Reflections from the Chief

After a long and cold spring, Boston has finally warmed up and our attention turns to the annual resident transition. The residents graduating in June are all moving on to wonderful fellowship opportunities. I must admit this class is a bit special to me because most of them were in the first class of interns to arrive just after I came to the MGH, now over seven years ago. It has been fun to see them grow into outstanding young surgeons but also to see how much the Department and the training program have evolved. The incoming class is an outstanding group of individuals who have already accomplished much in their careers.

There have been many noteworthy activities over the last 6 months, with many important events, awards, and accomplishments. Although it is merely a reflection of our “reputation,” it was nice to learn that US News and World Report/Doximity rated the MGH General Surgery Residency #1 in the United States. Although I personally have been convinced of this for a number of years, it was still gratifying to see actual “confirmation.”

To update you on our plans for “revitalizing” the MGH Surgical Society, we are in the process of updating our mailing list and working hard to regain contact with alumni who have been “lost to follow-up.” We are also exploring ways to strengthen the involvement of new grads and potentially move to a fully electronic format in order to reach more of our surgical alumni.

By way of reminder, the American College of Surgeons Clinical Congress will be held in Boston this year. I know it’s a busy time, but if you have an extra day or so and want to stop by the hospital, we will do everything we can to welcome you back “home.” I hope to see as many people as possible at the Annual Reception to be held on Monday evening, October 22, during the Clinical Congress.

Keith D. Lillemoe, M.D.
Surgeon-in-Chief, Massachusetts General Hospital
W. Gerald Austen Professor of Surgery, Harvard Medical School
Dear Colleagues:

Les Ottinger suggested it might be nice to have a few words from me in the Spring 2018 issue of the Surgical Society Newsletter. Given that the most recent meeting of the society was largely about the contributions of Austen, Russell, and Warshaw, I thought a few comments about one of their outstanding predecessors, Edward Churchill (1895-1972), might be in order. However, before remarking on Dr. Churchill and some of his major contributions, please indulge me for a brief story. In the mid-1970s, I noticed a small sign just outside the MGH operating room with the following words: “Books available due to retirement. Please come to room ___. Gordon Donaldson.” I have never been able to avoid a “good deal,” especially when it involves books, and so I went over to the local Stop & Shop, borrowed a large grocery cart, and wheeled it up to Dr. Donaldson’s office. I collected as many books as my cart could hold, and then made my way out to my car (in the MGH garage) and put them the trunk in preparation for going home. I tell this story here because my intent to remark on Dr. Churchill made me turn to two of Dr. Donaldson’s books, the *Annals of Surgery* (1963 and 1973 editions), with an article written by Oliver Cope in honor of Dr. Churchill’s retirement, and then ten years later, an article written by Dr. Francis Moore upon the death of Churchill.

Churchill was born in Illinois in 1895, entered Harvard Medical School in 1917 and graduated cum laude in 1920. He spent two years of internship and two years of residency training at the MGH, and became an instructor in surgery after his four years of training. An important hiatus for him was the awarding of a Moseley Traveling Fellowship for study abroad in 1926-1927, an experience which was later described by J. Gordon Scannell (Wanderjahr: The Education of a Surgeon). After two years of surgical research at Boston City Hospital, he moved back to the MGH in 1930. He had performed the first successful pericardiectomy in 1928 for constrictive pericarditis in the United States; he was soon named John Homans Professor of Surgery in 1931 (Chief of the West Surgical Service); was later Surgical Consultant to the North African and Mediterranean Theaters in World War II; and ultimately served as Surgeon-in-Chief of the MGH (East and West combined) from 1948 to 1962. Other “firsts” as noted by Cope included being the first to perform a segmental lobectomy and the first to envision an “occasional primary lobectomy for tuberculosis of the lung.” Many people consider his contributions during
MGH Thoracic Outlet Syndrome Program  
By Dean M. Donahue, MD

Over the past decade, the MGH Thoracic Outlet Syndrome (TOS) Program has grown into one of the largest in the country. In 2016, 306 new patients were evaluated for this condition by our program, and 194 thoracic outlet decompression operations were performed (Fig. 1). Personalized care is provided to patients by a multidisciplinary team comprised of thoracic and vascular surgeons, radiologists, colleagues from cardiovascular medicine, nurse practitioners, and physical therapists (Table 1). The MGH Department of Surgery has played a critical role in the evolution of care for TOS in this country. One of our fellow MGH surgical alumni, the late Dr. Harold Urschel (’54), performed over 5,000 first rib resections during his career at Baylor University Medical Center. He was instrumental in shedding light on what remains a poorly understood and often misdiagnosed condition.

Thoracic outlet syndrome is a spectrum of symptoms thought to result from compression of at least one of the following structures: the brachial plexus, the subclavian vein, or the subclavian artery. While they can coexist, nerve compression and vascular compression produce different clinical scenarios. Anatomic regions within the thoracic outlet that are susceptible to compression include the interscalene triangle, the costoclavicular space, and the subcoracoid space underneath the pectoralis minor muscle.

Why patients develop this painful syndrome is unknown. Some may be born with abnormalities in the thoracic outlet region that cause inherent restriction, predisposing them to injury. These injuries tend to occur when individuals engage in repetitive or over-the-head activities (raising one’s arms up narrows the tho-
Neurogenic TOS

Neurogenic thoracic outlet syndrome (NTOS) results from compression of the brachial plexus. It is the most common cause of TOS and is found in greater than 90% of patients presenting for an evaluation. Patients have a broad spectrum of symptoms that can vary greatly between individuals. While most patients have certain features in common, no sign or symptom is absolutely required for a patient to be diagnosed with TOS. Pain is the most common presenting symptom and can occur in the neck, the upper trapezius region, the upper pectoral region, and the axilla. The patient may have pain radiating down the entire upper extremity or it may localize to the medial or occasionally the lateral aspect of the arm and hand. Occipital headaches are occasionally seen, as is pain radiating up to the face or ear. Most patients will note intermittent symptoms of paresthesia involving the arm and hand. These also may be generalized, but more frequently they localize to the medial aspect of the upper extremity, particularly the fourth and fifth digits of the hand. Numbness in this region may occur, but this is a less common symptom. Motor symptoms may be present, but are often subjective and include vague weakness and diminished coordination of the hand. A minority of patients exhibit signs of vasomotor instability including skin discoloration and temperature discrepancy of the upper extremity. A patient’s symptoms are frequently exacerbated with arm activities. Physical findings in NTOS are non-specific, but a detailed exam is necessary to evaluate for other conditions that can mimic TOS.

Imaging studies play a controversial role in the diagnosis of TOS. Dr. Rajiv Gupta of the Department of Radiology, a member of our program, has developed a unique protocol for 3-dimensional CT scan reconstruction that provides excellent anatomic definition. While radiographic abnormalities do not make the diagnosis of TOS, having a clear picture of the patient’s anatomy combined with a detailed history and careful physical examination has improved our diagnostic capabilities. Additionally, a treatment approach our program is aggressively pursuing involves ultrasound-guided injec-
tions of botulinum toxin A into the scalene and pectoralis minor muscles. Theoretically, these injections “relax” the muscles, potentially creating greater space within the confines of the thoracic outlet. The injections are performed by Dr. Martin Torriani and other members of the Musculoskeletal Group of the Department of Radiology and serve both a diagnostic and therapeutic role.

Physical therapy (PT) is the first-line of treatment for the majority of NTOS patients. Unfortunately, there is no standardized approach that produces consistently effective results. Fortunately, our program has two outstanding physical therapists: Eileen Collins and Michael Orpin. Their expertise and dedication has been critical to the success of our program for managing many patients non-surgically. Several months of dedicated PT may be required before a patient notices symptomatic improvement.

The decision to operate on a patient with NTOS is difficult and no consensus exists regarding surgical indications. Despite our extensive experience, there is no established algorithm to follow. The decision to operate is made for each individual patient based on the collective results of their evaluation. Anatomic abnormalities identified on imaging, such as cervical ribs or elongated C7 transverse processes, do not represent an absolute indication for surgery even in the presence of symptoms. Approximately 30% of NTOS patients in our program eventually undergo surgery.

**Venous TOS**

The venous form of this condition occurs when patients suffer from a compression of the subclavian vein which lies between the clavicle and the first rib. This produces an injury to the vein which can cause narrowing and eventual clot formation leading to subclavian vein obstruction. This venous congestion causes swelling and cyanosis of the upper extremity with the development of subcutaneous collateral vessels around the shoulder and upper chest wall. Patients will often report a heavy sensation and occasionally an “ache” in their arm. Some of these patients may also feel some of the same symptoms reported by patients with NTOS. This may arise from direct compression of the brachial plexus from the narrowing within the thoracic outlet region; however, they may also result from nerve irritation caused by local inflammation from the blood clot. For suspected cases of VTOS, the initial management is immediate anticoagulation. Venous ultrasound studies are often used in the initial diagnosis, but the high degree of false negative studies limits their usefulness. A contrast venogram has greater diagnostic accuracy and a therapeutic capability as well. Catheter-delivered chemical thrombolysis, and possibly mechanical thrombectomy, may be used to reestablish vein patency as a bridge to surgery. The MGH program is fortunate to have two groups involved in this process: The Division of Interventional Radiology and the Division of Cardiovascular Medicine within the Department of Cardiology. Because VTOS patients are often young and have an underlying stenosis of the subclavian vein, over 80% will require surgical decompression of the thoracic outlet.

**Arterial TOS**

ATOS is a very rare condition that presents when severe compression of the subclavian artery causes a discrete injury, resulting in complete blockage or an aneurysm formation. The loss of a palpable radial pulse with arm elevation or a decrease in arterial flow found in artery testing is not considered a form of ATOS. The arterial injuries found in ATOS are almost always associated with a bone abnormality, such as a cervical rib or an elongated process of the C7 vertebral body. This is a potentially limb-threatening condition, and surgery involving resection of the cervical rib or C7 transverse process with first rib resection is mandatory. Dr. Christopher Kwolek of the Vascular Surgery Department, who manages these cases in our program, performs resection and graft reconstruction of the subclavian artery once the thoracic outlet is decompressed.

**Surgical Technique**

In our hands, the surgical technique for thoracic outlet decompression is similar regardless of etiology. This includes a supraclavicular first rib resection combined with partial scalenectomy with release of the brachial plexus from any surrounding scar tissue (Fig. 2). In general, this operation can be accomplished either through a transaxillary incision, a supraclavicular incision, or an infracavicular incision. Proponents of the transaxillary incision point to this being a more cosmetically appealing option. This technique typically allows the surgeon to stay close to the first rib during resection and to avoid contact with the surrounding neurovascular structures. In my experience, however, this “limited” resection can result in lower surgical success rates if the scalene muscles are also contributing to the compression of the brachial plexus. Our program strongly favors the supraclavicular approach because it provides greater exposure.
to the brachial plexus and scalene musculature, allowing for a more complete decompression. This approach also allows larger anomalous bone structures, such as cervical ribs or an elongated transverse process of C7, to be resected along with the first thoracic rib. Some cases of VTOS and all cases of ATOS require an additional infraclavicular incision for improved exposure to the costoclavicular space. Surgical outcomes for NTOS vary widely in the literature. In our program over 90% of patients with NTOS experience a decrease in preoperative pain scores of 50% or greater. The success of surgery in NTOS depends on both the accuracy of the diagnosis and a thorough decompression of the entire thoracic outlet. For VTOS and ATOS, vein and artery patency and freedom from symptoms occur in greater than 95% of cases.

Editor’s note: Dean received his Bachelor’s degree in Biology from Fordham University in 1983 and his MD from the Dartmouth-Brown Program in Medicine in 1987. He did all of his surgical residency at the MGH, completing his Chief Residency in Cardiothoracic Surgery in 1996. He is currently Associate Visiting Surgeon in the Thoracic Surgery Division at MGH and Associate Director of the General Surgery Residency at MGH. He is widely published on surgery for cancer of the lung and esophageal cancer, as well as tracheal and carinal resection. Over recent years, Dean has carefully studied thoracic outlet syndrome, its causes, and innovative treatment. Since Dean started the MGH Thoracic Outlet Syndrome Program in 2007, it has grown into one of the largest centers in the U.S. for the evaluation and treatment of this condition. The program attracts patients from around the country and internationally. Dean is an editor and co-author of the only textbook on this condition published in the last 25 years.

**Perspectives**

**My New Perspective on Group Projects**

By James S. Allan, MD, MBA

Last year, I had the opportunity to serve as the President of the American Society of Transplantation (AST), America’s largest professional society for the field of transplantation, which prides itself on having a broad, representative membership. I have been active in the society all the way back to the days of my cardiothoracic fellowship, and by the time I was elected to the Board of Directors, I must have served on at least a dozen committees, working groups, and task forces. Although I knew the field and the society well, I was convinced that my election to the presidency must be some sort of a clerical error. I had one year as President-Elect to figure out what I was going to do, and how I would go about doing it.

I first reflected on the conduct of the leaders I had worked with throughout my career. The basic question I...
sought to answer was what made some leaders good and other leaders bad? The answer came down to this. Good leaders are knowledgeable and competent in the subject at hand and function as fiduciaries for the people and organizations they lead. In other words, the measure of a leader is not the degree to which one uses the position for self-aggrandizement, rather how one uses it to create opportunities for others and to advance the mission of the organization.

My second major challenge in preparing for this role was overcoming my fear of delegating responsibility. I recall from my earliest school days how much I disliked working on a group project. To me, a “group project” simply meant I had to do all the work myself or face the very valid fear that one of my peers would drop the ball. It’s no surprise that I chose a career in surgery — a field full of perfectionists and control freaks. Fortunately, much like working at MGH, my colleagues at the AST were brilliant, highly motivated people, making delegation of responsibility a much easier task. In the end, I guess, it wasn’t the group work in school that I disliked. It was the group.

A few weeks prior to giving my presidential address, I wrote a blog about the nature of such orations, entitled “80,000 Minutes,” in which I actually extolled the virtues of working together as a community to achieve a common goal. I have reprinted this blog in part here:

“As I wind down my AST presidency, I have given much thought to what I would say at my presidential address. If you consider that 4,000 people attend the American Transplant Congress (ACT), and I will have 20 minutes to fill, the simple math is that I will be taking 80,000 minutes of your collective lives with my address. That’s equivalent to 56 days of human life. For me, this is a source of anxiety. I’ve always tried to be respectful of others’ time, and would feel terrible if, at the end of my address, everyone at the ATC said, ‘Well, there’s 20 minutes of my life I’ll never get back!’

“I’ve watched many of my colleagues struggle to find something profound and meaningful to say on similar occasions. The sad truth is most of us, myself included, don’t really have anything that profound to say. We are kidding ourselves if we choose to believe we are Lincoln at Gettysburg or Demosthenes at the Athenian Assembly — and I would totally forgive you, if you ran for the door to get a head start on your coffee break.

“It’s a common exercise in school to write an essay about a historical figure, examining whether ‘the man made the times’ or ‘the times made the man.’ However, this is a false choice. In truth, impactful moments in history require a truly special person to be at the right place, at the right time. As anyone with a rudimentary understanding of probability theory can tell you, it is far more likely you will be an ordinary person, at the wrong place, at the wrong time.

“So what do you do if you are an ordinary person? You join a community of other ordinary people and together accomplish something extraordinary. The AST is just such a place. With this realization, I will probably take your 20 minutes and show you the many things that you have already collectively accomplished — and the limitless potential of our continued work together.”

After setting the stage with this blog, I proceeded to give a short presidential address, not about me, not about my pet projects, but in part about how a discipline progresses through the cumulative work of many committed individuals. Not bad for a kid who spent his youth detesting group work.

For those who are gluttons for punishment, portions of my address are reprinted here:

“It’s been an absolute honor to serve as the President of the AST over the past year, and I want to extend my sincere thanks to the board members, the communities of practice (COPs), committee leaders, and staff who have worked so hard to make our society great. I also want to thank my colleagues and my family for supporting me throughout this presidency. While I have been at the hospital or travelling on business, my wife, Susan, has managed to raise two wonderful children, all the while holding down her own demanding full-time job. My children, Sara and James, have also been a huge support and inspiration to me, and I couldn’t be any prouder of them.

“When I arrived at college in 1982, my first assignment was to read a book by an author named Thomas Kuhn. The book was entitled The Structure of Scientific Revolutions. Thomas Kuhn obtained undergraduate and graduate degrees in physics from Harvard and initially conceived of this book after he was asked to teach a history of science course during a three-year post-doctoral fellowship at Harvard. Ultimately published in 1962, this monograph is perhaps the most influential modern philosophical work on the progress of science.

“The essence of Kuhn’s thesis is that science progresses in a cyclical fashion. First comes a period of
what Kuhn termed “normal science.” Normal science can be thought of as the slow, methodical work that most of us do every day. It is through this process that we either add another brick to the wall to support a current theory, or conversely, that we chip away at this wall as we discover flaws and inconsistencies in the currently accepted model. Ultimately, enough incongruities and complexities in a previously accepted theory are revealed and a crisis of confidence develops.

“This is the point at which science can progress significantly. The original set of theories and postulates are rejected and a new paradigm is created. Kuhn referred to this event as the ‘paradigm shift,’ and he is singularly responsible for the introduction of this term into our lexicon, almost to the point of triteness some half-century later.

“We have seen these paradigm shifts many times in the past. In the Copernican Revolution, Ptolemy’s model of the geocentric solar system was rejected in favor of a simpler heliocentric model. Einstein developed quantum theory to explain the photoelectric effect, for which he was awarded the Nobel Prize. He also taught us that the most constant thing in our everyday lives, time itself, is not at all constant — a theory that was empirically proved when an atomic clock flown around the world returned to earth showing a different time than a second earthbound clock to which it had been synchronized.

“Unfortunately, most of us will never receive the fame or accolades of Copernicus or Einstein, but take some comfort in knowing that the everyday work we do is the enabler for the occasional paradigm shift. Einstein’s success would not have been possible, if it were not for the results of an ordinary experiment performed a few years before by Max Plank. Copernicus’ transformative vision of the universe would not have been possible, if it were not for previous work done by two Islamic astronomers whose names are probably not known by most of the people in this room. Just as Pasteur said “Chance favors the prepared mind,” the paradigm shift only occurs when the rest of us prepare the playing field for the star athlete.

“So where are the opportunities for paradigm shifts in transplantation? One only needs to look at the current problems and limitations in our field. Transplantation faces two major obstacles. Our current paradigm of immunosuppressive therapy results in organ rejection, opportunistic infections, malignancies, and drug toxicities. The paradigm shift that will address this issue, and one that is occurring now, is that of tolerance induction.

“Second, our current paradigm of altruistic organ donation does not yield sufficient numbers of suitable organs to meet the growing demand for transplantation. Solutions to this problem are multifold. First, our burgeoning ability to modify the genome and humanize a xenograft could potentially allow us to have an unlimited supply of standardized off-the-shelf organs for immediate transplantation. Third, as our ability to control the differentiation of stem cells improves, de novo organ regeneration may be able to fill the need for transplantable organs. Fourth, progress in the technologies that underlie mechanical support devices may advance sufficiently that such support will offer acceptable destination therapy to patients with end-stage organ disease. Finally, the removal of financial impediments to living donation and the provision of regulated financial incentives may provide the impetus for increased living donation in a way that does not diminish human dignity, autonomy, and social justice. These are the paradigm shifts that we will recognize a half century from now in our field. The conceptualization of grand plans is easy, but making these transformative ideas a reality is far more difficult.

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“To this end, our field faces many challenges. First, our research is grossly underfunded. Members of our leadership team have taken a day-trip to Washington to participate in the White House summit intended to put a spotlight on transplantation. I have asked our hosts at the White House for several deliverables, including increased funding for research and a fully dedicated NIH study section to adjudicate grants in our field. Our second major challenge is that we have no nationwide system for conducting coordinated donor research. The AST in conjunction with the American Society of Transplant Surgeons (ASTS) is leading an effort to resolve this deficiency, but will need support at the national level for this to occur. Third, our field is horribly over-regulated. Our pharmaceutical partners have difficulty bringing drugs to market and lose much of their patent protection while performing years of trials with inappropriate endpoints mandated by regulatory bodies. Similarly, our centers are burdened with the yoke of metrics that cause disruptive behavior, rather than promote high-quality, cost-effective care. We are grateful for the recent support of a major initiative to examine and realign the metrics by which our performance is judged. But again, we will need a willingness at a national level to roll back
regulation if this goal is ever to come to fruition.

“As professionals, we are constantly exhorted to “think outside the box.” We are told that creative, unfettered thinking is what we need to achieve our own paradigm shifts. But the reality in which we practice is very different. Quite simply, if you want me to think outside of the box, you need to quit handing me boxes!

“When I wrote my first blog as president, I characterized the AST as strong and relevant. Thanks to the combined efforts of the many people gathered here, the AST has had a banner year. Our membership is at a record high and we are debt-free with $15M in liquid assets. The AST has an endowment that provides the society nearly a half-million dollars in annual operating income, without consuming the corpus of this fund. Our winter meeting was a spectacular success. We have also had the best year in nearly a decade with respect to fund raising, and internal philanthropy from our members has doubled in the past year. This year, we have provided $1.3 million in research grants. Most important, however, the AST is performing actively and with strategic consistency on every aspect of our mission.

“Over the next few years, you will see the AST transition to a more public facing organization. This paradigm shift in our society will allow us to leverage public support in our efforts to advocate for our field and to provide increased research and educational opportunities for our membership. Our logo and web page redesign, our incipient efforts in the cause marketing arena, and the relationships we have been recently building with patients and patient organizations are just first steps in this strategic transformation of our society. I have no doubt this transition will be challenging, but I have every confidence that the people in this room can do it, especially if we work together.

“It has been a privilege to serve as President of the AST, and I am forever grateful for your support.”

EDITOR’S NOTE: Jim Allan received his Bachelor’s degree from Harvard College and MD from Harvard Medical School (both Magna cum Laude). Additionally, he received a Health Policy Certificate from Harvard and an MBA in finance from Suffolk University. He trained in general surgery and cardiothoracic surgery at MGH. He joined the faculty of the Thoracic Surgical Division in 1995. Currently, he is an Assistant Professor in Surgery at Harvard Medical School and Associate Visiting Surgeon at the MGH.

A nn o u n c e m e n t s

Honors and Awards — Faculty

Liliana G. Bordeianou MD MPH (General and GI Surgery) received a 2017 Partners in Excellence Award in the category of Leadership and Innovation for her role in implementing the Enhanced Recovery After Surgery (ERAS) Pathway in Colorectal Surgery, which has been adopted system wide by Partners Healthcare.

Susan Miller Briggs MD MPH FACS (Trauma, Emergency Surgery and Surgical Critical Care) has been appointed the inaugural incumbent of the Carmella R. and Steven C. Kletjian Endowed Chair in Global Surgery.

Keith D. Lillemoe MD (Surgeon in Chief) was awarded this year’s Joseph B. Martin Dean’s Leadership Award for the Advancement of Women Faculty.

Andrea Merrill MD (PGY5) and Sareh Parangi MD (General and GI Surgery) along with their co-investigators received a generous Physician’s Foundation grant to implement and study the effectiveness of a nationwide coaching program through the Association of Women Surgeons.

Sareh Parangi MD also received the prestigious 2017 Robert F. Gagel International Thyroid Oncology Group Discovery Award for her proposal “Investigation of the role of myeloid/derived suppressor cells in the response to targeted therapies in advanced thyroid cancer.”

Paul S. Russell MD, former MGH Chief of Surgery, received the 2018 Barbara J. McNeil Faculty Award for Exceptional Institutional Service to the Harvard Medical School. This award identifies individuals with a strong history of exceptional service to Harvard, while engaging others in institutional service.

Honors and Awards — Residents

Congratulations to participants of the 7th Annual HMS Research Day. The Program Committee, including two representatives from MGH, Genevieve Boland MD PhD and Motaz Qadan MD PhD, identified 8 clinical and basic science abstracts for oral presentation. MGH garnered two of the top presentation awards. Andrew Geller, a rising 4th year medical student from HMS, received the top award for his clinical presentation “Are we heading in the wrong direction? Induction chemoradiotherapy for esophageal cancer: comparing carboplatin/paclitaxel with cisplatin/5-FU.” His mentor was Michael Lanuti MD (Thoracic Surgery). The second-place award
In Memoriam

Everett (Eddie) Knowles. In May of 1962, Ronald Malt and the West Surgical Service, one of the two surgery resident services, carried out the first known successful replantation of a severed extremity. The patient was Everett (Eddie) Knowles, a 12-year-old boy whose arm had been completely severed at the level of the mid-humerus (see Surgical Society Newsletter, Spring, 2006). Eddie and his right arm were lost to follow up after a couple of decades of monitoring by the service, though he continued to be spotted around town occasionally by someone who knew his history. Now a report of his activities over the last 10 years and an obituary has turned up in the Swellesley Report, a local Wellesley newspaper. To read it, you may search ‘eddie knowles swellesley’ on the internet.

Gerald S. Moss, MD, died on July 11, 2016. Born in Cleveland, OH, he received BA and MD degrees from Ohio State University and began his internship in surgery at the MGH in 1960 with a Berry Plan deferral. He completed the program in 1965, having done research under the mentorship of Charles Huggins. His first year in the U.S. Navy was spent in Vietnam where he was responsible for the Navy’s frozen blood and shock research unit. He received a Citation and Navy Commendation Medal for his service there. In 1968 he joined the Department of Surgery at the University of Illinois in Chicago where he became Professor of Surgery in 1973. From 1977 until 1989 he was Professor of Surgery at the University of Chicago Pritzker School of Medicine. He then became the Dean of the College of Medicine at the University of Illinois until his retirement in 2004. He is survived by five children and numerous grandchildren and great grandchildren.

Richard Kempczinski, MD, died on March 8, 2017. Born in Brooklyn, NY, he had graduated from Holy Cross and Harvard Medical School. Following a surgical internship at University Hospitals in Cleveland, Dick entered the surgery residency at the MGH, completing it in 1974. His residency had been interrupted by two years of service in the U.S. Army that included a year in Vietnam. After five years at the University of Colorado he became Associate Professor of Surgery and Chief of Vascular Surgery at the University of Cincinnati Medical Center. Here he made important contributions to the development of vascular diagnostic laboratories. A body surfing accident in 1994 left him quadriplegic, but he was able to continue making contributions to the management of vascular disease through his work as a consultant. His wife, Ann Marie Campbell, died of cancer in 1991. He is survived by his son and daughter.
of the late Ralph Ernest and Mary Emily Klingensmith. His father was a philosophy professor at Concord College in Athens, West Virginia (the little town where Walt grew up, which had one stop light!) as well as the principal of the regional high school that served the surrounding counties. His mother was a professional harpist who played in various orchestras throughout the region. He and his wife, BettyAnn Olssen, were married in 1953.

Walter attended Harvard College from 1946-1950 on a Pepsi Cola scholarship. At that time, Pepsi offered 50 full scholarships per year to high school seniors (one per state). Applicants were selected based on a written test score. Once you gained the scholarship, you were free to go wherever you could get accepted. When Walter applied to Harvard, he had never been to Boston. In fact, he had rarely been outside of West Virginia. He told a funny story about taking the train to Boston for his freshman year, finding his way by subway to Harvard Square, and then, after he got above ground, hailing a cab to take him to Wigglesworth Hall, his freshman dorm. The cabbie revved the engine without moving the taxi and then said, “That will be two dollars, you’re here!” (Little did he know, he was just outside the gate to his dorm.)

Walter was a graduate of Athens High School, Harvard College, Harvard Medical School, and the MGH surgical residency. During his residency he would consult with the off-duty interns and ask them what chores remained to be done. By the time the intern checked on them, Walter had already done them. As a resident, his technical skill, knowledge, energy, and good humor made him a great favorite of the staff and, particularly, of the junior residents for whom he was an admired mentor and friend. A terrific teacher both in and out of the operating room, Walter had a great sense of humor. I (W.M.D.) vividly remember assisting him on a vascular case, where he would calm the room with his sayings: “Tie that… if you can!” He loved his time in Boston, especially at the MGH, and the lifelong friendships he formed there. He came to Boston on the train with a guitar on his back and went back home 12 years later the same way to practice surgery.

After his training, Walter followed MGH alumnus Roger Wilcox to the Miners Hospitals in southern West Virginia. His thoracic surgery experience at Middlesex County Sanitarium while a resident and then in his early practice years had provided enough cases to allow him to sit for the Thoracic Board which he did in 1963. He settled in Beckley to serve the citizens and miners of the region. He also worked at the Beckley VA Hospital, Raleigh General Hospital, and later, after it merged with Miners, the Appalachian Regional Hospitals, serving as Chief of Surgery at Appalachian Regional and Raleigh General. He was an active member of the Raleigh County Medical Society. He was in practice for over 30 years as a board certified general, vascular, and thoracic surgeon with his long-time partner, Dr. Harry F. Cooper. Together they trained a number of surgeons who remain in practice in southern West Virginia and the Appalachian region. Walter also served Concord University and its Foundation for many years, and was the team physician for the Woodrow Wilson High School athletics program.

In 1964, while I (W.M.D) was in the US Public Health Service at the NIH, we visited Walter and his family in Beckley. What an adventure! A musician of note, he possessed a collection of stringed instruments; guitars, mandolins, ukuleles, violins, zithers, and he played them all. After dinner, Walter gave us a tour of Beckley, during which his car broke down. Within minutes a tow truck arrived and towed us home with Walter (and us) singing to the cheering crowd along the way. They loved him.

Walter is survived by his wife of 64 years, Betty, five children, and eight grandchildren and great grandchildren. His daughter Mary E. Klingensmith, M.D., is the Mary Culver Distinguished Professor and Vice Chair for Education in the Department of Surgery at Washington University School of Medicine in St. Louis, and has recently been named Chair of the Board of Directors of the American Board of Surgery. A superb clinical surgeon, Walter will long be remembered by his patients as the “Dean of Surgery” of Beckley.

Contributed by Willard Daggett, M.D., Leslie Ottinger, M.D., and Mary E. Klingensmith, M.D.
Senior Class Destinations

Front row (l-r): George Molina – Surgical Oncology Fellowship, Massachusetts General Hospital; Sonia Cohen – Surgical Oncology Fellowship, Memorial Sloan-Kettering Cancer Center; Christy Cauley – Colorectal Surgery Fellowship, Cleveland Clinic; Andrea Merrill – Surgical Oncology Fellowship, Ohio State University Comprehensive Cancer Center; Cornelia Griggs – Pediatric Surgery Fellowship, New York-Presbyterian/Columbia University Medical Center; Robert Goldstone – Colorectal Surgery Fellowship, Mount Sinai Hospital. Back row (l-r): Luis Tapias Vargas – Cardiothoracic Surgery Fellowship, Massachusetts General Hospital; Jordan Bohnen – Minimally Invasive Surgery Fellowship, Massachusetts General Hospital (2019); Geoffrey Anderson – Trauma and Critical Care Fellowship, Los Angeles County and University of Southern California Medical Center.

Incoming Class

Top (l-r): Elizabeth A. Calle – Yale School of Medicine; Avril K. Coley – Washington University School of Medicine, St. Louis; David C. Cron – University of Michigan Medical School; Kate Krause – Medical College of Wisconsin; Gregory Leya – Harvard Medical School. Bottom (l-r): Camille A. Mathey-Andrews – Harvard Medical School; Alyssa A. Mazurek – University of Michigan Medical School; Jason Mitchell – Harvard Medical School; Jessica L. Mueller – Harvard Medical School.