THE AMERICAN SOCIETY FOR RECONSTRUCTIVE MICROSURGERY

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RECONSTRUCTIVE MICROSURGERY

What's New in Reconstructive Microsurgery?

The 17th Annual Meeting of the American Society for Reconstructive Microsurgery

The 17th annual meeting of the American Society for Reconstructive Microsurgery was a complete success (if I do say so myself). In a manner similar to last year, we met in concert with the American Association for Hand Surgery and the American Society for Peripheral Nerve. Cancun, Mexico provided an outstanding venue for an exchange of ideas by day, and exchange of pesos for margaritas by night!

Two hundred and fifty registrants attended this year's meeting with 23 countries represented in the scientific program. A total of 180 abstracts were submitted. Ninety-six were presented as 6-minute presentations, 16 as 3-minute presentations, 24 poster presentations, and 3 video presentations (overall 77% of abstracts submitted will be presented in one form or another). Due to the success of the panel presentation format used during the 16th annual meeting, 6 new panels, reflecting a wide variety of controversial topics in microsurgery, were interspersed throughout the meeting.

Our meeting began on Saturday morning, January 12, as a combined session with all three societies. Four instructional courses were offered and provided an excellent review of topics of interest to all three groups. A combined panel reviewing controversies in the management of nerve entrapment then followed. Drs. David Chiu and Lee Dellon discussed the surgical options for ulnar nerve decompression at the elbow. Drs. Susan Mackinnon, Richard Meyer, and David Kline, along with Christine Novak, PT provided a thorough review of the evaluation and management of thoracic outlet syndrome.

The "Presidents' Lecture" was truly remarkable and was thoroughly enjoyed by all attendees. Drs. Robert Acland and Russell Shatford presented their unique 3D video review of upper extremity anatomy, as well as a dissection of the extended lateral arm flap. Their approach is a powerful one that will truly revolutionize how surgical anatomy is taught and specific operations reviewed.

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Enjoying the festivities at the Fiesta Mexicana: (left to right) Robert Walton, MD; Daniel Nagle, MD; Keith Brandt, MD; Jan Martin; and Lawrence Colen, MD.

Godina Lecturer William Zamboni, MD

Whither Reconstructive Surgery?

"Whither"; it's sort of an interesting word. I'm not particularly literary, but I looked it up and it does mean what I thought it means. The Oxford English Dictionary gives the following usage (among others): "To what result, condition, action, subject, cause, etc." My 1963 *Webster's New Collegiate Dictionary* makes this even more germane in its usage: "To what situation, position, degree, or end." So, my title for this editorial relates to where reconstructive surgery stands in the pantheon of other disciplines.

It has always been my feeling that there is really not a specialty of reconstructive surgery (at least reconstructive microsurgery), as reconstructive surgeons can have a myriad of backgrounds (primarily orthopaedic and plastic surgery in our society.) Other surgical specialties also perform reconstructive surgery, but this is generally specific for their anatomical area (bladder reconstruction comes to mind). Most reconstructive microsurgeons are "whole-body" specialists, and to a certain extent "generalists". This does not take away the fact that we often perform quite complex reconstructions of soft-tissue and bone defects from the cranium to the foot. It is also certainly true that our members perform many complex reconstructions without the aid of the microscope. In my own practice, I probably rely more on non-microsurgical flaps for wound coverage as time goes on, but this has not diminished the scope of my application of microsurgery to other areas. I suspect that all surgeons involved with reconstructive surgery alter their indications for free flap reconstruction with time and experience.

The basis of my discussion here is to ask who represents those surgeons whose practice consists primarily of reconstructive surgery and where does their work have a forum for presentation? A quick internet search reveals 266 website matches for "Reconstructive Surgery." The ASRM

EDITOR'S MESSAGE

William C. Pederson, MD

A quick internet search reveals 266 website matches for "Reconstructive Surgery." The ASRM appears as number 91 on the list....

appears as number 91 on the list (and as microsurgery.org—not a lot of information to those looking for us). The first three hits are society sites from the otolaryngology and ophthalmology fields. The majority of the other sites are private websites, mostly devoted to plastic surgery. There are in fact seven orthopedic practices listed, one hand surgery practice, and one podiatry practice. (The search also pulled up the Australian Centre for Penile Surgery, whatever that is!) The American Society of Plastic Surgeons doesn't come up. Neither does the American Academy of Orthopedic Surgeons, the American Society for Surgery of the Hand, or the American Association for Hand Surgery. Not finding the ASPS in a search for reconstructive surgery doesn't surprise me, as they removed our name a few years ago—all to avoid "confusing" lay people as to what the members were and what they did (i.e., cosmetic surgery.) Just for comparison, a similar web search found 1,201 sites for cosmetic surgery—five times as many as for reconstructive surgery. My intention is not to hammer on cosmetic surgeons, just to note that they are well-represented (not just on the web but with multiple societies as well).

I do want to make the point, however, that reconstructive surgery seems to have become a stepchild of our major parent organizations. This is despite the fact that the ASPS website gives statistics that reflect that about 45% of procedures performed by members are reconstructive (if you remove the nebulous category of "tumor removal.") Oh, I know they support reconstructive surgery—just go to a reconstructive session at the ASPS annual meeting. I've chaired reconstructive sessions at the annual meeting on several occasions when there have been perhaps 25 people in the audience. The ASRM does better than that, even on the last day of the meeting with a gorgeous day at the beach waiting! As a forum for presentation and discussion, the American Association of Plastic Surgeons' annual meeting represents reconstructive surgery well. But the topics presented at this meeting are mixed and the number of papers is limited. So who is there to represent us and where are we to present our major non-microsurgical reconstructive work?

The answer to this question may lie close to home. There have been a few papers on non-microsurgical reconstruction presented at the ASRM annual meeting over the last couple of years. While we don't want to change our primary focus, we may need to rethink our mission somewhat. As perhaps the only medical society that focuses primarily on reconstructive surgery, we may need to consider including more papers dealing with complex reconstruction not involving microsurgery at our

meeting. Even though this may not deal with microsurgery, we could provide an appropriate venue for presentation and discussion of new ideas. Our society represents members who practice the pinnacle of reconstructive surgery—reconstructive microsurgery. Faced with the facts concerning what's available to reconstructive surgeons, why shouldn't we broaden our interests a bit and include appropriate papers on sophisticated non-microsurgical reconstruction. (Come on, admit it, how many of you have had a free flap fail only to reconstruct the defect with a non-sophisticated local flap and/or skin graft.) The Council has discussed this possibility and we feel that it should be considered. I for one would like to have some feedback on this issue from the members, and would appreciate hearing from you at wcp@sbcglobal.net. RM

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.

President
Julia K. Terzis, MD, PhD

Editor
William C. Pederson, MD

Executive Director
Krista A. Greco

Managing Editor
Anne B. Behrens

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ASRM *Reconstructive Microsurgery*
20 N. Michigan Avenue, Suite 700
Chicago, IL 60602
312-456-9579
www.microsurg.org

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Taking Pride in Our Efforts

PRESIDENT'S LETTER

Julia K. Terzis, MD, PhD

The recent 17th ASRM annual meeting in Cancun was a great success, despite the September 11, 2001, events that changed permanently our way of life and the way we travel. Reconstructive microsurgery, from its very beginnings, flourished by constant networking and interchange of ideas among pioneers from around the world. This is perhaps one of the reasons that international societies were established first and many years later the need came for the creation of national societies. *As we enter the nineteenth anniversary of the existence of our society and take a look at the clinical and research body of work that has been accomplished, we should truly feel proud of what our efforts have meant to the many patients that we have touched.* However, despite the dedication, enthusiasm and search for perfection in our clinical endeavors, a changing financial climate and diminishing reimbursements for reconstructive procedures has forced many talented surgeons to turn in other directions to make a living. This is reflected in the diminishing number of new members who are joining our group.

Your Executive Council discussed these serious issues in a Strategic Planning Meeting that took place in January 10, 2002 in Cancun. Many ideas have been put forth which are being followed aggressively now by members of the Council and the various committee chairs.

At the same time, each one of us should play an active role in the recruitment of new members by emphasizing that microsurgery is only a necessary tool that allows us to offer better reconstructive procedures to our patients. To this end there are discussions going on whether our society should change its name and be called the American Society for Reconstructive Surgery. As one of our parent societies has dropped "Reconstruction" from its name, there are strong suggestions that we should be embracing all the reconstructive surgeons under our umbrella. The Council is seriously looking at this possibility and efforts are directed towards this goal. Your opinions are very important and I urge you to let us know your thoughts on this.

"As we enter the nineteenth anniversary of the existence of our society and take a look at the clinical and research body of work that has been accomplished, we should truly feel proud of what our efforts have meant to the many patients that we have touched."

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President's Message

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A greater recognition towards a selective group of international colleagues that enrich and contribute constantly to our annual meetings is being looked at by our By-Laws Committee at the present time. Such mutual reciprocity has taken place recently between the American Association of Plastic Surgeons and the European Association of Plastic Surgeons [EURAPS]. International interface and combined meetings of ASRM with other microsurgical societies has taken place previously and such experiences have enriched our scientific program, allowed our membership a look at different approaches to common problems and solidified international friendships. Towards this end an entire morning program of the 2003 meeting in Hawaii has been dedicated to a combined session between ASRM and the Hellenic Society for Reconstructive Microsurgery. This will be a unique opportunity for us to embrace colleagues from my home country, to listen to their contributions and to make new friends.

The Program Committee under the leadership of Dr. Nancy McKee is working tirelessly to establish the panels and courses for the 2003 meeting. They have been in close contact with our sister societies, AAHS and ASPN, and the program of the Saturday combined day nearly complete.

The Council has worked hard since the annual meeting to improve the ASRM funds investment performance. Different proposals have been solicited and a decision will be reached in the near future.

Also the Council is working on ways to build up the Godina Fund so that annual disbursements will come out of the interest and will not be depleting the fund itself. I urge you to be generous and contribute to this very worthwhile cause when the Central Office circulates donation requests.

The focus of my Presidency will be to continue work on all these issues important to the future ASRM and also to increase the awareness and recognition of women.

Being a member of the founding council of ASRM, my dream has always been to serve as your President one day. This only became possible recently and I want to publicly thank those that made it happen, and especially Dr. David Chiu and Dr. Berish Strauch. I am ready for this responsibility and honor, and embrace it with pride and determination. I am available to each one of you, and you are encouraged to reach me with your ideas, suggestions and comments so that together we can make this society a group that we are all proud to belong to. **RM**

Godina Traveling Fellow

Marko Godina was a visionary reconstructive microsurgeon, an insightful and enthusiastic teacher, and a remarkable man. Despite his abbreviated career, tragically cut short at the age of 43, he led the way for a generation of microsurgeons in understanding the care and treatment of complex extremity injuries through early reconstructive microsurgery. The American Society for Reconstructive Microsurgery knows no better way to honor the memory of Marko than through an ongoing investment into promising, upcoming, committed surgeons, who will, through study and investigation, continue to expand the horizons of our field. In this regard, the Godina Traveling Fellow has been established to allow a deserving individual, chosen by the ASRM to travel among numerous microsurgical centers, including Ljubljana, Marko's home.

The Godina Traveling Fellow will:

- Receive a maximum of $10,000 towards travel expenses, room and board. The expense cap for the Godina Fellowship is set by the Executive Council yearly.
- The Godina Traveling Fellow must include Ljubljana, Slovenia, Marko's home institution, in their travels.
- It is strongly suggested that non-North American fellows visit American institutions in addition to the required visit to Ljubljana.
- The Godina Traveling Fellow will be chosen prior to the ASRM Annual Meeting at which he/she is appointed, and opens their traveling year.
- The Godina Traveling Fellowship will begin at an ASRM Annual Meeting and will conclude at the subsequent annual meeting, at which time, the fellow will deliver the annual Godina Lecture.

Qualifications

- The applicant must submit at least three letters of recommendation from members of the ASRM or the World Microsurgical Society who can attest to the candidate's character and achievements.
- American and Canadian applicants must be members of the ASRM.
- Successful completion of a surgical residency and/or fellowship leading to the acquisition of competency in reconstructive microsurgery (i.e. plastic surgery, orthopedic surgery, general surgery, otolaryngology, hand and/or microsurgical fellowship.)
- A candidate's age at the time of appointment should reflect the spirit of Godina's youth.

Please contact the Central Office for an application. These are due by August 24, 2002. **RM**

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17th Annual Meeting

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The morning session was completed by a combined scientific session entitled "Outstanding Nerve Papers." Each of the three program chairs selected 2 manuscripts for presentation during this session. Topics ranged from outcome evaluation of obstetrical brachial plexus paralysis to the novel use of sural nerve grafting for cavernous nerve reconstruction following radical prostatectomy.

The afternoon provided all attendees with an opportunity to enjoy the Cancun environment. While residents and fellows attended their Symposium, which was beautifully organized by Dr. Milan Stevanovic, others participated in a catamaran sail, competed in the annual ASRM/AAHS golf tournament, or took advantage of the opportunity to freely explore the area on their own. Notables from the golf tournament included winner Howard Rodman, for the "longest drive," Dr. Alan Freeland, for the "longest putt," and Dr. Larry Hurst for "closest to the pin." Tournament winners were Drs. Joe Disa, Jeff Friedman, Dave Jensen and Gabe Kind. These "sandbaggers" seem to do exceedingly well every year and bear further watching!!

Saturday night was different from years' past. A combined "Fiesta Mexicana," with all three societies participating, left a palpable dent in Mexico's tequila reserves! The refreshments and entertainment were

Exhibit Hall

truly enjoyed by all. The "local" vendors, with their traditional Mexican artwork and wares, added to the unique character of the evening.

Following the President's and Program Chair's welcome on Sunday morning, a panel on the microsurgical applications to genitourinary reconstruction was presented. Moderated by Dr. David Gilbert, panel members included Dr. Gerald Jordan, a reconstructive urologist, Dr. David Chang, and Dr. David Gilbert. This was the first time this subject matter was discussed at our annual meeting. The topics included the current "state of the art" in penile reconstruction, cavernous nerve reconstruction to restore potency following radical prostatectomy, and penile revascularization following devastating pelvic trauma. This panel was extremely well received and is sure to become a "repeat performer" in future meetings of the ASRM.

"Upper extremity" manuscripts started the morning presentations. The morning concluded with a "freelance" session moderated by the distinguished Dr. Hanno Millesi entitled "Survey and Perspectives on Recent and Novel Nerve Repair Methods and Technologies." The "Head and Neck" session brought us to the early afternoon, at which time the meeting recessed, allowing for some free time to enjoy our meeting's beautiful surroundings.

Monday and Tuesday started quite early with a choice of four 1-hour long instructional courses each morning. Current techniques covering various aspects of reconstructive microsurgery were offered. In spite of the early hour, the sessions were well attended. On Monday morning, Dr. Randy Sherman then moderated a fantastic panel: "The Past Presidents." Dr. Joseph Kutz (third president), Dr. Bruce Williams (our fourth president), and Dr. Robert Russell (tenth president), joined Dr. Berish Strauch, our society's first president, on the podium. Their unique incites and perspectives filled an entertaining hour.

This year's Godina lecturer was Dr. William Zamboni. This "well deserved" award was bestowed upon an exceptional individual. His dedication to our specialty and his lifelong interest in "reperfusion injury" was well portrayed in his lecture. Bill was the first "Godina Fellow" to receive a travel stipend. During his address, he shared his travel experiences with us.

Past Presidents' Panel: (left to right) Robert Russell, MD; Joseph Kutz, MD; Berish Strauch, MD; H. Bruce Williams, MD.

The Godina Lecture was followed by our first concurrent scientific paper sessions with clinical "Nerve" and "Lower Extremity" papers being presented in one room and "Research" manuscripts in another. During the lunch hour, we were privileged to have the opportunity to have an "informal chat session" with Dr. Thomas Hunt. The "father of wound healing" fielded any and all questions. What a fabulous opportunity this was!

Dr. William Pederson (at left) converses with fellow attendees at the Fiesta Mexicana.

All attendees then reconvened for the fourth panel, moderated by Dr. Robert Walton: "Aesthetic Applications of Microsurgery." Dr. Bob Walton had an opportunity to review his experience with nasal surgery, Dr. Joe Serletti with lower extremity procedures, Dr. Bill Shaw reviewed his extensive breast surgery practice. Issues regarding patient financial responsibilities and how to decrease the hospital costs associated with these procedures were discussed. Monday's sessions concluded with a real treat. Dr. Robert Russell was the 17th annual Founders' lecturer. Bob's lecture, "Saskatoon to Cancun to You," entertained us all.

Nash Naam, MD (left) and Richard E. Brown, MD.

All in attendance marveled at his talent, sensitivity, and insight.

After the Tuesday morning instructional courses, the final day of the meeting commenced with the sixth and final panel: "What to do when the free flap fails?" Dr. Chris Attinger moderated this session. Dr. Hunt provided us with a scientific basis upon which wound management should be based. Dr. Fu-Chan Wei reviewed his extensive microsurgical experience, with emphasis on his "failures." Dr. Zamboni reviewed his clinical and research experience with the use of hyperbaric oxygen, and the Wake Forest experience with vacuum assisted wound management devices was presented. Following this panel, the remainder of the meeting

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ASRM Microsurgery CALENDAR

2002

European Federation of Societies for Microsurgery
6TH CONGRESS
June 20–23, 2002
Istanbul, Turkey

American Society for Reconstructive Microsurgery
MIDYEAR COUNCIL MEETING
June, 2002
Conference Call

American Society of Plastic Surgeons
ANNUAL MEETING
November 2–6, 2002
San Antonio, TX

2003

American Society for Reconstructive Microsurgery
ANNUAL MEETING
January 11–14, 2003
Hyatt Regency Kauai Resort & Spa
Koloa, Kauai, Hawaii

2004

American Society for Reconstructive Microsurgery
ANNUAL MEETING
January 17–20, 2004
Westin Mission Hills
Palm Springs, CA

2005

American Society for Reconstructive Microsurgery
ANNUAL MEETING
January 15–18, 2005
Sanibel Harbor
Sanibel, FL

2006

American Society for Reconstructive Microsurgery
ANNUAL MEETING
January 14 - 17, 2006
Loews Ventana Canyon
Tucson, AZ

17th Annual Meeting

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included concurrent sessions dealing with "Breast," "Head and Neck," "Lower Extremity," and "Miscellaneous" topics as well as 3-minute presentations. I spent much of my time moving from session to session. There was excellent attendance at all sessions, right up to the very end of the meeting.

As Program Chair, I owe a debt of gratitude to numerous individuals. The Central Office provided endless support and guidance in the administrative aspects of the meeting. The Program Committee was invaluable in the selection of manuscripts for presentation and facilitated the running of the meeting by acting as session moderators. Dr. Randy Sherman, our immediate past president, afforded me the latitude to construct a meeting that offered new and unusual topics. As part of his "vision" for our society, we attempted to "internationalize" the program. An effort was made to include "complex repair and wound management" approaches in addition to microsurgical solutions. I hope that these "changes" in format continue into the future of our society as well as its yearly symposia.

Lawrence Colen, MD
2002 Program Chairman
RM

Enjoying dinner at La Habichuela.

ANNUAL MEETING 2003

On-Line Abstract Submission

It is time again to gather your works for abstract submission to the ASRM Annual Meeting. The meeting will be held in Kauai, Hawaii, on January 11-14, 2003. As last year, abstracts will be accepted on-line. You may submit your abstract by going to the ASRM web site at www.microsurg.org.

Abstracts can be submitted as either a paper or poster presentation. As you begin the abstract submission process, your abstract will be assigned a four digit abstract ID and password. Using both of these, you may return at any time to update, modify, or delete your abstract. Your abstract will remain available and you may modify it, as many times as you like up until the final abstract submission date, which is May 1, 2002.

When entering the author information, please place the principal author first. All correspondence will be with the principle author. The principal author does not also need to be the presenter. Any subsequent author entry can be listed as a presenter. Be sure to include the e-mail address for all authors, as notification of acceptance of papers will be performed by e-mail.

You may type your abstract on any word processing program and then copy and paste your abstract to the "text box" on the abstract submission web site. There are also utilities available to include images and graphs. The total abstract submission, however, must be limited to 400 words. The number of available words will be reduced if an image or graph is included. At the end of the abstract submission process your entire abstract will display and you will have the opportunity to make corrections at that time or to return at a later date.

Return to the ASRM home page frequently to view details about the 2003 meeting in Kauai. As soon as the schedule of events is finalized it will be posted on the web site. After the abstracts have been accepted, the authors and their position in the program will also be posted.

Keith Brandt, MD, FACS
Chair, Electronic Communications Committee
RM

ASRM 2003 PROGRAM COMMITTEE

Invitation to Attend

The 18th Annual Meeting of the American Society for Reconstructive Microsurgery will be held at the Hyatt Regency Kauai on the island of Kaua'i, Hawaii. You can surf a Hawaii Web site (www.hawaii.com), with specific information on each of the islands, including Kaua'i. This island is known as "The Garden Island". It is also the oldest inhabited island of Hawaii, the greenest and, in some places, the wettest. The summit of Mount Wai'ale'ale is among the wettest spots in the world with an average annual rainfall of 444 inches. On the other hand, the average rainfall at Po'ipu Beach is 35 inches per year. This island boasts some of the most secluded and pristine beaches in Hawaii. The Waimeu Canyon, snorkeling, SCUBA, and golf are just some of the available activities.

As program chairman, I encourage members and guests to gather on this island. A special invitation has been made to feature our Greek colleagues. We also hope to entice participation from the entire Pacific rim. The program will include courses and special panels. The spectrum is broad and there should be something for each and everyone of us to learn, to share, and to discuss.

I look forward to receiving your abstracts and creating a great program with them. The abstract deadline is May 1, 2002.

See you in Hawaii!

Nancy McKee, MD
2003 ASRM Program Chair

By L. Scott Levin, MD
Chair, Education Committee

TIP #35

The Use of Surgicel in Microvascular Surgery

Surgicel or Cellulose is a cloth-like substance that helps to control bleeding. It can serve as a mechanical support for vessels and nerves following microvascular anastomosis or neurroraphy. Over the last several years, I have been using Surgicel to stabilize arteries and veins following microvascular anastomosis. Despite careful planning, at times the position of a vessel will change after the clamps are removed and it has filled with blood. This is particularly true in vessels such as the facial artery in the elderly, where the vessel may be tortuous once dissected. Surgicel stabilizes vessels that may have a tendency to curl and kink despite a patent anastomosis. The application of Surgicel will prevent this change in position for the first 24 to 48 hours, until normal local factors such as fibroblasts and inflammatory cells stabilize the vessel in proper position. I will often place Surgicel around the anastomosis after its completion to avoid a change in position. It is draped over the vessel and onto the surrounding tissue, but not circumferentially around the vessel. It can be placed very nearly around the vessel as Surgicel doesn't contract. In my experience, there has never been an instance of thrombosis relating to the use of Surgicel. The Surgicel sheet is applied dry over the top of the vessel and either irrigated with heparinized solution or blood. When it becomes wet it acts as a mat to secure the selected position of the artery and vein. The remainder of the flap then can be inset, and despite movement of the patient's head the vessels remain in position. Use of Surgicel can preclude the possibility of kinking and a possible change of vessel position that may lead to kinking and thrombosis. Surgicel can also be used to hold a nerve in a certain position following peripheral nerve repair.

TIP #36

The Use of Medicinal Leeches

Leeches have been used for quite some time in surgical practice. They have been utilized effectively in microvascular surgery to augment venous outflow when the venous anastomosis is compromised or insufficient. It is important to educate the nursing staff either in the intensive care unit or on the floor regarding the use of medicinal leeches. Without proper training, nurses in the unit or on the floor may not understand their proper application. We have modified our technique of leech application to maximize the leech's effectiveness while avoiding the usage of an inordinate number of these critters. The engorged area of the flap or replanted part should first be stuck with a needle. After egress of venous blood begins, a leech can be attached. The leech then becomes engorged and will fall off. The hirudin, which is the anticoagulant in leech's saliva, will keep the puncture site open. The nursing staff should be instructed that another leech should be applied only after the initial leech bite stops bleeding. At this time we will again prick the site with a needle and/or apply another leech. Heparinized pledgets are used to keep the leech bite open, so that we maximize the benefit of each leech. We have utilized leeches in extreme flap or digital salvage situations where blood loss can be excessive and multiple transfusions may be required. The continuation of leeching in this situation becomes an ethical and practical matter. In these cases, we obtain a hematology consult just to make sure that appropriate co-factors and other blood products are administered. While many sources state that only 3 to 4 days of leeching are required for digital salvage, we have found that most cases require 6 to 7 days of continuous venous blood-letting for the tissue to survive. Obviously, this depends on the color and turgor of the flap or replanted part, but peripheral inosculation of new vessels takes longer than has been traditionally reported. I will discuss the situation of the necessity for leeching with the family at the bedside prior to their application, and in almost every case they are agreeable and will usually actively participate in the process of leeching.

TIP #37

Stopping Anastomotic Leaks

Occasionally, after the release of occlusive clamps there is a small anastomotic leak. If the ooze and leak is quite small, bipolar cautery can be used to "spot weld" the adventitial surface, often resulting in a cessation of the leak. Intuitively, one might think that this might create a vascular wall injury that would predispose to thrombosis. This has not been the case in my experience and obviates the need to place a suture at the leak sites, which can be difficult. In cases where there is a large stream of blood, in particularly with arterial anastomosis, an adventitial bite can be taken on one side with the needle passing through a full thickness bite on the opposite vascular wall that may be protruding. While both sides of this suture do not include all three vessel wall components (adventitia, media and intima), it is sufficient to mechanically close the intima such that bleeding will stop.

TIP #38

Lower Extremity Reconstruction

In lower extremity reconstructions, superficial veins are often encountered on the way to deeper vessels such as the posterial tibial or anterial tibial artery bundles. Some of the cutaneous veins can be quite long and a good size match for the venous system of the flap. While it is our usual policy to use the vena committantes of the major vessels in the lower extremity, occasionally these are of insufficient size or may have been damaged, necessitating other venous outflow tracks. The superficial venous system should be remembered as a potential backup in all cases of lower extremity free flap reconstruction. We avoid damaging and dividing these veins as we make access incisions to the deeper vessels, as they can be utilized in many cases if the concomitant veins are unusable.

TIP #39

Microsurgery and Ilizarov Devices

It is often helpful when planning free tissue transfer for open fractures of extremities that involve placement or positioning of Ilizarov rings and wires, for a game plan to be established with the Ilizarov Surgeon prior to placement of the frame. The frames can be constructed so that they can be disassembled to allow access to vessels. After completion of the anastomosis, the Ilizarov team can easily reassemble the all of the parts of the frame to provide bony stability.

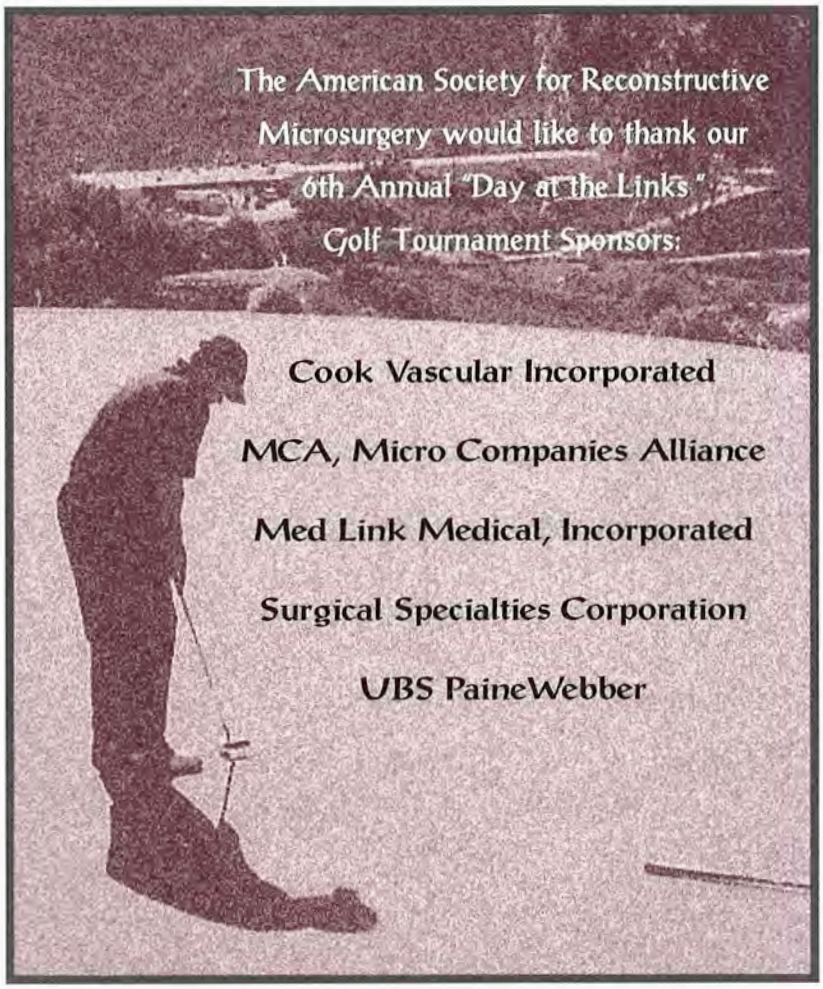
RM

COMMITTEE REPORT

CPT Coding Committee Report

The CPT coding committee has been working diligently over the last several months in regards to the microsurgery 69990 code. With the help of Drs. Keith Brandt and Dan Nagle, several options have been reviewed as to our future course of action. These options include identifying CPT codes that might utilize the microscope and creating new numbers for them. This has been accomplished and the advantage to this action is that multiple procedures would allow one to bill each time the microscope is used. The problem with this option, however, is the budget neutrality issue as it relates to HIFA regulations. Because we are asking for more codes and money, other CPT codes would have to be devalued in order to maintain a certain level. Alternatively, the use of an additional add-on code for microsurgery procedures for flaps and a separate code for nerves is another option. Unlike the 69990 code, we would submit the changes to use this add-on code for each procedure the microscope is used. We are currently waiting for further information from the RUC committee as to the most appropriate course of action. It appears that with the budget neutrality issues, a separate add-on code maybe the best route.

Gregory Evans
Chair, Coding and Reimbursement Committee
RM



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RECONSTRUCTIVE MICROSURGERY

20 N. Michigan Avenue, Ste. 700
Chicago, IL 60602
www.microsurg.org

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