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American College of Surgeons
Division of Education

Disclosure Information
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Learning Objectives and Outcomes
1. Exchange knowledge pertaining to current research practice and training in all aspects of surgery.

2. Design research studies to investigate new methods of preventing, diagnosing, and managing surgical diseases.
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SOCIAL EVENTS

Sunday, November 30

9am - Spa Programs
5pm  *Breakers Spa Complex*

10am- Noon   Men’s Tennis Tournament
              *Breakers Tennis Courts*
              Hosted by: Dr. Bryan Clary

Women’s Tennis Tournament
*Breaker’s Tennis Courts*
Hosted by: Mrs. Celine Croce

1-5pm   Men’s Handicap Golf Tournament
        *Ocean Course*
        Hosted by: Dr. Martin Croce

Women’s Handicap Golf Tournament
*Ocean Course*
Hosted by: Mrs. Gayle Meredith

2-4pm   Croquet / Bocce Ball Tournament
        *Main Lawn*
        Hosted by: Dr. Samir Fakhry and
                    Mrs. Cynthia Fakhry

Monday, December 1

9am - Spa Programs

5pm  *Breakers Spa Complex*

10am- Noon   Spouses’ Coffee/Tea
              *Gulfstream 3, 4*
              Hosted by: Mrs. Karen Evers

1-3pm   Island Bicycle Tour
        Hosted by: The Breakers
Monday, December 1 (continued)

5:30pm- New Members Reception
7pm Mediterranean Ballroom
(Members and guests are invited)

Tuesday, December 2

9am- Spa Programs
5pm Breakers Spa Complex

10am- Book Club: Orphan Train,
Noon by Christina Baker Kline
Gulfstream 2
Hosted by: Mrs. Carolynne Flint

1-4pm John D. MacArthur Kayak Tour
Hosted by: The Breakers

1-3pm Bridge Club
Gulfstream 2
Hosted by: Mrs. Gayle Meredith

6:30pm- Presidential Reception
7:30pm Mediterranean Courtyard

7:30pm- Association Dinner and Dance
11pm Venetian Ballroom

Wednesday, December 3

11:30am President’s Buffet Luncheon
Venetian Ballroom
(Members and guests are invited.)
SCIENTIFIC PROGRAM

Monday, December 1
8:30 a.m.  Morning Session
Business Meeting
  1. President
  2. Secretary
  3. Chairman, Committee on Arrangements
Presidential Address
Presentation of Papers 1 – 5

2:00 p.m.  Afternoon Session
Presentation of Papers 6 – 13

Tuesday, December 2
8:30 a.m.  Morning Session
Presentation of Papers 14 – 21

2:00 p.m.  Afternoon Session
Presentation of Papers 22 – 29

Wednesday, December 3
8:30 a.m.  Morning Session
Presentation of Papers 30 – 35

11:30 a.m. Business Meeting
  1. President
  2. Audit Committee
  3. Shipley Award for 2013

Noon  Meeting Adjournment
1. The Value of Primary Operative Drain Placement After Major Hepatectomy: A Multi-Institutional Analysis of 1041 Patients

Malcolm H. Squires III* Adam Brinkman* Robert C.G. Martin
Neha L. Lad* Charles R. Scoggins Maria C. Russell*
Sarah B. Fisher* Michael E. Egger* Emily Winslow*
David A. Kooby Kenneth Cardona* Charles A. Staley
Sharon M. Weber Clifford S. Cho* Shishir K. Maithel*

**Background:** The value of routine primary (intraoperative) drain placement after major hepatectomy remains unclear. We sought to determine if primary drainage decreased rates of complications, specifically intra-abdominal infection requiring a secondary (postoperative) drainage procedure.

**Methods:** All patients who underwent major hepatectomy (≥3 hepatic segments) at 3 institutions from 2000-2012 were identified. Patients with biliary anastomoses were excluded. Primary outcomes were any complication, rate of secondary drainage procedures, bile leak, and 30-day readmission.

**Results:** 1041 patients underwent major hepatectomy without biliary anastomosis; 564 (54%) had primary drains placed at the surgeon’s discretion. Primary drain placement was associated with increased complications (56% vs. 44%; p<0.001), bile leaks (7.3% vs. 4.2%; p=0.048), and 30-day readmissions (16.4% vs. 8.0%; p<0.001), but was not associated with a decrease in secondary drainage procedures (8.0% vs. 5.9%; p=0.23). Patients with primary drains had higher ASA class, greater blood loss, more transfusions, and larger resections. After accounting for these significant clinicopathologic variables on multivariate analysis, primary drain placement was not associated with increased risk of any complications. Primary drainage was, however, associated with increased risk of bile leak (HR: 2.04; 95% CI: 1.02-4.09; p=0.044) and 30-day readmission (HR: 1.79; 95% CI: 1.14-2.80; p=0.011; Table). There still was no reduction in the need for secondary drainage procedures (HR: 0.98; p=0.96).
**Conclusion:** Primary intraoperative drain placement after major hepatectomy does not decrease the need for secondary drainage procedures and may be associated with increased bile leaks and 30-day readmissions. Routine drain placement is not warranted.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Secondary Drainage Procedure</th>
<th>Bile Leak</th>
<th>30-day Readmission</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>OR (95% CI)</td>
<td>p-value</td>
<td>OR (95% CI)</td>
</tr>
<tr>
<td>ASA Class</td>
<td>1.7 (1.04-2.7)</td>
<td>0.04</td>
<td>1.6 (0.9-2.8)</td>
</tr>
<tr>
<td>Intraop Transfusion</td>
<td>1.3 (0.7-2.7)</td>
<td>0.42</td>
<td>1.7 (0.7-3.9)</td>
</tr>
<tr>
<td>EBL</td>
<td>1.0 (1.00-1.01)</td>
<td><strong>0.04</strong></td>
<td>1.0 (0.9-1.1)</td>
</tr>
<tr>
<td>Hepatectomy Type, Extended</td>
<td>0.5 (0.1-2.1)</td>
<td>0.37</td>
<td>0.3 (0.1-2.6)</td>
</tr>
<tr>
<td>Primary Drain</td>
<td>1.0 (0.6-1.7)</td>
<td>0.96</td>
<td><strong>2.0 (1.02-4.1)</strong></td>
</tr>
</tbody>
</table>

Division of Surgical Oncology at Emory University, University of Wisconsin, and University of Louisville

2. Development And Validation Of A Risk Stratification Score For Ventral Incisional Hernia Following Abdominal Surgery: Hernia Expectation Rates in Intra-Abdominal Surgery (The HERNIA Project)

    Mike K. Liang*  
    Christopher J. Goodenough*  
    Mylan T. Nguyen*  
    J. Scott Roth*  
    Tien C. Ko  
    Lillian S. Kao*

Ventral incisional hernias (VIHs) develop in 20% of patients following abdominal surgery. No suitable pre-operative risk-assessment tool exists. We aim to develop and validate a risk-assessment tool for VIH.
**Methods:** A prospective study of all patients undergoing abdominal surgery (excluding hernia repair) with at least 6 months follow-up was conducted at a single institution from 2008-2010. Variables were defined in accordance with the National Surgical Quality Improvement Project. VIH was determined through clinical and radiographic evaluation. A stepwise regression model was built from a training cohort (2008-2009) to identify predictors of VIH. The HERNIA score was calculated by converting the odds ratios to points and was evaluated on the validation cohort (2010) using a receiver operator characteristic curve and calculating the area under the curve (AUC).

**Results:** Of 656 patients, 481 (73.3%) were followed for a median (range) of 44 (6-65) months. 79 (16.4%) patients developed a VIH. The training cohort (n=333, VIH=60, 18.0%) identified four independent predictors: laparotomy (OR=11.1; 95% CI=10.9-11.3) or hand-assisted laparoscopy (10.0, 95% CI=9.9-10.1), COPD (OR=4.2; 95% CI=4.2-4.2), BMI≥30 (OR=3.5; 95% CI=3.5-3.6), and active smoking (OR=1.9; 95% CI=1.9-1.9). Factors that were not predictive included age, gender, ASA score, albumin, aneurysm, immunosuppression, prior surgery, and suture material/technique. The predictive score (table) had an AUC=0.82 (95% CI=0.71-0.93) using the validation cohort (n=148; VIH=19, 12.8%). Three classes based on the HERNIA score stratified the risk of VIH: Class I (0-11): 6.3%, Class II (12-18): 22.5%, and Class III (≥19): 50.0% (table).

**Conclusion:** The HERNIA score accurately identifies patients at increased risk for VIH. While further validation is needed, this provides a starting point to counsel patients and guide clinical decisions. Increasing the use of laparoscopy, weight-loss programs, and smoking cessation may help reduce rates of VIH.
Table: Predictive score for and stratified risk of ventral incisional hernia after abdominal surgery

HERNIA score = 10.0(HAL) + 11.1(laparotomy) + 4.2(COPD) + 3.5(BMI ≥ 30) + 1.9(Smoking)

<table>
<thead>
<tr>
<th>Risk of Hernia Formation Based on HERNIA score points*</th>
<th>Class I (0-11 points)</th>
<th>Class III (12-18 points)</th>
<th>Class III (≥ 19 points)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Training Cohort</td>
<td>8.1%</td>
<td>23.7%</td>
<td>45.5%</td>
</tr>
<tr>
<td>Validation Cohort</td>
<td>2.8%</td>
<td>19.4%</td>
<td>60.0%</td>
</tr>
<tr>
<td>Overall Cohort</td>
<td>6.3%</td>
<td>22.5%</td>
<td>50.0%</td>
</tr>
</tbody>
</table>

Abbreviations:
HAL = hand-assisted laparoscopy
COPD = chronic obstructive pulmonary disease
BMI = body mass index
*All scores were rounded to the nearest integer

Department of Surgery, University of Texas Health Sciences Center at Houston, Houston, TX

3. Prediction of Hepatocellular Carcinoma Recurrence after Liver Transplantation Utilizing a Novel Clinicopathologic Risk Score: Analysis of 865 Consecutive Liver Transplant Recipients

Vatche G. Agopian                                          Daniela Markovic*
Michael Harlander-Locke*                                   Richard Finn*
Ali Zarrinpar*                                             Saeed Sadeghi*
Fady M. Kaldas*                                            Myron Tong*
Douglas G. Farmer*                                         Jonathan R. Hiatt*
Hasan Yersiz*                                             Ronald W. Busuttil

While size criteria (Milan/UCSF) have led to improved outcomes following liver transplantation (LT) for hepatocellular carcinoma (HCC), recurrence remains a significant challenge. We analyzed our 30-year experience with LT for HCC to identify predictors of recurrence.
**Methods:** A risk score was developed from the weighted sum of each independent predictor based on the regression coefficient (log hazard ratio) derived from a multivariate Cox regression analysis of 865 LT recipients with HCC between 1984 and 2013.

**Results:** Overall patient and recurrence-free survival estimates were 83%, 68%, 60% and 80%, 64%, and 56% at 1-, 3-, and 5-years (Figure). HCC recurred in 117 recipients with a median time-to-recurrence of 15 months, involving the lungs (59%), abdomen/pelvis (38%), liver (35%), bone (28%), pleura/mediastinum (12%), and brain (5%). Multivariate predictors of recurrence included macro- (HR 8.89, CI 5.3-14.9) and micro- (HR 2.58, CI 1.6-4.2) vascular invasion, tumor grade/differentiation (G4/poor diff HR 7.05, CI 2.5-19.7; G2-3/mod diff HR 2.16, CI 1.1-4.5), non-downstaged tumors outside UCSF (HR 2.87, CI 1.5-5.7), radiographic max tumor diameter > 5cm (HR 2.85, CI 1.3-6.2), and pretransplant neutrophil-to-lymphocyte ratio (HR 1.25 per log SD, CI 1.1-1.5), max alphafetoprotein (HR 1.19 per log SD, CI 1-1.4), and total cholesterol (HR 1.15 per SD, CI 0.96-1.4). The risk score accurately predicted HCC recurrence (C-statistic =0.78, Figure).

**Conclusions:** In the largest single-institution experience with LT for HCC, excellent long-term survival was achieved. A novel clinicopathologic risk score accurately predicted HCC recurrence after LT and may guide pretransplant patient selection and post-transplant adjuvant therapy.

*Division of Liver and Pancreas Transplantation, Department of Surgery, David Geffen School of Medicine at University of California, Los Angeles, Los Angeles, CA*


   Traci L. Hedrick*  
   Taryn E. Hassinger*  
   Bernadette J. Goudreau*  
   Florence E. Turrentine*  
   Bindu A. Umapathi*  
   Charles M. Friel*  
   Kathleen M. Rea*  
   Irving L. Kron  
   Robert G. Sawyer  
   Robert H. Thiele*

Colorectal surgery is associated with significant morbidity and prolonged length of stay (LOS). Recognizing the need for improvement, we implemented an ERAS protocol for all patients undergoing elective colorectal surgery at an academic institution.
Methods: A multidisciplinary team implemented an ERAS protocol based on: preoperative counseling with active patient participation, carbohydrate loading, multimodal analgesia with avoidance of intravenous opioids, intraoperative goal-directed fluid resuscitation, immediate post-operative feeding and ambulation. Discharge requirements remained identical throughout. A before/after study design was undertaken comparing patients prior to (08/2012 – 02/2013) and following implementation of ERAS (08/2013 – 2/2014). Risk stratification was performed using the National Surgical Quality Improvement Program (NSQIP®) risk calculator to calculate the predicted LOS for each patient based on 23 variables.

Results: 109 consecutive patients underwent surgery during the study period (ERAS) compared to 98 consecutive historical controls (conventional). The risk adjusted predicted LOS was similar for each group at 5.1 and 5.2 days. Significant reductions were seen in LOS, morphine equivalents, intravenous fluids, return of bowel function, and overall complications with ERAS (Table). There was a $7,129 per patient reduction in direct cost equating to a cost savings of $777,061 in the ERAS group. Patient satisfaction as measured by Press Ganey® improved significantly during the study period.

Conclusion: Implementation of an ERAS protocol led to improved patient satisfaction and significant reduction in LOS, complication rates, and cost for patients undergoing both open and laparoscopic colorectal surgery. These data demonstrate that small investments in the perioperative environment can lead to large returns.
<table>
<thead>
<tr>
<th></th>
<th>Conventional (N=98)</th>
<th>ERAS (N=109)</th>
</tr>
</thead>
<tbody>
<tr>
<td>NSQIP mean predicted LOS</td>
<td>5.2 ± 1.5</td>
<td>5.1 ± 1.9</td>
</tr>
<tr>
<td>Laparoscopic</td>
<td>32%</td>
<td>39%</td>
</tr>
<tr>
<td>IV fluid balance, mL</td>
<td>4409.9 ± 5496.1</td>
<td>-182.4 ± 3933.1*</td>
</tr>
<tr>
<td>Morphine equivalents, mg</td>
<td>280.9 ± 395.7</td>
<td>63.7 ± 130.0*</td>
</tr>
<tr>
<td>Return of bowel function, days</td>
<td>2.5 ± 1.5</td>
<td>2.1 ± 2.2*</td>
</tr>
<tr>
<td>LOS, mean (median)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Open</td>
<td>6.8 (5)</td>
<td>4.6 (3)*</td>
</tr>
<tr>
<td>Laparoscopic</td>
<td>7.5 (6)</td>
<td>5.4 (4)*</td>
</tr>
<tr>
<td></td>
<td>5.5 (5)</td>
<td>3.9 (3)*</td>
</tr>
<tr>
<td>Readmission rate</td>
<td>17.3%</td>
<td>9.2%</td>
</tr>
<tr>
<td>Overall complication rate</td>
<td>30.1%</td>
<td>14.7%*</td>
</tr>
<tr>
<td>Mean 30-day direct cost</td>
<td>20,435 ± 12,857</td>
<td>13,306 ± 9,263*</td>
</tr>
<tr>
<td>Press Ganey® survey response</td>
<td></td>
<td></td>
</tr>
<tr>
<td>“Extent felt ready for</td>
<td></td>
<td></td>
</tr>
<tr>
<td>discharge”</td>
<td>41st percentile</td>
<td>99th percentile*</td>
</tr>
</tbody>
</table>

* P value < 0.001

Department of Surgery and Anesthesiology, University of Virginia, Charlottesville, VA

5. **Determining the Hospital Trauma Financial Impact (TFI) in a State Wide Trauma System**
   - Charles D. Mabry
   - Ron Robertson*
   - Michael Sutherland*
   - Kyle Kalkwarf*
   - Richard Betzold*
   - Todd Maxson*
## Significant Trauma Patients: All Patients with ISS of 9 or greater, Length of Stay (LOS) 2 or more days

<table>
<thead>
<tr>
<th>ISS Groups</th>
<th>Count</th>
<th>Mean ISS</th>
<th>Mean LOS</th>
<th>Mean ICU Days</th>
<th>Mean Vent Days</th>
<th>Mean Charges</th>
<th>Mean Payments</th>
<th>Mean PCC</th>
<th>Mean Margin</th>
</tr>
</thead>
<tbody>
<tr>
<td>ISS 9-15</td>
<td>2031</td>
<td>10.2</td>
<td>6.43</td>
<td>1.7</td>
<td>0.7</td>
<td>$48,829</td>
<td>$13,398</td>
<td>$14,340</td>
<td>($942)</td>
</tr>
<tr>
<td>ISS 16-24</td>
<td>593</td>
<td>18.8</td>
<td>10.1</td>
<td>4.8</td>
<td>2.5</td>
<td>$87,649</td>
<td>$22,299</td>
<td>$23,615</td>
<td>($1,316)</td>
</tr>
<tr>
<td>ISS 25+</td>
<td>354</td>
<td>31.8</td>
<td>17.1</td>
<td>9.8</td>
<td>7.5</td>
<td>$164,092</td>
<td>$41,132</td>
<td>$41,132</td>
<td>($275)</td>
</tr>
<tr>
<td>All ISS 9+, LOS 2 or more</td>
<td>2978</td>
<td>14.5</td>
<td>8.4</td>
<td>3.6</td>
<td>2.0</td>
<td>$70,942</td>
<td>$18,467</td>
<td>$19,404</td>
<td>($937)</td>
</tr>
</tbody>
</table>

## All Patients by Level of Trauma Center

<table>
<thead>
<tr>
<th>Level of Trauma Center (# of centers)</th>
<th>Count</th>
<th>Mean ISS</th>
<th>Mean LOS</th>
<th>Mean ICU Days</th>
<th>Mean Vent Days</th>
<th>Mean Charges</th>
<th>Mean Payments</th>
<th>Mean Estimated Cost</th>
<th>Mean Margin</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level I (3)</td>
<td>2116</td>
<td>11.0</td>
<td>11.0</td>
<td>2.2</td>
<td>1.4</td>
<td>$53,484</td>
<td>$12,514</td>
<td>$14,064</td>
<td>($1,550)</td>
</tr>
<tr>
<td>Level II (5)</td>
<td>4007</td>
<td>8.4</td>
<td>8.4</td>
<td>1.6</td>
<td>0.7</td>
<td>$36,867</td>
<td>$9,975</td>
<td>$8,756</td>
<td>$1,219</td>
</tr>
<tr>
<td>Level III (12)</td>
<td>4237</td>
<td>6.5</td>
<td>6.5</td>
<td>0.5</td>
<td>0.2</td>
<td>$18,726</td>
<td>$4,440</td>
<td>$6,049</td>
<td>($1,608)</td>
</tr>
<tr>
<td>Level IV (12)</td>
<td>816</td>
<td>5.3</td>
<td>5.3</td>
<td>0.0</td>
<td>0.0</td>
<td>$5,917</td>
<td>$1,331</td>
<td>$1,600</td>
<td>($269)</td>
</tr>
</tbody>
</table>

Arkansas instituted a state-wide trauma system in 2009 which now has four levels of trauma centers, a state-wide trauma call center, NTDB registry, quality improvement plan, a unique patient system identification number and uniform trauma triage guidelines. While there have been previous attempts to determine the trauma financial impact (TFI) of a hospital’s participation as a trauma center (TC), there has been no comprehensive study across an organized state-wide trauma system, using a standardized method to determine cost. TFI includes three costs: verification, response, and patient care cost (PCC).
**Methods:** We conducted a survey of participating TCs for fiscal financial year 2012, including separate accounting for verification and response costs. Data for each patient entered into the trauma registry was merged with their claims data, including payment and payer status. Each TC’s reasonable cost from the Medicare Cost Report (MCC) was adjusted to remove embedded costs for response and verification. The departmental Cost-to-Charge Ratios (CCR) were recalculated and used to calculate PCC for each patient. Total margin per patient was calculated as the total payment minus total PCC. 75% of the patients in the state trauma registry for 2012 (13,215 of 17,539 total records) had registry and claims data submitted for analysis.

**Results:**

**Verification and response costs** per patient treated were (mean ± SD) $1,492±647 for Level I&II TC, $515±357 for Level III TC and $450±457 for Level IV TC.

**Conclusions:** Using data from a state-wide trauma system and a unique standardized CCR methodology, we determined that PCC rose and total margin decreased with increasing levels of ISS, LOS, ICU days, and vent days for patients with LOS >2, ISS9+. Taking all patients admitted, Level I centers had the highest average ISS, LOS, ICU days, and vent days along with the highest PCC. Lower degrees of trauma accounted for lower charges, payments, and PCC for Level II, III, and IV trauma centers, while margin was variable. Verification / response costs were highest for Level I &II TCs. Determination of TFI across a state system using a novel methodology offers the opportunity to better understand the drivers of TFI, determine the lowest cost per best outcome for a given level & type of trauma, and to better allocate scarce resources within a TC and across a trauma system.

*Department of Surgery, University of Arkansas for Medical Sciences, Little Rock, AR*
6. **Utilizing Value Based Analysis (VBA) to Influence Outcomes in Complex Surgical Systems**

   John R. Kirkpatrick  
   Stanley Marks*  
   Michele Slane*  
   Donald Kim*  
   Lance Cohen*  

   Michael Cortelli*  
   Juan Plate*  
   Richard Perryman*  
   John Zapas*

Value Based Analysis (VBA) is a clinical management strategy used to determine the changes in value (Q/C) that occur when a usual practice (UP) is replaced by a best practice (BP). While effective in many clinical situations, the impact of VBA on quality (Q) and cost (C) in complex surgical systems (CSS) such as a service line (SSL) is unknown. To answer this question, we utilized VBA to assist a multi-hospital healthcare system (MHS) in correcting significant deficiencies in its cardiac surgery program (SSL).

**Methods:** Cardiac Surgery is a SSL that lends itself to VBA since: 1) outcome metrics have been formulated by the Society for Thoracic Surgery (STS) to provide an estimate of Q; 2) the optimum C is available from CMS (Center for Medicare and Medicaid Services); 3) the usual practice (UP) can be determined by a needs assessment of the program and 4) the best practice (BP) can be established by a meta-analysis of the literature utilizing outcome data from institutions with recognized excellence in cardiac surgery as measured by volume and STS performance.

**Results:** The needs assessment of the UP at MHS revealed significant deficiencies in: 1) selection of patients for surgery; 2) the surgery itself, including choice of procedure and outcome; 3) after-care; 4) appropriate follow-up and 5) surveillance of C to control expenditures. During the implementation phase, the UP was replaced by a BP to correct each deficiency. Changes included 1) replacement of most of the cardiac surgeons; 2) conversion to an employed physician model; 3) restructuring of a dedicated heart surgery unit (HSU); 4) recruitment of cardiac anesthesiologists; 5) introduction of an
interactive educational program and 6) reworking policies and procedures to eliminate unsafe practices and reduce cost.

### Outcome

<table>
<thead>
<tr>
<th></th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Volume</td>
<td>416</td>
<td>380</td>
<td>348</td>
<td>413</td>
<td>432</td>
</tr>
<tr>
<td>Readmissions</td>
<td>79 (19%)</td>
<td>56 (14.7%)</td>
<td>36 (10.3%)</td>
<td>33 (8.1%)</td>
<td>28 (6.4%)*</td>
</tr>
<tr>
<td>Complications</td>
<td>54 (13%)</td>
<td>26 (6.8%)</td>
<td>27 (7.8%)</td>
<td>24 (5.8%)</td>
<td>23 (5.3%)*</td>
</tr>
<tr>
<td>LOS (days)</td>
<td>7</td>
<td>8.5</td>
<td>6</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>Mortality</td>
<td>17 (4.1%)</td>
<td>13 (3.4%)</td>
<td>10 (2.9%)</td>
<td>6 (1.5%)</td>
<td>7 (1.6%)*</td>
</tr>
<tr>
<td>Cost/Case</td>
<td>$36,433</td>
<td>$30,988</td>
<td>$27,514</td>
<td>$29,757</td>
<td>$28,868</td>
</tr>
</tbody>
</table>

* P < 0.01 (2009 compared to 2013: Chi Square Analysis)

**Conclusions:** 1) there was a significant decrease in readmissions, complications, and mortality between 2009 and 2013; 2) In 2013, MHS was one of only 17 (1.7%) database participants (1009) to achieve a STS 3-Star rating in all three measured categories (CABG, AVR and AVR + CABG); 3) despite significant increases in Q, the cost/case and the LOS declined; 4) these changes created a savings opportunity of 14 million dollars with actual savings of 10.4 million dollars between 2009 and 2013. These findings suggest that VBA can be a powerful tool to enhance value (Q/C) in a CSS such as cardiac surgery.

*Georgetown University School of Medicine, Washington DC and Memorial Healthcare System (MHS), Hollywood, FL*

### Hepatic Parenchymal Preservation Surgery: Decreasing Morbidity And Mortality Rates In 4,152 Resections For Malignancy

**T. Peter Kingham***

Camilo Correa-Gallego***

Michael I. D’Angelica

Mithat Gönen***

Ronald P. DeMatteo***

**Peter J. Allen**

Yuman Fong

Leslie H. Blumgart

William R. Jarnagin

**Methods:** Records of patients undergoing liver resection for a malignant diagnosis from 1993-2012 at Memorial Sloan Kettering were analyzed. Patients were divided into early (1993-1999), middle (2000-2006), and recent (2007-2012) eras. Major
hepatectomy was defined as resection of 3 or more segments. Univariate and multivariate analyses were made with t-tests or Mann-Whitney tests.

**Results:** 3,875 patients underwent 4,152 resections for malignancy. The most common diagnosis was metastatic colorectal cancer (n=2,476, 64% of patients). Over the study period, 90-day mortality rate decreased from 5.2% to 1.6% (Table 1, p<0.001).

<table>
<thead>
<tr>
<th></th>
<th>‘93-’99 n=1275</th>
<th>‘00-’06 n=1465</th>
<th>‘07-’12 n=1412</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major hepatectomy (≥3 segments)</td>
<td>65.6% (836)</td>
<td>53.5% (784)</td>
<td>35.8% (505)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Segments resected (median, IQR)</td>
<td>4 (2-5)</td>
<td>3 (2 - 4)</td>
<td>2 (1-4)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Left hepatectomy percentage of all resections</td>
<td>6.9% (88)</td>
<td>8.6% (126)</td>
<td>8.4% (119)</td>
<td></td>
</tr>
<tr>
<td>Left trisectionectomy percentage of all resections</td>
<td>6.1% (78)</td>
<td>3.0% (44)</td>
<td>2.5% (36)</td>
<td></td>
</tr>
<tr>
<td>Right hepatectomy percentage of all resections</td>
<td>19.9% (254)</td>
<td>19.1% (280)</td>
<td>13.6% (192)</td>
<td></td>
</tr>
<tr>
<td>Right trisectionectomy percentage of all resections</td>
<td>27.8% (355)</td>
<td>16.6% (244)</td>
<td>6.7% (95)</td>
<td></td>
</tr>
<tr>
<td>Resection combined with ablation</td>
<td>0.6% (8)</td>
<td>4.4% (65)</td>
<td>19.2% (271)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Estimated blood loss (median -IQR)</td>
<td>650 (310 - 1110)</td>
<td>400 (200 - 750)</td>
<td>300 (200 - 565)</td>
<td>0.003</td>
</tr>
<tr>
<td>Complications</td>
<td>53.2% (679)</td>
<td>34.3% (502)</td>
<td>19.9% (281)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Major complications</td>
<td>13.2% (169)</td>
<td>11.2% (164)</td>
<td>9.8% (138)</td>
<td>0.017</td>
</tr>
<tr>
<td>90-day mortality</td>
<td>5.2% (66)</td>
<td>2.3% (34)</td>
<td>1.6% (22)</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>

Perioperative morbidity decreased from 53% to 20% (p<0.001). As parenchymal preservation became a surgical strategy in the recent era, the percentage of major hepatectomies decreased from 66% to 36% (p<0.001). The rate of perioperative transfusions decreased from 51% to 21% (p<0.001) as the median number of segments resected decreased from 4 to 2 (p<0.001). Perioperative morbidity changed markedly over time, with abdominal infections (43% of complications) overtaking cardiopulmonary complications (22% of complications). Peak postoperative bilirubin (OR 1.1,p<0.001), blood loss (OR 1.5,p=0.001), major hepatectomy (OR 1.3,p=0.031), and concurrent partial colectomy (OR 2.4,p<0.001) were independent predictors of perioperative morbidity. The mortality associated with trisectionectomy (6%) and right hepatectomy (3%) remained unchanged over time.

**Conclusion:** Morbidity and mortality rates after hepatectomy for cancer have decreased significantly with hepatic parenchymal preservation. Encouraging this
approach is vital for further improvement of liver resection outcomes, as the mortality rate for major liver resections remains unchanged over time. In addition, reducing intra-abdominal infections can further decrease postoperative morbidity.

Division of Hepatopancreatobiliary Surgery, Memorial Sloan Kettering Cancer Center, NY, NY

8. Effect Of Statins On Early And Late Clinical Outcomes Of Carotid Endarterectomy And The Rate Of Post-Carotid Endarterectomy Restenosis

Ali F. AbuRahma  Zachary AbuRahma*
Mohit Srivastava*  Will Jackson*
Patrick A. Stone*  L. Scott Dean*
Bryan Richmond  Albeir Y. Mousa*

Background: Statins have been recommended for cardiovascular risk modifications in many patients. However, only a few studies have reported on their benefits in patients undergoing carotid endarterectomy (CEA). This study will analyze their effect on clinical outcomes after CEA and the rate of restenosis.

Methods: This is a retrospective analysis of prospectively collected data of 500 consecutive CEAs followed routinely at 1, 6, and 12 months and every year thereafter. Perioperative and late outcomes (myocardial infarction [MI], stroke, and death) were analyzed for patients on statins versus no statins. A Kaplan-Meier analysis was used to estimate rate of freedom from MI, stroke, and death.

Results: 299 patients were on statins versus 201 without. All demographics were similar, except diabetes mellitus (44% versus 29%, p=0.001) and hypercholesterolemia (76% versus 58%, p<0.0001) for statin patients versus no statins. The perioperative MI, stroke, and death rates were: 2%, 1.7%, and 1% versus 2.5%, 2% and 1.5% for statins versus no statins, respectively. Combined perioperative MI/death rates were 2.7% versus 4% (p=0.416) and combined perioperative MI/stroke and death rates were 4% versus 5% (p=0.607) for statins versus no statins. At late follow-up (mean of 27 months, range 1-68 months), the early and late MI, stroke, and death rates were: 9.7%, 2.3%, and 2.3% versus 9%, 2.5% and 5% (p=0.18) for statins versus no statins, respectively. The combined early and late stroke/death rates for statins versus no statins were 4.3% versus 6% (p=0.4) and MI/stroke/death rates were 13% versus 13%. Overall, statins decreased the perioperative death rates by one-third and early and late
death rates by half. Subset analysis showed diabetic patients not on statins had 4 times more death than diabetics on statins (8.5% versus 2.3%) and twice as many strokes/deaths (10.2% versus 5.3%). Patients with hypercholesterolemia that were not on statins had twice as many deaths (4.3% versus 2.2%) and one-third more strokes/death. Rates of freedom at 1, 2, 3, and 4 years from stroke/MI/death rates were: 94%, 90%, 85% and 77% versus 94%, 89%, 85%, and 82% (p=0.87) for statins versus no statins. Rates of freedom from death only were: 98%, 98%, 97.4% and 97.4% versus 98%, 96%, 94.8% and 94.8% (p=0.191). For diabetic patients, the rates of freedom from death were 99%, 99%, 97%, and 97% for statins versus 97%, 90%, 90%, and 90% without statins (p=0.048). Post-CEA ≥50% restenosis rate was not significantly different between statins versus no statins: 10/269 (3.7%) versus 5/173 (2.9%, p=0.64).

**Conclusion:** Overall, patients on statins tended to have lower death rates, but not stroke rates after CEA. However, statins significantly lowered death rates in diabetics and tended to lower both death and stroke rates in diabetics and patients with hypercholesterolemia. Statins had no effect on post-CEA restenosis.

*Department of Surgery, West Virginia University/Charleston Area Medical Center, Charleston, WV*

**9. Impact Of Pathogen-Directed Antimicrobial Therapy For Ventilator-Associated Pneumonia In Trauma Patients On Charges And Recurrence**

John P. Sharpe*  
Louis J. Magnotti*  
Jordan A. Weinberg*  
Joseph M. Swanson*  
G. Christopher Wood*  
Timothy C. Fabian  
Martin A. Croce

Ventilator-associated pneumonia (VAP) represents one of the principal driving forces behind antibiotic usage in the intensive care unit. Prolonged exposure to unnecessary antibiotics remains one of the strongest predictors for the development of antibiotic resistance and contributes to increased patient charges. Unfortunately, resolution of clinical signs may be non-specific in trauma patients with other reasons for systemic inflammation, leading to subjectively prolonged therapy. In light of the nonspecific nature of traditional clinical signs for the presence of VAP and the potential limitations of choosing an arbitrary day cutoff for antibiotic therapy (relapse, antibiotic resistance), we advocate the use of a defined bacteriologic strategy with a quantitative response threshold to provide objective evidence for VAP resolution. In a previous study (PS),
we established a defined algorithm dictated solely by the causative pathogen (SSA 2010). In fact, for the past 5 years, duration of antimicrobial therapy for hospital-acquired VAP in our institution has followed that algorithm. The purpose of the current study (CS) was to evaluate the impact of pathogen-directed antimicrobial therapy for hospital-acquired VAP on recurrence and charges in trauma patients following implementation of that defined algorithm.

**Methods:** Patients with VAP ($\geq 10^5$ CFU/ml) secondary to methicillin-resistant *Staphylococcus aureus* (MRSA), *Acinetobacter baumannii* (AB), *Pseudomonas aeruginosa* (PA), *Stenotrophomonas maltophilia* (SM) or *Enterobacteriaceae* (ENB) over 5 years subsequent to the PS were evaluated. Duration of antimicrobial therapy was dictated by the causative pathogen: 14 days for PA; all others underwent repeat BAL on day 7 of appropriate therapy. If microbiological resolution (MR), defined as $\leq 10^3$ CFU/ml, was achieved, therapy was stopped by day 10. The remainder received 14 days of therapy. Recurrence was defined as $\geq 10^5$ CFU/ml on subsequent BAL performed within 2 weeks after completion of appropriate therapy.

**Results:** 529 VAP episodes were identified in 381 patients: 301 (79%) men and 80 (21%) women (mean age 44, mean ISS 31, 88% blunt) - 105 MRSA VAP episodes, 86 AB, 143 PA, 36 SM and 159 ENB. Overall recurrence was unchanged compared to the PS (1.5% vs 2%; p=0.3). There was a decrease in the number of BALs performed per patient compared to the PS (1.6 vs 2.3; p=0.24). In addition, there was a reduction of 4.8 antibiotic days per VAP episode compared to the PS (Table). Both changes resulted in a cumulative reduction of $3535.04 per patient ($1813.40 in antibiotic charges and $1721.64 in BAL charges), for a savings of $1.35 million over the study period.

<table>
<thead>
<tr>
<th>ABx days/VAP episode</th>
<th>MRSA</th>
<th>AB</th>
<th>SM</th>
<th>ENB</th>
<th>PA</th>
</tr>
</thead>
<tbody>
<tr>
<td>PS</td>
<td>12.5</td>
<td>10.8</td>
<td>11.1</td>
<td>10.7</td>
<td>13.1</td>
</tr>
<tr>
<td>CS</td>
<td>9.9</td>
<td>10</td>
<td>9.7</td>
<td>9.8</td>
<td>14</td>
</tr>
</tbody>
</table>

**Conclusion:** Hospital-acquired VAP can be managed effectively by a defined course of therapy dictated solely by the causative pathogen. Adherence to an established
algorithm simplified the management of VAP and contributed to a cumulative reduction in patient charges without impacting recurrence. Duration of antimicrobial therapy for VAP in trauma patients should be dictated by the causative pathogen, thereby minimizing the potential sequelae of increased resistant organisms and antibiotic-related complications/charges associated with prolonged unnecessary antibiotic exposure.

Department of Surgery, University of Tennessee Health Science Center, Memphis, TN

10. We’ve Heard of the Award- But Who Knows About Dr. Shipley?

Nancy D. Perrier Jon A. van Heerden

One of the highlights at the annual meeting of the Southern Surgical Association (SSA) is the presentation of the Shipley Award. This tradition has been an integral portion of the annual meeting for 55 years confirming its historical significance. The origin of this award and some facts about Dr. Shipley may be of interest to SSA members.

Arthur M. Shipley was a fifth generation member of the Shipley family and was born in Maryland in 1878. His early ancestor, Adam Shipley, arrived in Maryland in 1698 and in subsequent generations, the Shipley family became major land owners in Maryland.

Dr. Shipley graduated from the University of Maryland in 1902, was Chief of Surgical Services for evacuation hospital #8 during World War 1 and in 1911 was appointed Chairman of Surgery at the University of Maryland. He retired in 1948 and died in 1955 at the age of 77 years. During his career he was academically productive publishing 80 diverse manuscripts ranging from femoral fractures, pericarditis, surgical treatment of hypertension and the dehisced abdominal incision.

Dr. Shipley was elected to membership in the SSA in 1927 and was recognized as one of the outstanding teachers of surgery of his time. After his death in 1955 one of his residents, Dr. Hugh Bailey made a gift of $1,300 to provide a memorial in Dr. Shipley’s name. The council established the Shipley award to consist of a gold medal to be given annually to the new member judged to have presented the best paper during the first two years of his/her membership. In 1957, Dr. Felda Hightower was given the initial award. Dr. Shipley was an example of a clinician with compulsive attention to detail and in-depth knowledge of the medical and surgical literature. In 1928, Dr. Shipley was called in consultation on a patient by the Chairman of Medicine in Baltimore, Dr. Maurice Pincoffs. A pre-operative diagnosis of a medullary tumor of the
suprarenal gland was suggested and elective operation planned. On June 14, 1928, Dr. Shipley resected the first pre-operatively diagnosed pheochromocytoma. This event generated a publication in the Annals of Surgery entitled “Paroxysmal Hypertension Associated with Tumor of the Suprarenal”.

A piece of marble slab from this historic operating room is today on display in the library for the SSA historical collection at the University of Alabama in Birmingham. Few SSA members may realize that Dr. Shipley’s legacy, and interest in adrenal medullary tumors, continues to this day in the careers of multiple subsequent Shipley awardees including the co-authors of this manuscript. He did indeed “pay it forward” and that is the way it should be. He would have been pleased.

University of Texas, M.D. Anderson Cancer Center, Houston, TX

11. A Prospective Randomized Double Blind Placebo Controlled Trial on the Efficacy of Ethanol Celiac Plexus Neurolysis (ECPN) in Patients with Operable Pancreatic Ductal Adenocarcinoma (PDA)

Harish Lavu*
Eugene P. Kennedy*
Naomi M. Sell*
Theresa P. Yeo*
Sherry A. Burrell*
Jordan M. Winter*

Harry B. Lengel*
Joseph A. Baiocco*
Edward C. Pequignot*
Benjamin E. Leiby*
Charles J. Yeo

In past small studies ECPN has been reported to be somewhat effective in reducing long term tumor-related pain in patients with unresectable PDA. This study was designed to determine if ECPN is beneficial for patients with both resectable and unresectable PDA.

Methods: This is an IRB approved, single center, prospective, randomized, double blind placebo controlled trial (NCT00806611), examining the effect of ECPN in patients undergoing surgical treatment for PDA. Patients were stratified by preoperative pain (vs no pain) and disease resectability (vs unresectable), and were randomized to intraoperatively receive either ECPN with 50% ethanol or a normal saline control. The primary endpoint was long term pain control and the secondary endpoints included quality of life and overall survival.
Table – Celiac Plexus Neurolysis Outcomes: Resectable stratum

<table>
<thead>
<tr>
<th>Randomization Group</th>
<th>R/NP (n=274)</th>
<th>p-Value</th>
<th>R/P (n=120)</th>
<th>p-Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Etoh</td>
<td>Sal</td>
<td></td>
<td>Etoh</td>
<td>Sal</td>
</tr>
<tr>
<td>Pain score (0 mo)</td>
<td>0.52</td>
<td>NS</td>
<td>6.56</td>
<td>6.22</td>
</tr>
<tr>
<td>Pain score (3 mo)</td>
<td>1.41</td>
<td>NS</td>
<td>4.34</td>
<td>4.00</td>
</tr>
<tr>
<td>Pain Score (6 mo)</td>
<td>1.48</td>
<td>NS</td>
<td>3.20</td>
<td>3.48</td>
</tr>
<tr>
<td>Pain Score (9 mo)</td>
<td>1.53</td>
<td>NS</td>
<td>2.96</td>
<td>3.83</td>
</tr>
<tr>
<td>Pain Score (12 mo)</td>
<td>2.43</td>
<td>NS</td>
<td>5.26</td>
<td>4.07</td>
</tr>
<tr>
<td>Median Survival (mo)</td>
<td>18.5</td>
<td>NS</td>
<td>20.5</td>
<td>21.1</td>
</tr>
</tbody>
</table>

R/NP, Resectable/No pain Group; R/P, Resectable/Pain Group; Etoh, 50% ethanol; Sal, 0.9% normal saline; QOL, quality of life; Mo, months

**Results:** 485 patients were randomized (December 2008 – August 2013): 274 to resectable/no pain (R/NP), 120 to resectable/pain (R/P), 48 to unresectable/no pain (UR/NP), and 29 to unresectable/pain (UR/P). The demographic characteristics were similar between the 4 groups. The R/P group who received ethanol showed a trend toward reduced postoperative pain which lasted to 9 months, though this was not statistically significant. Patients in the UR/NP arm who received ethanol had reduced postop pain at 3 months (0.72 vs 2.66, p =0.01). Quality of life as measured by FACT-Hep (version 4) was relatively equal between groups, except for patients in the R/NP ethanol group who showed improvement in Emotional Well Being at 12 months (21.3 vs 23.7, p=0.02). Overall, survival was equivalent between the ethanol and saline groups in both the resectable and the unresectable strata.

**Conclusions:** In this study, the world’s largest randomized controlled trial evaluating ECPN in patients with operable PDA, we have demonstrated only a limited benefit to patients in terms of postoperative pain and quality of life, and no effect on survival.

*Jefferson Pancreas, Biliary and Related Cancer Center, Thomas Jefferson University, Philadelphia, PA*

12. **Should Gastric Cardia Cancers Be Treated with Esophagectomy or Total Gastrectomy: A Comprehensive Analysis of 4,996 NSQIP/SEER Patients**

Jeremiah T. Martin*  
Angela Mahan*  
Joseph B. Zwischenberger  
Patrick C. McGrath  
Ching-Wei D. Tzeng*
**Introduction:** Category 1 guidelines emphasize multimodality therapy (MMT) for patients with gastric cardia cancer (GCC). These patients are often referred to thoracic surgeons for “gastro-esophageal junction (GEJ)” cancers rather than to abdominal surgeons for “proximal gastric” cancers. This study sought to determine the ideal surgical approach using national datasets evaluating morbidity/mortality (M/M) and overall survival (OS).

**Methods:** Patients with resected GCC (CPT 151.0) were identified from the 2005-2012 ACS NSQIP dataset and the 1998-2010 SEER dataset. Multivariate 30-day M/M analyses were performed using NSQIP. Survival analyses were derived from SEER and stratified by surgical approach.

**Results:** 1,181 NSQIP patients with GCC included 81.8% esophagectomies and 18.1% gastrectomies. Major postoperative M/M occurred in 33.2%/3.7% patients after gastrectomy vs. 35.0%/2.4% after esophagectomy (p=0.260). While a major postoperative complication (OR-12.8, p<0.001) was an independent predictor of mortality on multivariate analysis, surgical approach was not.

3,815 SEER patients included 71.1% esophagectomies and 28.9% gastrectomies. Radiation use (surrogate for MMT) was administered more often with esophagectomy vs. gastrectomy (42.9% vs. 29.6%, p<0.001). Unadjusted median OS favored esophagectomy (26.0 vs. 21.0 months, p=0.025). However, multivariate analysis confirmed age (hazard ratio, HR-1.01), T/N stages (HR-1.12/1.91), and radiation use (HR-0.83, all p≤0.018), but not surgical approach (HR-0.95, p=0.259), as independent predictors of OS.

**Conclusion:** Tumor biology and MMT, rather than surgical approach, dictate oncologic outcomes for GCC. Therefore, the decision of esophagectomy vs. gastrectomy for GCC should be based on proximal/distal tumor extent and the multidisciplinary strategy with the lower rate of complications and the higher rate of MMT completion.
Table: Multivariate analyses of independent variables associated with 30-day mortality (logistic regression, NSQIP) and overall survival (cox proportional hazards regression, SEER).

Department of Surgery, University of Kentucky, Lexington, KY
13. Has IOC During Laparoscopic Cholecystectomy Become Obsolete in Era of Preoperative ERCP and MRCP?

Kenneth R. Sirinek
Kent R. Van Sickle*
Ross E. Willis*
Wayne H. Schwesinger

Preoperative endoscopic retrograde cholangiopancreatography (ERCP) and magnetic resonance cholangiopancreatography (MRCP) and intraoperative cholangiography (IOC) are standard procedures in evaluating patients with suspected choledocholithiasis. This study evaluates the changing practice patterns over time of these three procedures in a large cohort of patients undergoing laparoscopic cholecystectomy (LC) at a single tertiary care center.

Methods: Data from all patients undergoing a LC with or without preoperative ERCP, MRCP or IOC from 1/1/2004 to 12/31/2013 were prospectively collected and retrospectively reviewed, and analyzed by chi-square.
**Results:** 7427 patients underwent a successful LC with 5.8% having had a pre-op ERCP and 8.3% an IOC. Beginning in 2007, 5224 (98%) patients underwent a successful LC with 3.9% having had a pre-op MRCP, and 1.5% a pre-op MRCP/ERCP. Over 10 yrs, the number of patients undergoing either an IOC (11.9% to 7.6%) or a pre-op ERCP (7.2% to 1.5%) has significantly decreased. In the last 6 yrs, the number of patients with either a pre-op MRCP (0.9% to 8.6%) or a MRCP/ERCP (0.4% to 3.6%) has significantly increased. (Table)

<table>
<thead>
<tr>
<th>Year</th>
<th># LC</th>
<th>N (% IOC)</th>
<th>N (% ERCP)</th>
<th>N (% MRCP)</th>
<th>N (% MRCP/ERCP)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004</td>
<td>750</td>
<td>89 (11.9%)</td>
<td>54 (7.2%)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>2005</td>
<td>720</td>
<td>66 (9.2%)</td>
<td>66 (9.2%)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>2006</td>
<td>733</td>
<td>78 (10.6%)</td>
<td>54 (7.4%)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>2007</td>
<td>718</td>
<td>48 (6.7%)</td>
<td>49 (6.8%)</td>
<td>1 (0.1%)</td>
<td>2 (0.2%)</td>
</tr>
<tr>
<td>2008</td>
<td>781</td>
<td>75 (9.6%)</td>
<td>64 (8.2%)</td>
<td>7 (0.9%)</td>
<td>3 (0.4%)</td>
</tr>
<tr>
<td>2009</td>
<td>733</td>
<td>69 (9.4%)</td>
<td>37 (5.0%)</td>
<td>16 (2.2%)</td>
<td>6 (0.8%)</td>
</tr>
<tr>
<td>2010</td>
<td>771</td>
<td>30 (3.9%)</td>
<td>41 (5.3%)</td>
<td>18 (2.3%)</td>
<td>6 (0.8%)</td>
</tr>
<tr>
<td>2011</td>
<td>745</td>
<td>57 (7.7%)</td>
<td>39 (5.2%)</td>
<td>37 (5.0%)</td>
<td>9 (1.2%)</td>
</tr>
<tr>
<td>2012</td>
<td>756</td>
<td>53 (7.0%)</td>
<td>14 (1.9%)</td>
<td>61 (8.1%)</td>
<td>22 (2.9%)</td>
</tr>
<tr>
<td>2013</td>
<td>720</td>
<td>55 (7.6%)*</td>
<td>11 (1.5%)*</td>
<td>62 (8.6%)*</td>
<td>26 (3.6%)*</td>
</tr>
<tr>
<td>Total</td>
<td>7427</td>
<td>620 (8.3%)</td>
<td>429 (5.8%)</td>
<td>202 (3.9%)</td>
<td>74 (1.5%)</td>
</tr>
</tbody>
</table>

*P<0.01 vs 2004, **P<0.001 vs 2008

**Conclusion:** Despite a shift from IOC and preoperative ERCP to preoperative MRCP alone or with ERCP, a significant percentage (7.6%) of patients still underwent an IOC in 2013. Use of IOC during LC has decreased but is not obsolete and remains a valuable tool in evaluating bile duct anatomy, bile duct injury or suspected choledocholithiasis. IOC during uncomplicated LC should be reinstated in teaching programs to insure general surgery resident competency with the procedure.

*Division of General and Minimally Invasive Surgery, University of Texas Health Science Center at San Antonio, San Antonio, TX*
NOTES
Introduction: The first successful local resection of a periampullary tumor was performed by Halsted in 1898. Kausch performed the first regional resection in 1909, and the operation was popularized by Whipple in 1935. The operation was infrequently performed until the 1980s and 1990s.

Methods: 2000 consecutive pancreaticoduodenectomies performed by one surgeon (JLC) from the 1960s to the 2000s were retrospectively reviewed from a prospectively maintained database. The first 1000 were performed over a period of 34 years. The second 1000 over a period of 9 years.

Results: The most common indication throughout was adenocarcinoma of the head of the pancreas (PDAC)-(46%). Benign IPMN increased from 1% (1990s) to 8% (2000s) (p=0.002). Age range was 13 years to 103 years. Age increased from 59 years (1980s) to 66 (2000s) (p=0.001), as did those over 80 (3% to 12%. P=0.002). 30 day mortality was 1.4%; hospital mortality was 1.7%. Delayed gastric emptying (23%), pancreatic fistulas (16%), and wound infections (11%), were the most frequent morbidity, and have not decreased. Median number of blood transfusions decreased from 2 (1980s) to 0 (1990s and 2000s) (p=0.004). Length of stay decreased from 21 days (1980s) to 13 (1990s) days to 10 days (2000s) (p=0.002). 5-years survival for PDAC increased from 19% (1990s) to 24% (2000s) (p=0.02). 5-year survival for node-negative, margin negative PDAC patients was 39%.

Conclusion: The volume of pancreatic pathology has attracted 22 basic and clinical scientists to Hopkins, who have 28.5 million dollars of direct support and over 30 million dollars in endowments, to support research in pancreatic cancer. The volume of clinical material has also supported the training of many young surgeons, 15 of whom have become Department Chairmen, and over 20 have become Division Chiefs.
15. The Addition of Direct Peritoneal Lavage to Human Cadaver Organ Donor Resuscitation Improves Organ Parameters

Jason W. Smith*
Paul J. Matheson*
Gary L. Morgan*
Cynthia D. Downard*

Glen A. Franklin
Amy J. Matheson*
Richard N. Garrison

Organ donor resuscitation alters cardiovascular physiology and causes pulmonary edema, microcirculatory dysfunction, and systemic inflammation. Peritoneal lavage with dialysis solution (DPL) improves these derangements. This concurrent case-controlled study measures the effects of DPL on human organ donor characteristics.

**Methods:** Human brain dead consented organ donors received standard goal directed resuscitation (SDR, n=40) or SDR+DPL (n=20). SDR patients were case-matched 2:1 to DPL patients by donor organ potential. Hepatic blood flow (HBF), hemodynamic parameters, and organ function variables were recorded at 3 hour intervals from donor consent until organ procurement. Serum cytokine analysis was performed at 6 hour intervals. Organ outcomes and SRTR score matching were obtained from UNOS donornet.

### All Donors (ECD and SCD) ± DPL

![Graph showing liver blood flow (% change from baseline) over time (hours) for All Control patients and All DPL patients, with statistical significance marked by asterisks and daggers.](image)

* P<0.05 vs. Control
† P<0.05 vs. 0'
‡ P<0.05 vs. 3'
§ P<0.05 vs. 6' (none)
# P<0.05 vs. 9' (none)
**Results:** Donor age, gender, and mechanism of death were similar between groups. All donors reached the mean arterial pressure goal (MAP≥80mmHg). DPL donors received less crystalloid (6-hours: 1,723 vs 2,358cc, \(P<0.03\); 12-hours: 1,444 vs 1,796cc, \(P<0.05\)). DPL elevated HBF (see graph). DPL modestly increased serum pro-inflammatory cytokines (IL-6 and IL-8), decreased IL-1b, and significantly increased anti-inflammatory IL-10. Organs recovered (Actual/Expected) was greater with DPL (1.22±0.09 vs. 0.96±0.06, \(*P=0.02\), primarily due to lungs in standard criteria donors (DPL:6/16 vs. 6/32, \(P=0.144\)).

**Conclusion:** Brain dead organ donors given adjunctive DPL during resuscitation had improved HBF, required less IV fluids and pressor support to maintain MAP compared to SDR. DPL donors had a pronounced anti-inflammatory response at 6 and 12 hours of lavage. These improved donor variables suggest a role for DPL in the clinical management of organ donors to increase transplantable organs.

*Kentucky Organ Donor Affiliates, Louisville, KY and Departments of Surgery and Physiology & Biophysics, University of Louisville, Louisville, KY*

16. **How Slow is Too Slow?**

**Correlation of Operative Time to Complications – An Analysis from the Tennessee Surgical Quality Collaborative**

Brian J. Daley  
William Cecil*  
Oscar Guillamondegui  
Chris Clarke*  
Joseph B. Cofer

The Tennessee Surgical Quality Collaborative (TSQC) analyzes NSQIP data from 21 participating hospitals. The TSQC has reduced surgical complications, but causative factors are unclear. We sought to correlate surgical duration with complications to reveal mitigating strategies.

**Methods:** Risk-adjusted TSQC data on 103,656 general and vascular cases had a standard duration for 35 procedures (e.g. breast, colectomy) calculated and NSQIP outcomes complication rates recorded. We derived a Marginal Time Risk (MTR) for each extra hour of operative time and reported per 1,000 cases.

**Results:** Procedures taking <95th %upper confidence standard time limit (n=99,741) were deemed NOT LONG and had significantly fewer UTI, organ space/SSI, sepsis/septic shock, prolonged intubation and pneumonia. LONG cases had increased...
rates of these complications and also DVT, deep incisional infection and wound disruption. Per 1,000 cases there were 116 occurrences an OR hour. Surgical site infections occurred in 14.4/1,000 cases per hour; risk started at 42 minutes of OR time. Death, pneumonia and prolonged intubation saw their risks begin prior to OR. The highest MTR was for sepsis occurring 16.6 times per additional hour of OR over standard. Studying only the 25,146 clean procedures, a significant correlation (p<0.001) to OR duration persisted despite an occurrence incidence of 3.2%.

<table>
<thead>
<tr>
<th></th>
<th>Superficial SSI</th>
<th>Deep SSI</th>
<th>Organ SSI</th>
<th>PNA</th>
<th>Renal Failure</th>
<th>Sepsis</th>
<th>Death</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MTR</strong></td>
<td>14.1</td>
<td>6.1</td>
<td>14.4</td>
<td>10.5</td>
<td>3.6</td>
<td>16.6</td>
<td>2.77</td>
</tr>
<tr>
<td><strong>p value</strong></td>
<td>&lt;0.001</td>
<td>&lt;0.001</td>
<td>&lt;0.001</td>
<td>&lt;0.001</td>
<td>&lt;0.001</td>
<td>&lt;0.001</td>
<td>0.001</td>
</tr>
<tr>
<td><strong>Onset (hrs)</strong></td>
<td>0</td>
<td>0</td>
<td>0.7</td>
<td>- 0.75</td>
<td>0</td>
<td>0</td>
<td>-6.5</td>
</tr>
</tbody>
</table>

**Conclusion:** Duration of operation correlates with complications and time above a statewide established standard carries higher risk. To reduce risk of complications, this data supports expeditious surgical technique, pre-op pulmonary training and offers accurate outcome assessment for patient counselling based on case duration. This data can be used directly to counsel individual surgeons to improve outcomes.

*Department of Surgery, Box U-11, 1924 Alcoa Highway, Knoxville, TN*

17. **The SAVE Review: Sonographic Analysis Versus Excision for Axillary Staging In Breast Cancer**

   **Ronda Henry-Tillman**  
   **Katherine Glover-Collins***  
   **Michael Preston***  
   **Kristalyn Gallagher***  
   **Evan Tummel***  
   **Yara V. Robertson**  
   **Daniela Ochoa***  
   **Soheila Korourian***  
   **Kent Westbrook**  
   **V. Suzanne Klimberg**

**Background:** Health care reform goals involve more cost effective methods of delivering healthcare. The cost effectiveness of axillary ultrasound guided core needle biopsy (AUS-CNB) was compared to sentinel lymph node biopsy (SLNbx) when evaluating the status of the axilla in operable invasive breast cancer.
**Hypothesis:** Staging the axilla using AUS-CNB in comparison to performing SLNbx is cost effective and should be considered in the work up of operable invasive breast cancers.

**Methods:** An IRB approved retrospective review of patients undergoing ultrasound of the axilla ± core needle biopsy at our institution from 2007-2012. Accuracy of technique and cost analysis (TreeAge Pro 2009) of AUS-CNB vs SLNbx was conducted.

**Results:** The cohort of 93 patients were divided into two groups clinically positive (CP)(35%) and negative (CN)(68%) axilla. In the CP group 83% had a suspicious AUS, of which 90% were positive. In the CN group AUS was suspicious in 70% with a positive biopsy in 59%. The sensitivity and specificity of AUS-CNB was 94% (95%CI:84.3%to98.7%) and 52% (95%CI:36.1%to8.5%) respectively with PPV of 72% (95%CI:60.4%to82.5%) and NPV of 87% (95%CI:67.6%to97.2%). Cost estimates comparing AUS-CNB with SNLbx demonstrated a cost saving of $236,517 in the CP axilla and 248,490 in the CN axilla for a total cost savings of $485,007.

**Conclusion:** AUS-CNB is a sensitive diagnostic surgeon performed procedure. It is less invasive, time saving, and cost efficient; making it a viable option when evaluating the status of the axilla in invasive breast cancer, or staging prior to neoadjuvant chemotherapy.

*Division of Breast Surgical Oncology, University of Arkansas for Medical Sciences, Little Rock, AR*
18. High Tidal Volume Decreases ARDS, Atelectasis, and Ventilatory Days Compared to Low Tidal Volume in Pediatric Burned Patients with Inhalation Injury

Linda E. Sousse*  
David N. Herndon  
Clark R. Andersen*  
Arham Ali*  
Nicole C. Benjamin*  
Thomas Granchi*  
Oscar E. Suman*  
Ronald P. Mlcak*

Inhalation injury, which is among the causes of acute lung injury and acute respiratory distress syndrome (ARDS), continues to represent a major source of mortality and morbidity in burned patients. Inhalation injury often requires mechanical ventilation, but the ideal tidal volume strategy is not clearly defined in burned pediatric patients. The aim of the present study is to determine the effects of low and high tidal volume on the number of ventilatory days, ventilatory pressures, and incidence of atelectasis, pneumonia and ARDS in pediatric burned patients with inhalation injury within one year after injury.

Methods: From 1986-2014, inhalation injury was diagnosed by bronchoscopy in pediatric burned patients (n=932). Patients were divided into one of three groups: (1) unventilated (n=241), (2) high tidal volume (HTV, 15 ± 3 ml/kg, n=190), and (3) low tidal volume (LTV, 9 ± 3 ml/kg, n = 501).

Results: The use of HTV was associated with significantly decreased ventilator days ($p<0.005$) and maximum positive end expiratory pressure ($p<0.0001$), and significantly increased maximum peak inspiratory pressure ($p<0.02$) and plateau pressure ($p<0.02$) compared to patients with LTV. The incidence of atelectasis ($p<0.0001$) and ARDS ($p<0.02$) was significantly decreased with HTV compared to LTV.

Conclusion: HTV significantly decreases ventilatory days and the incidence of both atelectasis and ARDS compared to low tidal volume in pediatric burned patients with inhalation injury. Thus, the use of HTV may enable the interruption of pathogenic sequences leading to lung injury in our patient population.

Department of Surgery, University of Texas Medical Branch, Galveston, TX, and Shriners Hospitals for Children, Burn Unit, Galveston, TX
19. Preliminary Results of a Prospective Trial of Pre-Surgical Combined BRAF and MEK Targeted Therapy in Advanced BRAF Mutation-Positive Melanoma

Angela Davis, Holly Crandall
Tausha Tobitt, Mark C Kelley

We are conducting a prospective clinical trial of combined BRAF and MEK targeted therapy in advanced, operable BRAF mutation-positive melanoma to determine the feasibility of pre-surgical targeted therapy, tumor response rates and biomarkers of response and resistance.

Eleven patients (5 males, 6 females, median age 56 (24-68) with advanced (8 clinical stage IIIc, 2 IIB, 1 IIc; 8 recurrent) BRAF V600E mutation positive melanoma received a BRAF inhibitor, dabrafenib 150mg PO BID for 14 days followed by dabrafenib plus a MEK inhibitor, trametinib 2mg PO daily for 14 days prior to surgical resection. Biopsies and tumor measurements were obtained at baseline, days 14 and 28. Ten patients completed > 14 days of therapy and are included in this report. Grade 3 toxicity was seen in 2 patients (pyrexia/pain, rash) who discontinued treatment at days 5 and 16. Nine had ≥ grade 2 toxicity. All 10 patients had a major partial response (volume reduction 65+/−9% at day 14 and 77+/−17% at day 28 by modified RECIST criteria, figure 1) and underwent margin-negative resection. Biopsies were obtained at all time points and biomarkers of response are being analyzed. Three patients have recurred and two have died of disease.
Pre-surgical targeted therapy of advanced BRAF-positive melanoma is feasible, well tolerated, and rapidly induces tumor responses. This strategy facilitates correlative biomarker studies and validates the potential of targeted therapy to facilitate complete resection of advanced disease. Studies to evaluate the effect of pre surgical targeted therapy on recurrence and survival are being considered.

Division of Surgical Oncology, Vanderbilt University, Nashville TN

20. Putting The Value Framework To Work In Surgery

Kenan W Yount*  Christine L Lau
Florence E Turrentine*  R. Scott Jones

Introduction: Health policy experts have recently proposed a framework defining value as outcomes achieved per dollar spent. However, few institutions have attempted to quantify their delivery along these dimensions. Our objective was to measure the value of our surgical services over time.

Methods: All patients undergoing general and vascular surgery at a tertiary care, university hospital were reviewed from 2004-2012. Morbidity and mortality data
from the institutional American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP) database were risk-adjusted to calculate observed-to-expected ratios, which were then inverted into a numerator as a surrogate for quality. Costs, the denominator of the value equation, were determined both for each patient’s total hospitalization and by component (e.g., diagnostic, operating room, intensive care). The ratio was then transformed by a constant and analyzed with linear regression to measure value between 2004-2012.

**Results:** A total of 25,453 patients met criteria for inclusion. Overall, the value of surgical services increased between 2004-2012 (Figure 1). The observed increase in value was greater in general surgery than in vascular surgery. Although there was a greater improvement in outcomes in vascular surgery compared to general surgery, costs rose significantly higher ($1482/year vs. $13/year, $p < 0.001). These increased costs were mostly observed between 2007-2010 with the adoption of endovascular technology.

**Conclusions:** Despite the challenges posed by current information systems, calculating risk-adjusted value in surgical services represents a critical first step for providers seeking to improve outcomes, avoid ill-advised cost-containment, and determine the costs of innovation.

Figure 1. Value Over Time.

Department of Surgery, University of Virginia, Charlottesville, VA
21. Open Retromuscular Mesh Repair of Complex Incisional Hernia: Predictors of Wound Events and Recurrence

William S Cobb
Jeremy Warren*
Alex Burnikel*

Miller Merchant*
Alex Ewing*
Alfredo M Carbonell*

Mesh repair of incisional hernias has been consistently shown to diminish recurrence rates following repair. The use of mesh does carry the risk of added infectious complications of the wound and mesh itself. We present a consecutive series of elective, retro-rectus mesh repair of the abdominal wall and attempt to determine predictors of wound events and recurrence.

Methods: A retrospective review of the hernia center database was performed to include elective, retro-muscular mesh repairs of complex incisional hernias from 8/2006 to 8/2013. Demographics, operative details, and post-operative events to include any wound event, surgical site infections, and recurrences were recorded.

Results: Over the 7-year period, 257 retro-muscular mesh repairs were performed. Only midline, incisional defects were included for evaluation. Type of mesh utilized in the repairs consisted of polypropylene (65%), polyester (15%), bioabsorbable (14%), and biologic (6%). Median age was 58 years (21-85) with an average BMI of 32.2 (15.0-66.6). Comorbidities included diabetes (28%), tobacco use (34.6%), and previous mesh infection (14%). Size of fascial defect was 184.4 cm2 on average with recurrent defects making up 47% of repairs. Component separation was performed in 60% of repairs. Wound events occurred in 40.1% of cases, which included seroma (53), skin dehiscence (36), and cellulitis (21). Surgical site infections occurred in 20.1% of cases; mesh explantation due to infection was required in only 5 (1.9%) cases. At a mean follow-up of 16.8 months, overall recurrence rate was 17.1% with mean time to recurrence of 18.5 months (range:4-50 months). With respect to mesh type, recurrence rates were 15% with synthetic mesh, 20% for bioabsorbable mesh, and 25% for biologic mesh. Predictors of surgical site infection (SSI) included history of mesh infection (OR 4.8, CI 1.9-12.1; p<0.001) and recurrent repairs (OR 2.5, CI 1.1-5.8; p<0.05). The only predictor of recurrence was the presence of an SSI (OR 3.1, CI 1.5-6.3; p<0.01).

Conclusion: Wound events are common following open mesh repairs of complex incisional hernias. Previous mesh infections and recurrent repairs increase the likelihood of a surgical site infection, which significantly increases the risk of
recurrence. Recurrences following retro-rectus mesh repairs are not insignificant and can occur several months after the repair, which stresses the importance of long-term follow-up in reporting recurrence rates after complex incisional hernia repair.

*Department of Surgery, Division of Minimal Access and Bariatric Surgery, University of South Carolina School of Medicine-Greenville, Greenville, SC*
NOTES
Radio-iodine (RAI) remnant ablation in lieu of total thyroidectomy is not recommended. This study describes RAI utilization patterns and outcomes in patients with well-differentiated thyroid cancer (DTC) after thyroid lobectomy (TL).

**Methods:** A total of 170,330 patients diagnosed with DTC between 1998 and 2011 were identified using the National Cancer Database. RAI use was documented. Descriptive statistics and multivariable regression were performed.

**Results:** A total of 32,119 (20%) patients underwent TL as the definitive procedure. Mean age at diagnosis was 48 years; median tumor size was 1cm, 4% had extrathyroidal extension, 14% had positive lymph nodes and <1% distant metastases. RAI was administered to 24% of patients in the TL cohort and represented 10% of the overall RAI use. In multivariate analysis, RAI use was associated with age<45 (OR 1.5), community facilities (OR 1.26), >1cm tumors (OR 5.67), Stage II or III (OR 1.54 and 2.05), positive lymph nodes (OR 1.78) and gross extrathyroidal extension (OR 1.36). Although the five-year overall survival was greater in the RAI group (97% vs. 95%, p=0.003), by cox proportional hazards regression controlling for multiple patient and tumor factors, there was no difference in overall survival between groups (p=0.168).

**Conclusion:** Nearly a quarter of TL patients received RAI. The strongest predictors of RAI utilization were larger tumors and advanced stage. The use of RAI in these patients was not associated with improved survival. Future guidelines will need to more clearly address this practice and educate providers about the appropriate use of RAI in TL patients.

*Division of General Surgery, Vanderbilt University, Nashville, TN*
23. **Surgical Treatment of Hepatocellular Carcinoma in North America: Can Hepatic Resection Still Be Justified?**

William Chapman  
Goran Klintmalm*  
Alan Hemming  
Neeta Vachharajani*  
Majella Doyle*  
Ron DeMatteo*  
Victor Zaydfudim*

Keith Cavaness*  
Robert Goldstein*  
Ivan Zendajas*  
Laleh G Melstrom*  
David Nagorney*  
William Jarnagin

**Introduction:** The incidence of hepatocellular cancer (HCC) is increasing dramatically worldwide. Optimal management strategies remain undefined especially for well-compensated cirrhosis and HCC.

**Methods:** This retrospective analysis included five North American liver cancer centers. Patients with surgically treated HCC between 1990 and 2011 were analyzed including demographics, tumor characteristics, and survival.

**Results:** 1,765 patients underwent resection (884, 50.1%) or transplantation (881, 49.9%). 248 (28.1%) resected patients were transplant eligible based on tumor features (1 tumor <5 cm or 2/3 tumors all <3 cm, no major vascular invasion). These were compared to 496 matched transplant patients. 97 within-Milan resected patients had cirrhosis, and were compared to the 496 transplant cases. Overall survival at 5- and 10- years was significantly improved for transplants (74.3% v 52.8% and 53.7% v 21.7%, respectively) with greater differences in disease-free survival (71.8% v 30.1% at 5-years and 53.4% v 11.7% at 10-years p<0.0001). Results were striking when transplantation was compared with resection with cirrhosis for overall (74.3% v 46.5% at 5-years and 53.7% v 15.2% at 10-years), and disease-free survival (71.8% versus 18.4% at 5-years and 53.4% v 3.0% at 10-years, p<0.0001, see figure). Similar outcome differences were seen in non-cirrhotic solitary tumors also. On multivariate analysis, type of surgery was found to be an independent variable affecting all survival outcomes.

**Conclusion:** The increasing incidence of HCC stresses limited resources. Although transplantation results in better long-term survival, limited donor availability precludes widespread application. Hepatic resection will likely remain a standard therapy in selected patients with HCC.
Division of General Surgery, Washington University School of Medicine, St. Louis, MO; Department of Surgery, Baylor University, Waco, TX; Department of Surgery, University of California San Diego Health System, San Diego, CA; Department of Surgery, Memorial Sloan-Kettering Cancer Center, New York, NY; Department of Surgery, University of Virginia Health System, Charlottesville, VA; Department of Surgery, University of Florida Health, Gainesville, FL; and Department of Surgery, Mayo Clinic, Rochester, MN

24. Risk Stratification for Readmission Following Major Hepatectomy: Development of a Readmission Risk Score

Michael E. Egger* Sharon M. Weber*
Malcolm H. Squires* Emily R. Winslow*
David A. Kooby Robert C. G. Martin, II
Shishir K. Maithel* Kelly M. McMasters
Clifford S. Cho* Charles R Scoggins

Hospital readmission is quickly becoming a quality measure, despite poor understanding of the risks of readmission, especially following major hepatectomy.

Methods: A retrospective review was performed on patients who had undergone major hepatectomy at one of three academic centers between years 2000-2012. Clinicopathologic and perioperative data were analyzed for risk factors of readmission.
on the training set of data (60% of cases) using logistic regression. Model coefficients were used to create a readmission risk score that was tested against the validation set.

**Results:** Of the 1184 hepatectomies performed, 17.3% of patients were readmitted within 90 days. Factors found to be associated with readmission include operative blood loss (OR 1.0005), any postoperative complication (OR 4.31), a major complication (OR 5.68), postoperative pulmonary embolism (OR 12.2), no blood transfusion (OR 3.25), surgical site infection (OR 5.34), and post-hepatectomy hyperbilirubinemia (OR 1.13). A scoring system based on the risk factor coefficients was found to accurately predict the risk of readmission in the validation cohort. A score of >20 points had a positive predictive value (PPV) of 30.8% and a negative predictive value (NPV) of 95.6% while a score >50 had a PPV of 50.9% and a NPV of 87.7%. This score accurately stratifies readmission risk. (Figure; P<0.0001)

**Conclusion:** The risk of hospital readmission following major hepatectomy is high and is reliably predicted with a novel scoring system.

![Figure. Risk of 90-day readmission following major hepatectomy according to a novel readmission risk score.](image)

_Hiram C. Polk Jr, MD, Department of Surgery, Division of Surgical Oncology, University of Louisville, Louisville, KY_
Concurrent Chart Review Provides More Accurate Documentation and Increases Calculated Case Mix Index, Severity of Illness, and Risk of Mortality

Richard Frazee*         Justin Regner*
Anthony Matejicka*      Randall Smith*
Stephen Abernathy*      Daniel Jupiter*
Matthew Davis*          Harry Papaconstantinou
Travis Isbell*

Case mix index (CMI) is calculated to determine the relative value assigned to a diagnosis-related group (DRG). Accurate documentation of patient complications and comorbidities (CC) and major complications and comorbidities (MCC) changes CMI and can significantly affect hospital reimbursement and future pay for performance metrics. In 2010, our hospital initiated a physician panel to provide concurrent documentation review to the trauma/acute care service.

**Methods:** Starting in 2010, a physician panel concurrently reviewed the documentation of the trauma/acute care surgeons. Recommendations for Center for Medicare and Medicaid Services (CMS) term specific documentation were made by the panel and the surgeon could incorporate or decline the recommendations. A retrospective review of trauma/acute care inpatients was performed. The average severity of illness (SOI), risk of mortality (ROM), and case mix index from 2009 were compared to the three subsequent years to determine if concurrent review influenced the values. Average length of stay (LOS) was utilized as a surrogate estimate for patient acuity. Average Injury Severity Score (ISS) by year is listed as an addition measure of patient acuity. Statistical analysis was performed using ANOVA and t-test with p<0.05 for significance.

**Results:**

<table>
<thead>
<tr>
<th>Year</th>
<th>Cases</th>
<th>SOI</th>
<th>ROM</th>
<th>CMI</th>
<th>LOS</th>
<th>ISS</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>584</td>
<td>2.21</td>
<td>1.90</td>
<td>2.11</td>
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<td>2.08</td>
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<td>2011</td>
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<td>2.58</td>
<td>2.10</td>
<td>2.36</td>
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<tr>
<td>2012</td>
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<td>5.73</td>
<td>13.9*</td>
</tr>
<tr>
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<td>&lt;0.05</td>
<td>&lt;0.05</td>
<td>NS</td>
<td>&lt;0.05</td>
</tr>
</tbody>
</table>

Each year demonstrated a significant increase in SOI, ROM, and CMI compared to baseline values. LOS was not significantly different reflecting similar patient
populations throughout the study. ISS decreased in 2011 and 2012 compared to 2009 reflecting a lower level of injury in the trauma population.

**Conclusion:** A concurrent documentation review significantly increases SOI, ROM, and CMI scores in a trauma/acute care service compared to pre-program levels. These changes reflect more accurate key word documentation rather a change in patient acuity. The increased scores offer substantially increased hospital reimbursement and more accurately stratify outcome measures for care providers.

*Department of Surgery, Baylor Scott & White Healthcare, Temple, TX*

26. **Postmastectomy Radiation for N2/N3 Breast Cancer: Factors Associated with Low Compliance Rate**

Beth Townsend *  
Gloria Caldito *  
Quyen D. Chu

NCCN and ASCO guidelines recommend postmastectomy radiation therapy (PMRT) for women with N2/N3 breast cancer. We examined the compliance rate of PMRT utilizing the National Cancer Data Base (NCDB) and determined factors associated with low compliance rate with PMRT.

**Methods:** The NCDB consisting of 2,720,368 breast cancer cases diagnosed between 1998 and 2011 was evaluated. From this database, 56,990 women with N2/N3 diseases were evaluated. Statistics used include the chi-square test, two-sample t-test or Wilcoxon rank sum test, and multivariate analysis.

**Results:** The average age was 58 years and the median follow-up was 61 months. Majority of patients are from a comprehensive community cancer programs (59%), Caucasian (81%), had health insurance (96%), resided in urban communities (98%), and had no comorbidities (83%). Approximately 82% received chemotherapy, but only 65% had PMRT. Factors associated with PMRT are tumor grade (P=0.03), regional lymph node surgery (p=0.03), readmission within 30 days of surgical discharge (p=0.03), receipt of chemotherapy (p<0.01) and hormonal therapy (p<0.01), and 30-day mortality (p<0.01). Socioeconomic (SES) variables such as facility type (p=0.85), facility geographic location (p=0.27), race/ethnicity (p=0.12), insurance status (p=0.10), income level (p=0.43), education level (p=0.86), residential location (p=0.83), and comorbidities (p=0.83) were not contributory factors. Independent variables predicting compliance with PMRT include receipt of chemotherapy
(OR=4.55; p<0.01), readmission within 30 days after surgery (OR=1.14; p=0.01), and alive within 30 days after surgery (OR=1.55;p=0.04).

**Conclusion:** A third of patients with N2/N3 disease did not receive PMRT. SES variables were not contributory factors. Non-compliance to PMRT is related to lack of receipt of chemotherapy, non-readmission or death within 30 days after surgery.

*Division of Surgical Oncology, Department of Surgery, Louisiana State University Health Sciences Center – Shreveport, Shreveport, LA*

**27. Minimally Invasive Esophagectomy (MIE) Provides Significant Survival Advantage Compared To Open/Hybrid Esophagectomy (OHE) For Patients With Cancers Of The Esophagus and GE Junction (EC)**


MIE is increasingly used for the treatment of patients with EC. We previously reported that oncologic efficacy may be improved with MIE compared to OHE. We compared survival of patients undergoing MIE and OHE.

**Methods:** Our contemporary series of patients who underwent MIE (2008-2013) was compared to a cohort undergoing OHE (3-hole (39), Ivor Lewis (16), hybrid (13), 2000-2013). Summary statistics were calculated by surgery type; Kaplan-Meier methods were used to compare survival. Cox regression was used to assess the impact of surgery type (MIE vs. OHE) on mortality adjusting for age, gender, total lymph nodes, lymph node ratio (LNR), neoadjuvant chemoradiotherapy (CRT), and stage.

**Results:** MIE (n = 104) and OHE (n = 68) groups were similar with respect to age and gender. The MIE group tended to have higher BMI, earlier stage disease, and was less likely to receive CRT. The MIE group experienced lower operative mortality (4% vs. 9%, p=0.35) and significantly fewer major complications. Five-year survival between groups was significantly different (MIE-64%, OE-35%, p<0.001). Multivariate analysis demonstrated that patients undergoing OHE had a significantly worse survival compared to MIE independent of age, LNR, CRT, and pathologic stage (HR=2.00, p=0.019).
**Conclusion:** This study supports MIE for EC as a superior procedure with respect to overall survival, perioperative mortality, and severity of postoperative complications. Several biases may have affected these results: earlier stage in the MIE group and disparity in timing of the procedures. These results will need to be confirmed in future studies with longer follow-up.

The Jefferson Foregut Center and the Department of Surgery, Sidney Kimmel Medical College at Thomas Jefferson University, Philadelphia, PA

28. The Risk Paradox: Underuse of Cholecystectomy in Patients at Highest Risk of Developing Complications

Taylor S. Riall  Deepak Adhikari*
Abhishek D. Parmar*         Winston Crowell*
Nina P. Tamirisa*         Suzanne K. Linder*
Courtney M. Townsend, Jr.  James S. Goodwin*

We recently developed and validated a prognostic model that accurately predicts the 2-year risk of emergent gallstone-related hospitalization in older patients (Annals of Surgery, In Press).

**Methods:** We used 100% Texas Medicare data (1995-2007) to identify patients 66 and older with initial episode of symptomatic gallstones not requiring emergency hospitalization or admission. At presentation, we calculated each patient’s risk of 2-year gallstone-related emergent hospitalization using our validated model. Patients were placed into the following risk groups: <30%, 30-<60%, and ≥60%. Within each risk group, we calculated the percent of elective cholecystectomies (<2.5 months from initial episode) performed.

**Results:** 117,158 patients had an episode of symptomatic gallstones. The average age was 77.0 years and 61.1% were female. The model accurately predicted 2-year risk of gallstone-related hospitalizations in patients who did not undergo cholecystectomy (N=92,436), increasing from 20% to 47% to 73% across risk groups (Column 1). For the overall cohort, cholecystectomy rates increased only slightly with risk (Column 2); over 75% of patients with moderate and high risk of gallstone-related hospitalization did not undergo cholecystectomy. Even more concerning, in the healthiest older patients, cholecystectomy rates decreased as the risk of gallstone-related hospitalizations increased (Column 3). In patients who did not undergo
cholecystectomy, only 7.2% were seen by a surgeon in the 2.5 months following the initial episode.

<table>
<thead>
<tr>
<th>Risk Group</th>
<th>2-year Observed Gallstone-Related Hospitalization Rate N=92,436</th>
<th>Overall Cohort (N=117,158)</th>
<th>No Comorbidities (N=22,768)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>% (of patients without cholecystectomy)</td>
<td>Total N (% undergoing cholecystectomy)</td>
<td>Total N (% undergoing cholecystectomy)</td>
</tr>
<tr>
<td>&lt;30%</td>
<td>20.0%</td>
<td>107,788 (20.9%)</td>
<td>20,132 (31.9%)</td>
</tr>
<tr>
<td>30 - &lt;60%</td>
<td>47.1%</td>
<td>6,323 (22.2%)</td>
<td>1,629 (28.9%)</td>
</tr>
<tr>
<td>≥60%</td>
<td>72.8%</td>
<td>3,047 (24.3%)</td>
<td>1,007 (26.9%)</td>
</tr>
</tbody>
</table>

P<0.001

**Conclusion:** Cholecystectomy rates are low in the patients at highest risk for gallstone-related complications, with the majority of these patients never undergoing surgical evaluation. Incorporating the risk prediction model, especially at the level of the primary care physician, will improve outcomes by increasing surgical referrals and cholecystectomy rates, thereby avoiding the morbidity associated with complicated gallstone disease in this vulnerable population.

*Department of Surgery, University of Texas Medical Branch, Galveston, TX*

29. **How Do You Select Chronic Pancreatitis Patients For Total Pancreatectomy With Islet Autotransplantation? Are There Psychometric Predictors?**

Katherine A. Morgan  
Jeffrey Borckardt*  
David B. Adams

Selected patients with chronic pancreatitis pain may benefit from total pancreatectomy with islet autotransplantation (TPIAT). Patient selection, however, is challenging and outcomes assessment is essential.

**Methods:** A prospective database of TPIAT patients from March 2009 through May 2014 was reviewed. Attention was given to psychometric assessments, including...
ShortForm-12 QOL survey (SF-12), Center for Epidemiologic Studies Depression scale (CESD), and Current Opioid Misuse Measure (COMM) preoperatively and SF-12 postoperatively.

**Results:** 127 patients (76% women, mean age 40.5) underwent TPIAT. Preoperatively, the mean SF-12 physical QOL score (pQOL) was 27.24 (SD=9.9) and the mean psychological QOL score (mhQOL) was 38.5 (SD=12.8), with a score of 50 representing the mean of a healthy population. Mean improvements in pQOL relative to baseline at 1-year, 2-years, and 3-years post-surgery were 7.1 (n=92), 5.8 (n=62), and 7.8 (n=38) which represented significant change (all p<.001). Mean improvements in mhQOL relative to baseline at 1-year, 2-years, and 3-years post-surgery were 3.9, 4.9, and 6.6 which also represented significant improvement (all p<.001). The percentages of patients evidencing at least a 3-point (1/3 standard deviation) improvement in pQOL at 1-year, 2-years, and 3-years post-surgery were 65%, 60%, and 61% respectively. The percentages of patients evidencing this improvement in mhQOL at 1-year, 2-years, and 3-years post-surgery were 49%, 58%, and 66%. Exploratory regression analyses of SF-12, CESD and COMM data revealed limited baseline predictability of surgical response; however, higher opioid misuse scores at baseline were significantly related to pQOL improvement at 2-years (r(54) = .33, p = .02).

**Conclusion:** TPIAT can improve QOL in selected patients with chronic pancreatitis. PQOL improves quickly following surgery while mhQOL improvements are more gradual. Opioid misuse may predict pQOL improvement at 2-years.

*Department of Surgery and Department of Psychiatry and Behavioral Sciences, Medical University of South Carolina, Charleston, SC*
30. Readmission Following Pancreatectomy is Predictable with the Use of a Novel Risk Scoring System

Vicente Valero, III*  
Joshua C. Grimm*  
Arman Kilic*  
Russell L. Lewis*  
Jeffrey J. Tosoian*  
Jin He*  
Matthew J. Weiss*  
Charles M. Vollmer Jr.*  
John L. Cameron  
Christopher L. Wolfgang

Post-operative readmissions have been proposed by Medicare as a quality metric and may impact hospital reimbursement. Since readmission following pancreatectomy is common, we sought to identify factors associated with readmission and establish a predictive risk scoring system (RSS).

**Methods:** This is a retrospective analysis of 2,360 pancreatectomies performed at nine, high-volume pancreatic centers between 2005 and 2011. A predictive model was constructed using 44 factors associated with readmission. To derive and validate the RSS, the population was randomly divided into two cohorts in a 4:1 fashion. A multivariable logistic regression model was constructed and relative risk scores were assigned based on the odds ratio of each predictor. A 32-point composite Readmission After Pancreatectomy (RAP) score was generated and assigned to three risk strata.

**Results:** Overall, 464 (19.7%) patients were readmitted within 90-days. Eight pre and postoperative factors were independently predictive of readmission including prior myocardial infarction, ASA Class ≥3, dementia, hemorrhage, delayed gastric emptying, surgical site infection, sepsis and length of stay <10 days (Table 1). The RAP score was highly predictive of readmission in the validation cohort (AUC=0.72). The low (0-3), intermediate (4-7) and high risk (>7) groups correlated to 11.7%, 17.5% and 45.4% observed readmission rates, respectively (p<0.001).
**Conclusion:** The RAP score, a novel, clinically useful RSS has been developed, which is highly predictive of readmission following pancreatectomy. Identification of patients at high-risk for readmission may allow for clinical optimization prior to discharge and mitigate health care costs through focused preventive measures. It also has potential to serve as a new metric for comparative research and quality assessment.

*Department of Surgery, The Johns Hopkins University School of Medicine, Baltimore, MD*

<table>
<thead>
<tr>
<th>Covariates</th>
<th>Multivariable Analysis</th>
<th>Points Assigned</th>
</tr>
</thead>
<tbody>
<tr>
<td>ASA Class ≥ 3</td>
<td>1.34 (1.03-1.75)</td>
<td>2</td>
</tr>
<tr>
<td>Prior history of MI</td>
<td>2.03 (1.15-3.57)</td>
<td>3</td>
</tr>
<tr>
<td>Prior history of dementia</td>
<td>6.22 (1.78-21.81)</td>
<td>9</td>
</tr>
<tr>
<td>Sepsis</td>
<td>3.10 (1.94-4.95)</td>
<td>5</td>
</tr>
<tr>
<td>Hemorrhage</td>
<td>1.81 (1.21-2.73)</td>
<td>3</td>
</tr>
<tr>
<td>Delayed gastric emptying</td>
<td>1.78 (1.22-2.60)</td>
<td>3</td>
</tr>
<tr>
<td>Surgical site infection</td>
<td>3.31 (2.37-4.63)</td>
<td>5</td>
</tr>
<tr>
<td>Length of stay &lt; 10 days</td>
<td>1.51 (1.10-2.09)</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total points possible</strong></td>
<td><strong>-</strong></td>
<td><strong>32</strong></td>
</tr>
</tbody>
</table>

OR indicates odds ratio; CI, confidence interval; ASA, American Society of Anesthesiology; MI, myocardial infarction.

### 31. Pancreas Transplantation In C-Peptide Positive Patients: Does “Type” Of Diabetes Really Matter?

Robert J Stratta  
Hany El-Hennawy*  
Jeffrey Rogers*  
Michael Gautreaux*  
Alan C Farney*  
Amber Reeves-Daniel*  
Giuseppe Orlando*  
Amudha Palanisamy*  
Umar Farooq*  
Samy Iskandar*  
Yousef Al-Shraideh*  
Jason K Bodner*

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In the past, type 2 (C-peptide positive) diabetes was a contraindication for simultaneous pancreas-kidney transplantation (SPKT) because of insulin resistance. However, recent studies suggest that type 2 diabetes is a heterogeneous disorder that may be amenable to surgical therapy.

**Methods:** We retrospectively analyzed outcomes in SPKT recipients according to pretransplant C-peptide levels. Selection criteria for C-peptide positive candidates were similar to C-peptide negative candidates and included insulin-requiring for ≥5 years, daily insulin requirement <1 u/kg, age <60, BMI <30 kg/m², and low burden of co-morbidities. All SPKTs were performed as intent to treat with portal-enteric drainage. All patients received depleting antibody induction with tacrolimus/mycophenolate ± steroids.

**Results:** From 11/01 to 3/13, we performed 162 SPKTs including 132 in patients with absent or low C-peptide levels (<2.0 ng/ml, C-peptide negative) and 30 with C-peptide levels ≥2.0 ng/ml pretransplant (C-peptide positive group, mean C-peptide level 5.7 ng/ml, range 2.1-12.4). C-peptide positive patients had a higher proportion that were age ≥50 years (40% versus 23%, p=0.06), had a later age of onset (mean age 34 versus 16 years, p=0.0001) and shorter duration of pretransplant diabetes (mean 17 versus 25 years, p = 0.01), and had a greater proportion of African Americans (AA, 47% versus 17%, p=0.001) compared to C-peptide negative patients. With a mean follow-up of 5.5 years, patient survival (85% vs 87%), kidney graft survival (72% vs 77%), and pancreas graft survival (66% vs 57%, all p=NS) rates were comparable in C-peptide negative and positive patients, respectively. Death-censored kidney (both 85%) and pancreas (77% C-peptide negative versus 61% C-peptide positive) graft survival rates were similar. The incidences of early PT thrombosis (9.8% versus 3%) and early relaparotomy (36% versus 33%) were no different in C-peptide negative and positive groups, respectively. At 5 years follow-up, there were no differences in acute rejection episodes (29% versus 30%), surgical complications, major infections, readmissions, HbA1c and C-peptide levels, or serum creatinine and calculated GFR levels between the 2 groups. Survival outcomes in C-peptide negative (n=25) vs C-peptide positive (n=14) AA patients were likewise similar.

**Conclusion:** Diabetic patients with measurable pretransplant C-peptide levels appear to have a type 2 diabetes phenotype compared to insulinopenic patients undergoing SPKT. However, survival and functional outcomes were similar between groups. Consequently, pretransplant C-peptide levels should not be used exclusively to determine candidacy for SPKT.

*Department of General Surgery, Wake Forest School of Medicine, Winston-Salem, NC*
Factors Associated With Pulmonary Embolism Within 72 Hours of Admission In Trauma: A Multicenter Study

Jamie J. Coleman*  
Ben L. Zarzaur*  
Chad Katona*  
Zachary Plummer*  
Laura Johnson*  
Alison Fecher*  
Jamie O’Rear*  
David V. Feliciano  
Grace S. Rozycki

Recent studies using thromboelastography (TEG) indicate that patients are at risk for hypercoagulability early after injury. Pulmonary embolism (PE) is also well-known to cause significant morbidity and mortality following injury and can occur within 72 hours of admission (EARLY PE). Despite this risk, prophylactic anticoagulation is often delayed in patients with certain injuries due to fear of bleeding.

Methods: This was a retrospective study of injured patients with PE from 2007-2013 at three Level I trauma centers. Data collected included patient demographics, injury patterns, length of stay, timing of DVT prophylaxis and diagnosis of PE. Patients with EARLY PE (≤ 3 days) were compared to those with LATE PE (> 3 days) using bivariate and multivariable analysis.

Results: A total of 54,964 patients were admitted to the 3 centers during the study period, and 144 (0.26%) were diagnosed with a PE. Eleven were excluded from the study due to a lack of critical data leaving 133 patients (42% EARLY PE). Factors associated with EARLY PE included long bone fractures in the lower extremity and an AIS Extremity of ≥ 3. Higher Injury Severity Score, severe chest and head trauma (AIS ≥ 3), and not receiving DVT prophylaxis within 48 hours of hospital admission were not associated with EARLY PE.

Conclusion: EARLY PE is a significant clinical entity occurring in nearly half the patients who suffered a PE. EARLY PE is associated with long bone fractures and severe extremity trauma, but not severe thoracic injury. Timing of prophylactic anticoagulation had no impact on EARLY PE. All admitted trauma patients should be assessed for a hypercoagulable state after injury.
<table>
<thead>
<tr>
<th></th>
<th>Late PE n=76</th>
<th>Early PE n=57</th>
<th>p-value</th>
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<tbody>
<tr>
<td>Age</td>
<td>52.5</td>
<td>48.0</td>
<td>0.634</td>
</tr>
<tr>
<td>ISS (median)</td>
<td>23</td>
<td>14</td>
<td>0.07</td>
</tr>
<tr>
<td>AIS Head ≥ 3</td>
<td>48.7%</td>
<td>22.8%</td>
<td>0.006</td>
</tr>
<tr>
<td>AIS Thorax ≥ 3</td>
<td>53.9%</td>
<td>42.1%</td>
<td>0.176</td>
</tr>
<tr>
<td>AIS Extremity ≥ 3</td>
<td>25%</td>
<td>47.4%</td>
<td>0.007</td>
</tr>
<tr>
<td>General Anesthesia within 48 hours of admit</td>
<td>56.6%</td>
<td>66.7%</td>
<td>0.238</td>
</tr>
<tr>
<td>Long Bone Fracture</td>
<td>31.6%</td>
<td>50.1%</td>
<td>0.027</td>
</tr>
<tr>
<td>DVT Prophylaxis within 48 hours or admit</td>
<td>34.2%</td>
<td>42.1%</td>
<td>0.352</td>
</tr>
<tr>
<td>Mortality</td>
<td>9.5%</td>
<td>5.4%</td>
<td>0.385</td>
</tr>
</tbody>
</table>

Department of General Surgery, Indiana University School of Medicine, Indianapolis, IN

33. Cost Effectiveness Analysis of Diagnostic Approaches to Suspected Appendicitis in Children

Jay Pershad*  
Teresa M Waters*  
Max R Langham  
Eunice Y Huang*

Our group recently published a clinical pathway (LeB-P) that utilized Samuel’s Pediatric Appendicitis Score (PAS) with selective use of ultrasonography (USG) for diagnosis of children at risk for appendicitis. The objective of this study was to model the cost effectiveness of implementing the LeB-P compared to usual care.

**Methods:** We constructed a decision analytic model using TreeAge Pro software comparing hospital costs for four diagnostic strategies for suspected appendicitis: USG on all patients; the LeB-P; computerized tomography (CT) on all patients; and clinician judgment alone (CJ). Prevalence of disease, outcome probabilities and hospital costs of each option were derived from published literature and our previous study results. Effectiveness was calculated using predictive values, sensitivity, specificity and prevalence of disease.
Results: In the base case model, USG was the preferred strategy over LeB-P and CT. (Table 1) CJ was absolutely dominated by the other pathways based on its lower diagnostic accuracy and increased cost, which resulted from missed appendicitis and negative appendectomies (results not shown). Compared to the LeB-P, USG costs $589 less per patient evaluated but resulted in a 5% increase in the diagnostic error rate. Utilizing LeB-P over USG would cost our institution an additional $11,941 to eliminate one misdiagnosis, as calculated by the Incremental Cost Effectiveness Ratio (ICER).

Conclusion: Performing USG on all children with suspected appendicitis is the most cost effective strategy. However, utilizing PAS with selective use of USG (LeB-P) improved diagnostic accuracy at a modest increase in cost, while decreasing CT utilization.

Division of Emergency Medicine and Division of Pediatric Surgery, Department of Pediatrics, Department of Preventive Medicine and Department of Surgery, University of Tennessee Health Science Center, Memphis, TN
<table>
<thead>
<tr>
<th>Probability Parameters</th>
<th>Frequency</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sensitivity</td>
<td>92%</td>
<td></td>
</tr>
<tr>
<td>Specificity</td>
<td>95%</td>
<td></td>
</tr>
<tr>
<td>Pooled Sensitivity</td>
<td>94%</td>
<td></td>
</tr>
<tr>
<td>Pooled Specificity</td>
<td>95%</td>
<td></td>
</tr>
<tr>
<td>Pooled Sensitivity</td>
<td>73%</td>
<td></td>
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<tr>
<td>Pooled Specificity</td>
<td>97%</td>
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<tr>
<td>Sensitivity</td>
<td>46%</td>
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<tr>
<td>Specificity</td>
<td>72%</td>
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### TABLE 1B

<table>
<thead>
<tr>
<th>Estimated Hospital Costs</th>
<th>Median</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient with acute appendicitis (67% acute, 33% complicated), inpatient</td>
<td>$8,894</td>
</tr>
<tr>
<td>Patient with no appendicitis, receives CT, overnight observation</td>
<td>$2,400</td>
</tr>
<tr>
<td>Patient with no appendicitis, who receives a USG, overnight observation</td>
<td>$1,977</td>
</tr>
<tr>
<td>Patient with no appendicitis, no imaging, overnight observation</td>
<td>$1,817</td>
</tr>
<tr>
<td>Patient with no appendicitis, no imaging, discharged from ED</td>
<td>$680</td>
</tr>
<tr>
<td>Patient with “missed” appendicitis, returns w/ complicated appendicitis</td>
<td>$13,816</td>
</tr>
<tr>
<td>LeB-P - True negative; Weighted cost of selective USG/CT/Obs/ED-DC</td>
<td>$817</td>
</tr>
<tr>
<td>Cost of negative appendectomy – False positives</td>
<td>$6,804</td>
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</table>

### TABLE 1C

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Overall Cost</th>
<th>Incremental Cost</th>
<th>Effectiveness</th>
<th>Incremental Effectiveness</th>
<th>ICER</th>
</tr>
</thead>
<tbody>
<tr>
<td>USG All</td>
<td>$2,430</td>
<td>--</td>
<td>0.11</td>
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<tr>
<td>LeB-P</td>
<td>$3,018</td>
<td>$589</td>
<td>0.06</td>
<td>0.05</td>
<td>$11,941</td>
</tr>
<tr>
<td>CT All</td>
<td>$3,385</td>
<td>$366</td>
<td>0.05</td>
<td>0.01</td>
<td>$55,467</td>
</tr>
</tbody>
</table>

34. Retained Foreign Bodies Following Surgeries: Lessons Learnt

Zaid Al-Qurayshi*  
Adam Hauch*  
Douglas P. Slakey  
Emad Kandil*

Retained foreign bodies (RFB) following operative interventions are linked to increased risk of morbidity and mortality, and represent a medico-legal liability. We aim to identify factors related to the risk of iatrogenic RFB.

**Method:** Cross-sectional analysis performed of all operations that resulted in a secondary diagnosis of RFB in the Nationwide Inpatient Sample (NIS) from 2003-
2009. Comparative controls were randomly selected from patients who underwent similar procedures.

**Results:** 3,045 cases of RFB and 12,592 randomly selected controls were included. The majority of incidents, 968 (31.8%), were reported following gastrointestinal interventions. Risk of RFB was higher in teaching hospitals [OR: 1.26, 95%CI: (1.12, 1.42)]. In abdominopelvic procedures, patients admitted with traumatic injuries demonstrated a higher risk of RFB compared to electively admitted patients [OR: 2.87, 95%CI: (1.46, 5.65)]. However, in procedures outside the abdominopelvic region, patients admitted for trauma had lower risk [OR: 0.68, 95%CI: (0.52, 0.89)]. Obesity (BMI ≥ 30) and older age (≥ 51yr) were significantly associated with higher risk only for abdominopelvic procedures [OR: 1.73, 95%CI: (1.31, 2.28); OR: 1.81, 95%CI: (1.31, 2.50), respectively]. Teaching and large-sized hospitals were associated with higher risk of more than one event of RFB per year (p< 0.05). RFB were associated with significantly higher hospital charges compared to controls ($76,339.0 ± 2,260.36 vs. $37,807.0 ± 775.80, p<0.001).

<table>
<thead>
<tr>
<th>Procedure site</th>
<th>Variables</th>
<th>% RFB</th>
<th>aOR</th>
<th>95% CI</th>
<th>P value</th>
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</thead>
<tbody>
<tr>
<td></td>
<td><strong>Abdomino-pelvic Procedures</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Age (year)</td>
<td></td>
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<tr>
<td></td>
<td>&lt;51</td>
<td>14.7</td>
<td>Reference</td>
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<td>1.901, 2.922</td>
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<td>51-69</td>
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<td>28.8</td>
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<tr>
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<td>Admission/trauma status</td>
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<tr>
<td></td>
<td>Elective/Non-trauma</td>
<td>21.8</td>
<td>Reference</td>
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<td>Trauma</td>
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<td>Hospital teaching status</td>
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<tr>
<td></td>
<td>Non-teaching</td>
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<td>Reference</td>
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<td>1.090, 1.483</td>
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<td>Teaching</td>
<td>22.0</td>
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<td></td>
<td>Obesity(BMI ≥ 30)</td>
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<tr>
<td></td>
<td>No</td>
<td>19.2</td>
<td>Reference</td>
<td>1.729</td>
<td>1.314, 2.275</td>
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<td>Yes</td>
<td>29.9</td>
<td></td>
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<tr>
<td></td>
<td><strong>Non Abdomino-pelvic Procedures</strong></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Age (year)</td>
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<tr>
<td></td>
<td>&lt;51</td>
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<td>0.649</td>
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<td></td>
<td>Admission/trauma status</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Elective/Non-trauma</td>
<td>23.2</td>
<td>Reference</td>
<td>0.68</td>
<td>0.520, 0.890</td>
</tr>
<tr>
<td></td>
<td>Non-elective/Trauma</td>
<td>15.2</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Hospital teaching status</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non-teaching</td>
<td>16.9</td>
<td>Reference</td>
<td>1.261</td>
<td>1.082, 1.470</td>
</tr>
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<td></td>
<td>Teaching</td>
<td>21.2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Obesity (BMI ≥ 30)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>18.8</td>
<td>Reference</td>
<td>1.136</td>
<td>0.915, 1.411</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>22.7</td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

Abbreviations: aOR, adjusted odds ratio; CI, confidence interval; BMI, body mass index.

* Adjusted for age, gender, payer of health service, admission type, trauma, obesity, hospital teaching status, and procedure site.

**Conclusions:** RFB following abdominopelvic surgeries are not rare medical errors, especially in obese and trauma-related patients. Teaching and large-sized hospitals are
associated with a higher risk. Efforts are needed to avoid these disastrous and costly complications.

Department of General Surgery, Tulane University School of Medicine, New Orleans, LA

35. Acute Care Surgery: Defining Mortality in Emergency General Surgery in the State of Maryland

Mayur Narayan*  
Elena N. Klyushnenkova*  
Ronald Tesoriero*  
Hegang Chen*  
Brandon R. Bruns*  
Jose J. Diaz

Background: Emergency General Surgery (EGS) is a major component of Acute Care Surgery (ACS), however limited data exist regarding mortality with respect to trauma center (TC) designation. We hypothesized that mortality would be lower for EGS patients treated at a TC vs. non-TC.

Methods: A retrospective review of the Maryland HSCRC database from 2009-2013 was performed. AAST EGS ICD-9 codes were utilized to define EGS patients. Data collected included demographics, TC designation, ED admissions, and All Patients Refined Severity of Illness (APR_SOI). TC designation was utilized as a marker of a formal ACS program. Primary outcome was in-hospital mortality. Multivariable logistic regression analysis (MLRA) was performed controlling for age.

Results: There were 817,942 EGS encounters. Mean age was 60.1±18.7 years, 46.5% were males. 71.1% of encounters were at non-TCs. 75.8% were ED admissions. Overall mortality was 4.05%. Mortality based on TC designation and APR_SOI is shown in Table 1. Mortality was calculated based on TC designation controlling for age across APR_SOI strata. MLRA did not show statistically significant differences in mortality between hospitals levels for minor APR_SOI. For moderate APR_SOI, mortality was significantly lower for TCs compared to non-TCs (p <0.001). Among TCs, the effect was strongest for Level 1 trauma centers (OR=0.34, 95% CI: (0.18, 0.66)). For extreme APR_SOI, mortality was higher at TCs versus non-TCs (p<0.001).

Conclusion: EGS patients treated at TCs had lower mortality for moderate APR_SOI, but increased mortality for extreme APR_SOI, when compared to non-TCs. Further investigation is required to better evaluate this unexpected finding.
Table 1. Mortality by hospital trauma level and All Patients Refined Severity of Illness (APR_SOI)

<table>
<thead>
<tr>
<th>Trauma Level</th>
<th>APR_SOI</th>
<th>Minor</th>
<th>Moderate</th>
<th>Major</th>
<th>Extreme</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total, N</td>
<td>Expired N (%)</td>
<td>Total, N</td>
<td>Expired N (%)</td>
<td>Total, N</td>
</tr>
<tr>
<td>None</td>
<td>54,869</td>
<td>29 (0.05)</td>
<td>173,412</td>
<td>324 (0.19)</td>
<td>232,096</td>
</tr>
<tr>
<td>Level 3</td>
<td>4,611</td>
<td>3 (0.07)</td>
<td>16,328</td>
<td>31 (0.19)</td>
<td>25,118</td>
</tr>
<tr>
<td>Level 2</td>
<td>6,231</td>
<td>3 (0.05)</td>
<td>24,607</td>
<td>28 (0.11)</td>
<td>33,881</td>
</tr>
<tr>
<td>Level 1</td>
<td>7,075</td>
<td>1 (0.01)</td>
<td>23,358</td>
<td>9 (0.04)</td>
<td>36,415</td>
</tr>
</tbody>
</table>

| p value      | 0.54    | <0.001  | <0.001   | <0.001   |

Division of Acute Care Surgery, Program in Trauma, University of Maryland School of Medicine, Baltimore, MD
HONORARY FELLOWS

*Britt, Louis G., 4044 Dumaine Way, Memphis, TN 38117, Tel: 901-268-4661, louisgbritt@gmail.com
*Cohn, Isidore, Jr., 510 Iona Street, Metairie, LA 70005, Tel: 504-835-6135, drdrdrjr@gmail.com
*Copeland, Edward M. III, University of Florida College of Medicine, Department of Surgery, Room 6177, P.O. Box 100286, Gainesville, FL 32610-0286, Tel: 352-265-0169, Fax: 352-338-9809, edward.copeland@surgery.ufl.edu
*Diethelm, Arnold G., University of Alabama Medical School, 1808 7th Ave. South, 503 BDB, Birmingham, AL 35294, Tel: 205-934-5200, Fax: 205-731-9250, arnold.diethelm@ccc.uab.edu
*Haller, J. Alex, Jr., 1314 Glencoe Road, Glencoe, MD 21152, Tel: 410-955-6257, Fax: 410-472-4241, amancalled@comcast.net
*Lawrence, Walter, Jr., VCU Health System, 1200 East Broad Street, Box 980011, Richmond, VA 23298, Tel: 804-828-5016, Fax: 804-828-4808, wlawrence@mcvh-vcu.edu
*Polk, Hiram C., Jr., University of Louisville, Department of Surgery, School of Medicine, Louisville, KY 40292, Tel: 502-852-1897, Fax: 502-852-8915, hcpolk01@louisville.edu
*Sawyers, John L., 115 Bellebrook Circle, Nashville, TN 37205, Tel: 615-383-0229, drsawyers@aol.com

FELLOWS

A

*AbuRahma, Ali F., R.C. Byrd Health Sciences Center, West Virginia University, 3110 MacCorkle Avenue, SE, Charleston, WV 25304, Tel: 304-388-4887, Fax: 304-388-4879, ali.aburahma@camc.org
*Adams, David B.,
*Adams, John P., 804 Bay Avenue, Lewes, DE 19958, Tel: 202-244-8921, Fax: 302-645-6453, jpadams10@verizon.net
Adams, Reid B., University of Virginia Health Science Center, Department of Surgery, Box 800709, Charlottesville, VA 22908-0709, Tel: 434-924-2839, Fax: 434-982-4778, rba3b@virginia.edu
*Adams, David B., Medical University of South Carolina, 25 Courtenay Drive, MSC 290, Charleston, SC 29425, Tel: 843-792-9393, Fax: 843-876-4878, adamsdav@musc.edu

*Senior Members 65 †New Members
*Adamson, Jerome E., 207 Cedar Meadows Lane, Chapel Hill, NC 27517, Tel: 919-259-7457
†Ahuja, Nita, Johns Hopkins University, 600 North Wolfe Street, Blalock 685, Baltimore, MD 21287, Tel: 410-502-6135, Fax: 410-502-0982, nahuja1@jhmi.edu
*Albertson, David A., 4541 Chinaberry Lane, Winston-Salem, NC 27106, dalberts@triad.rr.com
*Aldrete, Joaquin S., 211 Second Street NW, #516, Rochester, MN 55901, Tel: 507-288-0555, mlaldrete@gmail.com
*Alexander, J. Wesley, Shriners Hospital for Children, 3229 Burnet AV, Cincinnati, OH 45229, Tel: 513-872-6066, Fax: 513-872-6072, jwesley.alexander@uc.edu
*Alford, William C., Jr., 402 Ellendale DR, Nashville, TN 37205
†Allen, Peter J., Department of Surgery, Memorial Sloan-Kettering Cancer Center, 1275 York Avenue, New York, NY 10021, Tel: 212-639-5132, Fax: 212-717-3645, allenp@mskcc.org
*Andersen, Dana K., National Institutes of Health, Bethesda, MD 20862, Tel: 301-594-8879, dana.andersen@nih.gov
*Anderson, Robert W., Duke University Medical Center, Department of Surgery, Box 3704, Durham, NC 27710, Tel: 919-681-2559, Fax: 919-681-2779
*Andrassy, Richard J., 6431 Fannin, MSB 4.020, Houston, TX 77030, Tel: 713-500-7200, Fax: 713-500-7213, richard.andrassy@uth.tmc.edu
*Anlyan, William G., 1516 Pinecrest Road, Durham, NC 27705-5817
*Arensman, Robert M., 330 S. Michigan Avenue, Apartment 2008, Chicago, IL 60604, Tel: 312-435-9002, Fax: 312-435-9003, rarensman@hotmail.com
*Arnold, Phillip G., 1106 8th Street S.W., Rochester, MN 55902, Tel: 507-285-1439, pgarnold@mayo.edu
Asensio, Juan A., Department of Surgery, Creighton University Medical Center, 601 North 30th ST, Ste. 3701, Omaha, NE 68131-2137, Tel: 402-717-4842, Fax: 402-717-6062, JuanAsensio@creighton.edu
Ashley, Dennis W., The Medical Center of Central Georgia, 777 Hemlock Street, HB 103, Macon, GA 31201, Tel: 478-633-1199, Fax: 478-633-6195, ashley.dennis@mccg.org
Ashley, Stanley W., Brigham and Women's Hospital, 75 Francis ST, Boston, MA 02115, Tel: 617-732-6730, Fax: 617-264-6366, sashley@partners.org
*Austin, Erle H. III, 201 Abraham Flexner Way, Suite 1200, Louisville, KY 40202, Tel: 502-561-2180, Fax: 502-561-2190

*Senior Members  66  †New Members
Bagwell, Charles E., Virginia Commonwealth University, Pediatric Surgery, 1200 East Broad Street, West Hospital, 7th Floor, East Wing, Richmond, VA 23298-0015, Tel: 804-828-3500, Fax: 804-828-8606, cebagwel@vcu.edu

*Baker, R. Robinson, 8717 McDonogh Road, Baltimore, MD 21208, Tel: 410-363-3731, rrbaker@jhmi.edu

*Baker, Christopher C., Carillion Clinic, Carillion Roanoke Memorial Hospital, 1906 Bellview AV 1-West, Roanoke, VA 24014, Tel: 540-853-0413, ccbaker@carilionclinic.org

*Baker, Lenox D., Jr., 600 Gresham Drive, Suite 8600, Norfolk, VA 23507, Tel: 757-388-6005, Fax: 757-388-6006, lxbaker@bellatlantic.net

*Baker, C.R.F., Jr., 2125 Bailey Island Lane, Edisto Island, SC 29438, Tel: 843-821-6610

*Baldwin, John C., Texas Tech University, Office of the President, 3601 4th Street, STOP 6258, Lubbock, TX 79430, Tel: 806-743-2900, Fax: 806-743-2474, john.baldwin@ttuhsc.edu

Baliga, Prabhakar, Medical University of South Carolina, PO Box 250611, Charleston, SC 29425, Tel: 843-792-3368, Fax: 843-792-8596, baligap@musc.edu

Barber, W. Henry, General Surgery, 1727 East Union ST, Greenville, MS 38703, Tel: 662-332-0032, Fax: 662-332-5008, wbarber@deltaregional.com

Barbul, Adrian, Medstar Washington Hospital Center, 110 Irving ST, NW, Washington, DC 20010-2975, Tel: 202-877-7000, abarbul009@gmail.com

Barie, Philip S., Weill Cornell Medical College, 525 E. 68th ST, P713A Surgery, New York, NY 10065, Tel: 212-746-5401, Fax: 212-746-6995, pbarie@med.cornell.edu

*Barker, Wiley F., 29129 Paiute Drive, Agoura, CA 91301-2938, Fax: 818-865-9901, wbarker@charter.net

*Barker, Clyde F., University of Pennsylvania Medical Center, 4 Silverstein Pavilion, 3400 Spruce Street, Philadelphia, PA 19104-4283, Tel: 215-662-2027, Fax: 215-614-0245, clyde.barker@uphs.upenn.edu

Barker, Donald E., 979 East Third Street, Suite 401, Chattanooga, TN 37403, Tel: 423-778-7695, Fax: 423-778-2950, donald.barker@universitysurgical.com

*Barnes, Robert W., 7 Beaverfork Place, Conway, AR 72032

*Barnett, William D., 6211 W. NW Hwy, Apt. G226, Dallas, TX 75225, Tel: 214-369-5631

†Bartlett, Stephen T., Department of Surgery, University of Maryland School of Medicine, 22 South Greene Street, N4E40 University of Maryland Medical Center, Baltimore, MD 21201, Tel: 410-328-8407, Fax: 410-328-0401, sbartlett@smail.umaryland.edu

*Senior Members

†New Members
Bass, Barbara Lee, The Methodist Hospital, Department of Surgery, 6550 Fannin, Suite 1661A, Houston, TX 77030, Tel: 713-441-5132, Fax: 713-790-6300, bbass@tmhs.org

*Batson, Robert C., LSU School of Medicine, Division of Vascular Surgery, 1542 Tulane AV, New Orleans, LA 70112, Tel: 504-568-4941, Fax: 504-568-4633,

*Baumgartner, William A., Johns Hopkins University School of Medicine, 735 N. Broadway, Suite 115, Baltimore, MD 21205, Tel: 410-955-2411, Fax: 410-502-9686, wbaumgar@jhmi.edu

*Beazley, Robert M., 45 W. Newton Street, Boston, MA 02118, Tel: 617-267-1758, Fax: 617-638-8457, beazley8@hotmail.com

*Beazley, Wyatt S., III, 2320 Monument Avenue, Richmond, VA 23220, Tel: 804-355-1956, Fax: 804-355-1956, wsbeasley@aol.com

Behnrs, Kevin E., University of Florida, Department of Surgery, P.O. Box 100286, Gainesville, FL 32610, Tel: 352-265-0622, Fax: 352-265-0701, kevin.behnrs@surgery.ufl.edu

†Beierle, Elizabeth A., 1600 7th Avenue South, Lowder Building, Room 300, Birmingham, AL 35233, Tel: 205-638-9688, Fax: 205-975-4972, elizabeth.beierle@childrensal.org

Bell, John L., University of Tennessee Medical Center Knoxville, Cancer Institute, 1934 Alcoa Highway, Suite 483, Knoxville, TN 37920, Tel: 865-305-9572, Fax: 865-305-6743, jlbell@utk.edu

*Bell, Richard M., 2 Pine Top RD, Camden, SC 29020, Tel: 803-432-8836, richard.bell@uscmed.sc.edu

Bellows, Charles F., III, Tulane University, Department of Surgery SL-22, 1430 Tulane AV, New Orleans, LA 70112, Tel: 504-202-8098, Fax: 504-988-4762, cbellows@tulane.edu

Bender, Jeffrey S., OUHSC, Department of Surgery, P.O. Box 26901, Oklahoma City, OK 73190, Tel: 405-271-8375, Fax: 405-271-3919, jeffrey-bender@ouhsc.edu

*Bender, Harvey W., Jr., 1801 Laurel Ridge Dr., Nashville, TN 37215, Tel: 615-322-0064, Fax: 615-343-9194

*Bentley, Frederick R., University of Arkansas Medical Science, Department of Surgery, 4301 West Markham, #520, Little Rock, AR 72205, Tel: 501-686-7428, Fax: 501-686-5696, frbentley@uams.edu

*Senior Members

†New Members
Berger, David H., Michael E. DeBakey VAMC, Surgery 112OCL, 2002 Holcombe Boulevard, Houston, TX 77030, Tel: 713-798-5783, dhb@bcm.tmc.edu

Bernard, Andrew C., University of Kentucky College of Medicine, 800 Rose ST, C206 General Surgery, Lexington, KY 40536-0298, Tel: 859-323-6346, Fax: 859-323-6840, andrew.bernard@uky.edu

*Berry, Robert E., 5437 Village Run, Roanoke, VA 24018, Tel: 540-776-9045, Fax: 540-776-9048, valber1@verizon.net

*Bingham, Hal C., 2617 NW 22nd Avenue, Gainesville, FL 32601

Blakely, Martin L., Vanderbilt University School of Medicine, 2200 Children's Way, Suite 7100, 7102 Doctor's Office Tower, Department of Pediatric Surgery, Nashville, TN 37232-9780, Tel: 615-936-1050, Fax: 615-936-1046, martin.blakely@vanderbilt.edu

*Bland, Kirby I., University of Alabama at Birmingham, 1808 7th AV South, Suite 502, Birmingham, AL 35294-0012, Tel: 205-975-5000, Fax: 205-975-2199, kbland@uabmc.edu

Block, Ernest F.J., Holmes Regional Medical Center, 1350 Hickory ST, Melbourne, FL 32901, Tel: 321-434-1911, ernest.block@health-first.org

*Blumgart, Leslie H., Memorial Sloan-Kettering Cancer Center, 1275 York Avenue, New York, NY 10065, Tel: 212-639-5526

Bochicchio, Grant V., Washington University School of Medicine, 660 S. Euclid AV, Campus Box 8109, Department of Surgery, St. Louis, MO 63110-1093, Tel: 314-362-9347, Fax: 314-362-5743, bochicchiog@wustl.edu

*Bollinger, R. Randall, 1120 Infinity Road, Durham, NC 27712, Tel: 919-681-3889, Fax: 919-681-8856, rrbdukedoc@msn.com

*Bolton, John S., Ochsner Clinic Foundation, 1514 Jefferson Highway, Department of Surgery, New Orleans, LA 70121, Tel: 504-842-4072, Fax: 504-842-4013, jbolton@ochsner.org

Borman, Karen R., Abington Memorial Hospital, Department of Surgery, 1245 Highland AV, Suite 604, Abington, PA 19001, Tel: 215-481-7460, Fax: 215-481-2159, krborman@earthlink.net

Boudreaux, J. Philip, LSU Health Sciences Center, 200 West Esplanade Avenue, Suite 200, Kenner, LA 70065, Tel: 504-464-8500, Fax: 504-464-8525, jboudr4@lsuhsc.edu

*Bowden, Talmadge A., Jr., Medical College of Georgia, Department of Surgery, GI Surgery Section, BI W-440, 1120 15th ST, Augusta, GA 30912-4000, Tel: 706-823-2244, Fax: 706-733-1074, putterdog60@hotmail.com

*Bowen, John C., Ochsner Clinic, 1514 Jefferson Highway, New Orleans, LA 70121, Tel: 504-842-4072, Fax: 504-842-4013, jbowen@ochsner.org

*Braasch, John W., 25 Page RD, Lincoln, MA 01773-2805, Tel: 781-259-0183, Fax: 781-273-5253

*Senior Members

†New Members
*Brabson, John A., 1030 N. Edgehill Road, Suite 308, Charlotte, NC 28207
*Brackney, Edwin Leland, 702 Amsterdam Avenue, NE, Atlanta, GA 30306-3402
*Bradham, R. Randolph, 5977 Shealy DR, Hollywood, SC 29449-6150
*Bradley, Merrill N., 2980 Mountain Brook PKWY, Birmingham, AL 35223, mbradleymd@bellsouth.net
*Bradley, Edward L., III, Florida State University College of Medicine, 201 Cocoanut Avenue, Sarasota, FL 34236, Tel: 941-923-1331, Fax: 941-923-3113, ed.bradley@med.fsu.edu
Branum, Gene, Harrisonburg Surgical Associates, 3320 Emmaus RD, Harrisonburg, VA 22801, Tel: 540-433-2351, Fax: 540-433-7507
*Brawley, Robert K., 914 Rolandvue RD, Baltimore, MD 21204, Tel: 410-296-2520
Brayman, Kenneth L., University of Virginia Hospital, P.O. Box 800709, Charlottesville, VA 22908, Tel: 434-924-9370, Fax: 434-924-5539, klb9r@virginia.edu
*Brennan, Murray F., Memorial Sloan-Kettering Cancer Center, Department of Surgery, 1275 York AV, New York, NY 10021, Tel: 212-639-6586, Fax: 212-794-3184
Britt, L. D., Eastern Virginia Medical School, Department of Surgery, 825 Fairfax AV, Suite 610, Norfolk, VA 23507-1912, Tel: 757-446-8964, Fax: 757-446-8407, brittld@evms.edu
*Britt, Louis G., 4044 Dumaine Way, Memphis, TN 38117, Tel: 901-268-4661, louisgbritt@gmail.com
Britt, Rebecca C., Eastern Virginia Medical School, 825 Fairfax AV, Suite 610, Norfolk, VA 23507, Tel: 757-446-8950, Fax: 757-446-8957, brittrc@evms.edu
*Browder, William, East Tennessee State University, Department of Surgery, Box 70575, Johnson City, TN 37614, Tel: 423-439-6268, Fax: 423-439-6259, browder@etsu.edu
Brunicardi, F. Charles, UCLA Santa Monica General Surgery, 1304 15th ST, Suite 102, Santa Monica, CA 90404, Tel: 310-319-4080, Fax: 310-394-5215, cbrunicardi@mednet.ucla.edu
Brunt, L. Michael, Washington University School of Medicine, Department of Surgery, 660 S. Euclid AV, Campus Box 8109, St. Louis, MO 63110, Tel: 314-454-7234, Fax: 314-222-6256, bruntm@wustl.edu
*Bryant, Lester R., 131 Magnolia Ridge DR, Jonesborough, TN 37659, Tel: 423-753-0005, Fax: 423-753-0005, bryantlmd@aol.com
*Bulkley, Gregory B., 28850 Ivory Pine Road, P.O. Box 46, Bly, OR 97622, Fax: 410-614-3537, gbulkley@wildblue.net
*Burch, Jon M., 6765 W. Princeton AV, Denver, CO 80235, jon.burch@q.com
*Burdette, Walter J., 239 Chimney Rock RD, Houston, TX 77024

*Senior Members
†New Members
*Burns, R. Phillip, UT College of Medicine Chattanooga, Department of Surgery, 979 East Third ST, Suite B-401, Chattanooga, TN 37403, Tel: 423-778-7695, Fax: 423-778-2950, phillip.burns@erlanger.org
Bush, Ruth L., Texas A&M Health Science Center, 3950 North A.W. Grimes BLVD, Suite N403B, Round Rock, TX 78665, Tel: 512-341-4915, Fax: 512-341-4212, rbush@medicine.tamhsc.edu
*Busuttil, Ronald W., UCLA, Department of Surgery, 757 Westwood Plaza, Suite 8236, Los Angeles, CA 90095-9574, Tel: 310-267-8054, Fax: 310-267-3668, rbusuttil@mednet.ucla.edu
*Byers, Robert M., University of Texas, M.D. Anderson Cancer Center, 1515 Holcomb BLVD, Houston, TX 77030

C

*Callender, Clive O., Howard University Hospital, Department of Surgery, 2041 Georgia AV, NW, Washington, DC 20060, Tel: 202-865-1441, Fax: 202-865-5396
*Cameron, John L., The Johns Hopkins Hospital, 600 N. Wolfe ST, 679 Blalock Building, Baltimore, MD 21287, Tel: 410-955-5166, Fax: 410-502-6978, jcamero1@jhmi.edu*Campbell, Gilbert S., 66 River Ridge RD, Little Rock, AR 72207
*Carey, Larry C., 13000 Bruce B. Downs BLVD - 11J, Tampa, FL 33612, Tel: 813-972-7682, Fax: 813-903-4871, larry.carey@va.gov
Carlson, Grant W., Emory University, 1365 C. Clifton Road, NE, 2nd Floor, Atlanta, GA 30322, Tel: 404-686-4255, grant_carlson@emory.org
*Carmichael, J. Donald, 2857 Canterbury RD, Birmingham, AL 35223-1201, Tel: 205-879-7849
Carrillo, Eddy H., Memorial Regional Hospital, Division of Trauma Services, 3501 Johnson ST, Hollywood, FL 33021, Tel: 954-265-5669, Fax: 954-965-3599, ecarrillo@mhs.net
*Carter, B. Noland II, 1500 Westbrook CT, Apt. 2109, Richmond, VA 23227, Tel: 804-200-1577
Chaikof, Elliot L., Harvard Medical School, Beth Israel Deaconess Medical Center, 110 Francis ST, Suite 9F, Boston, MA 02215, echaikof@bidmc.harvard.edu
*Chandler, James G., 3721 Mountain Laurel PL, Boulder, CO 80304, Tel: 303-545-6709, Fax: 303-545-6710, jasgchandler@comcast.net
Chang, Michael C., Wake Forest Baptist Health, Wake Forest School of Medicine, Medical Center BLVD, Department of General Surgery, Winston Salem, NC 27157, Tel: 336-716-7398, Fax: 336-716-9758, mchang@wakehealth.edu

*Senior Members 71 †New Members
Chapman, William C., Washington University at St. Louis, 660 S. Euclid, Campus Box 8109, St. Louis, MO 63110, Tel: 314-362-7792, Fax: 314-361-4197, chapmanw@wustl.edu
Chappuis, Charles W., University Medical Center, 2390 West Congress ST, Lafayette, LA 70506, Tel: 337-261-6787, Fax: 337-662-1211, surgcw@lsuhsc.edu
Chari, Ravi S., 1 Park Plaza, Bldg. II, Nashville, TN 37203, Tel: 615-344-5227, ravi.chari@hcahealthcare.com
*Chavez, Carlos M., Borta 751, Apartment 702, Miraflores, Lima, PERU, cchavez450@aol.com
Chavin, Kenneth D., Medical University of South Carolina, 96 Jonathan Lucas ST, MSC 611, Charleston, SC 29412, Tel: 843-792-3368, Fax: 843-792-8596, chavinkd@musc.edu
†Chwals, Walter J., Floating Hospital for Children, 800 Washington Street, Box #344, Boston, MA 02111
Cheadle, William G., University of Louisville School of Medicine, Department of Surgery, 550 So. Jackson Street, Louisville, KY 40202, Tel: 502-852-5675, Fax: 502-852-8915, wg.cheadle@louisville.edu
*Cheek, Richard C., 2084 Firefly Cove, Memphis, TN 38119
Chen, Mike K., University of Alabama at Birmingham, 1600 7th AV South, ACC 300, Division of Pediatric Surgery, Birmingham, AL 35233, Tel: 205-939-9688, Fax: 205-975-4972, mike.chen@childrensal.org
*Cherry, Kenneth J., Jr., University of Virginia, Division of Vascular Surgery, P.O. Box 800679, Charlottesville, VA 22908, Tel: 434-243-7052, Fax: 434-244-9430, kjc5kh@virginia.edu
Childs, Ed W., Morehouse School of Medicine, 720 Westview DR, Atlanta, GA 30310, Tel: 404-616-3562, echilds@msm.edu
*Chitwood, W. Randolph Jr., ECU School of Medicine, Department of Surgery, 115 Heart DR, Room 3107, Greenville, NC 27834, Tel: 252-744-4822, Fax: 252-744-3051, chitwoodw@ecu.edu
Choti, Michael A., University of Texas Southwestern Medical Center, 5323 Harry Hines BLVD, Department of Surgery, Dallas, TX 75390, Tel: 214-648-3509, michael.choti@utsouthwestern.edu
Christein, John D., University of Alabama at Birmingham, 1530 Third AV South, KB428, Section of Gastrointestinal Surgery, Birmingham, AL 35294, jdc16@uab.edu
Chu, Quyen D., LSU Health Sciences Center - Shreveport, PO Box 33932, Shreveport, LA 71103, Tel: 318-675-6123, Fax: 318-675-6171, qchu@lsuhsc.edu
Chung, Dai H., Vanderbilt University Medical Center, 2200 Children's Way, DOT 7100, Department of Pediatric Surgery, Nashville, TN 37232, Tel: 615-936-1050, Fax: 615-936-1046, dai.chung@vanderbilt.edu

*Senior Members
†New Members
Cigarroa, Francisco G., University of Texas Health System, Chancellor, 601 Colorado ST, Austin, TX 78701, Tel: 512-499-4201, Fax: 512-499-4215, fcigarroa@utsystem.edu
Cima, Robert R., Mayo Clinic, 200 First ST SW, Rochester, MN 55905, Tel: 507-284-9079, Fax: 507-284-1794, cima.robert@mayo.edu
Cioffi, William G., Jr., Rhode Island Hospital, Department of Surgery, 593 Eddy ST, APC 431, Providence, RI 02903, Tel: 401-444-6611, Fax: 401-444-6612, wcioffi@lifespan.org
Clancy, Thomas V., New Hanover Regional Medical Center, 2131 S. 17th ST, Box 9025, Wilmington, NC 28402, Tel: 910-667-9232, Fax: 910-763-4630, thomas.clancy@seahec.net
Clary, Bryan M., Duke University Medical Center, Department of Surgery, DUMC 3247, Durham, NC 27710, Tel: 919-684-6553, Fax: 919-681-7508, clary001@mc.duke.edu
Clements, Ronald H., Vanderbilt University Medical Center, D5203 MCN, 21 @Garland, Nashville, TN 37232-2577, Tel: 615-322-7555, Fax: 615-343-9485, ronald.clements@vanderbilt.edu
Cobb, William S. IV, Greenville Hospital System, 701 Grove RD, Department of Surgery, Greenville, SC 29605, Tel: 864-455-7886, Fax: 864-455-1320, wcobb@ghs.org
Cofer, Joseph B., University of Tennessee College of Medicine, 979 E. 3rd Street, Suite 401, Chattanooga, TN 37403, Tel: 423-778-7695, Fax: 423-778-2950, joe.cofer@erlanger.org
*Cohen, Alfred M., 32 Ridgewood Lane, Hilton Head Island, SC 29928, Tel: 520-400-0116, cohen.alfred@gmail.com
*Cohn, Isidore, Jr., 510 Iona Street, Metairie, LA 70005, Tel: 504-835-6135, drdrdrjr@gmail.com
*Cole, Philip A., LSU Health Sciences Center, 1501 Kings Highway, Department of Surgery, Shreveport, LA 71103, Tel: 318-424-8373, Fax: 318-424-6477, pcolemd@msn.com
Cole, David J., Medical University of South Carolina, Office of the President, 179 Ashley Avenue / MSC 001, Charleston, SC 29425-0010, Tel: 843-792-2211, Fax: 843-792-8827, coledj@musc.edu
*Coleman, Claude C., Jr., P. O. Box 558, Irvington, VA 22480
*Coleman, John J. III, Indiana University School of Medicine, 545 Barnhill DR, Emerson Hall, Suite 232, Indianapolis, IN 46202-5124, Tel: 317-274-8106, Fax: 317-278-8746, jjcolema@iupui.edu
Colombani, Paul M., 601 5th Street South, Suite 611, St. Petersburg, FL 33701, Tel: 727-767-2399, Fax: 727-767-2821, pc@jhmi.edu

*Senior Members  †New Members
*Condon, Robert E., 725 Ninth AV, #605, Seattle, WA 98104, Tel: 206-402-5550, recrcemd@comcast.net
*Conrad, Pete W., 4120 N. Ridgeview Road, McLean, VA 22101-5801
*Conti, Vincent R., University of Texas Medical Branch, Division of Cardiothoracic Surgery, 301 University BLVD, Rt. 0528 Galveston, TX 77555-0528, Tel: 409-772-1203, Fax: 409-772-1421, vconti@utmb.edu
*Cooley, Denton A., Texas Heart Institute at St. Luke's Episcopal Hospital, P. O. Box 20345, Houston, TX 77225-0345, Tel: 832-355-4900, Fax: 832-355-3424, dcooley@texasheart.org
*Copeland, Edward M. III, University of Florida College of Medicine, Department of Surgery, Room 6177, P.O. Box 100286, Gainesville, FL 32610-0286, Tel: 352-265-0169, Fax: 352-338-9809, edward.copeland@surgery.ufl.edu
Cornwell, Edward E. III, Howard University Hospital, 2041 Georgia Avenue, NW, Ste. 4B02, Washington, DC 20060, Tel: 202-865-1441, Fax: 202-865-5396, ecornwell@howard.edu
Coselli, Joseph S., Baylor College of Medicine, 6770 Bertner AVE, C-330, Houston, TX 77030, Tel: 832-355-9910, Fax: 832-355-9920, jcoselli@bcm.edu
Cox, Charles E., University of South Florida, 13330 Laurel DR, MDC 25, Tampa, FL 33612, Tel: 813-793-4272, Fax: 813-374-9671
*Crawford, Fred Allen Jr., MUSC, Department of Surgery, Division of Cardiothoracic Surgery, 25 Courtenay Drive, Ste. 7018, MSC 295, Charleston, SC 29425, Tel: 843-876-4840, crawfrdf@musc.edu
*Crisler, Crile, 1037 N. Shore Road, Norfolk, VA 23505-3119, Tel: 757-423-6111, Fax: 757-423-5555, eblboat@cox.net
Croce, Martin Alexander, University of Tennessee Health Science Center, Department of Surgery, 910 Madison Avenue, Suite 220, Memphis, TN 38163, Tel: 901-448-8140, Fax: 901-448-8472, mcroce@uthsc.edu
*Crosby, Ivan K., University of Virginia Health Science Center, Department of Surgery, Box 800679, Charlottesville, VA 22908, Tel: 434-243-5798, Fax: 434-982-3885, icrosby@virginia.edu
Cull, David L., Greenville Hospital System, University Medical Center, Academic Department of Surgery, 701 Grove RD, Greenville, SC 29605, Tel: 864-454-8272, Fax: 864-455-1320, dcull@ghs.org
Cunningham, Paul R.G., Dean & Vice Chancellor, Brody School of Medicine, East Carolina University, 600 Moye BLVD, AD52, Greenville, NC 27834, Tel: 252-744-2201, Fax: 252-744-9003, cunninghamp@ecu.edu
*Curreri, P. William, P. O. Box 1187, Daphne, AL 36526, Tel: 334-625-2201, Fax: 334-625-4439

*Senior Members
†New Members
D

Daley, Brian J., University of Tennessee Medical Center at Knoxville, 1924 Alcoa Highway, Box U-11, Knoxville, TN 37920, Tel: 865-305-6058, Fax: 865-305-9231, bdaley@mc.utmck.edu

*Dalton, Martin L., Jr., Medical Center of Central Georgia, 777 Hemlock Street, MSC 140, Macon, GA 31201, Tel: 478-633-1890, Fax: 478-633-5153, dalton.martin@mccg.org

*Daly, John M., 333 Cottman AV, Philadelphia, PA 19111, Tel: 215-214-3910, Fax: 215-728-3056, jmddoc@aol.com

D'Angelica, Michael I., Memorial Sloan-Kettering Cancer Center, 1275 York AV, New York, NY 10065, Tel: 212-639-3226, Fax: 212-717-3218, dangelim@mskcc.org

*Daniel, Thomas M., 826 Colridge Drive, Charlottesville, VA 22903, Tel: 434-295-1875, Fax: 434-295-9104, tmd5m@virginia.edu

Dart, Benjamin W. IV, Erlanger Hospital, 979 E. Third ST, Suite 401, Department of Surgery, Chattanooga, TN 37403, Tel: 423-778-7695, Fax: 423-778-2950, benjamin.dart@universitysurgical.com

*Daugherty, Michael E., 132 Ridge Run Drive, Whitefish, MT 59937, Tel: 406-862-7091, mdmd007@aol.com

Davidoff, Andrew M., St. Jude Children's Research Hospital, 262 Danny Thomas PL, Memphis, TN 38105, Tel: 901-595-4060, Fax: 901-595-6621, andrew.davidoff@stjude.org

*Davidson, Jesse T. III, Jefferson Surgical Clinic, 1234 Franklin Road, S.W., Roanoke, VA 24016, Tel: 540-345-1561, Fax: 540-857-4165, bing7marley3@aol.com

*Dean, Richard H., 2551 Warwick Road, Winston-Salem, NC 27104, Tel: 336-414-6105, rdean@wakehealth.edu

Deierhoi, Mark H., University of Alabama at Birmingham, 701 19th Street, South, Department of Surgery, LHRB 748, Birmingham, AL 35294-0007, Tel: 205-934-2131, Fax: 205-934-0320, mdeierhoi@uabmc.edu

†Delman, Keith A., Emory University School of Medicine, Winship Cancer Institute, 1365 Clifton RD NE, Suite C2004, Atlanta, GA 30322, Tel: 404-778-3303, Fax: 404-778-4255, kdelman@emory.edu

DeMaria, Eric J., New Hope Wellness Center, 9910 Strickland RD, Suite 100, Raleigh, NC 27615, Tel: 919-861-6366

Dempsey, Daniel T., Hospital of the University of Pennsylvania, 3400 Spruce ST, 4 Silverstein, Philadelphia, PA 19104, Tel: 215-614-0092, Fax: 215-349-8195, daniel.dempsey@uphs.upenn.edu

*DePalma, Ralph G., Department of Veterans Affairs, 810 Vermont Ave. NW, Washington, DC 20420, Tel: 202-273-8505, Fax: 202-273-9108

*Senior Members 75  †New Members
DeWeese, James A., 78 Winding Creek Lane, Rochester, NY 14625,
deweeseypnj@aol.com

Diaz, Jose J., University of Maryland Medical Center, R. Adams Cowely Shock
Trauma Center, 22 S. Greene ST, S4D07, Baltimore, MD 21207, Tel: 410-328-3055, Fax: 410-328-0687, jdiaz@umm.edu

Diethelm, Arnold G., University of Alabama Medical School, 1808 7th Ave. South,
503 BDB, Birmingham, AL 35294, Tel: 205-934-5200, Fax: 205-731-9250,
arold.diethelm@ccc.uab.edu

Dimick, Alan R., 2717 Lockerbie Circle, Birmingham, AL 35223-2911, Tel: 205-969-3106, Fax: 205-969-1409, alandimick@bellsouth.net

DiVincenti, Frank C., 1111 Avenue D. Suite 713, Marrero, LA 70072

Dodson, Thomas F., The Emory Clinic, 1364 Clifton Road, N.E., Suite B207, Section
of Vascular Surgery, Atlanta, GA 30322, Tel: 404-778-3320, Fax: 404-778-3101,
tdods02@emory.edu

Doherty, Gerard M., Boston University Medical Center, 88 East Concord ST,
Coolamore Suite 500, Boston, MA 02118-2307, Tel: 617-638-8607, Fax: 617-638-8609,
gerard.doherty@bmc.org

Donahoo, James S., East Orange Veterans Administration Medical Center, 385
Tremont Avenue, East Orange, NJ 07018-1023, Tel: 973-676-1000,
jdonahoo37@gmail.com

Donovan, Arthur J., 5540 West 5th ST, #175, Oxnard, CA 93035, Tel: 626-577-8190,
Fax: 626-577-8190, adonovan@sbcglobal.net

Dowling, James B., 111 Grand Cheniere, Mandeville, LA 70471, Tel: 985-845-4344,
Fax: 985-845-4344

Drucker, William R., Professor of Surgery, Emeritus, USUHS School of Medicine, 76
Orr Road, Jericho, VT 05465, Tel: 802-899-5171, Fax: 802-899-5171,
wdrucker@usuhs.mil

Dudrick, Stanley J., Department of Surgery, St. Mary’s Hospital, 56 Franklin Street,
Waterbury, CT 06706, Tel: 203-709-6314, Fax: 203-709-6089,
sdudrick@stmh.org

Duke, James H., Jr., University of Texas Medical School, 6431 Fannin, Suite 4168,
Houston, TX 77030, Tel: 713-500-7237, Fax: 713-500-7268,
james.h.duke@uth.tmc.edu

Duncan, Mark D., Johns Hopkins University, Department of Surgery, 4940 Eastern
Avenue, Baltimore, MD 21224, Tel: 410-550-5900, Fax: 410-550-2011,
mduncan@jhmi.edu

Durham, Rodney M., Sacred Heart Hospital, General Surgery, 5149 N. 9th Ave,
Pensacola, FL 32503, Tel: 850-416-6159, Fax: 850-416-7198,
rodney.durham@shhpens.org

*Senior Members 76 †New Members
Eastman, A. Brent, American College of Surgeons, 633 N. St. Clair ST, Chicago, IL 60611-3211, Tel: 858-678-7711, Fax: 858-678-6586, brent.eastmanmd@gmail.com
†Eastridge, Brian J., 7703 Floyd Curl Drive (MC 7740), San Antonio, TX 78229-3901, Tel: 210-567-3623, eastridge@uthscsa.edu
Eberlein, Timothy J., Washington University School of Medicine, Department of Surgery, 660 S. Euclid Avenue, CB#8109, St. Louis, MO 63110, Tel: 314-362-8020, Fax: 314-454-1898, eberleint@wudosis.wustl.edu
Eckhoff, Devin, University of Alabama at Birmingham, Division of Transplantation Surgery, 701 19th Street South, LHRB 710, Birmingham, AL 35294-0007, Tel: 205-975-7622, Fax: 205-934-8378, devin.eckhoff@ccc.uab.edu
*Edgerton, Milton T., Jr., 2245 Garth RD, Charlottesville, VA 22901, miltedgerton@gmail.com
*Edwards, Michael Joseph, University of Cincinnati, Department of Surgery, P.O. Box 670558, Cincinnati, OH 45267-0558, Tel: 513-558-5333, Fax: 513-558-2585, michael.edwards@uc.edu
Edwards, William H. Sr., 11 Burton Hills Boulevard, Apt. S160, Nashville, TN 37215, Tel: 615-383-9085, fmedwards@ourblakeford.com
*Edwards, William H., Jr., The Surgical Clinic, St. Thomas Medical Plaza East, 4230 Harding Road, Ste. 525, Nashville, TN 37205, Tel: 615-385-1547, Fax: 615-297-9161, wedwards@tsclinic.com
Eidt, John F., Greenville Hospital System, 701 Grove RD, GMH Support Tower, Floor 3, Department of Surgery, Greenville, SC 29605, Tel: 864-546-0791, jeidt@ghs.org
*Elias, E. George, 1214 Meredith's Ford RD, Towson, MD 21286-1320, Tel: 443-777-7911, Fax: 443-777-6311, egelias1@comcast.net
*Elkins, Ronald C., University of Oklahoma, W. Pavilion 2230, Oklahoma City, OK 73190, Tel: 405-271-5789, Fax: 405-271-3288, ronald-elkins@ouhsc.edu
Elliott, Lester Franklyn, Atlanta Plastic Surgery, Suite 100, 975 Johnson Ferry Road, NE, Atlanta, GA 30342, Tel: 404-250-3889, Fax: 404-250-3380, felliott@atlplastic.com
Ellis, Lee M., UT M.D. Anderson Cancer Center, 1400 Pressler ST, FCT17.5068, Houston, TX 77030, Tel: 713-792-6926, Fax: 713-745-1462, lellis@mdanderson.org
Elsey, James K., 631 Professional DR, Suite 300, Lawrenceville, GA 30046, Tel: 770-962-9977, jimelsey@mac.com
†Elster, Eric, Norman M. Rich Department of Surgery, Uniformed Services University, 4301 Jones Bridge Road, Bethesda, MD 20814, Tel: 301-295-3157, eric.elster@usuhs.edu

*Senior Members
†New Members
Endean, Eric D., University of Kentucky HealthCare, Division of General Surgery, 800 Rose Street, C215, Lexington, KY 40536-0293, Tel: 859-323-5273, Fax: 859-323-6840, edende0@uky.edu

*Ernst, Calvin B., 3904 N. Fairway Drive, Jupiter, FL 33477, Fax: 610-688-6690, cbernst@earthlink.net
*Etheredge, Edward E., 1850 Mariposa Avenue, Bartow, FL 33830, Tel: 941-534-1836, eeebartow55@aol.com
Eubanks, William S., Florida Hospital, 2415 N. Orange Avenue, Ste. 401, Orlando, FL 32804, Tel: 407-303-2939, Fax: 407-303-2936, steve.eubanks.md@flhosp.org
*Evans, James T., 11500 Partridge RD, Holland, NY 14080-9672, Tel: 716-537-2816, jamestevansmd@yahoo.com
Evers, B. Mark, Markey Cancer Center, University of Kentucky, 800 Rose ST, CC140, Lexington, KY 40536, Tel: 859-323-6542, Fax: 859-323-2074, mark.evers@uky.edu

F

*Fabian, Timothy C., University of Tennessee Health Science Center, Department of Surgery, 956 Court Avenue, G228, Memphis, TN 38163, Tel: 901-448-5914, Fax: 901-448-7306, tfabian@uthsc.edu
*Fabri, Peter J., University of South Florida, 12901 Bruce B. Downs BLVD, MDC 41, Tampa, FL 33612, Tel: 813-974-4478, Fax: 813-974-8359, pfabri@health.usf.edu
Fair, Jeffrey Haskell, University of Florida, Department of Surgery, P.O. Box 100118, Gainesville, FL 32610-0118, Tel: 352-265-0606, Fax: 352-265-0678, jeffrey.fair@surgery.ufl.edu
Fakhry, Samir M., Medical University of South Carolina, 96 Jonathan Lucas ST, CSB 426, Department of Surgery, Charleston, SC 29425, Tel: 843-792-9722, Fax: 843-792-1891, fakhry@musc.edu
Farnell, Michael B, Mayo Clinic, 200 First ST, SW, Rochester, MN 55905, Tel: 507-284-2717, Fax: 507-284-5196, farnell.michael@mayo.edu
Farrell, Timothy M., University of North Carolina at Chapel Hill, Department of Surgery, Campus Box 7081, Chapel Hill, NC 27599-7081, Tel: 919-966-8436, Fax: 919-966-8440, tfarrell@med.unc.edu
*Feliciano, David V., Indiana University, Department of Surgery, 545 Barnhill DR, Emerson Hall 509, Indianapolis, IN, Tel: 317-274-4990, Fax: 317-274-0241, davgfel@iupui.edu
*Ferrara, John J., Carilion Roanoke Memorial Hospital, 1906 Bellevue AV, #331, Roanoke, VA 24014, Tel: 540-981-8280, Fax: 540-981-8681, johnj@ferrara.cc

*Senior Members  †New Members
*Senior Members

Fraser, Howard C., 3478 Navigator Pointe, Knoxville, TN 37922, Tel: 865-850-9189, hcfraser@utk.edu
Fink, Aaron S., 4344 Conway Valley CT, NW, Atlanta, GA 30327-3602, Tel: 404-444-0821, afink01@comcast.net
Fischer, Josef E., William V. McDermot Professor of Surgery, Harvard Medical School, Hannon Hall, 29 Commonwealth AV, Suite 110, Boston, MA 02120, Tel: 617-248-1602, Fax: 617-248-1603, JFischerMD@surgery.harvard.edu
Fish, Jay C., 1205 Harborview DR, Galveston, TX 77555, Tel: 409-762-4074
*Filston, Howard C., 3478 Navigator Pointe, Knoxville, TN 37922, Tel: 865-850-9189, hcfilstonmd62@att.net
Fish, Aaron S., 4344 Conway Valley CT, NW, Atlanta, GA 30327-3602, Tel: 404-444-0821, afink01@comcast.net

†New Members

Fleming, Jason B., The Univ. of Texas M.D. Anderson Cancer Center, Department of Surgical Oncology, Unit 1484, 1400 Pressler ST, Houston, TX 77030, Tel: 713-745-0890, Fax: 713-745-4426, jbflemin@mdanderson.org
Fleshman, James W., Dr., Department of Surgery, Baylor University Medical Center, 3500 Gaston Avenue, First Floor Roberts; Dallas, TX 75246, Tel: 214-820-2468, Fax: 214-820-4538, james.fleshman@baylorhealth.edu
Fork, Lewis M., Jr., American College of Surgeons, Division of Education, 633 N. Saint Clair Street, Chicago, IL 60611-3211, Tel: 312-202-5224, Fax: 312-202-5021, lflint@facs.org
Floyd, Richard D., 913 The Curtilage, Lexington, KY 40502
Flint, Lewis M., Jr., American College of Surgeons, Division of Education, 633 N. Saint Clair Street, Chicago, IL 60611-3211, Tel: 312-202-5224, Fax: 312-202-5021, lflint@facs.org
Flynn, Timothy C., University of Florida College of Medicine, Department of Surgery, PO Box 100192, Gainesville, FL 32610, Tel: 352-273-7520, Fax: 352-273-7525, flynn@ufl.edu
Franklin, Glen A., University of Louisville, 550 S. Jackson ST, ACB Floor 2, Department of Surgery, Louisville, KY 40202, Tel: 502-852-1895, Fax: 502-852-8915, glen.a.franklin@gmail.com
Frazier, O. Howard, Professor of Surgery, Texas Heart Institute, MC-2114A, P.O. Box 20345, Houston, TX 77225-0345, Tel: 713-791-3000, Fax: 713-794-6798,
Frederick, Wayne A.I., Howard University, 2400 6th ST, NW, Washington, DC 20059, Tel: 202-865-6237, Fax: 202-865-7498, wfrederick@howard.edu
Freischlag, Julie Ann, Johns Hopkins Medical Institutions, 720 Rutland, Room 759 Ross, Baltimore, MD 21205, Tel: 443-287-3497, Fax: 443-287-3500, jfreisc1@jhmi.edu
Frey, Daniel J., University Medical Center, LSU Health Science Center, 2390 W. Congress, Lafayette, LA 70506, Tel: 337-261-8500, Fax: 337-261-8505, dfrey@lsuhsc.edu
Friedell, Mark L., University of Missouri Kansas City, 2301 Holmes ST, School of Medicine, Department of Surgery, Kansas City, MO 64108, Tel: 816-404-5364, mlf52@aol.com
*Fuchs, James C.A., 603 Brightwood Club DR, Lutherville, MD 21093-3632, Tel: 410-377-0570, Fax: 410-377-4965, jcafuchs@mindspring.com
Fuhrman, George M., Ochsner Clinic, 1514 Jefferson HWY, Clinic Tower 8, Department of Surgery, New Orleans, LA 70121, Tel: 504-842-2072, Fax: 504-842-4013, gfuhrman@ochsner.org
†Fullum, Terrence M., Howard University, 2041 Georgia Avenue, NW, Tower 4100B, Washington, DC 20060 Tel: 202-865-1286, Fax: 202-865-3063, tfullum@howard.edu
*Furlow, Leonard T., Jr., 3001 N.W. 28th Terrace, Gainesville, FL 32605, Tel: 352-372-7783, lfurlow@cox.net

G

Gaber, A. Osama, Houston Methodist Hospital, Department of Surgery, 6550 Fannin Street, Ste. SM1661A, Houston, TX 77030, Tel: 713-441-6170, Fax: 713-790-6839, aogaber@houstonmethodist.org
*Gadacz, Thomas R., 5353 Gulf Boulevard, Apt. A-201, St. Petersburg, FL 33706-2377, Tel: 727-360-8030, thomasgadacz@yahoo.com
*Gage, John O., Medical Center Clinic, 8333 North Davis Highway, Pensacola, FL 32514, Tel: 850-474-8345
Gaines, Barbara A., Children's Hospital of Pittsburgh, UPMC, 4401 Penn AV, 7147 Faculty Pavilion, Pittsburgh, PA 15224, Tel: 412-692-8288, Fax: 412-692-8299, barbara.gaines@chp.edu
Galadiuk, Susan, University of Louisville School of Medicine, Professor, Department of Surgery, Louisville, KY 40292, Tel: 502-852-4568, Fax: 502-852-8915, susan.galadiuk@louisville.edu
Galloway, John R., Emory University Hospital, 1364 Clifton Road, N.E., Suite H-124, Atlanta, GA 30322, Tel: 404-727-5807, Fax: 404-727-3316

*Senior Members  80  †New Members
Gann, Donald S., 1127 Greenspring Valley Road, Lutherville, MD 21093, Tel: 410-321-1548, Fax: 410-321-1027, dsgann@verizon.net

Gardner, Timothy J., Christiana Care, 4755 Ogletown-Stanton Road, Management Suite 1218, Newark, DE 19718, Tel: 302-733-1241, Fax: 302-733-1429

Garrett, Harvey Edward, Jr., University of Tennessee - Memphis, 6029 Walnut Grove, Suite 401, Memphis, TN 38120, Tel: 901-747-3066, Fax: 901-747-2966, egarrettmd@cvsclinic.com

Garrison, Donald R., University of Louisville School of Medicine, Department of Surgery, 550 South Jackson ST, ACB Building, Louisville, KY 40292, Tel: 502-852-5676, Fax: 502-852-8915, rntagrr01@louisville.edu

Gauderer, Michael W.L., Children’s Hospital, Greenville Hospital System, 890 W. Faris Road, MMOB 440, Greenville, SC 29605-4253, Tel: 864-455-5070, Fax: 864-455-4170, mgauderer@ghs.org

Georgeson, Keith, Providence Physicians Services, 101 W. 8th AV, #100L-1, Spokane, WA 99204, Tel: 509-474-5445

Gerber, David A., UNC School of Medicine, Department of Surgery, CB# 7211, 4024 Burnett-Womack Bldg., Chapel Hill, NC 27599, Tel: 919-966-8008, Fax: 919-966-6308, david_gerber@med.unc.edu

†Gillanders, William E., Washington University School of Medicine, 660 So. Euclid Avenue, St. Louis, MO 63110, Tel: 314-747-0072, gillandersw@wustl.edu

Giordano, Joseph Martin, 2150 Pennslyvania Avenue, NW, Washington, DC 20037, Tel: 202-741-3225, Fax: 202-741-3219, jgiordano@mfa.gwu.edu

Gittes, George K., Children's Hospital of Pittsburgh of UPMC, Pediatric Surgery, One Children's Hospital Drive, 4401 Penn AV, Pittsburgh, PA 15224, Tel: 412-692-7291, Fax: 412-692-8299, george.gittes@chp.edu

Given, Kenna S., 748 Tripps Court, Augusta, GA 30909, Tel: 706-721-4620, Fax: 706-721-6931, kgiven@georgiahealth.edu

Gleysteen, John J., VAMC, Surgical Service (112), 700 South 19th ST, Birmingham, AL 35233, Tel: 205-975-8750, Fax: 205-934-6351, john.gleysteen@va.gov

Gobbel, Walter G., Jr., 217 Baskin Drive, Nashville, TN 37205

Goldstein, Richard E., Norton Healthcare Pavilion, 315 East Broadway, Ste. 312, Louisville, KY 40202, Tel: 502-629-6950, Fax: 502-629-3183

Goldstein, Richard E., Norton Healthcare Pavilion, 315 East Broadway, Ste. 312, Louisville, KY 40202, Tel: 502-629-6950, Fax: 502-629-3183

Goldstein, Richard E., Norton Healthcare Pavilion, 315 East Broadway, Ste. 312, Louisville, KY 40202, Tel: 502-629-6950, Fax: 502-629-3183

Gray, Laman A., Jr., Rudd Heart & Lung Center, Univ. Cardiothoracic Surgical Associates, 201 Abraham Flexner Way, Suite 1200, Louisville, KY 40202, Tel: 502-561-2180, Fax: 502-561-2190, lgray@uksamd.com

Greene, Frederick L., 128 Altondale AV, Charlotte, NC 28207, Tel: 704-355-3176, Fax: 704-355-5619, fgreene@med.unc.edu; flgreene44@gmail.com

†New Members
*Greenfield, Lazar J., 7011 E. Calle Arandas, Tucson, AZ 85750
*Gregorie, Harry B., Jr., 2979 Combahee Road, Yemassee, SC 29945, Tel: 843-844-8003
*Gregory, Roger T., 5008 Lauderdale Ave., Virginia Beach, VA 23510, Tel: 757-363-0267, Fax: 757-363-0384, okdin@cox.net
*Griffen, Ward O., Jr., 4140 Peninsula Drive, Frankfort, MI 49635, Tel: 269-352-4494, Fax: 269-352-5487 (call, popswog@gmail.com
*Griffen, F. Dean, 1501 Kings Highway, Shreveport, LA 71103, Tel: 318-675-6126, Fax: 318-675-6141, fgriff@lsuhsc.edu
Griffen, Margaret M., Inova Fairfax Hospital, Trauma Acute Care Surgery Dept, 3300 Gallows RD, Falls Church, VA 22042, Tel: 703-776-2274, Fax: 703-776-3572, margaret.griffen@inova.org
Griswold, John A., Texas Tech University, Health Sciences Center, 3601 4th Street, STOP 8312, Lubbock, TX 79106-8312, Tel: 806-743-2370, Fax: 806-743-2113
Grobmyer, Stephen R., Cleveland Clinic, Director, Section of Surgical Oncology, 9500 Euclid AV, A81, Cleveland, OH 44195, Tel: 216-636-2842, Fax: 352-262-0894, grobmys@ccf.org
*Grosfeld, Jay L., JW Riley Hospital for Children, 702 Barnhill DR, Suite 2500, Indianapolis, IN 46202, Tel: 317-274-5716, Fax: 317-274-5777, jgrosfel@iupui.edu
*Grover, Frederick L., University of Colorado HSC, Department of Surgery, Academic Office One, Bldg. L15, Room 6117, Aurora, CO 80045, Tel: 303-724-2750, Fax: 303-724-2761, frederick.grover@ucdenver.edu
Gugliuzza, Kristene K., UTMB, Department of Surgery, 301 University Boulevard, Galveston, TX 77555-0533, Tel: 409-772-2412, Fax: 409-747-7364, kgugliuz@utmb.edu
Guillamondegui, Oscar D., Jr., Vanderbilt Medical Center, 1211 21st AV South, 404 Medical Arts BLDG, Division of Trauma, Nashville, TN 37212-1750, Tel: 615-936-1909, Fax: 615-936-0185, oscar.guillamondegui@vanderbilt.edu
Guillem, Jose G., Memorial Sloan Kettering Cancer Center, 1275 York AV, Room C-1077, New York, NY 10065, Tel: 212-639-8278, Fax: 646-422-2318, guillemj@mskcc.org


H

*Haisch, Carl E., ECU School of Medicine, 600 Moye BLVD, 4S-10 Brody Building, Department of Surgery / Surgical Immunology Transplantation, Greenville, NC 27858, Tel: 252-744-2620, Fax: 252-744-3452, haischc@ecu.edu

*Senior Members 82 †New Members
†Hakaim, Albert G., Mayo Clinic, 4500 San Pablo Rd, Jacksonville, FL 32224, Tel: 904-953-2077, Fax: 904-953-7368, hakaim.albert@mayo.edu
*Haller, J. Alex, Jr., 1314 Glencoe Road, Glencoe, MD 21152, Tel: 410-955-6257, Fax: 410-472-4241, amancalled@comcast.net
*Hallman, Grady L., Texas Heart Institute, 1101 Bates, Suite P-514, Houston, TX 77030, Tel: 832-355-4129, Fax: 832-355-3770, ghallman@heart.thi.tmc.edu
*Hammon, John W., Jr., Wake Forest School of Medicine, Department of Cardiothoracic Surgery, Medical Center Boulevard, Winston-Salem, NC 27157, Tel: 336-716-6002, Fax: 336-716-3358, jhammon@wfubmc.edu
*Hanks, John B., Univ. Virginia Health Systems, Department of Surgery, Box 800709, Charlottesville, VA 22908, Tel: 434-924-0376, Fax: 434-924-1128, jbh@virginia.edu
Hansen, Kimberley J., Wake Forest University School of Medicine, Department of General Surgery, Medical Center Blvd., Winston-Salem, NC 27157-1095, Tel: 336-713-5256, Fax: 336-716-2934, kjhansen@wfubmc.edu
Harbrecht, Brian G., University of Louisville, 550 S. Jackson ST, Department of Surgery, Louisville, KY 40292, Tel: 502-852-5675, Fax: 502-852-8915, briang.harbrecht@louisville.edu
*Harken, Alden H., Department of Surgery, Alameda County Medical Center, 1411 E. 31st ST, Oakland, CA 94602, Tel: 510-535-7770, Fax: 5104375127, alden.harken@ucsfmedctr.org
†Harland, Robert, East Carolina University, 600 Moye BLVD, 10 Brody Bldg, 4 South, Greenville, NC 27834, Tel: 252-744-2977, Fax: 252-744-5349, harlandr@ecu.edu
*Harmon, John W., Johns Hopkins Bayview Medical Center, Dept. Surgery, ASC, 4940 Eastern Avenue, Baltimore, MD 21224, Tel: 410-550-0401, Fax: 410-550-1245
*Harrison, Lynn H., Jr., Baptist Health Cardiac & Thoracic Surgical Group, 8950 N. Kendall Drive, Suite 607W, Miami, FL 33176, Tel: 786-596-1230, Fax: 786-596-1239, lynn@baptisthealth.net
*Hastings, Paul R., 1542 Tulane AV, Surgery, New Orleans, LA 70112, Tel: 504-568-4751, Fax: 504-568-4633, paulhastings@charter.net
*Hatcher, Charles R., Jr., Emory University, 1440 Clifton Road NE, Ste. 318-B, Atlanta, GA 30322, Tel: 404-778-5860, Fax: 404-727-5434, charles.hatcher@emoryhealthcare.org
*Hawkins, Michael L., Medical College of Georgia, Department of Surgery, 1120 15th Street, Room BA-4411, Augusta, GA 30912, Tel: 706-721-3153, Fax: 706-721-3239, mhawkins@georgiahealth.edu
Hawn, Mary T., University of Alabama School of Medicine, 1530 3rd Avenue South, Birmingham, AL 35294, Tel: 205-975-1932, Fax: 205-996-4959, mhawn@uab.edu

*Senior Members
†New Members
Hayes, Daniel H., Carolina Medical Center, Transplant Center, 1000 Blythe Boulevard, Charlotte, NC 28203

†Hebra, Andre, Pediatric Surgery, Medical University of South Carolina, 96 Jonathan Lucas ST, CSB 417/MSC 613, Charleston, SC 29425-6130, Tel: 843-792-3853; Fax: 843-792-3858, hebra@musc.edu

Helling, Thomas S., University of Mississippi Medical Center, 2500 N. State ST, Department of Surgery, Jackson, MS 39216, Tel: 601-815-1161, thelling@umc.edu

Hemming, Alan W., University of California at San Diego Medical Center, General Surgery, 200 West Arbor Drive, #8401, San Diego, CA 92103-8401, Tel: 619-543-5870, Fax: 619-543-7785, ahemming@ucsd.edu

*Henderson, J. Michael, The Cleveland Clinic Foundation, Division of Surgery, 9500 Euclid Avenue / E32, Cleveland, OH 44195, Tel: 216-444-8462, Fax: 216-444-8510

Heniford, B. Todd, Carolinas Medical Center, Department of Surgery, 1025 Morehead Medical Drive, Suite 300, Charlotte, NC 28204, Tel: 704-355-3168, Fax: 704-355-5619, theniford@carolinas.org

†Henry-Tillman, Ronda S., University of Arkansas for Medical Sciences, 4301 W. Markham, #725, Little Rock, AR 72205, Tel: 501-686-6503, Fax: 501-686-7861, henryrondas@uams.edu

*Herbst, Charles A., Jr., 407 Lake Shore Lane, Chapel Hill, NC 27514, Tel: 919-967-6625

*Hermann, Robert E., One Bratenahl Place, #1403, Bratenahl, OH 44108, Tel: 216-268-4684, Fax: 216-268-0007, rhermannmd@aol.com

*Herndon, David N., Chief of Staff, The University of Texas Medical Branch, 301 University Boulevard, Galveston, TX 77555-1220, Tel: 409-770-6731, Fax: 409-770-6919

Heslin, Martin J., University of Alabama at Birmingham, Department of Surgery, 1922 Seventh Ave. South, KB 321, Birmingham, AL 35294, Tel: 205-934-3064, Fax: 205-975-5971, marty.heslin@ccc.uab.edu

*Hewitt, Robert L., 1750 St. Charles Avenue, #202, New Orleans, LA 70130, Tel: 504-584-1662, Fax: 504-584-1874, rht@cox.net

*Hilbun, Benton M., 1001 DeBeau Drive, Tupelo, MS 38804, Tel: 662-842-8730, hilbun_b@comcast.net

*Hill, J. Laurance, 22 South Greene Street, Room N4E37, Baltimore, MD 21201

*Hill, Ronald C., Charles George VAMC, Dept. of Surgery/CT Section, 1100 Tunnel Road, Asheville, NC 28805, Tel: 828-298-7911, Fax: 828-299-2567, ronald.hill@va.gov

*Senior Members

†New Members
Hochwald, Steven N., Roswell Park Cancer Institute, Elm and Carlton Streets, 
Department of Surgical Oncology, Buffalo, NY 14263, 
steven.hochwald@roswellpark.org

*Hoffman, George C., 1225 Gates Avenue, Norfolk, VA 23507, Tel: 757-627-2655, 
Fax: 757-627-2658, hoffgeo@aol.com

*Holcomb, George W., Jr., 105 Leake Avenue, #67, Nashville, TN 37205
Holcomb, George W., III, Children's Mercy Hospital, Department of Surgery, 2401 
Gillham Road, Kansas City, MO 64108, Tel: 816-234-3578, Fax: 816-983-6885, 
gholmcomb@cmh.edu

*Hollens beck, John I., 2739 SW 3rd Place, Gainesville, FL 32607, Tel: 352-273-5670, 
Fax: 352-273-5683, jhollens beck.fla@gmail.com

*Hollier, Larry H., LSU Health Sciences Center, 433 Bolivar Street, Ste. 815, New 
Orleans, LA 70112, Tel: 504-568-4800, Fax: 504-568-5177, lholl@lsuhsc.edu

*Holloway, James B., Jr., 584 Forest Hill Drive, Lexington, KY 40509, Tel: 859-335-9863

Holman, William L., University of Alabama, Department of Surgery, ZRB719, 
Birmingham, AL 35294-0007, Tel: 205-934-3853, Fax: 205-975-6618, 
wholman@uab.edu

Holzman, Michael D., Vanderbilt University Medical Center, 1161 Medical Center 
Drive, D-5203 MCN, Division of General Surgery, Nashville, TN 37232-2577, 
Tel: 615-343-5613, Fax: 615-343-9485, miche holzman@vanderbilt.edu

*Hopkins, Richard Alan, Professor of Surgery, Children's Mercy Kansas City Hospital, 
2401 Gillham Road, Kansas City, MO 64108, Tel: 816-234-3519, Fax: 816-802-1245, rahopkins@cmh.edu

*Horsley, J. Shelton, III, 6161 River Road, Unit 1, Richmond, VA 23226

*Houck, William S., Jr., 701 Brockington Lane, Florence, SC 29501

*Howard, Richard J., University of Florida College of Medicine, Department of 
Surgery, P. O. Box 100286, Gainesville, FL 32610-0286, Tel: 352-265-0606, Fax: 
352-265-0678

*Howell, Charles G., Jr., Medical College of Georgia, Section of Pediatric Surgery, 
Augusta, GA 30912-4070

Hoyt, David B., American College of Surgeons, 633 N. Saint Clair ST, Chicago, IL 
60611-3211, Tel: 312-202-5305, Fax: 312-202-5016, d hoyt@facs.org

Hubbard, George Wilkins, II, 880 Kempsville Road, Suite 1000, Norfolk, VA 23502, 
Tel: 757-261-5000, Fax: 757-962-5320, wilkesh@cox.net

Huber, Thomas S., University of Florida College of Medicine, Department of Surgery, 
P.O.Box 100286, 1600 SW Archer Road, Rm. 6165, Gainesville, FL 32610-0286, 
Tel: 352-265-5484, Fax: 352-273-5515, huber@surgery.ufl.edu

*Hudspeth, Allen S., 211 Knollwood Street, Winston-Salem, NC 27104, Tel: 336-716- 
2124, Fax: 336-716-3348

*Senior Members

†New Members
Hughes, Steven J., University of Florida, 1600 SW Archer RD, Room 6164, General Surgery, Gainesville, FL 32610-0109, Tel: 352-265-0761, Fax: 352-265-1060, steven.hughes@surgery.ufl.edu

†Hughes, Tyler G., 1000 Hospital DR, Ste. 301, McPherson, KS 67460, Tel: 620-241-0917, Fax: 620-241-7786, tylerh@mcphersonhospital.org

*Hummel, Robert P., 24 Dockside Lane, PMB #473, Key Largo, FL 33037, Tel: 305-367-4909, hum5400@aol.com

*Humphrey, Loren J., 1639 Leggett RD, Sale Creek, TX 37373, lhumphrey1931@gmail.com

Hunt, Kelly K., M.D. Anderson Cancer Center, 1400 Pressler ST, Unit 1484, Houston, TX 77030, Tel: 713-792-7216, Fax: 713-792-0722, khunt@mdanderson.org

*Hussey, John L., West 9073, Ripley Road, Cambridge, WI 53513, Tel: 608-423-3773, Fax: 608-423-7019, jhussey@charter.net

*Hutson, Duane G., University of Miami School of Medicine, P.O. Box 016310 (R-312), Miami, FL 33101, Tel: 305-585-1280, Fax: 305-585-6043, drduhut@aol.com

*Hyde, Gordon L., 6001 Pelican Bay Boulevard #703, Naples, FL 34108, Tel: 239-513-0925, gordih@aol.com

I

*Ikard, Robert W., 308 Sunnyside Drive, Nashville, TN 37205, Tel: 615-385-0391, bnkikard@comcast.net

Inabnet, William B., III, Mount Sinai School of Medicine, Division of Metabolic, Endocrine, and Minimally Invasive Surgery, One Gustave L. Levy PL, Box 1259, New York, NY 10029, Tel: 212-241-3662, Fax: 212-534-2654, william.inabnet@mountsinai.org

*Irvin, George L. III, 535 Solano Prado, Coral Gables, FL 33156, Tel: 305-665-5557, glirvin@gmail.com

J

Jacobs, Danny O., The University of Texas Medical Branch, 301 University BLVD, Office of the Exec Vice President, Provost, and Dean, Galveston, TX 77555-0133, Tel: 409-772-4793, Fax: 409-772-9598, djacobs@utmb.edu

*Jacobs, J. Kenneth, 4500 Malone Place, Nashville, TN 37205, Tel: 615-383-3503, Fax: 615-383-8873, grnbubba@aol.com

*Senior Members

†New Members

86
Jacobs, Jeffrey P., Cardiac Surgical Associates, 625 Sixth AV South, Suite 475, Saint Petersburg, FL 33701, Tel: 727-235-3100, Fax: 727-551-0404, jeffjacob@msn.com

*Jaffe, Bernard M., Tulane University Medical Center, Department of Surgery, 1430 Tulane Avenue, New Orleans, LA 70112, Tel: 504-988-7123, Fax: 504-988-3793, bjaffe@tulane.edu

Jarnagin, William R., Memorial Sloan-Kettering Cancer Center, Department of Surgery, 1275 York Avenue, New York, NY 10021, Tel: 212-639-7601, Fax: 917-432-2387, jarnagiw@mskcc.org

Johannigman, Jay A., University of Cincinnati College of Medicine, 231 Albert Sabin Way, Cincinnati, OH 45267-0558, Tel: 513-558-5661, Fax: 513-558-3136, jay.johannigman@uc.edu

*Johnson, Robert H., Jr., 3410 Walton Way Ext., Augusta, GA 30909, abjohnson4@comcast.net

Johnson, Lynt B., Georgetown University Hospital, 3800 Reservoir Road, NW, 2 Main, Washington, DC 20007, Tel: 202-444-4557, Fax: 202-444-7987, lynt.johnson@medstar.net

*Johnson, Lester W., LSUHSC-Monroe, Department of Surgery, 4864 Jackson Street, P.O. Box 1881, Monroe, LA 71210, Tel: 318-330-7664, Fax: 318-330-7649, ljohns3@lsuhsc.edu

*Johnston, J. Harvey Jr., 1510 Douglass Drive, Jackson, MS 39211, hjohnston1@comcast.net

*Jones, Calvin E., 14016 Greencroft Lane, Hunt Valley, MD 21030-1108, Tel: 410-771-0041, caljonesmd@aol.com

Jones, David R., Memorial Sloan Kettering, 1275 York AV, Department of Surgery, New York, NY 10065, Tel: 434-243-6443, Fax: 434-244-9429, jonesd2@mskcc.org

*Jones, James W., 31 La Costa Drive, Montgomery, TX 77356-5325, Tel: 936-582-4577, Fax: 936-582-1493, jwjoness@bcmtmc.edu

*Jones, R. Scott, University of Virginia, Department of Surgery, P.O. Box 800709, Charlottesville, VA 22908, Tel: 804-924-2000, Fax: 804-982-1024

*Jones, Robert H., Duke University Medical Center, P. O. Box 2986, Durham, NC 27710, Tel: 919-668-8357, jones060@mc.duke.edu

*Jones, Ronald Coy, Baylor University Medical Center, Department of Surgery, 3500 Gaston Avenue, Dallas, TX 75246, Tel: 214-820-2468, Fax: 214-820-4538, rc.jones@bcm.tmc.edu

Jordan, William D., Jr., University of Alabama at Birmingham, Vascular Surgery and Endovascular Therapy, BDB 503, 1808 7th Avenue South, Birmingham, AL 35294-0012, Tel: 205-934-2003, Fax: 205-934-0024, wjdjordan@uab.edu

*Senior Members

†New Members
*Jordan, Paul H., Jr., 4718 Hallmark DR, Apt #607, Houston, TX 77056, Tel: 713-533-
0985, Fax: 713-793-7824, p_jordan@sbcglobal.net
*Jude, James R., 200 Edgewater Drive, Coral Gables, FL 33133, Tel: 305-772-5067,
Fax: 305-667-4824, jjude33333@aol.com

K

*Kaiser, George C., 10 Jefferson Road 1-D, Webster Groves, MO 63119-2933, Tel:
314-962-0446, georgeckaiser@gmail.com
*Karl, Richard C., 12902 Magnolia DR, FOB-2, Tampa, FL 33612, Tel: 813-745-1277,
Fax: 813-745-7229, richard.karl@moffitt.org
Kearney, Paul A., University of Kentucky Medical Center, Department of Surgery,
C223, 800 Rose Street, Lexington, KY 40536-0293, Tel: 859-323-6346, Fax: 859-
323-6840, pakear0@uky.edu
Kelley, Mark C., Vanderbilt University Medical Center, 2220 Pierce AV, 597PRB,
Nashville, TN 37232-6860, Tel: 615-322-2391, Fax: 615-343-4598,
mark.kelley@vanderbilt.edu
*Kellum, John M., VCU, Department of Surgery, P.O. Box 980519, Richmond, VA
23229, Tel: 804-828-9513, Fax: 840-827-0670, jmkellum@vcu.edu
*Kenady, Daniel Edward, Sr., University of Kentucky Medical Center, Department of
Surgery, 800 Rose ST, Lexington, KY 40536-0293, Tel: 859-323-6346, Fax: 859-
323-6840, dekena0@email.uky.edu
Kent, Raleigh B., III, Norwood Clinic, 2018 Brookwood Medical Center DR, Suite
202, Birmingham, AL 35209, Tel: 205-250-6897, Fax: 205-250-6927,
ralkent3@aol.com
*Kenyon, Norman M., 9855 S.W. 69th Ave., Miami, FL 33156, Tel: 305-661-2816,
Fax: 305-661-2927
Kerby, Jeffrey D., University of Alabama at Birmingham, 701 19th ST S, LHRB 112,
Birmingham, AL 35294, Tel: 205-996-4028, Fax: 205-975-7294, jkerby@uab.edu
Kern, John A., University of Virginia Health System, TCV Surgery, PO Box 800679,
Charlottesville, VA 22908, Tel: 434-982-4301, Fax: 434-244-7588,
jkern@virginia.edu
Kerwin, Andrew J., University of Florida College of Medicine - Jacksonville, 655 W.
8th ST, Surgery Dept, Acute Care Div, Jacksonville, FL 32209, Tel: 904-244-
6631, Fax: 904-244-4687, andy.kerwin@jax.ufl.edu
*Ketcham, Alfred S., 1120 San Pedro Avenue, Coral Gables, FL 33156
Kim, Hong J., UNC School of Medicine, 170 Manning DR, P1150 POB, CB #7213,
Chapel Hill, NC 27599-7213, Tel: 919-966-5221, Fax: 919-966-8806,
kimhj@med.unc.edu

*Senior Members

†New Members
†Kirk, Allan D., Duke University Medical Center, 2301 Erwin RD, Hafs Bldg, 7th Fl, Box 3704, Durham, NC 27710, Tel: 919-681-3445, Fax: 919-681-2779, allan.kirk@duke.edu

*Kirklin, James K., University of Alabama at Birmingham, 760 TH; 1900 University Blvd., Birmingham, AL 35294, Tel: 205-934-5486, Fax: 205-975-2553, jkirklin@uab.edu

*Kirkpatrick, John Russell, Washington Hospital Center, 110 Irving Street, NW, Suite G-253, Washington, DC 20010, Tel: 202-877-5133, Fax: 202-877-3699

Klein, Andrew S., Cedars-Sinai Medical Center, 8635 W. Third St., Ste. 590W, Los Angeles, CA 90048, Tel: 310-423-2641, Fax: 310-423-0234, andrew.klein@cshs.org

Klimberg, V. Suzanne, Arkansas Cancer Research Center, 4301 W. Markham, Slot 725, Little Rock, AR 72205, Tel: 501-686-6504, Fax: 501-526-6191, klimbergsuzanne@uams.edu

*Knight, T. T., Jr., 102 Pinnacle Ridge RD, Beech Mountain, NC 28604, Tel: 828-387-4942, knighttt@etsu.edu

Ko, Tien C., The University of Texas, Health Science Center at Houston, c/o Lyndon B. Johnson Hospital/HCHD, 5656 Kelly Street, Ste. 30S62008, Houston, TX 77026, Tel: 713-566-5095, Fax: 713-566-4583, tien.c.ko@uth.tmc.edu

Kon, Neal David, Bowman Gray School of Medicine, Department of Cardiothoracic Surgery, Winston-Salem, NC 27157-1096, Tel: 910-716-4338, Fax: 910-716-3348

Koniaris, Leonidas G., Indiana University, 535 Barnhill DR, Emerson – Floor 5, Indianapolis, IN 46202, Tel: 215-274-4967, ilkoniari@iu.edu

Kooby, David A., Emory University School of Medicine, 1365C Clifton RD NE (Floor 2), Atlanta, GA 30322, Tel: 404-778-3805, Fax: 404-778-4255, dkooby@emory.edu

Korndorffer, James R., Jr., Tulane University School of Medicine, 1430 Tulane AV, Dept of Surgery, SL-22, New Orleans, LA 70112, Tel: 504-988-7123, Fax: 504-988-3843, korndorffer@tulane.edu

Koruda, Mark J., University of North Carolina, Division of GI Surgery, 4035 Burnett-Womack, UNC-CH, CB #7081, Chapel Hill, NC 27599-7081, Tel: 919-966-8436, Fax: 919-966-8440

*Kouchoukos, Nicholas T., CTV Inc., 3009 N. Ballas Road, Suite 360C, St. Louis, MO 63131, Tel: 314-997-1614, Fax: 314-432-6068, ntkouch@aol.com

*Kron, Irving L., UVA Health System, Department of Surgery, P. O. Box 800679, Charlottesville, VA 22908-0679, Tel: 434-924-2158, Fax: 434-982-3885, ilk@virginia.edu

*Kudsk, Kenneth A., University of Wisconsin-Madison, Department of Surgery, H4/736, 600 Highland Ave., Madison, WI 53792-7375, Tel: 608-262-6246, Fax: 608-263-7652, kudsk@surgery.wisc.edu

*Senior Members

†New Members
Kuhn, Joseph A., Baylor University Medical Center, 7777 Forest Lane, Ste. C 400, Dallas, TX 75246, Tel: 214-823-5000, Fax: 214-824-7167, jkuhn@wlsdocs.com
Kuo, Paul C., Loyola University Medical Center, 2160 South First AV, Maywood, IL 60153, Tel: 708-327-2705, pkuo@lumc.edu

L

Lairmore, Terry C., Scott & White Memorial Hospital, Texas A&M University System Health Science Center, College of Medicine, 2401 South 31st Street, Temple, TX 76508, Tel: 254-724-5217, Fax: 254-724-9441, tlairmore@swmail.sw.org
Lally, Kevin P., UTHSC Houston, Department of Surgery, 6431 Fannin, MSB 5.258, Houston, TX 77030, Tel: 713-500-7300, Fax: 713-500-7296, kevin.p.lally@uth.tmc.edu

*Lang, Nicholas P., UAMS, 4301 W. Markham ST, #728, Little Rock, AR 72205, Tel: 501-686-8111, Fax: 501-686-8365, nplang@uams.edu
Langan, Eugene M. III, Greenville Hospital System University M.C., Department of Vascular Surgery, 701 Grove Road, Greenville, SC 29605, Tel: 864-455-7886, Fax: 864-455-1320, elangan@ghs.org
Langham, Max R., Jr., University of Tennessee Health Science Center, Department of Surgery, 777 Washington Avenue, P220, Memphis, TN 38105, Tel: 901-287-6300, Fax: 901-287-5191, mlangham@uthsc.edu
Larsen, Christian P., Emory University Hospital, 1364 Clifton RD NE, Suite B206, Department of Surgery, Atlanta, GA 30087, Tel: 404-727-5800, Fax: 404-727-4716, clarsen@emory.edu

*Lawrence, Walter, Jr., VCU Health System, 1200 East Broad Street, Box 980011, Richmond, VA 23298, Tel: 804-828-5016, Fax: 804-828-4808, wlawrence@mcvh-vcu.edu
Leach, Steven D., Johns Hopkins University, Division of Surgical Oncology, Broadway Research Building, 733 North Broadway, Room BRB 471, Baltimore, MD 21205, Tel: 410-955-5765, Fax: 410-614-2913

*Lee, W. Chapman, 11611 N. River Road, Port Allen, LA 70767, Tel: 225-358-1061, Fax: 225-358-1076, clee4@lsuhsc.edu
*Lee, Thomas C., c/o Susan Mahan, daughter, 1 Goldsboro, Bethesda, MD 20817, Tel: 301-467-3698
*Leffall, LaSalle D., Jr., Howard University Hospital, Department of Surgery, 2041 Georgia Avenue, NW, Washington, DC 20060, Tel: 202-865-6237, Fax: 202-865-6433, ileffall@howard.edu
*Leight, George S., Jr., Duke University Medical Center, Box 3513, Durham, NC 27710, Tel: 919-684-6849, Fax: 919-684-6810, leigh001@mc.duke.edu

*Senior Members
†New Members
LeSar, Christopher J., UT College of Medicine, University Surgical Associates, 979 E. 3rd ST, Suite 401, Department of Surgery, Chattanooga, TN 37403, Tel: 423-778-7695, Fax: 423-778-2950, lesarhome@aol.com

*Levi, Joe U., Sylvester Comprehensive Cancer Center, 1475 NW 12th Avenue (M-875), Miami, FL 33136, Tel: 305-243-4211, Fax: 305-243-4221, jlevi@med.miami.edu

Levi, David M., Carolinas Medical Center, PO Box 32861, Attn: Transplant Center, Charlotte, NC 28232, Tel: 704-355-6649, Fax: 704-355-5010, david.levi@carolinas.org

Levine, Edward A., Wake Forest Baptist Health, Department of Surgical Oncology, Medical Center Boulevard, Winston-Salem, NC 27157, Tel: 336-716-4276, Fax: 336-716-9758, elevine@wakehealth.edu

*Lewis, Frank R., American Board of Surgery, Ste. 860, 1617 JFK Boulevard, Philadelphia, PA 19103, Tel: 215-568-4000, Fax: 215-563-5718, flewis@absurgery.org

Li, Benjamin D., LSU Health Sciences Center, Department of Surgery, 1501 Kings Highway, Shreveport, LA 71130, Tel: 318-675-6102, Fax: 318-675-8566, bl1@lsuhsc.edu

Lillemoe, Keith D., Massachusetts General Hospital, Department of Surgery, 55 Fruit ST, WHT 506, Boston, MA 02114, Tel: 617-643-1010, Fax: 617-726-7593, klillemoe@partners.org

*Lindsey, Edward S., 4 Rosa Park, New Orleans, LA 70115-5044, Tel: 504-865-1551, edslindsey@yahoo.com

Lineaweaver, William C., Joseph M. Still Burn and Reconstruction Center, 346 Crossgates Boulevard, Ste. 202, Brandon, MS 39042, Tel: 601-824-3979, Fax: 601-824-3979, william.lineaweaver@jmsburncenters.com

*Livingstone, Alan S., DeWitt Daughtry Family Professor and Chairman, UM/JM Medical Center, Department of Surgery, P.O. Box 016310 (R-310), Miami, FL 33101-6310, Tel: 305-585-1284, Fax: 305-324-7488, alivings@med.miami.edu

*LoCicero, Joseph, III, 1158 Church ST, Mobile, AL 36604, Tel: 251-591-0061, Fax: 251-432-4142, lociceroj@comcast.net

*Lorimer, Wishard S., Jr., 1600 Texas ST, Apt. 1221, Fort Worth, TX 76102, Tel: 817-378-4297, lorimerwish@gmail.com

Lottenberg, Lawrence, University of Florida, Department of Surgery, 1600 SW Archer Road, Box 100286, Gainesville, FL 32610, Tel: 352-846-0375, Fax: 352-846-0387

*Luce, Edward A., 55 Saint Andrews Fairway, Memphis, TN 38111, Tel: 901-761-9030

*Lueterman, Arnold, University of South Alabama, 2451 Fillingim Street, Mobile, AL 36617, Tel: 251-471-7049, Fax: 251-470-5827, aluterma@usouthal.edu

*Senior Members  †New Members
Mabry, Charles D., 1801 W. 40th, Ste. 7B, Pine Bluff, AR 71603, Tel: 870-535-8280, Fax: 870-535-5458, cdmabry@msn.com
MacDonald, Kenneth G., Jr., Physicians East, P.A., 1850 West Arlington BLVD, Greenville, NC 27834, Tel: 252-413-6735, Fax: 252-752-2019, kmacdonald.physicianseast@gmail.com
MacFadyen, Bruce V., Jr., Medical College of Georgia, 1120 15th Street, BI 4076, Augusta, GA 30912-4004, Tel: 706-721-4651, Fax: 706-721-2063, bmacfadyen@georgiahealth.edu
Magnuson, Thomas H., Johns Hopkins University School of Medicine, 4940 Eastern AV, Department of Surgery, Baltimore, MD 21224, Tel: 410-550-6713, Fax: 410-550-1822, tmagnus@jhmi.edu
Maher, James William, Virginia Commonwealth University, Box 980519, 1200 E. Broad Street, West Hospital 15th Fl. West Wing, Richmond, VA 23298-0519, Tel: 804-828-0687, Fax: 804-828-9299, jwmaher@vcu.edu
Makary, Martin, Johns Hopkins University, 600 N. Wolfe ST, Osler 624, Baltimore, MD 21231, Tel: 410-502-6845, mmakary1@jhmi.edu
Malafa, Mokenge P., Moffitt Cancer Center, 12902 USF Magnolia Drive, Tampa, FL 33612, Tel: 813-745-1432, Fax: 813-745-7229, mokenge.malafa@moffitt.org
Malangoni, Mark A., American Board of Surgery, 1617 John F. Kennedy BLVD, Suite 860, Philadelphia, PA 19103-1847, Tel: 215-568-4000, Fax: 215-563-5718, malangoni@absurgery.org
Mandel, Stanley R., 415 Lake Shore Lane, Chapel Hill, NC 27514, Tel: 919-966-3583, Fax: 919-966-4873, smandel@aims.unc.edu
Mannick, John A., 81 Bogle Street, Weston, MA 02493, jmannick@rics.bwh.harvard.edu
Mansberger, Arlie R., Jr., Medical College of Georgia, Department of Surgery, Augusta, GA 30901-4000, Tel: 706-721-0671, Fax: 706-721-6828
Mantyh, Christopher R., Duke University Medical Center, Box 3117, Durham, NC 27710, Tel: 919-681-3977, Fax: 919-681-7934, christopher.mantyh@duke.edu

*Senior Members
†New Members
Martin, Robert C.G., II, University of Louisville, 315 E. Broadway, Room 313, Louisville, KY 40202, Tel: 502-629-3355, Fax: 502-629-3030, robert.martin@louisville.edu

*Martin, Raymond S., Jr., 3955 Greentree Place, Jackson, MS 39211-6739, Tel: 601-982-4482, Fax: 601-981-5110, radar4482@gmail.com

*Martin, Raymond S., III, The Surgical Clinic, PLLC, 4230 Harding Road, Ste. 525, Nashville, TN 37205, Tel: 615-385-1547, Fax: 615-386-3679, rmartin@tsclinic.com

*Martin, J. Kirk, Mayo Clinic Jacksonville, 4500 San Pablo Road, Jacksonville, FL 32224, Tel: 904-953-2523, Fax: 904-953-7368, martin.kirk@mayo.edu

*Martin, Lester W., 3094 Waynesville Road, Bellbrook, OH 45305-9741, Tel: 937-848-2307

*Martorell, Richard A., 11300 Cypress Drive, Temple Terrace, FL 33617

*Mason, G. Robert, 846 Bonnie Brae Place, River Forest, IL 60305, Tel: 708-771-5077, grmason@earthlink.net

Matthews, Brent D., Washington University School of Medicine, 660 S. Euclid AV, Campus Box 8109, Department of Surgery, St. Louis, MO 63110, Tel: 314-454-7195, Fax: 314-454-5396, matthewsbr@wustl.edu

*Mattox, Kenneth Leon, Baylor College of Medicine, One Baylor Plaza – BCM 390, Houston, TX 77030, Tel: 713-798-4557, Fax: 713-796-9605, kmattox@aol.com

*Maull, Kimball I., 3400 Danner Circle, Birmingham, AL 35243, maullki@upmc.edu

Maxwell, Robert A., University of Tennessee College of Medicine, Department of Surgery, 979 East Third Street, Ste. 401, Chattanooga, TN 37403, Tel: 423-778-7695, Fax: 423-778-2950, robert.maxwell@universitysurgica.com

*Maxwell, John Gary, 2116 Echo Lane, Wilmington, NC 28403-6021, Tel: 910-343-0899, madma0007@aol.com

May, Addison Kemp, Vanderbilt University Medical Center, 1211 21st AV South, 404 Medical Arts Building, Nashville, TN 37212, Tel: 615-936-0177, Fax: 615-936-0185, addison.may@vanderbilt.edu

*McAlhany, Joseph C., Jr., 279 Pelican Drive, Dewees Island, SC 29451, Tel: 843-886-5488, jmcalh@gmail.com

*McArthur, Michael S., P.O. Box 4848, Tyler, TX 75712, Tel: 903-592-8191, Fax: 903-592-0351, msmcarthur@caldwellfnd.com

*McClelland, Robert N., University of Texas, Southwestern Medical School, Department of Surgery, 5323 Harry Hines Blvd., Dallas, TX 75235-9031, Tel: 214-648-3540

*McCollum, Charles H., Baylor University, One Baylor Plaza, Suite 404D, Houston, TX 77030, Tel: 713-798-5700, mccollum@bcm.edu

*McCraw, John B., Univ. MS Medical Center, Department of Surgery, 2500 N. State Street, Jackson, MS 39216, Tel: 601-815-1313, Fax: 601-984-5068

*Senior Members

†New Members
*McFadden, P. Michael, Keck School of Medicine, University of Southern California, Department of Cardiothoracic Surgery, 1520 San Pablo Street, Suite 4300, Los Angeles, CA 90033, Tel: 323-442-5849, Fax: 323-442-5956, mmcfadden@surgery.usc.edu
McFadden, David W., John Dempsey Hospital, 263 Farmington AV, Department of Surgery, Farmington, CT 06030-3955, Tel: 860-679-4801, Fax: 860-679-1847, dmcfadden@uchc.edu
*McFee, Arthur S., University of Texas Health Sciences Center, Department of Surgery, 7703 Floyd Curl Drive - MC 7842, San Antonio, TX 78229-3900, Tel: 210-567-5730, mcfee@uthscsa.edu
McGahren, Eugene D., University of Virginia Health System, Department of Surgery, P.O. Box 800709, Charlottesville, VA 22902, Tel: 434-924-5643, Fax: 434-243-6129, edm6k@virginia.edu
McGiffin, David C., Alfred Health, 55 Commercial Road, Melbourne VIC 3004, P.O. Box 315 Prahran, VIC 3181 Australia, Tel: 03 9076 2156, d.mcgiffin@alfred.org.au
*McGinnis, LaMar S., Jr., American Cancer Society, 250 Williams ST, Atlanta, GA 30303-1002, Tel: 404-329-7625, Fax: 404-329-7530, lsm2045@bellsouth.net
McGrath, Patrick C., University of Kentucky Medical Center, Department of Surgery, 800 Rose Street, C-224, Lexington, KY 40536-0293, Tel: 859-323-6346, Fax: 859-323-6840, pcmcgr0@email.uky.edu
*McGuire, Hunter H., Jr., 27 Givens Court, Richmond, VA 23227, Tel: 804-675-5000, ahmcg37@gmail.com
McKenney, Mark George, Kendall Regional Medical Center, 11760 Bird RD, Suite 720, Miami, FL 33175, Tel: 305-585-1143, Fax: 305-326-7065, mark.mckenney@hcahealthcare.com
McKenzie, E. Dean, Texas Children's Hospital, 6621 W. Fannin ST, WT 19345 H, Houston, TX 77030, Tel: 832-826-1929, Fax: 832-825-1904, edmckenz@texaschildrens.org
*McKinnon, William M.P., 1529 Nashville Ave., New Orleans, LA 70115
*McLaughlin, Joseph S., 22 S. Greene St., Baltimore, MD 21201, Tel: 410-328-5842, Fax: 410-328-2750
McMasters, Kelly M., University of Louisville, Department of Surgery, Ambulatory Care Building, 550 So. Jackson Street, 2nd Floor, Louisville, KY 40202, Tel: 502-852-5447, Fax: 502-852-1704, mcmasters@louisville.edu
*McSwain, Norman E., Jr., Tulane Medical School, 1430 Tulane Avenue, Department of Surgery, SL22, New Orleans, LA 70112, Tel: 504-988-5111, Fax: 504-988-3683, norman.mcswain@tulane.edu

*Senior Members
†New Members
Melancon, Joseph K., Georgetown University Hospital, 2800 Reservoir RD, NW, 2 Main, Washington, DC 20007, Tel: 202-444-6058, Fax: 202-444-0096, joseph.melancon@medstar.net
Mellinger, John D., Southern Illinois University Medical Center, PO Box 19638, Springfield, IL 62794-9638, Tel: 217-545-7240, Fax: 217-545-0040, jmellinger@siumed.edu
*Mentzer, Robert M., Jr., Detroit Medical Center, University Health Center, 4201 St. Antoine, UHC-4J, Detroit, MI 48201, Tel: 313-577-5125, Fax: 313-745-1075, rmentzer@med.wayne.edu
Mercer, David W., University of Nebraska at Omaha, 983280 Nebraska Medical Center, Omaha, NE 68198-3280, Tel: 402-559-8272, Fax: 402-559-6749, dwmercer@unmc.edu
Merchant, Nipun B., Vanderbilt University Medical Center, 2220 Pierce Ave, 597 PRB, Nashville, TN 37232-6860, Tel: 615-343-9090, Fax: 615-936-6535, nipun.merchant@vanderbilt.edu
*Meredith, Jesse H., 2819 Bartram Road, Winston-Salem, NC 27106
*Meredith, J. Wayne, Wake Forest University School of Medicine, Department of Surgery, Medical Center Boulevard, Winston-Salem, NC 27157, Tel: 336-716-7579, Fax: 336-716-5414, merediw@wfumc.edu
*Merrell, Ronald C., Virginia Commonwealth University, Department of Surgery, P.O. Box 980480, Richmond, VA 23298, Tel: 256-634-0206, rcmerrel@vcu.edu
*Merrill, Walter H., 3701 West End AV #7, Nashville, TN 37205, walter.h.merrill@vanderbilt.edu
*Meyer, Anthony A., University of North Carolina, 4041 Burnett Womack Building, Campus Box 7050, Department of Surgery, Chapel Hill, NC 27599-7050, Tel: 919-966-4321, Fax: 919-966-6009, anthony_meyer@med.unc.edu
*Meyers, William C., Vincera Core Physicians, 1200 Constitution AV, Suite 110, Philadelphia, PA 19112, Tel: 267-592-3201, Fax: 888-393-3980, wmeyers@vincerainstitute.com
Michelassi, Fabrizio, Weill Cornell Medical College, 525 E. 68th ST, Box 129, Department of Surgery, New York, NY 10065, Tel: 212-746-5143, Fax: 212-746-8753, fam2006@med.cornell.edu
*Miller, Richard C., University of Mississippi Medical Center, Department of Surgery, 2500 North State Street, Jackson, MS 39216
*Miller, Joseph I., Jr., The Emory Clinic, Department of Thoracic Surgery, 550 Peachtree Street, N.E., 6th Floor, Atlanta, GA 30308, Tel: 404-686-2515, Fax: 404-686-4788
*Miller, Thomas Allen, McGuire VAMC, Department of Surgery, Division of General Surgery, P.O. Box 980519, Richmond, VA 23249, Tel: 804-675-5112, Fax: 804-675-5390
*Senior Members
†New Members
*Millikan, William J., Jr., 5255 Lake Newburgh Dr., Newburgh, IN 47630, Tel: 812-424-8231
*Mills, Stephen A., 306 Westwood Avenue, Suite 505, High Point, NC 27262, Tel: 336-889-7700, Fax: 336-889-7701, stevemills1@mac.com
Milner, Stephen M., Johns Hopkins University School of Medicine, Department of Surgery, 4940 Eastern AV, Baltimore, MD 21224, Tel: 410-550-0886, Fax: 410-550-8161, smilner3@jhmi.edu
Mitchell, Marc E., The University of Mississippi Medical Center, Department of Surgery, 2500 North State Street, Jackson, MS 39216-4505, Tel: 601-984-5105, Fax: 601-815-1028, memitchell@umc.edu
Moffat, Frederick L., Jr., University of Miami Medical Center, 1120 NW 14th ST, 4th Floor, Surgical Oncology (C232), Miami, FL 33136, Tel: 305-243-4902, Fax: 305-243-4907, f Moffat@med.miami.edu
Mondy, Joseph S., Savannah Vascular and Cardiac Institute, 4750 Waters AV, Suite 500, Savannah, GA 31404, Tel: 912-629-7863, Fax: 912-355-1414, smondy@savannahvascular.com
Money, Samuel R., Mayo Clinic, 13400 East Shea Boulevard, Scottsdale, AZ 85259, Tel: 480-342-2868, Fax: 480-342-2866, money.s Samuel@mayo.edu
*Monnin, Charles A., Jr., 600 Biltmore Way, Ste. 319, Coral Gables, FL 33134, Tel: 786-552-0047, Fax: 786-552-0047, medoc@bellsouth.net
*Moody, Frank G., University of Texas Medical School, 6431 Fannin Street, MSB 4.279, Houston, TX 70030, Tel: 713-500-7241, Fax: 713-500-7268, frank.g.mood y@uth.tmc.edu
*Morgan, Raymond F., University of Virginia Health System, Department of Plastic Surgery, P.O. Box 800376, Charlottesville, VA 22908-0376, Tel: 434-924-1234, Fax: 434-924-8122, rfm9u@virginia.edu
Morgan, Katherine A., Medical University of South Carolina, 25 Courtney DR, Charleston, SC 29425, Tel: 843-876-4268, Fax: 843-876-4878, morganka@musc.edu
*Morris, John A., Jr., Vanderbilt University Medical Center, 1211 21st Ave S, 404 MAB, Nashville, TN 37212, Tel: 615-936-0176, Fax: 615-936-3374
Morrison, John E., LSU Health Science Center, 1542 Tulane AV, School of Medicine, New Orleans, LA 70112, Tel: 504-568-4750, Fax: 504-568-4633, drmor jo@aol.com
Mozingo, David W., University of Florida, Department of Surgery, P.O. Box 100286, Gainesville, FL 32610, Tel: 352-273-5670, Fax: 352-273-5683, mozindw@surgery.ufl.edu
*Mulherin, Joseph L., Jr., 4230 Harding Road, Suite 525, Nashville, TN 37205-2013
*Murray, Douglas R., Emory Clinic, 1365 Clifton Road, Atlanta, GA 30322, Tel: 404-778-2448, Fax: 404-778-4255, murrayd840@aol.com

*Senior Members
†New Members
Nakayama, Don K., West Virginia University School of Medicine, Robert C. Byrd Health Sciences Center, PO Box 9238, Department of Surgery, 7700 HSS, Morgantown, WV 26506, Tel: 304-293-1258, Fax: 304-293-4824, dknakayama@hsc.wvu.edu

†Namias, Nicholas, University of Miami School of Medicine, 1120 NW 14 ST, Miami, FL 33136, Tel: 305-585-1822, Fax: 305-326-7065, nnamias@miami.edu

*Nance, Francis C., 309 White Oak Ridge Road, Shorthills, NJ 07078-1155, Tel: 973-467-7964, Fax: 973-467-6794, fcnance@comcast.net

Naslund, Thomas C., Vanderbilt Medical Center, Vascular Surgery, 1161 21st Ave. South, D-5237 MCN, Nashville, TN 37232, Tel: 615-322-2343, Fax: 615-343-4251, thomas.naslund@vanderbilt.edu

*Nealon, William H., Vanderbilt University School of Medicine, Department of Surgery/D4314 Medical Center North, 1161 21st Ave South, Nashville, TN 37232-0011, william.nealon@vanderbilt.edu

*Neblett, Wallace W., III, Vanderbilt Children's Hospital, Department of Pediatric Surgery, 2200 Children's Way, Suite 4150, Nashville, TN 37232, Tel: 615-936-1050, Fax: 615-936-1046

*Nelson, Norman C., 109 Cardinal Circle, Brandon, MS 39042

*Nesbit, Robert R., Jr., Medical College of Georgia, 1120 15th ST, Augusta, GA 30912, Tel: 706-721-1967, Fax: 706-721-1940, rnesbit@gru.edu

Newman, Kurt D., Children's National Medical Center, Department of Surgery, 111 Michigan Avenue, NW, Washington, DC 20010, Tel: 202-476-2153, Fax: 202-476-4174, knewman@cnmc.org

*Newsome, Heber H., Jr., 6411 Roselawn Road, Richmond, VA 23226

*Nolan, Stanton P., University of Virginia Health Sciences Center, 250 Pantops Mountain Road, Apartment 5204, Charlottesville, VA 22911-8702, Tel: 434-972-2439, Fax: 434-972-2566, snolan@virginia.edu

Nussbaum, Michael S., University of Florida College of Medicine - Jacksonville, Department of Surgery, 653 West 8th ST, Faculty Clinic Floor 3, Jacksonville, FL 32209, Tel: 904-244-5502, Fax: 904-244-6252, michael.nussbaum@jax.ufl.edu

*N Senior Members

† New Members
*O’Brien, John C., Jr., 8223 Forest Hills BLVD, Dallas, TX 75218, Tel: 214-320-9163, Fax: 214-320-9163, job8223@aol.com
*Oldham, H. Newland, Jr., 542 Cedar Club Circle, Chapel Hill, NC 27517
*O’Leary, J. Patrick, Florida International University, College of Medicine, 11200 SW 8th Street, Miami, FL 33199, Tel: 305-348-0607, Fax: 305-348-0123, olearyp@fiu.edu
*Oller, Dale W., 3341 White Oak Road, Raleigh, NC 27609, Tel: 919-350-8698, Fax: 919-350-7633, doller@med.unc.edu
Ollila, David W., University of North Carolina, 170 Manning DR, 3010 Old Clinic Building, CB #7213, Chapel Hill, NC 27599-7213, Tel: 919-966-5221, Fax: 919-966-8806, david_ollila@med.unc.edu
Olson, John A., University of Maryland School of Medicine, 22 S. Greene ST, Room S4B16, Baltimore, MD 21201-1595, Tel: 410-328-4471, Fax: 410-328-5919, jolson@smail.umaryland.edu
*O’Mara, Charles S., Baptist Cardiovascular Surgery, 501 Marshall ST, Suite 100, Jackson, MS 39202, Tel: 601-969-7047, omarach@gmail.com
*O’Neill, James A., Jr., Vanderbilt Childrens Hospital, 2200 Childrens Way, Suite 7100, Nashville, TN 37232, Tel: 615-936-1290, Fax: 615-936-1046, james.oneill@vanderbilt.edu
*Othersen, H. Biemann, Jr., MUSC, 96 Jonathan Lucas ST, CSB 418, MSC 613, Pediatric Surgery, Charleston, SC 29401, Tel: 843-792-3851, Fax: 843-792-3858, othershb@musc.edu

P

Paidas, Charles N., Tampa General Hospital, 1 Tampa General Circle, Room G-441, Tampa, FL 33606, Tel: 813-844-7315, Fax: 813-844-8045, cpaidas@health.usf.edu
*Pairolero, Peter C., Mayo Clinic, 200 First Street, S.W., Rochester, MN 55905, Tel: 507-284-2808, Fax: 507-284-0058
†Papaconstantinou, Harry T., Scott & White Healthcare, Texas A&M College of Medicine, 2401 South 31st ST, Temple, TX 76508
Pappas, Theodore N., Duke University Medical Center, Box 3479, Durham, NC 27710, Tel: 919-681-3442, Fax: 919-668-1826, theodore.pappas@duke.edu
*Parker, Peter Emens, Triad Surgical Associates, PA, 1900 S. Hawthorne RD, Suite 480, Winston-Salem, NC 27103, Tel: 336-765-0155, Fax: 336-765-5494, petereparker@gmail.com

*Senior Members 98  †New Members
*Parker, George A., 5855 Bremo Road, Suite 506, Richmond, VA 23238, Tel: 804-285-3225, Fax: 804-285-0360, george_parker@bshsi.org
*Parker, Telfair H., 510 Albemarle Road, Charleston, SC 29407, Tel: 843-723-6426
*Parrish, Robert A., Jr., 433 Scotts Way, Augusta, GA 30909, rapc99@comcast.net
†Passman, Marc A., University of Alabama at Birmingham, 1530 3rd AV South, BDB 503, Section of Vascular Surgery and Endovascular Therapy, Birmingham, AL 35294, Tel: 205-934-2006, Fax: 205-934-0053, mpassman@uabmc.edu
*Pate, James W., University of Tennessee, 910 Madison Avenue, 2nd, Rm. 201, Memphis, TN 38163, Tel: 901-448-5912, Fax: 901-448-7306, jpat@uthsc.edu
Pawlik, Timothy M., Johns Hopkins Hospital, 660 N. Wolfe ST, Harvey 611, Baltimore, MD 21287, Tel: 410-502-2387, Fax: 410-502-2388, tpawlik1@jhmi.edu
*Pellegrini, Carlos A., University of Washington, 1959 NE Pacific Street., BB487, Box 346410, Dept of Surgery, Seattle, WA 98195, Tel: 206-543-3106, Fax: 206-685-6912, pellegr@uw.edu
Pemberton, John H., Mayo Clinic, 200 First Street SW, Gonda 9-S, Department of Surgery, Rochester, MN 55905, Tel: 507-284-2359, Fax: 507-284-1794, pemberton.john@mayo.edu
*Pennell, Timothy C., 5401 Covenant Lane, Winston-Salem, NC 27106-6459, Tel: 336-722-3774, tcpennellmd@aol.com
*Pennington, Larry R., University of Oklahoma HSC, Department of Surgery, P.O. Box 26901, Oklahoma City, OK 73190, Tel: 405-271-6240, Fax: 405-271-3919
*Pennington, D. Glenn, Professor of Surgery, East Tennessee State University, Department of Surgery, VA Dogwood Lane, Bldg. 1, Johnson City, TN 37614-0575, Tel: 423-439-6771, Fax: 423-439-6259, penningg@etsu.edu
Perrier, Nancy D., The University of Texas M.D. Anderson Cancer Center, 1400 Holcomb BLVD, Unit 1484, Houston, TX 77030, Tel: 713-794-1345, Fax: 713-563-5727, nperrier@mdanderson.org
Perry, Roger R., Eastern Virginia Medical School, Department of Surgery, 825 Fairfax Avenue, Norfolk, VA 23507, Tel: 757-446-8950, Fax: 757-446-8951
*Pfaff, William W., 2445 NW 15th Place, Gainesville, FL 32610-0286, Tel: 352-378-2240, puffer12@aol.com
Pigott, John D., III, Tulane University, 1430 Tulane Ave., SL-22, New Orleans, LA 70112, Tel: 504-582-7998, Fax: 504-561-0792
Pinson, C. Wright, Vanderbilt University Medical Center, 801 Oxford House, Nashville, TN 37232-4753, Tel: 615-343-9324, Fax: 615-343-6478, wright.pinson@vanderbilt.edu
Pisters, Peter W.T., The University of Texas, M.D. Anderson Cancer Center, 1515 Holcombe BLVD, Unit 1639, Houston, TX 77030, Tel: 713-794-1572, Fax: 713-792-7829, ppisters@mdanderson.org

*Senior Members  †New Members
Pruitt, Basil A., Jr., UTHSC San Antonio, 7703 Floyd Curl Drive, Department of Surgery, San Antonio, TX 78229-3900, Tel: 210-567-3623, Fax: 210-567-0003, pruitt@uthscsa.edu

Pruitt, Scott K., Merck Research Laboratories, 126 E. Lincoln AV, RY34-A500, Rahway, NJ 07065, Tel: 732-594-7653, scott.pruitt@merck.com

Putnam, Joe B., Vanderbilt University Medical Center, 609 Oxford House, 1313 21st AV South, Nashville, TN 37232-4682, Tel: 615-343-9202, Fax: 615-322-3079, bill.putnam@vanderbilt.edu

*Raju, Seshadri, University of Mississippi Medical Center, 1020 River Oaks Drive, Suite 420, Jackson, MS 39232, Tel: 601-939-4230, Fax: 601-939-5210, rajumd@earthlink.net

*Randolph, Judson G., 3800 Whitland Avenue, Nashville, TN 37205

Rege, Robert V., The University of Texas Southwestern Medical Center, 5323 Harry Hines Boulevard, Dallas, TX 75390-9031, Tel: 214-648-3050, Fax: 214-648-6752, robert.rege@utsouthwestern.edu

Reiff, Donald A., University of Alabama, 1922 7th AVE South, Birmingham, AL 35294-0007, Tel: 205-975-9783, Fax: 205-975-3035, d.reiff@uabmc.edu

*Reiling, Richard B., 1150 S. King DR, Charlotte, NC 28207-1806, Tel: 704-575-7639, rbr@hargray.com

Reintgen, Douglas S., University of South Florida, 12901 Bruce R. Downs BLVD, MO.C.52, Tampa, FL 333612, Tel: 813-440-8554, dougreintgen@verizon.net


Riall, Taylor S., University of Texas Medical Branch, 301 University Boulevard, Galveston, TX 77555-0542, Tel: 409-772-1846, Fax: 409-747-2253, tsriall@utmb.edu

*Rice, Charles L., Uniformed Services University of the Health Sciences, Office of the President, 4301 Jones Bridge Road, Bethesda, MD 20814-4799, Tel: 301-295-3013, Fax: 301-295-1960, charles.rice@usuhs.edu

*Rich, Norman M., USUHS, Norman M. Rich Department of Surgery, 4301 Jones Bridge Road, Bethesda, MD 20814, Tel: 301-295-3155, Fax: 301-295-3627, nrich@usuhs.edu

*Richards, William O., University of South Alabama, Department of Surgery, 2451 Fillingim Street, Mastin 721, Mobile, AL 36617, Tel: 215-471-7993, brichards@usouthal.edu

*Senior Members

†New Members
Richardson, J. David, University of Louisville, Department of Surgery, 550 South
Jackson Street, Louisville, KY 40292, Tel: 502-852-5452, Fax: 502-852-8915,
jdrich01@louisville.edu

Richardson, William S., Ochsner Medical Center, 1514 Jefferson Highway, CT-8, New
Orleans, LA 70121, Tel: 504-842-4070, Fax: 504-842-5191,
wrichardson@ochsner.org

*Richie, Robert E., Vanderbilt University School of Medicine, Department of Surgery,
Room D-4303, Nashville, TN 37232

†Richmond, Bryan K., West Virginia University/Charleston Division, Room 3023,
3110 MacCorkle Avenue SE, Charleston, WV 25304, Tel: 304-347-1255, Fax:
304-556-3804, brichmond@hsc.wvu.edu

*Ricketts, Richard R., Emory University, 1405 Clifton RD NE, Atlanta, GA 30322,
Tel: 404-785-0781, Fax: 404-785-0800, rricket@emory.edu

Ricotta, John Joseph, 2018 Hillyer Place NW, Washington, DC 20009, Tel: 202-256-
2744, Fax: 202-877-3699, john.j.ricotta@medstar.net

*Rienhoff, William F., III, 24426 Smithville Road, Worton, MD 21678, Tel: 410-778-
5732

*Rikkers, Layton F., University of Wisconsin CSC, Department of Surgery, 1111
Highland Avenue, Office #5103, WIMR Building, Madison, WI 53705, Tel: 608-
263-1387, Fax: 608-252-0912, rikkers@surgery.wisc.edu

*Ritchie, Wallace P., Jr., 215 10th AV S, #604, Minneapolis, MN 55415

*Roberts, John W., Scott and White Clinic, 2401 South 31st Street, Temple, TX 76508,
Tel: 254-724-2547, Fax: 254-724-4483

*Robicsek, Francis, 1001 Blythe Boulevard, Suite 300, Charlotte, NC 28203, Tel: 704-
444-3901, Fax: 704-373-0781, francis.robicsek@carolinashealthcare.org

*Robinson, David S., Advanced General Surgery, 983 University Drive, Coral Springs,
FL 33071, Tel: 954-227-2030, davidrobinsonmd@msn.com

*Robson, Martin C., 2426 Waukazoo Trail, PO Box 345, Macatawa, MI 49434-0345

*Rodgers, Bradley M., UVA Health System, PO Box 800709, Charlottesville, VA
22902, Tel: 434-924-2673, Fax: 434-924-2656, bmr@virginia.edu

Roe, S. Michael, UT College of Medicine, Chattanooga Unit, Department of Surgery,
979 E. Third Street, Ste. 401, Chattanooga, TN 37403, Tel: 423-778-7695, Fax:
423-778-2950, doctorvol@aol.com

*Roehr, Michael S., 1050 Kelwyn Lane, Lewisville, NC 27023, Tel: 336-778-1419

*Root, H. David, 258 Riders Mills Road, Brainard, NY 12024, Tel: 210-567-3623, Fax:
210-567-0003, root@uthscsa.edu

Rosemurgy, Alexander S., II, Advanced Minimally Invasive and Robotic Surgery, 3000
Medical Park Drive, Suite 310, Tampa, FL 33613, Tel: 813-615-7030, Fax: 813-
615-8350, arosemurgy@hotmail.com

*Senior Members

†New Members
Rosenberg, Wade R., The Methodist Hospital, 6560 Fannin, #1750, Houston, TX 77030, Tel: 713-790-4830, Fax: 713-793-7824, wrosenberg@texassurgical.com

*Rothenberger, David Albert, University of Minnesota-Surgery, 420 Delaware Street SE, MMC 195, Minneapolis, MN 55455, Tel: 612-626-6122, Fax: 612-625-3660, rothe002@umn.edu

Rotondo, Michael F., University of Rochester Medical Center, 601 Elmwood AV, Box 706, Rochester, NY 14642, Tel: 585-276-6830, michaelrotondo@urmc.rochester.edu

*Rout, W. Robert, Univ. Florida Shands Hospital, Department of Surgery, P.O. Box 100286, Gainesville, FL 32610-0286, Tel: 352-265-0535, Fax: 352-265-0190

Rozycki, Grace S., Indiana University School of Medicine, 545 Barnhill DR, EH541, Department of Surgery, Indianapolis, IN 46202, grozycki@iupui.edu

Rue, Loring W., III, University of Alabama at Birmingham, Department of Surgery, LHRB 112, 701 S. 19th St., Birmingham, AL 35294, Tel: 205-934-1152, Fax: 205-975-7294

*Rushton, Fred W., Jr., University of Mississippi Medical Center, Division of Vascular Surgery, 2500 N. State St, L228-4, Jackson, MS 39216, Tel: 601-984-2680, Fax: 601-815-4563, frushton@surgery.umsmed.edu

*Russell, Hamilton Earle, Jr., Piedmont Neurosurgical PA, 3 Saint Francis DR, Suite 490, Greenville, SC 29601, Tel: 864-220-4263, Fax: 864-226-0680, earle@piedneuro.com

*Russell, William L., 120 Frank Martin RD, Suite 101, Shelbyville, TN 37160, Tel: 931-685-0986, Fax: 931-685-0988, russell.veins@gmail.com

S

*Sachatello, Charles R., 3021 Brookmonte Lane, Lexington, KY 40515, Tel: 859-272-0257, Fax: 859-272-0257, crsachatellomd@yahoo.com

†Sachdeva, Ajit K., American College of Surgeons, 633 N. Saint Clair Street, Chicago, IL 60611, Tel: 312-202-5405, Fax: 312-202-5110, asachdeva@facs.org

*Salam, Atef A., VA Medical Center, 1670 Clairmont RD, Surgery & Perioperative Care SL-112, Decatur, GA 30033, Tel: 404-321-6111, Fax: 404-329-2201, atef.salam@va.gov

Sarosi, George A., Jr., University of Florida College of Medicine, 1600 SW Archer RD, Box 100109, Department of Surgery, Gainesville, FL 32610, Tel: 352-265-9761, Fax: 352-265-3292, george.sarosi@surgery.ufl.edu

*Sasser, William F., Jr., #5 Woodbridge Manor Road, St. Louis, MO 63141, Tel: 314-577-8351, sasserwf@slu.edu

*Senior Members

†New Members
Sawyer, Robert G., University of Virginia Health System, Department of Surgery, P.O. Box 800709, Charlottesville, VA 22908, Tel: 434-982-1632, Fax: 434-924-2260, rws2k@virginia.edu
*Sawyers, John L., 115 Bellebrook Circle, Nashville, TN 37205, Tel: 615-383-0229, drsawyers@aol.com
†Scalea, Thomas M., University of Maryland School of Medicine, 22 S. Greene ST, Trauma, Baltimore, MD 21201, Tel: 410-328-8976, Fax: 410-328-8925, tscalea@umm.edu
*Schenk, Worthington G., III, UVA Health System, Department of Surgery, P.O. Box 800709, Charlottesville, VA 22908-0709, Tel: 434-924-0380, Fax: 434-982-6725, wgs@virginia.edu
*Schild, A. Frederick, Herbert Wertheim College of Medicine, 11200 SW 8th ST, HLS 11 693, Miami, FL 33199, Tel: 305-348-0697, afschild@fiu.edu
*Schirmer, Bruce D., University of Virginia, Department of Surgery, Box 800709, Charlottesville, VA 22908, Tel: 804-924-2104, Fax: 804-243-9433, bs@virginia.edu
*Schmidt, Frank E., 1137 Jefferson Avenue, New Orleans, LA 70115-3011, Tel: 504-895-6822, Fax: 504-895-1902, fesmd@bellsouth.net
Schulick, Richard David, Universitiy of Colorado, 12631 E. 17th AV, C-305, Department of Surgery, Aurora, CO 80045, Tel: 303-724-2750, Fax: 303-724-2761, richard.schulick@ucdenver.edu
Schwab, C. William, Hospital of the University of Pennsylvania, 3400 Spruce ST, 5 Maloney Building, Division of Traumatology, Surgical Critical Care and Emergency Surgery, Philadelphia, PA 19104, Tel: 215-662-7015, Fax: 215-349-5917, schwabc@uphs.upenn.edu
*Schwartz, Seymour I., University of Rochester Medical Center, Department of Surgery, 601 Elmwood Avenue, Box SURG, Rochester, NY 14642-8410, Tel: 585-275-7339, Fax: 585-276-0096, seymour_schwartz@urmc.rochester.edu
*Schwesinger, Wayne H., UTHSCSA, 7703 Floyd Curl Drive, San Antonio, TX 78284, Tel: 210-567-5727, Fax: 210-567-6609
Scoggin, Charles R., University of Louisville, Division of Surgical Oncology, 315 E. Broadway, Suite 303, Louisville, KY 40202, Tel: 502-629-3355, Fax: 502-629-3030, charles.scoggins@louisville.edu
*Seigler, Hillard F., Duke University Medical Center, P. O. Box 3118, 240 Hanes House, Durham, NC 27710, Tel: 919-684-3492, Fax: 919-684-6044, seigl001@mc.duke.edu
*Shack, R. Bruce, Vanderbilt University Medical Center, Department of Plastic Surgery, 1161 21st Ave. So., D-4207, MCN, Nashville, TN 37232-2345, Tel: 615-936-0169, Fax: 615-936-0167, bruce.shack@vanderbilt.edu

*Senior Members
†New Members
†Shaffer, David, Division of Kidney and Pancreas Transplantation, Vanderbilt University Medical Center, 912 Oxford House, Nashville, TN 37232, Tel: 615-936-0404, Fax: 615-936-0409, david.shaffer@vanderbilt.edu

*Sharp, Kenneth W., Vanderbilt University Medical Center, Room 5203, MCN, Nashville, TN 37232-2577, Tel: 615-343-9547, Fax: 615-343-9485, ken.sharp@vanderbilt.edu

Shen, Perry, Wake Forest University Medical Center, Medical Center BLVD, Winston-Salem, NC 27157, Tel: 336-716-0545, Fax: 336-716-9758, pshen@wfubmc.edu

*Shively, Eugene H., Taylor Regional Surgeons, 1698 Old Lebanon Road, Suite 2A, Campbellsville, KY 42718, Tel: 270-465-2821, Fax: 270-789-1756, eshively@trhosp.org

*Shokouh-Amiri, Hosein, 1501 Kings Highway, Department of Surgery, Louisiana State University, Shreveport, LA 71130, Tel: 318-675-6112, Fax: 318-675-6358, hshoko@lsuhsc.edu

Shortell, Cynthia K., Duke University Medical Center, DUMC Box 3538, Durham, NC 27710, Tel: 919-681-2223, Fax: 919-668-5284, cynthia.shortell@duke.edu

*Shuck, Jerry M., 2955 W. Belvoir Oval, Shaker Heights, OH 44122

*Sirinek, Kenneth R., UTHSCSA, Department of Surgery, 7703 Floyd Curl Drive, MC 7842, San Antonio, TX 78229-3900, Tel: 210-567-5730, Fax: 210-567-5797, sirinek@uthscsa.edu

Slakey, Douglas P., Tulane University, 1430 Tulane Avenue / SL 22, New Orleans, LA 70112, Tel: 504-988-2317, dslakey@tulane.edu

Slaughter, Mark S., University of Louisville, 201 Abraham Flexner Way, Suite 1200, Louisville, KY 40202, Tel: 502-561-2180, Fax: 502-561-2190, mscabg@aol.com

Slingluff, Craig L., Jr., University of Virginia, Department of Surgery, P.O. Box 800709, Charlottesville, VA 22908, Tel: 804-924-1730, Fax: 804-243-6844

Sloan, David A., Endocrine Surgery Clinic, 125 E. Maxwell, Suite 302, Lexington, KY 40508, Tel: 859-218-2782, Fax: 859-323-6727, dasloa0@uky.edu

*Smith, Robert B., III, Emory University Hospital, Department of Surgery, B206, 1364 Clifton Road, NE, Atlanta, GA 30322, Tel: 404-727-3573, Fax: 404-727-4716, robert.smith@emoryhealthcare.org

Smith, Samuel D., Arkansas Children’s Hospital, 800 Marshall St., #837, Little Rock, AR 72202-3591, Tel: 501-320-2943, Fax: 501-320-1516

*Smith, George V., 1401 River Road, Greenwood, MS 38930, Tel: 662-453-9305, Fax: 662-451-5157

*Smith, Charles D., III, Medical University of South Carolina, Division of Pediatric Surgery, 96 Jonathan Lucas Street, Suite 418 CSB, P.O. Box 250613, Charleston, SC 29425, Tel: 843-792-3851, Fax: 843-792-3858, smithcd@musc.edu

*Senior Members  105  †New Members
Smith, C. Daniel, Mayo Clinic Florida, Department of Surgery, 4500 San Pablo Road, Jacksonville, FL 32224, Tel: 904-953-6389, Fax: 904-953-7368, smith.c.daniel@mayo.edu

Smythe, W. Roy, Avia Health Innovation, 122 S. Michigan AVE, Ste. 900, Chicago, IL 60603, Tel: 312-999-9600, rsmythe@aviahealthinnovation.com

*Snyder, Samuel K., Scott and White Clinic, 2401 South 31st ST, Dept of Surgery, Floor 7, Temple, TX 76508, Tel: 254-724-4976, Fax: 254-724-7482, s.snyder@sw.org

*Snyder, Stanley O., Jr., The Surgical Clinic PLLC, 4230 Harding Road, Suite 525, Nashville, TN 37205, Tel: 615-385-1547, Fax: 615-297-9161, ssnyder@tsclinic.com

Solorzano, Carmen C., Vanderbilt University, 2220 Pierce AVE, 597 PRB, Division of Surgical Oncology and Endocrine Surgery, Nashville, TN 37232-6860, Tel: 615-322-2391, Fax: 615-936-6535, carmen.solorzano@vanderbilt.edu

*Souba, Wiley W., Jr., Dartmouth Medical School, Office of the Dean, 1 Rope Ferry RD, Hanover, NH 03755-1404, Tel: 603-650-1200, geisel.administration@dartmouth.edu

*Spencer, Frank C., NYU Medical Center, 530 First Avenue, Ste, 1508, New York, NY 10016, Tel: 212-263-0953, Fax: 212-263-0951, frank.spencer@nyumc.org

*Spotnitz, William D., University of Virginia Health System, PO Box 801370, 4361 Barringer, Charlottesville, VA 22908-1370, Tel: 352-514-5009, Fax: 352-331-0017, wspotnitz@virginia.edu

Squires, Ronald A., University of Oklahoma Health Science Center, Department of Surgery, 920 Stanton Young Blvd, Room 2140 Williams Pavillion, Oklahoma City, OK 73104, Tel: 405-271-6304, Fax: 405-271-3919, ronald-squires@ouhsc.edu

Stain, Steven C., Albany Medical College, Department of Surgery, 47 New Scotland Avenue, MC61GE, Albany, NY 12208-3479, Tel: 518-262-2919, Fax: 518-262-5692, stains@mail.amc.edu

Staley, Charles A., Emory University School of Medicine, Surgical Oncology, 1365 Clifton Road, NE, Atlanta, GA 30322, Tel: 404-778-0210, Fax: 404-778-4255, charles.staley@emoryhealthcare.org

Steinberg, Steven M., Ohio State University, Department of Surgery, 395 W. 12th Avenue, Room 630, Columbus, OH 43220, Tel: 614-293-3185, Fax: 614-293-9155, steven.steinberg@osumc.edu

†Stewart, John H., IV, Wake Forest Baptist Health, 1 Medical Plaza BLVD, Winston-Salem, NC 27157, Tel: 336-716-9377, jhstewar@wakehealth.edu

*Senior Members 106  †New Members
Stewart, Ronald M., UTHSCSA, Department of Surgery/Trauma, 7703 Floyd Curl Drive, MSC 7740, San Antonio, TX 78229-3900, Tel: 210-567-3623, Fax: 210-567-0003, stewartr@uthscsa.edu

*Stickel, Delford L., 73 Davison Drive, Durham, NC 27705, Tel: 919-384-2128, dstickel@duke.edu

Stone, William Martin, Mayo Clinic Arizona, 5777 E. Mayo Boulevard, Phoenix, AZ 85255, Tel: 480-301-2868, Fax: 480-301-2866, stone.william@mayo.edu

*Stone, H. Harlan, P.O. Box 523, Glenville, NC 28736, Tel: 828-743-6153

*Stoney, William S., Jr., 3822 Brighton Road, Nashville, TN 37205, Tel: 615-298-3505, wsstoney@comcast.net

Stratta, Robert J., Wake Forest University School of Medicine, Department of General Surgery, Medical Center Boulevard, Winston-Salem, NC 27157-1095, Tel: 336-716-6371, Fax: 336-713-5055, rstratta@wfubmc.edu

*Strodel, William E., Geisinger Medical Center, Department of Surgery, 100 N. Academy Avenue, Danville, PA 17822-2170, Tel: 570-214-7711, Fax: 570-271-6928, westrodel@geisinger.edu

†Sudan, Debra L., Duke University Medical Center, Box 3522, Durham, NC 27710, Tel: 919-668-2279, Fax: 919-684-8716, debra.sudan@duke.edu

Sudan, Ranjan, Duke University Medical Center, 200 Trent DR, DUMC Box 2834, Durham, NC 27710, Tel: 919-668-3101, Fax: 919-681-8856, ranjan.sudan@duke.edu

*Sugerman, Harvey J., 290 Southwinds Drive, Sanibel, FL 33957, Tel: 239-472-4625, Fax: 239-472-4675, hsugerman@comcast.net

Sundt, Thoralf M., III, Massachusetts General Hospital, 55 Fruit ST, Cox 630, Boston, MA 02114, Tel: 617-643-9745, Fax: 617-726-5804, tsundt@partners.org

Sweeney, John F., Emory University, 1364 Clifton Road, NE, Building A, Floor 5, A5037, Atlanta, GA 30322, Tel: 404-727-1540, Fax: 404-778-1944, john.sweeney@emoryhealthcare.org

*Sykes, Mellick T., 307 Lamont AV, San Antonio, TX 78209, Tel: 210-692-9700, Fax: 210-692-9730, msykes@pvasatx.com

*Symbas, Panagiotis, 3661 Cloudland Drive NW, Atlanta, GA 30327

T

Talamini, Mark A., UCSD Department of Surgery, 200 W. Arbor Drive, #8400, San Diego, CA 92103-8400, Tel: 619-543-6453, Fax: 619-516-8951, talamini@ucsd.edu

*Senior Members

†New Members
*Senior Members

Talbert, James L., University of Florida, Department of Surgery, P.O. Box 100286, College of Medicine, Gainesville, FL 32610-0286, Tel: 352-392-3718, Fax: 352-392-9081, jtalbert@ufl.edu

Talman, E. Armistead, 6128 St. Andrews Lane, Richmond, VA 23226

Taylor, Peyton T., Jr., University of Virginia Cancer Center, Box 800712, Charlottesville, VA 22908, Tel: 804-924-9933, Fax: 804-982-1840

Taylor, Spence M., Greenville Hospital System, Health Sciences Administration Building, 701 Grove RD, Greenville, SC 29605, Tel: 864-455-7992, Fax: 864-455-8404, staylor2@ghs.org

Tepas, Joseph J., III, University of Florida HSC, Surgery, 653 West 8th Street, Jacksonville, FL 32209, Tel: 904-244-3915, Fax: 904-244-3870, jjt@jax.ufl.edu

Thomas, Clarence S., Jr., 425 Westview AV, Nashville, TN 37205-3442

Thomas, Colin G., Jr., UNC School of Medicine, Department of Surgery / Oncology, CB 7228, Chapel Hill, NC 27599-7228, Tel: 919-843-8320, Fax: 919-966-9309, cgt@med.unc.edu

Thomason, Michael H., Carolinas Medical Center, PO Box 32861, Department of General Surgery, Charlotte, NC 28232, Tel: 704-355-8449, Fax: 704-355-7833, mthomason@carolinas.org

Thompson, C. Thomas, 4425 S. Florence AV, Ste. 200, Tulsa, OK 74505, Tel: 918-742-4495, Fax: 918-742-3071

Timberlake, Gregory A., University of Mississippi Medical Center, Department of Surgery, 2500 North State Street, Jackson, MS 39216-4505, Tel: 601-815-1312, Fax: 601-815-4570

Timmis, Hiliary H., 245 SW Hatteras Court, Palm City, FL 34990-4325, Tel: 772-223-7742, Fax: 772-223-7742, drstimmis@aol.com

Tompkins, Ronald K., UCLA Medical Center, Department of Surgery, 309 20th Street, Santa Monica, CA 90402, Tel: 310-394-8836, dr.ronald.k.tompkins@ucla.edu

Townsend, Courtney M., Jr., The University of Texas Medical Branch, Department of Surgery, 301 University Boulevard, Galveston, TX 77555-5027, Tel: 409-772-1285, Fax: 409-772-5611, ctownsen@utmb.edu

Tracy, Thomas F., Jr., Brown University / Rhode Island and, Hasbro Children's Hospital, 593 Eddy ST, Providence, RI 02903, Tel: 401-444-7605, Fax: 401-444-7629, ttracy@lifespan.org

Trible, Curtis G., University of Virginia, P.O. Box 800679, Charlottesville, VA 22908-0679, Tel: 434-924-2000, Fax: 434-244-7588, ctribble@virginia.edu

Trout, Hugh H., III, 8218 Wisconsin Avenue, #204, Bethesda, MD 20814, Tel: 301-652-1208, Fax: 301-951-8425, hhtrout@gmail.com

†New Members
Trunkey, Donald, Oregon Health and Science University, 3181 SW Sam Jackson RD, MC L223, Portland, OR 97239-3098, Tel: 503-494-9145, Fax: 503-494-8884, trunkeyd@ohsu.edu
Tuggle, David W., University of Oklahoma College of Medicine, 940 N.E. 13th Street, Room 2403, Oklahoma City, OK 73104, Tel: 405-271-5922, Fax: 405-271-3278, davidtuggle@gmail.com
Tunell, William P., 1224 Glenbrook Drive, Oklahoma City, OK 73118, Tel: 405-842-0664, wtunell@gmail.com
Turnage, Richard H., University of Arkansas for Medical Sciences, Department of Surgery, 4301 W. Markham St, #520, Little Rock, AR 72205, Tel: 501-686-7874, Fax: 501-686-5696, rhturnage@uams.edu
Turner, Charles S., 20 Cascade AVE, S.W., Winston-Salem, NC 27127, csiewersturner@gmail.com
Turner, Patricia L., American College of Surgeons, 633 North St. Clair ST, Chicago, IL 60611-5021, Tel: 312-202-5259, Fax: 312-202-5021, pturner@facs.org
Turner, William W., Jr., UT Southwestern Medical Center, Department of Surgery, 5323 Harry Hines BLVD, Mail Code 9156, Dallas, TX 75390-9156, Tel: 214-648-2818, Fax: 214-648-6700, william.turner@utsouthwestern.edu
Tyler, Douglas S., Duke University Medical Center, Box 3118, 240 Hanes House, Durham, NC 27710, Tel: 919-684-6858, Fax: 919-684-6044, tyler002@duke.edu
Tyson, Kenneth R.T., 601 Rocky Hollow Dr, Burnet, TX 78611-4103, Tel: 512-756-7591, kentyson@281.com

Underwood, Charles R., 598 Nancy Street, Suite 250, Marietta, GA 30060, Tel: 770-428-3713, Fax: 770-426-0730
Ungerleider, Ross M., Wake Forest Baptist Health, Medical Center BLVD, Winston-Salem, NC 27157, Tel: 336-716-1380, Fax: 336-716-1295, rungerle@wakehealth.edu
Upchurch, Gilbert R., Jr., University of Virginia, PO Box 800679, Charlottesville, VA 22908, Tel: 434-243-6333, Fax: 434-244-9430, gru6n@virginia.edu
Urist, Marshall M., University of Alabama at Birmingham, 1922 7th Avenue S, Suite 321, Birmingham, AL 35294-0016, Tel: 205-934-3065, Fax: 205-975-5971
Valentine, Rawson James, University of Texas Southwestern Medical Center, 5959 Harry Hines BLVD, Professional Office Building I, Suite 620, Division of Vascular Surgery, Dallas, TX 75390-9157, Tel: 214-645-2040, Fax: 214-645-0546, james.valentine@utsouthwestern.edu

*van Heerden, Jon A., 3039 Baywood Drive, Seabrook Island, SC 29455, Tel: 843-768-0532, vanheerden.jon@mayo.edu

*Van Trigt, Peter, III, 301 E. Wendover Avenue, Ste. 411, Greensboro, NC 27401, Tel: 336-832-3200, Fax: 336-832-3201, apvt18@gmail.com

*Vásconez, Luis O., University of Alabama at Birmingham, 510 20th St. South, (FOT-1102), Birmingham, AL 35294, Tel: 205-934-3245, Fax: 205-975-6155, luis.vasconez@ccc.uab.edu

Velazquez, Omaida C., University of Miami Miller School of Medicine, 1611 NW 12th AV, 3016 Holtz Building, Division of Vascular Surgery (R-310), Miami, FL 33136, Tel: 305-585-5284, Fax: 305-585-8569, ovelazquez@med.miami.edu

Vickers, Selwyn M., University of Alabama at Birmingham, 510 20th ST, South, Faculty Office Tower Floor 12, Birmingham, AL 35294, Tel: 205-934-1111, Fax: 205-975-6790, smv@uab.edu

Vitore, Gary C., University of Louisville School of Medicine, Department of Surgery, 550 South Jackson Street, Louisville, KY 40292, Tel: 502-629-2278, Fax: 502-629-7421, garyvitale@gmail.com

*Vogel, Stephen B., 3902 SW 77th Street, Gainesville, FL 32608

von Allmen, Daniel, Cincinnati Children's Hospital Medical Center, Division of General and Thoracic Surgery, 3333 Burnett Ave, MCL 2023, Cincinnati, OH 45229, Tel: 513-636-4371, Fax: 513-636-7657, daniel.vonallmen@cchmc.org

*Voyles, C. Randle, The Surgical Clinic Associates, P.A., 501 Marshall Street, Suite 500, Jackson, MS 39202

Walker, William E., 2831 Sackett Street, Houston, TX 77098, Tel: 713-520-0021, ww19@comcast.net

Walker, John Patrick, PO Box 481, Crockett, TX 75835, Tel: 936-544-7757, Fax: 936-545-0952, jpatrickwalker@rocketmail.com

*Wallace, Robert B., 1322 Darnall Drive, McLean, VA 22101, Tel: 703-356-4015, Fax: 703-356-1747, rbwallace@cox.net

*Wanebo, Harold J., Landmark Medical Center, 206 Cass Avenue, Woonsocket, RI 02895, Tel: 401-767-1595, Fax: 401-767-1508, hwanebo@rwmc.org

*Senior Members

†New Members
Wangensteen, Stephen L., 82 Red Bank Road, Rembert, SC 29128, Tel: 803-432-9490, Fax: 803-425-9631, stephen@hunterhorse.com

*Ward, C. Gillon, University of Miami Affiliated Hospitals, 3400 SW 27th AV, Apt #1505, Coconut Grove, FL 33133, Tel: 305-456-1646, gilward@mac.com

*Warshaw, Andrew L., Massachusetts General Hospital, Bullfinch 370, Boston, MA 02114, Tel: 617-726-8254, Fax: 617-726-1900, a_warshaw@partners.org

Weaver, William Lynn, Morehouse School of Medicine, Department of Surgery, 720 Westview Drive, Atlanta, GA 30310, Tel: 404-616-3562, Fax: 404-616-3091

*Webb, Watts R., 364 Windermere Boulevard, Alexandria, LA 71303, webbwatts@yahoo.com

*Weber, Collin J., Emory University School of Medicine, 5105 Woodruff Memorial Building, 101 Woodruff Circle, Atlanta, GA 30322, Tel: 404-727-0084, Fax: 404-727-3660, cweber@emory.edu

*Weirer, Leonard J., Jr., Eastern Virginia Medical School, Department of Surgery, 825 Fairfax Avenue, Ste. 610, Norfolk, VA 23507, Tel: 757-446-8950, Fax: 757-446-8951, weiretlj@evms.edu

Weiser, Martin R., Memorial Sloan Kettering Cancer Center, 1275 York AV, C1075, New York, NY 10065, Tel: 212-639-6698, Fax: 212-794-3198, weiser1@mskcc.org

*Wellons, Harry A., Jr., University of Virginia Medical Center, P.O. Box 800679, Charlottesville, VA 22908

*Wells, Samuel A., Jr., National Cancer Institute, Bethesda, MD 20892, wellss@mail.nih.gov

Westbrook, Kent C., UAMS Department of Surgery, 4301 W. Markham, Slot 520 UAMS, Little Rock, AR 72205, Tel: 501-686-5987, Fax: 501-686-5696, westbrookkentc@uams.edu

*Wheeler, Jock R., 801 Gilbert Circle, Virginia Beach, VA 23454

*Wheless, Clifford R., Jr., 1006 St. Georges Road, Baltimore, MD 21210, Tel: 410-323-9524, Fax: 410-323-9524

*Whelchel, John D., 52 Woodcrest Avenue N.E., Atlanta, GA 30309, Tel: 404-605-4600, Fax: 404-367-4447

*White, Raleigh R., IV, 619 N. 9th Street, Temple, TX 76501, rwhiteiv@gmail.com

*Wieman, Thomas Jeffery, Saint Lukes Cancer Institute, 4321 Washington Street, Suite 5100, Kansas City, MO 64111-5930, Tel: 816-932-6913, Fax: 816-932-9868, jwieman@saint-lukes.org

*Wilhelm, Morton C., 212 Montvue Dr., Charlottesville, VA 22901

*Williams, Carrington, Jr., 2300 Cedarfield Pkwy, Apt 414, Henrico, VA 23233

*Senior Members

†New Members
*Williams, G. Melville, Johns Hopkins Hospital, 611 Harvey Bldg., Baltimore, MD 21287, Tel: 410-955-5165, Fax: 410-614-2079
*Williams, Armistead M., 7 Bridgeway Road, Richmond, VA 23226, Tel: 804-282-8806
*Wilson, Wayne H., VA Medical Center, 1970 Roanoke Blvd., Mail Stop 658/112, Salem, VA 24153, Tel: 540-982-2463, Fax: 540-224-1961
*Wilson, John P., 8130 Cochran Mill Road, Palmetto, GA 30268, Tel: 770-463-0775, Fax: 770-463-5913
Wolf, Steven E., University of Texas - Southwestern Medical Center, 5323 Harry Hines BLVD, Dallas, TX 75390, Tel: 210-567-0468, steven.wolf@utsouthwestern.edu
*Wolfe, Walter G., Duke University Medical Center, Box 3507, Durham, NC 27710, Tel: 919-684-4117, Fax: 919-681-8912, wolfe001@mc.duke.edu
*Wolff, Bruce G., Mayo Clinic, Gonda 9-205, 200 First Street, SW, Rochester, MN 55905, Tel: 507-284-2472, Fax: 507-284-1794, wolff.brace@mayo.edu
Wolfgang, Christopher L., Johns Hopkins, 600 N. Wolfe ST, 685 Blalock, Baltimore, MD 21287, Tel: 410-502-4194, cwolfga2@jhm.edu
†Woltering, Eugene A., Department of Surgery, Louisiana State University, Health Sciences Center, 200 W. Esplanade, Ste. 200, Kenner, LA 70065, Tel: 504-464-8500, Fax: 504-464-8525, ewolte@lsuhsc.edu
*Wood, William C., Winship Cancer Institute, 1365C Clifton Road, NE, Room C5004, Atlanta, GA 30322, Tel: 404-778-3301, Fax: 404-778-4490, wwood@emory.edu
*Woolam, Gerald L., 4007 69th Street, Lubbock, TX 79413, Tel: 806-771-2222, Fax: 806-771-2224
*Wray, Charles H., 3115 Ramsgate Road, Augusta, GA 30909-3323, Tel: 706-736-6056, Fax: 706-736-3746, cwray@georgiahealth.edu
*Wren, Herbert B., III, 3 Pine Grove Place, Texarkana, TX 71854-7748
Wright, J. Kelly, Jr., Vanderbilt University Medical Center, 801 Oxford House, Nashville, TN 37232-4753, Tel: 615-936-0438, Fax: 615-936-0435, kelly.wright@vanderbilt.edu
Wynn, James J., University of Mississippi Medical Center, Department of Surgery, Division of Transplant Surgery, 2500 North State Street, Jackson, MS 39216, jwynn9154@gmail.com

Y

Yang, Stephen C., The Johns Hopkins Hospital, 600 N. Wolfe ST, Blalock 240, Baltimore, MD 21287, Tel: 410-614-3891, Fax: 410-614-9428, syang@jhmi.edu

*Senior Members
†New Members
Yeo, Charles John, Thomas Jefferson University, Department of Surgery, 1015 Walnut Street, Curtis Building, Suite 620, Philadelphia, PA 19107, Tel: 215-955-8643, Fax: 215-923-6609, charles.yeo@jefferson.edu
Young, Jeffrey S., UVA Health System, Department of Surgery, P.O. Box 800709, Charlottesville, VA 22908-0709, Tel: 434-982-3549, Fax: 434-924-2206, jsy2b@virginia.edu

Z

Zager, Jonathan S., Moffitt Cancer Center, 12902 Magnolia DR, SRB 4.24012, Cutaneous Oncology and Sarcoma, Tampa, FL 33612, Tel: 813-745-1085, Fax: 813-745-5725, jonathan.zager@moffitt.org
Zeiger, Martha A., Johns Hopkins University School of Medicine, 600 North Wolfe Street, Blalock 606, Baltimore, MD 21287, Tel: 410-614-1197, Fax: 410-502-1891, mzeiger@jhmi.edu
†Zenilman, Michael E., Johns Hopkins School of Medicine-Suburban Hospital, 8600 Old Georgetown Road, Bethesda, MD 20817, Tel: 301-896-6880, Fax: 301-897-2128, mzenilm1@jhmi.edu
Zervos, Emmanuel E., The Brody School of Medicine, Division of Surgical Oncology, 600 Moye Boulevard, Greenville, NC 27834, Tel: 252-744-4110, Fax: 252-744-5777, zervose@ecu.edu
Zibari, Gazi B., Willis Knighton / John C. McDonald Regional Transplant Center, 2751 Albert Bicknell ST, Suite 4A, Shreveport, LA 71103, Tel: 318-212-8932, Fax: 318-212-8356, gzbani@wkhs.com
*Zimmerman, Jack M., 830 West 40th Street, #103, Baltimore, MD 21211, Tel: 410-243-6614, Fax: 443-524-2130, djzim@jhu.edu
*Zinner, Michael J., Birgham and Women's Hospital, 75 Francis Street, Boston, MA 02115, Tel: 617-732-8181, Fax: 617-734-8353, pmtucker@partners.org
Zollinger, Richard William, II, 3701 Oldridge Court, Charlotte, NC 28226, Tel: 704-543-0122, Fax: 704-543-1782, r.zollinger@mac.com
*Zuidema, George D., 5 East 8th ST, #531, Holland, MI 49423, Tel: 616-355-4385, Fax: 616-355-4385
Zwischenberger, Joseph B., University of Kentucky, Department of Surgery, 800 Rose Street, MN 264 UKMC, Lexington, KY 40536, Tel: 859-323-6013, Fax: 859-323-1045, j.zwische@uky.edu

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GEOGRAPHICAL LISTING OF FELLOWS

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†Woltering, Eugene A.
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Zeiger, Martha A.
†Zenilman, Michael E.
Zimmerman, Jack M.

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Chaikof, Elliot L.
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Doherty, Gerard M.
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Johnston, J. Harvey
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McCraw, John B.
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O'Mara, Charles S.
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**MISSOURI**
Bochicchio, Grant V.
Brunt, L. Michael
Chapman, William C.
Eberlein, Timothy J.
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Friedell, Mark L.
†Gillanders, William E.
Holcomb, George W.
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Wieman, Thomas Jeffery

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Daugherty, Michael E.

NEBRASKA
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NEW HAMPSHIRE
Souba, Wiley W.

NEW JERSEY
Donahoo, James S.
Nance, Francis C.
Pruitt, Scott K.

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Asensio, Juan A.
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Blumgart, Leslie H.
Brennan, Murray F.
D'Angelica, Michael I.
DeWeese, James A.
Evans, James T.
Fong, Yuman
Guillem, Jose G.
Hochwald, Steven N.
Inabnet, William B.
Jarnagin, William R.
Jones, David R.
Michelassi, Fabrizio
Root, H. David
Rotondo, Michael F.
Schwartz, Seymour I.

NORTH CAROLINA
Adamson, Jerome E.
Albertson, David A.
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Anlyan, William G.
Bollinger, R. Randall
Brabson, John A.
Chang, Michael C.
Chitwood, W. Randolph
Clancy, Thomas V.
Clary, Bryan M.
Cunningham, Paul R.G.
Dean, Richard H.
DeMaria, Eric J.
Farrell, Timothy M.
Gerber, David A.
Greene, Frederick L.
Haisch, Carl E.
Hammon, John W.
Hansen, Kimberley J.
†Harland, Robert
Hayes, Daniel H.
Heniford, B. Todd
Herbst, Charles A.
Hill, Ronald C.
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Jones, Robert H.
Kim, Hong J.
†Kirk, Allan D.
Knight, T. T.
Kon, Neal David
Koruda, Mark J.
Leight, George S.
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Levine, Edward A.
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Spencer, Frank C.
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Weiser, Martin R.
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Maxwell, John Gary
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Meredith, J. Wayne
Meyer, Anthony A.
Mills, Stephen A.
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Oller, Dale W.
Ollila, David W.
Pappas, Theodore N.
Parker, Peter Emens
Pennell, Timothy C.
Pofahl, Walter E.
Pories, Walter J.
Reiling, Richard B.
Robicsek, Francis
Rohr, Michael S.
Seigler, Hillard F.
Shen, Perry
Shortell, Cynthia K.
†Stewart, John H., IV
Stickel, Delford L.
Stone, H. Harlan
Stratta, Robert J.
†Sudan, Debra
Sudan, Ranjan
Thomas, Colin G.
Thomason, Michael H.
Turner, Charles S.
Tyler, Douglas S.
Ungerleider, Ross M.
Van Trigt, Peter
Weeks, Paul M.
Wolfe, Walter G.
Zervos, Emmanuel E.
Zollinger, Richard William

**OHIO**
Alexander, J. Wesley
Edwards, Michael Joseph
Grobmyer, Stephen R.
Henderson, J. Michael
Hermann, Robert E.
Johannigman, Jay A.
Martin, Lester W.
Pollock, Raphael E.
Pritts, Timothy A.
Shuck, Jerry M.
Steinberg, Steven M.
von Allmen, Daniel

**OKLAHOMA**
Bender, Jeffrey S.
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Squires, Ronald A.
Thompson, C. Thomas
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Tunell, William P.

**OREGON**
Bulkley, Gregory B.
Trunkey, Donald

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Barker, Clyde F.
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Lewis, Frank R.
Malangoni, Mark A.
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Schwab, C. William
Strodel, William E.
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RHODE ISLAND
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Tracy, Thomas F.
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Adams, David B.
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Gauderer, Michael W.L.
Gregorie, Harry B.
†Hebra, Andre
Houck, William S.
Langan, Eugene M.
McAlhany, Joseph C.
Morgan, Katherine A.
Othersen, H. Biemann
Parker, Telfair H.
Russell, Hamilton Earle
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Taylor, Spence M.
van Heerden, Jon A.
Wangensteen, Stephen L.

TENNESSEE
Alford, William C.
Barker, William C.
Beauchamp, R. Daniel
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Cofer, Joseph B.
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Dart, Benjamin W.
Davidoff, Andrew M.
Edwards, William H., Jr.
Edwards, William H., Sr.
Fabian, Timothy C.
Filston, Howard C.
Garrett, Harvey Edward
Gobbel, Walter G.
Goldman, Mitchell H.
Guillamondegui, Oscar D.
Holcomb, George W.
Holzman, Michael D.
Ikard, Robert W.
Jacobs, J. Kenneth
Kelley, Mark C.
Langham, Max R.
LeSar, Christopher J.
Luce, Edward A.
Lynch, John B.
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Morris, John A.
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TEXAS
Andrassy, Richard J.
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Pellegrini, Carlos A.              

WEST VIRGINIA
AbuRahma, Ali F. WV               
Nakayama, Don K.                   
†Richmond, Bryan K.               

WISCONSIN
Foley, Eugene F.                   
Hussey, John L.                    
Kudsk, Kenneth A.                  
Rikkers, Layton F.
IN MEMORIAM

Carl Herman Almond, Florida

John Mann Beal, Georgia

Richard Jennings Field, Jr., Mississippi

Mario Gomez, Virginia

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