OPERATION IRAQI FREEDOM: A SURGEON'S PERSPECTIVE
DEPLOYMENT AND TRAINING OF A COMBAT SURGICAL HOSPITAL

During a sophomore medical school lecture, I clearly recall being told that the only person who ever benefits from war is the surgeon. It sounded rather bold, masculine and right up my alley since I had already decided to be a surgeon as early as junior college. I suppose that is why I have always remembered that comment for almost thirty years. Or maybe it was because the guy who said it was a real geek and I could never quite reconcile where he came about that bit of treasured knowledge that only a macho surgeon should know. I'm still not sure about those particulars, but I found myself as one of those surgeons mentioned recently. Far from a medical student, I found myself a 54 year old vascular surgeon serving in the Navy here in San Diego. Since September 11, 2001 I have had the experience of serving on the USS Enterprise (CVN-65) as she launched the first strike package into Afghanistan and most recently being (please see Navy, pg. 6)

News from the US Navy Medical Corps

By Captain Stephen F. McCartney, M.D.

where he came about that bit of treasured knowledge that only a macho surgeon should know. I'm still not sure about those particulars, but I found myself as one of those surgeons mentioned recently. Far from a medical student, I found myself a 54 year old vascular surgeon serving in the Navy here in San Diego. Since September 11, 2001 I have had the experience of serving on the USS Enterprise (CVN-65) as she launched the first strike package into Afghanistan and most recently being (please see Navy, pg. 6)

(please see Navy, pg. 6)

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Dear Editor,
The McGill Division of General Surgery is proud to have 2 abstracts accepted at this year's meeting of the American Surgical Association (April 15-17, 2004) in San Francisco. The first abstract from the Bariatric Surgery group entitled *Surgery Decreases Long Term Mortality in Obese Patients* reports clinical outcomes - 89% reduction in the relative risk of death in patients undergoing weight reduction surgery compared to non-operated morbidly obese controls.

The other Proving the Value of Simulation in Laparoscopic Surgery from Dr. Fried's group is on surgical education as it pertains to use of simulators in MIS training.

It is very unusual for the ASA to accept 2 abstracts from the same institution on a given year. This attests to the quality of research done in our division.

Nicolas V. Christou, M.D., MUHC

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Dear Editor,

It was very nice to hear from you. I am delighted to be able to donate a few dollars to the McGill Surgery Alumni Association. The Square Knot is required reading the day I get it as I love to hear what's going on with my McGill Friends.

Well, I have been in practice in Chicago for 10 years now (13 years altogether - how time flies). I have been in a large community hospital (>600 beds) for the last 5 years. We have General Surgery residents rotating through the service, but no CVT fellowship program. I still participate in multi-institutional clinical trials through the CALGB and run the hospital's weekly Multidisciplinary Chest Tumor Conference. The practice involves lung and esophageal cancer as well as benign lung and esophageal disease. I do quite a bit of thoracoscopy - treating malignant pleural effusion, doing lung biopsies, etc.

The only negative about practicing in Illinois these days is skyrocketing malpractice insurance premiums. In 2004, a cardiothoracic surgeon will have to pay $139,500 U.S. (an increase of 34% over 2003) for malpractice insurance which makes it almost unreasonable to continue to practice here. I will hold out for another year in the hope that the Senate passes National tort reform.

I am still in touch with Maureen Martin who is the Chief of Surgery at Kern Medical Center in Bakersfield, CA, but have lost touch with David Latter (the last I knew, he was at St. Mike's in Toronto).

I took up golf 8 years ago and have a handicap of 17. I spend my vacation/leisure time with friends and family travelling, playing golf, downhill skiing, and scuba diving. I work out 4 times per week and thankfully, I continue to enjoy great health.

That's about all that's new in my life.

Jemi Olak, M.D., Chicago, Illinois

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Dear Editor,

Thanks to Drs. David Mulder, John McFarlane and The Square Knot, I have been able to keep in touch with McGill ever since I left McGill. Dr. Fraser Gurd accepted me as a Junior Assistant resident in Surgery in 1966.

I believe the years and nature have been kind to us all. I became Professor of Surgery, University of Lagos in 1979. I later became College Dean of Clinical Sciences in 1982; Foundation Provost (Dean) Obafemi Awolowo College of Health Sciences, Ogun State, Nigeria in 1983; and Foundation Vice-Chancellor (President) of Lagos State University from October 1983 to October 1989. After that stint of University Administration in all its interesting ramifications, I returned to clinical and academic surgery. I moved to Saudi Arabia where I was Chief of Surgery and Postgraduate Residency Program Director in Hofuf General Hospital for some years.

I am now back at home (Lagos) and continue to practice as a General Surgeon, G.I. Endoscopist and Laparoscopic Surgeon, and Professor of Surgery.

God has been kind of us all. My wife Sade worked for 10 years in the University Library in the University of Lagos, becoming a Senior Librarian. She then moved to University Administration. Two years ago, she became the first female Registrar of the University of Lagos, an achievement we are all so proud of. Our son (who lives in Toronto) and two daughters, both lawyers, are all married. The youngest, another daughter, graduated as a dentist last fall.

I hope to visit the MUHC later this year. With best wishes.

Folabi Olumide, M.D., Lagos, Nigeria

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Editor's Note,

We are grateful to Susan Bexton (daughter of Dr. Fraser Gurd) for putting Dr. Olumide in touch with TSK. She lives in Portland, Oregon. She stopped working as an RN 4 years ago, having enjoyed many years in Cardiac Care and 

(please see Letters, pg. 23)

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Upcoming Event

**SYMPOSIUM OF COLON AND RECTAL SURGERY**

Everyone is reminded that the Symposium of Colon and Rectal Surgery will be held at the Sir Mortimer B. Davis - Jewish General Hospital from June 3-4, 2004. This has been organized in order to commemorate the 30th Anniversary of the Foundation of Colon and Rectal Surgery at that site. Many international guests have been invited and the Scientific Committee has organized a superb program.

EDM
Dr. Arthur Porter, a radiation oncologist, was named Executive Director and CEO of the McGill University Health Centre on January 30th. He takes over in April and replaces Dr. Hugh Scott who is being credited with advancing the cause of the MUHC in recent years. Dr. Porter at the age of 47 was at the helm over the re-organization of the Multi-site Detroit Medical Center — 1.6 billion dollar health complex that is the teaching and research site for the Wayne State University School of Medicine, the 4th largest in the United States.

Dr. Porter is a radiation oncologist specializing in prostate cancer and will give up his practice to come to Montreal.

As President of the Detroit Medical Center and its 10 hospitals, Dr. Porter was able to secure public funding through campaigns.

He is a graduate of the Cambridge School of Clinical Medicine in London. He has 2 Masters Degrees, one in Natural Science and another in Business Administration. He has certificates in Medical Management from Harvard University and the University of Toronto. He is a dual citizen of Canada and the United States.

Born in Sierra Leone, he speaks several languages and intends to learn to speak French in Montreal.

The Square Knot wishes him every success in this arduous endeavor. ♥

ONTARIO TO OXFORD TO WYTHAM:

OUR FIRST YEAR

Today is the WINTER SOLSTICE - December 21st - and it has been quite special in that the events of the day reflect living here and many of the wonderful things that have happened to us in the last 12 months. The day started with rain as the sun was rising. Within half an hour, the sun was out and the blue sky was drifting in from the north. Golf was confirmed at 9:30 and under the brilliant sky, with a certain amount of wind, a competitive round was played. The grass is an extraordinary green; the flowers of the Agen d'or are out as are the winter cherry. A brilliant day was settled on the last hole and followed by a glass in the spike bar. Later in the afternoon at the FESTIVAL OF THE NINE LESSONS, Jacqueline sang - a cappella - the first verse of 'Once in Royal David's City.' It was brilliant. The service was accompanied by the Kennefield Brass Band and followed by mince pies and mulled wine. One the way home, we stopped in the village pub, THE WHITE HART, for a glass with our neighbours, the Weavers and their new baby, Max. Then home for seared tuna and Gressingham duck with a glass of Gigondas from the cellars of Balliol College. This wonderful day completes our first seasonal cycle. How did we get from Montreal to Wytham?

We arrived in Oxford at the end of November 2002 and settled into a flat in a renovated Victorian home on Bradmore road, around the corner from Osler's home, more or less in the centre of Oxford and within walking distance of Colleges, cinema, concert halls, the park and shopping. The flat had high ceilings, some nice mouldings and single pane sash windows which could rattle in the wind and taught us about drafts. We had separated our household things and furnishings into three groupings, the first of which was moved into the flat giving us very quickly a sense of home. It was, however, immediately apparent that we needed to find a permanent home.

The festive season of 2002 was a brilliant reflection of the hospitality of Oxford and England. It started with Christmas dinner - black tie in hall - at Balliol on the 18th and continued through to Boxing Day with visits to the homes of many and dinners on Christmas Eve and day with folks who have become friends. Walking through the parks and byways of Oxford during this time was a treat; we found many plants in flower, often tiny flowers, and have in our album pictures of a dozen taken Christmas day on our return from a glorious service in Christchurch Cathedral.

The search, a preoccupation as our lease of the University was for a year, for a permanent home was concluded on January 20th when we visited a barn conversion in the Village of Wytham, situated in farmland a couple of miles or an hour's walk along the Thames from the centre of Oxford. A year ago it was a working set of byres with cattle, sheep and
chickens. Today it is a home with four small bedrooms but very large reception rooms with 15 foot ceilings and a roomy kitchen. Our address is:

**Rollers Barn, Rick yard Barns,**
Wytham, Oxford, UK, OX2 8QA  Tel.: (01)1865 722 557

We have put in a garden with a reasonable amount of lawn and lots of flowers. Only the Rosemary is in flower at the moment, however, we expect that as it matures we will have blooms of one sort or another all year long. The green and the flowers in all seasons make winter easier despite the wet and overcast sky.

Jacqueline has become involved in the musical life of Oxford as both a player and listener. We often walk to Holywell concert hall, where every Sunday there is a chamber concert. She has three quartets that meet at different times and is in addition in the Raddcliffe Orchestra which has three formal concerts a year. Last spring she participated in a quartet week which played three sessions a day and had an instructor. The collection of CDs and musical scores mount stored in locally made matching cabinets which sitting side by side holding CDs and sheet music, the music accessible and looking handsome.

Tennis for both of us has not been a great success as yet. Golf on the other hand has occupied one morning of most weekends. Jonathan joined Frilford Golf Club in January and has played most weekends since. For reasons that are unclear no games have been cancelled on account of rain and we have been drenched only once. The ability to play year round is fantastic, the course being very different in each of the four seasons. After a while it became apparent that old golfing skills had gone somewhere and could not be either found or identified. Help was required. On our holiday to Cornwall and Devon, visiting gardens, Dartmoor, some golf courses, the coast, taking some very nice walks and relaxing in what appears to have been the sunniest and warmest summer in memory. We have only been to the continent once, to a meet-

ing in Varese, as we get ourselves settled into our positions at the University and the Hospital.

Working in a completely new environment has created for us a new set of challenges. Being change agents provides opportunities as well difficulties. We are settling in pretty well although there are a number of cultural, organisational and administrative differences which continue to catch us by surprise. There are great opportunities to be creative and productive and while at times the going seems slow, progress is being made and our working lives are rewarding and interesting.

We have been blessed with lots of visitors. Interesting how it is possible in the down time of a weekend or a couple of evenings over dinners or walks through the woods that about our barn conversion or along the Thames to have a visit which we would not have the time for when back in our previous environment. We have valued these visits and look forward to the future and many more. In a way these events have all made us realise that we have emigrated from Canada to the UK and are in the process of integrating into a new society with a mostly common language. This brings us back to Wytham as we get ready to define a new set of traditions for the NEW YEAR in our new home in the tiny village of Wytham where we will have a candle lighting ceremony with our neighbours and midnight service in All Saints.

Best wishes for the coming year,
Jacquie & Joe Meakins

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**Welcome Aboard**

Dr. Marc Corriveau joined the Division of Vascular Surgery at the MUHC (RVH site) as of February 1st, 2004. Dr. Corriveau is a native Montrealer, trained in both General and Vascular Surgery at the Université de Montréal. Upon completing his residency in 2002, he did a fellowship in non-invasive vascular diagnosis at the University of Toronto under the director of **Dr. K. Wayne Johnston.** Dr. Corriveau brings to the division expertise in clinical outcomes research, advanced skills in non-invasive vascular assessment techniques and Doppler technology research.

**Thank You!**

The Square Knot wishes to thank **Dr. Dimitri Jimmy Petsikas** of Kingston, Ontario and **Dr. Ramesh Lokanathan** for their very generous donation to the McGill Surgery Alumni and Friends.
deployed to Kuwait and Iraq for 5 months.

In January of this year, nearly 200 medical personnel were sent from Naval Medical Center San Diego to the First Marine Expeditionary Force at Camp Pendleton for the purpose of providing surgical support to this large operational combat force. Three general surgeons, 1 vascular surgeon as well as 2 orthopedic, podiatric, oral surgery and a gynecological specialist were the corps surgical team. Nine non-surgical physicians as well as 6 dental officers, 2 psychologists, and a chaplain were assigned. We were supported by 24 nurses and over 100 corps staff and 32 USMC. We left Camp Pendleton in early February and flew from March Air Base in Kuwait. We were transported several hours up into northern Kuwait territory called Camp Coyote near the Iraqi border. We were assigned tents to stare off what was surprisingly cold weather, especially at night where we slept fully dressed. We had been issued 9 mm Beretta side arms with ammunition as well as flak jackets, Kevlar helmets, and a variety of undergarments, mosquito nets, sleeping bags and canteens. By no means were we completely unprepared. We had been assigned to this “platform” long before and had trained for such desert operations. We were joined by 2 other surgical companies and thus were now Alpha, Bravo and Charlie surgical companies, each given a specific surgical mission for the upcoming war. I was Chief of the Medical Staff (called “CPS”) and we promptly unloaded 212,000 lbs of our gear from large metal shipping containers off large flatbed trucks. In less than 24 hours, we stood up what is known as a Level 2 combat surgical hospital. This was my first sense that the essence of teamwork was going to be defined over and over again in this mission. We had our first surgical case within hours of turning on the first 200 Kw generator. On one of our six operating room tables, two of the biggest peritonsillar abscesses ever seen were drained. Within days, an errant M-16 round shattered a leg, which required surgery. Within hours, we diagnosed and operated upon a case of acute appendicitis on a young marine and were fully engaged in providing surgical care to over 25,000 USMC and coalition forces in the only U.S. Naval hospital in Kuwait. Over the next several weeks, over 900 patients would be seen and 24 surgeries performed prior to the war’s beginning. During the same time period, 24 mass casualty drills were held. The shrill of the whistle indicating incoming casualties became a common occurrence. The smooth flow of severely wounded from the landing zone 1/2 mile away all the way through the postoperative ward was drilled over and over. All scenarios from retained ordnance, threatening POWs, chemical assault to compartment syndromes and pulmonary emboli were trained for over and over. The camaraderie and confidence grew exponentially at Alpha Surgical Company. We would need every bit of it as March 20 arrived with a roar.

**OPERATION IRAQI FREEDOM BEGINS**

With no TV, usable phones, internet and mail being essentially non-functional for the most part, we only knew what our intelligence briefs had confirmed. War was imminent. Convoys had been driving by Camp Okinawa for three days without a break. USMC generals were dropping by for “tours” of our hospital more frequently. I believe it was for that last minute “warm fuzzy” of knowing we were ready for their soon to be bleeding marines. I made sure we had enough type 0 blood on hand, our walking blood bank was ready to make up for any shortfalls, and our anesthesia machines were stocked with enough Forane for unlimited use. The first of 36 scud missile attacks, with speedy runs into 8 foot deep bunkers, occurred the night before. Gas masks on, gas masks off when the “all clear” signal was given. Don’t run in the pitch dark or you will impale on an angulated tent stake aiming at your lower abdomen. Know the password of the day or the sentry will shoot. There were no misconceptions now as Chinese Seersucker II and Korean missiles were impacting a few miles away. Our Commanding General told me that it took 123 seconds for a scud missile launched in Basra to impact at Alpha Company. My desire to appear “in the know” was slightly less than my desire not to terrify the company, so I never shared that bit of information until days later.

The first CH-46 helicopter arrived in the morning with several wounded. An Iraqi officer with a large open defect behind his knee from a USMC M-16. He was white as a sheet and tachycardic, but I saw a clear save here if we could get some blood into him. Multiple IV attempts by the best of all of us failed and as we exposed the saphenous vein for cannulation, he arrests and dies from prolonged hemorrhagic shock. In the same ambulance is a young USMC officer. He is dead. Shot through the abdomen exiting in the lower back. I have to enter the ambulance to record the injuries. I have seen plenty of dead, having trained in a trauma center. But this is a “good guy”, not a gang banger. It isn’t exactly right. Now it is he and I inside the ambulance, and it is very quiet. I will have this discussion with myself many times in the next few weeks. The C-130 planes are now transporting in wounded as well as helicopters. It is controlled chaos. Calm determination describes our hospital company. All committed, all somewhat numbed. No one complains, they just work. They all have the same blank look on their faces. They all remember the young officer. There is no more rationalizing, no more denials, this
is war. No one falters. A group of young Marines and a Navy corpsman arrive. All have leg injuries from landmines. The corpsman was blown up running to the aid of one of his injured Marines. Their muscular legs are horrifically deformed and shredded full of holes. Under the tent lights, the shrapnel glistens and reflects from inside the wounds. The Marines are quiet. Answering questions. Polite and dignified. Even their injuries and pain doesn’t keep them from saying “Yes mam, no mam” or “Yes sir, no sir.”

The general surgeon meets with the orthopedist for an ad hoc discussion about immediate amputation versus limb salvage in some of the cases present. I started this policy a few weeks earlier to make sure all amputations were deemed the best option with the agreement of at least two surgeons. Two Marines and the Navy corpsman leave the resuscitation area for the OR for amputations. All wounds are left open. Four hours earlier in southern Iraq, a smoke break in the cab of a 7 ton USMC truck is interrupted by an RPG hitting the three Marines inside. Two arrive with shrapnel in their eyes and neck, but not serious enough to warrant immediate surgery. Their Master sergeant has open head wounds, skull fractures and is not arousable. He is intubated. Bleeding profusely from the head and face, he is taken to surgery. The bleeding is stopped and he is taken directly from the OR, while still intubated, to a Blackhawk helicopter. He sees an Army neurosurgeon within 2 hours and undergoes more surgery. We hear later he survived. A helicopter drops off several USMC ambushed while taking an Iraqi surrender. Nine of their fellow “devil dogs” are dead.

A corpsman from our hospital has been killed by an RPG during battle in Iraq. Many people knew him from San Diego. He had two children and a wife. He was twenty-six. Alpha Company begins to hurt. The numbness disappears quickly. A friendly fire injury brings in more young Marines. One marine escaped three burning vehicles only to be badly injured by our own A-10 Warthogs. He gets an exploratory lap, a colostomy and debridement of large buttocks and flank wounds from 30 mm cannon prior to medevac.

An Army soldier arrives after being shot through the left thigh and has no pulses. I joked with him about checking for proper HMO authorization. He laughs loudly. As we leave for the OR, a young Marine behind me is being lifted by the stretcher bearers for a journey to surgery as well. He looks down from the stretcher at the large puddle of his blood underneath and apologizes to the nurse for leaving a mess behind. He says his mother taught him to always clean up after himself. Looking at his face, it is clear it could not have been all that long ago. He appeared barely eighteen. I asked myself “Where do these young men come from?” “What makes them able to do this?” “How does the Marine Corps find them amongst all others?” At this point, I took my one and only trip to the “time out” box to take some deep breaths out in the cool night to regain composure before surgery. The soldier’s artery is grafted and regains its pulse and he is evacuated one hour after surgery. The other young man loses his leg at the knee at the same time as a Saddam Fedeyeen arrives. A dead serious Marine stands over him with an M-16. Any sudden move of a threatening nature and he is to be shot per my orders. His management turns out to be uncomplicated as a Marine sharpshooter has previously placed a shot through his left eye and his brain exits the large defect on the side of his head. A quick consultation with our Catholic Dominican chaplain and he is made comfortable. He arrives in “Martyr’s heaven” early in the morning while most of us have curled up on or under cots (called “racks”) anywhere we could find one. The incoming patients continued for five to six days. As the war moved north, Bravo and Charlie surgical companies were inserted into Iraq and our activity lessened. We received many walking wounded and some that were operated upon by our sister companies. The horrific injuries, unannounced arrival of dead soldiers and Marines, and emergency surgeries stopped almost as quick as they started a week earlier. Terrible weapons accidents as well as some heart-breaking suicides still occurred. Tired young men crashed their large trucks. No one wore seat belts as there was a morbid fear of being trapped after an RPG attack failing to extricate. Weapons were at the ready, but hard to use when confined by a seat belt. Some were just careless. I quietly yelled and screamed at these young men, their mangled bodies, for getting through the war and dying in a careless accident. Seeing the carnage still occurring after combat operations ceased was very difficult for Alpha Company. We thought we had been issued a free pass, or “get out of jail free” cards by late April, but it was not to be. Painful albeit irregular events plagued us. The Combat Stress Team and chaplain worked 24/7 dealing with the many heroes of Alpha Company. The performance of so many young people was so remarkable, but it is ludicrous to think that anyone got off without taking serious emotional and spiritual insults. Some had never seen a dead body, much less someone their own age. Many of us with children had to sort out what we did and the permanent images we have recessed in our psyche. The uninvited replays will be an unwelcome feature we all have to deal with. We dealt with it privately early on. Small groups formed up to discuss things, in most cases indirectly. No one wanted to awaken the sleeping monster yet, just whisper a bit and get some relief and sleep. One day we all apparently had the same epiphany and to my knowledge we haven’t spoken of the most painful
events ever again. There just wasn’t anything else to say. Words can’t describe the feelings so it’s best to not speak about it anymore. Perhaps later the words will come. I feel everyone’s journey will be different.

THE IRAQI PEOPLE
I left Alpha Company in May and assisted the Commanding General, of “123 seconds” fame, with medical affairs throughout Iraq and Kuwait. My duties took me to central Iraq. I was impressed by the infrastructure already in place. As opposed to Afghanistan, Iraq has much of what it needs. It just doesn’t work. I saw the opulence of Saddam’s palaces next to the harsh environs of his people. I saw children and teenagers jumping up and down on the streets happily when we drove by in convoy. Most adults looked at us with either a blank look or one of open hostility. Most of the Iraqis I interacted with were pleasant. The father of a severely injured 12 year old boy we cared for taught me much about the people and where they are coming from. This date farmer (with an MBA no less) now loves the three Navy doctors who cared so much for his son. He was very angry and hostile in the first days. I couldn’t blame him. Maybe nation building starts with the healing of the people. One by one, heart by heart. I never wandered about alone when I was in their cities. I was always armed with a pistol and sometimes an M-16. True meaningful social interaction is sharply stunted when you dress like that. But it was essential in the towns near Baghdad. Interestingly, about the time you think they all want you dead, a few people will walk up, as they did to me and say, “Thank you America ... thank you George Bush”. I feel whoever gives them water, fuel and electricity will always have their gratitude. They are very intelligent people, proud but dreamless, damaged by Saddam and other elements for so long. They love their children as we do ours. No great differences between moms and dads no matter where you live. The real future of Iraq I believe lies within the hearts of those kids jumping and dancing in the street. I hope they get a government that allows them the freedom to dream. I hope also that someday they will never forget the hundreds of young Marines, sailors and soldiers who sacrificed their future and died in Iraq so these children could have those dreams fulfilled.

Captain Stephen F. McCartney, Medical Corps US Navy
July 15, 2003, Point Loma, California

Canadian Association of General Surgeons President’s Dinner
September 2004, Vancouver, B.C.
On January 25, Robbie Burns Day, our thoughts naturally turned to the Scots and to Golf. Legend has it that Mary was spotted playing a few rounds of golf at St. Andrews shortly after the death by strangulation of her husband, Lord Darnley in 1567. Her grandfather, James IV of Scotland in 1502, after a truce with the English had reduced the need of archery practice and at the same time he lifted the ban on golf. Mary's own son, James I of England, was also known to be an avid golfer. When Mary went to France as a young girl, King Louis learned that she was passionate about golf. So, to accommodate her affinity, he had the very first golf course outside of Scotland built for her enjoyment. To make sure that she was properly looked after while she played, he ordered cadets from a military academy to accompany her. Mary took such a liking to those who assisted her in golf outings that when she returned to Scotland she took the practice with her. In French, the word "cadet" is pronounced “ca-day” and it was later anglicized to “caddy”.

Upon fleeing Scotland in 1568, Mary was tried for her role in the killing of Darnley, and remained a prisoner of the Government of England for the rest of her life. The man suspected of the murder of Lord Darnley, the Earl of Bothwell who became her husband, died in a Danish prison. Though Elizabeth was not a strict jailer, Mary plotted ceaselessly to regain her freedom and even to claim the English throne. Finally, in 1587, she was beheaded.  

(Adopted from "Golf's Book of Firsts")
Dr. Vincent Arlet attended the AO International Advanced Spine Course in September 2003 in Tokyo, Japan. Dr. Arlet was a Visiting Professor in Kuwait in December 2003. Also in December, he attended the AO Interactive Spine Course in Davos, Switzerland.

Dr. Paul Belliveau now of Kingston, Ontario has been appointed as President-Elect of the Canadian Association of General Surgeons for the year 2005-2006.

Dr. T.E. Benaroch, in November 2003 in Phoenix, Arizona, was on the Canadian Steering Committee on the Use of BOTOX in C.P.

Dr. Ray Chiu was invited to deliver a lecture at the Japanese Cardiology Society Annual Congress in Tokyo, Japan in September 2003 on his investigation in Using Adult Stem Cells for Myocardial Regeneration and Angiogenesis. He was also invited to lecture at the Congress of the Association of Thoracic and Cardiovascular Surgeons of Asia, held in Bangkok, Thailand in November 2003. In January 2004, he chaired a symposium on "Challenges and Opportunities for Global Cardiothoracic Surgery" at the Society of Thoracic Surgeons meeting in San Antonio, Texas. He served as Chairman of the Expert Committee on Robotic Surgery for the Canadian Foundation for Innovation.

Dr. Anna Derossis recently published her collaborative research with the Breast Service, Memorial Sloan-Kettering Cancer Center. The paper addressed the influence of body mass index (obesity) and age in the success of sentinel node biopsy. The title of her paper was Obesity Influences Outcome of Sentinel Lymph Node Biopsy in Early-Stage Breast Cancer.

Dr. Alain Deschamps, anesthetist at the RVH, received the 2003 Deidre M.M. Gillies Award for Excellence in the Teaching of Anesthesia. This award is presented by the residents in recognition of his "inspiring example both for his clinical and research teaching skills."

Dr. Patrick Ergina is currently enrolled in the Master’s Program in Evidence Based Health Care at Oxford University and will be completing it next year. This 3-year program has been partially supported by a grant from the Meakin’s family fund, the Retention and Recruitment Committee from the Department of Surgery, and time away from the RVH Cardiac Surgery group.

Dr. François Fassier of the Shriner’s Hospital was a Visiting Professor in Kuwait in December 2003.

Dr. Gerald Fried was installed as President of the Canadian Association of General Surgeons, and was appointed to the Board of Governors of the American College of Surgeons. He chaired the Post-graduate Course on Minimally Invasive Surgery at the Clinical Congress of the American College of Surgeons in Chicago in October. Dr. Fried represented the Canadian Association of General Surgeons on the International Federation of Societies of Endoscopic Surgeons. He was appointed to the Editorial Board of the Journal of American College of Surgeons. He was on the organizing committee and Chair of Communications for establishment of the Minimally Invasive Surgery Fellowship Council responsible for setting standards for MIS fellowships and initiating a matching process for fellowships across North America. Dr. Fried was also appointed to the American College of Surgeons Committee on Emerging Surgical Technologies and Education (CESTE). In December 2003, he was a Visiting Professor in the Department of Surgery at Columbia University in New York.

Dr. Philip H. Gordon of the JGH who was cited as one of the Best Doctors in Canada in 2002-2003 has been appointed to the History Committee of the American Society of Colon and Rectal Surgeons. Last November, Dr. Gordon was an invited participant at the 50th Anniversary Meeting of the South Western Ontario Surgical Association in London, Ontario. He was privileged to give the A.J. Grace Memorial Lecture entitled The Surgical Management of Diverticulitis - From Start to Finish and Everything in Between. Afterwards, he went on to make another presentation entitled So you want to write a Textbook - Do you? Confessions of a Tired Author.

Dr. Jean-Martin Laberge was promoted to Full Professor of Surgery as of January 1st, 2004.

Dr. Sarkis Meterissian was elected in December to the Editorial Board of the American Journal of Clinical Oncology.

Dr. Balfour M. Mount is to be congratulated for having been promoted within the Order of Canada. Previously honored by being appointed as a Member of the Order of Canada, he was promoted to be an Officer in the Governor General’s New Year’s Honour List.

Did you know that Dr. Darrell "Dag" Munro in 1971 was the first in Canada to use a flexible fiberoptic bronchoscope? Dr. Munro who now lives in Ste Agathe-des-Monts also started the 1st Anti-Smoking Program at the
Montreal Chest Hospital in the 50's. The Montreal Chest was then known as the Royal Edward Hospital.

Dr. Hani Shennib was the keynote speaker at the Japanese Association of Thoracic Surgery in Tokyo on November 21st, 2003. He spoke on Off Pump Coronary Bypass Surgery in High Risk Patients.

Dr. Andrew P. Steinberg was awarded the Best Paper in Laparoscopy at the 21st World Congress of Endourology in September 2003 for his paper entitled Is Intraoperative Heparin Necessary during Laparoscopic Donor Nephrectomy?

Dr. Dominique Shum-Tim was promoted to Associate Professor of Surgery as of January 1st, 2004. He also was the recipient of The RBC - Royal Bank Award. This award for excellence is given annually by the Royal Bank of Canada to a highly skilled researcher to continue his/her work on stroke. Dr. Shum-Tim of the Montreal Children's Hospital received this award for his project entitled Cardiopulmonary Bypass Management and Brain Protection in Pediatric Cardiac Surgery.

Dr. H. Bruce Williams was recognized as the First Annual INCO Lindsay/Thomson Lecturer at The Hospital for Sick Children, University of Toronto on November 21, 2003.

Achievements Residents and Fellows

Dr. Dennis Klassen (McGill MIS Fellow) presented a video at the Clinical Congress of the American College of Surgeons entitled Laparoscopic Distal Gastrectomy for Watermelon Stomach, which was co-authored by L.S. Feldman and G.M. Fried. Dennis has 8 presentations accepted or invited at the upcoming meeting of the Society of American Gastrointestinal and Endoscopic Surgeons in Denver, co-authored by L. Ferri, V. Sherman, S. Bergman, M. Vassiliou, L. Feldman, D. Stanbridge, and G. Fried. At the upcoming World Congress on Endoscopic Surgery in Cancun, Dennis will give 2 invited presentations. Dennis also has had a paper accepted for presentation at the 124th Annual Meeting of the American Surgical Association in San Francisco.

Dr. Calvin Wan, at the Society of Thoracic Surgeons meeting in San Antonio, Texas in January 2004, had a moderated poster session which was entitled The Outcome of Thirty-Five Patients with Type 2 Heparin-Induced Thrombocytopenia. Calvin was chosen as a finalist for the 4th AMBG Conference in February 2004. The title of his presentation was Tolerance of Adult Porcine Bone Marrow Stromal Cells Xenotransplanted into Rat Myocardium without Immunosuppression.

Dr. Marc Zerey in collaboration with Drs. P.H. Gordon, L.K. Beitel, M. Trifiro received the Canadian Society of Colon and Rectal Surgeons best paper award for a presentation entitled Functional Analysis of Human MLH1 Mutations in Saccharomyces Cerevisiae at the Canadian Surgery Forum in Vancouver in September 2003. Further, Marc Zerey in collaboration with Drs. I. Shrier, S. Caplan, E. Turner, C.A. Vasilevsky received the Canadian Surgery Forum/Bayer Inc. best poster award for a presentation entitled Increased Colorectal Cancer Risk in Patients with Chronic Lymphocytic Leukemia. This address was given in Vancouver last September.

From L to R: Dr. R.Côté, Dr. D. Shum-Tim, Mr. R. Légaré
The Day continued with three papers on Surgical Education by Dr. Ken Shaw, Pediatric Surgeon at the Children's and a 2003-04 Teaching Scholar, summarized his ongoing research work in developing learning modules and looking at speed-reading as a method to enhance learning. Dr. Cynthia Weston, Acting Director of the Centre for University Teaching and Learning and a consultant to the General Surgery Program, talked about her approach to Teaching residents how to teach. Finally, Dr. Sarkis Meterissian talked about his research into using a new assessment tool, called the Script Concordance Test to evaluate residents' intra-operative decision-making skills.

Next up was the highlight of the afternoon, a tough no holds-barred debate between Drs. Meterissian (Pro) and Metrakos (Con) on the topic: Residents Can Follow Article 12 and still become competent surgeons. Both combatants presented their arguments for 10 minutes; had 3 minutes to respond to their opponents' arguments and 1 minute to conclude. The presentations were exciting and heated and in the end a Selection Committee of 11 judges chose Dr. Meterissian as the winner.

The icing on the cake was Dr. Sachdeva's excellent presentation entitled Leadership Training for Surgeons: A Concept Whose Time Has Come.

We then headed to the Ritz-Carlton for a fantastic evening where we celebrated not only Dr. L.D. MacLean but also McGill General Surgery. Three retired surgeons in attendance were recognized: Dr. Roberto Estrada, Dr. John Hinhcey and Dr. Alexander Peter Henry McLean. This is the beginning of a tradition which the Division of General Surgery is trying to develop whereby the L.D. Maclean Day we hope will develop into opportunity for alumni of McGill General Surgery to return to their alma mater. Dr. L.D. MacLean gave an excellent and entertaining after-dinner speech and awards were given to the Best Resident Teachers (Dr. Prosanto Chaudhury) and Dr. Kosar Khwaja) and Best Staff Teacher (Dr. Peter Metrakos). Drs. Suneel Khetarpal, Barry Stein and Sarkis Meterissian were also recognized for their teaching efforts.

The following morning, Dr. Sachdeva presented an excellent Grand Rounds on the Core Competencies and this concluded an excellent and invigorating General Surgery Day. Another person who needs special mention is Ms. Rita Piccioni who was instrumental in organizing the Day.

Submitted by Dr. Sarkis Meterissian, Program Director, General Surgery Residency Training Program, McGill University

Editor's Note
We thank Rita Piccioni for the courtesy of using the photos shown here.
Highlights

1st Prize Winner
Melina Vassiliou

2nd Prize Winner
Moishe Liberman

3rd Prize Winner
Gabriel Chan

Resident Teacher Award
Kosar Khwaja

Resident Group

Staff Group

Resident Teacher Award
Prosanta Chaudhury
At the beginning of a New Year, the young, looking at the future, are wont to make resolutions for the coming year; while the old tend to look back amazed at how the years have sped by, and reflect on what has transpired in their own lives and what they have accomplished in their respective fields of endeavour.

Resolutions and Reflections

This year, 2004 A.D. marks the 43rd year of my association with the Department of Surgery of the Royal Victoria Hospital and McGill University, Faculty of Medicine. During those years, I have had the privilege of serving many patients and the pleasure of making the acquaintance of many professional colleagues whose friendship I treasure. It is postulated that one’s destiny can be shaped by many factors, including nature, nurture and good fortune. I am certain that my destiny took a turn for the better when I elected to come to Montreal rather than Toronto in 1961 and complete my surgical training at the “Vic”.

Reflecting on my own endeavours, there is no doubt that having a superb mentor like Dr. L.D. MacLean played a pivotal role in the career pathways I undertook over these past eventful years! When he arrived from Minnesota, by his personal involvement, he solidified the concept of basic and clinical research in our Department of Surgery as the means of advancing knowledge, and nurtured this in all those surgical trainees fortunate enough to come under his inspired tutelage.

In the year 1974, exactly 30 years ago, I learned about activities of the National Surgical Adjuvant Breast Project, a cooperative group of surgeons dedicated to carrying out clinical research in the form of randomized clinical trials under the inspired leadership of Dr. Bernard Fisher of Pittsburgh. I was fortunate enough to have been chosen as the principal investigator for the Royal Victoria Hospital. Prospectively randomized clinical trials, which are conducted to answer important biologic questions, were not conducted at all prior to this time at our institution. Thus we began a period of scientific endeavour that has led to our participation in clinical research that has given us the evidence to change the way we treat the patient with breast and, later, bowel cancer (The beginning of Evidence-Based Medicine!).

Our relationship with the NSABP first began with our accruing patients to clinical trial B-05, a protocol of adjuvant chemotherapy after surgery, randomizing high risk but potentially curable patients with lymph node positive breast cancer to either oral I-phenylalanine mustard or placebo. This was the first clinical trial to show statistically significant improvement in survival of the group of women with breast cancer who were treated with an anticancer agent. This has led to many subsequent adjuvant therapy protocols with various, newly developed anticancer agents that have clearly shown survival benefits and have dramatically changed the way in which we manage all patients with potentially curable breast cancer after surgery.

The second important trial into which we accrued patients was Protocol B-06. This landmark trial randomized women with lymph node positive breast cancer to 1) a modified radical mastectomy group, 2) a partial mastectomy (lumpectomy) group with axillary node dissection, and 3) a group receiving radiation to the breast alone after lumpectomy and axillary node dissection. Diligent follow-up of every patient entered into this trial revealed no statistical difference in overall survival between the 3 groups at 20 years, but did show that radiation to the breast decreased the incidence of ipsilateral breast cancer recurrences. This result has subsequently saved many an unfortunate woman from undergoing a mutilating mastectomy and has made breast conserving surgery or lumpectomy a household word!

Other trials that the NSABP has successfully initiated are:

1) The use of hormone receptors to randomize patients to subsets for trials with the aromatase inhibitor Tamoxifen;
2) The use of adjuvant therapy for Stage I (node negative) patients as well as Stage II;
3) The use of radiation and Tamoxifen for the treatment of ductal carcinoma in situ (DCIS), a potentially dangerous problem;
4) The use of neoadjuvant (pre-operative) chemotherapy in locally advanced breast cancer leading to downsizing and downstaging but not necessarily to improved survival; and
5) The landmark trial of Breast Cancer Prevention, P-1, using Tamoxifen which showed a definite decrease in the incidence of breast cancer in women receiving Tamoxifen over placebo.

This concept for clinical trials for breast cancer was later utilized for the adjuvant therapy of colorectal cancer in which we have contributed with similar success. The systematic careful, painstaking manner in which the NSABP has devised each and every protocol and the speed in which huge numbers...
of patient accrual is carried out has earned it the respect and admiration of the entire medical world. We are now up to Protocol B-35 in year 2004.

There is no doubt in my mind that the splendid organization that allowed the NSABP to achieve such remarkable results is due entirely to the tremendous vision and forthright leadership of Bernard Fisher. Unfortunate circumstances led to his stepping down as the Chairman after 26 years to be replaced by Dr. Norman Wolmark, once one of our own at McGill. “Bernie” still going strong, continues to contribute as our Scientific Director.

In summary, as I reflect on my endeavours and achievements over the years, I feel that the single most important contribution I have made as a member of the Department of Surgery has been as the Principal Investigator of the NSABP, bringing about clinical research in Oncology in the form of randomized clinical trials. This collaboration has definitely altered the way we manage cancer patients, the way we teach students and residents, and our appreciation of the importance of clinical trials. As such, I must acknowledge the efforts of my surgical colleagues in accruing patients to all the trials, the professional assistance of the clinical coordinators of the NSABP office, and the special skills of the Oncology nurses at the RVH.

Also, a special thanks to the Cedars Cancer Institute for establishing the Edward J. Tabah Oncology Day Center and the Cedars Breast Clinic of the MUH, which expedite the humane management of our cancer patients. Most of all, I wish to thank the more than one thousand Vic patients over the past 30 years who have heeded our appeal to participate in these important clinical trials, and duly volunteered to help produce the much-needed “evidence” necessary to scientifically modernize the treatment of breast and bowel cancer.

Henry R. Shibata, MD
Senior Surgeon, MUHC
Professor of Surgery and Oncology – McGill
Medical Advisor, Cedars Cancer Institute

WERE YOU THERE? SURGICAL ATTENDING STAFF - R.V.H. 1973

<table>
<thead>
<tr>
<th>SURGEON-IN-CHIEF</th>
<th>H. Himal, M.D.</th>
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<td></td>
<td>Geofrey Lehman, M.D.</td>
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<td>David T.W. Lin, M.D.</td>
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<td>P. Madore, M.D.</td>
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<td>Robert McLeod, M.D.</td>
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<td>Stanely C. Skoryna, M.D.</td>
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<td>H.D. Stevens, M.D.</td>
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<td>M.J. Wexler, M.D.</td>
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<td>ASSOCIATED SCIENTISTS</td>
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<td></td>
<td>Robert Demers</td>
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<td></td>
<td>J. Gordon, M.D.</td>
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<td>J.H. Oh, M.D.</td>
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<td>S. Pitzele, M.D.</td>
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<td></td>
<td>VETERINARY CONSULTANT</td>
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<td></td>
<td>Leslie Lord, D.V.M.</td>
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<th>ATTENDING STAFF</th>
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<tr>
<td>Senior Surgeons</td>
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<tr>
<td>Anthony R.C. Dobell, M.D.</td>
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<td>R.C. Long, M.D.</td>
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<tr>
<td>D.D. Munro, M.D.</td>
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<td>E.J. Tabah, M.D.</td>
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<td>Associate Surgeons</td>
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<tr>
<td>Ray N. Lawson, M.D.</td>
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<td>A.P.H. McLean, M.D.</td>
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<td>E.D. Monaghan, M.D.</td>
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<tr>
<td>Henry R. Shibata, M.D.</td>
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<tr>
<td>Assistant Surgeons</td>
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<tr>
<td>Jean Gay Beaudoin, M.D.</td>
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<td>N.J. Belliveau, M.D.</td>
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<td>M.S. Chughtai, M.D.</td>
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<td>Peter W. Cohen, M.D.</td>
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<td>A.N. Freedman, M.D.</td>
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<td>L.T. Genender, M.D.</td>
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OVERVIEW OF SEVERE OBESITY
AND MORBID OBESITY

Obesity can be defined as a disease in which excess fat has accumulated such that health may be adversely affected and mortality increased. Obesity is a serious public health threat. After smoking, it is the second leading cause of preventable, premature death.

Obesity is considered a multi-factorial disease, ultimately resulting from an imbalance between energy intake and expenditure. The causes for this energy imbalance are complex and only partially understood. Many of these factors have some genetic component; the genetic contribution to the causes of obesity is around 25-40%.

Morbidity obesity is defined as an abnormal health condition in which excess adipose tissue results in a Body Mass Index (BMI — weight/squared height ratio) greater > 40 kg/m².

Severe obesity and morbid obesity are associated with several co-morbidities such as Diabetes, Hypertension, Dyslipidemia, Sleep Apnea, Depression, Dyspnea (especially with exertion), Angina Pectoris, Arthritis/Joint pain, Pulmonary Embolism, Cancer (Breast, Colorectal, endometrial), Stroke etc.

In addition to the above, the activities of daily living (tying shoes, hygiene such ability to wipe oneself after a bowel movement, fitting into car, bus, or plane seat) are severely impacted by morbid obesity — depending on the specific BMI of the individual. Additionally, morbidly obese individuals also suffer from social stigmatization and discrimination.

The increase in obesity and morbid obesity is not confined to wealthy countries. The World Health Organization (WHO) has recognized an epidemic of obesity throughout most of the developed and developing world.

Canadian adult surveillance data show marked increases in obesity (BMI > 30 kg/m²) over a 13-year period: 5.6%, 9.2%, 13.4%, 12.7% and 14.8% for the years 1985, 1990, 1994, 1996 and 1998 respectively. In 1998, the adult population of Canada was 22.2 million; thus, the prevalence of obesity in that year translates into 3.3 million obese Canadians. There is no evidence that this epidemic in Canada or elsewhere has reached its peak. In addition the increasing prevalence of obesity in children is alarming and heralds a life long disorder with great risk of obesity related disease. The prevalence of obesity among 7 to 13 year olds rose from 5% in 1981 to 17% in 1996 for boys and 15% for girls. The Institut de la Statistique du Québec reports that almost a quarter of 9 year olds and half of 16 year olds in that province are at risk of heart disease in later life because of lifestyle factors, such as obesity, physical inactivity, or smoking.

Severe obesity and morbid obesity carries significant health risk. The relative risk of death and disease for patients with a BMI > 40 compared to normal BMI of 26-28 is shown below.

<table>
<thead>
<tr>
<th>RELATIVE RISK &gt; 5.0</th>
<th>RELATIVE RISK &gt; 2 TO 5.0</th>
<th>RELATIVE RISK 1 TO 2</th>
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<tr>
<td>Type 2 Diabetes</td>
<td>All cause Mortality</td>
<td>Cancer Mortality</td>
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<tr>
<td>Dyslipidemia</td>
<td>Hypertension</td>
<td>Breast cancer</td>
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<tr>
<td>Obstructive Sleep Apnea</td>
<td>Myocardial Infarction and Stroke</td>
<td>Prostate and Colon cancer in men</td>
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<tr>
<td>Breathlessness</td>
<td>Endometrial Carcinoma</td>
<td>Impaired Fertility</td>
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<tr>
<td>Excessive Daytime Sleepiness</td>
<td>Gallstones and complications including cancer</td>
<td>Obstetric complications including Fetal abnormalities</td>
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<td>Obesity Hypoventilation Syndrome</td>
<td>Polycystic ovary syndrome</td>
<td>Asthma</td>
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<tr>
<td>Idiopathic Intracranial Hypertension</td>
<td>Osteoarthritis (knees)</td>
<td>Gastroesophageal reflux</td>
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<tr>
<td>NASH</td>
<td>Gout</td>
<td>Anaesthetic Risk</td>
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ECONOMIC BURDEN TO SOCIETY

The total cost of obesity in 1997 was estimated at over 1.8 billion dollars in Canada (2.4% of total health care expenditures for all diseases). The three largest contributors were hypertension, type II diabetes, & coronary artery disease.

In 2001, the obese population was responsible for 1,569,000 GP physician and 37,000 specialist visits (65% of visits were by women). Females aged 40-59 were responsible for 1/3 of these visits.

Furthermore, obesity is associated with a 36% increase in both inpatient and outpatient spending, as well as a 77% increase in medication spending. This is greater than the increases attributed to smoking and alcoholism.
CURRENT TREATMENT OPTIONS

Medical Options
There are a variety of medical treatments for obesity including: Diet therapy, Physical Activity, Behavior Therapy, & Pharmacotherapy. The specifics of these treatments will not be discussed here.

It is important to note however, that medical management of morbid obesity is not successful. Fewer than 10% of morbidly obese patients that successfully reduced their weight using a combination of diet, behavior & exercise can maintain this weight loss for more then 1 year.

Surgical Options
The National Institutes of Health Consensus Conference, March 25-27, 1991 recommended the following:

- Medical therapies generally fail to control severe obesity
- Surgery should be considered for individuals with BMI > 40 Kg/m²
- With co-morbidities of obesity, such as diabetes or sleep apnea, consider surgery with BMI > 35 Kg/m²

Malabsorptive Procedures:
- Jejuno-ileal bypass (now abandoned due to high long term malabsorptive complications)
- Bilio-pancreatic bypass (with or without duodenal switch)

Restrictive procedures:
- Vertical Banded Gastropasty
- Roux-En-Y gastric bypass (GOLD STANDARD), with or without a malabsorptive component
- Adjustable Gastric Banding

BARIATRIC SURGERY AT MCGILL AND THE MUHC
The first weight loss surgery at McGill (Royal Victoria Hospital) was performed 40 years ago in 1963. This was a jejunoileal bypass by Dr. H. Shibata and Dr. R. Long. Data from such procedures were reported at the surgical forum in 1966: Henry R. Shibata, James R. Mackenzie, Richard C. Long: “Metabolic Effects of jejunoileal bypass”: Surg Forum XVII, 29-32, 1966.

In 1967 bariatric surgeons at the Vic (Dr. Shibata, Dr. LD MacLean) started performing the Jejunoileal bypass. This procedure was offered until 1980 when LD McLean reported significant complications on 45 cases with 8 year follow-up, including malnutrition, liver failure, severe diarrhea, and electrolyte imbalance.

Bariatric surgeons at the MUHC (LD MacLean, AR Forse, APH McLean) switched to vertical banded gastropasty without separation of the staple line. After several failures due to gastro-gastric fistula across this staple line surgeons started separating the staple line. Despite this they saw (and we continue to see up to 20 years later) failures due to stenosis at the outlet and pouch enlargement.

Following a randomized study reported by LD MacLean in 1989 which showed the following results, vertical banded gastropasty was replaced by the Isolated Roux-en-Y gastric bypass as the main weight loss surgical procedure.

<table>
<thead>
<tr>
<th></th>
<th>VERTICAL BANDED GASTROPLASTY</th>
<th>ISOLATED ROUX-EN-Y GASTRIC BYPASS</th>
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<tbody>
<tr>
<td>Procedures</td>
<td>54</td>
<td>43</td>
</tr>
<tr>
<td>Patients</td>
<td>25</td>
<td>30</td>
</tr>
<tr>
<td>Reversed</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>Follow-up (months)</td>
<td>70.9±5.8</td>
<td>35.8±19</td>
</tr>
<tr>
<td>Success</td>
<td>9(16%)</td>
<td>25(63%)</td>
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ISOLATED ROUX-EN-Y GASTRIC BYPASS
Since 1989 bariatric surgeons at the MUHC (Dr. R. Brown at the MGH site and Drs. LD MacLean, RA Forse, CN Nohr, APH McLean and NV Christou at the RVH site) offered the open Gastric bypass (Roux-en-Y at the RVH, loop gastrojejunostomy at the MGH) to prospective clients.

Dr. AR Forse relocated to the US in 1988. Dr. CN Nohr relocated to Alberta in 1995. Dr. LD MacLean retired from surgery in 1994. In 1995 Drs. NV Christou and APH McLean continued to offer open Isolated RY bypass to clients at the MUHC. With the retirement of Dr. APH McLean in 2000, Dr. NV Christou handles the entire surgical work load. He has limited his practice exclusively to weight loss surgical procedures.

Results on long term weight loss were published recently (MacLean et al Ann. Surg. 231:2000) and are

<table>
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<tr>
<th>VARIABLES</th>
<th>MORBIDLY OBESE</th>
<th>SUPER-OBESE</th>
<th>p VALUE</th>
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<tbody>
<tr>
<td>Number</td>
<td>147</td>
<td>96</td>
<td></td>
</tr>
<tr>
<td>Preop. BMI (kg/m²)</td>
<td>44 ± 3</td>
<td>56 ± 6</td>
<td>&lt;.0001</td>
</tr>
<tr>
<td>Lowest BMI (kg/m²)</td>
<td>26 ± 4</td>
<td>31 ± 5</td>
<td>&lt;.0001</td>
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<tr>
<td>Time of lowest BMI (yrs)</td>
<td>2.1 ± 1.4</td>
<td>2.3 ± 1.5</td>
<td>NS</td>
</tr>
<tr>
<td>Final BMI (kg/m²)</td>
<td>29 ± 4</td>
<td>35 ± 7</td>
<td>&lt;.0001</td>
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<tr>
<td>Excellent Result (BMI &lt; 30)</td>
<td>88 (60%)</td>
<td>25 (26%)</td>
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<tr>
<td>Good Result (BMI 30-35)</td>
<td>49 (33%)</td>
<td>30 (31%)</td>
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<tr>
<td>Failure (BMI &gt; 35)</td>
<td>10 (7%)</td>
<td>41 (43%)</td>
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summarized below. Our overall mortality is 0.5%. We strive to continually improve these outcomes at McGill. Our goal is to improve the failure rate (43%) in the super obese. In the past 3 years we have reduced this to 20%. These results are considered among the best results available in the literature.

Persistent Complication of open gastric bypass:
The most frequent and persistent complication of this open approach to gastric bypass has been wound infection in 20% of cases. We reported our findings on wound infections to the American Society of Bariatric Meeting in Boston June 2003 (paper in Press Jan 2004 issue of Obesity Surgery).

Almost all wound infections were followed by an incisional hernia that required 1-3 surgical interventions to correct.

LAPAROSCOPIC ROUX-EN-Y GASTRIC Bypass
One way to prevent the development of a wound infection is not to make a large incision. This could be accomplished by a laparoscopic approach to the isolated RY gastric bypass. The Roux-en-Y Gastric bypass was first performed by minimal access surgery (laparoscopic route) in 1993 by Allan Wittgrose.

We felt that the ability to hand-sew the gastrojejunosotmy (in order to create the very small pouch that we have shown is needed to achieve excellent results after gastric bypass surgery) was an essential component to our switching to a laparoscopic approach.

After visiting with experts in laparoscopic and bariatric surgery (Dr. Michel Gagne NY, one of our former residents, Dr. Philip Schauer Pittsburgh, Dr. Kelvin Higa, California, and others) over a 3 year period Dr. NV Christou performed the first laparoscopic RY isolated gastric bypass at the MUHC on February 8th 2002. Dr. Marvin Wexler assisted. The first case took 5 hours and 20 minutes to complete. The patient left the hospital in 60 hours.

On Jan 8th 2004 we completed our 200th laparoscopic RY gastric bypass. These are all done using an intracorporeal suturing technique of the gastro-jejunosotmy which permits pouch sizes fewer than 15 ml. The pouch size does not admit stapling instruments to do a stapled anastomosis. Also the leakage rate (a potentially lethal complication) has been shown to be less with this technique (with experience as evidenced at right).

Our preliminary results to date follow:
- N=200
- BMI range 39-58 (mean 51)
- OR time 90-120 min
- 4 leaks (all early technical problems in cases #9, #15, #26, #51. None since case #51)
- 2 Pulmonary Embolus
- 1 conversion to open Roux-en-Y Gastric bypass
- No wound infections
- 6 dilatations (at about 4-6 weeks)
- LOS 2.1 days (vs. 4.7 open)

THE FOLLOWING GRAPH SHOWS THE NUMBER OF BARIATRIC SURGERY PROCEDURES AT THE MUHC PER YEAR SINCE 1995

HERE IS A COMPARISON OF THE INCISIONS AFTER THESE TWO PROCEDURES:
LAPAROSCOPIC Isolated Gastric Bypass

LAPAROSCOPIC ADJUSTABLE GASTRIC BANDING (LAGB)
A new surgical method for weight loss has become available which uses a restrictive approach. Restrictive bands can be placed around the upper stomach to partition a small proximal pouch. Initially non-adjustable and designed for open placement, refinement of these devices has resulted in an adjustable appliance which can be placed laparoscopically. The major benefits are considered to be minimally invasive placement, adjustability and preservation of normal gastrointestinal integrity. Because there are no anastomoses the potential for infection subsequent to a leak is minimized, as is the operative mortality (0.17% vs. 0.50%). However, concern persists regarding the long term efficacy of laparoscopic gastric banding, the incidence of adverse events and the requirement for re-operation in a proportion of patients. We have performed 18 such procedures since we started to offer this to carefully selected patients in February 2003.

THE FUTURE OF BARIATRIC SURGERY AT THE MUHC
The obesity epidemic, combined with the low number of available surgeons offering weight loss surgery options in Canada and in particular Quebec, has placed a huge demand on the Bariatric Surgery Program of the Division of General Surgery, McGill University Health Center. Currently there are 1380 patients waiting for consultation with the surgeon (Dr. N. Christou, the only surgeon left offering this type of surgery at McGill). In addition 202 patients have been evaluated and are waiting to be scheduled for pre-admission and to be given a surgery date. Most of these patients have severe co-morbidity.

The MUHC is the only center in Canada currently offering a comprehensive open and laparoscopic bariatric surgery program. Patients requesting pancreaticobiliary diversion with duodenal switch are referred to our colleagues in Quebec City.

We also provide training in laparoscopic bariatric surgery to established surgeons across the country. Drs. Josee Mihangos and Dennis Bruilette from Val D’Or have been trained and currently perform about 25 laparoscopic RY gastric bypasses per year. Most recently Dr. Sylvain Beausoleil from Moncton NB finished a one month preceptorship at the MUHC and has performed his first 2 laparoscopic RY gastric bypasses in Moncton. He is the one at far left next to Ms. Lilly Poon, Head Nurse main OR theaters 11&12, and Dr. Fahad.
March 17 is St. Patrick's Day

SO YOU THINK YOU'RE IRISH?
TRY THIS SHORT QUIZ!

1. What is the leprechaun's legendary profession?
   a) tour guide
   b) tailor and cobbler
   c) banker
   d) garden ornament

2. Where was the seat of the High Kings of Ireland?
   a) Tara
   b) Dublin Castle
   c) Armagh
   d) Galway

3. Where did the potato blight of the 1840s, which led to famine in Ireland, originate?
   a) England
   b) Turkey
   c) Ireland
   d) The United States

4. What is a bodhrán (bow-rawn)?
   a) a musical instrument
   b) a type of cow
   c) a farm tool
   d) a musical tune

5. How many pints of stout does Guinness's fermenting vessel ferment at one brewing?
   a) 1,406,000
   b) 502,000
   c) 421,000
   d) 2,304,000

6. What is the official symbol of Ireland?
   a) the wolfhound
   b) the harp
   c) the shamrock
   d) the Celtic cross

7. What are the two most common surnames in Ireland?
   a) Kelly, O'Connor
   b) O'Sullivan, O'Connell
   c) McCarthy, Byrne
   d) Murphy, Kelly

8. On what days are Irish pubs closed?
   a) never
   b) every Sunday
   c) Good Friday and Christmas Day
   d) Ash Wednesday and Good Friday

9. Where is the Book of Kells displayed?
   a) the National Museum
   b) the National Gallery
   c) Dublin College
   d) Trinity College Library

10. What is "blarney"?
    a) lies
    b) flattery
    c) Gaelic
d) insults

(Find the answers on page 26)
Saddam Hussein was sitting in his office wondering whom to invade next when his telephone rang. "Hallo, Mr. Hussein!" a heavily accented voice said. "This is Paddy down at the Harp Pub in County Sligo, Ireland. I'm ringing to inform you that we are officially declaring war on you!"

God Bless the Irish!

"Well, Paddy," Saddam replied. "This is indeed important news! How big is your army?"

"Right now," Paddy replied, after a moment's calculation, "there is meself, my cousin Sean, my next door neighbour Seamus, and the entire dart team from the pub. That makes eight!"

Saddam paused. "I must tell you, Paddy, that I have one million men in my army waiting to move on my command."

"Begorra!" said Paddy. "I'll have to ring you back!"

Sure enough, the next day, Paddy called again. "Mr. Hussein, the war is still on! We have managed to acquire some infantry equipment!"

"And what equipment would that be, Paddy?" Saddam asked.

"Well, we have two combines, a bulldozer and Murphy's farm tractor."

Saddam sighed. "I must tell you, Paddy, that I have 16,000 tanks and 14,000 armoured personnel carriers. Also, I've increased my army to one and a half million since we last spoke."

"Saints preserve us!" said Paddy. "I'll have to get back to you."

Sure enough, Paddy rang again the next day. "Mr. Hussein, the war is still on! We have managed to get ourselves airborne! We've modified Harrigan's ultra-light with a couple of shotguns in the cockpit and four lads from the Shamrock Pub have joined us as well!"

Saddam was silent for a minute and then cleared his throat. "I must tell you, Paddy, that I have 1000 bombers and 2000 fighter planes. My military complex is surrounded by laser-guided, surface-to-air missile sites. And, since we last spoke, I've increased my army to TWO MILLION!"

"Jesus, Mary and Joseph!" said Paddy. "I'll have to ring you back."

Sure enough, Paddy rang again the next day. "Top o' the mornin', Mr. Hussein! I am sorry to tell you that we have had to call off the war."

"I'm sorry to hear that," said Saddam. "Why the sudden change of heart?"

"Well," said Paddy, "we've all had a long chat over a few pints and decided there's no bloody way we can feed two million prisoners."

God Bless the Irish!

Letters
(continued from pg. 2)

Dear Editor,
It was so good to hear from you. Life is good. My two boys, 7 and 8, are healthy and a great joy to their parents. Despite a very busy surgical practice, I think I am managing to be a good mother (actually I think I'm a great Mom!).

About 30% of my practice is hand surgery and 40% breast reconstruction. I strive to keep my cosmetic practice small, as I find it more rewarding to work on patients in need. This undoubtedly stems from my 5 years of General Surgical Residency at McGill. They were wonderful years. (I still sneak in the odd hernia repair).

I am surrounded by McGill graduates here in Moncton. I have had several consultation requests from Dr. Hinchey and Dr. Hreno (Amherst locums) in recent years. A surprise at first.

A McGill Plastic Surgery program graduate, Dr. Ali Husain, joined us in 2002 and he is a wonderful addition. His wife just had a baby.

I often find myself quoting my McGill Surgery Staff Mentors. Just the other day, I told a resident not to "Gild the Lily" (Shibata). You and Dr. Elhilali (and staff) deserve "Kudos" for your work with The Square Knot.

Maybe McGill University Surgery can find a reason to hold a reunion for all Alumni and staff throughout the years. I'll be there. ♥

Susan Skanes, M.D.
[General Surgery 1984-89]
Dieppe, New Brunswick
Visiting Professors

3rd SEMI-ANNUAL AO/ASIF VISITING PROFESSOR, NOVEMBER 20, 2003
Dr. Gregory R.D. Evans, Professor and Chief of the Aesthetic and Plastic Surgery Institute and the University of California, Irvine Orange, California, was the AO/ASIF Visiting Professor. Dr. Evans is an accomplished educator and clinician. He holds expertise in reconstructive microsurgery and maxillofacial trauma. A prolific author with voluminous peer reviewed publications, he recently has authored a leading textbook in Plastic Surgery. His leadership and contributions have been recognized by many prominent organizations. He currently serves as the Vice-President of the American Society of Maxillofacial Surgeons.

At Surgical Grand Rounds, Dr. Evans spoke on the Role of Technology, Science, and Research in the Reconstruction of a Mandible After Tumor Ablation. This was followed by a session on "Ask the Professor" in which cases were presented by Plastic Surgery residents. Dr. Evans then gave another talk entitled Fun Resident Quizzer: What Your ABPS Examiner Expects You to Know, followed by a luncheon with the residents.

It was a distinct honor to welcome Dr. Gregory Evans to McGill University as the 3rd Semi-Annual AO/ASIF Visiting Professor.

DIVISION OF SURGICAL RESEARCH:
THE SECOND ANNUAL COLLIP VISITING PROFESSOR IN INNOVATION IN BIOMEDICAL RESEARCH

On February 16th, 2004, Dr. David Hill, Professor of Medicine at the University of Western Ontario, Scientific Director of the Lawson Health Research Institute and V-P Research at St. Joseph's Health Care in London, Ontario, was this year's Collip Visiting Professor.

The day began with a tour of the laboratories in the University Surgical Clinic of the Montreal General Hospital, and then research seminars were held in the Fraser Gurd Conference Room.

9th ANNUAL
H. ROCHE ROBERTSON VISITING PROFESSOR IN TRAUMA
JANUARY 21-22, 2004
Dr. Steven Stylianos was educated at Rutgers University and the New York University School of Medicine. He completed his General Surgical training at Columbia Presbyterian Medical Center, and subsequently spent two years as the Trauma Fellow at the Kiwanis Pediatric Trauma Institute in Boston. Dr. Stylianos is currently the Medical Director of the Operating Room at the Children's Hospital of New York. He organized and directed the 30-member team of physicians and nurses who separated conjoined twins at Children's Hospital of New York in 1993, 1995 and 2000.

On Wednesday, January 21st, 2004, Dr. Stylianos attended Surgery, Radiology and Pathology Rounds at the Montreal Children's Hospital as well as attending the Residents' Clinic. After lunch, there was an academic program of resident presentations, followed by a Special Lecture given by Dr. Stylianos entitled The Injured Family: Hidden Morbidity in Pediatric Trauma. The winners in this year's resident competition were:

1st Prize Dr. Eric Roger
2nd Prize Dr. Stephen Walsh & Dr. Wendy Parker
3rd Prize Ms. Barbara Haas

On Thursday morning at Surgical Grand Rounds at the Montreal General Hospital, he spoke on Evidence-Based Guidelines in Pediatric Abdominal Trauma.

It was an honor to welcome Dr. Steven Stylianos to McGill as our 9th H. Rocke Robertson Visiting Professor in Trauma.

Following lunch, Dr. Hill gave a scientific presentation at the McIntyre Medical Sciences Building entitled Understanding the Limits and Drivers of Islet Plasticity. Later that day in the Osler Amphitheatre of the MGH, Dr. Hill gave a lecture entitled Challenges and Opportunities for Research in Canada in the 21st Century.

Following the lecture, a reception was held in the Livingston Hall Lounge.
O

n May 23rd, 1962, Dr. Ronald Malt, a resident in surgery at Massachusetts General Hospital was called on an emergency ambulance call. Malt had no idea that he might be taking part in a revolutionary experiment by the time his emergency duty day had been completed.

Mao’s Red Book Solves Replantation Problems

By Martin A. Ettlin, M.D.

The police had to make way through the crowd for Malt and the ambulance driver carrying the stretcher to where the injured person was lying. Malt realized that the young boy had amputated his left arm at the shoulder; he turned his attention to the patient to assess the loss of blood and the state of circulation. The boy was pale, but in reasonably good shape. He decided to start an intravenous saline drip and then turned his attention to the amputated arm that was lying on the gravel a few feet away.

Suddenly, a thought went through his mind: “I’d better bring the arm with me.” He put sterile bandages on the raw area at the shoulder and wrapped it into a blanket. Malt realized that after he alerted the main operating room that he has a “possible replantation” that he would need great persuasion to assure the vascular surgeon, the orthopaedic surgeon, the plastic surgeon, and the general surgeon, that it would be worthwhile to take part in a “unique experiment” of replanting the amputated arm, for the first time. By 3:00 a.m., Malt knew it was worthwhile: the replantation arm had good circulation and a new speciality was born.

The report of the successful replantation in Boston, which resulted in useful function to the boy’s arm, rapidly spread throughout the world.

Dr. Ch’en Chung Wei, the Chief of the Orthopaedic Service of the Sixth People’s Hospital in Shanghai, China, followed the recovery of the replanted limb of the twelve-year-old American boy with great interest. China was in the midst of industrial revolution with thousands of workers using machines whose safety features were not always reliable. Considering the number of hand injuries that resulted in this large workforce, China had “monopoly” on finger and limb amputations. The Sixth People’s Hospital in Shanghai being in the center of the industrial area had to treat a large number of these injuries. After the report by the American surgeons of successful replantation of the amputated limb, Ch’en Chung Wei saw tremendous possibilities of salvaging of the injured hands and limbs of the Chinese workers. Ch’en presented the story of the successful replantation, by the American surgeons, to chairman Mao Tse Tung, requesting permission to apply this method to Chinese workers.

Communication between China and the rest of the world was somewhat restricted during that period (1965-1975). Consequently, North American surgeons were intrigued to read medical articles in The Chinese Publication. During the late 60’s, reports about successful replantation of limbs and digits appeared among Chinese publications. Personal contact between Chinese medical groups and the rest of the world was non-existent. Consequently, the amazing achievements by the Chinese remained as hearsay until verified. In 1971, the Chinese medical publications reported successful replantation of scores of amputated limbs and hundreds of amputated digits. American replantation surgeons gathered at the annual meeting of the American Society of Surgery of the Hand in 1971 were amazed at the extent of success achieved by the Chinese replantation surgeons. They formed a group of North American Replantation Surgeons, and wrote to the Chinese Medical Association requesting permission to visit Chinese medical centers, in order to recognize the successful contribution by the Chinese surgeons.

In the Spring of 1973, the Chinese Medical Association agreed to host the eleven members of the North American Replantation Mission (ARM) with suggested itinerary of medical centers that included Canton, Shanghai, and Peking. The Chinese Medical Association generously provided hotel accommodations and transportation during our two week visit. They also arranged visits to important Chinese facilities, such as, silk factory, ivory carving factory, and other important establishments.

CHINESE EXPERIENCE

The Chinese Medical Association spared no effort to bring dozens of patients who underwent replantation of their amputated limbs and digits from many parts of China. At the Sixth People’s Hospital in Shanghai, we were able to examine the extent of the success of replantation, at leisure. Many had photographs, X-ray films, and other documentation as part of their medical records.

In addition, we were able to examine a number of patients at the hospital in various stages of healing after recent replantation. Especially productive were formal discussion periods between our Chinese hosts and members of the ARM: there were facilities that permitted presentation with slides so that meaningful exchanges were obtained.
Particularly memorable was the candid way in which Dr. Chi'en Chung Wei, the Chief of Service at the Shanghai Hospital, reviewed his experience over the ten years in which he had been involved in replantation. Up until about 1970, his overall success rate was 50-60% of replanted parts. He was frustrated by the fact that he could not achieve higher success. Chi'en described that, 24 hours after the repair of an artery, the vein and nerve for each finger, most of the fingers remained pink and warm; but he felt frustrated that half of the patients' fingers showed a dusky colour at the tip. He interpreted it as stagnation, which usually increased an area. Within a few days, the finger became darker and frequently gangrene would set in with loss of the replant.

Most of the surgeons who do replantation are too familiar with this process. Chi'en told us that during one bad period he observed this sequence of events in 19 consecutive implants. Realizing that there was something wrong in what he was doing, Chi'en decided to retreat into a commune to resolve the problem. The traditional Chinese 'retreat' consisted of working hard by day, and reading Chairman Mao's Red Book by night. Chi'en told us that one evening he came across a passage that seemed to have direct bearing on the problem that frustrated him. The passage read: "In dealing with forces of unequal strength, one has to strengthen the weak to overcome the strong."

We all knew that in replantation, the surgeon deals with two forces: a) strong, the dynamic artery; b) weak, the passive venous circulation. Traditionally, the surgeon repairs one artery and one vein for each finger. Sometimes, one vein was inadequate to provide venous drainage and gradual stagnation would lead to death of tissue. Mao's admonition suggested reinforcing "the weak to overcome the strong."

Chi'en could not wait to get to the hospital to try connecting two or three veins for each digit which solved the problem of inadequate venous drainage. Chinese surgeons achieved 80% survival of reimplanted complete amputations when using more than one vein. In symbiosis that resulted from exchange of valuable information with the Chinese surgeon benefited both sides. Dr. Chi'en was invited by the author of this article, who as a member of ARM, to present his findings at the Annual Meeting of the American Society for Surgery of the Hand, which was held in Dallas, in the early part of 1974. This was one of the first formal exchanges of medical information between "isolated" China and the Western Medical World. ✷

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**A Pod of Whales, A Pride of Lions**

Where would we be without a **gaggle** of geese, a **grunt** of pigs, a **murder** of crows, etc.?  

Here is a special list for Medical Specialists:  

- A **sneeze** of allergists  
- A **snooze** of anesthetists  
- A **chest** of CVT surgeons  
- A **rash** of dermatologists  
- A **clan** of family physicians  
- A **pair** of Geneticists  
- A **senate** of geriatricians  
- A **stone** of nephrologists  
- A **wave** of neurologists  

A **glow** of nuclear physicians  
An **eyeful** of ophthalmologists  
A **slab** of pathologists  
A **brood** of pediatricians  
A **primp** of plastic surgeons  
A **babble** of psychiatrists  
A **ray** of radiologists  
A **wheeeze** of respirologists  
A **joint** of rheumatologists  
A **duct** of urologists  
A **vein** of vascular surgeons  
A **slice** of general surgeons

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**Answers to the page 22 Quiz**

b) tailor and cobbler  
a) Tara  
d) The United States  
a) a tambourine  
d) Murphy and Kelly  
c) Good Friday and Christmas Day  
d) Trinity College Library  
b) flattery

So, did you do as well as you expected? Don't worry, these questions were borrowed from *So You Think You're Irish* by Margaret Kelleher. There are over 500 great questions on everything Irish.
NEW RECRUITS TO THE DIVISION OF GENERAL SURGERY HELP CARRY ON THE TRADITION

Many mature readers of The Square Knot can still reminisce of their remote junior and/or senior 6-month rotations as General Surgery residents at St Mary's Hospital. Under the close and involved, and sometimes obsessive, supervision of their eclectic staff surgeons, such as Jack Dinan, Frank Flood, Stanley Skoryna, Ben Thompson and Jose Rodriguez to mention a few, their usually very busy St Mary's surgical stints provided them with the much-appreciated opportunity to fine-tune their surgical skills in a rather unique combined community-teaching environment with a heavy and varied caseload.

This special environment relates to the fact that St Mary's has a very strong General Surgery tradition and a longstanding link with McGill. The hospital was initially established in the now Architectural Museum on Dorchester street in 1924 by the great Dr. Donald Hingston, then a young Surgeon working at Hotel Dieu Hospital where his father was the Surgeon-in-Chief. He recognized then the need for a hospital that would ensure access to quality care for all, including the seemingly neglected Irish Catholic community. The general surgeons, along with their colleagues, later provided the needed leadership to move to its current site on Lacombe and the subsequent expansion. A commitment to maintain a strong Division of General Surgery along with its Residency Training program, all within a vibrant Department of Surgery, have all been upheld by the successive Executive Directors, including Drs. Constance Nucci and Arvind K. Joshi who both had very active prior clinical practices at St. Mary's and strong ties with McGill University.

The Hospital administration opened the first formal General Surgery Surgical Teaching Office in 1982, along with excellent support staff, to ensure that all medical students and residents rotating through St. Mary's Division of General Surgery could be closely monitored and provided with both optimal clinical teaching and appropriate exposure to a large volume of surgical cases. Carl Emond, who recently completed two terms as Surgeon-in-Chief, and Dawn Anderson who has recently taken over the position as Director of Surgical Teaching have both benefitted in their efforts to provide optimal clinical teaching from the unflinching devotion of Catherine Kerr who has occupied the position of Administrative Surgical Teaching Coordinator since then, and is well known and much appreciated by all those who have rotated through St Mary's during the last 20 years.

The result of these efforts have been the Royal College's consistently highest ratings for St Mary's contribution to McGill's General Surgical Training Program, with the offshoot that it maintains its popularity as a training site for both students and residents. This reputation in turn facilitated the task of recruiting new General Surgeons to replenish the ranks and carry out the mandate of providing both then needed state-of-the-art surgical expertise of a University-affiliated institution, while at the same time covering all the surgical needs of a community-based hospital. In the last three years, the Division has recruited 5 new General Surgeons, including Gabriela Ghitulescu and Erica Patockai, both of whom subsequently moved due in part to a combination of over-recruitment relating to the complex Régie Régionale regulations along with healthy opportunities elsewhere. The remaining three recruits ensure the Division's ability to maintain its commitment to the needs of both its trainees and its community. Dawn Anderson, having completed her surgical oncology training at McGill provides additional expertise primarily for breast, thyroid, head and neck and gastrointestinal oncology-related issues. Naim Otaky, who rotated through St Mary's on a number of occasions, is finalizing a laparoscopic fellowship to compliment the laparoscopic expertise of Drs. Tataryn, Emond and Anderson who can now benefit from the recent opening of a brand...
new fully-equipped laparoscopic suite in the main OR, supported by the Hospital Foundation.

Finally, St Mary’s is extremely happy to welcome back Dr. Gordon Brabant, who rotated through St Mary’s as a junior resident in 1983 and completed his surgical residency at McGill in 1987. Gordie practiced in New York for many years before returning to Montreal in a reverse brain drain process. He provides a wide range of expertise, including breast and laparoscopic surgery. These recruits complement the more senior members, including Dr. Carl Emond who provides the Vascular Surgery expertise and benefits from a state-of-the art Vascular Laboratory, Dr. Jose Rodríguez who specializes in hernia repair, and Drs. Mego Sossoyan, Mohammed Chughtai and Richard Moralejo who all provide the Division with senior surgical expertise. Drs. Brian Buchler and John Keyserlingk round out the team.

An attractive component for the training program is the surgical caseload generated by the fact that the surgeons either have busy community offices and/or work in community outreach facilities such as the local Cote-des-Neiges Clinic or at Ville Marie downtown. The growth of St Mary’s Family Medicine Unit, now expanding into a new on-site facility and whose residents do their surgical training through the Surgical Teaching Office, contributes to the pool of interesting patients requiring surgical expertise. In 2002-03 fiscal year, the Division of General Surgery carried out 1597 procedures, 900 through the Surgical Day Center and 694 in-patients. This represented an increase of 7.3% in surgical day cases and 13.2% increase in in-patients with an overall total of 9.3%

Increasing over the last fiscal year. The Division of General Surgery used 106% of surgical time. This was possible due to a devoted surgical nursing staff, from the Pre-op Unit, through the expanded Day Center, the Recovery Room and the Floors, all under the excellent leadership of France Desjardins the Surgical Program Manager.

The following Divisions have also recruited new members:

Dr. Armand Zini is joining the Division of Urology as a full-time member of the staff to join Drs. Keith Matthews, Brian Morris and K.T. Tukaram. Dr. Zini is a graduate of the McGill program and has spent the last eight years at the Mount Sinai Hospital in Toronto. Dr. Zini plans to practice general urology at St Mary’s Hospital and be involved in male infertility studies at the Royal Victoria Hospital.

The Division of Plastic Surgery has added Dr. Patrick Harris to their numbers who include Drs. J. Cohen, W. Papanastasiou, A. Swift and their Director, Dr. Jorge Schwarz. Dr. Harris is coming on as an Associate Member and will run the Hand Clinic at St. Mary’s Hospital.

The future looks encouraging as Dr. Jack Sutton takes over as Surgeon-in-Chief of a Hospital that has always benefitted from the support of its community.

John R. Keyserlingk, M.D.
Director, Division of General Surgery
St. Mary’s Hospital Division of General Surgery New Recruits

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**Submitting Digital Photos to The Square Knot**

Digital photography has become so popular and convenient these days that you generally don’t need a basic knowledge of photography to operate a digital camera—just point and shoot. The best part is that you download your image files directly into your computer. No more negatives to develop and prints to wait for—it’s instant—very convenient for printing at home or sending via the internet. There are a few things to keep in mind however when you plan to submit your photos to a journal or a newsletter publication such as this one—just follow the simple guidelines listed below:

1) Set your camera to a MINIMUM of 1 or 2 megapixels (setting from Medium to High resolution).

2) Make sure you’re in focus on the important subject and not on the background.

3) Use your auto-flash when photographing indoors.

4) Avoid high reflecting backgrounds such as windows or mirrors.

5) Save your images as UNCOMPRESSED JPEG files when you download them to your computer. If you have an image manipulation program such as Adobe Photoshop, save your image files as either TIFF or PSD.

6) DO NOT include your images in a Word or any other word-processing document.

7) DO NOT convert your color images to grayscale (black and white), let us (Multimedia Services) or the publisher take care of that.

8) Save your image files onto a CD and submit it to the editor.

By following these few steps, you’ll gain a better understanding of how your digital camera works and how to properly submit photos for publication.

MGH-Medical Multimedia Services
Were You There?
House Staff - RVH 1959-60
Congratulations to the Montreal Children's Hospital
100 Years

100 YEARS OF MEDICAL BREAKTHROUGHS
AT THE CHILDREN'S!

1904 First patient is admitted to The Children's on January 30, 1904;
1932 First respirator in the world designed - later version known as the "Iron Lung";
1933 First speech therapy department in a Canadian pediatric hospital;
1938 First operation in Canada to repair a congenital heart defect;
1946 First cardiac catheterization performed in Canada;
1950 First pediatric hospital in Canada to establish a department of medical genetics;
First pediatric hospital in Canada to establish a psychiatry department;
1957 Pioneering of open heart surgery and first operation in Quebec on a child;
1958 First mental assessment and guidance clinic for the intellectually handicapped in Quebec;
1960 First Canadian pediatric hospital to open a centre for children with learning disorders;
1966 First therapeutic heart catheterization in Canada—a life-saving procedure to create a hole within the heart of a "blue baby";
1971 First hospital in Quebec with a pediatric burn unit;
1975 First hospital in Canada to establish a community pediatric research program;
1977 First CT scan performed in a pediatric setting in Canada;
1980 First bone marrow transplant performed in a pediatric setting in Canada;
1985 First successful liver transplant to the youngest recipient ever in Canada;
First hospital in Canada to set up a hospital-wide multiculturalism program;
1986 First Cochlear implant in a child in Quebec;
First pediatric hospital in Canada to open a comprehensive provincial centre for Sudden Infant Death Syndrome (SIDS) (The Jeremy Rill Centre);
1988 Heart transplant to the youngest recipient ever in Canada;
1990 First bone implanted hearing device in a child in Canada;
First hospital in Quebec to establish an injury prevention program;
1991 First hospital in Quebec to develop a Pediatric Advanced Life Support Program (PALS);
First living donor pediatric renal transplant program in Quebec;
First hospital in Quebec to offer Extra-Corporeal Membrane Oxygenation - ECMO;
1993 First pediatric hospital in Quebec to offer magnetic resonance imaging (MRI);
First hospital in Quebec to have a pediatric intermediate care unit;
1994 First pediatric hospital in Quebec to offer transoesophageal echography for young children;
1995 First pediatric voice and speech laboratory (Gustav Levinschi laboratory) in Canada;
1996 First multicultural clinic in Quebec;
First pediatric hospital in Quebec to create a short stay unit;
1997 First transcultural psychiatry clinic in Quebec;
2000 First foetal diagnosis and treatment group — developed as a McGill University Health Centre (MUHC) team;
2001 First hospital in Quebec (MUHC team) to perform EXIT Procedure (EX-utero Intrapartum Treatment) to deliver a baby;
2002 First mechanical heart device used as a bridge to transplant on the youngest patient ever in North America.
We can't do it without you!

Write to us! Send us your news!

We want to hear from our readers!
If you have any information you want published in THE SQUARE KNOT, comments about our newsletter or suggestions, we want to hear from you!

Send submissions to:
E.D. Monaghan, M.D. • Editor • THE SQUARE KNOT • The Royal Victoria Hospital
687 Pine Ave. W., Room: S7.30, Montreal (Quebec) Canada H3A 1A1
CALL US at: (514) 934-1934, local 42835 • FAX US at: (514) 934-8289
E-MAIL US at: marla.bikas@muhc.mcgill.ca
emma.lisi@mail.mcgill.ca
edmond.monaghan@muhc.mcgill.ca

McGILL SURGERY ALUMNI & FRIENDS
Contributions of $50.00 are appreciated in ensuring the continued publication of "The Square Knot" and supporting McGill Surgery Alumni activities. Please make cheque payable to the McGill Department of Surgery and forward to Maria Bikas, McGill Surgery Alumni & Friends, The Montreal General Hospital, 1650 Cedar Avenue, Room: L9-420, Montreal (Quebec) Canada H3G 1A4 Telephone: (514) 934-1934, ext.: 42028 Fax: (514) 934-8418.

MOVING?
If you change your address, or if you know someone who would like to receive this newsletter, please drop us a line.

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