New England Surgical Society

Newsletter

Volume 5, Number 2 **Summer 2003**

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FROM THE PRESIDENT

Albert W. Dibbins, M.D.

The New England Surgical Society was organized in the winter of 1916 and held its first meeting in October of that year. In 2015 we, the Society, will become a centenarian. Wishing to celebrate this event, and hoping to avoid the infirmities of old age, the Executive Committee proposes to make two changes to the Constitution and By-laws at the Annual Meeting in October 2003, and to open a discussion with the Members on the basic structure of the Society.

The first change is to create a permanent Archives Committee which will begin to collate the material which the Society already has. This is currently housed in the Countway Library of Medicine. More importantly, the Committee would begin to collect histories and other material from current members of the Society in order to be able to prepare a centennial history. Since the by-laws provide for no Society committees except the Executive and Nominating (the Program Committee is an offshoot of the Executive), a new by-law is needed to create it. In addition this group will need funding and a great deal of member support.

The second change is to provide for an orderly succession among the officers

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Editor's Corner

We have the capability of producing a newsletter with 6 or 8 or even 16 pages. We are able to print abstracts of the papers to be given at upcoming Annual Meetings. We can print any number of illustrations and photographs. And we can provide space for any member of NESS to ventilate. While the President and President-Elect are expected to be serious, this ancillary column can take a lighter approach to matters. The Newsletter Editor is kicking things off with the following offering and would love to receive feedback, not to mention future contributions to this space. Edward Z. Walworth, M.D., Editor

About every newspaper or "trade publication" that comes across our desks these days has a gloom and doom message about surgery. One article that put it all together was the column in the New York Times on Tuesday, June 10, by Steven G. Friedman (director of a vascular surgery residency program) entitled "Anyone in the O.R.?" Dr. Friedman mentions the malpractice crisis, the debt incurred by medical students, the new limits on hours of surgical training, cutbacks in Medicare reimbursement, and the fact that fewer and fewer medical graduates are going into surgery. The American Board of Surgery, the American College of Surgeons and the NESS, among others, are confronting and addressing these issues, which cut to the core of who we are and what we do.

So just why did we decide to become surgeons in the first place? Each of us has the opportunity, knowingly or unconsciously, to influence medical or pre-medical students along their career paths. Perhaps if we think back to our own deci-

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FROM THE PRESIDENT (continued from page one)

of the Society in case of death or disability. If the Society continues to elect septuagenarians such as myself to office, there is a possibility that this could occur. Since there is no provision for this in the present by-laws, if the President were to die he would be succeeded by the Vice-President. The Executive Committee feels the nature of the Society is such that the President-elect should assume the Presidency and a new President-elect be chosen. Provisions are made also for assumption of the duties of the Secretary, Recorder, and Treasurer.

The exact texts of these by-law changes are in this Newsletter. They may be passed at this Annual Meeting only by unanimous vote of all members present. Since I believe that there should be no controversy about these bits of housekeeping, I would ask all members to approve the changes in September.

However, a wide discussion among the members needs to be held about changing the basic character of the Society. At present the Active membership is limited to 300. One passes to Senior status at age 60. At present we have 270 Active and 361 Seniors. Ten active members will become Senior this year and there are 26 nominations for new Active members. Over the next 5 years about 15 members each year will change to senior status. Thus, we are reaching a saturation point and will be able to add fewer new members. It is these new members who will carry the Society toward the next centennial celebration.

Any active member who is absent from three consecutive meetings without a valid excuse is automatically dropped from membership. At each Executive Committee Meeting, the Secretary presents a list of all members who have missed two consecutive meetings. In recent years this has regularly represented 20-25% of the Active members. This year in January I wrote to each member on the list inviting each to tell me the reason for non-attendance. I received many thoughtful answers. Some who practice a specialty exclusively (vascular, transplantation, pediatric, trauma-critical care, oncology) find themselves having to choose between the specialty societies and NESS and choose the specialty meetings because it is more relevant to their day to day practice. Others, who are broad based general surgeons, find that there is greater educational value at other surgical meetings, particularly with the plethora of surgical meetings which occur in the fall of each year. In all of these instances, the members continue to pay dues and come only every third year because they must and no one wishes to have the onus of being asked to leave the Society.

In the last Executive Committee meeting we began a discussion of the two problems, feeling that they needed to be considered together, and reached no consensus. Removing the ceiling on the number of members would allow us to bring more young surgeons into the Society. It would be more incumbent on the present members to choose new members whom they felt were truly interested in and wished to participate in the New England Surgical Society. If the requirement to attend at least every third meeting were withdrawn, it would allow those who felt that New England Surgical was no longer relevant to their practices to quietly "fade into the sunset" with no onus attached. Those who wished to come once every six years could do so but would still have to maintain their dues paying status and the Society would have an even better financial position than it does now.

After long consideration, my personal opinion is that we should do both. I speak only for myself and not the rest of the Executive Committee. We will discuss it again at the next Executive Committee meeting in September. Although the Business Meeting this year in Newport has been contracted to Sunday morning only, all reports will be written and unless there is a question about them we should be able to open a discussion about these issues. I look forward to seeing as many of you as possible in Newport and/or hearing from you before then either by e-mail (adibbin1@maine.rr.com) or through the New England Surgical Society office (900 Cummings Center, Suite221-U, Beverly MA 01915).

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sions, we can rekindle the enthusiasm and pass it on to the next generation.

For my own part, I entered Columbia medical school without any preconceptions, having no physician role models in my immediate family. Gross Anatomy was fascinating, but at the time I did not see myself putting bodies back together. Similarly, the "man in the pan" demonstrations in Pathology did not inspire me to be the person to resect those organs before the prosector got to them. Even the two week introductory course in surgery in my second year left me cold.

I think it was a night case during my longer third year rotation on surgery that really got me interested. A GI bleeder in the days before cimetidine and flexible EGD needed an emergency laparotomy. Late in the case there was, to my alarm, some further bleeding way up under the diaphragm. As I pulled on retractors extra hard, the senior resident calmly coped with the situation, placing sutures somewhere way up out of sight. Then after closing and writing orders we went off to the lab to plant the peritoneal cultures. This was late in the 1960's when scut work was the province of students and residents alike.

Throughout the whole evening, David Kinne (who has probably not seen a stomach for years) explained his every maneuver and decision. There were no daytime lectures or rounds to pull me away. That lengthy one-on-one exposure was impressive, so I began to think about a surgical training. There must have been other moments of inspiration along the way, but I think that night started it all for me.

The last time I got my medical school alumni magazine, the list of graduates going into general surgery was in the single digits. The term P & S has a certain ring to it; I just hope that Columbia hangs onto the "& S."

10th Annual Surgical Resident/Fellow Research Presentation Day

The 10th Annual Surgical Resident and Fellow Research Presentation Day was held on Friday May 16, 2003 at the New England Medical Center in Boston.

A wonderful combination of clinical and basic science papers were presented and the event was highlighted by a guest lecture by Michael Steer, M.D., Professor and Chief of General Surgery at Tufts New england Medical Center. His presentation, "The Surgical Scientist in 2003," gave the participants advice for the future and their career planning.

The on-going support of the New England Surgical Society, along with the Massachusetts, Connecticut, Vermont and Maine chapters of the ACS is greatly appreciated by all the residents and fellows who participate in this event. There were 17 papers presented from over 11 programs throughout New England.

1ST PRIZE - CLINICAL SCIENCE

Malachi G. Sheahan, M.D.
Beth Israel Deaconess Medical Center
Amputation-Free Survival After Lower Extremity Revascularization: The Adverse Impact of Even Moderate Renal Dysfunction
$1,000 award sponsored by New England Surgical Society

1ST PRIZE - BASIC SCIENCE

Patrick J. Casey, M.D.
Massachusetts General Hospital
Poly ADP Ribose Inhibitors Modulate Neurologic Injury, Mortality and Systemic Inflammation Following Thoracic Aortic Ischemia Reperfusion
$1,000 award sponsored by Massachusetts Chapter of the American College of Surgeons

2ND PRIZE - OVERALL

Tippi C. MacKenzie, M.D.
Brigham and Women's Hospital
Long-term Expression of Factor IX After In Utero Injection of Adeno-Associated Viral Vectors in Hemophiliac Mice
$500 award sponsored by New England Surgical Society

3RD PRIZE - OVERALL

Lynn Chang, M.D.
Children's Hospital
The Inhibition of Lymphangiogenesis by Tumor
$250 award sponsored by the Maine, Connecticut and Vermont Chapters of the American College of Surgeons

HONORABLE MENTION

S.H. Lee, M.D.
Breast Health Center at Brown University
The Risk of Breast Cancer After Delayed First Parity
$100 award sponsored by the Maine, Connecticut and Vermont Chapters of the American College of Surgeons

Watch Your Mail for Details on the

11th Annual Surgical Resident/Fellow Research Presentation Day

Friday, May 21, 2004
8:30 - 5:00

New England Medical Center, Boston

FUTURE MEETINGS of the NEW ENGLAND SURGICAL SOCIETY

2003 Annual Meeting	2004 Annual Meeting	2005 Annual Meeting
September 19 - 21	**October 1 - 3**	**September 30 - October 2**
Hyatt Regency	Hilton Montreal Bonaventure	Mount Washington Hotel
Newport, Rhode Island	Montreal, Quebec, Canada	Bretton Woods, New Hampshire

FROM THE PRESIDENT-ELECT

Whither (or Wither) the NESS?

Walter B. Goldfarb, M.D.

I would like to thank the Nominating Committee and the membership for my election as President-Elect of the NESS. Being a member of this society has meant a great deal to me both professionally and socially, and I am most grateful. The educational and social value of our meetings and the friendships and contacts formed within the community of New England surgeons has been an important and significant part of my life.

As the New England Surgical Society reaches the midpoint of its eighth decade, it seems an appropriate time for us, as an organization, to pause and take stock of ourselves (given the stellar history of the Society) and to reflect on where we are, and more importantly, where we are going. A look back at our history, with help from former president (1975) Dr. J.J. Byrne's interesting story of the first 50 years of the Society should be noted (with my appreciation for his help).

There seem to be some ominous changes occurring within the Society. The first relates to the diminishing active participation of the membership in the scientific program at the annual meetings. For example, of 22 abstracts submitted for the 2002 Annual Meeting, 8 were chosen for presentation. Panel discussions are interesting, educational, and often provocative but should not replace member participation which historically has been the backbone of the annual meeting.

There has been a continued decrease in the number of abstracts submitted, from between 70-85 in the not too distant past with the acceptance of 15-20 for presentation. Of the 8 scientific papers presented at the 2002 meeting, 5 were published in the "NESS dedicated" issue of *The Archives of Surgery* including one from Texas, the winning resident paper! This modest number of published contributions is somewhat embarrassing and does not reflect well on the health of our Society .The submission of 67 abstracts for the 2003 meeting hopefully suggests a reversal of this recent trend.

The importance of the presentation of papers by New England surgeons at the Society's Annual Meeting was emphasized in 1915 by Dr. Samuel Mixter- our founding president (as noted by Dr. William H. Bradford of Portland in 1926) on the 10th anniversary of the Society:

> *"They (the founders) sought the opinion upon the subject from surgeons of the highest standing in New England. The response was immediate and most enthusiastic. Finally they presented the whole proposition, together with the correspondence, to Doctor Samuel J. Mixter of Boston, who first hesitated to sanction the idea as Boston men were overworked and overstocked with society affiliations, then sensing the possibilities of pleasure and profit by meeting with these men at least once a year, agreed to help in the organization of a society and to become its first President. "Gentlemen: I am very much honored by the office that you have conferred upon me. Personally I am very glad to see the New England Surgical Society formed. I believe there is a place for it, although when the idea was first expressed it seemed to be doubtful, inasmuch as there already exists many surgical societies in and about Boston. The aims of this society, however, are more comprehensive. They have for their object a mutual intercourse, both scientific and social, among the surgeons of good standing throughout the New England states. When the surgeons of New England convene I feel that we can be assured of an instructive and profitable meeting, and, after all, the great value of medical meetings is to meet men, to know men, and to get their views. I have learned to attach great importance in apprising the value of a medical paper, by hearing the paper read and knowing something about the personality of the author. Therefore, I believe that we can make this a very useful society. In the selection of members we must choose those who will be productive in adding to the social and scientific value of the organization. The New England Surgical Society is formed and I am very glad to be your first President."*

With these words the course of the organization was set. To maintain the viability of the Society and to capitalize on the vast array of surgical talent of our members, much more active involvement in the scientific proceedings is both desirable and necessary. A good way to start would be to urge all of the training program directors in New England to encourage their residents, fellows and young faculty/staff to become involved by submitting abstracts, as our President Dr. Dibbins has done this year. More participation by community surgeons, who form a majority of the membership in the society should be encouraged.

As Dr. Byrne noted in 1966 regarding broad participation of the membership in the programs:

> *"As one reads the list of the programs which have been presented there is no question that the goal of promoting the science of surgery in New England has been well maintained. The speakers have ranged through the entire membership of the Society and represent some of the great voices of New England surgery in the past and present. It would be futile to list all the men who have aided in this important teaching aspect of the Society, but the national and international fame of many now deceased members who spoke on numerous occasions is obvious."*

One wonders, as did Dr. Mixter in 1915, whether subspecialization and its attendant commitments both to other societies and journals has been responsible for this recent decline. Is it possible that just plain inertia - "It's just too much trouble." in the busy practice of our surgeons -is at work? In any event I think it is a reversible process, but requires effort. Hopefully this year's increase in the number of abstracts represents a renewed interest and vigor.

Another area of concern is the increasing number of mem-

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From the President-Elect *(continued from previous page)*

bers who have missed 2 successive meetings. This past year 59 members, 20% of the active membership, are in this category. This is the largest number in my years as a member. The bylaws state 3 successive missed meetings and membership is forfeited. As a society we should not and cannot afford to lose members for this reason.

Why this is happening is not clear and it may be related to the first concern - decreased member participation in the scientific program. Certainly one feeds on the other. The annual meetings are planned so as not to conflict with other major events or surgical meetings.

The Executive and Program Committees continue to consider ways to make the annual meetings interesting, fun, and worth attending. In recent years membership has been increased, hopefully to get more people involved; the annual spring meetings have been discontinued; the monetary prizes for winning resident papers were increased substantially a few years ago; and an award to new members who present a paper, to be implemented this year, is yet another attempt to stimulate activity for the scientific program.

The recent discontinuation of assigned discussors of the scientific papers, and thus hopefully opening up the discussion to the whole floor, is another effort to broaden participation and increase member involvement.

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As Dr. Byrne noted since the Society's founding in 1916: *"The following 50 years of the Society has demonstrated that it has fulfilled all its founding functions. Subsequent transactions have not been as loquacious as the early ones and the flavor of each meeting has been lost to posterity. However, I can assure future readers of our history that the New England surgeons are a talented group, not only with regards to surgery, but to dining, wining, dancing, sporting and sport watching. There is no question that the social goals of the Society have been attained. Our recent meetings have lost some of the nostalgic appeal of the early meetings. Thus the New England Surgical Society has fulfilled its historic mission and its increased strength attests to the wise intention of its founding fathers. It will need all its historical stamina, coupled with foresight and wisdom, to meet the scientific, social and economic changes of the next half-century."*

This is a crucial time in the history of this venerable and honorable society, of which we all should be proud to be members. The continued viability, the commitment to excellence, and the maintenance of its honored history depends on the involvement and participation of the membership. The members of the Executive Committee solicit your thoughts on how to regain and sustain our vigor so we do not wither after all these years.

Looking Back: THE NESS 25 YEARS AGO

It was 1978. In mid-September President Jimmy Carter had hosted a meeting with Anwar Sadat of Egypt and Menachem Begin of Israel that concluded with the signing of the Camp David Peace Accords. In April, the American Surgical Association met in Dallas with Dr. David Sabiston as president. Dr. John Braasch reported on a 25-year experience at the Lahey Clinic with the procedure of "last resort" in chronic pancreatitis-total pancreatectomy. The series made up one half the total cases reported in the world literature up to that time. Dr. Mark Ravitch assured fellow members that his history of the ASA was coming along on schedule and that he would have it ready for the Centenary Meeting in 1980.

Dr. Frederick P. Ross concluded his presidential year with an address entitled, "Master Surgeon, Teacher, Soldier and Friend: Elliott Carr Cutler, M.D. (1888-1947). Dr. Ross, Cutler's last resident, spoke endearingly of his chief .....

The 59th Annual Meeting of the New England Surgical Society was held at the Balsams in Dixville Notch, New Hampshire, September 29th-October 1st. Dr. Frederick P. Ross of Fitchburg, MA concluded his presidential year with an address entitled, "Master Surgeon, Teacher, Soldier and Friend: Elliott Carr Cutler, M.D. (1888-1947). Dr. Ross, Cutler's last resident, spoke endearingly of his chief who was a New Englander from Bangor, ME. Graduating first in his class from Harvard Medical School in 1913, Cutler acquired surgical training at Peter Bent Brigham Hospital and at Massachusetts General Hospital as well as research experience at the Rockefeller Institute before entering the military in 1917. He was decorated for service in both World Wars by the U.S., Britain and France. For eight years he was Professor of Surgery at Western Reserve in Cleveland before assuming the Moseley Professorship of Surgery vacated by Harvey Cushing in 1932. Elliott Cutler died fifteen years later of prostate cancer. In a career pattern akin to Halsted's,

H. David Crombie, M.D.

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Looking Back

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many of his trainees went on to positions of leadership and international recognition in surgery, among them: Robert Zollinger, Carl Walter, J.E. Dunphy, Stanley Hoerr, Richard Warren, Dwight Harken, Francis D. Moore, David Hume, J. Hartwell Harrison and Joseph Murray. Dr. Ross was succeeded as president by Dr. John Brooks of Boston. Dr. John Reed of Hartford was named president-elect.

At the scientific meeting Connecticut was the host state for the Friday afternoon session. Eight papers were presented by Connecticut members, then fifteen more on Saturday and Sunday with a total of 23 appearing in the April 1979 issue of *The American Journal of Surgery*. Our current Secretary, John Welch, and then surgical resident, John Russell reported on 40 patients with radiation injury to small and large bowel from Hartford Hospital. Obstruction was the most frequent small bowel condition requiring surgery while hemorrhage was the most common indication for surgery on the colon damaged by radiation. Cogent comments were contributed by Drs. Dunphy and Brad Patterson.

Perhaps prompted by the presence of Dr. Klatskin on the Yale faculty, Dr. Elton Cahow reported on his experience performing a modification of the Longmire procedure-cholangio jejunostomy without hepatic resection- in a small series of patients with Klatskin tumors. Also from Yale, Drs. Geha and Baue examined patency rates in coronary revascularization with and without the use of internal mammary artery grafts. Dr. Paul Kuehn, in collaboration with a surgical resident, Dr. Philip Seaver, drew upon the Connecticut Tumor Registry database back to 1937 to review 93 cases of adenoid cystic carcinoma (cylindroma) of the salivary glands. At the time these lesions comprised 10% of salivary gland malignancies with a 50% local recurrence rate and a 15-yr cure rate of just under 20%.

Other highlights of the scientific sessions included a report from the plastic surgery divisions of the Boston Children's Hospital and Peter Bent Brigham Hospital on a ten-year experience with major soft tissue injuries in 31 patients resulting from extravasation of intravenous solutions by Drs. Upton, Mulliken and Murray. Clear guidelines for the prevention of these devastating injuries were provided. David Brewster and colleagues at Massachusetts General Hospital gave a detailed account of the use of intraoperative autotransfusion in vascular surgery patients. At the time techniques had been evolving for about ten years. The Cell-Saver was a new device. In another report, Dr. Blake Cady presented a 26-year experience with elective hepatic resections at the Lahey Clinic-48 cases. Appropriately, the lead discussant of this paper was Dr. James Foster whose monograph on solid liver tumors had been published the preceding year.

Sadly, after years of bringing his expertise and wisdom on this and many other subjects to this Society and to the surgical world, Dr. Foster died of pancreatic cancer on June 17, 2003.

James H. Foster, M.D. (1930 - 2003)

Dr. Crombie has eulogized his colleague, James H. Foster and the complete memorial will appear in the 2003 Annual Meeting Program Book. The following are some excerpts:

On June 17, 2003, Dr. James H. Foster, died at his home after a one-year struggle with pancreatic cancer.

Jim graduated from Haverford College in 1950 and from Columbia University College of Physicians and Surgeons in 1954. He received his surgical training at the University of Oregon School of Medicine under the tutelage, and the admiring eye, of the revered surgeon and medical humanist, J. Englebert Dunphy.

In 1966, Hartford Hospital recruited Dr. Foster to be its first full-time Chief of Surgery. Within a few weeks he started a Morbidity and Mortality Conference, replacing a desultory complications conference. As his first chief resident, I can attest that this was a fearsome undertaking: presenting each case, accounting for wound infections, IV site phlebitis, urinary retentions, anastomotic failures, and of course, every death on all services. Jim sat at the front of the room presiding, but never allowing an adversarial environment to be created.

Each resident knew he had a chief who was on educational and oversight mode 24 hours a day. Each attending surgeon knew he had a chief to whom he would be accountable for his patient care and for his role in education.

A semi-dormant research laboratory was expanded. Residents became engaged in basic and clinical research, presentations at regional and national meetings became commonplace, and publications appeared more frequently in the literature.

Then in 1974, Dr. Foster set for himself the task of enhancing the knowledge about solid liver tumors with the hope of guiding better surgical treatment and improving patient care. Jim Foster became an international authority on the management of liver tumors, lending his expertise for the care of patients in Connecticut, and appearing on panels and in the literature until his retirement from surgery in 1993.

As Chief of Surgery during the seventies, Dr. Foster was a strong proponent of close ties between Hartford Hospital and the fledgling University of Connecticut School of Medicine. To encourage the process, Jim decided to relinquish his position at Hartford Hospital in 1978 to become Professor and Chairman of Surgery at the medical school. He brought strength, integrity, and energy to the surgical program and to the institution.

Viewing his life in its entirety one sees an individual whose multi-talents were extraordinary in variety and depth: an accomplished athlete, surgeon, physician, editor, writer, poet, artist, traveler, philosopher, leader, friend, and sponsor of the efforts of so many others, yet habitually embarrassed when any accolades came his way. He made an indelible mark on family, friends, and colleagues and he will be missed.

H. David Crombie, M.D.

Highlights of the EXECUTIVE COMMITTEE MEETING

June 11, 2003 - Waltham, Massachusetts

Report of the President

Dr. Dibbins had sent letters to members delinquent in their required attendance at the Annual Meetings. Responses received noted concerns about the ability to actively participate in the discussions and the timing of the Annual Meeting. These concerns are being addressed by the Program Committee and modifications to the format are being considered.

Membership Statistics

Current membership totals 671 surgeons: 270 Active, 361 Senior, 38 Associate, and 2 Honorary Members. Ten active members are transferring to Senior membership in 2003, opening 40 slots for Active membership consideration.

Report of the Treasurer

Total assets were $176,716, reflecting an approximate $24,000 increase over the previous year for the same period. The 2002 Annual Meeting generated a surplus of over $18,000 in large measure to the savings on the President's Banquet. An annual budget for the 2003-2004 year will be prepared for the Committee's consideration at its next meeting.

Report of the Charitable Foundation

The Charitable Foundation will underwrite the cost of a $1,000 prize for the best New Member Presentation during the Scientific Session. The Program Committee recommended the institution of the New Member Prize category to encourage submission of more abstracts from new members. Members eligible for consideration are those members elected between the year of initiation and up to five years thereafter.

Report of the Recorder

Five of the eight papers presented at the 2002 Annual Meeting together with the President's Address and the transcripts of the two panels were published as manuscripts in the April 2003 editions of the *Archives of Surgery*.

Report of the Program Committee

Sixty-eight abstracts were submitted for consideration (compared to 26 in the previous year). The increase can be attributed to several factors including letters sent to all general surgery program directors and other program directors in the region by President Dibbins; the ability to submit abstracts online; and the addition of a New Member Prize category.

Selected were 8 papers for oral presentation and 3 papers for a new "How I Do It," a three minute brief report presentation. In order to accommodate the number of papers and brief reports for Friday and Saturday, the Program Committee agreed to maintain the oral paper presentation at ten minutes followed by eight minutes of discussion and to limit each brief report to three minutes.

An historical review of abstracts submitted, accepted for presentation, and accepted for publication dating back to 1997 showed a significant decrease in the number of papers accepted for presentation and publication. For future meetings, the Executive Committee will consider concurrent sessions of basic science papers and clinical papers, as well as a poster session.

Report of the Archives Committee

The Committee recommended the establishment of a centralized clearing house for the collection of material and artifacts relating to the Society as it prepares for its 100th Anniversary in 2016. A budget will be developed and reviewed to allow the Society to record oral histories and interviews with senior members to add to the archival materials.

A change to the Bylaws will be proposed to establish the Archives Committee as a standing committee.

New Business

The Executive Committee voted to elect Edward M. Kwasnik, M.D. of Waterbury, Connecticut to a six-year term as the Connecticut Representative to the Executive Committee and to elect Richard J. Barth, Jr., M.D. of Lebanon, New Hampshire to serve a six-year term as the New Hampshire Representative to the Program Committee.

NESS State Representatives

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Please contact your State Representative with any issues you wish to bring to the attention of the Executive Committee.

Preliminary Program Highlights of the 84th Annual Meeting of the New England Surgical Society

September 19-21, 2003 / Hyatt Regency, Newport, Rhode Island

Friday, September 19

9:00 a.m. - Postgraduate Course - Modern Management of Venous Diseases Workshop *(Joint Program with NESVS)*

SCIENTIFIC SESSION Chair: Nick P. Perencevich, M.D.

Results Of Thoracoscopic Sympathicotomy In the Treatment Of Hyperhidrosis

Eric G. Lowe, Philip D. Allmendinger, Barbara F. Gaughan, Jo-Ann Smith, Robert Lowe, University of Connecticut School of Medicine, Farmington, CT and Hartford Hospital, Hartford, CT

Objective: As a less invasive alternative to thoracoscopic sympathectomy, we have treated upper extremity hyperhidrosis with thoracoscopic sympathicotomy (TS) since 1999.We present detailed follow-up on our initial experience with this procedure. **Design:** Retrospective analysis. **Setting:** General thoracic teaching service at a tertiary referral center. **Patients:** 23 consecutive patients underwent 38 operations for hyperhidrosis. Mean age was 29 years (range 18-46 years). Mean follow-up was 22 months (range 1-43 months).

Interventions: Initial contact by mailed structured questionnaire, and secondary telephone follow-up by an independent investigator.

Main Outcome Measures: Effective control of presenting symptoms, frequency of side effects and effect on quality of life, and overall satisfaction with the procedure.

Results: 86% of operations effectively controlled presenting symptoms. Side effects rated as inconvenient or worse included: compensatory sweating 64%, excessive hand dryness 55%, gustatory sweating 45%, and post-operative pain 18%. There were no instances of ptosis. 18% of operations resulted in a new onset of sensitivity to cold in the operated arm. Overall satisfaction was 82%.

Conclusions: Despite significant side effects, TS in the treatment of hyperhidrosis was associated with good control of presenting symptoms and high levels of patient satisfaction. Compensatory sweating was the most common side effect and reason for dissatisfaction. The development of a significant cold sensitivity in the sympathicotomized arm is contrary to what would be expected physiologically and represents a previously undescribed side effect about which patients should be warned, and further study is warranted.

Papillary Thyroid Carcinoma: Predicting Outcome and Directing Therapy

Sendia Kim, John P. Wei, Paresh Shah, Joshua M. Braveman, Gerald J. Heatley, David M. Brams, Lahey Clinic, Burlington, MA

Objective: The prognosis of papillary thyroid carcinoma has been stratified into low and high risk groups. Patients in the high risk group can be sub-stratified based on increasing age with implications for prognosis and treatment. **Design:** Retrospective study. **Setting**: Tertiary care center. **Patients**: 727 patients with papillary thyroid cancer treated at Lahey Clinic from 1940 to 1998.

Interventions: Stratification into low and high risk groups based on Age, Metastases, Extent and Size. High risk patients sub-stratified into "extremely high risk" group: age greater than 60. Effect of surgery, lymph node dissection and radiation therapy examined. **Main outcome measures**: Recurrence and survival

Results: 458 patients (63%) were classified as low risk and 269 patients (37%) as high risk. 20 year survival: Low risk patients: 99.5%; High risk patients: 74% (p=0.0001). High risk patients had early survival advantage with bilateral thyroidectomy (p=0.0088), but this advantage was lost over time. High risk group: node dissection and radioactive iodine ablation had no effect on outcome. Recurrence was more common in high-risk than in low risk patients (19% vs. 4%). 50 high risk patients recurred: 86% mortality; 22 low risk patients recurred: 13% mortality. Extremely high risk patients older than age 60 (n=113): 20 year survival: 58%.

Conclusions: Papillary thyroid carcinoma in low risk patients had a favorable prognosis regardless of treatment. High risk patients who had total thyroidectomy had a short-term survival benefit. "Extremely high risk" patients' prognosis was unaffected by extent of surgery, radioactive iodine ablation or node dissection.

Major Lower Extremity Amputation: Outcome Of A Modern Series

Bernadette Aulivola, Chantel N. Hile, Allen D. Hamdan, Malachi G. Sheahan, Jennifer R. Veraldi, John J. Skillman, David R. Campbell, Sherry D. Scovell, Frank W. LoGerfo, Frank B. Pomposelli, Jr., Beth Israel Deaconess Medical Center, Boston, MA

Objective: Assess outcomes associated with major lower extremity amputation. **Design:** Retrospective database query and chart review- January 1990 to December 2001. Mean follow-up 33.6 months.

Setting: Academic tertiary care center. **Patients:** Nine hundred fifty-nine consecutive major lower extremity amputations in 788 patients, including 704(73.4%) below-knee(BKA) and 255(26.6%) above-knee(AKA). Amputation level based solely upon attending surgeons' clinical assessment. Co-morbidities include diabetes(DM) in 635(80.6%), coronary artery disease in 480(60.9%), end-stage renal disease(ESRD) in 133(16.9%).

Main Outcome Measures: Patient survival, cardiac morbidity, infectious complications, re-operation.

Results: Overall 30-day mortality was 8.6%, worse for AKA(16.5%) than BKA(5.7%) patients(P<.0001). Mortality was only 1.1% for over 4,200 concurrent lower extremity revascularizations. Thirty-day mortality for guillotine amputation for sepsis control was 14.3%, compared to 7.8% for closed amputation(P=.03). Complications included cardiac(10.2%), wound infection(5.7%), pneumonia(4.5%). Twelve AKA(4.7%) and 115 BKA(16.3%) limbs required re-operation. Only 47 BKAs(6.7%) required conversion to AKA(average 77.1d post-operatively). Overall survival- 69.7% and 34.7% at 1 and 5 years, respectively. Survival significantly worse for AKA(50.6% and 22.5%) than BKA(74.5% and 37.8%)(P<.0001). DM, ESRD predicted worse prognosis. Survival in diabetics 69.4% and 30.9% vs. 70.8% and 51.0% in non-diabetics at 1 and 5 years(P=.002). Survival in ESRD 51.9% and 14.4% vs. 75.4% and 42.2% in non-renal failure patients at 1 and 5 years(P<.0001).

Conclusion: Major amputation continues to result in significant morbidity and mortality. Survivors with BKA require revision or conversion to AKA infrequently, even when level is determined by clinical assessment alone. Long-term survival is dismal for patients with DM, ESRD and those undergoing AKA.

BRIEF REPORT (QUICK SHOTS) SESSION

Chair: Thomas A. Colacchio, M.D.

Small Intestinal NSAID Injury - Identification By Videocapsule Endoscopy and Seven Cases Of Surgical Intervention

Perry A. Soriano, Doug Schneider, Laura Toth, Roger Mitty, David R. Cave, Renee Wolff, St. Elizabeth's Medical Center and New England Medical Center, Boston, MA *Sponsor: Marvin J. Lopez, M.D.*

Objective: To report seven operative cases of small intestinal injury identified by videocapsule endoscopy. **Design:** Consecutive case series.

Setting: Two institutions, an academic-affiliated community-based referral center and a tertiary academic center.

Patients: 200 patients referred for evaluation of obscure GI bleeding or intractable abdominal pain. 11 patients identified with NSAID-induced small bowel injury. 7 patients underwent surgery. 4 were managed conservatively.

Interventions: Videocapsule endoscopy was used to identify the lesions. Exploratory laparotomy with intra-operative enteroscopy and small bower resection was performed in 6 patients. One patient uderwent resection without intra-operative enteroscopy. NSAIDS were discontinued in 10 of 11 patients.

Main Outcome Measures: All 11 patients had resolution of GI bleeding.

Results: In all 11 patients strictures with ulcers were found at the time of laparotomy. From one to as many as 23 strictures were identified per patient. Six of seven surgical specimens showed strictures with one specimen unconfirmed by histolgy.

Conclusion: NSAID injury is effectively identified by videocapsule endoscopy and may be more common than previously expected. Intraoperative enteroscopy is recommended at the time of surgery to identify all strictures.

Experience With Cryopreserved Cadaveric Femoral Vein Allografts Used For Hemodialysis Access

Robert L. Madden, George S. Lipkowitz, Barry J. Browne, Aleksandr Kurbanov, Baystate Medical Center, Springfield, MA and Tufts University School of Medicine, Boston, MA

Objective: Review patency and complications of cryopreserved vein grafts for dialysis access, and to compare to concurrent group with polytetrafluoroethylene (PTFE) grafts. **Design:** Retrospective chart review. **Setting:** Tertiary referral center. Group of 4 experienced access surgeons. **Patients:** From Sept. 1999 – Nov. 2002, patients without adequate vasculature for native fistula were implanted with cryopreserved vein or PTFE graft at surgeon's discretion. Cryopreserved veins were reserved for patients with infection, clotting of previous PTFE grafts, steroids or chronic hypotension. Only cryopreserved (CRY) veins were used until Jan. 2001 when decellularized, cryopreserved Synergraft (SYN) veins became available. All patients receiving a cryopreserved vein in upper extremity were included: CRY group - 48 patients, SYN group - 42 patients. Control group: 100 patients randomly selected from billing records listing PTFE insertion from Sept 1999 – Dec. 2001. Mean follow-up: CRY – 13 mos, SYN – 12 mos, control – 16 mos. **Interventions:** Performed by surgeons or interventional radiologists. **Main Outcome Measures:** Primary, assisted primary, secondary patency. **Complications:** infection, aneurysm, steal syndrome. **Results:** Demographics were similar. The procedure was first access for 86% of controls, but for only 50% of CRY&SYN patients ($p<0.0001$). Primary, assisted primary and secondary patency were not significantly different at 1 or 2 years between groups ($p>0.05$). Complications: control vs CRY&SYN – infection 10%vs0% ($p<0.04$), aneurysm 2%vs18% ($p<0.001$), steal 12%vs12% ($p>0.05$). **Conclusions:** Despite being placed in higher risk patients, cryopreserved veins had similar patency to PTFE. Veins were more resistant to infection but significantly more prone to aneurysms than PTFE.

Pancreatic Head Excavation: A Variation on the Theme of Duodenum-Sparing Pancreatic Head Resection

Dana K. Andersen, Mark D. Topazian, UMass Memorial Health Care, Worcester, MA and Yale University, New Haven, CT

Introduction: Duodenum-sparing pancreatic head resections include the subtotal resection with end-to-end pancreaticojejunostomy (Beger) or the extended dochotomy with side-to-side pancreaticojejunostomy (Frey). Although both offer short-term pain relief for chronic pancreatitis, the Beger morbidity is similar to the Whipple procedure, and the Frey procedure is associated with symptomatic recurrence. We sought a method which incorporated the more definitive subtotal removal the proximal gland, but which retained the low morbidity of a single side-to-side pancreaticoenterostomy.

Methods: Excavation of the entire proximal ductal system was performed using the Cavitron Ultrasonic Aspirator (CUSA). The capsule of the pancreatic head was left intact superiorly, posteriorly, and inferiorly, and the periductal parenchyma was removed. A single side-to-side Roux-en-Y pancreaticojejunostomy was used. **Results:** Excavation of the proximal ductal system was accomplished without incident in four patients (3 with chronic obstructive pancreatitis and one with IPMT). No patient required transfusion or ICU care. All patients enjoyed an uncomplicated postoperative course, resumed an oral diet in 3 – 4 days, and were discharged home in 6 – 8 days. All have been asymptomatic in the 0.5 - 2 years since operation.

Conclusion: The CUSA allows for a controlled excavation of the subcapsular portion of the pancreatic head, with visualization of the distal common bile duct and the ampulla. A capsular margin of sufficient thickness to support a full-thickness, two-layer pancreaticojejunal anastomosis is achieved. Our initial experience reveals the absence of complications, and an improved cost and outcome of the procedure compared to more extensive resectional methods.

SCIENTIFIC SESSION — Chair: James C. Hebert, M.D.

Is Completion Lymphadenectomy Following A Positive Sentinel Lymph Node Biopsy For Malignant Cutaneous Melanoma Always Necessary?

Nahel Elias, Kenneth K. Tanabe, Arthur J. Sober, Michele A. Gadd, Martin C. Mihm, Barrett Goodspeed, Anthony B. Cosimi, Mass. General Hospital, Boston, MA

Objective: Lymphatic mapping for sentinel lymph node (SLN) biopsy has become the accepted staging method for regional nodes in patients with cutaneous melanoma. Completion lymph node dissection (LND) has usually been recommended following positive SLN biopsy to eradicate further metastases in non-sentinel nodes. Some investigators have suggested that selected patients with positive SLN(s) (e.g. those with negative non-sentinel nodes also included in the initial specimen) are at minimal risk for additional metastases, and may not require completion LND.

Design: Retrospective review of pathology specimens.

Setting: University affiliated tertiary care referral center.

Patients: Between January 1997 and April 2003, over 700 consecutive patients underwent SLN biopsy for staging primary cutaneous melanoma.Intervention: SLN biopsy identified 85patients (approximately 12%) with metastatic melanoma, of whom 77 underwent LND.

Results: 48 patients had negative non-sentinel nodes also included in the initial SLN specimen, 5(10.4%) of these had further positive nodes on completion LND. 29 patients had only positive nodes (1-3) at initial SLN biopsy. 7(24.1%) of these had further metastases on LND, a statistically significant difference ($p=0.02$).

Conclusion: Although no evidence of metastatic melanoma was found on completion LND in most patients in whom negative non-sentinel nodes had been removed with positives SLN(s) at the initial biopsy, 10% of these patients did have further metastases. This review has confirmed that this subgroup of patients (positive SLN(s) and negative non-sentinel nodes in the initial SLN biopsy) is at significantly lower risk for further metastasis, but completion LND cannot be safely omitted even for these patients.

Renal Transplant Survival From Older Donors: A Single Center Experience

Paul E. Morrissey, Reg Gohh, Angelito Yango, Amitabh Gautam, Anthony Monaco, Rhode Island Hospital, Providence, RI

Objectives: Although kidney transplantations from older donors have an increased risk of failure, the percentage of kidney donors older than 55 years has increased every year since 1990. We compared allograft outcomes from older (55-77 year old) versus younger (18-54 year old) donors.

Design: Retrospective cohort review with three year follow-up.

Setting: Academic transplant center.

Patients: Consecutive recipients (n=374) of renal transplants from adult donors.

Interventions: Patients were divided into four groups based on donor status: living versus cadaver donor and young versus elderly donor.

Main Outcome Measures: Allograft survival and function, incidence of acute rejection.

Results: Recipients of older donor kidneys were significantly older (56.3 years versus 45.3 years, $p<0.01$). Ten allografts (17 %) failed from 58 transplants from donors greater than 55 years old compared with 40 allografts (13 %) from 316 younger donors (p=NS). Death with a functioning allograft occured in 7/58 and 31/316 recipients from older and younger donors, respectively (p=NS). Renal function did not differ between the groups. Allograft survival at one, two and three years, censored for death with function, did not differ when comparing older versus younger donors (see table).

Group	N	Mean Donor Age	Mean Recip. Age	Mean Creat. (mg/dl)	Length of stay (days)	Acute Rejection	DGF (%)	Graft Survival 1-year	Graft Survival 2-year	Graft Survival 3-year
LD 18 - 54	155	38 years	43 years	1.49	6.25	23 %	2 %	100	100	99
LD over 55	16	59	52	1.61	6.07	12 %	6 %	100	100	100
CD 18 - 54	161	34	45	1.50	9.24	16 %	22 %	98	96	94
CD over 55	42	64	56	1.69	10.4	17 %	26 %	98	98	95

LD=living donor, CD=cadaver donor, Creat.=current creatinine, DGF=delayed allograft function, Survival=allograft survival censored for recipient death with function.

Conclusion: The majority of patients receiving allografts from older donors do well. The transplant success rate, censored for death-with-function, is greater than 95%. Kidney transplantation using older donors does not confer an increased mortality or adversely affect renal transplant function.

(continued on next page)

The Cost Of Operative Training For Residents

Timothy J. Babineau, James Becker, Gary Gibbons, Steven Sentovich, Donald Hess, Sharon Robertson, Michael Stone, Boston Medical Center, Boston, MA

Objective: We compared the operative times of academic surgeons performing 4 common surgical procedures before and after the introduction of a PGY III resident into a community teaching hospital.

Design: Retrospective review of prospectively collected data. During the study period, both surgeons and residents were blinded as to the study's intent.

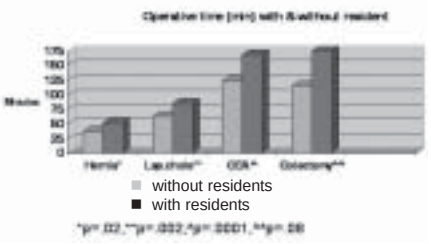
Setting: Community hospital recently integrated into a tertiary medical center system.

Participants: Four academic surgeons operating in the community setting and all patients undergoing 1 of 4 surgical procedures (ing. hernia, lap.chole., colectomy, carotid endarterectomy) from the period 1/1/01 through 3/31/03.

Intervention: The introduction of a PGY III resident into a community hospital.

Main Outcome Measures: Average increased operating time incurred through training a PGYIII resident on 1 of 4 common surgical procedures.

Results: Between 1/1/01 and 6/30/02 four academic surgeons operated without a resident in a community hospital. During that period surgeons operated alone (hernia) or assisting one another (lap. chole.,colectomy, CEA). From 7/1/02 through 3/31/03 these same 4 surgeons were assisted by a PGY III resident on similar cases.



For 3 of the 4 operative cases there was a significant increase in the operative time. (Table) With an OR cost estimate of $20/minute, this increased time increased costs by $300, $460, $880 and $1200 per case respectively.

Conclusions: We conclude that there is a significant increase in OR time and cost associated with the training of a PGY III resident.

Joint Session with NESVS - JUDAH FOLKMAN LECTURE

STATE CAUCUS MEETINGS

Saturday, September 20

SCIENTIFIC SESSION Chair: Thomas F. Tracy, Jr., M.D.

Thirty-Five Year Institutional Experience With End-To-Side Repair For Esophageal Atresia

Robert J. Touloukian, John H. Seashore, Yale University School of Medicine, New Haven, CT

Objective: End-to-end repair(E-E) with division of the tracheoesophageal fistula (TEF) is the standard of care for esophageal atresia (EA) but is accompanied by high rate of anastomotic stricture and gastroesophageal reflux (GERD) requiring modified fundoplication. Our institution has utilized the end to side repair(E-S) with ligation of the TEF to determine whether the risks of stricture and reflux could be reduced. **Design:** Case series with historical controls.

Setting: University Children's Hospital.

Patients: 96 infants with EA and distal TEF between 1968 and 2003.

Interventions: End-to-side repair with ligation of the TEF.

Main outcome: Patients were studied for overall survival, surgical complications and well-being during the first year of life compared to reports from the literature of E-E and division of the TEF.

Results: All as percent in E-S vs E-E patients. Survival was 92 vs.90; anastomotic leak 11 vs. 10; recurrent TEF 7 vs. 5; anastomotic stricture (requiring dilatation) 5.5 vs. 20; GERD requiring operation 6.5 vs. 20; esophageal dysmotility 75 vs. 90. Tracheomalacia related respiratory symptoms decreased from 50% to 11% at one year of age. Age-appropriate diet was achieved in 93% by one year; 5% experienced occasional dysphagia or choking episodes.

Conclusions: The end-to-side operation is accompanied by reduced rate of stricture and GERD requiring surgical correction compared to end-to-end repair. Earlier concerns regarding an unacceptable risk of recurrent TEF were not substantiated.

Role Of MRI Mammography In the Surgical Management Of Breast Cancer

Frederick H. Bagley, Sr., Rutland Regional Medical Center, Rutland, VT

Objective: to determine how MRI mammography affects surgical decision making in management of breast cancer.

Design: retrospective review of MRI mammography compared to mammography in 27 breast cancer patients.Setting : rural community hospital.

Patients: consecutive sample of patients with breast cancer who underwent prebiopsy or preoperative MRI mammography.

Intervention: surgical management of breast cancer.

Main outcome measure: prebiopsy or preoperative MRI mammography changed surgical management in 14/27 (52%) breast cancer patients by discovering more extensive cancer or multicentric cancers.

Results: MRI mammography using a GE 1.5 LXI with bilateral breast coils and dynamic gadolinium enhancement (Kaiser technique) was used on 237 patents who met high risk criteria over two years. Seven (7) patients with positive FNA biopsies of palpable masses had preoperative MRI; in 6/7 (84%), ipsilateral abnormalities (more extensive cancer or multifocal cancers) were discovered on the MRI that necessitated mastectomy rather than the desired breast conservation. Nineteen (19) patients had Category 4/5 mammograms. Five of these patients had stereotactic biopsies followed by MRI; 4/5 (80%) had changes on the MRI that required mastectomy rather than breast conservation. Fourteen (14) of these patients had MRI prior to their stereotactic biopsy; 4/14 (28%) had MRI abnormalities that required mastectomy. One patient had contralateral multicentric cancers not seen on mammography, necessitating bilateral mastectomies.

Conclusion: MRI mammography immediately prior to biopsy (based on Category 4/5 mammography) or immediately after FNA or stereotactic biopsy altered surgical management in 14/27 (52%) of breast cancer patients.

PANEL DISCUSSION - "Obesity"

Moderator: Peter N. Benotti, M.D.

Panelists: Kenneth W. Burchard, M.D., John J. Kelly, M.D. and Bruce A. Thayer, M.D.

PANEL DISCUSSION - "Open Abdomen"

Moderator: Rocco Orlando, III, M.D.

Panelists: Virginia A. Eddy, M.D., Lenworth M. Jacobs, Jr., M.D. and Wayne K. Stadelmann, M.D.

WHAT'S NEW LECTURE: SURGICAL TREATMENT OF MELANOMA

Kenneth K. Tanabe, M.D.

Sunday, September 21

ANNUAL BUSINESS MEETING (Members Only)

PRESIDENTIAL ADDRESS

Albert W. Dibbins, M.D.

ANNUAL SAMUEL JASON MIXTER LECTURE

David L. Nahrwold, M.D.

JOINT SESSION – ISSUES PANEL

Looking for your partner in the next decade. The recruitment and retention of quality young surgeons for both general and vascular surgery.

Moderator: Mark F. Fillinger, M.D.

Panelists: James C. Hebert, M.D., Edward M. Kwasnik, M.D., Frank W. LoGerfo, M.D., William C. Mackey, M.D., David L. Nahrwold, M.D., Erin Rowell, M.D. and Sherry Scoville, M.D.

NESS SOCIAL EVENTS

GOLF

Bring your clubs for the Golf Tournament, Saturday afternoon, September 20th. Staggered tee-times will be starting after 1 pm. Boxed lunches will be included in the registration fee along with greens/cart fees. Club rentals are an additional cost.

HARBOR TOUR

Enjoy a 3-hour sail through Newport Harbor and parts of Narragansett Bay aboard a classic schooner. Refreshments are available on board.

MANSIONS TOUR

Guided Tour of Newport & The Elms Mansion on Saturday, September 20th from 9:00 a.m. to 12:00 p.m. This narrated tour includes the colonial section, with its many authentic historical buildings and restored homes, the world famous Ten Mile Ocean Drive, and the magnificent collection of homes along Bellevue Avenue, where the millionaires built their fabulous "summer cottages". After the tour of Newport, the group will stop at The Elms. This magnificent summer residence of Mr. and Mrs. Julius Berwind was modeled after the mid-18th century French chateau d'Asnieres, and completed in 1901 at an estimated cost of $1.4 million. The grounds include Classical Revival gardens with terraces, scuplture, a park of fine specimen trees and more.

RESTAURANTS AND MORE…

We recommend you visit www.newportguide.com for sightseeing, shopping, recreation and dining suggestions. Friday night is a free evening. If you are staying in the Newport area, we encourage you to make your plans early, as Newport is very popular this time of year.

Dining in Newport

Our Critic's Picks.....

Canfield House, 5 Memorial Boulevard, (401) 847-0416

Christie's, 351 Thames Street, (401) 847-5400

Clarke Cooke, Bannister's Wharf, (401) 849-2900

La Forge Casino, 186 Bellevue Avenue, (401) 847-0418

Mooring Restaurant, America's Cup Avenue, (401) 846-2260

The Black Pearl, West Pelham Street, (401) 846-5264

The Landing Restaurant, 30 Bowen's Wharf, (401) 847-4514

White Horse Tavern, 26 Marlborough Street, (401) 849-3600

Social Events and Happenings in Newport .....

Rich in history, Newport prides itself on being a vibrant community offering a wide variety of events and activities all year-round. Newport offers you a picturesque location to relax and enjoy.

This unique island community blends the old and the new - colonial homes stand feet away from modern condominiums and offices. The bustling harbor glistens as elegant yachts, luxury liners and lobster boats compete for space. All of these are the charm that is Newport.

The Cliff Walk along the eastern shore is world famous as a public access walk that combines the natural beauty of the Newport shore line with the architectural history of Newport's gilded age.

Famed Bellevue Avenue is home to many of Newport's lovely Mansions. A trip to Newport is not complete without a tour of the Astors' Beechwood, Belcourt Castle, The Breakers, Chateau-Sur-Mer, The Elms, Marble House, & Rosecliff...to name but a few!

"Newport's Sporting Mansion", the International Tennis Hall of Fame on Bellevue Avenue, was the site of the first U.S. National Championships in 1881. The Hall of Fame has been host to the best tennis players in the world ever since. Tennis History comes alive in the world's largest tennis museum - a visual and interactive experience where visitors test their tennis savvy in displays that combine video, live action and touch screen technology. Fifteen galleries are filled with memorabilia from yesterday's champions through today's superstars.

For a more complete and detailed listing of restaurants and other attractions in the Newport area, please visit the following websites: www.newportguide.com and www.newportri.com.

PROPOSED BYLAW CHANGES

To be read and voted on at the Annual Meeting

Article III Officers - Section a.
To replace the sentence beginning..*During any vacancy or disability..*

If a vacancy occurs in the Office of the President, the duties of the President shall be assumed by the President-elect for the remainder of the vacated term. The President-elect will ask the Nominating Committee to select both a President for the succeeding year and a new President-elect at the subsequent annual meeting of the Society. If the President becomes disabled , the duties of the President will be assumed by the President-elect until the period of disability is over. If a vacancy occurs in the Office of President-elect, the President will ask the Nominating Committee to select a new President-elect and succeeding President- elect at the next annual meeting of the Society.
If a vacancy or disability occurs in the Offices of Secretary, Recorder, or Treasurer the President will assume the responsibility of the Office until the Nominating Committee chooses a new Secretary, Recorder, or Treasurer at the next annual meeting of the Society. The President may ask the President-elect to assume a portion of the responsibility by mutual agreement.

ARTICLE VIII (change present Article VIII to IX)

ARCHIVES
The archives of the Society will be assembled, maintained, and collated by the Archives Committee. The Chairman of the committee shall be appointed by the Executive Committee. Members of the committee shall be chosen by the Chairman. The Committee will prepare anniversary histories of the Society as appropriate.

84TH ANNUAL MEETING

September 19-21, 2003

Hyatt Regency, Newport, Rhode Island

SEE INSIDE FOR....

Complete Abstracts of the Papers being presented during the Annual Meeting

Social Events and Happenings during the Meeting

NEWPORT Area Attractions and Sites

New England Surgical Society
900 Cummings Center, Suite 221-U
Beverly, MA 01915

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