Minutes of the September 27, 2021 Executive Council Meeting

The Executive Council of the Boston Surgical Society met via ZOOM on Sept 27, 2021. Dr. Ehrlichman thanked the Council members for gathering on short notice to discuss the upcoming season.

The first item on the agenda was to determine the timing of the next in-person meeting. Due to the uncertainty of COVID-19 and its variants, the first two meetings of the 2021-2022 period will remain virtual. The Annual Business Meeting will be held in December, at which time Dr. McAneny will ascend to the role of President. Dr. Ehrlichman's Presidential Address will be moved to March 2022, in hopes that it will be safe for members to attend the meeting at the Harvard Club. The much-loved Resident Case Competition will remain in April. Dr. Ehrlichman plans to contact officers of the New York Surgical Society and Philadelphia Surgical Society to coordinate the Northeast Surgical Meeting for May 2022.

It was unanimously agreed that Dr. Mark Rubin will become President-Elect of the Boston Surgical Society. Potential candidates for Vice President and new Council members were considered. Dr. Pardon Kenney reminded the group that the Bylaws stipulate that only active members can be nominated as officers. The names of the new officers will be recorded in future minutes upon the candidate's acceptance of these positions.

Annual dues will remain $295. All officers will try to recruit five new members to the Society.

Potential topics for the upcoming year's meetings will be transmitted via email. Each Council member was encouraged to submit two or three ideas to Kristen Boyer for speakers or panel discussions to compete the 2021-2022 season's agenda.

A follow-up meeting was proposed for October 18, 2021.

Respectfully submitted,

Claire Cronin MD, MBA, FACS

The first meeting of the 2021-2022 Boston Surgical Society was held on November 8, 2021 through Zoom, with 35 members in attendance. The speaker was Dr. Ben Nelson, a recent graduate from the Boston Medical Center (BMC) surgical residency program, who is now on staff at the Waldo County General Hospital in Belfast, Maine. The title of Dr. Nelson's talk was "Personal Finance for Surgeons and Other Dummies." Dr. Ehrlichman ceded the floor to Dr. Jennifer Tseng, the Chair of Surgery at Boston Medical Center, to introduce Dr. Nelson. Dr. Tseng spoke glowingly of Dr. Nelson's career as a resident at BMC. Dr. Nelson had given a similar talk on financial literacy to the surgical residents during a grand rounds presentation, which was so well regarded that he was invited to present at the Boston Surgical Society.

Dr. Nelson thanked Dr. Tseng and disclosed that he has no formal financial training despite a brief stint as a life-insurance salesman during college. Dr. Nelson feels that it is important for surgeons to gain an understanding of their personal finances in order to achieve financial independence. Most medical students graduate with hundreds of thousand dollars in student loan debt, and don't have a plan to pay it off. Multiple studies in Canada and the US have shown that physicians and residents are not educated appropriately in the basics of finance, resulting in further stress on top of staggering debt. Academic debt has been shown to significantly influence the quality of physicians' family life including, decision of where to live, family size, and relationship with their significant other.

Surgical residents graduate later in life, with more complex financial situations than the average graduate student. Although many have a basic understanding of budgeting and loan repayments, most residents are unfamiliar with the mechanics of disability insurance, life insurance, investing, home buying, and retirement planning. In 2018, The American College of Surgeons issued a press release stating that the majority of surgical residents feel strongly that personal financial education should be offered during medical training.

Dr. Nelson clarified that there is a difference between income and wealth. Using the book, *The Millionaire Next Door* by Thomas G. Stanley and William Danko as an example, he disavowed the audience of the typical image of a millionaire standing in front of a jet with money raining down on him. Most millionaires in America have an average annual income of $131,000 but live frugally, and invest at least 20% of their income in retirement plans. Developing good financial habits is important for long term savings.

An overview of financial basics was given, starting with investing. Dr. Nelson explained that investing is using money to buy stocks and bonds through brokerage or retirement accounts. Stocks are a share of a company, while a bond is a loan to a company or government. Mutual Funds and Exchange Traded Funds (ETF's) are a collection of stocks or bonds. The goal is to take advantage of compound interest in these plans where the interest is reinvested back

into the principle, and grows exponentially. Since surgeons start retirement plans later in life, they should invest aggressively but remain diversified to limit risk. Despite short-term fluctuations in the market, the S&P tends to gain ~10% every year. Not investing is riskier than leaving money in a bank as it will lose value every year due to inflation (1-3% year.) Savings account return 0.5% per year and do not keep up with the rate of inflation.

The second subject Dr. Nelson reviewed was the fundamentals of insurance. Insurance is a way to protect your wealth. Health insurance is usually partially subsidized by a surgeon's employer or company while working, but upon retirement it can significantly eat in to one's savings. It is estimated that a healthy couple retiring in 2019 will spend an additional $390,000 on medical expenses, which is why it is wise to start saving now. One option is a Health Savings Account which allows individuals to put $3,550/year, or a family $7,200/year away in a tax-free account that can be used for health care expenses. The money will generate interest in these accounts which can be somewhat self-directed. The funds in a Health Savings Account can be used for other purposes, but will then be subjected to taxes.

On the subject of life insurance, Dr. Nelson highly recommends it. The two options are term life insurance and whole life insurance. The former is for a finite amount of time (20-40 years), but only about 1% of term life insurance policies get paid out. They are usually cheap plans in the range of $1,000/year for a million dollar policy, and by the time it expires, a frugal surgeon will have built enough wealth that a second policy will not be necessary. Whole life insurance pays out fully when you die but it is expensive (~$8,000/year), with higher fees, and low interest rates. Dr. Nelson recommends buying a term policy and investing the difference in the stock market.

Disability Insurance should be purchased early in one's career when discounts are available through organizations such as the Committee of Interns and Residences. It is important to invest in "own specialty" insurance which covers surgeons who can no longer operate, but can still be employed in a different manner.

The third financial basics topic was on debt. The average medical student leaves school with $201,490 at a 6.25% interest rate. For a ten year payback plan, $73,070 will be paid in interest alone vs $33,696 for a five year payback plan. By investing the ~$40,000 difference over thirty years at 10% in the market, one can generate almost ¾ of a million dollars. The conclusion is that the longer you have debt, the more you pay out in interest and lose in compound interest. The one exception is the Public Service Loan Forgiveness program for surgeons who are employed full-time in a not-for-profit company or government organization. Although only 2% of applicants are eligible, the program pays out the remainder of one's loan after 10 years of regular payments.

Retirement savings plans were the last topic of the evening. The government has created multiple vehicles to encourage people to save for their retirement. The Roth IRA was developed in 1997 as part of the Taxpayer Relief Act, by Senator William Roth from Delaware. Up to $6,000 ($7,000 if older than 50) of post-tax dollars can be invested in a plan of stocks,

bonds, or funds to grow tax-free and be used without further penalty starting at the age of 59½. The 401k and 403b plans are similar in that they use pre-tax dollars to invest in employer sponsored funds. The contribution limit is $19,500 ($26,000 if older than 50) and there is often an employer's match of a certain fraction of the investment. The 457b is an extra modality for putting away another $19,500 in pre-tax dollars, but is not universally offered by all companies. The 529 Plan is a Roth plan for your children's college expenses. Post-tax dollars are invested in a state plan, and the gains can be used tax-free to pay tuition and associated expenses. There is no annual limit but contributions greater than $75,000 are treated as a gift. The beneficiary can alternate between family members.

A final example of how these investment plans can result in wealth was outlined. If over a course of 30 years, a surgeon making $300,000/year saved ten percent of his salary in cash he or she would have accumulated $1.1 million, vs investing conservatively at 5%/year they can retire with $2.6 million, vs investing aggressively at 10%/year they will be retiring more comfortably with $7.1 million.

Dr. Nelson recommends investing any excess cash into a brokerage account that can be opened for free online. Warren Buffet recommends people invest in S&P 500 low-cost index funds which are diversified, passively managed, and come with low fees. Most stocks don't do better than the S&P in their lifetime.

The conclusion of Dr. Nelson's talk was to protect your wealth with insurances, stay out of debt, and contribute maximally to retirement savings accounts. For further information he recommended *The Millionaire Next Door*, *The White Coat Investor*, and a compound interest calculator to set financial goals.

Dr. Ehrlichman thanked Dr. Nelson for a fantastic talk and predicted that he will be in much demand from the residency directors attending the meeting. A vibrant question and answer discussion took place that touched upon the benefits of living debt free, philanthropy, and health disparity.

Respectfully submitted,

Claire Cronin MD, MBA, FACS

Dr. Ehrlichman welcomed the members of the Boston Surgical Society to the second meeting of the season on December 6, 2021. Another wave of COVID was surging through the state of Massachusetts with 11,000 new cases reported that day, and thus the meeting was once again held virtually through Zoom.

Dr. Pardon Kenney announced the slate of officers for the following year. The members of the Boston Surgical Society Council are Kevin McCarthy MD, Jennifer Tseng MD, Dana Fugelso MD, Jason Hall MD, and Kristen Raven MD. The Nominating Committee consists of the past three presidents of the society: Dr. Richard Ehrlichman, Dr. Fred Millham, and Dr. Mark Callery, who will also act as Chair. Dr. James Yoo will continue to serve as the Dinner Chair. The new Treasurer will be Dr. Dimitry Nepomnayshy. Dr. John Mullen is the new Vice-President, and Dr. Claire Cronin will continue in her role as Secretary. Dr. David McAneny will take the helm as President, with Dr. Marc Rubin stepping up as President-elect. The slate was approved with a show of hands.

Dr. Marc Rubin presented the treasurer's report. Expenses for the last two years have been low due to the absence of in-person meetings. Year-to-date expenses for 2021-2022 are $1,446. Society dues have not been solicited as of this meeting. The current cash on hand is $100,890.

Dr. Erlichman thanked Drs. Kenney and Rubin for their reports, and introduced the evening's program, which consisted of a panel of three surgeons representing late, mid, and early career viewpoints, entitled "A Lifelong Passion for Learning and Doing." Dr. Desmond Burkett from the Lahey Hospital was invited to lead the discussion.

"Life never works out like you planned," is how Dr. Burkett opened the discussion. As a senior resident in surgery at Guy's Hospital in London, Dr. Burkett was afforded the opportunity to spend some research time in America with Dr. Bill Silen from the Beth Israel Hospital. His stay in Boston was extended and ultimately led to a position at Boston University where he pursued his interest in the burgeoning field of gastric endoscopy. Dr. Burkett began using colonoscopes to remove gallstones through t-tubes placed during open cholecystectomies, and offered this service at 16 hospitals throughout the state. Faced with a patient with a large right upper quadrant abscess, whom the anesthesiologist refused to put to sleep, Dr. Burkett persuaded a radiologist to help him place a percutaneous drain to treat the infection. When he presented his series of ultrasound guided drainages at the American College of Surgeons, it raised considerable eyebrows. After publishing his results in the New England Journal of Medicine, a local surgeon wrote an editorial saying that this practice was unethical, but later offered a public apology when he successfully treated his own patients with drains.

After Dr. Jacques Marescaux, a French colleague, presented a video of a laparoscopic cholecystectomy at a SAGES meeting, Dr. Burkett spent a week in Bordeaux learning the

procedure during the day, and sampling the local wares in the evening. Dr. Burkett introduced the laparoscopic cholecystectomy to Boston under the umbrella of an IRB. He continues his pursuit of using technology to advance surgical procedures and is currently being trained on the Da Vince robot. Dr. Birkett believes that taking care of patients is a privilege and finding one's passion as a surgeon leads to professional fulfillment.

Dr. Ehrlichman introduced Dr. Claire Cronin to speak on her experience in leadership and administration. After a peripatetic childhood that started in South Africa and ended in Boston, Dr. Cronin studied medicine at Tufts University Medical School and did her training at the Beth Israel Deaconess Hospital. Her love of learning led her to pursue an MBA from Babson College and an MFA in creative writing from Lesley College, while practicing fulltime as a general surgeon at Newton Wellesley Hospital. Early in her career, she was offered leadership roles that included, chairing hospital committees, joining the Board of Trustees, and acting as the President of the Medical Staff. In thinking about why she was being offered these roles, Dr. Cronin believes that it was due to a certain level of surgical competence, along with a consistent presence at hospital events and meetings. When she moved to Atrius Health in 2016, she rose in ranks from Chief of Breast Surgery to the Executive Chair of Specialties.

Dr. Cronin described the different pathways that a surgeon can take once they are done with their training. Many surgeons become involved in research or teaching, but there is the opportunity between medicine and management to develop physicians as leaders. Research from the Harvard Business School shows that hospitals that are run by physicians are more successful with lower rates of staff burn-out. Basic leadership skills such as strategic and financial planning, managing, and mentoring others are not taught in medical school but can be learned. Her key takeaways that helped her become a surgical leader are to show up, step out of your comfort zone, trust your instincts, have interests outside of medicine, and never stop learning.

Dr. Rumbi Nzara, a young bariatric surgeon who trained at Boston University Medical Center, and is now practicing at the University of Maryland, was born and raised in Zimbabwe. She was initially drawn to medicine due to the overwhelming HIV problem she witnessed growing up in Africa but fell in love with surgery. She has recently transitioned from a resident to an attending, and it is from this point of view that she will frame her discussion.

In thinking about lifelong learning, Dr. Nzara believes that there are three concepts that are important to adopt. The first is a growth mindset. Being open to new technology and believing in one's ability to learn new procedures is essential to continuous development in surgery. Accepting that failure is part of the learning process is the second concept necessary to have a successful surgical career. Lastly, deliberate practice with focused repetition is instrumental to progression of specific skills. As a new attending, breaking down the steps of a procedure is important to self-improvement. Learning as part of a community, such as journal club and national meetings, is important to remain engaged with others. She believes that finding passion in her work brings her joy and is the driver that pushes her to continue to want to learn.

Dr. Erlichman opened the floor for questions and a lively discussion ensued. The importance of mentors in a surgical career was unanimously agreed upon. The meeting was closed with the intention of gathering in person in February 2022.

Respectfully submitted,

Claire Cronin MD, MBA

On a misty February night, the Boston Surgical Society had its largest meeting of the 2021-2022 season with 88 members in attendance on Zoom. Although the Society had hoped to meet in person, a winter surge of COVID was still raging with just over 7,000 new cases reported for February 7th. Dr. McAneny welcomed everyone and introduced Dr. Steven Stain, the new Chair of Surgery at Lahey Hospital and Medical Center. Dr. Stain's many accomplishments include serving as Director and Chair of the American Board of Surgery, the Chair of the Executive Committee of the American College of Surgeons Board of Governors, and currently an ACS Regent. The title of his talk tonight is "Pass-Fail USMLE 1: Are you kidding me!!"

The National Board of Medical Examiners decided to change the score reporting of the United States Medical Licensing Examination (USMLE) Step 1 from a three-digit numeric score to a pass-fail result as of January 2022. Dr. Stain, who has written test questions for the USMLE Step 2, and the American Board of Surgery certifying exam, feels this is a mistake. Some of the concerns from medical students about this change include the inability to differentiate themselves with good scores so that their ranking to residency programs will fall back on the reputation of their medical schools.

Dr. Stain authored two papers that impact tonight's discussion. The first was presented at the New England Surgical Society in 2012 and is entitled, "Characteristics of Highly Ranked Applicants to General Surgery Residency Programs." Dr. Stain called on 34 general surgery program directors to send the Electronic Residency Application Service (ERAS) data for their top 20 rated applicants. Twenty-two programs responded with 440 applications that included 333 unique individuals. The authors of the study ranked the submitting programs into three categories: highly competitive, very competitive, and competitive. The same authors blindly ranked the personal statements of the medical students into three categories: very high or high, average, and below average or poor. An analysis was performed of the programs by region, competitiveness of the program, and the strength of the applicant. The results showed that higher USMLE 1 scores, along with Alpha Omega Alpha status, research, publications, and Asian ethnicity correlated with the applications to the more competitive programs as well as the ranking of the applicant by the program. Personal statements and gender had little significance to the ranking process.

The second published study looked at the same 333 surgical applicants who had been ranked in the top twenty by the programs that they applied to and compared their original application to the results of their ABS qualifying and certifying exams. Only 251 of these surgical residents went on to take the ABS general surgery examinations, which was thought to be explained by these candidates opting to take specialty boards, as opposed to attrition. There was a 3.7% failure rate on their first attempt of the qualifying exam and a 14% failure rate for the certifying examination. The only predictive attributes for determining who would pass the exams on their first attempt were their scores on the USMLE Step 1 and 2 exams.

Historically the USMLE scores were intended to be a minimal competence exam and not for determining residency applications. The question is raised that good test takers remain good test takers and this may have no influence on actual surgical performance. Dr. Stain shared the concerns of performing a "Holistic Review" of every applicant as there has been no universal agreement on what this entails.

Dr. Stain opened the discussion by asking the participants how program directors can identify candidates from less prestigious schools and from disadvantaged backgrounds?

Dr. Don Hess, the program director at Boston Medical Center, felt that minority applicants who don't do well on USMLE Step1, will have more of an advantage with the pass-fail model as it forces program directors to look at other factors such as the dean's letter, or ranking in the class. Dr. Stain countered that reviewing 1,000 applications is difficult for any director to uncover favorable characteristics. Dr. Hess reports that he involves the faculty in the process to expand his ability to review the applications.

Dr. Mike Jaklitsch interviews candidates for the cardiothoracic surgery program at the Brigham and Women's Hospital and feels that there is very little information outside of test scores that he is provided with. Letters of recommendation are unreliable, as they are all glowing. High test scores play an important role in influencing who he invites for an interview.

Dr. Lilian Chen from Tufts Medical Center brought up the historically high attrition rate in surgical programs hovering around 20-30%, and that this may be an indicator that relying on test scores is not ideal. Matching a student into the culture of a residency program is more important than test scores. Tufts is using a new process called a SurgWise program. They invite psychiatrists to interview their candidates to help identify a cultural fit. Dr. Stain responded that training residents is hard and maybe a 20% attrition rate is not a bad thing in order to ensure we are graduating only those surgeons who are competent to treat patients.

Dr. Anne Larkin, the program director at University of Massachusetts Memorial Medical Center and Senior Associate Dean, believes getting rid of Step 1 forces residency programs towards a broader approach of selecting students. A message should be given to medical school deans on the importance of their letters. Dr Stain does not feel medical schools are good at evaluating students and there is no standard across schools.

Dr. Pardon Kenney brought up the point that the time spent in surgical clerkships during medical school is shrinking and not giving students an accurate understanding of the field of surgery, which may lead to the high attrition rate.

Dr. Jennifer Tseng from Boston Medical Center was given the last word of the evening. She has noted that they have been able to identify higher qualified applicants by adopting the more holistic approach to matching residents.

Dr. McAneny thanked the speakers and all the members who participated in the discussion. He is hoping to see everyone at the Harvard Club in March for Dr. Ehrlichman's presidential address.

Respectfully submitted,

Claire Cronin MD, MBA

After two years of COVID restrictions, the members of the Boston Surgical Society were reunited at the Harvard Club for Dr. Richard Ehrlichman's Presidential address on March 7, 2022. Forty-nine guests gathered in person, with more attending online via Zoom, in the first hybrid meeting in the Society's history. Dr. Ehrlichman served two terms as president, which hadn't been done since 1944. The atmosphere was electric as old friends and colleagues shared a handshake (or fist-bump) and a drink for the first time since March 2020.

Dr. Smink, the vice-president of the Boston Surgical Society, introduced Dr. Ehrlichman with a slideshow outlining his storied career, which started at the Brigham and Women's Hospital. After completing his general surgery residency at the Brigham, Dr. Ehrlichman entered into a plastic surgery fellowship at Massachusetts General Hospital. Dr. Ehrlichman is a Colonel in the US Army Medical Corp and is the Senior State Physician in the Massachusetts's National Guard. A lovely slideshow of Dr. Ehrlichman's life was shown including a family photograph of his wife, Nancy, and their five children.

Current President: Dr. David McAneny,
past President: Dr. Richard Ehrlichman, and
President-elect: Dr. Marc Rubin.

Dr. Ehrlichman took the podium and started the meeting off by asking for a moment of silence on behalf of the recent passing of Dr. Hardy Hendron, the former Chair of Surgery at Children's Hospital and a past president of the Boston Surgical Society.

The title of Dr. Ehrlichman's talk was, "A Military Surgeon's Response to the Pandemic: A Journey to Boston Hope." Boston Hope was a hospital set up by the city, the state, and Partners Healthcare to take care of the patients stricken by the greatest pandemic in our lifetime, COVID-19.

Dr. Ehrlichman was born in Washington DC but was raised in Atlanta, where his family owned a chain of grocery stores. He went to medical school at John Hopkins University in Baltimore and joined an eating club for male members of the medical school, entitled Society of Pithotomists, which roughly means to "tap a keg," and was meant to foster student-faculty relationships. Through the Pithotomy Club, Dr. Ehrlichman met a urologist who had trained at the Brigham and Women's Hospital and was encouraged to go to Boston for his training. This is where Dr. Ehrlichman met the renowned transplant surgeon, Dr. Jospeh Muray, who instilled in him that "service to society is the rent we pay for living on this planet." It is also where he met Dr. Chip Moore who encouraged him to join the National Guard. After his general surgery residency and plastics fellowship, Dr. Erlichman was employed at Lahey Clinic Medical Center before entering into private practice.

Dr. Ehrlichman's father and grandfather had served in the military, and with his old friend, Dr. Moore's encouragement, he enlisted in the National Guard, which serves both a state and federal role. Physicians must first undergo Basic Officer Learning Course (BOLC), where he learned land navigation and weaponry, before becoming part of the Professional Filler System

(PROFIS), which is the launching process for medical professionals to join active combat military units. In November 2011, Dr. Ehrlichman was called up to serve in Operation Enduring Freedom and was sent to Afghanistan.

Before his departure, Dr. Ehrlichman needed to retrain in trauma surgery and was sent to Tactical Combat Medical Corps in San Antonio Texas. He was then deployed to the 1-182 Infantry which is the oldest infantry regimen in the US Army. It was established in 1636 as the Massachusetts Militia, which eventually helped to start the American Revolution in 1775, by firing the "shot that was heard around the world."

The Kabul base camp was led by Dr. General Hammond and was comprised of 1,500 people from all over the world. The mission of the 1-182 Infantry was to provide security for the reconstruction of Afghanistan. The majority of Dr. Ehrlichman's medical work was in a level II, Battalion Aid Station where the goal patients were stabilized from the front line and transferred to Combat Support Hospitals if necessary. The mechanism of injury that was most prevalent was from improvised explosive devices (IED's) and gunshots. On the side, Dr. Ehrlichman would treat injured Afghani children that were dropped off at the entry of the base by their parents. He and the other surgeons would don full body armor to pick up these children and treat their burns or contractures outside of the hospital before returning them to their parents.

"Difficulties are opportunities," was another quote by Dr. Jospeh Murray that resonated with Dr. Ehrlichman. During the COVID-19 pandemic, the Commonwealth of Massachusetts developed a field hospital, entitled Boston Hope, which was intended to house the overflow of 500 non-acute COVID patients to decompress the hospitals, as well as another 500 beds for homeless patients who tested positive for the virus. Partners Healthcare System agreed to operationalize this endeavor with General Hammond, Dr. Ehrlichman's former commander from Afghanistan, taking the lead in operations. Dr. Ehrlichman was tapped to be the head of Clinical Design and Operations.

The incident command team built the 1,000-bed hospital in the empty shell of the Boston Convention Center. Coordination was needed to bring basic plumbing into the building, create ambulance access, train providers on the electronic medical record, EPIC, and obtain and recycle personal protective equipment (PPE), which was in low supply. A staffing call went out to the Boston hospitals and ninety physicians from Partners, Beth Israel Deaconess Hospital, and Atrius Health volunteered to staff Boston Hope. Many nurses and other support staff, who were furloughed from their parent institutions for financial reasons during the pandemic, volunteered as well.

Over the three months that it was open in 2020, Boston Hope provided care for 700 acute patients who were recovering from COVID-19. A significant portion of these patients came from Boston's homeless population and half of all patients were Spanish speaking. This mission could not have been executed without the cooperation and collaborative spirit of the State of Massachusetts, the City of Boston, the Federal Government, the Military, and the Boston Medical Institutions.

Dr. Ehrlichman presided over the Boston Surgical Society during an unprecedented pandemic. He navigated the Society's meetings to an online platform, and not one event was cancelled due to COVID-19. He thanked his family and his wife, Nancy, for allowing him to serve both his medical community and his country. He acknowledged Dr. Murray's daughter, Jean, who was in the audience. Dr. Ehrlichman closed the night by thanking the Society for allowing him to serve as president, and for everyone who came out to the Harvard Club on this special night.

Respectfully submitted,

Claire Cronin MD, MBA

On a chilly spring night, 52 members of the Boston Surgical Society gathered for the Sixth Annual Case of the Year Presentations, at the Doubletree Inn in Cambridge. This meeting is one of the highlights of the Boston Surgical Society season, as seven representatives from the local teaching hospitals vie to present the most interesting surgical case of the year. Members came early, eager to see each other after a two year in-person hiatus. It was April 4, 2022, and the Boston Celtics were in the play-offs.

Dr. McAneny welcomed Dr. John Mullen, the Vice-President of the Boston Surgical Society, who in keeping with tradition, was the host of the evening. Dr. Mullen reviewed the rules of the evening: the order of the presentations was alphabetical by parent institution, there was one judge from each hospital, and the prizes were $1000 for first place, $750 for second, and $500 for third.

Dr. Claire Sokas from the Beth Israel Deaconess Medical Center was called up to the podium and the evening was off to a great start with her talk entitled, “Something Fishy in the Duodenum.” A 64 year-old female with a history of GERD presented to the emergency department with five days of abdominal pain. Her work up revealed a WBC of 19.6 and CT scan showed a loculated abscess cavity around the duodenum. She was first admitted for a trial of antibiotics, but the next morning a reread of the CT scan showed a liner hyperdensity in the first portion of the duodenum. The patient was questioned and admitted to eating fish a week prior. A laparoscopy confirmed a large abscess cavity anterior to the duodenum. The video of the procedure resulted in a loud round of “oohing” from the audience as a 3cm fishbone was extracted from the center of the abscess. The patient was discharged on the second post-operative day with the sound advice of being careful when consuming fish in the future.

“Massive Intra-abdominal Liposarcoma Leading to Colonic Herniation into the Pericardium with Resultant Cardiac Tamponade,” was the pithy title of Dr. Olivia Duhaime presentation from Boston Medical Center. A 40 year-old male with a history of schizophrenia, who had required a subxiphoid pericardial window three years earlier after walking into a train, presented to the emergency department with chest pain, shortness of breath, nausea, vomiting, constipation, and anorexia. On exam his heart rate was in the 150’s and his abdomen was noted to be quite distended. Chest X-ray revealed bowel in his pericardium, and the CT scan showed a large soft-tissue density in the abdominal cavity displacing the intestine into the chest. He was brought to the operating room for an exploratory laparotomy due to worsening hypoxemia. A 50 pound, grade I, liposarcoma was encountered in the abdomen and was removed along with the colon. With the mass out of the way, the small intestine, a portion of the liver, and omentum, were noted to have herniated through the old pericardial window. All his abdominal contents were reduced from the chest, and an end ileostomy was performed. Plans are being made to reverse the ileostomy in the near future.

Continuing with the sarcoma theme, Dr. Arin Madenci from Brigham & Women's Hospital presented "Measure Twice, Cut once: Resection of an IVC Leiomyosarcoma." A 72 year-old female presented with new bilateral lower extremity edema. An ultrasound revealed bilateral DVT's of the femoral veins. A CT scan identified a mass of the inferior vena cava measuring 10 x 4.7 cm with intraluminal thrombus involving the left renal vein. A biopsy unveiled a high grade leiomyosarcoma for which the patient received neoadjuvant chemotherapy. A surgical team, involving cardiac surgery, transplant surgery, and vascular surgery spent five months planning the operation. The liver was mobilized to expose the vena cava. The proximal margin was identified below the hepatic venous confluence and thus cardiac bypass was not required. The tumor was resected with clear margins and the vena cava was reconstructed with a graft. Her postoperative course was complicated by a chyle leak which resolved with TPN and a drain. The teaching point of this case lay in the multidisciplinary team approach, and extensive preoperative planning.

Boston Children's Hospital fellow, Dr. Woo Do took the podium to introduce his case, "Whiteout." A three-year-old male was transferred from a community hospital one week after falling of a bed with symptoms of shortness of breath. After diminished chest sounds were noted on the right, a CXR revealed complete opacification of the right lung. Ultrasound suggested hemothorax and the team at the community hospital decided to place a pigtail catheter under general anesthesia. No blood was forthcoming and subsequent CXR demonstrated whiteout of

both lungs. CT scan showed a large thoracic mass with mediastinal shift. Biopsy revealed a high-grade rhabdomyosarcoma on the spectrum of pleuropulmonary blastoma. The child was started on chemotherapy and transferred to Children's hospital. The tumor did not respond to systemic therapy, and surgical planning was undertaken. An extra-pulmonary approach was intended after removal of the fifth rib. The pleura was dissected off the chest wall and care was taken to mark the area where the tumor was adherent to the anterior chest wall with clips for radiation purposes. The lung and the tumor were removed. Air was installed through a three-way stopcock attached to the chest tube to prevent significant mediastinal shift over the first few days. The child received radiation to the chest wall. The key takeaways from this case are that solid tumor masses should be considered in the differential diagnosis for whiteout of the chest in children.

Dr. Jacqueline Anderson, from Lahey Medical Center, interesting case was entitled, "Bubble Trouble." The patient was an 82 year-old female who was recovering from orthopedic surgery for a femur fracture. She developed abdominal pain, and obstipation while taking her post-op narcotics. Her exam was significant for abdominal distention and tenderness. Plain films revealed a 15cm gas collection with some dependent fluid and debris. She was brought to the operating room for colonoscopy which noted linear streaks of ischemia in the mucosa of the cecum. The bubble was not identified but her abdomen was noted to be expanding in the operating room as the colon was insufflated. A midline laparotomy was performed, and a giant sigmoid diverticulum was identified with a narrow neck. The cecum was drawn into the mass and perforated on manipulation. A segmental excision of the sigmoid was not possible due to fusion of the small bowel mesentery and duodenum. The diverticulum was opened, and the mucosa fulgurated. The sigmoid defect was repaired primarily, and drains were left in place. An ileocecectomy with loop ileostomy was performed to protect the anastomosis. Giant diverticula usually present with chronic complaints and not acutely. In review of this patient's old films from other orthopedic operations, the start of the bubble trouble could be seen in 2020.

"Calcium and the Captain: Hyperparathyroidism at the MGH," was presented by Dr. Elizabeth Calle. A 75-year-old woman with a history of hypertension, hyperpituitarism, and primary hyperparathyroidism, who presented with hypercalcemia and dehydration. A CT scan identified a left superior parathyroid mass and a mediastinal mass consistent with a thymoma.

Her labs were significant for an elevated parathyroid hormone (PTH), and calcium levels. The left superior parathyroid was removed and frozen section was consistent with an adenoma, however her intra-operative PTH levels did not decrease. The right superior parathyroid was removed and pathology was consistent with a hypercellular gland. Biopsy of the right inferior gland also revealed hypercellular tissue, however her PTH remained elevated. The left neck was re-explored, and no inferior gland was identified. Post-operative aspiration of the mediastinal mass revealed a PTH level over 5,000. A robotic assisted left thoracotomy was performed, and pathology revealed an intrathymic parathyroid cystic adenoma. Upon removal, her PTH returned to normal. The incidence of a mediastinal parathyroid gland is low. A Massachusetts General Hospital surgeon, Dr. Cope, first described the resection of a mediastinal parathyroid gland in the 1930's on a Captain Martel, who had been hospitalized for two years for loss of stature. It took the team seven operations to identify that the parathyroid adenoma was in the thymus.

The final presentation was a *Lord of the Rings* themed talk from Tufts Medical Center, entitled "The Two Towers." Dr. Min Suk "Sam" Han introduced his male patient of 63 years, who presents with five days of nausea, vomiting, and obstipation. He was distended but soft with mild tenderness. His past medical history was significant for a car accident at the age of 19 that required two right sided chest tubes. The CXR shows bowel loops with air fluid levels in the right chest. CT scan demonstrated a large right sided diaphragmatic hernia with the entire liver, small bowel, colon, and omentum in his chest cavity. There were two transition zones causing a bowel obstruction, and he was admitted for conservative management—a shout of laughter ensued from the crowd—until an operative plan was developed. There was a *fellowship* of thoracic, trauma, and anesthesia providers who gathered to plan the procedure. The team started laparoscopically, dividing adhesions until the small intestine could be reduced. A second *tower* was brought in and a thoracoscopic approach was used for the chest dissection. The reduction of the liver required a thoracotomy, and the diaphragm was closed with Gortex mesh.

The judges excused themselves to tally the votes. Dr. Mullen took the podium to announce the winders. As a surgical oncologist, he was delighted with the number of sarcomas presented. Third place was given to Olivia Duhaime MD from Boston Medical Center for "Massive Inra-abdominal Liposarcoma Leading to Colonic Herniation into the Pericardium with

Resultant Cardiac Tamponade." Dr. Sam Han from Tufts Medical Center was awarded second place with "The Two Towers," making this their third year in a row in the winner's circle. The honor of most interesting case for 2022, was given to Dr. Woo Do from Boston Children's Hospital for the second year in a row. Dr. Mullen thanked everyone and invited everyone back again in a year's time.

Respectfully submitted,

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