AMERICAN SURGICAL ASSOCIATION

Program of the 130th Annual Meeting

The Fairmont
Chicago, Illinois

Thursday, April 8th       Friday, April 9th
Saturday, April 10th    2010
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AMERICAN SURGICAL ASSOCIATION

Program of the 130th Annual Meeting
to be held at
The Fairmont
Chicago, Illinois

Thursday, April 8th    Friday, April 9th
Saturday, April 10th   2010
THE AMERICAN SURGICAL ASSOCIATION

2009-2010

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President
Donald D. Trunkey

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Kirby I. Bland

Vice-President
Thomas R. DeMeester

Secretary
E. Christopher Ellison

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Jay L. Grosfeld ................................................................. 2007-2010
Courtney M. Townsend, Jr. ............................................... 2008-2011
Anthony D. Whitemore .................................................. 2009-2012

President, President-Elect, Vice President, Secretary,
Treasurer and Recorder

American Surgical Association
Administrative Offices
900 Cummings Center, Suite 221-U
Beverly, MA 01915
Phone: (978) 927-8330   Fax: (978) 524-8890
Email: ASA@prri.com
Or visit: www.americansurgical.info
### ADVISORY MEMBERSHIP COMMITTEE

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<td>Lewis M. Flint, Jr., Chair</td>
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<td>Jean C. Emond</td>
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<td>Julie Ann Freischlag</td>
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<td>David A. Fullerton</td>
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<td>Danny O. Jacobs</td>
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<td>Larry R. Kaiser</td>
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<td>Robin S. McLeod</td>
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<td>Monica Morrow</td>
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<td>Sean J. Mulvihill</td>
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### ARRANGEMENTS COMMITTEE

**130th Annual Meeting**

Jeffrey B. Matthews, Chair

### AUDIT COMMITTEE

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<td>Edward E. Cornwell, III, Chair</td>
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<td>Andrew L. Warshaw</td>
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### HONORARY FELLOWSHIPS COMMITTEE

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<td>Michael J. Zinner</td>
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American Surgical Association

Flance-Karl Award Committee
Michael J. Edwards, Chair ............................................................. 2005-2010
Stanley W. Ashley .......................................................................... 2008-2013
Jonathan S. Bromberg ................................................................. 2006-2011
Richard A. Hodin ........................................................................... 2009-2014
Jeffrey B. Matthews ....................................................................... 2007-2012

Nominating Committee
Jay L. Grosfeld, Chair ................................................................. 2007-2012
Carlos A. Pellegrini ........................................................................ 2006-2011
Hiram C. Polk, Jr. .......................................................................... 2005-2010
Courtney M. Townsend, Jr. ........................................................... 2008-2013
Anthony D. Whittemore ................................................................ 2009-2014

Program Committee
B. Mark Evers, Chair ..................................................................... 2005-2010
R. Daniel Beauchamp ..................................................................... 2008-2013
K. Craig Kent .................................................................................. 2007-2012
Theodore N. Pappas ...................................................................... 2009-2014
Carolyn E. Reed ............................................................................. 2006-2011

President, President-Elect, Secretary, and Recorder, ex officio with vote
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FOUNDATION

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Vice Chair
Hiram C. Polk, Jr.

Secretary
E. Christopher Ellison

Treasurer
Barbara L. Bass

Trustees
Jay L. Grosfeld
Carlos A. Pellegrini
Courtney M. Townsend, Jr.

Ex-Officio
Donald D. Trunkey
AMERICAN SURGICAL ASSOCIATION

REPRESENTATIVES

AMERICAN BOARD OF SURGERY

L.D. Britt ............................................................... 2007-2013
V. Suzanne Klimberg ............................................ 2007-2013
Richard C. Thirlby ............................................... 2006-2012
Selwn M. Vickers .................................................. 2009-2015

AMERICAN BOARD OF PLASTIC SURGERY

Nicholas B. Vedder .................................................. 2004-2010

AMERICAN BOARD OF THORACIC SURGERY

Valerie W. Rusch .................................................... 2002-2011
Richard J. Shemin .................................................. 2005-2011

AMERICAN COLLEGE OF SURGEONS, BOARD OF GOVERNORS

Ernest E. Moore, Jr ................................................. 2007-2010
Susan L. Orloff ....................................................... 2008-2011

AMERICAN COLLEGE OF SURGEONS, ADVISORY COUNCIL FOR SURGERY

W. Scott Melvin ....................................................... 2009-2012

AMERICAN COLLEGE OF SURGEONS, SURGICAL RESEARCH COMMITTEE

Thomas M. Krummel .............................................. 2007-2010

ASSOCIATION OF AMERICAN MEDICAL COLLEGES, COUNCIL OF ACADEMIC SOCIETIES

William G. Cioffi ................................................... 2008-2010
Linda G. Phillips .................................................... 2008-2010

NATIONAL ASSOCIATION FOR BIOMEDICAL RESEARCH

Yuman Fong .......................................................... 2005-2010
FUTURE MEETINGS OF THE AMERICAN SURGICAL ASSOCIATION

April 14-16, 2011
Boca Raton Resort & Club
Boca Raton, Florida

April 26-28, 2012
The Fairmont
San Francisco, California
The Fairmont in Chicago, Illinois is the headquarters of the American Surgical Association for the 130th Annual Meeting, April 8-10, 2010.

REGISTRATION: The Registration Desk for the 130th Annual Meeting is located in the Imperial Ballroom Foyer during the following hours:

- Wednesday, April 7th: 2:00 p.m. – 6:00 p.m.
- Thursday, April 8th: 7:00 a.m. – 5:15 p.m.
- Friday, April 9th: 7:30 a.m. – 5:00 p.m.
- Saturday, April 10th: 7:30 a.m. – 11:00 a.m.

Fellows and invited guests who have pre-registered are required to sign the registration book and pick up registration materials at the ASA Registration Desk. Registration is also available onsite.

SPEAKERS AND DISCUSSANTS: All manuscripts presented at the Scientific Sessions of the Annual Meeting must be submitted electronically to The Annals of Surgery at http://www.editorialmanager.com/annsurg prior to the presentation of the paper. The time allowed for each presentation is ten minutes. Following the presentation, the Primary Discussant will be allotted three minutes for discussion. All additional discussants will be allotted two minutes. The total amount of time provided for discussion is fifteen minutes. Please note the use of slides will NOT be permitted for discussants.

SPEAKER READY ROOM: The Speaker Ready Room is located in the Regal Room. Authors are requested to submit their PowerPoint presentations on USB memory drive or CD-ROM the day prior to their session to the technician in the Speaker Ready Room. Presentations may be forwarded in advance to the ASA meetings coordinator at the Association’s Administrative Office at cheatrice@prri.com. Speaker Ready Room hours are:

- Wednesday, April 7th: 2:00 p.m. – 6:00 p.m.
- Thursday, April 8th: 7:00 a.m. – 5:15 p.m.
- Friday, April 9th: 7:30 a.m. – 5:00 p.m.
- Saturday, April 10th: 7:30 a.m. – 11:00 a.m.
MESSAGES: A Message Board is maintained in the Registration Area during registration hours. Please check it often. There is no paging in the Scientific Sessions. The following number may be used to contact the Fairmont Chicago: 312-565-8000. Please ask for the ASA Registration Desk.

BANQUET: The Annual Reception and Banquet is open to Fellows of the Association and their spouses, as well as Invited Guest Physicians and their spouses. The Reception and Banquet is scheduled for Friday, April 9th, with the reception and dinner in the International Ballroom (black tie preferred, but dark suits are acceptable).

SPECIAL EVENTS:

- Address By the President: Thursday, April 8th, 11:00 a.m.
- Forum Discussion: Friday, April 9th, 10:30 a.m.
- “The Impact of Healthcare Reform on Surgery” Executive Session (Fellows Only): Friday, April 9th, 4:00 p.m.
- Reception & Banquet: Friday, April 9th, 7:00 p.m.

SPOUSE/GUEST HOSPITALITY: The Spouse/Guest Hospitality Suite is located in Chancellor Room from Wednesday, April 7th through Friday, April 9th. The Local Arrangements Committee will have information on activities of interest and maps available in the room.
ACCREDITATION INFORMATION

CME MISSION/PURPOSE AND CONTENT
The Continuing Medical Education Mission of the American Surgical Association is to provide a national forum for presenting the developing state-of-the-art and science of general and sub-specialty surgery and the elevation of the standards of the medical/surgical profession. This mission is accomplished primarily by conducting an annual scientific meeting consisting of selected presentations containing the most current information available on clinical and research topics related to surgery or surgical specialties, including studies on outcomes, practice and science of surgery and ethical and other issues that affect its practice. In addition, the meeting features special invited speakers who address a variety of topics directly or indirectly related to the practice of surgery. The meeting is presented for the benefit of those physicians, surgeons and researchers involved in the study, treatment and cure of diseases associated with the entire spectrum of human disease. The meeting provides for a free exchange of information and serves the professional needs of the membership and invited guests. The Association’s mission is augmented by the publication of the scientific papers presented at the annual meeting in the Annals of Surgery, a monthly scientific publication distributed to subscribers throughout the world and by the publication of the Proceedings of the Annual Meeting and the scientific papers in the Transactions of the American Surgical Association, an annual publication distributed to the membership.

LEARNING OBJECTIVES
The Annual Meeting of the American Surgical Association is designed to provide two and one half days of comprehensive educational experiences in the fields of clinical surgery, experimental surgery and related sciences, surgical education and the socioeconomic aspects of surgical care. It is the Association’s intent to bring together at this meeting the leading surgeons and scientists from North America and other continents to freely and openly discuss their latest clinical and research findings.
LEARNING OUTCOMES
At the conclusion of the Annual Meeting, participants should have an enhanced understanding of the latest techniques and current research specifically related to the fields of clinical surgery, experimental surgery and related sciences, surgical education and the socioeconomic aspects of surgical care. Through the open discussion periods and the Forum Discussion, participants will have the opportunity to hear the pros and cons of each paper presented to gain an overall perspective of their current practices and utilize results presented to select appropriate surgical procedures and interventions for their own patients and integrate state-of-the-art knowledge into their current practice and/or research.

EDUCATIONAL METHODS
Authored papers supported by audio/visual presentations, panel discussion and open group discussion.

ACCREDITATION STATEMENT
This activity has been planned and implemented in accordance with the Essential Areas and Policies of the Accreditation Council for Continuing Medical Education through the joint sponsorship of the American College of Surgeons and the American Surgical Association. The American College of Surgeons is accredited by the ACCME to provide continuing medical education for physicians.

AMA PRA CATEGORY 1 CREDITS™
The American College of Surgeons designates this educational activity for a maximum of 17 AMA PRA Category 1 Credits™. Physicians should only claim credit commensurate with the extent of their participation in the activity.
FACULTY DISCLOSURE INFORMATION

In compliance with ACCME regulations, the American College of Surgeons, as the accredited provider of this activity, must ensure that anyone in a position to control the content of the educational activity has disclosed all relevant financial relationships with any commercial interest. Members of the program committee were required to disclose all financial relationships and speakers were required to disclose any financial relationship as it pertains to the content of the presentations. ACS defines a “commercial interest” as any proprietary entity producing health care goods or services consumed by, or used on patients. The ACCME does not consider providers of clinical service directly to patients to be commercial interests. The ACS considers “relevant” financial relationships as financial transactions (in any amount) occurring within the past 12 months that may create a conflict of interest.

ACS is also required, through our joint sponsorship partners, to manage any reported conflict and eliminate the potential for bias during the activity. The program committee members (if applicable) and speakers were contacted and the conflicts listed below have been managed to our satisfaction. However, if you perceive a bias during a session, please report the circumstances on the session evaluation form.

Please note we have advised the speakers that it is their responsibility to disclose at the start of their presentation if they will be describing the use of a device, product, or drug that is not FDA approved or the off-label use of an approved device, product, or drug or unapproved usage.

The requirement for disclosure is not intended to imply any impropriety of such relationships, but simply to identify such relationships through full disclosure, and to allow the audience to form its own judgments regarding the presentation.

Please refer to the Author and Faculty Disclosures on the following pages. Any disclosure information not available at press time will be included in supplemental material distributed at the Annual Meeting.
## PROGRAM COMMITTEE DISCLOSURE LIST

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<td>R. Daniel Beauchamp</td>
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## FACULTY DISCLOSURE LIST

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## Discussant Disclosure List

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## AMERICAN SURGICAL ASSOCIATION

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THURSDAY, APRIL 8th

8:15 a.m.  President’s Opening Remarks  Imperial Ballroom
Secretary’s Welcome and Introduction of New Fellows Elected in 2009
President’s Introduction of Honorary Fellows
Report of the Committee on Arrangements
Presentation of the Medallion for Scientific Achievement

9:10 a.m.  Scientific Session I  Imperial Ballroom
Moderator: Donald D. Trunkey, MD

11:00 a.m.  Address by the President  Imperial Ballroom
Donald D. Trunkey, MD

1:30 p.m.  Scientific Session II  Imperial Ballroom
Moderator: Kirby I. Bland, MD
FRIDAY, APRIL 9th

8:00 a.m.  Scientific Session III  Imperial Ballroom
          Moderator: Donald D. Trunkey, MD

10:30 a.m. Forum Discussion:  Imperial Ballroom
          “The Impact of Healthcare Reform on Surgery”
          Moderator: Donald D. Trunkey, MD

1:30 p.m.  Scientific Session IV  Imperial Ballroom
          Moderator: Tom R. DeMeester, MD

4:00 p.m.  Executive Session  Imperial Ballroom
          (Fellows Only)
          Presentation of the Flance-Karl Award

7:00 p.m.  Annual Reception  International Ballroom

8:00 p.m.  Annual Banquet  International Ballroom
          (Black tie preferred, but dark suits are acceptable.)

SATURDAY, APRIL 10th

8:00 a.m.  Scientific Session V  Imperial Ballroom
          Moderator: New President-Elect

11:00 a.m. Adjourn
AMERICAN SURGICAL ASSOCIATION

AMERICAN SURGICAL ASSOCIATION
130th ANNUAL MEETING
April 8-10, 2010
The Fairmont
Chicago, Illinois

PROGRAM OUTLINE

THURSDAY, APRIL 8, 2010

8:15 AM  President's Opening Remarks

Secretary’s Welcome & Introduction of New Fellows
Elected in 2009

President’s Introduction of Honorary Fellows

Report of the Committee on Arrangements

Presentation of the Medallion for Scientific Achievement
9:10 AM – 11:00 AM

SCIENTIFIC SESSION I

Moderator: Donald D. Trunkey, MD

9:10 AM – 9:35 AM

1
Local and Regional Control in Breast Cancer After Sentinel Node Biopsy without Axillary Lymph Node Dissection: Results From a Randomized Trial

Armando E. Giuliano, MD1, Linda McCall, MS2*, Peter Beitsch, MD3*, Pat W. Whitworth, MD3*, Peter Blumencranz, MD5*, Marilyn Leitch, MD6*, Sukamal Saha, MD7*, Kelly K. Hunt, MD8, Monica Morrow, MD9, Karla Ballman, PhD10*

1John Wayne Cancer Institute, Santa Monica, CA; 2American College of Surgeons Oncology Group, Durham, NC; 3Dallas Surgical Group, Dallas, TX; 4Nashville Breast Center, Nashville, TN; 5Morton Plant Hospital, Clear Water, FL; 6University of Texas Southwestern Medical Center Surgery, Dallas, TX; 7McLaren Regional Medical Center, Michigan State University, Flint, MI; 8MD Anderson Cancer Center, Houston, TX; 9Memorial Sloan-Kettering Cancer Center, New York City, NY; 10Mayo Clinic, Rochester, MN

9:35 AM – 10:00 AM

2
Primary Fibrinolysis Is Integral in the Pathogenesis of Acute Coagulopathy of Trauma

Jeffry L. Kashuk, MD1*, Ernest E. Moore, MD2, Michael Sawyer, MD2*, Max Wohlauer, MD3*, Carlton Barnett, MD2*, Walter Biffl, MD2*, Clay C. Burlew, MD2*, Jeffrey L. Johnson, MD2*, Angela Sanaa, MD, PhD2*

1Penn State Hershey Medical Center and Penn State University College of Medicine, Hershey, PA; 2Denver Health Medical Center and University of Colorado, Denver Health Sciences Center, Denver, CO

* By Invitation
10:00 AM – 10:25 AM

3
Early Tracking Would Improve Operative Experience of General Surgery Residents
Steven C. Stain, MD1, Thomas W. Biester, MS2*, John B. Hanks, MD3, Stanley W. Ashley, MD4, R. James Valentine, MD5, Barbara L. Bass, MD6, Jo Buyske, MD2*
1Albany Medical College, Albany, NY; 2American Board of Surgery, Philadelphia, PA; 3University of Virginia, Charlottesville, VA; 4Brigham and Women’s Hospital, Boston, MA; 5University of Texas Southwestern Medical Center, Dallas, TX; 6The Methodist Hospital, Houston, TX

10:25 AM – 10:50 AM

4
Is Risk Adjusted Mortality an Indicator of Quality of Care in General Surgery? A Comparison of Risk Adjustment to Peer Review
Steven Shackford, MD, Talia Ben-Jacob, MD*, John Ratliff, JD*, Neil Hyman, MD
University of Vermont College of Medicine, Burlington, VT

10:50 AM – 11:00 AM

Introduction of the President
Tom R. DeMeester, MD

11:00 AM – 12:00 PM

Address by the President
Donald D. Trunkey, MD

* By Invitation
1:30 PM – 5:15 PM
SCIENTIFIC SESSION II
Moderator: Kirby I. Bland, MD

1:30 PM – 1:55 PM
5 Ulceration as a Predictive Marker for Response to Interferon alpha-2b Adjuvant Therapy in Melanoma Patients
Kelly M. McMasters, MD, PhD1, Charles R. Scoggins, MD1*, Merrick I. Ross, MD2, Robert C.G. Martin, II, MD, PhD1*, Marshall Urist, MD3, Michael J. Edwards, MD4
1University of Louisville, Louisville, KY; 2University of Texas, MD Anderson Cancer Center, Houston, TX; 3University of Alabama, Birmingham, Birmingham, AL; 4University of Cincinnati, Cincinnati, OH

1:55 PM – 2:20 PM
6 Stem Cell Mobilization Is Lifesaving in an Animal Model of Acute Liver Failure
Andrew Cameron, MD, PhD*, Anthony Mark, MD*, Daniel Warren, PhD*, G. Melville Williams, MD, Robert Montgomery, MD*
The Johns Hopkins University School of Medicine, Baltimore, MD

* By Invitation
2:20 PM – 2:45 PM

7
Surgical Quality and Nodal Ultrastaging Is Associated with Long-Term Disease-Free Survival in Early Colorectal Cancer: An Analysis of Two International Multicenter Prospective Trials
Anton Bilchik, MD, PhD, FACS1, Avi Nissan, MD2*, Zev Wainberg, MD3*, Perry Shen, MD3*, Martin McCarter, MD4*, Mladjan Protic, MD5*, Robin Howard, MA6*, David Elashoff, PhD1*, George Peoples, MD6*, Alexander Stojadinovic, MD6*
1University of California Los Angeles, Los Angeles, CA; 2Hadassah University, Jerusalem, Israel; 3Wake Forest University, Winston Salem, NC; 4University of Colorado, Denver, CO; 5University of Novi Sad, Novi Sad, Serbia; 6Uniformed Services University of the Health Sciences, Washington, DC

2:45 PM – 3:10 PM

8
The Efficacy of Medical Team Training: Improved Team Performance and Decreased Perioperative Delays – A Detailed Analysis of 3,580 Cases
Francis A. Wolf, MD1*, Lawrence W. Way, MD2, Lygia Stewart, MD1*
1UCSF/SF VAMC, San Francisco, CA; 2UCSF, San Francisco, CA

* By Invitation
3:10 PM – 3:35 PM

9
A Validated Value-Based Model to Improve Hospital-Wide Perioperative Outcomes
Thanjavur S. Ravikumar, MD1, Cordelia Sharma, MD1*, Garry Ritter, PAC2*, Corrado Marini, MD1*, Rafael Barrera, MD2*, Mimi Kim, ScD3*, Kathy Vandervoort, BS4*, Marcella DeGennimo, MS2*, Lindsay Baker, BS4*, Peter Levi, MD4*
1Geisinger Health System, Wilkes-Barre, PA; 2LIJ Medical Center, New Hyde Park, NY; 3Albert Einstein College of Medicine, Bronx, NY; 4Montefiore Medical Center, Bronx, NY

3:35 PM – 4:00 PM

10
Tep Inguinal Hernia Repair Compared with Lichtenstein (The Level-Trial): A Randomised Controlled Trial
H.H. Eker, MD1*, H.R. Langeveld, MD1*, W.F. Weidema, MD, PhD2*, L.P.S. Stassen, MD, PhD3*, E.W. Steyerberg, MD, PhD1*, H.J. Bonjer, MD, PhD1*, J.F. Lange, MD, PhD 1*, J. Jeekel, MD, PhD 1
1Erasmus Medical Center, Rotterdam, Rotterdam, Netherlands; 2Ikazia Ziekenhuis, Rotterdam, Rotterdam, Netherlands; 3Reinier de Graaf gasthuis, Delft, Netherlands

4:00 PM – 4:25 PM

11
HuR Status Is a Powerful Marker for Prognosis and Response to Chemotherapy for Resected Pancreatic Ductal Adenocarcinoma Patients
Nathan G. Richards, MD*, Agnes K. Witkiewicz, MD*, Christina L. Costantino, BA*, Dane R. Grenda, BS*, David W. Rittenhouse, MD*, Eugene P. Kennedy, MD*, Jonathan R. Brody, PhD*, Charles J. Yeo, MD
Thomas Jefferson University, Philadelphia, PA

* By Invitation
4:25 PM – 4:50 PM

12
Segmental Instead of Total Colectomy in Colon Cancer Patients Meeting Amsterdam Criteria: It’s Not Worth the Metachronous Risk
Matthew F. Kalady, MD*, Ellen McGannon, BS*, Jon D. Vogel, MD*, Susan Fay, BS*, Victor W. Fazio, MD, James M. Church, ChB, MS
Cleveland Clinic, Cleveland, OH

4:50 PM – 5:15 PM

13
A Statewide Assessment of Surgical Site Infection (SSI) Following Colectomy: The Role of Oral Antibiotics
Michael J. Englesbe, MD†, Martin A. Luchtefeld, MD‡, James Kubas, MS‡, James P. Lynch, MD§, Vic Velanovich, MD†, Anthony J. Senagore, MD∥, John C. Eggenberger, MD∥, Lynda Brooks, RN∥, Darrell A. Campbell, Jr., MD†
†University of Michigan, Ann Arbor, MI; ‡Spectrum Health Medical Center, Grand Rapids, MI; §William Beaumont Hospital, Troy, MI; §Henry Ford Health System, Detroit, MI; ∥St Joseph’s Mercy Health System, Ann Arbor, MI

* By Invitation
8:00 AM – 8:25 AM
14
Acute Glucose Elevation Is Highly Predictive of Infection and Outcome in Critically Injured Trauma Patients
Grant Bochicchio, MD, PhD*, Kelly Bochicchio, RN, MS*, Manjari Joshi, MD*, Obeid Ilahi, MD*, Thomas Scalea, MD
University of Maryland, Baltimore, MD

8:25 AM – 8:50 AM
15
Glucose Control in Severely Thermally Injured Pediatric Patients: What Glucose Range Should Be the Target?
Marc G. Jeschke, MD*, Robert Kraft, MD*, Fatemeh Emdad, PhD*, Gabriela A. Kulp, MS*, Felicia N. Williams, MD*, David N. Herndon, MD
UTMB, Galveston, TX

8:50 AM – 9:15 AM
16
A National Study of Attrition During General Surgery Training: Which Residents Leave, and Where Do They Go?
Heather Yeo, MD1*, Emily Bucholz, BA1*, Julie Ann Sosa, MD1*, Leslie Curry, PhD, MPH1*, Frank R. Lewis, MD, Jr2,
Andrew T. Jones, PhD2*, Kate Viola, MD1*, Zhenqui Lin, PhD1*, Richard H. Bell, Jr., MD2
1Yale University, New Haven, CT; 2American Board of Surgery, Philadelphia, PA

* By Invitation
9:15 AM – 9:40 AM

17 Prevention of Surgical Resident Attrition By a Novel Selection Strategy
Rachel R. Kelz, MD, MSCE*, James L. Mullen, MD, Larry R. Kaiser, MD, Lori A. Pray, BA*, Gregg Shea, MBA*, Jeff A. Drebin, MD, Chris J. Wirtalla, BA*, Jon B. Morris, MD

Department of Surgery, University of Pennsylvania, Philadelphia, PA

9:40 AM – 10:05 AM

18 Primary Payer Status Affects Mortality for Major Surgical Operations
Damien J. LaPar, MD*, Castigliano M. Bhamidipati, DO*, Carlos M. Mery, MD, MPH*, George J. Stukenborg, PhD*, David R. Jones, MD, Bruce D. Schimmer, MD, Irving L. Kron, MD, Gorav Ailawadi, MD*

University of Virginia, Charlottesville, VA

10:05 AM – 10:30 AM

19 Hospital Factors Do Not Explain Away Socioeconomic-Based Disparities in Surgical Outcomes
Kyla M. Bennett, MD*, John E. Scarborough, MD*, Theodore N. Pappas, MD, Thomas B. Kepler, PhD*

Duke University Medical Center, Durham, NC

* By Invitation
10:30 AM – 12:00 PM

FORUM DISCUSSION

The Impact of Healthcare Reform on Surgery

Moderator: Donald D. Trunkey, MD

Richard A. Cooper, MD*
University of Pennsylvania
Philadelphia, PA

George F. Sheldon, MD
University of North Carolina at Chapel Hill
Chapel Hill, NC

* By Invitation
1:30 PM – 1:55 PM
20
Mark F. Conrad, MD*, Emel A. Ergul, MS*, Virendra I. Patel, MD*, Christopher J. Kwolek, MD*, Richard P. Cambria, MD
Massachusetts General Hospital, Boston, MA

1:55 PM – 2:20 PM
21
Bariatric Surgery Is Safe and Effective Treatment for Diabetes in Non-Morbidly Obese Patients: Results Reported By ASMBS Bariatric Surgery Centers of Excellence (BSCOE) in Bariatric Outcomes Longitudinal Database (BOLD)
Eric J. DeMaria, MD1*, Deborah Winegar, PhD2*, Virginia Pate, MS2*, Quinn Swanger, MS2*, Walter J. Pories, MD3
1Duke University, Durham, NC; 2Surgical Review Corporation, Raleigh, NC; 3East Carolina University, Greenville, NC

2:20 PM – 2:45 PM
22
A Clinical Nomogram Predicting Pathologic Lymph-Node Involvement in Esophageal Cancer Patients
Puja Gaur, MD1*, Boris Sepesi, MD2*, Wayne L. Hofstetter, MD1*, Arlene M. Correa, MD1*, Manoop S. Bhutani, PhD1*, Jack A. Roth, MD1, Ana A. Vaporciyan, MD1*, Jeffrey H. Peters, MD2, Thomas J. Watson, MD2*, Stephen G. Swisher, MD1
1UT MD Anderson Cancer Center, Houston, TX; 2University of Rochester School of Medicine, Rochester, NY

* By Invitation
2:45 PM – 3:10 PM

23 Determinants of Embolization During Carotid Angioplasty and Stenting: Symptomaticity and Coronary Artery Disease Increase Embolic Risk
Christine Chung, BS*, Tejas Shah, MD*, Hyun Joo Shin, MD*, Michael Marin, MD, Peter Faries, MD*
Mount Sinai School of Medicine, New York, NY

3:10 PM – 3:35 PM

24 Identification of E-Selectin as a Novel Target for the Regulation of Post-Natal Neovascularization: Implications for Diabetic Wound Healing
Zhao-Jun Liu, MD, PhD†, Runxia Tan, MD†, Weijun An, MD†, Ying Zhuge, MD†, Yan Li, BS†, Hongwei Shao, MD†, Bianca Habib, BS†, Alan S. Livingstone, MD, Omaida C. Velazquez, MD†
University of Miami, Miami, FL

3:35 PM – 4:00 PM

25 Impact of Hospital Volume on In-Hospital Mortality of Children Undergoing Repair of Congenital Diaphragmatic Hernia
Brian T. Bucher, MD‡*, Rebecca M. Guth, MPH‡*, Jacqueline M. Saito, MD†**, Tasnim A. Najaf, MD†**, Brad W. Warner, MD†
†Washington University School of Medicine, St. Louis, MO; ‡St. Louis Children’s Hospital, St. Louis, MO

* By Invitation
4:00 PM – 5:00 PM
EXECUTIVE SESSION
Fellows Only
Presentation of the Flance-Karl Award

7:00 PM  ANNUAL RECEPTION

8:00 PM  ANNUAL BANQUET
8:00 AM – 11:00 AM

SCIENTIFIC SESSION V
Moderator: New President-Elect

8:00 AM – 8:25 AM

26 Circulating Thyrotropin Receptor (TSHR) mRNA as a Novel Marker of Thyroid Cancer: Clinical Applications Learned From 1,758 Samples
Mira Milas, MD*, Joyce Shin, MD*, Manjula Gupta, PhD*, Tomislav Novosel, MD*, Christian Nasr, MD*, Jamie Mitchell, MD*, Eren Berber, MD*, Allan Siperstein, MD
Cleveland Clinic, Cleveland, OH

8:25 AM – 8:50 AM

27 Long-Term Patient Outcome and Quality of Life After Liver Transplantation: A Prospective Analysis of 20-Plus Year Survivors
John P. Duffy, MD*, Kenneth Kao, MD*, Clifford Ko, MD, Douglas G. Farmer, MD*, Sue V. McDiarmid, MD*, Robert S. Venick, MD*, Susan Feist, RN*, Leonard Goldstein, MD*, Jonathan R. Hiatt, MD, Ronald W. Busuttil, MD, PhD
UCLA, Los Angeles, CA

8:50 AM – 9:15 AM

28 Combinatorial Effect of Donor and Recipient Age Is Critical in Determining Host Immunoresponsiveness and Renal Transplant Outcome
Stefan G. Tullius, MD, PhD*, Huong Tran, MD*, Indira Guleria, MD*, Sayeed K. Malek, MD*, Nicholas L. Tilney, MD, Edgar Milford, MD
Brigham and Women’s Hospital and Harvard Medical School, Boston, MA

* By Invitation
9:15 AM – 9:40 AM

29 Analysis of Over 3,000,000 Patients Screened for Abdominal Aortic Aneurysm: Development of a Novel Scoring Tool for the Identification of Large >5 cm Aneurysms

Giampaolo Greco, PhD, MPH1*, Natalia Egorova PhD, MPH1*, Robert M. Zvolak PhD, MPH2*, Thomas S. Riles, MD1, Andrew J. Manganaro, MD1*, Alan J. Moskowitz, MD1*, Annette C. Gelijns, PhD1*, K. Craig Kent, MD5

1Mount Sinai School of Medicine, New York, NY; 2Dartmouth-Hitchcock Medical Center, Lebanon, NH; 3NYU Langone Medical Center, New York, NY; 4Life Line Screening, Independence, OH; 5University of Wisconsin, Madison, WI

9:40 AM – 10:05 AM

30 Choledochoceles: Are They Choledochal Cysts?

Kathryn M. Ziegler, MD*, Henry A. Pitt, MD, Nicholas J. Zyromski, MD*, Aakash Chauhan, MS*, Stuart Sherman, MD*, Glen A. Lehman, MD*, Keith D. Lillemoe, MD, Frederick J. Rescorla, MD, Karen W. West, MD*, Jay L. Grosfeld, MD

Indiana University School of Medicine, Indianapolis, IN

10:05 AM – 10:30 AM

31 Operative Failures After Parathyroidectomy for Hyperparathyroidism: The Influence of Surgical Volume

Herbert Chen, MD1, Tracy Wang, MD, MP2*, Tina Yen, MD, MS3*, Kara Doffek, BS2*, Elizabeth Krzywda, NP2*, Sarah Schaefer, NP1*, Rebecca S. Sippel1*, Stuart Wilson, MD2

1University of Wisconsin, Madison, WI; 2Medical College of Wisconsin, Milwaukee, WI

* By Invitation
10:30 AM – 10:55 AM

32
Normothermia After Gastrointestinal Surgery: Holy Grail or False Idol?
Simon J. Lehtinen, BA*, Georgiana Onicescu, ScM*, Kathy Kuhn, RN*, David J. Cole, MD, Nestor F. Esnaola, MD*

Medical University of South Carolina, Charleston, SC

11:00 AM  ADJOURN
THURSDAY MORNING, APRIL 8th

8:15 AM
Imperial Ballroom

President’s Opening Remarks

Secretary’s Welcome and Introduction of New Fellows Elected in 2009

President’s Introduction of Honorary Fellows

Report of the Committee on Arrangements

Presentation of the Medallion for Scientific Achievement
Local and Regional Control in Breast Cancer After Sentinel Node Biopsy without Axillary Lymph Node Dissection: Results From a Randomized Trial

Armando E. Giuliano, MD1, Linda McCall, MS2, Peter Beitsch, MD3*, Pat W. Whitworth, MD4*, Peter Blumencranz, MD5*, Marilyn Leitch, MD6*, Sukamal Saha, MD7*, Kelly K. Hunt, MD8, Monica Morrow, MD9, Karla Ballman, PhD10*

1John Wayne Cancer Institute, Santa Monica, CA; 2American College of Surgeons Oncology Group, Durham, NC; 3Dallas Surgical Group, Dallas, TX; 4Nashville Breast Center, Nashville, TN; 5Morton Plant Hospital, Clear Water, FL; 6University of Texas Southwestern Medical Center Surgery, Dallas, TX; 7McLaren Regional Medical Center, Michigan State University, Flint, MI; 8MD Anderson Cancer Center, Houston, TX; 9Memorial Sloan-Kettering Cancer Center, New York City, NY; 10Mayo Clinic, Rochester, MN

Objective: Sentinel node biopsy (SNB) revolutionized the management of breast cancer by eliminating the need for axillary dissection (ALND) in patients whose sentinel node (SN) is tumor-free. Completion ALND for patients with tumor-involved SN remains the standard to achieve loco-regional control. Few studies have examined the outcome of patients who do not undergo ALND for positive SN. We now report local and regional recurrence in H&E-node-positive women after SNB alone compared to those treated with ALND.

Methods: ACOSOG Z0011 is a prospective randomized trial examining survival of patients with SN metastases detected by standard H&E and treated with and without ALND or axillary radiation. Local and regional recurrence was evaluated.

* By Invitation
Results: 446 patients were randomized to SNB alone and 445 to SNB + ALND. Patients with SNB alone were similar to those with SNB + ALND with respect to age, Bloom-Richardson score, estrogen receptor status, the use of adjuvant systemic therapy, tumor type, T stage, and tumor size. Patients randomized to SNB + ALND had a median of 17 axillary nodes removed compared to a median of only 2 SN removed with SNB only (p < .001). ALND also removed more involved nodes (p < .001). Median follow-up was 5.9 years. Neither differences in local recurrence (p < .169) nor regional recurrence (p < .443) were statistically significant between the two groups.

Conclusion: Despite the potential of residual disease in the axilla, SNB alone can offer excellent regional control and may be reasonable management for selected patients with breast cancer.
Primary Fibrinolysis Is Integral in the Pathogenesis of Acute Coagulopathy of Trauma

Jeffry L. Kashuk, MD1*, Ernest E. Moore, MD2, Michael Sawyer, MD2; Max Wohlauer, MD2, Carlton Barnett, MD2, Walter Biffl, MD2, Clay C. Burlew, MD2, Jeffrey L. Johnson, MD2, Angela Sauaia, MD, PhD2

1Penn-State Hershey Medical Center and Penn State University College of Medicine, Hershey, Pa; 2Denver Health Medical Center and University of Colorado, Denver Health Sciences Center, Denver, CO

Objective(s): The existence of primary fibrinolysis (PF) and a defined mechanistic link to the “Acute Coagulopathy of Trauma” is controversial. Rapid thrombelastography (r-TEG) offers point of care comprehensive assessment of coagulation. We hypothesized that PF occurs early in shock, leading to postinjury coagulopathy, and ultimately hemorrhage related death.

Methods: Consecutive patients over 14 months at risk for postinjury coagulopathy were stratified by transfusion requirements into massive (MT), >10 units/6 hours (n = 32), moderate (Mod), 5–9 units/6 hours (n = 15) and minimal (Min), <5 units/6 hours (n = 14). r-TEG was performed by adding tissue factor to uncitrated whole blood. Estimated percent lysis (EPL) was categorized as PF with >15% EPL. Coagulopathy was defined as clot strength = G <5.3 dynes/cm2. Logistic regression defined independent predictors of PF.

![Graph showing estimated probabilities of early fibrinolysis and death by G-value at 1 hr postinjury](image-url)

* By Invitation
Results: 34% of patients requiring MT had PF, which was associated with lower systolic blood pressure, temperature, and worse base deficit/pH/lactate (p < 0.0001). Mortality correlated significantly with PF (p = 0.026); occurred early (median 58 min, IQR 1.2 min-95.9 min); and every one unit drop in G increased the risk of PF by 30%, and death by over 10% (Figure).

Conclusions: Our results confirm the existence of PF as detected by r-TEG in severely injured patients. It occurs early (<1 hour) and is associated with massive transfusion requirements, coagulopathy, and hemorrhage related death. These data warrant renewed emphasis on early diagnosis and treatment of fibrinolysis in this cohort.
Early Tracking Would Improve Operative Experience of General Surgery Residents

Steven C. Stain, MD1, Thomas W. Biester, MS2*, John B. Hanks, MD1, Stanley W. Ashley, MD4, R. James Valentine, MD5, Barbara L. Bass, MD6, Jo Buyske, MD2*

1Albany Medical College, Albany, NY; 2American Board of Surgery, Philadelphia, PA; 3University of Virginia, Charlottesville, VA; 4Brigham and Women’s Hospital, Boston, MA; 5University of Texas Southwestern Medical Center, Dallas, TX; 6The Methodist Hospital, Houston, TX

Objective(s): High surgical complexity and individual career goals has led most general surgery (GS) residents to pursue fellowship training, resulting in a shortage of surgeons who practice broad based general surgery. We hypothesize that early tracking of residents would improve operative experience of residents planning to be general surgeons, and could foster greater interest and confidence in this career path.

Methods: Operative data from GS and fellowship bound residents (FB) applying for the 2008 American Board of Surgery Qualifying Exam (QE) was used to construct a hypothetical training model with 6 months of early specialization (ESP) for FB residents in 4 specialties (cardiac, vascular, colorectal, pediatric); and presumed these cases would be available to GS residents within the same program.

<table>
<thead>
<tr>
<th>Operation</th>
<th>GS Experience</th>
<th>1/2 FB Chief Cases</th>
<th>Total #</th>
<th>(% increase)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mastectomy</td>
<td>21.7</td>
<td>1.4</td>
<td>23.1</td>
<td>(6.5%)</td>
</tr>
<tr>
<td>Colon resection</td>
<td>63.0</td>
<td>14.3</td>
<td>77.3</td>
<td>(22.8%)</td>
</tr>
<tr>
<td>Gastrectomy</td>
<td>9.4</td>
<td>2.2</td>
<td>11.6</td>
<td>(23.4%)</td>
</tr>
<tr>
<td>Antireflux procedure</td>
<td>7.7</td>
<td>1.8</td>
<td>9.5</td>
<td>(23.4%)</td>
</tr>
<tr>
<td>Pancreatic resection</td>
<td>9.1</td>
<td>3.4</td>
<td>12.5</td>
<td>(37.4%)</td>
</tr>
<tr>
<td>Liver resection</td>
<td>8.2</td>
<td>2.4</td>
<td>10.6</td>
<td>(29.3%)</td>
</tr>
<tr>
<td>Endocrine procedures</td>
<td>35.2</td>
<td>6.9</td>
<td>42.1</td>
<td>(19.6%)</td>
</tr>
<tr>
<td>Trauma operations</td>
<td>33.7</td>
<td>4.5</td>
<td>38.2</td>
<td>(13.4%)</td>
</tr>
<tr>
<td>GI endoscopy</td>
<td>66.0</td>
<td>4.3</td>
<td>71.3</td>
<td>(6.5%)</td>
</tr>
</tbody>
</table>

* By Invitation
Results: 142 training programs had both FB residents (n = 237) and GS residents (n = 402), and represented 70% of all 2008 QE applicants. GS residents completed a mean of 1091 cases during residency and FB residents performed a mean of 252 cases in the chief year; theoretically making 126 cases available for each GS resident. GS experience and FB Chief are means case #s; and Total # is the predicted 5 yr GS case volume if ESP was adopted in these programs.

Conclusions: The ESP model improves operative experience of GS residents, particularly for complex gastrointestinal procedures. The expansion of subspecialty ESP should be considered.
Is Risk Adjusted Mortality an Indicator of Quality of Care in General Surgery? A Comparison of Risk Adjustment to Peer Review

Steven Shackford, MD, Talia Ben-Jacob, MD*, John Ratliff, JD*, Neil Hyman, MD
University of Vermont College of Medicine, Burlington, VT

Objective(s): Profiling of hospitals using risk-adjusted mortality rates as a measure of quality is becoming increasingly frequent. We aimed to determine the validity of this approach by comparing the risk adjusted predicted mortality to the findings of concurrent peer review and retrospective chart review of deaths that occur on a general surgery service.

Methods: Consecutive patients admitted to a busy general surgery service from 1/00–1/06 were prospectively entered into the Surgical Activity Tracking System. Rigorous, systematic peer review was performed concurrently by service members on all deaths. Adjudication was later validated by an independent senior surgeon. Three methodologies of risk adjustment (University Health Consortium [UHC], Physiological and Operative Severity Score for the enUmeration of Mortality [POSSUM], and the Charlson index) and compared the “excess mortality” predicted by each to the number of potentially preventable deaths determined by peer review.

Results: 9623 patients were admitted and 75 died (0.7%). UHC and POSSUM predicted an excess mortality of 62 and 65 deaths, respectively; Charlson predicted that 73% of the cohort would be dead in 1 year. Concurrent and retrospective peer review found that death was potentially preventable in only 22 and 21 patients, respectively.

Conclusions: Peer adjudication and extensive clinical review adds much to the analysis of an adverse outcome, similar to the “black box” in an airplane crash. While methods of risk adjustment may be helpful in identifying patients for peer review, they should be used for internal process improvement and not published as metrics of hospital or provider performance.

* By Invitation
10:50 AM – 11:00 AM
Imperial Ballroom

Introduction of the President

Tom R. DeMeester, MD

11:00 AM – 12:00 PM
Imperial Ballroom

Address by the President

Donald D. Trunkey, MD
Ulceration as a Predictive Marker for Response to Interferon alpha-2b Adjuvant Therapy in Melanoma Patients

Kelly M. McMasters, MD, PhD1, Charles R. Scoggins, MD1*, Merrick I. Ross, MD2, Robert C.G. Martin, II, MD, PhD1*, Marshall Urist, MD3, Michael J. Edwards, MD4

1University of Louisville, Louisville, KY; 2University of Texas, MD Anderson Cancer Center, Houston, TX; 3University of Alabama, Birmingham, Birmingham, AL; 4University of Cincinnati, Cincinnati, OH

Objective(s): Several studies have demonstrated that adjuvant therapy of high-risk melanoma patients with interferon alfa-2b (IFN) improves disease-free survival (DFS), although the impact on overall survival (OS) is controversial. Recent data have suggested that IFN therapy may preferentially benefit patients with ulcerated primary tumors.

Methods: Post-hoc analysis was performed of a prospective multi-institutional randomized study of observation vs. adjuvant IFN therapy for melanoma. Patients were stratified by Breslow thickness, ulceration and nodal status. Kaplan-Meier analysis of disease-free survival (DFS) and overall survival (OS), univariate and multivariate analyses were performed.

Results: A total of 1770 patients were analyzed (1311 without ulceration, 459 with ulceration) with a median f/u of 70 months. Overall, IFN treatment was not associated with significant improvement in DFS or OS in either SLN-negative or positive patients. However, among node-positive patients randomized to observation vs. IFN therapy (N = 217), there was a significant improvement in DFS only among patients with ulcerated tumors.

* By Invitation
IFN therapy had no significant impact on OS regardless of ulceration status, however. On multivariate analysis, IFN treatment was a significant independent predictor of DFS among ulcerated patients (OR 0.65, p = 0.0012), but not among patients without ulceration.

Conclusions: These data support the conclusion that ulceration is a predictive marker for response to adjuvant IFN therapy. Future studies should evaluate the differential effect of IFN on patients with ulcerated melanomas.
Stem Cell Mobilization Is Lifesaving in an Animal Model of Acute Liver Failure

Andrew Cameron, MD, PhD*, Anthony Mark, MD*, Daniel Warren, PhD*, G. Melville Williams, MD, Robert Montgomery, MD*

The Johns Hopkins University School of Medicine, Baltimore, MD

Objective(s): No therapy except liver transplantation currently exists for patients with Acute Liver Failure (ALF). Our laboratory studies stem cells in liver disease and our aim was to examine whether stem cell mobilization would aid in liver repair and survival benefit in an animal model of ALF.

Methods: Mice were treated with a single near-lethal intraperitoneal injection of carbon tetrachloride (CCl₄). Twelve hours later mice were randomized to receive either Mozibil and G-CSF (agents known to mobilize marrow derived stem cells) or saline vehicle injection. Mice were followed for survival as well as evidence of liver injury by transaminase level and histopathology.
Results: With control treatment only 25% of animals were alive within 2 days of CCl₄ exposure, consistent with our established near-lethal model of ALF. In contrast, the group that received treatment with agents that mobilize stem cells displayed 87% survival (n = 8, p < 0.05).

Conclusions: Our results demonstrate a possible therapy for patients with Acute Liver Failure, a group for whom liver transplant or death are often the only alternatives. This therapy exerts its action via mobilization of marrow derived stem cells which participate in liver recovery. This process may help avoid liver transplant in patients with acute liver failure and aid a wide variety of medical and surgical patients with liver injury.
Surgical Quality and Nodal Ultrastaging Is Associated with Long-Term Disease-Free Survival in Early Colorectal Cancer: An Analysis of Two International Multicenter Prospective Trials

Anton Bilchik, MD, PhD, FACS1, Avi Nissan, MD2*, Zev Wainberg, MD1*, Perry Shen, MD3*, Martin McCarter, MD4*, Mladjan Protic, MD5*, Robin Howard, MA6*, David Elashoff, PhD1*, George Peoples, MD6*, Alexander Stojadinovic, MD6*

1University of California Los Angeles, Los Angeles, CA; 2Hadassah University, Jerusalem, Israel; 3Wake Forest University, Winston Salem, NC; 4University of Colorado, Denver, CO; 5University of Novi Sad, Novi Sad, Serbia; 6Uniformed Services University of the Health Sciences, Washington, DC

Objective: The National Quality Forum has endorsed a 12 lymph node (LN) minimum as a surrogate measure of quality in colorectal cancer (CRC). The prognostic value of ultrastaging hematoxylin and eosin (H&E) negative LN’s (N0) using cytokeratin immunohistochemistry (CK-IHC) is unknown. We hypothesized that both surgical quality and focused pathology analysis improves survival.

Methods: Between 2001 and 2007, 253 evaluable patients with resectable CRC were enrolled. Multiple sectioning and CK-IHC was performed on N0 LN’s (stage II). The primary end-point was four-year disease free survival (DFS).

Four Year DFS Based on AJCC Stage and LN Number

<table>
<thead>
<tr>
<th>Stage</th>
<th>N</th>
<th>&lt;12LN’s</th>
<th>&gt;12LN’s</th>
<th>P*</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>68</td>
<td>92%</td>
<td>98%</td>
<td>0.22</td>
</tr>
<tr>
<td>II</td>
<td>91</td>
<td>71%</td>
<td>95%</td>
<td>0.0083</td>
</tr>
<tr>
<td>III</td>
<td>94</td>
<td>70%</td>
<td>70%</td>
<td>0.72</td>
</tr>
</tbody>
</table>

* log rank test

* By Invitation
Results: There were 177 (70%) patients with N0 and 76 (30%) with N1 disease. Using ultrastaging in N0 patients, 36 (20%) were found to have micrometastases (MM). At a mean follow up of 3.4 years (±1.6), 39 (15%) have recurred. The recurrence rate was only 3.7% in patients >12 LN's, negative by H&E and IHC, compared to 18.8% with <12 LN's (P* = 0.0032).

Conclusion: This represents the first prospective report demonstrating that both surgical quality and nodal ultrastaging impacts survival in Stage II CRC. Patients with Stage II CRC with >12 LN's negative for MM (N0i–) are likely cured by surgery alone. Both surgical and pathological quality measures are imperative in early CRC in order to improve patient selection for adjuvant chemotherapy.
The Efficacy of Medical Team Training: Improved Team Performance and Decreased Perioperative Delays – A Detailed Analysis of 3,580 Cases

Francis A. Wolf, MD1*, Lawrence W. Way, MD2, Lygia Stewart, MD1*

1UCSF/SF VAMC, San Francisco, CA; 2UCSF, San Francisco, CA

Objective(s): Medical Team Training (MTT) has been touted as a way to improve teamwork and patient safety in the operating room (OR). This study was designed to determine whether MTT actually has tangible benefits.

Methods: OR personnel (surgeons, anesthesiologists, nurses) completed a one-day intensive MTT training. A standardized briefing/debriefing/perioperative routine was developed, including documentation of OR miscues, delays, and defined case score (1–5) assigned by the team. A multi-disciplinary committee reviewed and rectified any systems problems identified. Debriefing items were analyzed comparing baseline data with 12 and 20-month follow-up. A safety attitudes questionnaire was administered at baseline and one year.

Results: 3,580 MTT debriefings were analyzed. One year following MTT, case delays decreased (23% to 9%, p = 0.001), mean case score increased (4.07 to 4.87, p < 0.0005); both changes were sustained at 20 months. One-year and 20-month follow-up data demonstrated decreased frequency of preoperative delays (16% to 8%, p = 0.03), hand-off issues (5.4% to 0.3%, p = 0.022), equipment issues/delays (24% to 6%, p < 0.0005), cases with low (<3) conduct scores (23% to 3%, p < 0.0005); and timing of prophylactic antibiotic administration improved (85% to 97%, p < 0.0001). Surveys documented perception of improved teamwork and patient safety. A major systems issue regarding preoperative medication orders was identified and corrected.

Conclusions: MTT produced sustained improvement in OR team function, including decreased delays and improved case scores. When combined with a high-level debriefing/problem-solving process, MTT can be a foundation for improving OR performance. This is the largest case analysis of MTT and one of the few to document an impact of MTT on objective measures of operating room function and patient safety.

* By Invitation
A Validated Value-Based Model to Improve Hospital-Wide Perioperative Outcomes

Thanjavur S. Ravikumar, MD1, Cordelia Sharma, MD1*, Garry Ritter, PAC2*, Corrado Marini, MD3*, Rafael Barrera, MD2*, Mimi Kim, ScD3*, Kathy Vandervoort, BS4*, Marcella DeGermino, MS2*, Lindsay Baker, BS4*, Peter Levi, MD4*

1Geisinger Health System, Wilkes-Barre, PA; 2LIJ Medical Center, New Hyde Park, NY; 3Albert Einstein College of Medicine, Bronx, NY; 4Montefiore Medical Center, Bronx, NY

Objective(s): We hypothesized that building safe hospital systems to improve value-based surgical outcomes is predicated on workflow redesign for dynamic risk stratification, coupled with “real time” mitigation of risk.

Methods: Prospective implementation of “Surgical Continuum of Care” (SCoC) Model: Interdisciplinary team rounds, acuity stratified care rounding based on dynamic risk score, intensivist/hospitalist co-management of surgical patients and targeted response.

Study: Pre-and Post-intervention with concurrent cohort control design.

Setting: Academic Medical Centers.


Results: See table. Total >100,000 admissions. CMI unchanged during study in each campus. SICU, PCU and total hospital patient-days significantly decreased in IG group (p < 0.05) reflecting enhanced throughput. In addition to decreased LOC, cost savings were in PCU ($1.74M/yr) and top DRGs (e.g.) $452K/yr. Nested study in validation cohort of hospital wide vs. surgery alone (observed/expected mortality index) demonstrated significant benefit to SCoC.

Conclusions: SCoC is patient-centered, outcomes-driven, value-based approach for hospital wide surgical patient safety. The principles of this value paradigm are adaptable to other hospitals.

* By Invitation
### PILOT STUDY

<table>
<thead>
<tr>
<th>VARIABLE</th>
<th>IG</th>
<th>PCG</th>
<th>P VALUE</th>
</tr>
</thead>
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<tr>
<td>Overall</td>
<td>232/21,838</td>
<td>243/17,256</td>
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<tr>
<td>Mortality*</td>
<td>(1.0%)</td>
<td>(1.4%)</td>
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<tr>
<td>PCU</td>
<td>17/3693</td>
<td>35/2181</td>
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<tr>
<td>Mortality</td>
<td>(0.4%)</td>
<td>(1.6%)</td>
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<tr>
<td>SICU</td>
<td>127/1587</td>
<td>134/1434</td>
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<tr>
<td>Mortality</td>
<td>(8.0%)</td>
<td>(9.3%)</td>
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<tr>
<td>SICULOS</td>
<td>4.4 + 4.6</td>
<td>4.5 + 4.3</td>
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<tr>
<td>PCULOS</td>
<td>2.7 + 1.7</td>
<td>3.7 + 2.0</td>
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* No Δ in mortality at GUG, 1.25% vs 1.35% (p=ns)

### VALIDATION STUDY

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<thead>
<tr>
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<th>PG-V</th>
<th>IG-V</th>
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<td>Overall</td>
<td>436/22,067</td>
<td>191/11,934</td>
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<tr>
<td>Mortality</td>
<td>(1.97%)</td>
<td>(1.60%)</td>
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<td>Hosp/Surg</td>
<td>1.26/1.16</td>
<td>1.1/0.85</td>
<td>&lt;0.01</td>
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<td>LOS</td>
<td>Actual &gt; Budget 0.4 d</td>
<td>Actual &lt; Budget 0.65 d</td>
<td>&lt;0.01</td>
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Tep Inguinal Hernia Repair Compared with Lichtenstein
(The Level-Trial): A Randomised Controlled Trial
H.H. Eker, MD1*, H.R. Langeveld, MD1*,
W.F. Weidema, MD, PhD2, L.P.S. Stassen, MD, PhD3*,
E.W. Steyerberg, MD, PhD3*, H.J. Bonjer, MD, PhD1*;
J.F. Lange, MD, PhD1*,
J. Jeekel, MD, PhD 1
1Erasmus Medical Center, Rotterdam, Rotterdam, Netherlands;
2Ikazia Ziekenhuis, Rotterdam, Rotterdam, Netherlands;
3Reinier de Graaf gasthuis, Delft, Netherlands

Objective(s): Comparison of minimally invasive versus open inguinal hernia repair. Although mesh repair is generally preferred for surgical correction of inguinal hernia, it is still debated whether open or endoscopic techniques should be used. In this study, the most common technique for open mesh repair (Lichtenstein) was compared with the currently preferred minimally invasive technique (total extra peritoneal, TEP).

Methods: In this multi center trial, 660 patients were randomised to either Lichtenstein or TEP. Primary outcome was postoperative pain. Recurrences, complications, operating time, hospital stay, period until complete recovery, QoL, chronic pain and costs were secondary endpoints.

Results: Three-hundred-thirty-six patients were randomised to TEP and 324 to Lichtenstein repair. TEP was associated with less postoperative pain until 6 weeks postoperatively (p = 0.01). Impairment of inguinal sensibility was less seen after TEP (7% versus 30%, p = 0.01). Peroperative complications were more frequent after TEP (6% versus 2%, p < 0.001), while there was no difference in length of hospital stay. Postoperative complications (33% versus 33%) and QOL were comparable. After TEP, patients had a faster recovery of daily activities (ADL) (p < 0.002) and less absence from work (p = 0.001). After a mean follow-up of 66 months, recurrences and total costs were comparable for both groups.

Conclusions: Although TEP procedure was associated with more preoperative complications, postoperative recovery was faster with less postoperative pain, faster recovery of daily activities, quicker return to work, and less impairment of inguinal sensibility after 1 year. Recurrence rates and incidence of chronic pain were comparable. TEP can be recommended in experienced hands.

* By Invitation
HuR Status Is a Powerful Marker for Prognosis and Response to Chemotherapy for Resected Pancreatic Ductal Adenocarcinoma Patients

Nathan G. Richards, MD*, Agnes K. Witkiewicz, MD*, Christina L. Costantino, BA*, Dane R. Grenda, BS*, David W. Rittenhouse, MD†, Eugene P. Kennedy, MD*, Jonathan R. Brody, PhD†, Charles J. Yeo, MD

Thomas Jefferson University, Philadelphia, PA

Objective(s): Treatment of pancreatic ductal adenocarcinoma (PDA) typically includes chemotherapy with gemcitabine. No reliable biomarker exists for overall prognosis or response to chemotherapy. Two previously proposed prognostic markers, COX-2 and VEGF, are regulated by HuR, an mRNA binding protein that we have demonstrated to be a promising predictive marker of gemcitabine response (Cancer Research 2009, 69:4567–72). This study was designed to evaluate a clinically useful biomarker for PDA.

Methods: A tissue microarray of specimens including 53 with PDA, who underwent potentially curative resection, was analyzed. HuR, COX-2, and VEGF status were correlated with clinical data and compared for relative utility.
Results: Roughly 50% (27/53) of patients had elevated cytoplasmic HuR expression (HuR+). These patients had worse pathologic features (i.e. positive lymph nodes [75%] and AJCC pathologic stage 2 or greater [94%]) compared to HuR- patients. Cytoplasmic HuR status correlated with staging better than VEGF or COX-2 expression alone. When used in combination, HuR cellular positivity with VEGF+ status yielded 100% lymph node positivity. Additionally, HuR status was an unprecedented positive predictive marker for overall survival in patients treated with gemcitabine pushing median survival over 40 months in the HuR+ patient population (p-value 0.0049).

Conclusions: HuR status is a robust predictor of outcome for patients with resected PDA. This study supports the notion that HuR should be used by clinicians for the individualized treatment for PDA.
Segmental Instead of Total Colectomy in Colon Cancer Patients Meeting Amsterdam Criteria: It’s Not Worth the Metachronous Risk

Matthew F. Kalady, MD*, Ellen McGannon, BS*, Jon D. Vogel, MD*, Susan Fay, BS*, Victor W. Fazio, MD, James M. Church, ChB, MS
Cleveland Clinic, Cleveland, OH

Objective(s): Due to the nearly 80% lifetime colorectal cancer risk of patients meeting Amsterdam criteria for diagnosis of Hereditary Nonpolyposis Colorectal Cancer, a total rather than segmental resection to reduce the risk of metachronous colorectal cancer is advocated. The effectiveness of surveillance after segmental colectomy in preventing subsequent cancer is not well-documented. This study examines the results of such surveillance.

Methods: A hereditary colorectal cancer database was reviewed for patients meeting Amsterdam criteria who underwent colectomy for cancer. Patient demographics, surgical management, and subsequent follow-up were recorded. The primary endpoints were subsequent adenoma formation and second cancer development.

Results: 311 patients were included, 79 treated primarily at our institution and 232 referred to our registry after index resection. 157 cancers were right-sided. Mean age at index surgery was 52 years. 254 patients underwent a segmental colectomy of which 191 had documented colonoscopic surveillance. 105 of 191 (55%) had subsequent polypectomy, with removal of 198 adenomas including 95 that were high-risk by size or histology criteria. 51 of 191 (27%) segmental colectomy patients subsequently developed colorectal cancer at mean 120 months after index surgery. Stages at second resection were I-21, II-16, III-14. Five of 57 patients (8.8%) who underwent total colectomy developed subsequent cancer.

Conclusions: Amsterdam patients undergoing partial colectomy have a high rate of metachronous high-risk adenomas and cancers, including advanced stage. Total colectomy for the index cancer remains the procedure of choice. If patients have an initial segmental colectomy, yearly surveillance is essential, with intervention to prevent metachronous cancer.
A Statewide Assessment of Surgical Site Infection (SSI) Following Colectomy: The Role of Oral Antibiotics

Michael J. Englesbe, MD1*, Martin A. Luchtefeld, MD2*, James Kubus, MS1*, James P. Lynch, MD3*, Vic Velanovich, MD4, Anthony J. Senagore, MD2*, John C. Eggenberger, MD4*, Lynda Brooks, RN1*, Darrell A. Campbell, Jr., MD1

1University of Michigan, Ann Arbor, MI; 2Spectrum Health Medical Center, Grand Rapids, MI; 3William Beaumont Hospital, Troy, MI; 4Henry Ford Health System, Detroit, MI; 5St Joseph’s Mercy Health System, Ann Arbor, MI

Objective: Bowel preparation prior to colectomy remains controversial. Our hypothesis is that mechanical bowel preparation with oral antibiotics (compared to without) is associated with lower SSI rates.

Methods: 24 Michigan hospitals participated in the Michigan Surgical Quality Collaborative – Colectomy Best Practices Project. Standard ACS NSQIP peri-operative data, bowel preparation process measures and C.difficile colitis outcomes were prospectively collected. Among patients receiving mechanical bowel preparation, a logistic regression model generated a propensity score that classified cases into receiving oral antibiotics or not. A SAS Greedy macro was used for matching cases.

Results: Overall, 2062 elective colectomies occurred between January 2008 and June 2009. No bowel prep was given to 233 patients (11.3%) and they were excluded from the analysis; 49.6% received a mechanical prep and 36.4% received a mechanical prep and oral antibiotics. Propensity analysis created 382 paired cases (differing only in receiving oral antibiotics). Patients receiving oral antibiotics were less likely to have any SSI (4.5% vs.11.8%, p = 0.0001), to have an organ space infection (1.8% vs. 4.2%, p = 0.044) and to have a superficial SSI (2.6% vs. 7.6%, p = 0.001). Patients receiving bowel prep with oral antibiotics were also less likely to have a prolonged ileus (3.9% vs. 8.6%, p = 0.011) and had similar rates of C. difficile colitis (1.3% vs. 1.8%, p = 0.58).

Conclusions: Most patients in Michigan still receive mechanical bowel preparation prior to colectomy. Oral antibiotics at the time of mechanical bowel preparation may reduce the incidence of SSI.
Acute Glucose Elevation Is Highly Predictive of Infection and Outcome in Critically Injured Trauma Patients

Grant Bochicchio, MD, PhD*, Kelly Bochicchio, RN, MS*, Manjari Joshi, MD*, Obeid Ilahi, MD*, Thomas Scalea, MD
University of Maryland, Baltimore, MD

Objective(s): To evaluate whether acute glucose elevation (AGE) is predictive of infection and outcome in critically injured trauma patients during the first 14 days of ICU admission.

Methods: A prospective study was conducted on 2200 patients admitted to the ICU over a 2 1/2 year period. The diagnosis of infection was made via a multidisciplinary fashion utilizing CDC criteria. After early glucose stabilization occurred (no significant change for 48 hours after admission) monitoring for AGE was performed utilizing a computational and graded algorithmic model. Iatrogenic causes of AGE were excluded. Stepwise regression models were performed controlling for age, gender, mechanism of injury, diabetes, injury severity and APACHE 2 score. ROC curves were used to evaluate the positive predictive value of the test.

Results: 77% of the cohort were male (77%) and admitted for blunt injury (n = 1870 or 85%). The mean age, ISS, and APACHE score were 44 ± 20 years, 29 ± 13, and 13 ± 7 respectively. The mean admission serum glucose value was 141 ± 36 mg/dl (range 64–418 mg/dl). 616 (28%) patients were diagnosed with an infection during the first 14 days of admission. AGE had a 91% positive predictive value for infection diagnosis. In addition, AGE was associated with a significant increase in ventilator, ICU and hospital days as well as mortality even when adjusted for age, injury severity, APACHE score, and diabetes (p < 0.001).

Conclusions: AGE is a highly accurate predictor of infection and should stimulate clinicians to identify a new source of infection.

* By Invitation
Objective(s): Tight euglycemic control was rapidly implemented in ICUs around the world, but there is increasing evidence that tight euglycemic control is associated with detrimental outcomes. Currently, no study exists that indicates which glucose range should be targeted. The objective of this study was to determine which glucose levels are associated with improved morbidity and mortality in thermally injured patients.

Methods: Two-hundred eight severely burned pediatric patients with burns over 30% of their total body surface area (TBSA) were included in this trial. Several statistical models were used to determine the daily average and 6 a.m. glucose target that were associated with improved morbidity and mortality. Patients were then divided into good glucose controlled and poor glucose controlled patients and demographics, clinical outcomes, infection, sepsis, inflammatory and hypermetabolic responses were determined.

Results: Statistical modeling showed that hyperglycemia is a strong predictor of adverse hospital outcome and that daily 6 a.m. glucose level of 130 mg/dl and daily average glucose levels of 140 mg/dl are associated with improved morbidity and mortality postburn. When patients were divided into good glucose control and poor glucose control we found that patients with glucose levels of 130 mg/dl exert attenuated hypermetabolic and inflammatory responses, as well as significantly lower incidence of infections, sepsis, and mortality compared to patients with poor glucose control, p < 0.05.

Conclusions: Given the controversy over glucose range, glucose target, and risks and detrimental outcomes associated with hypoglycemia we suggest that in severely burned patient’s blood glucose of 130 mg/dl should be targeted.
A National Study of Attrition During General Surgery Training: Which Residents Leave, and Where Do They Go?
Heather Yeo, MD1*, Emily Bucholz, BA1*, Julie Ann Sosa, MD1*, Leslie Curry, PhD, MPH1*, Frank R. Lewis, MD, Jr.2, Andrew T. Jones, PhD2*, Kate Viola, MD1*, Zhenqui Lin, PhD1*, Richard H. Bell, Jr., MD2
1Yale University, New Haven, CT; 2American Board of Surgery, Philadelphia, PA

Objective(s): Implementation of the 80-hour mandate was expected to reduce attrition from general surgery (GS) residency. This is the first quantitative report from a national prospective study of resident-program characteristics associated with attrition.

Methods: Analysis included all categorical GS residents entered on American Board of Surgery (ABS) residency rosters in 2007–8. Cases of attrition were identified by program report, individually confirmed, and linked to demographic data from the National Study of Expectations and Attitudes of Residents in Surgery (NEARS) administered January 2008.

Results: 6,303 categorical GS residents were analyzed for overall attrition. Complete NEARS demographic information was available for 3,962; the total and survey groups were similar with regard to important characteristics. 3.1% of U.S categorical residents resigned in 2007–8, and 0.4% had contracts terminated. Across all years (including research), there was a 19.5% cumulative risk of resignation. Attrition was highest in R1 (6.1%), R2 (4.4%) and research year(s) (4.3%). Women were no more likely to leave programs than men (2.4% vs. 2.0%). Of several program/resident variables examined, PGY-level was the only independent predictor of attrition in multivariate analysis. Residents who left GS whose plans were known most often pursued non-surgical residencies (85%), particularly anesthesiology (26%) and radiology (15%). Only 15% left for surgical specialties.

Conclusions: Attrition rates are high despite mandated work hour reductions; one in five GS categorical residents resigns, and most pursue nonsurgical careers. Residents are at risk for attrition early in training and during research, and this could afford educators a target for intervention.

* By Invitation
Prevention of Surgical Resident Attrition By a Novel Selection Strategy
Rachel R. Kelz, MD, MSCE*, James L. Mullen, MD, Larry R. Kaiser, MD, Lori A. Pray, BA*, Gregg Shea, MBA*, Jeff A. Drebin, MD, Chris J. Wirtalla, BA*, Jon B. Morris, MD
Department of Surgery, University of Pennsylvania, Philadelphia, PA

Objective(s): Despite implementation of the ACGME work rules, lifestyle and generational priorities have fostered a persistently high attrition rate for surgical trainees. We proactively sought to evaluate/modify the resident selection strategy (RSS) to reduce resident attrition (RA).

Methods: An independent external review of residents who left the training program and a detailed analysis of the RSS were performed by an organizational management expert. Modifications implemented in 2005 (the intervention) included standardization of the screening and interview format. Applicants were required to submit a 500 word essay related to stress management, organizational skills, future aspirations, and prioritization abilities. This formed the basis of an extended, personalized, and structured interview script. Candidate characteristics and RA were compared for the five years before and after the intervention using Fisher’s exact test or chi-square.

Impact of Selection Model on Resident Performance and Attrition

<table>
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<tr>
<th>Characteristic</th>
<th>Traditional</th>
<th>Modified</th>
<th>p-value</th>
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<tbody>
<tr>
<td>#applicants interviewed</td>
<td>368</td>
<td>232</td>
<td></td>
</tr>
<tr>
<td>Faculty Evaluation</td>
<td></td>
<td></td>
<td>0.001</td>
</tr>
<tr>
<td>Below Mean</td>
<td>19</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Above Mean</td>
<td>14</td>
<td>26</td>
<td></td>
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<tr>
<td>Attrition</td>
<td></td>
<td></td>
<td>0.013</td>
</tr>
<tr>
<td>Yes</td>
<td>9 (27.3%)</td>
<td>1(3.2%)</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>24</td>
<td>30</td>
<td></td>
</tr>
</tbody>
</table>

* By Invitation
Results: Age, sex, birthplace, medical school ranking, step 1 score and ABSITE performance were not significantly different between the interview strategies. Risk factors for RA included gender, ABSITE performance and faculty evaluations. Resident performance and RA were significantly affected by the RSS.

Conclusions: RA was dramatically reduced following the intervention. A custom designed process to identify candidates most likely to succeed substantially improved resident retention in a demanding academic training program.
Primary Payer Status Affects Mortality for Major Surgical Operations
Damien J. LaPar, MD*, Castigliano M. Bhamidipati, DO*, Carlos M. Mery, MD, MPH*, George J. Stukenborg, PhD*, David R. Jones, MD, Bruce D. Schirmer, MD, Irving L. Kron, MD, Gorav Ailawadi, MD*
University of Virginia, Charlottesville, VA

Objectives: Medicaid and Uninsured populations are a significant focus of current healthcare reform. We hypothesized that outcomes following major surgical operations in the United States is dependent on primary payer status.

Methods: From 2003–2007, 893,658 major surgical operations were evaluated using the National Inpatient Sample (NIS) database: lung resection, esophagectomy, colectomy, pancreatcetomy, gastrectomy, abdominal aortic aneurysm repair, hip replacement, and coronary artery bypass. Patients were stratified by primary payer status: Medicare (n = 491,829), Medicaid (n = 40,259), Private Insurance (n = 337,535), and Uninsured (n = 24,035). Multivariate regression models were applied to assess outcomes.

Results: Unadjusted mortality for Medicare (4.4%, OR = 3.51), Medicaid (3.7%, OR: 2.86) and Uninsured (3.2%, OR: 2.51) patient groups were higher compared to Private Insurance groups (1.3%, p < 0.001). Moreover, mortality was lowest for Private Insurance patients independent of operation. Importantly, after controlling for age, gender, income, geographic region, operation, and 30 comorbid conditions, Medicaid payer status was associated with the longest length of stay and highest total costs (p < 0.001). In addition, Medicaid (p < 0.001) and Uninsured (p < 0.001) payer status independently conferred the highest adjusted risks of mortality (Table 1).

Table 1: Multivariate Regression Analyses for Adjusted Outcomes

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Medicaid</th>
<th>Uninsured</th>
<th>Medicare</th>
<th>Private Insurance</th>
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<tbody>
<tr>
<td>In-Hospital Mortality*</td>
<td>1.97</td>
<td>1.74</td>
<td>1.54</td>
<td>Ref</td>
</tr>
<tr>
<td>(1.84–2.10)</td>
<td>(1.60–1.90)</td>
<td>(1.48–1.61)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Length of Stay (days)</td>
<td>10.49 ± 0.04</td>
<td>7.01 ± 0.03</td>
<td>8.77 ± 0.01</td>
<td>7.38 ± 0.01</td>
</tr>
<tr>
<td>Total Costs ($)</td>
<td>$79,140 ± 251.4</td>
<td>$65,667 ± 231.0</td>
<td>$69,408 ± 53.1</td>
<td>$63,057 ± 53.0</td>
</tr>
</tbody>
</table>

* p < 0.001. Reference group: Private Insurance. In-hospital mortality reflected as Odds Ratios (95% Confidence Interval), Length of Stay and Total Costs reflected as adjusted means.

* By Invitation
Conclusions: Medicaid and Uninsured payer status confers increased risk of adjusted mortality. Medicaid was further associated with the greatest adjusted length of stay and total costs despite risk factors or operation. Possible explanations include delays in access to care or disparate differences in health maintenance.
Hospital Factors Do Not Explain Away Socioeconomic-Based Disparities in Surgical Outcomes

Kyla M. Bennett, MD*, John E. Scarborough, MD*, Theodore N. Pappas, MD, Thomas B. Kepler, PhD*

Duke University Medical Center, Durham, NC

Objective: Recent studies drawn from Medicare data suggest that hospital-related factors largely explain socioeconomic-based disparities in surgical outcomes. We used an all-payor nationally representative database to test this hypothesis.

Methods: The Nationwide Inpatient Sample from 2001–2006 was used to determine association between postoperative in-hospital mortality and patient- and hospital-level variables for 13 complex cardiovascular and oncologic procedures. Given available predictor variables, a subset of all possible logistic regression models for prediction of mortality was examined exhaustively and the Akaike Information Criterion (AIC) computed for each model. Model selection was performed by minimizing the AIC over all models. Model averaging was performed by weighting each model by AIC-based probability and summing over models.

Results: 1,059,003 patients were included for analysis. After adjustment for patient-related factors (age, gender, race, comorbidity), hospital procedure volume and hospital socioeconomic status (SES), low patient SES remained a significant positive predictor of postoperative mortality for 11 of 13 procedures analyzed. By both model selection and model averaging, patient SES was as important as or more important than hospital SES or hospital procedure volume in predicting postoperative mortality.

Conclusions: In contrast to recent reports, we find that patient SES is as important as or more important than hospital-related factors such as procedure volume and hospital SES in predicting mortality after complex surgery. Policies that attempt to reduce socioeconomic-based disparities by addressing only these hospital-related factors are likely to be inadequate.

* By Invitation
FRIDAY MORNING, APRIL 9th, CONTINUED

10:30 AM – 12:00 PM
Imperial Ballroom

FORUM DISCUSSION

The Impact of Healthcare Reform on Surgery

Moderator: Donald D. Trunkey, MD

Richard A. Cooper, MD*
University of Pennsylvania
Philadelphia, PA

George F. Sheldon, MD
University of North Carolina at Chapel Hill
Chapel Hill, NC

* By Invitation

Mark F. Conrad, MD*, Emel A. Ergul, MS*, Virendra I. Patel, MD*, Christopher J. Kwolek, MD*, Richard P. Cambria, MD
Massachusetts General Hospital, Boston, MA

Objective(s): Prospective trials have shown improved peri-operative mortality with endovascular repair of thoracic aortic pathologies (TEVAR) compared to conventional surgery (OPEN). However, there are currently no long-term population data detailing the impact of TEVAR on practice patterns and mortality rates for treatment of descending thoracic aortic pathology (DTA); which is the goal of this study.

Methods: All procedures performed on the DTA captured in the Medicare database from 2004–2007 were identified by ICD-9 codes and stratified into OPEN and TEVAR cohorts. Outcomes included peri-operative mortality (chi-square) and 5-year actuarial survival.

Results: There were 11166 patients identified (4838 [43%] TEVAR, 6328 [57%] OPEN) with 7247 (65%) non-ruptured aneurysms (TAA), 2701 (24%) dissections, 1033 (9%) ruptures and 185 (2%) traumatic aortic tears. The distribution of cases changed significantly during the study period (p < 0.0001) with an increase in TEVAR, decrease in OPEN, and increase in total cases over time (Table). The peri-operative mortality was lower in the TEVAR group for the entire population (360 [7.4%] TEVAR vs. 1175 [18.5%] OPEN, p < 0.0001), and for the individual pathologies: TAA (182/3529 [5%] TEVAR, 451/3718 [12%] OPEN, p < 0.001), dissections (76/833 [9%] TEVAR, 399/1868 [21%] OPEN, p < 0.001), ruptures (87/368 [24%] TEVAR, 298/665 [45%] OPEN, p < 0.0001). The 5 year survival (all curves
significantly favored TEVAR due to perioperative mortality) by indication was: entire population (53.4% TEVAR, 53.3% OPEN), TAA (55.8% TEVAR, 59.7% OPEN), dissection (58.2% TEVAR, 50.6% OPEN) and ruptures (23.3% TEVAR, 25.3% OPEN).

Conclusions: There has been a significant increase in the use of TEVAR to manage disease of the descending thoracic aorta. TEVAR offers a significant peri-operative survival advantage when compared to OPEN regardless of the indication for repair. However, in the Medicare population, the 5-year survival is similar between the two cohorts.

### Distribution of Cases Over Time

<table>
<thead>
<tr>
<th>YEAR</th>
<th>TEVAR</th>
<th>OPEN</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004</td>
<td>467 (21%)</td>
<td>1798 (79%)</td>
<td>2265</td>
</tr>
<tr>
<td>2005</td>
<td>1012 (38%)</td>
<td>1627 (62%)</td>
<td>2639</td>
</tr>
<tr>
<td>2006</td>
<td>1630 (52%)</td>
<td>1503 (48%)</td>
<td>3133</td>
</tr>
<tr>
<td>2007</td>
<td>1729 (55%)</td>
<td>1400 (45%)</td>
<td>3129</td>
</tr>
<tr>
<td>Totals</td>
<td>4838 (43%)</td>
<td>6328 (57%)</td>
<td>11166</td>
</tr>
</tbody>
</table>
Objective(s): Small case series suggest bariatric surgery may be effective treatment for diabetes in patients who do not meet criteria for morbid obesity (BMI < 35 kg/M²), but large multi-institutional series, which allow better assessment of the safety/efficacy of treatment, have not been reported.

Methods: Data from 66,264 research-consented patients with a surgery encounter in BOLD were queried to identify patients with BMI ≥30 but <35 kg/m² (1.2%, n = 794) and diabetes (DM) requiring any medication (29% of group).

Results: 235 patients met inclusion criteria. The 2 most common procedures (adjustable gastric banding AGB, n = 109 and gastric bypass, n = 109) were compared. Laparoscopic access was utilized in 92% of procedures. Gender (77% female), race (80% Caucasian), and age (mean 52.6 ± 10.4 yrs) did not differ between procedure groups.

Conclusions: Remission (cessation of medications) of DM was reported in 47.8% of patients within 6–12 months of surgery. Gastric bypass provided superior weight loss and DM remission, but demonstrated more frequent complications (90-day AE: 12% vs. 3%, p < 0.05). No mortalities were reported. The data suggest successful surgical treatment of diabetes in patients not meeting criteria for morbid obesity. Gastric bypass provides more effective early treatment for DM within 6–12 months.

* By Invitation
A Clinical Nomogram Predicting Pathologic Lymph-Node Involvement in Esophageal Cancer Patients
Puja Gaur, MD1*, Boris Sepesi, MD2*, Wayne L. Hofstetter, MD1*, Arlene M. Correa, MD1*, Manoop S. Bhutani, PhD1*, Jack A. Roth, MD1, Ara A. Vaporciyan, MD1*, Jeffrey H. Peters, MD2, Thomas J. Watson, MD2*, Stephen G. Swisher, MD1

1UT MD Anderson Cancer Center, Houston, TX; 2University of Rochester School of Medicine, Rochester, NY

Objective(s): Esophageal cancer patients with pathologic lymph-node involvement (pN1) generally have a poor prognosis with surgery alone. We, therefore, constructed a nomogram to predict the risk of pN1 prior to surgical resection and externally validated the clinical utility of the model.

Methods: 273 esophageal adenocarcinoma patients treated with surgery alone were reviewed from two different institutions (MDACC = 164, training set; URMC = 109, validation set). Pretreatment clinical parameters were utilized to construct a nomogram for predicting the risk of pN1. Internal and external validation of the nomogram was performed to assess clinical utility.

Results: Of the 164 patients in the training set, 56 patients (34%) had lymph-node involvement (pN1). Significant factors associated with pN1 on univariable logistic regression analysis (using a p-value of <.05) included endoscopically-determined clinical tumor depth (cT), clinical nodal (cN) status, and clinical tumor length (cL). Multivariable analysis suggested the significant independent factors were cT (OR:5.6, 95% CI:1.7–18.6, p < 0.01) and cL >2 cm (OR:7.0, 95% CI:2.7–18.1, p < 0.001). Regression tree analysis was used to determine the best cutoff for cL. A nomogram was created for pN1 using these clinical parameters and was internally validated by bootstrapping with a predicted accuracy of 85.1%. External validation performed on the validation set demonstrated an original C-index of 0.777 suggesting good clinical utility.

Conclusions: Our analyses demonstrate that the risk of pathologic nodal involvement in esophageal adenocarcinoma patients can be estimated by this clinical nomogram, which will allow the identification of patients at high-risk of harboring positive lymph-nodes who may be candidates for en-bloc resection and/or neoadjuvant treatment.
Determinants of Embolization During Carotid Angioplasty and Stenting: Symptomaticity and Coronary Artery Disease Increase Embolic Risk
Christine Chung, BS*, Tejas Shah, MD*, Hyun Joo Shin, MD*, Michael Marin, MD, Peter Faries, MD*
Mount Sinai School of Medicine, New York, NY

Objective: Patients at high risk for surgery have been routinely offered carotid angioplasty and stenting (CAS) as an alternative to endarterectomy for the treatment of severe carotid disease. However, the safety of CAS in this population continues to be a matter of debate, and appropriate patient selection for carotid interventions has emerged as the key to reducing adverse outcomes. Our goal is to determine whether the presence of coronary artery disease (CAD) is associated with greater embolic risk by analyzing debris from protective filters during CAS.

Methods: 233 CAS procedures were performed between 2003–2009. Filters from 162 patients (CAD [N = 86], non-CAD [N = 76]) were quantified by stereomicroscopy and video imaging software.

Results: Mean age of patients was 71.6 years, and 56.2% were male. Particulate debris was present in 134 (83%) filters. Univariate analysis revealed a greater number of particles in CAD patients than non-CAD patients (CAD: 12.6 ± 13.0 vs. non-CAD: 7.2 ± 7.8, p = .002). CAD patients had smaller mean (CAD: 351 µm ± 216 vs. non-CAD: 429 µm ± 429, p < .001) and minimum (CAD: 136 µm ± 115 vs. non-CAD: 195 µm ± 237, p < .001) particle sizes compared with non-CAD patients.

Conclusions: Our study suggests that CAD is associated with increased embolic risk during CAS. CAD patients release a greater number of particles of smaller size that may pose increased neurologic risk by escaping capture by protection devices. Therefore, the benefits of a percutaneous carotid intervention must be carefully weighed against the potential for worse neurologic outcome in CAD patients referred for CAS.

* By Invitation
Identification of E-Selectin as a Novel Target for the Regulation of Post-Natal Neovascularization: Implications for Diabetic Wound Healing

Zhao-Jun Liu, MD, PhD*, Runxia Tian, MD*, Weijun An, MD*, Ying Zhuge, MD*, Yan Li, BS*, Hongwei Shao, MD*, Bianca Habib, BS*, Alan S. Livingstone, MD, Omaida C. Velazquez, MD*

University of Miami, Miami, FL

Objectives: We previously reported that stromal cell-derived factor-1α (SDF-1α; homing signal for recruiting endothelial progenitor cells (EPC) to areas of neovascularization), is down-regulated in diabetic wounds (J Clin Invest, 2007). We now investigate signals whereby mature endothelial cells (EC) and circulating EPC achieve SDF-1α-mediated EPC homing.

Methods: SDF-1α levels in diabetic wounds were therapeutically increased by injection of SDF-1α-engineered bone marrow-derived fibroblasts versus control cells (N = 48 (20, NOD), (28, STZ-C57)). PCR-array gene expression differences were validated by Western blotting and immunohistochemistry. The role of adhesion molecule(s) in mediating SDF-1α-induced EPC homing and wound healing was further studied using antagonists in vitro and in vivo.

Results: Increasing wound SDF-1α via cell-base therapy promotes healing in diabetic mice (20% increase, \( P = 0.006 \)). SDF-1α increased EC-EPC adhesion and specifically upregulated E-selectin expression in human microvascular ECs (4.6-fold increase, \( P < 0.01 \)). This effect was also significant in blood vessels of the experimental mice and resulted in increased wound neovascularization. The regulatory effects of SDF-1α on EC-EPC adhesion and EPC homing were specifically mediated by E-selectin, as the application of E-selectin antagonists significantly inhibited SDF-1α-induced EC-EPC adhesion, EPC homing, wound neovascularization, and wound healing.

Conclusions: SDF-1α-engineered cells promote diabetic wound healing in mice by specifically upregulating E-selectin expression in mature ECs leading to increased EC-EPC adhesion, EPC homing and increased wound neovascularization. These findings provide novel insight into the signals underlying the effect of SDF-1α on EPC homing and point to E-selectin as a new potential target for therapeutic manipulation of EPC traffic in diabetic wound healing.

* By Invitation
Impact of Hospital Volume on In-Hospital Mortality of Children Undergoing Repair of Congenital Diaphragmatic Hernia

Brian T. Bucher, MD1*, Rebecca M. Guth, MPH2*, Jacqueline M. Saito, MD1*, Tasnim A. Najaf, MD1*, Brad W. Warner, MD1
1Washington University School of Medicine, St. Louis, MO; 2St. Louis Children’s Hospital, St. Louis, MO

Objectives: Congenital diaphragmatic hernia (CDH) continues to remain a significant cause of neonatal morbidity and mortality. Previous studies have suggested hospital volume is an independent predictor of in-hospital mortality. We sought to validate this effect using a large National database incorporating 38 free-standing Children’s Hospitals in the United States.

Methods: Infants whom underwent repair of CDH from 2000–2008 at Pediatric Health Information Systems (PHIS)-member hospitals were evaluated. Using generalized linear mixed models with random effects, we computed the risk adjusted odds ratio of mortality by yearly hospital volume, after adjustment for salient patient and hospital characteristics.

Results: There were 2231 infants whom underwent repair with an overall survival of 82%. Average yearly hospital volume varied from 1.4 to 17.5 cases per year. Smaller birthweight, year of birth, need for governmental assistance, chromosomal abnormalities, longer time to repair, and requirement for Extracorporeal Membrane Oxygenation (ECMO) or Nitric Oxide were all independently associated with mortality (Table). Compared to low volume, medium and high volume hospitals have a significantly lower mortality. The rate of ECMO use at each facility was not independently associated with mortality.

Conclusion: This large, population based study suggests that hospitals who perform high volumes of CDH repairs achieve lower in-hospital mortality. This data support the paradigm of regionalized centers of excellence for the management of infants with this morbid condition.

* By Invitation
## Independent Risk Factors for Mortality in Children with CDH

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Univariate Analysis</th>
<th>Multivariate Analysis</th>
<th>p-Value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Crude OR</td>
<td>Adjusted OR</td>
<td></td>
</tr>
<tr>
<td>Birthweight per Kg</td>
<td>0.63 (0.53–0.75)</td>
<td>0.49 (0.39–0.63)</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Year of Birth per year from 2000</td>
<td>0.99 (0.95–1.05)</td>
<td>0.89 (0.84–0.95)</td>
<td>0.0006</td>
</tr>
<tr>
<td>Payer Source</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Government Insurance</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Private Insurance</td>
<td>0.60 (0.46–0.77)</td>
<td>0.60 (0.43–0.84)</td>
<td>0.004</td>
</tr>
<tr>
<td>Self-Insured</td>
<td>0.55 (0.21–1.46)</td>
<td>0.76 (0.22–2.66)</td>
<td>0.6</td>
</tr>
<tr>
<td>Other</td>
<td>0.69 (0.50–0.96)</td>
<td>0.93 (0.61–1.44)</td>
<td>0.8</td>
</tr>
<tr>
<td>Chromosomal Abnormalities Present vs. Absent</td>
<td>2.34 (1.24–4.43)</td>
<td>4.60 (1.81–11.71)</td>
<td>0.001</td>
</tr>
<tr>
<td>Time to Repair per Week</td>
<td>1.34 (1.24–1.46)</td>
<td>1.07 (1.00–1.23)</td>
<td>0.047</td>
</tr>
<tr>
<td>Need for ECMO Present vs. Absent</td>
<td>18.27 (13.62–24.52)</td>
<td>10.54 (7.28–15.24)</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Need for Nitric Oxide Present vs. Absent</td>
<td>9.59 (7.11–12.92)</td>
<td>4.54 (3.02–6.84)</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Hospital Volume Low Volume (&lt;6 cases/year)</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Medium Volume (6–13 cases/year)</td>
<td>0.75 (0.50–1.10)</td>
<td>0.55 (0.33–0.91)</td>
<td>0.02</td>
</tr>
<tr>
<td>High Volume (&gt;13 cases/year)</td>
<td>0.52 (0.30–0.89)</td>
<td>0.33 (0.14–0.74)</td>
<td>0.008</td>
</tr>
<tr>
<td>Hospital ECMO Rate per 10%</td>
<td>1.34 (1.17–1.54)</td>
<td>1.10 (0.90–1.34)</td>
<td>0.25</td>
</tr>
</tbody>
</table>
FRIDAY AFTERNOON, APRIL 9th, CONTINUED

4:00 PM – 5:00 PM
Imperial Ballroom

EXECUTIVE SESSION
Fellows Only

PRESENTATION OF THE FLANCE-KARL AWARD
FRIDAY EVENING, APRIL 9th

7:00 PM
International Ballroom

ANNUAL RECEPTION

8:00 PM
International Ballroom

ANNUAL BANQUET
Circulating Thyrotropin Receptor (TSHR) mRNA as a Novel Marker of Thyroid Cancer: Clinical Applications Learned From 1,758 Samples

Mira Milas, MD*, Joyce Shin, MD*, Manjula Gupta, PhD*, Tomislav Novosel, MD*, Christian Nasr, MD*, Jamie Mitchell, MD*, Eren Berber, MD*, Allan Siperstein, MD
Cleveland Clinic, Cleveland, OH

Objectives: Since thyroglobulin, no new blood tests for differentiated thyroid cancer (DTC) have been introduced into routine clinical practice. In initial studies, the detection of circulating DTC cells by TSHR mRNA measurement distinguished benign from malignant thyroid diseases. This prospective validation study tests the ability of TSHR mRNA to diagnose DTC preoperatively and to detect cancer recurrence.

Methods: TSHR mRNA was measured by quantitative RT-PCR from blood drawn preoperatively in patients undergoing thyroid surgery (n = 526), postoperatively in patients undergoing DTC follow-up (n = 418) and in patients monitored for known benign disease (n = 151). The reference range for TSHR mRNA was previously defined from 663 samples from patients with normal, benign and malignant thyroid disease.

Results: In patients with indeterminate or suspicious cytology, preoperative TSHR mRNA >1 ng/ug had 96% predictive value for DTC, whereas no patients with undetectable mRNA and benign thyroid sonography had cancer at operation. In patients with DTC, elevated TSHR mRNA levels became undetectable in all patients (n = 45) on the first postoperative day,
except in 5 who manifested persistent or recurrent cervical disease within the year. In long-term follow-up of DTC patients with thyroglobulin antibodies, all with undetectable TSHR mRNA also had no radiologic evidence of cancer recurrence.

Conclusions: TSHR mRNA provides an additional clinical tool for the evaluation of patients with thyroid nodules. It is particularly useful in guiding appropriate initial surgery for indeterminate thyroid lesions. TSHR mRNA also represents a new blood test to aid assessment of disease status in thyroid cancer follow-up.
Long-Term Patient Outcome and Quality of Life After Liver Transplantation: A Prospective Analysis of 20-Plus Year Survivors

John P. Duffy, MD*, Kenneth Kao, MD*, Clifford Ko, MD, Douglas G. Farmer, MD*, Sue V. McDiarmid, MD*, Robert S. Venick, MD*, Susan Feist, RN*, Leonard Goldstein, MD*, Jonathan R. Hiatt, MD, Ronald W. Busuttil, MD, PhD

UCLA, Los Angeles, CA

Objective: To evaluate allograft function and Quality-of-Life (QOL) 20-years after liver transplantation (LT).

Summary Background Data: While LT is the treatment of choice for acute and chronic liver failure, long-term allograft function and recipient quality-of-life (QOL) remain undefined.

Methods: We performed a prospective, single-institution study of LT recipients surviving 20+ years. From 2/1/84–12/31/88, 293 patients (179-adults, 114-children) received 348 LTs. Graft function, QOL (SF-36; Liver Disease Quality-of-Life) and cognition (NeuropsychiatricImpairmentScale) were evaluated.

Results: After 20-years, 68 of 87 survivors (78%) retained original allografts. Twenty year survival for adults transplanted for HCC (20%) or HBV (16%) was lower than for other diagnoses (p < 0.001). Actuarial 10- and 20-year survival were 56% and 52% (patient) and 49% and 42% (graft). Factors associated with 20-year survival are shown in the table.

<table>
<thead>
<tr>
<th>20 Year Survivors</th>
<th>Non-20 Year Survivors</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age &lt;18 yr, %</td>
<td>53</td>
<td>33</td>
</tr>
<tr>
<td>Urgent transplantation, %</td>
<td>25</td>
<td>46</td>
</tr>
<tr>
<td>Retransplantation, %</td>
<td>9</td>
<td>19</td>
</tr>
<tr>
<td>Male, %</td>
<td>38</td>
<td>47</td>
</tr>
<tr>
<td>Rejection, %</td>
<td>35</td>
<td>27</td>
</tr>
<tr>
<td>Biliary complication, %</td>
<td>7</td>
<td>11</td>
</tr>
<tr>
<td>Total ischemia times (cold + warm), hr</td>
<td>6.2 ± 1.5</td>
<td>8.7 ± 2.3</td>
</tr>
</tbody>
</table>

* By Invitation
Survivors’ laboratory values showed intact graft function: mean creatinine-1.2 mg/dL, bilirubin-3.2 mg/dL, albumin-3.9 g/dL, and INR-1.3. The majority (64%) completed school; 78% resumed employment. Compared to the general population, survivors had lower physical scores (p < 0.01) but comparable mental scores. Overall QOL was significantly better than in patients with CHF, diabetes, depression, and ESLD.

**Conclusion:** Fifty-percent of LT recipients survive 20-years with intact graft function. Twenty-year survivors demonstrate better QOL than patients with chronic conditions and are free of cognitive deficits. LT is a durable operation which restores both long-term physiologic and psychologic well-being in patients with end-stage liver disease.
Combinatorial Effect of Donor and Recipient Age Is Critical in Determinating Host Immunoresponsiveness and Renal Transplant Outcome
Stefan G. Tullius, MD, PhD*, Huong Tran, MD*, Indira Guleria, MD*, Sayeed K. Malek, MD*, Nicholas L. Tilney, MD, Edgar Milford, MD*
Brigham and Women’s Hospital and Harvard Medical School, Boston, MA

Objective(s): A variety of risk factors influence the survival of transplanted kidneys and their hosts. We tested the impact of donor and recipient age by cohorts and covariant risks.

Methods: We followed more than 108,000 recipients of deceased donor kidneys in the UNOS data base transplanted between 1995–2008. Graft, patient survival and rejections were evaluated by uni- and multivariate analysis and compared by age cohorts.

Results: Overall, transplant survival was lowest in elderly recipients. However, when censored for patient’s death with a functioning transplant, graft survival improved with every decade of increasing recipient age, although older recipients had received less well matched and poorer quality organs (5 year graft survival: 67% and 81% in recipients aged 18–29 and >50; p = 0.001). Acute rejection rates decreased with every decade of increasing age (29% and 16% for young and older recipients by 1 year, p < 0.0001). In contrast, increasing donor age correlated with more frequent acute rejections (p < 0.001). Moreover, effects of both donor and recipient age on graft outcome became particularly obvious in a combinatorial analysis. Older kidneys had a relative risk of graft loss of >9 when transplanted into young recipients compared to <3 in old recipients (p < 0.0001).

Conclusions: Increasing recipient age is associated with improved transplant survival, lower rates of rejection and superior outcome of older donor organs. Physiological and/or immunological aspects of organ and recipient age determine, at least in part, transplant outcome. Those results have implications for optimized utilization of organs and immunosuppression.
Analysis of Over 3,000,000 Patients Screened for Abdominal Aortic Aneurysm: Development of a Novel Scoring Tool for the Identification of Large >5 cm Aneurysms

Giampaolo Greco, PhD, MPH1*, Natalia N. Egorova PhD, MPH1*, Robert M. Zwolak PhD, MPH1*, Thomas S. Riles, MD3, Andrew J. Manganaro, MD4*, Alan J. Moskowitz, MD1*, Annetine C. Gelijns, PhD1*, K. Craig Kent, MD5

1Mount Sinai School of Medicine, New York, NY; 2Dartmouth-Hitchcock Medical Center, Lebanon, NH; 3NYU Langone Medical Center, New York, NY; 4Life Line Screening, Independence, OH; 5University of Wisconsin, Madison, WI

Objective(s): Current screening criteria for Abdominal Aortic Aneurysm (AAA) are designed to identify >3 cm aneurysms in ever smoking 65–75 yo males. However, more than 50% of ruptures occur in individuals not within this patient cohort and only a subset of AAAs detected are large enough to warrant surgery. In this analysis, we evaluated over 3 million screened individuals and developed a scoring tool that allows identification of ≥5 cm AAAs in the entire population at risk.

Methods: From 2003–2008, demographics and risk factors were collected from 3.1 million patients undergoing ultrasound screening for AAA by Life Line Screening. Using multivariable logistic regression analysis, we identified risk factors and developed a scoring system to predict the presence of ≥5 cm AAAs.

Results: Smoking had a profound influence on the risk of AAA, which increased with cigarettes smoked and years of smoking and decreased following smoking cessation. Novel findings included a protective effect of exercise, healthy diet, normal weight and black/Hispanic ethnicity. Using these and other factors, a simple scoring system was created with good predictive accuracy (c-statistic = 0.76). Using this scoring system we estimated the presence of 130,000 [95% CI:110,000–150,000] ≥5 cm aneurysms in the US population (prevalence: 0.16%). Demonstrating the inadequacy of the current screening recommendations, half of AAAs were among females, non-smokers and individuals younger than 65.

Conclusions: Based upon the largest cohort of patients ever screened for AAA, we have developed a novel easily implemented screening strategy that, when compared to current guidelines, identifies large AAAs in a broad population of individuals at risk.

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Objective(s): Choledochoceles have been classified as Type III choledochal cysts. However, most surgical series of choledochal cysts have reported few choledochoceles because they are managed primarily by endoscopists. Therefore, the aim of this analysis was to report a multidisciplinary series comparing choledochoceles to Types I, II, IV and V choledochal cysts.

Methods: Surgical, endoscopic, and radiologic records were reviewed at our children’s and university hospitals to identify patients with choledochal cysts. Patient demographics, presenting symptoms, radiologic studies, associated abnormalities, surgical and endoscopic procedures as well as outcomes were reviewed.

Results: One hundred forty-five patients with “choledochal cysts” including 44 children (29%) and 26 with choledochoceles (18%) were identified, which represents the largest Western series. The relative proportion of Types I (53%), II (6%), IV (15%) and V (8%) did not differ between adults and children. Types I, II, IV, and V also were similar with respect to age, gender and presentation. Patients with choledochoceles, however, were more likely to be adult (25 vs 2%, p < 0.05), older (55.5 vs 29.0 yrs, p < 0.001), and male (42 vs 22%, p < 0.05), to present with pancreatitis (60 vs 18%, p < 0.001) to have pancreas divisum (31 vs 9%, p < 0.01), and to develop a pancreatic neoplasm (8 vs 1%, p < 0.08).

Conclusions: Choledochoceles differ from choledochal cysts with respect to age, gender, presentation, pancreatic ductal anatomy and propensity to develop pancreatic tumors. The significant associations between choledochoceles, pancreas divisum, and pancreatic neoplasms are new observations. Therefore, we conclude that classifications of choledochal cysts should not include choledochoceles.
Operative Failures After Parathyroidectomy for Hyperparathyroidism: The Influence of Surgical Volume
Herbert Chen, MD1, Tracy Wang, MD, MP2*, Tina Yen, MD, MS2, Kara Doffek, BS2, Elizabeth Krzywda, NP2, Sarah Schaefer, NP1*, Rebecca S. Sippel1*, Stuart Wilson, MD2

1University of Wisconsin, Madison, WI; 2Medical College of Wisconsin, Milwaukee, WI

Objective(s): The surgical success rate for hyperparathyroidism from high volume centers exceeds 95%, but many patients have unsuccessful parathyroidectomies. While operative failure can be due to hyperfunctioning parathyroids in ectopic locations, less experienced surgeons may miss an abnormal parathyroid in normal anatomic locations, which we describe as “preventable operative failure”. We hypothesize that surgical volume influences the cause of operative failures.

Methods: We utilized two prospective databases containing over 2000 consecutive patients who underwent parathyroidectomy. We identified 159 patients with persistent/recurrent hyperparathyroidism subsequently cured with additional surgery. The initial failed operations were classified as being performed at high (>50 cases/year) or low volume (<50 cases/year) hospitals. Hospital volume was obtained from a state database of 89 hospitals which reported 6,336 parathyroid operations during the same decade.

Results: Patients having their initial operation performed at the high or low volume centers were similar with regard to age, laboratory values, gender, and parathyroid weights. Despite a higher incidence of multi-gland disease (which increases the likelihood of operative failure) in the high volume...
group, patients in the low volume group were more likely to have a missed parathyroid gland in a normal anatomic location (89% vs. 13%, p < 0.0001) and thus a higher proportion of preventable operative failures.

Conclusions: Surgical volume influences the failure pattern after parathyroidectomy for hyperparathyroidism. Preventable surgical failures are more common in low volume centers.
Normothermia After Gastrointestinal Surgery: Holy Grail or False Idol?
Simon J. Lehtinen, BA*, Georgiana Onicescu, ScM*, Kathy Kuhn, RN†, David J. Cole, MD, Nestor F. Esnaola, MD*
Medical University of South Carolina, Charleston, SC

Objectives: Although active warming during colorectal (CR) surgery decreases surgical site infections (SSIs), there is limited evidence that immediate postoperative hypothermia (IPH, T < 36°C) *per se* is associated with SSIs. Nonetheless, hospitals currently report postoperative normothermia rates after CR surgery as part of CMS’ Surgical Care Improvement Project.

Methods: We conducted a nested, matched, case-control study to analyze the association between IPH and SSIs after gastrointestinal (GI) surgery. Cases consisted of all GI surgery patients (pts) entered into our National Surgical Quality Improvement Program (NSQIP) database between 3/2006–3/2009 who developed SSIs. Patient/surgery risk factors for SSI were obtained from the NSQIP database. Perioperative temperature/antibiotic/glucose data was obtained from medical records. Cases/controls were compared using univariate random effects regression models. Independent risk factors for SSIs were identified using multivariate random effects logistic regression models.

Results: 146 cases and 323 matched controls were identified; 82% of pts underwent non-CR surgery. Cases/controls were similar with respect to percentage of pts with IPH (29.4% v. 34.7%, respectively, P = 0.27). Emergent surgery and/or contaminated wounds were associated with lower rates of IPH. Independent risk factors for SSIs were diabetes, surgical complexity, and small bowel/non-laparoscopic surgery. There was no association between IPH and SSIs, even when controlling for pt/surgery/wound-characteristics and perioperative antibiotics/glucose (adjusted OR, 1.14; 95% CI, 0.65–2.00; P = 0.66).

Conclusions: IPH is not associated with SSIs after GI surgery. Pay-for-reporting measures focusing on normothermia after CR surgery may be of limited clinical value. Trials to determine the benefit of active warming during non-CR GI surgery are warranted.

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AMERICAN SURGICAL ASSOCIATION

DIRECTORY OF FELLOWS

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*ABBOTT, WILLIAM M, M.D., Professor of Surgery, Harvard Medical School, Chief of Vascular Surgery Emeritus, Massachusetts General Hospital, 63 Sudbury Road, Weston, MA 02493, Tel: 781-899-4785, FAX: 617-726-3322, EMAIL: wabbott@partners.org

*ABCARIAN, HERAND, M.D., Turi Josefson Professor and Head, University of Illinois-Chicago, Department of Surgery, University of Illinois, Chicago, 840 So Wood, M/C 958, Chicago, IL 60612, Tel: 312-996-2061, FAX: 312-996-1214, EMAIL: abcarian@uic.edu

ABECASSIS, MICHAEL M, M.D., Chief, Division of Organ Transplantation; J. Roscoe Miller Distinguished Professor of Surgery and Microbiology – Immunology, Northwestern Memorial Hospital, 675 No St. Clair, #17-200, Chicago, IL 60611, Tel: 312-695-0254, FAX: 312-695-1817, EMAIL: mabecass@nmh.org

ABU-ELMAGD, KAREEM M, M.D., Professor of Surgery, Director, Intestinal Rehabilitation & Transplant Center, 3459 5th Ave., 7 South, Pittsburgh, PA 15213, Tel: 412-647-1458, FAX: 412-647-0362, EMAIL: abuelmagdkm@upmc.edu

*ABUMRAD, NAJI N, M.D., Chairman, Department of Surgery, Vanderbilt University, 1161 21st Ave., South, D4313MCN, Nashville, TN 37232-2730, Tel: 615-343-2735, FAX: 615-343-5365, EMAIL: naji.abumrad@vanderbilt.edu

*ABURAHMA, ALI F, M.D., Professor of Surgery and Chief of Vascular Surgery, Robert C. Byrd Health Sciences Center of West Virginia University, 3110 MacCorkle Ave., SE, Charleston, WV 25304, Tel: 304-388-4887, FAX: 304-388-4879, EMAIL: ali.aburahma@camc.org

ACKER, MICHAEL A, M.D., William Maul Measey Professor of Surgery, Chief, Division of Cardiothoracic Surgery, University of Pennsylvania Health System, 3400 Spruce St., 6 Silverstein, Philadelphia, PA 19104, Tel: 215-349-8305, FAX: 215-349-5798, EMAIL: michael.acker@uphs.upenn.edu
ACKERMAN, NORMAN B, M.D., Professor of Surgery, New York Medical College, 201 East 66th Street, #2M, New York, NY 10021, Tel: 212-681-2731, FAX: 212-794-6278, EMAIL: normacker@aol.com

ADAMS, DAVID B, M.D., Professor and Head, Section of Gastrointestinal & Laparoscopic Surgery, Medical University of South Carolina, 25 Courtenay Drive, Ste. 7100A, Charleston, SC 29425, Tel: 843-792-9393, FAX: 843-792-2985, EMAIL: adamsdav@musc.edu

ADAMS, JAMES T, M.D., Professor of Surgery, The University of Rochester Medical Center, 601 Elmwood Avenue, Rochester, NY 14642, Tel: 585-275-2726, FAX: 585-273-1252, EMAIL: jadams06@rochester.rr.com

ADSON, MARTIN, M.D., Emeritus, Mayo Clinic, 200 First St. SW, Rochester, MN 55905, Tel: 507-281-4818, FAX: 407-284-5036, EMAIL: padson@aol.com

ADZICK, N. SCOTT, M.D., C. Everett Koop Professor of Pediatric Surgery, University of Pennsylvania School of Medicine; Director, The Center for Fetal Diagnosis and Treatment; Surgeon-in-Chief, The Children’s Hospital of Philadelphia, 34th St. and Civic Center Blvd., Philadelphia, PA 19104-4399, Tel: 215-590-2727, FAX: 215-590-4875, EMAIL: adzick@email.chop.edu

AKINS, CARY W, M.D., Visiting Surgeon; Clinical Professor of Surgery, Harvard Medical School; Massachusetts General Hospital, 55 Fruit St., Surgery, Cox 648, Boston, MA 02114, Tel: 617-726-8218, FAX: 617-726-3781, EMAIL: cakins@partners.org

AKWARI, ONYE E, M.D., Professor of Surgery; Associate Professor of Physiology in Cell Biology, Duke University Medical Center, Box #3076, Department of Surgery, Durham, NC 27710, Tel: 919-489-8121, FAX: 919-401-0101, EMAIL: akwari@nc.rr.com

ALBANESE, CRAIG T, M.D., Professor of Surgery, Pediatrics, Obstetrics and Gynecology; Chief, Division of Pediatric Surgery; John A. and Cynthia Gry Gunn Director of Surgical Services, 780 Welch Rd., Ste. 206, Stanford, CA 94305-5733, Tel: 650-724-3664, FAX: 650-725-5577, EMAIL: calbanese@lpch.org

ALDEA, GABRIEL S, M.D., Professor, Cardiothoracic Surgery; Chief of Adult Cardiac Surgery, University of Washington; Chief of Cardiac Surgery, Northwest Hospital, Box 356310, 1959 NE Pacific St., Seattle, WA 98195, Tel: 206-221-3166, FAX: 206-543-0325, EMAIL: aldea@u.washington.edu
ALDRETE, JOAQUIN S, M.D., Professor of Surgery Emeritus, University of Alabama at Birmingham, 6229 Paseo Alta Rico, Carlsbad, CA 92009, Tel: 760-476-3773, FAX: 760-931-2710, EMAIL: jsamla332@aol.com

ALEXANDER, H. RICHARD, JR, M.D., Senior Investigator, National Cancer Institute, Surgery Branch, University of Maryland Medical Center, 22 S. Greene Street, Suite S4B05, Baltimore, MD 21201, Tel: 410-328-7320, EMAIL: HRAlexander@smail.umaryland.edu

ALEXANDER, J. WESLEY, M.D., Professor of Surgery; Director Emeritus of Transplantation Division, William A. Altemeier Chair of Surgery, University of Cincinnati Medical Center, 231 Albert Sabin Way, Department of Surgery, Cincinnati, OH 45267-0558, Tel: 513-558-6006, FAX: 513-558-3580, EMAIL: jwesley.alexander@uc.edu

ALFREY, EDWARD J, M.D., 701 No. First St., D-327, PO Springfield, IL 62794-9638, Tel: 217-545-7240, FAX: 217-545-0040, EMAIL: ealfrey@siumed.edu

ALLISON, DAVID C, M.D., Professor of Surgery and Physiology and Molecular Medicine, The University of Toledo College of Medicine, 3000 Arlington Avenue, MS 1000, Toledo, OH 43614, Tel: 419-383-3970, FAX: 419-383-6230, EMAIL: david.allison@utoledo.edu

ALTMAN, R. PETER, M.D., Senior Vice President for Medical Affairs, Children’s Health Network, New York-Presbyterian Hospital, 3959 Broadway, Rm 116 South, New York, NY 10032, Tel: 212-305-5804, FAX: 212-305-9305, EMAIL: rpal@columbia.edu

ALTORKI, NASSER K, M.D., Chief, Division of Thoracic Surgery, Weill Medical College of Cornell University; Professor of Cardiothoracic Surgery; Attending Cardiothoracic Surgeon, New York-Presbyterian Hospital, 525 East 68th St., New York, NY 10021, Tel: 212-746-5156, FAX: 212-746-8828, EMAIL: nkaltork@med.cornell.edu

ALVERDY, JOHN C, M.D., Professor of Surgery, Director of Minimally Invasive Surgery, The University of Chicago, 5841 S Maryland Ave., MC 6090, Chicago, IL 60637, Tel: 773-702-4876, FAX: 773-834-0201, EMAIL: jalverdy@surgery.bsd.uchicago.edu

ANDERSEN, DANA K, M.D., Professor and Vice-Chair, Department of Surgery, Johns Hopkins University School of Medicine; Surgeon-in-Chief, Johns Hopkins Bayview Medical Center, 4940 Eastern Avenue, Suite A-558, Baltimore, MD 21224, Tel: 410-550-2821, EMAIL: dander54@jhmi.edu
ANDERSEN, MURRAY N, M.D., Professor of Surgery Emeritus, Erie County Medical Center, 162 Hidden Ridge Cmn, Williamsville, NY 14221-5765, Tel: 716-741-2398

ANDERSON, CHARLES B, M.D., Professor of Surgery, Washington University School of Medicine, 710 S. Hanley Rd., Apt. 12C, Saint Louis, MO 63105-2654, Tel: 314-362-7406, FAX: 314-454-3923, EMAIL: cba1938@charter.net

ANDERSON, KATHRYN D, M.D., Professor of Surgery Emeritus, University of Southern California, 23 River Rock CT, Azusa, CA 91702-6274, Tel: 626-292-2225, FAX: 626-292-2234, EMAIL: kathyanderson99@yahoo.com

ANDERSON, ROBERT W, M.D., David C. Sabiston Jr. Professor and Chairman, Department of Surgery, Duke University Medical Center, P.O. Box 3704, Durham, NC 27710, Tel: 919-681-2559, FAX: 919-681-2779, EMAIL: ander043@mc.duke.edu

ANDRASSY, RICHARD J, M.D., Denton A. Cooley, M.D. Chair in Surgery, Professor and Chairman, Department of Surgery, University of Texas Medical School at Houston; Chief of Pediatric Surgery, MD Anderson Cancer Center, 6431 Fannin St., MSB 4.020, Houston, TX 77030, Tel: 713-500-7200, FAX: 713-500-7213, EMAIL: elizabeth.clouser@uth.tmc.edu

ANDRIOLE, GERALD L, JR, M.D., Professor and Chief of Urology, Washington University School of Medicine; Director of Urologic Research Center, Barnes-Jewish Hospital, 4960 Children’s Place, Campus Box 8242, St. Louis, MO 63110, Tel: 314-362-8212, FAX: 314-361-2203, EMAIL: andrioleg@wustl.edu

ANKENEY, JAY L, M.D., Emeritus Professor of Surgery, Case Western University School of Medicine, University Hospitals of Cleveland, 17030 Catsden Rd., Chagrin Falls, OH 44023, FAX: 216-543-1213

ANLY AN, WILLIAM G, M.D., Professor of Surgery, Chancellor Emeritus, Duke University; Trustee, the Duke Endowment, Duke Medical Center, 109 Seeley G Mudd Bldg., Box 3626, Durham, NC 27710, Tel: 919-684-3438, FAX: 919-684-3518, EMAIL: anlya001@mc.duke.edu

APRAHAMIAN, CHARLES, M.D., Chief, Section General Surgery, Wood Veterans Administration Hospital; Professor Surgery, Medical College of Wisconsin, 3400 Burlawn Parkway, Brookfield, WI 53005, EMAIL: caprahamian@wi.rr.com
*ARANHA, GERARD V, M.D., Professor and Chief, Section of Surgical Oncology, Loyola University Medical Center; Chief, General Surgical Service, Hines V.A. Hospital, 2160 So First Ave., Bldg. 110, Rm 3236, Maywood, IL 60153, Tel: 708-327-3430, FAX: 708-327-3565, EMAIL: garanha@lumc.edu

*ARENSMAN, ROBERT M, M.D., Professor of Surgery and Pediatrics, Ochsner Clinic, 330 S. Michigan Ave., #2008, Chicago, IL 60604, Tel: 504-842-3907, EMAIL: rarensman@ochsner.org

*ARGENTA, LOUIS C, M.D., Professor and Chairman, Department of Plastic & Reconstructive Surgery; Director, NC Center for Cleft & Craniofacial Deformities, Wake Forest University School of Medicine, 525 Knobview Drive, Winston-Salem, NC 27104, Tel: 336-716-4416, FAX: 336-716-7755, EMAIL: largenta@wfubmc.edu

*ARIYAN, STEPHAN, M.D., FACS, Professor of Surgery, Yale University School of Medicine, 60 Temple St., Ste. 4B, New Haven, CT 06510-2716, Tel: 203-786-3000, FAX: 203-772-2814, EMAIL: request@ariyan.com

*ARNOLD, PHILLIP G, M.D., Chief, Plastic and Reconstructive Surgery, Mayo Clinic, 1106 8th Street SW, Rochester, MN 55902, Tel: 507-285-1439, FAX: 507-285-9392, EMAIL: pgarnold@mayo.edu

ASCHER, ENRICO, M.D., Chief, Division of Vascular Surgery; Medical Director, Vascular Diagnostic Laboratory; Program Director, ACCME General Vascular Fellowship, Maimonides Medical Center, 4802 Tenth Ave., Brooklyn, NY 11219, Tel: 718-283-7957, FAX: 718-635-7050, EMAIL: eascher@maimonidesmed.org

*ASCHER, NANCY L, M.D., 513 Parnassus Ave., Rm S-320, San Francisco, CA 94143-0104, Tel: 415-476-1236, FAX: 415-476-6263, EMAIL: ascher@ surgery.ucsf.edu

*ASHCRAFT, KEITH W, M.D., 6700 High Drive, Mission Hills, KS 66208, Tel: 913-362-8884, FAX: 913-362-5973, EMAIL: kashcraft@kc.rr.com

ASHLEY, STANLEY W, M.D., Frank Sawyer Professor and Vice Chairman, Department of Surgery, Harvard Medical School, Brigham & Women’s Hospital, 75 Francis Street, ASBII-III, Boston, MA 02115, Tel: 617-732-6730, FAX: 617-739-1728, EMAIL: sashley@partners.org
ATKINSON, JAMES B, M.D., Executive Vice Chair, Department of Surgery; Chief of Pediatric & General Surgery; Professor of Surgery; Surgeon in Chief, Mattel Children’s Hospital, UCLA Medical Center, 10833 LeConte Ave., Box 951749, Los Angeles, CA 90095-1749, Tel: 310-206-2429, FAX: 310-206-1120, EMAIL: jatkinson@mednet.ucla.edu

*AUCHINCLOSS, HUGH, JR, M.D., Deputy Director National Institute of Allergy and Infectious Diseases, NIH, 31 Center Drive, 7A-03, MSC 2520, Bethesda, MD 20892, Tel: 301-496-9677, EMAIL: auchinclossh@niaid.nih.gov

*AUFSES, ARTHUR H, M.D., Professor of Surgery and Health Policy, Department of Health Policy, Mount Sinai Medical Center, 1 Gustave L. Levy Pl, Surg, Box 1077, New York, NY 10029, Tel: 212-659-9560, FAX: 212-423-2998, EMAIL: arthur.aufses@mssm.edu

*AUST, J. BRADLEY, M.D., Dorn Distinguished Professor, Department of Surgery, University of Texas, Health Science Center at San Antonio, 7703 Floyd Curl Dr., San Antonio, TX 78284-7840, Tel: 210-567-6363, FAX: 210-567-7085, EMAIL: aust@uthscsa.edu

*AUSTEN, W. GERALD, M.D., Edward D. Churchill Professor of Surgery, Harvard Medical School; Surgeon-in-Chief, Emeritus, Massachusetts General Hospital, 32 Fruit St., Bulfinch 370-A, Boston, MA 02114-2698, Tel: 617-726-2050, FAX: 617-726-1900, EMAIL: wgausten@partners.org

AZIZKHAN, RICHARD G, M.D., Lester Martin Professor of Surgery and Pediatrics; Vice Chair, Department of Surgery; Director, Division of Pediatric Surgery; Surgeon-in-Chief, Cincinnati Children’s Hospital Medical Center, 3333 Burnet Avenue, Cincinnati, OH 45229-3039, Tel: 513-636-4576, FAX: 513-636-7657, EMAIL: richard.azizkhan@cchmc.org

*BAILEY, H. RANDOLPH, M.D., 6550 Fannin, Suite 2307, Houston, TX 77030, Tel: 713-790-9250, FAX: 713-790-9251, EMAIL: h.r.bailey@uth.tmc.edu

*BAILEY, LEONARD L, M.D., Surgeon-in-Chief, Loma Linda University Children’s Hospital; Professor and Chairman, Department of Surgery, Loma Linda University Medical Center, 11175 Campus St. #21120, Loma Linda, CA 92354, Tel: 909-558-8744, FAX: 909-558-4116, EMAIL: lbailey@llu.edu
*BAINS, MANJIT S, M.D., Clinical Professor of Surgery, Cornell University Medical Center; Attending Surgeon, Thoracic Service, Department of Surgery, Memorial Sloan Kettering Cancer Center, 1275 York Ave., Room C-861, New York, NY 10021, Tel: 212-639-7450, FAX: 917-432-2366, EMAIL: bainsm@mskcc.org

*BAIRD, RONALD J, M.D., Professor Emeritus of Surgery, University of Toronto, Honorary Surgeon, Toronto Hospital, 76 Rathnelly Avenue, Toronto, Ontario M4V 2M6, Canada, Tel: 416-340-3540, FAX: 416-340-3803

*BAKER, CHRISTOPHER C, M.D., FACS, The Isidore Cohn, Jr. Professor & Chairman, LSU Health Sciences Center, 1542 Tulane Ave., Room 741, New Orleans, LA 70112, Tel: 504-568-4751, FAX: 504-568-4633, EMAIL: cbake5@lsuhsc.edu

*BAKER, J. DENNIS, M.D., Professor of Surgery, UCLA School of Medicine; V.A. Medical Center, Surgical Services (112), 11301 Wilshire Blvd., Los Angeles, CA 90073, Tel: 310-825-3684, FAX: 310-268-4741, EMAIL: dennis.baker@va.gov

*BAKER, R. ROBINSON, M.D., Warfield M. Frior Professor of Surgery and Professor of Oncology, Johns Hopkins Hospital, 8717 McDonogh Rd., Baltimore, MD 21208, Tel: 410-363-3731, EMAIL: rrbaker@jhmi.edu

*BAKER, ROBERT J, M.D., Professor of Surgery, University of Chicago, 5841 So Maryland Ave., MC 5031, Chicago, IL 60637, Tel: 773-564-5990, FAX: 773-834-8140, EMAIL: rjbaker@yahoo.com

*BAKER, WILLIAM H, M.D., Professor of Surgery; Head of Section of Peripheral Vascular Surgery, Loyola University Medical Center, 2160 S. First Ave., EMS, Bldg. 110, #3215, Maywood, IL 60153, Tel: 708-327-2685, FAX: 708-327-2698, EMAIL: wbaker@lumc.edu

*BALCH, CHARLES M, M.D., Department of Surgery, Johns Hopkins Medical Institutions, Baltimore, MD; Executive Vice President and CEO, American Society of Clinical Oncology, 600 N. Wolfe St., Osler 624, Baltimore, MD 21287, Tel: 410-614-3889, FAX: 410-614-8719, EMAIL: balch@jhmi.edu

*BALDWIN, JOHN C, M.D., President, Texas Tech University Health Sciences Center, 3601 4th St., STOP 6258, Lubbock, TX 79430-6258, Tel: 806-743-2900, FAX: 806-743-2910, EMAIL: president@ttuhsc.edu
AMERICAN SURGICAL ASSOCIATION

*BALIGA, PRABHAKAR K, M.D., Professor of Surgery; Chief Division of Transplant Surgery; Medical Director, Medical University of South Carolina, 96 Jonathan Lucas St., CSB 404, Charleston, SC 29425, Tel: 843-792-3368, FAX: 843-792-8596, EMAIL: baligap@musc.edu

*BALLINGER, WALTER F, II, M.D., Professor of Surgery Emeritus, Washington University School of Medicine, 1203 Log Cabin Lane, St. Louis, MO 63124, Tel: 314-994-3172, EMAIL: dryopt@aol.com

*BANDYK, DENNIS F, M.D., Director, Division of Vascular Surgery, Professor of Surgery, University of South Florida College of Medicine, 2 Tampa General Circle, Ste. 7010, Tampa, FL 33606, Tel: 813-259-0956, FAX: 813-259-0606, EMAIL: dbandyk@health.usf.edu

BARBUL, ADRIAN, M.D., Professor of Surgery, Johns Hopkins Medical Institutions; Surgeon-in-Chief, Sinai Hospital of Baltimore, 2435 W. Belvedere Ave., Department of Surgery, Baltimore, MD 21215, Tel: 410-601-5547, FAX: 410-601-5835, EMAIL: abarbul@jhmi.edu

BARRIE, PHILIP S, M.D., MBA, Associate Professor of Surgery, Weill Medical College of Cornell University; Chief, Div. of Critical Care/Trauma, Department of Surgery, Weill Medical College; Director, Surgical ICU, New York Presbyterian Hospital, New York Hospital-Cornell Medical Center, 525 East 68th St., P-713A, New York, NY 10021, Tel: 212-746-5401, FAX: 212-746-6995, EMAIL: pbarie@med.cornell.edu

*BARKER, CLYDE F, M.D., Professor and Chairman, Department of Surgery, University of Pennsylvania, 3400 Spruce St., 4 Silverstein, Philadelphia, PA 19104, Tel: 215-662-2027, FAX: 215-615-0471, EMAIL: clyde.barker@uphs.upenn.edu

*BARKER, HAROLD G, M.D., Emeritus Professor of Clinical Surgery, Special Lecturer in Surgery, Columbia University; Consultant in Surgery, Presbyterian Hospital, 5028 Theall Rd., Rye, NY 10580-1445, Tel: 914-967-1124, FAX: 914-967-4988

*BARKER, WILEY F, M.D., Professor of Surgery, Emeritus, University of California Los Angeles Medical School, 29129 Paiute Drive, Agoura, CA 91301, Tel: 818-865-9904, FAX: 818-865-9901, EMAIL: wbarker@charter.net

BARKSDALE, EDWARD M, JR, M.D., 11100 Euclid Ave., Cleveland, OH 44106, Tel: 216-844-3015, FAX: 216-844-8687, EMAIL: edward.barksdale@UHhospitals.org
BARKUN, JEFFREY S.T., M.D., 687 Pine Ave. West, Ste., S10.30, Montreal, Quebec H3A 1A1, Canada, Tel: 514-934-1934, FAX: 514-843-1434, EMAIL: jeffrey.barkun@muhc.mcgill.ca

*BARLOW, BARBARA, M.D., Director of Surgery, Harlem Hospital; Professor of Surgery, Harlem Hospital; Professor of Surgery in Epidemiology, Mailman School of Public Health – Columbia University; Director of Injury Free Coalition for Kids 506 Lenox Avenue Ste. 11104, New York, NY 10037, Tel: 212-939-3533, FAX: 212-939-3536, EMAIL: bab1@columbia.edu

*BARNER, HENDRICK B, M.D., Adjunct Professor of Surgery, St. Louis University; Clinical Professor of Surgery, Washington University, 3635 Vista, St. Louis, MO 63110, Tel: 314-577-8359, FAX: 314-577-8315, EMAIL: hbarner@slu.edu

*BARNES, ROBERT W, M.D., Professor Emeritus of Surgery, University of Arkansas for Medical Sciences, 4301 West Markham St., Slot 520-2, Little Rock, AR 72205, Tel: 501-686-6176, FAX: 501-686-5328, EMAIL: barnesrobertw@uams.edu

BARTLETT, DAVID L, M.D., Bernard Fisher Professor of Surgery; Chief, Division of Surgical Oncology, University of Pittsburgh, 5150 Centre Ave., Ste. 415, Pittsburgh, PA 15232, Tel: 412-692-2852, FAX: 412-692-2520, EMAIL: bartlettdl@upmc.edu

*BARTLETT, ROBERT H, M.D., University of Michigan Medical Center, 200 Zina Pitcher Pl, 7679 Kresge I, Ann Arbor, MI 48109-0522, Tel: 734-936-5822, FAX: 734-936-5830, EMAIL: robbar@umich.edu

BARTLETT, STEPHEN T, M.D., Barbara Baur Dunlap Professor and Chair, Department of Surgery, University of Maryland School of Medicine, Surgeon-in-Chief, University of Maryland Medical Center, 29 So Greene St., N4E40, Baltimore, MD 21201, Tel: 410-328-5408, FAX: 410-328-3837, EMAIL: sbartlett@mail.umm.edu

BASS, BARBARA L, M.D., John F. & Carolyn Bookout Distinguished Endowed Chair, Department of Surgery, The Methodist Hospital, 6550 Fannin St., Suite 1661 A, Houston, TX 77030, Tel: 713-441-5132, FAX: 713-790-6300, EMAIL: bbass@tmhs.org

BATJER, H. HUNT, M.D., Michael J. Marchese Professor and Chair, Northwestern University Feinberg School of Medicine, 676 N. St. Clair, Ste. 2210, Chicago, IL 60611, Tel: 312-695-6284, FAX: 312-695-0225, EMAIL: hbatjer@nmff.org
*BAUE, ARTHUR E, M.D., Professor of Surgery Emeritus; Emeritus Vice President, The Medical Center at Saint Louis University, P.O. Box 396, Fishers Island, NY 06390, Tel: 314-577-8573, FAX: 631-788-5591

*BAUMGARTNER, WILLIAM A, M.D., Vincent L. Gott Professor, The Johns Hopkins Hospital, 600 No Wolfe St., Blalock 618, Baltimore, MD 21287-4618, Tel: 410-955-5248, FAX: 410-955-3809, EMAIL: wbaumgar@csurg.jhmi.jhu.edu

BAVARIA, JOSEPH E, M.D., Vice-Chief, Division of Cardiothoracic Surgery; Professor of Surgery, University of Pennsylvania Health System, 3400 Spruce, 4 Silverstein, Surgery, Philadelphia, PA 19104, Tel: 215-662-2017, FAX: 215-349-5798, EMAIL: joseph.bavaria@uphs.upenn.edu

*BEAL, JOHN M, M.D., Professor Emeritus of Surgery, Northwestern University Medical School, 432 Georgetown Circle, Valdosta, GA 31602, Tel: 912-241-8867, EMAIL: bealjmbeal@cs.com

BEAR, HARRY D, M.D., Ph.D., Professor of Surgery and Microbiology and Immunology; Chairman, Division of Surgical Oncology, Virginia Commonwealth University, P.O. Box 980011, Richmond, VA 23298-0011, Tel: 804-828-9325, FAX: 804-828-4808, EMAIL: hdbear@vcu.edu

*BEART, ROBERT W, JR, M.D., Professor of Surgery, USC Department of Surgery, Healthcare Consultation Center, Center for Colorectal Diseases, 222 Eulalia #100A, Glendale, CA 91204, Tel: 818 244 8161, FAX: 818 244 5122, EMAIL: rbeart@usc.edu

BEAUCHAMP, R. DANIEL, M.D., J.C. Foshee Professor and Chairman, Section of Surgical Sciences, Vanderbilt University School of Medicine; Surgeon-in-Chief, Vanderbilt University Medical Center, 1161 21st Ave. South, D-4316 MCN, Nashville, TN 37232-2730, Tel: 615-322-2363, FAX: 615-343-5365, EMAIL: daniel.beauchamp@vanderbilt.edu

*BEAZLEY, ROBERT M, M.D., Retired Emeritus, Boston University School of Medicine, 45 West Newton St., Boston, MA 02118-3813, Tel: 617-267-1758, FAX: 617-638-8457, EMAIL: Beazley8@hotmail.com

*BECKER, DONALD P, M.D., Professor and Chief, Division of Neurosurgery; UCLA School of Medicine, Div. of Neuros, 18-226, Box 957039, Los Angeles, CA 90024, Tel: 310-825-3998, FAX: 310-794-2147, EMAIL: lora@neurosurg.medsch.ucla.edu
*BERNE, THOMAS V, M.D., Chief Physician, Department of Surgery; Professor of Surgery, Vice-Chairman for Clinical Affairs, LAC & USC Medical Center, 1200 No State St., Room 10850, Los Angeles, CA 90033, Tel: 323-226-7720, FAX: 323-226-5996, EMAIL: berne@usc.edu

*BERNHARD, VICTOR M, M.D., 3627 Grand Valley Canal Road, Palisade, CO 81526, Tel: 970-464-4653, FAX: 970-464-4654, EMAIL: bernhard@surgey.bsd.uchicago.edu

*BERNHARD, WILLIAM F, M.D., Professor of Surgery Emeritus, Harvard Medical School, Cardiac Surgeon, West Roxbury VA Hospitals, 58 Singletary Lane, Framingham, MA 01702-6161, Tel: 508-879-0730

BERTAGNOLLI, MONICA M, M.D., 75 Francis St., Department of Surgery, Boston, MA 02115, Tel: 617-732-8910, FAX: 617-582-6177, EMAIL: mbertagnolli@partners.org

BESNER, GAIL E, M.D., 700 Children’s Drive, ED-321, Columbus, OH 43205, Tel: 614-722-3914, FAX: 614-722-3903, EMAIL: besnerg@chi.osu.edu

*BESSEY, PALMER Q, M.D., Professor of Surgery, Associate Director, William Randolph Hearst Burn Center, New York Presbyterian Hospital, 525 E. 68th St., P-703, Burn Center, New York, NY 10065, Tel: 212-746-0242, FAX: 212-746-5114, EMAIL: pqb2001@med.cornell.edu

BILCHIK, ANTON J, M.D., Ph.D., Director of Gastrointestinal Surgical Oncology, Director of Gastrointestinal Program, Chairman of Fellowship Steering Committee, Associate Director, Surgical Oncology Fellowship Program – John Wayne Cancer Institute, Saint Johns Health Center, 2336 Santa Monica Blvd. #206, Santa Monica, CA 90404, Tel: 310-696-0716, FAX: 310-696-0724, EMAIL: abilchik@aol.com

BILLIAR, TIMOTHY R, M.D., George Vance Foster Professor and Chair, Department of Surgery, University of Pittsburgh, 200 Lothrop St., #F-1281, Pittsburgh, PA 15213, Tel: 412-647-1749, FAX: 412-647-3247, EMAIL: billiartr@upmc.edu

BIRKMEYER, JOHN D, M.D., George D. Zuidema Professor and Chair, Surgical Outcomes Research, Department of Surgery, University of Michigan, 211 N. Fouth Ave., Ste. 2A, Ann Arbor, MI 48104, Tel: 734-764-9436, FAX: 734-936-5830, EMAIL: jbirkmey@umich.edu
*BIRCH, ALAN G, M.D., Emeritus Professor of Surgery, Southern Illinois University School of Medicine, 2606 W. Lake Dr., Springfield, IL 62712-9523, Tel: 217-529-5885, EMAIL: birtch32@aol.com

*BLAISDELL, F. WILLIAM, M.D., Professor of Surgery, University of California, Davis Medical Center, 2221 Stockton Blvd., Sacramento, CA 95817, Tel: 916-734-2207, FAX: 916-734-5119, EMAIL: fwblaisdell@ucdavis.edu

*BLAND, KIRBY I, M.D., Fay Fletcher Kerner Professor and Chairman, Department of Surgery, University of Alabama at Birmingham, 1530 3rd Avenue South, BDB 502, Birmingham, AL 35294-0012, Tel: 205-975-5000, FAX: 205-975-2199, EMAIL: kirby.bland@ccc.uab.edu

*BLOCK, MELVIN A, M.D., Emeritus Chairman, Department of Surgery, Scripps Clinic; Emeritus Professor, Clinical Surgery, University of California, San Diego, 4575 Excalibur Way, San Diego, CA 92122, Tel: 619-453-8872

*BLOOM, DAVID A, M.D., Chair and Professor of Urology, University of Michigan, 1500 E. Medical Center Dr., Ann Arbor, MI 48109-5330, Tel: 734-232-4943, FAX: 734-936-8037, EMAIL: dabloom@umich.edu

*BLUMGART, LESLIE H, M.D., Professor of Surgery, Cornell University Medical Center; Chief, Hepatobiliary Service, Department of Surgery, Memorial Sloan-Kettering Cancer Center, 1275 York Ave., Surgery Department, Rm CS91, New York, NY 10021-6094, Tel: 212-639-5526, FAX: 212-794-5852, EMAIL: blumgarl@mskcc.org

*BOLES, E. THOMAS, JR, M.D., Professor Emeritus, Department of Surgery, Ohio State University College of Medicine; Chief, Pediatric Surgery, Children's Hospital, 2750 Crafton Park, Columbus, OH 43221, Tel: 614-722-3900, FAX: 614-722-3903, EMAIL: et10@columbus.rr.com

BOLLING, STEVEN F, M.D., Professor of Surgery, University of Michigan, 1500 E. Medical Center Dr., 5144 CVC, Ann Arbor, MI 48109-5864, Tel: 734-936-4981, FAX: 734-764-2255, EMAIL: sbolling@umich.edu

*BOLLINGER, R. RANDAL, M.D., Professor of Surgery, Professor of Immunology, Duke University Medical Center, Chief of General Surgery, Department of Surgery, Duke Medical Center, 1120 Infirmary Rd., Durham, NC 27712, Tel: 919-684-5209, FAX: 919-684-8716, EMAIL: boll001@mc.duke.edu
BOLMAN, R. MORTON, III, M.D., Professor of Surgery, Harvard Medical School; Chief, Division of Cardiac Surgery, Brigham and Women’s Hospital, 75 Francis Street, Boston, MA 02115, Tel: 617-732-6964, FAX: 617-264-6319, EMAIL: rbolmanIII@partners.org

BORGEN, PATRICK I, M.D., Chairman, Department of Surgery, Maimonides Medical Center; Director, Brooklyn Breast Cancer Program, Maimonides Cancer Center, 4802 Tenth Ave., Brooklyn, NY 11219, Tel: 718-283-7170, FAX: 718-635-7460, EMAIL: pborgen@maimonidesmed.org

BOUVET, MICHAEL, M.D., 3855 Health Sciences Drive, Mail Code, La Jolla, CA 92039-0987, Tel: 858-822-6191, FAX: 858-822-6192, EMAIL: mbouvet@ucsd.edu

*BOVE, EDWARD L, M.D., Professor of Surgery, Head, Section of Cardiac Surgery, Chief Pediatric Cardiac Surgery, University of Michigan Medical Center, 1500 E. Medical Center Dr., CVC 5144/SPC 5864, Ann Arbor, MI 48109-5864, Tel: 734-936-4980, FAX: 734-763-7353, EMAIL: elbove@umich.edu

*BOWEN, JOHN C, M.D., Chairman Emeritus, Department of Surgery, Ochsner Clinic Foundation, 1514 Jefferson Hwy, New Orleans, LA 70121, Tel: 504-842-4072, FAX: 504-842-4013, EMAIL: jbowen@ochsner.org

*BOYCE, WILLIAM H, M.D., Professor of Surgery and Urology Emeritus, Wake Forest School of Medicine, Wake Forest University, P.O. Box 457, Patrick Springs, VA 24136-0457, Tel: 540-694-3028, FAX: 540-694-8184, EMAIL: whboyce@worldnet.att.net

*BRAASCH, JOHN W, M.D., Senior Consultant, Lahey Clinic, 25 Page Road, Lincoln, MA 01773-2805, Tel: 781-259-0183, EMAIL: braajw73@aol.com

*BRADLEY, EDWARD L, III, M.D., Professor of Clinical Sciences and Surgery, Florida State University College of Medicine, 201 Cocanaut Ave., Sarasota, FL 34236-4917, Tel: 941-316-8120, FAX: 941-923-3113, EMAIL: ed.bradley@med.fsu.edu

*BRANDT, MARY L, M.D., Professor and Vice Chair, Texas Children’s Hospital, 6621 Fannin, CC650.00, Houston, TX 77030, Tel: 832-822-3135, FAX: 832-825-3141, EMAIL: brandt@bcm.tmc.edu
BRAYMAN, KENNETH L, M.D., Professor of Surgery, Director of Renal, Pancreas and Islet Transplant Program, University of Virginia Health System, P.O. Box 800709, Department of Surgery, Charlottesville, VA 22908-0709, Tel: 434-924-9370, FAX: 434-924-5539, EMAIL: klb9r@virginia.edu

*BREDENBERG, CARL E, M.D., Surgeon-in-Chief, Emeritus, Maine Medical Center, Professor of Surgery, University of Vermont College of Medicine, 8 Fox Hill Road, Cape Elizabeth, ME 04107, Tel: 207-662-2934, FAX: 207-662-6389, EMAIL: bredec@mmc.org

*BREMNER, CEDRIC G, M.D., Professor of Surgery; Director of Clinical Research, P.O. Box 1081, Lonehill, Johannesburg, 2062, South Africa, EMAIL: bremner@hsc.usc.edu

*BRENNAN, MURRAY F, M.D., Chairman Emeritus, Department of Surgery, Memorial Sloan-Kettering Cancer Center, 1275 York Ave., Room C-1265, New York, NY 10021, Tel: 212-639-8691, FAX: 212-794-5845, EMAIL: brennamm@mskcc.org

*BREWSTER, DAVID C, M.D., Clinical Professor of Surgery, Harvard Medical School, Massachusetts General Hospital, 15 Parkman St., Apt. 440, Boston, MA 02114, Tel: 617-523-4293, FAX: 617-726-8230, EMAIL: dcbrewster@partners.org

BRITT, L.D., M.D., M.P., Brickhouse Professor and Chairman, Department of Surgery, Eastern Virginia Medical School, 825 Fairfax Ave., #610, Surgery Department, Norfolk, VA 10065, Tel: 757-446-8965, EMAIL: brittld@evms.edu

*BREMMER, LEO G, M.D., Professor Emeritus, University of Tennessee Health Science Center, 4044 Dumaine Way, Memphis, TN 38117, Tel: 901-452-5208, FAX: 901-327-1274, EMAIL: bigtvoldoc@aol.com

*BROADIE, THOMAS A, M.D., Frederic W. Taylor Professor of Surgery, Emeritus IU School of Medicine; Chief of Surgery, Wishard Memorial Hospital; Indiana University Hospital, Indianapolis, Indiana, 8160 Sycamore Road, Indianapolis, IN 46240, Tel: 317-630-6727, FAX: 317-630-8721, EMAIL: tbroadie@iupui.edu

*BROELSCH, CHRISTOPH, M.D., Professor and Chairman; Department of General Surgery and Transplantation, University Hospital Essen, Sybelstr 26, Dusseldorf, 40239, Germany, Tel: 49-2017231100, FAX: 49-2017235946, EMAIL: broelsch@gmx.de
BROMBERG, JONATHAN S, M.D., Professor of Surgery, Gene and Cell Medicine, Mount Sinai School of Medicine, 1 Gustave L Levy Pl, Box 1104, New York, NY 10029-6574, Tel: 212-659-8008, FAX: 212-348-2474, EMAIL: jon.bromberg@mountsinai.org

*BROWDER, I. WILLIAM, M.D., William Henry Reed Professor and Chairman, East Tennessee State University College of Medicine, P.O. Box 70575, Department Surgery, Johnson City, TN 37614, Tel: 423-439-6268, FAX: 423-439-6259, EMAIL: browder@etsu.edu

*BROWN, JOHN W, M.D., Harris B. Shumacker Professor of Surgery; Chief, Section of Cardiothoracic Surgery, Indiana University School of Medicine, 545 Barnhill Dr., #215, Indianapolis, IN 46202, Tel: 317-274-7150, FAX: 317-274-2940, EMAIL: jobrown@iupui.edu

BRUNICARDI, F. CHARLES, M.D., Professor and Chairman, Michael E. DeBakey Department of Surgery at Baylor College of Medicine, 1709 Dryden, Ste. 1500, Houston, TX 77030, Tel: 713-798-8020, FAX: 713-798-6609, EMAIL: cbrunica@bcm.edu

*BRYANT, LESTER R, M.D., 131 Magnolia Ridge Drive, Jonesborough, TN 37659, Tel: 423-753-0005, EMAIL: bryantlmd@aol.com

BUCHMAN, TIMOTHY G, M.D., Ph.D., Director, Emory Critical Care Center; Professor of Surgery, Emory University Hospital, 1364 Clifton Rd., NE, Suite F524, Atlanta, GA 30322, Tel: 404-712-2609, FAX: 404-712-2654, EMAIL: tbuchma@emory.edu

*BUCHWALD, HENRY, M.D., Ph.D., Professor of Surgery and Biomedical Engineering, University of Minnesota, 420 Delaware St. SE, MMC 290, Minneapolis, MN 55455, Tel: 612-625-8413, FAX: 612-625-3206, EMAIL: buchw001@umn.edu

*BUCKBERG, GERALD D, M.D., Professor of Surgery, UCLA Medical Center, 10833 Le Conte, Rm 62-258 CHS, Los Angeles, CA 90024-1741, Tel: 310-206-1027, FAX: 310-825-5895, EMAIL: gbuckberg@mednet.ucla.edu

*BURDICK, JAMES F, M.D., Professor of Surgery, Director, End Stage Renal Disease Program, Johns Hopkins Hospital, P.O. Box 1283, St. Michaels, MD 21663, Tel: 410-955-6875, FAX: 410-614-2079, EMAIL: jburdick@att.net
*BURKE, JOHN F, M.D., Helen Andrus Benedict Professor of Surgery Emeritus, Harvard Medical School, Chief of Trauma Services Emeritus, Massachusetts General Hospital, 55 Fruit St., Warren 941, Boston, MA 02114, Tel: 617-726-2809, FAX: 617-726-2441, EMAIL: burke.john@mgh.harvard.edu

*BURNS, R. PHILLIP, M.D., Professor and Chairman, Department of Surgery, University of Tennessee College of Medicine, 979 E. Third St., #401, Department of Surgery, Chattanooga, TN 37403, Tel: 423-778-7695, FAX: 423-778-2950, EMAIL: burnsrp@erlanger.org

BURNS, DAVID G, M.D., FACS, Professor and Chairman of the Norman M. Rich Department of Surgery, F. Edward Hebert School of Medicine, USUHS, 4301 Jones Bridge Rd., Bethesda, MD 20814, Tel: 301-295-3155, FAX: 301-591-1978, EMAIL: dburris@usuhs.mil

*BUSUTTIL, RONALD W, M.D., Ph.D., Distinguished Professor and Executive Chairman, UCLA, Department of Surgery, 757 Westwood Plaza, Ste. 8236, Los Angeles, CA 90095, Tel: 310-825-5318, FAX: 310-206-7760, EMAIL: rbusuttil@mednet.ucla.edu

*CADY, BLAKE, M.D., Professor of Surgery Emeritus, Brown Medical School; Harvard Medical School; Staff surgeon, Cambridge Hospital, 24 Walnut Place, Brookline, MA 02445, Tel: 617-665-2001, EMAIL: bcady123@comcast.net

*CALDWELL, MICHAEL D, M.D., Ph.D., Director Wound Healing Program, Marshfield Clinic, 1000 North Oak Avenue, Marshfield, WI 54449-5777, Tel: 715-221-7474, FAX: 715-387-5588, EMAIL: caldwelm@mmrf.mfldclin.edu

*CALLANDER, CLIVE O, M.D., LaSalle D. Leffall, Jr., Professor and Chairman, Department of Surgery, Howard University Hospital, 2041 Georgia Ave. NW, #4B41, Washington, DC 20060, Tel: 202-865-1441, FAX: 202-865-5396, EMAIL: ccallender@howard.edu

*CALLOW, ALLAN D, M.D., Research Professor of Surgery, Boston University School of Medicine, 329 Hammond St., Chestnut Hill, MA 02467-1207, Tel: 617-638-5692, FAX: 617-638-5693, EMAIL: allancallow@peoplepc.com

CAMBRIA, RICHARD P, M.D., Professor of Surgery, Harvard Medical School; Chief, Division of Vascular Surgery, Massachusetts General Hospital, 55 Parkman St., WAC 458, Boston, MA 02114, Tel: 617-726-8278, FAX: 617-726-8700, EMAIL: rcambria@partners.org
CAMERON, DUKE E, M.D., Professor of Surgery and Pediatrics, The Johns Hopkins University, 600 No Wolfe St., Blalock 618, Baltimore, MD 21287, Tel: 410-955-2698, FAX: 410-955-3809, EMAIL: dcameron@jhmi.edu

*CAMERON, JOHN L, M.D., Professor and Chairman, Department of Surgery, The Johns Hopkins University, Chief of Surgery, The Johns Hopkins Hospital, 600 No Wolfe St., 679 Blalock, Surgery, Baltimore, MD 21287, Tel: 410-955-5166, FAX: 410-502-6978, EMAIL: jcameron@jhmi.edu

*CAMISHION, RUDOLPH C, M.D., Professor and Head, Division of General Surgery, UMDNJ-Robert Wood Johnson Medical School at Camden, 3 Cooper Plaza, #411, Camden, NJ 08103, Tel: 856-342-3412, FAX: 856-365-1180, EMAIL: camishrl@umdnj.edu

*CAMPBELL, DARRELL A, JR, M.D., Chief of Staff, Office of Clinical Affairs, University of Michigan Hospitals and Health Centers, 1500 E. Medical Center Dr., C201 MIB #0825, Ann Arbor, MI 48109-0825, Tel: 734-936-5814, FAX: 734-936-9406, EMAIL: darrelle@umich.edu

*CAMPBELL, GILBERT S, M.D., Professor of Surgery Emeritus, University of Arkansas for Medical Sciences, 66 River Ridge Road, Little Rock, AR 72207, Tel: 501-225-8116

CANCE, WILLIAM G, M.D., Chair, Department of Surgical Oncology, Surgeon in Chief, Roswell Park Cancer Institute, Elm Street & Carton Streets, Buffalo, NY 14263, Tel: 352-265-0622, FAX: 352-265-0701, EMAIL: William.cance@roswellpark.org

CANIANO, DONNA A, M.D., Professor of Surgery and Pediatrics, Ohio State University College of Medicine; Surgeon-in-Chief, Children’s Hospital, 700 Children’s Drive, ED 379, Columbus, OH 43205, Tel: 614-722-3912, FAX: 614-722-3903, EMAIL: donna.caniano@nationwidechildrens.org

*CANNON, JACK A, M.D., 25132 Via Pacifica, Dana Point, CA 92629-2049, Tel: 949-481-3328, EMAIL: jack12@cox.net

*CAREY, LARRY C, M.D., Department of Surgery, University of South Florida, College of Medicine, 13000 Bruce B Downs Blvd., Tampa, FL 33612, Tel: 813-972-7682, FAX: 813-259-0985, EMAIL: larry.carey@va.gov

*CARSON, CULLEY C, III, University of North Carolina at Chapel Hill, 427 Burnett Womack Building, Chapel Hill, NC 27599-7235, Tel: 919-966-2574, FAX: 919-966-0098, EMAIL: carson@med.unc.edu
*CASTANEDA, ALDO R, M.D., Surgeon-in-Chief Emeritus, Children’s Hospital; William E. Ladd Professor of Surgery Emeritus, Harvard Medical School, 9a Ave. 8-10, Zona 11, Guatemala City, 01011, Guatemala, Tel: 15024751908, FAX: 15024751908, EMAIL: unicarp@terra.com.gt

*CERILLI, JAMES, M.D., Emeritus Professor of Surgery, University of Rochester, 12 Brams Point Road, Hilton Head Island, SC 29926, Tel: 843-689-2338, EMAIL: cerilli0623@hargray.com

CHAIKOF, ELLIOT L, M.D., John E. Skandalakis Professor of Surgery; Chief, Division of Vascular Surgery, Emory University, 101 Woodruff Circle, 5105 WMB, Atlanta, GA 30322, Tel: 404-727-8413, FAX: 404-727-3396, EMAIL: echaiko@emory.edu

CHANG, ALFRED E, M.D., Hugh Cabot Professor of Surgery and Chief, Division of Surgical Oncology, University of Michigan, 1500 E. Medical Center Dr., 3302CCGC, Ann Arbor, MI 48109-0932, Tel: 734-936-4392, FAX: 734-647-9647, EMAIL: aechang@umich.edu

*CHANG, HELENA R, M.D., Professor of Surgery, UCLA Department of Surgery; Director, Revlon/UCLA Breast Center and Women’s Cancer Program, Jonsson/UCLA Comprehensive Cancer Center, 200 UCLA Medical Plaza, #B265, Los Angeles, CA 90095, Tel: 310-794-5624, FAX: 310-206-2982, EMAIL: hchang@mednet.ucla.edu

CHAPMAN, WILLIAM C, M.D., Professor of Surgery, Chief, Division of General Surgery and Section of Transplantation, Washington University School of Medicine, 660 So Euclid Ave., CB 8109, St. Louis, MO 63110, Tel: 314-747-7792, FAX: 314-361-4197, EMAIL: chapmanw@wusl.edu

*CHASE, ROBERT A, M.D., Emile Holman Professor of Surgery; Chief, Division of Anatomy, Stanford University School of Medicine, Anatomy 1215 Welch Rd., Stanford, CA 94305, Tel: 650-723-2404, FAX: 650-725-8668, EMAIL: mu.rac@forsythe.stanford.edu

CHEADLE, WILLIAM G, M.D., Professor Surgery, Associate Chief of Staff for Research and Development, VAMC Louisville, 530 South Jackson St., ACR, Louisville, KY 40202, Tel: 502-852-6230, FAX: 502-852-8915, EMAIL: wg.cheadle@louisville.edu

*CHEN, HERBERT, M.D., Professor and Vice Chairman, University of Wisconsin Hospital, 600 Highland Ave., H4/722 CSC, Madison, WI 53792-7375, Tel: 608-263-1387, FAX: 608-263-7652, EMAIL: chen@surgery.wisc.edu
*CHERRY, KENNETH J, JR, M.D., Chair, Vascular Surgery Division; Chair, Vascular Center; Professor of Surgery, University of Virginia, P.O. Box 800679, Charlottesville, VA 22908, Tel: 434-243-7052, FAX: 434-982-1026, EMAIL: kjc5kh@virginia.edu

*CHEUNG, LAURENCE Y, M.D., 16001 West Nine Mile Road, Southfield, MI 48075, Tel: 248-849-8901, EMAIL: laurence.cheung@providence-stjohnhealth.org

*CHITWOOD, W. RANDOLPH, JR, M.D., Professor and Chairman, Department of Surgery; Chief, Division of Cardiac Surgery, East Carolina University School of Medicine, 600 Moye Blvd., Department of Cardiovascular Sc, Greenville, NC 27834, Tel: 252-744-4822, FAX: 252-744-3051, EMAIL: chitwoodw@ecu.edu

*CHIU, CHU-JENG (RAY), M.D., Professor and Chairman, Cardio-Thoracic, McGill University, 1650 Cedar Ave., Rm C-9169, Montreal, Quebec H3G 1A4, Canada, Tel: 514-937-6011, FAX: 514-934-8289, EMAIL: ray.chiu@mcgill.ca

CHOTI, MICHAEL A, M.D., MBA, Professor of Surgery, Johns Hopkins University, 600 No Wolfe, Blalock 665, Baltimore, MD 21287, Tel: 410-955-7113, FAX: 410-614-4667, EMAIL: mchoti@jhmi.edu

*CHRISTOU, NICOLAS V, M.D., Professor of Surgery, McGill University; Head, Division of General Surgery, Director, Surgical Intensive Care Unit, Royal Victoria Hospital, 687 Pine Ave. West, Rm SC24, Montreal, Quebec H3A 1A1, Canada, Tel: 514-843-1351, FAX: 514-843-1693, EMAIL: nicolas.christou@muhc.mcgill.ca

CHUNG, DAI H, M.D., Professor, Vanderbilt University Medical Center, 2200 Children’s Way, 4150 DOT, Nashville, TN 37232-9780, Tel: 615-936-1050, FAX: 615-936-1046, EMAIL: dai.chung@vanderbilt.edu

*CHUNG, RAPHAEL S.K., M.D., The Cleveland Clinic Foundation, Department of Surgery, Huron Hospital; Chairman, 13951 Terrace Rd., Cleveland, OH 44112, Tel: 216-761-4223, FAX: 216-761-3499, EMAIL: rschung@hotmail.com

*CHUNG, STEPHAN W, M.D., Professor of Surgery; Medical Director, Surgical Services; Director of Research, British Columbia Transplant, 2775 Laurel St., 5th Floor, Vancouver, British Columbia V5Z 1M9, Canada, Tel: 604-875-4459, FAX: 604-875-5869, EMAIL: stephen.chung@vch.ca
CHURCH, JAMES M, M.D., Victor Fazio Professor of Colorectal Surgery; Vice Chairman, Department of Colorectal Surgery; Director of David Tagelman Registry for Inherited Colorectal Cancer, Cleveland Clinic Foundation, 9500 Euclid Ave., Desk A30, Cleveland, OH 44195, Tel: 216-444-9052, FAX: 216-445-8627, EMAIL: churchj@ccf.org

CHUTER, TIMOTHY A.M., M.D., 400 Parnassus Ave., A-581, San Francisco, CA 94143, Tel: 415-353-4366, FAX: 415-353-4370, EMAIL: chutert@surgery.ucsf.edu

CIOFFI, WILLIAM G, M.D., Chairman Department of Surgery, Professor of Surgery, Brown University School of Medicine; Rhode Island Hospital, Department of Surgery, 593 Eddy St., Surgery, APC 431, Providence, RI 02903, Tel: 401-444-6611, FAX: 401-444-6612, EMAIL: wcioffi@lifespan.org

* CIVETTA, JOSEPH M, M.D., Director of Surgery at Hartford Hospital; Professor and Chairman, Department of Surgery, University of Connecticut Health Center, 263 Farmington Ave., Surgery, MC3955, Farmington, CT 06030-3955, Tel: 860-679-3467, FAX: 860-679-1497, EMAIL: civetta@nso.uchc.edu

* CLAGETT, G. PATRICK, M.D., Professor of Surgery and Chairman, Division of Vascular Surgery, Jam and Bob Pickens Professor of Medical Science, University of Texas SW Medical Center, 5909 Harry Hines Blvd., Dallas, TX 75390-9157, Tel: 214-648-3516, FAX: 214-648-2790, EMAIL: patrick.clagett@utsouthwestern.edu

* CLARK, ORLO H, M.D., Chief of Surgery, UCSF/Mount Zion, Professor and Vice Chair, Department of Surgery, UCSF, 1600 Divisadero St., Rm C3-47, San Francisco, CA 94143-1674, Tel: 415-885-7616, FAX: 415-885-7617, EMAIL: clarko@surgery.ucsf.edu

* CLARKE, JOHN R, M.D., Professor of Surgery, Drexel University, 412 Mc Clenaghan Mill Road, Wynnewood, PA 19096-1006, Tel: 215-762-1545, FAX: 215-762-8389, EMAIL: jclarke@linc.cis.upenn.edu

* CLAYMAN, RALPH V, M.D., Dean (interim) and Professor of Urology, UC Irvine School of Medicine, 1001 Health Science Rd., 252 Irvine Hall, Irvine, CA 92697-3950, Tel: 714-456-3329, FAX: 714-456-5062, EMAIL: rclayman@uci.edu
CLOWES, ALEXANDER W, M.D., Professor of Surgery, Chief, Division of Vascular Surgery, University of Washington School of Medicine, 1959 NE Pacific, Box 356410, Seattle, WA 98195-6410, Tel: 206-543-9890, FAX: 206-616-7495, EMAIL: clowes@u.washington.edu

COTT, JOSEPH P, M.D., 55 Fruit St., GRB 444, Boston, MA 02114

CODY, HIRAM S, III, M.D., Attending Surgeon, Memorial Sloan-Kettering Cancer Center, Professor of Clinical Surgery, Weill Medical College of Cornell University, 1275 York Ave., The Breast Service, New York, NY 10021, Tel: 212-639-8261, FAX: 212-794-5812, EMAIL: codyh@mskcc.org

COE, NICHOLAS P.W., M.D., Director, Surgical Education, Baystate Medical Center; Professor of Surgery, Tufts University School of Medicine, 759 Chestnut Street, Springfield, MA 01199, Tel: 413-794-5165, FAX: 413-794-1835, EMAIL: nicholas.coe@bhs.org

COFER, JOSEPH B, M.D., 979 East 3rd St., Ste. 401, Chattanooga, TN 37403, Tel: 423-778-7695, FAX: 423-778-2950, EMAIL: joe.cofer@erlanger.org

COHEN, ALFRED M, M.D., Professor of Surgery, University of Arizona; Surgical Director, Arizona Cancer Center, 420 S. Pinto Place, Tucson, AZ 85748, Tel: 520-626-6789, FAX: 520-626-7785, EMAIL: acohen@surgery.arizona.edu

COHEN, I. KELMAN, M.D., Professor of Surgery (Plastic), Medical College of Virginia, 1400 Aqua Vista Lane, Richmond, VA 23231, Tel: 804-895-2887, FAX: 804-795-1500, EMAIL: kelman@comcast.net

COHEN, JON R, M.D., Chief Medical Officer, Quest Diagnostics, 3 Lake Rd., North, Great Neck, NY 11020, Tel: 973-520-2012, FAX: 516-465-8144, EMAIL: jcohenmd@gmail.com

COHEN, ZANE, M.D., Professor of Surgery, University of Toronto, 600 University Ave., #451, Toronto, Ontario M5G 1X5, Canada, Tel: 416-586-8346, FAX: 416-586-8644, EMAIL: z.cohen@utoronto.ca

COHN, ISIDORE, JR, M.D., Professor of Surgery, Louisiana State University, School of Medicine, 510 Iona, Metairie, LA 70005, Tel: 504-835-6135, EMAIL: drdrdrjr@aol.com
COHN, LAWRENCE H, M.D., Hubbard Professor of Cardiac Surgery, Harvard Medical School, Division of Cardiac Surgery, Brigham and Women’s Hospital, 75 Francis Street, Boston, MA 02115, Tel: 617-732-6569, FAX: 617-732-6559, EMAIL: lcohn@partners.org

COHN, STEPHEN M, M.D., Witten B. Russ Professor, University of Texas Health Science Center, 7703 Floyd Curl Dr., Department of Surgery, San Antonio, TX 78229-3900, Tel: 210-567-5705, FAX: 210-567-3447, EMAIL: Cohn@uthscsa.edu

COIT, DANIEL G, M.D., Professor of Surgery, Cornell University Medical School; Member, Memorial Hospital; Attending Surgeon, Memorial Hospital, MSKCC, 1275 York Ave., Department of Surgery, New York, NY 10021, Tel: 212-639-6325, FAX: 212-717-3400, EMAIL: coitd@mskcc.org

COLE, DAVID J, M.D., McKoy Rose Professor and Head, Division of General Surgery, Vice-Chair, Department of Surgery, Medical University of South Carolina, P.O. Box 250613, Charleston, SC 29425, Tel: 843-792-4638, FAX: 843-792-3315, EMAIL: coledj@musc.edu

COLEMAN, JOHN J, III, M.D., Chairman, Division of Plastic Surgery, Professor of Surgery, Indiana University Medical Center, 545 Barnhill Dr., Emerson Hall 239, Indianapolis, IN 46202-5124, Tel: 317-274-8106, FAX: 317-274-7612, EMAIL: jjcolema@iupui.edu

COLLETTI, LISA M, M.D., C. Gardner Child Professor of Surgery; Division Chief – Gastrointestinal Surgery; Associate Dean and Director for Graduate Medical Education, University of Michigan, 1500 E. Medical Center Drive, Ann Arbor, MI 48109-0331, Tel: 734-936-7944, FAX: 734-936-5830, EMAIL: colletti@umich.edu

COLLICOTT, PAUL E, M.D., Director, Member Services, American College of Surgeons, 633 No Saint Clair Street, Chicago, IL 60611-3211, Tel: 312-202-5259, FAX: 312-202-5021, EMAIL: pcollicott@facs.org

COLLINS, JOHN J, JR, M.D., Vice Chairman, Department of Surgery, Brigham and Women’s Hospital, 75 Francis St., Cardiac Surgery, Boston, MA 02115, Tel: 617-732-7678, FAX: 617-732-6559

COLLINS, WILLIAM F, JR, M.D., Harvey and Kate Cushing Professor Emeritus, Department of Neurosurgery, Yale University School of Medicine, 12134 Putnam Green Row, San Diego, CA 92128-3270, Tel: 203-453-2034, EMAIL: wfcollin@aol.com
COLOBAMI, PAUL M, M.D., Robert Garrett Professor of Pediatric Surgery; Professor of Surgery, Pediatrics and Oncology; Chief, Division of Pediatric Surgery; Pediatric Surgeon-in-Chief, Johns Hopkins University, 600 No Wolfe St., Harvey 319, Baltimore, MD 21287, Tel: 410-955-2717, FAX: 410-550-5314, EMAIL: pc@jhmi.edu

*COMEROTA, ANTHONY J, M.D., Professor of Surgery, Chief of Vascular Surgery, Director, Jobst Vascular Center, 2109 Hughes, #400-Conrad Jobst Twr, Toledo, OH 43606, Tel: 419-291-2088, FAX: 419-479-6980, EMAIL: anthony.comerotaMD@promedica.org

*CONDON, ROBERT E, M.D., Professor and Chairman Emeritus, Department of Surgery, The Medical College of Wisconsin; Clinical Professor Emeritus, The University of Washington, 2722 86th Avenue NE, Clyde Hill, WA 98004-1653, Tel: 425-453-7860, FAX: 425-453-7860, EMAIL: recrecmd@comcast.net

*CONNOLLY, JOHN E, M.D., Professor of Surgery, University of California at Irvine, 333 The City Blvd., West, Ste. 1205, Orange, CA 92868, Tel: 714-456-5756, FAX: 714-456-8519, EMAIL: jeconnol@uci.edu

*COOLEY, DENTON A, M.D., Clinical Professor of Surgery, University of Texas Medical School; Surgeon-in-Chief and President, Texas Heart Institute, P.O. Box 20345, Houston, TX 77225-0345, Tel: 832-355-4932, FAX: 832-355-3424, EMAIL: dcooley@heart.thi.tmc.edu

COONEY, ROBERT N, M.D., Charlene J. Smith Professor and Chief, Division of General Surgery, Penn State MSH Medical Center, The Milton S. Hershey Medical Center, Hershey, PA 17033, Tel: 717-531-6241, FAX: 717-531-3649, EMAIL: ConneyR@Upstate.edu

*COOPER, JOEL D, M.D., Evarts A. Graham Professor of Surgery, Chief, Division of Cardiothoracic Surgery, Washington University School of Medicine, 3400 Spruce St., 6 Silverstein, Philadelphia, PA 19104, Tel: 215-662-2022, FAX: 215-614-0282, EMAIL: joel.cooper@uphs.upenn.edu

*COPELAND, EDWARD M, III, M.D., Edward R. Woodward Professor and Chairman; Distinguished Professor of Surgery, Department of Surgery, University of Florida, College of Medicine, P.O. Box 100286, Gainesville, FL 32610-0286, Tel: 352-265-0378, FAX: 352-338-0262, EMAIL: copelem@surgery.ufl.edu
*CORAN, ARNOLD G, M.D., Professor of Surgery, Section of Pediatric Surgery; C.S. Mott Children’s Hospital, University of Michigan, F3970, Box 0245, Ann Arbor, MI 48109-0245, Tel: 734-764-6482, FAX: 734-936-9784, EMAIL: acoran@umich.edu

*CORMAN, MARVIN L, M.D., Professor of Surgery, Stony Brook University, HSC 18-060, Department of Surgery, Stony Brook, NY 11794-8191, Tel: 631-444-3431, FAX: 631-444-7784, EMAIL: marvin.corman@stonybrook.edu

CORNWELL, EDWARD E, III, M.D., LeSalle D. Leffall Professor and Chair, Department of Surgery, Howard University Hospital, 2041 Georgia Ave., NW, Rm 4B-02, Washington, DC 20060, Tel: 202-865-1441, FAX: 202-865-5396, EMAIL: ecornwell@howard.edu

COSSELLI, JOSEPH S, M.D., Professor and Cullen Foundation Endowed Chair, Division of Cardiothoracic Surgery – Baylor College of Medicine St. Luke’s Episcopal Hospital/Texas Heart Institute, One Baylor Plaza, BCM-390, Houston, TX 77030, Tel: 832-355-9910, FAX: 832-355-9920, EMAIL: jcoselli@bcm.edu

*COSGROVE, DELOS M, M.D., Chairman, Department of Thoracic and Cardiovascular Surgery, Cleveland Clinic Foundation, 9500 Euclid Ave., CT Surgery, F-25, Cleveland, OH 44195, Tel: 216-444-6733, FAX: 216-444-3119, EMAIL: dmc@ccf.org

*COSIMI, A. BENEDICT, M.D., Claude E. Welch Professor of Surgery, Harvard Medical School, Chief Emeritus Transplantation Unit, Massachusetts General Hospital, 55 Fruit St., Department of Surgery, Boston, MA 02114, Tel: 617-726-8256, FAX: 617-726-8137, EMAIL: cpadyk@partners.org

*COUCH, NATHAN P, M.D., Retired Associate Professor of Surgery, Harvard Medical School and Brigham and Women’s Hospital, 5 High Rock Rd., Dover, MA 02030, Tel: 508-785-1861, EMAIL: piercecouch@earthlink.net

*COUTURE, JEAN G, M.D., Professor of Surgery, Laval University, 123 – 18 Jardins Merici, Apt. 123, Quebec City, Quebec G1S 4W1, Canada, Tel: 418-682-7894, FAX: 418-682-3331, EMAIL: jean.couture@chg.ulaval.ca

*COX, CHARLES S, JR, M.D., 6431 Fannin St., Ste. 5,236, Houston, TX 77030, Tel: 713-500-7307, FAX: 713-500-7296, EMAIL: charles.s.cox@uth.tmc.edu
*COX, JAMES L, M.D., Professor of Surgery Emeritus, Division of Cardiothoracic Surgery, Washington University School of Medicine, 3300 Old Slido Road, LaGrange, KY 40031, Tel: 502-222-9003, FAX: 502-222-9555, EMAIL: jamescoxmd@aol.com

*CRAWFORD, FRED A, JR, M.D., Distinguished University Professor, Medical University of South Carolina, Head, 25 Courtenay Dr., #7018, Department of Surgery, Charleston, SC 29425-2950, Tel: 843-876-4840, FAX: 843-876-4866, EMAIL: crawfrdf@musc.edu

CROCE, MARTIN A, M.D., Professor of Surgery, Chief, Trauma and Critical Care – University of Tennessee Health Science Center, 910 Madison Ave., #219, Memphis, TN 38163, Tel: 901-448-8140, FAX: 901-448-7306, EMAIL: mcroce@utmem.edu

*CRONENWETT, JACK L, M.D., Chief, Section of Vascular Surgery, Professor of Surgery, Dartmouth-Hitchcock Medical Center, One Medical Center Dr., Lebanon, NH 03756, Tel: 603-650-8670, FAX: 603-650-4973, EMAIL: jack.cronenwett@hitchcock.org

*CRUFT, GEORGE E, M.D., Director of Special Projects, American Board of Surgery, 48 Orquidia Ct, Palm Desert, CA 92260, EMAIL: gcruft@msn.com

*CRUZ, ANATOLIO B, M.D., Professor of Surgery, Chief of Surgical Oncology, University of Texas Health Science Center at San Antonio, 7703 Floyd Curl Dr., Surgery, San Antonio, TX 78284, Tel: 210-567-5750, FAX: 210-567-6862, EMAIL: cruza@uthscsa.edu

CRYER, H. GILL M, M.D., 757 Westwood Plaza, #8501, Los Angeles, CA 90095, Tel: 310-825-5981, FAX: 310-206-2472, EMAIL: hcryer@mednet.ucla.edu

*CUNNINGHAM, JOSEPH N, M.D., Chairman, Department of Surgery, Program Director, Brooklyn South Surgical Training Program; Program Director, Cardiothoracic Training Program, Maimonides Medical Center, 4802 10th Ave., Department of Surgery, Brooklyn, NY 11219, Tel: 718-283-7686, FAX: 718-283-7392, EMAIL: jcunningham@maimonidesmed.org

CURET, MYRIAM J, M.D., 300 Pasteur Dr., H-3680, Stanford, CA 94305-5655, Tel: 650-723-8603, FAX: 650-736-1613, EMAIL: mcuret@stanford.edu
CURLEY, STEVEN A, M.D., Professor of Surgery; Chief, Gastrointestinal Tumor Surgery; Director, Surgical Oncology Fellowship Program; Program Director, Gastrointestinal Tumor Multidisciplinary Care Center, MD Anderson Cancer Center, 1515 Holcombe Blvd., Box 444, Houston, TX 77030, Tel: 713-794-4957, FAX: 713-745-5235, EMAIL: scurley@mdanderson.org

*CURRERI, P. WILLIAM, M.D., Chairman, Strategem of Alabama, Inc, P.O. Box 1187, Daphne, AL 36526, Tel: 334-652-2205, FAX: 334-625-4439, EMAIL: curcur@msn.com

D’ALESSANDRO, ANTHONY M, M.D., Professor of Surgery; Executive Director, University of Wisconsin Hospital & Clinics Organ Procurement Organization, 600 Highland Ave., Department of Surgery, Madison, WI 53792-7375, Tel: 608-263-2527, FAX: 608-262-6280, EMAIL: ADalessandro@uwhealth.org

*DACEY, RALPH G, JR, M.D., Schwartz Professor and Chairman, Department of Neurosurgery, Washington University School of Medicine, CB 8057, St. Louis, MO 63110, Tel: 314-362-3571, FAX: 314-362-2107, EMAIL: daceyr@nsurg.wustl.edu

*DAFOE, DONALD C, M.D., Professor of Surgery, Director of Surgical Education, Department of Surgery, Director, Pancreas Transplantation, Comprehensive Transplant Center, Cedars-Sinai Medical Center and Clinical Professor of Surgery, David Geffen School of Medicine at UCLA, 8635 West Third St. #590W, Los Angeles, CA 90048, Tel: 310-423-4848, FAX: 310-423-0889, EMAIL: donald.dafoe@cshs.org

*DAGGETT, WILLARD M, M.D., Professor of Surgery Emeritus, Harvard Medical School; Senior Surgeon, Department of Surgery, Massachusetts General Hospital, 55 Fruit Street – Cox 656, Boston, MA 02114, Tel: 617-726-8640, FAX: 508-785-9049, EMAIL: wdaggett@partners.org

♦DALMAN, RONALD L, M.D., 300 Pasteur Dr., Ste. H3642, Stanford, CA 94305-5642, Tel: 650-723-2031, FAX: 650-498-6044, EMAIL: rld@stanford.edu

DALSING, MICHAEL C, M.D., Professor of Surgery; Director of Vascular Surgery, Indiana University Medical School, 1801 N. Senate, MPC II, #3500, Indianapolis, IN 46202, Tel: 317-630-8787, FAX: 317-962-0289, EMAIL: mdalsing@iupui.edu
AMERICAN SURGICAL ASSOCIATION

*DALTON, MARTIN L, JR, M.D., Professor, Chairman, and Program Director Surgical Residency, Mercer University School of Medicine, 777 Hemlock St., MSC 140, Macon, GA 31201, FAX: 478-633-5153, EMAIL: dalton.martin@mccg.org

*DALY, JOHN M, M.D., Dean, Temple University School of Medicine, 3500 North Broad St., Rm 1141 MERB, Philadelphia, PA 19140, Tel: 215-707-8773, FAX: 215-707-8431, EMAIL: johndaly@temple.edu

DAMIANO, RALPH J, JR, M.D., John M. Shoenberg Professor of Surgery; Division Cardiothoracic Surgery, Washington University School of Medicine, 660 South Euclid, Campus Box 8234, St. Louis, MO 63110, Tel: 314-362-7327, FAX: 314-747-0917, EMAIL: damianor@wustl.edu

*D’AMICO, THOMAS A, M.D., Professor of Surgery, Duke University Medical Center, Box 3496, Duke South Room 3589, Durham, NC 27710, Tel: 919-684-4891, FAX: 919-684-8508, EMAIL: damic001@mc.duke.edu

*DANIELSON, GORDON K, M.D., Roberts Professor of Surgery, Mayo Medical School, 200 First St. SW, Plummer N-10, Rochester, MN 55905, Tel: 507-284-2691, FAX: 507-284-5036, EMAIL: danielson.gordon@mayo.edu

*DASGUPTA, TAPAS K, M.D., Professor of Surgery and Head, Department of Surgical Oncology, University of Illinois at Chicago, 840 So Wood St., Chicago, IL 60612, Tel: 312-996-6134, FAX: 312-996-9365, EMAIL: tkdg@uic.edu

*DAVID, TIRONE E, M.D., Head, Division of Cardiovascular Surgery; Professor, Department of Surgery, University of Toronto, The Toronto Hospital, 457 – 200 Elizabeth Street, Toronto, Ontario MS2C4, Canada, Tel: 416-346-4789, FAX: 416-340-4020, EMAIL: tirone.david@uhn.on.ca

DAVIES, MARK G, M.D., Ph.D., Associate Professor of Surgery, The Methodist Hospital, 6550 Fannin Smith 1401, Houston, TX 77030, Tel: 713-441-5200, FAX: 713-441-6299, EMAIL: mark.daviesmdphd@gmail.com

*DAVIS, JOHN H, M.D., Professor, Department of Surgery, The University of Vermont, School of Medicine, 21 Ridgewood Dr., Burlington, VT 05408, Tel: 802-658-1939, FAX: 802-658-1939, EMAIL: herschel.davis@comcast.net
DAVIS, ROBERT D, JR, Director, Transplantation, DUMC Professor of Surgery with Tenure, Duke University, DUMC 3864, Trent Dr., Duke So, Rm 3543, Durham, NC 27710, Tel: 919-681-4760, FAX: 919-681-4797, EMAIL: Davis053@mc.duke.edu

*DAY, ARTHUR L, M.D., Brigham and Women’s Hospital, 75 Francis Street, Boston, MA 02115, Tel: 617-525-7777, FAX: 617-734-8342, EMAIL: aday1@partners.org

*DAYTON, MERRIL T, M.D., Chairman, SUNY Buffalo, 100 High St., Department of Surgery, Buffalo, NY 14203, Tel: 716-859-1339, FAX: 716-859-1829, EMAIL: mdayton@buffalo.edu

*DEAN, RICHARD E, M.D., Emeritus Professor, Michigan State University College of Medicine, B-409 Clinical Center, East Lansing, MI 48823, FAX: 517-353-6392, EMAIL: richard.dean@ht.msu.edu

*DEAN, RICHARD H, M.D., President Emeritus, Wake Forest University Health Sciences, 2551 Warwick Road, Winston-Salem, NC 27104, Tel: 336-722-6992, EMAIL: rdean@wfubmc.edu

DEARANI, JOSEPH ALBERT, M.D., 200 First Street SW, Rochester, MN 55905, Tel: 507-255-2034, FAX: 507-255-8674, EMAIL: jdearani@mayo.edu

*DEBAS, HAILE T, M.D., Executive Director, UCSF Global Health Sciences, Professor of Surgery, 3333 California St., San Francisco, CA 94143-0443, Tel: 415-502-6045, FAX: 415-502-6052, EMAIL: hdebas@globalhealth.ucsf.edu

*DECKERS, PETER J, M.D., Professor of Surgery and Dean Emeritus, University of Connecticut School of Medicine, 263 Farmington Avenue, Farmington, CT 06030-1920, Tel: 860-679-2594, FAX: 860-679-1371, EMAIL: deckers@nso.uchc.edu

*DEEB, G. MICHAEL, M.D., Professor of Surgery, University of Michigan, 1500 E. Medical Center, 5144 Cardiovascular, Ann Arbor, MI 48109-5864, Tel: 734-936-4984, FAX: 734-764-2255, EMAIL: mdeeb@umich.edu

*DEITCH, EDWIN A, M.D., 185 South Orange, G-506, Newark, NJ 07103, Tel: 973-972-5045, FAX: 973-972-6803, EMAIL: edeitch@umdnj.edu

*DELANEY, JOHN P, M.D., Professor of Surgery Emeritus, University of Minnesota, 516 Delaware St. SE, Box 195, Minneapolis, MN 55455, Tel: 612-625-1621, FAX: 612-625-8496, EMAIL: delan001@umn.edu
*DELGUERCIO, LOUIS R.M., M.D., Retired Chief of Surgery, Westchester Medical Center; Professor and Chairman of Surgery Emeritus, New York Medical College, Department of Surgery, Valhalla, NY 10595, Tel: 914-834-8265, FAX: 914-993-4359, EMAIL: lou@delguercio.com

*DELLINGER, E. PATCHEN, M.D., Professor of Surgery; Vice-Chairman, Department of Surgery; Chief, General Surgery Division; Associate Medical Director, University of Washington Medical Center, Department Surgery, Box 35-6410, Seattle, WA 98195, Tel: 206-543-3682, FAX: 206-543-8136, EMAIL: patch@u.washington.edu

*DELMONICO, FRANCIS L, M.D., Professor of Surgery, Harvard Medical School, Emeritus Director, Renal Transplantation, Massachusetts General Hospital; Medical Director, New England Organ Bank, 55 Fruit Street, Surgery, Boston, MA 02114-2696, Tel: 617-726-2825, FAX: 617-726-9229, EMAIL: francis_delmonico@neob.org

DEMATTEO, RONALD P, M.D., Vice Chair, Department of Surgery, Chief Division of General Surgical Oncology. Director, General Surgical Oncology Fellowship Program Memorial Hospital for Cancer and Allied Diseases, Memorial Sloan Kettering Cancer Center, 1275 York Ave., Box 203, New York, NY 10065, Tel: 212-639-3976, FAX: 212-639-4031, EMAIL: dematter@mskcc.org

*DEMEESTER, TOM R, M.D., Professor and Chairman, Department of Surgery, University of Southern California School of Medicine, 1510 San Pablo St, #514, Los Angeles, CA 90033-4612, Tel: 323-442-5925, FAX: 323-442-5872, EMAIL: tdemeester@surgery.usc.edu

DEMETRIADES, DEMETRIOS, M.D., Professor of Surgery, Director of Trauma, Emergency Surgery and Surgical Critical Care, University of Southern California School of Medicine, 216 Jameson Court, Sierra Madre, CA 91024, Tel: 323-226-7761, FAX: 323-226-6238, EMAIL: demetria@usc.edu

*DEMETRIOU, ACHILLES A, M.D., Chairman, Department of Surgery, Cedars-Sinai Medical Center; Professor of Surgery, UCLA School of Medicine, 11100 Euclid Ave., Lakeside 1027, Cleveland, OH 44106, Tel: 216-844-7951, FAX: 216-844-3276, EMAIL: achilles.demetriou@uhhospitals.org

DEMPSEY, DANIEL T, M.D., Professor and Chairman of Surgery, Temple University, 1100 Stratford Avenue, Melrose Park, PA 19027, Tel: 215-707-5080, FAX: 215-707-1915, EMAIL: daniel.dempsey@tuhs.temple.edu
*DEMUTH, WILLIAM E, JR, M.D., Professor Emeritus of Surgery, Pennsylvania State University, 1 Longsdorf Way, Carlisle, PA 17015-7623, Tel: 717-249-3116

*DENT, THOMAS L, M.D., Emeritus Chair, Department of Surgery, Abington Memorial Hospital, 505 Owen Road, Santa Barbara, CA 93108-1839, Tel: 805-695-8643, FAX: 805-695-8653, EMAIL: tldent@cox.net

*DEPALMA, RALPH G, M.D., Professor of Surgery, Vice Chair Surgery, Associate Dean, Department of Veterans Affairs, 810 Vermont Ave. NW, Rm 111B, Washington, DC 20420, Tel: 202-273-8505, FAX: 202-273-9108, EMAIL: rgdepalma@mail.va.gov

DESCHAMPS, CLAUDE, M.D., 200 First St. SW, MA12-45W, Rochester, MN 55905, Tel: 507-284-8462, FAX: 507-284-0058, EMAIL: deschamps.claude@mayo.edu

*DESCHENES, LUC L, M.D., Emeritus Professor, Department of Surgery, Laval University, 16, Jardins Merici, Apt. 741, Quebec, Quebec G1S 4V9, Canada, Tel: 418-658-3534, FAX: 514-873-1369, EMAIL: luc.deschenes009@sympatico.ca

*DEVENEY, CLIFFORD W, M.D., Professor and Chief, Division of General Surgery, Oregon Health Sciences University, 3181 SW Sam Jackson Pk Rd., L223A, Portland, OR 97201, Tel: 503-494-9145, FAX: 503-494-8884, EMAIL: deveneyc@ohsu.edu

*DEVENEY, KAREN E, M.D., Professor of Surgery, Program Director in Surgery, Oregon Health & Science University, 3181 SW Sam Jackson Park Rd., Portland, OR 97239, Tel: 503-494-7344, FAX: 503-494-5615, EMAIL: deveneyk@ohsu.edu

*DEWEESE, JAMES A, M.D., 78 Winding Creek Lane, Rochester, NY 14625, Tel: 716-248-9412, EMAIL: deweesejnj@aol.com

*DIETHELM, ARNOLD G, M.D., Professor Emeritus, Department of Surgery, University of Alabama School of Medicine, 500 22nd St., South, Birmingham, AL 35233, Tel: 205-934-5200, FAX: 205-731-9250, EMAIL: arnold.diethelm@ccc.uab.edu

DISESA, VERDI J, M.D., Clinical Professor of Surgery, University of Pennsylvania School of Medicine; Chair, Department of Surgery, University Hospital, Dubai, 526 S. Sydbury Lane, Wynnewood, PA 19096, Tel: 484-343-2849, FAX: 610-642-5902, EMAIL: verdi.disesa@gmail.com
*DOBELL, ANTHONY R.C., M.D., Professor Emeritus, Department of Surgery, Royal Victoria Hospital, 687 Pine Ave. W, S845, Montreal, Quebec H3A 1A1, Canada, Tel: 514-843-1519, FAX: 514-843-1602, EMAIL: dobell@polyinter.com

*DOBERNECK, RAYMOND C, M.D., Professor Emeritus, University of New Mexico, 1516 Plaza Encantada NM, Albuquerque, NM 87107, Tel: 505-345-3897

*DOBYNS, BROWN M, M.D., Professor of Surgery Emeritus, Case Western Reserve University, 9930 Kirtland Road, Chardon, OH 44024, Tel: 440-286-9680, FAX: 440-286-9680

DOHERTY, GERARD M, M.D., NW Thompson Professor of Surgery; Section Head, General Surgery, University of Michigan, 2920 Taubman Center, 1500 E. Medical Center, Ann Arbor, MI 48109-5331, Tel: 734-615-4741, FAX: 734-936-5830, EMAIL: gerardd@umich.edu

*DONAHOE, PATRICIA K, M.D., Director, Pediatric Surgical Research Laboratories, Marshall K. Bartlett Professor of Surgery, Massachusetts General Hospital, 185 Cambridge St., CPZN 6206, Boston, MA 02114, Tel: 617-724-1600, FAX: 617-726-5057, EMAIL: donahoe.patricia@mgh.harvard.edu

*DONAHUE, PHILIP E, M.D., Professor, University of Illinois at Chicago; Chairman, Division of General Surgery, Cook County Hospital, 1226 N. Belleforte Ave., Oak Park, IL 60302, Tel: 312-864-5256, EMAIL: phil@eolas.net

DONOHUE, JOHN H, M.D., Professor of Surgery, Mayo Clinic, 200 First Street SW, Rochester, MN 55905, Tel: 507-284-0362, FAX: 507-284-5196, EMAIL: donohue.john@mayo.edu

*DONOVAN, ARTHUR J, M.D., Emeritus Professor of Surgery, Keck School of Medicine, USC, P.O. Box 94475, Pasadena, CA 91109-4475, Tel: 626-577-8190, FAX: 626-577-8190, EMAIL: adonovan@sbcglobal.net

*DOTY, DONALD B, M.D., Clinical Professor of Surgery, University of Utah School of Medicine; Chief, Department Surgery LDS Hospital, 1998 East Maplehollow Dr., Bountiful, UT 84010, Tel: 801-298-8407, FAX: 801-408-1086, EMAIL: donald.doty@intermountainmail.org

*DOWNS, ALLAN R, M.D., Emeritus, Faculty of Medicine, University of Manitoba, 309 Kelvin Blvd., Winnipeg, Manitoba R3P 0J1, Canada, Tel: 204-787-7857, FAX: 204-787-4837, EMAIL: allandowns@hotmail.com
*DOZOIS, ROGER R, M.D., Professor of Surgery, Emeritus, Mayo Clinic, 9032 Rocky Lake Ct, Sarasota, FL 34238, Tel: 507-284-2644, FAX: 507-284-1794, EMAIL: cmrdozois@aol.com

DREBIN, JEFFREY A, M.D., Professor and Chief, Section of GI Hospital of the University of Pennsylvania, 3400 Spruce St., Silverstein 4, Philadelphia, PA 19104, Tel: 215-662-2165, FAX: 215-349-8195, EMAIL: jeffrey.drebin@uphs.upenn.edu

*DRUCKER, WILLIAM R, M.D., Professor of Surgery, Emeritus, USUHS School of Medicine, D-319 Given Building, Burlington, VT 05405-0068, Tel: 802-899-5171, FAX: 802-899-5171, EMAIL: wdrucker@usuhs.mil

*DUDRICK, STANLEY J, M.D., Program Director Emeritus and Chairman Emeritus of Surgery, Saint Mary’s Hospital/Yale Affiliate; Professor of Surgery,Yale University Medical School, 56 Franklin St., Waterbury, CT 06706, Tel: 203-709-6314, FAX: 203-709-5877, EMAIL: sdudrick@stmh.org

*DUFF, JOHN H, M.D., Professor, Department of Surgery, University of Western Ontario University Hospital, 1092 St. Anthony Road, London, Ontario N6H 2P6, Canada, Tel: 519-663-2923, FAX: 519-663-3906, EMAIL: jduff1@julian.uwo.ca

DUH, QUAN-Y ANG, M.D., Professor, University of California, San Francisco Surgical Service, Department of Surgery, V.A. Medical Center, 4150 Clement St., Surgery (112), San Francisco, CA 94121, Tel: 415-750-2131, FAX: 415-750-2181, EMAIL: quan-ang.duh@med.va.gov

DULCHA VSKY, SCOTT A, M.D., Wayne State University, 2799 W. Grand Blvd., Surgery K8, Detroit, MI 48202, Tel: 313-916-3037, FAX: 313-916-9445, EMAIL: sdulcha1@hfhs.org

*DUMONT, ALLAN E, M.D., Emeritus Professor of Surgery, New York University, Clinical Professor of Surgery, University of Connecticut School of Medicine, 7 Alpine Court, Orono, ME 04473, Tel: 207-866-4963

DUNN, DAVID L, M.D., Ph.D., Vice President for Health Sciences, University of Buffalo, 201 Harriman Hall, 3435 Main St., Buffalo, NY 14214-8025, Tel: 612-626-1999, FAX: 612-626-0654, EMAIL: dldunn@buffalo.edu

DUNNINGTON, GARY L, M.D., Professor and Chairman of Surgery, Southern Illinois University School of Medicine, P.O. Box 19638, Springfield, IL 62794-9638, Tel: 217-545-8880, FAX: 217-545-8827, EMAIL: gdunnington@siu.edu
DURANCEAU, ANDRE C.H., M.D., Professor of Surgery; Chair, Thoracic Surgery Program and Thoracic Surgery Division, Universite de Montreal, 1560 Sherbrooke Est, Montreal, Quebec H2L 4M1, Canada, Tel: 514-890-8000, FAX: 514-412-7855, EMAIL: andre.duranceau@umontreal.ca

EASTER, DAVID W, M.D., Professor of Clinical Surgery, University of California, San Diego Medical Center, 200 W. Arbor Drive, San Diego, CA 92103-8401, Tel: 619-543-3225, FAX: 619-543-7785, EMAIL: deaster@ucsd.edu

EASTMAN, A. BRENT, M.D., Clinical Professor of Surgery, University of California, San Diego; N. Paul Whittier Chair of Trauma, Scripps Memorial Hospital; Chief Medical Officer, Scripps Memorial Hospital, 4275 Campus Point Court, San Diego, CA 92121, Tel: 619-626-6350, FAX: 858-678-6556, EMAIL: eastman.brent@scrippswell.org

EBERLEIN, TIMOTHY J, M.D., Bixby Professor and Chairman, Department of Surgery, Washington University School of Medicine, 660 So Euclid Ave., Box 8109, Saint Louis, MO 63110, Tel: 314-362-8020, FAX: 314-454-1898, EMAIL: eberlein@wustl.edu

ECKHAUSER, FREDERIC E, M.D., Professor of Surgery, Department of Surgery, Johns Hopkins Bayview Medical Center, 1230 Algonquin Rd., Crownsville, MD 21032, Tel: 410-502-0932, FAX: 410-502-1561, EMAIL: feckhau2@jhmi.edu

ECONOMOU, JAMES S, M.D., Professor and Chief, Division of Surgical Oncology, Professor of Microbiology, Immunology and Molecular Genetics, UCLA School of Medicine, 10833 LeConte Ave., 54-140 CHS, Los Angeles, CA 90095-1792, Tel: 310-825-2644, FAX: 310-825-7575, EMAIL: jeconomou@mednet.ucla.edu

EDGERTON, MILTON T, M.D., Alumni Professor of Plastic and Maxillofacial Surgery, University of Virginia, Health Sciences Center, Charlottesville, VA 22908, Tel: 804-924-5068, FAX: 804-924-1333

EDLICH, RICHARD E, M.D., Distinguished Professor Emeritus of Plastic Surgery and Biomedical Engineering, University of Virginia School of Medicine, 22500 NE 128 Circle, Brush Prairie, WA 98606, Tel: 503-690-7912, FAX: 503-690-8382, EMAIL: richardedlichmd@gmail.com
*EDMUNDS, L. HENRY, JR, M.D., Julian Johnson Professor of Cardiothoracic Surgery, University of Pennsylvania, 3440 Market St., Ste. 306, Philadelphia, PA 19104, Tel: 215-662-2092, FAX: 215-614-0416, EMAIL: hank.edmunds@uphs.upenn.edu

EDWARDS, MICHAEL J, M.D., Christian R. Holmes Professor & Chairman, University of Cincinnati, 231 Albert Sabin Way, SRU 1469, Cincinnati, OH 45267-0558, Tel: 513-558-5333, FAX: 513-558-2585, EMAIL: michael.edwards@uc.edu

*EDWARDS, WILLIAM H, SR M.D., H. William Scott Professor of Surgery Emeritus, Vanderbilt University Medical Center, 50 Concord Park East, Nashville, TN 37205-4705, Tel: 615-383-9085, FAX: 615-383-9116, EMAIL: wedwards1927@comcast.net

*EGDAHL, RICHARD H, M.D., Alexander Graham Bell Professor of Health Care Entrepreneurship; Boston University, 53 Bay State Rd., Boston, MA 02215, Tel: 617-353-4525, FAX: 617-353-6330, EMAIL: regdahl@bu.edu

EIDT, JOHN F, M.D., Professor of Surgery; Chief, Vascular Surgery University Hospital of Arkansas, 4301 W. Markham, Slot 520-2, Little Rock, AR 72205, Tel: 501-686-6176, FAX: 501-686-5328, EMAIL: eidtjohnf@uams.edu

*EILBER, FREDERICK R, M.D., Professor and Chief, Division of Surgical Oncology, UCLA School of Medicine, 10833 LeConte Ave., 54-140 CHS, Los Angeles, CA 90024, Tel: 310-825-7086, FAX: 310-825-7575, EMAIL: feilber@mednet.ucla.edu

*EISEMAN, BEN, M.D., Emeritus Professor of Surgery and Medicine, VA Distinguished Physician, University of Colorado Health Science Center, 2552 E. Alameda Ave. #07, Denver, CO 80209-3325, Tel: 303-399-8020, FAX: 303-315-8098, EMAIL: bernard.eisenmann@chru-strasbourg.fr

*EISENBERG, HOWARD M, M.D., Chairman and Professor, Department of Neurosurgery, University of Maryland, 22 So Green Street, Baltimore, MD 21201, Tel: 410-328-3514, FAX: 410-328-0756, EMAIL: heisenberg@surgery1.ah.umd.edu

*EISENBERG, M. MICHAEL, M.D., Professor of Surgery; Director of Surgical Education, Cornell University Medical Center, 525 E. 68th St., #F-1926, New York, NY 10021, Tel: 212-746-5439, FAX: 212-746-8440, EMAIL: meisenb798@worldnet.att.net
*ELKINS, RONALD C, M.D., Professor, Department of Surgery, Section of Thoracic Surgery, University of Oklahoma Health Science Center, P.O. Box 26901, Oklahoma City, OK 73190, Tel: 405-271-5789, FAX: 405-271-3288, EMAIL: ronald-elkins@ouhsc.edu

*ELLIS, F. HENRY, JR, M.D., Chief Emeritus, Division of Cardiothoracic Surgery, Clinical Professor of Surgery Emeritus, Harvard Medical School, Beth Israel Deaconess Hospital, 21 Fairmount Street, Brookline, MA 02445, Tel: 617-632-8383, FAX: 617-632-7562, EMAIL: slerman@bidmc.harvard.edu

ELLIS, LEE M, M.D., Professor of Surgery and Cancer Biology, William C. Liedtke, Jr. Chair in Cancer Research, University of Texas MD Anderson Cancer Center, P.O. Box 301429, Houston, TX 77030-1429, Tel: 713-792-6926, FAX: 713-792-6152, EMAIL: lellis@mdanderson.org

ELLISON, E. CHRISTOPHER, M.D., Associate Vice President for Health Sciences, Vice Dean of Clinical Affairs, Robert M. Zollinger Professor and Chair, Department of Surgery, The Ohio State University Medical Center, 395 W. 12th Ave., Room 670, Columbus, OH 43210, Tel: 614-293-8701, FAX: 614-293-3654, EMAIL: Christopher.ellison@osumc.edu

EMOND, JEAN C, M.D., Thomas S. Zimmer Professor of Surgery, Vice Chairman and Chief of Transplantation Services, College of Physicians & Surgeons of Columbia University, 622 West 168th St., PH14C, New York, NY 10031, Tel: 212-305-9691, FAX: 212-342-5600, EMAIL: je111@columbia.edu

*ENGELMAN, RICHARD M, M.D., Professor of Surgery, University of Connecticut School of Medicine; Clinical Professor of Cardiothoracic Surgery, Tufts University School of Medicine; Chief, Cardiac Surgical Research, Baystate Medical Center, 759 Chestnut St., Springfield, MA 01199, Tel: 413-794-5303, FAX: 413-794-4212, EMAIL: richard.engelman@bhs.org

*ENKER, WARREN E, M.D., Vice Chairman, Department of Surgery, Chief Colorectal Surgery; Chief of Surgical Oncology, Continuum Cancer Centers of New York; Professor of Surgery, Albert Einstein College of Medicine, Beth Israel Medical Center, 350 East 17th St., Department of Surgery, New York, NY 10003, Tel: 212-420-3960, FAX: 212-420-2846, EMAIL: wenker@chpnet.org
*ERNST, CALVIN B, M.D., Retired, 3904 N. Fairway Drive, Jupiter, FL 33477, Tel: 561-214-3580, FAX: 561-745-9489, EMAIL: cbernst@earthlink.net

*ESQUIVEL, CARLOS O, M.D., The Arnold and Barbara Silverman Professor of Pediatric Transplantation; Professor of Surgery and Chief, Division of Transplantation; Stanford University School of Medicine, 750 Welch Rd., #319, Palo Alto, CA 94304-1510, Tel: 650-498-5689, FAX: 650-498-5690, EMAIL: esquivel@stanford.edu

*ESSELSTYN, CALDWELL B, JR, M.D., Head, Section of Thyroid and Parathyroid Surgery, Cleveland Clinic Foundation, 9500 Euclid Ave., A-80, Cleveland, OH 44195-5043, Tel: 216-444-6662, FAX: 216-445-7653

*ETHEREDGE, EDWARD E, M.D., 1850 Mariposa Avenue, Bartow, FL 33830-7351, Tel: 863-534-1836, FAX: 863-534-3063, EMAIL: eebartow@cs.com

• EUBANKS, STEVE, M.D., Professor of Surgery, University of Missouri Health Center, One Hospital Drive, Room M580, Columbia, MO 65212, Tel: 573-882-4158, FAX: 573-884-4585, EMAIL: eubankssw@health.missouri.edu

EVANS, DOUGLAS B, M.D., Ausman Family Foundation Professor of Surgery, Chairman, Department of Surgery, Medical College of Wisconsin, 9200 W. Wisconsin Ave., #3510, Milwaukee, WI 53226-3596, Tel: 414-805-5706, EMAIL: devans@mcw.edu

EVANS, STEPHEN R.T., M.D., Vice President for Medical Affairs and Chief Medical Officer, Georgetown University Hospital, 3800 Reservoir Rd. NW, 4th Flr, PHC, Washington, DC 20007, Tel: 202-444-9731, FAX: 202-444-7987, EMAIL: sevans02@gunet.georgetown.edu

EVERS, B. MARK, M.D., Director, Endowed Chair, Markey Cancer Center, Professor and Vice-Chair for Research, Department of Surgery, Physician-in-Chief, Oncology Service Line, University of Kentucky, 800 Rose Street, CC140, Lexington, KY 40536-0093, Tel: 859-323-6542, FAX: 859-323-2074, EMAIL: mark.evers@uky.edu

*FABER, L. PENFIELD, M.D., Professor of Surgery and Vice-Chairman, Department of Cardiovascular/Thoracic Surgery, Rush University Medical Center, 1725 W. Harrison, Ste. 774, Chicago, IL 60612, Tel: 312-738-3732, FAX: 312-738-9763, EMAIL: pfaber@rush.edu
*FABIAN, TIMOTHY C, M.D., Professor and Deputy Chairman of Surgery; Director of Trauma, University of Tennessee, 956 Court Ave., Rm G228, Memphis, TN 38163, Tel: 901-448-5914, FAX: 901-448-7689, EMAIL: tfabian@utmem.edu

*FABRI, PETER J, M.D., Ph.D., Chief, Surgical Service and Program Director Division of General Surgery, Associate Dean for Clinical Affairs, James A. Haley V.A. Medical Center, 12901 Bruce B Downs Blvd., MDC Bx 41, Tampa, FL 33612, Tel: 813-974-9744, FAX: 813-974-8359, EMAIL: pfabri@health.usf.edu

*FAHEY, THOMAS J, III, M.D., Professor of Surgery, Chief Division of Endocrine Surgery, NY Presbyterian Hospital-Weill Cornell Medical Center, 525 E. 68th St., Rm F2024, Surgery, New York, NY 10065, Tel: 212-746-5130, FAX: 212-746-8771, EMAIL: tfahey@med.cornell.edu

FAIRMAN, RONALD M, M.D., 3400 Spruce St., 4 Silverstein, Philadelphia, PA 19104, Tel: 215-614-0243, FAX: 215-662-4871, EMAIL: ron.fairman@uphs.upenn.edu

FALLAT, MARY E, M.D., Hirikati S. Nagaraj Professor, Department of Surgery, University of Louisville; Director, Division of Pediatric Surgery, Chief of Surgery, Kosair Children’s Hospital, 315 E. Broadway, #565, Louisville, KY 40202, Tel: 502-629-8638, FAX: 502-583-9735, EMAIL: mefall01@louisville.edu

FARMER, DIANA L, M.D., Professor & Chief, Pediatric Surgery, Surgeon-in-Chief, UCSF Children’s Hospital, 513 Parnassus Ave., Rm HSW-1601, San Francisco, CA 94143-0570, Tel: 415-502-7387, FAX: 415-476-2314, EMAIL: diana.farmer@ucsfmedctr.org

*FARNELL, MICHAEL BROWNING, M.D., 200 First St. SW, Rochester, MN 55905, Tel: 507-284-2717, FAX: 507-284-5196, EMAIL: mfarnell@mayo.edu

*FAZIO, VICTOR W, M.D., Cleveland Clinic; Chairman, Digestive Disease Institute, Rupert B. Turnbull Jr. Chair, Emeritus Chairman, Department of Colorectal Surgery, Professor of Surgery, Lerner College of Medicine, CWRU, 9500 Euclid Avenue, A-30, Cleveland, OH 44195, Tel: 216-444-6673, FAX: 216-445-8627, EMAIL: faziov@ccf.org
AMERICAN SURGICAL ASSOCIATION

*FELICIANO, DAVID V, M.D., Surgeon-in-Chief, Grady Memorial Hospital; Adjunct Professor of Surgery, Uniformed Services University of Health Sciences; Professor of Surgery, Emory University School of Medicine, 69 Jesse Hill Jr., Drive, SE, #304, Atlanta, GA 30303, Tel: 404-616-5456, FAX: 404-616-7333, EMAIL: dfelici@emory.edu

FERGUSON, MARK K, M.D., Professor of Surgery, 5841 S. Maryland, MC-5035, Chicago, IL 60637, Tel: 773-702-3551, FAX: 773-702-2642, EMAIL: mferguso@surgery.bsd.uchicago.edu

*FERGUSON, RONALD M, M.D., Professor and Chairman, Department of Surgery, Ohio State University, 30 Pickett Place, New Albany, OH 43054, Tel: 614-293-6322, FAX: 614-293-4541, EMAIL: rfergus@insight.rr.com

FERGUSON, T. BRUCE, JR, M.D., Professor and Vice Chair, Division of CT Surgery; Chief, Division of Clinical Effectiveness, Department of Surgery Brody School of Medicine at ECU, Department of CV Sciences, 115 Heart Drive, Greenville, NC 27834, Tel: 252-744-5232, FAX: 252-744-5233, EMAIL: Fergusont@ecu.edu

*FERGUSON, THOMAS B, M.D., Professor of Surgery, Division of Cardiothoracic Surgery, Washington University School of Medicine, Barnes Hosp, 3108 Queeny Twr, St. Louis, MO 63110, Tel: 314-362-7256, FAX: 314-367-0585, EMAIL: ats@wustl.edu

FERRARA, JOHN J, M.D., Program Director, Phoenix Integrated Surgical Residency, 925 East McDowell, Phoenix, AZ 85006, Tel: 602-239-2282, FAX: 602-495-9112, EMAIL: john.ferrara@bannerhealth.com

FESSLER, RICHARD G, M.D., Ph.D., 676 N. St. Clair Ave., #2210, Chicago, IL 60611, EMAIL: rfessler@nmff.org

*FILLER, ROBERT M, M.D., Professor of Surgery & Pediatrics, University of Toronto; Medical Director, External Affairs, Hospital for Sick Children, 555 University Ave., #1518, Toronto, Ontario M5G 1X8, Canada, Tel: 416-813-8922, FAX: 416-813-6011, EMAIL: robert.filler@sickkids.ca

*FILSTON, HOWARD C, M.D., Professor of Pediatric Surgery & Pediatrics, Chief, Pediatric Surgery and Pediatric Trauma, Vice Chairman, Department of Surgery, University of Tennessee Medical Center at Knoxville, 1924 Alcoa Hwy, Box U11, Knoxville, TN 37920-6999, Tel: 423-544-9232, FAX: 423-544-6898, EMAIL: hfilston@utmem.edu
*FINK, MITCHELL P, M.D., Chief, Critical Care Medicine; Professor of Surgery, Anesthesiology and Critical Care Medicine, University of Pittsburgh Medical Center, 200 Lothrop St. Department of Critical Care Med, Pittsburgh, PA 15213, Tel: 412-647-3136, FAX: 412-647-5258, EMAIL: finkmp@anes.upmc.edu

*FINLEY, RICHARD J, M.D., Head, Division of Thoracic Surgery, University of British Columbia, 910 West 10th Ave., Rm 3100, Vancouver, British Columbia V5Z 4E3, Canada, Tel: 604-875-4150, FAX: 604-875-4036, EMAIL: rjfinley@shaw.ca

*FINLEY, ROBERT K, JR, M.D., Clinical Professor of Surgery, Wright State University School of Medicine, 4045 Middletown Rd., Oregonia, OH 45054, Tel: 513-897-5756, FAX: 513-897-5756, EMAIL: rfinley1998@yahoo.com

*FIORE, ANDREW C, M.D., Professor of Surgery; Director of Pediatric Cardiac Surgery, St. Louis University School of Medicine, 1465 South Grand Boulevard, St. Louis, MO 63104-1095, Tel: 314-268-4180, FAX: 314-577-5313, EMAIL: fiorem2@slu.edu

*FISCHER, JOSEF E, M.D., Chairman, Department of Surgery, Beth Israel Deaconess Medical Center, 1135 Tremont St., #511–512, Boston, MA 02120, Tel: 617-754-9242, FAX: 617-754-9230, EMAIL: jfische1@bidmc.harvard.edu

*FISCHER, RONALD P, M.D., Professor of Surgery, University of Texas Medical School at Houston, Lyndon B. Johnson General Hospital, 801 Holly Ridge, Houston, TX 77024, Tel: 713-636-5095, FAX: 713-636-4583, EMAIL: fischerronald@hotmail.com

*FISH, JAY C, M.D., University of Texas Medical Branch, P.O. Box 1010, Woodville, TX 75979-1010, Tel: 409-762-4074, FAX: 409-763-8008

*FISHER, BERNARD, M.D., Distinguished Service Professor, University of Pittsburgh School of Medicine, 5636 Aylesboro Ave., Pittsburgh, PA 15217, Tel: 412-802-8700, FAX: 412-802-8707, EMAIL: fisherb2@upmc.edu

*FISHERMAN, STEVEN J, M.D., Senior Associate in Surgery, Children’s Hospital, 300 Longwood Avenue, Fegan 3, Boston, MA 02115, Tel: 617-355-3040, FAX: 617-730-0752, EMAIL: steven.fishman@childrens.harvard.edu
AMERICAN SURGICAL ASSOCIATION

*FITZGIBBONS, ROBERT J, JR, M.D., Dr. Harry E. Stuckenhoff Endowed Professor of Surgery; Chief, Division of General Surgery, Creighton University, 601 North 30th St., #3700, Omaha, NE 68131, Tel: 402-280-4503, FAX: 402-280-4851, EMAIL: fitzjr@creighton.edu

*FLAMM, EUGENE S, M.D., Professor & Chairman, Department of Neurosurgery, Albert Einstein College of Medicine; Department of Neurosurgery, Beth Israel Hospital North, 170 East End Ave., New York, NY 10128

FLESHMAN, JAMES W, M.D., Professor of Surgery, Chief of Section of Colon and Rectal Surgery, Washington University in St. Louis, 660 So Euclid, Box 8109, #1402 QT, St. Louis, MO 63110, Tel: 314-454-7183, FAX: 314-454-5249, EMAIL: fleshmanj@wustl.edu

*FLETCHER, WILLIAM S, M.D., Hugh & Georgeina Hedinger Professor of Surgical Oncology, Oregon Health Sciences University, 1600 SW 88th Avenue, Portland, OR 97225, Tel: 503-292-2375, EMAIL: fletcherws@aol.com

*FLINT, LEWIS M, JR, M.D., Editor-in-Chief, Selected Readings in General Surgery Division of Education, American College of Surgeons, 633 North St. Clair Street, Chicago, IL 60611-3211, Tel: 312-202-5224, FAX: 312-202-5203, EMAIL: LFlint@facs.org

FLUM, DAVID R, M.D., Professor of Surgery; Adjunct Professor Health Services, University of Washington Medical Center, 1959 NE Pacific St., Box 356410, Seattle, WA 98195-6410, Tel: 206-616-5440, FAX: 206-543-8136, EMAIL: daveflum@u.washington.edu

*FLYE, M. WAYNE, M.D., Professor of Surgery, Molecular Microbiology and Immunology, Washington University School of Medicine, Suite 5103 Queeney Tower, St. Louis, MO 63110, Tel: 314-362-7145, FAX: 314-454-3923, EMAIL: flyew@msnotes.wustl.edu

*FLYNN, TIMOTHY C, M.D., Professor, Department of Surgery, University of Florida. Associate Dean for Graduate Medical Education, Shands University of Florida, P.O. Box 100128, Gainesville, FL 32610, Tel: 352-265-0152, FAX: 352-265-8966, EMAIL: flynn@surgery.ufl.edu

*FOGARTY, THOMAS J, M.D., Professor of Surgery, Stanford University Medical Center, 3270 Alpine Rd., Portola Valley, CA 94028, Tel: 650-854-1822, FAX: 650-854-2778, EMAIL: tjl@fogartybusiness.com
FOKER, JOHN E, M.D., Professor of Surgery, University of Minnesota, 420 Delaware St., SE, MMC-495, Minneapolis, MN 55455, Tel: 612-625-0910, FAX: 612-625-4106, EMAIL: foker001@umn.edu

FOLK, FRANK A, M.D., Professor Emeritus of Surgery, Loyola University; Consultant Surgery, V.A. Hospital, 446 South Columbia, Naperville, IL 60540-5418, Tel: 708-202-2036, FAX: 708-216-2180, EMAIL: fafolk@aol.com

FOLSE, J. ROLAND, M.D., Emeritus Professor and Chairman, Southern Illinois University School of Medicine, Department of Surgery, 2 Virginia Lane, Springfield, IL 62712, Tel: 217-782-8880, FAX: 217-524-1793, EMAIL: rfolse@sbcglobal.net

FONG, YUMAN, M.D., Murray F. Brennan Chair in Surgery, Memorial Sloan-Kettering Cancer Center; Professor of Surgery, Cornell University Medical College, 1275 York, New York, NY 10021, Tel: 212-639-7119, FAX: 646-422-2358, EMAIL: fongy@mskcc.org

FONKALSRUD, ERIC W, M.D., Emeritus Professor and Chief of Pediatric Surgery, UCLA School of Medicine, 428 24th Street, Santa Monica, CA 90402, Tel: 310-825-6712, FAX: 310-794-9462, EMAIL: efonkalsrud@mednet.ucla.edu

FORD, HENRI R, M.D., Vice-President and Surgeon-in-Chief, Children’s Hospital Los Angeles; Professor of Surgery and Vice Chair, University of Southern California/Keck School of Medicine, 4650 Sunset Blvd., Mailstop #72, Los Angeles, CA 90027, Tel: 323-361-2104, FAX: 361-664-8678, EMAIL: hford@chla.usc.edu

FORDE, KENNETH A, M.D., Jose M. Ferrer Professor Emeritus of Surgery, Columbia University College of Physicians and Surgeons, Department of Surgery, P.O. Box 307, MHB 7SK, Scarborough, NY 10510, Tel: 212-305-2735, FAX: 212-305-3236, EMAIL: kaf2@columbia.edu

FORSE, R. ARMOUR, M.D., Lempka Professor and Chairman, Department of Surgery, Creighton University Medical Center, 601 No 30th St., #3700, Surgery Department, Omaha, NE 68131, Tel: 402-280-5292, FAX: 402-280-4540, EMAIL: armour.forse@creighton.edu

FOSTER, ROGER S, JR, M.D., Glenn Professor of Surgery Retired, Emory University, 395 Stevenson Road, New Haven, CT 06515, Tel: 203-389-3309, EMAIL: halirock@aol.com
FOX, IRA J, M.D., University of Nebraska Medical Center, 45th Street and Penn Avenue, 6130FP, Pittsburgh, PA 15201, Tel: 412-692-6693, FAX: 412-692-6599, EMAIL: foxi@upmc.edu

FRAKER, DOUGLAS L, M.D., Hospital of the University of Pennsylvania, 3400 Spruce Street, 4 Silverstein, Philadelphia, PA 19104, Tel: 215-662-7866, FAX: 215-662-3629, EMAIL: frakerd@uphs.upenn.edu

FRASER, CHARLES D, M.D., Professor of Surgery and Pediatrics, Baylor College of Medicine, Co-Director, Congenital Heart Surgery at Texas Heart Institute. The Donovan Chair Chief, Congenital Heart Surgery, Texas Children’s Hospital, 6621 Fannin, WT19345H, Houston, TX 77030-2399, Tel: 832-826-1929, FAX: 832-825-1905, EMAIL: charlesf@bcm.tmc.edu

*FRAZIER, O. HOWARD, M.D., Professor of Surgery, University of Texas Medical School, Clinical Professor of Surgery, Chief of Cardiopulmonary Transplantation, Baylor College of Medicine, P.O. Box 20345 MC 2114A, Houston, TX 77225-0345, Tel: 832-355-3000, FAX: 823-355-6798, EMAIL: lschwenke@heart.thi.tmc.edu

*FREEMAN, HAROLD P, M.D., President and Chief Executive Officer, North General Hospital, 1919 Madison Avenue, New York, NY 10035, Tel: 212-987-1777, FAX: 212-987-1776, EMAIL: hfreeman@mail.nih.gov

FREISCHLAG, JULIE ANN, M.D., William Stewart Halsted Professor of Surgery, Johns Hopkins University School of Medicine, 720 Rutland Ave., Ross 759, Baltimore, MD 21205, Tel: 443-287-3497, FAX: 443-287-3500, EMAIL: jfreisc1@jhmi.edu

FREISE, CHRIS E, M.D., 505 Parnassus Ave., Rm., M-896, Box 0780, San Francisco, CA 94143-0780, Tel: 415-353-1898, FAX: 415-353-8709, EMAIL: chris.freise@ucsfmedctr.org

FREMES, STEPHEN EDWARD, M.D., 2075 Bayview Ave., #H-Wing Room 410, Toronto, Ontario M4N 3M5, Canada, Tel: 416-480-6073, FAX: 416-480-6072, EMAIL: stephen.fremes@sunnybrook.ca

*FREY, CHARLES F, M.D., Emeritus Professor and Executive Vice Chairman, Department of Surgery, University of California, Davis Medical Center, 2351 Green Springs Ct., Rescue, CA 95672, Tel: 530-677-9770, FAX: 530-677-8100, EMAIL: cffreynd@pacbell.net
FRIED, GERALD M, M.D., Professor of Surgery and Adair Chair of Surgical Education, McGill University; Steinberg-Bernstein Chair of Minimally Invasive Surgery & Innovation, McGill University Health Centre, 1650 Cedar Ave., Rm L9-309, Montreal, Quebec H3G 1A4, Canada, Tel: 514-934-8044, FAX: 514-934-8438, EMAIL: gerald.fried@mcgill.ca

*FRIEDMANN, PAUL, M.D., Professor Emeritus of Surgery, Tufts University School of Medicine, Past Chairman, Department of Surgery, Baystate Medical Center; Executive Director, Pioneer Valley Life Sciences Institute, 3601 Main Street, Springfield, MA 01199, Tel: 413-794-0653, FAX: 413-794-0643, EMAIL: paul.friedmann@bhs.org

*FROMM, DAVID G, M.D., Penberthy Professor and Chairman Emeritus, Department of Surgery, Wayne State University, University Health Center, P.O. Box 750, Occidental, CA 95465, Tel: 707-874-2585, FAX: 707-874-2584, EMAIL: dfsurg@aol.com

*FRY, DONALD E, M.D., Executive Vice President, Michael Pine and Associates, 5020 S. Lake Shore Dr., #304N, Chicago, IL 60615, Tel: 773-643-1700, FAX: 773-643-6601, EMAIL: dfry@consultmpa.com

*FRY, ROBERT D, M.D., Chairman, Department of Surgery, Pennsylvania Hospital; Chief, Division of Colon and Rectal Surgery, UPHS, 301 South 8th St., Ste. 4D, Philadelphia, PA 19106, Tel: 215-662-2664, FAX: 215-662-3118, EMAIL: robert.fry@uphs.upenn.edu

FULLERTON, DAVID A, M.D., Professor of Surgery; Chief, Division of Cardiothoracic Surgery, University of Colorado Hospital, 12631 E. 17th Ave., Box 6511, Aurora, CO 80045, Tel: 303-724-2798, FAX: 303-724-2806, EMAIL: david.fullerton@ucdenver.edu

FUNG, JOHN J, M.D., Professor of Surgery; Chairman, Department of HPB/Transplant Surgery; Chairman, Department of General Surgery; Director, Transplant Center; Cleveland Clinic, 9500 Euclid Ave., A100, Cleveland, OH 44195, Tel: 216-444-3776, FAX: 216-444-2153, EMAIL: fungj@ccf.org

GABER, AHMED OSAMA, M.D., 6550 Fannin Street, Ste. SM1661A, Houston, TX 77030, Tel: 713-441-6170, FAX: 713-790-6839, EMAIL: aogaber@tmhs.org

*GADACZ, THOMAS R, M.D., Professor Emeritus, Medical College of Georgia, 5353 Gulf Blvd., A-201, St. Petersburg, FL 33706, Tel: 727-360-8030, EMAIL: thomasgadacz@yahoo.com
GALANDIUK, SUSAN, M.D., Professor of Surgery, Program Director, Section of Colon & Rectal Surgery, University of Louisville, 550 So Jackson, Department Surgery, Louisville, KY 40202, Tel: 502-852-4568, FAX: 502-852-8915, EMAIL: sgala01@gwise.louisville.edu

GALLOWAY, AUBREY C, JR, M.D., Seymour Cohn Professor & Chairman, Department of Cardiothoracic Surgery, NYU School of Medicine, 530 First Ave., #9V, New York, NY 10016, Tel: 212-263-7185, FAX: 212-263-2042, EMAIL: galloway@cv.med.nyu.edu

*GAMELLI, RICHARD L, M.D., Dean Stritch School of Medicine and Robert J. Freeark Professor of Surgery, Loyola University Medical Center; Chief, Burn Center; Director, Burn & Shock Trauma Institute, Stritch School of Medicine, Rm 428, Maywood, IL 60153, Tel: 708-327-2240, FAX: 708-327-2852, EMAIL: rgamell@lumc.edu

*GANN, DONALD S, M.D., Professor and Executive Vice-Chairman, Department of Surgery, University of Maryland School of Medicine, 1127 Greenspring Valley Rd., Lutherville, MD 21093-3611, Tel: 341-321-1548, FAX: 410-321-1027, EMAIL: dsgann@verizon.net

*GARDNER, BERNARD, M.D., Professor Emeritus, Surgery, New Jersey Medical School UMDNJ, 300 Venice Golf Club Drive, Venice, FL 34292, Tel: 941-492-5298, FAX: 941-492-2989, EMAIL: mdbg10012@comcast.net

*GARDNER, TIMOTHY J, M.D., Medical Director, Center for Heart & Vascular Health, Christiana Care Health System, 4755 Ogletown-Stanton Rd., Ste. 1003, Newark, DE 19718, Tel: 302-733-1241, FAX: 302-733-1429, EMAIL: tgardner@christianacare.org

*GARRISON, R. NEAL, M.D., Professor, University of Louisville, 550 So Jackson St., Surgery, Louisville, KY 40202, Tel: 502-852-5675, FAX: 502-852-8915, EMAIL: rngarr01@gwise.louisville.edu

*GASPAR, MAX R, M.D., Clinical Professor Emeritus of Surgery, University of Southern California, 1780 St. John Road, #48-C, Seal Beach, CA 90740, Tel: 562-799-3318, FAX: 562-429-0807, EMAIL: mgaspar@usc.edu

*GAY, WILLIAM A, JR, M.D., Professor of Surgery, Washington University School of Medicine, Division of Cardiothoracic Surgery, 1 Barnes Hosp Pl, 3108 Queeney Twr, St. Louis, MO 63110, Tel: 314-747-1315, FAX: 314-367-8459, EMAIL: gayw@wustl.edu
*GEHA, ALEXANDER S, M.D., Professor & Chief Emeritus, Cardiothoracic Surgery, University of Illinois Medical Center at Chicago; Professor of Cardiothoracic Surgery, University of California San Diego Medical Center, P.O. Box 1693, Rancho Santa Fe, CA 92067-1693, Tel: 858-759-8891, FAX: 858-552-7590, EMAIL: ageha@uic.edu

♦ GELLER, DAVID A, M.D., Richard L. Simmons Professor of Surgery, Co-Director UPMC Liver Cancer Center, UPMC Montefiore Hospital 7S: 3459, 5th Ave., Pittsburgh, PA 15213, Tel: 412-692-2001, FAX: 412-692-2002, EMAIL: gellerda@upmc.edu

*GEORGESON, KEITH, M.D., Professor of Surgery; Chief, Division of Pediatric Surgery, Children's Hospital, 1600 7th Ave. South, Birmingham, AL 35233, Tel: 205-939-9688, FAX: 205-975-4972, EMAIL: keith.georgeson@ccc.uab.edu

*GEWERTZ, BRUCE L, M.D., Surgeon-in-Chief and Chairman, Department of Surgery; Vice President for Interventional Services, Cedars-Sinai Medical Center, 8300 Beverly Blvd., N. Tower, Ste. 8215, Los Angeles, CA 90048, Tel: 310-423-5884, FAX: 310-423-0231, EMAIL: bruce.gewertz@cshs.org

GHOBRIAL, R. MARK, M.D., Ph.D., Professor of Surgery, Division of Liver and Pancreas Transplantation, David Geffen School of Medicine at UCLA. Service Director, Liver, Pancreas & Small Bowel Transplantation; Surgical Director, Pancreas Transplantation; Director, Living Donor Liver Transplantation, The Methodist Hospital, 6550 Fannin St., SM 1661, Houston, TX 77030, Tel: 713-441-6935, FAX: 713-793-7151, EMAIL: RMGhobrial@tmhs.org

GIBRAN, NICOLE S, M.D., Professor of Surgery; Attending Surgeon; Director of the University of Washington Burn Center, 325 Ninth Avenue, Mailbox 359796, Seattle, WA 98104, EMAIL: nicoleg@u.washington.edu

*GILLESPIE, ROBERT W, M.D., Clinical Professor of Surgery, Medical Director, Burn Center, Clarkson Hospital, University Hospital, Nebraska Health System, 13625 East County Line, Longmont, CO 80504, Tel: 303-485-0615, EMAIL: bgburndoc@aol.com

GITTES, GEORGE K, M.D., Thomas Holder and Keith Ashcraft Chair of Pediatric Surgical Research; Associate Prof., University of Missouri at Kansas City; Dir., Surgical Research, Children’s Mercy Hospital, Division of Pediatric Surgery; Director, Laboratory for Surgical Organogenesis, 3705 Fifth Avenue, Pittsburgh, PA 15213, Tel: 412-692-7291, EMAIL: george.gitesse@chp.edu
*GIULIANO, ARMANDO E, M.D., Clinical Professor of Surgery, University of California, Los Angeles; Chief of Surgical Oncology, Director, Joyce Eisenberg Keefer Breast Cancer Center, John Wayne Cancer Institute, 2200 Santa Monica Blvd., #113, Santa Monica, CA 90404, Tel: 310-829-8089, FAX: 310-998-3995, EMAIL: giulianoa@jwci.org

*GLENN, JAMES F, M.D., Professor of Surgery Emeritus, University of Kentucky Medical Center, P.O. Box 2155, Boca Grande, FL 33921, Tel: 941-964-0976, FAX: 859-873-0962, EMAIL: drjglenn@aol.com

GLICK, PHILIP L, M.D., Vice Chair, Finance and Development, Department of Surgery, SUNY at Buffalo, 219 Bryant St., Department of Surgery, Buffalo, NY 14222, Tel: 716-878-7449, FAX: 716-878-7998, EMAIL: glicklab@aol.com

*GLOTZER, DONALD J, M.D., Associate Professor of Surgery, Harvard Medical School, HSDM, Dev. Biol., 188 Longwood Av, Boston, MA 02115, Tel: 617-432-2366, FAX: 617-432-0638, EMAIL: donald_glotzer@hms.harvard.edu

GOLD, JEFFREY P, M.D., Provost and Executive Vice President for Health Affairs, Dean for the College of Medicine, University of Toledo, 3045 Arlington Ave., Rm 213, Toledo, OH 43614, Tel: 419-383-4243, FAX: 419-383-6100, EMAIL: jeffrey.gold@utoledo.edu

*GOLDBERG, STANLEY M, M.D., FRACS, FRACS Eng., Clinical Professor of Surgery, Division of Colon and Rectal Surgery, Department of Surgery, University of Minnesota Medical School, 6363 France Ave., South, Ste. 212, Minneapolis, MN 55435-2140, Tel: 651-312-1700, FAX: 952-920-4148, EMAIL: goldb003@umn.edu

*GOODALE, ROBERT L, JR, M.D., Professor of Surgery, University of Minnesota, 420 Delaware St. SE, Box 379 UMHC, Minneapolis, MN 55455, Tel: 612-625-5121, FAX: 612-625-8496, EMAIL: gooda001@umn.edu

*GOODNIGHT, JAMES E, JR, M.D., Chairman, Department of Surgery, Pearl Stamps Stewart Professor, University of California, Davis Medical Center, 2221 Stockton Blvd., Rm 3112, Sacramento, CA 95817, Tel: 916-734-3190, FAX: 916-734-5119, EMAIL: james.goodnight@ucdmc.ucdavis.edu

*GOODWIN, CLEON W, JR, M.D., Commander/Director US Army Institute of Surgical Research, 1951 Montview Dr., Greeley, CO 80631-5230, Tel: 970-350-6304, FAX: 970-350-6306, EMAIL: cleon.goodwin@bannerhealth.com
AMERICAN SURGICAL ASSOCIATION

*GOTT, VINCENT L, M.D., Emeritus Professor, Department of Surgery, The Johns Hopkins Hospital, 250 Pantops Mt. Road, Apt. 334, Charlottesville, VA 22911, Tel: 410-955-3297, FAX: 410-955-3809, EMAIL: vgott@csurg.jhmi.jhu.edu

GRAHAM, ALAN M, M.D., Chief of Vascular Surgery, Vice-Chairman Department of Surgery, Robert Wood Johnson Medical School, UMDNJ, 1 R Wood Johnson Place, Rm 514, New Brunswick, NJ 08901, Tel: 732-235-8770, FAX: 732-235-8538, EMAIL: grahamal@umdnj.edu

GRAHAM, LINDA M, M.D., Professor, Cleveland Clinic Lerner College of Medicine – CWRU, 2932 Broxton Rd., Shaker Heights, OH 44120, Tel: 216-445-9878, FAX: 216-444-7370, EMAIL: grahaml@ccf.org

*GRANT, CLIVE S, M.D., Department of Surgery, Mayo Clinic; Professor of Surgery, Mayo Medical School, 200 First St. SW, Department of Surgery, Rochester, MN 55905, Tel: 507-284-2644, FAX: 507-284-5196, EMAIL: cgrant@mayo.edu

GRANT, DAVID, M.D., Professor of Surgery, University of Toronto; Surgical Director, Multiorgan Transplantation Program, University Health Network, 585 University Ave., Toronto, Ontario M5G 2N2, Canada, Tel: 416-340-4190, FAX: 416-340-5242, EMAIL: david.grant@uhn.on.ca

*GRAY, LAMAN A, JR, M.D., Professor of Surgery; Director, Division of Thoracic and Cardiovascular Surgery, University of Louisville School of Medicine, 201 Abraham Flexner Way, #1200, Louisville, KY 40202, Tel: 502-561-2180, FAX: 502-588-0753, EMAIL: lgray@ucArchmed.com

*GRAYHACK, JOHN T, M.D., Professor and Chairman, Department of Urology, Northwestern University Medical School, 303 East Chicago Avenue, Chicago, IL 60611

*GRECO, RALPH S, M.D., Johnson & Johnson Professor; Chief, Division of General Surgery and Program Director, Stanford University School of Medicine, 773 Frenchmans Road, Stanford, CA 94305, Tel: 650-736-1250, FAX: 650-736-1663, EMAIL: grecors@stanford.edu

*GREEN, RICHARD M, M.D., Chairman, Department of Surgery, Lenox Hill Hospital, 100 East 77th St., New York, NY 10021, Tel: 212-434-3400, FAX: 212-434-3410, EMAIL: rgreen@lenoxhill.net
*GREENBURG, A. GERSON, M.D., Ph.D., Professor Emeritus of Surgery, Brown University; Vice President Medical Affairs, Biopure Corporation, 11 Hurley Street, Cambridge, MA 02141, Tel: 617-234-6541, FAX: 617-234-6507, EMAIL: aggreenburg@biopure.com

*GREENE, FREDERICK L, M.D., Chairman, Department of Surgery; Clinical Professor of Surgery, University of North Carolina, Carolinas Medical Center, P.O. Box 32861, Charlotte, NC 28232-2861, Tel: 704-355-3176, FAX: 704-355-5619, EMAIL: frederick.greene@carolinashealthcare.org

*GREENFIELD, LAZAR J, M.D., Professor of Surgery and Chair Emeritus, University of Michigan, 1500 E. Medical Center Dr., TC2101 SPC5346, Ann Arbor, MI 48109-5346, Tel: 734-545-0435, FAX: 734-998-0173, EMAIL: lazarg@med.umich.edu

GREENHALGH, DAVID G, M.D., Chief of Burns Division, UC Davis Medical Center; Professor, Department of Surgery, UC Davis Medical Center; Chief of Burns, Shriners Hospital for Children, 2425 Stockton Blvd., Sacramento, CA 95817, Tel: 916-453-2050, FAX: 916-453-2373, EMAIL: david.greenhalgh@ucdmc.ucdavis.edu

*GREENLEE, HERBERT B, M.D., Professor Emeritus of Surgery, Loyola University School of Medicine, 1917 Wyman School Rd., Caledonia, IL 61011, Tel: 815-765-3016, EMAIL: hbgreenlee@earthlink.net

*GRIEFF, RANDALL B, M.D., Chairman, Division of Cardiothoracic Surgery, Mount Sinai Medical Center, 1190 Fifth Avenue, New York, NY 10029, Tel: 212-659-9495, FAX: 212-659-6818, EMAIL: Randall.Griepp@msnyuhealth.org

*GRIFFEN, WARD O, JR, M.D., Clinical Professor of Surgery Emeritus, University of Kentucky Medical Center, 4140 Peninsula Drive, Frankfort, MI 49635, Tel: 231-352-4494, FAX: 231-352-5487, EMAIL: popswo@coslink.net

*GRiffTH, BARTLEY P, M.D., Professor and Chief, Division of Cardiac Surgery, University of Maryland Medical Center, 22 So Greene St., N4W94, Baltimore, MD 21201, Tel: 410-328-3822, FAX: 410-328-2750, EMAIL: bgriffith@smail.umariland.edu

*GROSFELD, JAY L, M.D., Professor of Pediatric Surgery and Chairman Emeritus, Indiana University School of Medicine, 702 Barnhill Dr., #2500, Ped Surgery, Indianapolis, IN 46202, Tel: 317-274-5716, FAX: 317-274-5777, EMAIL: jrgrosfeld@iuui.edu
*GROVER, FREDERICK L, M.D., Professor and Chair, Department of Surgery, University of Colorado Denver SOM, 12631 E. 17th Ave., MSC305, Rm 6117, Aurora, CO 80045, Tel: 303-724-2750, FAX: 303-724-2761, EMAIL: frederick.grover@ucdenver.edu

GRUESSNER, RAINER W.G., M.D., Professor and Chairman, Department of Surgery, University of Arizona; Chief, Division of Abdominal Transplantation; University of Arizona, 1501 N. Campbell Ave., Rm 4410, Tucson, AZ 85724, Tel: 520-626-4409, FAX: 520-626-9118, EMAIL: rgruessner@surgery.arizona.edu

*GRUSS, JOSEPH S, M.D., Chief Craniofacial Plastic Surgery, Children’s Hospital; Marlys C. Carson Professor and Endowed Chair in Pediatric Craniofacial Surgery, Children’s Hospital and Regional Medical Center, 4800 Sand Point Way NE, Box 5371, Seattle, WA 98105-0371, Tel: 206-987-2039, FAX: 206-987-3925, EMAIL: joseph.gruss@seattlechildrens.org

GUICE, KAREN S, M.D., Executive Director, Federal Recovery Coordination Program, Department of Veterans Affairs, 4424 North Lake Dr., Shorewood, WI 53211, Tel: 414-266-6557, FAX: 414-266-6579, EMAIL: ksguice@earthlink.net

GUILLEM, JOSE G, M.D., Attending Surgeon, Colorectal Service, Memorial Hospital; Professor of Surgery, Cornell University Medical College; Director, Familial Colorectal Cancer Registry, Memorial Sloan-Kettering Cancer Center, 1275 York Ave., Rm C 1077, New York, NY 10021, Tel: 212-639-8278, FAX: 646-422-2318, EMAIL: guillemj@mskcc.org

*GUMP, FRANK E, M.D., Professor of Surgery Emeritus, Columbia University, 33 Prospect Hill Ave., Summit, NJ 07901, Tel: 908-273-1395

GUNDERLY, STEVEN R, M.D., Cardiovascular Institute of Palm Springs, 555 Tachevah Drive, 3W-103, Palm Springs, CA 92262, Tel: 760-323-5553, FAX: 760-323-5554, EMAIL: docsrg@aol.com

*GURLL, NELSON J, M.D., Professor, Department of Surgery, University of Iowa Hospitals and Clinics, 1530 JCP, Iowa City, IA 52242, Tel: 319-356-1794, FAX: 319-356-8378, EMAIL: nelson-gurll@uiowa.edu

*GUTIN, PHILIP H, M.D., Chair, Department of Neurosurgery, Fred Lebow Chair in Neuro-Oncology, Memorial Sloan-Kettering Cancer Center, 1275 York Avenue, Neurosurgery, New York, NY 10065, Tel: 212-639-8556, FAX: 212-717-3231, EMAIL: gutinp@mskcc.org
*GUYTON, ROBERT A, M.D., Charles R. Hatcher, Jr., Professor of Surgery and Chief of Cardiothoracic Surgery, Emory University, 1365 Clifton Rd. NE, #2223, Atlanta, GA 30322, Tel: 404-778-3836, FAX: 404-778-5039, EMAIL: robert_guyton@emoryhealthcare.org

*HAISCH, CARL E, M.D., Professor of Surgery; Director, Division of Surgical Immunology Transplantation; Program Director of Surgical Residency, East Carolina University, 4S-10 Brody Bldg., Surgery Immuno, Greenville, NC 27858-4354, Tel: 252-744-2900, FAX: 252-744-3452, EMAIL: haischc@ecu.edu

*HALGRIMSON, CHARLES G, M.D., Professor of Surgery and Associate Dean, University of Colorado School of Medicine, 245 South Glencoe, Denver, CO 80222

*HALLER, J. ALEX, JR, M.D., Professor of Pediatric Surgery Emeritus, Johns Hopkins University Hospital, 600 N. Wolfe, Harvey 315, Baltimore, MD 21205, Tel: 410-472-4241, FAX: 410-472-3477, EMAIL: amancalled@netzero.com

*HALLETT, JOHN W, JR, M.D., Professor of Surgery; Eastern Maine Medical Center, 316 Calhoun St., Charleston, SC 29401, Tel: 843-720-5665, EMAIL: johnjeb.hallett@rsfh.com

*HALLMAN, GRADY L, M.D., Attending Physician, St. Luke’s Episcopal Hospital, Texas Children’s Hospital, and Texas Heart Institute; Clinical Professor of Surgery, University of Texas at Houston and Baylor College of Medicine, P.O. Box 20345, Houston, TX 77225, Tel: 832-355-4129, FAX: 832-355-3770, EMAIL: ghallman@heart.thi.tmc.edu

HAMILTON, STEWART MCLEOD, M.D., 2D4.47 WMC, 8440-112 Street, Edmonton, Alberta T6G 2B7, Canada, Tel: 780-407-6306, FAX: 780-407-1422, EMAIL: stewart.hamilton@capitalhealth.ca

*HAMMON, JOHN W, JR, M.D., Professor, Department of Cardiothoracic Surgery, Wake Forest School of Medicine, Medical Center Blvd., Winston-Salem, NC 27157-1096, Tel: 336-716-6002, FAX: 336-716-3348, EMAIL: jhammon@wfubmc.edu

*HAMMOND, GRAEME L, M.D., Professor of Surgery, Yale University School of Medicine, 37 Old Orchard Rd., North Haven, CT 06473, Tel: 203-785-2702, EMAIL: graeme.hammond@yale.edu

*HAMPSON, LAWRENCE G, M.D., Montreal General Hospital, 1650 Cedar Ave., Rm 947, Livingston Hill, Montreal, Quebec H3G 1A4, Canada
*HANKS, JOHN B, M.D., C Bruce Morton Professor and Chief, Division of General Surgery, University of Virginia Health System, P.O. Box 800709, Charlottesville, VA 22908-0709, Tel: 434-924-0376, FAX: 434-924-1128, EMAIL: jbh@virginia.edu

*HANLON, C. ROLLINS, M.D., President, Warren and Clara Cole Foundation; Executive Consultant, American College of Surgeons, 633 No Saint Clair Street, Chicago, IL 60611-3211, Tel: 312-202-5416, FAX: 312-202-5007, EMAIL: rhanlon@facs.org

HANSEN, KIMBERLEY J, M.D., Prof. of Surgery, Interim Chair, Director of the Clinical Vascular Laboratory, Program Director of the Vascular Surgery Residency Program, Div. of Surgical Sciences, Department of Vascular and Endovascular Surgery, Wake Forest University School of Medicine, Medical Center Boulevard, Winston-Salem, NC 27157-1095, Tel: 336-713-5256, FAX: 336-716-5414, EMAIL: kjhansen@wfubmc.edu

HANTO, DOUGLAS W, M.D., Ph.D., Chief, Division of Transplantation, Beth Israel Deaconess Medical Center, Transplant, 110 Francis St., 7th Floor, Boston, MA 02215, Tel: 617-632-9810, FAX: 617-632-9820, EMAIL: dhanto@bidmc.harvard.edu

*HARDY, MARK A, M.D., Auchincloss Professor of Surgery, Columbia College of Physicians and Surgeons, 630 West 168th Street, New York, NY 10032, Tel: 212-305-5502, FAX: 212-342-4061, EMAIL: mah1@columbia.edu

*HARKEN, ALDEN H, M.D., Professor and Chairman, University of California, San Francisco-East Bay, 1411 East 31st Street, Oakland, CA 94602, Tel: 510-437-4091, FAX: 510-437-5127, EMAIL: harkena@surgery.ucsf.edu

*HARMON, JOHN W, M.D., Professor of Surgery, Johns Hopkins University School of Medicine and Section of Surgical Sciences, Johns Hopkins Bayview Medical Center, 4940 Eastern Ave., Department of Surgery, Baltimore, MD 21224, Tel: 410-550-0401, FAX: 410-550-1245, EMAIL: jharmon@jhmi.edu

HARMS, BRUCE A, M.D., 600 Highland Ave., Madison, WI 53792-7375, Tel: 608-263-1738, FAX: 608-263-7652, EMAIL: harms@surgery.wisc.edu
HARPOLE, DAVID H, JR, M.D., Professor of Surgery with Tenure, Department of Surgery; Chief of General Thoracic Surgery, Division of Thoracic Surgery, Duke University Medical Center; Chief of Cardiothoracic Surgery, Durham V.A. Medical Center, DUMC Box 3627, Durham, NC 27710, Tel: 919-668-8413, FAX: 919-668-7157, EMAIL: harpo002@mc.duke.edu

HARRIS, HOBART W, M.D., M.P., Chief, Division of General Surgery; Professor of Surgery, University of California San Francisco, 513 Parnassus Ave., S-301, San Francisco, CA 94143-0104, Tel: 415-514-3891, FAX: 415-476-0164, EMAIL: hobart.harris@ucsfmedctr.org

HARRIS, KENNETH A, M.D., Director, Office of Education, Royal College of Physicians & Surgeons of Canada, 774 Echo Drive, Ottawa, Ontario K1S 5N8, Canada, Tel: 613-730-6283, FAX: 613-730-3707, EMAIL: kharris@rcpsc.edu

HARRISON, TIMOTHY S, M.D., 125 Miller Ave., Rumford, RI 02916, Tel: 717-274-2273

HASSELGREN, PER-OLOF J, M.D., Vice Chairman of Research, Director of Endocrine Surgery, Beth Israel Deaconess Medical Center, 330 Brookline Ave., Stoneman 9-919, Boston, MA 02215, Tel: 617-667-5231, FAX: 667-667-1819, EMAIL: phasselg@bidmc.harvard.edu

HASSETT, JAMES M, M.D., Professor and Vice Chairman for Education, SUNY Buffalo, NY, Buffalo General Hospital, 100 High St., Buffalo, NY 14203, Tel: 716-859-1344, FAX: 716-859-1829, EMAIL: jhassett@kaleidahealth.org

HATCHER, CHARLES R, JR, M.D., Director Emeritus, Woodruff Health Science Center of Emory University; Professor of Surgery, Emeritus, Emory University School of Medicine, 1365-B Clifton Rd., NE, Ste. 6205, Atlanta, GA 30322, Tel: 404-778-3838, FAX: 404-778-2182, EMAIL: charles_hatcher@emoryhealthcare.org

HAWKINS, JOHN A, M.D., 100 North Mario Capecchi Dr., Ste. 2800, Salt Lake City, UT 84113, Tel: 801-662-5566, FAX: 801-662-5571, EMAIL: john.hawkins@hsc.utah.edu

HEALY, GERALD B, M.D., FACS, Professor Otology & Laryngology, Harvard Medical School, 194 Grove St., Wellesley, MA 02482, Tel: 617-355-5064, FAX: 617-730-0611, EMAIL: gbhmd194@yahoo.com
HEBERT, JAMES C, M.D., Albert G. Mackay, M.D. and H. Gordon Page, M.D. Professor of Surgery, University of Vermont College of Medicine, 111 Colchester Ave., Fletcher 462, Burlington, VT 05405, Tel: 802-847-3667, FAX: 802-847-5552, EMAIL: james.hebert@vtmednet.org

*HECHTMAN, HERBERT B, M.D., Professor of Surgery, Harvard Medical School, Department of Surgery, Brigham and Women’s Hospital, 75 Francis Street, Boston, MA 02115, Tel: 617-732-6098, FAX: 617-739-3927, EMAIL: hhechtman@partners.org

*HEIMBACH, DAVID M, M.D., Professor of Surgery, University of Washington, Department of Surgery, Harborview Medical Center, 325 9th Avenue, Box 359796, Seattle, WA 98104-6410, Tel: 206-744-3140, FAX: 206-744-2896, EMAIL: heimbach@u.washington.edu

*HEIMBECKER, RAYMOND, M.D., Professor Emeritus, University of Western Ontario, RR #1, Toad Hall, Collingwood, Ontario L9Y 3Y9, Canada, Tel: 705-445-9649, FAX: 705-445-9649, EMAIL: rheim8@aol.com

*HELMSWORTH, JAMES A, M.D., 840 Van Dyke, Cincinnati, OH 45226

HELTON, SCOTT, M.D., Chairman, Department of Surgery, Hospital of Saint Raphael, 1450 Chapel Street, New Haven, CT 06511, Tel: 203-789-3501, FAX: 203-867-5240, EMAIL: shelton@srhs.org

HEMMING, ALAN W, M.D., Professor & Chief, Transplantation & Hepatobiliary Surgery, University of California San Diego, 200 W. Arbor Drive, #8401, San Diego, CA 92103-8401, Tel: 619-543-5870, FAX: 619-543-7785, EMAIL: ahemming@ucsd.edu

*HENDERSON, J. MICHAEL, M.D., Chief Quality Officer, Cleveland Clinic, 9500 Euclid Ave., E32, Cleveland, OH 44195, Tel: 216-444-8462, FAX: 216-888-8510, EMAIL: henderm@ccf.org

*HENDREN, W. HARDY, M.D., Robert E. Gross Distinguished Professor of Surgery, Harvard Medical School, Chief of Surgery, Emeritus, Children’s Hospital, 247 King Caesar Road, Duxbury, MA 02332, Tel: 781-934-6828, FAX: 781-934-6176, EMAIL: ehen247@aol.com

*HERMANN, ROBERT E, M.D., Emeritus Consultant, Department of General Surgery, The Cleveland Clinic Foundation, One Bratenahl Pl, 1403, Bratenahl, OH 44108, Tel: 216-268-4684, FAX: 216-268-0007, EMAIL: rhermannmd@aol.com
HERNDON, DAVID N, M.D., Jesse H Jones Distinguished Chair; Professor of Surgery, University of Texas Medical Branch, Chief of Staff, Shriners Burn Institute, 815 Market Street, Galveston, TX 77550-2725, Tel: 409-770-6731, FAX: 409-770-6919, EMAIL: dherndon@utmb.edu

*HERTER, FREDERIC P, M.D., Professor Emeritus of Surgery, Columbia University; President, Emeritus, American University of Beirut, 784 Park Avenue, New York, NY 10021, Tel: 212-988-8880, FAX: 212-570-1643

*HERTZER, NORMAN R, M.D., Emeritus Chairman, Department of Vascular Surgery, Cleveland Clinic Foundation, 3050 Science Park Drive, Beachwood, OH 44122, Tel: 216-444-7030, FAX: 216-445-1521, EMAIL: hertzen@ccf.org

*HEWITT, ROBERT L, M.D., Regents Professor and Chairman Emeritus, Department of Surgery, Tulane University School of Medicine, 1750 St. Charles Avenue #202, New Orleans, LA 70130, Tel: 504-680-8451, EMAIL: rhet@cox.net

HIATT, JONATHAN R, M.D., Professor and Chief, Division of General Surgery, Vice Chair for Education, Department of Surgery, David Geffen School of Medicine at UCLA, 650 C.E. Young Dr., S. Box 956904, Los Angeles, CA 90095-6904, Tel: 310-794-7066, FAX: 310-825-0189, EMAIL: jhiatt@mednet.ucla.edu

*HILL, J. LAURANCE, M.D., Professor of Surgery, Retired, University of Maryland, 100 Harborview Dr., Unit 27B, Baltimore, MD 21230, Tel: 410-328-5730, FAX: 410-328-0652, EMAIL: hilljl@aol.com

*HINMAN, FRANK, JR, M.D., Clinical Professor of Urology, University of California San Francisco, 400 Parnassus Street, #A633, San Francisco, CA 94143-0738, Tel: 415-476-4472, FAX: 415-476-8849

*HINSHAW, DAVID B, M.D., President, Loma Linda University Medical Center, 2426 Lakeview Dr., Santa Rosa, CA 95405-8661, Tel: 909-215-0057, EMAIL: whitestag@att.net

HIRSCHL, RONALD B, M.D., Professor of Surgery; Surgeon-in-Chief, Mott Children’s Hospital; Chief Medical Information Officer, University of Michigan Health Systems, F3970 Mott Childrens Hosp, Ped Surgery, Ann Arbor, MI 48109-0245, Tel: 734-764-6846, FAX: 734-936-9784, EMAIL: rhirschl@med.umich.edu
HODGSON, PAUL E, M.D., Professor of Surgery, Emeritus, University of Nebraska Medical Center, 420 No 61st Street, Omaha, NE 68132-1953, Tel: 402-588-2841, EMAIL: pehodg@gmail.com

HODIN, RICHARD A, M.D., Professor of Surgery, Harvard Medical School, Surgical Director, MGH Crohns and Colitis Center, Chief, Endocrine Surgery, Wang 460, 15 Parkman Street, Boston, MA 02114-3117, Tel: 617-724-2570, FAX: 617-724-2574, EMAIL: rhodin@partners.org

HOLCOMB, GEORGE W, III, M.D., Surgeon in Chief; Katherine Berry Richardson Professor of Surgery, Children’s Mercy Hospital, 2401 Gillham Rd., Kansas City, MO 64108, Tel: 816-234-3578, FAX: 816-983-6885, EMAIL: gholcomb@cmh.edu

HOLCOMB, JOHN B, M.D., FACS, Professor of Surgery; Chief, Division of Acute Care Surgery; Director, Center for Translational Injury Research, University of TX Health Science Center, 6431 Fannin, MSB-4.170, Houston, TX 77030, Tel: 713-500-5493, EMAIL: john.holcomb@uth.tmc.edu

*HOLCROFT, JAMES W, M.D., Professor, University of California, Davis Medical Center, 2221 Stockton Blvd., 2nd Flr., Sacramento, CA 95817-2214, Tel: 916-734-2130, FAX: 916-734-7104, EMAIL: james.holcroft@ucdmc.ucdavis.edu

*HOLDER, THOMAS M, M.D., Emeritus Professor of Surgery, University of Missouri at Kansas City, 16 Compton Ct, Prairie Village, KS 66208-5204, Tel: 913-383-0108, FAX: 816-234-3821, EMAIL: holdertom@aol.com

*HOLLIER, LARRY H, M.D., Dean, LSU School of Medicine, 433 Bolivar St., New Orleans, LA 70112, Tel: 504-568-4800, FAX: 504-568-5177, EMAIL: lholl@lsuhsc.edu

HOLMAN, WILLIAM L, M.D., Professor in Surgery; Director, Division of Cardiothoracic Surgery, Birmingham V.A. Medical Center; Associate Director for Resident Education, Division of Cardiothoracic Surgery, University of Alabama at Birmingham, 703 So 19th St., Zeigler Res Bldg. 719, Birmingham, AL 35294, Tel: 205-934-3853, FAX: 205-975-6618, EMAIL: wholman@uab.edu

*HOLMES, E. CARMACK, M.D., Professor of Surgery, Chairman, Department of Surgery, UCLA School of Medicine, 10833 Le Conte Ave., Rm 64-140 CHS, Los Angeles, CA 90095-7313, Tel: 310-206-2105, FAX: 310-206-8823, EMAIL: cholmes@mednet.ucla.edu
*HOOVER, EDDIE L, M.D., Professor and Chairman of Surgery, Chief of Cardiothoracic Surgery, Erie County Medical Center, 3495 Bailey Ave., Buffalo, NY 14215, Tel: 716-862-3291, FAX: 716-862-8600, EMAIL: eddie.hoover@med.va.gov

*HOPKINS, RICHARD A, M.D., Chief Adult Congenital Cardiac Surgery and Director of the Cardiac Research Laboratories, The Children’s Mercy Hospital, 4 W. Tower, Card. Surgery 2401 Gillham Rd., Kansas City, MO 64108, Tel: 816-234-3580, FAX: 816-983-6380, EMAIL: rahopkins@cmh.edu

*HOPKINS, ROBERT W, M.D., Professor Emeritus of Medical Science, Brown University, The Miriam Hospital, 1073 Brush Hill Rd., Milton, MA 02186, Tel: 401-793-4525, FAX: 401-793-4725, EMAIL: adhrwh@comcast.net

*HORSLEY, J. SHELTON, III, M.D., Professor Emeritus of Surgery, Medical College of Virginia, 6161 River Road Unit 1, Richmond, VA 23226, Tel: 804-288-7692, FAX: 804-828-4808

*HORVATH, KEITH A, M.D., Director, Cardiothoracic Surgery Research Program, NHLBI, NIH, Bldg. 10, Rm 2N-246, 10 Center Dr. MSC1454, Bethesda, MD 20892, Tel: 301-451-7098, FAX: 301-480-1649, EMAIL: khorvath@nih.gov

*HOSKINS, WILLIAM J, M.D., Executive Director of Surgical Activities, Department of Surgery, Memorial Sloan-Kettering Cancer Center, Professor of OB/GYN, Weill Cornell Medical College, Cornell University, 1275 York Ave., New York, NY 10065, Tel: 212-639-2994, FAX: 212-717-1317, EMAIL: hoskinsw@mskcc.org

*HOWARD, JOHN M, M.D., Professor of Surgery, Emeritus, University of Toledo Medical Center, 3065 Arlington Ave., Department of Surgery, Toledo, OH 43614, Tel: 419-383-4921, FAX: 419-383-3105, EMAIL: patricia.oconnor@utoledo.edu

*HOWARD, RICHARD J, M.D., Robert H. and Kathleen M. Axline Professor of Surgery, Director of Transplantation Program, Medical Director, Organ Procurement Organization, University of Florida College of Medicine, Box 100118, Department of Surgery, Gainesville, FL 32610-0118, Tel: 352-265-0606, FAX: 352-265-0678, EMAIL: howard@surgery.ufl.edu
HOWARD, THOMAS JOHN, M.D., Willis D. Gatch Professor of Surgery, Indiana University Medical Center, 545 Barnhill Dr., EH 517, Indianapolis, IN 46202-5125, Tel: 317-274-4999, FAX: 317-274-0241, EMAIL: tjhoward@iupui.edu

HOWE, JAMES R.V., M.D., Professor of Surgery; Director of Surgical Oncology and Endocrine Surgery, University of Iowa Hospitals & Clinics, 4644 JCP, 200 Hawkins Drive, Iowa City, IA 52242-1086, Tel: 319-356-7945, FAX: 319-356-1218, EMAIL: james-howe@uiowa.edu

*HOYT, DAVID B, M.D., The John E. Connolly Professor of Surgery; Chairman, Department of Surgery; Executive Vice Dean, School of Medicine, University of California Irvine, 333 City Blvd., #700, City Tower, Orange, CA 92868, Tel: 714-456-6262, FAX: 714-456-6377, EMAIL: dhoyt@uci.edu

HUDDLESTON, CHARLES B, M.D., Professor of Surgery, WA University School of Medicine; Chief, Pediatric Cardiothoracic Surgery, St. Louis Children’s Hospital; Director, Pediatric Heart Transplant Program, St. Louis Children’s Hospital; Director, Pediatric Heart/Lung Transplant Program, St. Louis Children’s Hospital, One Children’s Place, #5S 50, St. Louis, MO 63110, Tel: 314-454-6165, FAX: 314-454-2381, EMAIL: huddlestonc@wustl.edu

*HUGHES, CARL W, M.D., Distinguished Professor of Surgery Emeritus, Uniformed Services University of Health Sciences, 5423 Linden Court, Bethesda, MD 20814, Tel: 301-530-4348

*HUMMEL, ROBERT P, M.D., Vice Chairman Emeritus, Department of Surgery; Chief of Staff, University Hospital, University of Cincinnati, 24 Dockside Lane, #473, Key Largo, FL 33037, Tel: 513-333-0206, FAX: 513-333-0207

*HUMPHREY, EDWARD W, M.D., Windmill Harbour, 95 Harbour Passage, Hilton Head Island, SC 29926, Tel: 803-681-2950, FAX: 843-342-6793

*HUMPHREY, LOREN J, M.D., Professor of Surgery Emeritus, University of Missouri School of Medicine, 3462 Woodrail Terrace, Columbia, MO 65203, Tel: 573-443-8213, EMAIL: ljens@centurytel.net

*HUNT, JOHN L, M.D., Professor, Department of Surgery; Chairman, Division of Burn, Trauma, Critical Care, University of Texas Southwestern Medical Center, 5323 Harry Hines Blvd., Dallas, TX 75235-9158, Tel: 214-648-2152, FAX: 214-648-8464, EMAIL: john.hunt@utsouthwestern.edu
HUNT, KELLY K, M.D., Professor of Surgery, Department of Surgical Oncology; Chief, Surgical Breast Section, MD Anderson Cancer Center, 1515 Holcombe, Box 444, Rm FC12:3050, Houston, TX 77030, Tel: 713-792-7216, FAX: 713-792-4689, EMAIL: khunt@mdanderson.org

*HUNT, THOMAS K, M.D., Professor of Surgery, Vice Chair for Research Affairs, University of California San Francisco, 513 Parnassus Ave., Rm HSW 1619, San Francisco, CA 94143-0522, Tel: 415-476-0410, FAX: 415-476-5190, EMAIL: wound@itsa.ucsf.edu

HUNTER, JOHN G, M.D., Mackenzie Professor and Chairman, Department of Surgery, Oregon Health Sciences University, 3181 SW SamJackson Park Rd., (L-223), Portland, OR 97239, Tel: 503-494-7758, FAX: 503-494-5615, EMAIL: hunterj@ohsu.edu

*HURST, JAMES M, M.D., Professor of Surgery, Vice-Chairman, Clinical Department of Surgery, University of Cincinnati Medical Center, 110 Francis Street, Suite 9-F, Boston, MA 02215, Tel: 617-632-9581, FAX: 617-632-9701, EMAIL: jhurst@bidmc.harvard.edu

*HUTSON, DUANE G, M.D., Professor of Surgery, University of Miami School of Medicine, P.O. Box 016310, Miami, FL 33101, Tel: 305-585-1280, FAX: 305-324-9779, EMAIL: dhutson@med.miami.edu

HYMAN, NEIL, M.D., Chief, Division of General Surgery, UVM College of Medicine, 111 Colchester Ave., Mail Stop 320FL4, Burlington, VT 05401, Tel: 802-847-2194, FAX: 802-847-4937, EMAIL: neil.hyman@vtmednet.org

*IGLEHART, J. DIRK, M.D., Brigham & Women’s Hospital, 75 Francis Street, Department of Surgery, Boston, MA 02115, Tel: 617-632-5178, FAX: 617-632-3709, EMAIL: jiglehart@partners.org

*IMBEMBO, ANTHONY L, M.D., 13815 Cuba Road, Cockeysville, MD 21030, Tel: 410-785-9200

*IMPARATO, ANTHONY M, M.D., Professor Emeritus of Surgery, New York University Medical Center, 4717 Dolphin Cay Lane S., Apt. 602, St. Petersburg, FL 33711, Tel: 212-263-7311, FAX: 212-763-7222, EMAIL: Amimpanatomdprnj@aol.com

*IRVIN, GEORGE LEE, III, M.D., Professor of Surgery, University of Miami School of Medicine, 635 Solano Prado, Coral Gables, FL 33156, Tel: 305-243-4211, FAX: 305-243-4221, EMAIL: girvin@miami.edu
AMERICAN SURGICAL ASSOCIATION

*ISOM, O. WAYNE, M.D., Prof. and Chairman, Department of Cardiothoracic Surgery, Weill Cornell Medical College, New York Presbyterian Hospital, 525 East 68th St., M-404, New York, NY 10065, Tel: 212-746-5151, FAX: 212-746-8388, EMAIL: owisom@med.cornell.edu

*IVATURY, RAO R, M.D., Director, Trauma and Critical Care; Professor of Surgery & Emergency Medicine, Virginia Commonwealth University, Medical College of Virginia, P.O. Box 980454, Richmond, VA 23298-0454, Tel: 804-828-7748, FAX: 804-827-0285, EMAIL: rivatury@hscl.vcu.edu

JACOBS, DANNY O, M.D., M.P., David C. Sabiston, Jr., Professor & Chairman, Duke University Medical Center, DUMC 3704, Durham, NC 27710, Tel: 919-681-3445, FAX: 919-681-2779, EMAIL: jacob060@mc.duke.edu

*JACOBS, LENWORTH M, JR, M.D., 80 Seymour St., Hartford, CT 06102, Tel: 860-545-3112, FAX: 860-545-5132, EMAIL: ljacobs@harthosp.org

*JAFFE, BERNARD M, M.D., Professor of Surgery, Emeritus Tulane University School of Medicine, 1430 Tulane Ave., Surgery SL-22, New Orleans, LA 70112, Tel: 504-585-7123, FAX: 504-584-3793, EMAIL: baffe@tulane.edu

JAKSIC, TOM, M.D., Associate Professor of Surgery, Harvard Medical School; Vice Chairman, Pediatric Surgery, Children’s Hospital, 300 Longwood Ave., Fegan 3, Boston, MA 02115, Tel: 617-355-9600, FAX: 617-730-0477, EMAIL: tom.jaksic@childrens.harvard.edu

*JANNETTA, PETER J, M.D., Vice Chairman, Department of Neurosurgery, Allegheny General Hospital, 420 E. North Ave., #302, Neurosurgery, Pittsburgh, PA 15212, Tel: 412-359-4810, FAX: 412-359-4811, EMAIL: pjannett@wpahs.org

JAQUES, DAVID P, M.D., Vice President for Surgical Services, Barnes Jewish Hospital, 4200 Laclede Road, Apt. 301, St. Louis, MO 63108, Tel: 314-362-2178, FAX: 314-362-7897, EMAIL: dpj3427@bjc.org

JARNAGIN, WILLIAM R, M.D., Associate Professor, Vice Chairman, Acting Chief of Hepatobiliary Services, Memorial Sloan-Kettering Cancer Center, 1275 York Ave., Hepatobiliary Svc, New York, NY 10021-7988, Tel: 212-639-7601, FAX: 917-432-2387, EMAIL: jarnagiw@mskcc.org
JARRELL, BRUCE E, M.D., Professor, University of Maryland School of Medicine, 655 W. Baltimore St., Rm 14-031, Baltimore, MD 21201, EMAIL: bjarrell@som.umaryland.edu

JENKINS, ROGER L, M.D., Professor of Surgery, Tufts University School of Medicine; Chairman of Surgery, Lahey Clinic, 41 Mall Road, #4 West, Burlington, MA 01805-0001, Tel: 781-744-2500, FAX: 781-744-5743, EMAIL: roger.l.jenkins@lahey.org

JOEHL, RAYMOND J, M.D., Professor of Surgery, Loyola University Medical Center; Chief, Surgical Service (112), Edward Hines, Jr., V.A. Hospital, 5000 South 5th Ave., Hines, IL 60141, Tel: 708-202-2036, FAX: 708-202-2180, EMAIL: raymond.joehl@va.gov

JOHANSEN, KAJ H, M.D., 1600 E. Jefferson St., #101, Seattle, WA 98122, Tel: 206-320-3100, FAX: 206-322-8615, EMAIL: kaj.johansen@swedish.org

JOHNSON, DALE G, M.D., Retired: Formerly Surgeon-in-Chief, Primary Children’s Medical Center; Head, Division of Pediatric Surgery, Emeritus Professor of Surgery and Pediatrics, University of Utah School of Medicine, 447 Northmont Way, Salt Lake City, UT 84103-3322, Tel: 801-588-3350, FAX: 801-588-3364, EMAIL: dale.johnson@hsc.utah.edu

JOHNSON, FRANK E, M.D., 3735 Vista at Grand, Box 15250, Saint Louis, MO 63110, Tel: 314-920-1403, FAX: 314-771-1945, EMAIL: frank.johnson1@va.gov

JOHNSON, LYNT B, M.D., MBA, Professor and Chairman, Department of Surgery, Georgetown University Hospital, 3800 Reservoir Road NW, 4 PHC, Washington, DC 20007, Tel: 202-444-4557, FAX: 202-444-7304, EMAIL: lynt.johnson@medstar.net

JOHNSTON, K, WAYNE, M.D., Professor of Surgery, R. Fraser Elliott Chair in Vascular Surgery, University of Toronto and The Toronto Hospital, 200 Elizabeth St., Eaton C5-309, Toronto, Ontario M5G 2C4, Canada, Tel: 416-340-3552, FAX: 416-340-5029, EMAIL: Wayne.Johnston@uhn.on.ca

JONAS, RICHARD A, M.D., Chief of Cardiovascular Surgery; Co-Director of the Congenital Heart Program, Children’s National Medical Center, 111 Michigan Avenue NW, Washington, DC 20010, Tel: 202-476-2811, FAX: 202-318-7243, EMAIL: rjonas@cnmc.org
JONES, DAVID R, M.D., Professor of Surgery, University of Virginia, Department of Surgery, P.O. Box 800679, Charlottesville, VA 22908-0679, Tel: 434-243-6443, FAX: 434-982-1026, EMAIL: djones@virginia.edu

*JONES, JAMES W, M.D., Visiting Professor of Medical Ethics, Baylor College of Medicine, 31 La Costa Dr., Montgomery, TX 77356, Tel: 936-582-4577, FAX: 936-582-1493, EMAIL: jwjones@bcm.tmc.edu

*JONES, R. SCOTT, M.D., Professor and Chairman, Emeritus, Department of Surgery, University of Virginia, 3123 Rabbit Valley Road, P.O. Box 156, North Garden, VA 22959, Tel: 434-924-2000, FAX: 434-982-1024, EMAIL: rsj@virginia.edu

*JONES, ROBERT H, M.D., Duke University Medical Center, Box 17969, Department of Surgery, Durham, NC 27715, Tel: 919-668-8357, FAX: 919-684-5700, EMAIL: jones060@mc.duke.edu

*JONES, RONALD C, M.D., Chief of Surgery/Program Director for Surgical Residency Program, Baylor University Medical Center, 3500 Gaston Ave., Department of Surgery, Dallas, TX 75246-9989, Tel: 214-820-2468, FAX: 214-820-4538, EMAIL: rc.jones@baylorhealth.edu

*JORDAN, PAUL H, JR, M.D., Professor of Surgery Emeritus, Baylor College of Medicine, 1111 Hermann Dr., Apt. 18C, Houston, TX 77004, EMAIL: p_jordan@sbcglobal.net

*JUDE, JAMES R, M.D., Clinical Professor of Surgery, University of Miami School of Medicine, 200 Edgewater Drive, Miami, FL 33133, Tel: 305-772-5067, FAX: 305-667-4824, EMAIL: jjude33333@aol.com

*JURKIEWICZ, MAURICE J, M.D., Professor of Surgery Emeritus, Emory University, 715 Old Post Road NW, Atlanta, GA 30328, Tel: 404-252-9148, FAX: 404-252-9148, EMAIL: palmhill1@ mindspring.com

JURKOVICH, GREGORY J, M.D., Professor of Surgery; Chief, Trauma Services, Harborview Medical Center, University of Washington, Box 359796, Seattle, WA 98104-6410, Tel: 206-731-8485, FAX: 206-731-3656, EMAIL: jerryj@u.washington.edu

*KAGAN, RICHARD J, M.D., Chief of Staff, Shriners Hospital for Children, Chief Division of Burn Surgery, Professor of Surgery, University of Cincinnati College of Medicine, 3229 Burnet Ave., Cincinnati, OH 45229, Tel: 513-872-6210, FAX: 513-872-6396, EMAIL: rkagan@shriners.org
*KAHAN, BARRY D, M.D., Professor of Surgery, Director of Immunology and Organ Transplantation, University of Texas Medical School, 6431 Fannin Street, MSB 6.240, Houston, TX 77030, Tel: 713-500-7400, FAX: 713-500-0785

*KAISER, GEORGE C, M.D., Emeritus Professor and Chief, Cardiothoracic Surgery, St. Louis University Medical Center, 30 Joy Avenue, Webster Groves, MO 63119-2502, Tel: 314-962-0446, FAX: 314-961-4103, EMAIL: kaisergc@att.net

*KAISER, GERARD A, M.D., Senior Vice President for Medical Affairs, Jackson Memorial Hospital; Professor and Deputy Dean for Clinical Affairs, University of Miami School of Medicine, P.O. Box 019132 (M863), Miami, FL 33101, Tel: 305-585-6086, FAX: 305-325-4262

KAISER, LARRY R, M.D., President and Alkek-Williams Distinguished Professor; University of Texas Health Science Center at Houston, 7000 Fannin St., 17th Floor, Houston, TX 77030, Tel: 713-500-3010, FAX: 713-500-3059, EMAIL: Larry.Kaiser@uth.tmc.edu

*KAM, IGAL, M.D., Professor of Surgery; Chief of Transplant Surgery, University of Colorado Health Sciences Center, 1635 Aurora Court, Aurora, CO 80045, Tel: 720-848-0833, FAX: 720-848-0841, EMAIL: igal.kam@ucdenver.edu

*KAMINSKI, DONALD L, M.D., Professor of Surgery, Retired, St. Louis University, 1025 Joanna Ave., St. Louis, MO 63122, Tel: 314-966-6986, EMAIL: kaminsmm@charter.net

KANDEL, JESSICA J, M.D., Altman Professor of Surgery and Pediatrics in the Institute for Cancer Genetics, Columbia University, 3959 Broadway, Rm 214N, New York, NY 10032, Tel: 212-342-8585, FAX: 212-342-5240, EMAIL: jjk47@columbia.edu

*KAPLAN, EDWIN L, M.D., 5841 So Maryland Ave., MC 5031, Chicago, IL 60637, Tel: 773-702-6155, FAX: 773-702-0564, EMAIL: ekaplan@surgery.bsd.uchicago.edu

*KARL, RICHARD C, M.D., Richard G. Conner Professor and Chairman, H. Lee Moffitt Cancer Center; University of South Florida, 12902 Magnolia Drive, Tampa, FL 33612, Tel: 813-974-4826, FAX: 813-974-7096, EMAIL: rkarl@hsf.usf.edu
KARPEH, MARTIN S, JR, M.D., Chief, Surgical Oncology, Professor of Surgery, Director of the Long Island Cancer Center, 1st Ave. & 16th St. Baird Hall, 16th Floor, New York, NY 10003, Tel: 212-420-4044, FAX: 212-844-7696, EMAIL: mkarpeh@chpnet.org

*KAUFFMAN, GORDON L, JR, M.D., Professor of Surgery, Cellular and Molecular Physiology and Humanities, Penn State Hershey Medical Center, 500 University Dr., H070, Hershey, PA 17033, Tel: 717-531-8815, FAX: 717-531-4433, EMAIL: gkauffman@psu.edu

KAUFMAN, DIXON B, M.D., Ph.D., Fowler McCormick Professor, Department of Surgery, Feinberg School of Medicine, Northwestern University, 675 No St. Clair, Galter 17-200, Chicago, IL 60611, Tel: 312-695-0257, FAX: 312-695-9194, EMAIL: d-kaufman2@northwestern.edu

*KEAGY , BLAIR A, M.D., University of North Carolina at Chapel Hill, 2146 Bioinformatics Bldg., CB 7212, Chapel Hill, NC 27599-7212, Tel: 919-966-3391, FAX: 919-966-2898, EMAIL: bkeagy@med.unc.edu

*KEALEY , GERALD P, M.D., Professor of Surgery; Division Director for Trauma, Burns, Critical Care and Emergency General Surgery, University of Iowa Hospitals and Clinics, 200 Hawkins Dr., Iowa City, IA 52242, Tel: 319-356-3221, EMAIL: gerald-kealey@uiowa.edu

*KEITH, ROGER G, M.D., Professor of Surgery, University of Saskatchewan, Royal Univ Hospital, Surgery, Saskatoon, Saskatchewan S7N 0W8, Canada, Tel: 306-966-8631, FAX: 306-966-1611, EMAIL: roger.keith@usask.ca

*KELLUM, JOHN M, JR, M.D., Professor, Department of Surgery, Division of General/Trauma Surgery, Medical College of Virginia, P.O. Box 980519, Richmond, VA 23298-0519, Tel: 804-828-9513, FAX: 804-827-0670, EMAIL: jmkellem@vcu.edu

*KELLY , KEITH A, M.D., Professor of Surgery, Emeritus, Mayo Clinic, 13400 E. Shea Blvd., Department of Surgery, Scottsdale, AZ 85259, Tel: 480-301-9692, FAX: 480-301-7346, EMAIL: kelly.keith@mayo.edu

*KEMENY , M. MARGARET, M.D., Professor of Surgery, Mount Sinai School of Medicine; Director, Queens Cancer Center, 82-68 164th St., Jamaica, NY 11432, Tel: 718-883-4031, FAX: 718-883-6295, EMAIL: kemenym@nychhc.org
KEMPCZINSKI, RICHARD, M.D., University of Cincinnati Medical Center, 3435 Golden Ave., Apt. 201, Cincinnati, OH 45226, Tel: 513-321-4724, FAX: 513-321-7350, EMAIL: kemprf@fuse.net

KENT, K. CRAIG, M.D., A.R. Curreri Professor, Chairman, Department of Surgery University of Wisconsin School of Medicine and Public Health, 600 Highland Ave., Suite H4/ 710D, Madison, WI 53792-7375, Tel: 608-265-8854, FAX: 608-265-5963, EMAIL: kent@surgery.wisc.edu

KEON, WILBERT J, M.D., Director General, University of Ottawa Heart Institute, 140 Wellington St., Ste. 902, Ottawa, Ontario K1A 0A4, Canada, Tel: 613-943-1415, FAX: 613-943-1796

KERRIGAN, CAROLYN L, M.D., Professor of Surgery; Division Chief; Program Director, Dartmouth Hitchcock Medical Center, 1 Medical Center Dr., Lebanon, NH 03756, Tel: 603-650-5881, FAX: 603-650-5809, EMAIL: carolyn.l.kerrigan@hitchcock.org

KERSTEIN, MORRIS D, M.D., Chief of Staff, V.A. Medical Center and Regional Office Center, 1214 Valley Rd., Villanova, PA 19085, Tel: 610-527-4316, FAX: 610-520-9293, EMAIL: LK1122@comcast.net

KESHA VJEE, SHAF, M.D., Head, Division of Thoracic Surgery, Director, Toronto Lung Transplantation Program; Professor & Chair, Division of Thoracic Surgery, University of Toronto, 200 Elizabeth St., EN 9N-947, Toronto, Ontario M5G 2C4, Canada, Tel: 416-340-4010, FAX: 416-340-4556, EMAIL: shaf.keshavjee@uhn.on.ca

KETCHAM, ALFRED S, M.D., Emeritus Professor of Surgery and Professor of Oncology Emeritus, University of Miami, 1120 San Pedro Avenue, Coral Gables, FL 33156, Tel: 305-666-1026, EMAIL: alfketch@aol.com

KILMAN, JAMES W, M.D., Professor of Surgery, Emeritus, Ohio State University College of Medicine, 4231 Jackson Place, Grove City, OH 43123, Tel: 614-875-6570, FAX: 614-875-9157, EMAIL: leoline@aol.com

KIMURA, KEN, M.D., Emeritus Professor of Surgery, University of Iowa Hospitals & Clinics, 6750 Hawaii Kai Dr., #801, Honolulu, HI 96825, Tel: 808-395-1581, FAX: 808-395-1572, EMAIL: ken-kimura@uiowa.edu

KINDER, BARBARA K, M.D., William H. Carmalt Professor of Surgery, Yale University School of Medicine, P.O. Box 596, Vinalhaven, ME 04863-0596, Tel: 203-785-2562, FAX: 203-737-4067, EMAIL: barbara.kinder@yale.edu
KING, HAROLD, M.D., Division of Thoracic and Cardiovascular Surgery, Indiana University Medical Center, Emerson Hall, 545 Barnhill Dr., Rm 212, Indianapolis, IN 46207, Tel: 317-264-7949, FAX: 317-274-2940

KING, THOMAS C, M.D., J.M. Ferrer Professor of Surgery, Emeritus, 35 Claremont Ave., #6-S, New York, NY 10027-6823, Tel: 212-222-1472, FAX: 212-222-1875

KINNE, DAVID W, M.D., David V Habif Emeritus Professor of Surgery, College of Physicians & Surgeons of Columbia University and The Presbyterian Hospital, Department of Surgery, 340 East 64th Street, New York, NY 10021, Tel: 212-644-9395, EMAIL: kathkin@aol.com

KINNEY, JOHN M, M.D., Visiting Professor and Physician, The Rockefeller University, 2104 Kendall Way, Sleepy Hollow, NY 10591-1058, Tel: 914-478-4467, FAX: 914-478-5015

KIRKLIN, JAMES K, M.D., Professor of Surgery, University of Alabama, 1900 University Blvd., 760 THT, Birmingham, AL 35294, Tel: 205-934-5486, FAX: 205-934-5261, EMAIL: jkirklin@uab.edu

KIRSH, MARVIN M, M.D., Clinical Professor of Surgery, University of California Irvine, 368 Santa Louisa, Irvine, CA 92606-0800, Tel: 714-456-3634, FAX: 714-456-8870, EMAIL: marvink@umich.edu

KITTLE, C. FREDERICK, M.D., Professor of Surgery Emeritus, Rush-Presbyterian-St. Luke’s Medical Center, 811 S. Lyle St. Apt. 510, Chicago, IL 60607-4152, Tel: 312-243-4130, FAX: 312-666-2937

KLEIN, ANDREW S, M.D., Professor of Surgery, Chief, Division of Transplantation; Director, Comprehensive Transplant Center, 8635 W. Third St., #590W, Transplant, Los Angeles, CA 90048, Tel: 310-423-2641, FAX: 310-423-0565, EMAIL: kleinas@cshs.org

KLIBERG, V. SUZANNE, M.D., Professor of Surgery, Director, Women’s Oncology, ACCS. Chief Breast Service Department of Surgery, Chief, Breast Service VAMC, 4301 W. Markham, Slot #725, Little Rock, AR 72205-7199, Tel: 501-686-6504, FAX: 501-526-6191, EMAIL: klibergsuzanne@uams.edu
KLINTMALM, GORAN B, M.D., Chairman, Baylor Institute of Transplantation Sciences; Director, Dallas Liver Transplant Program; Medical Director, Transplantation Services, Baylor University Medical Center, 3500 Gaston Avenue, Dallas, TX 75246, Tel: 214-820-1757, FAX: 214-820-4527, EMAIL: karenhan@baylorhealth.edu

KNECHTLE, STUART J, M.D., Professor of Surgery, Emory University School of Medicine, 101 Woodruff Circle, #5105-WMB, Atlanta, GA 30322, Tel: 404-727-8465, FAX: 404-727-3660, EMAIL: stuart.knechtle@emoryhealthcare.org

KNUDSON, M. MARGARET, M.D., Professor, San Francisco General/U.C.S.F. Hospitals, 1462 Topar Avenue, Los Altos, CA 94024, Tel: 415-206-4623, FAX: 415-206-5484, EMAIL: pknudson@sfgsurg.ucsf.edu

KO, CLIFFORD Y, M.D., MSHS, 10833 Le Conte Ave., Room 72-215, Los Angeles, CA 90095, Tel: 310-498-6032, FAX: 310-825-0189, EMAIL: cko@mednet.ucla.edu

*KODNER, IRA J, M.D., Professor of Surgery; Chief, Section of Colon and Rectal Surgery, Washington University School of Medicine, 26 Portland Dr., St. Louis, MO 63131, Tel: 314-454-7177, FAX: 314-454-5249, EMAIL: ijkodner@aol.com

*KOHMAN, LESLIE J, M.D., SUNY Distinguished Service Professor, Professor of Surgery, State University of New York, 750 E. Adams St., #8141, Syracuse, NY 13210, Tel: 315-464-1857, FAX: 315-464-6234, EMAIL: KohmanL@upstate.edu

KOLTUN, WALTER, M.D., Chief, Division of Colon and Rectal Surgery; Peter and Mareshia Carlino Chair in Inflammatory Bowel Disease, Penn State Milton S. Hershey Medical Center, P.O. Box 850, Colorectal Surgery H137, Hershey, PA 17033, Tel: 717-531-5164, FAX: 717-531-0646, EMAIL: wkoltun@psu.edu

KON, NEAL D, M.D., Howard Holt Bradshaw Professor and Chair; Residency Program Director; Department of Cardiothoracic Surgery, Wake Forest University School of Medicine, Medical Center Blvd., Winston-Salem, NC 27157-1096, Tel: 336-716-4338, FAX: 336-716-3348, EMAIL: nkon@wfubmc.edu

*KOOP, C EVERETT, M.D., Chairman, C. Everett Koop Institute at Dartmouth; Co-Director, Carnegie Foundation’s National Ready to Learn Council, 7025 Strasenburg Building, Hanover, NH 03755-3860
KORMOS, ROBERT L. M.D., Professor of Surgery, Director, Artificial Heart Program, University of Pittsburgh, Presbyterian University Hospital, 200 Lothrop St., #C-700, Pittsburgh, PA 15213, Tel: 412-648-6259, FAX: 412-648-6356, EMAIL: kormosrl@upmc.edu

*KOTTMIEIER, PETER K. M.D., Professor of Surgery Emeritus, State University of New York Health Science Center at Brooklyn, 2544 Holston River Dr., Rutledge, TN 37861, Tel: 865-828-3335, EMAIL: pnkottmeyer@frontiernet.net

*KOUCHOUKOS, NICHOLAS T. M.D., Division of Cardiac, Thoracic and Vascular Surgery, Missouri Baptist Medical Center, 3009 No Ballas Rd., Ste. 360C, St. Louis, MO 63131, Tel: 314-996-5287, FAX: 314-432-6068, EMAIL: ntkouch@aol.com

*KRAFT, RICHARD O. M.D., 323 Rock Creek Ct, Ann Arbor, MI 48104, Tel: 734-663-6774, FAX: 734-663-8726, EMAIL: rkraft@umich.edu

*KRAISS, LARRY W. M.D., Professor of Surgery; Chief, Division of Vascular Surgery; Director, Vascular Surgery Fellowship; Medical Director, Non-Invasive Vascular Laboratory, University of Utah Medical Center, School of Medicine, 30 N. 1900 East, Room 3C344, Salt Lake City, UT 84132, Tel: 801-585-7519, FAX: 801-581-3433, EMAIL: larry.kraiss@hsc.utah.edu

*KRAYBILL, WILLIAM G. M.D., 410 West 10th Avenue, N924 Doan Hall, Columbus, OH 43210, Tel: 614-293-7742, FAX: 614-293-3465, EMAIL: william.kraybill@osumc.edu

*KRIEGER, KARL H. M.D., Attending Cardiothoracic Surgeon, NY Presbyterian Hospital; Michel C. Bergeac Professor of Cardiothoracic Surgery; Vice Chairman, Department of Cardiothoracic Surgery, Weill Medical College of Cornell University, 525 E. 68th St., Rm F2106, New York, NY 10021, Tel: 212-746-5152, FAX: 212-746-8388, EMAIL: khkriege@med.cornell.edu

*KRIEZEK, THOMAS J. M.D., Professor of Sport Ethics, Director, Center for Sport Ethics, St. Leo University, 13411 Thoroughbred Dr., Dade City, FL 33525-6247, Tel: 813-974-9864, FAX: 813-907-8004, EMAIL: tflynnk@aol.com
KRON, IRVING L, M.D., S. Hurt Watts, Professor & Chairman, Department of Surgery; Division of Thoracic and Cardiovascular Surgery, University of Virginia Health System, 1215 Lee St., 4th Fl HEP Bldg., Room 4066, Charlottesville, VA 22908-0679, Tel: 434-924-2158, FAX: 434-982-3885, EMAIL: ilk@virginia.edu

KRUMMEL, THOMAS M, M.D., Emile Holman Professor and Chair, Department of Surgery, Stanford University Medical Center, 701-B Welch Road, Suite 225, Surgery, Stanford, CA 94305-5784, Tel: 650-498-4292, FAX: 650-725-3918, EMAIL: tkrummel@stanford.edu

*KUDSK, KENNETH A, M.D., Professor of Surgery, University of Wisconsin Medical School, 600 Highland Ave., Rm H4/736 CSC, Madison, WI 53792-7375, Tel: 608-263-1036, FAX: 608-265-8810, EMAIL: kudsk@surgery.wisc.edu

KUO, PAUL C, M.D., Chief, Division of General Surgery, Duke University Medical Center, Box 3522, 110 Bell Bldg., Surgery, Durham, NC 27710, Tel: 919-668-1856, FAX: 919-684-8716, EMAIL: kuo00004@mc.duke.edu

LAFRENIERE, RENE, M.D., Professor, Department of Surgery, University of Calgary; Professor, Departments of Oncology and Anesthesia, University of Calgary, 1403 29th St. NW, Calgary, Alberta T2N 2T9, Canada, Tel: 403-944-1697, FAX: 403-270-8409, EMAIL: rene.lafreniere@shaw.ca

*LAKS, HILLEL, M.D., 10833 LeConte Ave., Rm 62-182A, Los Angeles, CA 90095, Tel: 310-206-1837, FAX: 310-206-0852, EMAIL: hlaks@mednet.ucla.edu

LALLY, KEVIN P, M.D., A.G. McNeese Professor and Chief, Division of Pediatric Surgery, University of Texas-Houston, 6431 Fannin St., #5.258, Houston, TX 77030, Tel: 713-500-7300, FAX: 713-500-7296, EMAIL: kevin.p.lally@uth.tmc.edu

LANDRENEAU, RODNEY J, M.D., Professor of Surgery, Division of Thoracic and Foregut Surgery, University of Pittsburgh Medical Center, UPMC Shadyside Hospital, 5200 Centre Ave., Ste. 715, POB #1, Pittsburgh, PA 15232, Tel: 412-623-2025, FAX: 412-623-0329, EMAIL: landreneaurj@msx.upmc.edu

*LANGER, BERNARD, M.D., Professor of Surgery, Toronto General Hospital, 180 Gordon Rd., Toronto, Ontario M2P 1E8, Canada, Tel: 416-445-5368, FAX: 416-446-7667, EMAIL: drblanger@cs.com
LANGER, JACOB C, M.D., Professor of Surgery, University of Toronto; Chief, Pediatric General and Thoracic Surgery, Hospital for Sick Children, 555 University Ave., Rm 1526, Toronto, Ontario M5G 1X8, Canada, Tel: 416-813-7340, FAX: 416-813-7477, EMAIL: jacob.langer@sickkids.ca

LANGNAS, ALAN NORMAN, 600 42nd St., Box 983285, Omaha, NE 68198-3285, Tel: 402-559-8390, FAX: 402-559-3434, EMAIL: alangnas@unmc.edu

LAQUAGLIA, MICHAEL P, M.D., Memorial Sloan-Kettering Cancer Center, 1275 York Ave., #C-1176, New York, NY 10021, Tel: 212-639-7002, FAX: 212-717-3373, EMAIL: laquaglm@mskcc.org

*LARSON, DAVID L, M.D., Professor and Chairman, Department of Plastic Surgery, Froedtert Hospital, Medical College of Wisconsin, 8700 W. Watertown Plank, Milwaukee, WI 53226, Tel: 414-805-5445, FAX: 414-259-0901, EMAIL: dlarson@mcw.edu

*LAUFMAN, HAROLD, M.D., Ph.D., Emeritus Professor of Surgery, Albert Einstein College of Medicine, 31 East 72nd St., New York, NY 10021, Tel: 212-737-4343, FAX: 212-737-4628, EMAIL: halauf@aol.com

LAURENCIN, CATO T, M.D., Vice President of Health Affairs, Dean of School of Medicine, Albert and Wilda Van Dusen Chair in Academic Medicine, Distinguished Professor of Orthopaedic Surgery, The University of Connecticut, 50 Far Hills Drive, Avon, CT 06001-2877, Tel: 434-243-0250, FAX: 434-243-0252, EMAIL: laurencin@uchc.edu

*LAWRENCE, PETER F, M.D., Associate Dean of Clinical Affairs, Vice President for Specialty Services, Professor of Surgery, UCI College of Medicine, 200 Medical Plaza, #510-6, Vasc Surg, Los Angeles, CA 90095, Tel: 310-267-0182, FAX: 310-267-0189, EMAIL: pflawrence@mednet.ucla.edu

*LAWRENCE, WALTER, JR, M.D., Professor Emeritus, Division of Surgical Oncology and Director Emeritus, Massey Cancer Center, Virginia Commonwealth University, 1200 E. Broad St., Box 980011, Richmond, VA 23298, Tel: 804-828-9323, FAX: 804-828-4808, EMAIL: wlawrence@mcvh-vcu.edu

*LAWS, EDWARD R, JR, M.D., University of Virginia Health Sciences Center, 875 Blake Wilbur Drive, CC2330, Stanford, CA 94305-5821, Tel: 650-739-2062, FAX: 650-736-8100, EMAIL: eflaws@stanford.edu
*LAWS, HENRY L, M.D., Surgeon, Carraway Methodist Medical Center and Norwood Clinic; Clinical Professor of Surgery, University of Alabama at Birmingham, 1455 County Road 43, Clanton, AL 35046, Tel: 205-280-0234, FAX: 205-280-6690, EMAIL: lawsh@bellsouth.net

LAZAR, HAROLD L, M.D., Professor, Cardiothoracic Surgery, Boston University School of Medicine; Attending, Cardiothoracic Surgeon, Boston Medical Center; Attending Surgeon, Quincy Hospital, 88 E. Newton St., Boston, MA 02118, Tel: 617-638-7350, FAX: 617-638-7228, EMAIL: harold.lazar@bmc.org

LEACH, STEVEN D, M.D., The Paul K. Neumann Professor, Chief, Division of Surgical Oncology and Director of Surgical Research, Johns Hopkins University, BRB 471, 733 N. Broadway, Baltimore, MD 21205, Tel: 410-955-5765, FAX: 410-614-2913, EMAIL: stleach@jhmi.edu

*LEATHER, ROBERT P, M.D., Professor Emeritus, Albany Medical College, 47 New Scotland Ave., MC-157, Albany, NY 12208, Tel: 518-262-5640, FAX: 518-262-6720

*LEDGERWOOD, ANNA M, M.D., Director of Trauma, Detroit Receiving Hospital; Professor of Surgery, Wayne State University, 4201 St. Antoine, Room 2V, Detroit, MI 48201, Tel: 313-745-3485, FAX: 313-993-7729, EMAIL: aledgerw@med.wayne.edu

LEE, JEFFREY E, M.D., Professor of Surgery, UT MD Anderson Cancer Center, 1515 Holcombe Blvd., Unit 444, Houston, TX 77030, Tel: 713-792-7218, FAX: 713-745-5068, EMAIL: dhunter@mdanderson.org

*LEFFALL, LASALLE D, JR, M.D., Charles R. Drew Professor of Surgery, Department of Surgery, Howard University Hospital, 2041 Georgia Ave. NW, #4B02, Washington, DC 20060, Tel: 202-865-6237, FAX: 202-865-6433, EMAIL: lleffall@fac.howard.edu

*LEMPERT, NEIL, M.D., Professor of Surgery, Emeritus, Albany Medical College, 19 Pheasant Lane, Delmar, NY 12054, Tel: 518-439-6747, FAX: 518-262-5571

*LEONG, STANLEY P.L., M.D., Professor of Surgery, University of California, San Francisco, Mount Zion Medical Center, 1600 Divisadero, Room C-333, San Francisco, CA 94143-1674, Tel: 415-885-7309, FAX: 415-353-7721, EMAIL: leongs@surgery.ucsf.edu
LEPOR, HERBERT, M.D., Professor and Martin Spatz Chairman, Department of Urology, New York University School of Medicine, NYU Urology Associates, 150 East 32nd St., 2nd floor, New York, NY 10016, Tel: 646-825-6340, FAX: 646-825-6397, EMAIL: herbert.lepor@nyumc.org

*LEVENSON, STANLEY M, M.D., University Professor Emeritus; Director, Surgical Intensive Care – Burn Unit, Albert Einstein College of Medicine, 1661 Pine St., #815, San Francisco, CA 94109, Tel: 718-918-5566, FAX: 718-918-5567

*LEVINE, BARRY A, M.D., Retired, 1035 Park Ave., Apt. 2B, New York, NY 10028, Tel: 212-348-0948, FAX: 212-348-4838, EMAIL: barry@queso.com

*LEVITSKY, SIDNEY, M.D., David W. and David Cheever Professor of Surgery, Harvard Medical School; Chief, Division of Cardiothoracic Surgery, Beth Israel Deaconess Hospital, 110 Francis St., Ste. 2C, Boston, MA 02215-5501, Tel: 617-632-8383, FAX: 617-632-7562, EMAIL: slevitsk@caregroup.harvard.edu

*LEWIS, FRANK R, M.D., Executive Director, American Board of Surgery, 1617 JFK Blvd., #860, Philadelphia, PA 19103, Tel: 215-568-4000, FAX: 215-563-5718, EMAIL: flewis@absurgery.org

LI, BENJAMIN D, M.D., 1501 Kings Highway, Shreveport, LA 71130, Tel: 318-675-6123, FAX: 318-675-6171, EMAIL: bli@1suhsc.edu

LILLEMOE, KEITH D, M.D., Professor and Chairman, Department of Surgery, Indiana University School of Medicine, 545 Barnhill Drive, EH 203, Surgery, Indianapolis, IN 46202-5124, Tel: 317-274-5707, FAX: 317-274-8769, EMAIL: klillemo@iupui.edu

*LIM, ROBERT C, JR, M.D., Professor of Surgery, University of California, 533 Parnassus Ave., Box 780, San Francisco, CA 94143-0780, Tel: 415-353-1888, FAX: 415-476-3417, EMAIL: limr@surgery.ucsf.edu

*LIND, JAMES F, M.D., Professor and Emeritus Chairman, Department of Surgery, Eastern Virginia Medical School, 825 Fairfax Ave., Hotheimer Hl, Norfolk, VA 23507, Tel: 757-446-8950, FAX: 757-446-5197

*LINDENAUER, S. MARTIN, M.D., Professor Emeritus, V.A. Medical Center, 2228 Belmont Road, Ann Arbor, MI 48104-2833, Tel: 734-973-1752, FAX: 734-973-5535, EMAIL: smartinl@umich.edu
AMERICAN SURGICAL ASSOCIATION

*LITTLE, ALEX G, M.D., Chair and Professor, Wright State University, 1 Wyoming St., #7000 WCHE, Dayton, OH 45409, Tel: 937-208-3771, FAX: 937-208-2105, EMAIL: alex.little@wright.edu

*LITWAK, ROBERT S, M.D., Professor and Senior Cardiothoracic Surgeon, Mount Sinai Medical Center, 5th Ave. and 100th St., #7-54, New York, NY 10029, Tel: 212-241-8181, FAX: 212-659-6818, EMAIL: litwak@optonline.net

LIVINGSTON, DAVID H, M.D., Wesley J. Howe Professor and Chief of Trauma Surgery, UMDNJ-New Jersey Medical School, University Hospital, M234, 150 Bergen St., Newark, NJ 07103, Tel: 973-972-6869, FAX: 973-972-7441, EMAIL: livingst@umdnj.edu

LIVINGSTON, EDWARD H, M.D., Hudson-Penn Professor of Surgery, University of Texas Southwestern Medical Center, 5323 Harry Hines Blvd., #E7-126, Dallas, TX 75390-9156, Tel: 214-648-5043, FAX: 214-648-6700, EMAIL: edward.livingston@utsouthwestern.edu

*LIVINGSTONE, ALAN S, M.D., Chairman, Department of Surgery, University of Miami School of Medicine; Chief, Division of Surgical Oncology, University of Miami School of Medicine; Associate Vice President for Clinical Affairs and Co-Medical Director of the University of Miami School of Medicine, 310T, Room 3550, 1475 N.W. 12th Avenue, Miami, FL 33136, Tel: 305-585-1284, FAX: 305-324-7488, EMAIL: alivings@med.miami.edu

*LOCICERO, JOSEPH, III, M.D., Director of Surgical Oncology Maimonides Medical Center, 1158 Church St., Mobile, AL 36604, Tel: 251-591-0061, FAX: 251-432-4142, EMAIL: lociceroj@comcast.net

*LOGERFO, FRANK W, M.D., William V. McDermott Professor of Surgery, Harvard Medical School, Chief, Division of Vascular Surgery, New England Deaconess Hospital, 110 Francis St., #5-B, Boston, MA 02215, Tel: 617-632-9955, FAX: 617-632-7356, EMAIL: flogerfo@bidmc.harvard.edu

*LONG, DONLIN MARTIN, M.D., Professor and Chairman, Department of Neurosurgery, Johns Hopkins University School of Medicine, 600 North Wolfe Street, Baltimore, MD 21287-7709, Tel: 410-955-2252, FAX: 410-955-6407, EMAIL: dmlong@jhmi.edu
LONGAKER, MICHAEL T, M.D., Professor of Surgery; Director of Children’s Surgical Research Program, Stanford University, 257 Campus Drive, Stanford, CA 94305-5148, Tel: 650-736-1706, FAX: 650-736-1705, EMAIL: longaker@stanford.edu

LONGO, WALTER E, M.D., Professor of Surgery; Chief, Division of Gastrointestinal Surgery; Director of Colon and Rectal Surgery, Yale University School of Medicine, 330 Cedar St., LH 118, P.O. Box 208062, New Haven, CT 06520-8062, Tel: 203-785-2616, FAX: 203-785-2615, EMAIL: walter.longo@yale.edu

*LOOP, FLOYD D, M.D., CEO and Chairman, Board of Governors, Cleveland Clinic Foundation, 1950 Richmond Rd., #TR302, Cleveland, OH 44124, Tel: 216-297-8780, FAX: 216-297-8785, EMAIL: FDL@ccf.org

LORBER, MARC I, M.D., Vice President and Global Program Head; Novartis Pharmaceuticals Corporation, 1 Health Plaza, 405-2063, East Hanover, NJ 07936, Tel: 862-778-1859, FAX: 973-781-6512, EMAIL: marc.lorber@novartis.com

*LOWE, JAMES E, M.D., Professor of Surgery, Duke University Medical Center, Box 3954, Durham, NC 27710, Tel: 919-684-3235, FAX: 919-681-7524, EMAIL: lowe0004@mc.duke.edu

*LOWRY, STEPHEN F, M.D., Professor and Chairman, Department of Surgery, UMDNJ-Robert Wood Johnson School of Medicine, 125 Paterson St., #7300, Clinical Bldg., New Brunswick, NJ 08903, Tel: 732-235-6096, FAX: 732-235-6003, EMAIL: lowrysf@umdnj.edu

*LUCAS, CHARLES E, M.D., Professor of Surgery, Wayne State University, 4201 Saint Antoine Street, Detroit, MI 48201, Tel: 313-745-3485, FAX: 313-993-7729, EMAIL: clucas@med.wayne.edu

*LUCE, EDWARD A, M.D., Kiehn-DesPrez Professor and Chief, Division of Plastic and Reconstructive Surgery, University Hospitals of Cleveland, 55 Saint Andrews Fairway, Memphis, TN 38111, EMAIL: edluce@yahoo.com

LUCHETTE, FRED A, M.D., The Gladys and Ambrose Bowyer Professor of Surgery, Loyola University Medical Center, 2160 So First Ave., Department of Surgery, Maywood, IL 60153, Tel: 708-327-2072, FAX: 708-327-3474, EMAIL: fluchet@lumc.edu
LUKETICH, JAMES D., M.D., The Henry T. Bahnson Endowed Professor of Surgery; Chief, The Heart, Lung and Esophageal Surgery Institute, University of Pittsburgh Medical Center, C-800, PUH, 200 Lothrop Street, Pittsburgh, PA 15213, Tel: 412-647-2911, FAX: 412-647-3007, EMAIL: luketichjd@upmc.edu

LUND, DENNIS P, M.D., Surgeon-in-Chief, American Family Children’s Hospital; Chairman, Division of General Surgery, University of Wisconsin, H4/710 CSC, 600 Highland Ave., Madison, WI 53792-7375, Tel: 608-263-9419, FAX: 608-263-7652, EMAIL: lund@surgery.wisc.edu

*LYNCH, JOHN B, M.D., Professor and Chairman, Department of Plastic Surgery, Vanderbilt University Medical Center, 5810 Hillsboro Pike, Nashville, TN 37215-4602, Tel: 615-936-0160, FAX: 615-936-0167

*LYNCH, THOMAS G, M.D., Professor of Surgery, Associate Dean for Veterans Affairs, University of Nebraska Medical Center, 9721 Spring St., Omaha, NE 68124, Tel: 402-391-5811, FAX: 402-559-6749, EMAIL: tlynch@unmc.edu

*LYTLE, BRUCE W, M.D., Staff Surgeon, Department of Thoracic and Cardiovascular Surgery, Cleveland Clinic Foundation, 9500 Euclid Ave. MC J4-1, Cleveland, OH 44195, Tel: 216-444-6962, FAX: 216-444-3119, EMAIL: lytleb@ccf.org

*MACBETH, ROBERT A, M.D., Professor Emeritus of Surgery, University of Alberta, 3 Marine Parade Drive, Apt. 1204, Toronto, Ontario M8Y 3Z5, Canada, Tel: 416-443-0776

*MACHIEDO, GEORGE W, M.D., Vice Chairman, Department of Surgery, UMDNJ-New Jersey Medical School, 185 So Orange Ave., Newark, NJ 07103, Tel: 973-972-2858, FAX: 973-972-2925, EMAIL: george.machiedo@med.va.gov

*MACHLEDER, HERBERT I, M.D., Professor of Surgery, UCLA Center for Health Sciences, Box 956904, Los Angeles, CA 90095-6904, Tel: 310-825-5717, FAX: 310-441-9229, EMAIL: hmachleder@mednet.ucla.edu

*MACKENZIE, JAMES W, M.D., Dean Emeritus, Professor of Surgery Emeritus, Department of Surgery, UMDNJ-Robert Wood Johnson Medical School, One RW Johnson Place, P.O. Box 19, New Brunswick, NJ 08903-0019, Tel: 732-235-7802, FAX: 732-235-8150, EMAIL: mackenjw@umdnj.edu
MACKINNON, SUSAN E, M.D., Shoenberg Professor and Chief, Division of Plastic Surgery, Washington University School of Medicine, 660 So Euclid Ave., Box 8238, St. Louis, MO 63110, Tel: 314-362-4586, FAX: 314-362-4536, EMAIL: mackinnons@wustl.edu

*MACLEAN, LLOYD D, M.D., 80 Berlioz, Apt. 1402, Montreal, Quebec H3E 1N9, Canada, Tel: 514-765-9219, EMAIL: lloydm@vdn.ca

♦MADDAUS, MICHAEL A, M.D., Co-Director, Minimally Invasive Surgery Center; Garamella-Lynch Jensen Chair in Thoracic Cardiovascular Surgery; Professor, Program Director, University of Minnesota Medical Center, 420 Delaware St. S.E., Minneapolis, MN 55455, Tel: 612-624-9461, FAX: 612-625-9657, EMAIL: madda001@umn.edu

MADOFF, ROBERT D, M.D., Professor of Surgery, Chief, Division of Colon and Rectal Surgery, University of Minnesota Medical School, 420 Delaware St. SE, MMC450, Minneapolis, MN 55455, Tel: 612-625-7992, FAX: 612-625-4406, EMAIL: madoff@umn.edu

*MAGOVERN, GEORGE J, M.D., Professor and Chairman, Department of Surgery, Allegheny General Hospital, Allegheny Professional Building, 490 East North Ave., #302 14th Floor, Pittsburgh, PA 15212, Tel: 412-359-3715, FAX: 412-359-3878, EMAIL: ldernus@wpahs.org

MAHVI, DAVID M, M.D., James R. Hines Professor of Surgery, Vice Chair, Clinical Affairs, Northwestern Memorial Hospital, 676 N. St. Clair St., #650, Chicago, IL 60611, Tel: 312-695-1419, FAX: 312-695-1462, EMAIL: dmahvi@nmh.org

*MAIER, RONALD V, M.D., Surgeon-in-Chief, Harborview Medical Center, University of Washington, Box 359796, 325 Ninth Ave., Surgery, Seattle, WA 98104-2499, Tel: 206-731-3299, FAX: 206-731-8582, EMAIL: rommaier@u.washington.edu

MAKOWKA, LEONARD, M.D., Ph.D, FRCS(C), FACS, Emeritus Chairman Department of Surgery, Director of Transplantation Services, Cedars-Sinai Medical Center, 4401 Wilshire Blvd., Los Angeles, CA 90010, Tel: 323-556-5640, FAX: 323-556-5643, EMAIL: doclm1@gmail.com

*MALANGONI, MARK A, M.D., Professor, Department of Surgery, Case Western Reserve University; Chair, Department of Surgery, MetroHealth Medical Center, 2500 Metro Health Drive, H914, Cleveland, OH 44109-1998, Tel: 216-778-4558, FAX: 216-778-1099, EMAIL: mmalangoni@metrohealth.org
*MALM, JAMES R, M.D., Professor Emeritus of Surgery, Columbia University College of Physicians and Surgeons, 17 Osprey Village Drive, Fernandina Beach, FL 32034, Tel: 904-261-6489, EMAIL: jrmalmmd@aol.com

*MALONEY, JAMES V, JR, M.D., Louis D. Beaumont Professor of Surgery Emeritus, UCLA Medical Center, 139 N. Sautier Avenue, Los Angeles, CA 90049-2911, Tel: 310-472-9226, FAX: 310-471-3031

MANCINI, MARY C, M.D., Professor of Surgery, Chief of Cardiothoracic Surgery, Louisiana State University Health Sciences Center Shreveport, 1501 Kings Highway, Shreveport, LA 71130, Tel: 318-675-6514, FAX: 318-675-8246, EMAIL: mmanci@lsuhsc.edu

*MANNICK, JOHN A, M.D., FACS, Moseley Distinguished Professor of Surgery Emeritus, Harvard Medical School; Surgeon-in-Chief Emeritus, Brigham and Women’s Hospital, 81 Bogle St., Weston, MA 02493, Tel: 617-732-6820, FAX: 617-582-6169, EMAIL: jmannick@rics.bwh.harvard.edu

*MANSBERGER, ARLIE R, JR, M.D., Professor and Chairman of Surgery Emeritus, Medical College of Georgia, One 7th St., Unit 1502, Augusta, GA 30901, Tel: 706-721-0671, FAX: 706-721-6828, EMAIL: ellenmansberger@aol.com

*MANSON, PAUL NE, M.D., FACS, Professor and Chief, Plastic Surgery, Johns Hopkins Outpatient Center, 601 N. Caroline St., 8152 F McElderry, Baltimore, MD 21287-0981, Tel: 410-955-9469, FAX: 410-614-4333, EMAIL: pmanson@jhmi.edu

MARIN, MICHAEL L, M.D., Henry Kaufmann Professor and Chairman, Department of Surgery, Mount Sinai School of Medicine, 5 East 98th St., Box 1273, Surgery, New York, NY 10029, Tel: 212-241-5392, FAX: 212-423-0724, EMAIL: michael.marin@mountsinai.org

MARINCOLA, FRANCESCO M, M.D., Senior Investigator, National Institutes of Health, 10 Center Drive, Bldg. 10, Bethesda, MD 20892, Tel: 301-496-3098, FAX: 301-496-0011, EMAIL: fmarincola@cc.nih.gov

*MARK, JAMES B.D., M.D., (Jim and Maxie), Professor of Cardiothoracic Surgery Emeritus, Stanford University School of Medicine, 300 Pasteur Dr., Falk CV Research Center, Stanford, CA 94305-5407, Tel: 650-725-3816, FAX: 650-725-3846, EMAIL: jbdm@stanford.edu
MARKMANN, JAMES F, M.D., Ph.D., Associate Professor of Surgery, Hospital of the University of Pennsylvania, 55 Fruit St., White 503, Transplant Div., Boston, MA 02114, Tel: 617-643-4533, FAX: 617-654-4579, EMAIL: jmarkmann@partners.org

*MARSHALL, JOHN C, M.D., Professor of Surgery, University of Toronto, St. Michaels Hospital, 30 Bond St., Room 4-007, Bond Wing, Toronto, Ontario M5B 1W8, Canada, Tel: 416-864-5225, FAX: 416-864-5141, EMAIL: marshallj@smh.toronto.on.ca

*MARTIN, LESTER W, M.D., Emeritus Professor of Surgery and Pediatrics, University of Cincinnati, The Children's Hospital, 3094 Waynesville Rd., Bellbrook, OH 45305-9741, Tel: 937-848-2307, FAX: 740-636-1180, EMAIL: lmartin001@ameritech.net

♦ MARTINDALE, ROBERT G, M.D., Professor and Chief, Division of General Surgery; Medical Director for Hospital Nutrition Services, Oregon Health & Science University, 3181 SW Sam Jackson Park Rd., L223A, Portland, OR 97239, Tel: 503-494-9145, FAX: 503-494-8884, EMAIL: martinr@ohsu.edu

%MASON, EDWARD E, M.D., Professor Emeritus, University of Iowa, Hospitals and Clinics, Iowa City, IA 52246, Tel: 319-356-2779, FAX: 404-969-3725, EMAIL: edward-mason@uiowa.edu

%MASON, G. ROBERT, M.D., Retired, 846 Bonnie Brae, River Forest, IL 60305, Tel: 708-771-5077, FAX: 708-327-2382, EMAIL: grmason@earthlink.net

%MATAS, ARTHUR J, M.D., University of Minnesota Hospitals, 420 Delaware St. SE, MMC 328, Minneapolis, MN 55455, Tel: 612-625-6460, FAX: 612-624-6969, EMAIL: matas001@umn.edu

%MATHISEN, DOUGLAS J, M.D., Chief, Cardiothoracic Surgery, Massachusetts General Hospital; Hermes C. Grillo Professor of Thoracic Surgery, Harvard Medical School; Exec. Comm., Board of Directors, First Vice President, Society for Thoracic Surgeons, 55 Fruit St., Blake 1570, Boston, MA 02114, Tel: 617-726-2806, FAX: 617-726-7667, EMAIL: dmathisen@partners.org

MATTHEWS, JEFFREY B, M.D., Dallas B. Phemister Professor and Chairman, Department of Surgery, University of Chicago, 5841 S. Maryland Ave., MC 5029, Chicago, IL 60637, Tel: 773-702-0881, FAX: 773-702-2140, EMAIL: jmatthews@surgery.bsd.uchicago.edu
*MATTHEWS, LARRY S, M.D., University of Michigan Medical School, Section of Orthopaedic Surgery, 5830 No Campbell Avenue, Tucson, AZ 85718, Tel: 734-936-5685, FAX: 734-763-0190

*MATTOX, KENNETH L, M.D., Chief of Staff; Chief of Surgery; Professor and Vice Chairman of Surgery, Baylor College of Medicine, One Baylor Plaza, Houston, TX 77030, Tel: 713-798-4557, FAX: 713-796-9605, EMAIL: redstart@aol.com

*MAULL, KIMBALL I, M.D., Adjunct Professor of Surgery, UPMC, Head-Section of Trauma Surgery, Hamad General Hospital, Box 3050, Qatar, Tel: 974-659-1402, FAX: 974-439-1872, EMAIL: maullki@upmc.edu

*MAVROUDIS, CONSTANTINE, M.D., Professor of Surgery, Northwestern University Medical School; Division Head, Cardiovascular Surgery, Children’s Memorial Hospital, 9500 Euclid Ave., M41-02, Cleveland, OH 44195, Tel: 216-636-5288, FAX: 216-636-5859, EMAIL: mavrouc@ccf.org

*MAY, JAMES W, JR, M.D., Professor of Surgery, Harvard Medical School; Chief, Division of Plastic Surgery, Massachusetts General Hospital, 15 Parkman St., WAC 435, Boston, MA 02114, Tel: 617-726-8220, FAX: 617-724-8606, EMAIL: jmcaninch@urology.ucsf.edu

*MCANINCH, JACK W, M.D., Professor of Urology, University of California, San Francisco; Chief of Urology, San Francisco General Hospital, Department of Urology, Suite 3A2D, San Francisco, CA 94110, Tel: 415-476-3372, FAX: 415-206-5153, EMAIL: jmcaninch@urology.ucsf.edu

*MCCANN, RICHARD L, M.D., Professor of Surgery, Duke University Medical Center, Department of Surgery, DUMC 2990, Durham, NC 27710, Tel: 919-684-2620, FAX: 919-681-8679, EMAIL: mccan002@mc.duke.edu

*MCCARTHY, JOSEPH G, M.D., FACS, Lawrence D. Bell Professor of Plastic Surgery, Director, Institute of Reconstructive Plastic Surgery, New York University Medical Center, 530 First Avenue, New York, NY 10016, Tel: 212-263-5209, FAX: 212-988-7230, EMAIL: joseph.mccarthy@med.nyu.edu

MCCAULEY, ROBERT L, M.D., Professor of Surgery, Division of Plastic Surgery; Professor, Department of Pediatrics, University of TX Medical Branch; Chief Plastic and Reconstructive Surgery, Medical Director, Shriners Burns Hospital Tissue Bank, 815 Market Street, Galveston, TX 77550, Tel: 409-770-6741, FAX: 409-770-6919, EMAIL: rmccauley@utmb.edu
MCCLELLAND, ROBERT N, M.D., Professor Emeritus of Surgery, The University of Texas Southwestern Medical Center at Dallas, 5323 Harry Hines Blvd., Surgery MC-9156, Dallas, TX 75390-9156, Tel: 214-648-3540

MCCOLLUM, CHARLES H, M.D., Professor of Surgery, Baylor College of Medicine, 10 S. Briar Hollow #6, Houston, TX 77027, Tel: 713-798-8400, FAX: 713-790-6849, EMAIL: mccollum@bcm.tmc.edu

MCCORMACK, ROBERT M, M.D., Professor of Plastic Surgery Emeritus, University of Rochester School of Medicine & Dentistry, 280 Kings Highway, Cape May Court House, NJ 08210, Tel: 251-990-9472, EMAIL: urdmac@aol.com

MCDONALD, JOHN C, M.D., Professor and Chairman, Surgeon-in-Chief, Louisiana State University Medical Center, P.O. Box 33932, Shreveport, LA 71130, Tel: 318-675-5240, FAX: 318-675-5244, EMAIL: jmcdon@lsumc.edu

MCFADDEN, DAVID W, M.D., Professor and Chairman, Department of Surgery, University of Vermont, 111 Colchester Ave., Fletcher House 301, Burlington, VT 05401, Tel: 802-847-5354, FAX: 802-847-5552, EMAIL: david.mcfadden@vtmednet.org

MCFEE, ARTHUR S, M.D., Professor Emeritus, General Surgery, The University of Texas Health Science Center, 7703 Floyd Curl Dr., MC7842, San Antonio, TX 78229-3900, Tel: 210-567-5730, FAX: 210-567-7085, EMAIL: mcfee@uthscsa.edu

MCGRAVTH, MARY H, M.D., Professor of Surgery, Division of Plastic Surgery, University of California, San Francisco, 505 Parnassus Ave., MS93, San Francisco, CA 94143-0932, Tel: 415-353-4283, FAX: 415-502-4767, EMAIL: mary.mcgrath@ucsfmedctr.org

MCHENRY, CHRISTOPHER R, M.D., Professor of Surgery, Case Western Reserve University School of Medicine, Vice Chairman, Department of Surgery, MetroHealth Medical Center, Cleveland, Ohio, 2500 MetroHealth Drive, Cleveland, OH 44109-1998, Tel: 216-778-4753, FAX: 216-778-3774, EMAIL: cmchenery@metrohealth.org

MCILRATH, DONALD C, M.D., Emeritus Professor and Chairman, Department of Surgery, Mayo Medical School, 2525 Hillside Lane SW, Rochester, MN 55902, Tel: 507-289-7284, EMAIL: donald25@aol.com
*MCKNEALLY, MARTIN F, M.D., Professor Emeritus of Surgery and Member, Joint Centre for Bioethics, University of Toronto, 77 Forest Grove Drive, Toronto, Ontario M2K 1Z4, Canada, Tel: 416-223-7609, FAX: 416-223-7657, EMAIL: martin.mckneally@utoronto.ca

*MCNAUGHTHIN, JOSEPH S, M.D., Professor and Head, Division of Thoracic and Cardiovascular Surgery, University of Maryland Hospital, 10 East Lee St., #2507, Baltimore, MD 21202, Tel: 410-328-3218, FAX: 410-328-2750, EMAIL: jmclaughlin@smtp.umm.edu

MCLEOD, ROBIN S, M.D., Professor of Surgery and Health Policy, Management & Evaluations, University of Toronto, 600 University Ave., #449, Toronto, Ontario M5G 1X5, Canada, Tel: 416-586-4800, FAX: 416-586-8644, EMAIL: rmcleod@mtsina.on.ca

MCMASTERS, KELLY M, M.D., Ph.D., Sam and Lolita Weakley Professor and Chairman, Department of Surgery, University of Louisville, Ambulatory Care 550 S. Jackson St. 2nd Floor, Louisville, KY 40202, Tel: 502-852-5447, FAX: 502-852-1704, EMAIL: mcmasters@louisville.edu

*MCNAMARA, J. JUDSON, M.D., Professor Emeritus, John A. Burns School of Medicine, University of Hawaii, 28 Niuhi Street, Department of Surgery, Honolulu, HI 96821-1517, Tel: 808-586-2920, FAX: 808-586-1140

*MCNAMARA, J. JUDSON, M.D., Emeritus Professor, University of Oxford, 1509 Sherbrooke St., West, Apt. 21, Montreal, Quebec H3G 1M1, Canada, Tel: 514-750-0280, EMAIL: jonathan.meakins@muhc.mcgill.ca

MEAKINS, JONATHAN L, M.D., Emeritus Professor, University of Oxford, 1509 Sherbrooke St., West, Apt. 21, Montreal, Quebec H3G 1M1, Canada, Tel: 514-750-0280, EMAIL: jonathan.meakins@muhc.mcgill.ca

*MEGUID, MICHAEL M, M.D., Ph.D., Professor, Department of Surgery, Physiology and Neuroscience; Program Director, Surgical Metabolism and Nutrition Lab; Chief, Surgical Nutrition Service; Associate Director, Breast Care Program; Administrator, Combined Surgical Research Labs, University Hospital, 750 E. Adams Street, Syracuse, NY 13210, Tel: 315-464-6283, FAX: 315-464-6238, EMAIL: meguidmi@upstate.edu
MELVIN, W. SCOTT, M.D., Professor of Surgery, Chief, Division of General & Gastrointestinal Surgery, Director of Center for Minimally Invasive Surgery – The Ohio State University Medical Center, N. 729 Doan Hall, 410 W. Tenth Ave., Columbus, OH 43210-1228, Tel: 614-293-9989, FAX: 614-293-4826, EMAIL: scott.melvin@osumc.edu

*MENGUY, RENE, M.D., Professor of Surgery Emeritus, University of Rochester School of Medicine and Dentistry; Senior Attending Surgeon, The Genesee Hospital, 16 Bramblewood Point, Naples, FL 34105, Tel: 239-643-0763, FAX: 239-643-6564, EMAIL: rmenguy@earthlink.net

*MENTZER, ROBERT M, JR, M.D., Professor of Surgery and Physiology, Wayne State University School of Medicine, 4201 St. Anoine, UHC-4J, Detroit, MI 48201, Tel: 313-577-1335, FAX: 313-577-8777, EMAIL: rmentzer@med.wayne.edu

MENTZER, STEVEN J, M.D., 75 Francis St., Thoracic Surgery, Boston, MA 02115, Tel: 617-732-6988, FAX: 617-730-2898, EMAIL: smentzer@partners.org

*MENZOIAN, JAMES O, M.D., Professor of Surgery, University of Connecticut; Medical Director Collaborative Center for Clinical Care Improvement, University of CT Health Center, 263 Farmington Ave., Department of Surgery, Farmington, CT 06030-3806, Tel: 860-679-7650, FAX: 860-679-4948, EMAIL: jmenzoian@uchc.edu

MERCER, DAVID W, M.D., Associate Professor in Surgery, Vice Chairman, Department of Surgery, University of Texas Medical School; Chief of Surgery, Lyndon B. Johnson General Hospital, 983280 Nebraska Medical Center, Omaha, NE 68198-3280, Tel: 402-559-8272, FAX: 402-559-6749, EMAIL: dwmercer@unmc.edu

MEREDITH, J. WAYNE, M.D., Director, Division of Surgical Sciences and Chief of Surgery, Wake Forest University Baptist Medical Center; Residency Program Director, Medical Center Blvd., Surgery, Winston-Salem, NC 27157, Tel: 336-716-7579, FAX: 336-716-5414, EMAIL: merediw@wfubmc.edu

*MERENDINO, K. ALVIN, M.D., Professor and Chairman Emeritus, University of Washington Medical Center, The Highlands, Seattle, WA 98177-5001, Tel: 206-361-2718, EMAIL: k.merendino@comcast.net

MERION, ROBERT M, M.D., Professor of Surgery, University of Michigan, 2922 Taubman Center, SPC 5331, Ann Arbor, MI 48109-5331, Tel: 734-936-7336, FAX: 734-763-3187, EMAIL: merionb@umich.edu
*MERRIEL, RONALD C, M.D., Medical College of Virginia, Department of Surgery, West Hospital, P.O. Box 980480, 1101 E. Marshall St., Richmond, VA 23298-0480, Tel: 804-827-1020, FAX: 804-827-1029, EMAIL: rmerrell@mcvh.vcu.edu

*MERRICK, HOLLIS W, III, M.D., Chief, Division of General Surgery; University Medical Center, 3000 Arlington Ave., Toledo, OH 43614, Tel: 419-383-6937, FAX: 419-383-3057, EMAIL: hollis.merrick@utoledo.edu

*MERRILL, WALTER H, M.D., Professor of Surgery, Cardiothoracic Surgery, University of Mississippi Medical Center, 2500 North State St., Cardiothoracic Sur, Jackson, MS 39216-4505, Tel: 601-984-5176, FAX: 601-984-5198, EMAIL: wmerrill@surgery.umsmed.edu

MESSINA, LOUIS M, M.D., Chief, Division of Vascular Surgery; Vice Chair, Department of Surgery, University of Massachusetts Medical School, 55 Lake Avenue North, Worcester, MA 01655-0337, Tel: 508-856-5599, FAX: 508-856-8329, EMAIL: messinal@ummhc.org

*MEYER, ANTHONY A, M.D., Colin G. Thomas Jr. Professor and Chairman, Department of Surgery, University of North Carolina School of Medicine, 2115 BioInformatics CB 7050, Chapel Hill, NC 27599-7050, Tel: 919-966-4321, FAX: 919-966-6009, EMAIL: aameyer@med.unc.edu

*MEYERS, WILLIAM C, M.D., Professor and Chairman, Department of Surgery; Senior Associate Dean, Drexel University College of Medicine, 245 No 15th St., MS 413, Surgery Dept, Philadelphia, PA 19102-1192, Tel: 215-762-4157, FAX: 215-762-6275, EMAIL: wmeyers@drexelmed.edu

MICHELASSI, FABRIZIO, M.D., Lewis Atterbury Stimson Professor of Surgery; Chairman, Department of Surgery, Weill Medical College of Cornell University; Surgeon-in-Chief, New York Presbyterian Hospital-Weill Cornell Medical Center, 525 E. 68 St., Rm F-739, Box 129, New York, NY 10065, Tel: 212-746-5143, FAX: 212-746-8753, EMAIL: fam2006@med.cornell.edu

*MILLARD, D. RALPH, JR, M.D., 16531 NE 35th Ave., Apt. 2, No Miami Beach, FL 33160-3876, Tel: 305-792-0887

MILLER, CHARLES M, M.D., Director of Liver Transplantation, Cleveland Clinic Foundation, 9500 Euclid Avenue, Desk A-110, Cleveland, OH 44195, Tel: 216-445-2381, FAX: 216-444-9375, EMAIL: millerc8@ccf.org
*MILLER, D. CRAIG, M.D., Professor of Cardiovascular Surgery, Stanford University School of Medicine, 300 Pasteur Dr., Falk CV Research Center, Stanford, CA 94305-5407, Tel: 650-725-3826, FAX: 650-725-3846, EMAIL: dcm@stanford.edu

*MILLER, DON R, M.D., Professor of Surgery, Emeritus, University of California at Irvine, 743 Louisiana, Lawrence, KS 66044, Tel: 785-842-7430

*MILLER, FLETCHER A, M.D., 17538 Caminito Balata, San Diego, CA 92128, Tel: 858-675-9697, EMAIL: fmiller5@san.rr.com

*MILLER, JOSEPH I, JR, M.D., Professor of Cardiothoracic Surgery; Chief, Section of General Thoracic Surgery, Emory University School of Medicine, 550 Peachtree Street NE, 6th Floor MOT, Atlanta, GA 30308, Tel: 404-686-2515, FAX: 404-686-4788, EMAIL: jmiller6331@aol.com

*MILLER, JOSHUA, M.D., Research Professor, Northwestern University, 675 N. Saint Claire St., Galter 17-200, Chicago, IL 60611, Tel: 312-503-1801, FAX: 312-503-3366, EMAIL: joshuamiller@northwestern.edu

*MILLER, SIDNEY F, M.D., Professor, Ohio State University Hospital, 410 West 10th Ave., N717 Doan Hall, Columbus, OH 43210-1228, Tel: 614-293-5710, FAX: 614-293-3425, EMAIL: sidney.miller@osumc.edu

*MILLER, STEPHEN H, M.D., MPH, Clinical Professor of Surgery and Family Medicine, UCSD School of Medicine, 39289 Beringer Drive, Murrieta, CA 92563, Tel: 951-461-0635, FAX: 951-461-0635, EMAIL: shmillermd@yahoo.com

*MILLER, THOMAS A, M.D., Ammons Professor of Surgery, Medical College of Virginia, 1201 Broad Rock Blvd., Surgery Svc (112), Richmond, VA 2329, Tel: 804-675-5112, FAX: 804-675-5390, EMAIL: thomas.miller3@med.va.gov

*MILLIKAN, WILLIAM J, JR, M.D., Professor and Vice-Chairman Emeritus, Texas Tech University Hospital Sciences Center, 520 Mary St., Ste. 520, Evansville, IN 47710

MOLEY, JEFFREY F, M.D., Professor of Surgery, Washington University, 660 So Euclid, Box 8109, St. Louis, MO 63110, Tel: 314-747-0064, FAX: 314-747-1310, EMAIL: moleyj@wustl.edu
*MONACO, ANTHONY P, M.D., Professor of Surgery, Harvard Medical School, New England Deaconess Hospital, 110 Francis St., 7th Fl, Boston, MA 02215, Tel: 617-632-9822, FAX: 617-632-9820, EMAIL: amonaco@bidmc.harvard.edu

*MONCURE, ASHBY C, M.D., Clinical Professor of Surgery, Harvard Medical School, Massachusetts General Hospital, 3 Glen Oak Drive, Wayland, MA 01778, Tel: 617-724-3760

MONETA, GREGORY L, M.D., Professor of Surgery, Chief of Vascular Surgery, Oregon Health & Science University, 3181 SW Sam Jackson Pk Rd., OP-11, Portland, OR 97239, Tel: 503-494-7593, FAX: 503-494-4324, EMAIL: monetag@ohsu.edu

*MOODY, FRANK G, M.D., Professor of Surgery, Department of Surgery, University of Texas Health Science Center at Houston, 6431 Fannin St., MSB4284, Houston, TX 77030, Tel: 713-500-7241, FAX: 713-500-7268, EMAIL: frank.g.moody@uth.tmc.edu

MOON, MARC R, M.D., Joseph C. Bancroft Professor of Surgery, Washington University School of Medicine, St. Louis Missouri, 660 S. Euclid, Campus box 8234, St. Louis, MO 63110-1013, Tel: 314-362-0993, FAX: 314-747-0917, EMAIL: moonm@wustl.edu

*MOORE, ERNEST E, JR, M.D., Chief, Department of Surgery, Denver General Hospital; Professor and Vice Chairman of Surgery, University of Colorado Health Sciences Center, 777 Bannock Street, Denver, CO 80204, Tel: 303-436-6558, FAX: 303-436-6572, EMAIL: ernest.moore@dhha.org

MOORE, FRANCIS D, JR, M.D., Professor of Surgery, Harvard Medical School; Chief, Division of General & Gastrointestinal Surgery; Chief, Endocrine Surgery Unit, Brigham & Women’s Hospital, 75 Francis St., Boston, MA 02115, Tel: 617-732-6830, FAX: 617-739-1728, EMAIL: fmoore@partners.org

MOORE, FREDERICK A, M.D., Professor of Surgery, Weill Cornell Medical College; Head, Division of Surgical Critical Care & Acute Care Surgery, Department of Surgery, The Methodist Hospital, 6550 Fannin St. #SM1661, Houston, TX 77030, Tel: 713-441-6489, FAX: 713-790-6489, EMAIL: FAMoore@tmhs.org
MOORE, THOMAS C, M.D., Ph.D., FACS, Professor of Surgery, UCLA Medical School, Chief of Pediatric Surgery, Harbor-UCLA Medical Center, 1000 West Carson St., Surgery, Torrance, CA 90509, Tel: 310-544-2221, FAX: 310-377-2564, EMAIL: tcmoore@ucla.edu

MOORE, WESLEY S, M.D., Professor, UCLA, 200 UCLA Medical Plaza, Ste. 510-6, Los Angeles, CA 90095-6908, Tel: 310-825-9641, FAX: 310-794-7648, EMAIL: wmoore@mednet.ucla.edu

MOOSSA, A. RAHIM, M.D., Professor of Surgery and Emeritus Chairman, Associate Dean and Special Counsel to the Vice Chancellor for Health Sciences, Director of Tertiary and Quarternary Referral Services, University of California, San Diego Medical Center, 9300 Campus Point Dr., MC 7212, La Jolla, CA 92037, Tel: 858-657-6112, FAX: 858-657-6116, EMAIL: amoossa@ucsd.edu

MORGENSTERN, LEON, M.D., Director, Bioethics Program, Emeritus Director of Surgery, Cedars-Sinai Medical Center; Emeritus Professor of Surgery, UCLA School of Medicine, 8700 Beverly Blvd., #216, Los Angeles, CA 90048, Tel: 310-423-9636, FAX: 310-423-9638, EMAIL: morgenstern@csbs.org

MORRIS, JOHN A, JR, M.D., Professor of Surgery, Director, Trauma & Burn Patient Care Center, Vanderbilt University Medical Center, 1211 21st Avenue S., 404 MAB, Nashville, TN 37212, Tel: 615-936-0176, FAX: 615-936-3374, EMAIL: john.morris@vanderbilt.edu

MORRIS, JON BENJAMIN, M.D., Professor and Vice Chair of Education; Department of Surgery, University of Pennsylvania School of Medicine, 3400 Spruce St., 4 Silverstein, Philadelphia, PA 19104, Tel: 215-662-2131, FAX: 215-349-8195, EMAIL: morrisjo@uphs.upenn.edu

MORROW, MONICA, M.D., Chief of the Breast Service, Anne Burnett Windfohr Chair in Clinical Oncology, Memorial Sloan-Kettering Cancer Center, 1275 York Ave., New York City, NY 10021, Tel: 212-639-5248, FAX: 212-319-2284, EMAIL: morrowm@mskcc.org

MORTON, DONALD L, M.D., Emeritus Professor of Surgery, UCLA; Chief, Melanoma Program, Director, Fellowship Program, John Wayne Cancer Institute at St. John’s Health Center, 2200 Santa Monica Blvd., Santa Monica, CA 90404, Tel: 310-829-8781, FAX: 310-582-7185, EMAIL: mortond@jwci.org
*MOSS, GERALD S, M.D., Dean, College of Medicine, University of Illinois at Chicago; Professor of Surgery, University of Illinois, 1853 W. Polk St., MC 784, Chicago, IL 60612, Tel: 312-996-3500, FAX: 312-996-9006, EMAIL: gmoss@uic.edu

MOSS, R. LAWRENCE, M.D., Robert Pritzker Professor and Chief, Yale University School of Medicine; Surgeon-Chief, Yale New Haven Children’s Hospital, 333 Cedar St., FMB 132, P.O. Box 208062, New Haven, CT 06520-8062, Tel: 203-785-2701, FAX: 203-785-3820, EMAIL: larry.moss@yale.edu

*MOULDER, PETER V, M.D., Adjunct Prof., Department of Biomedical Engineering, Tulane University; Emeritus Prof. of Surgery, Tulane University School of Medicine; Medical Director, Vital Assist/BioSouth Research Laboratories; Clinical Prof. of Surgery, Louisiana State University School of Medicine, 1542 Tulane Ave., Thoracic Surg., #756, New Orleans, LA 70112-2822, Tel: 504-568-8199, FAX: 504-568-4633, EMAIL: pmould@lsumc.edu

*MOYLAN, JOSEPH A, M.D., Duke University Medical Center, Box 3708, Durham, NC 27710, EMAIL: moyla001@mc.duke.edu

*MUELLER, C. BARBER, M.D., Professor Emeritus of Surgery, McMaster University, 139 Dalewood Crescent, Hamilton, Ontario L8S 4B8, Canada, Tel: 905-522-4819, EMAIL: charbermueller@cogeco.ca

*MULDER, DAVID S, M.D., Interim Chair McGill Department of Surgery; Director of Thoracic Surgery McGill University, 1650 Cedar Ave., Rm L9-512, Montreal, Quebec H3G 1A4, Canada, Tel: 514-935-4888, FAX: 514-937-5522, EMAIL: david.mulder@muhc.mcgill.ca

*MULDER, DONALD G, M.D., Emeritus Professor of Surgery, Department of Thoracic Surgery, UCLA Medical Center, 410 Amalfi Drive, Pacific Palisades, CA 90272, Tel: 310-825-0857, FAX: 310-825-5895, EMAIL: dmmulder@mednet.ucla.edu

MULHOLLAND, MICHAEL W, M.D., F. A. Coller Professor and Chairman, Department of Surgery, University of Michigan Medical Center, 1500 E. Medical Center Dr., Rm 2920, THCC, Ann Arbor, MI 48109-0331, Tel: 734-936-3236, FAX: 734-763-5615, EMAIL: micham@med.umich.edu
*MULLEN, JAMES L, JR, M.D., Vice Chair, Surgery Education; Corporate Director, Perioperative Services; Professor of Surgery, Hospital of the University of Pennsylvania, University of Pennsylvania Health System, 3400 Spruce St., 4 Maloney, Philadelphia, PA 19104, Tel: 215-662-2089, FAX: 215-614-0953, EMAIL: mullen@uphs.upenn.edu

*MULLER, WILLIAM H, JR, M.D., Vice President for Health Affairs, Emeritus, Professor of Surgery Emeritus, Department of Surgery, University of Virginia, 132 Lancaster Dr., Box 34, Irvington, VA 22480, Tel: 434-296-1766

MULLIGAN, MICHAEL S, M.D., Associate Professor; Director, Lung Transplant Program; Laboratory Director, Cardiopulmonary Surgery, University of Washington, 1959 NE Pacific, Rm AA115, Bx 356310, Seattle, WA 98195-6310, Tel: 206-221-2504, FAX: 206-543-0325, EMAIL: msmmd@u.washington.edu

*MULLINS, RICHARD J, M.D., Professor of Surgery; Chief of Trauma/Critical Care Section, Oregon Health & Science University, 3181 SW Sam Jackson Park Rd., L223A, Portland, OR 97239, Tel: 503-494-5300, FAX: 503-494-6519, EMAIL: mullinsr@ohsu.edu

MULVIHILL, SEAN J, M.D., Professor of Surgery; Chair, Department of Surgery, University of Utah, 30 N. 1900 East, Room 3B110 SOM, Salt Lake City, UT 84132-2301, Tel: 801-581-7304, FAX: 801-581-6612, EMAIL: sean.mulvihill@hsc.utah.edu

*MURPHY, JOHN J, M.D., Professor of Urology, Emeritus, University of Pennsylvania School of Medicine, 941 Wootton Rd., Bryn Mawr, PA 19010-2227, Tel: 610-534-6182, FAX: 410-828-7275

*MURRAY, GORDON F, M.D., Professor and Chairman, Chief of Surgical Services, West Virginia University, 4217 Skelington Court, Southport, NC 28461, Tel: 910-454-7078, EMAIL: gmurray@hsc.wvu.edu

*MURRAY, JOSEPH E, M.D., Chief of Plastic Surgery Emeritus, 108 Abbott Road, Wellesley Hills, MA 02181, Tel: 781-235-4356, FAX: 781-235-2612, EMAIL: josmurray@aol.com

MYERS, STUART I, M.D., Associate Professor, Division of Vascular Surgery, Virginia Commonwealth University Health System, 1500 S. 48th St., Ste. 614, Lincoln, NE 68506, Tel: 423-757-0860, FAX: 423-490-3574, EMAIL: smyers1951@aol.com
*NABSETH, DONALD C, M.D., Professor of Surgery, Emeritus, Tufts University, Clinical Professor of Surgery, Stanford University School of Medicine, 23500 Cristo Rey Dr., Cupertino, CA 95014, Tel: 650-694-7334

NAGORNEY, DAVID M, M.D., Professor, Division of General Surgery, Mayo Clinic, 200 First St. SW, Rochester, MN 55905, Tel: 507-284-4321, FAX: 507-284-5196, EMAIL: nagorney.david@mayo.edu

*NAHRWOLD, DAVID L, M.D., Professor of Surgery Emeritus, Northwestern University, 2052 Claridge Court, Northbrook, IL 60062, Tel: 847-714-1143, FAX: 847-714-1134, EMAIL: dnahrwold@northwestern.edu

*NAJAFI, HASSAN, M.D., Professor, Rush Medical College; Surgical Director, Rush Heart Institute, Rush-Presbyterian St. Luke’s Medical Center, 1725 West Harrison St., #1156, Chicago, IL 60612, Tel: 312-563-2762, FAX: 312-563-4388, EMAIL: hnajafimd@yahoo.com

*NAJARIAN, JOHN S, M.D., Clinical Professor of Surgery and Regents’ Professor Emeritus, Department of Surgery, University of Minnesota, 516 Delaware St. SE, 11-132 PWB, Minneapolis, MN 55455, Tel: 612-625-8444, FAX: 612-625-5420, EMAIL: najar001@umn.edu

*NAJI, ALI, M.D., J. William White Professor of Surgery, Hospital of the University of Pennsylvania, 3400 Spruce Street, Philadelphia, PA 19104, Tel: 215-662-2066, FAX: 215-349-5906, EMAIL: ali.naji@uphs.upenn.edu

NAKAYAMA, DON K, M.D., Milford B. Hatcher Professor of Surgery; Chair, Department of Surgery; Program Director, General Surgery, Mercer University School of Medicine, 777 Hemlock St., Macon, GA 31201, Tel: 478-633-1367, FAX: 478-633-5153, EMAIL: nakayama.don@mccg.org

*NANCE, FRANCIS C, M.D., Chairman, Department of Surgery, Emeritus, St. Barnabas Medical Center; Professor of Surgery, UMDNJ-Newark, 309 White Oak Ridge Rd., Short Hills, NJ 07078-1155, Tel: 973-467-7964, FAX: 973-467-6794, EMAIL: carter@fcnance.net

NAPOLITANO, LENA M, M.D., Professor of Surgery, Chief, Surgical Critical Care; Associate Chair, Department of Surgery, University of Michigan Medical Center, 1500 E. Medical Center Dr., Box 0033, Ann Arbor, MI 48109-0033, Tel: 734-936-9690, FAX: 434-936-9657, EMAIL: lenan@umich.edu
AMERICAN SURGICAL ASSOCIATION

NEWMAN, KURT D, M.D., Executive Director, Joseph E. Robert, Jr., Center for Surgical Care; Professor of Surgery and Pediatrics, George Washington University; Surgeon-in-Chief, Children’s National Medical Center, 111 Michigan Avenue, NW, Washington, DC 20010, Tel: 202-884-2151, FAX: 202-884-4174, EMAIL: knewman@cnmc.org

*NEWSOME, HEBER H, JR, M.D., Dean, School of Medicine at Virginia Commonwealth University, P.O. Box 980565, Richmond, VA 23298, Tel: 804-828-9788, FAX: 804-828-7628, EMAIL: newsome@som.vcu.edu

*NICHOLS, RONALD L, M.D., Attending Surgeon; Senior Visiting Surgeon, Medical Center of Louisiana at New Orleans; The William Henderson Professor of Surgery; Professor of Microbiology and Immunology, 1430 Tulane Ave., SL-22, New Orleans, LA 70112, Tel: 504-988-5168, FAX: 504-988-3843, EMAIL: ronald.nichols@tulane.edu

*NIEDERHUBER, JOHN E, M.D., Director, National Cancer Institute, 31 Center Dr., Bldg. 31, Rm 11A48, MSC 2590, Bethesda, MD 20892-2590, Tel: 301-496-5615, FAX: 301-402-0338, EMAIL: niederj@mail.nih.gov

*NOLAN, STANTON P, M.D., Professor of Surgery Emeritus, University of Virginia Health Sciences Center, 250 Pantops Mountain Rd., Apt. 5204, Charlottesville, VA 22911, Tel: 434-972-2439, FAX: 434-972-2566, EMAIL: snolan@virginia.edu

*NOONE, R. BARRETT, M.D., FACS, Executive Director, American Board of Plastic Surgery; Clinical Professor of Surgery, University of Pennsylvania School of Medicine, Seven Penn Center, 888 Glen Brook Ave., Bryn Mawr, PA 19010, Tel: 610-527-4833, FAX: 610-527-3568, EMAIL: parsal@aol.com

*NORMAN, JOHN C, M.D., 281 Hunters Ridge Road, Concord, MA 01742, Tel: 978-369-1266, EMAIL: jcn281@hotmail.com

*NORTON, JEFFREY A, M.D., Professor of Surgery, Stanford University School of Medicine, 300 Pasteur Drive, Rm H3591, Stanford, CA 94305-5461, Tel: 650-498-6606, FAX: 650-736-1663, EMAIL: janorton@stanford.edu

*NUMANN, PATRICIA J, M.D., Lloyd S. Rogers Professor Emeritus, Upstate Medical University, 323 Highland Ave., Syracuse, NY 13203, Tel: 315-476-4741, EMAIL: numannp@upstate.edu
NUSSBAUM, MICHAEL S, M.D., Professor of Surgery; Professor and Chair Department of Surgery, University of Florida College of Medicine, Jacksonville, 653 West 8th Str., 3rd Floor, Faculty Clin, Jacksonville, FL 32209, Tel: 904-244-5502, FAX: 904-244-6252, EMAIL: michael.nussbaum@jax.ufl.edu

NYBERG, SCOTT L, M.D., Ph.D., Professor of Surgery, Mayo Clinic, 200 First Street SW, Rochester, MN 55905, Tel: 507-266-6772, FAX: 507-266-2810, EMAIL: nyberg.scott@mayo.edu

OBERHELMAN, HARRY A, JR, M.D., Chief of Division of Gastro-Intestinal Surgery, Stanford University School of Medicine, 300 pasteur dr, Stanford, CA 94305, Tel: 650-736-7964, FAX: 650-723-5704, EMAIL: hoberelman@hotmail.com

OCHSNER, JOHN L, M.D., Chairman Emeritus, Department of Surgery, Ochsner Clinic, 1514 Jefferson Hwy, BH231, New Orleans, LA 70121, Tel: 504-842-4073, FAX: 504-842-6767, EMAIL: jlochsner@me.com

O’DONNELL, THOMAS F, JR, M.D., Andrews Professor of Surgery; C.E.O. and President of New England Medical Center, 750 Washington St., Box 259, Boston, MA 02111, Tel: 617-636-5660, FAX: 617-636-5936, EMAIL: todonnell@tufts-nemc.org

OJEMANN, ROBERT G, M.D., Professor of Surgery, Harvard Medical School; Visiting Neurosurgeon, Massachusetts General Hospital, 32 Fruit St., Boston, MA 02114, Tel: 617-726-2936, FAX: 617-726-3126, EMAIL: rojemann@partners.org

OLDHAM, H. NEWLAND, JR, M.D., Professor Emeritus, Division of Thoracic Surgery, Duke University Medical Center, 542 Cedar Club Circle, Chapel Hill, NC 27517-7214, Tel: 919-259-7588, FAX: 919-383-1801, EMAIL: newandjo@yahoo.com

OLDHAM, KEITH T, M.D., Professor and Chief, Division of Pediatric Surgery, Children’s Hospital of Wisconsin, 999 N. 92nd St., Ste. C320, Milwaukee, WI 53226, Tel: 414-266-6557, FAX: 414-266-6579, EMAIL: koldham@mcw.edu

O’LEARY, J. PATRICK, M.D., Executive Associate Dean, Clinical Affairs and Assistant Vice President for Strategic Planning, Florida International University College of Medicine, 11200 SW 8th St., HLS II, Suite 693, Miami, FL 33199, Tel: 305-348-0570, FAX: 305-348-0123, EMAIL: olearyp@fiu.edu
*OLINGER, GORDON N, M.D., Professor and Chief, Emeritus, Division of Cardiothoracic Surgery, Medical College of Wisconsin, 5108 Horned Owl Way, Parker, CO 80134-2766, Tel: 303-284-9855, FAX: 303-284-9856, EMAIL: gnolinger@comcast.net

*OLSSON, CARL A, M.D., John K. Lattimer Professor and Chairman, Emeritus, Department of Urology, Columbia Presbyterian Medical Center, 161 Fort Washington Avenue, New York, NY 10032, Tel: 212-305-0100, FAX: 212-305-0106, EMAIL: cao2@columbia.edu

OLTHOFF, KIM M, M.D., Professor of Surgery; Director, Liver Transplant Program, University of Pennsylvania, 3400 Spruce St., 2 Dulles, Philadelphia, PA 19104, Tel: 215-662-6136, FAX: 215-662-2244, EMAIL: kim.olthoff@uphs.upenn.edu

*OLUWOLE, SOJI F, M.D., Professor of Surgery, Columbia University; Associate Director of Surgery; Program Director, General Surgery; Director of Cancer Control Center, Harlem Hospital Center, 506 Lenox Ave., HHC MLKP 11-103, New York, NY 10037, Tel: 212-939-1639, FAX: 212-939-3536, EMAIL: so5@columbia.edu

*O’NEILL, JAMES A, JR, M.D., J.C. Foshee Professor and Chairman Emeritus, Section of Surgical Sciences, Vanderbilt University Medical Center, 2200 Children’s Way, Ste. 4150, Nashville, TN 37232-2730, Tel: 615-936-1290, FAX: 615-936-0982, EMAIL: james.oneill@vanderbilt.edu

*ORLOFF, MARSHALL J, M.D., Distinguished Professor of Surgery; Chair of Surgery, Emeritus University of California, San Diego, 200 West Arbor Drive, San Diego, CA 92103-8999, Tel: 619-543-5865, FAX: 619-543-6253, EMAIL: morloff@ucsd.edu

ORLOFF, SUSAN L, M.D., Professor of Surgery; Director & Chief, Abdominal Transplantation, Adjunct Professor of Molecular Microbiology & Immunology, Oregon Health & Science University, 3181 SW Sam Jackson Pk Rd., L590, Portland, OR 97239, Tel: 503-494-7810, FAX: 503-494-5292, EMAIL: orloffs@ohsu.edu

*ORRINGER, MARK B, M.D., Professor and Head, Section of Thoracic Surgery, University of Michigan, 1500 E. Medical Center Dr., 2120 Taubman Center, Ann Arbor, MI 48109-0344, Tel: 734-936-4975, FAX: 734-615-2656, EMAIL: morrin@umich.edu
AMERICAN SURGICAL ASSOCIATION

*OSBORNE, MICHAEL P, M.D., Director of Breast Programs, Continuum Cancer Centers of New York, Attending Surgeon, Appel-Venet Comprehensive Breast Services, Beth Israel Medical Center, 10 Union Square East, Ste. 4E, New York, NY 10003, Tel: 212-844-8770, FAX: 212-844-8954, EMAIL: mosborne@chpnet.org

*OTHERSEN, H. BIEMANN, JR, M.D., Professor of Surgery & Pediatrics; Emeritus Chief, Pediatric Surgery; Medical Director, Medical University of South Carolina, 3 West St., Charleston, SC 29401-1929, Tel: 843-792-3851, FAX: 843-792-3858, EMAIL: jnbothersen@bellsouth.net

*OTTINGER, LESLIE W, M.D., 6 Harbor Terrace, Nantucket, MA 02554, Tel: 508-228-8710, EMAIL: lwojso@comcast.net

OURIEL, KENNETH, M.D., Chairman, Division of Surgery; Chairman, Department of Vascular Surgery, Cleveland Clinic Foundation; Professor of Surgery, Cleveland Clinic Lerner College of Medicine at CWRU, 14 E. 60th St., Ste. 1201, New York, NY 10022, Tel: 212-326-8705, FAX: 216-326-8703, EMAIL: ourielk@nyp.org

OZAKI, C. KEITH, M.D., FACS, Vascular and Endovascular Surgery, Brigham and Women’s Hospital, 75 Francis St., Boston, MA 02115, Tel: 857-307-1920, FAX: 857-307-1922, EMAIL: ckozaki@partners.org

*PACHTER, H. LEON, M.D., George David Stewart Professor and Chairman Department of Surgery, NYU School of Medicine, 530 First Ave., #6-C, New York, NY 10016, Tel: 212-263-7302, FAX: 212-263-7511, EMAIL: pachth01@popmail.med.nyu.edu

*PACIFICO, ALBERT D, M.D., University of Alabama at Birmingham, 200 Cahaba Farms, Indian Springs, AL 35124, Tel: 205-988-3088, FAX: 205-934-7514, EMAIL: alpacifico@yahoo.com

*PADBERG, FRANK T, M.D., Retired, Director, Fellowship and Graduate Education Departments, American College of Surgeons, P.O. Box 7418, Little Rock, AR 72217, EMAIL: fpadbergsr@msn.com

*PAIROLERO, PETER C, M.D., Professor and Chairman, Department of Surgery, Mayo Medical Center, 200 First St. SW, Rochester, MN 55905, Tel: 507-284-2808, FAX: 507-284-0058, EMAIL: pairolero.peter@mayo.edu

*PALOYAN, EDWARD, M.D., S.C., 3 Natoma Dr., Oak Brook, IL 60523-7711, Tel: 630-655-0722, FAX: 630-655-0728, EMAIL: epaloyan@sbeglobal.net
PAPPAS, THEODORE N, M.D., Vice Chairman, Department of Surgery; Chief of Surgery, Durham V.A. Hospital; Chief of Gastrointestinal Residency Program; Director for Surgical Endoscopy, Duke University Medical Center, Box 3479, Durham, NC 27710, Tel: 919-681-3442, FAX: 919-684-6671, EMAIL: pappat01@mc.duke.edu

PARK, ADRIAN E, M.D., Campbell and Jeanette Plugge Professor & Vice Chair, Department of Surgery; Head, Division of General Surgery; Adjunct Professor, Bioengineering; Medical Director, Aerodigestive Center, University of Maryland, 22 S. Greene St., 41B14, Baltimore, MD 21201, Tel: 410-328-7994, FAX: 410-328-4084, EMAIL: apark@smail.umd.edu

PARKER, FREDERICK B, JR, M.D., State University of New York Health Sciences Center, 310 Dewittshire Rd. South, Dewitt, NY 13214, Tel: 315-464-5549, FAX: 315-446-8495, EMAIL: parkerf@upstate.edu

PARODI, JUAN C, M.D., Professor of Surgery & Radiology, Washington University School of Medicine, 1611 NW 12th Ave., E. Tower #3016, Miami, FL 33136, Tel: 305-585-5284, FAX: 305-585-8569, EMAIL: jparodi@med.miami.edu

PARSONNET, VICTOR, M.D., Director of Surgery, Newark Beth Israel Medical Center, 201 Lyons Ave., Osborne Terrace, Newark, NJ 07112, Tel: 201-379-5888, FAX: 973-926-4874

PASIEKA, JANICE L, M.D., Clinical Professor of Surgery & Oncology; Clinical Professor, Internal Medicine, Division of Endocrinology; Regional Chief, Division of General Surgery, Foothills Medical Center; Head, Division of General Surgery, University of Calgary, 1403 29th Street NW, Calgary, Alberta T2N 2T9, Canada, Tel: 403-944-2491, FAX: 403-283-4130, EMAIL: janice.pasieka@calgaryhealthregion.ca

PASS, HARVEY I, M.D., Professor of Surgery and Cardiothoracic Surgery; Chief, Division of Thoracic Surgery and Thoracic Oncology, Department of Cardiothoracic Surgery, NYU School of Medicine and Clinical Cancer Center, 530 First Ave., #9V, New York, NY 10016, Tel: 212-263-7417, FAX: 212-263-3950, EMAIL: harvey.pass@med.nyu.edu

PASSARO, EDWARD, JR, M.D., Chief, Surgical Services, Professor, West Los Angeles V.A. Medical Center, 11301 Wilshire Boulevard, Los Angeles, CA 90073, Tel: 310-268-3572, FAX: 310-268-4967
AMERICAN SURGICAL ASSOCIATION

*PATE, JAMES W, M.D., University Distinguished Professor, University of Tennessee College of Medicine; University Physicians Foundation, 910 Madison Ave., #201, Memphis, TN 38163, Tel: 901-448-5912, FAX: 901-448-7588, EMAIL: jpate@uthsc.edu

*PATON, BRUCE C, M.D., Clinical Professor of Surgery, 5380 E. Mansfield Ave., Denver, CO 80237, Tel: 303-692-0764, FAX: 303-692-8225, EMAIL: cardsurg@comcast.net

*PATTERSON, ALEC, M.D., Evarts A. Graham Professor of Surgery; Chief of Cardiothoracic Surgery, Washington University School of Medicine, 1 Barnes Hosp Plaza, 3108 Queeny Twr, St. Louis, MO 63110, Tel: 314-362-6025, FAX: 314-747-4087, EMAIL: pattersona@wustl.edu

*PATTERSON, RUSSEL H, M.D., Professor of Neurosurgery, New York Hospital-Cornell Medical Center, Retired, 146 West 57th Street, Apt. 65A, New York, NY 10019-3301, Tel: 212-586-9237, FAX: 212-315-3877, EMAIL: mail49212@pop.net

PATTI, MARCO G, M.D., Professor of Surgery, Director, Center for Esophageal Diseases University of Chicago Pritzker School of Medicine, 5841 S. Maryland Ave., MC 5094, Rm G 201, Chicago, IL 60637, Tel: 773-702-4865, FAX: 773-834-1995, EMAIL: mpatti@surgery.bsd.uchicago.edu

PATY, PHILIP B, M.D., 1275 York Ave., Rm C1081, New York, NY 10021, Tel: 212-639-6703, FAX: 212-794-3198, EMAIL: patyp@mskcc.org

*PAULSON, DAVID F, M.D., Professor and Chief of Urology, Duke University Medical Center, Box 2977-DUMC, Urology, Surg, Durham, NC 27710, Tel: 919-684-5057, FAX: 919-684-4611, EMAIL: pauls002@mc.duke.edu

*PAYNE, WILLIAM D, M.D., Professor of Surgery, University of Minnesota Medical Center, 420 Delaware St. SE, MMC195, Minneapolis, MN 55455, Tel: 612-625-5151, FAX: 612-625-8496, EMAIL: payne001@umn.edu

*PEACOCK, ERLE E, JR, M.D., Clinical Professor of Surgery, University of North Carolina School of Medicine, 645 Rock Creek Rd., Chapel Hill, NC 27514, Tel: 800-662-7403, FAX: 919-829-0055, EMAIL: eepeacockmd@aol.com
*PEARCE, WILLIAM H, M.D., Attending Surgeon, Director of Noninvasive Blood Flow Laboratory; Professor of Surgery, Northwestern University Medical School, 201 East Huron #10-105, Vasc Surgery, Chicago, IL 60611, Tel: 312-926-7775, FAX: 312-695-4955, EMAIL: wpearce@nmh.org

*PEARSON, F. GRIFFITH, M.D., Professor of Surgery Emeritus, University of Toronto; Staff Surgeon, Division of Thoracic Surgery, Toronto General Hospital, 796535 3rd Line East, RR#1, Mansfield, Ontario L0N 1M0, Canada, Tel: 519-925-6658, FAX: 519-925-6221, EMAIL: fgpearson@sympatico.ca

*PEITZMAN, ANDREW B, M.D., Professor and Chief, Division of General Surgery; Executive Vice Chairman, Department of Surgery, University of Pittsburgh, Presbyterian University Hospital, 200 Lothrop St., Room F1281, Pittsburgh, PA 15213, Tel: 412-647-0635, FAX: 412-647-3247, EMAIL: peitzmanab@upmc.edu

*PELLEGRINI, CARLOS A, M.D., The Henry N. Harkins Professor and Chairman, Department of Surgery, University of Washington, Box 356410, BB 487, 1959 NE Pacific, Seattle, WA 98195-6410, Tel: 206-543-3106, FAX: 206-685-6912, EMAIL: pellegri@u.washington.edu

*PELLETIER, L. CONRAD, M.D., Emeritus Professor of Surgery, University of Montreal, Montreal Heart Institute, 6100 Ch Deacon App 10P, Montreal, Quebec H3S 2V6, Canada, Tel: 514-376-3330, FAX: 514-376-4766, EMAIL: conrad.pelletier@sympatico.ca

*PEMBERTON, JOHN H, M.D., Professor of Surgery, Mayo Clinic, 200 First Street SW, Gonda 9-S, Rochester, MN 55905, Tel: 507-284-2359, FAX: 507-284-1794, EMAIL: pemberton.john@mayo.edu

*PENNINGTON, D. GLENN, M.D., Professor of Surgery, East Tennessee State University, P.O. Box 70575, Dogwood Ln, Bldg. 1, Johnson City, TN 37614, Tel: 423-439-6771, FAX: 423-439-6259, EMAIL: penningg@etsu.edu

PERLER, BRUCE A, M.D., Julius H. Jacobson, II, Professor, Department of Surgery; Director of the Division of Vascular Surgery and Endovascular Therapy; Director of the Vascular Noninvasive Laboratory, Johns Hopkins Hospital, 600 N. Wolfe St., Harvey 611, Baltimore, MD 21287-8611, Tel: 410-955-2618, FAX: 410-614-2079, EMAIL: bperler@jhmi.edu

PERRY, ROGER R, M.D., Robert L. Payne, Jr., Professor of Surgery; Chief, Division of Surgical Oncology, Eastern Virginia Medical School, 825 Fairfax Ave., Department of Surgery, Norfolk, VA 23507-1912, Tel: 757-446-8950, FAX: 757-446-8951, EMAIL: perryrr@evms.edu
PESCOVITZ, MARK D, M.D., Vice-Chair for Research, Department of Surgery; Director, Transplant Immuno Lab; Professor of Surgery; Professor of Microbiology/Immunology, Indiana University School of Medicine, 635 Barnhill Dr., MS-2031, Indianapolis, IN 46202, Tel: 317-274-4370, FAX: 317-278-3268, EMAIL: mmpescov@iupui.edu

*PESKIN, GERALD W, M.D., Clinical Professor of Surgery, University of California, Davis Medical Center, Highland General Hospital, 1411 East 31st Street, Oakland, CA 94602, Tel: 510-437-4338, FAX: 510-437-5127, EMAIL: prljrry@majornet.com

PETERS, JEFFREY H, M.D., Seymour I. Schwartz Professor and Chairman, University of Rochester School of Medicine and Dentistry; Surgeon-in-Chief, Strong Memorial Hospital, 601 Elmwood Ave., Rochester, NY 14642, Tel: 585-275-2725, FAX: 585-275-8513, EMAIL: jeffrey_peters@urmc.rochester.edu

*PETRELLI, NICHOLAS J, M.D., Professor of Surgery, Thomas Jefferson University; Director, Helen F. Graham Cancer Center, 4701 Ogletown Stanton Rd., Newark, DE 19713, Tel: 302-623-4550, FAX: 302-623-4554, EMAIL: npetrelli@christianacare.org

*PFAFF, WILLIAM W, M.D., University of Florida School of Medicine, Box 100286, Department of Surgery, Gainesville, FL 32610-0286, Tel: 352-265-0606, FAX: 352-265-0678, EMAIL: pfaffww@mail.surgery.ufl.edu

PHILLIPS, LINDA G, M.D., Professor and Chief, Division of Plastic Surgery, University of Texas Medical Branch, 301 University Blvd., Galveston, TX 77555-0724, Tel: 409-772-1255, FAX: 409-772-1872, EMAIL: lphillip@utmb.edu

*PICKLEMAN, JACK R, M.D., Retired, 1301 N. Dearborn St., #1102, Chicago, IL 60610, Tel: 312-943-0037, FAX: 630-214-5574, EMAIL: docpicleman@aol.com

*PIERCE, GEORGE E, M.D., Professor of Surgery, University of Kansas Medical Center, 570 Mohawk West, Lake Quivira, KS 66217, Tel: 913-268-5631, FAX: 913-588-7540, EMAIL: drgepierce@kc.rr.com

*PIERCE, WILLIAM S, M.D., Professor Emeritus, Department of Surgery, Pennsylvania State University, Milton S. Hershey Medical Center, Hershey, PA 17033, Tel: 717-531-8328, FAX: 717-531-4464, EMAIL: wpierce@hmc.psu.edu
PIERSON, RICHARD N, III, M.D., Professor of Surgery, Director, Surgical Clinical Care Center, VA Maryland Health Care System; Clinical Director, Heart & Lung Transplantation Programs, University of Maryland Medical Center, V.A. Maryland Health Care System, 22 So Greene St., N4W94, Cardiac Surg, Baltimore, MD 21201, Tel: 410-328-5842, FAX: 410-328-2750, EMAIL: rpierson@smail.umaryland.edu

*PILCH, YOSEF H, M.D., 33 Rue Poussin, Paris, 75016, France, Tel: 331 465 14962, FAX: 331 465 14962, EMAIL: ypilch@free.fr

*PILLSBURY, HAROLD C, III, M.D., Chief, Division of Otolaryngology-Head and Neck Surgery, University of North Carolina at Chapel Hill, 1115 Bioinformatics Bldg., Chapel Hill, NC 27599, Tel: 919-966-8926, FAX: 919-966-7656, EMAIL: hcp@med.unc.edu

PINSON, C. WRIGHT, M.D., MBA, Deputy Vice Chancellor for Health Affairs, Vanderbilt University Medical Center, D3300 MCN, Nashville, TN 37232-5545, Tel: 615-343-9324, FAX: 615-343-6478, EMAIL: wright.pinson@vanderbilt.edu

PISTERS, PETER W.T., M.D., Professor of Surgery, Chief, Sarcoma Service, University of Texas, MD Anderson Cancer Center, Box 301402l, 1400 Holcombe, Unit 444, Houston, TX 77230-1402, Tel: 713-794-1572, FAX: 713-792-4689, EMAIL: ppisters@mdanderson.org

*PITT, HENRY A, M.D., Surgery Department, 535 Barnhill Dr., RT130D, Indianapolis, IN 46202, Tel: 317-274-2304, FAX: 317-274-4554, EMAIL: hapitt@iupui.edu

*POLK, HIRAM C, JR, M.D., Ben A. Reid, Senior Professor and Chairman, University of Louisville, 550 S. Jackson St., Amb. 2nd Fl, Louisville, KY 40292, Tel: 502-852-1897, FAX: 502-852-8915, EMAIL: hcpol01@gwise.louisville.edu

POLLAK, RAYMOND, M.D., DEO-Hippocrates Consulting, 4240 Dempster, Suite F, Skokie, IL 60076, Tel: 630-527-5672, FAX: 630-527-3836, EMAIL: raymond.pollak@gmail.com

POLLOCK, RAPHAEL E, M.D., Ph.D., Head, Division of Surgery; Chair, Department of Surgical Oncology; Professor of Surgery and Professor of Cancer Biology, University of Texas, MD Anderson Cancer Center, 1515 Holcombe Blvd., Box 106, Houston, TX 77030, Tel: 713-792-6928, FAX: 713-792-4689, EMAIL: rpollock@mdanderson.org
*PONSKY, JEFFREY L, M.D., Oliver H. Payne Professor and Chairman, Department of Surgery, University Hospitals and CWRU, 11100 Euclid Ave., LKS-5047, Cleveland, OH 44106-5047, Tel: 216-844-3209, FAX: 216-983-7230, EMAIL: jponsky@yahoo.com

*PORIES, WALTER J, M.D., Professor of Surgery and Biochemistry of Surgery, Pitt County Memorial Hospital, East Carolina University School of Medicine, 7464 NC Highway 43 West, MacClesfield, NC 27852-9734, EMAIL: pories@brody.med.ecu.edu

POSNER, MITCHELL C, M.D., Thomas D. Jones Professor and Vice-Chairman; Chief, Section of General Surgery and Surgical Oncology, Department of Surgery, The University of Chicago, 5841 So Maryland Ave., MC 5094, Chicago, IL 60637, Tel: 773-834-4007, FAX: 773-834-4022, EMAIL: mposner@surgery.bsd.uchicago.edu

*POSTIER, RUSSELL G, M.D., John A. Schilling Professor & Chairman, Department of Surgery, University of Oklahoma College of Medicine, PO Box 26901, Surgery, WP2140, Oklahoma City, OK 73190, Tel: 405-271-7912, FAX: 405-271-3919, EMAIL: russell-postier@ouhsc.edu

*PRICE, JOHN B, JR, M.D., Professor of Surgery, Columbia Presbyterian Medical Center, 2110 Kendal Way, Sleepy Hollow, NY 10591-1058, EMAIL: johnbpj@gmail.com

*PRINZ, RICHARD A, M.D., Helen Shedd Keith Professor and Chairman, North Shore University Health System Evanston, IL, 2650 Ridge Ave. Walgreen Bldg. #2507, Evanston, IL 60201, Tel: 847-570-2561, FAX: 847-570-2930, EMAIL: RPrinz@northshore.org

PRUETT, TIMOTHY L, M.D., Charles O. Strickler Family Professor of Transplantation, Chief, Transplant Surgery, The University of Virginia Health System, P.O. Box 800709, Charlottesville, VA 22908, Tel: 434-924-9462, FAX: 434-924-5539, EMAIL: tp2w@virginia.edu

*PRUITT, BASIL A, JR, M.D., Clinical Professor of Surgery, University of Texas Health Science Center at San Antonio; Professor of Surgery, Uniformed Services University at the Health Sciences, 7330 San Pedro, #654, San Antonio, TX 78216-6250, Tel: 210-342-7903, FAX: 210-342-2966, EMAIL: pruitt@uthscsa.edu
*PURDUE, GARY F, M.D., Professor, Department of Surgery, UT Southwestern Medical Center, Burn Center, Parkland Memorial Hospital, Dallas, TX, 5323 Harry Hines Blvd., Dallas, TX 75390-9158, Tel: 214-648-2041, FAX: 214-648-8464, EMAIL: gary.purdue@utsouthwestern.edu

*PUTNAM, CHARLES W, M.D., Professor of Surgery; Lecturer, Molecular and Cellular Biology, 6581 West Box Canyon Drive, Tucson, AZ 85745, Tel: 520-743-7945, FAX: 520-621-3709, EMAIL: cwp@u.arizona.edu

*QUAEGEBEUR, JAN MODEST, M.D., Professor of Surgery, Columbia University College of Physicians & Surgeons; Director, Pediatric Cardiac Surgery, New York-Presbyterian Hospital, 3959 Broadway, CHN 276, New York, NY 10032, Tel: 212-305-5975, FAX: 212-305-2439, EMAIL: rom9014@nyp.org

*QUAN, STUART H.Q., M.D., Clinical Professor of Surgery, Cornell University Medicine School; Senior Attending Surgeon, Memorial Sloan-Kettering Hospital, 1275 York Ave., 9th Floor, New York, NY 10065-6007, Tel: 212-639-5506, FAX: 212-794-3198, EMAIL: quans@mskcc.org

QUINONES-BALDRICH, WILLIAM J, M.D., Professor of Surgery; Secretary-Treasurer of Southern California Vascular Surgical Society; Department of Surgery, UCLA Medical Center, 200 UCLA Medical Plaza, Suite 510-3, Los Angeles, CA 90095-6904, Tel: 310-825-7032, FAX: 310-206-2592, EMAIL: wquinones@mednet.ucla.edu

*RAINER, W. GERALD, M.D., Distinguished Clinical Professor of Surgery, University of Colorado Health Sciences Center, 2552 East Alameda Ave., #48, Denver, CO 80209-3323, Tel: 303-601-0532, FAX: 303-837-6527, EMAIL: wrainer@qwest.net

*RAMENOFSKY, MAX L, M.D., 100 No Academy Ave., Department of Surgery, Danville, PA 17822-2170, Tel: 570-271-6361, FAX: 570-271-5785, EMAIL: mramenofsky@geisinger.edu

*RAND, ROBERT W, M.D., Director, Neuro-oncology, Associate Medical Director, John Wayne Cancer Institute, 2200 Santa Monica Blvd., Santa Monica, CA 90404, Tel: 310-472-0155, FAX: 310-472-1131
AMERICAN SURGICAL ASSOCIATION

*RANDALL, PETER, M.D., FACS, Professor Emeritus of Plastic Surgery, Hospital of the University of Pennsylvania, 609 Foulkeways, Gwynedd, PA 19436, Tel: 215-283-7249, FAX: 215-646-2917, EMAIL: peterrandallmd@verizon.net

*RANDOLPH, JUDSON G, M.D., Professor of Surgery Emeritus, George Washington University, 3800 Whitland Ave., Nashville, TN 37205, Tel: 615-383-3757, EMAIL: jrpedsurg@aol.com

RAPER, STEVEN E, M.D., Associate Professor of Surgery, Hospital of the University of Pennsylvania, 3400 Spruce St., 4 Silverstein Pav, Philadelphia, PA 19104, Tel: 215-614-0382, FAX: 215-349-8195, EMAIL: rapers@uphs.upenn.edu

RATNER, LLOYD EVAN, M.D., 622 West 168th St., PH 14 stem 408, New York, NY 10032, Tel: 212-342-3539, FAX: 212-342-4061, EMAIL: lr2182@columbia.edu

RATTNER, DAVID W, M.D., Chief, Division of Gastrointestinal and General Surgery; Associate Professor of Surgery, Harvard Medical School; Massachusetts General Hospital, 15 Parkman St., Surgery, ACC 460, Boston, MA 02114, Tel: 617-726-1893, FAX: 617-724-0355, EMAIL: drattner@partners.org

RAVIKUMAR, THANJAVUR S, M.D., John D. Mountain Professor of Surgery; Albert Einstein College of Medicine; Surgeon in Chief & Senior V.P. for Surgery, NSLIJ Health System, 1000 E. Mountain Blvd., Wilkes-Barre, PA 18711-3463, Tel: 570-808-5953, FAX: 516-562-4821, EMAIL: tsravi2008@gmail.com

*READ, RAYMOND C, M.D., Chief, Surgical Service, John L. McClellan Memorial Veterans Hospital; Professor of Surgery, University of Arkansas for Medical Sciences, 515 North Plaza Circle, Little Rock, AR 72205, Tel: 501-660-2038, FAX: 501-296-3045

*REBER, HOWARD A, M.D., Vice Chairman, Professor of Surgery, Department of General Surgery, UCLA School of Medicine, 10833 Le Conte Ave., Gen Surgery, Los Angeles, CA 90095, Tel: 310-825-4976, FAX: 310-206-2472, EMAIL: hreber@mednet.ucla.edu

*REDO, S. FRANK, M.D., Emeritus Chief Pediatric Surgery Professor, New York Hospital, 200 E. 62nd St., Apt. 29D, New York, NY 10065-8327, Tel: 212-734-6601, FAX: 212-288-1882
REED, CAROLYN E, M.D., Professor of Surgery; Associate Director for Clinical Affairs, Hollings Cancer Center, Medical University of South Carolina, 25 Courtenay St., #7018, Charleston, SC 29425, Tel: 843-876-4845, FAX: 843-876-4866, EMAIL: reedce@musc.edu

*REGE, ROBERT V, M.D., Professor and Chairman, Division of Gastrointestinal and Endocrine Surgery, University of Texas Southwestern Medical Center, 5323 Harry Hines Blvd., Dallas, TX 75390-9031, Tel: 214-648-3050, FAX: 214-648-6752, EMAIL: robert.rege@utsouthwestern.edu

*REICHLE, FREDERICK A, M.D., Chairman, Department of Surgery, Presbyterian Hospital of the University of Pennsylvania, JFK Memorial Hospital, P.O. Box 42891, Philadelphia, PA 19101, Tel: 267-971-6930, FAX: 215-743-6736

*REITZ, BRUCE A, M.D., The Norman E. Shumway Professor of Cardiothoracic Surgery, Stanford University School of Medicine, 300 Pasteur Dr., Department CT Surgery, Stanford, CA 94305-5407, Tel: 650-725-4497, FAX: 650-725-7733, EMAIL: breitz@stanford.edu

*REITZ, BRUCE A, M.D., The Norman E. Shumway Professor of Cardiothoracic Surgery, Stanford University School of Medicine, 300 Pasteur Dr., Department CT Surgery, Stanford, CA 94305-5407, Tel: 650-725-4497, FAX: 650-725-7733, EMAIL: breitz@stanford.edu

*REITZ, BRUCE A, M.D., The Norman E. Shumway Professor of Cardiothoracic Surgery, Stanford University School of Medicine, 300 Pasteur Dr., Department CT Surgery, Stanford, CA 94305-5407, Tel: 650-725-4497, FAX: 650-725-7733, EMAIL: breitz@stanford.edu

*REPLOGLE, ROBERT L, M.D., University of Chicago, 1160 East 56th St., Chicago, IL 60637-1541, Tel: 773-493-8399, FAX: 773-493-8984, EMAIL: bob@replogle.org

RESCORLA, FREDERICK J, M.D., Professor of Surgery; Director, Section of Pediatric Surgery; Indiana University School of Medicine, Surgeon-in-Chief, Riley Hospital for Children, 702 Barnhill Dr., Room 2500, Indianapolis, IN 46202, Tel: 317-274-4681, FAX: 317-274-4491, EMAIL: frescorl@iupui.edu

*REUL, GEORGE J, JR, M.D., Associate Chief of Surgery, Texas Heart Institute; Medical Director, Peripheral Vascular Laboratory, St. Luke’s Hospital, P.O. Box 20345, Houston, TX 77225, Tel: 832-355-4929, FAX: 832-355-3424, EMAIL: greul@heart.thi.tmc.edu

*REYES, HERMAN M, M.D., Professor of Surgery Emeritus, Rush Presbyterian St. Luke’s Medical Center, Chairman Emeritus, Department of Surgery, Cook County Hospital, P.O. Box 1165, Captiva Island, FL 33924, Tel: 941-472-2933, EMAIL: hmrey33@aol.com

REYES, JORGE D, M.D., Chief, Pediatric Transplantation, Seattle Children’s Hospital; Professor & Chief, Division of Transplant Surgery, University of Washington, 1959 NE Pacific St., Box 356174, Seattle, WA 98195, Tel: 206-543-9738, FAX: 206-543-3876, EMAIL: reyesjd@u.washington.edu
REZNICK, RICHARD K, M.D., R.S. McLaughlin Professor and Chair, Faculty of Medicine, University of Toronto, 100 College St, Banting Inst, #311, Toronto, Ontario M5G 1L5, Canada, Tel: 416-978-2623, FAX: 416-978-3928, EMAIL: richard.reznick@utoronto.ca

*RHODES, MICHAEL, M.D., Chair, Department of Surgery, Christiana Care Health Systems, Professor of Surgery, Thomas Jefferson University, 4745 Ogletown-Stanton Rd. Ste. 128, Newark, DE 19713, Tel: 302-733-4500, FAX: 302-733-4507, EMAIL: mrhodes@christianacare.org

*RHODES, ROBERT S, M.D., American Board of Surgery, 1617 John F Kennedy Blvd., #860, Philadelphia, PA 19103-1847, Tel: 215-568-4000, FAX: 215-563-5718, EMAIL: rrhodes@absurgery.org

*RHOTON, ALBERT L, JR, M.D., R.D. Keene Family Professor and Chairman, Department of Neurological Surgery, University of Florida College of Medicine and Shands Hospital, P.O. Box 100265, Neurological Surgery, Gainesville, FL 32610-0265, Tel: 352-392-4331, FAX: 352-392-8413, EMAIL: rhoton@neocortex.health.ufl.edu

*RICE, CHARLES L, M.D., President, Uniformed Services University of Health Sciences, 4301 Jones Bridge Rd., Bethesda, MD 20814-4799, Tel: 301-295-3013, FAX: 301-295-1960, EMAIL: crice@usuhs.edu

*RICH, NORMAN M, M.D., Heaton and Packard Professor of Surgery, Uniformed Services University of the Health Sciences, 4301 Jones Bridge Rd., Bethesda, MD 20814, Tel: 301-295-3155, FAX: 301-295-3627, EMAIL: nrich@usuhs.mil

RICHARDS, WILLIAM O, M.D., Professor of Surgery; Director of Laparoscopic Surgery, Vanderbilt University School of Medicine, 2451 Fillinig St., Mastin 719, Mobile, AL 36617, Tel: 251-471-7993, EMAIL: brichards@usouthal.edu

*RICHARDSON, J. DAVID, M.D., Professor and Vice Chairman, Department of Surgery, University of Louisville, 530 So. Jackson Street, Louisville, KY 40292, Tel: 502-852-5453, FAX: 502-852-8915, EMAIL: jdrich01@gwise.louisville.edu

*RICHIE, JEROME P, M.D., Elliott C. Cutler Professor of Urological Surgery; Chairman Harvard Program in Urology; Chief Surgeon, Urology, Brigham & Women’s Hospital, 45 Francis St., ASB II-3, Boston, MA 02115, Tel: 617-732-6325, FAX: 617-566-3475, EMAIL: jrichie@partners.org
AMERICAN SURGICAL ASSOCIATION

*RICOTTA, JOHN J, M.D., 110 Irving Street NW, Room G253, Washington, DC 20010, Tel: 202-877-5133, FAX: 202-877-3699, EMAIL: john.j.ricotta@medstar.net

*RIKKERS, LAYTON F, M.D., Professor, Department of Surgery, University of Wisconsin Clinical Sciences Center, 1111 Highland Ave., 5103 WIMR, Madison, WI 53705-2275, Tel: 608-265-8854, FAX: 608-265-5963, EMAIL: rikkers@surgery.wisc.edu

*RILES, THOMAS S, M.D., 530 First Avenue, HCC, Ste. #6-D, New York, NY 10016, Tel: 212-263-2330, FAX: 212-263-2380, EMAIL: thomas.riles@med.nyu.edu

*RITCHIE, W ALLACE P, JR, M.D., Former Executive Director, American Board of Surgery, 1617 J F Kennedy Blvd., #860, Philadelphia, PA 19103, Tel: 215-568-4000, FAX: 215-563-5718, EMAIL: wallace.ritchie@verizon.net

ROBERTS, JOHN P, M.D., Professor of Surgery; Chief of Transplant Service, University of California, San Francisco, Liver Transplant Service, 505 Parnassus Ave., M896, San Francisco, CA 94143-0780, Tel: 415-353-9321, FAX: 415-353-8709, EMAIL: john.roberts@ucsfmedctr.org

*ROBSON, MARTIN C, M.D., Emeritus Professor of Surgery, University of South Florida, 4224 Cove Lake Circle, #208, Stuart, FL 34997-5695, Tel: 772-223-8475, Fax: 772-223-9864, EMAIL: mcrobson@earthlink.net

*RODGERS, BRADLEY M, M.D., Maurice LeBauer Professor of Surgery; Chief, Division of Pediatric Surgery, University of Virginia Hospital, P.O. Box 800709, Department of Surgery, Charlottesville, VA 22908, Tel: 434-924-2673, FAX: 434-924-2656, EMAIL: bmr@virginia.edu

*ROE, BENSON B, M.D., Professor and Chief Emeritus of Cardiothoracic Surgery, University of California, 100 Thorndale Drive #346, San Rafael, CA 94903, Tel: 415-353-1606, FAX: 415-499-1354, EMAIL: benson346@gmail.com

*ROMBEAU, JOHN L, M.D., Professor of Surgery, Temple University Hospital, 3401 N. Broad St., 4 Parkinson, Zone C, Philadelphia, PA 19140, Tel: 215-707-7725, FAX: 215-707-3945, EMAIL: john.rombeau@tuhs.temple.edu

*ROOT, H. DAVID, M.D., Professor of Surgery, University of Texas Health Science Center, 258 Riders Mills Rd., Brainard, NY 12024, Tel: 512-567-5725, EMAIL: root@uthscsa.edu
AMERICAN SURGICAL ASSOCIATION

*ROSATO, ERNEST F, M.D., Chief, Division of Gastrointestinal Surgery, Hospital of the University of Pennsylvania, 3400 Spruce Street, Philadelphia, PA 19104, Tel: 215-662-2033, FAX: 215-349-8195

ROSE, ERIC A, M.D., Chairman, Department of Surgery; Valentine Mott, Johnson and Johnson Professor of Surgery, College of Physicians & Surgeons of Columbia University, 35 East 62nd Street, New York, NY 10085, Tel: 212-572-5163, EMAIL: erose@mafgrp.com

ROSEMURGY, ALEXANDER S, M.D., Surgical Director, Center for Digestive Disorders, Tampa General Hospital; Professor of Surgery; Professor of Medicine; Reeves/Culverhouse Endowed Chair in Pancreatic Cancer and Digestive Disorders, University of South Florida, P.O. Box 1289, Room F-145, Tampa, FL 33601, Tel: 813-251-7393, FAX: 813-844-7396, EMAIL: arosemur@hsc.usf.edu

ROSENBERG, LAWRENCE, M.D., A.G. Thompson Chair of Surgical Research; Professor of Surgery; Director, Division of Surgical Research, McGill University Health Center, 6507 Fern Road, Montreal, Quebec H4V 1E4, Canada, Tel: 514-934-1934, FAX: 514-934-8289, EMAIL: lawrence.rosenberg@mcgill.ca

*ROSENBERG, STEVEN A, M.D., Chief of Surgery, National Cancer Institute, National Institute of Health, Building 10, Room 2B42, Bethesda, MD 20892, Tel: 301-496-4164, FAX: 301-402-1738, EMAIL: sar@nih.gov

*ROSES, DANIEL F, M.D., Jules Leonard Whitehill Professor of Surgery and Oncology, NYU Langone Medical Center, 530 First Avenue HCC 6B, New York, NY 10016, Tel: 212-263-7330, FAX: 212-263-7581, EMAIL: daniel.roses@med.nyu.edu

ROSS, MERRICK I, M.D., Professor of Surgery; Chief, Melanoma Section, Department of Surgical Oncology; Associate Director of the Melanoma/Skin Center, MD Anderson Cancer Center, 1515 Holcombe Blvd., Surgery Onc, #444, Houston, TX 77030, Tel: 713-792-7217, FAX: 713-792-4689, EMAIL: mross@mdanderson.org

*ROTH, JACK A, M.D., Professor and Bud Johnson Clinical Distinguished Chair, Professor of Molecular and Cellular Oncology; Director, W.M. Keck Center for Innovative Cancer Therapies, Department of Thoracic and Cardiovascular Surgery, University of Texas, MD Anderson Cancer Center, 1515 Holcombe Blvd., Unit 445, Houston, TX 77030, Tel: 713-792-7664, FAX: 713-794-4901, EMAIL: jroth@mdanderson.org
*ROTHENBERGER, DAVID A, M.D., Professor and Deputy Chair, Department of Surgery, University of Minnesota Medical School; Associate Director of Clinical Research and Programs, Masonic Cancer Center, 420 Delaware St., SE, MMC195, Minneapolis, MN 55455, Tel: 612-626-6122, FAX: 612-625-3660, EMAIL: rothe002@umn.edu

ROTSTEIN, ORI D, M.D., Professor of Surgery; University of Toronto Hospital; Surgeon in Chief; St. Michael’s Hospital, 30 Bond St., CC 16-044, Toronto, Ontario M5B 1W8, Canada, Tel: 416-864-5304, FAX: 416-360-0637, EMAIL: rotsteino@smh.toronto.on.ca

*ROWE, MARC I, M.D., 4747 Rue Belle Mar, Sanibel Island, FL 33957, Tel: 941-472-2283, FAX: 941-472-5953, EMAIL: mirowe@worldnet.att.net

ROZYCKI, GRACE S, M.D., Vice-Chair, Department of Surgery; Director, Trauma/Surgical Critical Care; Professor of Surgery, Emory University School of Medicine, 69 Jesse Hill Jr., Dr., SE, Ste. 302, Atlanta, GA 30303, Tel: 404-616-3553, FAX: 404-616-7333, EMAIL: grozyck@emory.edu

*RUDICK, JACK, M.D., Emeritus Professor of Surgery, Mount Sinai School of Medicine, 6 Van Buren Court, Cresskill, NJ 07626, Tel: 201-569-0235, FAX: 201-569-6686, EMAIL: jrudick1@optonline.net

RUE, LORING W, III, M.D., Professor of Surgery; Vice Chairman; Senior Associate Dean for Clinical Affairs, University of Alabama at Birmingham, 701 So 19th St., LHRB 112, Birmingham, AL 35294, Tel: 205-975-3030, FAX: 205-975-3040, EMAIL: loring.rue@ccc.uab.edu

RUSCH, VALERIE W, M.D., Attending Surgeon; Professor of Surgery, Cornell University Medical College; Alfred P. Sloan Chair, Memorial Sloan-Kettering Cancer Center, 1275 York Ave., Rm C-868, New York, NY 10021, Tel: 212-639-8695, FAX: 212-717-3682, EMAIL: ruschv@mskcc.org

*RUSH, BENJAMIN F, JR, M.D., Distinguished Professor of Surgery, UMDNJ-New Jersey Medical School, 140 Bergen St., Ste. E1620, Newark, NJ 07108-2499, Tel: 973-972-2540, FAX: 973-972-2407, EMAIL: rushe@umdnj.edu

*RUSSELL, PAUL S, M.D., John Homans Distinguished Professor of Surgery; Senior Surgeon, Harvard Medical School, Massachusetts General Hospital, 32 Fruit Street, Room #510, Boston, MA 02114, Tel: 617-726-2801, FAX: 617-726-3713, EMAIL: psrussell@partners.org
AMERICAN SURGICAL ASSOCIATION

*RUSSELL, THOMAS R, M.D., Executive Director, American College of Surgeons, 633 N. Saint Clair Street, Chicago, IL 60611-3211, Tel: 312-202-5305, FAX: 312-202-5016, EMAIL: trussell@facs.org

*RUTHERFORD, ROBERT B, M.D., Emeritus Professor of Surgery, University of Colorado School of Medicine, 14337 Dorsal St., Corpus Christi, TX 78418, Tel: 361-949-0327, FAX: 361-949-8381, EMAIL: rbruth@aol.com

*RYAN, ROBERT R, M.D., Emeritus Professor of Surgery, Tulane University Medical School, 10100 Hillview Dr., Apt. 1206, Pensacola, FL 32514, Tel: 850-492-0055

SACHDEVA, AJIT K, M.D., Adjunct Professor of Surgery, Northwestern University Feinberg School of Medicine; Professor of Surgery, Drexel University School of Medicine, Director, Division of Education, American College of Surgeons, 633 N. St. Clair St., Chicago, IL 60611, Tel: 312-202-5405, FAX: 312-202-5011, EMAIL: asachdeva@facs.org

*SAFFLE, JEFFREY R, M.D., Professor, Department of Surgery; Director, Intermountain Burn Center, University of Utah School of Medicine, 30 North 1900 East, Rm 3B306, Salt Lake City, UT 84132, Tel: 801-581-3595, FAX: 801-585-2435, EMAIL: jeffrey.saffle@hsc.utah.edu

*SAFI, HAZIM J, M.D., Professor, Chairman and Chief, Department of Cardiothoracic and Vascular Surgery, Memorial Hermann Hospital, University of Texas Medical School, 6400 Fannin, Ste. 2850, Houston, TX 77030, Tel: 713-500-5304, FAX: 713-500-0647, EMAIL: hazim.j.safi@uth.tmc.edu

*SALTZSTEIN, EDWARD C, M.D., Professor of Surgery and Director, University Breast Care Center, 4800 Alberta, Department of Surgery, El Paso, TX 79905, Tel: 915-545-6400, FAX: 915-545-6987, EMAIL: Edward.Saltzstein@ttuhsc.edu

*SALVATIERRA, OSCAR, JR, M.D., Professor of Surgery, Urology and Pediatrics; Director, Pediatric Renal Transplantation, Stanford University Medical Center, 703 Welch Road, #H2, Palo Alto, CA 94304, Tel: 415-498-5481, FAX: 415-498-5557, EMAIL: oscars@stanford.edu

*SAZLMAN, EDWIN W, M.D., Professor Emeritus of Surgery, Harvard Medical School, Beth Israel Medical Center, 68 Francis Ave., Cambridge, MA 02138, Tel: 617-868-9165, EMAIL: cwsalzman@comcast.net
*SANNO, KEIJI, M.D., Director, Professor Emeritus of University of Tokyo; Director, Tokyo Neurocenter, 4-1-17 Toransmon, Tokyo, 145001, Japan, Tel: 0544-23-5155, FAX: 0544-26-0937, EMAIL: webmaster@tokyo-neurological-center.com

*SANTIAGO DELPIN, EDUARDO A, M.D., MS, Distinguished Professor of Surgery, University of Puerto Rico; Director, Puerto Rico Transplant Program, Auxilio Mutuo Hospital, P.O. Box 360359, Hato Rey, PR 00936-0359, Tel: 787-765-7650, FAX: 787-766-4038, EMAIL: prtp@coqui.net

*SARFEH, I. JAMES, M.D., Professor of Surgery, University of California, Irvine Medical Center, 24536 Via Del Oro, Laguna Niguel, CA 92677, Tel: 714-634-6675, EMAIL: ijsarfeh@aol.com

SARR, MICHAEL G, M.D., Division of General and GI Surgery, JC Masson Professor of Surgery, Mayo Medical School, 200 First St. SW, Department of Surgery, Rochester, MN 55905, Tel: 507-284-2511, FAX: 507-255-6318, EMAIL: sarr.michael@mayo.edu

*SATAVA, RICHARD M, M.D., Professor of Surgery, University of Washington School of Medicine; Program Manager, DARPA (Defense Advanced Research Projects Agency); Special Assistant, U.S. Army Medical Research and Material Command, P.O. Box 356410, Seattle, WA 98195, Tel: 206-616-2250, FAX: 206-543-8136, EMAIL: rsatava@u.washington.edu


*SAYWERS, JOHN L, M.D., John Clinton Foshee Distinguished Professor of Surgery, Emeritus, Vanderbilt University, 115 Bellebrook Circle, Nashville, TN 37205-4442, Tel: 615-936-1290, FAX: 615-936-0982

SCALEA, THOMAS M, M.D., Physician-in-Chief, Shock Trauma Center; Francis X. Kelly Professor of Trauma Surgery; Director, Program in Trauma, University of Maryland School of Medicine, 22 South Greene St. – T3R31, Baltimore, MD 21201-1595, Tel: 410-328-8976, FAX: 410-328-8925, EMAIL: tscalea@umm.edu

*SCARDINO, PETER T, M.D., Chairman Department of Surgery, David H. Koch Chair, Memorial Sloan Kettering Cancer Center, 1275 York Ave. Box 65, New York, NY 10065, Tel: 212-639-4322, EMAIL: scardinp@mskcc.org
*SCHAFF, HARTZELL V, M.D., Consultant, Division of Cardiovascular Surgery, Stuart W. Harrington Professor of Surgery, Mayo Clinic, 200 First St. SW, Rochester, MN 55905, Tel: 507-255-7068, FAX: 507-255-7378, EMAIL: schaff@mayo.edu

SCHAUER, PHILIP R, M.D., Professor of Surgery, Cleveland Clinic Lerner College of Medicine; Director, Cleveland Clinic Bariatric and Metabolic Institute, Cleveland Clinic Foundation, 9500 Euclid Ave., Genl Surgery M61, Cleveland, OH 44195, Tel: 216-444-4794, FAX: 216-445-1586, EMAIL: schauerp@ccf.org

*SCHECTER, WILLIAM P, M.D., Department of Surgery, University of California, San Francisco, 1001 Potrero Ave., Ward 3-A, Surgery, San Francisco, CA 94110, Tel: 415-206-4626, FAX: 415-206-5484, EMAIL: bschect@sfghsurg.ucsf.edu

SCHIRMER, BRUCE D, M.D., Stephen H. Watts Professor of Surgery, University of Virginia Health Sciences Center, Box 800709, Department of Surgery, Charlottesville, VA 22908-0709, Tel: 434-924-2104, FAX: 434-243-9433, EMAIL: bs@virginia.edu

*SCHLOERB, PAUL R, M.D., Professor of Surgery Emeritus, University of Kansas Medical School, 12344 Pembrok Lane, Leawood, KS 66209, Tel: 913-588-7565, FAX: 913-588-6195, EMAIL: pschloer@kumc.edu

*SCHMIZT, ROBERT L, M.D., Emeritus Professor of Surgery, University of Illinois College of Medicine at Chicago, 400 East Randolph Dr., #3620, Chicago, IL 60601, Tel: 312-527-1123

SCHNITZER, JAY J, M.D., Ph.D., Associate Chief Medical Officer; Vice President, Boston Scientific Corporation; Associate Professor of Surgery, Harvard Medical School. 100 Boston Scientific Way, Marlborough, MA 01752-1234, Tel: 508-683-4910, FAX: 508-683-5610, EMAIL: jay.schnitzer@bsci.com

*SCHOETZ, DAVID J, JR, M.D., Chairman Emeritus, Department of Colon & Rectal Surgery; Chairman, Medical Education; Professor of Surgery, Tufts University School of Medicine, 41 Mall Rd., Colon/Rectal Surgery, Burlington, MA 01805, Tel: 781-744-8889, FAX: 781-744-2945, EMAIL: david.j.schoetz@lahey.org
*SCHOLZ, PETER M, M.D., Chief, Division of Cardiothoracic Surgery; James W. Mackenzie Professor of Surgery, UMDNJ-Robert Wood Johnson Medical School, University of Medicine and Dentistry of New Jersey, 1 RW Johnson Pl, Department Surgery, New Brunswick, NJ 08903-0019, Tel: 732-235-7642, FAX: 732-235-7013, EMAIL: scholz@umdnj.edu

*SCHROCK, THEODORE R, M.D., Professor of Surgery, Emeritus, University of California at San Francisco, 27414 N. 150th St., Scottsdale, AZ 85262, Tel: 406-682-4179, FAX: 406-682-7629, EMAIL: tschrock@3rivers.net

*SCHULAK, JAMES A, M.D., Director of Transplantation, Professor of Surgery, Case Western Reserve University, 11100 Euclid Ave., Cleveland, OH 44106, Tel: 216-844-0307, FAX: 216-844-5398, EMAIL: james.schulak@UHhospitals.org

*SCHWAB, C. WILLIAM, M.D., Chief, Division of Traumatology and Surgical Critical Care, University of Pennsylvania Medical Center, 3440 Market St., 1st Fl Trauma, Philadelphia, PA 19104, Tel: 215-662-2891, FAX: 215-662-3955, EMAIL: schwab@uphs.upenn.edu

*SCHWARTZ, MARSHALL Z, M.D., Professor of Surgery & Pediatrics, Director, Pediatric Surgery Research Laboratory, Drexel University College of Medicine; Surgeon-in-Chief, Pediatric Surgery, St. Christopher’s Hospital for Children, Erie Ave. at Front Street, Philadelphia, PA 19134, Tel: 215-427-5446, FAX: 610-527-6119, EMAIL: mzschwartz@msn.com

SCHWARTZ, MYRON E, M.D., Professor of Surgery; Director, Surgical Oncology; Associate Director, Liver Transplantation, Mount Sinai School of Medicine, 1 Gustave L. Levy Pl, Box 1104, New York, NY 10029, Tel: 212-241-2891, FAX: 212-996-9688, EMAIL: myron.schwartz@mssm.edu

*SCHWARTZ, SEYMOUR I, M.D., President-Elect, American College of Surgeons; Distinguished Alumni Professor, Department of Surgery, University of Rochester School of Medicine and Dentistry, Strong Memorial Hospital, 601 Elmwood Ave., Rochester, NY 14642-8410, Tel: 585-275-7339, FAX: 585-276-0079, EMAIL: seymour_schwartz@urmc.rochester.edu

*SCHWEITZER, ROBERT J, M.D., Clinical Professor of Surgery, University of California, Davis East Bay; Associate Clinical Professor of Surgery, University of California, San Francisco, P.O. Box 1137, Stinson Beach, CA 94970-1137, Tel: 510-547-5288, FAX: 510-547-5293, EMAIL: AJSandRJS@aol.com
*SCHWESINGER, WAYNE H, M.D., Professor Surgery, Director, Surgical Endoscopy, Division of General and Laparoendoscopic Surgery, Department of Surgery, University of Texas Health Science Center, 7703 Floyd Curl Dr., Surgery, San Antonio, TX 78284, Tel: 210-567-5730, FAX: 210-567-5797, EMAIL: schwesinger@uthscsa.edu

*SCOTT-CONNER, CAROL E.H., M.D., Professor and Head, Department of Surgery, University of Iowa College of Medicine, 200 Hawkins Dr., #4601 JCP, Iowa City, IA 52242-1086, Tel: 319-356-0330, FAX: 319-353-6399, EMAIL: carol-scott-conner@uiowa.edu

*SEIGLER, HILLIARD F, M.D., Professor of Surgery, Professor of Immunology, Chief of Surgical Oncology, Duke University Medical School, Box 3966, Trent Dr., Durham, NC 27710, Tel: 919-684-3942, FAX: 919-684-6044, EMAIL: seigl001@mc.duke.edu

SELLKE, FRANK W, M.D., Karl Karlson and Martha Karlson Professor and Chief of Cardiothoracic Surgery, Brown Medical School, 593 Eddy Street, APC 424, Providence, RI 02903, Tel: 401-444-2732, FAX: 401-444-2380, EMAIL: fsellke@lifespan.org

SENER, STEPHEN F, M.D., Vice Chairman, Department of Surgery, Evanston Northwestern Healthcare, Professor of Surgery, Northwestern University Feinberg School of Medicine, 910 Golfview Road, Glenview, IL 60025

*SHACKFORD, STEVEN R, M.D., Surgeon in Chief, Fletcher Allen Health Care; Professor and Chairman, Department of Surgery, University of Vermont, 550 Washington St., #641, San Diego, CA 92103, Tel: 619-299-2600, EMAIL: shackford.steven@scrippshealth.org

*SHAFTAN, GERALD W, M.D., Chairman Emeritus of Surgery, Nassau University Medical Center; Professor of Surgery Emeritus, State University of New York Health Sciences Center at Brooklyn, 60 Gramercy Park North, New York, NY 10010-5456, Tel: 212-674-7542, FAX: 212-475-8310, EMAIL: gwshaftan@worldnet.att.net

*SHAH, DHIRAJ M, M.D., Professor of Surgery, Director, Institute for Vascular Health and Disease, Albany Medical College, 43 New Scotland Ave., MC157, Albany, NY 12208, Tel: 518-262-8720, FAX: 518-262-6720, EMAIL: shahd@albanyvascular.com
SHAH, JATIN P, M.D., Professor of Surgery, Cornell University Medical College; Chief, Head and Neck Service, E.W. Strong Chair in Head & Neck Oncology, Memorial Sloan-Kettering Cancer Center, 1275 York Avenue, New York, NY 10021, Tel: 212-639-7233, FAX: 212-717-3302, EMAIL: shahj@mskcc.org

SHAHA, ASHOK R, M.D., Professor of Surgery, Cornell University Medical Center; Attending Surgeon, Memorial Sloan-Kettering Cancer Center, 1275 York Ave., Head & Neck Svc, New York, NY 10021, Tel: 212-639-7649, FAX: 212-717-3302, EMAIL: shahaa@mskcc.org

SHAKED, ABRAHAM, M.D., Professor of Surgery, Chief, Liver Transplant Program, Hospital of the University of Pennsylvania, 3400 Spruce St., Surgery, 4 Silverstein, Philadelphia, PA 19104, Tel: 215-662-6723, FAX: 215-662-2244, EMAIL: shaked@mail.med.upenn.edu

SHAMBERGER, ROBERT C, M.D., Robert E. Gross Professor of Surgery, Harvard Medical School, Chief of Surgery, Children’s Hospital, Boston, 300 Longwood Ave., Department Surgery, Boston, MA 02115, Tel: 617-355-8326, FAX: 617-730-0299, EMAIL: robert.shamberger@childrens.harvard.edu

SHAPIRO, MARC J, M.D., Professor of Surgery and Anesthesiology; Chief of General Surgery, Trauma, Critical Care and Burns, Department of Surgery, SUNY-Stony Brook, Department of Surgery, HSC T-19, 060, Stony Brook, NY 11794-8191, Tel: 631-444-8330, FAX: 631-444-6176, EMAIL: mjshapiro@notes.cc.sunysb.edu

SHAPIRO, RON, M.D., Professor of Surgery; Robert J. Corry Chair in Transplantation Surgery; Director, Kidney, Pancreas and Islet Transplantation; Thomas E. Starzl Transplantation Institute, University of Pittsburgh Medical Center, 3459 Fifth Ave., UPMC Montefiore 7 So, Pittsburgh, PA 15213-3236, Tel: 412-647-5800, FAX: 412-647-3736, EMAIL: shapiror@upmc.edu

SHARP, KENNETH W, M.D., Chief, Division of General Surgery; Professor of Surgery, Vanderbilt University, Room D-5203 MCN, Nashville, TN 37232-2577, Tel: 615-322-0259, FAX: 615-343-9483, EMAIL: kcn.sharp@vanderbilt.edu

SHAW, BYERS W, JR, M.D., Merle M. Musselman Centennial Professor, Department of Surgery, University of Nebraska Medical Center, 985235 Nebraska Medical Center, Omaha, NE 68198-5235, Tel: 402-559-5565, FAX: 402-559-6749, EMAIL: bshaw@unmc.edu
*SHELDON, GEORGE F, M.D., Professor of Surgery and Social Medicine, University of North Carolina School of Medicine, 4006 Burnett Womack, CB #7050, Chapel Hill, NC 27599-7050, Tel: 919-966-4052, FAX: 919-966-0369, EMAIL: gsheldon@med.unc.edu

SHEMIN, RICHARD J, M.D., Vice Chair, Surgery; Chief, Cardiac and Thoracic Surgery, University of California, Los Angeles, School of Medicine, 10833 Le Conte Ave., 62-182 CHS, Los Angeles, CA 90095, Tel: 310-206-8232, FAX: 310-825-7473, EMAIL: rshemin@mednet.ucla.edu

♦ SHEPPARD, BRETT C, M.D., 3181 SW Sam Jackson Park Rd., L223 A, Portland, OR 97239, Tel: 503-494-4949, FAX: 503-494-8884, EMAIL: sheppard@ohsu.edu

SHERMAN, RANDY, M.D., Chair, Division of Plastic Surgery; Vice-Chair, Department of Surgery; Associate Medical Director, Surgery, University of Southern California, 1450 San Pablo St., #2000, Los Angeles, CA 90033, Tel: 323-442-6482, FAX: 323-442-6481, EMAIL: rsherman@surgery.usc.edu

*SHIZGAL, HARRY M, M.D., Professor of Surgery, Royal Victoria Hospital, 809-5845 Marc Chagall, Cote St. luc, Quebec H4W 3K4, Canada, Tel: 514-488-9905, FAX: 514-843-1687, EMAIL: harry.shizgal@mcgill.ca

♦ SHORTELL, CYNTHERIA K, M.D., Chief of Vascular Surgery; Program Director, Vascular Surgery, Duke University Medical Center, DUMC Box 3538, Durham, NC 27710, Tel: 919-681-2915, FAX: 919-668-5284, EMAIL: cynthia.shortell@duke.edu

*SHUCK, JERRY M, M.D., Department of Surgery, Case Western Reserve University School of Medicine, 11100 Euclid Avenue, Cleveland, OH 44106, Tel: 216-844-3872, FAX: 216-844-1949, EMAIL: jms24@po.cwru.edu

*SHUMACKER, HARRIS B, JR, M.D., Distinguished Professor of Surgery Emeritus, Indiana University; Distinguished Professor of Surgery, Uniformed Services University of the Health Sciences, 8140 Shorieridge Ter, Indianapolis, IN 46236-8640, Tel: 561-274-4826, FAX: 561-278-6560

SHUMWAY, SARA J, M.D., Professor and Vice-Chief of Cardiothoracic Surgery; University of Minnesota Medical Center, 420 Delaware St. SE, Mail Code 207, Minneapolis, MN 55455, Tel: 612-626-0976, FAX: 612-625-1683, EMAIL: shumw001@umn.edu
*SICARD, GREGORIO A, M.D., Professor of Surgery; Director of the Vascular Service, Washington University School of Medicine, 660 South Euclid Avenue, Box 8109, St. Louis, MO 63110, Tel: 314-362-7841, FAX: 314-454-3923, EMAIL: sicardg@wusl.edu

SIDAWY, ANTON N, M.D., Chief, Surgical Services, V.A. Medical Center; Professor of Surgery, Georgetown University; Professor of Surgery, George Washington University Hospital, 50 Irving St., NW, Washington, DC 20422, Tel: 202-745-8295, FAX: 202-745-8293, EMAIL: ansidawy@aol.com

*SIEGEL, JOHN H, M.D., Wesley J. Howe Professor, of Trauma Surgery, Retired. Emeritus Professor, New Jersey Medical School, 184 Summit St., Englewood, NJ 07631, Tel: 201-567-4527, FAX: 201-567-0598, EMAIL: jhsiegelmd@aol.com

SIGURDSON, ELIN R, M.D., Program Director, Fox Chase Cancer Center, 333 Cottman Ave., Philadelphia, PA 19111, Tel: 215-728-2773, FAX: 215-728-3519, EMAIL: e_sigurdson@fcc.edu

*SILEN, WILLIAM, M.D., FACS, Faculty Dean for Development and Diversity, Johnson & Johnson Distinguished Professor of Surgery, Harvard Medical School, Beth Israel Hospital, 130A Seminary Ave., Apt. 307, Auburndale, MA 02466, Tel: 781-235-1874, FAX: 617-432-1224, EMAIL: silenw@comcast.net

*SILVER, DONALD, M.D., Surgeon-in-Chief, University of Missouri Hospital and Clinics Operating Services; W. Alton Jones Distinguished Professor of Surgery, Chairman, Department of Surgery, University of Missouri-Columbia, One Hospital Dr., Columbia, MO 65212, Tel: 573-882-8188, FAX: 573-884-5885, EMAIL: donald_silver@surgery.missouri.edu

SIMEONE, DIANE M, M.D., Associate Professor, University of Michigan, 1500 E. Medical Center, 2210B Taubman, Ann Arbor, MI 48109-5343, Tel: 734-615-1600, FAX: 734-936-5830, EMAIL: simeone@umich.edu

*SIMMONS, RICHARD L, M.D., Distinguished Service Professor of Surgery; Medical Director, University of Pittsburgh Medical Center, 3550 Terrace St., 497 Scaife Hall, Pittsburgh, PA 15261, Tel: 412-647-0680, FAX: 412-648-2045, EMAIL: simmonsr@msx.upmc.edu
AMERICAN SURGICAL ASSOCIATION

SIMMS, H. HANK, M.D., FACS, Prof. of Surgery, Jefferson Medical College; Chairman, Department of Surgery, Albert Einstein Medical Center, 5501 Old York Rd., Klein #510, Philadelphia, PA 19141, Tel: 215-456-6930, FAX: 215-456-3529, EMAIL: simmsh@einstein.edu

SINGER, SAMUEL, M.D., Professor of Surgery, Weill Medical College of Cornell University; Member, Memorial Sloan-Kettering Cancer Center, 1275 York Ave., Howard 1209, New York, NY 10021, Tel: 212-639-2940, FAX: 646-422-2300, EMAIL: singers@mskcc.org

SIPERSTEIN, ALLAN E, M.D., Head, Section of Endocrine Surgery; Program Director, Department of General Surgery, The Cleveland Clinic Foundation, 9500 Euclid Ave., Surgery A80, Cleveland, OH 44195, Tel: 216-444-5664, FAX: 216-445-7653, EMAIL: sipersa@ccf.org

*SIRINEK, KENNETH R, M.D., Professor of Surgery, Chief, Division of General and Laparoendoscopic Surgery, Department of Surgery, University of Texas Health Science Center, 7703 Floyd Curl Drive, San Antonio, TX 78229-3900, Tel: 210-567-5730, FAX: 210-567-5797, EMAIL: sirinek@uthscsa.edu

SITZMANN, JAMES V , M.D., Professor of Surgery, Indiana University School of Medicine, 1481 W. 10th St., C4068, Indianapolis, IN 46202, Tel: 317-630-6784, FAX: 317-630-8721, EMAIL: jvsitzma@iupui.edu

*SKILLMAN, JOHN J, M.D., Professor of Surgery, Harvard Medical School, Chief, Division of Vascular Surgery, Beth Israel Hospital, 110 Ox Bow Road, Weston, MA 02493, EMAIL: jskillman@aol.com

*SKINNER, DONALD G, M.D., Professor and Chairman, Department of Urology, University of Southern California School of Medicine, 1441 Eastlake Ave., Ste. 7414, Los Angeles, CA 90033, Tel: 213-764-3707, FAX: 213-762-1120

SLAKEY, DOUGLAS PHILIP, M.D., 1430 Tulane Ave., (SL-22), New Orleans, LA 70112, Tel: 504-988-2317, FAX: 504-988-1874, EMAIL: dslakey@tulane.edu

SLINGLUFF, CRAIG L, JR, M.D., Joseph Helms Farrow Professor of Surgery, University of Virginia, Box 800709, Charlottesville, VA 22908-0709, Tel: 434-924-1730, FAX: 804-243-6844, EMAIL: ch8h@virginia.edu

*SLOAN, HERBERT E, M.D., Emeritus Professor of Surgery, University of Michigan Medical Center, 471 Barton North Drive, Ann Arbor, MI 48105, Tel: 734-662-6123, FAX: 734-662-8303, EMAIL: hsloan@umich.edu
SMITH, CRAIG R, M.D., Chief, Division of Cardiothoracic Surgery; Calvin F. Barber Professor of Surgery; Director, Cardiothoracic Residency Program, New York Presbyterian Hospital-Columbia University, 177 Fort Washington Ave., MHB 7GN-435, New York, NY 10032, Tel: 212-305-8312, FAX: 212-305-0905, EMAIL: crs2@columbia.edu

SMITH, DAVID J, JR, M.D., Director, Division of Plastic Surgery and Reconstructive Surgery, University of South Florida, 4 Columbia Dr., #650, Tampa, FL 33606, Tel: 813-259-0964, FAX: 813-259-0985, EMAIL: dsmith3@hsc.usf.edu

SMITH, LOUIS L, M.D., Professor of Surgery Emeritus, Loma Linda University Medical Center, 430 Sunnyside Ave., Redlands, CA 92373-5628, Tel: 909-792-9472, FAX: 909-798-0833

SMITH, PETER K, M.D., Professor and Chief, Cardiothoracic Surgery, Duke University Medical Center, Box 3442, Durham, NC 27710, Tel: 919-684-2890, FAX: 919-681-7905, EMAIL: smith058@mc.duke.edu

SMITH, ROBERT B, III, M.D., John E. Skandalakis Professor of Surgery, Emeritus, Emory University Hospital, Clin Bldg. A, 1365 Clifton Rd. NE, Atlanta, GA 30322, Tel: 404-727-3573, FAX: 404-727-4716, EMAIL: robert.smith@emoryhealthcare.org

SMITH, ROGER F, M.D., Chairman Emeritus, Department of Surgery, Henry Ford Hospital, 5312 Otter Creek Court, Brentwood, TN 37027, Tel: 615-661-9601, EMAIL: rfsmith23@comcast.net

SMYTHE, WILLIAM R, M.D., 2401 South 31st Street, Temple, TX 76508, Tel: 254-724-2595, FAX: 254-724-7482, EMAIL: rsmythe@swmail.sw.org

SOBEL, MICHAEL, M.D., Professor and Vice-Chairman, Department of Surgery, University of Washington; Professor and Chief, Puget Sound Veterans Affairs Health Care System, 1660 S. Columbian Way, SS (112), Seattle, WA 98108-1597, Tel: 206-764-2255, FAX: 206-764-2529, EMAIL: michael.sobel@med.va.gov

SOLLINGER, HANS W, M.D., University of Wisconsin Hospitals and Clinics, 600 Highland Avenue, Madison, WI 53792-7375, Tel: 608-263-1406, FAX: 608-262-6280, EMAIL: hans@surgery.wisc.edu

SONDAK, VERNON K, M.D., Department Chair, Cutaneous Oncology, H. Lee Moffitt Cancer Center, 12902 Magnolia Drive SRB-4, Tampa, FL 33612, Tel: 813-745-8788, FAX: 813-979-7211, EMAIL: vernon.sondak@moffitt.org
SOPER, NATHANIEL J, M.D., Loyal and Edith Davis Professor and Chairman, Department of Surgery, Northwestern University Feinberg School of Medicine, 251 E. Huron St., Galter 3-150, Chicago, IL 60611, Tel: 312-926-4962, FAX: 312-926-7404, EMAIL: nsoper@nmh.org

*SOPER, ROBERT T, M.D., Professor, Department of Surgery, University of Iowa Hospital, Department of Surgery, Rm 1516 JCP, Iowa City, IA 52242-1086, Tel: 319-356-2679, FAX: 319-356-8378, EMAIL: rsoper@surgery.uiowa.edu

*SOROFF, HARRY S, M.D., Professor of Surgery, State University of New York at Stony Brook, 25 Asharoken Ave., Northport, NY 11768, Tel: 516-444-2039, FAX: 631-754-2282, EMAIL: ASoroff@hotmail.com

SOUBA, WILEY W, M.D., Dean, College of Medicine, Ohio State University, 370 W. 9th Ave., 254 Meiling Hall, Columbus, OH 43210-1238, Tel: 614-292-2600, FAX: 614-292-4254, EMAIL: chip.souba@osumc.edu

SOYBEL, DAVID I, M.D., Associate Professor of Surgery, Harvard Medical School; Staff Surgeon, Brigham & Women’s Hospital; Consulting Surgeon, Boston V.A. Healthcare System, 75 Francis St., Boston, MA 02115, Tel: 617-432-2267, FAX: 617-232-9576, EMAIL: dsoybel@partners.org

SPAIN, DAVID A, M.D., Professor of Surgery; Chief of Trauma/Surgical Critical Care, Stanford University, 300 Pasteur Dr., N3680, Stanford, CA 94305-5655, Tel: 650-723-0173, FAX: 650-725-0791, EMAIL: dspain@stanford.edu

*SPEES, EVERETT K, JR, M.D., Clinical Professor of Surgery, University of Colorado Health Sciences Center, Center for Bioethics and Humanities, 1836 Baseline Road, Boulder, CO 80302-7644, Tel: 303-448-1447, EMAIL: ekshae@aol.com

*SPELLMAN, MITCHELL W, M.D., Director of International Exchange Programs, Harvard Medical School, 12957 San Vicente Blvd., Los Angeles, CA 90049-4812, Tel: 310-458-0341, FAX: 310-458-0741, EMAIL: mitchell_spellman@hms.harvard.edu

*SPENCER, FRANK C, M.D., Professor, Department of Surgery, New York University Medical Center, 550 First Ave., Rm HCC 1508, New York, NY 10016, Tel: 212-263-0952, FAX: 212-263-0951, EMAIL: frank.spencer@nyumc.org
SPOTNITZ, HENRY M, M.D., Attending Surgeon, Columbia-Presbyterian Medical Center; George H. Humphreys, II, Professor of Surgery, Vice Chairman, Department of Surgery, Vice Chairman, Research and Information Systems, Columbia University Medical Center, 622 West 168th St., VC-1010, New York, NY 10032, Tel: 212-305-6191, FAX: 212-305-9724, EMAIL: hms2@columbia.edu

SPOTNITZ, WILLIAM D, M.D., Professor, Department of Surgery, University of Virginia, P.O. Box 801370, Charlottesville, VA 22980-1370, Tel: 352-514-5009, FAX: 352-331-0017, EMAIL: wspotnitz@bellsouth.net

SPRAY, THOMAS L, M.D., Professor of Surgery, University of Pennsylvania; Chief of Cardiovascular Surgery, The Children’s Hospital of Philadelphia, 34th St. & Civic Center Blvd., #8527 Main, Philadelphia, PA 19104, Tel: 215-590-2708, FAX: 215-590-2715, EMAIL: spray@email.chop.edu

STABLE, BRUCE E, M.D., Professor of Surgery, Chairman, Department of Surgery, Harbor-UCLA Medical Center, 1000 W. Carson St., Box 25, Torrance, CA 90502-2059, Tel: 310-222-2701, FAX: 310-782-1562, EMAIL: bstable@ucla.edu

STAHIL, WILLIAM M, M.D., Director, Department of Surgery, Lincoln Medical and Mental Health Center; Professor and Vice Chairman of Surgery, New York Medical College, 145 Rockland Ave., Larchmont, NY 10538, Tel: 914-834-2969, EMAIL: mdreedman@aol.com

STAIN, STEVEN C, M.D., Neil Lempert Professor and Chair, Department of Surgery, Albany Medical College, 47 New Scotland Ave., MC 61, Albany, NY 12208-3479, Tel: 518-262-2919, FAX: 518-262-5692, EMAIL: stains@mail.amc.edu

STAMEY, THOMAS A, M.D., Professor, Stanford Medical Center, Department of Urology, Stanford, CA 94305, Tel: 415-725-5542, FAX: 415-498-6106, EMAIL: tstamey@leland.stanford.edu

STAMOS, MICHAEL J, M.D., 333 City Blvd. West, Ste. 850, Orange, CA 92868, Tel: 714-456-8511, FAX: 714-456-6027, EMAIL: mstamos@uci.edu

STANLEY, JAMES C, M.D., Section of Vascular Surgery, Professor of Surgery, Director Cardiovascular Center, University of Michigan, 1500 E. Medical Center Dr., SPC 5867, Ann Arbor, MI 48109-5867, Tel: 734-936-5786, FAX: 734-647-9867, EMAIL: jstanley@umich.edu
STAREN, EDGAR D, M.D., Senior Vice President for Medical Affairs, Cancer Treatment Centers of America, 2520 Elisha Ave., Zion, IL 60099, Tel: 847-746-7174, EMAIL: edgar.staren@ctca-hope.com

*STARLING, JAMES R, M.D., Professor Emeritus, University of Wisconsin-Madison, 600 Highland Ave., H4/750, Madison, WI 53792-7375, Tel: 608-263-2521, EMAIL: starling@surgery.wisc.edu

STARNES, VAUGHN A, M.D., Distinguished Professor and Chair, Department of Surgery; Keck School of Medicine of the University of Southern California, 1520 San Pablo Street, Los Angeles, CA 90033-4612, Tel: 323-442-6878, FAX: 323-442-6199, EMAIL: starnes@usc.edu

*STARR, ALBERT, M.D., Director, Heart Institute, St. Vincent Hospital; Professor of Surgery, Oregon Health Sciences University, 9155 SW Barnes Rd., #240, Portland, OR 97225-6629, Tel: 503-296-4027, FAX: 503-216-2488, EMAIL: astarr@starrwood.com

*STARZL, THOMAS E, M.D., Professor of Surgery, University of Pittsburgh, 3601 Fifth Ave., 4W Falk Clinic, Pittsburgh, PA 15213, Tel: 412-624-0112, FAX: 412-624-0192, EMAIL: mangani@upmc.edu

*STATE, DAVID, M.D., Professor of Surgery Emeritus, Harbor-UCLA Medical Center, 1000 West Carson, Torrance, CA 90509, Tel: 213-533-2701

*STEED, DAVID L, M.D., Professor of Surgery; Associate Professor of Anesthesia & Critical Care; Director, Wound Healing/Limb Preservation Clinic; Presbyterian University Hospital, 200 Lothrop St., A-1011, Pittsburgh, PA 15213, Tel: 412-802-3333, FAX: 412-291-1669, EMAIL: steeddl@upmc.edu

*STEEL, GLENN D, JR, M.D., President and Chief Executive Officer, Geisinger Health Systems, 100 No Academy Ave., MC 22-01, Danville, PA 17822, Tel: 570-271-6168, FAX: 570-271-6927, EMAIL: gsteele@geisinger.edu

*STEER, MICHAEL L, M.D., Professor of Surgery, Harvard Medical School, Beth Israel Hospital, 860 Washington St., Department of Surgery, Boston, MA 02111, Tel: 617-667-4261, FAX: 617-667-2978, EMAIL: mike_steer@msn.com

*STEICHEN, FELICIEN M, M.D., Professor of Surgery, New York Medical College, 7 Kassel Court, Mamaroneck, NY 10543, Tel: 914-686-1562, FAX: 914-946-6226, EMAIL: michelesteichen@optonline.net
STEINBERG, STEVEN M, M.D., Professor of Surgery, Vice-Chair for Clinical Affairs, Department of Surgery, Director, Division of Critical Care, Trauma & Burn, Ohio State University Medical Center, 395 W. 12th Ave., Rm 630, Columbus, OH 43210, Tel: 614-293-3185, FAX: 614-293-4030, EMAIL: steven.steinberg@osumc.edu

*STELLATO, THOMAS A, M.D., Professor of Surgery, Case Western Reserve University; Medical Director, Wright Surgery Center, University Suburban Health Center, 1611 South Green Rd., South Euclid, OH 44121, Tel: 216-297-3223, FAX: 216-297-3225, EMAIL: tsstellato@ushchealth.com

*STEPHENSON, LARRY W, M.D., Professor and Chief, Wayne State University, Cardiothoracic Surgery; Chief, Detroit Medical Center, Cardiothoracic Surgery; Chief, Harper Hospital, Cardiothoracic Surgery, Harper Professional Bldg., #228, Detroit, MI 48201, Tel: 313-745-1413, FAX: 313-993-0572, EMAIL: lstephen@dmc.org

*STERIOFF, SYLVESTER, M.D., James C. Masson Professor of Surgery Emeritus, Mayo Medical School; Director, Division of Transplantation, Department of Surgery; Member, Board of Governors, Mayo Clinic, 200 First Street SW, Rochester, MN 55901, Tel: 507-284-8392, FAX: 507-284-5196, EMAIL: ssterioff@mayo.edu

STERN, HARTLEY S, M.D., Professor and Chairman, Department of Surgery, University of Ottawa, The Ottawa Hospital, 3755, CH. De La Cote-Ste-Catherine Road, Montreal, Ontario H3T 1E2, Canada, Tel: 514-340-8222, FAX: 514-340-7530, EMAIL: hstern@jgh.mcgill.ca

*STERN, W. EUGENE, M.D., Emeritus Professor of Neurosurgery, UCLA School of Medicine, 435 Georgina Avenue, Santa Monica, CA 90402-1909, Tel: 310-393-6976, EMAIL: westernmd1@verizon.net

*STEVENSON, THOMAS R, M.D., Chief – Division of Plastic Surgery, UC Davis Medical Center; Professor, Department of Surgery, Division of Plastic Surgery, University of California, Davis, School of Medicine, 2221 Stockton Blvd., 2nd Floor, Sacramento, CA 95817, Tel: 916-734-2568, FAX: 916-734-7104, EMAIL: thomas.stevenson@ucdmc.ucdavis.edu

*STIEGEMANN, GREGORY V, M.D., Professor; Head of GI, Tumor and Endocrine Surgery, University of Colorado Health Sciences Center, 12631 E. 17th Ave., MS C313, Aurora, CO 80045, Tel: 303-724-2731, FAX: 303-724-2733, EMAIL: greg.stiegemann@ucserver.edu
STOCK, PETER G, M.D., Ph.D., Professor of Surgery – UCSF; Director – UCSF Pancreas and Pancreatic Islet Transplant Program; Surgical Director – UCSF Pediatric Renal Transplant Program; Chair – American Society for Transplant Surgeons Fellowship Training Committee; Co-Chair – UNOS Pancreas Transplant Committee; UCSF Resident Research Committee and Resident Education Committee. 505 Parnassus Ave., Rm M-884, San Francisco, CA 94143-0780, Tel: 415-353-1061, FAX: 415-353-8974, EMAIL: stockp@surgery.ucsf.edu

*STOLAR, CHARLES J, M.D., Professor of Surgery and Pediatrics, Columbia University College of Physicians and Surgeons; Babies Hospital, 3959 Broadway, Room 212N, New York, NY 10032, Tel: 212-305-2305, FAX: 212-305-5971, EMAIL: cjs3@columbia.edu

*STONE, H. HARLAN, M.D., P.O. Box 523, Glenville, NC 28736, Tel: 828-743-6153, FAX: 602-495-9112, EMAIL: jstone7723@nctv.com

*STONEY, RONALD J, M.D., Emeritus Professor of Surgery, Weill Medical College of Cornell University, 505 Parnassus Ave., Room M-884, San Francisco, CA 94143-0780, Tel: 415-353-1061, FAX: 415-353-8974, EMAIL: rstoneymd@earthlink.net

*STROMBERG, STEVEN M, M.D., Professor, Head Section Hepatobiliary – Pancreatic and Gastrointestinal Surgery; Washington University School of Medicine, 4921 Parkview Place, 8th Floor, Ste. C, St. Louis, MO 63110, Tel: 314-362-7147, FAX: 314-367-1943, EMAIL: strasbergs@wustl.edu

*STRODEL, WILLIAM E, III, M.D., Chairman, Department of Surgery, Geisinger Health Systems, 100 N. Academy Avenue, Danville, PA 17722-2170, Tel: 570-214-9372, EMAIL: westrodel@geisinger.edu

*STUART, FRANK P, M.D., Emeritus Professor of Surgery, Northwestern University Medical School, 5747 Kimbark Ave., Chicago, IL 60637, Tel: 773-634-5435, FAX: 773-643-3054, EMAIL: stuart.f@sbcglobal.net

*STUBENBORD, WILLIAM T, M.D., Emeritus Professor of Surgery, Weill Medical College of Cornell University, 25 Sunset Rd., Old Saybrook, CT 06475, Tel: 860-388-1533, EMAIL: jstubie@aol.com

*STREMPLE, JOHN F, M.D., Emeritus Professor of Surgery, University of Pittsburgh School of Medicine, 160 Monks Road, Saxonburg, PA 16056, Tel: 724-352-4691, FAX: 724-352-4693, EMAIL: jfstrem@zoominternet.net
SUDAN, DEBRA L, M.D., Professor of Surgery, Chief, Division of Transplant Surgery; Duke University Medical Center, 223 Haines House, DUMC 3522, Durham, NC 27710, Tel: 919-668-2279, FAX: 919-684-8716, EMAIL: debra.sudan@duke.edu

SUGARBAKER, DAVID J, M.D., Chief, Division of Thoracic Surgery, Richard E. Wilson Professor of Surgical Oncology, Brigham & Women’s Hospital, Harvard Medical School, 75 Francis St., Division of Thoracic Surgery, Boston, MA 02115, Tel: 617-732-5004, FAX: 617-566-6434, EMAIL: dsugarbaker@partners.org

*SUGARBAKER, PAUL H, M.D., Director of Surgical Oncology, The Washington Cancer Institute; Washington Hospital Center, 110 Irving St. NW, Washington, DC 20010, Tel: 202-877-3908, FAX: 202-877-8602, EMAIL: paul.sugarbaker@medstar.net

*SUGAWA, CHOICHI, M.D., Professor of Surgery and Director of Surgical Endoscopy, Wayne State University, 4201 St. Antoine, 6-C UHC, Detroit, MI 48201, Tel: 313-577-5013, FAX: 313-577-5310, EMAIL: csugawa@med.wayne.edu

*SUGERMAN, HARVEY J, M.D., Emeritus Professor of Surgery, Virginia Commonwealth University, 290 Southwinds Drive, Sanibel, FL 33957, Tel: 239-472-4625, FAX: 239-472-4675, EMAIL: hsugerman@comcast.net

*SUMNER, DAVID S, M.D., Distinguished Professor of Surgery, Chief, Section of Peripheral Vascular Surgery, Southern Illinois University School of Medicine, P.O. Box 19230, Department of Surgery, Springfield, IL 62794-1312, Tel: 217-782-7804, FAX: 217-524-1793, EMAIL: dsunner1@aol.com

SUMPIO, BAUER E, M.D., Professor of Surgery and Radiology; Chief of Vascular Surgery, Yale-New Haven Hospital; Yale University School of Medicine, 333 Cedar St., Surgery, BB 204, New Haven, CT 06520, Tel: 203-785-6217, FAX: 203-785-7609, EMAIL: bauer.sumpio@yale.edu

SUNDT, THORALF M, M.D., Professor of Surgery, Mayo Medical School, Consultant, Mayo Clinic, 200 First St. SW, Rochester, MN 55905, Tel: 507-255-7064, FAX: 507-277-7378, EMAIL: sundt.thoralf@mayo.edu

*SUTHERLAND, DAVID E.R., M.D., Professor of Surgery, Head, Transplant Division, Director, Diabetes Institute for Immunology & Transplantation, University of Minnesota Hospital, 420 Delaware St. SE, Box 280, Minneapolis, MN 55455, Tel: 612-625-7600, FAX: 612-625-5855, EMAIL: dsuther@umn.edu
AMERICAN SURGICAL ASSOCIATION

*SWAN, KENNETH G, M.D., Chief, Section of General Surgery, UMDNJ-New Jersey Medical School, 666 Longview Rd., South Orange, NJ 07079, Tel: 973-972-5016, FAX: 973-972-6803, EMAIL: pedrettl@umdnj.edu

SWANSTROM, LEE L, M.D., Clinical Professor of Surgery; Director, Department of Minimally Invasive Surgery, Oregon Health Sciences University, 1040 NW 22nd Avenue, #560, Portland, OR 97210, Tel: 503-281-0561, FAX: 503-281-0575, EMAIL: lswanstrom@aol.com

*SWENSON, ORVAR, M.D., 2 Bishop Gadsden Way Unit 1056, Charleston, SC 29412-3581, Tel: 843-406-6601, EMAIL: swenson16@comcast.net

SWISHER, STEPHEN G, M.D., Chairman and Professor of Surgery; Department of Thoracic and Cardiovascular Surgery, University of Texas MD Anderson Cancer Center, 1515 Holcombe Blvd., Box 445, Houston, TX 77030, Tel: 713-792-8659, FAX: 713-794-4901, EMAIL: sswisher@mdanderson.org

*SYMBAS, PANAGIOTIS, M.D., Professor Emeritus of Cardiothoracic Surgery, Emory University School of Medicine, 3661 Cloudland Dr., NW, Atlanta, GA 30327, Tel: 404-616-4461, FAX: 404-616-4509

*SZILAGYI, D. EMERICK, M.D., Consultant in Vascular Surgery, Henry Ford Hospital, 1008 Stratford Pl, Bloomfield Hills, MI 48304, Tel: 248-644-3688

TALAMINI, MARK A, M.D., Professor and Chairman, Department of Surgery, University of California, San Diego, 200 W. Arbor Drive, MC 8400, San Diego, CA 92103-8400, Tel: 619-543-6453, FAX: 619-543-3763, EMAIL: talamini@ucsd.edu

*TALBERT, JAMES L, M.D., P.O. Box 100277, Gainesville, FL 32610-0286, Tel: 352-395-0630, FAX: 352-392-9081, EMAIL: talbert@surgery.ufl.edu

TANABE, KENNETH K, M.D., FACS, Chief, Division of Surgical Oncology, Massachusetts General Hospital; Deputy Clinical Director, MGH Cancer Center; Director, Division of Surgical Oncology Research Laboratories, Massachusetts General Hospital, 55 Fruit St., Yawkey 7924, Boston, MA 02114-6217, Tel: 617-724-3868, FAX: 617-724-3895, EMAIL: ktanabe@partners.org
TAYLOR, BRYCE R, M.D., Professor, Department of Surgery; Associate Chair, Department of Surgery, University of Toronto; Surgeon-in-Chief & Director of Surgical Services, University Health Network-Toronto General Hospital, Toronto Western Hospital, Princess Margaret Hospital, 190 Elizabeth St., Elliott Bldg. #408, Toronto, Ontario MSG 2C4, Canada, Tel: 416-340-3863, FAX: 416-340-4761, EMAIL: bryce.taylor@uhn.on.ca

♦ TAYLOR, SPENCE M, M.D., Senior Associate Dean for Academic Affairs, Chairman and Clinical Professor, Greenville Hospital Systems, University Medical Center, 701 Grove Rd., Greenville, SC 29605, Tel: 864-455-7886, FAX: 864-455-1320, EMAIL: staylor2@ghs.org

TEITELBAUM, DANIEL H, M.D., Professor of Surgery, Section of Pediatric Surgery, University of Michigan, C.S. Mott Children’s Hospital, F3970 Mott Childrens Hospital, Box 024, Ann Arbor, MI 48109, Tel: 734-936-8464, FAX: 734-936-9784, EMAIL: dtitbm@umich.edu

TELFORD, GORDON L, M.D., Professor of Surgery, Medical College of Wisconsin, 9200 W. Wisconsin Ave., Milwaukee, WI 53226, Tel: 414-805-5750, FAX: 414-454-0152, EMAIL: gtelford@mcw.edu

THAL, ALAN P, M.D., Clinical Professor, University of New Mexico, Box 116, Buena Vista, NM 87712, Tel: 505-387-2925, FAX: 505-387-2925, EMAIL: thala@hughes.net

THAL, ERWIN R, M.D., Professor of Surgery, University of Texas Southwestern Medical Center, 5323 Harry Hines Blvd., Surgery, Dallas, TX 75390, Tel: 214-648-3531, FAX: 214-648-5477, EMAIL: erwin.thal@utsouthwestern.edu

THIELE, BRIAN L, M.D., Professor of Surgery, University of Queensland; Director, Medical Services, Bundaberg Base Hospital, 4 Arthur Brown Court, Innes Park, QN 4670, Australia, Tel: 07 4159 3639, EMAIL: barbthiele@bigpond.com

THIRLBY, RICHARD C, M.D., Attending Surgeon, Virginia Mason Medical Center, 1100 Ninth Ave., P.O. Box 900, (C6-GSUR), Seattle, WA 98111, Tel: 206-223-6636, FAX: 206-625-7245, EMAIL: richard.thirby@vmmc.org

THOMAS, COLIN G, JR, M.D., Byah Thomason-Doxey Sanford Professor of Surgery, Chair Emeritus, University of North Carolina School of Medicine, CB 7228, Department of Surgery, Oncology, Chapel Hill, NC 27599-7228, Tel: 919-843-4230, FAX: 919-966-0369, EMAIL: cgt@med.unc.edu
*TILNEY, NICHOLAS L, M.D., Francis D. Moore Professor of Surgery, Harvard Medical School, Brigham and Women’s Hospital, 75 Francis Street, Boston, MA 02115, Tel: 617-732-6817, FAX: 617-525-7723, EMAIL: ntilney@partners.org

*TILSON, M. DAVID, M.D., Ailsa Mellon Bruce Professor of Surgery, St. Luke’s Roosevelt Hospital Center, 105 Garth Road, Apt. B2, Scarsdale, NY 10583, Tel: 212-523-7779, FAX: 212-523-6495, EMAIL: mdt1@columbia.edu

*TODD, THOMAS R.J., M.D., Director Physician Consulting Canadian Medical Protective Association, 163 St. Paul St., Almonte, Ontario K0A 1A0, Canada, Tel: 613-725-9965, FAX: 613-725-1300, EMAIL: ttodd@cmpa.org

*TODO, SATORU, M.D., Adjunct Professor of Surgery, Thomas E. Starzl Transplantation Institute, Hokkaido University School of Medicine, N-15, W-7, Kita-ku, 1st Department of Surgery, Sapporo, 060-8638, Japan, Tel: 81-11-7065923, FAX: 81-11-7177515, EMAIL: stodo@med.hokudai.ac.jp

TOMPKINS, RONALD G, M.D., John Francis Burke Professor of Surgery, Harvard Medical School; Chief, Trauma/Burn Services, Massachusetts General Hospital, 55 Fruit St., GRB 1302, Boston, MA 02114, Tel: 617-726-3447, FAX: 617-367-8936, EMAIL: rtomkins@partners.org

*TOMPKINS, RONALD K, M.D., Professor Emeritus of Surgery, UCLA School of Medicine, 309 20th Street, Santa Monica, CA 90402, Tel: 310-394-8336, EMAIL: rtopkin@ucla.edu

*TOULOUKIAN, ROBERT J, M.D., Professor of Surgery and Pediatrics, Chief, Pediatric Surgery, Program Director, Yale University School of Medicine, P.O. Box 208062, 333 Cedar St., Surgery, New Haven, CT 06520, Tel: 203-785-2701, FAX: 203-785-3820, EMAIL: robert.touloukian@yale.edu

*TOWNE, JONATHAN B, M.D., Medical College of Wisconsin, 9200 West Wisconsin Ave., Milwaukee, WI 53226, Tel: 414-805-9172, FAX: 414-456-6216, EMAIL: jtowne@mail.mcw.edu

*TOWNSEND, COURTNEY M, JR, M.D., Professor and Chairman, University of Texas Medical Branch, Department of Surg, 301 University Blvd., Galveston, TX 77555-0527, Tel: 409-772-1285, FAX: 409-772-5611, EMAIL: ctownsen@utmb.edu
TRACY, THOMAS F, JR., M.D., Vice Chairman, Department of Surgery; Professor of Surgery and Pediatrics, Brown Medical School; Pediatric Surgeon-in-Chief, Hasbro Children’s Hospital, 593 Eddy Street, Room 147, Providence, RI 02903, Tel: 401-444-7605, FAX: 401-444-7629, EMAIL: thomas_tracy@brown.edu

*TRAVERSO, L. WILLIAM, M.D., Associate Clinical Professor, University of Washington, Virginia Mason Clinic, 1100 Ninth Ave., C6-G, Surgery, Seattle, WA 98101, Tel: 206-223-8855, FAX: 206-625-7245, EMAIL: traversolw@msn.com

TRIBBLE, CURTIS G, M.D., 2500 North State St., CT Surgery, Jackson, MS 39211, Tel: 601-984-5170, EMAIL: ctribble@surgery.umsmed.edu

*TROOSKIN, STANLEY Z, M.D., Professor and Chief, Division of General Surgery, Robert Wood Johnson Medical School, One RWJ Place, P.O. Box 19, MEB-443, New Brunswick, NJ 08903-0019, Tel: 732-235-7920, FAX: 732-235-7079, EMAIL: troosksz@umdnj.edu

*TROUT, HUGH H, III, M.D., Clinical Professor of Surgery, George Washington Medical Center, 8218 Wisconsin Ave., #204, Bethesda, MD 20814, Tel: 301-652-1208, FAX: 301-951-8425, EMAIL: hhtroat@gmail.com

*TRUNKLEY, DONALD D, M.D., Professor and Chairman, Department of Surgery, Oregon Health Sciences University, 3181 SW Sam Jackson Park Rd., Portland, OR 97201, Tel: 503-494-9145, FAX: 503-494-8884, EMAIL: truncleyd@ohsu.edu

*TRUSLER, GEORGE A, M.D., The Hospital for Sick Children, 555 University Ave., #1525, Toronto, Ontario M5G 1X8, Canada, Tel: 416-598-6420, FAX: 416-813-7477

*TURCOTTE, JEREMIAH G, M.D., Professor of Surgery, University of Michigan Health Systems, 1327 Jones Dr., Ste. 201, Ann Arbor, MI 48105, Tel: 734-998-0167, FAX: 734-998-0173, EMAIL: turcotte@umich.edu

TURNAGE, RICHARD H, M.D., Professor of Surgery and Chairman, University of Arkansas for Medical Sciences, 4301 W. Markham, Slot 520, Little Rock, AR 72205, Tel: 501-686-7874, FAX: 501-686-5696, EMAIL: RTurnage@uams.edu

*TURNIPSEED, WILLIAM D, M.D., Professor, University of Wisconsin Hospital and Clinics, 600 North Highland Ave., #H4-730, Madison, WI 53792, Tel: 608-263-1388, FAX: 608-263-7652, EMAIL: turnip@surgery.wisc.edu
*TYERS, G. FRANK O, M.D., Professor and Head, The University of British Columbia, Division of Cardiovascular and Thoracic Surgery, 1675 Trimble Street, Vancouver, British Columbia V6R 4J6, Canada, Tel: 604-228-0302, FAX: 604-228-0302, EMAIL: GFOT@telus.net “

TYLER, DOUGLAS S, M.D., Professor of Surgery; Vice-Chairman, Department of Surgery; Associate Medical Director of Oncology Services, Duke University Medical Center, Box 3118, Department of Surgery, Durham, NC 27710, Tel: 919-684-6858, FAX: 919-684-6044, EMAIL: tyler002@duke.edu

*TYSON, R. ROBERT, M.D., Honorary Executive Director, Emeritus Professor and Chairman, Department of Surgery, Temple University, Blue Shield Institute of Pennsylvania, 307 Founders Village, Lansdale, PA 19446, Tel: 610-584-3946

TZAKIS, ANDREAS G, M.D., Professor of Surgery; Director, Liver/GI Transplant Program; Co-Director Division of Transplantation; University of Miami School of Medicine, 1801 NW 9th Ave., Ste. 300, Miami, FL 33101, Tel: 305-355-5011, FAX: 305-355-5012, EMAIL: atzakis@med.miami.edu

UDELSMAN, ROBERT, M.D., Chairman of Surgery, Yale University, Department of Surgery, P.O. Box 20862, 330 Cedar St., FMB 102, New Haven, CT 06520-8062, Tel: 203-785-2697, FAX: 203-737-2116, EMAIL: robert.udelsman@yale.edu

*UNGERLEIDER, ROSS M, M.D., Chief, Pediatric Cardiac Surgery, Oregon Health & Sciences University, 11100 Euclid Ave., RBC 380, MS RBC 6021, Cleveland, OH 44106, Tel: 216-844-3058, FAX: 216-844-3517, EMAIL: ross.ungerleider@UHhospitals.org

URIST, MARSHALL M, M.D., Professor of Surgery; Division of General Surgery; Section of Surgical Oncology, University of Alabama at Birmingham, UAB Station, 321 Kracke Bldg., Birmingham, AL 35294, Tel: 205-934-3065, FAX: 205-975-5971, EMAIL: mmurist@ccc.uab.edu

*URSCHEL, HAROLD C, JR, M.D., Chair of Cardiovascular & Thoracic Surgical Research, Education & Clinical Excellence, Baylor University Medical Center, 3600 Gaston Avenue, #1201 Barnett, Dallas, TX 75246, Tel: 214-824-2503, FAX: 214-824-2505, EMAIL: drurschel@me.com
AMERICAN SURGICAL ASSOCIATION

*VACANTI, JOSEPH P, M.D., John Homans Professor of Surgery, Harvard Medical School; Chief of Pediatric Surgery, Massachusetts General Hospital, 55 Fruit St., Warren 1151, Boston, MA 02114, Tel: 617-724-1725, FAX: 617-726-2167, EMAIL: jvacanti@partners.org

VALENTINE, R. JAMES, M.D., Professor and Vice Chairman, Alvin Baldwin Jr. Chair in Surgery; Director, Department of Surgery Residency Program, University of Texas Southwestern Medical Center, 5323 Harry Hines Blvd., MC-9031, Dallas, TX 75390-9031, Tel: 214-648-3514, FAX: 214-648-6752, EMAIL: james.valentine@utsouthwestern.edu

*VAN HEERDEN, JON A, M.D., Professor of Surgery, Medical University of South Carolina, 3039 Baywood Dr., Seabrook Island, SC 29455, Tel: 843-792-2720, FAX: 843-792-3315

*VAN WAY, CHARLES W, III, M.D., Sosland/Missouri Endowed Chair of Trauma Research, University of Missouri Kansas City, 2411 Holmes Street, MG-C01, Kansas City, MO 64108, Tel: 816-404-5364, FAX: 816-404-5363, EMAIL: vanwayne@umkc.edu

*VANDER SALM, THOMAS J, M.D., Clinical Professor of Surgery, Harvard Medical School, Chief, Cardiac Surgery, North Shore Medical Center, 81 Highland Ave., Salem, MA 01970, Tel: 978-354-2500, FAX: 978-354-2494, EMAIL: tvandersalm@partners.org

*VASCONEZ, LUIS O, M.D., Professor and Chief, Division of Plastic Surgery, University of Alabama at Birmingham, 510 20th St., South FOT-1102, Birmingham, AL 35294-3411, Tel: 205-934-3245, FAX: 205-975-6155, EMAIL: luis.vasconez@ccc.uab.edu

*VAUGHAN, E. DARRACOTT, JR, M.D., James J. Colt Professor of Urology and Chairman, Department of Urology, Cornell University Medical Center; Urologist-in-Chief, The New York Hospital, 525 E. 68th St., Box 94, Rm F901, New York, NY 10021, Tel: 212-746-5480, FAX: 212-746-8153, EMAIL: evaughan@med.cornell.edu

VEDDER, NICHOLAS B, M.D., Professor of Surgery and Orthopaedics; Chief of Plastic Surgery, Vice Chair, Department of Surgery, University of Washington, 325 Ninth Ave., Box 359796, Surgery, Seattle, WA 98104-2499, Tel: 206-731-3209, FAX: 206-731-3656, EMAIL: vedder@u.washington.edu

*VEIDENHEIMER, MALCOLM C, M.D., Retired, Lahey Clinic, P.O. Box 88, Etna, NH 03750, Tel: 603-643-1390, EMAIL: mandsveid@aol.com
AMERICAN SURGICAL ASSOCIATION

*VEITH, FRANK J, M.D., Professor, Division of Vascular Surgery, Cleveland Clinic Foundation & New York University Medical Center, 4455 Douglas Ave., #11E, New York, NY 10471, Tel: 718-549-3140, FAX: 718-549-3142, EMAIL: fjvmd@msn.com

VELANOVICH, VIC, M.D., Division Head, General Surgery, Henry Ford Hospital; Professor of Surgery (Clinician Educator), Wayne State University, 2799 West Grand Blvd., Detroit, MI 48202-2689, Tel: 313-916-8984, FAX: 313-916-9920, EMAIL: vvelano1@hfhs.org

VELMAHOS, GEORGE C, M.D., Associate Professor of Surgery, Division of Trauma & Critical Care, Keck School of Medicine at the University of Southern California; Chief, Trauma Service, Los Angeles County & University of Southern California Medical Center, 165 Cambridge St., #810, Boston, MA 02114, Tel: 617-726-9591, FAX: 617-726-9121, EMAIL: gvelmahos@partners.org

*VERRIER, EDWARD D, M.D., Chief of Cardiothoracic Surgery Division, William K. Edmark Professor of Cardiovascular Surgery, Vice Chairman, Department of Surgery, University of Washington, Box 356310, 1959 NE Pacific, Seattle, WA 98195-6310, Tel: 206-543-3093, FAX: 206-616-9063, EMAIL: edver@u.washington.edu

*VETTO, JOHN T, M.D., 3181 SW Sam Jackson Pk, L619, Portland, OR 97239-3098, Tel: 503-494-4879, FAX: 503-494-7573, EMAIL: vettoj@ohsu.edu

*VETTO, R. MARK, M.D., D.SC, Professor of Surgery Emeritus, Oregon Health Sciences University, 3330 SW Fairmount Blvd., Portland, OR 97239, Tel: 503-223-3337, EMAIL: rmarkvetto@aol.com

VICKERS, SELWYN M, M.D., Jay Phillips Professor and Chairman, Department of Surgery, University of Minnesota, 420 Delaware St. SE, MMC 195, Minneapolis, MN 55455, Tel: 612-626-1999, FAX: 612-626-0654, EMAIL: vickers@umn.edu

*VILLAR, HUGO V, M.D., Professor of Surgery & Radiation Oncology, Chief, Section of Surgical Oncology, Arizona Health Sciences Center, Department of Surgery, Tucson, AZ 85724, Tel: 520-626-6785, FAX: 502-626-7785, EMAIL: hvillar@azcc.arizona.edu

*VLAHAKES, GUS J, M.D., Professor of Surgery, Harvard Medical School; Division of Cardiac Surgery, Massachusetts General Hospital, 55 Fruit St., COX652, Boston, MA 02114-2696, Tel: 617-726-1861, FAX: 617-726-5804, EMAIL: vlahakes.gus@mgh.harvard.edu
VON ALLMEN, DANIEL, M.D., 3333 Burnett Ave., MCL 2023, Cincinnati, OH 45229, Tel: 513-636-7365, EMAIL: daniel.vonallmen@cchmc.org

*WACHTEL, THOMAS L, M.D., Medical Director; Clinical Professor of Surgery, Scottsdale Healthcare, 5702 East Via Buena Vista, Paradise Valley, AZ 85253, Tel: 480-368-8036, FAX: 480-675-4276, EMAIL: twachtel@shc.org

WAIT, RICHARD B, M.D., Chairman, Department of Surgery, Baystate Medical Center, 759 Chestnut St., Springfield, MA 01199, Tel: 413-794-5161, FAX: 413-794-5940, EMAIL: richard.wait@bhs.org

WAKEFIELD, THOMAS W, M.D., Section Head, Vascular Surgery; S. Martin Lindenauer Professor of Surgery, University of Michigan, 1500 E. Medical Center Dr., THCC 2210, Ann Arbor, MI 48109-0329, Tel: 734-936-5820, FAX: 734-647-9867, EMAIL: thomasww@med.umich.edu

*WALDHAUSEN, JOHN A, M.D., John W. Oswald, Professor and Chair of Surgery, Emeritus, Pennsylvania State University College of Medicine, Milton S. Hershey Medical Center, 500 University Drive, Box 850, Hershey, PA 17033, Tel: 717-531-8330, FAX: 717-531-3664, EMAIL: jawaldhausen@aol.com

♦ WALDHAUSEN, JOHN H.T., M.D., Pediatric Surgery Training Program Director; Division Chief Pediatric Surgery; Professor of Surgery University of Washington School of Medicine, 4800 Sand Point Way NE, W7753, Seattle, WA 98105-6410, Tel: 206-997-3925, EMAIL: john.waldhausen@seattlechildrens.org

*WALKER, PAUL M, M.D., Ph.D., Adjunct Professor of Surgery, University of Toronto; CEO Spectral Diagnostics, Inc., 135-2 The West Mall, Toronto, Ontario M9C 1C2, Canada, Tel: 416-626-3233, FAX: 416-626-2739, EMAIL: pwalker@spectraldx.com

*WALL, WILLIAM J, M.D., Professor of Surgery, University of Western Ontario; Director of Multi-Organ Transplant Program, London Health Sciences Centre, 339 Windermere Rd., University Campus, London, Ontario N6A5A5, Canada, Tel: 519-663-2940, FAX: 519-663-3067, EMAIL: william.wall@lhsc.on.ca

*WALLACE, ROBERT B, M.D., Retired, 1322 Darnall Drive, McLean, VA 22101, Tel: 703-356-4015, FAX: 703-356-1747, EMAIL: rbwallace@cox.net
WALLACK, MARC K, M.D., Professor of Surgery, New York Medical College; Chairman, Department of Surgery, St. Vincent's Hospital and Medical Center of New York, 1901 First Ave., Rm 12A1, Surgery, New York, NY 10029, Tel: 212-423-6614, FAX: 212-423-2913, EMAIL: marc.wallack@nychhc.org

WALSH, PATRICK C, M.D., Urologist-in-Chief and David Hall McConnell Professor & Chairman, Department of Urology, Johns Hopkins Hospital, 600 No Wolfe, Park 224, Baltimore, MD 21287-2101, Tel: 410-614-3377, FAX: 410-955-0833, EMAIL: pwalsh@jhmi.edu

WANEBO, HAROLD J, M.D., Director of the Division of Surgical Oncology, Landmark Medical Center; Professor of Surgery, Boston University; Adjunct Professor of Surgery, Brown University, 206 Cass Ave., Woonsocket, RI 02895, Tel: 401-767-1595, FAX: 401-767-1508, EMAIL: hwanebo@rwmc.org

WANGENSTEEN, STEPHEN L, M.D., 82 Red Bank Road, Rembert, SC 29128, Tel: 803-432-9490, FAX: 803-425-8887, EMAIL: stephen@hunterhorse.com

WARDEN, GLENN D, M.D., MBA, Professor of Surgery, University of Cincinnati College of Medicine, Chief of Staff, Shriners Burn Institute, 5470 Pioneer Fork Road, Salt Lake City, UT 84108, Tel: 801-971-3762, FAX: 801-583-1439, EMAIL: glenn@wardenbio.com

WARNER, BRAD W, M.D., Professor of Surgery, Washington University School of Medicine; Apolline Blair Professor; Surgeon-in-Chief, St. Louis Children’s Hospital, One Children’s Place, Ste. 5540, St. Louis, MO 63110, Tel: 314-454-6022, FAX: 314-454-2442, EMAIL: brad.warner@wustl.edu

WARNOCK, GARTH L, M.D., Woodward Professor and Head, Department of Surgery, University of British Columbia; Surgeon-in-Chief of Vancouver Teaching Hospitals, Vancouver Coastal Health, 910 West 10th Ave., Rm 3100, 3rd Fl., Vancouver, British Columbia V5Z 4E3, Canada, Tel: 604-875-4136, FAX: 604-875-4036, EMAIL: garth.warnock@ubc.ca

WARSHAW, ANDREW L, M.D., Surgeon-in-Chief, Chairman, Department of Surgery, W. Gerald Austen Professor of Surgery, Harvard Medical School, Massachusetts General Hospital, 55 Fruit Street, WHT 506, Boston, MA 02114-2696, Tel: 617-726-8254, FAX: 617-726-7593, EMAIL: awarshaw@partners.org
AMERICAN SURGICAL ASSOCIATION

*WATKINS, MICHAEL T, M.D., 15 Parkman St., Ste. 440, Boston, MA 02114, Tel: 617-726-0908, FAX: 617-726-2560, EMAIL: mtwatkins@partners.org

*WATNE, ALVIN L, M.D., 1653 Mooregate CT, Marietta, GA 30062, Tel: 815-264-7902, FAX: 815-264-7902, EMAIL: alwatne6242@yahoo.com

WAY, LAWRENCE W, M.D., Professor of Surgery, University of California at San Francisco, 4 Koret Way, LR-101, Box 0475, San Francisco, CA 94143-0475, Tel: 415-476-6359, FAX: 415-476-9557, EMAIL: bway@aol.com

WEAVER, FRED A, M.D., M.M., Professor of Surgery; Chief, Division of Vascular Surgery and Endovascular Therapy, University of Southern California, Department of Surgery, 1520 San Pablo St., #4300, Los Angeles, CA 90033, Tel: 323-442-6835, FAX: 323-442-5735, EMAIL: fweaver@surgery.usc.edu

*WEAVER, W. LYNN, M.D., 720 Westview Dr., SW, Atlanta, GA 30310-1495, Tel: 404-616-3562, FAX: 404-616-3091, EMAIL: weaverw@msm.edu

*WEBB, WATTS R, M.D., Clinical Professor of Surgery, Louisiana State University School of Medicine, 364 Windermere Blvd., Alexandria, LA 71303, Tel: 504-568-6574, FAX: 504-568-4633, EMAIL: watsrwebb@yahoo.com

*WEBER, COLLIN J, M.D., William C. McGarity Professor of Surgery, Emory University, Department of Surgery, 5105 WMB, 1639 Pierce Drive, Atlanta, GA 30322, Tel: 404-727-0084, FAX: 404-727-3660, EMAIL: cweber@emory.org

*WEBER, THOMAS R, M.D., Hope Children’s Hospital, Pediatric Surgery, 4440 W. 95th St., Ste. 1323H, Oak Lawn, IL 60453, Tel: 708-684-4808, FAX: 708-684-4808, EMAIL: trwmd1945@aol.com

*WEBSTER, MARSHALL W, M.D., Executive Vice President & Chief Medical Officer, University of Pittsburgh Medical Center; President & CEO, University of Pittsburgh Physicians, 3600 Forbes Ave., 9th Floor, Ste. 9019, Pittsburgh, PA 15213, Tel: 412-647-1912, FAX: 412-647-1919, EMAIL: webstermw@upmc.edu

*WECHSLER, ANDREW S, M.D., Stanley K. Brockman Professor and Chairman, Department of Cardiovascular Medicine and Surgery, Drexel University College of Medicine, 245 No 15th St., Mail Stop 111, Philadelphia, PA 19102-1192, Tel: 215-762-4955, FAX: 215-762-1858, EMAIL: andrew.wechsler@drexelmed.edu
AMERICAN SURGICAL ASSOCIATION

*WEDGE, JOHN H, M.D., Surgeon-in-Chief, The Hospital for Sick Children; R.S. McLaughlin Professor and Chair, Department of Surgery, University of Toronto, 555 University Ave., Department Surgery, Toronto, Ontario M5G 1X8, Canada, Tel: 416-978-2623, FAX: 416-978-3928, EMAIL: john.wedge@utoronto.ca

*WEEKS, PAUL M, M.D., Chief of Plastic Surgery, Washington University School of Medicine, 1 Barnes Hosp Pl, #17424, St. Louis, MO 63110, Tel: 314-362-4593, FAX: 314-367-0225, EMAIL: pmweeks@worldnet.att.net

WEIGEL, RONALD J, M.D., Professor and Head, Department of Surgery, University of Iowa, 200 Hawkins Drive, #1516 JCP, Iowa City, IA 52242-1086, Tel: 319-353-7474, FAX: 319-356-8378, EMAIL: Ronald-Weigel@uiowa.edu

*WEIGELT, JOHN A, M.D., Professor, Department of Surgery, Division of Trauma/Critical Care, Medical College of Wisconsin, 9200 W. Wisconsin Ave., Trauma/Crit Care, Milwaukee, WI 53226, Tel: 414-805-8636, FAX: 414-805-8641, EMAIL: jweigelt@mcw.edu

*WEIL, RICHARD, III, M.D., 746 Riomar Drive, Vero Beach, FL 32963, Tel: 772-234-0042, EMAIL: popw@webTV.net

*WEIN, ALAN J, M.D., Professor and Chairman, Division of Urology, Hospital of the University of Pennsylvania, 34th St. & Civic Center Blvd., Nine Penn Twr, Philadelphia, PA 19104, Tel: 215-662-6755, FAX: 215-662-3975, EMAIL: alan.wein@uphs.upenn.edu

*WEIR, BRYCE, M.D., Maurice Goldblatt Professor and Chief, Section of Neurosurgery, Director, Brain Research Institute, The University of Chicago Medical Center, 5841 So Maryland, MC3026, Chicago, IL 60637, Tel: 773-702-2123, FAX: 773-702-3518

*WEISEL, RICHARD D, M.D., Professor of Surgery, Director of Toronto General Research Institute, 3501 – 750 Bay Street, Toronto, Ontario M5G 1N6, Canada, Tel: 416-204-9377, FAX: 416-340-3475, EMAIL: weisel9377@rogers.com

*WEISER, MARTIN R, M.D., 1275 York Ave., Ste. C-1075, New York, NY 10021, Tel: 212-639-6698, FAX: 212-794-3198, EMAIL: weiser1@mskcc.org
WEISS, ROBERT M, M.D., Professor and Interim Chairman, Department of Surgery; Chief of the Section of Urology, Yale University School of Medicine, P.O. Box 208041, YPB-321, Urology, New Haven, CT 06520-8041, Tel: 203-785-7671, FAX: 203-785-4043, EMAIL: robert.weiss@yale.edu

WELLS, SAMUEL A, JR, M.D., Center for Cancer Research, National Cancer Institute, NIH, 10 Center Dr., Bldg. 10, Rm 3-2571, Bethesda, MD 20892, Tel: 919-201-0310, FAX: 919-644-1664, EMAIL: wellsS@wudosis.wustl.edu

WESSON, DAVID E, M.D., Professor of Surgery – Baylor College of Medicine; Chief Division Pediatric Surgery Service – Baylor College of Medicine, Texas Children’s Hospital, 6621 Fannin, CC650.00, Houston, TX 77030, Tel: 832-822-3135, FAX: 832-825-3141, EMAIL: davidw@bcm.tmc.edu

WEST, MICHAEL A, M.D., Professor and Vice Chair, Department of Surgery, University California San Francisco, 1001 Potrero Ave., Ward 3 A, San Francisco, CA 94110, Tel: 415-206-4626, FAX: 415-206-5484, EMAIL: michael.west@ucsf.edu

WHEAT, MYRON W, JR, M.D., Clinical Professor of Surgery, University of South Florida College of Medicine, 8413 SW 55th Place, Gainesville, FL 32608, Tel: 727-418-1046, FAX: 352-336-9874, EMAIL: myronwheat@msn.com

WHEELER, H. BROWNELL, M.D., Professor, Department of Surgery, University of Massachusetts Medical School, 52 Cloyster Rd., South Portland, ME 04106, Tel: 207-799-1222, EMAIL: bwheel1@maine.rr.com

WHITAKER, LINTON A, M.D., FACS, Professor & Chairman of Plastic Surgery, University of Pennsylvania Medical Center, 3400 Spruce St., 10 Penn Tower, Philadelphia, PA 19104-4385, Tel: 215-662-2048, FAX: 215-349-5895, EMAIL: linton.whitaker@uphs.upenn.edu

WHITE, RODNEY A, M.D., Chief of Vascular Surgery; Associate Chair, Department of Surgery; Director, General and Vascular Surgery Residency, Harbor-UCLA Medical Center, 1000 W. Carson Street, Torrance, CA 90502-2059, Tel: 310-222-2704, FAX: 310-787-1889, EMAIL: rawhite@ucla.edu
*WHITEHOUSE, WALTER M, JR, M.D., Adjunct Clinical Professor of Surgery, University of Michigan Medical School; Chairman, Department of Surgery, St. Joseph’s Mercy Hospital; Michigan Heart and Vascular Institute, 5325 Elliott Dr., #104, P.O. Box 974, Ann Arbor, MI 48106, Tel: 734-434-4200, FAX: 734-434-4229, EMAIL: whitehow@trinity-health.org

*WHITTEMORE, ANTHONY D, M.D., Professor of Surgery, Harvard Medical School; Chief of Vascular Surgery, Emeritus; Chief Medical Officer/Senior Vice President for Clinical Affairs, Brigham & Women’s Hospital, 75 Francis Street, PB-4, Boston, MA 02115, Tel: 617-732-8515, FAX: 617-264-6366, EMAIL: awhittemore@partners.org

*WILCOX, BENSON R, M.D., Chief Emeritus, Division of Cardiothoracic Surgery, University of North Carolina, 3040 Burnett-Womack Bldg., CB 7065, Chapel Hill, NC 27599, Tel: 919-966-3381, FAX: 919-966-3475, EMAIL: bensonreid@aol.com

*WILKINS, EARLE W, M.D., Senior Surgeon, Clinical Professor of Surgery Emeritus, Harvard Medical School, 240 South St., Box 593, Williamstown, MA 01267, Tel: 413-458-9104, EMAIL: ewwilki@adelphia.net

*WILLIAMS, DAVID I, M.D., Dean of the Institute of Urology, University of London; Senior Lecturer, Institute of Child Health; Urologist, Hospital for Sick Children, Great Ormond Street and St. Peter’s Hospitals and King Edward VII Hospital for Officers, 66 Murray Rd., Wimbledon Common, London, SW 19 4PE, England, Tel: 0181-879-1042

*WILLIAMS, G. MELVILLE, M.D., Bertram M. Bernheim Professor of Surgery, Surgeon-in-Chief, The Johns Hopkins Hospital, Division of Transplantation and Vascular Surgery, 600 No Wolfe St., Harvey 606, Baltimore, MD 21287-8611, Tel: 410-955-5174, FAX: 410-614-2079, EMAIL: gmelville2004@yahoo.com

*WILLIAMS, ROGER D, M.D., 27010 NW 8th Lane, Newberry, FL 32669, Tel: 352-472-3188, FAX: 352-472-3188

*WILMORE, DOUGLAS W, M.D., Frank Sawyer Professor of Surgery, Harvard Medical School, Brigham and Women’s Hospital, Department of Surgery, 75 Francis Street, Boston, MA 02115, Tel: 617-732-5280, FAX: 617-732-5506, EMAIL: dwilmore@partners.org

*WILSON, ROBERT F, M.D., Professor of Surgery, Wayne State University School of Medicine, Department of Surgery, 4201 St. Antoine, 4V-23, Detroit, MI 48201, Tel: 313-745-3487, FAX: 313-745-2965, EMAIL: rwilson3@dmc.org
*WILSON, SAMUEL E, MD, UCI Medical Center, Orange, CA 92868, Tel: 714-456-7246, FAX: 714-456-8205, EMAIL: wilsonse@uci.edu

*WILSON, STUART D, M.D., Professor and Chief, Division of Pancreatobiliary/Endocrine Surgery, Medical College of Wisconsin, 9200 W. Wisconsin Avenue, Milwaukee, WI 53226, Tel: 414-805-5723, FAX: 414-454-0152, EMAIL: swilson@mcw.edu

*WINCHESTER, DAVID P, M.D., Professor of Surgery, Northwestern University Medical School; Chairman of the Department of Surgery, Evanston Hospital, 2650 Ridge Ave., Evanston, IL 60201-1718, Tel: 847-570-2560, FAX: 847-570-2930, EMAIL: dwinchester@enh.org

*WISE, LESLIE, M.D., Professor and Chairman, Department of Surgery, New York Methodist Hospital, 506 Sixth St., Brooklyn, NY 11215, Tel: 718-780-3288, FAX: 718-780-7186, EMAIL: lew9001@nyp.org

WISNER, DAVID H, M.D., Lloyd and Rosemargaret Donant Professor and Acting Chair, Department of Surgery, University of California Davis Medical Center, 2221 Stockton Blvd., Rm 3112, Sacramento, CA 95817, Tel: 916-734-8298, FAX: 916-734-5119, EMAIL: david.wisner@ucdmc.ucdavis.edu

*WOLFE, BRUCE M, M.D., Professor of Surgery; Oregon Health & Science University., 3181 SW Sam Jackson Park Rd., BTE223, Portland, OR 97239-3098, Tel: 503-494-1299, FAX: 503-494-2059, EMAIL: wolfeb@ohsu.edu

WOLFE, WALTER G, M.D., Program Director, Thoracic Surgery, Professor of Surgery, Duke University Medical Center, Box 3507, Durham, NC 27710, Tel: 919-684-4117, FAX: 919-681-8912, EMAIL: Wolfe001@mc.duke.edu

WOLFF, BRUCE G, M.D., Professor of Surgery, Mayo Clinic and Mayo Foundation; Chairman, Division of Colon and Rectal Surgery, Mayo Clinic Rochester, 200 First Street, SW, Gonda 9 South, Rochester, MN 55905, Tel: 507-284-2472, FAX: 507-284-1794, EMAIL: wolff.bruc@mayo.edu

*WOLMARK, NORMAN, M.D., Director, Cancer Center and Division of Surgical Oncology, Allegheny General Hospital, 320 East North Ave., Pittsburgh, PA 15212-4772, Tel: 412-359-3336, FAX: 412-359-8685, EMAIL: n wolmark@wpals.org
WONG, W. DOUGLAS, M.D., Professor of Surgery, Cornell University Medical Center; Chief, Colorectal Service, Stuart H.Q. Quan, Chair in Colorectal Surgery, Memorial Sloan-Kettering Cancer Center, 1275 York Avenue, #C-1067, New York, NY 10065, Tel: 212-639-5506, FAX: 212-717-3679, EMAIL: wongd@mskcc.org

WOOD, DOUGLAS E, M.D., Professor and Chief, Division of Cardiothoracic Surgery; Endowed Chair in Lung Cancer Research, University of Washington, 1959 NE Pacific, Box 356310, Seattle, WA 98195-6310, Tel: 206-685-3228, FAX: 206-543-0325, EMAIL: dewood@u.washington.edu

WOOD, WILLIAM C, M.D., Distinguished Joseph Brown Whitehead Professor, Department of Surgery, Emory University, 1364 Clifton Rd., NE, Rm C 2040, Atlanta, GA 30322, Tel: 404-778-3301, FAX: 404-727-4716, EMAIL: wwood@emory.edu

WOODLE, E. STEVE, M.D., Professor of Surgery; Director, Division of Transplantation; Director of Renal Transplantation, Department of Surgery, University of Cincinnati College of Medicine; Chairman; Board of Directors, Israel Penn International Tumor Registry, University of Cincinnati College of Medicine, P.O. Box 670558, 231 Albert B. Sabin W, Cincinnati, OH 45267-0558, Tel: 513-558-6001, FAX: 513-558-8689, EMAIL: woodlees@uc.edu

WOOLLEY, MORTON M, M.D., Emeritus Professor of Surgery, University of Southern California School of Medicine, Emeritus Surgeon-in-Chief, Childrens Hospital, Los Angeles, 14 Churchill Lane, Rancho Mirage, CA 92270, Tel: 760-770-6087, FAX: 760-770-7837, EMAIL: mortwoolley@dc.rr.com

WREN, SHERRY M, M.D., Professor of Surgery; Associate Dean Academic Affairs, Stanford University School of Medicine, Surgical Services G112, 3801 Miranda Ave., Palo Alto, CA 94304, Tel: 650-852-3461, FAX: 650-852-3430, EMAIL: swren@stanford.edu

YANCEY, ASA G., SR., M.D., Professor of Surgery Emeritus, Emory University School of Medicine; Clinical Professor of Surgery, Morehouse School of Medicine, 2845 Engle Rd. NW, Atlanta, GA 30318-7216, Tel: 404-799-5045, FAX: 404-799-0046
*YAO, JAMES S.T., M.D., Emeritus Professor of Surgery, Division of Vascular Surgery, Northwestern University, Feinberg School of Medicine 676 North St Clair St., Ste. 650, Chicago, IL 60611, Tel: 312-695-2716, FAX: 312-695-4955, EMAIL: jyao@nmh.org

*YELLIN, ALBERT E, M.D., Professor of Surgery, Associate Chief of Staff, Medical Director of Operating Rooms, Los Angeles County University of Southern California School of Medicine, 59-415 Kawowo Road, Haleiwa, HI 96712, EMAIL: aeyellin@hawaii.rr.com

YEO, CHARLES J, M.D., Samuel D. Gross Professor and Chair, Department of Surgery, Thomas Jefferson University, 1015 Walnut St., Curtis, Ste. 620, Philadelphia, PA 19107, Tel: 215-955-8643, FAX: 215-923-6609, EMAIL: charles.yeo@jefferson.edu

*YOUNG, BYRON, M.D., Johnston-Wright Endowed Chair, Chief, Division of Neurosurgery, University of Kentucky Medical Center, 800 Rose St., Rm MS-101, Lexington, KY 40536-0084, Tel: 859-323-5864, FAX: 859-323-6343, EMAIL: byoun1@email.uky.edu

*YURT, ROGER W, M.D., Johnson and Johnson Professor of Surgery; Vice Chairman, Department of Surgery; Director, Burn Center, Weill Medical College of Cornell University, 525 E. 68th St., Rm L-706, New York, NY 10021, Tel: 212-746-5410, FAX: 212-746-8991, EMAIL: ryurt@med.cornell.edu

*ZARINS, CHRISTOPHER K, M.D., Chairman, Division of Vascular Surgery, Chidester Professor of Surgery, Stanford University Medical Center, 300 Pasteur Dr., RM H3638, Stanford, CA 94305-5642, Tel: 650-725-7830, FAX: 650-498-6044, EMAIL: zarins@stanford.edu

*ZELENOCK, GERALD B, M.D., Professor of Surgery, Section of Vascular Surgery; Chairman, Department of Surgery, University of Toledo, 3065 Arlington Ave., Mailstop 1085, Toledo, OH 43614, Tel: 419-383-3759, FAX: 419-383-6636, EMAIL: gzelenock@hotmail.com

ZENILMAN, MICHAEL E, M.D., Clarence and Mary Dennis Professor and Chairman, Department of Surgery, SUNY Downstate Medical Center, 450 Clarkson Ave., Box 40, Brooklyn, NY 11203, Tel: 718-270-1421, FAX: 718-270-2826, EMAIL: mzenilman@downstate.edu

*ZIEGLER, MORITZ M, M.D., Surgeon-in-Chief; Chairman, Department of Surgery, Children’s Hospital, 1056 East 19th Ave., B323, Aurora, CO 80045, Tel: 303-861-6524, EMAIL: ziegler.moritz@tcden.org
*ZINNER, MICHAEL J, M.D., FACS, Surgeon-in-Chief, Moseley Professor of Surgery, Harvard Medical School, Brigham and Women’s Hospital; Chairman, Department of Surgery, 75 Francis Street, Department of Surgery, Boston, MA 02115, Tel: 617-732-8181, FAX: 617-734-8353, EMAIL: mzinner@partners.org

*ZOLLINGER, ROBERT M, JR, M.D., Professor Emeritus, CWRU School of Medicine, Cleveland; Clinical Professor of Surgery, University of Arizona, 5296 N. via Sempreverde, Tucson, AZ 85750, Tel: 216-844-3023, FAX: 216-844-1350, EMAIL: rmz3@case.edu

*ZOOK, ELVIN G, M.D., Professor Emeritus, Southern Illinois School of Medicine, 747 N. Rutledge St., P.O. Box 19653, Springfield, IL 62794-9653, Tel: 217-782-8869, FAX: 217-545-2588, EMAIL: ezook@siumed.edu

*ZUIDEMA, GEORGE D, M.D., Vice Provost for Medical Affairs Emeritus, Professor of Surgery, Emeritus, University of Michigan Medical Center, 5 East Eighth St., Holland, MI 49423, Tel: 616-355-4385, EMAIL: gjuidema@macatawa.com

*ZUKOSKI, CHARLES F, M.D., Emeritus Professor, V.A. Medical Center, 1901 E. Miraval Cuarto, Tucson, AZ 85718, Tel: 520-299-6312, FAX: 520-299-6312, EMAIL: czukoski@thriver.com

ZWISCHENBERGER, JOSEPH B, M.D., Johnston-Wright Professor and Chairman for the Department of Surgery at the University of Kentucky, MN264 AB Chandler Medical Center, 800 Rose St., Lexington, KY 40536, Tel: 859-323-6013, FAX: 859-323-1045, EMAIL: j.zwische@uky.edu
Honorary Members

ACOSTA, JUAN M, M.D., Ph.D., Ex-Professor and Chairman, Department of Surgery, Rosario Medical Schools, National University of Rosario, Argentina; Ex-Professor of Clinical Surgery, Department of Surgery, University of Southern California, Neptuno 817 Bis. Apt. 01-01, Santa Fe, 2000, Argentina, Tel: +54 341 435 6140, EMAIL: acosjuan@fibertel.com.ar

AIKAWA, NAOKI, M.D., Professor and Chairman, Department of Emergency & Critical Care Medicine, School of Medicine, Keio University, 35 Shinanomachi, Shinjuku, Tokyo, 160-8582, Japan, Tel: 81-3-33531368, FAX: 81-3-32269877, EMAIL: aikawan@sc.itc.keio.ac.jp

AJAYI, OLAJIDE O.A., M.D., Professor of Surgery, College of Medicine, University College Hospital, PMB 5116, Nigeria, Tel: 234-2-8103250, FAX: 234-2-8105199, EMAIL: jijayi@skannet.com

AKIYAMA, HIROSHI, M.D., Professor of Surgery, Tokyo Medical University; President, Toranomon Hospital, 2-2-2 Toranomon, Minato-ku, Tokyo, 105-8470, Japan, Tel: 81-3-3588-1111, FAX: 81-3-3582-7068, EMAIL: h.akiyama@toranomon.gr.jp

BALIBREA, JOSE L, M.D., Ph.D., Professor of Surgery, Chairman, Department of Surgery, University Complutense of Madrid, Hospital Universitario San Carlos, Ciudad Univ, Facultad de Medicina, Madrid, 28040, Spain, Tel: 34-1-330-31-77, FAX: 34-1-330-31-77, EMAIL: jbalibrea.hsc@salud.madrid.org

BARRACLOUGH, BRUCE H, M.B., FACS, Professor/Director, Cancer Services, Northern Sydney Health & University of Sydney, Chair Australian Council for Safety and Quality in Health Care, Royal North Shore Hospital, Level 3, 65 Martin Place, Sydney, NW 2076, Australia, Tel: 61 412 330974, FAX: 61 294 875374, EMAIL: bbarra@ozemail.com.au

BEGER, HANS G, M.D., Professor Emeritus of Surgery, Steinhevelstrasse 9, Ulm, D-89075, Germany, Tel: 49-73150026775, FAX: 49-73150026786, EMAIL: hans.beger@uniklinik-ulm.de

BISMOOTH, HENRI, M.D., Professor and Chairman of the Hepato-Biliary Center, Hospital Paul Brousse, 14 Av P V Couturier, Villejuif, 94800, France, Tel: 331-45593331, FAX: 331-45593857, EMAIL: henri.bismuth@pbr.ap-hop-paris.fr
BORST, HANS G, Emeritus Professor of Surgery; Head, Division of Thoracic and Cardiovascular Surgery, Hannover Medical School, 7 Widenmayerstr, Munich, D-80538, Germany, Tel: 00498929161191, FAX: 49 89 1222 16431, EMAIL: hgborst@gmx.net

CALNE, ROY YORKE, FRS, Professor, Department of Surgery, University of Cambridge, 18 Trumpington Rd., Cambridge, CB2 2AH, England, Tel: 223-361467, FAX: 223-301601, EMAIL: cpp1000@com.ac.uk

CARPENTIER, ALAIN F, M.D., Ph.D., Professor and Chairman, Cardiovascular Surgery Department, Hospital Broussais, 20 Rue Leblanc, CV Surgery, Paris, 75015, France, Tel: +33-1-5609-3601, FAX: +33-1-5609-3604, EMAIL: alain.carpentier@egp.aphp.fr

CARTER, DAVID C, University, Professor, Department of Surgery; Chief Medical Officer for Scotland, 19 Buckingham Terrace, Edinburgh, EH4 3AD, Scotland, Tel: 0131-332-5554, FAX: 0131-228-2661, EMAIL: david.c.carter@virgin.net

CSENDES, ATTILA, M.D., Professor of Surgery, Chairman, Department of Surgery, Clinical Hospital, University of Chile, Hospital J.J. Aguirre, Santos Dumont 999, Chile, Tel: 56-2-777-4387, FAX: 56-2-777-5043, EMAIL: acsendes@med.uchile.cl

CUSCHIERI, ALFRED, M.D., Chief Scientific Advisor, Institute for Medical Science and Technology, University of Dundee, Dundee Medipark, 1 Wurzburg Loan, Dundee, DD2 1FD, Scotland, Tel: 01382-632174, FAX: 01382-496361, EMAIL: alfred@acuschieri.com

DE SANTIBANES, EDUARDO, M.D., Professor and Chairman, General Surgical Services and Liver Transplant Unit, Hosp Italiano de Buenos Aires, Gascon 450 (CP1181), Buenos Aires, 1181, Argentina, Tel: 54-11-49814501, FAX: 54-11-498-14041, EMAIL: e.desantibanes@gmail.com

DUDLEY, HUGH A.F., CBE, Consulting Surgeon, St. Mary’s Hospital, London; Emeritus Professor, London University, Broombae, Glass, Huntley, Aberdeenshire, AB54 4XH, Scotland, Tel: 01466-700376, FAX: 01466-700376, EMAIL: dudleyhugh@aol.com

FORREST, A. PATRICK M, M.D., FRCS, Professor Emeritus, University of Edinburgh, 19 St. Thomas Road, Edinburgh, EH9 2LR, Scotland, Tel: 131-677-3203, FAX: 131-662-1193, EMAIL: patrickforrest@ed.ac.uk
GOLEMATIS, BASIL C, M.D., Chairman, Department of Surgery, University of Athens; Chairman, National Health Council; Chairman, Cardiothoracic Institute of the Onassis Foundation; Vice-Chair of the National Cancer Institute; Executive Consultant of National Health Care Policy, Kifissias 87, Athens, 11523, Greece, Tel: 30-210-6921902, FAX: 30-210-3614739, EMAIL: golemati@otenet.gr

GROTH, CARL G, M.D., Professor Emeritus, Department of Transplantation Surgery, Karolinska Institute, Fogdevreten 2A, Stockholm, SE-171-77, Sweden, Tel: 46-8-52482276, FAX: 46-8-52482274, EMAIL: carl.groth@ki.se

GUTIERREZ, VICENTE P, M.D., Professor of Surgery, Universidad de Buenos Aires; Academico de Medicina, Billinghurst 2524, Buenos Aires, 1425, Argentina, Tel: 54-1148021668, FAX: 54-1148018933, EMAIL: v Gutierrez maxwell@gmail.com

HABERAL, MEHMET, M.D., President of the University; Professor of Surgery, Baskent University, 1 Cad No: 77, Bahcelievler, Ankara, 06490, Turkey, Tel: 90-3122127393, FAX: 90-3122150835, EMAIL: rektorluk@baskent-ank.edu.tr

HABR-GAMA, ANGELITA, M.D., Professor of Surgery, Department of Gastroenterology, University of Sao Paulo, Rua Manoel da Nobrega, 1564, Sao Paulo, 04001-005, Brazil, Tel: 5511-38871757, FAX: 5511-38848845, EMAIL: gamange@uol.com.br

HENNESSY, THOMAS P.J., M.D., Regius Professor of Surgery & Head of Department of Surgery, Trinity College Dublin, St. James Hospital, Dublin, 8, Ireland, Tel: 353-1-4537479, FAX: 353-1-4546534, EMAIL: thennessy@tcd.ie

HERFARTH, CHRISTIAN, M.D., Professor Emeritus, Department of Surgery, University of Heidelberg, Im Neuenheimer Feld 110, Heidelberg, D-69120, Germany, Tel: 496221564780, FAX: 496221564789, EMAIL: christian_herfarth@med.uni-heidelberg.de

HILVANO, SERAFIN C, M.D., Professor and Chair, College of Medicine Philippine General Hospital, University of the Philippines Manila, Taft Avenue, Ermita, Manila, 1000, Philippines, Tel: 632-567-4114, FAX: 632-526-4356, EMAIL: schilvano@gmail.com
HOBBSLEY, MICHAEL, Professor Emeritus of Surgery, University College London Medical School, 67-73 Riding House St., Department Surgery, London, W1W 7EJ, England, Tel: 0171-380-9312, FAX: 0171-636-5176, EMAIL: m.hobsley@ucl.ac.uk

IHSE, INGEMAR, M.D., Professor of Surgery, Emeritus, Prarcum University Hospital, Fylkingavagen 10, Lund, 22474, Sweden, Tel: 46-46172965, FAX: 46-46-176094, EMAIL: ingemar.ihse@med.lu.se

IRVING, MILES H, Emeritus Professor of Surgery, University of Manchester, Juniper, Aydon Road, Corbridge, NE45 5EH, England, Tel: 44-1434-634243, FAX: 44-1912131968, EMAIL: m.h.irving@ncl.ac.uk

JACKSON, BARRY T, M.S., Past President Royal Society of Medicine, London Emeritus Consultant Surgeon, St. Thomas Hospital, Past President, Royal College of Surgeons of England, 7 St. Matthew’s Avenue, Surbiton, Surrey, KT6 6JJ, England, Tel: 44-2083993157, FAX: 44-2079283748, EMAIL: barryjck7@aol.com

JAMIESON, GLYN G, M.D., Professor and Chairman, Department of Surgery, University of Adelaide and Royal Adelaide Hospital, Department of Surgery, North Terrace, Adelaide, SA 5000, Australia, Tel: 61-8-8225516, FAX: 61-8-8225896, EMAIL: glyn.jamieson@adelaide.edu.au

JATENE, ADIB D, M.D., Hospital do Coracao, R Des Eliseu Guilherme, 123, Sao Paulo, 04004-030, Brazil, Tel: 011-38876611, FAX: 011-3887661, EMAIL: ajatene@hcor.com.br

JEKEL, J. HANS, M.D., Head, Department of Surgery, Professor of Surgery, University Hospital, Rotterdam, P.O. Box 2040, Rotterdam, NL-3000, Netherlands, Tel: 31-10-4633734, FAX: 31-10-4634746, EMAIL: j.jeekel@ezasmus.mc.nl

KAY, ANDREW WATT, 5 Loch Rd., Milngavie, Glasgow, G62 8BB, Scotland, Tel: 0141-9563378

KITAJIMA, MASAKI, M.D., President International University of Health & Welfare, 1-4-3 Mita, Minato-ku, Tokyo, 108-8329, Japan, Tel: 81-3-3451-8121, FAX: 81-3-5765-0582, EMAIL: kitajima@iuhw.ac.jp

♦ LAUNOIS, BERNARD, M.D., Clinique Chirurgicale, Rennes, 35000, France, Tel: 33-0-6 14 10 13 01, FAX: 33-0-2-99-09-15-14, EMAIL: b.launois@wanadoo.fr
LERUT, ANTOON E.M.R., M.D., Professor of Surgery, Chairman, Department of Thoracic Surgery, U.Z. Gasthuisberg, Herestraat 49, Thoracic Surgery, Leuven, 3000, Belgium, Tel: 321-634-6820, FAX: 321-634-6821, EMAIL: Toni.Lerut@uz.kuleuven.ac.be

LI, ARTHUR K.C., M.D., Secretary for Education and Manpower, Government of the Hong Kong Special Administrative Region, 31-37 Des Voeux Rd. Central, Hong Kong, China, FAX: 852-26453602, EMAIL: guoman@lioffice.com

MAKUUCHI, MASATOSHI, M.D., 4-1-22 Hiroo, Shibuya-ku, Tokyo, 150-8935, Japan, Tel: 813-3400-9517, FAX: 813-3400-9517, EMAIL: makuuchi_masatoshi@med.jrc.or.jp


MATSUNO, SEIKI, M.D., Director, Professor Emeritus, Tohoku University, 1-12-1 Fukumuro, Miyaginoku, Sendai, 983-8512, Japan, Tel: 81-22-387-5538, FAX: 81-22-387-5538, EMAIL: smatsuno@tohoku-knhp.ne.jp

MAY, JAMES, M.D., Bosch Professor of Surgery, University of Sydney; President, International Society for Cardiovascular Surgery; President-Elect, International Society of Endovascular Specialists, Department of Surgery, University of Sydney, Department of Surgery, Sydney, NW 2006, Australia, Tel: 61-2-93513358, FAX: 61-2-93517075, EMAIL: vascsurg@med.usyd.edu.au

MERCADO, MIGUEL A, M.D., Professor and Chairman; Department of Surgery, Instituto Nal Nutricion, Vasco de Quiroga 15, Col. Seccion XVI, Tlalpan, DF 14000, Mexico, Tel: 555-487-0900, FAX: 55-739-321, EMAIL: miguel.mercadod@quetzal.innsz.mx

MORENO GONZALEZ, ENRIQUE, M.D., Full Professor of General Surgery and Abdominal Organ Transplantation, Hospital Doce de Octubre, University of Madrid, Carretera De Andalucia Km 5, 400, Madrid, 28041, Spain, Tel: 3491-390-8329, FAX: 3491-390-8523, EMAIL: emorenog@lidc.insalud.es

MORRIS, PETER J, M.D., 35-43 Lincolns Inn Fields, London, WC2A 3PE, England, Tel: 020-7869-660, FAX: 020-7869-6644, EMAIL: pmorris@rcseng.ac.uk
MOSCA, FRANCO, M.D., Professor of Surgery, University of Pisa, Cisanello Hospital, Division of General Surgery, Pisa, 56124, Italy, Tel: 39-050-996930, FAX: 39-050-543692, EMAIL: fmosca@patchir.med.unipi.it

MYBURGH, JOHANNES A, Emeritus Professor, Department of Surgery, University of the Witwatersrand Medical School, York Rd., Parktown, Johannesburg, 2193, South Africa, Tel: 011-647-2376, FAX: 011-484-2717, EMAIL: 042bert@chiron.wits.ac.za

NIMURA, YUJI, M.D., President, Aichi Cancer Center, 1-1, Kanokoden, Chikusa-ku, Nagoya, 464-8681, Japan, Tel: 81-52-764-2900, FAX: 81-52-751-6948, EMAIL: ynimura@aichi-cc.jp

O’DONNELL, BARRY, M.D., Past President, Royal College of Surgeons in Ireland; Emeritus Professor of Pediatric Surgery, 28 Merlyn Road, Ballsbridge, Dublin, 4, Ireland, Tel: 353-1-2694000, FAX: 353-1-2694000, EMAIL: bodonnel@indigo.ie

OROZCO, HECTOR, M.D., Emeritus Professor and Chairman Surgical Division, Instituto Nacional de Ciencias Medicas y Nutricion, Colon #79-A Centro C.P. 59000, Saltillo, Michoacan, 59000, Mexico, Tel: 52-353-5324161, FAX: 52-5555739321, EMAIL: tloorazco@yahoo.com.mx

PATINO, JOSE F, M.D., Chairman of Surgery, Centro Medico de Los Andes, Calle 119 no.9-33, Colombia, Tel: 571-214-9002, FAX: 571-216-6668

PERACCHIA, ALBERTO, M.D., Professor and Chairman of Surgery, Head of the Department of General Surgery and Surgical Oncology, University of Milan School of Medicine, Place Repubblica 25, Milan, 20124, Italy, Tel: 39-0229004412, FAX: 00390229004412, EMAIL: alperacchia@tiscali.it

PERISSAT, JACQUES, M.D., Professor Emeritus D.E.T.E.R.C.A. University Victor Segalen Bordeaux 2, 146 Rue Leo Saignat, Bordeaux Cedex, F-33076, France, Tel: 33-557-57-1719, FAX: 33-556-96-2614, EMAIL: PrfJPerissat@aol.com

PURI, PREM, M.D., Our Lady’s Hosp for Sick Children, Crumlin, Dublin, 12, Ireland, Tel: 353-1-4096420, FAX: 353-1-4550201, EMAIL: prempuri@ucd.ie

RAU, BHIMANAKUNTE K, M.D., Professor Emeritus, Tamilnadu Dr. MGR Medical University, 9 Chandra Bagh Ave., 2nd St., Chennai, 600 004, India, Tel: 91 44 2847 3577, EMAIL: bkr@vsnl.com
REEVE, THOMAS S, M.D., Emeritus Professor of Surgery, University of Sydney, Royal North Shore Hospital, P.O. Box 134, Beecroft, NSW 2119, Australia, Tel: 61-2-98751191, FAX: 61-2-98752256, EMAIL: treeve@med.usyd.edu.au

SHEIL, AINSLIE G.R., M.D., Chairman and Director of the Australian National Transplantation Unit; Professor and Head, Department of Transplantation Surgery, University of Sydney, 80 Alexandra St., Hunters Hill, NSW 2110, Australia, Tel: 02 989 65436, FAX: 02 987 96596, EMAIL: agrs@liver.rpa.cs.nsw.gov.au

SIEWERT, J. RUDIGER, M.D., CEO University of Heidelberg Medical Centre, Im Neuenheimer Feld 672, Heidelberg, 69120, Germany, Tel: 49-0-6221-56-4800, FAX: 49-0-6221-56-4870, EMAIL: jr.siewert@med.uni-heidelberg.de

SLANEY, GEOFFREY, FRCS, Professor Emeritus, Department of Surgery, Queen Elizabeth Hospital, Collins Green, Knightwick, Worcester, WR6 5PT, England, Tel: 0121-4540261

SPERANZA, VINCENZO, M.D., Professor and Head II, Clinica Chirurgica, Universita La Sapienza, Montemignaio 60, Rome, 00192, Italy, Tel: 39-064451300, FAX: 39-064451300, EMAIL: emanuele.lezoche@uniroma1.it

STRONG, RUSSELL W, M.D., Emeritus Professor and Consultant Surgeon, Princess Alexandra Hospital, Brisbane, Ipswich Road, Brisbane, QN 4102, Australia, Tel: 07-3240-2767, FAX: 07-3240-2767, EMAIL: tammy_lye@health.qld.gov.au

TANG, ZHAO-YOU, M.D., Professor & Chairman, Liver Cancer Institute of Fudan University, 136 Yi Xue Yuan Rd., Shanghai, 200032, China, Tel: 8621 6403 7181, FAX: 8621 6403 7181, EMAIL: zytang@scrap.stc.sh.cn

TERBLANCHE, JOHN, M.D., Emeritus Professor of Surgery, University of Cape Town, 14 Balfour Road, Rondebosch, Cape Town, 7700, South Africa, Tel: 27-21-6895004, EMAIL: jterblan@iafrica.com

TREDE, MICHAEL, M.D., Professor Emeritus, Department of Surgery, University of Heidelberg, Theodor Kutzer Ufer 1-3, Mannheim, D-68167, Germany, Tel: 0621-383-2225, FAX: 0621-383-2116, EMAIL: michael.trede@chir.ma.uni-heidelberg.de

TURINA, MARKO I, M.D., Professor of Surgery, University of Zurich, Haldenbach 18, Zurich, CH-8091, Switzerland, Tel: +44-44-422-84-72, FAX: 12559270, EMAIL: marko.turina@usz.ch
WILLIAMS, NORMAN S, M.D., 3rd Floor Alexandra Wing, Whitechapel, London, E1 1BB, United Kingdom, Tel: +44 20 7377 7079, FAX: +44 20 7377 7283, EMAIL: n.s.williams@qmul.ac.uk

WONG, JOHN, M.D., Professor and Head, Department of Surgery, The University of Hong Kong, Queen Mary Hosp, Pokfulam Rd., China, Tel: 852-2855-4610, FAX: 852-2816-2094, EMAIL: jwong@hkucc.hku.hk
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United States

ALABAMA

Birmingham
Bland, Kirby I
Diethelm, Arnold G
Georgeson, Keith
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<td>Connolly, John E, Hoyt, David B, Stamos, Michael J, Wilson, Samuel E</td>
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COLORADO
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Boulder
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Avon
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DELAWARE
   Newark
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DISTRICT OF COLUMBIA
   Washington
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   Cornwell, Edward E, III
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   Evans, Stephen R.T.
   Johnson, Lynt B
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FLORIDA
   Bartow
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   Hutson, Duane G
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   Williams, Roger D

No Miami Beach
   Millard, D. Ralph, Jr

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Sanibel Island
Rowe, Marc I

Sanibel
Sugerman, Harvey J

Sarasota
Bradley, Edward L, III
Dozois, Roger R

St. Petersburg
Gadacz, Thomas R
Imparato, Anthony M

Stuart
Robson, Martin C

Tampa
Bandyk, Dennis F
Carey, Larry C
Fabri, Peter J
Karl, Richard C
Rosemurgy, Alexander S
Smith, David J, Jr
Sondak, Vernon K

Venice
Gardner, Bernard

Vero Beach
Weil, Richard, III

GEORGIA

Atlanta
Buchman, Timothy G
Chaikof, Elliot L
Feliciano, David V
Guyton, Robert A
Hatcher, Charles R, Jr
Jurkiewicz, Maurice J
Knechtle, Stuart J
Miller, Joseph L, Jr
Rozycki, Grace S
Smith, Robert B, III
Symbas, Panagiotis

Weaver, W. Lynn
Weber, Collin J
Wood, William C
Yancey, Asa G, Sr

Augusta
Mansberger, Arlie R, Jr

Macon
Dalton, Martin L, Jr
Nakayama, Don K

Marietta
Watne, Alvin L

Valdosta
Beal, John M

HAWAII

Haleiwa
Yellin, Albert E

Honolulu
Kimura, Ken
McNamara, J. Judson

ILLINOIS

Caledonia
Greenlee, Herbert B

Chicago
Abcarian, Herand
Abecassis, Michael M
Alverdy, John C
Arensmman, Robert M
Baker, Robert J
Batjer, H. Hunt
Collicott, Paul E
DasGupta, Tapas K
Faber, L, Penfield
Ferguson, Mark K
Fessler, Richard G
Flint, Lewis M, Jr
Fry, Donald E
Grayhack, John T
Hanlon, C. Rollins
Kaplan, Edwin L
Kaufman, Dixon B
Kittle, C. Frederick
Mahvi, David M
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Najafi, Hassan
Patti, Marco G
Pearce, William H
Pickleman, Jack R
Posner, Mitchell C
Replogle, Robert L
Russell, Thomas R
Sachdeva, Ajit K
Schmitz, Robert L
Soper, Nathaniel J
Stuart, Frank P
Weir, Bryce
Yao, James S.T.

Evanston
Prinz, Richard A
Winchester, David P

Glenview
Sener, Stephen F

Hines
Joehl, Raymond J

Maywood
Aranha, Gerard V
Baker, William H
Gamelli, Richard L
Luchette, Fred A

Naperville
Folk, Frank A

Northbrook
Nahrwold, David L

Oak Brook
Paloyan, Edward, S.C.

Oak Lawn
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Oak Park
Donahue, Philip E

River Forest
Mason, G. Robert

Skokie
Pollak, Raymond

Springfield
Alfrey, Edward J
Birtch, Alan G
Dunnington, Gary L
Folse, J. Roland
Sunner, David S
Zook, Elvin G

Zion
Staren, Edgar D

INDIANA

Evansville
Millikan, William J, Jr

Indianapolis
Broadie, Thomas A
Brown, John W
Coleman, John J, III
Dalsing, Michael C
Grosfeld, Jay L
Howard, Thomas John
King, Harold
Lillemoe, Keith D
Pescovitz, Mark D
Pit, Henry A
Rescorla, Frederick J
Shumacker, Harris B, Jr
Sitzmann, James V
Monrovia
Bennett, James E

IOWA

Iowa City
Behrendt, Douglas M
Gurl, Nelson J
Howe, James R. V.
Kealey, Gerald P
Mason, Edward E
Scott-Conner, Carol E. H.
Soper, Robert T
Weigel, Ronald J

KANSAS

Kansas City
Thomas, James H

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Mission Hills
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KENTUCKY

LaGrange
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Lexington
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Zwischenberger, Joseph B

Louisville
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Galandiuk, Susan
Garrison, R. Neal
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McMasters, Kelly M
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LOUISIANA

Alexandria
Webb, Watts R

Metairie
Cohn, Isidore, Jr

New Orleans
Baker, Christopher C
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Jaffe, Bernard M
McSwain, Norman E
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Shreveport
Li, Benjamin D
Mancini, Mary C
McDonald, John C

MAINE

Cape Elizabeth
Bredenberg, Carl E

Orono
Dumont, Allan E

South Portland
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Vinalhaven
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MARYLAND
Baltimore
Alexander, H. Richard, Jr
Andersen, Dana K
Baker, R. Robinson
Balch, Charles M
Barbul, Adrian
Bartlett, Stephen T
Baumgartner, William A
Cameron, Duke E
Cameron, John L
Choti, Michael A
Colombani, Paul M
Eisenberg, Howard M
Freischlag, Julie Ann
Griffith, Bartley P
Haller, J. Alex, Jr
Harmon, John W
Hill, J. Laurance
Jarrell, Bruce E
Leach, Steven D
Long, Donlin Martin
Manson, Paul Ne
McLaughlin, Joseph S
Park, Adrian E
Perler, Bruce A
Pierson, Richard N, III
Scalea, Thomas M
Walsh, Patrick C
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Bethesda
Auchincloss, Hugh, Jr
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Marincola, Francesco M
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Cockeysville
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Lutherville
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St. Michaels
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MASSACHUSETTS
Auburndale
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Boston
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Cambria, Richard P
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Fishman, Steven J
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Hurst, James M
Iglehart, J. Dirk
Jaksic, Tom
Lazar, Harold L
Levitsky, Sidney
LoGerfo, Frank W
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Mathisen, Douglas J
May, James W, Jr
Mentzer, Steven J
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Moore, Francis D, Jr
O’Donnell, Thomas F, Jr
Ojemann, Robert G
Ozaki, C. Keith
Rattner, David W
Richie, Jerome P
Russell, Paul S
Shamberger, Robert C
Soybel, David J
Steer, Michael L
Sugarbaker, David J
Tanabe, Kenneth K
Tilney, Nicholas L
Tompkins, Ronald G
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Velmahos, George C
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Warshaw, Andrew L
Watkins, Michael T
Whittemore, Anthony D
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Cambridge
Greenburg, A. Gerson
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Dover
Couch, Nathan P

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Weston
Abbott, William M
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Bartlett, Robert H
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Sundt, Thoralf M  
Wolff, Bruce G  

Chapman, William C  
Dacey, Ralph G, Jr  
Damiano, Ralph J, Jr  
Eberlein, Timothy J  
Ferguson, Thomas B  
Fiore, Andrew C  
Fleshman, James W  
Flye, M. Wayne  
Gay, William A, Jr  
Haddleston, Charles B  
Jaques, David P  
Johnson, Frank E  
Kaminski, Donald L  
Kodner, Ira J  
Kouchoukos, Nicholas T  
Mackinnon, Susan E  
Moley, Jeffrey F  
Moon, Marc R  
Naunheim, Keith S  
Patterson, Alec  
Sicard, Gregorio A  
Strasberg, Steven M  
Thompson, Robert W  
Warner, Brad W  
Weeks, Paul M  
Kaiser, George C  

MISSISSIPPI  
Brandon  
Nelson, Norman C  
Jackson  
Merrill, Walter H  
Tribble, Curtis G  

MISSOURI  
Columbia  
Eubanks, Steve  
Humphrey, Loren J  
Silver, Donald  

Kansas City  
Holcomb, George W, III  
Hopkins, Richard A  
Van Way, Charles W, III  

St. Louis  
Anderson, Charles B  
Andriotte, Gerald L, Jr  
Ballinger, Walter F, II  
Burner, Hendrick B  

NEBRASKA  
Lincoln  
Myers, Stuart I  

Omaha  
Fitzgibbons, Robert J, Jr  
Forse, R. Armour  
Hodgson, Paul E  
Langnas, Alan Norman  
Lynch, Thomas G  
Mercer, David W  
Shaw, Byers W, Jr  
Thompson, Jon S
NEW HAMPSHIRE
- Etna: Veidenheimer, Malcolm C
- Hanover: Koop, C Everett
- Lebanon: Cronenwett, Jack L; Kerrigan, Carolyn L

NEW JERSEY
- Camden: Camishion, Rudolph C
- Cape May Court House: McCormack, Robert M
- Cresskill: Rudick, Jack
- East Hanover: Lorber, Marc I
- Englewood: Siegel, John H
- New Brunswick: Graham, Alan M; Lowry, Stephen F; Mackenzie, James W; Scholz, Peter M; Trooskin, Stanley Z
- Newark: Deitch, Edwin A; Livingston, David H; Machiedo, George W; Parsonnet, Victor; Rush, Benjamin F, Jr
- Short Hills: Nance, Francis C

South Orange: Swan, Kenneth G
Summit: Gump, Frank E

NEW MEXICO
- Albuquerque: Doberneck, Raymond C

NEW YORK
- Albany: Bernard, Harvey R; Leather, Robert P; Shah, Dhiraj M; Stain, Steven C
- Brainard: Root, H. David
- Brooklyn: Ascher, Enrico; Borgen, Patrick I; Cunningham, Joseph N; Wise, Leslie; Zenilman, Michael E
- Buffalo: Cance, William G; Dayton, Merril T; Dunn, David L; Glick, Philip L; Hassett, James M; Hoover, Eddie L
- Delmar: Lempert, Neil
- Dewitt: Parker, Frederick B, Jr
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AMERICAN SURGICAL ASSOCIATION

Veith, Frank J
Wallack, Marc K
Weiser, Martin R
Wong, W. Douglas
Yurt, Roger W

Northport
Soroff, Harry S

Rochester
Adams, James T
DeWeese, James A
Peters, Jeffrey H
Schwartz, Seymour I

Rye
Barker, Harold G

Scarborough
Forde, Kenneth A

Scarsdale
Tilson, M. David

Sleepy Hollow
Kinney, John M
Price, John B, Jr

Stony Brook
Corman, Marvin L
Shapiro, Marc J

Syracuse
Kohman, Leslie J
Meguid, Michael M
Numann, Patricia J

Valhalla
DelGuercio, Louis R.M.

Williamsville
Andersen, Murray N

NORTH CAROLINA

Chapel Hill
Carson, Culley C, III

Keagy, Blair A
Meyer, Anthony A
Oldham, H. Newland, Jr
Peacock, Erle E, Jr
Pillsbury, Harold C, III
Sheldon, George F
Thomas, Colin G, Jr
Wilcox, Benson R

Charlotte
Greene, Frederick L.

Durham
Akwari, Onye E
Anderson, Robert W
Anlyan, William G
Bollinger, R. Randal
D’Amico, Thomas A
Davis, Robert D, Jr
Harpole, David H, Jr
Jacobs, Danny O
Jones, Robert H
Kuo, Paul C
Lowe, James E
McCann, Richard L
Moylan, Joseph A
Pappas, Theodore N
Paulson, David F
Seigler, Hilliard F
Shortell, Cynthia K
Smith, Peter K
Sudan, Debra L
Tyler, Douglas S
Wolfe, Walter G

Glenville
Stone, H. Harlan

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Chatwood, W. Randolph, Jr
Ferguson, T. Bruce, Jr
Haisch, Carl E

MacClesfield
Pories, Walter J
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Southport
Murray, Gordon F

Winston-Salem
Argenta, Louis C
Dean, Richard H
Hammon, John W, Jr
Hansen, Kimberley J
Kon, Neal D
Meredith, J. Wayne

OHIO
Beachwood
Hertzer, Norman R

Bellbrook
Martin, Lester W

Bratenahl
Hermann, Robert E

Chagrin Falls
Ankeney, Jay L

Chardon
Dobyns, Brown M

Cincinnati
Alexander, J. Wesley
Azizkhan, Richard G
Edwards, Michael J
Helmsworth, James A
Kagan, Richard J
Kempczinski, Richard
von Allmen, Daniel
Woodle, E. Steve

Cleveland
Barksdale, Edward M, Jr
Chung, Raphael S.K.
Church, James M
Cosgrove, Delos M
Demetriou, Achilles A
Esselstyn, Caldwell B, Jr
Fazio, Victor W
Fung, John J
Henderson, J. Michael
Loop, Floyd D
Lytle, Bruce W
Malangoni, Mark A
Mavroudis, Constantine
McHenry, Christopher R
Miller, Charles M
Ponsky, Jeffrey L
Schauer, Philip R
Schulak, James A
Shuck, Jerry M
Siperstein, Allan E
Ungerleider, Ross M

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Besner, Gail E
Boles, E. Thomas, Jr
Caniano, Donna A
Ellison, E. Christopher
Kraybill, William G
Melvin, W. Scott
Miller, Sidney F
Souba, Wiley W
Steinberg, Steven M

Dayton
Little, Alex G

Grove City
Kilman, James W

New Albany
Ferguson, Ronald M

Oregonia
Finley, Robert K, Jr

Perrysburg
Thomford, Neil R

Shaker Heights
Graham, Linda M

South Euclid
Stellato, Thomas A
Toledo
Allison, David C
Comerota, Anthony J
Gold, Jeffrey P
Howard, John M
Merrick, Hollis W, III
Zelenock, Gerald B

OKLAHOMA
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Elkins, Ronald C
Postier, Russell G

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Portland
Deveney, Clifford W
Deveney, Karen E
Fletcher, William S
Hunter, John G
Martindale, Robert G
Moneta, Gregory L
Mullins, Richard J
Orloff, Susan L
Sheppard, Brett C
Starr, Albert
Swanson, Lee L
Trunkey, Donald D
Vetto, John T
Vetto, R. Mark
Wolfe, Bruce M

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Bryn Mawr
Murphy, John J
Noone, R. Barrett

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DeMuth, William E, Jr

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Ramenofsky, Max L
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Strodel, William E, III

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Randall, Peter

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Cooney, Robert N.
Kauffman, Gordon L., Jr
Kolton, Walter
Pierce, William S
Waldhausen, John A

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Tyson, R. Robert

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Dempsey, Daniel T

Philadelphia
Acker, Michael A
Adzick, N. Scott
Barker, Clyde F
Bavaria, Joseph E
Bell, Richard H, Jr
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Daly, John M
Drebin, Jeffrey A
Edmunds, L. Henry, Jr
Fairman, Ronald M
Fry, Robert D
Lewis, Frank R
Meyers, William C
Morris, Jon Benjamin
Mullen, James L, Jr
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Raper, Steven E
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Rhodes, Robert S
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Rosato, Ernest F
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Schwartz, Marshall Z
Shaked, Abraham
Sigurdson, Elin R
Simms, H. Hank
Spray, Thomas L
Wechsler, Andrew S
Wein, Alan J
Whitaker, Linton A
Yeo, Charles J

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Fink, Mitchell P
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Landreneau, Rodney J
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Magovern, George J
Peitzman, Andrew B
Shapiro, Ron
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Steed, David L
Webster, Marshall W
Wolmark, Norman

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Stremple, John F

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Kerstein, Morris D

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Ravikumar, Thanjavur S

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Clarke, John R
DiSesa, Verdi J

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Hato Rey
Santiago Delpin, Eduardo A

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Cioffi, William G
Sellke, Frank W
Tracy, Thomas F, Jr

Rumford
Harrison, Timothy S

Woonsocket
Wanebo, Harold J

South Carolina
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Adams, David B
Cole, David J
Crawford, Fred A, Jr
Hallett, John W, Jr
Othersen, H. Biemann, Jr
Reed, Carolyn E
Swenson, Orvar

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Baliga, Prabhakar K

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Taylor, Spence M

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Cerilli, James
Humphrey, Edward W

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Wangensteen, Stephen L

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van Heerden, Jon A

Tennessee
Brentwood
Smith, Roger F

Chattanooga
Burns, R. Phillip
Cofer, Joseph B
Johnson City
Browder, I. William
Pennington, D. Glenn

Jonesborough
Bryant, Lester R

Knoxville
Filston, Howard C

Memphis
Britt, Louis G
Croce, Martin A
Fabian, Timothy C
Luce, Edward A
Pate, James W

Nashville
Abumrad, Naji N
Beauchamp, R. Daniel
Bender, Harvey W, Jr
Chung, Dai H
Edwards, William H, Sr
Lynch, John B
Morris, John A, Jr
Neal, William H
O’Neill, James A, Jr
Pinson, C. Wright
Randolph, Judson G
Sawyers, John L
Sharp, Kenneth W

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Kottmeier, Peter K

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Rutherford, Robert B

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Clagett, G. Patrick
Hunt, John L
Jones, Ronald C
Klintmalm, Goran B
Livingston, Edward H
McClelland, Robert N
Purdue, Gary F
Rege, Robert V
Thal, Erwin R
Thompson, Jesse E
Urschel, Harold C, Jr
Valentine, R. James

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Saltzstein, Edward C

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Hernon, David N
McCauley, Robert L
Phillips, Linda G
Townsend, Courtney M, Jr

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Andrassy, Richard J
Bailey, H. Randolph
Bass, Barbara L
Brandt, Mary L
Brunicardi, F. Charles
Cooley, Denton A
Coseili, Joseph S
Cox, Charles S, Jr
Curley, Steven A
Davies, Mark G
Ellis, Lee M
Fischer, Ronald P
Fraser, Charles D
Frazier, O. Howard
Gaber, Ahmed Osama
Ghabrial, R. Mark
Hallman, Grady L
Holcomb, John B
Hunt, Kelly K
Jordan, Paul H, Jr
Kahan, Barry D
Kaiser, Larry R
Lally, Kevin P
Lee, Jeffrey E
Mattos, Kenneth L
McCullam, Charles H
Moody, Frank G
Moore, Frederick A
Pisters, Peter W.T.
Pollock, Raphael E
Reul, George J, Jr
Ross, Merrick I
Roth, Jack A
Safi, Hazim J
Swisher, Stephen G
Wesson, David E

Lubbock
Baldwin, John C

Montgomery
Jones, James W

San Antonio
Aust, J. Bradley
Cohn, Stephen M
Cruz, Anatolio B
McFee, Arthur S
Pruitt, Basil A, Jr
Schwesinger, Wayne H
Sirinek, Kenneth R

Temple
Smythe, William R

Woodville
Fish, Jay C

VERMONT
Burlington
Davis, John H
Drucker, William R
Hebert, James C
Hyman, Neil
McFadden, David W

VIRGINIA
Charlottesville
Brayman, Kenneth L
Cherry, Kenneth J, Jr
Edgerton, Milton T
Gott, Vincent L
Hanks, John B
Jones, David R
Kron, Irving L
Nolan, Stanton P
Pruett, Timothy L
Rodgers, Bradley M
Schirmer, Bruce D
Slingluff, Craig L, Jr
Spotnitz, William D

Irvington
Muller, William H, Jr

McLean
Wallace, Robert B

Norfolk
Britt, L.D.
Lind, James F
Perry, Roger R

North Garden
Jones, R. Scott

Patrick Springs
Boyce, William H

Richmond
Bear, Harry D
Cohen, I. Kelman

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Bountiful
Doty, Donald B

Salt Lake City
Hawkins, John A
Johnson, Dale G
Kraiss, Larry W
Mulvihill, Sean J
Nelson, Russell M
Neumayer, Leigh A
Saffle, Jeffrey R
Warden, Glenn D
Horsley, J. Shelton, III
Ivatury, Rao R
Kellum, John M, Jr
Lawrence, Walter, Jr
Merrell, Ronald C
Miller, Thomas A
Newsome, Heber H, Jr

WASHINGTON

Brush Prairie
Edlich, Richard E

Clyde Hill
Condon, Robert E

Seattle
Aldea, Gabriel S
Clowes, Alexander W
Dellinger, E. Patchen
Flum, David R
Gibran, Nicole S
Gruss, Joseph S
Heimbach, David M
Johansen, Kaj H
Jurkovich, Gregory J
Maier, Ronald V
Merendino, K. Alvin
Mulligan, Michael S
Neligan, Peter C
Pellegrini, Carlos A
Reyes, Jorge D
Satava, Richard M
Sauvage, Lester R
Sobel, Michael
Thirlby, Richard C
Traverso, L. William
Vedder, Nicholas B
Verrier, Edward D
Waldhausen, John H.T.
Wood, Douglas E

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Charleston
AbuRahma, Ali F

WISCONSIN

Brookfield
Aprahamian, Charles

Madison
Chen, Herbert
D’Alessandro, Anthony M
Harms, Bruce A
Kent, K. Craig
Kudsk, Kenneth A
Lund, Dennis P
Rikkers, Layton F
Sollinger, Hans W
Starling, James R
Turnipseed, William D

Marshfield
Caldwell, Michael D

Milwaukee
Evans, Douglas B
Larson, David L
Oldham, Keith T
Telford, Gordon L
Towne, Jonathan B
Weigelt, John A
Wilson, Stuart D

Shorewood
Guice, Karen S
AMERICAN SURGICAL ASSOCIATION

Canada

ALBERTA
  Calgary  
    LaFreniere, Rene
    McPhedran, N.T.
    Pasieka, Janice L.
  Edmonton  
    Hamilton, Stewart McLeod

BRITISH COLUMBIA
  Vancouver  
    Chung, Stephan W
    Finley, Richard J
    Tyers, G. Frank O
    Warnock, Garth L

MANITOBA
  Winnipeg  
    Downs, Allan R

ONTARIO
  Almonte  
    Todd, Thomas R.J.
  Collingwood  
    Heimbecker, Raymond
  Hamilton  
    Mueller, C. Barber
  London  
    Duff, John H
    Wall, William J

Mansfield  
  Pearson, F. Griffith

Montreal  
  Stern, Hartley S

Ottawa  
  Harris, Kenneth A
  Keon, Wilbert J

Toronto  
  Baird, Ronald J
  Cohen, Zane
  David, Tirone E
  Filler, Robert M
  Fremes, Stephen Edward
  Grant, David
  Johnston, K. Wayne
  Keshavjee, Shaf
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  Marshall, John C
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  Trusler, George A
  Walker, Paul M
  Wedge, John H
  Weisel, Richard D
QUEBEC

Cote St. luc
Shizgal, Harry M

Montreal
Meakins, Jonathan L
Barkun, Jeffrey S.T.
Chiu, Chu-Jeng (Ray)
Christou, Nicolas V
Dobell, Anthony R.C.
Duranceau, Andre C.H.
Fried, Gerald M
Hampson, Lawrence G
MacLean, Lloyd D
Mulder, David S
Pelletier, L. Conrad
Rosenberg, Lawrence
Thompson, Alan G

Quebec City
Couture, Jean G

Quebec
Deschenes, Luc L

SASKATCHEWAN

Saskatoon
Keith, Roger G
Other Countries

ARGENTINA
Buenos Aires
De Santibanes, Eduardo
Gutierrez, Vicente P
Santa Fe
Acosta, Juan M

AUSTRALIA
NEW SOUTH WALES
Beecroft
Reeve, Thomas S
Hunters Hill
Sheil, Ainslie G.R.
Sydney
Barraclough, Bruce H
May, James

QUEENSLAND
Brisbane
Strong, Russell W
Innes Park
Thiele, Brian L

SOUTH AUSTRALIA
Adelaide
Jamieson, Glyn G

BELGIUM
Leuven
Lerut, Antoon E.M.R.

BRAZIL
Sao Paulo
Habe-Gama, Angelita
Jatene, Adib D

CHILE
Santiago
Csendes, Attila

CHINA
Hong Kong
Li, Arthur K.C.
Wong, John
Shanghai
Tang, Zhao-You

COLOMBIA
Bogota
Patino, Jose F

ENGLAND
Cambridge
Calne, Roy Yorke
Corbridge
Irving, Miles H
London
Hobsley, Michael
Mansfield, Averil O
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Williams, David I
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Kay, Andrew Watt

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Cape Town
Terblanche, John

Johannesburg
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Myburgh, Johannes A

SPAIN
Madrid
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Lund
Ihse, Ingemar

Stockholm
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Alfred A. DeLorimier, M.D., Geyserville, CA
H.H.G. Eastcott, M.D., England
Paul A. Ebert, M.D., Granite Bay, CA
Johann L. Ehrenhaft, M.D., Iowa City, IA
Sidney Goldring, M.D., St. Louis, MO
Donald G. McQuarrie, M.D., Edina, MN
Eric Munoz, M.D., Newark, NJ
Paul F. Nora, M.D., Chicago, IL
Malcolm O. Perry, M.D., Jacksonville, TX
William H. ReMine, M.D., Ponte Vedra, FL
Robb H. Rutledge, M.D., Fort Worth, TX
Edward F. Scanlon, M.D., Northbrook, IL
James M. Seeger, M.D., Gainesville, FL
Vallee L. Willman, M.D., Saint Louis, MO
AMERICAN SURGICAL ASSOCIATION

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1973  ROBERT E. GROSS, M.D.
      Boston, Massachusetts

1976  OWEN H. WANGENSTEEN, M.D.
      Minneapolis, Minnesota

1977  ROBERT M. ZOLLINGER, SR., M.D.
      Columbus, Ohio

1978  FRANCIS D. MOORE, SR., M.D.
      Boston, Massachusetts

1979  JONATHAN E. RHoads, M.D.
      Philadelphia, Pennsylvania

1981  MICHAEL E. DEBAKEY, M.D.
      Houston, Texas

1987  RICHARD L. VARCO, M.D.
      Minneapolis, Minnesota

1990  THOMAS E. STARZL, M.D.
      Pittsburgh, Pennsylvania

1991  JOSEPH E. MURRAY, M.D.
      Boston, Massachusetts

1992  NORMAN E. SHUMWAY, M.D.
      Stanford, California

1995  FOLKERT O. BELZER, M.D.
      Madison, Wisconsin

1997  M. JUDAH FOLKMAN, M.D.
      Boston, Massachusetts

1998  BASIL A. PRUITT, JR., M.D.
      San Antonio, Texas
MEDALLION FOR
SCIENTIFIC ACHIEVEMENT (Continued)

2000 BERNARD FISHER, M.D.
Pittsburgh, Pennsylvania

2001 JOHN W. KIRKLIN, M.D.
Birmingham, Alabama

2002 ROBERT H. BARTLETT, M.D.
Ann Arbor, Michigan

2003 CLYDE F. BARKER, M.D.
Philadelphia, Pennsylvania

2004 SAMUEL A. WELLS, JR., M.D.
Durham, North Carolina

2006 STEVEN A. ROSENBERG, M.D.
Bethesda, Maryland

2007 RONALD W. BUSUTTIL, M.D.
Los Angeles, California

2008 JOSEF E. FISCHER, M.D.
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Philadelphia, Pennsylvania

M. JUDAH FOLKMAN, M.D. 1998
Boston, Massachusetts

NORMAN E. SHUMWAY, M.D. 1999
Stanford, California

FRANCIS D. MOORE, SR., M.D. 2000
Boston, Massachusetts

BERNARD FISHER, M.D. 2001
Pittsburgh, Pennsylvania

STEPHEN A. ROSENBERG, M.D. 2002
Bethesda, Maryland

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New Brunswick, New Jersey

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Tippi C. MacKenzie, M.D.  2010-2012
Genevieve Melton-Meaux, M.D.  2010-2012
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Ronald W. Busuttil, M.D., Ph.D.  
Haile T. Debas, M.D.  
Tom R. DeMeester, M.D.  
Arnold G. Diethelm, M.D.  
David L. Dunn, M.D., Ph.D.  
Timothy J. Eberlein, M.D.  
Thomas J. Fogarty, M.D.  
Robert D. Fry, M.D.  
Lazar J. Greenfield, M.D.  
Jay L. Grosfeld, M.D.  
Mehmet Haberal, M.D.  
David B. Hoyt, M.D.  
R. Scott Jones, M.D.  
Paul H. Jordan, Jr., M.D.  
Mr. Gene Kile  
Susan E. Mackinnon, M.D.  
James B.D. Mark, M.D.  
James A. O’Neill, Jr., M.D.  
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Carlos A. Pellegrini, M.D.  
Basil A. Pruitt, Jr., M.D.  
Heran M. Reyes, M.D.  
Gregorio A. Sicard, M.D.  
W. Eugene Stern, M.D.  
Courtney M. Townsend, Jr., M.D.  
Andrew L. Warshaw, M.D.  
Michael J. Zinner, M.D.  

Major Contributors

Herand Abcarian, M.D.  
James T. Adams, M.D.  
Hiroshi Akiyama, M.D.  
J. Wesley Alexander, M.D.  
Dana K. Andersen, M.D.  
Kathryn D. Anderson, M.D.  
Charles B. Anderson, M.D.  
Louis C. Argenta, M.D.  
Nancy L. Ascher, M.D.  
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L.D. Britt, M.D.  
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Jonathan S. Bromberg, M.D.  
Henry Buchwald, M.D., Ph.D.  
Gerald D. Buckberg, M.D.  
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Major Contributors (Continued)

Richard P. Cambria, M.D.  
John L. Cameron, M.D.  
Donna A. Caniano, M.D.  
William G. Cheadle, M.D.  
Laurence Y. Cheung, M.D.  
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Robert W. Hopkins, M.D.  
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Charles B. Huddleston, M.D.  
Carl W. Hughes, M.D.
Major Contributors (Continued)

Robert P. Hummel, M.D.
Kelly K. Hunt, M.D.
Anthony M. Imparato, M.D.
O. Wayne Isom, M.D.
Bernard M. Jaffe, M.D.
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Ronald L. Nichols, M.D.
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Susan L. Orloff, M.D.
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Frank T. Padberg, M.D.
Frederick B. Parker, Jr., M.D.
John H. Pemberton, M.D.
Henry A. Pitt, M.D.
Hiram C. Polk, Jr., M.D.
Jeffrey L. Ponsky, M.D.
Mitchell C. Posner, M.D.
Richard A. Prinz, M.D.
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<thead>
<tr>
<th>Name</th>
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</tr>
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<td>Judson G. Randolph, M.D.</td>
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<td>Grace S. Rozycki, M.D.</td>
<td>Nicholas L. Tilney, M.D.</td>
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<tr>
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</tr>
<tr>
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</tr>
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<td>John A. Waldhausen, M.D.</td>
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</tr>
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</tr>
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</tr>
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<td>Everett K. Spees, Jr., M.D.</td>
<td>Asa G. Yancey, Sr., M.D.</td>
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<td>Steven C. Stain, M.D.</td>
<td>Gerald B. Zelenock, M.D.</td>
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<tr>
<td>Thomas E. Starzl, M.D.</td>
<td>Moritz M. Ziegler, M.D.</td>
</tr>
</tbody>
</table>
Contributors (Continued)

Douglas L. Fraker, M.D.  Richard J. Kagan, M.D.
Julie Ann Freischlag, M.D.  Gerard A. Kaiser, M.D.
Charles F. Frey, M.D.  Igal Kam, M.D.
Gerald M. Fried, M.D.  Donald L. Kaminski, M.D.
Susan Galandiuk, M.D.  Keith A. Kelly, M.D.
R. Neal Garrison, M.D.  Ken Kimura, M.D.
William A. Gay, Jr., M.D.  M. Margaret Knudson, M.D.
Robert R. M. Gifford, M.D.  Ira J. Kodner, M.D.
George K. Gittes, M.D.  Nicholas T. Kouchoukos, M.D.
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Lynt B. Johnson, M.D.  Jonathan L. Meakins, M.D.
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Ronald C. Merrell, M.D.
Fletcher A. Miller, M.D.
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Joseph I. Miller, Jr., M.D.
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Charitable Remainder Trusts and Other Planned Gifts  
W. Gerald Rainer, M.D. & Mrs. Lois Sayre Rainer  
The Estate of James C. Thompson, M.D.
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RECORD OF ATTENDANCE FOR CONTINUING MEDICAL EDUCATION (CME) CREDIT

ACCME Accreditation Statement
This activity has been planned and implemented in accordance with the Essential Areas and Policies of the Accreditation Council for Continuing Medical Education through the joint sponsorship of the American College of Surgeons and the American Surgical Association. The American College of Surgeons is accredited by the ACCME to provide continuing medical education for physicians.

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The American College of Surgeons designates this educational activity for a maximum of 17 AMA PRA Category 1 Credits™. Physicians should only claim credit commensurate with the extent of their participation in the activity.

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<th>Session(s) Attended</th>
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TOTAL HOURS (maximum 17 credits):

This is to certify that I, ____________________________ M.D., attended the 130th Annual Meeting of the American Surgical Association from April 8–10, 2010 in Chicago, Illinois.

THIS CARD IS YOUR PERSONAL RECORD OF ATTENDANCE FOR CONTINUING MEDICAL EDUCATION (CME) CREDIT AND SHOULD BE RETAINED BY YOU.

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American Surgical Association
900 Cummings Center, Suite 221-U
Beverly, MA 01915 USA
SCHEDULE-AT-A-GLANCE

THURSDAY, APRIL 8th

8:15 a.m.  President’s Opening Remarks  Imperial Ballroom
Secretary’s Welcome and Introduction of New Fellows
Elected in 2009
President’s Introduction of Honorary Fellows
Report of the Committee on Arrangements
Presentation of the Medallion for Scientific Achievement

9:10 a.m.  Scientific Session I  Imperial Ballroom
Moderator: Donald D. Trunkey, MD

11:00 a.m.  Address by the President  Imperial Ballroom
Donald D. Trunkey, MD

1:30 p.m.  Scientific Session II  Imperial Ballroom
Moderator: Kirby I. Bland, MD

FRIDAY, APRIL 9th

8:00 a.m.  Scientific Session III  Imperial Ballroom
Moderator: Donald D. Trunkey, MD

10:30 a.m.  Forum Discussion:  Imperial Ballroom
“The Impact of Healthcare Reform on Surgery”
Moderator: Donald D. Trunkey, MD

1:30 p.m.  Scientific Session IV  Imperial Ballroom
Moderator: Tom R. DeMeester, MD

4:00 p.m.  Executive Session (Fellows Only)  Imperial Ballroom
Presentation of the Flance-Karl Award

7:00 p.m.  Annual Reception  International Ballroom

8:00 p.m.  Annual Banquet  International Ballroom
(Black tie preferred, but dark suits are acceptable.)

SATURDAY, APRIL 10th

8:00 a.m.  Scientific Session V  Imperial Ballroom
Moderator: New President-Elect

11:00 a.m.  Adjourn