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

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

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

Just a few days ago, I was performing a Thoracodorsal-Artery Perforator flap to a diabetic ankle wound. The case went well, and I was pleased that a new group of residents and fellows were able to participate and learn from all of the mistakes I have made and those that other colleagues have shared with me over many years, often at WSRM meetings over a cup of...
many challenges that I have just described? We have a
acknowledge our past, but surge ahead and face the
of the WSRM assure that we continue to look back and
caused many of us to take pause. How do we as members
challenges to democracy and world health burdens have
instability of our global economy, the political shifts and
However, the impact of the tragedy of 9-11, the economic
The first hand transplant had just been performed (1998).
replantation (1968). Many of our leaders were alive then and
their microsurgical offspring. Three decades had passed
since the report of Susumo Tamai’s first report of thumb
Our international microsurgical pioneers were still “raising”
membership. Looking back, the world was a different place.
organization that was open to the world for scientific
that time was to create one microsurgical international
Society for Reconstructive Microsurgery. The goal at
International Microsurgical Society and the International
The WSRM was founded in 1999 by combining the
World Society for Reconstructive Microsurgery.

Urgent return to the operating room revealed a clotted
posterior tibial artery. Based on the perfusion pressure after
a Fogarty catheter was used to clear the thrombosis, I felt
that it was unwise to re-establish inflow from this source
vessel. Looking back over my experience and knowledge,
it was clear that a 15 cm vein graft from the dorsalis pedis
artery (end to side) to the flap pedicle would be required
to reestablish arterial inflow. We surged ahead, arterial
inflow was reestablished and the flap survived! The moral
of this particular story is that we can only surge ahead and
create new knowledge for others, by looking back and not
forgetting our past. And we must share this history in person
– not only on a blog or in a chat room. Experience comes
from bad judgment, and good judgment often follows bad
experiences. As microsurgeons we hate to fail, and have
tremendous determination and grit that often saves a dire
situation. Sometimes we just have to “will” the flap to survive!
The WSRM was founded in 1999 by combining the
International Microsurgical Society and the International
Society for Reconstructive Microsurgery. The goal at
that time was to create one microsurgical international
organization that was open to the world for scientific
exchange, camaraderie and professional support for its
membership. Looking back, the world was a different place.
Our international microsurgical pioneers were still “raising”
their microsurgical offspring. Three decades had passed
since the report of Susumo Tamai’s first report of thumb
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The first hand transplant had just been performed (1998).
However, the impact of the tragedy of 9-11, the economic
instability of our global economy, the political shifts and
challenges to democracy and world health burdens have
caused many of us to take pause. How do we as members
of the WSRM assure that we continue to look back and
acknowledge our past, but surge ahead and face the
many challenges that I have just described? We have a
responsibility and an obligation to surge forward. As our
microsurgical prowess has exponentially expanded, we must
pass it on to the next generation of WSRM members, and
provide access to our society benefits that include not only
professional support and value, but a personal connection to
young colleagues around the world who live or want to live
“under the microscope” and have passion for microsurgery.
Our work ethic and commitment result in remarkable
success rates. Knowledge of very complex and technically
demanding operations that benefit our patients must be
passed on to the next generation so that in time they can
build on established techniques and then become innovators.

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

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

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

The Microsurgery Fellowship Match sponsored by the American Society for Reconstructive Microsurgery (ASRM) was established in 2010 with the goal of coordinating fellowship appointments. The participating programs do not make appointments until the match has been completed. Therefore, the Microsurgery Fellowship Match results in participating programs conducting interviews for fellowship applicants during the same timeframe and provides prospective fellows with a chance to visit multiple training programs without being forced to commit to a fellowship before all visits are complete. The Spring match date allows applicants to secure a fellowship position at an earlier time over 12 months from the conclusion of residency training. The most recent match took place on May 22, 2014. Any post-match vacancies were released to applicants who did not match on the following day, providing them with another opportunity to apply for fellowship training. Currently, over 25 programs participate in the Microsurgery Fellowship Match. More information can be found on the ASRM website: http://www.microsurg.org/fellowships/match/. Starting January 5, 2015 fellowship applicants will be able to register for the next fellowship match, which will occur in the Spring of 2015 for fellowships starting in June 2016.

ASRM 2015 Annual Meeting

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

Welcome to WSRM 2015

5 good reasons for you to come

1. **A Great list faculty**: It will be a meeting of the ‘Who’s Who’ of microsurgery. A wonderful opportunity to meet the masters and get inspired.

2. **A Great Scientific treat awaits you**: President’s lecture on the theme of ‘Looking back and surging ahead’, three theme lectures, the inaugural S & T lecture by Ian Taylor, 12 master classes, 30 symposia, ‘my most challenging case’, by experts and free papers.

3. **A great venue**: Grand Hyatt at Mumbai is the perfect venue for the congress.

4. **Great Value for money**: This congress has a low registration fees and accommodation at the venue is a great value for money.

5. **A Dedicated Organizing team**: We are doing everything possible to make it a congress to remember.

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

For details visit the website www.wsrm2015umbai.com
Bring your family along. We guarantee them a good time.

Dr S. Scott Levin
President - WSRM

Dr Sunilkumar Sahapathy
Organizing Chairman - WSRM 2015

Dr Samir Kunia
Chair Scientific Committee

Dr Rajendra Nehete
Organizing Secretary

Dr Vinita Puri
Congress Co-ordinator

– continued on page 4
The 2nd APFSRM in Buyeo, Korea 2014

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

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

On behalf of the organizing committee, the president of the APFRSM, Professor Kyoung Moo Yang, and the chairman of the scientific committee, Professor Jeong Tae Kim, expressed their appreciation to those who participated in the 2nd APFRSM meeting. The attending 23 national delegates, including Professor David Chwei-Chin Chuang, the next president of WSRM, Dr. Kazuteru Doi, the past president of WSRM and Dr. Soo Heong Tan, the past president of 1st APFRSM, voted and decided that the 3rd APFRSM meeting will be held in Beijing, China two years later.
Free Flap Reconstruction of the Abdominal Wall: When Mesh is not Enough

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

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

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

His soft tissue reconstruction of his abdominal wall was achieved with a free ALT flap with anastomoses to his left inferior epigastric vessels and the fascia of the flap inset on top of the mesh (Figure 2). He recovered uneventfully and has a stable abdominal wall reconstruction at one year follow up without hernia recurrence (Figure 3).

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

References

Interesting Cases

Ongoing Gracilis Myocutaneous Flap Functioning Free Muscle Transplantation

Provided by: David Chwei-Chin Chuang, MD¹ (professor), Tommy Nai-Jen Chang, MD¹. (clinical fellow)
Aleksandra M. McGrath MD, PhD¹,² (clinical fellow)
1, Department of Plastic Surgery, Chang Gung Memorial Hospital, Chang Gung University, Taipei-Linkou, Taiwan
2, Department of Clinical Sciences, Umeå University, Umeå, Sweden

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

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

History Summary:
1. 24 Y/O, left brachial plexus injury (BPI), had nerve reconstruction previously, subclavian artery segmental thrombosis, radial pulsation (-), plan to do gracilis FFMT for elbow flexion and EDC, innervated by XI. No preoperative angiography.
2. Intraoperatively,
   (1) Thoracoacromial artery and nearby vein were explored (usually four branches are present: clavicular, pectoral, acromial and deltoid) (Fig. A)
   (2) Initially, in the recipient site, the pectoral branch superficial to pectoralis minor muscle was selected. The patency test with jeweler’s forceps and spurting from one of the side branches indicated sufficient antegrade blood flow.
   (3) In the donor site, the right gracilis myocutaneous flap was harvested. It had two arteries and two veins of the same size conjoining proximally (Fig. B).
   (4) The pectoral branch was anastomosed to the gracilis artery, but no venous outflow was observed.
   (5) The artery anastomosis was divided and there was no bleeding from the pectoral branch, although it was still pulsating.
   (6) Multiple thrombi were observed in the lumen of the pectoral branch, which was irrigated several times with diluted heparin solution (0.1ml in 500ml normal saline). All visible thrombi were tried to remove but difficult. The vessel was segmentally resected proximally until 1 cm from the branching point. It was still filled with thrombosis plugs.
   (7) The pectoralis branch was abandoned and the acromial branch was instead selected. The clavicular branch was ligated to mobilize the pectoral branch. It became short for anastomosis.
   (8) The gracilis had two arteries joining proximally. One of them was ligated distally (close to the muscle), and reversed and anastomosed to the acromial branch (Fig. C) without need of vein graft.
   (9) Given up the pectoral branch vein. Dissected the basilar vein distally, transected and transferred proximally to anastomose the the conjoined gracilis vein.
   (10) The recipient artery continued to be prone to spasm. Extensive stripping of the adventitia on both sides of the anastomosis was done. Additionally, repeated heparin bolus (0.4ml, 2000IU) was given for four times. Each time heparin bolus was given, the blood flow improved.
   (11) Postoperatively, the heparin boluses were continued, 0.4ml (2000IU) in each 500ml lactate ringer, with total 12,000IU /day) for the next 4 days. The postoperative period was uneventful and the flap survived without any local complications (Fig. D).

Keys for the flap success
• avoiding any compression along the course of the thoracoacromial vessels (sample space was obtained by creating a trough in the pectoralis minor muscle) (Fig C)
• copious, repeated flushing of the intentionally left longer pectoral branch with diluted heparin, which could indirectly dilating the collateral branches, or subclavian artery.
• leaving a length of the pectoral branch (1 cm in length) to attract the potential new thrombi (Fig. 1C).
• choosing another, thrombus-free branch for anastomosis,
• repeated injections of heparin bolus (0.4ml, 2000 IU) intravenous and postoperatively
• heparin infusion (2000 IU in each 500 ml Ringer solution (12,000IU/day to 24,000IU/day is OK) for at least 2 days; controlled with APTT test frequently in the range of 1.5-2.0).

Corresponding author: David Chwei-Chin Chuang MD, Department of Plastic Surgery, Chang Gung Memorial Hospital, 5, Fu-Hsing Street, Kuei-Shan, Taoyuan 33305, Taiwan. Email: dearchuang@gmail.com

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References:

Fig 1.
A - type III gracilis pedicle with two vessels of the same size conjoining proximally.
B- branching pattern of thoracoacromial artery (T-A artery).
C- the schematic representation of the final anastomosis.

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

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

Candidate Applicants
Manish C. Champaneria, MD  United States

Journal of Reconstructive Microsurgery

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

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

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

Continued on page 8
We have a Special Topic issue on Lymphedema planned for the upcoming year, with guest editor Jaume Masia, MD.

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

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

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

Bernard Lee, MD
Editor

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

**Mark Your Calendar**

**Future WSRM Congresses**

- **2015 WSRM World Congress**  
  March 19 - 22, 2015  
  Mumbai, India  
  www.wsrm2015mumbai.com

- **2017 WSRM World Congress**  
  June 15-18, 2017  
  Seoul, Korea  
  www.wsrm2017.com

- **2019 WSRM World Congress**  
  Summer 2019  
  Shanghai, China

**Global Meetings**

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

- American Society for Reconstructive Microsurgery  
  January 24-27, 2015  
  Paradise Island, Bahamas  
  www.microsurg.org

- 26th Annual EURAPS Meeting  
  May 28-30, 2015  
  Edinburgh, United Kingdom  
  http://www.euraps.org/meetings/

- 13th EFASM Congress  
  April 21-24, 2016  
  Antalya, Turkey  
  www.efasm2016.org
## News from the Executive Council

### 2013 - 2015 Executive Council

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Embrace the power of our collective community by sharing critical WSRM news, celebrating our individual and collective accomplishments, sharing cases and engaging in didactic discussion, and making decisions together ... all in real-time. This kind of visibility to each other and more globally will enhance the WSRM and the value we each derive from it. Visit [www.formd.com](http://www.formd.com) and start communicating! All WSRM members have free access to the WSRM private network located on for[MD].
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.

Know someone who wants to become a member?
The application process is simple, and applications can be obtained at www.wsrm.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.