The McGill Department of Surgery Planning Committee held its first meeting on November 21st, 1994 to organize the Department of Surgery "Retreat" which was held on January 7th, 1995 in the McIntyre Medical Sciences Building. The Executive Committee of the McGill Department of Surgery under its Chairman, Dr. David S. Mulder, formed a Planning Committee which consisted of Dr. Mostafa Elhilali (Chair), Dr. Gerald Fried, Dr. Carl Nohr, Dr. Claude Gagnon, Dr. Jean-E. Morin, Dr. Carolyne Kerrigan, Dr. Dante Marchesi, Dr. Francois Fassier, Dr. Kenneth Shaw and Dr. Judith Trudel.

The Department of Surgery as all other McGill departments is faced with an 18 to 20% budgetary cut at the university level and an equivalent or perhaps larger cut at the hospital level. There has also been active planning related to the concept of a McGill University Hospital Centre (M.U.H.C.). Planning thus becomes a very dynamic process and it was felt that this could be better accomplished by annual planning sessions with broad participation. The McGill Department of Surgery has used the Forward Planning Report prepared by Dr. H.B. Williams in October of 1991 as a baseline beacon in this regard.

The January 7th Planning Session commenced at 8:30 a.m. with Dr. Mulder welcoming more than 130 participants from the Department of Surgery and representatives from Nursing and representatives of Administration from all participating hospitals. Mr. Boyd Whittall attended, representing the Board of Governors of the new McGill University Hospital Centre. Dean Richard Cruess gave a brief historical review of his tenure as Dean and his intimate relationships with the Department of Surgery, and outlined his vision for the future of the Faculty of Medicine at McGill. Mr. Gerard Douville then talked of the current budget difficulties, of the changing demographics in Quebec, and of the state of planning of the University Hospital Centre, including a newly structured board.
Dr. Gilbert Pinard, Chairman of the McGill Faculty of Psychiatry, chaired a recent Department of Surgery Cyclical Review which had as its external examiner, Dr. Bernard Langer from the University of Toronto. He presented the "report card" to the group and emphasized that overall the McGill Department of Surgery continues to perform at a high level. He discussed several of the areas where the cyclical review process suggested change, one of these related to Governance, one to Surgical Education, and one related to representation of the Executive Committee. This provided a good background for the group to break out into five workshops which were coordinated by animators as follows:

**Governance:** G. Fried and M. Elhilali  
**Research:** C. Gagnon and C. Kerrigan  
**Practice Plan:** J. Trudel and K. Shaw with Dr. Gilbert Pinard as a resource person.  
**Surgical Education:** C. Nohr and F. Fassier  
**Centres of Excellence:** J. Morin and D. Marchesi

Each break out session saw lively and innovative discussions during which there was a broad grassroots participation. The tenor of discussions was constructive and positive, and there appeared to be a genuine mood for change.

After a buffet luncheon, Dr. Duncan Sinclair, Dean of the Faculty of Medicine of Queen’s University spoke on Alternative Funding - The Dean’s Perspective. He was followed by Dr. Peter Brown, who is the Acting Chairman of Queen’s University Department of Surgery, who addressed the practical implications of such a plan for a department of surgery. This provided a provocative viewpoint from one Canadian university who has chosen an innovative method to funding the Faculty of Medicine in a manner appropriate to its local situation.

At 14:30, all of the animators presented a brief report. Minutes of these reports were kept and will form the basis for action groups of the Planning Committee.

From the Research point of view, Dr. Carolyn Kerrigan reported that the McGill Department of Surgery ranked high in terms of laboratory research and needed to improve in the area of clinical research. Her work group also pointed to the need for a central organization and planning committee, and in general supported the 1991 recommendations for the creation of a department or division of surgical research.

Dr. Carl Nohr presented the viewpoint of Surgical Education and provided a current overview of teaching activities as they now exist. He discussed some of the important issues, such as mechanisms for rewarding teachers for accomplishments, and development of methods to improve teaching skills amongst the faculty. There was general support for the concept of surgical education being a career pathway for academic advancement in the Department of Surgery. Suggestions were made regarding mechanisms to consolidate surgical teaching.

Dr. Jean-E. Morin presented the Centres of Excellence workshop. The McGill Department of Surgery should take a proactive role in this via the Planning Committee as now chaired by Dr. Elhilali in conjunction with the Medical Advisory Committee of the McGill University Hospital Centre.

The Practice Plan workshop was presented by Dr. Judith Trudel. It was pointed out by the Dean that the establishment of the Practice Plan is one of the key criteria to be recognized as a university hospital centre in Quebec. There was general agreement that a pro-active discussion on a practice plan should be pursued. Dr. Trudel emphasized the basic principles of their workshop, that the Practice Plan should be transparent and controlled by a management committee with representation from all members. It should be specialty based and there was a tendency to suggest that until the McGill University Hospital Centre evolves, that it should be hospital based. The final recommendation was that each surgical discipline begin a pro-active practice plan appropriate for its specialty, coordinated by the McGill Department of Surgery and meeting Faculty of Medicine guidelines.

The Governance workshop was presented by Dr. Gerald Fried, and again there were very significant discussions which took place related to current organizational structures; the controversy versus department and divisional status; the role of other allied surgical groups; and the concept of a university based approach for every surgical discipline and co-ordination by a University Department of Surgical Sciences. The important recommendation was the formation of a Task Force which would come up with a recommendation regarding governance which would result in hospital concordance, which would be university based, which would examine all items of governance including representation in the McGill Department of Surgery Executive Committee.

The McGill Department of Surgery Executive Committee has met since the retreat and instituted an "Action Plan". The first item relates to a small working committee chaired by Dr. Mostafa Elhilali, and including Dr. H.B. Williams, Dr. Gerald Fried, Dr. Nelson Mitchell with the strong input of Dean Crueess to come up with a proposal related to governance which would embody many of the discussion points from the retreat. The Department of Surgery will actively participate in the Medical Advisory Committee of the M.U.H.C.
The Department of Surgery Retreat should be congratulated on its enthusiastic participation. The current fiscal realities and change related to the McGill University Hospital Centre will require active surgical planning. The "retreat" created a mood for change which should allow all of us to plan a smaller but better McGill Department of Surgery.

David S. Mulder

POSTOPERATIVE:
Letter Carrier

We have received some laudatory letters. Some excerpts:

Letters to the Editor

"It truly makes interesting reading and values the achievements made in our Department. It gives us a sense of belonging which is important".


"Many thanks for continuing to send the Square Knot. I enjoyed the report on the Centennial".


"Most of us read it from cover to cover".

—H. Bruce Williams, M.D., Jan. 5, 1995.

"An extremely enjoyable, readable and interesting communication which I look forward to receiving".


"It is quite interesting to see that so many familiar faces are still around".


Upcoming Events

E.J. Tabah Visiting Professor in Surgical Oncology
Dr. Michael Lotze Professor of Surgery
University of Pittsburgh

McGill General Surgical Alumni Day:
Dr. Henrik Kehlet, Visiting Professor,
University of Copenhagen, Dr. David R. Owen, Organizer.

April 20, 1995.
H. Rocke Robertson Visiting Professor for Surgery in Trauma.

American College of Surgeons Spring Meeting,
Boston, Massachusetts.

Fraser Gurd Day: Dr. LaSalle Leffall, Jr.,
Visiting Professor, President-Elect,
American College of Surgeons.

June 1-4, 1995.
Quebec Association of General Surgeons Annual Convention, Hilton Hotel, Quebec City.

June 1, 1995.
Stikeman Visiting Professor: Dr. Peter C. Pairolero
Chairman, Department of Surgery, Mayo Clinic.

October 5-7, 1995.
American Society of Peripheral Nerve Surgery,
Montreal.

October 7-11, 1995.
The American Society of Plastic and Reconstructive Surgeons, the largest Plastic Surgery organization in the world will hold their annual meeting in Montreal. The members of the Teaching Faculty in Plastic Surgery at McGill as well as other local members of ASPRS are actively involved in the organization of this meeting which will include over 6,000 participants.
THE CASE FOR AN EMERGENCY (AVAILABILITY) O.R.

A Surgeon's life revolves around the Operating Room. Accordingly, we are always trying to maximize its usage. Pre-operatively, patients are processed assiduously so that they understand the nature of the intervention, sign an informed consent, are pre-admitted and pre-booked. Scheduling is sometimes done a long time in advance at the convenience of the patient, the surgeon and the operating room personnel. Recently, because of budgetary constraints, and to maintain efficiency, this block time has become rather inflexible.

What to do with emergencies or with cases that do not quite fit into the regular schedule?

Things have slowly evolved into a paradoxical situation where electives are given priority because they are "booked" and emergencies go on a "wait list". Unless there is a dire emergency, one surgeon is reluctant to "bump" another if the patient can be safely made to wait. However, frequently such operations end up being done in the evenings or at night following all the elective day cases.

A solution is available and that is the institution of an emergency or availability O.R. The operating room management team must organize the theatres according to the principles of surgical urgency. This should provide access to the Operating Room for patients needing emergency surgery of categories 1, 2 and 3 during the daytime hours. A corollary of this is that there would be less pressure on the Operating Rooms in the evenings and at nights. Anaesthetists worry that there might not be enough cases to fill such an O.R. and that they would be left all day to "twiddle their thumbs". This need not be so if all Surgical Specialties were to use this special O.R. for other types of cases also, such as previously cancelled cases; semi-urgent cases; patients already in hospital awaiting surgery who have been worked up in preparation for this surgery; and vascular access procedures to service medical patients etc. For trauma, the Trauma Association of Canada in its guidelines stipulates that for a Tertiary Trauma Centre, there must be an Operating Room available 24 hours a day for immediate surgery with the necessary equipment and personnel. For District Trauma Centres and Primary Trauma Centres, an Operating Room must be available within thirty minutes!

The Canadian Council on Health Services Accreditation goes into some detail in the description of priority treatments and affirms that for the expectations of the client/patient to be met, priority is given to cases that are "high risk, high volume and problem prone".

It behoves surgical divisions to work together to stratify surgical urgencies and work out the details with Anaesthetists and Nurses to maximize the efficiency to such an availability theatre so that we can achieve better quality care for our surgical patients.

Dr. Conrad Pelletier gave Surgical Grand Rounds at the RVH on December 15, 1994. His topic was on Surgical Research at the Université de Montréal. He made a very erudite presentation pointing out the great progress which the Department of Surgery of the U. de M. has made in recent history.

Dr. Thomas O'Donnell who is the Andrew's Professor and Chairman of the Department of Surgery at Tufts-School of Medicine and the Surgeon-in-Chief and Chief of Vascular Surgery at the New England Medical Center in Boston gave Surgical Grand Rounds at the RVH on January 26, 1995. His topic was New Approach to an Old Problem: Management of Chronic Venous Insufficiency. He emphasized how they divide chronic venous efficiency into superficial and deep varieties. His focus was mainly on the Deep Venous Thrombosis. Duplex Scanning is the best method of evaluation and, when indicated, they correct the incompetent valves high up in the thigh by a clever method of valvuloplasty.

Dr. Andrew C. Novick—
The Seventh L.D. MacLean Visiting Professor.
On November 17th 1994, McGill was pleased to welcome one of its Alumnus who is currently Chairman of the Department of Urology at the Cleveland Clinic Foundation in Ohio.

Dr. Novick was born in Montreal and graduated from McGill with a B.Sc. in 1970 and his M.D. in 1972. After doing his Surgical Residency at the RVH and at the QMVH, he did his Urological Training at the Cleveland Clinic Foundation. Since then, he has become head of the section of Renal Transplantation since 1985 and he is a Professor in the Department of Surgery.
His presentations were as follows:
1) Contemporary Approaches to Treatment of Renal Cell Carcinoma.
2) Surgical Adrenal Disease.

That evening Dr. Novick was the guest speaker at a black tie banquet for all Surgeons and Scientists of the Department of Surgery at the University Club. Dr. Jonathan L. Meakins and L.D. MacLean were the other keynote speakers.

EDM

McGILL UNIVERSITY HOSPITAL CENTRE
M.U.H.C. — At a meeting held on Wednesday, December 7, the Interim Board of the McGill University Hospital Center (MUHC) finalized and approved the by-laws of the MUHC. Among other things, these provide for the establishment of a Joint Planning Committee which will ensure the collaboration of our representatives with the Ministry, the regional board and the City of Montreal in the planning of the MUHC, and professional advisory committees to coordinate the integration of services.

Update

By L.D. Monaghan, M.D.

At the same meeting, the Board also appointed Arnold Steinberg as Vice-Chairman, a volunteer position. Alex Paterson was appointed Chairman at the previous meeting. In order to staff the process, the Interim Board named three associate executive directors of the Centre, reporting to MUHC Executive Director Gerard R. Douville.

Phillip P. Aspinall, President and Chief Executive Officer of the Royal Victoria Hospital, will become Associate Executive Director in charge of the planning of the MUHC. He will be the senior staff person working with the Joint Planning Committee. His current responsibilities at the Montreal Children's Hospital will be assumed by an associate executive director; a search committee has been struck to seek a replacement.

Charles W. McDougall, Executive Vice-President and Chief Operating Officer at the Royal Victoria Hospital, will become Associate Executive Director responsible for the operations of The Montreal General Hospital and the Royal Victoria Hospital.

These nominations will become effective on January 1, 1995 subject to ratification by the boards of their respective institutions.

Joy Shannon continues in her position as executive director of the Montreal Neurological Hospital. She will continue to report to the MNH board and Dr. Steinmetz’s successor will report to the Children’s board.

"The Interim Board’s new appointments reflect our priorities for the next six months", said Gerard Douville. "The first is the planning of the new centre. Our boards approved the project in March 1994 and the intervening months have been needed to obtain government approvals and funding. Now these are in place and it’s time to proceed”.

The second priority is to implement the MUHC structure beginning with an integrated senior management team, i.e. the Executive Director and Associate Executive Directors. During the initial stages, the forces will be on the integration of the two adult general hospitals - the MGH and the RVH. However, as administrative and support services at these hospitals combine, the corresponding services at the Children’s and the Neuro will be offered the opportunity for full participation in the integration of that service. In clinical areas, initial opportunities for integration are generally in the adult general hospitals.

"We know that people must have ready access to and on-site decision-making process", commented Mr. Douville. "Flexibility will be very important as we move ahead. We shall be talking go people throughout the institutions and seeking their input. The structure will be in constant evolution”.

As of February 10, 1995, there are now 6 standing committees of the Interim Board.

• Finance
• Research
• Medical Advisory
• Nursing
• Multidisciplinary
• Joint Planning

abridged from "The Bulletin"

—RVH courtesy of Mrs. Cicely Lawson-Smith
**Position Statement Regarding On-Call Time for Canadian Association of General Surgeons**

General Surgeons provide essential surgical services across the country. They are in the front line of trauma care and provide care for the sickest surgical patients in general hospitals. These duties frequently require excessive demands on the surgeon’s time. The Board of CAGS believes that Canadians should have reasonable access to the services of certified General Surgeons. These surgeons must have sufficient time free of surgical duties for maintenance of competence, other medical responsibilities, rest, family, as well as other non-medical obligations and interests. This is essential for physician well being and in the long run run safe and efficient patient care.

The Canadian Association of General Surgeons has endorsed a maximum one in five night call system in a well developed general surgical service. However, CAGS recognizes that this may not always be possible.

In negotiating on-call responsibilities with hospital administrations, the following principles should be borne in mind:

1. Upon recruitment, the scope and breadth of duties, as well as the timing of on-call schedules, should be agreed upon between the hospital and the general surgeon. This should be reviewed periodically.
2. No surgeon can be expected to provide continuous call or more frequent call than is compatible with safe patient care and the surgeon’s personal well being.
3. It is the responsibility and right of a surgeon to state when he/she is incapable of providing safe on all coverage.
4. It is the responsibility and obligation of Hospital Boards to provide a level of staffing which allows for sufficient off-call time. On-call duties require adequate access to elective OR time.
5. Call systems should recognize that due to age or ill health, surgeons may be less able to provide a high frequency of call and this should be recognized in physician resource planning.

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**Obituaries**

**Dr. Martin Laberge Sr.** died January 30, 1995. He was a General Surgeon at the Hôtel-Dieu in Quebec City. He trained at the Mayo Clinic. Later, he was Director of the Quebec Health Insurance Board. He was the father of Dr. Jean-Martin Laberge of the Montreal Children’s Hospital; of Philippe, an Obstetrician/Gynecologist in Quebec City; and of Pierre, a Microbiologist in Sept-Îles. A brother Gabriel is a C.V.T. Surgeon in Sherbrooke. Martin was 69.

**Dr. William Mersereau** passed away on January 25th, 1995. He arrived at the newly established McGill University Surgical Clinic of the Montreal General Hospital in 1959, having been recruited by Dr. Rocke Robertson, Chairman of the Department of Surgery. In subsequent years, he pursued research on atherosclerosis and renal hypertension with Dr. Sean Moore, and obtained a Ph.D. in Physiology from McGill. He was appointed as an Assistant Professor of Surgery in the Division of Experimental Surgery, and Assistant Director of the University Surgical Clinic. His subsequent research activities, carried out in close collaboration with Dr. John Hinchey, were in the area of pathogenesis of stress ulcers. He was the recipient of an MRC operating grant, and published many peer-reviewed papers in important international scientific journals, such as the Journal of Gastroenterology, Gut, and Surgery. Highly innovative and dexterous, he hand-made a lot of the equipment for his own studies, and was always available to assist young research fellows and residents, many of them in the research laboratory for the first time in their lives. His expertise in small animal anesthesia and surgery was a highly valued resource for surgical research at The Montreal General Hospital for many years. Many projects benefitted from his assistance and advice. He retired from active laboratory research in 1993, and his untimely death shortly after his retirement was a shock to those who worked closely with him. Dr. Mersereau was closely associated with and symbolized the excellence of the MGH University Surgical Clinic. A gathering in memory of Dr. Mersereau was held on Thursday, February 2nd, 1995 in the Surgery Conference Room on the 9th Floor. His colleagues and friends paid tribute to his personal and professional contributions to the Department of Surgery.
McGILL SPORT MEDICINE CLINIC
HAS OPENED ITS DOORS
The McGill Sport Medicine Clinic, located in the Department of Athletics, has officially opened its doors as of January 18, 1995.

Good News! In comparison to the limited space and equipment in the old Sports Injury Clinic which mainly serviced varsity athletes, the new facility is now available to McGill students, faculty staff, gym club members, alumni and the community at large. The clinic is totally self-financed.

The Sport Medicine Clinic is open daily from 8:00 am to 7:00 pm, Monday through Friday.

The Sport Medicine Clinic Medical Director is Dr. David Mulder, Chief of Surgery at The Montreal General Hospital. Consultation is available with Dr. Eric Lenczner, orthopedic surgeon at The Montreal General Hospital with Dr. Vincent Lacroix, McGill Athletics Department Team Physician.

The therapy staff includes Head Athletic Therapist, Lynn Bookalam; Senior Physiotherapist/Certified Athletic Therapist, Stephen Cross; Staff Physiotherapists, Stephane Tremblay, Reggie Rudich; and receptionist Dayle Vincent.

The clinic houses state-of-the-art equipment such as a computerized Biodex Isokinetic strengthening and testing device, Biodex Upper Body Ergometer, Biodex Lower Body Ergometer, Sport Specific Pulley Systems, hydrotherapy and electrical modalities.

Appointments are required for visits with the therapists and doctors.

The McGill Sport Medicine Clinic is a leader in comparison to other Canadian universities. State-of-the-art equipment puts McGill number one on the Sports Medicine map.

In addition, the new Varsity Clinic opened its doors in early January 1995. The smaller 600 square foot clinic is located on the track level of the new field house. The facility will be used for pre- and post-event preparation for varsity athletes, from 4:30 - 8:00 pm daily. This facility will provide first aid services for intramural athletes from 8:00 - 10:00 pm, Monday to Friday and 12:00 - 2:00 pm, Saturday and Sunday.

For further information, contact us at 398-7007 or come and visit the clinic located in the Currie Gymnasium, 475 Pine Avenue West just one street east of University.

RESEARCH GROUP IN UROLOGIC ONCOLOGY
1994 was a special year for research in The Urology Division, with the creation at The Montreal General Hospital Research Institute of a Research Group in Urologic Oncology. The initial team of investigators is composed of Dr. Simone Chevalier, who is the scientific director, together with Drs. Armen Aprikian and Michel Bazinet, as well as post-doctoral fellows, graduate students and research assistants. The scope of research is centered on the role and function of androgen-insensitive epithelial cells in prostate cancer. It must be emphasized that tremendous activity is now devoted to this field as such cells are responsible for the development of the androgen-refractory state which rapidly kills patients with advanced prostate cancer.

The Blue General and Oncology Surgery Service RVH

Front Row L to R: C. Milne, H.R. Shibata, E.D. Monaghan
Royal Victoria Hospital — 1962-1963 House Staff

FRONT ROW:

SECOND ROW:

GRIPE:
Suitcase
THIRD ROW:

BACK ROW:

SIGMOID:
A Famous Viennese Psychoanalyst
The death of Harry Houdini — Was a McGill Student Responsible?

On October 18th, 1926, the world famous magician, Harry Houdini, opened at the Princess Theatre in Montreal. At the age of 52, Mr. Houdini had electrified the world by his masterful escapes from handcuffs and underwater chains and like David Copperfield today, he could make an elephant disappear on stage. He was visited in his dressing room by a young man whose name was Samuel J. Smilovitch and his friend, Mr. Jack Price. A first year McGill student called Whitehead was with them. The first year McGill student asked Houdini whether it was true that punches to the abdomen did not hurt him. Houdini who was in good physical shape allowed Whitehead to give him some very hammer-like blows below the belt particularly in the right lower quadrant. After at least four very hard body blows, Houdini stopped him suddenly and wincingly avowed that he had had enough. At first the blows seemed to have no ill effect. Houdini closed in Montreal on October 23rd, then went to Detroit. He began to feel ill and ran a temperature of 104. C. He was seen by a doctor who diagnosed acute appendicitis and he was taken to Grace Hospital where his gangrenous appendix was removed that afternoon. His surgeon, Dr. Charles Kennedy, wrote, "We found that his appendix was a great long affair which started in the right lower pelvis where it normally should, extended across the mid-line and lay in his left pelvis, exactly where the blow had been struck. Reconsidering the history afterwards, we concluded that his appendix had ruptured somewhere near St. Thomas, Ontario and that he had carried on the entire performance that same evening at the Garrick Theatre with a ruptured appendix spreading peritonitis". Four days later, he had to be re-operated because his "bowels had become paralyzed". He never recovered and died in his wife's arms on the afternoon of October 31st.

It seems clear that the patient died of peritonitis brought on by the ruptured appendix. But could repeated blows to the abdomen cause an appendix to rupture? Dr. Kennedy believed before the first operation that perhaps the cecum had been ruptured, but all he found was a ruptured appendix. He said, "It is the only case of traumatic appendicitis I have ever seen in my lifetime, but the logic of the thing seems to indicate that Mr. Houdini died of appendicitis, the direct result of the injury".

A survey of the medical literature could not find evidence of acute appendicitis being caused by physical injury.

What seems most likely is that Houdini was already suffering from appendicitis before the famous incident, and that the blows either aggravated it or prevented him from realizing that his condition was something more than a mere bruise until it was too late. ✤


catgut (kat’gut) n.

Ask anyone about the origin of the word "catgut" and it is natural to reply that this is a suture made out of the intestine of cats. This is not so. The Shorter Oxford Dictionary defines catgut as the dried and twisted intestines of sheep, horse and ass, used for the strings of musical instruments etc. Professor Paul Bacquet of Sorbonne affirms in his book Etymologie Anglaise that the prefix cat rather comes from the words cattle, catel or chatel. Cattlegut therefore gave rise to the word catgut. According to Mr. Bacquet, never has cat intestine been used to make cords for musical instruments. Anyway, Dorland's Illustrated Medical Dictionary describes catgut as "an absorbable sterile strand obtained from collagen derived from healthy mammals originally prepared from the submucous layer of the intestines of sheep; used as a surgical ligature". ✤

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NOTICE ☠

Division of General Surgery, McGill University Surgical Alumni Day, Thursday, March 23, 1995

Presentations by local staff & returning alumni
Visiting professor:
Dr. Henrik Hehlet, University of Copenhagen
Submit your topic to:
Dr. David Owen
The Montreal Hospital, 1650 Cedar Ave. Room: A1-113
Montreal, Quebec H3G 1A4
Registration:
$125.00 includes lunch and dinner
$75.00 additional dinner guest
Social Program
The International Cancer Congress sponsored by the Union Internationale Contre Le Cancer (UICC), like the Olympics, takes place every 4 years. The 16th International Congress was held in New Delhi, India from October 30th to November 5, 1994.

Henry Shibata
Goes to India

The Organizing Committee, under the able leadership of Dr. P. B. Desai, Director of the TATA Memorial Centre in Bombay, India did everything in its power to have a successful meeting. However, because of the unfortunate outbreak of the pneumonic plague in Surat near Bombay in mid September, it was doubtful whether this congress would ever be held. Due to the tremendous efforts of the medical profession and the liberal use of antibiotics, this threat was overcome. However, out of an estimated 10,000 people who were scheduled to attend this important congress, only about 4,000 actually attended. Those who stayed away missed a golden opportunity to not only benefit from the science of this meeting, but to savor the historical and cultural gems that this proud nation of over 900 million people has to offer.

My participation was as a chairperson of a poster session on "Cancer Education in Developing Countries" and a member of two panels, the first on "Chemoprevention of Breast Cancer" and the second on "Cancer Education in Developed Countries". I also presented a paper on "Hospital Tumor Boards: Teaching of Multidisciplinary Care and Quality Control".

One of the most memorable lectures at this congress was given by Dr. P. Desai on "From Cancer Biology to Clinical Oncology and Beyond - Bridging the Gap".

Thursday, October 27th, was the Indian New Year, called "Diwali", and there were no meetings, so my wife and I took this opportunity to take a 3 hour bus ride to the city of Agra to see the world famous Taj Mahal. This magnificent building of pure white marble was built about 341 years ago as a memorial of love by Shah Jahan for his wife, Queen Mumtaz Mahal. Incidentally, his wife provided him with 14 children in 19 years! She allegedly died giving birth to her 14th child, according to the tour guide. The other highlight was a visit to the monument honouring Mahatma Ghandi in New Delhi.

The city of New Delhi seems to have an active, purposeful atmosphere. The people appear hopeful and industrious, and although there still is a big gulf between the have's and the have-not's, the future appears bright for this nation which, among its many accomplishments, gave rise to two great religions of the world, Hinduism and Buddhism.

The long trip back was punctuated by short visits to Bangkok and Hong Kong, and a longer stay in the country of my ancestors, Japan. There, 30 of my classmates and I celebrated the 40th anniversary of our graduation from the Hiroshima Medical School, with a banquet, a bus tour of an ancient archeological site, and a golf tournament.

As a Visiting Professor to my alma mater, 3 talks were given: (1) "The Modern Management of Breast Cancer" to 3rd and 4th year medical students; (2) "The Surgical Oncology Fellowship Training Program in Canada"; and (3) "Organ Transplantation at the RVH" to attending staff, residents and fellows in the Department of Surgery.

One of my classmates, the present President of the Kure Medical Association (city of about 750,000 people, the largest naval port during World War II), invited me to give a talk to 85 members of his association on "The Present Status of Medicare in Canada".

This trip was a once in a lifetime experience for me, and was well worth the time and effort. ✽
Dr. Ray Chiu of the MGH has been newly appointed to the Editorial Boards of The Journal of Heart and Lung Transplantation and The Canadian Journal of Surgery. Also, he has been appointed to the Grants Review Committee of the National Institute of Health USA. In December of 1994, he chaired a Cardiac Assist Symposium sponsored by the Heart-Lung Blood Institute of the NIH in Bethesda, Maryland. On January 30, 1995, he presented a paper on Myocardial Regeneration at the Society of Thoracic Surgeons Meeting in Palm Springs, California.

Dr. Nicholas Christou of the RVH informs us that the Department of Surgery of McGill University at the Royal Victoria Hospital has been selected as one of two centers to participate in the International Norsept II Trial. This examines the use of a monocromal antibody to Tumor Necrosis Factor for the treatment of patients in septic shock.

Dr. Philip H. Gordon of the JGH has both been recertified by and elected to the American Board of Colon and Rectal Surgeons. He will exercise much influence in his field because in Canada he is also a member of the Specialty Committee in Colon and Rectal Surgery of the Royal College.

Dr. Alan Graham of New Jersey has been made a member of the Society of University Surgeons.

Dr. Gitte Jensen and her husband Alex Cruikshank are pleased to announce the birth of their son Alasdair, on October 25, 1994 at the RVH.

In October in Chicago, Dr. Lloyd D. MacLean as outgoing President of the ACS installed the new President, Alexander J. Walt MD, FACS, the 75th President of the College. Dr. Walt, a General Surgeon, is a Distinguished Professor of Surgery at Wayne State University in Detroit. Originally he is from South Africa and his presidential address very much emphasized the fact that he is the first Foreign Medical Graduate to be President of the College and how well he was treated in the U.S.

Dr. Jonathan L. Meakins wrote the section What's New in Critical Care and Metabolism in the January issue of the Bulletin of the ACS. It is very difficult to put together such a document. There are 58 references; two of which are from McGill. The section on "magic bullets" is particularly informative.

The Credentials Committee was happy to welcome again the return of Dr. David Mulder to its meeting on January 23 and 24, 1995.

Dr. Harvey Sigman at the JGH was a member of the Accreditation Survey Team visiting the Stritch School of Medicine Loyola University Chicago for the LCME last November. In addition, he was a member of the Guest Faculty for the 11th annual course on Controversies, Problems and Techniques in Surgery at the Albert Einstein College of Medicine and Montefiore Medical Center in New York City last December.

This year thousands of athletes from around the world will meet in Manchester, England at the 10th World Transplant Games. These were founded in 1978 by Dr. Maurice (Taffy) Slapak of Portsmouth England. Taffy graduated from the McGill Postgraduate Residency Training Program in General Surgery (RVH) in 1967. In the first year of the games, there were fewer than 100 kidney transplant patients. This August, it is estimated that several thou-

sand kidney, liver, lung and pancreas transplant recipients will gather from more than 30 countries.

Dr. H. Bruce Williams was presented with the Distinguished Service Award from the American Association of Plastic Surgeons last May in St. Louis, Missouri. He also received the Distinguished Service Award from the American Society of Plastic and Reconstructive Surgeons during the annual meeting held in San Diego, California last September. Dr. Williams was elected President of the American Society of Peripheral Nerve Surgery which will hold its annual meeting in Montreal, October 5-7, 1995. He was also elected President of the International Surgical Society in Nara, Japan. This latter organization is a multidisciplinary basic and clinical scientist group with major interest in microsurgery and includes representatives from over 50 countries.

Drs. David Mulder and Nick Christou were invited Professors at the Seventh Pan-American Trauma Congress in Cartagena, Colombia in November of 1994. They were accompanied by their wives Norma and Katina. David and Nick were granted Honorary Memberships in the Colombian Trauma Association. Nick gave two keynote addresses entitled Workup of the Septic Patients in the ICU and Therapeutic Options in the Septic Abdomen.

Secretion: Hiding anything
Dr. Sameh Barayan, a McGill Department of Surgery graduate in 1994, and his wife Tamara are the proud parents of a baby girl, Ranya, who was born on February 7, 1995.

Achievements of Residents and Fellows

Dr. Carlos A. Barba and his wife Sylvia are living in Hartford, Connecticut where he is an Assistant Professor of Surgery at the University of Connecticut Health Center. He is a Fellow of the Royal College and an Associate of the American College of Surgeons. He started working at St. Francis Hospital Medical Center in the Trauma Services and the Surgical Critical Care Unit in July 1993. Dr. Barba came to McGill from the University of Panama and graduated from our Training Program in General Surgery in 1991. His interests are in Trauma and Surgical Critical Care. He is also a member of the Board of Hispanic Health Council in Hartford.

Dr. Anna Maria Derossis and her fiance Adam Adamakakis are to be married on May 21, 1995.

Dr. Liane Feldman and her fiance Hillel Rosen are also planning their wedding on June 25, 1995.

Dr. Brett Ferdinand, R-II in General Surgery, has written and edited a text entitled The Gold Standard for Medical School Admission - Ruvenedo, Press. This is a 400 page manual on the Basic Sciences in preparation for the Medical College Admissions Test (M.C.A.T.) and the admissions process in general. So far, over 1500 copies have been sold in Canada throughout the first year. A second edition is due in March.

Dr. Chen Lee, who graduated from McGill in 1993 after doing his residency in Plastic Surgery, has accepted a position at the University of California in San Francisco as an Assistant Professor. He is actively engaged in basic research at that institution.

Dr. Daniel Obrand and his fiancee Caroline Michel are planning their wedding which will take place on April 30, 1995.

Dr. Neville G. Poy, the first Research Fellow in Dr. H. Bruce Williams' laboratory has established the Poy Foundation for Research in the Division of Plastic Surgery at McGill with a generous donation to the University. The official announcement of this Foundation was made on Wednesday, November 23rd, 1994 when a reception was held in the Osler Library and those in attendance included the Principal, Dr. Bernard Shapiro, Dean Richard Cruess, Vice-Principal (Academic) T.H. Chan, Vice-Principal (Advance-ment) Michael Kiefer and a member of the Board of Governors, Mr. Arthur Lau. Short presentations were made by Drs. Cruess, Williams and Poy and this generous support is greatly appreciated by all members of the Division and by the Department of Surgery.

Dr. John Yee, a Ph.D. candidate and a 5th year surgical resident in the Department of Surgery, had his paper accepted in the December 1994 Archives of Surgery as the lead article to be featured on the front page. The paper is entitled: The local role of tumor necrosis factor α in the modulation of neutrophil function at sites of inflammation.

Residents in Neurosurgery Training Program

R-I
Dr. Jeffrey Atkinson
Dr. Diane Diorio

R-II
Dr. Dongwoo John Chang
Dr. William Choi
Dr. Gordon Chu
Dr. Isam Khoja

Clinical Fellow II
Dr. Kamal Balkhoyor

R-III
Dr. Raquel Dureza

R-IV
Dr. Catalino Dureza
Dr. Cornelius Lam
Dr. Maria Li

R-V
Dr. David Clarke
Dr. Karen Johnston
Dr. Michael Vassilyadi

R-VI
Dr. Mark Preul

Clinical & Research Fellow
Dr. Olivier Vernet

Research Fellow
Dr. Mario Alonso

Gaston Schwarz, M.D., F.R.C.S.(C), F.A.C.S.
1506 Dr. Penfield Ave., Montreal, Quebec, H3G 1B9.
We are already approaching 80 liver transplantations done at the Royal Victoria Hospital, McGill University in the "new" era since 1991.

The First Pig Liver Ex-vivo done in Canada

By Jean Tchervenkov

We recently achieved some notoriety despite our relatively small numbers of patients transplanted at the Royal Victoria Hospital. Back in November 1994, a 55 year old lady was suffering from advanced primary biliary cirrhosis and had been on the transplant list for over one year. She had waited that long because she was of small size (few livers to match) and also had been highly sensitized from numerous blood transfusions, her ability to be transplanted safely without major rejections being relatively compromised. Nevertheless, we pursued our efforts to find a liver for her, compatible in both size and blood group (she is a blood group O). In December 1994, she fell suddenly more ill and slipped into a Stage IV coma. She eventually was transferred to the Intensive Care Unit where she had to be intubated for airway protection. She then developed Stage V encephalopathic coma as she was not responsive to even deep pain stimuli. She had been on the National Transplant List as Status 4 (priority from coast to coast) for 3 days, but not a single donor could be found in Canada. In desperation, after finding her clinically slipping into Stage V coma, we inserted an intracranial pressure monitor which showed that her intracranial pressures were increasing rapidly. At this point, several maneuvers were performed in an attempt to reverse her rapidly rising intracranial pressure. On the evening of December 19, 1994, after discussing this with some of my residents in the Intensive Care Unit, Dr. Joseph Tector and Dr. Shaf Ahmed, we came up with the idea of perfusing her circulation with an ex-vivo pig liver to try and keep her alive until a human donor liver became available. We went to the Administrative Chief of the hospital, Dr. Sylvia Cuess and Dr. J.L. Meakins, to get the authorization from the hospital and the Human Ethics Committee to attempt this innovative procedure. The whole medical community at McGill University was extremely supportive. After our discussions with the family and the medical ethicist, Dr. E. Berezza, we became wholly convinced that this was truly the thing to do. We were able to prepare because of the initiative, meticulous groundwork, and important leg work done by Dr. Tector, who is currently doing his research at McGill University with Dr. L. Rosenberg and myself. We reviewed the literature, called American centres which had actually tried to do this, contacted Dr. Mulder at The Montreal General Hospital and prepared the pig laboratory at The Montreal General Hospital. The perfusionists at the RVH and Dr. B. DeVarennes inserted the cannulae into the femoral veins and the patient was then prepared for the ex-vivo perfusion. Meanwhile, the liver transplant team harvested the pig liver at The Montreal General Hospital.

Briefly, the whole set-up is as appears in the picture: cannulation of the patient's left femoral vein with a Biomedicus pump through which her blood is pumped into an oxygenator and a warmer, and eventually through the portal vein of the pig liver. The blood is then returned back to the patient from the pig vena cava, back into the patient's right femoral vein. The purpose of the whole procedure is to perfuse the pig liver which then acts to detoxify the patient's blood. With the help of the nurses in the Intensive Care Unit, the pig liver was connected to the patient at 20:30 hours on the night of December 20, 1994. Within 40 minutes, the patient opened her eyes spontaneously. The patient started having some purposeful movements and responded to simple commands such as "open and close your eyes and squeeze my hand". The atmosphere in the SICU that evening was electric. There was a lot of excitement on the part of the nurses and the doctors involved in this. Throughout the 4 1/2 hour ordeal, Dr. Tector stayed behind on the vigil, and watched that the perfusion went according to plan. After 4 1/2 hours of perfusion, we decided to terminate the procedure as the pressures through the pig liver were increasing and the flow was slowing down. Throughout this, we measured ammonia levels before and after the pig liver in the circuit, along with other parameters, and there was objective evidence that the pig liver was working as hoped. The patient's vital signs became more stable, and her intracranial pressure dropped from 45 mmhg to 10 mmhg. While we were finishing up with the perfusion, a call came from Quebec Transplant indicating that they had located a donor for our patient in Toronto. We accepted this donor and the human liver was removed by the Toronto Hospital group, and flown in the next morning from Toronto. We transplanted the patient the next afternoon in a 5 hour operation. With the human liver inside her, she was even more stable and the next morning she woke up. She was extubated within 48 hours, demonstrating complete neurological recovery. Her liver function recovered slowly postoperatively, and is now completely normal. On January 27, 1995, a press conference was held to describe our work which was a first in Canada, and made Mrs. McArule only the fourth patient worldwide to be successfully "bridged" to transplant with this procedure. We are proud of this successful event, and this work will be the basis for further research by Dr. Tector in the laboratory for his Ph.D. thesis. I would like to underline the importance of the contributions of Drs. Shaf Ahmed, Nahel Elias, Jonathan Fridell, Steve Paraskevas, and Joe Tector to the overall success of this procedure and the survival of the patient.
We can’t do it without you!

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