  
Alessio Pigazzi, Michael J. Stamos  
*University of California, Irvine*

## **Poster 9. American College of Surgeons Risk Calculator Overestimates the Risk of Complications for Cancer Patients Undergoing Palliative Procedures**

Rodrigo Rodriguez, Molly McClain, Bridget N. Fahy, Katherine T. Morris  
*University of New Mexico*

*1:30pm*

**Exhibit Teardown**

*1:30pm – 4:00pm*

**SCIENTIFIC SESSION III – Moderator:** Kenneth Sirinek

*1:30pm - 3:30pm*

**Special Discussion – Moderator:** Clive Grant

## **Surgery 2025: Who Will I Work For, What Will Surgical Practice Be, How Will We Train?**

Myself - Tyler Hughes  
A Large Practice – Richard Thirlby  
An Academic Institution – Jonathan R. Hiatt

## **Panel Discussion**

## **Debate: General Surgery Residency Training Should Be Contracted To A Period Of Basic Training Followed By Subspecialty Training For All Residents.**

Pro – David Mahvi  
Con – David Farley

*3:30pm – 3:45pm*

**Beverage Break**

*3:45pm*

**Moderator:** Kenneth Sirinek

## **Quick Shots:**

## **Ejection from a Motor Vehicle: A Good Reason for Trauma Team Activation**

Nicholas Manguso, Galinos Barmparas, Heidi Hotz, Nicolas Melo, Rex Chung,  
Matthew Bloom, Eric J. Ley, Daniel Margulies  
*Cedars-Sinai Medical Center*

# SCIENTIFIC PROGRAM CONTINUED

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## **Critical Assessment of Surgical Palliation in Unresectable Pancreas Cancer**

Eileen Bock O'Halloran, William Gange, Elizabeth Berger, Gerard Abood,  
Sam G Pappas, MD, Gerard Aranha  
*Loyola University Medical Center*

## **The Utility of MRCP in Clinical Practice: A Waste of Time and Money**

Jayson D. Aydelotte, Phuong Huynh, Ben Coopwood, John Uecker, Carlos Brown  
*University Medical Center Brackenridge*

4:15pm – 5:15pm      **Annual Business Meeting** (members only)

7:00pm – 8:00pm      **President's Reception**

8:00pm – 11:00pm      **President's Dinner Dance**

## **TUESDAY, NOVEMBER 5**

7:00am – 8:00am      **Continental Breakfast for Physicians and Spouses**

7:00am – 12noon      **WSA Registration Open**

8:00am – 12:00noon      **SCIENTIFIC SESSION IV – Moderator:** (President Elect)

### **20. Should Liver Transplantation Be Used for Patients with Resectable de novo Hilar Cholangiocarcinoma?**

Kristopher P. Croome, Charles Rosen, Julie Heimbach, David M. Nagorney  
*Mayo Clinic-Rochester*

**Invited Discussant: Robert C.G. Martin, Louisville, Kentucky**

### **21. Liver Transplant Outcomes Using Grafts From Donation After Cardiac Death (DCD) Donors**

Maria B Majella Doyle, Neeta Vachharajani, Jason Wellen, Surendra Shenoy,  
Jeff A Lowell, William C. Chapman  
*Washington University*

**Invited Discussant: Richard R. Lopez, Jr., Torrance, California**

# SCIENTIFIC PROGRAM CONTINUED

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## **22. Traumatic Cardiopulmonary Arrest and Resuscitation in Blunt Trauma:**

### **Impacts on Organ Donation**

Rebecca Striker, Rachel Titus, Alistair J. Chapman, Alan Davis, Carlos Rodriguez, Gaby Iskander

*Spectrum Health, Grand Rapids Medical Education Partners, Michigan State University*

**Invited Discussant: Ali Salim, Boston, Massachusetts**

## **23. A Low Cost, Low Tech Solution to Operating Room Efficiency**

Charles W. Kimbrough, Jeff Canary, Lisa Jackson, Ian Farrah, Mark V. Boswell, Kelly M. McMasters, Charles Scoggins

*University of Louisville*

**Invited Discussant: Rifat Latifi, Tucson, Arizona**

## **24. Gastric-Esophageal Stenting for Malignant Dysphagia: Results of Prospective Clinical Trial Evaluation of Gastro-Esophageal Reflux and Quality of Life Related Symptoms**

Prejesh Philips, Charles Scoggins, D Alan North, Melissa Schlegel, Robert CG Martin

*University of Louisville*

**Invited Discussant: Gary L. Timmerman, Sioux Falls, South Dakota**

## **25. Early National Experience with Laparoscopic Pancreaticoduodenectomy (LPD) For Ductal Adenocarcinoma (PDCA): A Comparison of LPD and Open Pancreaticoduodenectomy (OPD) from the National Cancer Data Base**

Susan M. Sharpe, Mark S. Talamonti, Chihsung Wang, Richard A. Prinz, Kevin K. Roggin, David J. Bentrem, David J. Winchester, Robert D.W. Marsh,

Susan J. Stocker, Marshall S. Baker

*NorthShore University HealthSystems*

**Invited Discussant: Michael Farnell, Rochester, Minnesota**

*10:10am*      **Beverage Break**

## **26. Role of Estrogen Therapy in ER Positive Colon Cancer: Study in an Orthotopic Murine Model**

Tafadzwa P. Makarawo, Jasneet Singh Bhullar, Milessa Decker, Jacqueline Tilak, Barry Herschman, Deepa Taggarshe, Vijay K. Mittal

*Providence Hospital and Medical Center*

**Invited Discussant: William Cirocco, Columbus, Ohio**

# SCIENTIFIC PROGRAM CONTINUED

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**27. Variation In Bilateral Mastectomy Rates According To Racial Groups In Young Women: A Report From The National Cancer Data Base, 1998-2011.**

Laura Grimmer, Erik Liederbach, Chi Wang, Jose Velasco, Katharine Yao  
*NorthShore University HealthSystem*

**Invited Discussant: Anees B. Chagpar, New Haven, Connecticut**

**28. Surgical Energy-Based Device Injuries and Fatalities Reported to the Food and Drug Administration (FDA)**

Douglas Overbey, Nicole Townsend, Brandon Chapman, Daine Bennett,  
Lisa Foley, Aline Rau, Jeniann Yi, Thomas Robinson  
*University of Colorado*

**Invited Discussant: John Garry, Fresno, California**

*11:25am*      **Meeting Concludes**

*Italics indicates a member of the Western Surgical Association*

\*Indicates a new member ■ Indicates Aust Award Candidate

# PAST RECIPIENTS OF THE "J. BRADLEY AUST AWARD"

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## FOR BEST PAPER BY A NEW MEMBER

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### 2011

M.B. Majella Doyle  
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Aurora, Colorado

### 2009

Karen Borman  
Abington, Pennsylvania

### 2008

Mark B. Faries  
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### 2001

Kelly M. McMasters  
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### 2000

M. Ashraf Mansour  
Maywood, Illinois

### 1999

William C. Chapman  
Nashville, Tennessee

### 1998

R. Stephen Smith  
Ranoke, Virginia

*Presenting author must be a new WSA member within the past 2 years in order to qualify for the J. Bradley Aust Award.*

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# Abstracts

Individual abstracts of the papers to be presented at this year's annual meeting appear on the following pages:

# ABSTRACTS

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FIRST SCIENTIFIC SESSION | Sunday, November 9, 2014 | 7:30am – 12Noon

**Moderator:** Steven C. Stain

## **Quick Shots:**

### **Thermal Ablation Of Single Foci Of Hepatic Pancreatic Adenocarcinoma Metastases To The Liver Is Of Dubious Health Care Value**

W Scott Helton, Flavio Rocha, Adnan Alseidi, Thomas Biehl, Mehran Footohi, Bert Crane, Ellen Hauptman  
*Virginia Mason Medical Center*

### **Endovascular Repair Of Ruptured Aortic Aneurysms**

Shruthi Thiagarajasubramanian, Timothy Liao, Ashraf Mansour  
*Michigan State University College*

### **Correlation Between Twitter Metrics And Impact Factor Of Surgical Journals**

Anees B. Chagpar  
*Yale University*

### **Safety and Efficacy of PerOral Endoscopic Myotomy after Prior Interventions for Achalasia**

Yalini Vigneswaran, Matthew Gitelis, Joann Carbray, Michael Ujiki\*  
*NorthShore University HealthSystem*

FIRST SCIENTIFIC SESSION | Sunday, November 9, 2014 | 7:30am – 12Noon

## COST EFFECTIVENESS OF A FAST TRACK PROTOCOL FOR URGENT CHOLECYSTECTOMIES AND APPENDECTOMIES

Karina Katchko, Colleen M. Trevino, Amy Verhaalen, Marie Bruce, Travis P. Webb  
*Medical College of Wisconsin*

**Background:** Fast track protocols (FTP) have been used to decrease length of stay (LOS) and hospital costs for elective outpatient procedures. However, few institutions have implemented FTP for urgent procedures such as laparoscopic cholecystectomy (LC) and laparoscopic and open appendectomy (LA).

**Hypothesis:** LOS and costs will decrease while outcomes will be unaltered after instituting a FTP for LC and LA.

**Design:** Retrospective single institution cohort

**Setting:** Tertiary academic center; Acute Care Surgery Service (ACS)

**Patients and Methods:** All patients undergoing urgent LC or LA between July 1, 2010-May 1, 2013 were included. Exclusion criteria included elective procedures, laparoscopic converted to open cholecystectomy, perforated appendicitis, or procedure related intra-abdominal injury. The historical control (PRE-TX, n=256) prior to July 1, 2011 was compared to those after July 1, 2011 (POST-TX, n=474). Also, those who completed the FTP (n=86) and those who failed to complete the FTP (n=48) were compared. T-tests and chi square were used.

**Results:** A significant reduction in mean LOS was noted when comparing the PRE-TX and POST-TX (2.0 vs 1.48 days,  $t(727)=2.6$ ,  $p<0.01$ ) and readmission rates were comparable (2.1% vs 6.6%,  $X^2=0.34$ ,  $p=0.07$ ). There was a significant reduction in LOS comparing those completing the FTP and those failing to complete the FTP (0.68 days vs 1.82 days,  $t(387)=6.8$ ,  $p<0.01$ ) and readmission rates were similar (2.6% vs 7.7%,  $X^2=0.32$ ,  $p=0.57$ ). Total hospital charges for PRE-TX were reduced by over \$3000 as compared to POST-TX (\$30200 vs \$26,787,  $t(728)=-3.0$ ,  $p<0.01$ ). Patients completing the FTP realized a \$1,000 hospital charge savings compared to those failing to complete the FTP (\$23,898 vs \$24,915,  $t(74)=1.12$ ,  $p=0.27$ ).

**Conclusion:** Fast track protocols for urgent appendectomies and cholecystectomies can significantly reduce hospital costs by reducing length of stay while outcomes remain similar.

# ABSTRACTS CONTINUED

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FIRST SCIENTIFIC SESSION | Sunday, November 9, 2014 | 7:30am – 12Noon

SMALL BOWEL OBSTRUCTION IS A SURGICAL DISEASE: PATIENTS WITH ADHESIVE SMALL BOWEL OBSTRUCTION REQUIRING OPERATION HAVE MORE EFFICIENT CARE WHEN ADMITTED TO A SURGICAL SERVICE

Phillip A. Bilderback, Danielle La Selva, Ryan Smith, Dan Satchell, W. Scott Helton.  
*Virginia Mason Medical Center*

**Background:** Adhesive small bowel obstruction (ASBO), while a potential surgical emergency, is increasingly being cared for by medical hospitalists due to the high likelihood that patients will not require operation. However, failure to make a timely decision to operate when necessary can lead to prolonged hospital stay (LOS) and increased cost.

**Hypothesis:** Patients admitted to the medical service for presumed ASBO have increased LOS and charges compared to patients admitted to the surgical service.

**Design:** Retrospective, single-institution series.

**Setting:** Stand-alone urban teaching hospital.

**Patients and Methods:** 601 consecutive patients admitted with presumed ASBO from 2009 to 2013 were retrospectively reviewed and grouped according to the admitting service and whether they had an operation during their stay. Differences between group means were made with unpaired T-tests.

**Results:** 76% of patients were admitted to medicine. 29% of all patients had an operation; 17% of those admitted to medicine and 69% admitted to surgery. LOS among patients who resolved their ASBO non operatively was similar for those on the surgical and medical services (4.1 days vs. 4.2 days,  $p=0.49$ ). However, in patients who did not resolve their ASBO non-operatively, those admitted to medicine had significantly longer LOS when compared to those admitted to the surgical service (11.3 days vs. 7.3 days,  $p<0.0001$ ) and higher charges (\$47,560 vs. \$33,400). Patients admitted to medicine that had surgery, waited longer for their operations compared to patients admitted to surgery (71.4 hours vs. 21.26 hours,  $p<0.0001$ ). Medicine services utilized abdominal imaging more frequently than surgical services (median number of images 3 vs. 1,  $p<0.0001$ ). There were 5 deaths (0.8% mortality) but none were due to delays in care.

**Conclusion:** Patients with ASBO are treated in a heterogeneous fashion in our hospital resulting in disparate outcomes depending upon the initial admitting service. Admitting all patients suspected of having ASBO to the surgical service has the potential to dramatically reduce LOS and reduce waste in those requiring operation, thereby reducing health care expenditures.

# ABSTRACTS CONTINUED

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FIRST SCIENTIFIC SESSION | Sunday, November 9, 2014 | 7:30am – 12Noon

## ABDOMINAL INJURIES IN THE “FOUND DOWN”: IS IMAGING JUSTIFIED?

Ara Ko, Galinos Barmparas, Nathan McNeil, Andrea Zaw, Debora Lee, Nicole Fierro,  
Daniel Margulies, Eric J. Ley  
*Cedars-Sinai Medical Center*

**Background:** We sought to investigate the incidence of abdominal injuries in “found down” trauma patients to better understand the value of emergency department imaging studies.

**Hypothesis:** “Found down” patients are at a low risk for abdominal injuries.

**Design:** A retrospective, single institution study.

**Setting:** Urban, level I trauma center.

**Patients and Methods:** The trauma registry was queried over a 10-year period ending 12/2013 for “found down” patients admitted after an unknown traumatic mechanism with altered mental status. Demographics, CT of the abdomen/pelvis (A/P), FAST scans and injuries were abstracted. The primary outcome was significant abdominal injury, defined as AIS A/P  $\geq 3$ , or injury requiring surgical intervention. Secondary outcome was mortality.

**Results:** Of 352 patients that met criteria, seven (2%) were pronounced dead in the ED. For the remainder, the mean age  $\pm$  SD was  $46.4 \pm 19$  years and 82% were male. A total of 123 (36%) patients received abdominal imaging: 11 (3%) FAST, 101 (29 %) CT A/P, and 11 (3%) both FAST and CT A/P. None of these imaging studies resulted in change in management and no patients had an abdominal injury. One patient underwent a negative exploratory laparotomy. Total mortality was 8% with the majority of these deaths (54%) attributed to serious head trauma.

**Conclusion:** Although patients found down have a high mortality, abdominal injuries are highly unlikely. Imaging of the abdomen in these patients is of limited value. Rather, efforts should focus on rapidly identifying and treating other causes of mortality.

FIRST SCIENTIFIC SESSION | Sunday, November 9, 2014 | 7:30am – 12Noon

## THE PROTECTIVE EFFECT OF REMOTE ISCHEMIC CONDITIONING IN A SEPTIC MICE MODEL

Mazhar Khalil, Bellal Joseph, Irada Ibrahim-zada, Ammar Hashmi, Narong Kulvatunyou, Andrew Tang, Terence O'keeffe, Lynn Griesse, Donald J. Green, Randall S. Friesse, Peter Rhee  
*The University of Arizona*

**Background:** Sepsis remains the leading cause of death in surgical intensive care unit. Prior studies have demonstrated a survival benefit of remote ischemic conditioning (RIC) in many diseases.

**Hypothesis:** The aim of the study was to determine the effects of RIC on survival in sepsis and study the alterations in inflammatory profiles.

**Design:** Basic science

**Setting:** Laboratory at our level 1 trauma center

**Patients and Methods:** 8-12 week C57BL/6 mice received intra-peritoneal injection of 12.5mg/kg lipopolysaccharide (LPS). Septic animals in experimental group underwent RIC at two hours after LPS. The femoral artery was dissected out surgically and six 4 minute-cycles of ischemia-reperfusion were performed. Primary outcome was survival at 5 days post-LPS injection. Secondary outcome was to assess the following serum cytokine levels using Mouse proinflammatory 7-Plex Ultra-Sensitive Kit (MSD, Gaithersburg, MD): interferon- $\gamma$  (IFN- $\gamma$ ), interleukin (IL)- 10, IL-1 $\beta$ , and tumor necrosis factor-alpha (TNF- $\alpha$ ) at the baseline before LPS injection and at 0, 2, 4 and 24 hours post RIC. Kaplan-Meier survival analysis and log-rank test were utilized. ANOVA test was used to compare cytokine measurements.

**Results:** We performed experiments on 24 mice: 14 controls and 10 RIC mice. 70% (7/10) of mice in the RIC group survived 5 days compared to only 21% (3/14) of mice in the control group. RIC group had increased survival at 5 days post-LPS ( $p=0.0453$ ) with hazard ratio of 0.296 (95% CI 0.09, 0.98). In the RIC group, serum concentration of IFN- $\gamma$ , IL-10, IL1 $\beta$ , and TNF $\alpha$  peaked at 2 hours post-RIC and then decreased significantly over 24 hours ( $p<0.0001$ ) compared to the control group. There was a 0.7, 1.9, and 0.5 fold decrease in the IL-10, IL1 $\beta$ , and TNF $\alpha$  in the RIC group at 24 hours, respectively, compared to the pre-treatment (0hr) level ( $p<0.0001$ ).

**Conclusion:** RIC improves survival in sepsis and has potential for implementation in the clinical practice. Early implementation of RIC may play an immunomodulatory role in sepsis. Further studies are necessary to refine understanding of the observed survival benefits and its implications in sepsis management.

# ABSTRACTS CONTINUED

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FIRST SCIENTIFIC SESSION | Sunday, November 9, 2014 | 7:30am – 12Noon

## LONG-TERM SURVIVAL WITH LONG-ACTING SOMATOSTATIN ANALOGUES PLUS AGGRESSIVE CYTOREDUCTIVE SURGERY IN PATIENTS WITH METASTATIC NEUROENDOCRINE CARCINOMA

Gary B. Deutsch, Manabu Fujita, Ji Hey Lee, Myung Sim-Shin, Anton Bilchik  
*John Wayne Cancer Institute*

**Background:** Long-acting somatostatin analogues (S-LAR) improve recurrence-free survival in patients with metastatic gastroenteropancreatic neuroendocrine cancer (GNC), but their impact on overall survival when combined with aggressive cytoreductive surgery is unclear. Our study, with an approximate 10-year median follow-up, is the first to evaluate the long-term benefits of combination therapy.

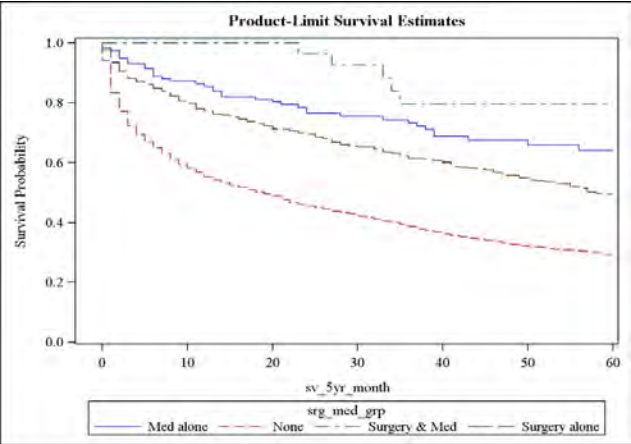
**Hypothesis:** S-LAR plus aggressive cytoreductive surgery increases the long-term survival of patients with metastatic neuroendocrine cancer.

**Design and Setting:** Review of our cancer center's database to identify patients with resected metastatic GNC between December 1997 and June 2013. Review of the SEER-Medicare database to identify all metastatic GNC cases between January 2003 and December 2010 was performed to verify and expand our results.

**Patients and Methods:** Overall survival from diagnosis was compared between 49 patients from our cancer center and 3,384 SEER-Medicare patients. Kaplan-Meier survival analysis and Cox-proportional hazards model were used to measure the impact of therapy (surgery+S-LAR, surgery alone, S-LAR alone) on survival. Patient age and sex, tumor stage and location, and procedure number/type/approach were also considered.

**Results:** Median follow-up of patients at our center was 112 months. Most of these patients had primary lesions in the small intestine (22/49 [44.9%]) or pancreas (14/49 [28.6%]); 37 patients (75.5%) had metastatic disease at presentation. Our patients underwent one (32/49 [65.3%]), two (11/49 [22.4%]), or at least three (6/49 [12.3%]) surgical procedures; 33 (67.3%) underwent resection plus ablation and 19 (38.7%) underwent major hepatectomy. Survival of the 36 patients (73.5%) who received S-LAR before (12/36 [33.3%]) or after (24/36 [66.7%]) aggressive cytoreduction was 94%, 78%, 64%, and 31% at 1, 5, 10 and 15 years, respectively. In the SEER-Medicare population, rates of 5- and 10-year overall survival were 83.3% and 63.3%, respectively, for 30 surgery+S-LAR patients, 68.4% and 62.4%, respectively, for 117 S-LAR-only patients, and 55.1% and 47.82%, respectively, for 550 surgery-only patients ( $p<0.0001$ ) (Figure).

**Conclusion:** S-LAR combined with aggressive cytoreductive surgery improves long-term survival of selected patients with metastatic GNC.





FIRST SCIENTIFIC SESSION | Sunday, November 9, 2014 | 7:30am – 12Noon

## DEFINITION OF READMISSION IN 3041 PATIENTS UNDERGOING HEPATECTOMY

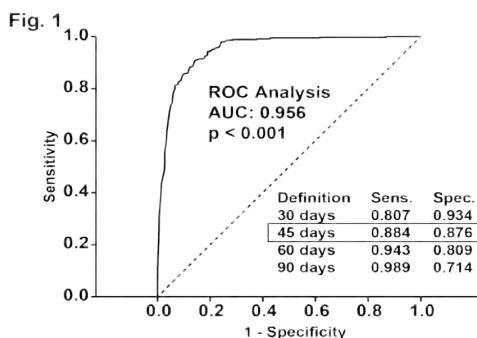
Kristoffer W. Brudvik, Yoshihiro Mise, Claudius Conrad, Giuseppe Zimmitti, Thomas A. Aloia, Jean-Nicolas Vauthey  
*The University of Texas MD Anderson Cancer Center*

**Background:** Readmission rates of 9.7%-30.0% after hepatectomy have recently been reported. However, these results are difficult to interpret as different definitions of readmission have been used. The aim of this study was to refine the definition of readmission after hepatectomy on the basis of the timing and causes.

**Patients and Methods:** A prospectively maintained database of 3041 patients undergoing hepatobiliary surgery from 1998 through 2013 was reviewed to identify patients readmitted within 1 year after discharge. Receiver operating characteristic analysis of all readmissions was used to determine the time interval best accounting for unplanned readmissions and risk factors were determined by multivariate analysis.

**Results:** The time interval that best accounted for unplanned readmissions was 45 days after discharge (area under the curve, 0.956;  $p < 0.001$ ; Figure 1), during which 389 patients (12.8%) were readmitted (unplanned:  $n = 312$  [10.3%]; planned:  $n = 77$  [2.5%]). In comparison, the 30-days-after-surgery definition used in the ACS-NSQIP database missed 65 unplanned readmissions, and the 90-days-after-discharge definition added only 12 unplanned readmissions. Multivariate analysis revealed the following risk factors for unplanned readmission within 45 days after discharge: major complication during the index stay (odds ratio [OR], 2.4;  $p < 0.001$ ), right-sided hepatectomy (OR, 2.1;  $p = 0.034$ ), bile duct resection (OR, 1.9;  $p = 0.034$ ), abdominal complication (OR, 1.8;  $p = 0.010$ ), and diabetes (OR, 1.6;  $p = 0.024$ ). Length of index stay  $>7$  days and hepatobiliary complication during the index stay were not risk factors.

**Conclusions:** To accurately assess readmission after hepatectomy, patients should be followed for 45 days after discharge regardless of length of the index stay.



FIRST SCIENTIFIC SESSION | Sunday, November 9, 2014 | 7:30am – 12Noon

## DOES POSITRON EMISSION TOMOGRAPHY HAVE CLINICAL UTILITY IN THE MANAGEMENT OF PATIENTS WITH INTRADUCTAL PAPILLARY MUCINOUS NEOPLASM?

Alexandra M Roch, Morgan R Barron, Richard Barnes, Mark Tann, Oscar W Cummings, Kumar Sandreswaran, Katheryn N Hannaford, John M DeWitt, Mohammad A Al-Haddad, Eugene P Ceppa, Michael G House, Nicholas J Zyromski, Attila Nakeeb, C Max Schmidt

*Indiana University School of Medicine*

**Background:** Intraductal Papillary Mucinous Neoplasm (IPMN) are well established pancreatic precancerous lesions. The indications for surgical resection are outlined by the 2012 updated International Consensus Guidelines (ICG). Owing to the low specificity of the ICG, many patients will undergo potentially unnecessary surgery for non-malignant IPMN. Several retrospective studies have demonstrated that Positron Emission Tomography (PET) was highly sensitive and specific in detecting malignant IPMN.

**Hypothesis:** We hypothesized that PET compliments the ICG in identification of malignant IPMN.

**Setting:** From 2009 to 2013, patients with a suspected clinical diagnosis of IPMN were prospectively enrolled in a clinical trial at a single center.

**Patients and Methods:** Results of the preoperative PET on determination of IPMN malignancy (high-grade dysplastic and invasive IPMN) were compared to surgical pathology. PET uptake was considered increased if Standardized Uptake Value was  $\geq 3$ .

**Results:** Of the 67 patients enrolled, 50 patients met all inclusion criteria. Increased PET uptake was associated with significantly more malignant and invasive IPMN (80% vs. 13%,  $p < 0.0001$  and 40% vs. 3%,  $p = 0.004$ ). When patients were divided into Branch-Duct (BD) and Main-Duct (MD)-IPMN, an increased PET uptake was also associated with more malignancy (60% vs. 0%,  $p = 0.006$  for BD-IPMN and 100% vs. 23%,  $p = 0.003$  for MD-IPMN). Patients with ICG criteria (worrisome features and high-risk stigmata) *and* increased PET uptake had more malignant and invasive IPMN than patients with ICG criteria *but no* increased uptake (78% vs. 17%,  $p = 0.001$  and 33% vs. 3%,  $p = 0.03$ ). The sensitivity and specificity of the ICG criteria for detecting malignancy were 92% and 27%, whereas PET was less sensitive (62%) but more specific (95%). When ICG criteria and PET were combined, the association resulted in 78% sensitivity and 100% specificity.

**Conclusion:** The addition of PET to the preoperative work-up improves the performance of the 2012 ICG for predicting malignant risk in patients with IPMN.

# ABSTRACTS CONTINUED

SECOND SCIENTIFIC SESSION | Monday, November 10, 2014 | 7:30am – 12Noon

## DONOR AGE-BASED ANALYSIS OF LIVER TRANSPLANT (OLT) OUTCOMES: SHORT AND LONG-TERM RESULTS ARE SIMILAR REGARDLESS OF DONOR AGE.

William C Chapman, Neeta Vachharajani, Jason R Wellen, Ying Lin, Surendra Shenoy, Jeffery A Lowell, M B Majella Doyle  
*Washington University*

**Background:** The shortage of donor organs has led to increasing use of extended criteria donors, including older donors. Concern exists however that older donor livers will not provide equivalent short and long term results as younger donor livers.

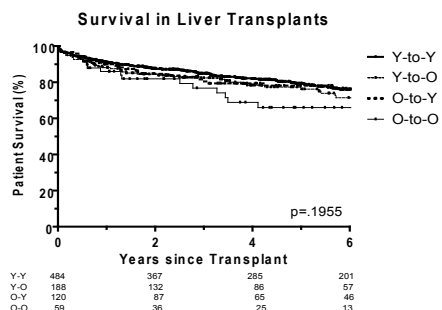
**Hypothesis:** Donor age does not affect OLT outcomes

**Design:** Retrospective analysis of 1036 adult transplants from a prospectively maintained database for adult OLT performed between 1/1/2000 and 12/31/2013.

**Patients and Methods:** 9 living-donor OLT, 44 DCD, 43 multi-organ transplants, 75 re-transplants, 8 missing data cases were excluded. Of 857 studied, distribution was as follows: Young (<60) donor grafts to young (<60) recipients (N=489, 240 HCV) (Y to Y); Young (<60) donor grafts to older (>60) recipients (N=188, 55 HCV) (Y to O), Older (>60) donor grafts to young (<60) recipients (N=120, 63 HCV) (O to Y), Older (>60) donor grafts to older (>60) recipients (N=60, 16 HCV) (O to O).

**Results:** Race and gender distribution was comparable between groups and so also were cold and warm ischemia times. Patient and graft survival rates were similar in 4 groups. ICU stay (P=.101), hospital stay (P=.132), re-admission rates at 30-days (P=.581) and 90-days(.479), rates of rejection (P=.077), bile leak (p=.166), and *de Novo* dialysis need (P=.192) were also comparable. HAT rate was higher in O-to-Y group (5%, P=.038). HCV recurrence was significantly lower in the O to O group (43.8% P=.03). Deaths due to renal and/or hepatic failure, cardiac and/or respiratory failure, sepsis, and malignancies were comparable. 31 young recipients (<60) received grafts from donors aged ≥70. Their survival and other complication rates were comparable to Y to Y group.

**Conclusion:** Excellent long term outcomes are seen in liver transplant patients receiving grafts from older donors regardless of recipient age and age matching between donors and recipients.



SECOND SCIENTIFIC SESSION | Monday, November 10, 2014 | 7:30am – 12Noon

## IS THERE AN OBJECTIVE AND FAIR METHOD TO ASSESS GENERAL SURGERY RESIDENT PERFORMANCE? *YES!*

Jad Abdelsattar, Phillip Rowse, Raaj Ruparel, Yazan AlJamal, David Farley  
*Mayo Clinic-Rochester*

**Background:** Faculty evaluations and ABSITE scores often tell little about true resident performance. We sought a tool to better identify stellar trainees versus those in need of remediation prior to advancing to the next PGY level. We developed five, inexpensive, 15 minute, simulation stations for objective assessment (“X-Games”) to differentiate surgical skills, judgment, and knowledge among General Surgery (GS) trainees.

**Hypothesis:** Performance in X-Games will prove more useful in identifying areas of strengths or weakness among GS residents than biased faculty evaluations, ABSITE scores, or Operative Case Logs.

**Design:** A comparative study of “X-Games” performance scores with resident ABSITE results, faculty evaluations, and operative experience.

**Setting:** Academic general surgery residency training program.

**Methods:** PGY 2-5 GS residents (n=35) tested in a semiannual “X-Games” assessment using multiple simulation stations: laparoscopic skills, bowel anastomosis, CT/CXR analysis, chest tube placement, etc. over the 2013-14 academic year. Resident scores were compared to their ABSITE, faculty evaluation, and OR case #s.

**Results:** Results varied greatly (range) except for staff evaluations:

	<u>PG-2</u>	<u>PG-3</u>	<u>PG-4</u>	<u>PG-5</u>
X-Games (%)	45-70	37-65	56-83	6-38
ABSITE (%tile)	29-84	39-97	23-99	13-84
OR cases (#s)	35-215	95-500	207-682	666-905
Staff eval (1-7)	4.95-5.95	5.47-6.25	4.99-6.04	5.59-6.93

Higher overall scores on the X-Games assessment correlated positively with increased operative experience (p<0.05) and was *inversely* related to faculty rotation evaluation (p<0.05).

**Conclusion:** “X-Games” assessment generated wide differentiation of resident performance quickly, inexpensively, and objectively. While “Minnesota-nice” surgical staff may feel all GS trainees are ‘above average’, objective assessment tells us otherwise.

# ABSTRACTS CONTINUED

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SECOND SCIENTIFIC SESSION | Monday, November 10, 2014 | 7:30am – 12Noon

## IMPACT OF ACOSOG Z0011 ON THE NUMBER OF AXILLARY NODES REMOVED FOR PATIENTS WITH EARLY STAGE BREAST CANCER

Katharine Yao\*, Erik Liederbach, Chi Wang, Catherine Pesce, David J Winchester.  
*NorthShore University HealthSystem*

**Background:** The ACOSOG Z0011 randomized trial showed that breast cancer survival and recurrence for sentinel node (SN) biopsy was not inferior to axillary node dissection for a tumor positive SN in patients undergoing lumpectomy (LP) and whole breast radiation.

**Hypothesis:** The number of nodes removed for patients with a tumor positive SN has decreased since publication of the trial for both LP and mastectomy (MA) patients.

**Design:** Retrospective review of an observational oncology dataset

**Setting:** National Cancer Data Base.

**Methods:** We selected 19,220 (39%) LP patients with cancers that fulfilled Z011 eligibility criteria: size  $\leq 5$ cm, clinically node negative, 1-2 positive nodes. We also examined 28,918 (61%) MA patients with the same tumor features. Chi-square tests and logistic regression models were used to examine trends and correlates for the median number of nodes removed from 2009-2011.

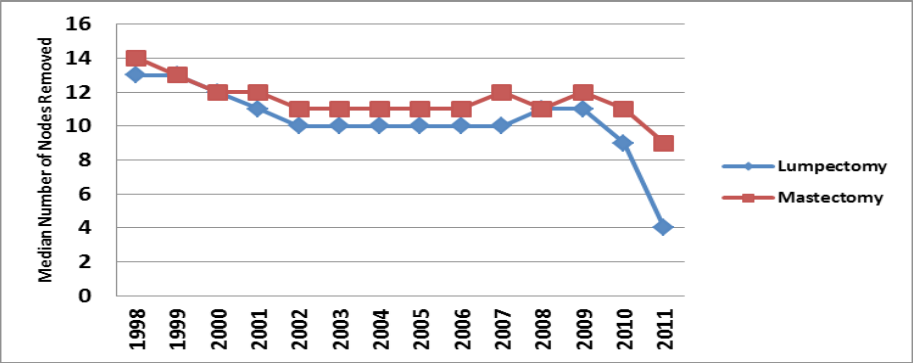
**Results:** The median number of nodes removed for LP and MA patients significantly decreased from 2010 to 2011 (Figure 1). 34.8% of LP patients had  $\leq 3$  nodes examined in 2010 compared to 64.1% in 2011 ( $p < 0.001$ ) and 20.4% of MA patients had  $\leq 3$  nodes examined in 2010 compared to 31.1% in 2011 ( $p < 0.001$ ). For patients  $\leq 45$  years old who underwent a LP, 26.5% had  $\leq 3$  nodes examined in 2010 compared to 58.4% in 2011; for triple negative patients the corresponding numbers were 26% and 50%; for HER2neu positive patients 28.3% compared to 59%; for patients with one tumor positive node 41.3% compared to 70.5%; and for patients with two tumor positive SNs 12.6% compared to 39%. Independent factors associated with having more than 10 nodes removed for LP patients fitting within Z0011 criteria were facilities in the East North Central region (WI, MI, IL, IN, OH), community facilities, patients  $< 50$  years old, tumors  $> 2$ cm, two positive nodes compared to one node, triple negative tumors, and Her2neu positive tumors. Independent factors associated with having  $\leq 3$  nodes removed for MA patients with the same Z0011 criteria were facilities in the New England region,  $> 70$  years old, white race, one positive node vs. two positive nodes, tumor  $< 2$ cm, and lobular carcinomas.

**Conclusion:** The Z0011 trial has significantly decreased the number of nodes removed

# ABSTRACTS CONTINUED

for early stage breast cancer for both LP and MA patients. It has resulted in a change in clinical practice that will have a positive impact on patients for years to come.

Figure 1. Median number of axillary nodes removed for pT1-2, clinically node negative breast cancer patients with 1-2 tumor positive nodes ( $p<0.001$ ).



# ABSTRACTS CONTINUED

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SECOND SCIENTIFIC SESSION | Monday, November 10, 2014 | 7:30am – 12Noon

## DOES CT CHEST PROVIDE CLINICALLY MEANINGFUL INFORMATION IN PATIENTS WITH SUSPECTED RIB FRACTURES?

Brandon C. Chapman, Feven Tesfalidet, Kristofer Schramm, Robert T. Stovall, Gregory J. Jurkovich, Fredric M. Pieracci  
*University of Colorado Denver*

**Background:** Recent advancements in the management of severe rib fractures include paravertebral percutaneous analgesic catheters and operative rib fixation.

**Hypothesis:** We hypothesized that trauma patients with either clinical or chest x-ray (CXR) suspicion of rib fractures would benefit from routine chest CT in terms of change in management.

**Design:** Retrospective cohort study

**Setting:** Blunt trauma patients at a Level I trauma center.

**Patients and Methods:** Patients with rib fractures who had both a CXR and a CT chest were included. The CT finding of  $\geq 3$  additional fractures in patients with  $\leq 3$  rib fractures on CXR was considered clinically meaningful. We used univariate and multivariable logistic regression to identify variables associated with a change in management based on clinically meaningful rib fractures.

**Results:** There were 499 patients with rib fractures, 93 (18.6%) had CXR only, 7 (1.4%) had chest CT only, and 399 (79.9%) had both CXR and chest CT. Among these 399 patients, a total of 1,969 rib fractures were identified: 1,467 (74.5%) were missed by CXR. The median number of fractures on CXR was 0 (range 0-13) and on chest CT 4 (range 1-18). The median number of additional fractures identified by CT was 3 (range -4 – 15), and 212 (42.5%) patients had a clinically meaningful increased number of fractures identified by CT. In this subgroup, management changed based on CT findings in 92 (43.4%); specifically, 67 (31.6%) admitted to SICU, 16 (7.5%) had pain catheter placed, 23 (10.8%) had epidural placed, 27 (12.7%) had chest tube placed for pneumothorax and/or hemothorax, and 3 (1.4%) had rib plating. In the overall sample of 399 patients, chest tube was placed in 50 patients for pneumothorax and/or hemothorax and rib fixation in 10 patients for the diagnosis of flail chest on CT findings alone. By univariate analysis, mechanism of fall ( $p < 0.01$ ) and age  $> 55$  years ( $p < 0.01$ ) predicted change in management based on chest CT. By multivariable logistic regression, only age predicted change in management ( $p = 0.05$ ).

**Conclusion:** CXR missed approximately 75% of rib fractures seen on chest CT, and nearly half of these patients had a clinically significant increase in the number of rib fractures diagnosed. This discrepancy frequently changed management, particularly in elderly patients. Based on these data, we recommend CT chest for all trauma patients with either clinical or CXR suspicion of rib fractures.

SECOND SCIENTIFIC SESSION | Monday, November 10, 2014 | 7:30am – 12Noon

## A MULTI-INSTITUTION PROSPECTIVE OBSERVATIONAL STUDY OF SMALL BOWEL OBSTRUCTION: CLINICAL AND COMPUTERIZED TOMOGRAPHY PREDICTORS OF WHICH PATIENTS MAY REQUIRE EARLY SURGERY

Narong Kulvatunyou, Viraj Pandit, Sadoun Moutamn, Kenji Inaba, Konstantinos Chouliaras, Marc A. DeMoya, Naraghi Leily, Bobby T. Kalb, Hina Tiwari, Sindhu Kumar, Bellal Joseph, Donald J Green, Lynn Gries, Terence O’Keeffe, Andrew L Tang, Peter Rhee

*University of Arizona*

**Background:** In patients with small bowel obstruction (SBO), early surgical intervention after a failed trial of conservative treatment can improve outcome. However, deciding which patients require early surgery is difficult, given the lack of specific clinical or radiographic signs.

**Hypothesis:** We can identify clinical and computerized tomography (CT) predictors of which patients required early surgery.

**Design:** 2-year Prospective observational study

**Setting:** Multi-institution tertiary centers

**Patients and Methods:** We included patients who were admitted with a diagnosis of SBO. Excluded were patients with early postoperative SBO, external hernia-related SBO, or Crohn’s disease SBO. Clinical and laboratory variables were collected prospectively. CT signs (e.g., transitional point, free fluid, mesenteric edema) were interpreted by a designated radiologist (blinded to individual patients’ clinical outcomes) from each institution. To identify significant predictors which patient may require early surgery, we performed a multivariable regression analysis.

**Results:** During our 22-month study period, we enrolled 235 patients with SBO at 3 participating institutions. Patients’ mean age was  $59 \pm 18$  years; 52% were male. A total of 67 patients underwent surgery but only 60 (26%) had positive operative findings. For patients who underwent surgery, the mean duration of conservative treatment was  $2 \pm 1.5$  days. Our regression model showed that the following patients were likely to require early surgery: those who vomited (odds 3.5,  $P=0.02$ ); those who did not pass flatus (odds 3.2,  $P=0.001$ ); those with a sodium level  $< 138$  (odds 2.5,  $P=0.008$ ); and those with CT interpretation of free fluid (odds 2.6,  $P=0.01$ ), mesenteric edema (odds 2.3,  $P=0.02$ ), and a high-grade obstruction (odds 2.4,  $P=0.01$ ).

**Conclusion:** Identifying which SBO patients require early surgery can be challenging. We identified several parameters that might help clinicians decide whether and when to perform surgery and that might help improve clinical outcomes.



# ABSTRACTS CONTINUED

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SECOND SCIENTIFIC SESSION | Monday, November 10, 2014 | 7:30am – 12Noon

## PREDICTORS OF SURVIVAL IN PATIENTS WITH RESECTABLE GASTRIC CANCER TREATED WITH NEOADJUVANT CHEMORADIATION THERAPY AND GASTRECTOMY

Brian Badgwell, Mariela Blum, Jeannelyn Estrella, Yi-Ju Chiang, Prajnan Das, Paul Mansfield, Keith Fournier, Jaffer Ajani

*MD Anderson Cancer Center*

**Background:** The purpose of this study was to determine the overall survival (OS) in patients with resectable gastric cancer treated with neoadjuvant chemoradiation therapy and gastrectomy and to identify clinicopathologic variables associated with survival.

**Patients and Methods:** The medical records of patients with gastric and gastroesophageal adenocarcinoma presenting to our institution (1/1995-12/2012) were reviewed to identify patients who underwent diagnostic laparoscopy, neoadjuvant chemoradiation, and gastrectomy. Associations between various clinicopathologic factors and OS were examined with Cox proportional hazards models. Kaplan-Meier curves were created to compare OS between groups.

**Results:** Of 192 patients who met inclusion criteria, 103 (54%) required total gastrectomy and 89 (46%) subtotal gastrectomy. One hundred sixty-eight patients (88%) had a D2 lymph node dissection, 26 (14%) had resection of adjacent organs, and 178 (93%) had an R0 resection. The median follow-up time for all patients was 3.4 years and for surviving patients was 4.2 years. The median OS for all patients was 5.8 years, and 5-year OS rate was 56%. On multivariate analysis, variables associated with diminished OS included age  $\geq 65$  (hazard ratio [HR] = 1.8; 95% CI, 1.2-2.7), male gender (HR = 1.8; 95% CI, 1.2-2.8), and pathologic N1 stage (HR = 2; 95% CI, 1.3-3) or N3 stage (HR = 8.6; 95% CI, 3.7-20.1). Five-year OS rates for patients with pathologic N0, N1, N2, and N3 disease were 67%, 42%, 43%, and 0%, respectively.

**Conclusion:** Patients with gastric cancer who undergo diagnostic laparoscopy, neoadjuvant chemoradiation, and gastrectomy have a high frequency of obtaining an R0 resection and have excellent OS rates. Nodal status after surgery remains an important determinant of OS.

SECOND SCIENTIFIC SESSION | Monday, November 10, 2014 | 7:30am – 12Noon

## A CHANGE IN MELD SCORE IS ASSOCIATED WITH IMPROVED MORTALITY IN TRAUMA PATIENTS WITH CHRONIC LIVER DISEASE

Allan Peetz, Reza Askari, Marc De Moya, Tracey G. Simon, Fiona K. Gibbons, Ali Salim, Kenneth B. Christopher  
Brigham and Woman's Hospital

**Background:** Cirrhosis is present in approximately 1% of all trauma admissions and is a well-known risk factor for increased morbidity and mortality following injury. The Model for End-Stage Liver Disease (MELD) Score has been shown to predict outcomes in trauma patients. Currently, it is not known if changes in MELD Score have any prognostic implications.

**Hypothesis:** A decrease in MELD score in trauma patients with chronic liver disease during hospitalization is associated with decreased *mortality*.

**Design:** Retrospective data registry study

**Setting:** Two academic level I trauma centers

**Patients and Methods:** Adult (age  $\geq 18$  years) trauma patients with chronic liver disease admitted to the intensive care unit between 1998 and 2012. MELD scores were calculated on admission and then at 48 hours. The primary outcome was all cause mortality determined by the US Social Security Death Master File. Adjusted odds ratios were estimated by multivariable logistic regression models with inclusion of covariates thought to interact with both change in MELD score and 30 day mortality

**Results:** 525 patients were included in the analysis. The cohort was 71% male, 76% white and had a mean (SD) age of 55.0 (12.4) years. The mean (SD) MELD at ICU admission was 19.3 (9.7). The 30-day mortality was 21.9%. The odds of 30-day mortality for each 1 increase in ICU admission MELD score was 1.03 (95%CI 1.01-1.06). The odds of 30-day mortality in patients with a change in MELD score of -14 to -2, -2 to -0.5, and  $>+4$  were 0.23 (95%CI 0.10-0.51), 0.30 (95%CI 0.10-0.85) and 1.31 (95%CI 0.58-2.96) respectively, relative to patients with change in MELD of -0.5 to +0.5.

**Conclusion:** In chronic liver disease patients following injury, MELD score at ICU admission is predictive of mortality. A decline in MELD score within 48 hours of ICU admission is associated with improved mortality. Furthermore, a decline in MELD score more than 2 is associated with a 70% reduced odds of mortality.

SECOND SCIENTIFIC SESSION | Monday, November 10, 2014 | 7:30am – 12Noon

## OUTCOMES OF THORACIC ENDOVASCULAR AORTIC REPAIR AND SUBCLAVIAN REVASCULARIZATION TECHNIQUES

Kimberly Zamor; Mark Eskandari; Heron Rodriguez; Mark Morasch; Andrew W. Hoel  
*Northwestern University*

**Background:** Practice guidelines regarding management of the left subclavian artery (LSA) during thoracic endovascular aortic repair (TEVAR) are based on low quality evidence and there is limited literature that addresses optimal revascularization techniques. The purpose of this study is to compare 30-day and mid-term outcomes of LSA coverage during TEVAR, as well as revascularization techniques.

**Hypothesis:** We hypothesize that maintaining LSA patency will have improved outcomes, and that carotid subclavian bypass (CSB) and carotid subclavian transposition (CST) will have similar 30-day and mid-term outcomes.

**Design:** Retrospective cohort study

**Setting:** Single center

**Patients and Methods:** From January 2001 to December 2013, 80 TEVAR with coverage of the left subclavian artery were performed. Patients were categorized as +/- revascularization and by revascularization technique, CSB or CST. 30-day and mid-term stroke, spinal cord ischemia, vocal cord paralysis, upper extremity ischemia, patency of revascularization, and mortality were evaluated using univariate and bivariate analysis.

**Results:** Left subclavian artery coverage without revascularization was performed in 20 patients (25%). The remaining patients underwent CSB (N=22, 27.5%) or CST (n=38, 47.5%). Mean follow-up was 23 months. 30-day stroke and upper extremity ischemia were significantly higher in the unrevascularized versus revascularized group (25% vs 1.67%,  $p=0.003$ ) and (15% vs 0%,  $p=0.014$ ), respectively. However, there was no difference in 30-day or mid-term spinal cord ischemia, vocal cord paralysis, or mortality. Comparison of 30-day and midterm outcomes for CSB vs CST showed no statistical significance, however, vocal cord paralysis was more prevalent with CST vs CSB at 30-days (10.53% vs. 4.55%,  $p=0.643$ ). Patency of revascularizations were 100%.

**Conclusion:** During TEVAR, left subclavian coverage without revascularization is associated with an increased risk of cerebrovascular events and upper extremity ischemia. When LSA coverage is required during TEVAR, carotid subclavian bypass (CSB) and carotid subclavian transposition (CST) are equally acceptable options.

SECOND SCIENTIFIC SESSION | Monday, November 10, 2014 | 7:30am – 12Noon

## COMPARATIVE EVALUATION OF EXTENDED HOSPITAL LENGTH OF STAY AFTER BARIATRIC SURGERY BACKGROUND

John Morton; Ulysses S. Rosas, Trit Garg, Homero Rivas  
*Stanford*

Postoperative length of stay (LOS), readmissions, and complications are important quality metrics used by hospitals and payers. While laparoscopic approach to bariatric surgery has significantly reduced LOS, there is still some variation in LOS among patients, and among bariatric surgery types. Few studies have investigated the relationship between LOS after bariatric surgery, with anthropometric and biochemical risk factor (BCRF) profiles.

**Hypothesis:** Here we aim to characterize the preoperative differences between patients with a short and long LOS for each laparoscopic bariatric surgery type—Roux-en-Y gastric bypass (LRYGB), adjustable gastric band (LAGB), and sleeve gastrectomy (LSG).

**Design:** Retrospective analysis of prospectively maintained database

**Setting:** Accredited, academic bariatric hospital

**Patients and Methods:** 1,482 patients undergoing bariatric surgery at a single academic institution enrolled prospectively. Preoperative data collected included patients' demographic information, anthropometric features, and BCRF values, including total cholesterol, LDL, HDL, lipoprotein A, homocysteine C, insulin, Hba1c, and triglycerides. Duration of postoperative LOS was recorded, as well as any incidence of complications and readmissions. A "long" LOS was defined as a LOS of greater than 2 days. One-way ANOVA and chi squared test were used as appropriate. A multivariate logistic regression was also performed to determine if Los predicted incidence of complication. All analysis was performed by STATA, release 12.

**Results:** 81.4% (n=1,207) patients underwent LRYGB, 7.1% (n=105) underwent LAGB, and 11.5% (n=170) underwent LSG. Mean LOS was significantly different among surgery types, with 2.84 days for LRYGB, 1.33 days for LAGB, and 2.29 days for LSG ( $p<0.00$ ). There was no significant difference in preoperative age, sex, excess body weight, and body mass index (BMI) between patients with long and short LOS for each surgery type. Patients undergoing LRYGB with long LOS had significantly higher preoperative total cholesterol (185 vs. 181,  $p=0.05$ ), LDL cholesterol (114 vs. 108,  $p=0.007$ ), triglycerides (161 vs. 143,  $p=0.038$ ), and homocysteine (10.4 vs. 9.28,  $p<0.00$ ) than those with a shorter LOS. Similarly, patients undergoing LAGB with long LOS had significantly higher

# ABSTRACTS CONTINUED

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preoperative total cholesterol (234 vs. 183,  $p=0.012$ ) and LDL cholesterol (151 vs. 113,  $p=0.031$ ) than those with a shorter LOS. Patients undergoing LSG with a long LOS had no significant difference in preoperative BCRF values than those with a shorter LOS. Patients undergoing LRYGB, longer LOS predicted incidence of complication ( $OR=1.56$ ,  $p=0.022$ ), and of readmission ( $OR=1.62$ ,  $p=0.05$ ) after controlling for age, sex, race, insurance, and preoperative BMI. No such relationship was found for patients undergoing either LAGB or LSG.

**Conclusions:** LRYGB and LAGB patients with a long LOS have significant worse preoperative BCRF profiles. A longer LOS predicts incidence of readmission and complication after LRYGB alone, and not for LAGB and LSG. BCRFs such as total cholesterol and LDL cholesterol may help inform who may be at risk for longer LOS after bariatric surgery.

SECOND SCIENTIFIC SESSION | Monday, November 10, 2014 | 7:30am – 12Noon

## COMPOSITE MEASUREMENT OF OUTCOMES IN LAPAROSCOPIC CHOLECYSTECTOMY

Donald E. Fry, Michael Pine, David Locke, Gregory Pine

*Michael Pine and Associates*

**Background:** Objective measurement of outcomes in surgical care remains elusive because standard definitions, effective and consistent surveillance, and identification of significant post-discharge events are all problematic.

**Hypothesis:** Inpatient and 90-day post-discharge deaths, risk-adjusted length-of-stay outliers for the index hospitalization, and 90-day post-discharge readmissions capture the significant adverse events of surgical care in laparoscopic cholecystectomy.

**Design:** Analysis of inpatient and 90-day post-discharge care of elective and emergent laparoscopic cholecystectomy for hospitalized Medicare patients.

**Setting:** The 1,171 acute care hospitals that met rigorous present-on-admission coding accuracy standards for the years 2009-2011.

**Patients and Methods:** We designed logistic prediction models for inpatient mortality, prolonged length of stay(prLOS) as a measure of serious inpatient complications, and all-cause 90-day post-discharge(90-DPd) deaths and hospital readmissions for elective and emergent laparoscopic cholecystectomy from the Medicare Inpatient file in qualifying hospitals that had more than 20 cases for the study period. The 90-DPd models employed prLOS of the index hospitalization as an additional potential risk factor to predict deaths and readmissions.

**Results:** 1,171 hospitals had 64,021 laparoscopic cholecystectomies. There were 509 inpatient deaths (0.8%) and 4,624 (7.2%) were prLOS. At 90-DPd: 729 patients died without readmission with a prediction model of 15 variables (C-statistic=0.848), and 11,052 patients (17.4% of live discharges) were readmitted (1165 died) with a prediction model of 36 variables (C-statistic=0.674). Among significant ( $P<0.0001$ ) odds ratios(ORs), 90-DPd deaths were associated with age > 84 years (OR=3.7), prLOS (OR=7.8), operations performed on day 3 or thereafter in the index hospitalization (OR=1.6), and other chronic disease variables. Similar variables were associated with 90-DPd readmissions. A composite measure of all inpatient and 90-DPd deaths, prLOS for the index hospitalization, and 90-DPd readmissions resulted in an overall Adverse Outcome rate of 23.7% (15,194/64,021).

**Conclusion:** A composite measure for adverse outcomes can be observed with total deaths, prLOS, and 90-DPd readmissions and provides an objective target for care redesign and improvement. The post-discharge period is the greatest source of Adverse Outcome events in laparoscopic cholecystectomy. Composite measurement of Adverse Outcomes becomes a meaningful tool for the design of surgical warranties for episode-based, bundled payment initiatives.

# ABSTRACTS CONTINUED

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SECOND SCIENTIFIC SESSION | Monday, November 10, 2014 | 7:30am – 12Noon

## A DOUBLE BLINDED RANDOMIZED TRIAL TO COMPARE MINIMALLY INVASIVE PROCEDURES USING PATIENT REPORTED OUTCOMES

Juliane Bingener, Pam Skaran, Andrea McConico, Paul Novotny, Peter Wettstein, Jeff Sloan

*Mayo Clinic – Rochester*

**Background:** The Institute of Medicine has listed the comparison of minimally invasive surgical techniques in its research agenda. This study seeks to evaluate a model for the comparison of minimally invasive procedures with each other using early postoperative patient reported outcomes (PRO) and the example of single port (SP) and four port laparoscopic cholecystectomy (FP).

**Hypothesis:** Early postoperative PRO can detect differences between SP and FP

**Design:** Double blinded RCT

**Setting:** Tertiary Care center, single surgical team

**Patients and Methods:** After baseline data were obtained and standardized anesthesia induced, patients undergoing elective cholecystectomy were randomized per computer sequence to SP or FP. Perioperative care, including pain medication, was standardized. Using identical occlusive dressings patients and outcomes assessor remained blinded until POD2. Primary outcome was pain (VAS) on postoperative day 1, secondary outcomes were quality of life (PROMIS, LASA), serum cytokines, and operative duration. Analysis was intention to treat.

**Results:** 55 patients were randomized to each arm. There was no difference in demographics or peri-operative pain medication received. Of patients in the FP group, 47% believed they had SP. VAS pain score on POD 1 was significantly different from baseline in each group (SP  $1.6 \pm 1.9$  to  $4.2 \pm 2.4$  versus FP  $1.8 \pm 2.3$  to  $4.2 \pm 2.2$ ) but not different from each other ( $p=0.83$ ). Patients in the FP arm reported significantly less fatigue (LASA) on POD 7 than the in the SP group ( $3.1 \pm 2.1$  vs  $4.2 \pm 2.2$ ;  $p=0.009$ ), with significantly less patients reporting severe fatigue ( $>5$ ) in the FP group (22 vs 49%;  $p=0.005$ ). Anesthesia and OR time, cytokines levels were similar between arms. In patients followed  $> 1$  year, no difference in umbilical hernia rates was noted.

**Conclusion:** With standardized perioperative care, differences between SP and FP are minimal. Early postoperative QOL enabled capture of differences in fatigue, possibly indicating improved recovery.

SECOND SCIENTIFIC SESSION | Monday, November 10, 2014 | 7:30am – 12Noon

## LAPAROSCOPIC LINX PROCEDURE VS LAPAROSCOPIC NISSEN FUNDOPPLICATION: A MATCHED-PAIR ANALYSIS OF 100 PATIENTS

Jessica L. Reynolds, Joerg Zehetner, Phil Wu, Peter Crookes, Nikolai Bildzukewicz, Namir Katkhouda, Kulmeet Sandhu, John C Lipham

*University of Southern California Keck Medical Center*

**Background:** Since its introduction in 2008, the efficacy and safety of the LINX sphincter augmentation device has been reported in several short-and long-term studies, rivaling historic results of laparoscopic Nissen fundoplication (LNF) but with fewer side effects. However, LNF patients often present with more severe GERD, as manifested by higher grades of esophagitis, higher incidence of Barrett's esophagus and a larger hiatal hernia compared to those receiving the LINX. There have been no studies comparing patients with similar disease to validate these results.

**Hypothesis:** The LINX Reflux Management System has similar efficacy and less side effects compared to LNF at 1-year follow-up when comparing patients with similar disease severity.

**Design:** Retrospective observational propensity-matched analysis of 1-year outcomes of patients undergoing LNF and LINX.

**Setting:** A single institution academic tertiary-referral center.

**Patients and Methods:** All patients undergoing LNF or LINX from 6/2010-6/2013 were included. A propensity analysis was performed, incorporating preoperative variables including age, gender, BMI, hiatal hernia size, esophagitis grade, presence of Barrett's esophagus and Hill grade.

**Results:** There were 144 patients that met inclusion criteria, 87 underwent LNF and 57 received the LINX. Propensity score matching identified 50 patients in both groups using the "best-fit" model. At 1-year, there were no LINX explantations or LNF requiring revisions. Both groups had similar GERD-HRQL scores ( $4.1 \pm 5.03$  LNF and  $2.8 \pm 4.03$  LINX  $p=0.335$ ) with only 4% (2/50) of patients in each group requiring PPI use post-operatively for recurrent symptoms. There was significantly less gas-bloat symptoms after LINX compared to LNF (LNF 47.2% , LINX 19.0%,  $p=0.033$ ). Nearly all LINX patients were able to belch normally (94.7% LINX vs 66.7% LNF,  $p=0.033$ ). There was no difference in dysphagia rates (24.3% LNF vs 33.3% LINX,  $p=0.481$ ). Only 6 LNF patients and 1 LINX patient were dissatisfied with the procedure and would not have it again ( $p=0.263$ ).

**Conclusion:** While GERD patients had similar control of reflux symptoms after both LNF and LINX, the side-effects including gas-bloating and inability to belch were significantly less with the LINX procedure. The LINX reflux management system should be considered as the preferred surgical therapy for patients within the current indications for GERD patients.



# ABSTRACTS CONTINUED

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THIRD SCIENTIFIC SESSION | Monday, November 10, 2014 | 1:30pm – 4:00pm

## **Special Panel Discussions:**

### **Surgery 2025: Who Will I Work For, What Will Surgical Practice Be, How Will We Train?**

Myself - Tyler Hughes

A Large Practice – Richard Thirlby

An Academic Institution – Jonathan R. Hiatt

### **Panel Discussion**

### **Debate: General Surgery Residency Training Should Be Contracted To A Period Of Basic Training Followed By Subspecialty Training For All Residents.**

Pro – David Mahvi

Con – David Farley

## **Quick Shots:**

### **Ejection from a Motor Vehicle: A Good Reason for Trauma Team Activation**

Nicholas Manguso, Galinos Barmparas, Heidi Hotz, Nicolas Melo, Rex Chung, Matthew Bloom, Eric J. Ley, Daniel Margulies

*Cedars-Sinai Medical Center*

### **Critical Assessment of Surgical Palliation in Unresectable Pancreas Cancer**

Eileen Bock O'Halloran, William Gange, Elizabeth Berger, Gerard Abood, Sam G Pappas, MD, Gerard Aranha

*Loyola University Medical Center*

### **The Utility of MRCP in Clinical Practice: A Waste of Time and Money**

Jayson D. Aydelotte, Phuong Huynh, Ben Coopwood, John Uecker, Carlos Brown

*University Medical Center Brackenridge*

FOURTH SCIENTIFIC SESSION | Tuesday, November 11, 2014 | 8:00am – 12Noon

## SHOULD LIVER TRANSPLANTATION BE USED FOR PATIENTS WITH RESECTABLE *DE NOVO* HILAR CHOLANGIOCARCINOMA?

Kristopher P. Croome, Charles Rosen, Julie Heimbach, David M. Nagorney  
*Mayo Clinic – Rochester*

**Background:** Liver transplantation (LTX) has been established as a curative treatment for selected patients with hilar cholangiocarcinoma (HC) in the setting of primary sclerosing cholangitis. The outcome of LTX versus resection (RTX) for patients with *de novo* HC remains unclear.

**Null Hypothesis:** Survival after LTX and RTX in patients with *de novo* HC will be similar.

**Design and Setting:** Single Tertiary Care Center, Retrospective Review

**Patients and Methods:** Records of patients with *de novo* HC treated by protocol LTX (90) and RTX (124) from 1993 to 2013 were reviewed. Based on preoperative imaging RTX was undertaken for Bismuth-Corlette III HC and LTX for unresectable Bismuth-Corlette IV HC.

**Results:** Unadjusted analysis showed that overall survival was greater for LTX than RTX ( $p=0.003$ ). One, 3 and 5 year overall survival rates were 90%, 71% and 59% for LTX and 81%, 53% and 36% for RTX. Factors adversely correlated with overall survival on univariate analysis were: age, tumor size, tumor grade, lymph node metastases and RTX. Frequency of lymph node metastases ( $p=0.001$ ) and grade 3 and 4 histopathology ( $p=0.001$ ) was greater in the RTX than LTX group. Survival was not different between LTX and RTX after adjusting for patient age, lymph node metastases and tumor size. Following postoperative pathologic review, HC after RTX was reclassified as Bismuth-Corlette IV based on the necessity of multiple biliary anastomoses in 40 patients to more accurately compare treatment outcome. Overall survival was greater for LTX than RTX for Bismuth-Corlette IV HC.

**Conclusion:** After multivariate adjustment there was no difference in survival between transplantation and resection. In patients with resectable HC (Bismuth-Corlette III), resection should be the treatment of choice as results do not warrant the use of donor organs. In patients with unresectable HC, LTx is the only potential curative option and provides similar results to patients undergoing resection. More accurate pre-operative assessment of HC Bismuth-Corlette stage, tumor size and nodal status are critical in stratifying treatment recommendations.

# ABSTRACTS CONTINUED

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FOURTH SCIENTIFIC SESSION | Tuesday, November 11, 2014 | 8:00am – 12Noon

## LIVER TRANSPLANT OUTCOMES USING GRAFTS FROM DONATION AFTER CARDIAC DEATH (DCD) DONORS

Maria B Majella Doyle, Neeta Vachharajani, Jason Wellen, Surendra Shenoy, Jeff A Lowell, William C Chapman  
*Washington University*

**Background:** Previous reports suggest that DCD liver grafts have increased primary non-function (PNF) and biliary cholangiopathy thought to be due to the graft warm ischemia (Graft WIT) prior to cold flushing.

**Hypothesis:** DCD grafts have similar long-term outcomes to standard grafts.

**Design:** Retrospective study

**Setting:** Single center

**Patients and Methods:** From Jan 2005 to May 2014 831 adult liver transplants were performed at our institution. 47 (5.7%) patients received DCD donor grafts. A prospectively maintained database was utilized for the current analysis.

**Results:** DCD donors were younger (age 29.7, range 10-60) than non-DCD (age 44.3, range 9-80) ( $p < .0001$ ), with similar recipient age (56.9 and 54.5 years,  $p = .11$ ). The mean lab MELD was lower in DCD recipients (18.7 vs 22.2,  $p = .03$ ). Mean cold and warm ischemia time was similar (5.7 vs 5.7 hours,  $p = .97$  and 34 vs 32 minutes  $p = .28$ ). The mean DCD graft ischemic time was 23 minutes ( $\pm 8$ ). Median ICU and hospital stay was 2 days ( $p = .37$ ) and 7.5 days ( $p = .37$ ) in both groups. There was no difference in need for reoperation (10.6% (4/31) in DCD vs. 9.2% in non-DCD  $p = .79$ ). Median followup was 5.0 and 3.4 years respectively. Long-term outcomes have been similar between groups with 1-, 3- and 5- year patient survival of 95.7%, 90.4%, and 86.9% in DCD vs. 90.3%, 83.1% and 77.8% in the non-DCD ( $p = .24$ ) with graft survival of 93.5%, 85.7%, and 79.2% vs 88%, 80.7%, and 75.5% ( $p = .59$ ). 4 (8.5%) recipients developed ischemic cholangiopathy (IC) at 2-, 3-, 6- and 8-months. One of the 4 died awaiting retransplantation 3 months post OLT and the others were retransplanted at 0.8, 1.2 and 3.1 years post-OLT. PNF and HAT did not occur in any patient in DCD group. Incidence of bile leak was also comparable (12.8% vs. 7.6%  $p = .26$ ). A longer graft WIT was associated with IC development ( $p = .004$ )

**Conclusion:** Careful selection of DCD donors can provide suitable donors with results of liver transplantation comparable to standard brain dead donors.

FOURTH SCIENTIFIC SESSION | Tuesday, November 11, 2014 | 8:00am – 12Noon

## TRAUMATIC CARDIOPULMONARY ARREST AND RESUSCITATION IN BLUNT TRAUMA: IMPACTS ON ORGAN DONATION

Rebecca Striker, Rachel Titus, Alistair J. Chapman, Alan Davis, Carlos Rodriguez, Gaby Iskander

*Spectrum Health, Grand Rapids Medical Education Partners, Michigan State University*

**Objective:** Traumatic cardiopulmonary arrest (TCPA) following blunt trauma carries a dismal prognosis. Initiating aggressive resuscitative efforts for this population presents risks to providers and often carries a significant cost. These observations have led the American College of Surgeons Committee on Trauma to recommend that resuscitation be withheld for many victims of blunt trauma who suffer an arrest. Few studies have examined the incidence of organ donation in blunt TCPA patients. Our study examines the impact of resuscitation after blunt TCPA on organ donation and identifies patient characteristics that may be associated with successful organ procurement.

**Methods:** This is a retrospective cohort study examining all trauma patients who suffered a blunt TCPA. Patients admitted to the trauma service between 1/1/2003 and 8/15/2013 were included. A chart review was completed and patient demographics, Injury Severity Score (ISS), Abbreviated Injury Scale (AIS) Head, location of CPR, and final organ disposition were determined. Patients were defined as donors if solid organs were procured for organ transplantation.

**Results:** 170 blunt trauma patients developed cardiopulmonary arrest and underwent CPR during the study period. There were 13 survivors (7.6%) and 157 fatalities (92.4%). 8/13 survivors had severe neurologic deficits and were discharged to long-term care facilities. The remaining 5 survivors were discharged home with good neurologic outcome. Of the 157 fatalities, 13 patients met the criteria for organ procurement. 38 solid organs were procured for transplantation from these 13 patients. Donor organs included 22 kidneys, 8 livers, 3 pancreas, 3 lungs and 2 hearts. The average age of donors was 40 yrs. Donors had a significantly higher median AIS Head score (5 vs 3). The ISS, sex and the location of CPR administration were not significantly different. The median hospital cost for donors was \$23,000.

**Conclusions:** Resuscitation following blunt TCPA rarely leads to functional neurologic outcome in survivors, however, can have a meaningful outcome in the form of organ donation. In blunt trauma, young patients with severe head injuries may be most suitable for successful organ procurement. Although there is a high mortality following blunt TCPA, the potential for organ donation may justify the use of hospital resources in the face of severe organ shortage.

# ABSTRACTS CONTINUED

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FOURTH SCIENTIFIC SESSION | Tuesday, November 11, 2014 | 8:00am – 12Noon

## A LOW COST, LOW TECH SOLUTION TO OPERATING ROOM EFFICIENCY

Charles W. Kimbrough, Jeff Canary, Lisa Jackson, Ian Farrah, Mark V. Boswell, Kelly M. McMasters

*University of Louisville*

**Background:** Suboptimal operating room (OR) efficiency is a universal complaint among surgeons. Nonetheless, maximizing efficiency is critical to institutional success. Prior studies have focused on isolated interventions, large scale process redesign, or costly systems. Here, we report improvement achieved from low cost, low technology measures.

**Hypothesis:** Straightforward measures such as improved preadmission testing and OR schedule management can improve OR efficiency

**Design:** Retrospective review of prospectively-maintained OR case data

**Setting:** Tertiary-care academic medical center/Level I Trauma center

**Patients and Methods:** Improvements in pre-admission testing and OR scheduling were instituted in March 2012. Most importantly, a senior nurse anesthetist was appointed to direct OR utilization—armed with a cell phone for text messaging residents, fellows and attendings; a voice communication system for communication with all OR and anesthesia staff; and a magnetic strip OR schedule board. Additionally, regular OR performance reports were made transparent among administrators and providers. OR performance metrics before and after these changes were compared using Mann-Whitney and Chi-squared tests. Changes over time were analyzed with linear and non-linear regression.

**Results:** Data including all surgical cases were available for a 36-month period; 10 months (6581 cases) prior to program implementation and 26 months afterwards (17574 cases). Dramatic improvement was seen in first case on-time starts, which increased from 39.3% to 82.7% ( $p < 0.0001$ ). Similarly, since implementation of OR changes, the percent utilization of available OR time demonstrated a steady linear increase ( $R^2 = 0.481$ ,  $p < 0.001$ ). After an initial lag, case volume has also improved, with a non-linear increase observed in the 12-month rolling average of cases per month ( $R^2 = 0.966$ ,  $p < 0.001$ ).

**Conclusion:** After many years of what seemed an insoluble problem, simple changes fostering collaboration among services, including active management of the OR schedule and transparent data, have resulted in substantial improvement in OR efficiency and case volume.

FOURTH SCIENTIFIC SESSION | Tuesday, November 11, 2014 | 8:00am – 12Noon

## GASTRIC-ESOPHAGEAL STENTING FOR MALIGNANT DYSPHAGIA: RESULTS OF PROSPECTIVE CLINICAL TRIAL EVALUATION OF GASTRO- ESOPHAGEAL REFLUX AND QUALITY OF LIFE RELATED SYMPTOMS

Prejesh Philips, Charles Scoggins, D Alan North, Melissa Schlegel, Robert CG Martin  
*University of Louisville*

**Background:** Stenting across the gastro-esophageal(GE) junction for adenocarcinoma has historically been contraindicated secondary to the concerns for severe GE reflux (GER) symptoms. Thus the aim of this study was to demonstrate minimal quality of life(QOL) side effects in patients undergoing esophageal stenting across the GE junction.

**Hypothesis:** GE junction esophageal stenting does not lead to an increase in GER symptoms.

**Design:** Prospective Single Arm Quality of Life Study.

**Setting:** Tertiary Referral Center.

**Patients and Methods:** A IRB approved prospective clinical trial evaluating patients (pts) with Stage 2 or 3 GE junction adenocarcinoma undergoing neo-adjuvant therapy (from baseline to 10 weeks post stenting) after stenting across the GE junction for GER symptoms and QOL GER assessments (EORTC-QLQ-O25 & FACT-E).

**Results:** Forty (40) Consecutive pts were enrolled in this clinical trial, with 84% male, 19% female, median age 62 years (47-83). Median dysphagia score of 3 (only liquids tolerated) pre-stent was significantly improved to a score of 0 (ability to eat all foods) post stent ( $P=0.01$ ). There was a significantly improved AND sustained swallowing QOL from 2weeks to 10 weeks (Figure 1a & 1b,  $p=0.01$ ) post-stent. GER QOL scores were similar 2 weeks post-stent, but were significantly improved throughout the rest of the study (Figure 1c,  $p=0.03$ ). Proton pump inhibitors were being used in 58% of pts pre-stent and in 85% of pts at their 2 week to 10 week follow up. Planned chemotherapy and/or chemo-radiation therapy was completed in 95% of all pts. Stent migration (Radiologic/ Complete) was seen in 63% of pts at some time in their therapy and corresponded to pathologic response in 85% of those pts.

**Conclusion:** Esophageal stenting across the GE junction remains the optimal therapy for dysphagia relief in esophageal malignancies AND does not adversely affect a patient's GER QOL. Esophageal stenting across the GE junction is not contra-indicated and should be the initial therapy in a patient management.

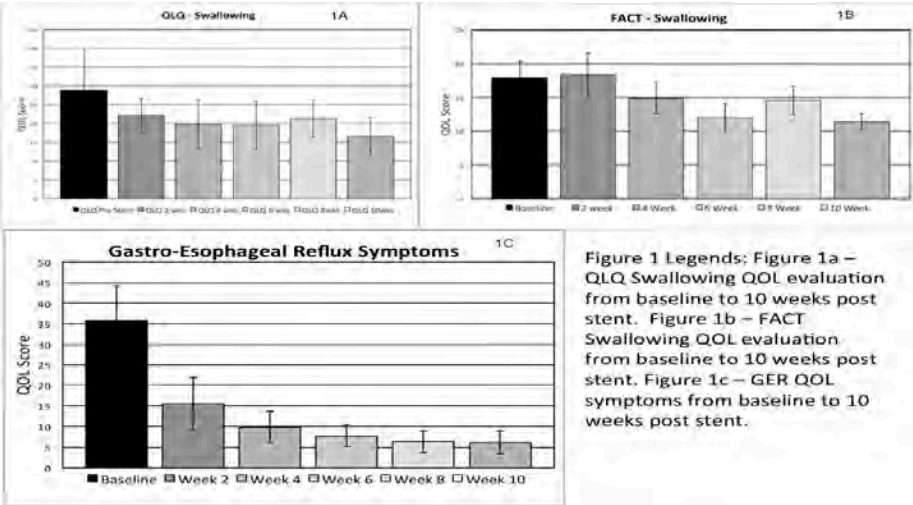


Figure 1 Legends: Figure 1a – QLQ Swallowing QOL evaluation from baseline to 10 weeks post stent. Figure 1b – FACT Swallowing QOL evaluation from baseline to 10 weeks post stent. Figure 1c – GER QOL symptoms from baseline to 10 weeks post stent.

FOURTH SCIENTIFIC SESSION | Tuesday, November 11, 2014 | 8:00am – 12Noon

EARLY NATIONAL EXPERIENCE WITH LAPAROSCOPIC  
PANCREATICODUODENECTOMY (LPD) FOR DUCTAL  
ADENOCARCINOMA (PDCA): A COMPARISON OF LPD AND OPEN  
PANCREATICODUODENECTOMY (OPD) FROM THE NATIONAL CANCER  
DATA BASE

Susan M. Sharpe, Mark S. Talamonti, Chihlung Wang, Richard A. Prinz, Kevin K. Roggin, David J. Bentrem, David J. Winchester, Robert D.W. Marsh, Susan J. Stocker, Marshall S. Baker

*NorthShore University HealthSystems*

**Background:** Studies examining outcomes from the laparoscopic approach to PDCA in the pancreatic head have been small, single institution retrospective reviews. There is substantial debate regarding the safety of LPD and the clinical equivalence of LPD to OPD for PDCA.

**Hypothesis:** Patients undergoing LPD for PDCA will have shorter lengths of stay (LOS) but similar rates of margin-negative resection, lymph node counts, post-operative readmission, and 30-day mortality when compared to patients undergoing OPD.

**Design:** Retrospective review of the National Cancer Data Base (NCDB)

**Setting:** National database

**Patients and Methods:** We queried the NCDB to identify patients undergoing LPD and OPD for PDCA between 2010 and 2011. Chi square and student's t-tests were used to evaluate differences between the two approaches. Multivariate logistic regression modeling (MVR) was performed to identify patient, tumor, or facility factors associated with perioperative mortality.

**Results:** 4,565 (92%) underwent OPD. 401 (8%) underwent LPD. There were no statistical differences between the two surgical cohorts with regard to age, race, Charlson score, insurance status, tumor size, pathologic grade, stage, treatment with neoadjuvant chemoradiotherapy, margin status, or lymph node counts. LPD demonstrated a statistically shorter LOS ( $10 \pm 7.9$  vs.  $12 \pm 9.7$  days,  $p < 0.0001$ ) and lower rates of unplanned readmission ( $5.5\%$  vs.  $9.2\%$ ,  $p = 0.014$ ) than OPD. There was a trend toward an increased rate of 30-day mortality in the LPD cohort although this trend did not reach statistical significance ( $5.5\%$  vs.  $3.8\%$ ,  $p = 0.107$ ). MVR predicting peri-operative mortality controlling for age, Charlson score, tumor size, nodal positivity, stage, facility type, and pancreaticoduodenectomy (PD) volume identified age (OR 1.05,  $p < 0.0001$ ), Charlson



# ABSTRACTS CONTINUED

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score of 2 (OR 1.83,  $p=0.01$ ), positive margins (OR 1.42,  $p=0.032$ ), and LPD (OR 1.80,  $p=0.0135$ ) as associated with an increased probability of 30-day mortality; hospital volume  $>10$  PD was associated with a lower risk of 30-day mortality (OR 0.98,  $p<0.0001$ ). The difference in mortality seen with LPD appeared related to procedure volume. In institutions that had performed  $>10$  LPD, the 30-day mortality rate of the laparoscopic approach was equal to that for the open approach (0.00% vs 1.01%,  $p=0.297$ ).

**Conclusion:** LPD provides a shorter LOS than OPD without compromising perioperative oncologic outcomes. There is an observed trend toward a higher 30-day mortality rate with LPD but this appears driven by a surmountable learning curve for the procedure.

FOURTH SCIENTIFIC SESSION | Tuesday, November 11, 2014 | 8:00am – 12Noon

## ROLE OF ESTROGEN THERAPY IN ER POSITIVE COLON CANCER: STUDY IN AN ORTHOTOPIC MURINE MODEL

Tafadzwa P. Makarawo, Jasneet Singh Bhullar, Milessa Decker, Jacqueline Tilak, Barry Herschman, Deepa Taggarshe, Vijay K. Mittal  
*Providence Hospital and Medical Center*

**Background:** Colorectal cancer (CRC) has a known lower incidence in women leading to assertions that estrogen, may protect against CRC. Multiple *in vitro* studies have demonstrated estrogen's anti-tumor effects in ER beta positive (ER- $\beta$ ) CRC. However, no experimental studies have proven this effect *in vivo*.

**Hypothesis:** To evaluate the therapeutic effect, if any, of estrogen therapy on CRC tumor growth in an orthopic murine model.

**Design:** Laboratory study

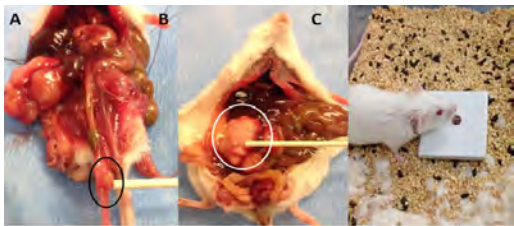
**Setting:** Animal research laboratory

**Patients and Methods:** Using NOD SCID mice (n=32) orthotopic CRC murine model was created using transanal electrocautery then instillation of CRC cells. CRC cell lines used were COLO-205 and DLD-1 (n=16 each; treatment n=8, controls n=8) both of which have ER- $\beta$  positivity and tumor regression with estradiol *in vitro*. In treatment mice, estradiol therapy was given from day 8 via daily oral servings of 1.12  $\mu$ g of 17  $\beta$ -estradiol mixed in hazelnut cream. Interval serum samples confirmed therapeutic levels for study duration. In controls, mice were sacrificed at weeks 3,5 and 7 to observe tumor growth. In treatment mice, sacrifice occurred at study midpoint and end to obtain serum estradiol levels. All remaining mice were survived until study end (Day 94) or natural demise.

**Results:** Differences in tumor incidence, metastatic spread and overall survival are summarized in Table below. COLO 205 tumors were more aggressive than DLD-1, with a higher tumor incidence and metastatic spread and shorter survival. For COLO-205, treatment mice had lower tumor incidence (25% vs 100%), and number of metastases (1 vs 16) and longer survival (73 days vs 63 days) versus controls. For DLD-1, treatment mice had lower tumor incidence (50% vs 12.5%), lower number of metastases (4 vs 6) and longer survival (86 days vs 78 days). Further scrutiny of surviving treatment mice (N=3), revealed survival for the full study duration (94 days) in two mice (one COLO-205, one DLD-1) despite having metastases, an effect not seen in controls.

# ABSTRACTS CONTINUED

**Conclusion:** Estrogen therapy induced lower tumor incidence and metastases and increased survival compared to controls even in the presence of metastases. This successful treatment with estrogen may introduce a novel chemotherapeutic strategy for local or systemic therapy in patients.



**Figure A:** Dissected mouse showing the in situ colonic tumor (marker).  
**B :** Showing the dissected mouse with metastatic matted lymph nodes (marker).  
**C:** Shows technique of theoral estradiol feeding of the treatment group.

	COLO- 205 Control (8)	COLO-205 Treatment (8)	DLD – 1 Control (8)	DLD – 1 Treatment (8)
Tumor Incidence	8/8 (100%)	2/8 (25%)	4/8 (50%)	1/8 (12.5%)
Metastatic spread (%)	7/8 (87.5%)	1/2 (50%)	3/4 (75%)	1/1 (100%)
Total number of mets sites	16	1	6	4
Mean survival sacrifice (days)	62.6	73.1	77.7	85.86

# ABSTRACTS CONTINUED

FOURTH SCIENTIFIC SESSION | Tuesday, November 11, 2014 | 8:00am – 12Noon

## VARIATION IN BILATERAL MASTECTOMY RATES ACCORDING TO RACIAL GROUPS IN YOUNG WOMEN: A REPORT FROM THE NATIONAL CANCER DATA BASE, 1998-2011.

Laura Grimmer, Erik Liederbach, Chi Wang, Jose Velasco, Katharine Yao  
*NorthShore University HealthSystems*

**Background:** The rate of bilateral mastectomy (BM) for unilateral breast cancer has increased over the past decade particularly for young patients.

**Hypothesis:** BM utilization is highest amongst Caucasians (White) compared to Black, Hispanic or various Asian racial groups.

**Design:** Retrospective review of a large observational oncology dataset.

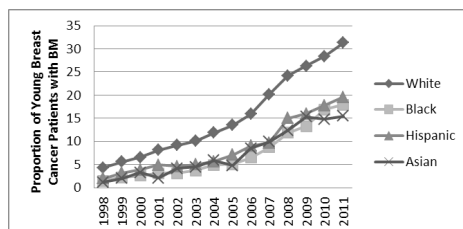
**Setting:** The National Cancer Data Base (NCDB).

**Patients and Methods:** We selected 1,864,919 women  $\leq 45$  years old with Stage 0-II breast cancer who underwent surgery from 1998-2011. Chi-square and logistic regression models were used to examine trends and correlates of BM utilization.

**Results:** The increase in BM rates for young women from 1998 to 2011 differed amongst different racial groups with White patients having the highest rates (Figure 1). In 2011 BM rates were 31.3% for White, 19.6% for Hispanic, 17.9% for Black, and 15.5% for Asians. After adjusting for patient age, insurance status, facility type and location, tumor stage, grade and molecular phenotype, Blacks were 53% less likely to undergo BM than Whites (OR 0.47 95%CI: 0.43-0.51), Hispanics 42% less likely (OR 0.58 95%CI: 0.53-0.65), and Asians 59% less likely (OR 0.41 95%CI: 0.36-0.47). Amongst different Asian ethnicities in women  $< 45$  years old, Pacific Islanders, Vietnamese and Filipino were all at least two times more likely to undergo BM than Chinese and Japanese ethnicities ( $P < 0.05$ ) when adjusting for the aforementioned factors.

**Conclusion:** BM rates are highest in Caucasians compared to other racial groups despite tumor stage and other patient and facility factors. BM rates amongst different asian racial groups are also different on adjusted analysis. Future studies are needed to investigate why Caucasians are choosing BM more frequently than other racial groups.

Figure 1. Bilateral mastectomy rates from 1998-2011 amongst different racial groups,  $\leq 45$  years old ( $p < 0.001$ ).



# ABSTRACTS CONTINUED

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FOURTH SCIENTIFIC SESSION | Tuesday, November 11, 2014 | 8:00am – 12Noon

## SURGICAL ENERGY-BASED DEVICE INJURIES AND FATALITIES REPORTED TO THE FOOD AND DRUG ADMINISTRATION (FDA)

Douglas Overbey, Nicole Townsend, Brandon Chapman, Daine Bennett, Lisa Foley, Aline Rau, Jeniann Yi, Thomas Robinson

*University of Colorado*

**Background:** Energy-based devices are used in virtually every operation. Because complications from these devices are uncommon, no large series of energy-based device complications exist in the surgical literature

**Hypothesis:** Our purposes were (1) to describe causes of energy-based device complications leading to injury or death; (2) to determine if common mechanisms leading to injury or death can be identified.

**Design:** Retrospective retrieval of FDA database adverse event reports.

**Setting:** Adverse events reported by hospitals across the United States.

**Patients and Methods:** The FDA's Manufacturer and User Facility Device Experience (MAUDE) database was searched for surgical energy-based device injuries and deaths (code GEI) reported over 20 years (01/94 - 01/14). Device failures and injuries/deaths were recorded and analyzed.

**Results:** 152 deaths and 3,098 injuries were analyzed. Common patterns of complications were thermal burns 65%, hemorrhage 16% and fire 9%. Severe injury or death accounted for 47% of all reports.

**TIMING:** Events occurred intra-operatively 83%, inpatient postop 8% and post discharge 9%. 12% of all deaths occurred following discharge home.

**THERMAL BURNS:** Common mechanisms for thermal burns were direct application 33%, dispersive electrode burn 29%, insulation failure 14% and capacitive coupling 9%. Thermal injury was the most common reason for death (36%) and direct application was the most common mechanism causing death (87%,  $p < 0.001$  vs. composite of all other mechanisms).

**FIRES:** Fires were most common with monopolar "bovie" devices (87%;  $p < 0.001$  vs. composite of all other devices). Fires were most common in head and neck operations 65% ( $p < 0.001$  vs. composite all other locations). Most common fire fuel source was oxygen 64%, followed by drapes 17%.

**Conclusion:** Complications due to energy-based devices occur from three main causes: thermal burn, hemorrhage and fire. Thermal burns are the most common reason for both injury and death. Knowledge that direct application most commonly accounts for injury/death can help modify surgeons' practices to avoid these complications. This is the largest report of complications resulting from surgical energy-based devices which are ubiquitously used in the modern operating room.





# Bylaws

# BYLAWS

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## ARTICLE I: Membership

SECTION 1. The ACTIVE MEMBERSHIP shall be limited to three hundred and fifty (350). The HONORARY MEMBERSHIP shall be limited to fifteen (15).

SECTION 2. ACTIVE MEMBERS. To be eligible for consideration for active membership, an individual shall be a graduate of an accredited medical school, shall have completed formal residency training, and shall have been established in his/her current practice locale for a minimum of two years. To be considered, the individual must be board certified in his or her specialty, have established an excellent reputation as a surgeon, and be a Fellow of the American College of Surgeons. The individual must be recommended by the Membership Committee of the Association and approved by at least three-fourths of the Executive Committee to be presented to the members of the Association. Nominees to be Active Membership shall be elected to membership by the favorable vote of three-fourths of the members voting by secret ballot at the Executive Session of the Annual Meeting. Membership shall not be denied because of race, creed, color, or sex. Desired qualifications include:

- a. Practice limited to a surgical specialty, to a career in academic surgery, or to a career in administrative surgical fields.
- b. Contributions to scientific literature and/or documented leadership activity in local, state, or regional medical and surgical organizations.
- c. Evidence of a sincere interest in making a professional contribution to the Association.

Under special circumstances, renowned surgeons not meeting the above requirements may be granted membership.

A nomination shall be initiated by a member sponsor who shall be responsible for obtaining the curriculum vitae of the nominee which is to be submitted on a form provided by the Secretary of the Association. The nomination shall be endorsed by two (2) members. The completed nomination form and letters of recommendation from the sponsor and endorsers must be received in the office of the Secretary by May 1 of the year in which the nominee is to be considered.

SECTION 3. The Secretary will solicit additional letters of comment on the nominees from members of the Association. Each completed nomination received by the Secretary shall be presented to the Chairman of the Membership Committee. The Membership Committee shall consider all nominations and make recommendations to the Executive Committee. A final list of nominees shall be prepared by the Executive Committee for presentation to the members at the Annual Business Meeting for approval and acceptance.



# BYLAWS CONTINUED

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SECTION 4. Upon notification by the Secretary of election to membership in the Association, the nominee must accept the election within three (3) months by payment of the initiation fee and the annual dues to the Treasurer of the Association. To become an Active member, the nominee shall be expected to attend the first Annual Meeting after election to be introduced to the Association and to receive the certification of membership. Should the nominee fail to attend the first subsequent meeting, the second Annual Meeting must be attended. If the nominee is unable to attend the second meeting, membership will not be conferred subject to action by the Executive Committee. Fees contingent on membership will not be refunded.

SECTION 5. Nominees who have not been recommended for active membership after three (3) consecutive years of consideration by the Membership Committee and the Executive Committee shall be withdrawn from consideration. This action shall not preclude subsequent nominations for membership after an interval of two (2) years.

SECTION 6. A Senior Membership shall be any active member who has reached the age of sixty (60) years, or has retired from the active practice of surgery. He/she may be recommended for Senior Membership for other acceptable reasons if so ordered by the Executive Committee. A Senior Member shall retain all rights and privileges of membership, but he/she shall be relieved of the rules of attendance. He/she shall pay dues and any assessments until the age of sixty-five (65) or upon retirement, whichever shall occur first.

SECTION 7. HONORARY MEMBERS may be selected from individuals of scientific eminence or from among those who have made unusual contributions to surgery. They shall be proposed to the Association by the Executive Committee and elected in the same manner as active members. They shall not be required to pay dues or fees nor shall they be privileged to vote or hold office.

SECTION 8. The resignation of a member in good standing submitted in writing may be accepted by the Executive Committee.

SECTION 9. Any Active Member who fails to attend three consecutive annual scientific meetings shall be notified of his/her absences by the Secretary. Written requests for excused absence will be considered by the Executive Committee. If the truant member fails to attend the next successive Annual Meeting, membership shall be forfeited unless for good and sufficient cause which the Executive Committee shall determine otherwise.

SECTION 10. Any member may be expelled for unprofessional or unethical conduct by unanimous vote of the Executive Committee. This action requires confirmation by the Association at the next Executive Session. Charges shall be preferred in writing and signed by three (3) members before consideration by the Executive Committee. If the vote of the Executive Committee is not unanimous, the charges may be adopted by mutual consent of the members of the Executive Committee, or they may be presented by the Executive Committee to the Association in Executive Session.

A three-fourths vote of the members voting by secret ballot (Article VI, Section 2) at the Executive Session of the Annual Meeting shall be required for expulsion.

SECTION 11. An active member, temporarily residing outside the continental limits of the United States or Canada, may be placed on temporary inactive status if such request is presented in writing and approved by the Executive Committee. Temporary inactive status relieves the member of attendance requirements and dues payment. Such status shall be granted for a period no longer than three (3) years.

## **ARTICLE II: Duties of Executive Committee and Officers**

SECTION 1. The EXECUTIVE COMMITTEE shall be the executive body of the Association and shall consider all the business and policies pertaining to the affairs of the Association. It shall make nominations for officers and fill vacancies arising among officers. It shall select the sites and dates for Annual Meetings and appoint the Chairman of the Committee on Local Arrangements. It shall recommend the amount of the dues for the consideration of the membership. It shall make recommendations for Active, Senior, Honorary and Temporary Inactive Membership and shall act upon resignations and forfeitures of membership as necessary. It shall consider and act upon charges of unprofessional conduct and charges against members for alleged offenses against the Constitution and Bylaws. It shall also submit, for the vote of the membership in Executive Session, its recommendation concerning expulsion of a member. It shall direct the conservation and investment of funds held by the Association.

A report of the Executive Committee shall be presented to the members during the Executive Session of the Association during each Annual Meeting. No decisions or recommendations of the Executive Committee shall be binding on the Association unless accepted by a three-fourths vote of the members voting in Executive Session at the Annual Meeting.

Meetings of the Executive Committee shall be held at the call of the Chairman of the Executive Committee. Seven members present shall constitute a quorum.

# BYLAWS CONTINUED

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The most immediate Past President of the Association in attendance shall be Chairman of the Executive Committee, and the Secretary of the Association shall be Secretary of the Executive Committee.

SECTION 2. The PRESIDENT shall preside at the meetings of the Association, preserve order, regulate debates, appoint committees not otherwise provided for, announce results of elections, perform all other duties appertaining to his office, ex-officio member of all committees. The President shall hold office for one (1) year. In the absence of the President, the order of succession to the Chair shall be the First Vice President, the Second Vice President and then the Senior Member of the Executive Committee present.

SECTION 3. The SECRETARY shall attend to the correspondence of the Association, shall notify officers and new Members of their election, and shall notify and instruct new members of the Program Committee, the Membership Committee, and of other specially designed committees. The Secretary shall keep minutes of the Executive Committees executive sessions. Such minutes shall be the property of the Association and shall be the Custodian of the Seal of the Association and shall, upon direction by the Executive Committee, affix it to papers and documents. Together with the President, the Secretary shall sign all official papers. The Secretary shall pass upon all bills for expenses to be paid by the Treasurer. The Secretary shall publish a list of all nominees presenting their age, address, surgical board certification status, College of Surgeons fellowship status, and the names of the sponsor and endorsing members. This information on the nominees will be mailed to the members of the Association with a request for comment on individual nominees at an appropriate interval before the meeting of the Membership Committee. The Secretary shall send invitations to guests invited to attend the Annual Meeting at the request of a member. The Secretary shall be custodian of the records of attendance of all meetings of the Association. The Secretary shall make an annual report to the Executive Committee and to the Membership at the Annual Executive Session of the Association. The Secretary shall be an ex-officio member of all committees.

SECTION 4. The TREASURER shall be the custodian of all the moneys of the Association and shall be responsible to the Executive Committee. The Treasurer shall keep full and accurate books of account, containing a record of all moneys received and expended, which books shall be the property of the Association and open to the inspection of the authorized officers at all reasonable times. The Treasurer shall collect initiation fees, dues and assessments, and shall report to the Executive Committee the names of those members in arrears. The Treasurer shall present an annual report of account for audit which shall be made a part of the report of the Executive Committee. The Treasurer shall cooperate with the Chairman of the Local Committee on arrangements regarding finance.

SECTION 5. The Association shall have an official journal chosen by vote of the membership. The RECORDER will be the liaison between the Association and the editor of the official journal. The Recorder shall contact the corresponding authors of all scientific papers presented before the Association. Authors shall be instructed to forward manuscripts to the Editor of the official journal prior to presentation at the annual meeting. The Recorder shall be responsible for the Transactions of the Western Surgical Association, published in the Program Book. The Transactions includes a list of past presidents and meeting places; a list of J. Bradley Aust awardees; the previous year's scientific program; the previous year's Presidential Address; and a list of deaths and memorials. The Recorder will send one copy of the Transactions to the National Library of Congress to be kept in perpetuity. The Recorder shall maintain an up-to-date file of the membership.

SECTION 6. The RECORDER shall act as Historian for the organization and maintain and transfer appropriate archival material from the organization to the Library of Medicine.

SECTION 7. DISTRICT REPRESENTATIVES. There shall be four (4) District Representatives, one of whom shall be elected each year for a term of four (4) years. The tenure of office shall be staggered in order to facilitate continuity in committee activities. These representatives shall be elected to represent widely diverse geographical sections of membership. They shall represent the best interests of the entire Association to the membership of their general areas, and in turn shall represent the will and pleasure of the membership of their general geographical areas to the Executive Committee.

SECTION 8. The Association is represented on the American Board of Surgery. When requested by the Board, the Executive Committee shall submit the names of three (3) member nominees for each position to the membership for approval of an Annual Meeting. Upon approval the panel of nominees will be forwarded to the American Board of Surgery who will notify the Association of the nominees selected for this office.

SECTION 9. The Association is regularly represented on the Board of Governors of the American College of Surgeons by one (1) member. When required, the Executive Committee shall submit the names of three (3) nominees approved by the membership for this office.

SECTION 10. The Association is regularly represented on the Advisory Council on Surgery of the American College of Surgeons by one member. When requested, the Executive Committee shall submit the names of three (3) nominees approved by the membership of this office.

# BYLAWS CONTINUED

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## **ARTICLE III: Initiation Fee and Annual Dues**

SECTION 1. Every active member on his/her election shall pay an initiation fee, thereby acknowledging and accepting the Constitution and Bylaws. The amount of the fee may be changed at any Annual Meeting on recommendation of the Executive Committee and approved by a majority of the membership of the Association at the Executive Session of the Annual Meeting.

SECTION 2. Annual dues of every active member shall be paid by May 1 of each calendar year. The amount of the dues may be changed at the Executive Session of the Association on recommendation of the Executive Committee and approval by the majority of the members present.

SECTION 3. Any member who fails to pay dues or assessments for one year shall be notified by the Treasurer in writing. If the member fails to pay the required dues within two (2) months thereafter, the membership will be forfeited. The Treasurer shall notify the Executive Committee of this forfeiture. Waiver of membership fees or assessments shall be the prerogative of the Executive Committee.

## **ARTICLE IV: Programs and Publications**

SECTION 1. A balanced program for the Annual Scientific Meeting will be arranged by the Program Committee, a copy of which shall be distributed to the membership. Abstracts submitted for consideration to be included in the program shall represent original material which shall not have been submitted for publication previously.

SECTION 2. All papers read before the Association shall be presented by a member or sponsored guest. The sponsoring member or co-author member shall be responsible for the content and quality of presentation. An excuse not to do this will require permission of the President.

SECTION 3. The time allowed for presentation of papers shall be determined by the Program Committee. The manuscript must be completed for publication in accordance with the guidelines of the official journal of the Association, and must be submitted in a timely fashion in accordance with published guidelines of the Association.

SECTION 4. The Executive Committee shall have full power to omit from the published records any paper, in part or in whole, which may have been read before the Association.

SECTION 5. The Executive Committee shall cooperate with the editorial board of the official journal of the association to obtain prompt publication of the scientific papers.

SECTION 6. The expense of publication of papers and costs in excess of that allowed by the publisher shall be subject to assessment against the author. All papers published in the official journal identified with the Western Surgical Association shall have been read before the Association.

## **ARTICLE V: Meetings**

SECTION 1. The place and time of the Annual Meeting and the Chairman of the Committee on Local Arrangements shall be selected by the Executive Committee.

- a. The date and location of the next two (2) succeeding meetings shall be published in the program at the time of the Annual Meeting each year.
- b. After such publication, the selected place of the meeting may be changed only by unanimous vote of the Executive Committee.
- c. Members shall sign the permanent register of the Association as a record of their attendance.
- d. A special register shall be provided for guests.

SECTION 2. A special meeting of the Association may be called at any time by the President, with the concurrence of the Executive Committee, and it shall be his duty to do so upon receipt of a written petition signed by ten (10) percent of the members.

SECTION 3. A member may invite a Doctor of Medicine or other distinguished scientist to participate in the scientific and social functions of the Association. A member inviting a guest to the Annual Scientific Meeting should send the name to the Secretary at least one (1) month before the date of the Annual Meeting. The Secretary shall forward an official invitation to the guest. The invited guests attending the meeting will receive a program of the meeting at the time of their registration. The President may extend to guests the privilege of participating in the discussions. Each guest will be assessed a Registration Fee. A senior medical student or a resident in surgery from an accredited residency program may attend the scientific meetings without charge upon presentation of appropriate identification and certification at the time of registration.

# BYLAWS CONTINUED

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## **ARTICLE VI: Quorum**

SECTION 1. A minimum of twenty-five (25) percent of the membership shall be required at any Executive Session to form a quorum for transaction of the ordinary business of the Association, for elections, for changes in the Constitution and Bylaws, or for ordering assessments.

SECTION 2. A minimum of fifty-one (51) percent of the membership shall be required to form a quorum to consider the expulsion of a member.

## **ARTICLE VII: Committees**

SECTION 1. All standing and ad hoc committees shall act in an advisory capacity to the duly elected Executive Committee of the Association.

SECTION 2. The Membership Committee shall be composed of six (6) members: four (4) presidential appointees, each to serve for a period of four (4) years; the other two (2) members shall be District Representatives assigned by the Executive Committee for the latter two-year (2-year) portion of their term of office. The President, the Secretary, and the Treasurer shall be ex-officio members of the Committee.

- a. The Chairman shall be the senior appointed member of the Committee, i.e. that appointed member who is in his/her fourth year on the Committee.
- b. The deadline for submission of applications to the Secretary of the Association shall be May 1 preceding the Annual Meeting.
- c. The Secretary of the Association shall send all applications and related data to this Committee at an appropriate interval preceding the Annual Meeting.
- d. The Membership Committee shall convene and present annually to the Executive Committee the complete list of candidates and their recommendation on each of them.

# BYLAWS CONTINUED

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SECTION 3. The Program Committee shall consist of six (6) members: four (4) presidential appointees, each to serve for a period of four (4) years; the other two (2) members shall be District Representatives assigned by the Executive Committee for the first two-year (2-year) portion of their term of office. The President, the Secretary, and the Recorder shall be ex-officio members.

- a. The Chairman shall be the senior appointed member, i.e. that appointed member who is in his/her fourth year on the Committee.
- b. The deadline for submission of abstracts to the Secretary of the Association shall be in accordance with published guidelines of the Association.
- c. After individual preliminary evaluation of all abstracts, this Committee shall convene for purposes of final selection of the program for the Annual Meeting.

SECTION 4. The Executive Committee shall act as a Budget Committee with reference to necessary secretarial expenditures for officers and committee members, subject to the approval of the membership.

SECTION 5. ADVISORY NOMINATING COMMITTEE. The Executive Committee shall act as the Nominating Committee at the Annual Meeting. In turn, the Executive Committee shall appoint an Advisory Committee, consisting of the three (3) immediate Past-Presidents and the senior District Representative. The Chairman of this Advisory Committee shall be the immediate Past-President. This Advisory Committee shall discuss suitable nominees to fill the officer and representative vacancies which shall occur at the time of the Annual Meeting, and shall submit its recommendations to the Executive Committee for consideration. The President and Secretary shall serve as ex-officio members.

SECTION 6. The Executive Committee shall appoint the Chairman of the Committee on Local Arrangements at least one (1) year in advance. In coordination with the Secretary and Treasurer he/she shall be responsible for all details pertaining to the Annual Meeting unless otherwise ordered by the Executive Committee.

## **ARTICLE VIII: Seal and Certificate of Membership**

SECTION 1. The Seal shall be circular in form and bear the name of the Association about the border. In the center shall be portrayed the Western Country, similar to the State Seal of Kansas. The Association was founded in Topeka, Kansas, 1891.

SECTION 2. The Association shall issue a Certificate of Membership signed by the President and Secretary.



# BYLAWS CONTINUED

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SECTION 3. The Certificate of Membership shall be as follows:

WESTERN SURGICAL ASSOCIATION  
FOR THE CULTIVATION PROMOTION AND DIFFUSION OF  
KNOWLEDGE OF THE ART AND SCIENCE OF SURGERY  
HAS ELECTED

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TO ACTIVE MEMBERSHIP  
OR  
HONORARY MEMBERSHIP



---

President \_\_\_\_\_ Secretary \_\_\_\_\_

\_\_\_\_\_  
Date

## **ARTICLE IX: Nominations and Elections**

SECTION 1. Nominations for all Officers shall be made at the Executive Session of the Annual Meeting by the Executive Committee of the Association. Additional nominations may be made from the floor.

SECTION 2. The election of Officers shall take place at the Executive Session of the Annual Meeting. An affirmative vote of a majority of the members voting at the Executive Session shall constitute an election.

SECTION 3. Any vacancy occurring during the year among the Officers of the Association shall be filled by the action of the Executive Committee. Any vacancy occurring among Committee Members shall be filled by action of the President.

## **ARTICLE X: Order of Business**

SECTION 1. Order of Business of the Executive Committee

1. Reading of minutes of last meeting
2. Reports:
  - a. Secretary
  - b. Treasurer
  - c. Recorder
3. Reports of Program and Membership Committees
4. Reports of Representatives of American Board of Surgery and the Board of Governors and Advisory Council on Surgery of the American College of Surgeons
5. Unfinished Business
6. New Business
7. Nominations:
  - a. Locations of Future Meetings
  - b. Chairman of Committee on Local Arrangements
8. The report of the Advisory Committee on Nominations shall be considered, and a slate of nominations for officers shall be prepared.
9. The report of the Executive Committee of the Association shall be discussed in preparation for its presentation by the Secretary to the membership of the Association in Executive Session at the Annual Meeting.

# BYLAWS CONTINUED

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## SECTION 2. Executive Session of the Annual Meeting

1. Reading of previous year's minutes of the Executive Session of the Annual Meeting
2. Report of Executive Committee meetings to the Association by the Secretary
3. Report of the Treasurer
4. Report of the Recorder
5. Report of the Representative Board of Governors, American College of Surgeons
6. Report of the Representative American Board of Surgery
7. Report of the Representative Advisory Council on Surgery, American College of Surgeons
8. Report of Program & Membership Committees
9. Unfinished Business
10. New Business
11. Election of New Members
12. Election of New Officers
13. Adjournment

## **ARTICLE XI: Alterations in the Constitution and Bylaws**

No part of the Constitution or Bylaws may be amended, altered or replaced, except at a regular Annual Meeting of the Association in Executive Session. The suggested amendment, alteration or repeal in the Constitution or Bylaws must have been presented in writing at the Executive Session of the previous Annual Meeting, signed by three (3) members. Notice of the proposed amendment, alteration or repeal shall be given in writing with the call to the Annual Meeting. The adoption of the suggested amendment, alteration or repeal shall be by vote of three-fourths of the members voting, a quorum being present at the Executive Session.

## **ARTICLE XII: Parliamentary Authority**

Sturgis' Standard Code of Parliamentary Procedure, the current edition, shall be the parliamentary authority in all matters not specified in the Constitution, Bylaws or standing rules of this organization.





# **Past Presidents & Meeting Places**

# PAST PRESIDENTS & MEETING PLACES

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PRESIDENT	PLACE	YEAR
S.S. Todd*	Topeka	1891
Milo B. Ward*	Kansas City	1892
Milo B. Ward*	Des Moines	1893
Lewis Schooler*	Omaha	1894
John E. Summers, Jr.*	Kansas City	1895
Thomas J. Beattie*	Topeka	1896
Joseph Eastman*	Denver	1897
David S. Fairchild*	Omaha	1898
Homer C. Crowell*	Des Moines	1899
O. Beverly Campbell*	Minneapolis	1900
August F. Jonas*	Chicago	1901
James E. Moore*	St. Joseph	1902
Alexander H. Ferguson*	Denver	1903
Charles H. Mayo*	Milwaukee	1904
Harvey D. Niles*	Kansas City	1905
Malcolm L. Harris*	Salt Lake City	1906
Charles W. Oviatt*	St. Louis	1907
William W. Grant*	Minneapolis	1908
Arthur L. Wright*	Omaha	1909
John P. Lord*	Chicago	1910
Amos W. Abbott*	Kansas City	1911
Lewis L. McArthur*	Cincinnati	1912
Jabez N. Jackson*	St. Louis	1913
Bryon B. Davis*	Denver	1914
Joseph R. Eastman*	Des Moines	1915
Lawrence W. Littig*	St. Paul	1916
Leonard Freeman*	Omaha	1917
James F. Percy*	Chicago	1918
Roland Hill*	Kansas City	1919
Arthur T. Mann*	Los Angeles	1920
Charles D. Lockwood*	St. Louis	1921
Miles F. Porter*	Minneapolis	1922
Horace G. Wetherill*	Colorado Springs	1923
Donald Macrae, Jr.*	French Lick Springs	1924
Willard D. Haines*	Wichita	1925
Robert C. Coffey*	Duluth	1926
Lewis H. McKinnie*	Omaha	1927
Kellog Speed*	Chicago	1928
E. Starr Judd*	Del Monte	1929

# PAST PRESIDENTS & MEETING PLACES

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Carl E. Black*	Kansas City	1930
Clarence G. Toland*	Denver	1931
Harry P. Ritchie*	Madison	1932
Samuel C. Plummer*	Cincinnati	1933
Frank R. Teachenor*	St. Louis	1934
Reginald H. Jackson*	Rochester	1935
Thomas G. Orr*	Kansas City	1936
Fred W. Bailey*	Indianapolis	1937
Casper F. Hegner*	Omaha	1938
Vernon C. David*	Los Angeles	1939
Alfred Brown*	Topeka	1940
Albert H. Montgomery*	St. Paul	1941
Willis C. Gatch*	No General Meeting	1942
Willis D. Gatch*	No General Meeting	1943
Willis D. Gatch*	Chicago	1944
James C. Masson*	Chicago	1945
Arthur R. Metz*	Memphis	1946
William M. Mills*	Colorado Springs	1947
Harry B. Zimmerman*	St. Louis	1948
Robert L. Sanders*	Santa Barbara	1949
Warren H. Cole*	Minneapolis	1950
Erwin R. Schmidt*	Colorado Springs	1951
George B. Packard*	Houston	1952
Lawrence Chaffin*	Chicago	1953
Herbert H. Davis*	Colorado Springs	1954
Michael L. Mason*	Seattle	1955
Charles G. Johnston*	Cincinnati	1956
Everett P. Coleman*	Salt Lake City	1957
James B. Brown*	Rochester	1958
James T. Priestley*	Colorado Springs	1959
Caleb S. Stone, Jr.*	Detroit	1960
John T. Reynolds*	San Francisco	1961
Jacob K. Berman*	St. Louis	1962
Charles W. Mayo*	Galveston	1963
Eugene A. Osius*	Colorado Springs	1964
Arthur J. Hunnicutt*	Omaha	1965
Walter W. Carroll*	Phoenix	1966
O. Theron Claggett*	Los Angeles	1967
Merle M. Musselman*	Chicago	1968
Arthur C. Pattison*	Dallas	1969

# PAST PRESIDENTS & MEETING PLACES

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PRESIDENT	PLACE	YEAR
Kenneth C. Sawyer*	Colorado Springs	1970
Raleigh R. White*	Portland	1971
Carl P. Schlicke*	Rochester	1972
Tom D. Throckmorton*	Houston	1973
Darrell A. Campbell*	San Francisco	1974
Chester B. McVay*	Colorado Springs	1975
William P. Mikkelsen*	Coronado	1976
Allen M. Boyden*	Las Vegas	1977
D. Emirick Szilagyi*	Scottsdale	1978
Harvey R. Butcher, Jr.*	Colorado Springs	1979
William H. ReMine*	Salt Lake City	1980
Paul E. Hodgson*	Albuquerque	1981
James J. Berens*	Kansas City	1982
Robert E. McCurdy*	Monterey	1983
George L. Jordan, Jr.*	Colorado Springs	1984
Martin A. Adson*	Rochester	1985
R. Dale Liechty*	Detroit	1986
Alexander J. Walt*	Dallas	1987
Melvin A. Block	Coronado	1988
J. Bradley Aust*	St. Louis	1989
David G. Ashbaugh	Scottsdale	1990
John L. Glover*	Colorado Springs	1991
Arthur J. Donovan	San Antonio	1992
George E. Block*	Seattle	1993
Basil A. Pruitt, Jr.	Palm Desert	1994
Norman W. Thompson	Chicago	1995
Jon A. van Heerden	Portland	1996
Jack R. Pickleman	Colorado Springs	1997
Jay L. Grosfeld	Indianapolis	1998
Thomas V. Berne	Santa Fe	1999
Amilu S. Rothhammer	Dana Point	2000
J. David Richardson	San Antonio	2001
Claude H. Organ*	Vancouver, British Columbia	2002
Richard A. Prinz	Tucson	2003
Fabrizio Michelassi	Las Vegas	2004
Arthur S. McFee	Rancho Mirage, CA	2005
Richard C. Thirlby	Los Cabos, México	2006
Merril T. Dayton	Buffalo, NY	2007
Bruce L. Gewertz	Santa Fe, NM	2008



# PAST PRESIDENTS & MEETING PLACES

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Wayne H. Schwesinger	San Antonio, TX	2009
Michael B. Farnell	Chicago, IL	2010
Gregory J. Jurkovich	Tucson, AZ	2011
Raymond J. Joehl	Colorado Springs, CO	2012
Clive S. Grant	Salt Lake City, UT	2013
Steven C. Stain	Indian Wells, CA	2014

*\*Deceased*





# *Deaths & Memorials*

# IN MEMORIAM CONTINUED

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## DEATHS REPORTED 2013–2014

William David Barnett

Jack Alroy Barney

John Beal Jr.

LeGrande Dwight Cherry

Jack C. Cooley

Bernard T. “Dan” Daniels

Robert W. Gillespie

Leroy J Kleinsasser

Joseph Allen Kuhn

Shields Osco Livingston

Robert (Bob) E. McCurdy

A.R. “Babs” Moossa

Charles R. Morris

James Edward Pridgen

Thomas R. Russell

Bob Rutherford

Ambrose Byron Shields

E. Stewart Taylor

Roger D. Williams

Earl F Wolfman, Jr.

# IN MEMORIAM CONTINUED

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## **William David Barnett**

William David Barnett, M.D., was born January 24, 1928 to John Bryan Barnett, M.D., Sr. and Gladys Crockett in Thorton, Limestone County, Texas. They moved to Marlin, Texas where David grew up, as his father practiced general medicine. He excelled in all endeavors at M.H.S., and continued to do so, completing his B.S. and a pre-med degree at Texas A&M in 3 years. He then graduated from the University of Texas Medical Branch in Galveston (which he and his father--also a UTMB grad., termed "The Treasure Isle"). He interned at Kansas City General Hospital (as did his father) and then joined the USAF, as a captain, and was a base surgeon at Winpole Park, England. He returned to Dallas to serve his surgical residency at Parkland Memorial Hospital. He did a fellowship in colon and rectal surgery under Dr. Robert Rowe before starting his private practice. His surgical skills were unparalleled. He was devoted to medicine, surgery, and his patients. He spent countless hours training young surgical residents in the art and practice of surgery. He taught the code instilled by his father--"LISTEN to the patient. They are really trying to tell you what's wrong with them." He was held in the highest esteem by his residents "forever". David belonged to numerous organizations, including The American College of Surgeons, Southern Surgical, Western Surgical, Dallas Society of Surgeons, TMS, AMA, and especially, The Texas Surgical Society, for which he served as secretary, and then President in 1982. He was Chief of Surgery at Gaston Episcopal Hospital from 1981 to 1988. He died August 25, 2013 following a long illness. He is survived by his wife of 56 years, Betty; his daughter, "Missy" and her husband, Jim Callahan; his brother John Bryan Barnett, M.D., Jr., two nephews, and a niece. Graveside services will be held on Friday, August 30, 2013 at 9:30 a.m. at Sparkman/Hillcrest Memorial Park. If desired, contributions may be made to the Southwestern Medical Foundation. - See more at: <http://www.legacy.com/obituaries/dallasmorningnews/obituary.aspx?pid=166676814#sthash.B5T67Qqx.dpuf>



## **Jack Alroy Barney**

Jack Alroy Barney of Oklahoma City, OK passed away after an extended illness on December 4, 2013. Dr. Barney was born on October 25, 1931 in Watonga, OK the son of Jack Barney and Emylin McGuire Barney. He was preceded in death by his loving wife, Louise (July 15, 2012). Dr. Barney attended undergraduate school at the University of Oklahoma and the University Of Oklahoma School Of Medicine where he graduated in 1956. His general surgery residency was interrupted by two years of service in the U.S. Air Force. He practiced general surgery for 36 years at St. Anthony Hospital in OKC, OK. Dr. Barney was a fellow of the American College of surgeons, certified by the American Board of Surgery, and a member of the Southwestern Surgical Congress, Western Surgical Association, Oklahoma City Surgical Society, and Oklahoma Chapter of the ACS, Oklahoma County and State Medical Associations as well as the Sigma Alpha Epsilon fraternity.

Dr. Barney loved to play duplicate bridge (Life Master), fishing and gardening. He is survived by his daughter, Pamela Louise Barney, his sister Anna Sue Barney of Indianapolis, IN; as well as many sisters, brothers-in-law, and cousins.

# IN MEMORIAM CONTINUED

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## John Beal Jr.

Dr. John Beal Jr. juggled teaching, research and a medical practice during nearly 20 years as chairman of the department of surgery at what was then Northwestern University Medical School. “He made a number of important contributions to surgical research as a young man before he came to Northwestern and continued to foster research through the faculty he recruited,” said Dr. David Nahrwold, who succeeded Dr. Beal in 1982.

Tall and handsome, with a trace of a Southern drawl from his boyhood in Mississippi, Dr. Beal was a meticulous surgeon — “one whom trainees would want to emulate” — said Nahrwold, professor emeritus at what is now Northwestern’s Feinberg School of Medicine.

Dr. Beal, 97, died of complications of pneumonia Monday, June 3, in Southern Georgia Medical Center in Valdosta, according to his son John III. He had lived in Valdosta since the mid-1990s. Dr. Beal was born in Starkville, Miss. He moved with his family to Chicago when he was 13 years old after his father took a job as professor of botany at the University of Chicago. He went through high school, college and medical school at the the U. of C. He was a surgical intern and then resident at what was then the New York Hospital-Cornell University Medical Center in New York City and stayed there until mid-1943, when he was drafted to serve as an Army surgeon in evacuation hospitals in Europe.

Before being drafted, he married Mary Phemister, after meeting her through her brother, who was Dr. Beal’s fraternity brother. Her father, Dr. Dallas Phemister, was the first chairman of the department of surgery of the U. of C. Medical School.

After the war, Dr. Beal returned to New York as a surgical resident before being recruited to California in the late 1940s, where he joined the initial faculty of the UCLA Medical School and became chief surgeon at the school’s teaching hospital.

Dr. Beal returned to New York in 1953 as attending surgeon at the New York Hospital and associate professor of clinical surgery at Cornell Medical College, positions he held until coming back to Chicago in 1963 as head of the department of surgery at Northwestern. Nahrwold said Dr. Beal’s training, reputation and accomplishments would have identified him as an up-and-coming star in the surgery world, putting him in position to chair the department. Dr. Beal was also head of surgery at both Pas-savant Memorial Hospital and Wesley Memorial Hospital and was instrumental in the union of the two hospitals in the early 1970s to form Northwestern Memorial Hospital.

Dr. Beal wrote chapters in medical textbooks and journal articles on surgical subjects. “He was best known for his research and clinical activity in the gallbladder and biliary duct system,” Nahrwold said. “He wrote about how to take out the gallbladder and how to operate on biliary ducts, the small tubes that lead from the liver to the intestine.”

Dr. Beal was very active in a number of professional associations, including the American College of Surgeons. He was president of the organization from 1982 to 1983. He was also a member of the American Board of Surgery, the certifying body for U.S. surgeons, where he was chairman from 1970 to 1971.

He stepped down as Northwestern department chairman in 1982 and retired in 1984.

“His focus always was across the board of teaching, practice and research,” John Beal said of his father’s work, especially in Chicago. “He was proud of the level of patient care and of training of residents and students, and of the improvement in the quality of where residents were placed.”

Dr. Beal is also survived by a daughter, Margaret Loeb; another son, Bruce; and four grandchildren. His wife died in 2005. A Chicago memorial service is planned this summer.



## **LeGrande Dwight Cherry**

Dr. LeGrande Dwight Cherry, 93, of Lincoln, died June 5, 2014. Much loved father, grandfather, doctor and friend. Born Oct. 30, 1920 to Charles L. and Eva (Woltors) Cherry. Retired physician and surgeon, avid horseman and farmer. WWII Navy veteran. Member of American College of Surgeons, past chief of staff LGH, past president of County Medical Society, past president of Nebraska State Medical Society, past president of Lincoln Saddle Club, American Legion Post #3, NE American College of Surgeons, past governor of American College of Surgeons.

Family members include children, Ava Lynne (Cherry) O'Rourke and John & Judy (Ernst) Cherry of Lincoln; grandchildren, Jessica Cherry & Robert Busey of Fairbanks, Alaska, Timothy Cherry & Rachel Yung; and great grandchildren, Calvin Cherry and Henry Cherry of Boston. Nieces and nephews include Ms. Elizabeth Tenhulzen of Lincoln, among many. Preceded in death by wife, Ava Lynne (Ivins) Cherry; parents; brother, Byron Cherry; sister, Elizabeth (Cherry) Short; and son (in-law) James Daniel O'Rourke.

Funeral service: 1:30 p.m. Monday, June 9, at Roper and Sons Chapel, 4300 O Street, Pastor Renae Johnson officiating. Internment Lincoln Memorial Park. Visitation: 2-8 Sunday at Roper and Sons, Lincoln. Memorials to UN Foundation, Sheldon Art Gallery or donor's choice. Condolences: [roperandsons.com](http://roperandsons.com)



# IN MEMORIAM CONTINUED

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## **Jack C. Cooley**

Cooley, Dr. Jack C., 89, of Scottsdale, AZ, passed away on July 17, 2014, with his family at his side. He was born on September 4, 1924, in Redfield, SD to Dr. Frank Cooley and Crystal [Crain] Cooley. Jack had a remarkable career as a cardiac and thoracic surgeon after completing a fellowship at Mayo Clinic. He then had a 32 year career at Carle Clinic in Urbana, IL, where he was Chief of Surgery for nearly 25 years. Jack was associated with the University Of Illinois Department Of Physiology and the author of 57 articles published on thoracic and vascular surgery. He retired in 1990 and moved to Mesa, Az, with his wife Gloria [Gamage] Cooley. He had a love for golfing, showing horses and dogs, and was an avid fan of sports. He is preceded in death by his loving wife of 62 years, Gloria. He is survived by his sister Joan (Frank) Kiefer; daughters Crystal (Michael DiFiglio) Cooley and Carolyn (Neil) Stamm; son Craig Cooley; grandchildren Jared Stamm and Carter and Cameron Cooley as well as his great grandchild, Zachary Stamm and many wonderful friends. A celebration of his life will be held at 11:00 am, Monday July 21, 2014, at Mariposa Gardens Cemetery Chapel, 6747 E. Broadway Rd in Mesa, AZ. In lieu of flowers, donations may be made to The Carle Center for Philanthropy, 611 West Park Street, Urbana, IL 61801 or The Grayhawk Classic Residents' Foundation, Box 100, 7501 E. Thompson Peak Parkway, Scottsdale, AZ 85255. Arrangements entrusted to Mariposa Gardens (480) 830-4422

- See more at: <http://www.legacy.com/obituaries/azcentral/obituary.aspx?pid=171778650#sthash.wwDu5Wny.dpuf>

# IN MEMORIAM CONTINUED

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## **Bernard T. “Dan” Daniels**

Dr. Bernard T. “Dan” DANIELS Age 92, of Yankton, SD, Denver and Greeley, CO, and Carlisle, PA has died on March 28, 2007 in the UCC’s Thornwald Home after a long illness. His survivors include John and Phyllis Daniels; Matt Daniels and Heather Snookal and their son, Elliot; and Steve Daniels and Phoebe Anderson, all of Seattle. Please see full obituary at [www.since1853.com](http://www.since1853.com).

# IN MEMORIAM CONTINUED

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## **Robert W. Gillespie**

Robert W. Gillespie (Bob), 86, resided in Longmont, Colorado with his wife Patricia. He passed away peacefully at their home on July 25, 2013.

Bob was born on December 30, 1926 in Sioux City, Iowa to parents Hamilton Sawyer Gillespie Jr. and Marie McDonald Gillespie. He is predeceased by four of his five siblings: Adele, Hamilton Sawyer III, Mary and Jean. He is survived by sister Jane Palmer of Mobile, Alabama and brother-in-law Louis Burgher M.D. and wife Susan of Omaha, Nebraska.

He attended the University of South Dakota School of Medicine where he graduated with a Bachelor of Science degree in Medicine. Following graduation, he and his wife M. Jeanne Osbey, moved to Omaha, Nebraska to attend University of Nebraska School of Medicine. He graduated with a degree of Medical Doctor at the age of 24. Loving the surgery rotation, he picked Wayne County Hospital in Eloise, Michigan for his four-year residency. At the young age of 28, Bob Gillespie embarked on what would become an enormously successful career as a surgeon.

Following his residency he joined the U.S. Army as a Captain in the Medical Corps stationed in Ft. Benning Georgia. He was honorably discharged in 1957. He moved to Lincoln, Nebraska to set up his private surgery practice and performed surgery at St. Elizabeth Community Health Center, Bryan Memorial Hospital and Lincoln General Hospital.

With a keen interest in trauma and burn care—specifically involving children—Bob joined the American Burn Association in 1969. As Medical Director, he opened the Burn and Trauma unit in St. Elizabeth's hospital in 1974. This was the first private hospital burn unit between Salt Lake City and Chicago.

He and Patricia Burgher Hallberg wed in 1985 and worked together caring for burn patients until they retired in 2002. In 1987 and 1989 respectively, they developed the Advanced Burn Life Support Provider Course and the Pre-Hospital Burn Life Support Course, which were the quintessential burn educational tools for medical personnel. For a dozen years, they taught more than 100 courses nationally and internationally to help improve burn care from onset to release.

In 1995, he moved to Blair, Nebraska and developed the Clarkson Burn Center where he served as Medical Director.

Along with organizing and supervising numerous burn, trauma and emergency programs throughout the country and internationally, Bob published dozens of medical journal articles, videos and conducted numerous scientific experiments to help advance burn care treatment.

He is survived by his wife Patricia of Longmont, five sons, Tom and his wife Suzi of Boise, Idaho, Kevin of Lincoln, Nebraska, Greg and his wife Mary Jo of Lincoln, Nebraska, Todd Hallberg and his wife Andrea of Centennial, Colorado and Mark Hallberg and his wife Laurie of Parker, Colorado.

He is survived by three daughters, Jeanne and her husband Mike of Woodinville, Washington, Kathy of Denver, Colorado and Peg Hallberg of Golden, Colorado.

Bob is survived by 15 grandchildren of whom he was very proud: Megan, Keelan, Jeff, Kevin, Lindsey, Tommy, Kelly, Erin, Anne-Marie, Cara, Daniel, Molly, Tyler, Derian and Allison. He has two great grandchildren, Rory and Avery.

He will be known for his compassionate patient care and his love of teaching.



## **Leroy J. Kleinsasser**

Leroy J Kleinsasser was born February 24, 1913 in Chaseley, North Dakota. He graduated from the University of South Dakota “Cum Laude” and received his medical degree from University of Nebraska in 1936. He completed internships at University of Nebraska and University of Minnesota and a residency in General Surgery at Charity Hospital of New Orleans on the Tulane Surgical Division, ending in 1942. He served during World War II as Chief of a Vascular Surgical Center and rose to the rank of Major. He left the military in 1946 to serve as Chief of Surgery at the Dallas Veterans Administration Hospital for 4 years. He served as the Director of the Caruth Surgical Research Laboratory at Baylor University Medical Center and the Program Director for the General Surgery Residency from 1950 to 1956. He performed the first homologous aortic bifurcation graft replacement procedure of an abdominal aortic aneurysm at Baylor in Dallas in 1954. He served as Clinical Professor of Surgery at Southwestern Medical School and Parkland Hospital. He practiced general, vascular and thoracic surgery in private practice until 1987. He was member of the Society of University Surgeons, Southwestern Surgical Society and the Western Surgical Association. He continued to regularly attend Grand Rounds at Baylor until 2011 and celebrated his 100th birthday at Grand Rounds at Baylor in 2013.

Dr. Kleinsasser was married to Dorothy Aldwyth Waggener during his residency at Charity Hospital, where she was a social worker. During their 42 years together, they had 2 sons and 2 daughters, 5 grandchildren and 4 great grandchildren. He is remembered for his quick wit and sense of humor, excellent surgical skills, love of golf, fishing, painting, dancing and the outdoors and humility.

Written by: Drs. James Fleshman and Ron Jones

# IN MEMORIAM CONTINUED

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## **Joseph Allen Kuhn**

Joseph Allen Kuhn was born October 3, 1958 in Ames, Iowa. Dr Kuhn did his undergraduate work at Texas A&M before graduating AOA from University of Texas Medical Branch in Galveston in 1984. He completed his General Surgical Residency at Baylor University Medical Center in Dallas, followed by a 3 year Surgical Oncology Fellowship at City of Hope Hospital in Los Angeles, California. He returned to private practice at Baylor University Medical Center in 1992 where he contributed to the residency program as director of Surgical Research and Medical Director of the Bariatric Center of Excellence. He carried an appointment as Associate Clinical Professor of Surgery at Texas A&M. He was a member of the Society of Surgical Oncology, the Southern Surgical Association and the Western Surgical Association. Dr Kuhn met and married Mollie, his wife of 36 years, while at Texas A&M and together they have 3 children. Dr Kuhn will be remembered as an enthusiastic teacher, who loved to operate and a loving father. His untimely death from renal cancer July 20, 2014 is regretted by all.

Written by: Drs. James Fleshman and Ron Jones



## **Shields Osco Livingston**

Shields Osco Livingston was born December 14, 1919 in Morristown, Tennessee. He served in World War II as Lieutenant Commander in the Naval Air Force. He obtained his Medical Degree from Washington University in St Louis in 1950, where he met and married his wife of 62 years, Harriet Lutz Livingston. He completed his General Surgery Residency at the Veterans Administration Hospital in McKinney, Texas in 1955. He joined the attending staff at Baylor University Medical Center in Dallas and Harriette became an anesthesiologist at Presbyterian Hospital of Dallas. He served as the 11th Chairman of the Department of Surgery at Baylor from September, 1986 until July, 1987. He retired from active practice in June, 1990 after 40 years of practicing general surgery. He is remembered as an excellent surgeon with a kind, sweet disposition who cared deeply for his patients, family and friends. He died in Dallas on June 28, 2011 after suffering a stroke. He has 3 children, 5 grandchildren and several great-grandchildren.

Written by: Drs. James Fleshman and Ron Jones

# IN MEMORIAM CONTINUED

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## **Robert (Bob) E. McCurdy**

Robert (Bob) E. McCurdy, MD, retired surgeon and long-time Denver resident died in Denver, Colorado on February 16, 2014. He was 91 years old. Bob was born in Purcell, Oklahoma on September 18, 1922, and graduated as valedictorian of his Purcell High School class in 1940. He attended the University Of Oklahoma Undergraduate and Medical Schools, earning his MD in March, 1946 as a result of an accelerated program sponsored by the military during World War II.

He did his internship at the University of Maryland in 1946-47. He completed his surgical residency at The Denver Veterans Hospital from 1947-51 under Paul Ireland, MD, and subsequently received his American Board of Surgery Certification. In 1951, he went to work with Dr. Kenneth Sawyer (President of the Western Surgical Association in 1970) in Denver and in 1953 entered into private practice. Bob practiced surgery for the next 40 years in Denver, mainly at Presbyterian Medical Center, until his retirement in 1993.

Dr. McCurdy was a member of the Western Surgical Association since 1960 and was elected its President in 1983. In addition to the Western Surgical Association, he was President of the Denver Academy of Surgery and President of the Colorado Chapter of the American College of Surgeons. Dr. McCurdy was a member and delegate of the AMA, a member of the American College of Surgeons, served on the board of directors for HealthOne, and was past chief of surgery at Presbyterian Medical Center Denver. He was an Associate Clinical Professor of Surgery at the University of Colorado and served for a time on the Medical School admissions committee.

Dr. McCurdy married Carolyn Faught in 1947 and they had two daughters and a son. His son died in an automobile accident in 1975, and his wife died in 1999. They have two granddaughters and two grandsons. They were members of St. John's Cathedral in Denver and Cherry Hills Country Club.

Dr. McCurdy was a passionate golfer (loved to compete) and dry fly fisherman. He loved Dewar's scotch, anything chocolate, and Welsh Terriers. For his whole life, he was an avid supporter of all sports teams of the University of Oklahoma.

Dr. McCurdy was an outstanding surgeon who practiced with absolute integrity and unending compassion for his patients. He loved life, was always considerate, and had an upbeat personality. His presence always meant laughter and celebration. He simply brought joy and comfort to so many, and he will be greatly missed by all who knew and loved him.

# IN MEMORIAM CONTINUED

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## **A.R. “Babs” Moossa**

The surgical community mourns the passing of A.R. “Babs” Moossa, MD, FRCS, FACS, Distinguished Professor of Surgery, and Emeritus Chairman of the UC San Diego Department of Surgery. Dr. Moossa died peacefully at his home in the early morning of July 17th, 2013, with his family by his side.

Dr. Moossa was appointed as Chairman of the UC San Diego Department of Surgery in 1983. From 2003 to 2009, Dr. Moossa also served as Associate Dean and Special Counsel to the Vice Chancellor for Health Sciences and Director of Tertiary and Quaternary Referral Services for UCSD. Under his leadership, UCSD Health Sciences became an internationally renowned facility with patients and research collaborations coming from every corner of the world.

Babs was a master surgeon. His passion, dedication and careful attention to the highest principles of patient care defined his notable career. He was a dedicated physician, a champion surgeon, an inspiring teacher and an influential leader. His legacy and contributions to the medical community will impact generations to come.



# IN MEMORIAM CONTINUED

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## **Charles R. Morris**

Charles R. Morris, M.D., F.A.C.S., longtime staff member and first Medical Director of St. Paul Hospital, Dallas TX, passed away peacefully on May 23, 2009. A visitation will be held on Wed, May 27 from 6:00-8:00pm with rosary at 7:00pm at Sparkman/Hillcrest; Mass of Christian burial will be Thurs, May 28 at 11:00 AM at St. Monica Catholic Church, 9933 Midway Rd. Dr. Morris was born 07/24/1916, in Washburn, Wisconsin, attended the Univ of Wisc. Med School, Northwestern Univ, and completed a surgical residency at the Mayo Clinic. During WWII, he served with the Medical Corps as part of Chennault's Flying Tigers in SE Asia. In 1950, he married his bride of 59 yrs, Jeannette (Ray) Morris, and moved to Dallas where he established a general surgical practice. He was a member of the Dallas County Med Society, the Dallas General Surgeons, the TX Surgical Society and the Western Surg. Assoc., in addition to numerous other professional affiliations. Prior to and after his retirement, he was actively involved in the community and especially the Serra Club of Greater Dallas, a Catholic men's organization. Additionally, he was an avid hunter and outdoorsman and grew over the years to share his wife's passion for fishing. Dr. Morris came from a large family of 8 children; he was preceded in death by parents Alice and Charles Francis, sisters, Margaret Morris, Ellie Loomis, Katherine Morris, brothers Bill, Tom, Bob and John and grandchild Anne Elizabeth Morris. He is survived by beloved wife, Jeannette; children, Charles R. Morris Jr. and his wife Ruth of Overland Park, Kansas, Tim Morris and his wife Mary of Grapevine, Texas, Patricia Morris Johnson and her husband Max of Stillwater, Oklahoma, and Martha Morris Johnson and her husband John of Garland, Texas; six grandchildren, four great-grandchildren and many friends and associates. The family requests that memorials be made to the St. Vincent De Paul Society, 3811 Gilbert Ave., Dallas, TX 75219



## **James Edward Pridgen**

James Edward Pridgen, MD, age 95, of San Antonio, TX, passed away at home on Christmas Eve, 2013 in the presence of his loving and devoted family. He went by many names. To his children, he was Daddy or Dad. To his grandchildren he was Daddy Jim. To his hundreds of patients he was Dr. Pridgen and to his myriad of friends he was simply, Jim.

Jim was born in Cuero, TX at the Burns Hospital to Dr. James Howard Pridgen and Ada Beth Harwood Pridgen. He graduated from Cuero High School and was Sultan in the 1938 Cuero Turkey Trot. He enrolled in Texas A&M University where he was first chair clarinet in the Aggie Band as a freshman. Reflecting on this accomplishment, Jim felt this was his 'main claim to fame'. After two years, Jim transferred to the University

of Texas, becoming a member of the SAE fraternity and graduated in 1939. Progressing on to Tulane Medical School in New Orleans, Jim was President of Nu Sigma Nu fraternity and graduated with Honors in 1943.

Dr. Pridgen had accepted a surgical fellowship at the Mayo Clinic in Rochester, MN, which had to be delayed because of military service as a combat medical officer with the Army in WWII. Dr. Pridgen was honorably discharged achieving the rank of Major, with a Bronze Star with Clusters. Upon his return, he married Betty Jo Rabb of Atlanta, TX and fulfilled his obligations to the Mayo Clinic. During his five years there, he earned a Masters Degree in Surgery and became a Diplomat of the American Board of Surgery. In 1951, he moved his family to San Antonio and started a private surgical practice.

One of Dr. Pridgen's outstanding achievements was his vision for a hospital, medical school and later a medical center in the northwest part of San Antonio. He was instrumental in raising funds, building and the development of the Methodist Hospital of South Texas. Upon its completion, he performed the first surgery in November of 1963. He was the first Chief of Surgery and was later Chief of Staff. The Hospital became the impetus for the geographically important South Texas Medical Center it has become today. Dr. Pridgen was the last of the doctor pioneers to be alive who orchestrated the beginnings of the hospital. His efforts were vital in the development of the South Texas Medical Center, which now comprises 900 acres, 13 hospitals and numerous medical offices. For many years, he served on the Board of Trustees of the San Antonio Medical Foundation which oversees the stewardship of the South Texas Medical Center.

Dr. Pridgen was also instrumental in starting the medical school now known as the University of Texas Health Science Center. This medical school became a reality in 1968. Later, the University Teaching Hospital was built and Dr. Pridgen became the first Chief of Staff at this hospital and was appointed clinical professor of surgery. Dr. Pridgen's role gave the new school credibility and guaranteed a working relationship amongst the medical communities. The James E. Pridgen, MD Scholarship Trust was first endowed at the medical school as a joint effort between the Christ Healing Center of San Antonio and the Health Science Center. It honors the awarded student and acknowledges Dr. Pridgen's role in helping to build a first rate medical school in the city.

Jim was active in various medical professional organizations. He served as President of Texas Surgical Society, International Medical Assembly, San Antonio Surgical Society and the Mayo Clinic Alumni Society. He was a member of the prestigious Southern Surgical Society and Western Surgical Society

# IN MEMORIAM CONTINUED

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and he served as Governor of the American College of Surgeons South Texas Chapter.

Being a consultant for some 25 years at Wilford Hall Hospital and Brooke Army Medical Center, Dr. Pridgen received an “Outstanding Civilian Consultant Award” from both institutions. In 1994, Jim formally retired from surgery and for the next 15 years he was a consultant at the Veteran’s Administration Outpatient Clinic in San Antonio. When he completely retired, he was 92 years of age.

Dr. Pridgen was more than just a pioneer doctor. His influence and “hands on” approach to practicing medicine will be felt in this city for years to come. He was also a man whose faith in Jesus Christ sustained him and led him throughout his life. He believed strongly in the power of prayer and in the precept, “Where the doctor leaves off, the Lord takes over.” He was a member of the Alamo Heights United Methodist Church for over 60 years. Serving in many capacities, he was President of the church board, a member of the Foundation Board, teaching Sunday school, singing in the choir and ushering until three months before his death.

A great lover of music, he was interested in the Symphony and Opera and particularly enjoyed the Happy Jazz Band on the San Antonio riverwalk with family and friends. He played multiple instruments including the piano, guitar and the clarinet.

Jim served on the Alamo Council of the Boy Scouts for several years. Both of his grandsons, Kelly and Clint, admit Daddy Jim was very supportive and influential in their becoming Eagle Scouts.

Jim enjoyed people and loved to be around them. He was a member of several social organizations which reflected his style as one of the last true gentlemen. His membership in The Argyle, San Antonio Country Club, Texas Cavaliers and the Conopus Club exhibits his genteel social spirit.

Jim’s greatest pride and joy were his children. He enjoyed vacationing with them over the years, especially in Port Aransas, where family reunions were held. He cherished long walks with his daughters on the beach and riding four wheelers with his son at his Cuero ranch.

Jim Pridgen was preceded in death by his parents and his loving wife of 65 years, Betty Rabb Pridgen. He is survived by two daughters and their spouses, Elizabeth Gay and Steve Swanson of San Antonio, Carol and Gerry Storey of Dallas and son, James E. Pridgen, Jr. of San Antonio. He is also survived by six grandchildren and their spouses, Kelly and Kara Gray of Houston, Bethany Gray of Galveston, Clint Storey of Kerrville, Clair Storey of Dallas, Erin and Erik Phelps of Hawaii and Jennifer Pridgen of San Antonio; four great grandchildren, Dylan Gray, Owen and Summer Phelps and Alannah Pridgen.

We would like to thank his wonderful caregivers, Robert Redgrave, Fannie Angel, Mina Martinez, Jose Lopez and his Odyssey Hospice nurse, Sally Ledesma.

- See more at: <http://www.legacy.com/obituaries/sanantonio/obituary.aspx?pid=168770366#sthash.wWihPEEC.dpuf>



## **Thomas R. Russell**

Dr. Thomas R. Russell, Executive Director of the American College of Surgeons (ACS) from January 2000 through January 2010, died August 4, after a four-year battle with cancer. He was 73 years old and is fondly remembered by colleagues and patients as a dedicated leader and kind surgeon.

A native San Franciscan, he attended The Thacher School, where the curriculum stressed academic studies and character-building through the care of horses. This experience profoundly affected how he would conduct his personal and professional life.

He earned an undergraduate degree in Zoology from the University of California, Berkeley, and a medical degree from Creighton University Medical School, Omaha, NE. He trained at the University of California, San Francisco, and served as a Lieutenant Commander/U.S. Navy flight surgeon in the Vietnam War. In 1975, he joined a San Francisco general and colorectal surgery practice, and in 1980 was appointed chair of the California Pacific Medical Center's department of surgery.

Throughout his professional career, Tom was active in many surgical organizations, quickly rising to prominence in the ACS and its Northern California Chapter, as well as the Pacific Coast Surgical Association.

As an ACS Regent (1993-1999), Tom demonstrated a keen understanding of the problems facing surgery, so it wasn't surprising that the College tapped him to serve as Executive Director. Under his leadership, the ACS reorganized, expanded its presence in Washington, DC, and its educational programming, and brought the National Surgical Quality Improvement Program into the private sector as ACS NSQIP®.

Ultimately, Tom is remembered most for his efforts to build an all-inclusive house of surgery—one united in its mission to advance optimal care of surgical patients.

# IN MEMORIAM CONTINUED

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## **Bob Rutherford**

Bob was born in Edmonton, Alberta, Canada and grew up in Edmonton, Vancouver, Toronto, and Australia. In 1947 he moved to New York City and attended McBurney School. Bob attended Johns Hopkins University in Baltimore, MD receiving a BA degree in 1952 and an MD degree in 1956. After a surgical internship at Johns Hopkins Hospital in 1956-57 he completed his surgical training at the University of Colorado School of Medicine in 1963. In 1961-62 he spent the year doing surgery at the University of Lund in Malmo, Sweden supported by a Fulbright Scholarship. After residency, Bob spent 2 years in the research laboratory of the Walter Reed Army Medical Center in Washington DC. Then, Bob went on the faculty of the surgery department of the Johns Hopkins Hospital from 1965-70 until he was recruited to the surgery department of the University of Colorado School of Medicine by William R Waddell, MD. He remained on the full-time faculty in Colorado until 1996 when he retired as an Emeritus Professor of Surgery. Bob was certified in General Surgery, Cardiothoracic Surgery, and later Vascular Surgery. Initially Bob had many research interests, but vascular surgery soon occupied most of his time. He published over 400 articles, wrote many book chapters, and 6 textbooks. Bob's textbook Vascular surgery was first published in 1977 and currently is in its 7th edition. Bob edited Seminars in Vascular Surgery from 1988-2012 and was co-editor of the Journal of Vascular Surgery from 1996-2003. He was a director of the American Board of Surgery for 6 years and chairman of that board's Vascular Surgery Committee. Bob was a member of over 20 professional societies and president of 4- most notably the Society of Vascular Surgery. He was awarded an honorary fellowship in the Royal College of Surgeons, Glasgow in 1996 when he delivered the Lister Lecture that year in Scotland. Bob was tireless in developing standards for uniform reporting practices in vascular surgery and disease specific severity scoring as a basis for comparing treatment outcomes. It would be hard to say Bob ever really retired. He spent his later years between Colorado, Maine, and Texas. His interests were varied- skiing, wind surfing, sailing, tennis, biking, fishing, bird photography, piano, and golf. He was an above average skier and spent years trying and failing to be as accomplished in that sport as his wife Kay. Bob and Kay were married 58 years and have 5 children, 7 grandchildren, and 3 great grandchildren. In life, Bob Rutherford was a giant physically (6'8" tall) and a giant intellectually as the above memorial confirms.

Written by: Erick Ratzer, MD



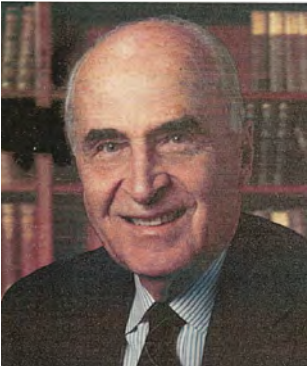
## **Ambrose Byron Shields**

Dr. Ambrose “Bucky” Shields died at home in Portland on November 2, 2013, surrounded by his family. He was 99 years old and succumbed to heart disease. Born in 1914 on the family homestead in Wellsville, Kansas, he was the seventh of the nine children of Byron Shields and Maude Dixon Shields. He attended a one room grammar school and after graduation from Wellsville High School, he earned a Bachelor of Science degree (1938) and a Doctor of Medicine degree (1940) at the University of Kansas. He worked his way through KU in a variety of jobs, including threshing wheat, picking peonies and washing dishes. He was so hard-pressed for money that if a dean had not given him one dollar to complete payment of his fees in 1934, “Bucky” would have had to drop out of college. After his 1940 marriage to Alice Louise Crane, of Olathe, Kansas, he moved with his new bride to Portland where he completed an internship and then started a residency in surgery at St.

Vincent Hospital. He volunteered for the Army Medical Corps in 1942 and served for the duration of World War II in North Africa and Europe. Upon his return from war, Dr. Shields embarked on a distinguished career as a surgeon, which spanned 46 years and was acknowledged with many professional accolades. Family, patients, colleagues, and friends will remember “Bucky” for his loving and giving nature, his zest for life, his humor and wise counsel, and his passion for medicine. He was a gifted storyteller with a prodigious memory of people and events. An avid outdoorsman and accomplished golfer, he hunted, fished, and played an amazing eighteen holes well into his nineties. “Bucky” was preceded in death by Alice, his wife of 68 years. He is survived by two sons, Dr. Paul Shields (Aletha) and Alan Shields (Teri Jo), and his daughter Mary Antiochos (Spiro); his six grandchildren, who lovingly referred to him as “Pa” , are Brent and Ryan Shields, Anne Marie Charnholm, Katie Lynne Ifrah, Brendan and Brian Antiochos. “Bucky” also leaves behind six great-grandchildren: Coralie and Keelan Shields, Amy and Megan Charnholm, Nathan Ifrah and Clay Antiochos. A Memorial Service for Ambrose “Bucky” Shields will be held at a later date to be announced. Donations in his memory may be made to the Dr. A. B. Shields Nursing Scholarship Fund, Providence St. Vincent Medical Foundation, 9205 SW Barnes Rd, Suite 211, Portland, OR 97221. “Bucky” expressed the wish to live to 100, but he will live much longer than that because love lasts forever in the hearts of family and friends.

# IN MEMORIAM CONTINUED

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## **E. Stewart Taylor**

E. Stewart Taylor, MD died in Denver, CO on February 5, 2014 at the age of 102. Dr. Taylor was a member of the Western Surgical Association since 1952.

Dr. Taylor was born in Hecla, SD on August 20, 1911, grew up in Highmore, SD, and received his undergraduate degree and attended medical school at the University of Iowa where he obtained his MD degree in 1936. He interned at Hurley Hospital in Flint, MI from 1936-1937 and then did a 4 ½ year residency program in Obstetrics and Gynecology at Long Island College Hospital in Brooklyn, NY. Dr. Taylor practiced briefly in Worthington, MN before joining the US Army in 1942. He entered Europe via Normandy in June, 1944, was assigned to the 107th Evacuation Hospital of George Patton's 3rd US Army, and

did over 1000 operations before his discharge from the service. Dr. Taylor was awarded 5 battle stars for his service in Normandy, France, Ardennes (Bulge), Rhine, and Germany.

After discharge from the Army, Dr. Taylor again practiced in Worthington, MN before moving to Denver, CO in January, 1947. In Denver, Dr. Taylor joined the practice of Clarence Ingraham, MD who was the volunteer chairman of Obstetrics and Gynecology at the Colorado School of Medicine. D. Ingraham retired in late 1947 and that year Dr. Taylor became the first full time chairman of the School of Medicine's Obstetrics and Gynecology Department. He retired as chairman in 1976 after 29 years but remained many more years on the faculty. He saw patients until he was 80.

During his chairmanship, Dr. Taylor trained one third of the obstetrics and gynecologic physicians in Colorado. Dr. Taylor was a prolific author, editor, and officer of the leading organizations in his specialty. He was president of the American Association of Obstetricians and Gynecologists in 1971. Dr. Taylor edited the Obstetrics and Gynecologic Survey for 25 years and wrote and edited several editions of both Essentials of Gynecology and Beck's Obstetrical Practice. In 1986, Dr. Taylor received the Distinguished Service Award of the American College of Obstetricians and Gynecologists.

Also during Dr. Taylor's chairmanship he helped develop a program addressing prematurity and infant mortality and collaborated in a program studying fetal physiology and fetal growth and their association with fetal and infant mortality. He also worked with a school of Medicine nephrologist, Joseph Holmes, MD on the use of ultrasound in obstetrics. Dr. Holmes was one of the pioneers in the development of ultrasound in medicine.

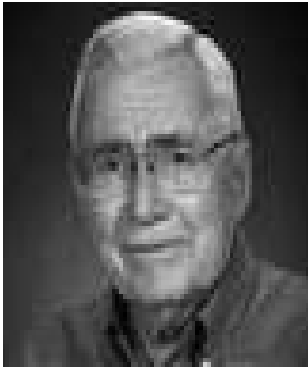
In 1998, the University of Colorado established the E. Stewart Taylor, MD endowed chair in Obstetrics and Gynecology. During his retirement Dr. Taylor kept busy teaching, horseback riding, attending local meetings, reading about the American Civil War and World War II, bookbinding, and helping his wife Ruth.

Dr. Taylor was married to Ruth Fatherson for 65 years (she died in 2005). Together they have 3 children, 7 grandchildren, and 8 great grandchildren. Dr. Taylor was a remarkable man.



# IN MEMORIAM CONTINUED

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## **Roger D. Williams**

Roger Davis (Doc) Williams of Newberry, Florida died at home on Tuesday, December 22, 2009. He was 85.

He is survived by his wonderful wife of 52 years, Jeanne Weideman Williams and three children; Diana Williams Shanks and her husband Douglas of Rye, NY, Roger Davis Williams Jr. (Dave) and his wife Julie of Newberry, and George Monroe Williams and his wife Donna of Hendersonville, TN, as well as eight grandchildren; Katherine, Tyler, Laura, Nat, Amy, Kimberly, Kelsey, Melissa and one great-grandchild, Nia. Roger was one of

five children of the late Edward E. Williams and Lucy Davis Williams of Charlotte, N.C. He was predeceased by his sister, Lucy W. McClelland of Charlotte; and brothers, John K. Williams of Lookout Mountain, TN, and Edward E. Williams Jr. of Greenville S.C. His brother Bill R. Williams resides in Rome, Georgia.

Roger was a graduate of Duke University and the Duke University School of Medicine. He went on to service with the United States Marines during the Korean War as Executive Officer, 1st Medical Battalion, 1st Marine Division. After the War, he taught as Professor of Surgery at Ohio State University College of Medicine in Columbus, Ohio, and then at the University of Texas Medical Branch in Galveston as Professor and Chairman of Surgery. In 1968, he moved his family to Fort Lauderdale, FL where he joined Dickey, Fisher, Williams Associates practicing general surgery and specializing in vascular surgery. He retired to Diroge Ranch in Newberry in 1983 to raise cattle and establish a vineyard.

A memorial service will be held at First United Methodist Church of Newberry at 2:00 PM on Tuesday, December 29, 2009. Family visitation will follow the service in the church fellowship hall.

In lieu of flowers, memorials should be made to First United Methodist Church of Newberry. Arrangements are under the care of ICS CREMATION & FUNERAL HOME, Lake city, FL.

- See more at: <http://www.legacy.com/obituaries/gainesville/obituary.aspx?n=roger-d-williams&pid=137810256#sthash.bXvrVKEr.dpuf>



# IN MEMORIAM CONTINUED

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## **Earl F. Wolfman, Jr.**

First Department of Surgery Chair at UC Davis

Earl Wolfman was a man of respect whose opinions on life, academics, surgery, the multiple people we knew in common really intrigued me. His particular surgical interest was endocrine disease, but he was a true general surgeon. Earl was born in Buffalo but shortly moved with his family to Detroit. He attended Harvard on a Navy scholarship, where due to the urgency created by World War II, he completed a four- year curriculum in two.

He returned to the University of Michigan for medical school, and remained in Ann Arbor for internship and residency in general surgery. The Korean War interrupted his surgery training, but on active duty with the U.S. Navy, he served as a battalion surgeon, treating wounded combat personnel. Back in Ann Arbor, he completed surgical training and joined the Department of Surgery faculty at Michigan. As a young professor, he excelled in clinical work, research, and administration, and over his career published nearly a hundred papers.

In 1966, C. John Tupper, founding dean of the new medical school at UC Davis, recruited Earl Wolfman to be the first chair of surgery. Working out of a “temporary” building on the Davis campus, Drs. Wolfman and Tupper began the daunting task of recruiting faculty and developing curriculum.

The UC Davis Medical Center has always been a major trauma center. Dr. Wolfman and his new faculty were very busy doing trauma and a wide variety of general surgery. At the same time, Dr. Wolfman also was the school’s associate dean with all the duties mentioned above. The medical school became Earl’s passion, which continued for the remainder of his life. In this endeavor, he chaired almost every committee in the school and the hospital at some point. In later years, Dr. Wolfman wrote a history of the founding of the UC Davis School of Medicine.

Following his retirement from the UC Davis, Dr. Wolfman served as a member of the Board of Trustees of the California Medical Association and as a member of the House of Delegates of the AMA. He joined the Western Surgical Association in 1965. Just after his first semester at the University of Michigan, Earl married Lois Jeannette Walker, his high-school sweetheart. Their wonderful union ended only by Lois’ death in 2007. They had two daughters, Nancy and Carol, a son, David (ENT surgeon in Sacramento), and six grandchildren.

David H. Wisner, Professor of Surgery, observed a few years ago, “.....on a personal level, one of the things that always impressed me about Earl is his unfailingly genteel manner,”

# SAVE THE DATE



**November 7–10, 2015**

**Western Surgical Association**

## **2015 ANNUAL MEETING**

**Meritage Resort**  
*Napa Valley, California*



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