



World Society for Reconstructive Microsurgery



L. Scott Levin, MD, FACS
President WSRM.

Message from the editor

As I write this, I reflect on the theme of the WSRM meeting -“Looking back-Surging ahead” and pause to reflect on my own training and surgical practice over the last 32 years. In 1982, when I began my training, there were no cellphones. We carried bulky pagers and were “paged” for inpatient care issues. The pagers required frequent battery changes. These pages required a return phone call to a number, and hopefully the individual who dialed the page was there to speak to you about the issue. The conversation subsequently resulted in a physician evaluation of the patient at the bedside, and ultimate decisions regarding therapy were made based on the physical examination and history of events provided by the patient and/or the nursing staff.

Much has changed over three decades. There are work hour restrictions for residents in many countries. Patient handoffs and sign-out of patients to those less familiar with the course of a patient are now the rule. Physician “assistants” and advanced nursing practitioners may evaluate and treat the patient directly, without the participation of a physician. Continuity of care in many instances has been compromised, often without demonstration of improved surgical outcomes despite fewer hours of duty. We can instantly send a digital image of a radiograph, arteriogram, injured face, mutilated extremity, or a flap that appears congested. We can obtain real-time face-to-face advice on procedures or complications from a senior microsurgical colleague on the other side of the world using WSRM’s forMD, Skype, iCHAT or facetime.

We can determine tissue viability by use of implantable probes that can measure physiologic parameters and provide auscultable signals for blood flow. The microsurgical reconstructive ladder has added many rungs, and we now live in a new era of restorative surgery. And, in time, perhaps certain reconstructive procedures may even become obsolete – replaced with primary Vascularized Composite Allotransplantations. I remember the controversy over the concept of the emergency free flap or immediate toe-to-hand transfer. These now time honored procedures in select patients? History is likely to repeat itself. Witness our evolution from the routine use of large myocutaneous flaps to the preference of many using perforator flaps for a variety of reconstructive needs. As members of the WSRM, we carry the torch of passion for reconstructive microsurgery. We are the keepers of its flame. As the late President John F. Kennedy stated in his inaugural address in 1962, “The torch must be passed to the next generation.”

Just a few days ago, I was performing a Thoracodorsal-Artery Perforator flap to a diabetic ankle wound. The case went well, and I was pleased that a new group of residents and fellows were able to participate and learn from all of the mistakes I have made and those that other colleagues have shared with me over many years, often at WSRM meetings over a cup of

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coffee or in a lecture hall. However, those mistakes were hidden from the view of my trainees in many ways. Patient positioning, communication with anesthesia colleagues, step-by-step flap elevation, attention to detail and technique during vascular anastomosis, and careful and precise flap inseting seemed to them routine and resulted in an efficient operation and a healthy flap on exit from the operating room. Despite doing things the right way, microsurgical success is usually an assumption, but not always a guarantee. Just two hours after leaving the operating room, the arterial signal from our flap was lost. The initial anastomosis was performed to the posterior tibial artery. My immediate evaluation of the patient (at the bedside) demonstrated flap ischemia.

Urgent return to the operating room revealed a clotted posterior tibial artery. Based on the perfusion pressure after a Fogarty catheter was used to clear the thrombosis, I felt that it was unwise to re-establish inflow from this source vessel. Looking back over my experience and knowledge, it was clear that a 15 cm vein graft from the dorsalis pedis artery (end to side) to the flap pedicle would be required to reestablish arterial inflow. We surged ahead, arterial inflow was reestablished and the flap survived! The moral of this particular story is that we can only surge ahead and create new knowledge for others, by looking back and not forgetting our past. And we must share this history in person – not only on a blog or in a chat room. Experience comes from bad judgment, and good judgment often follows bad experiences. As microsurgeons we hate to fail, and have tremendous determination and grit that often saves a dire situation. Sometimes we just have to “will” the flap to survive!

The WSRM was founded in 1999 by combining the International Microsurgical Society and the International Society for Reconstructive Microsurgery. The goal at that time was to create one microsurgical international organization that was open to the world for scientific exchange, camaraderie and professional support for its membership. Looking back, the world was a different place. Our international microsurgical pioneers were still “raising” their microsurgical offspring. Three decades had passed since the report of Susumo Tamai’s first report of thumb replantation (1968). Many of our leaders were alive then and still surging ahead.

The first hand transplant had just been performed (1998). However, the impact of the tragedy of 9-11, the economic instability of our global economy, the political shifts and challenges to democracy and world health burdens have caused many of us to take pause. How do we as members of the WSRM assure that we continue to look back and acknowledge our past, but surge ahead and face the many challenges that I have just described? We have a

responsibility and an obligation to surge forward. As our microsurgical prowess has exponentially expanded, we must pass it on to the next generation of WSRM members, and provide access to our society benefits that include not only professional support and value, but a personal connection to young colleagues around the world who live or want to live “under the microscope” and have passion for microsurgery. Our work ethic and commitment result in remarkable success rates. Knowledge of very complex and technically demanding operations that benefit our patients must be passed on to the next generation so that in time they can build on established techniques and then become innovators.

To have this occur without prejudice or barrier, we must find a way to open WSRM to the entire world, and not just those who can afford 200 US dollars in dues. I am currently reaching out to colleagues around the world and with leadership in Plastic Surgery, Orthopaedic Surgery, Neurosurgery, Otolaryngology, Urology, Hand Surgery and Microsurgery organizations, to request support for their national society and specialty members who will benefit from WSRM membership, but cannot join due to individual financial constraints – particularly in underserved countries. I firmly believe that our society’s future is dependent on inclusion and not exclusion.

We are the World Society for Reconstructive Microsurgery and will surge ahead to include all and leave no surgeon behind who seeks our WSRM society benefits and offering of friendship. I look forward to seeing you all in Mumbai. Bring a friend. Bring someone young. Bring someone that you know will benefit from a unique and engaging scientific program organized by my friends Raja Sabapathy and Samir Kumta. Our meeting in India will result in an inspiring exchange of cultures, karma, ideas and scientific dialogue respecting all viewpoints. I hope you will enthusiastically join me in passing the baton of knowledge and microsurgical karma to someone you do not know. Together, we will look back while surging ahead. I look forward to seeing you in Mumbai. Thanks for your support.

L. Scott Levin, MD, FACS

Editor - in - Chief, President



Liaison Update

North American Update

By Matthew M. Hanasono, MD, WSRM North American Representative

Microsurgery Fellowship Match



The Microsurgery Fellowship Match sponsored by the American Society for Reconstructive Microsurgery (ASRM) was established in 2010 with the goal of coordinating fellowship appointments. The participating programs do not make appointments until the match has been completed. Therefore, the Microsurgery Fellowship Match results in participating programs conducting interviews for fellowship applicants during the same timeframe and provides prospective fellows with a chance to visit multiple training programs without being forced to commit to a fellowship before all visits are complete. The Spring match date allows applicants to secure a fellowship position at an earlier time over 12 months from the conclusion of residency

training. The most recent match took place on May 22, 2014. Any post-match vacancies were released to applicants who did not match on the following day, providing them with another opportunity to apply for fellowship training. Currently, over 25 programs participate in the Microsurgery Fellowship Match. More information can be found on the ASRM website: <http://www.microsurg.org/fellowships/match/>. Starting January 5, 2015 fellowship applicants will be able to register for the next fellowship match, which will occur in the Spring of 2015 for fellowships starting in June 2016.

ASRM 2015 Annual Meeting

Registration is now open for the ASRM 2015 Annual Meeting. The Annual Meeting will be held in the beautiful Bahamas, at the Atlantis Resort on Paradise Island. Goetz Giessler, MD, and Steven L. Moran, MD, are the program chairs. The theme for this year's meeting will be "Artistry in Microsurgery: A Celebration of Innovation," showcasing the art and creativity within our specialty. International speakers from Europe and Asia have been invited to provide a global perspective on topics ranging from perforator flaps to resident education. This year's meeting will continue the tradition of featuring always entertaining Best Case/Best Save forum as well as introduce the Old Turks/Young Turks SmackDown where seasoned veterans and individuals from the Young Microsurgeon's Group will face each other in a lively, good-spirited competition to see who can be the most creative in solving complex reconstructive problems. The program will also feature cutting-edge updates from the American Society of Lymphatic Surgery (ASLS) as well as the American Society for Reconstructive Transplantation (ASRT). More information can be found by visiting: <http://www.microsurg.org/events/meetings>.



Welcome to WSRM 2015

5 good reasons for you to come

- 1. A Great list faculty:** It will be a meeting of the 'Who's Who' of microsurgery. A wonderful opportunity to meet the masters and get inspired.
- 2. A Great Scientific treat awaits you:** President's lecture on the theme of 'Looking back and surging ahead', three theme lectures, the inaugural S & T lecture by Ian Taylor, 12 master classes, 30 symposia, 'my most challenging case', by experts and free papers.
- 3. A great venue:** Grand Hyatt at Mumbai is the perfect venue for the congress.
- 4. Great Value for money:** This congress has a low registration fees and accommodation at the venue is a great value for money.
- 5. A Dedicated Organizing team:** We are doing everything possible to make it a congress to remember.

A pre-congress video workshop of 'Must see videos', by acknowledged experts in the field on the morning of 19th March, 2015 (separate registration required).

For details visit the website www.wsr2015mumbai.com
Bring your family along. We guarantee them a good time.

Dr L Scott Levin
President - WSRM

Dr S Raja Sabapathy
Organising Chairman - WSRM 2015

Dr Samir Kumta
Chair-Scientific Committee

Dr Rajendra Nehete
Organising Secretary

Dr Vinita Puri
Congress Co-ordinator

Liaison Update - *continued from pg 3*

The 2nd APFSRM in Buyeo, Korea 2014

The 2nd meeting of Asian Pacific Federation of Societies for Reconstructive Microsurgery (APFSRM) was held at the Lotte Resort & Hotel in Buyeo, the beautiful historic place in Korea, on July 3-5, 2014. APFSRM, the biennial conference, was first organized in Singapore, in year 2012. The 2nd scientific meeting was announced to all Asian countries, and it is now one of the most important conferences on reconstructive microsurgery in Asia.

The 2nd meeting of APFSRM was organized with 11 plenary lectures, 10 instructional courses, 14 invited sessions, 16 free paper sessions, and 27 posters. Three hundred fourteen participants from 23 different countries, including Middle East and Central Asia, joined in and contributed to the meeting. The scientific sessions were designed to reflect various topics on recent advances in microsurgery. The meeting provided great opportunities for all the participants, not only to exchange the latest knowledge, but also to share their scientific backgrounds and far advanced techniques in the field of reconstructive microsurgery.

On behalf of the organizing committee, the president of the APFSRM, Professor Kyoung Moo Yang, and the chairman of the scientific committee, Professor Jeong Tae Kim, expressed their appreciation to those who participated in the 2nd APFSRM meeting. The attending 23 national delegates, including Professor David Chwei-Chin Chuang, the next president of WSRM, Dr. Kazuteru Doi, the past president of WSRM and Dr. Soo Heong Tan, the past president of 1st APFSRM, voted and decided that the 3rd APFSRM meeting will be held in Beijing, China two years later.



Group photo with all the attendees at the sunny outside of the venue



Delegates photo contributing the 2nd APFSRM in Buyeo, Korea 2014

Interesting Cases

Free Flap Reconstruction of the Abdominal Wall: When Mesh is not Enough

Ventral hernias are a commonly encountered clinical condition occurring after elective laparotomy with a high frequency (1). Massive ventral hernias can also arise after severe abdominal trauma or intra-abdominal sepsis in patients who are treated with damage control laparotomy technique (2,3). This technique leaves the fascia and the soft tissue envelope of the abdomen open while the patient is treated for their injuries. The underlying visceral block is then skin grafted, allowing the patient to recover and perform their hernia repair in an elective fashion six months to one year later.

Increasingly, reconstructive surgeons are asked to assist in the repair of these large ventral defects. It can be challenging to achieve soft tissue coverage over the underlying mesh reconstruction of the fascia in patients with massive defects. Many of these patients will also have the need for concomitant intra-abdominal procedures. Poor soft tissue coverage over the mesh reconstruction can be problematic and lead to hernia recurrence (4). At the University of Pennsylvania, we have used free tissue transfer to overcome the challenge of soft tissue coverage of the abdominal wall to assist in the reconstruction of these patients.

We describe a 29-year-old patient with multiple penetrating injuries to the abdomen and pelvis. He was treated with emergent laparotomy and ultimately underwent skin grafting to his underlying viscera following the damage control approach to severe intra-abdominal trauma. He was left with a massive defect of his abdominal wall (**Figure 1**). He recovered from his injuries, and a year later underwent elective repair of this massive defect. His fascia was reconstructed with biologic mesh secondary to concomitant repair of an enterocutaneous fistula.

His soft tissue reconstruction of his abdominal wall was achieved with a free ALT flap with anastomoses to his left inferior epigastric vessels and the fascia of the flap inset on top of the mesh (**Figure 2**).

He recovered uneventfully and has a stable abdominal wall reconstruction at one year follow up without hernia recurrence (**Figure 3**).

Massive defects of the abdominal wall can be challenging to reconstruct. Lack of soft tissue can be difficult to overcome. We have used microsurgical flaps with good results as illustrated in our case to assist in the reconstruction and rehabilitation of these challenging patients. Free tissue transfer should be considered an important tool in the treatment of these patients.

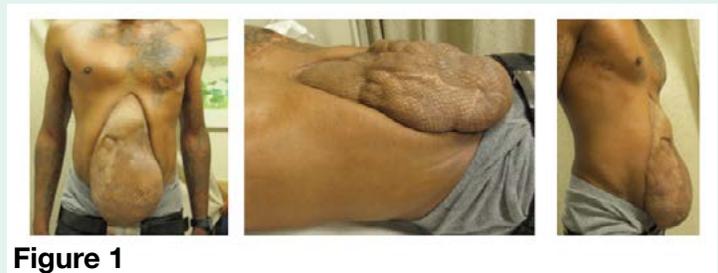


Figure 1



Figure 2



Figure 3

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Interesting Cases

Ongoing Gracilis Myocutaneous Flap Functioning Free Muscle Transplantation

Provided by: David Chwei-Chin Chuang, MD¹ (professor), Tommy Nai-Jen Chang, MD¹, (clinical fellow) Aleksandra M. McGrath MD, PhD^{1,2} (clinical fellow)

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Classification:

Challenging case, not resolved yet, needs your suggestion
Challenging case, already resolved, needs your comments

Purposes:

Ongoing gracilis myocutaneous flap functioning free muscle transplantation (FFMT) for elbow flexion and finger extension, the recipient vessels (pectoral branch of thoracoacromial vessel) the artery was filled with thrombosis, the way to resuscitate the flap and the flap survived finally and the patient discharged smoothly.

History Summary:

1. 24 Y/O, left brachial plexus injury (BPI), had nerve reconstruction previously, subclavian artery segmental thrombosis, radial pulsation (-), plan to do gracilis FFMT for elbow flexion and EDC, innervated by XI. No preoperative angiography.
2. Intraoperatively,
 - (1) Thoracoacromial artery and nearby vein were explored (usually four branches are present: clavicular, pectoral, acromial and deltoid) (Fig. A)
 - (2) Initially, in the recipient site, the pectoral branch superficial to pectoralis minor muscle was selected. The patency test with jeweler's forceps and spurting from one of the side branches indicated sufficient antegrade blood flow.
 - (3) In the donor site, the right gracilis myocutaneous flap was harvested. It had two arteries and two veins of the same size conjoining proximally (Fig. B).
 - (4) The pectoral branch was anastomosed to the gracilis artery, but no venous outflow was observed.
 - (5) The artery anastomosis was divided and there was no bleeding from the pectoral branch, although it was still pulsating.
 - (6) Multiple thrombi were observed in the lumen of the pectoral branch, which was irrigated several times with diluted heparin solution (0.1ml in 500ml normal saline). All visible thrombi were tried to remove but

difficult. The vessel was segmentally resected proximally until 1 cm from the branching point. It was still filled with thrombosis plugs

- (7) The pectoralis branch was abandoned and the acromial branch was instead selected. The clavicular branch was ligated to mobilize the pectoral branch. It became short for anastomosis.
- (8) The gracilis had two arteries joining proximally. One of them was ligated distally (close to the muscle), and reversed and anastomosed to the acromial branch (Fig. C) without need of vein graft.
- (9) Given up the pectoral branch vein. Dissected the basilar vein distally, transected and transferred proximally to anastomose the the conjoined gracilis vein.
- (10) The recipient artery continued to be prone to spasm. Extensive stripping of the adventitia on both sides of the anastomosis was done. Additionally, repeated heparin bolus (0.4ml, 2000IU) was given for four times. Each time heparin bolus was given, the blood flow improved.
- (11) Postoperatively, the heparin boluses were continued, 0.4ml (2000IU) in each 500ml lactate ringer, with total 12,000IU /day) for the next 4 days. The postoperative period was uneventful and the flap survived without any local complications (Fig. D).



Fig. D

Keys for the flap success

- avoiding any compression along the course of the thoracoacromial vessels (sample space was obtained by creating a trough in the pectoralis minor muscle) (Fig C)
- copious, repeated flushing of the intentionally left longer pectoral branch with diluted heparin, which could indirectly dilating the collateral branches, or subclavian artery.
- leaving a length of the pectoral branch (1 cm in length) to attract the potential new thrombi (Fig. 1C).
- choosing another, thrombus-free branch for anastomosis,
- repeated injections of heparin bolus (0.4ml, 2000 IU) intra- and postoperatively
- heparin infusion (2000 IU in each 500 ml Ringer solution (12,000IU/day to 24.000IU/day is OK) for at least 2 days; controlled with APTT test frequently in the range of 1.5-2.0).

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Interesting Cases - continued from pg 6

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1. Chuang DCC. Gracilis flap. In: Wei FC, Mardini S. Flaps and Reconstructive Surgery. Philadelphia: Saunders; 2009:395-408.

Fig 1.

- A - type III gracilis pedicle with two vessels of the same size conjoining proximally.
- B- branching pattern of thoracoacromial artery (T-A artery).
- C- the schematic representation of the final anastomosis.

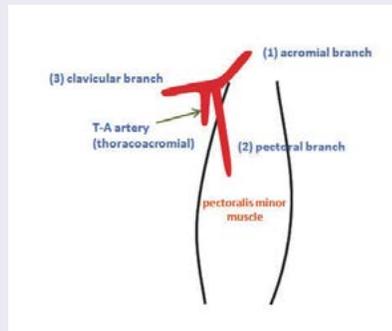


Figure A

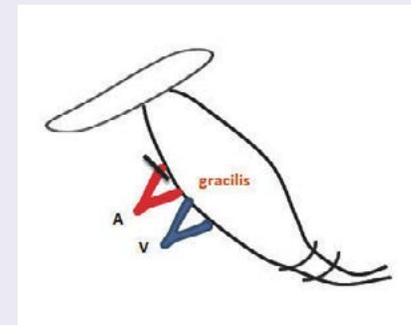


Figure B

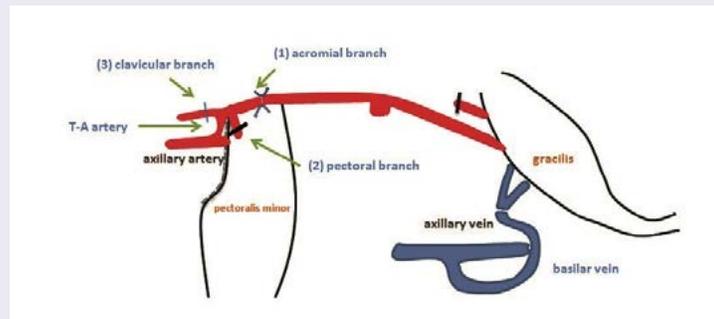


Figure C

2014 WSRM New Members (as of November 1, 2014)

Active Applicants

Ajay Chauhan, MBBS, FRACS	Australia
Vinay Jacob, MS, M Ch, DNB	India
Anh H. Nguyen, MD	United States
Jaime Pachon Suarez, MD	Colombia

Candidate Applicants

Manish C. Champaneria, MD	United States
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Journal of Reconstructive Microsurgery

The *Journal of Reconstructive Microsurgery* serves as the official journal for the World Society for Reconstructive Microsurgery. We have had a very successful transitional year as the Editor-in-Chief position has been passed from Peter Neligan, MD to Bernard Lee, MD.

We have had two successful initiatives in conjunction with the WSRM 2013 meeting. In July, we published a collection of scientific papers presented at the meeting held in Chicago. In September, we published a Special Topic issue from a panel at the meeting entitled, "Flaps, Flaps, Flaps." Guest edited by Joon Pio Hong, MD, this issue focused on communicating new ideas about flap design.

The authors represent the latest advances in reconstructive surgery, and are all making valuable contributions to the field. These two issues strengthen the relationship between WSRM and JRM, and we hope to continue these collaborations in the future. We have had a number of very highly downloaded manuscripts, in particular "The Use of Magnetic Resonance Angiography in Vascularized Groin Lymph Node Transfer: An Anatomic Study" by Joseph H. Dayan, MD et. al., published in the first issue of 2014. This paper has already become one of the most requested papers of the year and features important work in the field of functional lymphatic surgery.

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Journal of Reconstructive Microsurgery - *continued from pg 7*

We have a Special Topic issue on Lymphedema planned for the upcoming year, with guest editor Jaume Masia, MD.

The Journal of Reconstructive Microsurgery is a peer-reviewed, indexed journal that provides an international forum for the publication of articles focusing on reconstructive microsurgery and complex reconstructive surgery. WSRM members have free access to the journal as part of their membership. If you have any questions about access please contact the publisher directly at graham.brumfield@thieme.de.

The journal welcomes original articles, short reports, controversial topics, book reviews, and letters to the Editor, in order to complete the balanced spectrum of information available in the Journal of Reconstructive Microsurgery.

Submit your paper here:
<http://mc.manuscriptcentral.com/jrm>

Bernard Lee, MD
Editor



WSRM Endorsement Microsurgery Seminars, Meetings & Workshops Worldwide

WSRM is making an effort to show its support of the various microsurgery activities and meetings that take place around the world. Please visit www.wsrn.net to view the endorsement guidelines. A formal request must be submitted addressing the guidelines stated and your qualifications. The WSRM will not endorse a meeting within the same region and within one year of the biennial congress. The WSRM will only endorse national meetings.

Mark Your Calendar



2015 WSRM World Congress

March 19 - 22, 2015

Mumbai, India

www.wsrn2015mumbai.com

2017 WSRM World Congress

June 15-18, 2017

Seoul, Korea

www.wsrn2017.com

2019 WSRM World Congress

Summer 2019

Shanghai, China

Global Meetings*

*The posting of these meetings does not define the WSRM as a sponsor or endorser.

American Society for Reconstructive Microsurgery

January 24-27, 2015

Paradise Island, Bahamas

www.microsurg.org

26th Annual EURAPS Meeting

May 28-30, 2015

Edinburgh, United Kingdom

<http://www.euraps.org/meetings/>

13th EFSM Congress

April 21-24, 2016

Antalya, Turkey

www.efsm2016.org



News from the Executive Council

2013 - 2015 WSRM Committee Roster

Congress Organizing Committee

Raja Sabapathy, MD, Host Chairman
Gautam Biswas, MD
Samir Kumta, MD
Ravi Mahajan, MD
Rajendra Nehete, MD
Ashok Koul, MD
Vinita Puri, MD

Membership Committee

David Chwei-Chin Chuang, MD, Chairman (Taiwan)
Raja Sabapathy, MD (India)
Peirong Yu, MD (USA)
Joon Pio Hong, MD (Korea)
Hung-Chi Chen, MD (Taiwan)

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Marco Innocenti, MD (Italy)
Chih-Hung Lin, MD (Taiwan)
G. Balakrishnan, MD (India)

Constitution and Bylaws Committee

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Batia Yaffe, MD (Israel)
Damien Grinsell, MD (Australia)
Katerina Vlastou, MD (Greece)
Michael Zenn, MD (USA)

Know someone who wants to become a member?

The application process is simple, and applications can be obtained at www.wsrn.net and submitted via email, mail or fax to the Central Office. Applications are accepted and reviewed on a continual basis, so we encourage applicants to submit the information as soon as possible to start taking advantage of the membership benefits.

World Society for Reconstructive Microsurgery

Fall / Winter 2014 - Volume 5 / Issue 6

Purpose

The object of the Society shall be to stimulate and advance knowledge of the science and art of Microsurgery and thereby improve and elevate the standards of practice in this field of surgical endeavor. The Society shall be the highest medium of recognition in the field of Microsurgery as evident by superior attainment and by contribution to its advancement. It shall provide an international forum for the exchange of ideas and the dissemination of innovative techniques.

L. Scott Levin, MD, FACS
Editor-in-Chief, President

Kazuteru Doi, MD
Isao Koshima, MD
Associate Editors

Krista A. Greco
Executive Director

The WSRM Newsletter is published two times yearly for members of WSRM, a non-profit organization. Subscriptions are included in the annual membership dues. All correspondence, address changes, and news for upcoming events should be addressed to:

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