



# THE PEDICLE

Newsletter

Division of Plastic Surgery | University of British Columbia | MAY 2017 | ISSUE #5

## CHAIR'S REPORT



Peter Lennox, MD, FRCS

### INAUGURAL ALUMNI DAY

A number of years ago, Dr. Nick Carr wrote in the inaugural edition of The Pedicle that "It's cause to celebrate", as the UBC Division of Plastic Surgery had reached a point in its development that an annual newsletter was justified to provide news and updates to our many alumni and members. It is my pleasure to state that "it's cause to celebrate" again. This May, we will celebrate the first ever UBC Plastic Surgery Alumni day in conjunction with our annual Research Day. This is the culmination of discussions over a number of years amongst division members. Many of us had the experience in large academic centres during fellowship training of an alumni event. The UBC Division of Plastic Surgery has crossed a threshold and a similar event here is well justified. We now have over 70 resident alumni and a similar number of fellow alumni scattered across Canada, the United States, Africa, Europe and Australia and the Middle East.

Our inaugural Alumni day will follow our research day, and we have invited all alumni to return and have the opportunity to give a formal presentation. We have had an overwhelming response, and look forward to an outstanding day to connect with friends and colleagues, share information, and plan for future events.

### ADMINISTRATION

The Division has had an outstanding year. Administratively, we have incorporated as a

"Not For Profit Society", which has given us complete autonomy over our finances and will allow us to plan academically into the future to support our Residency, Research and Fellowship programs with safe funding models.

Similarly, under the leadership of Dr. Jugpal Arneja, we have created internally funded research awards to allow seed funding for research projects or surgical missions within the division. Last year, we had 9 successful awards. A number of these have progressed to national and international presentation and publication.

### THE BCPFF BURN AND WOUND HEALING LAB

The BCPFF Burn and Wound Healing lab continues to thrive under the leadership of Dr. Aziz Ghahary, and is currently conducting the first ever Phase I trial of a drug produced at UBC. Dr. Ghahary is being recognized at the annual BCPFF gala for all of his contributions to burn care and wound healing. The lab has also benefited from our recruitment of Dr. David Granville who also has a very successful stream of research with a focus on granzymes and their role in inflammation and disease.

### RESIDENCY PROGRAM

Like all surgical programs in Canada, we are preparing for the transition to Competency Based Training in our residency program. Dr. Mark Hill continues to lead this as Program Director. With the changes in the program, it is anticipated that we will recruit an Associate Program Director in the near future. We have two residents graduating this year. Dr. Morgan Evans and Dr. Aaron Knox. Dr. Evans will be heading to Seattle for a craniofacial and paediatric fellowship. Dr. Knox has completed the Clinical Investigator Program, with a focus on education and competency based training. He will be heading to Sydney, Australia for a hand, upper extremity and peripheral nerve fellowship.

### NEW FACULTY MEMBERS

We have had two new faculty join us in the past year. Dr. Ashley Tregaskiss has joined the adult side, and will have a focus on complex reconstruction, craniofacial surgery, as well as general plastic surgery at UBCH and VGH. Dr. Erika Henkelman has joined the staff at BC Children's Hospital, with a similar focus on craniofacial surgery, cleft surgery and general paediatric plastic surgery. Administratively, Ms. Parm Sidhu has joined us as our Senior Administrative Assistant to work with Maureen Berard. Please join me in welcoming our new additions!

I believe you will find that the other major events and news of the last year are well covered in the remainder of the newsletter. I would like to take the opportunity to thank our entire faculty, both those directly involved in the program and those who contribute in the community, for your hard work. I believe the UBC Division of Plastic Surgery is stronger than ever, and all of you are to thank for that! Please enjoy this edition of the Pedicle, and I hope to see you at our inaugural Alumni Day.

### IN THIS ISSUE

- 2 Pearls & Perspectives
- 3 DOBC Section Update
- 4 How I Do It?
- 5 CMPA Update
- 8 New Surgeon Spotlight  
Dr. Ashley Tregaskiss
- 9 New Surgeon Spotlight  
Dr. Erika Henkelman
- 10 Fellowship Program
- 10 Undergraduate Education
- 12 Residents Corner
- 14 Academic Grant Fund
- 17 Achievements UBC Division  
of Plastic Surgery

# PEARLS & PERSPECTIVES



Jason Gray, MD, FRCSC

## When I think over my 30

*During my time as a resident at BCCH I worked with an esteemed Scottish pediatric surgeon. He was passionate about surgery and had the skill to lead a surgical team while empowering those around him through mutual respect. He told me that the key to a successful surgical career was adherence to the three A's. **Namely Availability, Affability and Ability.** He felt the latter was actually the least important.*

When I think over my 30+ years spent in residency and practice, there are a few pieces of advice received or experiences encountered that might be viewed as pearls. Most of these were passed on by people far wiser than myself and I feel fortunate to have trained and to continue working in an environment of strong collegiality, surrounded by staff for whom I have great respect.

During my time as a resident at BCCH I worked with an esteemed Scottish pediatric surgeon. He was passionate about surgery and had the skill to lead a surgical team while empowering those around him through mutual respect. He told me that the key to a successful surgical career was adherence to the three A's. Namely Availability, Affability and Ability. He felt the latter was actually the least important.

My personal experience has been shaped by my patient encounters. Early on I had a patient who underwent a breast reduction with support from her East coast mother who had flown in to look after her young granddaughter. The patient developed a severe post-op infection with *Clostridium perfringens*, which led to a prolonged hospitalization. Every day I approached her room on the ward I had to force myself to go in and visit. I was sure she held me responsible for her complication and the disruption of the lives of her mother, child and herself. On the day of her discharge after debridement, delayed closure and skin grafting, she gave me a long hug and said, "I could not have got through that without your help." We must not forget it is the patient's complication, not ours. All they expect is that we will stay the course and be there to look after them. Legal action is more likely to arise when a patient feels abandoned or mistreated. They want us to be human.

I try to make a point of connecting with my patients by actually sitting on their bedside and "laying on of a hand" before getting down to symptom interrogation, drain evaluation and incision scrutiny. A patient's perception of the time their doctor spent visiting is amplified if there is physical contact. If the patient comments on how busy we are, it usually means we are running behind, make them feel rushed or do not spend enough time with them.

My final thought relates to the support we give our colleagues, especially those early in their practice. I remember struggling to find the posterior shelf of an orbital floor blow-out fracture and feeling the anxiety build. I finally bottled my pride and asked the circulating nurse to call a colleague for help. The response was immediate. "Sure I will be right there." The orbital anatomy became apparent before my willing colleague had actually made it to the OR. It is often just the knowledge that help is available if required, and is given in a gracious way, that restores one's calm and focus. The anxiety we feel is triggered by a concern that our patient get the best possible treatment. That is what makes us good physicians.

# SECTION OF PLASTIC SURGERY, DOCTOR'S OF BC



Nancy Y. Van Laeken, MD, FRCSC

*Dr. Stan Valnicek stepped aside as the Section Head for the Division of Plastic Surgery this year. He should be thanked by all members for his dedicated service which extended well beyond the usual term. Since becoming the Section Head I have had the opportunity to attend the Society of Specialists meetings and the following points will provide an update from the most recent meetings.*

## CHANGING THE GOVERNANCE STRUCTURE

One of the most important issues recently addressed by the Doctors of BC is changing the governance structure. A recent referendum has passed the proposed structure with the two most significant changes as follows: The Doctors of BC Board has now been replaced with dual structured governance model. This consists of a nine member Board and a Representative Assembly which will contain 104 members. It will be critical that the Society of Specialists have appropriate representation in the Representative Assembly to ensure that the needs of the Specialist Group are appropriately voiced. There will be one representative from each specialty group. The Section of Plastic Surgery will be able to nominate their own representative.

The second item of the referendum which passed successfully was changing of the Society's Act. The association has now become a member funded society which means that it is responsible to its members and not to the public. The Doctors of BC will be working in the next few months to setup the new governance structure with the Representative Assembly members being appointed. This has been felt by the Society of Specialists to be positive changes allowing the SSC to exert more influence within the new DBC structure which may have not have been possible before.

## TELEPHONE CONSULT FEES

There was a proposal that the telephone consultation fees would be prorated because the budget has been exhausted for the current fiscal year. After some effective lobbying with different members of the Society of Specialists proration was not allowed. There will be new accountability models for the use of these billing codes and this model will be finalized and distributed to members when it is available.

## DISPARITY DATA AND OVERHEAD WORKING GROUP UPDATE

The Doctors of BC are currently completing a survey to identify office overhead. The

Section of Plastic Surgery's participation in the overhead survey is currently being assessed. Based on the experience of the surgeons who were involved with the original process a number of years ago recommendations were made as to how we should participate. Not participating may lead to an arbitrary assignment of overhead with penalty which would be undesirable. Further information on how the Section will approach the response will be forthcoming after further investigations are made with the Doctors of BC, and after discussion at the next section meeting May 26, 2017 after Resident's Day.

***Currently the Medical On Call Availability Program is being assessed by way of a survey. The results of that survey are not yet available.***

## ROYAL COLLEGE OF PHYSICIANS AND SURGEONS STANDARDS FOR PRIVATE SURGICAL FACILITIES

It has been identified by owners of private surgical facilities that the requirements and standards that have been set by the Royal College of Physicians and Surgeons is higher than what is required in a public institution. All facilities require accreditation from the Royal College. The requirements that are currently being put into place are not based on data supportive of patient's safety. The Section of Plastic Surgery would like to garner support from other surgical specialties who own private facilities and take this item of concern to the Doctors of BC for support. It will be put on the Agenda for the next meeting of Society of Specialists.

## UPDATE FROM FINANCE COMMITTEE

Dr. A. Lee has worked diligently to update billing codes for Breast Reconstruction. A new schedule will soon be provided to members. These new codes have been supported by reallocation of disparity funds. Some disparity funds will also go to consult fees. Retroactive pay has been sent for the new flaps/graft codes. Further discussion and detail to be provided at the section meeting.



# HOW I DO IT?



Anthony Papp, MD, PhD, FRCSC

## Optimizing functional results after skin grafting The principle of Preventive Reconstruction

Split thickness skin grafting is considered one of the most basic procedures in plastic surgery. Wound bed preparation is crucial and the success of skin graft take is greatly dependent on wound bed viability. Wound excision to “pin point bleeding” is often not enough. The wound bed has to “look” right, and to learn to evaluate this takes years, even decades of experience. Doing burn surgery for over 20 years has taught me a lot in recognizing risk areas and how to prevent scar problems rather than revising/reconstructing them later. Much thought should be placed into how to place the grafts. Skin grafts tend to contract at the seams. Therefore, seam placement is crucial. Long straight lines look nice on the operating table, but will cause problems later and should hence be avoided.

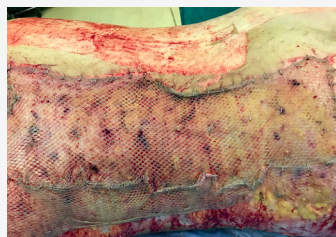


Fig 1b



Fig 1a

### STEP 2

Small transposition flaps can easily be used to break the straight line as well. This is specifically true in the anterior axillary fold. (Fig 2a and b)

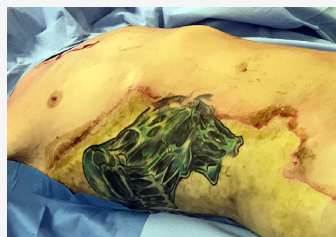


Fig 3a



Fig 3b

### STEP 4

It is fast and an easy way to prevent future problems and decrease the need for later scar revisions. This small flap will widen over time under stretch preventing contractures. (Fig 4)

### STEP 1

Large skin grafted areas should be built up like a brick wall, avoiding long straight lines (Fig 1a and b). This is very common in the chest and trunk area. Also, it is important to avoid seams that cross longitudinally over the flexor side of large joints, such as the knee, elbow and wrist.



Fig 2a

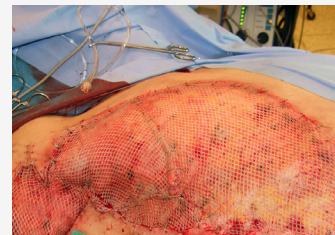


Fig 2b

### STEP 3

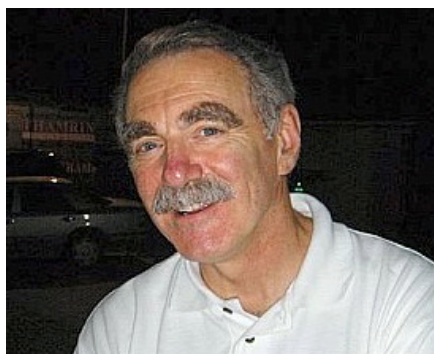
Often, the axillary skin is not injured. This small fence can be used anywhere in the body. (Fig 3a and b)



Fig 4

Careful consideration must be used when placing skin grafts in place and small local flaps are readily available to break the straight lines. Small things can be done to prevent scar contractures later.

# CMPA UPDATE



David Naysmith, MD, FRCSC

*OK, so it's not an exciting title! When asked if I would submit an article for the 2017 edition of The Pedicle on "What's new with CMPA and how it impacts our practice." I was very eager to do so. **Why?** Because there have been some dramatic changes that have taken place with your mutual medical protective association since 2015.*

Note that I refer to "Your mutual medical protective association" because the Canadian Medical Protective Association is in fact "us". Physicians, (over 95,000 across Canada) make up the membership of the CMPA and elect Council members (myself and twenty-nine others across the country) who govern the Association and give direction and oversight to management who carry out the work of the Association in protecting members integrity and all that this task entails. Mutuality is a critical aspect of our agreement to come together and protect each other when challenges arise. Later in this article I will address the concept of mutuality and what that means to each of us.

## So, what's changed since 2015?

In November 2014 CMPA Council adopted a new five-year STRATEGIC PLAN. Is that exciting? You bet.

I have served on Council since 2003 and the new strategic plan is the most progressive and ambitious initiative I have seen. The focus of the plan is, as it has always been for over one hundred years, the protection of members' integrity. However, the Association is working in a collaborative way with stakeholders to enhance member outcomes by leveraging patient safety programs and continuing medical education and is considered to be a world leader in both. By assisting physicians, contributing to safe medical care, and supporting the sustainability of the medical liability system, the CMPA will continue to be an essential component of the Canadian healthcare system. Here are some examples of what this will look like for you:

- **ASSISTING PHYSICIANS** – This is where I dig in to the concept of mutuality. Since its formation, the CMPA has enjoyed a reciprocal relationship with its members defined by the principles of mutuality. We collectively share in the costs, risks, and benefits associated with membership. We also share a responsibility to practice and act in a manner that aligns with the ethics and expectations of the profession and supports the values of the Association (or mutual) as whole. This includes working proactively to reduce risk, decrease medical-legal incidents and promote safer care.

As partners in a mutual, CMPA members support these goals. In fact, the latest member survey indicates that the majority of members are in favour of the CMPA working more closely with members whose medical liability experience is greater than their peers

in the same specialty. In response, the CMPA is expanding its assistance opportunities and developing an enhanced support program for members. Stay tuned for details in upcoming CMPA communications.

- **CONTRIBUTING TO SAFE MEDICAL CARE** – The CMPA offers members a continuum of services – from individual advice and assistance, to varied educational products and services assisting us through all stages of our careers -- Supporting medical trainees; Physicians and Teams in practice; and Supporting Physician leaders. All of this is informed by some of the best medical legal data and analysis available in this country. As a result, we are provided with education and risk advice on the latest developments in the healthcare industry including opioid prescribing, medical assistance in dying and much more. On top of this, the CMPA is looking at managing high risk areas within the healthcare system by working with partners and stakeholders. It has just completed a very successful pilot project to improve outcomes in obstetrics, long considered a high risk practice, and the hope is that this will translate into fewer poor outcomes for mothers and their babies. These are some of the most costly cases for the CMPA.
- **ENSURING THE SUSTAINABILITY OF THE MEDICAL LIABILITY SYSTEM** – Some of the major challenges of any medical malpractice organization are sustainability and relevance. We live in an ever more collaborative environment and stakeholders oversee what we do with microscopic intensity. Other than members (the majority of our stakeholders) we deal with provincial and territorial medical associations, governments, medical regulators (Colleges), health authorities and hospitals. The new strategic plan seeks to collaborate with stakeholders to provide system level changes that will help physicians provide the best possible care. As well, stakeholders demand financial accountability



## CMPA UPDATE cont.

and the responsible use of funds. As a mutual, the CMPA is funded by the membership fees physicians annually pay to the Association. While an insurance company would likely assign individual risk levels to each of us based on our medical liability experience, the CMPA is not an insurer and it recognizes that this experience is not a good indication of our clinical abilities. We all know colleagues who are excellent clinicians who invariably get the most challenging cases and hence may be more susceptible to adverse medical outcomes and litigation. The mutual model is one in which we share the risks amongst the profession and so the CMPA sets fees based on the risk of our type of work and region – not on our personal history.

- **COSTS** – The cost of providing medical liability protection do vary significantly across the country (with Ontario being far and away the most expensive) and so the regional approach makes a great of sense. Both revenues and costs are attributed to one of four regions (BC and Alberta, Ontario, Quebec and Saskatchewan, Manitoba, the Atlantic provinces and the Territories) and there is no subsidization between the four regions.

In paying our CMPA fees, we are making ourselves eligible for CMPA's assistance for medical liability issues arising from the professional practice of medicine and the care provided in that year – regardless of when the medical liability issue becomes known. This is referred to as occurrence-based protection and it provides all of us with the comfort of knowing that, even many years after the care (or even after we have retired), we will remain eligible for CMPA assistance. Given that many claims are not known until several years after the care was provided, the CMPA uses actuarial models to estimate the costs that will eventually result from that year of care,

recognizing it may take 35 years or more before all of those costs are paid.

Over the past several years, the CMPA fees have been increasing and this is a source of concern to members and to the CMPA Council. It is important to understand the drivers underpinning these increases.

The single largest component of CMPA costs are the payment, on behalf of members, of compensation to patients who have been injured as a result of negligent care. While there is considerable variance on a year to year basis, the average cost per case continues to rise at a rate that is much faster than inflation and this has an impact on our membership fees. The CMPA continues to actively advocate for a civil justice system that is fair to both defendant physicians and injured patients, one in which the compensation is reasonable.

The second biggest cost driver are legal expenses incurred assisting members and the CMPA works hard to ensure that the right legal resources are applied to each case and that we (and by "we" I mean all members) are getting value for our membership fees when it comes to the CMPA's legal team. In fact, the legal expenditures have remained fairly constant in the past few years, notwithstanding the double digit increases in members seeking assistance with College and hospital matters. I remain so impressed by the high quality lawyers the Association engages on our behalf and we should all be confident in their skills and their dedication to our profession.

The CMPA also incurs operating costs in providing advice and assistance, delivering high quality education programs, managing the investment portfolio whose income helps to reduce our fees and all of the other functions that come with a \$750 million annual revenue enterprise. As Chair of the CMPA Audit Committee, I continue to be struck by the

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innovative means through which our management team is able to deliver services to an expanding membership while controlling these costs.

In short, the CMPA has been quite successful in controlling those costs within our control, namely legal, experts and operations. However, some of this success gets overtaken by the higher compensation payments which, in turn, lead to the increases in fees.

Like many of you, I occasionally come across media reports (often from parties with a vested interest) that decry the CMPA's defense philosophy for members. These critics claim the CMPA will go to all ends to avoid paying claims to injured patients. While such statements may attract the headliner writers, they are simply untrue. Each and every case undergoes a thorough review both by CMPA staff physicians and clinical experts to determine if the care provided was negligent and, if so, if it contributed to patient harm. When that is the case, the Association works hard to settle the case with appropriate compensation and in an expeditious manner that respects the rights of both the physician and the patient. Contrary to the headlines, over 40% of legal cases are resolved through a mutually acceptable settlement with the patient. That said, when the CMPA and expert



opinions indicate the physician acted appropriately, we will defend the case in an ethical and determined manner. We take the same reasoned approach to dealing with College and hospital matters where our goal is to ensure the member physician is provided due process and, if sanctions are justified, that these are reasonable and appropriate. Our goal is to help physicians maintain a meaningful and fulfilling practice and, if there are areas for possible professional improvement, to help them in seeking the remedial support they may require.

- **REIMBURSEMENT** – Another poorly understood element of the Canadian system relates to the reimbursement

that physicians may receive from governments to help offset the costs of medical liability protection. Almost 30 years ago and during a period when protection costs were rising and forcing physicians to consider the viability of practicing medicine in Canada, the provincial medical associations across the country very wisely negotiated some form of reimbursement (the particulars differ by province). These programs which help today's physicians by providing greater certainty of our costs, demonstrate that stable medical liability protection costs are in the best interests of the healthcare system and that patients, healthcare authorities, governments benefit from the confidence that results

when physicians know that the CMPA will be there to assist them and that the costs of those services will remain affordable for them.

I am sure that any poll of physicians would indicate that, as a profession, we feel under greater stress and pressure than any time before; that is certainly what members tell the CMPA and what I hear from my colleagues. In such challenging times, I have always drawn comfort from knowing that the CMPA stands behind doctors and is available to support us when faced with a medical legal problem, be it a civil action, College complaint, a difficulty with our privileges or any one of several other matters.



Peter Lennox President CSPA June 2016, Ottawa, ON



## NEW SURGEON SPOTLIGHT

Get to Know  
DR. ASHLEY TREGASKISS

### INTERVIEW

**WHERE YOU DID MEDICAL SCHOOL, RESIDENCY AND FELLOWSHIPS AND ANY OTHER DEGREES; WHAT ARE YOUR AREAS OF CLINICAL AND RESEARCH INTEREST?**

**Medical School:** University College London Medical School

**Residency:** South West England Residency Program

**Fellowships:** Research fellowship, Kleinert institute, Louisville, Ky.

**Clinical fellowships:** St.Vincent's Hospital Sydney, interest in Head and neck reconstruction and Aesthetics; VGH Craniofacial and Breast fellowships.

**Higher degree;** Masters of Public Health, Univ. of Louisville.

**Clinical interests:** Adult CMF, reconstructive microsurgery, head and neck reconstruction.

**Research interest:** surgical decision making, innovations in reconstructive surgery

**WHAT DO YOU SEE AS THE GREATEST CHALLENGE YOU HAVE FACED IN STARTING PRACTICE AND HOW DID YOU ENDEAVOR TO MANAGE IT?**

The challenge i have struggled with most, and continue to wrangle with is practice management. Maintaining a broad practice presents challenges in terms of running an efficient, streamlined and to some extent automated practice, for both myself and office support staff.

There are a number of ways i have dealt with this problem, examining how colleagues run their practices, automating as much of my practice as possible and finally getting extra help as the practice demands have increased.

**WHAT ADVICE WOULD YOU GIVE CURRENT RESIDENTS AND FELLOWS ABOUT THE TRANSITION TO PRACTICE?**

In making clinical decisions, always put the patient first. Seek advice readily from colleagues. If you need help, pick up the phone and speak to people personally. Try to join an existing office/practice with established infrastructure. Once established, think about where you want your practice to be in 3-5 years and aim to reverse engineer that.

**WHERE DO YOU SEE THE PRACTICE OF MEDICINE GOING OVER THE COURSE OF YOUR CAREER AND WHAT OPERATION DO YOU THINK WE WILL NOT BE DOING IN THE FUTURE THAT WE ARE DOING NOW?**

The financial challenges facing healthcare will continue to get steadily worse. A growing elderly population, increasing patient longevity, as well as increasing (and potentially expensive) treatment modalities will combine to strain budgets even further. Ultimately difficult decisions will have to be made regarding what treatments are available in a public health system with a finite budget.

In future there will be greater emphasis on outcome measurement in surgery, we can expect far greater scrutiny than presently exists in this regard. This will be better for patient care but will potentially present a challenge for individual specialists, as well as diverse specialities like our own where the 'outcome' is not always objective and readily measured.

Regarding operations we wont be doing in future, i think facial aesthetic surgery will see a radical fall in numbers, but perhaps not disappear completely. The increasing use of fillers, botox, PRP, and lipolysis agents combined with patient desire for limited downtime will (and has) lessened demand greatly.





# NEW SURGEON SPOTLIGHT

## Get to Know DR. ERIKA HENKELMAN

### INTERVIEW

#### **WHERE YOU DID MEDICAL SCHOOL, RESIDENCY AND FELLOWSHIPS AND ANY OTHER DEGREES; WHAT ARE YOUR AREAS OF CLINICAL AND RESEARCH INTEREST?**

I studied marine biology at Dalhousie University and medicine at the University of Toronto. Following that, I completed two years of research at the University of Michigan, and then did my residency at the Southern Illinois University School of Medicine in Springfield. My fellowships were in pediatric (soft tissue / non-craniofacial) plastic surgery at Sick Kids (Toronto), craniofacial surgery at Western University (London), and pediatric complex craniofacial surgery at Lurie Children's Hospital of Chicago.

#### **WHAT DO YOU SEE AS THE GREATEST CHALLENGE YOU HAVE FACED IN STARTING PRACTICE AND HOW DID YOU ENDEAVOR TO MANAGE IT?**

The hardest thing was being patient enough (and lucky enough?) to find the right position. A mentor in residency encouraged me to define my "dream job," and I decided that my ideal position would be: all pediatrics, in a pediatric hospital, in a place with a team or a mentor. I started looking for positions a year before my graduation from residency. I applied to every position I found, and I sent out hundreds of e-mails asking if a position might be created for me. I interviewed at institutions that had never had pediatrics, and those who had so many pediatric plastic surgeons that there didn't seem to be room for one more. And after each I had to decide whether the job was close enough to what I had hoped for, and whether I could be really happy there. I have watched colleagues fill these other positions, and already I have seen several of them move on to other institutions. It took me four years to get to my dream job, but I am incredibly thankful that I didn't compromise.

#### **WHAT ADVICE WOULD YOU GIVE CURRENT RESIDENTS AND FELLOWS ABOUT THE TRANSITION TO PRACTICE?**

Keep breathing, roll with the punches, and don't try to reinvent the wheel. It can feel overwhelming dealing with business and legal issues (for the first time), hiring a secretary and an accountant, learning new computer systems, finding instruments similar to what you know, and sussing out the politics and the culture, all while facing the barrage of paperwork that you thought would get better after residency. Write the letter. Do the dictation. Pay the bill. Apologize when you've wronged someone. Thank those who help you. Forgive others for not reading your mind and forgive yourself when things don't go smoothly. It will get easier. And above all, ask the people around you for help, because they are wise and have done this before.

#### **WHERE DO YOU SEE THE PRACTICE OF MEDICINE GOING OVER THE COURSE OF YOUR CAREER AND WHAT OPERATION DO YOU THINK WE WILL NOT BE DOING IN THE FUTURE THAT WE ARE DOING NOW?**

I suspect that we will become much more adept at tissue engineering, and develop the ability to create durable tissues of controllable cellular compositions, shapes, and textures. We will grow autogenous patient-specific bones for facial and skull reconstruction. We will implant autogenous cartilaginous frameworks for ear and nose reconstruction, we will take prelamination and prefabrication of flaps to a whole new level, and fat grafting will become more and more common.

At the same time, we will recognize that the homeostasis of congenital differences does not capitulate to surgical intervention, and I believe we will decrease our attempts to balance asymmetries in still-growing children. The Potter rhinoplasty, the 6-year-old mandibular distraction for hemifacial microsomia, and the facial onlay bone grafting for facial asymmetry will become less popular as we acknowledge the long-term futility of these types of procedures.

## FELLOWSHIP PROGRAM



Erin Brown,  
MD, PhD, FRCSC

Over time, the goals of Fellowship training have matured, and the scope of training opportunities have expanded (Breast Reconstruction, Craniofacial Surgery, Hand & Microsurgery, Pediatric Plastic Surgery, Aesthetic & Breast Surgery and Breast Reconstruction Research). The philosophy of training at UBC has been to provide subspecialty level experiences to fully trained Plastic Surgeons, as opposed to "general" Fellowship programs (R6 year).

The increasing difficulties graduates are experiencing in obtaining fellowship training opportunities outside of Canada make the need for high quality training at UBC essential to contribute to the further development of our future colleagues. Given the long history of education excellence within the UBC Division of Plastic Surgery, the development and maturation of these fellowship programs reflects the natural evolution of a commitment to training excellent surgeons.

### FELLOWS 2017

#### IAN MAXWELL

Breast Reconstruction Fellow  
July 1, 2016 to December 31, 2016  
Residency: University of Ottawa

#### MUHAMMAD (ASIM) BASHIR

Craniofacial Fellow  
July 1, 2016 to December 31, 2016  
Residency: Wexham Park Hospital, Chelsea & Westminster Hospital, St Thomas' Hospital and Great Ormond Street Children's Hospital, 'London Deanery'.

#### SEAN SMITH

Aesthetic Fellow, Kelowna  
July 1, 2016 to December 31, 2016  
Residency: University of Ottawa

#### VÉRONIQUE ST-SUPÉRY

Breast Reconstruction Fellow  
July 1, 2016 to December 31, 2016  
Residency: University of Montreal

#### JESSICA ROBB

Hand & Microsurgery Fellow  
July 1, 2016 to June 30, 2017  
Residency: University of Alberta

#### VÉRONIQUE ST-SUPÉRY

Craniofacial Fellow  
January 1, 2017 to June 30, 2017  
Residency: University of Montreal

## UNDERGRADUATE EDUCATION



Dr. A.A. Demianczuk,  
MD, FRCSC



A large volume of Third and Fourth year medical students continue to stream through the academic hospitals, rotating through the Division of Plastic Surgery in two week rotations.



A total of 288 medical students successfully entered first year UBC medical school in 2016, maintaining the mandate of an expanded medical school initiated in 2004. Providing a meaningful educational experience for this large number of students continues to stress limited clinical resources.



Added to the grouping is Fourth-year 'Out of Province' medical students, as audition electives prior to CaRMS continue to be extremely popular in preparation for application to our highly desirable Residency Program.

Similar to Post-Graduate education, the concept of competency based medical education is gaining traction, and replacing traditional models. EPA's (Entrustable Professional Activities) are an emerging concept, and require multiple simultaneous competencies to be reached in order to satisfactorily pass a rotation. Progressive clinical responsibility and graded autonomy are not new concepts, however they are replacing the traditional models of end of service OSCE exams and Oral exams. Mobile technology and electronic portfolios require students to competently complete supervised task specific activities in order to successfully complete a rotation. Although competency based models are intuitively attractive and effective as a means to develop learning programs, the various competencies have proven difficult to assess objectively. While scholarly knowledge and technical surgical skills are well suited to "competency assessment", other components of medical education such as Professionalism, Leadership, Collaboration and Communication are more challenging to evaluate. Competency based education models have both their suitors and detractors, however it is the over-riding theme in Medical Education in the 21st century.



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# Residents Corner

➔ PLASTIC SURGERY RESIDENTS 2016/2017



Mark K. Hill, MD, FRCSC

We continue to move towards Competency by Design with initial meetings starting this fall to move forward with the process. The completion is still pegged for 2019. Our external review has been pushed back to 2020. We underwent an extensive internal review of our program this year.

WorkSafe BC has continued its support for our Microsurgery Lab with a 3 year funding agreement which we are really excited about. This will allow us to continue to provide world class microsurgical skills instruction. Our 2016 Annual Residents Research Day was once again a highlight of our year. Our

Visiting Professor, Paul Cederna, was excellent and provided innovation and optimism for the future of Plastic Surgery. We had a record number of local presenters which was truly exceptional. Special thanks to David Naysmith, Jenny Cheng, Jennifer Robinson, Ben Gelfant, Jim Boyle and Doug Courtemanche for sharing their ideas in such an expert fashion. Morgan Evans, R4 won the Dr. Robert Cowan Best Clinical Resident Paper Award, "From Bench to Bed 2: The Safety of Topically Delivered FS2 in Humans" and Diana Forbes, R2 won the Dr. Robert Cowan Best Basic Science Resident Paper Award, "Growth Hormone Therapy



## UBC Division of Plastic Surgery 2016 Annual Resident Retreat Keats Island



Accelerates Axonal Regeneration, Promotes Motor Reinnervation, and Reduces Muscle Atrophy following Peripheral Nerve Injury”.

We also want to thank the Section of Plastic Surgery for their continued support of this important event. Our other visiting professors in 2016 were Tom Hayakawa from Winnipeg who shared his experience in complex reconstruction and Amanda Gosman from San Diego.

Our 2017 Resident Day will be expanded this year to include the first Resident and Fellow Alumni day following the regular Friday session. We have a record number of

exhibitors this year. We are looking forward to our visiting professor Dr. Babak Mehrara.

A congratulation to our last year's graduating residents, **Krista Genoway** and **Jorga Zabojava**. Krista is completing a fellowship at the Buncke Clinic in San Francisco and Jorga is completing fellowships in Sweden and New Zealand. This year's graduating residents are **Morgan Evans** who is off to Seattle for a Craniofacial fellowship and **Aaron Knox** who is off to Melbourne for a Hand fellowship. Our newly accepted residents this year for our R1 positions are **Jacques Zhang**

and **Janine Roller** both from UBC. Our Residents represented us very well around the province, country and internationally. **Aaron van Slyke** our 2nd year resident had a podium presentation at the ASPRS meeting. Several of our residents presented papers and posters at the CSPS meeting. Locally we once again had the most papers accepted at the Chung Surgical day at UBC.

We would like to congratulate Morgan and Shannon Evans for the arrival of their baby girl Skylar as well as Aaron and Michela Knox for their baby girl Rowen.

## ⊕ Plastic Surgery Residents 2016 - 2017



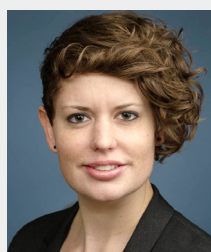
Morgan Evans - PGY-5



Aaron Knox - PGY-5 (CIP)



Leslie Leung - PGY-4



Karen Slater - PGY-4



Daniel Dempsy - PGY-3 (CIP)



Tyler Omeis - PGY-3



Diana Song - PGY-3 (CIP)



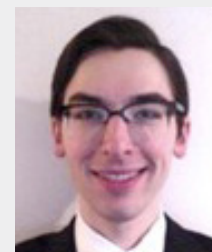
Stahs Pripotnev - PGY-2



Aaron Van Slyke - PGY-2



Sofie Schlagintweit - PGY-1



Peter Mankowski - PGY-1 (CIP)



**COMMITTEE:**

Jugal Arneja (Chair)  
Peter Lennox  
Sean Bristol

**2014-2016**  
**\$139,500.42**  
**GRANTS**

# UBC PLASTIC SURGERY ACADEMIC FUND

## Redefining an Academic "Tithe"

The UBC Plastic Surgery Academic Fund is the latest initiative in the division. For the past three years, full-time division faculty have contributed \$4000 annually to this fund in an effort to grow academic or philanthropic interests for the division. Since our division's members may have differing pursuits from philanthropic clinical service, to advancing a specific educational mandate, or acquiring seed grant funding to support a research initiative, the terms of reference are deliberately broad so as to give our members equal opportunity for an initiative that meets their objectives. Herein are the 2014-2016 grant awardees and their pursuit, consisting of 30 grants totaling \$139,500.42, and the return on investment to date of these endeavors.

### 2014 (\$33,335)

<b>DR. CARR</b>	Uganda philanthropic travel	<b>\$5000 grant awarded</b>
<b>DR. HILL</b>	Uganda philanthropic travel	<b>\$5000 grant awarded</b>
<b>DR. BROWN</b>	Bolivia philanthropic travel	<b>\$5000 grant awarded</b>
<b>DR. COURTEMANCHE</b>	Cleft-Q research project <i>{Presented at Western Regional Meeting, Carmel, CA, January 28, 2016, Breuning E, Courtemanche RJ, Courtemanche DJ. Qualitative Interviews with Parents of Young Children with Cleft Lip and Palate. J Invest Med, Jan 2016; 64 (1) p.227-8. Eleonore Breuning received a WAFMR Scholar Award for her presentation in Carmel. Presented at Healthy Mothers &amp; Healthy Babies PSBC'S 2nd Biennial Conference, March 11-12, 2016 Vancouver, BC.}</i>	<b>\$3335 grant awarded</b>
<b>DR. BRISTOL</b>	Nerve transfer/COPM project <i>{study ongoing}</i>	<b>\$5000 grant awarded</b>
<b>DR. SEAL</b>	Hand-in-Hand app project <i>Currently available on the App Store and Google Play. Ethics approval for randomized controlled trial to assess patient reported satisfaction using the app obtained</i>	<b>\$5000 grant awarded</b>
<b>DR. ARNEJA</b>	Reconstructing journal club research project <i>Presented at Western Regional Meeting, Jan 28-30 2016, Carmel, CA. J. Investig Med. 2016;64:135-345. Abstract 433. ACCEPTED FOR PUBLICATION</i>	<b>\$5000 grant awarded</b>
<b>DR. CARR</b>	Cosmetic Surgery & Smoking Cessation Project <i>Presented at ASPS Sept. 23-27 2016, LA, CA. ACCEPTED FOR PUBLICATION. Van Slyke AC, Carr M, Knox A, Genoway K, Carr N (2017). Perioperative and long-term smoking behaviors in cosmetic surgery patients. Plastic and Reconstructive Surgery, (in press, assigned to Sept. 2017 issue)</i>	<b>\$5000 grant awarded</b>



**2015 CALL 1 (\$45,000)**

<b>DR. BOVILL</b>	Uganda philanthropic travel	<b>\$5000 grant awarded</b>
<b>DR. BROWN</b>	Critical Thinking Project {study ongoing}	<b>\$5000 grant awarded</b>
<b>DR. MACADAM</b>	Uganda philanthropic travel	<b>\$5000 grant awarded</b>
<b>DR. LENNOX</b>	Breast Implant Biofilm project {study ongoing}	<b>\$5000 grant awarded</b>
<b>DR. WELLS</b>	Uganda philanthropic travel	<b>\$5000 grant awarded</b>
<b>DR. BRISTOL</b>	Nerve transfer/COPM project {study ongoing}	<b>\$5000 grant awarded</b>
<b>DR. SEAL</b>	Hand-in-Hand app projec  <i>Currently available on the App Store and Google Play. Ethics approval for randomized controlled trial to assess patient reported satisfaction using the app obtained</i>	<b>\$5000 grant awarded</b>
<b>DR. ARNEJA</b>	Gynecomastia workup project  <i>Presented at Western Regional Meeting, Jan 27-29, 2017, Carmel, CA. Journal of Investigative Medicine Jan 2017, 65 (1) p128-129; TO BE PRESENTED at CSPA 2017, Winnipeg, MB &amp; SUBMITTED FOR PUBLICATION</i>	<b>\$5000 grant awarded</b>

**2015 CALL 2 (\$30,770.65)**

<b>DR. CARR</b>	Surgical Drill Integrated Depth Gauge  <i>TO BE PRESENTED CAOS (Computer Assisted Orthopaedic Surgery) 2017 in Aachen, Germany, TO BE PRESENTED CSPA 2017 in Winnipeg, MB Master's Thesis in Mechanical Engineering, June 2017 TO BE SUBMITTED FOR PUBLICATION IJMRCAS (International Journal of Medical Robotics and Computer Assisted Surgery), PATENTS PENDING</i>	<b>\$5000 grant awarded</b>
<b>DR. PAPP</b>	Canadian Burn Symposium, Vancouver, BC	<b>\$5000 grant awarded</b>
<b>DR. COURTEMANCHE</b>	Limb Length Discrepancy in Vascular Anomalies Patients  <i>Presented at ILLRS Congress, November 4-7, 2015 Miami FL. Sepehri A, Chhina H, Courtemanche D, Cooper A. The Multiplier Method for Predicting Limb Length Discrepancy in Patients with Vascular Anomalies in the Lower Limb. J Limb Lengthen Reconstr 2015; 1 Suppl S1:1-117</i>	<b>\$4286.54 grant awarded</b>
<b>DR. VERCHERE</b>	Sup-ER splint, Shoulder/Elbow Function {study ongoing}	<b>\$4785 grant awarded</b>
<b>DR. SEAL</b>	Hand-in-Hand app project  <i>Currently available on the App Store and Google Play. Ethics approval for randomized controlled trial to assess patient reported satisfaction using the app obtained</i>	<b>\$4853 grant awarded</b>

## 2015 CALL 2 (\$30,770.65)

DR. BUSH	Uganda philanthropic travel	\$5000 grant awarded
DR. ARNEJA	Travel grant AAPS Meeting <i>PRESENTED AT American Association of Plastic Surgeons, Scottsdale, AZ, 2015 AND PUBLISHED IN PRS: Zhang J, Song D, Bedford J, Bucevska M, Courtemanche DJ, Arneja J. What Is the Best Way to Measure Surgical Quality? Comparing the American College of Surgeons National Surgical Quality Improvement Program versus Traditional Morbidity and Mortality Conferences. Plast Reconstr Surg. 137(4):1242–50, 2016</i>	\$1846.11 grant awarded

## 2016 CALL 1 (\$30,394.77)

DR. CARR	Uganda philanthropic travel	\$5000 grant awarded in February 2017
DR. LENNOX	Breast Implant Biofilm project	\$5000 grant awarded in February 2017
DR. HILL	Uganda philanthropic travel	\$2894.77 grant awarded in February 2017
DR. BRISTOL	Travel (CSPS Nerve presentation) philanthropic travel	\$2500 grant awarded in February 2017
DR. SEAL	Scaphoid Advance Fixation Equipment (SAFE) - Device Design	\$5000 grant awarded in February 2017
DR. VAN LAEKEN	India philanthropic travel	\$5000 grant awarded in February 2017
DR. ARNEJA	India philanthropic travel (Smile Train)	\$5000 grant awarded in February 2017





Sheina Macadam, MD, MHS, FRCSC

## ACHIEVEMENTS UBC DIVISION OF PLASTIC SURGERY

Another year and another set of achievements for the residents and staff of the UBC Division of Plastic Surgery. Our division and labs published a total of 20 journal articles in peer-reviewed publications and were awarded \$250,000 in grants. Dr Peter Lennox was elected President of the Canadian Society of Plastic Surgery (CSPS) and Vice President of the Canadian Society of Aesthetic Plastic Surgery. Dr Sheina Macadam ended a 4-year term as the CSPS GAM Secretary/President. Dr Richard Warren will be the 2017-2019 Traveling Professor for the American Society for Aesthetic Plastic Surgery and Dr Nick Carr was nominated to the Editorial Board of the Aesthetic Surgery Journal. Dr David Granville relocated his laboratory from St Paul's Hospital to ICORD and is now serving as the Associate Director of the BC Firefighters' Burn and Wound Healing Group.

**Congratulations to our members who continue to enhance the reputation of the UBC Division of Plastic Surgery. We would like to highlight the following individuals:**

GRANTING AGENCY	TITLE	AMOUNT	PI
UNIVERSITY OF BRITISH COLUMBIA SUMMER STUDENT RESEARCH PROGRAM GRANT	IS ROUTINE LABORATORY INVESTIGATION NECESSARY IN PUBERTAL GYNECOMASTIA? A RETROSPECTIVE STUDY	\$3,150	DR. JUGPAL ARNEJA
UNIVERSITY OF BRITISH COLUMBIA SUMMER STUDENT RESEARCH PROGRAM GRANT	A NEEDS ASSESSMENT AUDIT OF THE CLEFT PALATE CLINIC: ARE WE MEETING THE DEMAND OF OUR PATIENT POPULATION WITH OUR AVAILABLE RESOURCES?	\$1,600	DR. DOUGLAS COURTEMANCHE
UNIVERSITY OF BRITISH COLUMBIA SUMMER STUDENT RESEARCH PROGRAM GRANT	THE IMPACT OF NON-OPERATIVE EMERGENCY REFERRALS ON W1 MANAGEMENT	\$1,600	DR. DOUGLAS COURTEMANCHE
DR. ROBERT COWAN BEST RESIDENT PAPER AWARD	FROM BENCH TO BED 2: THE SAFETY OF TOPICALLY DELIVERED FS2 IN HUMANS		DR.. MORGAN EVANS
BC TRANSPLANT RESEARCH FOUNDATION GRANT	GRANZYME K IN CARDIAC ALLOGRAFT VASCULOPATHY	\$25,000	DR. DAVID GRANVILLE
INTERNATIONAL COLLABORATION ON REPAIR DISCOVERIES GRANT	GRANZYME B IN SPINAL CORD INJURY	\$20,000	DR. DAVID GRANVILLE
RICK HANSEN INSTITUTE GRANT	GRANZYME B INHIBITORS AS THERAPEUTICS FOR PRESSURE ULCER MANAGEMENT	\$130,000	DR. DAVID GRANVILLE
RICK HANSEN INSTITUTE + MITAC GRANT	A PILOT STUDY OF TREATING PRESSURE ULCERS WITH POWDERED RECONSTITUTED LIQUID SKIN SUBSTITUTE	\$30,000	DR. AZIZ GHAHARY
UNIVERSITY OF BRITISH COLUMBIA SUMMER STUDENT RESEARCH PROGRAM GRANT	POST-OPERATIVE INTRAVENOUS FLUID ORDERING PRACTICES FOR PEDIATRIC PATIENTS BY PLASTIC SURGERY TRAINEES IN NORTH AMERICA	\$3,200	DR. ERIKA HENKELMAN (CO-PI)
UBC FACULTY OF MEDICINE	START UP AWARD	\$5000	DR. REZA JALILI
CIHR STUDENTSHIP AWARD	START UP AWARD	\$5000	DR. REZA JALILI



GRANTING AGENCY	TITLE	AMOUNT	PI
UNIVERSITY OF BRITISH COLUMBIA CONTINUING PROFESSIONAL DEVELOPMENT MEDICAL EDUCATION RESEARCH GRANT	MEETING THE SUTURING NEEDS OF MEDICAL STUDENTS: EVALUATING THE EFFECTIVENESS OF AN INNOVATIVE SUTURING SIMULATOR FOR TEACHING SUTURING SKILLS	\$500	DR. AARON KNOX (CO-PI)
UNIVERSITY OF BRITISH COLUMBIA CONTINUING PROFESSIONAL DEVELOPMENT RESEARCH GRANT	EFFECT OF COSMETIC SURGERY ON LONG-TERM SMOKING CESSATION	\$500	DR. AARON KNOX (CO-PI)
UNIVERSITY OF BRITISH COLUMBIA CONTINUING PROFESSIONAL DEVELOPMENT EDUCATIONAL RESEARCH GRANT	MEETING THE SUTURING NEEDS OF MEDICAL STUDENTS: EVALUATING THE EFFECTIVENESS OF AN INNOVATIVE SUTURING SIMULATOR FOR TEACHING SUTURING SKILLS	\$500	DR. AARON VAN SLYKE (CO-PI)
UNIVERSITY OF BRITISH COLUMBIA SUMMER STUDENT RESEARCH PROGRAM GRANT	OUTPATIENT SEDATED BURN DRESSINGS AT BC CHILDREN'S HOSPITAL: A 10-YEAR AUDIT	\$3,200	DR. CINDY VERCHERE

## PUBLICATIONS

<b>BURNS</b>	<ul style="list-style-type: none"> <li>Miliszewski M, Kirchhof M, Sikora S, Papp A, Dutz J: Stevens-Johnson Syndrome and Toxic Epidermal Necrolysis: An Analysis of Triggers and Implications for Improving Mortality Outcomes. <i>American Journal of Medicine</i>. 2016 Nov;129(11):1221-1225.</li> <li>Toor J, Crain J, Kelly C, Verchere C, Fish J. Pediatric Burns from Glass-Fronted Fireplaces in Canada: A Growing Issue Over the Past 20 Years. <i>Journal of Burn Care Research</i>. 2016 Sep;37(5):e483–8.</li> </ul>
<b>WOUND HEALING LAB</b>	<ul style="list-style-type: none"> <li>Jalili RB, Zhang Y, Hosseini-Tabatabaei A, Kilani RT, Khosravi Maharlooee M, Li Y, Salimi Elizei S, Warnock GL, Ghahary A. Fibroblast Cell-Based Therapy for Experimental Autoimmune Diabetes. <i>PLoS One</i>. 2016 Jan 14;11(1):e0146970.</li> <li>Khosravi-Maharlooee M, Pakyari M, B Jalili R, Salimi-Elizei S, Lai JC, Poormasjedi-Meibod M, Kilani RT, Dutz J, Ghahary A. Tolerogenic Effect of Mouse Fibroblasts on Dendritic Cells. <i>Immunology</i>. 2016. May: 148(1):22-33.</li> <li>Li Y, Adomat H, Guns ET, Hojabrpour P, Duronio V, Curran TA, Jalili RB, Jia W, Delwar Z, Zhang Y, Elizei SS, Ghahary A. Identification of a Hematopoietic Cell Dedifferentiation-Inducing Factor. <i>Journal of Cell Physiology</i> 2016 Jun;231(6):1350-63.</li> <li>Li Y, Jalili RB, Ghahary A. Accelerating skin wound healing by M-CSF through generating SSEA-1 and -3 stem cells in the injured sites. <i>Scientific Reports</i> 6. 2016 Jul 1;6:28979.</li> <li>Merkulova Y, Shen Y, Parkinson LG, Raithatha SA, Zhao H, Westendorf K, Sharma M, Bleackley RC, Granville DJ. Granzyme B inhibits keratinocyte migration by disrupting epidermal growth factor receptor (EGFR)-mediated signalling. <i>Biological Chemistry</i>. 2016: 397(9):883-95.</li> <li>Poormasjedi-Meibod MS, Salimi Elizei S, Leung V, Jalili RB, Ko F, Ghahary A. Kynurenine Modulates MMP-1 and Type-I Collagen Expression Via Aryl Hydrocarbon Receptor Activation in Dermal Fibroblasts. <i>Journal of Cell Physiology</i>. 2016 Dec;231(12):2749-60.</li> <li>Shen Y, Cheng F, Sharma M, Merkulova Y, Raithatha SA, Parkinson LG, Zhao H, Westendorf K, Bohunek L, Bozin T, Hsu I, Ang LS, Williams SJ, Bleackley RC, Eriksson JE, Seidman MA, McManus BM, Granville DJ. Granzyme B Deficiency Protects against Angiotensin II-Induced Cardiac Fibrosis. <i>American Journal of Pathology</i>. 2016: 186(1):87-100.</li> <li>Sharma M, Merkulova Y, Raithatha S, Parkinson LG, Shen Y, Cooper D, Granville DJ. Extracellular Granzyme K Mediates Endothelial Activation Through the Cleavage of Protease Activated Receptor-1 (PAR-1). <i>FEBS J</i>. 2016; 283(9):1734-47.</li> </ul>

## PUBLICATIONS CONT.

<b>WOUND HEALING LAB</b>	<ul style="list-style-type: none"> <li>Zhang Y, Jalili RB, Kilani RT, Elizei SS, Farrokhi A, Khosravi-Maharlooei M, Warnock GL, Ao Z, Marzban L, Ghahary A. IDO-Expressing Fibroblasts Protect Islet beta Cells from Immunological Attack and Reverse Hyperglycemia in Non-Obese Diabetic Mice. <i>Journal of Cell Physiology</i>. 2016 Sep;231(9):1964-73.</li> </ul>
<b>BREAST</b>	<ul style="list-style-type: none"> <li>Knox A, Ho A, Leung L, Tashakkor A, Lennox P, Van Laeken N, Macadam S. Comparison of Outcomes Following Autologous Breast Reconstruction using the DIEP and Pedicled TRAM Flap: A 12 Year Clinical Retrospective Study and Literature Review. <i>Plastic and Reconstructive Surgery</i>. 2016 Jul;138(1):16-28.</li> <li>Song D, Slater K, Papsdorf M, Van Laeken N, Zhong T, Hazen A, Vidal D, Macadam SA. Autologous Breast Reconstruction in Women Older Than 65 Years Versus Women Younger Than 65 Years: A Multi-Center Analysis. <i>Annals Plastic Surgery</i>. 2016 Feb;76 (2):155–63.</li> </ul>
<b>EDUCATION</b>	<ul style="list-style-type: none"> <li>Zhang JX, Song D, Bedford J, Bucevska M, Courtemanche DJ, Arneja JS. What Is the Best Way to Measure Surgical Quality? Comparing the American College of Surgeons National Surgical Quality Improvement Program versus Traditional Morbidity and Mortality Conferences. <i>Plastic and Reconstructive Surgery</i> 2016 Apr;137(4):1242–50.</li> </ul>
<b>PEDIATRIC</b>	<ul style="list-style-type: none"> <li>Zhang J, Arneja J. The Unilateral Cleft Lip Repair and Primary Cleft Rhinoplasty. <i>Plastic Reconstructive Surgery Glob Open</i> 2016;4:e1125.</li> </ul>
<b>COSMETIC</b>	<ul style="list-style-type: none"> <li>Klassen AF, Cano SJ, Alderman A, Soldin M, Thoma A, Robson S, Kaur M, Papas A, Van Laeken N, Taylor VH, Pusic AL. The BODY-Q: A Patient Reported Outcome Instrument for Weight Loss and Body Contouring Treatments. <i>Plastic and Reconstructive Surgery Glob Open</i>. 2016 Apr 13;4(4):e679.</li> </ul>
<b>HAND &amp; PERIPHERAL NERVE</b>	<ul style="list-style-type: none"> <li>Berger M, Regan WR, Seal A, Bristol S. Reliability of the “Ten Test” for Assessment of Discriminative Sensation in Hand Trauma. <i>Journal of Plastic, Reconstructive and Aesthetic Surgery</i>. 2016 Oct 69(10): 1411-1406.</li> <li>Catapano J, Demsey D, Ho ES, Zuker RM, Borschel GH. Cross-Face Nerve Grafting with Infraorbital Nerve Pathway Protection: Anatomic and Histomorphometric Feasibility Study. <i>Plastic and Reconstructive Surgery Glob Open</i>. 2016 Sep 23;4(9):e1037. eCollection 2016.</li> <li>Meisel E, Seal A, Yao C, Ghiassi A, Stevanovic M. Management of Scaphoid Nonunion with Iliac Crest Bone Graft and K-wire Fixation. <i>European Journal of Orthopaedic Surgery and Traumatology</i>. November, 2016.</li> <li>Tuffaha SH, Budihardjo JD, Sarhane KA, Khusheim M, Song D, Broyles JM, et al. Growth Hormone Therapy Accelerates Axonal Regeneration, Promotes Motor Reinnervation, and Reduces Muscle Atrophy following Peripheral Nerve Injury. <i>Plastic and Reconstructive Surgery</i>. 2016 Jun;137(6):1771–80.</li> </ul>
<b>BOOK CHAPTERS</b>	<ul style="list-style-type: none"> <li>Arneja, J.S. and Gosain, A.K. Velopharyngeal Inadequacy. In: Lin, S. and Hijjawi, J., (eds.) <i>Plastic Surgery Pearls of Wisdom</i>, 3rd Ed. New York, NY: McGraw Hill, 2016, 603-609.</li> <li>Gilardino, M, Arneja, J. and Kanevsky, J. Pediatric Burn Reconstruction. In: Bentz, M, Bauer, B., Zuker, R. (eds.) <i>Principles and Practice of Pediatric Plastic Surgery</i>, 2nd Ed. Thieme, New York, NY, 2016, 169-197.</li> <li>Rozzelle, A.A. and Arneja, J.S. Cleft Lip and Cleft Palate. In: McInerney, T.K., Adam, H.M., Campbell, 4. D., Kamat, D.K., Kelleher, K.J., (eds.) <i>American Academy of Pediatrics Textbook of Pediatric Care</i>, 2nd Ed. Elk Grove Village, IL: American Academy of Pediatrics, 2016, 1849-1858.</li> <li>Benson, A. Gilardino, M. and Arneja, J.S. Hemangiomas. In: McInerney, T.K., Adam, H.M., Campbell, D., Kamat, D.K., Kelleher, K.J., (eds.) <i>American Academy of Pediatrics Textbook of Pediatric Care</i>, 2nd Ed. Elk Grove Village, IL: American Academy of Pediatrics, 2016, 2110-2117.</li> </ul>

## EDITOR'S NOTE



Jugpal Arneja,  
MD, MBA, FRCSC

"I have no special talent.  
I am only passionately  
curious."

-Albert Einstein

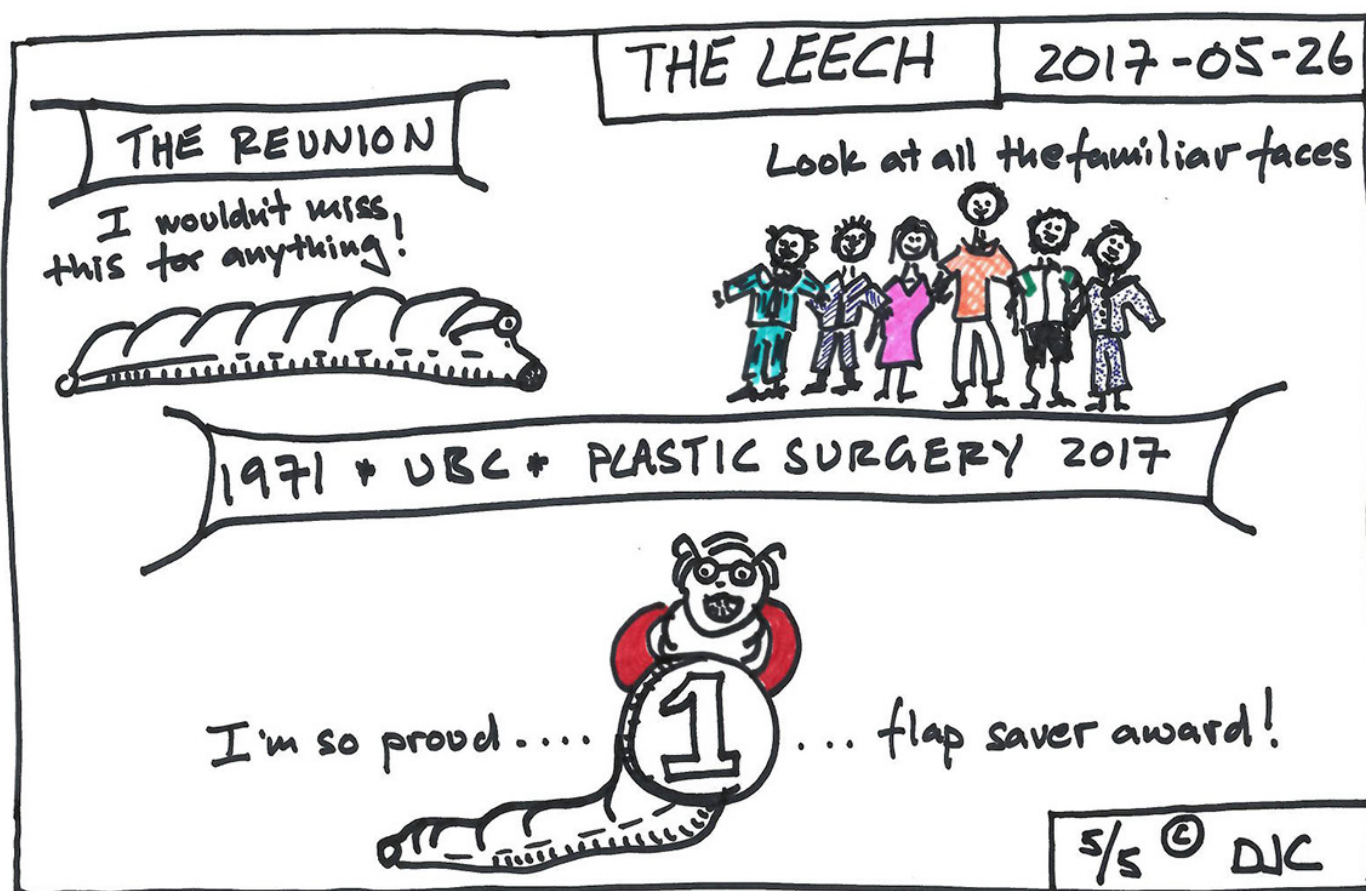
Curiosity, as defined by Merriam-Webster, is "desire to know: interest leading to inquiry". Curiosity leads to innovation and there are many clear examples in this edition of the pedicle of the same. Although what is remarkable is maintenance of this zeal for knowledge over a sustained period of time. For people like Nick Carr and Doug Courtemanche, despite all they've accomplished, and after having been in the ring for more than 25 years, their passionate curiosity is front and centre at teaching rounds, in their mentorship of trainees, and in the research questions they study. If curiosity wanes, complacency waxes; being complacent is easy, being curious requires persistent effort.

John Mulliken has taught many of us a great deal of things, but the paper that has influenced and inspired the

most is entitled "A sense of wonder".<sup>1</sup> Despite the 500+ publications he has contributed to the literature, Mulliken describes the characteristics of a surgeon-scientist he learned from his mentor, Dr. Joseph Murray, nobel leaureate: curiosity, imagination, and persistence. Mulliken goes on to suggest that curiosity can be upregulated by teachers and mentors. On a daily basis I see examples of this upregulation in our division and I salute our talented team of mentors, colleagues, trainees, and support staff who collectively make this happen.

A special thanks to Stryker for sponsoring this 5th edition of the Pedicle and to Maureen Berard and Norine Mayede for all they do.

**References:** 1. Mulliken JB. A sense of wonder. *Plast Reconstr Surg.* 2002 Oct;110(5):1353-9.



## Support Us

If you are interested in financially supporting any of the UBC Division of Plastic Surgery Programs please contact Maureen Berard at 604.875.4084.