Temperature-controlled laser-soldering system and its clinical application for bonding skin incisions

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1 Introduction

Historically, many research groups have used laser-bonding techniques to overcome the disadvantages of current surgical methods. Photothermal tissue bonding involves the heating of the edges of an incision gently to partially denature the collagen structure, while photochemical tissue bonding makes use of a photosensitizing dye and a visible laser beam, which initiates a chemical reaction that regenerates protein crosslinks. Two photothermal laser-bonding techniques have been developed: (1) laser tissue welding (LTW), in which the edges of an incision are approximated and then laser energy is applied to heat these edges and (2) laser tissue soldering (LTS), wherein a biological solder is spread over the incision prior to the laser heating. LTW experiments were conducted first, using different lasers, operating at different wavelengths under different conditions. Later, in order to reduce the thermal damage and increase the LTW strength, biological protein-based solders were introduced. LTS has been carried out with different types of lasers, together with various types of biological solders, such as fibrinogen, albumin, collagen, or chitosan. The solder was usually applied on the surface to be joined, and then laser energy was used to adhere the underlying wound edges together, and at the same time attaching the solder to the tissue surface, resulting in increased strength and generating a watertight seal. CO₂ laser beam at a wavelength in the middle infrared (IR) spectrum (λ = 10.6 μm) is highly absorbed by all biological solders and, therefore, can easily heat the solder and the underlying tissue. On the other hand, the radiation of other lasers used (e.g., diode lasers emitting at the near-IR around 800 nm) is not absorbed by many of the solders. Therefore, special dyes (i.e., chromophores), designed to absorb the specific wavelengths of those lasers, were added to the solders so that they would absorb the laser radiation and generate heat.

LTW and LTS have been investigated in many different medical disciplines, including ophthalmology, urology, microsurgery, neurosurgery, dermatology, and others. LTS is potentially a method that is easier to use than the existing closure methods, and it is expected that the healing process would be faster and, if performed correctly, will leave minimal scarring. Previous studies have usually examined the laser power, beam diameter, beam profile, power density, and the length of the procedure. Unfortunately, the absorption was dependent on the tissue type, its thickness, and state of hydration (which also changes from person to person), and therefore, it was very difficult to accurately control the conditions needed to obtain good results. This is the reason why most of the results reported in the literature could not be easily reproduced. Many of the researchers did not consider one of the most important parameters—the temperature of the heated spot. Tissue damage is exponentially dependent on the tissue temperature and linearly dependent on the heating time. Thus, a slight change in the heating time makes little difference. On the other hand, slight overheating may lead to severe thermal damage to the tissue, whereas heating to a low temperature may lead to weak bonding. Therefore, the exact measurement of the temperature is crucial to the success of laser bonding of tissues. Measuring the tissue temperature under laboratory conditions would absorb the laser radiation and generate heat.
will never reflect the momentary true tissue temperature under operating room conditions. We therefore hypothesized that temperature monitoring and control are crucial for overcoming these problems.

The Applied Physics Group at Tel Aviv University has developed a temperature-controlled laser-bonding system based on a CO₂ laser operating at λ = 10.6 μm and incorporating special optical fibers made of polycrystalline silver halides (AgClBr). These fibers are highly transparent over a very broad spectral range in the middle IR, with low losses (0.2 dB/m) at λ = 10.6 μm, and they are very flexible, insoluble in water, and biocompatible.22 The first generation LTS system with temperature control was developed in 1993,23 and it made use of two silver halide fibers. One fiber, the delivery fiber, transmitted the radiation from the CO₂ laser to heat a spot on an incision. The second silver halide fiber, the sensing fiber, transmitted the IR radiation emitted from the heated tissue (i.e., black-body emission) to an IR detector. A computer program connected between the two devices in a negative feedback loop and maintained a desirable surface temperature Tₛ with an accuracy of ±3°C. Recently, the system software was modified to give a better control of the tissue temperature. When tested on tissues ex vivo, the improved system showed faster and better temperature control.

For the LTS process, the edges of the incision were approximated, albumin solder was spread over the incision, and then the fiber-optic laser system was used to heat the incision area, spot-by-spot. It was found that the optimal conditions for laser soldering for all soft tissues were as follows: temperature Tₛ = 60 to 65°C and heating time t = 10 to 12 s.24 This was an average temperature value, and the center was generally somewhat hotter than the periphery. However, the albumin layer absorbed most of the heat so that the maximal temperature at the tissue surface, under the albumin, was kept at the set temperature (Fig. 1), which prevented the thermal damage.

LTS has been carried out in our group using this system, on many different organs, in different animal models, using bovine albumin as a biological solder. This method was used to bond incisions in the cornea,25 urinary bladder,26 dura,27 arteries,28 and esophagus.29 In most cases, the procedure was very fast and easy to carry out, compared with suturing. One of the great advantages of the fiber-optic system is that it can be used for endoscopic tissue bonding. Preliminary experiments have also been carried out in urology, for endoscopic bonding of incisions at the ureteropelvic junction.30

Before embarking on a human study, a series of experiments, using the improved temperature-controlled laser-soldering system, was carried out for bonding of incisions in the skins of large farm pigs,31 thus validating the performance of the system. Tensile strength measurements revealed that soldering was equivalent to or stronger than the other bonding methods. The laser-soldered incisions were examined histologically and exhibited no thermal damage. The healing time in the laser-soldered incisions was faster, and showed minimal scarring.

The excellent results achieved motivated us to proceed to a pilot clinical trial for soldering incisions in human skin. The study was performed on patients undergoing laparoscopic cholecystectomies for the following reasons: (1) In this operation, four incisions are made, which allows soldering of two and suturing of the other two incisions, each patient serving as its own control. (2) The Israeli Helsinki Committee required a preliminary study on small incisions, in a restricted number of patients.

## 2 Materials and Methods

### 2.1 Clinical Study

This pilot study was undertaken in the Department of Surgery B, Ha’Emek Medical Center, Afula, Israel. It was approved by the hospital and by the Israeli National (Ministry of Health) Helsinki Ethics Committees, approval # HTA 1884 (NLM Identifier NCT02149979). The study was designed as an open label prospective double-arm, pilot trial on volunteer patients. All patients received a fully explained study protocol and signed an informed consent document. Each patient served as his own control.

The study was carried out on 10 consecutive healthy patients, undergoing elective laparoscopic removal of an uncomplicated symptomatic gallbladder (cholelithiasis), under general anesthesia. All the surgical operations were performed by or under the supervision of the principal surgeon (D.K.). In each patient, four abdominal skin incisions were made for the introduction of trocars (J&J, Cincinnati, Ohio). These trocars are round air-tight tubes that serve as ports for inserting endoscopic instrumentation into the abdominal cavity. In this study, we used two 5-mm-diameter and two 10- to 12-mm-diameter trocars. The sites of introduction are shown in Fig. 2:

![Fig. 1](https://example.com/fig1.png)

**Fig. 1** For a set temperature of Tₛ = 65°C, the maximal temperature at the topmost layer can reach tens of degrees above the set value, while at the albumin tissue interface, the temperature is much lower. Therefore, the albumin layer protects the tissue from overheating.

![Fig. 2](https://example.com/fig2.png)

**Fig. 2** The location of the skin incisions on the abdomen: incisions 1 and 2 were 10 mm long, and incisions 3 and 4 were 20 mm long. The patients were divided into two groups: in group I, cuts 2 and 3 were sutured, and cuts 1 and 4 were soldered; and in group II, cuts 1 and 4 were sutured, and cuts 2 and 3 were soldered.
below the umbilicus, #2 at the upper midline, #3 just below the median part of the right costo-chondral arc, and #4 just below the anterior lateral part of the right costo-chondral arc. Initially, incisions 1 and 2 were 20 mm long and incisions 3 and 4 were 10 mm long. To extirpate the gallbladder, one of the incisions had to be lengthened. Thus, the final lengths of the incisions varied between 10 and 43 mm. At the end of the procedure, the fatty subcutaneous layers were approximated by a single subcutaneous Vicryl suture (Ethicon Inc., Somerville, New Jersey). The patients were divided into two groups: in group I (patients # 1, 3, 5, 7, and 9), incisions 1 and 4 were soldered, and incisions 2 and 3 were sutured. The inverse method of closure was done in group II (patients # 2, 4, 6, 8, and 10). For skin suturing, interrupted Nylon 4/0 sutures (Ethicon Inc.) were used and placed at an approximate distance of 5 mm in between two neighboring sutures. The laser-soldered incisions were approximated by a mechanical vacuum device (see the figure in our previous publication \cite{simhon2} and patent \cite{simhon3}). This device consisted of two arms that had been placed longitudinally on both sides of the incision and were attached to the tissue surface using vacuum. The arms pulled the incision edges toward each other, to provide an optimal approximation. A thin layer (0.25 ± 0.05 mm) of human albumin was applied over the approximated edges and then the improved fiber-optic temperature-controlled laser-soldering system was operated. During the procedure, the laser power changed between 0 and 0.7 W (depending on the particular conditions). The working distance between the distal tips of the fibers and each incision was 5 ± 0.5 mm, giving rise to a spot diameter of ~3 mm. The temperature control was set to $T_s = 65\, ^\circ C$. On each spot, the set temperature was immediately stabilized and then maintained for ~10 s, before the distal tip was moved to the next neighboring spot, with a slight overlap of 0.5 to 1 mm. The visual signs of a slight bleach of the albumin indicated the need to move to the next spot. The time required for each procedure was recorded. For the soldered incisions, two time lags were recorded: the total time required (which involves the approximation of the incision edges and the laser-soldering process) and the net time required for performing the soldering itself. On average, it took a total of ~1 to 2 min (net time) to bond each incision. At the end of the procedure, the approximation device was removed and adhesive tapes (Steri-Strip, 3M, Maplewood, Minnesota) were placed on both the sutured and the laser-bonded incisions. These tapes were placed in order to prevent unintentional friction between the incisions and the patient’s cloths. All the suturing and the laser-soldering procedures were performed by the same surgeon (D.S).

On postoperative day (POD) 2, the tapes covering the wounds were removed and the patients were asked to gently wash the incision. The sutures were removed on POD 7. On PODs 1, 7, and 30, the patients indicated the strength of pain in each incision, using a visual analog scale 1 to 10. The amount of pruritus in each wound and the requirement of analgesics, using an analog scale of 1 to 5, were also recorded. Each wound was evaluated for bleeding, oozing, discharge, redness, edema, infection, subcutaneous collection, dehiscence, step-off borders (i.e., the edges are not on the same plane), contour irregularities (wrinkled edges), scar width, edge inversion, and excessive inflammation. The wounds were graded for overall cosmetic appearance. Follow-up of the surgical incision healing was documented by pictures of the abdomen taken on PODs 2, 7, and 30. In four patients, we were able to obtain pictures on POD 90 as well. On all PODs, the patients were also asked to estimate the esthetical appearance of the wounds, by comparing the ones that were sutured to the ones that were soldered.

### 2.2 Laser Soldering System

Soldering was performed with our improved fiber-optic temperature-controlled laser system. It consisted of two silver halide core-only fibers (NA = 0.23), each of diameter 0.7 mm. The CO$_2$ laser (Model 40C, Sharplan Lasers Inc., Warwick, Rhode Island) beam at wavelength $\lambda = 10.6\, \mu m$ was focused using a ZnSe lens, to the proximal tip of one fiber. The beam exiting from the distal tip served to heat a spot on the incision. The heated spot emitted IR radiation whose intensity was proportional to the temperature of the spot and this radiation entered the distal end of the second fiber. The radiation reached the proximal tip of the second fiber and was then coupled to an IR radiometer, based on a pyroelectric detector (Model P3782-05, Hamamatsu Photonics, Hamamatsu, Japan). The reading of the radiometer served for determining the temperature of the heated spot.

### 2.3 Human Serum Albumin

For the clinical experiments, we used an aqueous solution of human albumin. We placed 1 ml of 25% human serum albumin (Omnin Biopharmaceuticals Ltd., Tel Aviv, Israel) in each of a lyophilization vial. The vials were vacuum dried for 6.5 h under a pressure of 50 mbar at a shelf temperature of 14°C. The final concentration of albumin was 40 to 45% w/v.

### 2.4 Statistical Study

The results for the two groups (laser soldered and sutured) were compared, using the two-sided Student’s $t$ test for unpaired or paired data—as appropriate. A $p$ value <0.05 was considered statistically significant.

### 3 Results

Figure 3 shows the temperature control that was achieved in a spot on one of the incisions, during the clinical trial. The tissue temperature easily stabilized at the set temperature value of $T_s = 65\, ^\circ C$ with a ±5°C error. Similar temperature stabilizations were observed in all the other laser-soldering procedures.

The patient characteristics are provided in Table 1. All 20 incisions, except one, were successfully laser soldered. The
single incision in which soldering initially failed was immediately resoldered successfully. The mean of the combined lengths of the sutured and the soldered incisions of all patients was comparable: 40.7 ± 6.8 mm versus 40.0 ± 7.2 mm (mean ± s.d.), with $p = 0.84$. The mean of the combined time of closure was calculated by $s/mm$. The combined suturing time, the combined total soldering time, and the combined net soldering time for each patient are given in Table 2.

The suturing time and the total soldering time were comparable ($p = 0.062$), while the net soldering time was much shorter than the suturing time ($p = 0.001$). On POD 2, there were no stains on the tapes that covered the laser-soldered wounds, unlike the tapes that covered the sutured wounds. This proves the watertight nature of the laser-sealed wounds, which remained totally dry during the entire postoperative

Table 1  The patient characteristics.

<table>
<thead>
<tr>
<th>Patient #</th>
<th>Gender (M/F)</th>
<th>Age (years)</th>
<th>Weight (kg)</th>
<th>Height (cm)</th>
<th>Fitzpatrick (grade)</th>
<th>Skin color</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>F</td>
<td>24</td>
<td>58</td>
<td>163</td>
<td>III</td>
<td>Beige olive</td>
</tr>
<tr>
<td>2</td>
<td>F</td>
<td>52</td>
<td>74</td>
<td>158</td>
<td>III</td>
<td>Beige olive</td>
</tr>
<tr>
<td>3</td>
<td>F</td>
<td>17</td>
<td>78</td>
<td>158</td>
<td>III</td>
<td>Fair pale</td>
</tr>
<tr>
<td>4</td>
<td>M</td>
<td>56</td>
<td>65</td>
<td>164</td>
<td>II</td>
<td>Fair pale</td>
</tr>
<tr>
<td>5</td>
<td>F</td>
<td>52</td>
<td>88</td>
<td>168</td>
<td>II</td>
<td>Fair pale</td>
</tr>
<tr>
<td>6</td>
<td>F</td>
<td>52</td>
<td>85</td>
<td>163</td>
<td>III</td>
<td>Fair pale</td>
</tr>
<tr>
<td>7</td>
<td>F</td>
<td>37</td>
<td>72</td>
<td>163</td>
<td>II</td>
<td>Beige olive</td>
</tr>
<tr>
<td>8</td>
<td>M</td>
<td>32</td>
<td>130</td>
<td></td>
<td>II</td>
<td>Brown</td>
</tr>
<tr>
<td>9</td>
<td>F</td>
<td>21</td>
<td>95</td>
<td>172</td>
<td>II</td>
<td>Pale</td>
</tr>
<tr>
<td>10</td>
<td>F</td>
<td>31</td>
<td>59</td>
<td>162</td>
<td>III</td>
<td>Beige</td>
</tr>
</tbody>
</table>

Table 2  The combined suturing time, the combined total soldering time, and the combined net soldering time for each patient ($t = \text{time}$, $l = \text{length}$, AVG = average, and STD = standard deviation).

<table>
<thead>
<tr>
<th>Patient #</th>
<th>Suturing</th>
<th>Soldering—net</th>
<th>Soldering—total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$t$ (s)</td>
<td>$l$ (mm)</td>
<td>$t$ (s)</td>
</tr>
<tr>
<td>1</td>
<td>256</td>
<td>41</td>
<td>6.2</td>
</tr>
<tr>
<td>2</td>
<td>330</td>
<td>45</td>
<td>7.3</td>
</tr>
<tr>
<td>3</td>
<td>284</td>
<td>32</td>
<td>8.9</td>
</tr>
<tr>
<td>4</td>
<td>310</td>
<td>48</td>
<td>6.5</td>
</tr>
<tr>
<td>5</td>
<td>266</td>
<td>40</td>
<td>6.7</td>
</tr>
<tr>
<td>6</td>
<td>276</td>
<td>41</td>
<td>6.7</td>
</tr>
<tr>
<td>7</td>
<td>285</td>
<td>54</td>
<td>5.3</td>
</tr>
<tr>
<td>8</td>
<td>304</td>
<td>38</td>
<td>8.0</td>
</tr>
<tr>
<td>9</td>
<td>278</td>
<td>34</td>
<td>8.2</td>
</tr>
<tr>
<td>10</td>
<td>300</td>
<td>34</td>
<td>8.8</td>
</tr>
<tr>
<td>AVG</td>
<td>288.9</td>
<td>40.7</td>
<td>7.3</td>
</tr>
<tr>
<td>STDDEV</td>
<td>22.2</td>
<td>6.8</td>
<td>1.2</td>
</tr>
</tbody>
</table>

Fig. 4  The appearance of all four wounds in one of the patients on postoperative days (POD): (a) POD 2, (b) POD 7, (c) POD 30, and (d) POD 90.
The results of the pain evaluation for the sutured wounds in group I were compared to the equivalent results in group II, for each of the three PODs, using the Student’s $t$ test for unpaired data. The same comparison was made for the soldered wounds in the same groups. As there was no statistical difference between the two groups, the pain score for all the sutured wounds was compared to that of all soldered wounds, using the Student’s $t$ test for paired data. All these results are given in Table 3 and show that there was no statistical difference between the different groups and between the closure methods used. The same evaluations made for pruritus are given in Table 4, which (except for POD 7) showed no difference between the groups.

The esthetical estimation of the wounds by the patients for POD 7 and POD 30 are given in Table 5, showing a preference for the soldered incisions on POD 7.

### 4 Discussion

The classical method for closure of skin incisions is by using sutures, which are inexpensive, reliable, and readily available. However, there are some complications associated with this technique: foreign body reaction to sutures, development of transverse scarring, and the fact that the suture line may become a port of entry for microorganisms. The use of metal clips involves similar problems. We postulated that laser soldering may at least overcome some of the drawbacks of suturing.

The laser closure technique applies gentle heating to the approximated cut edges and speeds up the tissue healing process, as already shown. LTW and LTS methods were already described. Many groups have presented impressive results using different types of lasers for laser soldering of a large variety of tissues. However, the results were not always consistent.

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**Table 3** The pain score (1 = no pain, 10 = severe pain), comparing group I to group II, and the total sutured wounds to all soldered wounds.

<table>
<thead>
<tr>
<th></th>
<th>Group I versus group II</th>
<th>Sutures versus soldering</th>
</tr>
</thead>
<tbody>
<tr>
<td>POD 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sutures</td>
<td>Group I</td>
<td>7.80 ± 7.26</td>
</tr>
<tr>
<td></td>
<td>Group II</td>
<td>7.00 ± 5.83</td>
</tr>
<tr>
<td>Soldering</td>
<td>Group I</td>
<td>4.40 ± 6.80</td>
</tr>
<tr>
<td></td>
<td>Group II</td>
<td>6.40 ± 6.88</td>
</tr>
<tr>
<td>POD 7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sutures</td>
<td>Group I</td>
<td>3.60 ± 5.68</td>
</tr>
<tr>
<td></td>
<td>Group II</td>
<td>5.40 ± 1.14</td>
</tr>
<tr>
<td>Soldering</td>
<td>Group I</td>
<td>1.60 ± 3.05</td>
</tr>
<tr>
<td></td>
<td>Group II</td>
<td>2.80 ± 2.59</td>
</tr>
<tr>
<td>POD 30</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sutures</td>
<td>Group I</td>
<td>2.20 ± 2.17</td>
</tr>
<tr>
<td></td>
<td>Group II</td>
<td>1.40 ± 1.95</td>
</tr>
<tr>
<td>Soldering</td>
<td>Group I</td>
<td>0.80 ± 1.30</td>
</tr>
<tr>
<td></td>
<td>Group II</td>
<td>1.60 ± 1.52</td>
</tr>
</tbody>
</table>

---

**Fig. 5** A close-up appearance of two umbilical wounds, sutured in the upper row and soldered in the lower row, on PODs 2, 7, 30, and 90 (from left to right).
and in our opinion, the failure was related to a lack of temperature monitoring and control of the incision throughout the procedure. In order to overcome this problem, we first developed a sensor based on a mid-IR fiber and an IR detector that was capable of monitoring the temperature of a heated spot.23 The heating laser beam was coupled to a second mid-IR fiber and both fibers were inserted into one hand-piece to be held by the surgeon. The laser and the sensor were connected to a computer, where a control program controlled the laser power and maintained the average surface temperature at the desired value of 65°C. In the past, we carried out several successful animal experiments33,34. In particular, we carried out temperature-controlled laser soldering of incisions on the backs of large farm pigs31 and demonstrated a high-quality reparative outcome. In the present work, we embarked on a pilot clinical study, where each patient served as its own control.

We found that the total time required for soldering was equivalent to that required for suturing. However, there was a clear statistical difference in the comparison made with the net soldering time—which was shorter than the suturing time. We believe that in the future, when a better method of approximation is developed (like using an instrument that will stretch the edges of the incision, thus achieving a rapid adjustment of its borders), the total time of soldering will be reduced.

Except for POD 7 for pruritus, no statistical difference was found between the groups for pain and pruritus, for each POD. Possibly, the reason was the small number of participants. If we consider the visual appearance of the wounds, as evaluated by the patients themselves, no practical difference was reported between the two types of closure.

Some of the laser-soldered incisions were located next to the patient’s umbilicus—a very challenging area, where the skin is not a flat surface. The successful bonding of these incisions demonstrated the ability of the LTS system to operate in situations that are not ideal. This result is attributed to the improved automatic system, which reduced the sensitivity to working distance, compensating for small deviations that may have been made by the surgeon, and thus making possible the bonding of incisions of different curvatures.

In conclusion, the data obtained in this pilot study showed that the temperature-controlled laser-soldering method successfully bonded human skin incisions, in flat and curved surfaces. It confirmed that the results produced by soldering are at least equivalent to suturing.

Further large-scale clinical studies are necessary to establish better statistical results and to validate the use of temperature-controlled laser soldering of longer skin incisions. As the last phase of the wound healing (remodeling and contraction) can continue for six months or longer,35 a much longer follow-up is required to compare the final appearance of soldered to that of sutured incisions.

Recently, we have further improved the laser-soldering system, by replacing the two fibers by a single fiber. With this system, we obtained excellent results for bonding of incisions in the cornea.36 We expect that it will improve the bonding of skin incisions as well, shortening the procedure and perhaps resulting in even less scarring.

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References

Simhon et al.: Temperature-controlled laser-soldering system and its clinical application.


David Simhon is a physician (MD) and a postgraduate (PhD) in the field of tissue engineering. He is the former medical director of Medispec, a shockwave medical device company, and Nicast, an electrospinning nanofiber medical device company, and served as COO in IOPtima. He is an expert in the field of laser-assisted tissue bonding and has specialized in designing albumin-based biomaterials for tissue engineering as well as designing preclinical and clinical experiments.

Ilan Gabay is currently a postdoctoral research scholar at FemtoLab at the University of Texas at Austin, leading research focused on image-guided subsurface microsurgery. Before that, as a postdoctoral research associate at Harvard University, he developed an ultrasensitive fiber-optic spectrometer using a quantum cascade laser for detection of chemicals in water. As a PhD candidate at the Applied Physics Group, Tel Aviv University, his research focused on laser bonding of tissues.

Gregory Shpoliansky completed his MD studies at the Kishinev Medical University, Moldova, the former Soviet Union. He holds Israeli board licenses in general surgery. Since 2004 to present, he is working as an attending surgeon at Ha’Emek Medical Center. He is a member of the examination committee, lectures on trauma management. He is a member of the committee for trauma management, quality of Ha’Emek Medical Center, member of the Israeli Surgical Association, and a member of the Israeli Hernia Society. His special clinical interests include hernia and abdominal wall surgery.

Tamar Vasileyev completed his PhD study on material science and MSc degree in engineering of machinery for electronic equipment from the Ukrainian Polytechnic University of Lvov. He worked as a researcher in the Applied Physics Group at Tel Aviv University in the field of IR electro-optics. He specifically dealt with laser systems and detectors based on optical fibers. His general topics of the work include laser bonding of biological tissues, IR spectroscopy, and studies of IR optical fiber features and their applications.

Israel Nur is a director of the Ethicon Biosurgery Concept Team, while being a cofounder of Omrix Biopharmaceuticals Inc, back in the late 1990s. While working for Octapharma to 1992 to 1996, he developed a line of plasma-derived products, such as double inactivated FVIII and highly purified Alpha 1 antitrypsin. He was a visiting fellow, Laboratory of Biochemical Pharmacology, NIAADD, NIH, in Bethesda, Maryland. Before that, he has been a research fellow in NIAID, Fort Dietrich, Frederick, Maryland.

Roberto Meidler is currently working as a research fellow at Omrix Biopharmaceuticals, part of Ethicon Biosurgery, Johnson & Johnson. His main expertise includes hemostasis and fibrin sealants. He has worked working at Omrix Biopharmaceuticals since 2002, leading to the development of novel hemostatic products, including EVARRST (fibrin sealant patch) and Evicol (second generation fibrin sealant). He is a recipient of the Johnson medal for research and development (2012). He received his PhD in the Biochemistry Department, Life Science Faculty at Tel Aviv University in 2001. He received his BSc degree at Tel Aviv University Chemistry School in 1993.

Ossama Abu Hatoum is working as the deputy chief of the Department of Surgery B and in charge of colon and rectum surgery at the Ha’Emek Medical Center, Afula, Israel. He completed his MD graduation from Hebrew University in 1992. He has been a general surgeon since 1999. He had been a clinical and research fellow at the Medical College of Wisconsin, from 2000 to 2006, with more than 30 publications. His main operative time was spent in gastrointestinal
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