



World Society for Reconstructive Microsurgery



David W. Chang, MD
President WSRM

Message from the Editor

It is my great honor to serve as the next President of WSRM for 2019-2021. I would like to congratulate and thank Dr. Isao Koshima for his leadership and vision over the past 2 years as the President of WSRM. It has been 20 years since the WSRM was created by the merging of two international societies, the IMS and ISRM, in 1999. The first Congress was in 2001 in Taipei with Dr. Victor Meyer as the President and Dr. Fu-Chan Wei as the Chairman of the Congress. WSRM has grown tremendously over the past 20 years, thanks to hard work and leadership of previous leaders and our members.

We once again had a very successful meeting at Bologna, Italy from June 12-15, 2019 with over 1600 participants from 65 Countries attending the meeting. I would like to congratulate and thank Congress Chairman Dr. Georgio DeSantis and Scientific Program Chair Dr. Marco Innocenti for endless hardwork and leadership for organizing a very successful meeting.

The future of our organization and our field depends on our younger generation of reconstructive surgeons. We need to create opportunities for leadership experience and to help develop young members into future leaders of the organization. It is important for us to continue to collaborate with regional and local organizations and to look for new opportunities for our members to advance the art and science of microsurgery and complex reconstruction. It is critical to WSRM's mission to continue to support education programs such as Research Grants, Travel Grants, and the Visiting Professor Programs. To provide these great opportunities we need strong support from our members.

I look forward to working with you for next 2 years to make WSRM even better than before. Please join me in congratulating Dr. Eric Santamaria and the Co-Chairs of Program Committee, Drs. Javier Lopez and Alex Cardenas for hosting and organizing our next meeting in beautiful Cancun, Mexico from June 9-12, 2021. I would encourage all members to work with them and to provide necessary support to help make this best meeting ever.

Sincerely,

David W. Chang
WSRM President, 2019-2021

In this edition

Invitation Message to
WSRM 2021 2

Interesting Cases 3

A Case Study 7

WSRM 2019
in Bologna 9

Meetings Around
the World 10

Mark Your Calendar 13

2019 - 2021
Executive Council 14

2019 - 2021 WSRM
Committee Roster 14



Eric Santamaria, MD
WSRM 2021
Congress Chairman

Invitation Message to WSRM 2021

Dear Microsurgeons from Around the World, Colleagues And Friends:

On behalf of the organizing committee of the 11th congress, of the World Society for Reconstructive Microsurgery it is a great pleasure to inform you that we are very advanced in all the preparations of our next congress that will take place in Cancun, Mexico, from June 9 to 12, 2021.

After the great success of the last two WSRM congresses in Seoul, South Korea and Bologna, Italy, it is clear that there is a growing worldwide interest in Reconstructive Microsurgery and this Society has grown by leaps and bounds. Our biannual congress is the most important scientific event at international level, and therefore we are putting all our effort into organizing an unforgettable meeting, with the participation of the majority of microsurgeons from all corners of the world.

We are aware that previous conferences have set high standards that must be continued and improved and therefore we are delighted to work very hard to develop a first class scientific program and present cutting-edge science and practice that will allow WSRM members and colleagues to return to their countries with relevant information. In addition to embracing new technology and innovations, at this meeting we will focus also on investing in the future generation of reconstructive microsurgeons

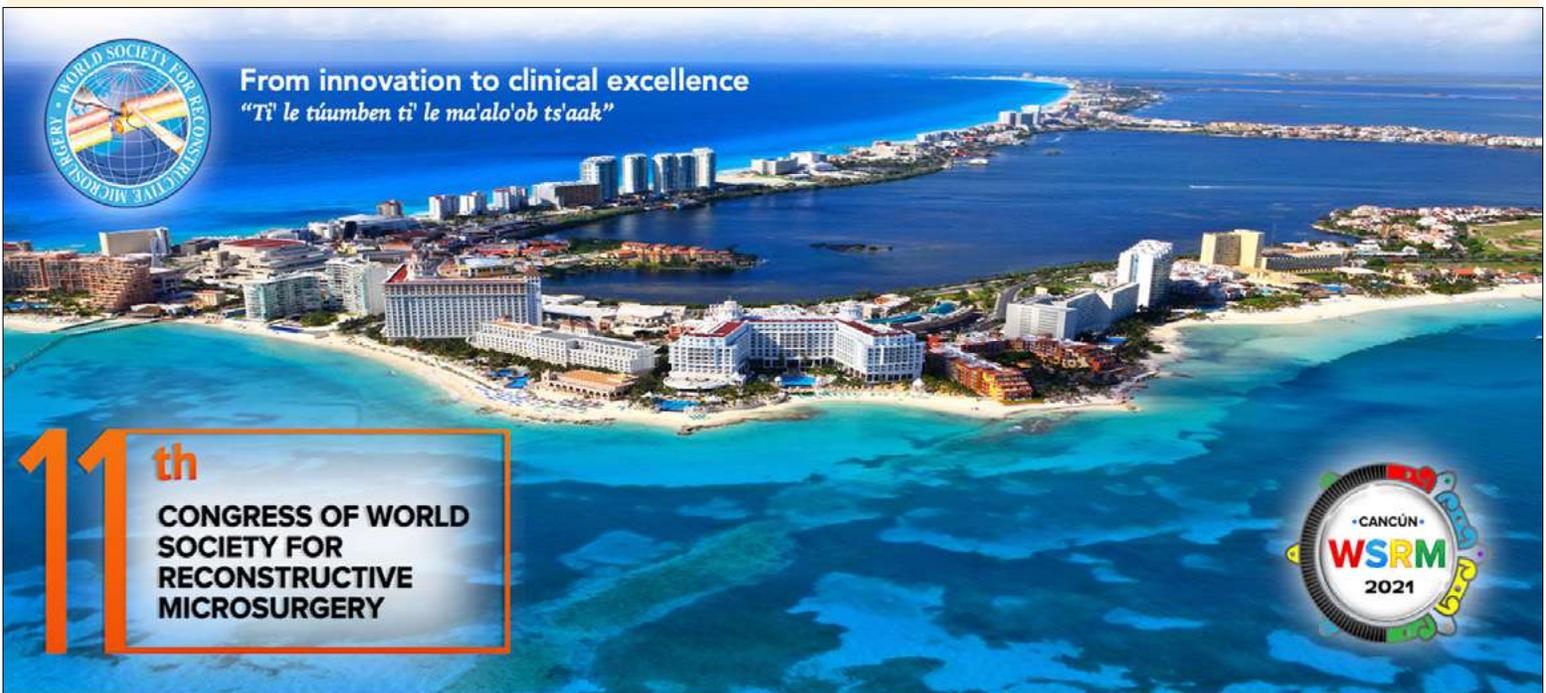
throughout the world, the role of social networks in our practice, women in microsurgery, and there will be multiple competitions in practical skills and oral and poster presentations among others.

Cancun is one of the main tourist destinations in the world with easy access and an experienced world class congress venue. Our congress will take place at Cancun International Convention Center which is a modern, compact building by the sea, centrally located in Cancun, within walking distance of the main hotel district. The place will comfortably house WSRM requirements under one roof, with ample space for exhibitions and meetings very close to each other.

Cancun is the new face of Mexico. With a strategic location in the Yucatan peninsula, it is a very safe destination with a truly multi-cultural ambiance. Our social program includes carrying out multiple activities so you can enjoy our traditions, world famous cuisine and above all the warmth of our people. Together with your family, you can visit our Mayan archaeological sites and natural wonders; have fun in any of the several nearby amusement parks or simply in the Caribbean Sea, famous for its turquoise waters and white sand beaches

Looking forward to welcoming all of you to Cancun, Mexico in 2021 for an exciting WSRM congress!!!

Eric Santamaria, MD
WSRM2021 Congress Chairman
www.wsr2021.com



Interesting Cases

Simple Yet Functional Reconstruction for Unilateral Total Maxillectomy Defect Using Antero Lateral Thigh Free Flap

Author: Parintosa Atmodiwirjo, MD, Sara Triatmoko, MD, M. Rachadian Ramadan, MD, Maryam Nur Arina, MD

From: Reconstructive Microsurgery Section, Division of Plastic Surgery, Dr. Ciptomangunkusumo National Hospital, Faculty of Medicine, Universitas Indonesia, Jakarta, Indonesia

HISTORY

- A 55-year-old patient complained of an increased mass in the left maxillary area since ten months ago.
- Biopsy showed the non-keratinizing squamous cell carcinoma of the left nasal cavity.
- CT-Scan revealed a solid mass with malignant necrotic components in the left maxilla with extension to the nasal cavity, ethmoid sinuses, left frontal sinuses, and bone destruction.

PROBLEM LIST

- Expected large mass volume deficit which includes skin, mucosa, bone and soft tissue (Figure 1) and causes similar defect to the type IIIB defect of Cordeiro and Santamaria classification.¹
- Defect of the orbits requiring closure and base creation for future prosthesis placement.
- The need to separate oral and nasal passages, including sinuses, to ensure proper function of swallowing, breathing, and speech.
- The requirement of vascularized bony reconstruction to the maxilla for future placement of osseointegrated dental implants.
- Limited option to only a single free flap reconstruction due to: limited surgery times for excision and primary reconstruction, limited coverage of the insurance, the possibility of loss to follow up due to patient lives in far rural areas.
- The patient planned for radiotherapy.

PLANNING AND SURGERY

- Planned for total maxillectomy, left eye exenteration, and primary reconstruction using Antero Lateral Thigh (ALT) free flap.
- The defect was reconstructed with fasciocutaneous ALT free flap. The size of the skin paddle was 14 cm x 9 cm x 0.5 cm.



Figure 1. Preoperative and intra-operative pictures



Figure 2. ALT free flap planning and post-operative pictures.

- ALT free flap was insetted to reconstruct the palatal wall, lateral nasal wall, and orbital skin. The remaining skin of ALT was deepthelialised to add more bulk and obliterate the total maxilla defect.
- Recipient artery is superior thyroidal artery while the recipient's veins are external jugular vein and facial vein.

DISCUSSION

- Since the patient only amenable for a single free flap with limited surgery time, fasciocutaneous ALT free flap was chosen. This will provide good alternatives to myocutaneous rectus abdominis flap a proposed by Cordeiro and Santamaria.^{1,2}
- In author opinion, the fasciocutaneous ALT will provide a sufficient soft tissue volume with less morbidity compared to myocutaneous rectus abdominis flap.

Interesting Cases - *continued from pg 3*

- The need to separate oral and nasal passage, to ensure proper function of swallowing, breathing, and speech were achieved.
- Since no bony reconstruction was performed for the maxilla, the future planning for dental prosthesis and the goals for good aesthetic results were ultimately sacrificed.
- However, in the future, the patient will be able to function normally and do the necessary activities like eating, drinking, and speaking.
- Since there are high possibilities of cancer recurrence and patients planned for radiotherapy, it is wise not to “burn the bridges” by pushing to do definitive bony reconstruction.
- The author sincerely hoped that the patient would come back for further reconstruction with vascularized bone flaps and further flap refinements.

REFERENCES

1. Cordeiro PG, Santamaria E. A classification system and algorithm for reconstruction of maxillectomy and midfacial defects. *Plastic and reconstructive surgery*. 2000;105(7):2331-46; discussion 47-8.
2. Hanasono, M. M., Matros, E., & Disa, J. J. Important Aspects of Head and Neck Reconstruction. *Plastic and Reconstructive Surgery*. 2014;134(6), 968e–980e.

Thoracic Outlet Syndrome with Compression of Subclavian Artery, Vein and Brachial Plexus Following Axillary Lymph Node Dissection and Radiation

Author: Shao-Yun Hsu, MD¹; Nai-Jen Chang, MD¹; Ming-Huei Cheng, MD, MBA, FACS^{1,2}

From: ¹ Division of Reconstructive Microsurgery, Department of Plastic and Reconstructive Surgery, Chang Gung Memorial Hospital, Taoyuan, Taiwan

² Center for Tissue Engineering, Chang Gung Memorial Hospital, Taipei, Taiwan.

Corresponding to:

Ming-Huei Cheng, MD, MBA, FACS
Division of Reconstructive Microsurgery,
Department of Plastic Surgery,
Center of Lymphedema Microsurgery,
Center of Tissue Engineering,
Chang Gung Memorial Hospital,
Adjunct Professor, Section of Plastic Surgery,
The University of Michigan.
5, Fu-Hsing Street, Kueishan, Taoyuan 333, Taiwan
Tel. 886-3-3281200 Ext. 3355
Fax. 886-3-3972681 E-mail: minghueicheng@gmail.com

A CASE REPORT

A 60-year-old female was a victim of right breast recurrent invasive ductal carcinoma underwent modified radical mastectomy and right axilla lymph node dissection without reconstruction and followed by radiation therapy since 18 months ago. She developed right upper limb lymphedema and brachial plexus injury. At physical examination, right clavicle fracture with severe chest wall scar contracture, and decreased radial artery pulsation were noted. Computer tomography revealed right clavicle osteoradionecrosis, right thoracic outlet syndrome (TOS) with compression of subclavian artery and vein. Lymphoscintigraphy revealed right upper extremity lymphedema. Removal of right necrotic clavicle, neurolysis of the brachial plexus, release of contracture and soft tissue flap coverage were arranged for the patient.

SURGICAL TECHNIQUE

The patient was put on supine position under general anesthesia with two teams approach. The first team was to explore the supra-clavicular and infra-clavicular brachial plexus. Lateral part of right clavicle showed poor circulation and was resected without reconstruction after consultation with orthopedics. The lateral segment of clavicle displaced inward and compressed the brachial plexus from level II to level IV. The subclavian artery and vein were pushed medially by the fractured bone and scarring tissue.

Interesting Cases *continued from pg 4*

The brachial plexuses, subclavian artery and vein were completely released and reposition to anatomical site. The necrotic sternal part of pectoral major muscle was resected. Right external jugular vein, cephalic vein, basilic vein, and right brachial vein were thrombosed. The only patent vein was the right internal jugular vein. A 25-cm graft of great saphenous vein was harvested to bridge brachial vein to internal jugular vein (through 15-cm vein graft) and right cephalic vein to internal jugular vein (through 10-cm vein graft). Neurolysis of the three trunks of right brachial plexus were performed. All the severe scar and fibrotic skin on right axilla and chest wall were removed, which resulted a huge soft tissue defect.

A deep inferior epigastric artery perforator (DIEP) flap, measured 34 x 15 cm with two perforators was entirely used to cover the defect by the second team. The deep inferior epigastric artery was anastomosed with right transverse cervical, and deep inferior epigastric vein was anastomosed to internal jugular vein with an end-to-side fashion. Total operation time was 16 hours.

POST-OPERATIVE CARE AND OUTCOME

The patient was transferred to microsurgery intensive care unit for standard post-microsurgery care. The DIEP flap completely survived without any congestion event. The patient was discharged two weeks postoperatively and returned to normal daily activity one month after the surgery. Right after the surgery, the right upper extremity pulsation recovered to normal. At a 7-months of follow-up, the range of motion of right shoulder abduction improved from 70 degrees to 100 degrees, grip power of right hand improved from 1 to 2, and muscle power of right elbow flexion improved from 2 to 3 postoperatively. The right limb lymphedema remained the same.

DISCUSSION

The TOS is a well-defined disorder related to compression of brachial plexus and/or the subclavian vessels, which can be divided in three types: neurogenic TOS, venous TOS, and arterial TOS.¹ The etiology of TOS is impingement of bony structure including two common places of scalene triangle and the costoclavicular space, the former place always causes brachial plexus compression (neurogenic TOS) and the later place usually causes subclavian vein compression (venous TOS).² Subclavian vessels compression in costoclavicular space usually caused by first rib impingement, rarely related to clavicle fracture or displacement. Gadinsky et. al presented two case of brachial plexus compression secondary to displaced clavicle fracture caused by traumatic injury.³ To our knowledge, it is the first case report of complication after breast cancer treatment with TOS with severe compression of brachial plexus and subclavian vessels caused by clavicle osteoradionecrosis and fracture.

The DIEP flap has been widely used in breast reconstruction and large soft tissue defect due to its abundance of skin and soft tissue. When more than 70% of the flap is required for reconstruction, the perfusion of zone IV in DIEP flap is concerned.⁴ Cheng et al, presented the reliability of zone IV in DIEP flap up to the use of mean 85.6% of the flap. Arterial perfusion of zone IV in DIEP flap is always adequate.⁵ The complication of zone IV usually caused by venous congestion,⁶ which can be salvaged using the superficial vein augmentation.⁷

The right upper limb lymphedema was caused by the axillary lymph node dissection and radiation, with superimposition of occlusion of subclavian vein. The release of subclavian vein compression and anastomosis of cephalic vein to IJV did not improve the upper limb lymphedema, but may provide a better chance for a secondary vascularized lymph node flap transfer.

BIBLIOGRAPHY

1. Kuhn JE, Lebus GF V, Bible JE. Thoracic outlet syndrome. *J Am Acad Orthop Surg.* 2015;23(4):222-232. doi:10.5435/JAAOS-D-13-00215.
2. Yuschak E, Haq F, Chase S. A Case of Venous Thoracic Outlet Syndrome: Primary Care Review of Physical Exam Provocative Tests and Osteopathic Manipulative Technique Considerations. *Cureus.* 2019;11(6):e4921. doi:10.7759/cureus.4921.
3. Gadinsky NE, Smolev ET, Ricci MJ, Mintz DN, Wellman DS. Two cases of brachial plexus compression secondary to displaced clavicle fractures. *Trauma Case Rep.* 2019;23:100219. doi:10.1016/j.tcr.2019.100219.
4. Kroll SS. Fat necrosis in free transverse rectus abdominis myocutaneous and deep inferior epigastric perforator flaps. *Plastic and Reconstructive Surgery.* 2000;106(3):576-583. doi:10.1097/00006534-200009030-00008.
5. Cheng MH, Robles JA, Ulusal BG, Wei FC. Reliability of zone IV in the deep inferior epigastric perforator flap: a single center's experience with 74 cases. *Breast.* 2006;15(2):158-166. doi:10.1016/j.breast.2005.06.006.
6. Chang C-C, Huang J-J, Wu C-W, et al. A strategic approach for DIEP flap breast reconstruction in patients with a vertical midline abdominal scar. *Annals of Plastic Surgery.* 2014;73 Suppl 1:S6-S11. doi:10.1097/SAP.0000000000000244.
7. Ali R, Bernier C, Lin YT, et al. Surgical Strategies to Salvage the Venous Compromised Deep Inferior Epigastric Perforator Flap. *Annals of Plastic Surgery.* 2010;65(4):398-406. doi:10.1097/SAP.0b013e3181d9ab27.

Interesting Case - *continued from pg 5*

FIGURE LEGENDS

Figure 1A. Right clavicle osteoradionecrosis with severe scar contracture of chest wall and axilla, and limited range of motion of right shoulder.

Figure 1B. A deep inferior epigastric perforator (DIEP) flap 34 x 15 cm was designed, which was completely used for the reconstruction.

Figure 1C. Yellow arrow: Right cephalic vein was reconstructed through a vein graft from great saphenous vein to internal jugular vein. White arrow: Brachial vein was reconstructed through a vein graft from great saphenous vein to internal jugular vein. Neurolysis of all the three trunks of brachial plexus were also performed.

Figure 1D. The DIEP flap was inset, and the pedicle vessels were anastomosed. Yellow arrow: The deep inferior epigastric artery was anastomosed to right transverse cervical artery. White arrow: Deep inferior epigastric vein was anastomosed to internal jugular vein with an end-to-side fashion

Figure 1

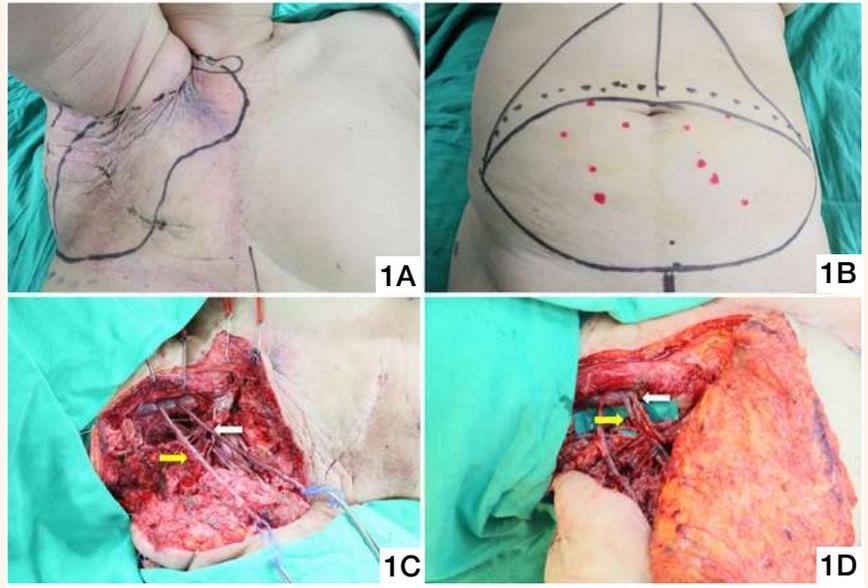
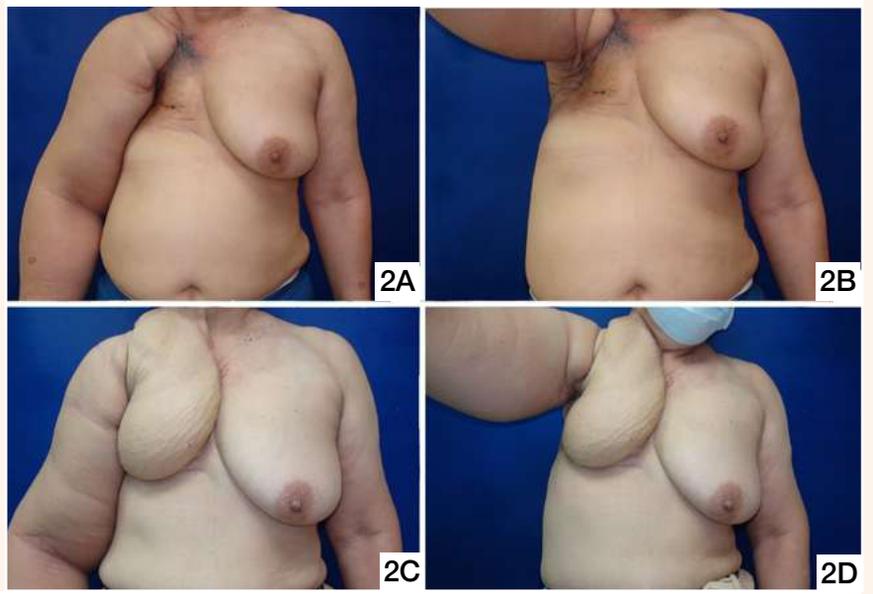


Figure 2

Figure 2A and 2B. Preoperative photographs of the patient with right clavicle osteoradionecrosis with severe scar contracture of right chest wall and right shoulder inward rotation and limited abduction.

Figure 2C and 2D. At a 7-months post-operatively. The reconstructed DIEP flap completely survived. Right shoulder returned to normal position. Improved range of motion arm elevation and shoulder abduction.



A Case Study

Complete Proximal Scaphoid Pole Replacement Using a Free Vascularised Cortico-Cartilagenous Flap From the Lateral Femoral Trochlea for the Treatment of Recalcitrant Non-Union. A Case Study.

Author:

H. Bürger¹, L. Jiga², J. Higgins³, Z. Jandali², M. Anoshina⁴

From:

- 1 – Privat Hospital Maria Hilf, Klagenfurt, Austria.
- 2 – Department of Plastic, Reconstructive and Hand Surgery, Evangelisches Hospital Oldenburg, Germany.
- 3 – The Curtis National Hand Center, MedStar Union Memorial Hospital, Baltimore, Maryland, USA.
- 4 – Department of Orthopaedics and Traumatology, University Medical Center, Graz, Austria.

Address of correspondence: Lucian P. Jiga, MD, Department of Plastic, Reconstructive and Hand Surgery, Evangelisches Hospital, Steinweg 13-17, 26122 - Oldenburg, Germany. E-mail: jigalucian@gmail.com

INTRODUCTION

Proximal scaphoid fracture non-unions pose a particularly challenging scenario for any hand surgeon. Proximal pole resection and its microsurgical reconstruction using a free medial femoral trochlea (MFC-C) flap was already described by Bürger and Higgins in 2013.(1) Later on, Wong et al. underlined the possible use of the lateral femoral condyle flap as alternative reliable source of vascularised bone from the distal femur.(2)

Here we present a 23-years old patient referred to us for a non-union after a Herbert type B3 scaphoid fracture (Fig 1A). While the preoperative MRI revealed a complete necrosis of the proximal scaphoid pole, its complete removal and reconstruction of the joint surface to the radius were



Fig 1A

requested to achieve an optimal functional result (Fig 1B). After complete resection of the proximal pole, the scaphoid was successfully reconstructed using a free lateral femoral trochlea flap (LFC-C).

SURGICAL APPROACH

Recipient site

A volar approach to the scaphoid lateral to the sheath of the FCR tendon is performed. After opening the joint capsule, the non-union is exposed volarly and the entire proximal pole is removed en-bloc with the non-union site (Fig 2A). Using sterile wax, a “fingerprint” of the missing scaphoid part is obtained (Fig 2B). The palmar branch of the radial artery and one of its committant veins are then dissected out and prepared as recipient vessels for the flap.

FLAP HARVESTING

The lateral femoral condyle was approached through a transverse incision directly above the projection of the ventral margin of the distal iliotibial tract. The deep transversal branch of the superolateral genicular artery (SLGA) which is the vessel nourishing the latero-ventral part of the trochlea was exposed. This branch was followed ventrally to the knee capsule, which was opened to expose the trochlea cartilage. At this point the main components of the LFC-C flap were identified (Fig 3A). The pedicle dissection was started proximally, just distal from the point where the SLGA gives off its distal branch supplying the distal part of the lateral femoral condyle. Freeing these fine vessels from the condyle periosteum, demands utmost care. Approaching the terminal

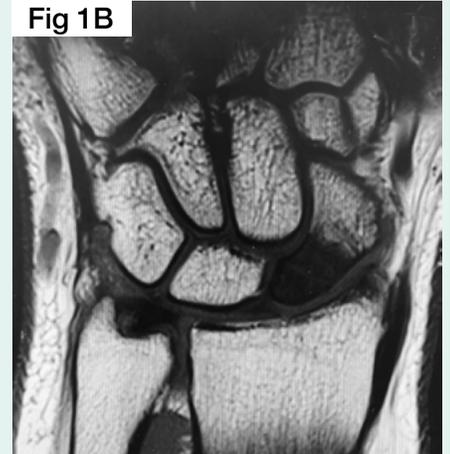


Fig 1B



Fig 2A



Fig 2B

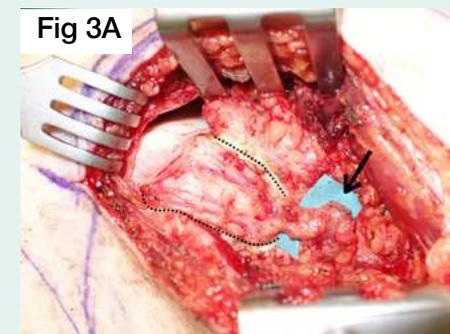


Fig 3A

A Case Study - *continued from pg 7*

branches, the dissection became subperiosteal, a measure mandatory to protect this fine network nourishing the cartilage. Using the wax template, the flap was marked and harvested through a total of three osteotomies (Fig 3 B,C).



Fig 3B

FLAP INSET

The LFC-C flap was inserted so as to reconstruct the entire proximal pole of the scaphoid and its articular facet to the radius and fixed with two 1mm K-wires and an additional 1,2mm titanium cortical screw. Under the operative microscope, the flap pedicle was microscurgically anastomosed to the palmar branch of the radial artery and its prepared venae comitantes in a end-to-end fashion. When closing the wound, care was exercised not to exert any compression of the vascular pedicle.



Fig 3C

POSTOPERATIVE REGIME AND OUTCOMES

The wrist was splinted in a circular scaphoid cast for 8 weeks. The K-wire was taken out after a CT examination shown complete healing of the bone transplant (Fig 4A). After two months of physiotherapy the patient was able to return to his normal life and was declared healed.

The knee was splinted for 1 week while allowing full weight-bearing from the 1st postoperative day after which full active ROM was permitted.

REFERENCES

1. Higgins SP, Bürger HK: Proximal scaphoid arthroplasty using the medial femoral trochlea flap. J Wrist Surg; 2013; 2(3):228-233.
2. Wong VW, Bürger HK, Iorio ML, Higgins JP. The lateral femoral condyle flap: An alternative source of vascularised bone from the distal femur. J Hand Surg Am; 2015; 40(10):1972-1980.

CONCLUSION

Fracture non-unions of the proximal scaphoid are difficult to treat, both because of imminent necrosis of the pole proximal to the non-union and the necessity to replace the cartilage surface of the scaphoid to the radius to adequately restore the anatomy of the radiocarpal joint. The superolateral genicular artery has been previously shown to exhibit a more constant and reliable anatomy as compared to its medial counterpart (the descending genicular artery) and provide through its distal branch a reliable donor site to both corticocancellous bone, fascia and skin flaps. Here we show that the same artery can support through its transversal deep branch, harvesting of a cartilage carrying bone flap from the lateral femoral trochlea. This is, to the best of our knowledge the first description and successful clinical use of the lateral femoral trochlea flap for reconstruction of the proximal scaphoid pole after fracture and non-union.

LEGENDS TO THE FIGURES

Figure 1. Preoperative imaging of the scaphoid non-union. (A) CT: evident non-union with subchondral bone sclerosis towards the articular surface to the radius (*red arrow*), (B) MRI: Coronal T1 slice with evident degenerative marrow edema as sign of advanced avascular necrosis of the proximal pole of the scaphoid.

Figure 2. Intraoperative view of the recipient site. (A) Empty scaphoid fossa after complete removal of the proximal scaphoid pole (*asterisk - distal pole of the scaphoid*). (B) The wax "fingerprint" depicting the required bone volume as well as the facets to the distal scaphoid pole (*S*), radius (*R*) and lunate (*L*).

Figure 3. Intraoperative view of the donor site. (A) Flap pedicle prepared for harvesting (*black arrow*). The interrupted line depicts the area where pedicle dissection is performed subperiosteally. (B, C) Harvested flap alongside the wax "fingerprint".

Figure 4. Postoperative aspect of the recipient site. (A) Immediate postoperative X-rays depicting the final result after reconstruction (*white arrow indicating the new articular surface of the scaphoid to the radius*). (B) Complete healing with acceptable reconstruction of the proximal articular surface of the scaphoid at 8 weeks postoperatively.

WSRM 2019 in Bologna: A Great Success Beyond Expectations!



Chairman opening

For the first time ever the WSRM Meeting occurred in Italy. **Prof Giorgio De Santis**, Chief of the Division of Plastic Surgery of University of Modena and Reggio Emilia was the hosting person and Congress Chairman, and **Prof Marco Innocenti** chaired the Scientific Committee.

The meeting turned out to be a great success: **more than 1,600 microsurgeons** from **64 countries** participated, and **more than half were under 40 years old**. This aspect has been very much rewarding for us and for the Society because indicates a favorable trend for the future.

The most qualified experts from all over the world provided their contributions in all specific fields, and the three-days scientific program was outstanding. The theme of the Congress was **“Ad Augusta per Angusta”** which means “Great Achievements through narrow paths” synthesizes the spirit and the essence of microsurgery.

Five Invited Lectures, twelve Instructional Courses, eighteen key-note lectures were delivered by the most distinguished experts in the world. After this, **66 panel sessions, selected free papers and free papers** allowed for covering all hot topics of Microsurgery.

The attitude of all was friendly and constructive. **Bologna**, the hosting city, provided a warm and friendly environment. 40 kilometres of Porticos built in late Middle Ages, beautiful buildings and churches are the setting for the oldest university of western countries: The Alma Mater Studiorum, founded in 1088.

Aside from all scientific aspects, the meeting was also an opportunity to get in touch with some of the Italian culture and typical food. History, art and stunning atmospheres were made available for all participants. Key note social event was the **Concert of Banda Nazionale dei Carabinieri** during the **Opening Ceremony**. The **conference dinner** was served inside Palazzo Re Enzo, built between 1244 and 1246 as an extension of **Palazzo del Podesta** right in the heart of Piazza Maggiore, Bologna's central square.



Banda Nazionale dei Carabinieri Concert (Opening)



Master of Disaster Soccer Team



Faculty Dinner at Cantina Bentivoglio

We want to thank again all participants wishing the best for WSRM 2021 in Cancun.



(from left to right): **President, David Chang; Scientific Committee Chairman, Marco Innocenti; Congress Chairman, Giorgio De Santis; Past President, Isao Koshima**



2019 World Congress Gala

Meetings Around the World



The Oldenburg-Groningen **Advanced** Training Program in Reconstructive Microsurgery

PERFORATOR FLAPS
INTENSIVE TRAINING IN
PERFORATOR FLAP HARVESTING

Invited faculty:

Share this event



Yixin Zhang - China



Salvatore D'Arpa - Italy



Peter Suh - South Korea



Davide Ciclamini - Italy



Emanuelle Cigna - Italy



Elena Lucatelli - Italy

www.advancedmicrosurgery.org

May 27-29.2020
Groningen, The Netherlands

Endorsed by:



World Society for Reconstructive Microsurgery
European Federation of Societies for Microsurgery

www.advancedmicrosurgery.org



www.wsrn.net



www.efsm.eu

Meetings Around the World



The Oldenburg-Groningen
Advanced
Training Program in
Reconstructive
Microsurgery

LYMPHATIC MICROSURGERY
INTENSIVE TRAINING IN MICROSURGICAL
LYMPHATIC RECONSTRUCTION

Invited faculty:

Share this event



Corradino Campisi - Italy



Hung Chi-Chen - Taiwan



Joseph Dayan - USA



Takumi Yamamoto - Japan

www.advancedmicrosurgery.org

May 25-26.2020
Groningen, The Netherlands

Endorsed by:
World Society for Reconstructive Microsurgery
European Federation of Societies for Microsurgery



www.wsrn.net



www.efsm.eu

www.advancedmicrosurgery.org

Meetings Around the World



Module 3



The Oldenburg-Groningen
Advanced
Training Program in
Reconstructive
Microsurgery

SMALL BONE TRANSFERS
INTENSIVE TRAINING IN BONE FLAP
HARVESTING AND **RECONSTRUCTION**
OF THE **WRIST**

Invited faculty:

Share this event



- Limited places - 10 participants
- Fresh-frozen upper and lower extremity human anatomical specimens
- 1 participant/anatomical specimen
- 1:1 trainer:trainee teaching model
- 6 bone flap combinations from the medial & lateral femoral condyle (e.g. cancellous, periosteal, cartilage)
- Simulation of scaphoid and lunate reconstruction (articular surface, bone components)



Heinz Bürger - Austria



James Higgins - USA



Maria Anoshina - Austria



Jason Ko - USA



Takcin Özalp - Turkey

October 15-16, 2020
Groningen, The Netherlands

Endorsed by:



World Society for Reconstructive Microsurgery
European Federation of Societies for Microsurgery

www.advancedmicrosurgery.org

www.advancedmicrosurgery.org



www.wsrn.net



www.efsm.eu



WSRM SERVICE INITIATIVE – CALL FOR VOLUNTEERS

WSRM has a new initiative to sponsor surgical missions to needy world areas to perform complex microsurgical reconstructions. The team would provide care to needy patients and also provide education in approach to management of complex disorders for the local surgeons and support staff. The support for these mission trips would need to come from donations from individuals and major health organizations and industry. In addition, the initiative would address:

- A. Service to local hospitals, including lectures and surgeries
- B. Service to teaching local surgeons, accepting candidates for short term or long-term service
- C. Patient Care, patients traveling to the participating hospital (WSRM doctor's hospital) for treatment.

To further this initiative the Ad Hoc Service Committee has been created to look at opportunities for WSRM to engage in clinical/ educational service missions, investigate funding and cost issues to WSRM as well as investigate Medical /Legal issues of service work. If you are interested in serving on this committee and have service work experience please contact Krista Greco at kristagreco@isms.org as soon as possible.



Mark Your Calendar



2021 WSRM World Congress

June 9 to 12, 2021

Cancun, Mexico

www.wsr2021.com

2023 WSRM World Congress

May 2023

New York City, New York, USA

Global Meetings*

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

AMERICAN SOCIETY FOR RECONSTRUCTIVE MICROSURGERY

January 10-14, 2020

Ft. Lauderdale, Florida, USA

www.microsurg.org

INDONESIAN SOCIETY FOR RECONSTRUCTIVE MICROSURGERY

The 6th Indonesian Society for Reconstructive Microsurgery Course and Symposium.

February 21-22, 2020

Jakarta, Indonesia

www.instagram.com/microsurgery.indonesia

PATAGONIA MICROSURGERY MEETING

February 28, 2020

Puerta Varas, Chile

www.patagoniamicro.com

EUROPEAN FEDERATION OF SOCIETIES FOR MICROSURGERY

15th Congress of European Federation of Societies for Microsurgery

April 27 – May 1, 2020

Cluj – Napoca, Romania

www.efsm.eu

ASIAN-PACIFIC FEDERATION OF SOCIETIES FOR RECONSTRUCTIVE MICROSURGERY

November 18-20, 2020

Kitakyushu, Japan

www.apfsm.org

2019 - 2021 Executive Council

PRESIDENT

David W. Chang, MD, FACS

Chicago, IL, USA

dchang@surgery.bsd.uchicago.edu

PRESIDENT-ELECT

Robert Walton, MD

Chicago, IL, USA

doctornotlaw@gmail.com

VICE PRESIDENT

Gregory R. D. Evans, MD, FACS

Orange, CA, USA

gevans@uci.edu

SECRETARY GENERAL

Joon Pio Hong, MD

Seoul, South Korea

joonphong@amc.seoul.kr

HISTORIAN

David T. W. Chiu, MD

New York, New York, USA

dtwc@davidchiumd.com

IMMEDIATE PAST-PRESIDENTS

Isao Koshima, MD

Hiroshima City, Japan

koushimaip@gmail.com

David Chwei-Chin Chuang, MD

Taipei, Taiwan

dccchuang@gmail.com

MEMBERS-AT-LARGE

Ming Huei Cheng, MD

Tao-Yuan, Taiwan

minghueicheng@gmail.com

Jaume Masia, MD

Barcelona, Spain

jmasia@santpau.cat

Samir Mardini, MD

Rochester, Minnesota, USA

mardini.samir@mayo.edu

Sinikka Suominen, MD

Helsinki, Finland

sinikka.suominen@hus.fi

Omer Ozkan, MD

Antalya, Turkey

omozkan@hotmail.com

ASIAN REPRESENTATIVE

Omer Ozkan, MD

Antalya, Turkey

omozkan@hotmail.com

EUROPEAN REPRESENTATIVE

Alejandro Muset, MD

Argentona, Spain

dr.muset@musetinstitute.com

NORTH AMERICAN REPRESENTATIVE

Lawrence Gottlieb, MD

Chicago, Illinois, USA

lgottlie@surgery.bsd.uchicago.edu

LATIN AMERICAN REPRESENTATIVE

Susana Correa, MD

Bogota, Colombia

susicorreagtz@hotmail.com

2021 CONGRESS CHAIRMAN

Eric Santamaria, MD

Mexico City, Mexico

ericsanta@prodigy.net.mx

Congress Organizing Committee

2019 - 2021 WSRM Committee Roster

Organizing Committee Chairman

Eric Santamaria, MD

Membership Committee

Robert Walton, MD, Chairman (USA)

Yixin Zhang, MD (China)

Sinnika Suominen, MD (Finland)

Raja Sabapathy, MD (India)

Marzia Salgarello, MD (Italy)

Nominating Committee

Isao Koshima, MD, Chairman (Japan)

Joan Lipa, MD (Canada)

Michael Sauerbier, MD (Germany)

Steve Moran, MD (USA)

Xin Wang, MD (China)

Constitution and Bylaws Committee

B. K. Tan, MD, Chairman (Singapore)

Alex Wong, MD (USA)

Muneera Bin Nakhi, MD (Kuwait)

Stefan Hofer, MD (Canada)

Milomir Ninkovic, MD (Germany)

15th Congress of the European Federation of Societies for Microsurgery

IN CONJUNCTION WITH

The National Conference of the Romanian Association of Plastic Surgeons

April 28 – May 1, 2020 / Cluj-Napoca, Romania

PRE-CONGRESS COURSES

– 3rd International Course on Perforator Flaps
– Basic Microsurgery Course

April 26 – 28, 2020 / Cluj-Napoca, Romania

WSRM Symposium - April 28, 2020



Romanian Society
for Reconstructive
Microsurgery



ROMANIAN ASSOCIATION
OF PLASTIC SURGEONS

efsm2020.medevents.ro

Know someone who wants to become a member?

The application process is simple. 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

Winter 2019 – Volume 9/ Issue 1

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.

David W. Chang, MD
Editor-in-Chief, President

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:

**WSRM Central Office | 20 North Michigan Avenue, Suite 700
Chicago, Illinois 60602 | USA**

The views expressed in articles, editorials, letters and or publications published by The WSRM Newsletter are those of the authors and do not necessarily reflect the society's point of view.