



MGH SURGICAL SOCIETY

President

Robb H. Rutledge, M.D.

President-Elect

Jo Buyske, M.D.

Surgeon-in-Chief

Andrew L. Warshaw, M.D.

Councillors

Kimberly S. Kirkwood, M.D.

Dennis P. Lund, M.D.

Jennifer F. Tseng, M.D.

Secretary-Treasurer

Charles M. Ferguson, M.D.

Co-Editors

John F. Burke, M.D.

Robb H. Rutledge, M.D.

Managing Editor

Suzanne Williams

Editorial Office

Massachusetts General Hospital

55 Fruit St., WHT506

Boston, MA 02114-2696

TEL: 617 726 8254

FAX: 617 726 7593

mghsurgsoc@partners.org

**WANTED
PROFESSIONAL
AND PERSONAL
NEWS**

*Please send to
Editorial Office
address above*

The MASSACHUSETTS GENERAL HOSPITAL SURGICAL SOCIETY

Newsletter

Fall 2006

Volume 7, Issue 2

A MESSAGE FROM THE PRESIDENT

The Importance of Being First

An example of the importance of being first involves the first successful non-stop transatlantic flight between New York and Paris to win the \$25,000 Orteig Prize. In May 1927 there were four pilots ready to try.

Charles Nungesser, the French war hero with his navigator, Francois Coli, went first. They took off from Paris in the White Bird on May 8. Taking the more difficult east to west route they crossed the Atlantic Ocean but were lost around Newfoundland and have never been found.

The three American pilots were Charles Lindbergh, Admiral Richard Byrd, and Clarence Chamberlin. All three were at Roosevelt Field in New York making final tests and waiting for the weather to clear. As the bad weather broke Lindbergh took off alone in the Spirit of St. Louis early on May 20, and made his successful flight to Paris receiving unmatched acclaim and adulation.

Admiral Byrd abandoned his plan altogether and made his successful Antarctic expedition the following year instead.

In the medical world performing the first successful gastrectomy was a challenge similar to the first transatlantic flight for the Orteig prize. Many surgeons were interested.

Theodor Billroth was not naïve. He was well aware of the importance of being first. He and his students had done extensive research work on the feasibility of gastric resection. Billroth wrote, "The gastric resection was as completely developed by my pupils and myself on an anatomic, physiologic, and a technical basis as any new operation can be."

Unsuccessful gastric resections had been performed by Jules Pean on April 9, 1879, and by Ludwig Rydygier on November 16, 1880. When the appropriate patient appeared Billroth was ready and performed the world's first successful gastrectomy on January 29, 1881. He reported it in the Wiener Medizinische Wochenschrift on February 5, just 7 days postoperatively. This was followed by a formal report of Billroth's first four cases 3 months later.

The second successful case was done by Bernard Bardenheuer in Cologne on March 18, 1881, just 7 weeks after Billroth's success. Then Rydygier had a successful case on November 21, 1881, and further successes were reported from six or seven clinics in the next half-year.

Medical discoveries are frequently surrounded by controversy. One person gets the credit although several people have made significant contributions.

Rydygier always thought that he should receive the credit for the first gastric resection. His first case, although unsuccessful, preceded Billroth's by about 2 months. After thorough study, however, the general consensus was that the priority was clearly Billroth's. Billroth had done the first successful resection, had done 5 years of extensive research, and had made prompt and complete reports. Consequently, we now have Billroth I and Billroth II, but very little is remembered about Bardenheuer or Rydygier.

Robb Rutledge♦

A MESSAGE FROM THE CHAIRMAN

It has been said that the constant in life is change. The MGH Department of Surgery is happily conforming to that dictum with new faces, new programs and new "digs". (I refer in the latter case neither to the three new buildings completed or in progress on our campus nor to the infamous Big Dig nearby.)

What's new?

New Faculty: Bordeianou, Conrad, Fagan, Ferrone, Rosengard

New Clinical Programs: colorectal, liver, pancreas, foregut, endocrine

New Digs: Wang 4 (Gen Surg, Plastics, Vascular), Yawkey (Surg Onc),
Cox 6 (Cardiac), White 5 (Transplant)

(Warshaw continued on page 5)



On a Saturday morning in April 1953, I found myself in the cloistered atmosphere of the small library on White 4 sitting across the reading table from Dr. Churchill. We were having a conversation that was going to influence significantly, not only the next two years of my life, but the remainder of it as well.

Early in a 2 ½ year tour of duty with the Navy which began at the end of my internship, it was possible to visit the MGH on that memorable Saturday morning, as I was temporarily stationed in Rhode Island. What was intended as a perfunctory call on Dr. Churchill became a very important experience. He quickly learned that my principal concern was being out of the mainstream of medicine, and responded by noting that instead of trying to use the next two years to learn medicine, to consider them a continuation of a liberal arts education, and to utilize the opportunity for world travel which it offered. Interspersed through his comments on the general educational value of military experience were such pearls as "You will meet people from other lines of work who are just as capable as the physicians you know," and "You'll learn that doctors aren't as important as doctors think they are."

When he learned that my next assignment was to be the Navy base at Port Lyautey, Morocco, he began to describe what an interesting country this would be to see. He mentioned, with brief vignettes, Fez, Meknes, Marrakech, the Roman ruins at Volubulis, Tanger, and other cities and places of interest.

At the conclusion of the time together, he handed me a sketched outline of Morocco with the points of interest he had mentioned, which he was drawing as we talked. For the four months I then spent in Morocco, that simple, very thoughtful map became my guide-book. Each weekend when I had leave, it was off to another of the places E.D.C. had described. It was very evident how well he had used his time as a surgical consultant to the Army in World War II to learn about the countries in which he was serving.

This whole conversation, and then the guide to Morocco, launched me on a journey to see as much of the world as possible during my military service. Fortunately the Navy granted my requests for sea duty, which began in the Mediterranean. This made it possible to visit ports from Beirut to Gibraltar, followed by a cruise around Cape Horn from Hampton Roads to Bremerton, stopping at selected South American cities on the way. The final assignment was to a cruiser operating in the Western Pacific and visiting Hong Kong, as well as several Japanese cities on Honshu and Kyushu. Dr. Churchill's guidance made possible an invaluable global perspective, as well as the realization that international travel to places on the opposite side of the world was easily within reach.

The 2½ years of surgical training at the MGH which occurred after my return to civilian life provided lessons which were constantly useful during a residency and then twenty-eight years of practice in pathology, principally surgical pathology. The obvious helpful experiences made it possible to understand quite clearly the problems which surgeons are constantly facing from both the medical and the emotional standpoint. From both the superb models and teachers I was privileged to watch and learn from, and the quality of the other house staff members, there were less tangible but vitally important lessons such as the paramount importance of providing the finest possible care for the patients, regardless of the personal goals of the physicians involved in the care of a particular patient.

Having been raised at the foot of the Colorado Rockies, I have always enjoyed both hiking and skiing in the mountains which offer incredible beauty. In addition, backcountry experiences create a situation in which social facades quickly disappear giving mountain enthusiasts a chance to quickly develop meaningful and lasting relationships. As my two sons came of age to enjoy the high country, and as the demands of practice began to subside somewhat, it was possible to spend increasing amounts of time climbing, which included summiting the 54 peaks in Colorado over 14,000 feet high. This proved to be the first of two times that time and weather allowed climbing all the "14ers". As retirement approached, a strong interest in seeing some of the great peaks of the world developed. As the fourteen peaks over 8,000 meters (26,247') are all in Central Asia, the comfort about traveling to and in this part of the world which Dr. Churchill had been instrumental in developing came naturally into play. Seeing the highest of the Himalayas and Karakoram from the ground involved trekking well beyond the extent of roads. To view all but one of these awesome peaks, it was sometimes necessary to reach an altitude just over 18,000 feet. There were three trips to Nepal, one to Tibet to see the spectacular Kang-chung face of Everest, and one to the Baltoro Glacier and the K-2 base camp in Pakistan. Interspersed with these Asian trips was one to Africa to climb Kilimanjaro (19,340'), the high point in Africa, as well as to Southern Russia to climb Mt. Elbrus (18,481'), the highest peak in Europe. Closer to home have been Mt. Whitney and Mt. Rainier, and the Grand Teton. Making these trips with my wife, Connie Hauver, as well as close friends, have made them especially meaningful and happy.

The reunions of the M.G.H. Surgical Society have intensified the realization that the time on the Surgical Service was significantly formative in both a medical career, and later in a full life after leaving medicine. It has also been rewarding to be able to renew the previous and important friendships developed during that time. All of this instills a deep gratitude for being included in this membership. *(Editor's note: Giles Toll is both a skilled surgical pathologist and a genuine mountaineer. He is the third generation of Tolls in Colorado who have been in love with the mountains. One of his uncles, Roger Toll, was the superintendent of Yellowstone National Park and had two mountain peaks named after him. Mount Toll in Indian Peaks Wilderness and Toll Mountain in the Big Bend National Park. Giles graduated from Williams College in 1947 and from HMS in 1951. After a year of surgical training at the MGH he went into the Navy. When he returned in 1955 he took two more years of surgery, followed by a complete pathology residency at the MGH finishing in 1960. He returned to Denver, took a fellowship, and then went into the private practice of pathology first at Presbyterian and later at Saint Luke's Hospital. He was a Clinical Assistant Professor at the University of Colorado. In 1999 he received the "Distinguished Pathologist Award" from the Colorado Society of Clinical Pathologists. He retired in 1989 and then began his Second Career. With family and friends he has climbed all 54 Colorado fourteeners at least twice, ascended Kilimanjaro, and Mount Elbrus, and had five treks in the Himalayas and Karakoram.)*◆

Memories of Kansas by Edward Dunn "56



During the years after WW II, the Surgical Service at the MGH maintained a rotation to the Snyder-Jones Clinic in Winfield, Kansas. The rotation was one of two at that time, the other being to Salem Hospital. Since I was the last resident to rotate to Kansas, I thought it might be worthwhile to describe the Snyder-Jones Clinic Experience.

I'm not quite certain just how the rotation started but it surely had its genesis in the close relationship between Dr. Churchill, Theater Consultant to the U.S. Army and Howard E. Snyder, who served with him in the Mediterranean theater as Consultant to the Fifth Army. The clinic had been established by Dr. Howard I. Snyder and his sons, Howard E. and Cecil who, together with their internist colleague, Dr. Jones, headed the eponymous clinic which served a wide area of south central Kansas and adjacent Oklahoma.

In addition to the clinical services, the clinic, through a foundation, supported a research program focused on multiple sclerosis. The biochemist in charge was interested in performing a large array of biochemical blood tests looking for markers of MS. This constellation of blood testing was referred to as a "cross-section" and was performed on many of the patients we encountered at the hospital, who, of course, served as controls. I am not aware that anything of clinical import resulted from this, however, but it was an interesting sidelight of the Winfield experience.

Winfield, with a population of about eleven or twelve thousand, was located on land that had been bought from the Osage Indians and grew with the railroads. Oil, in the early years of the twentieth century, and later a wartime air force base, contributed to the local economy, but by 1954 it was primarily agricultural and served as a regional mercantile and professional center for the area. It boasted two hospitals at that time, New Memorial and St. Mary's, both used by the clinic.

In addition to the MGH resident, there was also a resident from Jefferson who also rotated for six months but overlapping the MGH resident so that while we were on an April and October rotation, the Jefferson resident was on a January and July one. The Jefferson connection apparently related to the fact that the Drs. Snyder and their father were, I believe, Jefferson alumni.

My immediate predecessors were Hermes Grillo and Jack Tetirick, but I didn't have much of an opportunity to get the "lay of the land" before departing from Boston. Both Hermes and Jack were very fondly remembered at the clinic and clearly made a lasting impression.

I was met at the airport in Wichita by the clinical manager who drove me to Winfield, made the necessary introductions and brought me to the rented cottage I would be calling home for the next six months. The clinic also provided me with a car, a late model Plymouth as I recall. A bachelor with no culinary skills except for scrambled eggs, I ate breakfast daily at the hospital which was especially good when it took place at St. Mary's where the sisters seemed totally committed to fighting hunger! Lunch was also taken at the hospital and I usually had dinner at one of the local restaurants or "take-out". The cottage kitchen saw very little use.

My time was spent almost entirely at either of the two hospitals, in the OR or making rounds, with only a brief time at the clinic itself. Most often, I would commence the day scrubbing with one of the two Snyders or with the third surgeon, Wendell Grosjean.

These were largely private patients but there were a fair number of other patients, trauma victims, the indigent, and patients referred from the nearby state training school which had a population of around seven thousand mentally and emotionally challenged patients. The latter provided me with my largest experience of rectal prolapse and procidentia (repaired generally by resection of redundant colon and a Ripstein suspension).

Although Winfield was "dry" by local option, nearby Arkansas City was not and there was predictable heavy vehicular traffic between the two on weekends with equally predictable resultant trauma.

Howard Snyder had a major interest in trauma with significant wartime experience and had served on the Trauma Committee of the ACS for many years. Cecil was a very busy surgeon and a delightful host, but the real role model (at least for me) was Wendell Grosjean. Technically skilled and able to tackle the vast majority of surgical problems presenting in a semi-rural setting, he was both a fine surgical teacher and an always reliable source of assistance.

Most of the cases from the nearby state training school as well as the other "service" cases were operated on with him. His surgical compass included not only general abdominal and thoracic surgery, but surgical gynecology as well as the occasional hip nailing or burr holes as well as repair of some of the nastiest injuries I've seen resulting from farm machinery.

Recreation primarily took place at the local country club which boasted a very nice swimming pool and a 9-hole golf course whose unwatered fairways under the Kansas summer sun guaranteed significant roll on any stroke. Hunting for prairie chicken (which did not appeal to me) and barbecues (which did) also helped to pass the time. I also used some of my weekends off call to visit nearby Ponca City and Tulsa, Oklahoma, as well as Lawrence, Kansas a university town reminiscent of New England with its rolling green hills but also with a tragic history of pre-civil war violence (the Quantrill raid).

My six months over, I flew back to Boston and the MGH in time for a beautiful New England autumn. Although there were several tornado alarms during my time in Winfield, I never experienced one. However, six months later, in May 1955, a terrible tornado tore through nearby Udall, Kansas, killing 77 people and devastating the small hamlet. I could not help thinking of the devastating impact on the trauma services in Winfield as a result of that and felt some sense of guilt at not being there to help.

Although the Winfield experience was a useful one in many ways, the considerable distance from Boston and the sense of being "out-of-the-loop" with the availability of the excellent clinical opportunities at Lynn led to the termination of the Kansas rotation. I remain grateful that is provided me with the exposure to a different world of surgery than that of the MGH. (Editor's note: 1956 was a big year for Ed Dunn. He completed his surgical residency at the MGH and married Audrey Hatch, an MGH nurse. After three children and four grandchildren, they have celebrated their 50th wedding anniversary. After completing his residency, Ed followed Cliff Straehley and Eji Suyama as Chief of Surgery at the VA Hospital in Syracuse, NY. He went into private practice in Syracuse in 1958 and became a Clinical Professor of Surgery at the Upstate Medical Center. In 1974 he moved to Waterbury, Connecticut as the Director of Yale's General Surgical Residency program. He was a Clinical Professor of Surgery at Yale until he retired in 1993. Clem Hiebert introduced Ed and Audrey to the four seasonal joys of Stowe. They built their second home there and have now retired full time.) ♦

Long before the days of fast food franchises, the sobriquet “Big Mac” was reserved with admiration and affection amongst the MGH surgical house staff for Dr. Leland S. McKittrick, a surgeon of well-earned national reputation for his pithy observations on matters of abdominal surgery. His place on the front row of Surgical Attendings on Thursday mornings Grand Rounds was assured. He was Big Mac to us, since his younger brother, John, served as a junior attending for a few years before moving to California, and was, inevitably, Little Mac.

During a coveted two-month rotation with Dr. McKittrick and as such, covering other surgeons’ patients during my nights on call, I received a frantic message in the middle of the night from an obviously harried nurse. The nurse was calling about an 85-year old gentleman in the Baker who had undergone a Miles abdomino-perineal resection that morning. The surgeon for this gentleman, who was never accorded the front row at Rounds, and for good reason (and shall remain nameless in this essay), had a unique way of completing the perineal resection. When the excision was finished, he merely took a rubber dam and stuffed it up into the pelvis and filled the open canal with a number of abdominal pads, which were then taped in place. His thinking, apparently, was that ultimately granulation tissue and Mother Nature would close this gaping wound. In fact, his patients were sent home in this state, and he managed the final wound healing from his office. On the unforgettable night, when I got to the patient’s room the nearly hysterical nurse pulled the sheet down from the patient, and there between his legs lay most of his small bowel. He had apparently coughed out the wad of dressings and eviscerated through the pelvic wound. The old gent appeared to be breathing his last. Needless to say, I was thunderstruck. I looked at the seemingly endless coils of intestine and at the gray unconscious patient, and decided that a trip to the OR or even the treatment room was out of the question. The bloody, soiled bandages and bowel seemed to call for some form of cleansing, so I chose Zephiran (we used to dip our hands and forearms in the stuff after a 10-minute scrub before donning gown and gloves). I thought it was relatively non-toxic and perhaps had a bit of magical cleansing power. There with sterile gloves, while the nurse held the patient’s knees apart, I laboriously returned the bowel, loop by stubborn loop, up through the perineal wound into its home in the peritoneal cavity. After a rather tedious hour, I man-

aged to plug the canal with a fresh sterile rubber dam and many abdominal pads. With gauze and a couple of rolls of 2-inch tape, I fashioned a set of diapers. Fortunately, for the patient (and for me) he never turned a hair, and went home to the care and usual routine of the unnamed surgeon.

In contrast to the scrupulous and exacting surgical service meetings each week for the East and West Surgical Services with the senior visit and two junior visiting surgeons in attendance, the monthly service meeting involving the private surgical services encompassing the activities of the Baker and the two Phillips House operating rooms was somewhat lax. However, you would not believe the clamor of discussion weeks later in the monthly complication meeting held for the Baker and Phillips House. Outlandish suggestions of what should have been done ranged from excising contaminated bowel to a variety of operative approaches under anesthesia by the reopened incision. A number of scowls and glances in my direction indicated that some of the junior Visits clearly thought that I had not measured up. It was a serious blow to my pride.

The next day while assisting Dr. McKittrick and hoping for a little salve for my bruised ego, I described the situation to him as we worked, and asked him what he would have done. He continued operating silently for more than an hour, and I thought (a) he was ignoring me or (b) was upset that I had the temerity to interrupt his thoughts during a case. Finally, as we were cruising through the closure, he paused, looked up at me and said tersely, “I think I would have fixed it so it never would have happened in the first place!” We finished the case and that’s all he had had to say on the subject.

That very afternoon at about 5:00 p.m., I received a call from Dr. McKittrick’s office stating that a patient of his was coming to the Emergency Room. She was a 30-year old woman who had previously undergone total colectomy for ulcerative colitis, and I was to be on deck to meet her in the Emergency room and then report to Dr. McKittrick. On examination, it was clear that this lady had intestinal obstruction and would need to go to the operating room. So I set things up and then called Dr. McKittrick’s office. I told him that his patient would be rehydrated in an hour or so, and that if it was convenient to him, we could operate any time after about 7:00 p.m. He agreed, showed up, and we sallied forth into the abdomen of this young woman. She did, in fact, have all the hallmarks of intestinal obstruction with typical distended

loops. We searched for the point of obstruction and, Lo and Behold, a small knuckle of bowel was trapped in a DEFECT in the pelvic floor of about an inch and half in length. Dr. McKittrick was then forced to address the defect in the pelvis, which he did with strong nonabsorbable sutures. I tied each suture down very, very carefully. I never looked up to catch his eye. I think I held my breath throughout most of this part of the repair, hoping he would have forgotten our exchange from the morning. We then carefully replaced the bowel, closed the abdomen, and he left me to close the skin, saying, “I must now go out and speak to the family.” When he left the operating room I breathed a huge sigh of relief that we were not going to revisit the conversation of the morning. After I had completed the closure, put on the dressing, and was sitting writing the orders, the door to the operating room opened about six inches, and Dr. McKittrick’s head appeared in the opening. He looked over to me and said, “Well, the chickens came home to roost a little early today, didn’t they?” And the operating room door swung shut.

That was Big Mac in all his fine, honest, strong self. He was a great man and a great surgeon, worthy of his place on the front row at Surgical Rounds, and in the hearts of the surgical house staff. Additionally, even at 65, he could beat most us on the squash court. (*Editor’s note: Judson Graves Randolph, M.D. was born in Macon, Georgia, and had his undergraduate work at Vanderbilt University. In the period, 1945-46, he served on the USS Alabama in the Pacific Theater, returning to graduate from Vanderbilt University School of Medicine in 1953. From 1954 to 1958, he was a surgical resident at the MGH. He then migrated to the Children’s Hospital in Boston where he was the Chief Resident Surgeon, 1960-61. On completion of his surgical training, he was appointed to the staff of the Children’s Hospital and in 1963 he was appointed Professor of Surgery, George Washington University, Washington, D.C., and Surgeon-in-Chief, Children’s National Medical Center. At present he is Professor of Surgery Emeritus, George Washington University and Professor of Surgery Meharry Medical College. Judd Randolph has been a prime mover in the development of training programs in pediatric surgery. The many honors given to him throughout the world reflect the importance of these contributions.*) ♦

(Warshaw continued from page 1)

New Faculty

Five surgeons are joining the Department to expand our clinical services and our research portfolios.



Liliana Bordeianou, a 2005 graduate of our surgical residency returns home from the University of Minnesota where she took advanced training in colorectal surgery and mini-fellowship in pelvic floor physiology and assessment. Liliana brings that added qualification back to help expand our colorectal capabilities as a part of the new colorectal program.



Mark Conrad trained in surgery at the Henry Ford Hospital in Detroit and in vascular surgery at the MGH. He has research training in trauma/critical care and in vascular surgery. Mark has already established a substantial publication record and will apply his talents to clinical research with special interest in endovascular and complex aortic procedures under Richard Cambria.



Shawn Fagan joined us as an assistant professor from the University of Texas Medical Branch and Shriners Burn Hospital in Galveston. After surgical residency at Baylor College of Medicine in Houston, Dr Fagan was attending surgeon and surgical intensivist for four years at the Houston VA Medical Center. He comes to our division of burns after completing a formal surgical critical care fellowship at UTMB. Mark will be attending both the adult and pediatric burn units while committing substantial efforts to basic research in the inflammatory response under Ron Tompkins.



Christina Ferrone rejoins us from Memorial Sloan-Kettering Cancer Center, where she completed a surgical oncology fellowship (having previously spent two years there as a surgical research fellow). Christina will continue her excellent and productive record in clinical research with a focus on liver and pancreatic cancers. She will join The General/ Gastrointestinal Surgery division with a clinical effort in liver and pancreas cancers and a laboratory focus on developing novel vaccine-based therapy in collaboration with investigators at the Dana-Farber Cancer Institute.



Bruce Rosengard joins the Cardiac Surgery Division and the Transplantation Biology Research Center as surgical director of cardiac transplantation at MGH and director of the large animal research arm of the cardiac portion of the TBRC. Dr. Rosengard has previously held appointments as associate professor of surgeons (with tenure) at the University of Pennsylvania School of Medicine and more recently as British Heart Foundation Professor and Chair of Cardiothoracic Surgery at the University of Cambridge, UK, in addition to cardiac transplantation Bruce will direct his clinical practice at valve reconstruction.

New Surgical Specialty Programs

In a prior newsletter, I outlined my thoughts about the evolution of surgery into more focused clinical programs and the rational driving and justifying a creative departmental response (spring 2006). The switch has now been thrown on the first five of these programs: colorectal, pancreatic, liver, foregut (esophagus/ stomach), and endocrine surgery. The programs will comprise matrix efforts, which cross traditional divisional lines. That is, Surgeons from Surgical Oncology, General and Gastrointestinal Surgery, Thoracic Surgery and Transplant Surgery may join forces in various combinations as appropriate to the effort.

The program leaders have been designated: David Berger - Colorectal; Carlos Fernandez-del Castillo - pancreas; Kenneth Tanabe - Liver; David Rattner - foregut; Richard Hodin - endocrine.

They have been charged to develop a plan to:

- 1) Measure outcomes and use them to improve the quality and processes of care.
- 2) Through clinical trial and translational research, importation of new technology, and development of new clinical areas.
- 3) Focus the efforts of faculty to promote expertise.
- 4) Forth the career of junior faculty.
- 5) Grow clinical volume and market share.
- 6) Increase national presentations and publications.

New "Digs"

Ten years ago when I started my goals in this department in hopes of being given the opportunity to work toward achieving them, one of the highest on the list was colocalization of the dispersed practices in order to build collaborations, synergies and efficiencies, as you realize, space is a highly limiting commodity in our constructed environment. However, with the Yawkey Building coming on line, the Surgical Oncology Division moved from the Cox Building to Yawkey, with adjacency to Medical Oncology. This change has allowed us to coalesce Cardiac Surgery on Cox 6. Complete reconstruction of Wang 4 and part of Wang 3 is in progress and will be completed in phases over the next year. This fall all of the General and Gastrointestinal surgeons, along with surgical clinics, will move into new space of their design, allowing for expanded shared procedural and conference facilities, practice assistants and a reception area. Plastic Surgery and Vascular Surgery will follow in the second and third phases. (The Thoracic, Pediatric, and trauma divisions are together now. ♦

In Memoriam

***Bradford Cannon
Hermes Grillo
Eldred Mundth
John Remensnyder
William Waddell
Roger Wilcox***

EVENTS OF NOTE

- *Your Health Care Questions Answered*, by **Arthur Baue** has been published by Xlibris (2005). The book synthesizes 40 years of practical medical wisdom. Dr. Baue answers questions patients frequently ask, defines medical terms patients find mysterious, and provides tips for choosing doctors and hospitals.
- **Alfred Cohen** retired from his position of Director of the Markey Cancer Center in Lexington on his 65th birthday. He and his wife Conner moved to a horse ranch south of Tucson. Future plans to focus on all things Western, except Bull-riding (he feels he has dealt with enough BS in his career).
- On June 9, **Judah Folkman** received the 12th Jacobson Innovation Award of the American College of Surgeons at a dinner ceremony in Chicago. This award honors living surgeons who develop a new technique in any field of surgery and was made possible by a donation from Julius Jacobson. Dr. Folkman is the 12th honoree. The first was Professor Francois Dubois for his work in laparoscopic cholecystectomy in 1994. Two other recipients are MGHers – Joel Cooper in 1996 for lung transplantation and Jack Burke in 1999 for burn care and Integra.
- The Warren Alpert Foundation awarded its 18th annual foundation prize, worth \$150,000 to **Judah Folkman** for discovering that tumors require angiogenesis and for championing the concept of anti-angiogenic therapies for cancer and other diseases.
- **Matthew Hutter**, an HMS Instructor in Surgery at the MGH has been involved with the American College of Surgeons accreditation program for morbidly obese patients with a body mass greater than 35. The Centers for Medicare and Medicaid Service now provide a national uniform insurance coverage for patients undergoing bariatric surgery.
- **Charles McCabe** is the recipient of the 2006 Harvard Medical School Special Faculty Prize for Sustained Excellence in Teaching.
- In April 2006, **Ashok Muniappan**, fourth year resident in General Surgery, was awarded the 2005 Stanford Calderwood Prize in Cardiac Surgery and Cardiology (\$6000) for his manuscript “heart and En-Bloc Thymus Transplantation in Cynomolgus Monkeys” prepared while he was a Research Fellow in the Transplantation Biology Research Center at the MGH.
- **Scott Regenbogen** fourth year resident in General Surgery, was awarded a slot on an NRSA (T32) Institutional Research Training Grant from the Agency for Healthcare Research and Quality (AHRQ).
- **David Sachs** has been awarded a MERIT award by The National Institutes of Health. The NIH recognizes researchers who have demonstrated superior competence and outstanding productivity in research endeavors by the highly selective award, the MERIT (Method to Extend Research in Time) Award provides long-term support to investigators with impressive records of scientific achievement in research areas of special importance or promise. Less than 5 percent of NIH-funded investigators are selected to receive MERIT Awards.
- **Clifford Straehley** received his Bachelor of Arts degree from Saint Mary’s College of California in June of this year, 64 years after leaving his undergraduate studies at the University of Michigan Ann Arbor for Harvard Medical School at the request of the US Army in order to fill the need for surgeons during World War II.
- **Parsia Vagefi**, fourth year resident in General Surgery, was awarded 1st Place Resident Prize at the New England Surgical Society 87th Annual Meeting for his paper “Evolving Patterns in the Detection of Pancreatic Neuroendocrine Neoplasms (PNEs): The Massachusetts General Hospital Experience from 1977 to 2005”.
- The 2006 Department of Surgery Junior Faculty Awards have been granted to **David Kling** for his proposal “Development of an Ex Vivo Screen to Identify Retinoic Acid Signaling Deficiencies in Patients with Congenital Diaphragmatic Hernia” and **Michael Lanuti** for “Evaluation of Relaxin in a Murine Model of Lung Cancer. Selection of these awards (\$25,000 direct costs) is based on the highest scores received from internal and external reviewers.

LETTERS TO THE EDITORS

Greetings to all MGH surgeons and Bruins fans.

Can you believe Lord Stanley's Cup is in Raleigh NC, otherwise known formerly as the MGH South Annex. Home to Ike Manly, Preston Gada, Dick Myers, and Woody Cannon.

Rex Hospital is a major sponsor to the Hurricanes and if you watched the telecast you saw the Rex signs. All of us have been President of the Medical Staff and Chief of Surgery over the years, and I am currently Chair of the Hospital Board of Trustees. Yes, I was there for game 7. It was more exciting than 1972 when Earl Wilkins and Ashby Moncure took me to see the Bruins beat the St Louis Blues and I was Chief of the East.

How times change. My best to all in Beantown and hope to see all of you at the next reunion.

Dick Myers '65

To the Editors,

How sad it was for me to hear, and that almost simultaneously, of the deaths of Hermes Grillo and Scot Remensnyder, both of whom had a key role in my own education and practice at the MGH. Hermes was the program director when I started and Scot actually succeeded him in that position – logical choices for both were notably devoted to the education of the residents. For Hermes, who can forget his unremitting stream of new ideas, his technical excellence, and his dogged persistence until things came right. And Scot, with similarly gifted technical skills, brought breadth and originality to reconstructive and burn surgery, especially in children, and made his department at the MGH one to be envied and emulated. Both were shaped during the Churchill resident years and both had an international impact. When will we again see the likes of either?

Les Ottinger '60



← Jennifer Wargo and Steven Rosenberg on the occasion of Dr. Rosenberg's visit to the MGH as a guest lecturer. Dr. Wargo will rejoin the MGH in the Division of Surgical Oncology in July of '09 upon completion of a two-year fellowship at the NIH.

Jenny
&
Matteo



← Apple
&
Henry

← The Intern Class of 2006 on "The Rock" on the occasion of their welcoming clambake at the Warshaw's Martha's Vineyard home in June.

**MGH SURGICAL SOCIETY RECEPTION
CHICAGO
2006**





The Massachusetts General Hospital
Surgical Society
55 Fruit Street
Boston, MA 02114