

**THE AMERICAN
SOCIETY
FOR RECONSTRUCTIVE
MICROSURGERY**

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**RECONSTRUCTIVE
MICROSURGERY**

The mission of the American Society for Reconstructive Microsurgery is to promote, encourage, foster and advance the art and science of reconstructive micro-neurovascular surgery; and to establish a forum for teaching, research and free discussion of reconstructive microsurgical methods and principles among members.

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RECONSTRUCTIVE MICROSURGERY

What's New in Reconstructive Microsurgery

By Roger K. Khouri, MD

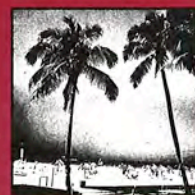
With 94 free paper presentations, two panel discussions, two named lectures, a historic Presidential address, and 21 morning courses, the scientific program of our 10th Anniversary Meeting was the largest ever. There were many excellent presentations of clinical and laboratory research that attest to the dynamic and innovative spirit of our Society. Space will allow me to only highlight some of these in this column on *What's New in Microsurgery*.

Perforator Flaps: An interesting advance in flap surgery expanded upon in the morning courses, is the transfer of the cutaneous territory of musculocutaneous flaps without sacrifice of the muscle, the so-called perforator flaps. The authors from Louisiana State University have shown that the TRAM flap can be reliably transferred based upon one, two, or three musculocutaneous perforators that are followed through the rectus muscle to the deep inferior epigastric vessels with complete sparing of the muscle. This technique has all the advantages of the musculocutaneous flaps with the decreased possibility of ventral hernia or muscle weakness.

End to Side Nerve Coaptation:
Expanding upon the work presented by Viterbo at the 9th Annual Meeting of ASRM, the group from the University of Toronto, brought further proof to the possibility of functional return following end to side nerve coaptation. In a rabbit model, immediate end to side nerve coaptation of a divided motor nerve to an adjacent intact nerve

(continued on page 4)

**Robert C. Russell, MD
relinquishes his presidential
gavel to incoming President
Ralph T. Manktelow, MD.**



Marco Island

**REPORT FROM
THE 10TH
ANNIVERSARY
MEETING
PROGRAM
CHAIRMAN**



Editorial Board adopts new directions

Over the past decade, our Society has experienced unprecedented growth in its membership and scientific activities. This is primarily due to its respected and energetic membership, its visionary leadership, and the remarkable and widespread advances in the teaching of microsurgery.

The theme of growth and development of our Society must, in my opinion, continue into the future. To facilitate this goal, the Editorial Board of *Reconstructive Microsurgery* has adopted new directions. The recruitment of young, active members is essential to the vitality and growth of our Society; a "young member column" is planned in upcoming issues of the newsletter which is intended not only to offer our new and younger members an opportunity to contribute, but also to foster their talents as active contributors to our Society and as its future leaders.

A unique feature of our Society is the opportunity it affords its members for close interaction with an immense number of microsurgical colleagues from many renowned centers across the world. This is manifested by the large attendance and active

EDITOR'S MESSAGE



Saleh M. Shenaq, MD

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participation of our international colleagues at all levels of the Society's annual scientific meetings. A new "international column" aimed at disseminating points of view of scientific and educational merit by our international colleagues will be established.

A "pros and cons column" is also planned to address controversial issues in microsurgery. Such topics, when carefully selected and discussed by experts, will enhance the educational mission of the newsletter and benefit its readers.

Reconstructive Microsurgery Newsletter has blossomed under the direction of its past editor, Dr. Peter Stern. As a new editor of the newsletter, I am fortunate to have Dr. Stern's guidance and example.

In order to accommodate the rapid growth and the educational needs of our Society, the Council has expanded the editorial board of the newsletter to include a new, young, and energetic group, Roger Kouri, Dan Nagle, and Marie Kuechel. I am grateful to the Council for their guidance and support, especially for providing the board the opportunity to steer our newsletter in its "new directions" for the future. **RM**

1996 multidisciplinary symposium

"Advances in Limb Reconstruction: A Multidisciplinary Approach" will be held May 9 - 11, 1996 in Seattle, Washington. Advances in reconstruction of the leg and upper extremity following trauma, infection and tumors will be presented including discussions of innovative techniques, pitfalls and outcomes.

Goals of the program include evaluation of the classification of injury, and selecting optimal reconstructive techniques from the options available for the category

of disease, infection and tumors. Controversies regarding treatment of open fractures in adults and children with internal fixation, external fixation or Ilizarov fixation as well as soft tissue reconstruction are analyzed separately for the upper extremity, leg ankle and foot. Selection and design of free tissue transfers are highlighted with panels of experts. Options such as bone grafting, Ilizarov bone transport, vascularized bone grafting are discussed in protocols for infections and non-unions. Reconstruction of skeletal

and soft tissue defects following tumor surgery are discussed including techniques such as combined allografts and vascularized bone grafting in limb salvage surgery.

The course is co-sponsored by the ASRM and the Plastic Surgery Educational Foundation, with Thomas Trumble, MD and L. Scott Levin, MD serving as co-chairs. The Orthopaedic Trauma Association and the American Society for Surgery of the Hand have endorsed the symposium. **RM**

Active defines Society's agenda

The Society's 10th Annual Meeting in Marco Island was exceptional for the quality of the Scientific Program, the site location, and the 417 registrants, which represented a record attendance for the Society. The Founder's Lecture by Nguyen Huy Phan, MD was an eye-opener into what can be accomplished by a microsurgeon in a less than ideal scientific and resource environment. Mark Schusterman, MD gave a stimulating account of the development of head and neck microsurgery in his unit and showed us the direction which head and neck reconstruction will be taking in the future. President Robert Russell, MD provided us with a moving account of the first ten years of the Society, finishing his presentation with a hi-tech performance of Society highlights accompanied by the stirring music of "You Are My Hero."

The Marco Island meeting signaled the end of the first decade of the Society's life. I think we were all impressed by how far we had come and what had been accomplished in Reconstructive Microsurgery and in the development of the Society's educational and research objectives.

In the coming year the Society will be actively involved with many important issues through its committees.

The ASRM newsletter will continue to be used as the primary educational and informational tool for members. We hope to expand the newsletter to three per year and add new columns with timely information.

The Coding and Reimbursement Committee under the leadership of Daniel Nagle, MD will continue to work at relative value codes for microsurgical procedures. This committee's work to date is impressive and will be outlined in detail in this newsletter.

The Education Committee under Thomas Trumble, MD is planning a microsurgical symposium for May 9 - 11, 1995 in Seattle, Washington. This will be the first symposium that

PRESIDENT'S LETTER



Ralph T. Manktelow, MD

*We were all impressed
by how far we had
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the Society has underwritten and in cooperation with the PSEF and with the endorsement of many other societies. The topic of this symposium will be "Limb Salvage and

Reconstruction: A Multidisciplinary Approach." This committee is also involved with the development of educational brochures. The financial feasibility of these brochures and marketing decisions are presently being explored.

Our Correspondence Newsletter Committee is off to a running start under Sandy McClinton, MD with many interesting letters being provided by the members. This will continue in the coming year.

Under the stimulus of Past President Graham Lister, MD the Society established a Clinical Guidelines and Outcomes Study Committee. This is a most important area for our Society to be involved with given the changes in health care funding and support. This committee is working in cooperation with other Societies involved in the same area. We look forward to this committee providing us with useful studies and clinical guidelines.

Next year's annual meeting will take place in Tucson, Arizona, January 14-17. There are some exciting new features that the Program Committee is working on for the meeting. This should be an exceptional scientific meeting that combines education and recreation.

RM

One more way to help enhance your skills.

We're proud to serve as exclusive sponsors of the ASRM newsletter. We see it as one more opportunity to deliver on our promise to make your work easier.

It's a promise we made more than two decades ago when we began crafting Sharpoint® microsurgical sutures and knives. From the beginning, their advanced design, superior sharpness, and exceptional consistency helped make each procedure less stressful, more efficient, and more effective. They still do.

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What's New in Reconstructive Microsurgery

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does result in nerve regeneration across the end to side coaptation with subsequent reinnervation of the denervated muscle. This finding may show promise in facial nerve palsy and brachial plexus palsy.

Treatment of Arteriovenous Malformations (AVM) with Free Flaps:

In a series from Seoul, Korea, seven patients with huge AVMs of the head and neck area underwent grossly incomplete excisions of the lesions followed by reconstruction of the defects with radial forearm free flaps. The procedure proved to be curative in all seven patients, followed-up for two to seven years. Most interestingly, the authors obtained long term follow-up biopsies for the originally diseased tissues at the margins of resection next to the free flap, and documented histological regression of the AVM changes. They attribute this regression to the ability of the well vascularized free flaps to block the vicious cycle of ischemia which perpetuates the AVM.

Endoscopic Microsurgery: The groups from Emory University, New York University, and Harvard University at the Brigham Hospital shared their early experiences with the endoscopic harvest of free flaps and of sural nerve grafts. The NYU group used a specially designed balloon to dissect the tissue planes with CO₂ insufflation to develop and optical cavity; to obtain the same effect, the Harvard group used a tumescent technique with dilute epinephrine injection and large skin sutures for external traction, while the Emory group, in addition, used specially designed retractors. The techniques have obvious steep learning curves and the first few cases were arduous, and the incisions were many; their combined length often added up to what most of us would have needed for a conventional dissection. Nonetheless, with further experience, the authors argue that the operative time and the incisions can be reduced to far below the

conventional techniques. The advantages of minimally invasive dissection are obvious, and the possibility of minimizing the rectus fascia incision, for example, in the case of the rectus muscle harvest could significantly reduce the morbidity of the procedure.

Value of Microsurgery:

More outcomes studies are clearly

Performing costly microsurgical reconstructions to give these survivors a worthwhile quality of life is a fiscally responsible endeavor.

necessary to document the cost effectiveness of complex microsurgical reconstructions in this era of specialist bashing and health care cost containment. This topic of cost and value of microsurgery was brought up in an international panel discussion moderated by our President, Dr. Robert Russell. In addition, a series of five papers dealt with this issue. The group from Duke University reviewed a series of 123 consecutive free flaps and found that the extensively traumatized patients, the patients who require multiple staged procedures, or the ones who develop complications were significantly driving up the costs.

The group from UCLA showed how a formal microsurgery program, by streamlining the operations into a routine, reducing the incidence of complications, shortening the operative time and in-hospital stays, can significantly reduce the cost of delivery of free flap surgery. The group from Louisville compared patients who had a staged reconstruction of complex hand defects with those who has an immediate composite free flap reconstruction. There was a significant improvement in the

quality of the results, along with reduced costs and reduced time off work for the patients undergoing the complex single stage reconstruction.

The group from the Mayo Clinic further put to rest the issue of pectoralis major versus free flap reconstruction of head and neck defects. Their data showed that, comparing similar patients with similar defects, the free flap group had a significantly shorter hospital stay, suffered less complications, required less additional procedures, and their care which led to a better result ended up costing much less than the technically simpler pectoralis muscle flap.

The group from Hamilton, Canada, reviewed their experience with the treatment of 16 patients with devastating oromandibular carcinoma leading to through and through defects. Although the one year survival was only 50%, those who survive one year have a good probability of long term survival. Therefore, performing costly microsurgical reconstructions to give these survivors a worthwhile quality of life is a fiscally responsible endeavor, even in this era of health care cost containment.

Revascularization of the end-stage ischemic upper extremity:

In patients with severe distal disease, no vascular outflow, and impending tissue loss, the authors from San Antonio, Texas, and the Brigham Hospital in Boston, have shown that revascularization is possible through the implantation of an omental free flap in the severely ischemic territory. The well vascularized omentum seemed to provide enough blood flow to the ischemic extremities to yield objective evidence of revascularization of the distal vessels despite the lack of successful distal anastomosis. At more than one year follow-up, these patients were symptom free, had healed the ulcers, and had no further tissue loss.

Status of Vein Grafts: While there is no doubt that the reconstructions requiring vein grafting are in a particularly high risk group because of the more

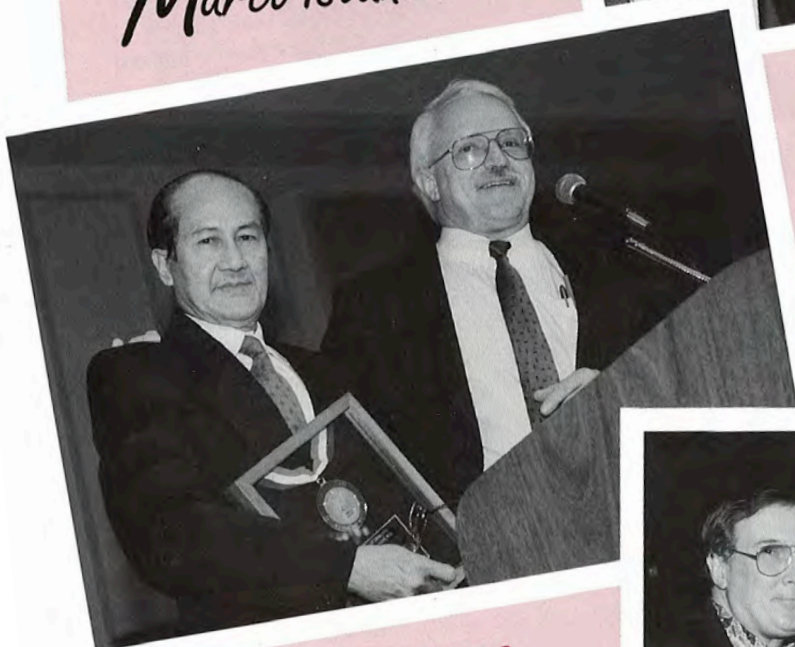
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Marco Island



William C. Lineweaver, MD, Timothy Whitney, MD, Luke Curtsinger, MD, Mrs. Anne Whitney and Mrs. Jane Wood (Lineweaver).



ASRM Past President Robert C. Russell, MD with Founder's Lecturer Professor Nguyen Phan, the driving force of reconstructive microsurgery in the People's Republic of Vietnam.



ASRM Vice President Dr. William M. and Mrs. Cindy Swartz with Dr. Alan E. Freeland.



Dr. Robert C. and Mrs. Anne Russell with Dr. Allen and Mrs. Sharon Van Beek.

What's New in Reconstructive Microsurgery

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complex nature of the original problem, the authors from Ludwigshafen and Bochum, Germany reviewed their experience with 82 vein grafts in 49 patients. Although the take-back rate of 16.3% for thrombosis was high in this group of patients, the final flap survival rate was 95.9% and was comparable to the more straight forward, similar extremity reconstruction cases without vein grafting. This result dispels the notion that vein grafts are evils to be avoided at all costs, and reinforces the dogma that it is safer to use a vein graft to tap into a proximal healthy vessel than to use local damaged recipients. In another series from Duke University, the authors compared their result with acute vein grafting using AV loops versus delayed staged transfer into a pre-implanted AV loop. Surprisingly, they found that the single stage transfer into an acute AV loop yielded a much higher success rate than the staged transfers into previously implanted loops.

Nail Reconstruction with Microvascular Transfer of Partial Big Toe Nail: The authors from Tokyo, Japan, reviewed their experience with 50 vascularized nail grafts. While the transfer of the second toe nail leads to an unsightly short nail that always resembles a toe tip on the hand, the authors showed exquisitely beautiful results with a flap design that utilizes part of the longer nail of the big toe to exactly reconstruct the defect on the hand and preserve the big toe.

Breast Reconstruction: Anatomical dissections and clinical series have renewed the interest in the internal mammary vessels as the recipients, for not only the gluteal flaps but also the TRAMs. At the second intercostal space, a greater than 3.0 mm internal mammary vein

was found bilaterally in 100% of the dissections, while at the 3rd intercostal space, 100% of the veins were >3 mm on the right side, and only 33% on the left. In a clinical series of 60 free flaps, the internal mammary vessels were satisfactory in all but six cases, five of which where the axilla is scarred from previous surgery and radiation is

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obvious. Furthermore, with the use of the internal mammary recipient sites, the incision can be limited to the breast, and a scar extending towards the axilla can be prevented. Simultaneous bilateral breast reconstruction with bilateral free hemi-TRAMs is becoming a more accepted technique as the procedure is now more predictable and has become standardized in many centers.

Experimental Research: The group from Washington University has shown that in a rabbit model of humeral defect, a reconstruction equivalent to that of vascularized autogenous bone graft can be achieved by the combination of recombinant osteogenic protein (OP-1 or BMP-7) treated lyophilized allografts with an intramedullary transfer of muscle flaps. The lyophilized allografts provide the biomechanical structure and the extracellular matrix while the muscle flap supplies the construct with a source of mesenchymal cells which differentiate into bone forming tissue under the effect of OP-1. On long term follow-up in the OP-1 treated group, the muscle was completely

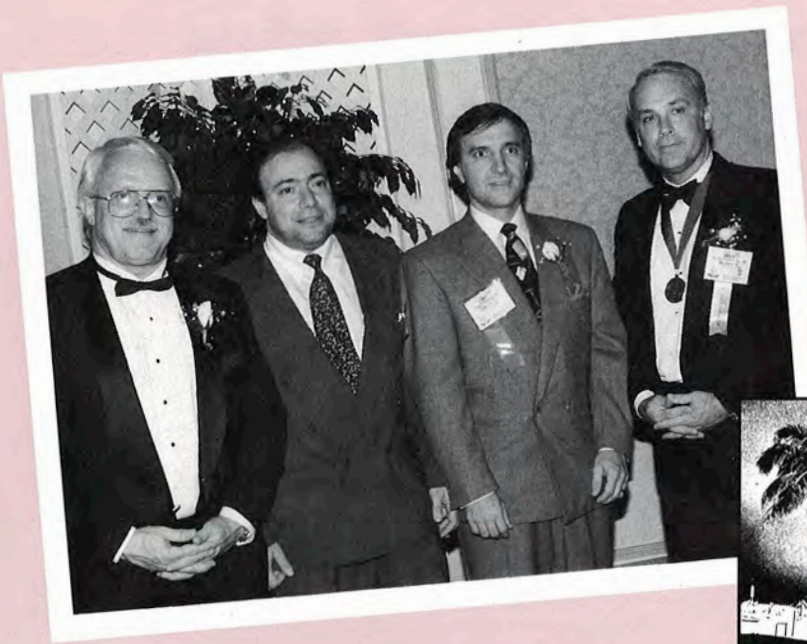
transformed into cancellous bone and marrow and was surrounded by thick live cortical bone, while it became a fibrous scar in the absence of OP-1, and there was much less repopulation of the allograft cortex with live investigators.

The group from Hopkins University showed that pre-expansion of a flap improves its tolerance to ischemia. The group from Southern Illinois University further elaborated upon the mechanism of ischemia reperfusion injury by showing that arteriolar vasoconstriction is thromboxane A2 dependent, while neutrophil-endothelial adherence is a more primary event, which is not TxA2 dependent.

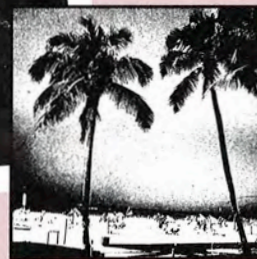
Still the group from Duke University showed that calcitonin gene-related peptide (CGRP), reduces reperfusion injury in the rat cremaster model by releasing prostacyclin which relieves the ischemia-induced vasospasm and improves capillary perfusion. However, although the microcirculation is restored, myocyte dysfunction is not prevented. The group from Davies Medical Center showed that heparin, in addition to its antithrombotic effect, has in a rat model of flap ischemia, a salutary angiogenic effect capable of accelerating neovascularizations that can sustain survival of the flap.

Another highlight of the meeting was the international panel of experts moderated by Dr. Graham Lister on the reconstruction of severely mutilated upper extremities. Despite their widely different backgrounds, there was an amazing consensus among the experts on what to do for these severe injuries. While there were many possible procedures that can be done, for each scenario, the preferred method seemed to be well established. This proves that this application of reconstructive microsurgery has gone beyond the realm of frontier exploration; we reached the point where all the experts recognize what works and what is a futile exercise.

RM



Past ASRM President Robert C. Russell, MD and ASRM Program Chair Roger K. Khouri, MD, AAHS Program Chair Rod J. Rohrich, MD and 1995 AAHS Past President David J. Smith, Jr., MD.



Joint meeting day presents unique educational opportunity

Marco Island

The first joint scientific meeting of the ASRM and American Association for Hand Surgery held in Marco Island, Florida on January 14, 1995 brought together microvascular surgeons and hand surgeons in an exchange of advanced surgical techniques. The joint day of programming, following the ASRM annual scientific meeting, was attended by over 700 attendees including physicians and therapists. ASRM Program Chairman Roger K. Khouri, MD stated, "Part of advancing the specialty involves sharing knowledge with others whose work is related to our own. The joint meeting of our Society and the AAHS presented an open forum to exchange information and techniques, and to look at things from a different

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perspective than what we typically may."

The combined day of programming included instructional courses, 53 vendor exhibits, and 22 papers. An international panel presentation "Microsurgery in Hand Surgery: Conventional vs. Microvascular Approaches," moderated by Graham Lister, MD was presented with international

panelists Jacques Baudet, MD, Guy Foucher, MD, Gunther Germann, MD, Paul M. Weeks, MD and Fu-Chan Wei, MD.

Florida treasure hunter Pat Clyne, the keynote speaker for the joint day of programming, presented his story of finding gold off the Florida coast while searching for the Spanish galleon, the Atocha. His presentation was attended by members, spouses and their families—all equally in awe of Mr. Clyne and his search team's determination, expense and treasure finally found.

Concluding the joint day was an evening beach reception brought indoors because of the rainy Gulf Coast weather. Rain did not, however dampen spirits. Hand and microsurgeons and their families enjoyed socializing among the sandcastles brought indoors. **RM**

Committee secures relative work values

The Federal Register of December 8, 1994 lists the current relative work values as well as total relative values for use in calculating reimbursement from Medicare for procedures. Through the efforts of the ASRM members and the Coding and Reimbursement Committee, we were able to secure the following relative work values and total relative values.

Relative work values are that portion of the total relative value of a procedure related to physician work such as preoperative, intraoperative, and postoperative care. Not included in this figure are the relative value units calculated for practice expense and malpractice expense. The total relative value is that number which would be multiplied by the current conversion factor (39.447) to calculate the actual dollar amount to be reimbursed by Medicare for a particular procedure (see Table I on following page).

Tables II and III indicate how these total relative values compare to the relative values of other procedures. This should give you an idea as to where microsurgery stands in regard to other procedures. The Society can be relatively pleased with the total relative values assigned to the procedures that were surveyed.

In regard to reporting multiple procedures, the current methodology to apply is to charge 100% for the first procedure and 50% for the second, third, fourth, and fifth procedures. If more than five procedures are carried out, they will be reimbursed on a per case basis. These rules, of course, only apply to Medicare.

The Coding and Reimbursement Committee would like to thank the membership for their participation in our past survey efforts and to enlist your support for future surveys. The data that is supplied is absolutely critical to the development of relative values.

TABLE II

Rank of Microsurgical Relative Work Values (RVW) and Total Relative Values (RVT) among 5923 Codes

Code	Descriptor	RVT	RANK
20808	REPL Hand	126.99	3
20805	REPL Forearm	102.14	6
20973	GT toe to hand	93.47	7
20969	Osteo cut free flap	88.78	10
20972	Free MT	87.64	13
20970	Free Iliac	86.97	15
20802	REPL Arm	83.45	22
20838	REPL Foot	83.45	21
20955	Free Fib	79.28	34
20824	REPL Thumb Prox	63.75	139
20816	REPL Digitzone II	62.60	157
15755	Free Flap	62.60	158
20827	REPL Thumb Dist	53.21	261
20822	REPL Digit Zone I	51.75	280

TABLE III

Rank of Microsurgical Relative Work Values (RVW) and Total Relative Values (RVT) among 5923 Codes

Code	Reference Code Rank	RVT	Rank
47135	Liver Transplant	140.58	1
33935	Heart/Lung Transplant	132.72	2
33945	Heart Transplant	115.41	4
47136	Liver Transplant	105.33	5
33870	Aortic Arch Graft	90.08	9
27447	Total Knee	49.95	309

Without adequate data, we are unable to defend ourselves before the AMA Relative Value Update Committee. These values do, in fact,

translate to the level of reimbursement that we will receive for our microsurgical procedures.

RM

TABLE I

CPT	Full Descriptor	95RVW	95RVP	95RVM	95RVT	95 NATL FEE
15755	Free flap (microvascular)	28.33	30.09	5.33	63.75	2,514.75
20802	Replantation, arm (includes surgical neck of humerus through elbow joint); complete amputation	39.56	37.72	6.17	83.45	3,291.85
20805	Replantation, forearm (includes radius and ulna to radial carpal joint); complete amputation	48.41	46.17	7.56	102.14	4,029.12
20808	Replantation, hand (includes hand through metacarpalphalangeal joints); complete amputation	60.19	57.40	9.40	126.99	5,009.37
20816	Replantation, digit, excluding thumb (includes metacarpalphalangeal joint to insertion of flexor sublimis tendon); complete amputation	29.67	28.30	4.63	62.60	2,469.38
20822	Replantation, digit, excluding thumb (includes distal tip to sublimis tendon insertion); complete amputation	24.53	23.39	3.83	51.75	2,041.38
20824	Replantation, thumb (includes carpometacarpal joint to MP joint); complete amputation	29.67	28.30	4.63	62.60	2,467.38
20827	Replantation, thumb (includes distal tip to MP joint); complete amputation	25.22	24.05	3.94	53.21	2,098.97
20838	Replantation, foot; complete amputation	39.56	37.72	6.17	83.45	3,291.85
20955	Bone graft with microvascular anastomosis; fibula	37.58	35.84	5.86	79.28	3,127.36
20969	Free osteocutaneous flap with microvascular anastomosis; other than iliac crest, rib, metatarsal, or great toe	42.08	40.13	6.57	88.78	3,502.10
20970	Free osteocutaneous flap with microvascular anastomosis; iliac crest	41.22	39.31	6.44	86.97	3,430.71
20972	Free osteocutaneous flap with microvascular anastomosis; metatarsal	41.54	39.61	6.49	87.64	3,457.14
20973	Free osteocutaneous flap with microvascular anastomosis; great toe with web space	44.31	42.25	6.91	93.47	3,687.11

Annual business meeting highlights

The ASRM Annual Business Meeting was held on Friday, January 13th. Treasurer William P. Cooney, MD reported that the Society is in good financial health and that an audit took place last April. He is investigating different investment options for the Society's monies.

Bylaws Committee Chair William M. Swartz, MD presented two proposed bylaw changes to the membership which were voted on and approved. In summary, the requirement of attending one annual meeting every three years to maintain active membership has been eliminated; and senior or inactive membership is now defined as being retired from active practice, or having reached age 65 or over.

Ralph T. Manktelow, MD, Membership Committee Chair, presented the list of proposed new members which had been previously circulated to the entire membership. A vote was taken and unanimously approved.

Graham Lister, MD, Nominating Committee Chair, presented the slate of candidates for the forthcoming Council. Each position was voted on individually and unanimously approved. The floor was opened up for nominations for two positions on both the nominating committee and membership committee. The nominations were voted on and approved.

President Robert C. Russell, MD introduced incoming President Ralph T. Manktelow, MD and installed him into office with the passing of the presidential medallion and gavel. **RM**

Message from the Program Chair

The 1996 ASRM Annual Meeting in Tucson, Arizona is designed to provide a forum for an exciting and interactive exchange of ideas. In addition to free paper presentations, there will be a video session and a new format for poster presentations. The Founders and Godina lectureships will again be a focus of the program and are designed to stimulate and provoke. The program committee is also planning a Pre-Conference Symposium on Sunday, January 14, of free tissue transfer for residents and fellows with interactive small group problem sessions for the established practitioner.

I look forward to and encourage your participation in the 1996 Annual Meeting.

Ronald Zuker, MD



Godina Memorial Lecturer

Applications are now welcome for individuals interested in presenting the Godina Lecture at the Eleventh Annual Meeting in Tucson, January 14-17, 1996. The lecturer must be a member of ASRM, under the age of 43 when the lecture is given. He or she will receive an honorarium of \$500 and the Godina Memorial Plaque.

Members interested should submit a single paragraph outline of a 30 minute lecture by May 30, 1995 to:

Ralph Manktelow, MD
The Toronto Hospital
Toronto Western Division
West Wing 5-835
399 Bathurst Street
Toronto, Ontario M5T 2S8

The Godina Memorial Lecture, as established by the trustees of the Marko Godina Fund, is in honor of Marko Godina, MD who died in 1986 at age 43, in the prime of a very successful career in microsurgery. **RM**

1995 ASRM Council and Committee Roster

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Louis A. Bonaldi

Ralph T. Manktelow

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William M. Swartz – Chair for 1998

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Robert C. Russell

Allen L. Van Beek

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J. David Gibeault

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ASRM Jewelry Order Form

	Gold Filled	10K Solid Gold	14K Solid Gold
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Please allow 4-6 weeks for delivery. All orders must be pre-paid.

RECONSTRUCTIVE MICROSURGERY

444 East Algonquin Road
Arlington Heights, Illinois 60005

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Microsurgery Calendar

September 13-16, 1995

ASSH 50th Annual Meeting
San Francisco, CA
Contact: ASSH
(303) 771-9236

October 7-11, 1995

ASPRS/PSEF/ASMS
Annual Meeting
Montreal, Canada
Contact: ASPRS
(800) 766-4955, ext. 404

January 10-13, 1996

AAHS 26th Annual Meeting
Palm Springs, CA
Contact: AAHS
(708) 228-8375

January 14-17, 1996

ASRM 11th Annual Meeting
Tucson, Arizona
Contact: ASRM
(708) 228-9717

February 22-27, 1996

AAOS Annual Meeting
Atlanta, GA
Contact: AAOS
(708) 823-7186

May 9-11, 1996

ASRM/PSEF
Optimal Leg and Upper
Extremity Reconstruction:
Orthopaedic, Plastic and
Microsurgical Advances
Seattle, WA
Contact: PSEF
(708) 228-9900