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**Iranian
American
Medical
Association**

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IAMA Bulletin

Fall 2015 ~ Vol. 22, No. 37

A PUBLICATION OF THE IRANIAN AMERICAN MEDICAL ASSOCIATION

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3. The IAMA Bulletin has the right to edit and/or shorten submitted articles.
4. Please enclose the original manuscript as well a translation.
5. Pictures and sketches should be sent separately.
6. Quoting from IAMA's Bulletin is permissible.

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Editorial

The main purpose of this writing is to remind us of our obligations to IAMA as a personal duty for making it a stronger and meaningful organization.

This does not take too much time but it needs a bit of heart. We have to believe that our efforts will bear fruits not only in short run but for many years to come.

We are not only friends and colleague we are genetically related, we have the same past and the same blood.

We are brothers and sisters!

IAMA is a gift from us to future generations and a source of love and respect for all. We

are bonded by many similarities and we should use this bond as one unit for progress and success. That is our philosophy, our goal and nothing else.



Also in this issue of the bulletin, as previous ones, you will be informed about last years events which is a credit to many who devoted their time and talents to IAMA on the front line.

Let us hope that next year we have much more to report.

Best to all!

Parviz Pishvazadeh, MD
Editor-in-Chief

IAMA needs your support.

Your donations make IAMA stronger to serve you better & support our young generation to achieve their goals. Your generous donation is tax deductible.

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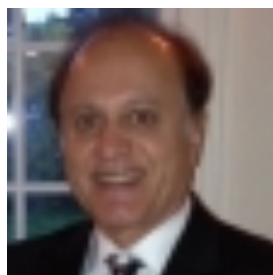
IAMA
PO Box 8218
Haledon, NJ 07538

President's Message

Dear Friends and Colleagues,

When the Iranian American Medical Association (IAMA) was established some twenty-two years ago, its founders had a dream and a vision. The dream of having a professional organization for all Iranian American allied health professionals inclusive of physicians, dentists, veterinarians, podiatrists, pharmacists, chiropractors, nurses, physician assistants, and clinical and biomedical researchers. The vision was to build a bridge across all social, cultural and scientific interests by which members of the organization could share their experience and benefit from experience of their member colleagues and friends. It is so heart-warming to see that over so many years both, the dream and the vision have been realized. The organization has served thousands of Iranian American allied health professionals from various disciplines and specialties and in various capacities.

In recent years, due to the influx of medical and dental graduates from Iran and a significant increase in the number of first generation Iranian Americans pursuing medical education here in US, we have observed a significant increase in demand for help and assistance from IAMA. We have attempted to respond to such demand by updating our infra-structure and building a dynamic new website for members to interact with the Organization and gain more access to the services and information they are looking for. So, we are obviously at a



critical juncture where we need to raise the bar for both the quality and quantity of services we currently provide to the members of Iranian American allied health community. We need to make sure that our services are sustainable and continue to benefit Iranian medical graduates for many years to come, and for that very reason, we need your help. We need you to join us in our mission to gather all Iranian American allied health professionals under the IAMA umbrella for the sole purpose of creating a strong network for scientific, social and cultural exchanges.

When we all join hands, we can become an organization that is stronger, prouder, and more inclusive than ever. If you are already a member, we thank you for your support and for being an important part of our organization. If you are a past member and have not had a chance to renew your membership, please do so by visiting www.iama.org. If you have never been a member, this is a great opportunity for you to join your friends and colleagues at IAMA and to become an important part of its mission. So, please join us by visiting www.iama.org.

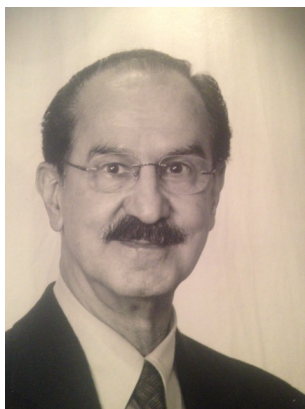
IAMA is proud to be a professional advocate for all members of Iranian American allied health community.

Khalil Sharifzadeh, DVM, MPH
President

Be In IAMA with IAMA

Dear Member of IAMA,

It is my honor & privilege to share the progress of IAMA with you. The authorities of IAMA have been busy in different areas to progress your organization. At the level of the Board of Trustees, according to the Bylaws we had to have an election for the vacant seats for the vice chair & secretary of the executive Board of Trustees. This election was performed and as the result Drs. Jasmin Moshirpur and Shahriar



Bozorgzad were reelected for another four years term, congratulations. Unfortunately, due to the death of one of our co-founders, we had to have an election, and by majority vote of eligible members, Dr. Jasmin Moshirpur was elected as a co-founder. In Bam, there has been very good progress by establishment of IAMA NGO in Iran. The members of the Board of Directors and Trustees of Iran, especially by the efforts of Drs. Abas. Esmaeili & Ali Maghsoudi, have been actively working on the code of receiving the fee of the land to be owned by IAMA NGO. For more details please refer to the article at the end of this Bulletin. This year the ECFMG & USMLE office suddenly announced that from now on they do not let medical graduates from Iran participate in the exam. The Boards of IAMA immediately wrote a letter of protest and this action caused the change of the decision less than a week. Again you may read the full text of this action in this issue of the Bulletin. Signing the Nuclear agreements between Iran and 5+1

nations was another very important event which according to your requests (members of IAMA) the support letter was written to the authorities involved which again you may see

it in this issue of the Bulletin. Office of the IAMA CME did a fantastic job by the directorship of Dr. H. Shokouhamiri and the members of his committee during the Annual Meeting of IAMA in Cincinnati, OH. After CME presentations and during the Luncheon Award meeting, three (Layla Armin Fund) scholarships was given to the

best papers presented by the young generation. The website of IAMA was transferred to another Web Company by the efforts of Dr. Shahriar Bozorgzad, Secretary of the Executive Board of Trustees. Here I have to thank and appreciate the great work of the previous web master of IAMA, Dr. Roya Saleh.

At the level of the Board of Directors, all members of the Board have had a busy schedule in different sections of IAMA as assigned to them by the Bylaws under the directorship of the president, Dr. K. Sharifzadeh. There have been monthly conference calls with participation of the Board members, representatives of the chapters, Javanan Section & executive members of the Board of Trustees. Last year's Annual Meeting of IAMA was a real success & was the best of the past 22 years of its' activities. Congratulations and thank you Dr. & Mrs. Ghazi & the dedicated Committee members. Again you will read the full

activities of 22nd Annual meeting of IAMA in this issue.

Election of the remaining members of the Board of Directors of IAMA for 2016 were elected and they, along with Dr. H. SHokouhamiri, who was elected last year, will start performing their functions in the middle of 2016.

Chapters of IAMA also had elections and the results are: 1- IAMA TX chapter started its activities by the efforts of Dr. H. Mohajer and Dr. H. Guilak, they have done a great job by spending time and efforts with the wonderful success to reestablish this chapter, congratulations. At this point also I have to thank Dr. Z. Johnson, the previous president of TX Chapter & her Board Members for their activities and hope that they continue their cooperation and activities with the new Board . 2- Election of the Chapter of NY also was performed and as the results: Dr. Reza Hedayati was elected as president and with his Board Members started their work. 3- In NJ also Dr. Shervin Mortazavi, Vice president of IAMA, elected as chairman of the chapter with other Board members have started their activities too. Congratulations and good luck

to all of them & looking forward to a better year with more progress in IAMA. The Public Awareness Program has been started in the NY, NJ state Chapters with suggestion of Dr. & Mrs. Afshari. This program have been established in NY & NJ and are alternating every other month for the Iranian public which has been a real success during the last year.

This year the Annual Meeting of IAMA will be in Boston. As usual the Board of IAMA with close cooperation of the Board of Trustees and MA Chapter are preparing this great occasion and CME committee also has already asked the members and non members of IAMA to submit their abstracts. We are looking forward to see all members and non members in this great scientific, social and friendly gathering.

This has been a very brief report of some major activities of IAMA by its dedicated elected leaders. Please join your organization to make it stronger & more powerful to help each other and our young generation. Your constructive comments are very much appreciated. Be in touch so we could be in touch.

Amir Ganchi, MD

IAMA PUBLIC AWARENESS IN HEALTH ISSUES

According to the Bylaws, IAMA has started "Public Awareness in Health Issues" in the medical and allied fields for Iranians in the United States. This program will alternate between the NY and NJ Chapters every other month. IAMA would like to encourage all other chapters to initiate this program in the state which is part of the IAMA Bylaws. If you don't have a chapter in your area, we encourage you to make one or you can call the IAMA Office to discuss ways to promote this program.

If you are interested in being a speaker in the medical and allied topics at one of these seminars, please email IAMA at iama@iama.org or calling the office at [973-595-8888](tel:973-595-8888).

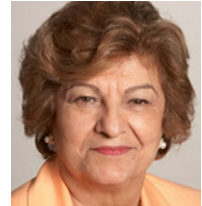
Please be sure to include your topic and your information.

Thank you for your support in helping to promote public health awareness.

ELECTION

IAMA BOARD MEMBERS

**Dr. Jasmin Moshirpur has been elected
as co-founder of IAMA**



Executive Board of Trustees

Dr. Jasmine Moshirpur - Vice-Chairperson

Dr. Shahriar Bozorgzad - Secretary



Members of the 2016 Board of Directors

are elected

Dr. Reza Saidi

Dr. Sohrab Fallahi

Dr. Sina Madani

Dr. Hanjani Soheil

Dr. Farhad Askarian

Dr. Faye Mirfakhraee

Dr. Tannaz Armaghany

Dr. Homayoun Attai

Dr. Freidoon Ghazi

Let Us Know the President- Elect

I, Hosein Shokouh-Amiri am a Transplant and General Surgeon with special interest in Hepato-Pancreato-Biliary Surgery. I received my Medical Degree from Pahlavi University Medical School in Shiraz, Iran in 1976. I started my surgical training in Iran, but moved to Denmark in 1980, where I finished my general surgery residency, and subspecialty in gastrointestinal and transplant surgery. During my 13 year stay in Denmark, I established the second liver transplant program there and became the first vice president of Denmark's transplant society before moving to the USA in 1992 to continue my career in transplantation at University of Tennessee.



My areas of expertise are in Transplantation with special interest in pancreas, liver and kidney. My other interest and expertise is in the management of hepato-pancreato-biliary pathology, including benign and malignant liver tumors, benign and malignant pancreas tumors and complications of laparoscopic surgery.

I did some of my residency at Saadi and Nemazee Hospital, Pahlavi University, Shiraz, Iran. I redid my residency again at Kommune Hospital and Rigs Hospital in Copenhagen, Denmark. I did my subspecialty training in gastrointestinal surgery and transplantation fellowship at Herlev Hospital, University of Copenhagen, and Aarhus Community Hospital, University of Aarhus in Denmark.

I have been a member of IAMA since 2002 and have presented several articles at IAMA's annual meetings. Since then, I have participated in IAMA's voluntary and humanitarian trips to Iran on many occasions. I have been honored by receiving the IAMA's Outstanding Achievement in Medical Science, Art of Surgery and Contribution to Academic Program of IAMA

and Iran in 2003 and 2014. My utmost achievement is the Ellis Island Medal of Honor that I received in 2006 which is awarded annually to a group of distinguished American citizens who exemplify a life dedicated to community service and people who preserve and celebrate the history, traditions and values of his/her ancestry and who dedicate themselves to creating a better world for us all. I received the Best Teaching Faculty of the Year at Louisiana State University Health Sciences Center – Shreveport 2009. I have mentored and trained over 20

fellows and graduate students in research and clinical transplantation from different parts of the world including Japan, Egypt, Iran, Denmark and USA. Also, I have been a Professor of Surgery training more than 200 surgery residents during my tenure at University of Tennessee and Louisiana State University Health Sciences Center – Shreveport. I have published 162 peer review articles, more than 13 book chapters and have given numerous talks nationally and internationally. I have carried out various voluntary trips to Egypt and Iran trying to establish liver and pancreas transplant programs.

I have been serving as IAMA's CME Committee Chairman since 2006. Currently, I am the Director of Liver Transplant Program and Co-Director of Transplant Center at John C. McDonald Regional Transplant Center, Shreveport LA.

Through the love of my country, Iran, I have a great passion for the causes that the Iranian American Medical Association, IAMA, represents. Among its many causes, I feel very strongly about IAMA's mentorship program, which lends guidance and support to young Iranian healthcare professionals pursuing careers in the United States. Through this program, these healthcare professionals are given the

proper direction and encouragement to secure the specialty of their choice.

When I left my country 35 years ago, I endured many hardships transitioning into a life and successful career outside of Iran. This transition period was a very difficult and trying time in my life and it is through these experiences that I hope to impart any advice and/or assistance to my fellow Iranian colleagues. Through the continued efforts and support of IAMA, we can ensure that this transition period is less difficult for others.

Overall, I strive most to bring honor to our beloved country, Iran. Only in the United States, a wonderful land of opportunity, are we able to use our collective scientific and humanitarian achievements to bring this recognition to Iran. If I am given the honor of becoming your president, together we will achieve these goals and continue to strengthen IAMA and its many causes. I will do my utmost to promote the growth and further success of our organization

I have learned in my life that

I should not argue with the fools. Let them live happily within their frivolous world.

And not have discussion with crude, they have nothing to loose but can spoil my soul.

I better keep distance from jealous folk, they would keep hating me even if I could give them the whole world.

I have learned to prefer being alone rather than sharing time with those I do not belong to

And I always keep in mind three facts:

1 - I cannot help everybody.

2 - I cannot change every things.

3 - I cannot be loved by all.

And If you choose to judge me and judge my life

First wear my shoes and pass the roads that I have gone through.

Weep same as I have wept.

Go through the roads that I have traversed.

Live in those years same as I did

Fall again and again on the rocks that I fell

Then stand up and keep walking through all those hard years again.

If you do so then you may deserve to judge about me and my life and not be silly.

IN THE NEWS....



ECFMG®

**EDUCATIONAL COMMISSION FOR
FOREIGN MEDICAL GRADUATES**

Verification of Iranian Medical Credentials

May 29, 2015

ECFMG verifies the authenticity of credentials related to physicians' medical education, training, and registration/licensure directly with the institutions that issued the credentials. The Office of Foreign Assets Control (OFAC) of the U.S. Department of the Treasury currently restricts certain interactions between U.S. organizations and entities in Iran. ECFMG is in the process of clarifying the allowed parameters of interacting with educational, health care, and medical registration/licensing institutions in Iran for the purpose of verifying credentials issued by those institutions. Pending this clarification, ECFMG is not processing requests to verify credentials issued by institutions in Iran.

ECFMG is aware of the potential impact of this situation on its clients and is working actively to resolve the situation. At this time, ECFMG is in the process of:

- Seeking clarification of the impact of OFAC restrictions on its ability to contact medical schools, hospitals, medical regulatory authorities, and other institutions in Iran;
- Determining available alternatives for verifying medical credentials issued by institutions in Iran;
- Notifying clients affected by the current situation; and
- Developing informed and accurate informational materials to provide guidance and minimize disruption for affected clients.

ECFMG is committed to maintaining the highest quality credentials verification for all physicians and organizations that we serve. We regret any inconvenience, and we thank all of our clients for their patience and cooperation.

USMLE, Action and IAMA Response



IRANIAN AMERICAN MEDICAL ASSOCIATION

P.O. Box 8218 • Haledon, NJ 07538-0218 • (973) 595-8888 • Fax (973) 790-7755
E-mail: iama@iama.org

June 1, 2015

Ms. Elizabeth Ingraham,
Assistant Vice President, Communications & Outreach
ECFMG
3624 Market Street
Philadelphia, PA 19104-2685 USA
eingraham@ecfm.org

Dear Ms. Ingraham:

Iranian American Medical Association (IAMA) is a not for profit healthcare professional organization in the United States.

It has been brought to our attention that ECFMG has put on hold the certification process for the ECFMG applicants from Iran.

The sanctions against Iran, enforced by the Department of Treasury Office of Foreign Asset control, have been in place for several years. Furthermore, these sanctions normally do not affect medical education. Has there been any recent modifications of the OFAC regulations that has prompted your organization to take such drastic action?

In the absence of any recent modifications or changes to the OFAC rules, we respectfully request that ECFMG reconsiders its position on punishing individual foreign medical school graduates of Iranian descent.

Much appreciate your attention to this important matter.

Best regards,

Shahriar Bozorgzad, MD
Secretary of Board of Trustees
Iranian American Medical Association
bozorgzad@msn.com

IAMA IS PLEASED TO ANNOUNCE THAT DUE TO OUR DILIGENT WORK ACTION HAS BEEN TAKEN TO REVERSE THE DECISION.

From the ECFMG website: Update: Verification of Iranian Credentials June 5, 2015

ECFMG is pleased to announce that it will resume processing of requests for verification of medical credentials issued by educational, health care, and medical registration/licensing institutions in Iran. As previously announced, ECFMG was not processing such requests, pending clarification of restrictions of the Office of Foreign Assets Control (OFAC) of the U.S. Department of the Treasury. On June 5, ECFMG was advised by OFAC officials that it is permitted to engage in verification activities for medical credentials issued in Iran.

ECFMG would like to thank all affected physicians and clients for their patience and cooperation while we worked toward positive resolution of this important issue.

**He who knows not, and knows
not that he knows not, is a fool,
shun him; He who knows not,
and knows that he knows not,
is a child, teach him. He who
knows, and knows not that he
knows, is asleep, wake him. He
who knows, and knows that he
knows, is wise, follow him.**

IRAN - 5 +1 Nation Agreement



IRANIAN AMERICAN MEDICAL ASSOCIATION

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August 27, 2015

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Dear Senator

The Iranian American Medical Association (IAMA) is a non-profit national medical professional organization with twenty-two years of activity and service to its members, Iranian-American and American communities. It represents physicians, dentists, veterinarians, pharmacists, PhD's, chiropractors, podiatrists, nurses, and all other allied health professionals.

Since its inception in 1993, IAMA has engaged in ongoing educational medical, and humanitarian missions in the US and Iran, including the establishment of the advanced medical center in Bam, Iran, after the devastating earthquake about 10 years ago to serve and give free medical services to needy Iranians and historic public health educational exchanges in partnership with the US government.

While fully nonpartisan, the Iranian American Medical Association strongly supports the Iran nuclear agreement on a humanitarian basis. Without a doubt, the agreement significantly reduces the possibility of war. Therefore, it is consistent with IAMA's objectives to promote peace and to improve cultural and medical scientific relationships between the two countries.

We urge you to vote in favor of the agreement and hope that with your support the agreement becomes an instrument to promote peace and prosperity for the people of the United States and Iran.

Best regards, Shahriar Bozorgzad, MD
Secretary of the Executive Board of Trustees of IAMA

TRUST • COMMITMENT • STRENGTH & EDUCATION

Highlights of the 22nd IAMA Annual Meeting, Cincinnati, OH



A Memorable Event at the 22nd Annual Meeting of IAMA

**22nd Annual Meeting of
IAMA Meeting Highlights
Memorial Weekend ~ May 22-25, 2015
Hilton Cincinnati – Netherland Plaza - Cincinnati, OH**

Friday - May 22, 2015

The evening started off with registration and was followed by a
River Cruise Dinner in the evening.

All enjoyed a breath-taking cruise along the beautiful Ohio River

Saturday – May 23, 2015

The day began with registration and breakfast followed by
CME presentations and Coffee Break.

In the afternoon, there were IAMA Javaan functions and a new Board was elected
President: Zohreh Saadabadi, MD (new); Vice President: Elham Rahgozar, Pharmacy Student;
Secretary: Hirbod Azmi, Members at Large: Alireza Ziaei, MD, Navid Shayegh, MD, Mohsen Tabrizi MD

On Saturday evening there was a music concert performed by the Cincinnati
Persian Music Ensemble under the direction of Dr. Freidoon Ghazi at the
prestigious Corbett Auditorium, University of Cincinnati, also all enjoyed
authentic Persian Dancing

Sunday, May 24, 2015

The day began with breakfast followed by a morning of
CME presentations and Coffee Break

Next there was a Luncheon and the Young Investigator Awards were presented.

After the award ceremony, there was a General Membership Meeting

In the evening there was a Reception followed by the Gala Dinner.

At the Gala, Dr. Mehrnaz Hadian was presented with a plaque a bouquet of flowers
for her help in advancing IAMA's progress, Dr. Roya Saleh was also presented
with a plaque and bouquet of flowers for heading IAMA's Technology

Department. Dr. and Mrs. Freidoon Ghazi was thanked and presented with a
plaque for their organization of such a wonderful and memorable annual meeting.

Monday, May 25, 2015

The last day began with a Breakfast Meeting Combined Boards
Founders, Chapters, IAMA Javaan Sections, and Committee Chairs

***Looking forward to this years 23rd Annual Meeting in Boston, MA,
May 27 – 30, 2016***

From the 22nd IAMA Annual Conference & CME Committees Thank You!

May 22 – 25, 2015 ~ Hilton Cincinnati ~ Cincinnati, OH

Dear IAMA Family,

Our CME program, held in Cincinnati this year, was followed by a special session that provided an exceptional platform for the attending members to voice concerns, critiques, and pragmatic solutions. This session was received by a great number of IAMA enthusiasts who actively participated and exchanged constructive views with a host of panel members, including the founders of our beloved organization, the members of our board of trustees, and the members of our board of directors. It was a true pleasure observing the younger members of the IAMA audience being actively involved and providing the majority of input and recommendations. Overall, this session was a valid learning experience for all of us. A brief outline of comments and recommendations has been summarized as follows:

- 1.) The need for a more dynamic and user-friendly website.
- 2.) The need for more efficient secretarial assistance with greater coverage hours.
- 3.) The need for a more sustainable marketing plan and strategy for membership promotion and fundraising.

The panel members of IAMA are in agreement with the aforementioned comments and recommendations and acknowledge that the strength and well-being of IAMA is solely dependent on its membership and active involvement of its members. This being said, we also recognize

that for these recommendations to be put into action, our organization will require the necessary funds. Therefore, the board unanimously voted to conduct a fundraising event at the Gala Dinner.

Many thanks to everyone who was able to donate to our cause. Because of the generous contributions received at the Gala Dinner, we were able to raise \$19,000. Donations ranged from \$500 to \$3,000. This fundraising event clearly demonstrated that our members are willing and prepared to support IAMA when they are presented with a well-defined set of plans for the advancement of our beloved organization. The dedication of IAMA's members was further illustrated when two individuals, who were unable to attend the Gala Dinner, called in their donations via telephone. Altogether, these two charitable donations equaled \$1,500. As a result of all generous contributions given during and after the Gala Dinner, we were able to raise a grand total of \$20,500.

For a nonprofit organization to offer and maintain quality services to its members, fundraising must be an ongoing process. Therefore, we encourage all of you who are able to or wish to support IAMA to consider donating to our organization; any amount is greatly appreciated. It is of utmost importance for a greater number of IAMA members to become active donors.

I would like to close with expressing our heartfelt gratitude to the following members

who made generous, tax-deductible contributions to IAMA during the Gala Dinner. Names of contributors, in alphabetical order, are as follows:

Afshari Family
Ahadi Family
Azar Family
Boozarjomehri Family
Bozorgzad Family
Fallahi Family
Ganchi Family
Ghazi Family
Hedayati Family
Lari Family
Mehzad Family
Mirfakhraei Family
Moshirpour Family
Naderi Family
Razavi Family
Seraji Family
Sharifzadeh Family
Shokouh-Amiri Family
Soltani Family

Individuals who made pledges after the Gala Dinner also deserve special thanks. These contributors include:

Saberi Family
Saidi Family

Please provide any comments, questions, and/or donations to IAMA by contacting Dr. Hosein Shokouh-Amiri, Chairman of CME Committee.

Thank you all again for your continued support and efforts to enhance and better our beloved organization.

this year @ the annual meeting of IAMA in Cincinnati there was a fund raising by the efforts of Dr. Shokouhamiri, chairman of the CME & president elect of IAMA. As the result about was raised to back up the secretary & IAMA web site budget. Thank you for you support & generous contribution. 15

Hosein Shokouh-Amiri, MD, FACS, FICS
Chairman of CME Committee
hshokouh@wkhs.com
318-344-3760

بنی آدم اعضای یک پیکرند که در آفرینش ز یک گوهرند
هو عضوی به درد آورد روزگار دگر عضوها را نماند قرار
تو کز محنت دیگران بی غمی نشاید که نامت نهند آدمی
سعدی

***Human beings are members
of a whole,***

***In creation of one essence and
soul.***

***If one member is afflicted with
pain,***

***Other members uneasy will
remain.***

***If you've no sympathy
for human pain,***

***The name of human
you cannot retain.***

**Saadi Shirazi, 13th century poet
Translation by M. Aryanpoor**

CME Report: 2015 Annual Meeting in Cincinnati, OH

IAMA's 22nd annual meeting was a great success; thanks to our wonderful local organizing committee, chaired by Dr. Ghazi and his entire team. The meeting was full of cultural activities and entertainment that were second to none.

We received 29 abstracts for clinical and basic science presentations. Even though we experienced a few last minute cancellations, our dynamic audience easily adapted to these unforeseen circumstances. As a result, a few excellent speakers volunteered to present their work and were enthusiastically received by our audience. These volunteer speakers, Mrs. Faye Mirfakhraii, Dr. Vahid Gerami, Dr. Marzieh Salehi, and Dr. Sohrab Fallahi, deserve special thanks for helping to make our meeting a success. I would also like to acknowledge Dr. Sina Madani for his hard work on the audiovisual and PowerPoint presentation; he created a flawless presentation and is very much appreciated.

This year, Dr. Karimi, Dr. Abdehou, and Dr. Seifi received the Laila Armin's Young Investigators' Award. Each recipient was given a certificate and \$500 cash. The CME sessions were interactive and ample time was allotted for audience members to provide their opinions and to ask questions. The participants evaluated both the moderators and the speakers. These evaluations will be meticulously reviewed and will serve to improve our future meetings and to enhance the scientific standards of our CME program. The participants who filled out evaluation forms will be receiving certificates via mail from our CME activity sponsor, the International College of Surgeons.

I look forward to receiving as many abstracts as possible to be presented at our next meeting. Thank you again for continuing to make IAMA a successful and well-respected organization.

Hosein Shokouh-Amiri, MD, FACS, FICS
Chairman of CME Committee

Winners of the Young Investigator
Award receiving their certificate,
Farinaz Seifi, MD, Nika Karimi, MD
and Sophia T. Abdehou, MD



Thank you for your generous donations!

Below is a list of donors who have helped in 2014 and 2015. We are deeply grateful for their generosity to help make IAMA stronger and better able to serve you.

Soudabeh Ahadi, Monroe, IL
Ali Reza Armin, Royal Oaks, MI
Ali Azimpoor, MD, Houston, TX
Ali R. Berenji, Oxnard, CA
Najma Fooladi, MD, Randolph, NJ
Javad Kardan, MD, Dayton, OH
Alfred Kohan, MD, Plainview, NY
Hormoz Mohtashemi, MD, Wayne, NJ
Hessam Nasiri, MD, Houston, TX
Nazmii Peyman, MD, Richmond, VA
Mansour Saberi, MD, Lewes, DE
Faramarz Salimi, MD, Morton Grove, IL
Nasser Tavakoly, R-CSA, Southborough, MA



Thank You!

How the name "Iran" replaced Persia for our land 80 years ago

Iran used to be called by different names by the western nations since the Medieval years. These names included Perse, by French, Persia by the British and Persis by Greek. The identical name for Iran was Eran and it had been used before 600 years ago

It was in January of 1893 AD that the name was officially changed to Iran by the foreign ministry and other officials of the country.

It was Mr. Said Nafici who suggested the change of name in December of 1892.

The suggestion for change of name confronted controversial opinions. Those who opposed the change argued that the name of Persia carries with it the history of its precious culture and civilization which should not be omitted furthermore it is an internationally known name for the country. On the other hand those who were in favor of the change believed that the name Iran was an old name which was used for the land even before the Aryans migrated to it. It is written in the book "the masterpieces of Iranian arts" By Professor Arthur Ephraim Pope, the famous scholar of Iran study (1881-1969) that The Name of Iran used to be applied to the Iranian Plateau and its geographic environs as far as 1000 years before migration of Aryans to This land. (This book was translated to Persian by Dr, Parviz Khanlary in the year 1917)

The word Iran consist of two parts, the first part means, authentic, and Noble, the second part means the land and environments.

In the book of Shahnameh from Ferdosi (One of the nationalistic Iranian poet) there are many occasions that the word Iran is used. Also sentences such as the great

Iranian people, the land of Iran, Iran versus Rome, the city of Iran, or Aniran are used. Also the words Iranian and Iranians are used more than 350 times.

Iran means the land of freedom or the land of largess. Ferdosi also talk about the largess character of Iranians for example in regard to treating the enemies he advises:

You should behave with goodness towards your enemies, that is what the Iranian (the largess) should do.

Dr M. Moeen (1872-1929), a famous eloquent Iranian scholar has written about the route of "Iran" word that, This word together with Arya are associated with many historic events. It reminds us of the nations which settled in the west of India and European lands. Arya and Aryan words represent the race that our common ancestors in India and Iran proudly introduced themselves with it. The route of the word Iran is from the same word, Arya.

Dr. Bahram Farahvashi, (1983 - 1950) a former professor of Tehran University, and Iranian scholar write about the route of Iran word as follow:

Iran Called Airya in Zoroastrian Avesta also was called Aria in ancient Persian language. So it indicates them as noble, authentic and tribe with dignity. It is identical to the word "Ir-land" which means the land of Noble people.

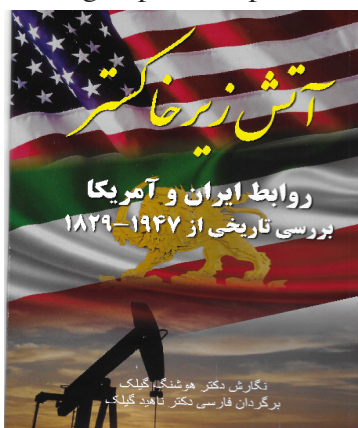
(The above article is the translated part of the book " How we became Iran Written by Mr. Mojtaba Anvary in 1965")

The Persian Translation of the Book “Fire Beneath the Ashes Iran-United States Relation, Perspective Studies from 1829-1947

This book was authored by Dr. Hooshang Guilak and published in English on March 2011. It details the relation between these two nations in depth and complete documentation. It was an instant success among those who were interested in the political intricacy and were keen in defining the role of this liaison.

Contrary to the general belief the relation between Iran and the United States was never smooth and far from being on a straight path or pattern. It has undergone, as most foreign policies do, severe fluctuations complete severance. The book, step by step, the measurers of wrong and how possibly it change the course of the

Subject of Human attention by the author, who nation under the colonial stand on its feet and make life



suffering received great deal of emphasized the burden of a power of the time, trying hard to tolerable for its citizens.

During all nineteenth and twentieth centuries, the United States Foreign policy was to follow, almost blindly, the policies dictated by the British Foreign Office. By and large the American representatives in Tehran had minuscule knowledge about the country and the people that they were sent and had to deal with. In most cases they would echo what they were told by the British. In extremely rare instances, if the United States had someone who was really familiar with their assignment and would suggest deviating from the British dictated policy, the State Department would file their inputs and disregard their suggestions. On occasion the State Department would send the note of its representatives in Iran who were critical of the British behavior to the Britain's Foreign Office, as a measure of Good Will!

After publishing the English version, author received numerous requests by Iranians for a Persian translation of the book. Some two years ago, Dr. Nahid Guilak undertook the task of translating the book into Persian.

The book will be available in early February 2016. It is over 460 pages and contains more photographs and minor updates that the information were not available at the time of original publishing. It is in two forms, the paper back and a limited number in hardback.

Book can be ordered through:

***Guilak Publishing ~ 19 Carriage House Way, Conroe, TX 77384 or
by emailing to: hguilak@gmail.com***

CHAPTER ACTIVITIES

New York

Election of the new officers of the New York and Connecticut chapter of IAMA happened on July 1st ,2015 meeting of IAMA members and these IAMA members were elected as new officers:

- 1- Reza Hedayati,M.D. President
- 2- Hale Yarmohammadi,M.D. Vice President
- 3- Reza Peymani,M.D. Secretary
- 4- Mehran Motamed,M.D. Treasurer

The New York Chapter had it's third public awareness seminar on August 16, 2015 at Patough Restaurant in Queens ,NY. The speaker was Dr. Hormoz Ashtiyani , The subject was sleep apnea. Dr.& Mrs. Afshari were instrumental in arranging this meeting.

The chapter is planning to continue these seminars as scheduled every other month.

Expanding IAMA's membership is the number one goal of the New York/Connecticut chapter and we are working to have as many allied health professionals as possible to become IAMA member.

Texas

This year after many months of negotiations and with the help of the Chairman of the Board of Trustee and other members, we finally reorganized the IAMA- Texas Chapter. Based on this, on August 6, 2015, the new board members of IAMA-Texas are introduced as follows:

- 1.President - Shahin Tavackoli, MD.
- 2.Vice president - Tanaz Armaghany, MD
- 3.Treasurer - Homaoun Ataei, MD.
- 4.Secretary - Ehsan Arabzadeh, DDS.
- 5.Member at Large-Homayoon Mohajer, DC
- 6.Member at Large - Neda Ghedami, DC
- 7.Advisor to IAMA-TX-Hooshang Guilak, MD

It is our great pleasure to inform you of several important decisions for the future of IAMA -Texas Chapter. In first three months we activated our website, Facebook, and Twitter accounts for the Texas Chapter. We will be in process of resuming our medical lecture series for public awareness on a quarterly basis. We are in process of contacting Asheghaneh Magazine to start publishing our monthly medical articles for the Iranian community in Texas.

Next year we will announce the annual scholarships of IAMA-Texas through the media and offices on different college campuses.

Also we are going to create our updated membership directory, in order to promote the membership registry, attract new members, and contact all previous members. We do not have our group pictures at this time.

New Jersey

NJ chapter of IAMA had its most recent Public Awareness event on Sunday, September 20. This event was part of monthly educational sessions going on for more than a year now to fulfill the mission of promoting public health and awareness.

On the same day NJ chapter held its board meeting to elect directors for the upcoming period.

The following chapter BOD was elected by vote.

President: Shervin Mortazavi, MD

Vice President: Pegah Ameri, DDS

Treasurer: Ali Tabarrokhi, MD

Secretary: Sahar Geramifard



Dr. Mortazavi as the president of NJ chapter, Dr. Pegah Ameri Vice President, Dr. Payam Torrei and Dr. Sahar Geramifard secretaries of the board.

Ohio

The Ohio chapter of IAMA meets on a quarterly basis. During these meetings we discuss different strategies to attract young physicians and allied professionals to become members and engage in IAMA activities. We also invite members of the community to discuss different medical

topics with IAMA physicians. Music and poetry will usually follow our discussions before we adjourn. Everybody is looking forward to attending the annual meeting in Boston in May 2016.

Massachusetts

The past years, years of 2014-15, was very important check point in the history of IAMA, Chapter of Massachusetts. The reason is; we started to build a solid rock and stable ground-work within IAMA-MA. We agreed to this point that there is no great organization without excellent and solid foundation. We started focusing on advertisement and introducing our organization to our medical community in Massachusetts. We also focused on younger generation of physicians, dentists, Pharmacists, PhDs and other health-care professionals. We started to change the base of IAMA-MA with being belonged to a certain groups to a non-profit organization, which belongs to everyone in the Medical and Health-care field. To be able to reach this goal, we established different committees with assigning chairs and members to each committee. We started working on outreaching members with improving our Facebook account with placing up-to-date pictures and useful information. We also started to invite people in healthcare field to our monthly board meetings. In my opinion, the core of each organization is the board of trustees and expansion of this core is equal to expansion of organization. Then we focused to established quarterly high quality

conferences and events to be able to introduce our organization as academic as possible with inviting well known world-class speakers. As an example Dr. Soheyla Gharib, who is a legend in the field of endocrinology/osteoporosis, and Dr. Golshan, chief of breast surgery at BWH and Dr. Lotfi, breast radiologist from BWH. Dr. Ali Amin, gastroenterologist from University of Massachusetts and Dr. Kambiz Negahban, Ophthalmologist from Boston University. These are only few examples of the great lecturer in the years of 2014-15. The other achievement was raising the concern of appropriate care for our elderly population being without proper access to Farsi language nursing homes or living facilities. We established a separate committee with assigned chair and members for this matter as "Iranian senior living facility of Massachusetts". The committees that we worked very hard were membership and fundraising committees, which I raised few suggestions for improvement to the IAMA national board of trustees meeting last August. So far in 2014-15, we had six social/scientific. During the past two years our Facebook members and followers from 78 in early 2014 jumped to 388 members as of 11/12/2015, and this number is growing in a matter of days.

In the past, we have to make tremendous effort to interest well known attending in medical field to give us lecture in our event. However, at this moment I am so proud to announce that we are booked for the year of 2016 with great world class speakers in different popular fields. None of this would happen if we would not concentrate in advertising and building a great core in our

medical community. The other example our one of the social/scientific lecture on October 3rd 2014, we had over 160 attendees in our which was at least twice of the number compare with 2013 and the years before.

At this moment we started to write down our goals for upcoming year of 2016. We will work and concentrate on membership program. We will make our members as twice as it has ever been before. Our concentration would be advertising the fact that the best way to support our activity and help us to expand is become a member.

The Year of 2015 is almost over and 2016 is upon us. I want to take this, as an opportunity to extend my heartfelt thanks and appreciation to you all for our great accomplishments and achievements in IAMA-MA. The past year has been a great year as far as achieving our targeted goals are concerned. I thank all of you and IAMA-MA members, specifically our board members, board advisers, and whoever involved in helping our organization, for your support and dedication, for being in our events and meetings, and the extra hours that all of you worked to achieve and complete our targeted goals.

The upcoming New Year 2016 also provides an opportunity to look at the successes of the past year back and set new goals for the future. We are so pleased to strive those goals with you. We look forward to another productive year with all of you. Another year and another round of whole new changes for a better service of our Iranian-American Healthcare professionals of Massachusetts. The only thing that is not

going to change is the formula of hard work and dedication for getting good results. Working hard and keep perseverance to achieve desired success. I look forward to another year with passion to exceed and expand our networking among our Iranian healthcare community in Massachusetts as well as raising the bar in term of quality of services to our community.

New year is a time to dream bigger for IAMA, to reach every single Iranian from our profession who needs help and/or assistance. We have even more projects and great ideas and goals lined up for next year including but not limited to Iranian Senior Residential Center (ISRC) of Massachusetts, expanding mentorship program, providing better service to our quarterly Social/Scientific conferences/lectures. I am sure with your dedication and determination we will be able to complete those also in time. One of the great news and plans for next year will be coming up on May 27-30, 2015, which would be our annual National IAMA Conference at Boston, MA. With our presence and hosting this conference, we can expand our networking communication and plans beyond our state with meeting Iranian-American healthcare professionals from all over the USA and even from Iran. I thank you all, for your support and hope this organization with good relationship, great communication and fabulous networking continue and we achieve great success together in 2016.

I wish you a fantastic new year; that makes your dreams come true, brings you happiness and prosperity. My best wishes also to your families for a safe, happy holiday season and a very happy new year.

Ba Sepas Va Dorode Faravan,

Yours Sincerely,

Farhad Askarian, MD
President of Massachusetts Chapter of
IAMA



from left to right is Mahnaz Edaltapour,
Anahita Hadioonzadeh, Farhad Askarian,
and Nahal Panah

***Let us realize that what happens around us is largely
out of our control, but that the way we choose to
react to it is inside our control.***

Scientists Recover First Genome of Ancient Human From Africa

By: Carl Zimmer – NY Times – Oct. 8, 2015

A team of scientists reported on Thursday that it had recovered the genome from a 4,500-year-old human skeleton in Ethiopia — the first time a complete assemblage of DNA has been retrieved from an ancient human in Africa.

The DNA of the Ethiopian fossil is strikingly different from that of living Africans. Writing in the journal *Science*, the researchers conclude that people from the Near East spread into Africa 3,000 years ago. In later generations, their DNA ended up scattered across the continent.

“It’s a major milestone for the field,” said Joseph Pickrell, an expert on ancient DNA at the New York Genome Center who was not involved in the study. For decades, scientists had doubted that ancient DNA could survive in the tropics. The study raises hopes that scientists can recover far older human genomes from Africa — perhaps dating back a million years or more.

“I would bet it’s not that far in the future,” said Lee Berger, a paleoanthropologist at the University of the Witwatersrand who recently announced the discovery of an ancient humanlike species called Homo naledi.

In the 1980s, few scientists would have believed it possible to reconstruct an entire genome from the DNA in a fossil. Once a human or other animal dies, its DNA starts to fall apart. Bacteria swiftly colonize the corpse, overwhelming it with their own DNA.



But by the 1990s scientists were beginning to retrieve fragments of DNA and piece them together into longer segments. In 2010, researchers assembled the genome of a Neanderthal from 38,000-year-old fossils from Croatia. In many other cases, researchers failed to find ancient DNA in human fossils. Because it was widely suspected that the heat and humidity in the

tropics would destroy genetic material, many scientists flocked to places like Siberia to seek ancient DNA.

That skepticism proved to be unwarranted. In recent years, Ron Pinhasi, an archaeologist at University College Dublin, and his colleagues have been surveying different bones to see if any are particularly good for preserving DNA. They found that the bone surrounding the inner ear can hold an abundance of genetic material even when other bones have lost theirs.

As they reported last year, the scientists were able to pull out genomes from the ear bones of hundreds of Europeans who lived

thousands of years ago. Their success gave them hope that they might be able to rescue ancient DNA from African skeletons.

They got their chance when John W. Arthur and Kathryn Weedman Arthur, archaeologists at the University of South Florida, and their colleagues uncovered the skeleton of a man in the Mota cave, in the highlands of southern Ethiopia. Mota, as the scientists refer to the man, was laid out in a ceremonial burial. His head rested on a pillowlike stone, his hands were folded under his body, and he was surrounded by stone tools.

The researchers sent Dr. Pinhasi a sample of the inner ear bone, hoping that he and his colleagues could fish out some DNA. They succeeded spectacularly, extracting enough DNA to reconstruct Mota's entire genome.

Dr. Pinhasi and his colleagues also got some clues about what Mota was like by looking at some of his genes. He was probably brown-skinned and had brown eyes, for example. He also had genetic adaptations for living at high altitudes — the same adaptations found in Ethiopian highlanders today.

The scientists then sought to fit Mota into the history of humankind. Ethiopia is home to the oldest fossils of our species, dating back about 200,000 years. Humans later expanded across Africa. Later, sometime between 100,000 and 50,000 years ago, our species began to spread into Asia and Europe.

In recent years, scientists have found segments of DNA in Ethiopians and other

Africans that bear a striking resemblance to those found in people from Europe and Asia. They proposed that there was a “backflow” of genes into Africa roughly 3,000 years ago.

Dr. Pinhasi and his colleagues found that Mota, who lived 1,500 years before that time, had no trace of Eurasian DNA in his genome. “It's an African without this backflow,” he said.

Armed with this early genome, Dr. Pinhasi and his colleagues took a new look at the spread of Eurasian genes into Africa. They pinpointed the source of the DNA to ancient farmers in the Near East. Once those people spread into Africa, their DNA traveled across the continent over the generations.

“The most astonishing thing is there's quite a lot of backflow in all modern African populations,” Dr. Pinhasi said. He and his colleagues estimate that 7 percent of the genomes of the Yoruba people of Nigeria are of Eurasian origin. In the genomes of Mbuti pygmies who live in the rain forest in the Democratic Republic of Congo, 6 percent of the DNA comes from Eurasians.

Ryan L. Raaum, an anthropological geneticist at Lehman College, part of the City University of New York, called the new study “fantastic” but questioned its conclusions. If people from the Near East moved into Africa, he argued, a drastic shift in the archaeology of the region would logically follow. But no such shift occurred. It is also possible that Eurasian DNA moved into Africa earlier than 3,000 years ago, Dr. Raaum argued. Mota might have simply

lived in an isolated community that never encountered people with those genes.

The best way to test the conclusions of Dr. Pinhasi and his colleagues, Dr. Raaum said, would be to gather more DNA from African fossils of the same age. If the researchers are

right, they would also lack Eurasian DNA. “Then the argument starts to seem a lot more plausible,” Dr. Raaum said.

Dr. Pinhasi is ready to look for those skeletons. “We need more genomes cross space and time,” he said.

As we grow older, and hence wiser, we slowly realize that wearing a \$300 or \$30.00 watch - - - - -

they both tell the same time...

Whether we carry a \$300 or \$30.00 wallet/handbag - - -

the amount of money inside is the same;

Whether we drink a bottle of \$300 or \$10 wine - - - - -

the hangover is the same;

Whether the house we live in is 300 or 3000 sq. ft. - - - -

loneliness is the same.

You will realize, your true inner happiness does not come from the material things of this world.

Whether you fly first or economy class, if the plane goes down - - - - -

you go down with it...

Therefore.. I hope you realize, when you have mates, buddies and old friends, brothers and sisters, who you chat with, laugh with, talk with, have sing songs with, talk about north-south-east-west or heaven & earth

That is true happiness!!



**Save
the
Date**



**23rd Annual Meeting of
IAMA**

Memorial Weekend ~ May 27-30, 2016

Boston Sheraton

Boston, MA



Will you ever be able to upload your Brain?

Opinion by Kenneth D. Miller, A professor of neuroscience at Columbia and co-director of the Center for Theoretical Neuroscience – NY Times – Oct. 11, 2015

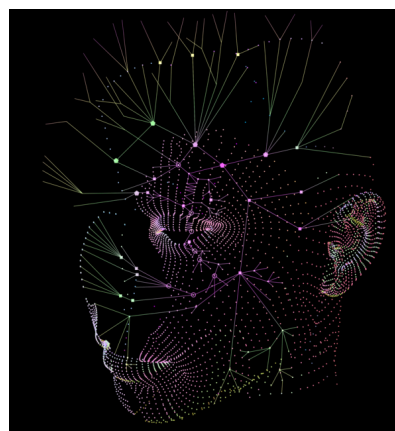
SOME hominid along the evolutionary path to humans was probably the first animal with the cognitive ability to understand that it would someday die. To be human is to cope with this knowledge. Many have been consoled by the religious promise of life beyond this world, but some have been seduced by the hope that they can escape death in this world. Such hopes, from Ponce de León's quest to find a fountain of youth to the present vogue for cryogenic preservation, inevitably prove false.

In recent times it has become appealing to believe that your dead brain might be preserved sufficiently by freezing so that some future civilization could bring your mind back to life. Assuming that no future scientists will reverse death, the hope is that they could analyze your brain's structure and use this to recreate a functioning mind, whether in engineered living tissue or in a computer with a robotic body. By functioning, I mean thinking, feeling, talking, seeing, hearing, learning, remembering, acting. Your mind would wake up, much as it wakes up after a night's sleep, with your own memories, feelings and patterns of thought, and continue on into the world.

I am a theoretical neuroscientist. I study models of brain circuits, precisely the sort of models that would be needed to try to reconstruct or emulate a functioning brain from a detailed knowledge of its structure. I don't in principle see any reason that what I've described could not someday, in the very far future, be achieved (though it's an active field of philosophical debate). But to accomplish this, these future scientists would need to know details of staggering complexity about the brain's structure, details quite likely far beyond what any method today could preserve in a dead brain.

How much would we need to know to reconstruct a functioning brain? Let's begin by defining some terms. Neurons are the cells in the brain that electrically carry information: Their electrical activity somehow amounts to your seeing, hearing, thinking, acting and all the rest. Each neuron sends a highly branched wire, or axon, out to connect or electrically "talk" to other neurons. The specialized connecting points between neurons are called synapses. Memories are commonly thought to be largely stored in the patterns of synaptic connections between neurons, which in turn shape the electrical activities of the neurons.

Your mind and all its complexity, dies with you. And that's it.



Much of the current hope of reconstructing a functioning brain rests on connectomics: the ambition to construct a complete wiring diagram, or "connectome," of all the synaptic connections between neurons in the mammalian brain. Unfortunately connectomics, while an important part of basic research, falls far short of the goal of reconstructing a mind, in two ways. First, we are far from constructing a connectome. The current best achievement was determining the connections in a tiny piece of brain tissue containing 1,700 synapses; the human brain has more than a hundred billion times that number of synapses. While progress is swift, no one has any realistic estimate of how long it will take to arrive at brain-size connectomes. (My wild guess: centuries.)

Second, even if this goal were achieved, it would
28 be only a first step toward the goal of describing

the brain sufficiently to capture a mind, which would mean understanding the brain's detailed electrical activity. If neuron A makes a synaptic connection onto neuron B, we would need to know the strength of the electrical signal in neuron B that would be caused by each electrical event from neuron A. The connectome might give an average strength for each connection, but the actual strength varies over time. Over short times (thousandths of a second to tens of seconds), the strength is changed, often sharply, by each signal that A sends. Over longer times (minutes to years), both the overall strength and the patterns of short-term changes can alter more permanently as part of learning. The details of these variations differ from synapse to synapse. To describe this complex transmission of information by a single fixed strength would be like describing air traffic using only the average number of flights between each pair of airports.

Underlying this complex behavior is a complex structure: Each synapse is an enormously complicated molecular machine, one of the most complicated known in biology, made up of over 1,000 different proteins with multiple copies of each. Why does a synapse need to be so complex? We don't know all of the things that synapses do, but beyond dynamically changing their signal strengths, synapses may also need to control how changeable they are: Our best current theories of how we store new memories without overwriting old ones suggest that each synapse needs to continually reintegrate its past experience (the patterns of activity in neuron A and neuron B) to determine how fixed or changeable it will be in response to the next new experience. Take away this synapse-by-synapse malleability, current theory suggests, and either our memories would quickly disappear or we would have great difficulty forming new ones. Without being able to characterize how each synapse would respond in real time to new inputs and modify itself in response to them, we cannot reconstruct the dynamic, learning, changing entity that is the mind.

But that's not all. Neurons themselves are complex and variable. Axons vary in their speed and reliability of transmission. Each neuron

makes a treelike branching structure that reaches out to receive synaptic input from other neurons, as a tree's branches reach out to sunlight. The branches, called dendrites, differ in their sensitivity to synaptic input, with the molecular composition as well as shape of a dendrite determining how it would respond to the electrical input it receives from synapses.

Nor are any of these parts of a living brain fixed entities. The brain's components, including the neurons, axons, dendrites and synapses (and more), are constantly adapting to their electrical and chemical "experience," as part of learning, to maintain the ability to give appropriately different responses to different inputs, and to keep the brain stable and prevent seizures. These adaptations depend on the dynamic molecular machinery in each neural structure. The states of all of these components are constantly being modulated by a wash of chemicals from brainstem neurons that determine such things as when we are awake or attentive and when we are asleep, and by hormones from the body that help drive our motivations. Each element differs in its susceptibility to these influences.

To reconstruct a mind, perhaps one would not need to replicate every molecular detail; given enough structure, the rest might be self-correcting. But an extraordinarily deep level of detail would be required, not only to characterize the connectome but also to understand how the neurons, dendrites, axons and synapses would dynamically operate, change and adapt themselves.

I don't wish to suggest that only hopelessly complicated models of the brain are useful. Quite the contrary. Our most powerful theoretical research tools for understanding brain function are often enormously simplified models of small pieces of the brain — for example, characterizing synapses by a single overall strength and ignoring dendritic structure. I make my living studying such models. These simple models, developed in close interaction with experimental findings, can reveal basic mechanisms operating in brain circuits. Adding complexity to our models does not necessarily give us a more realistic picture of

brain circuits because we do not know enough about the details of this complexity to model it accurately, and the complexity can obscure the relationships we are trying to grasp. But far more information would be needed before we could characterize the dynamic operation of even a generic whole brain. Capturing all of the structure that makes it one person's individual mind would be fantastically more complicated still.

Neuroscience is progressing rapidly, but the distance to go in understanding brain function is enormous. It will almost certainly be a very long time before we can hope to preserve a brain in sufficient detail and for sufficient time that some civilization much farther in the future, perhaps thousands or even millions of years from now, might have the technological capacity to "upload" and recreate that individual's mind.

I certainly have my own fears of annihilation. But I also know that I had no existence for the 13.8 billion years that the universe existed before my birth, and I expect the same will be true after my death. The universe is not about me or any other individual; we come and we go as part of a much larger process. More and more I am content with this awareness. We all find our own solutions to the problem death poses. For the foreseeable future, bringing your mind back to life will not be one of them.

**A blind man
who sees is
better than a
sighted man
who is blind.**

Persian Proverb

SCIENTIFIC ABSTRACTS PRESENTED AT THE
22nd ANNUAL MEETING OF IAMA
May 22 - 25, Cincinnati, OH

Mesenchymal Stem Cells and Co-Stimulation Blockade Enhance Bone Marrow Engraftment and Induce Immunological Tolerance

Reza Saidi, MD

Background: Organ transplantation currently requires long-term immunosuppression. This is associated with multiple complications including infection, malignancy and other toxicities. Immunologic tolerance is considered the optimal solution to these limitations.

Aim: To induce Tolerance using mesenchymal stem cells

Materials & Methods: We studied to achieve tolerance to skin grafts (SG) through mixed chimerism (MC) by simultaneous skin graft and non-myeloablative donor bone marrow transplantation (DBMT) +/- mesenchymal stem cell (MSC). All recipients received rapamycin and CTLA-4 Ig without radiation

Results: DBMT+MSC combined with costimulation blockage and rapamycin led to stable mixed chimerism, expansion of Tregs population and donor-specific skin graft tolerance. The flow cytometry analysis revealed that recipient mice developed 15%-85% chimerism. The skin allografts survived long term. Elimination of MSC failed to induce mixed chimerism and tolerance.

Discussion: Our results demonstrate that donor specific immune tolerance can be effectively induced by non-myeloablative DBMT-MSC combination without any additional cytoreductive treatment. This approach provides a promising and non-toxic allograft tolerance strategy.

Conclusion: Our results demonstrate that donor specific immune tolerance can be effectively induced by non-myeloablative DBMT-MSC combination without any additional cytoreductive treatment. This approach provides a promising and non-toxic allograft tolerance strategy.

Split Thickness Skin Graft as a Successful Limb Salvage Option for Diabetic Wounds secondary to Gas Gangrene

Morteza Khaladj, DPM

Background: Research performed by Dr. Morteza Khaladj and four residents at Trinitas Regional Medical Center on three patients who were followed from date of onset until the date of last visit completely healed post operatively.

Research Paper: Khaladj Morteza, Safar Sina, Lalehparvar Sanaz, Siddiqui Aqsa, Mohiuddin Ayesha. Split Thickness Skin Graft as a Successful Limb Salvage Option

for Diabetic Wounds Secondary to Gas Gangrene.

Aim: To have a successful, efficient, earlier, and healthier outcome of using Split Thickness Skin Graft as a means of secondary closure from emergent gas gangrene surgical intervention.

Materials: Split Thickness Skin Graft from donor site of patient's lower leg. Equipment used to harvest and apply Split Thickness Skin Graft to graft site. Negative Pressure Wound Therapy (Wound Vac) to prepare surgical site for Split Thickness Skin Graft with manual wound care debridements of non viable soft tissue during wound care visits. Status post Split Thickness Skin Graft wound care management.

Results: Three patients had successful outcomes with being fully healed with Split Thickness Skin Graft.

Discussion: After emergent successful surgical intervention of three patients with gas gangrene, the decision was made to have them follow up for local wound care management with manual debridements during the visits to prepare the surgical wounds with a healthy, granular, bleeding base to allow the negative pressure wound therapy (Wound VAC) to enhance the area to be further healthier for the application of split thickness skin graft. After the application of split thickness skin graft, careful wound care management allowed the patient to fully recover and heal in a more efficient, healthier, and earlier time frame.

Conclusion: Utilizing Split Thickness Skin Graft as a means of a limb salvage option for diabetic wounds associated with gas gangrene has been shown to have a successful outcome.

Lymphangioma Like Non HIV Kaposi Sarcoma in the Lower Extremity Presenting as Stasis Verruciformis

Morteza Khaladj, DPM

Background: Research was done by Dr. Morteza Khaladj and three residents at Trinitas Regional Medical Center following one patient for Stasis Verruciformis which later biopsied resulted in Non HIV Kaposi Sarcoma of the lower extremity.

Research: Khaladj Morteza, Safar Sina, Kotzias George, Agunbiade Modupe. Lymphangioma Like Non HIV Kaposi Sarcoma in the Lower Extremity Presenting as Stasis Verruciformis.

Aim: Diagnose patient initially thought to have necrotic Stasis Verruciformis lesions that went unimproved by sending biopsies of lesions in lower extremity to Cornell University Pathology Lab and to further assess patient care of plan once results came back.

Materials & Methods: Local wound care management for initial clinical diagnosis of necrotic stasis verruciformis lesions in lower extremity punch biopsy Cornell University Pathology Lab. Referred patient to cancer center.

Results: Diagnosis of NON HIV Kaposi Sarcoma from pathology lab of Cornell University utilizing skin biopsies.

Discussion: Patient originally being followed at wound care center for early diagnosis for necrotic stasis verruciformis went unimproved. At that time, suspicion was something underlying, so skin biopsies were obtained and sent to Cornell for further studies, resulting in Non HIV Kaposi

Sarcoma. Patient was immediately referred to Cancer Center upon results.

Conclusion: Patients who present with typical lymphedema associated dermatitis or verruciformis can mask underlying superior malignancies such as Kaposi Sarcoma in this atypical presentation not associated with HIV.

Does the presence of intra-amniotic "sludge" affect pregnancy outcome in patients undergoing cerclage for a short cervix?

Fereshteh Boojarjomehri, MD

Background: Previous studies have shown that intra-amniotic "sludge" (IAS), an ultrasound (US) finding of hyperechoic matter in the amniotic fluid (AF) close to the internal os, is associated with high risk for preterm birth due to intra-amniotic (IA) infection.

Aim: The aim of this study was to determine if IAS is correlated with markers of IA infection and adverse pregnancy outcome in patients (pts) undergoing an US indicated cerclage for a short cervix (Cx)

Materials & Methods: Records of 46 consecutive pts, who underwent McDonald cerclage between 16-24 6/7 weeks (wks) from 2007-2013, were reviewed. Prior to cerclage, transvaginal US was performed and images were evaluated for Cx length and presence or absence of IAS. AF was collected at the time of cerclage (transabdominal amnioreduction) and evaluated for infection by culture, Gram stain (GS), glucose (Glu), red (RBC) and white blood cell (WBC) count. Pt characteristics, AF results, and pregnancy outcomes were compared between those with and without IAS.

Results: Pts with IAS had shorter Cx lengths at the time of the procedure 8.9 ± 7.1 vs. 17.2 ± 6.3 mm; $P = 0.007$) and more often had Cx funneling ($P = 0.005$). Cerclage occurred at earlier GA for the IAS Group. Other baseline characteristics were largely similar. 41/46 pts had amniocentesis. All culture and GS results were (-). No differences between groups were detected with regard to Glu, RBC or WBC and pregnancy outcomes were similar (Table)

Amniotic fluid results				No Sludge (n=8)	
Sludge		(n=33)		P-Value	
Glu1	32 (20,89)	32 (22,49)		0.889a	
RBC1	16 (0,70)	16 (0,233)		0.383a	
WBC1	5 (0,34)	5 (2,233)		0.506a	
(+) Culture2	0/8 (0%)	0/33 (0%)		1.00b	
(+) GS2	0/8 (0%)	0/33 (0%)		1.00b	
Pregnancy Outcomes				No Sludge (n=13)	
Sludge		(n=33)		P-Value	
GA at delivery (wks)		1 37 5/7 (23 1/7, 40 2/7)	37 2/7 (22 3/7, 40 3/7)		
				0.643c	

Discussion: The presence of IAS in asymptomatic pts with an US short Cx at mid-trimester does not constitute an indication for an amniocentesis to rule out IA infection. Also in these pts, post-cerclage pregnancy outcome is similar in pts with or without IAS.

Conclusion: IAS is not associated with intra-amniotic infection, therefore it should not be a contraindication for cervical cerclage in pts with short Cx who may benefit from cerclage.

Pregnancy outcome after placement by a single operator of “high” cerclage in second trimester patients with a sonographically short cervix.

Fereshteh Boozarjomehri, MD

Background: Cerclage for cervical (Cx) insufficiency is a common procedure. However, there is operator variation in technique that may impact its effectiveness in improving pregnancy outcome.

Aim: The aim of the study was to evaluate the effectiveness of “high” Cx cerclage by a single operator.

Materials & Methods

We studied 54 consecutive patients (pts) with ultrasound (US) Cx length

Results: 43/54 pts (80%) had amnioreduction. The distribution of pre and post-op Cx lengths were as follows: Preop Cx lengths: 14 (26%) pts 25-15 mm, 40 (74%) pts

Discussion: This is the largest reported group of “high” cervical cerclages by single operator with a very successful pregnancy outcome, given the previously reported high failure rate.

Conclusion: Under appropriate conditions, “high” cervical cerclage by an experienced operator, in pts with short Cx appears safe and is associated with excellent pregnancy outcomes.

Management Of Malignant And Benign Ampullary And Duodenal Lesions: A Single Center Experience

Sophia T. Abdehou

Background: Malignant and benign ampullary and duodenal lesions are rare and

their management strategy has not been established.

Aim: The aim of this study was to evaluate our experience in management of malignant and benign ampullary and duodenal lesions.

Materials & Methods: In this IRB-approved retrospective chart-review study, the charts of all patients who had surgery at our center, from 2000 to 2014, for treatment of malignant and benign pancreatoduodenal lesions were evaluated. Among these patients, those who had malignant or benign ampullary or duodenal lesions were selected. Demographics, tumor characteristics and surgical outcomes were gathered for all the selected patients.

Results: Among 422 patients who had surgery at our center for treatment of malignant and benign pancreatoduodenal lesions, 32 had duodenal or ampullary lesions (mean age of 61.9 ± 11.4 years, male=16 [50%], Caucasian=22 [69%]). Sixteen patients had malignant lesions (6 ampullary adenocarcinoma, 4 duodenal adenocarcinoma, 4 neuroendocrine tumor, 2 gastrointestinal stromal tumor) and 16 patients had benign lesions (7 duodenal tubular adenoma, 4 duodenal polyp, 4 duodenal villous adenoma, 1 hamartoma). The surgical procedures included 9 Whipple operations (4 for malignant and 5 for benign lesions), 6 ampullectomies (3 for malignant and 3 for benign lesions) and 17 duodenectomy or resection of duodenal lesions (9 for malignant and 8 for benign lesions). In patients with malignant lesions with mean duration of follow-up of 1.6 year, all surgical resection margins were negative and only one patient died during follow-up 7 years post operation.

Discussion: Local resection is a viable option for ampullary and duodenal lesions that have not grown to the head of pancreas.

Conclusion: Local resection is a viable option for ampullary and duodenal lesions that have not grown to the head of pancreas.

Comparison of open, laparoscopic and robotic adrenalectomy: A 15 year single surgeon experience

Sophia T. Abdehou

Background: Laparoscopic and robotic methods of adrenalectomy are proposed alternatives to open adrenalectomy. The potential advantages and disadvantages of these minimally invasive methods, as compared with open adrenalectomy, remain to be found.

Aim: The aim of this study was to compare outcomes of open, laparoscopic and robotic adrenalectomy for treatment of adrenal lesions.

Materials & Methods: In this retrospective IRB-approved study we evaluated the charts of 85 patients who underwent adrenalectomy by a single surgeon from 1999 to 2014. Baseline demographics and tumor characteristics as well as surgical outcomes were compared between patients with open, laparoscopic and robotic adrenalectomies.

Results: A total of 88 adrenalectomies were performed in 85 patients: 59 laparoscopic (mean age= 47.3 ± 13.8 years, male= 21 [36%] and Caucasian= 42 [71%]), 16 open (mean age= 53.8 ± 10.7 years, male= 8 [50%] and Caucasian= 15 [94%]) and 10 robotic (mean age= 49.8 ± 16.7 years, male= 4 [40%] and Caucasian= 7 [70%]). There were no significant differences between these 3 groups in terms of age, sex and race. The

only significant differences between 3 groups in terms of baseline characteristics were the tumor size (8 ± 5.2 cm in open, 5 ± 3 cm in laparoscopic and 7.1 ± 5.2 cm in robotic group, $p=0.025$) and type of tumor pathology. In laparoscopic group, there were more aldosteronoma ($n=12$) and functional and nonfunctional cortical adenoma ($n=4$ and $n=9$, respectively). Except for estimated blood loss which was significantly higher in open group, other surgical outcomes including post-op complication rate were not significantly different between 3 groups.

Conclusion: Our results show that minimally invasive methods of adrenalectomy could have comparable or even better surgical outcomes compared with open adrenalectomy.

**A gentle hand
may lead even
an elephant by
a single hair.**
Persian Proverb

Identification of Xq22.1-23 as a region linked with hereditary recurrent spontaneous abortion in a family

Sahar Shekoochi, M.Sc

Background: Recurrent spontaneous abortion (RSA) is one of the most common health complications with a strong genetic component. Several genetic disorders were identified as etiological factors of hereditary X linked RSA. However, more genetic factors remain to be identified.

Aim: In this study we performed linkage analysis on a large X linked RSA pedigree to find a novel susceptibility locus for RSA.

Materials & Methods: A linkage scan using 11 microsatellites was performed in 27 members of a large pedigree of hereditary X-linked RSA. Two point parametric Linkage was performed using Superlink v 1.6 program.

Results: Evidence of linkage was observed to markers at Xq23, DXS7133 and at Xq22.1 DXS101, with LOD score of 3.12 and 1.60, respectively

Discussion: In this study we report mapping of a novel region on X chromosome (Xq23) in relation to X linked recurrent abortion following linkage analysis. Our result is in agreement with previous reports of linkage for autism loci; particularly those reported by Kilpinen et al and linkage for X-linked dominant genodermatosis incontinentia pigmenti (22, 23). This region is tracked by markers DXS101 and DXS7133 at approximately 10 cM distance. Our results suggest a possible gene on chromosome Xq23 that might be responsible for X-linked.

Conclusion: Identified locus in this study may carry a responsible gene in RSA. Narrowing down of this region may leads to identification of this gene.

Chromosomal Study of Couples with the History of Recurrent Spontaneous Abortions with Diagnosed Blighted Ovum

Sahar Shekoochi, M.Sc

Background: Spontaneous abortion (SAb) is the most common complication of early pregnancy. Numerous risk factors are associated with an increased risk of pregnancy loss such as: Blighted ovum.

Aim: The aim of this study was to determine the frequency of balanced chromosomal translocations in couples with a history of recurrent spontaneous abortions and ultrasound diagnosed blighted ovum.

Materials & Methods: Sixty Eight couples with the history of spontaneous abortion (diagnosed blighted ovum) were selected and introduced into this survey during 2007-2012 at Medical Genetics department of Mashhad University of Medical Sciences. Giemsa banding technique was used to search for chromosomal balanced translocations.

Results: Demographic assessment has not shown any age difference between blighted ovum suffering couples and general population. Consanguineous marriages in blighted ovum suffering couples was significantly higher.

Discussion: In the present study, couples presenting recurrent spontaneous abortion at the first trimester of gestation with characteristic blighted ovum were candidate for chromosomal investigation since previous studies indicated that abortion

occurring at or before 8 weeks of gestation are blighted ovum. From a cytogenetic point of view, previous studies suggested that abnormal fetal karyotypes occur in 90% of unembryonic products of conception.

Conclusion: According to the obtained results, the importance of chromosomal studies in non-relative couples affected with recurrent abortion becomes clearer. In this study, Chi square statistical analysis indicated a significant difference between the frequency of RSA occurrence between consanguineous and non-consanguineous marriage.

Evaluation Of The Effects Of Platelet Rich Plasma plus Demineralized Bone Matrix In The Treatment Of Periodontal Intrabony Defects .

Ali Aliabadi, DVM

Background: periodontitis leads to attachment loss resulting in partial or full edentulism. The goal of periodontal therapy is to improve periodontal health and thereby to satisfy the patient's esthetic and functional needs or demands. Conventional periodontal therapy includes non-surgical treatment as well as a variety of surgical approaches (1). True periodontal regeneration is the reformation of a functionally oriented periodontal ligament with collagen fibers inserting in both regrown alveolar bone and reformed cementum over a previously diseased root surface. The study of materials to promote bone regeneration is a key issue in oral surgery (2). The autologous bone is still considered as the gold standard (3). But due to number of disadvantages, in recent years several biocompatible materials have emerged as substitutes of autologous bone. Demineralised bone matrix (DBM) is Biologic biomaterial which has shown

repeatedly significant improvement in soft and hard clinical tissue parameters for the treatment of intrabony periodontal defect (4). Over the last 20 years a large number of publications advocating the use of platelet-rich plasma (PRP) in oral surgery(5,6). Platelet rich plasma (PRP) is a preparation, serving as an autologous source of highly concentrated doses of platelets.

Aim: The hypothesis of this study is that the combination of PRP and demineralized bone matrix can replace autologous grafts in promoting bone regeneration in mandibular bone defects.

Materials & Methods: Ten adult male mongrel dogs (mean weight 17 kg) were used. The animals were anesthetized with intravenous injection of sodium pentobarbital solution (12 mg/kg). The mandibular first premolars had been previously extracted and the extraction sites had been allowed to heal for 2 months. At the mesial and distal aspect of the left and right mandibular second premolar twenty 3-wall intrabony defects (4x4x4 mm) were created after elevating mucoperiosteal flap. The defect were filled with gutta-percha to prevent spontaneous regeneration and the flaps were sutured. 30 days after that, the defects were treated in four equal groups. At the moment of treatment a notch was made on the root surface of the bone defect with round bur. In the first group the defect was filled with coagulum and consider as control group. The second group treated with PRP, in the third group the defect was filled with DBM and the last group was treated with combination of PRP + DBM. Wound closure was accomplished following defect treatment, with 5-0 vicryl suture material. After 60 days animals were scarified and histological sections were prepared to evaluate the new epithelium, new cementum, new bone formation and

connective tissue extension . Data were analyzed by one-way ANOVA test. A p value ≤ 0.05 was considered statistically significant.

Results: Clinically, the healing response was good for all treatments. In histological evaluations Bone and periodontal ligament showed a better organization in sites where platelet rich plasma was combined with demineralized bone matrix. In the site treated only with DBM, zones of resorption were observed. Histometric results are shown a superior area of new bone in the sites treated with PRP+DBM and DBM(12.62 ± 2.52 mm² and 14.80 ± 2.30 mm²). Data analysis also showed a significant difference in connective tissue extension in PRP+DBM and PRP (1.65 ± 0.36 mm and 1.47 ± 0.27 mm) groups compare with other two groups.

Discussion: Although it is not well clarified, PRP presents its effects through enhancement of soft and hard tissue healing processes. On the other hand, there are plenty of publications that show that there is not enough scientific evidence to support the use of PRP in accelerating bone healing

Conclusion: Finally it concluded that the association of PRP with DBM may be useful in treatment of such defects and accelerate the healing time in mandibular area of dogs. Further studies are require to investigate the advantages and limitations of these materials in the treatment of periodontal defects.

Executive Action for Immigration Reform: Is This a Real Breakthrough Cure?

Mahsa Khanbabai

Background: President Obama announced an Executive Order that addresses sorely needed immigration issues for persons in the

USA, some of which are extremely beneficial for healthcare professionals.

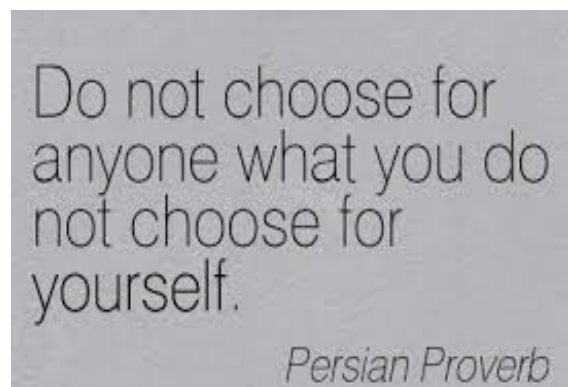
Aim: Apprise audience of the new immigration provisions related to health care professionals.

Materials & Methods: An Immigration Attorney that specializes in Immigration Issues for Healthcare Professionals.

Results: President Obama's Executive Order may provide significant immigration benefits for healthcare professionals.

Discussion: What are the provisions of the Executive Order and how does one qualify.

Conclusion: President Obama's Executive Order may provide significant immigration benefits for healthcare professionals.



ASCVD guidelines for pharmacological treatment of dyslipidemia

Tooraj Zahedi, MD

Background: Dyslipidemias are major risk factors for cardio-vascular diseases. As our knowledge of the impact of lipids and their management on development of Atherosclerosis have evolved over the years, the guidelines for management of these conditions have changed as well. The latest guidelines recommended by the joint conference of the American College of Cardiology and National Institute of Health was first published in November 2013 and have been the subject of heated discussions and debate by the clinicians and academics alike.

Aim: I will briefly discuss the highlights and important aspects of these recommendations and areas of disagreements and debate

Materials & Methods: I use the published guidelines and subsequent articles discussing the different aspects of these recommendations

Results: Statins are the drugs of choice for dyslipidemias

Discussion: Different Statins with different doses are categorized based on the degree of LDL reduction to low intensity, moderate intensity and high intensity. The recommendations for Statin therapy is different based on the type and degree of the risk

Conclusion: Management of Dyslipidemia is recommended in many individual with or without risk factors for cardiovascular disease based on the levels of the LDL and HDL.

Neonatal Outcomes in Preterm Severe Preeclampsia as Compared to Other Etiologies of Prematurity

Seifi.Farinaz, MD, Carolyn Salafia, MD, MS, Jasmin Moshirpur, MD; Aleksandr Fuks, MD

Background / Objectives: Expectant management of patients diagnosed with severe preeclampsia between 24 and 34 weeks of gestation has become a standard of care. This study evaluates neonatal outcome in pregnancies complicated by severe preeclampsia and delivered between 24 and 34 weeks after a period of conservative expectant management as compared to the neonatal outcomes of pregnancies with other etiologies of preterm delivery, delivered between 24 and 34 weeks gestation.

Methods and Material: This is a retrospective case control study involving patients with expectantly managed severe preeclampsia and patients with other causes of preterm delivery who were managed and delivered at Queens Hospital Center, Queens, NY. Inclusion criteria for cases: severe preeclampsia diagnosed between 24 0/7 weeks and 33 6/7 weeks. Inclusion criteria for control group: all non-preeclampsia causes of preterm delivery between 24 0/7 weeks and 33 6/7 weeks. Exclusion criteria: loss to follow up, presence of fetal anomalies, in – utero fetal demise. Study interval: 1/2009 to 10/30/2014. The groups will be compared with respect to baseline demographic parameters, obstetrical history, obstetrical interventions in the current pregnancy, exposure to magnesium sulfate, antenatal steroids and antibiotic. Primary outcome to be analyzed: length of stay in NICU. Other outcomes include: rate of RDS, neonatal sepsis, IVH and neonatal intubation.

Results: 52 infants were delivered preterm because of severe preeclampsia and 157 infants were delivered preterm because of other etiologies met study inclusion criteria. Final analysis will be ready by 4/1/2015.

Conclusion: pending results. We hypothesize that there is a difference between neonatal outcomes among patients delivered preterm in pregnancies complicated by severe preeclampsia as compared to neonates delivered preterm due to other etiologies.

Read the writing on the wall: the dos and don'ts of residency

Mehrnaz Hadian, MD, MScCR, FCCM

Although getting into a postgraduate residency program is almost guaranteed for most of American medical school graduates, it is proven to be a much more challenging process and at times seemingly impossible goal to achieve for most international medical graduates (IMGs). However, many IMGs believe being accepted into a residency program means that the biggest hurdle in the way of their clinical career is overcome, and the road to success is all paved. Well, not so fast! While being accepted into a residency is a major accomplishment, and a prerequisite for having a successful clinical career in the US, the challenge is far from being over.

In recent years, many IMGs who have had great academic qualifications who were accepted into prestigious residency programs, found themselves caught up in seemingly trivial conflicts with their residency program which escalated beyond their control ultimately resulting in the residents being subject to probation, termination, or lost fellowship opportunities they had worked so hard for. It is sad to see that someone's professional future crumble

in front of their very eyes. But what is even more saddening is that these IMGs often do not realize what got them into so much trouble to begin with and why they ended up in an impasse with their program. More importantly, because of cultural differences, language barriers, and lack of familiarity with the administrative process, IMGs often do not recognize or trivialize the early signs of the troubles they find themselves in. Furthermore, they may fail to recognize early on the root causes of difficulties they experience in their residency programs, or realize what rights they do have as an individual trainee and resident employee, all which contribute to ultimate adverse outcome.

The goal of this talk is, through discussing real life examples, to bring attention to this most important issue for post graduate medical trainees especially IMGs who already secured their residency programs here in the US. The objectives of the talk is to make sure post graduate medical trainees are aware of the dos and don'ts of a post graduate training program, and can recognize the writing on the wall early on, and are able to take corrective steps to save the situation from deteriorating to the point of no return, and to prevent their professional career from coming into a halt, while saving themselves a great deal of disappointments and heartaches.



Ebola Epidemic ~ A Whole New Perspective

Khalil Sharifzadeh, DVM, MPH

The 2014 Ebola Epidemic in West Africa, sent a shiver of fear and panic throughout the world causing significant psychological and economic stress on the family of nations specifically those of the Western Hemisphere. While the mobilization of medical and para-medical forces was not completely unfounded, there was a significant gap between perceptions and facts based on poorly established epidemiological features of an Ebola outbreak.

Healthcare providers are able to use the science based knowledge of epidemiological features of Ebola infection for an effective communication with their concerned patients. The purpose of this presentation is to present a different perspective on the overall properties of Ebola virus as it relates to its infectious and pathogenic nature. Special emphasis will be placed on the epidemiological characteristics and laboratory confirmation options for the infection.

The presentation is based on my extensive review of literature and case studies related to the 1914 Ebola Epidemic. It is also based on the most recent surveillance data published by the World Health Organization (WHO) and the federal Centers for Disease Control & Prevention (CDC).

When a cluster of cases of Ebola infection occurs anywhere in the World, the local community Primary-Care physicians should be in a unique position to provide their concerned and curious patients with accurate and science based information with regards

to the prevention, control, and the on-going clinical trials for various treatment options.

The morcellation controversy - how to safely get big things through small holes in surgery!

Soheil Hanjani, MD

Background: Electromechanical power morcellation was approved in 1995, allowing large growths to be cut into small fragments and removed through small incisions in the abdomen when performing minimally invasive surgery.

Aim: However controversy arose re risk of dissemination of undiagnosed malignancy using this technique. Highlighted by one patient in Boston in 2012.

Materials & Methods: Review of the current state of operative minimally invasive morcellation and the effects of the controversy, and the impact of the recommendations from the FDA, as well as national OBGYN organizations: ACOG (American College of Obstetrics and Gynecology) and AAGL (American Association of Gynecologic Laparoscopists).

Results: Concern was raised re power morcellation causing trauma, disruption of tissue and dispersion of undiagnosed malignancy.

Discussion: Alternatives have been investigated and are being used: vaginal morcellation; minilaparotomy; enclosed morcellation within bag.

Conclusion: Open morcellation as previously known is most likely no longer going to be utilized - in bag morcellation will most likely take its place. This will allow continuing benefits of minimally invasive surgery for removing large tissue through small incisions.

Permanent Device Implantation Using the Transfemoral Route

Mehran Attari, MD

Background: There exists a small minority of patients in whom conventional lead placement using the subclavian vein is not feasible due to various anatomical considerations. The femoral vein has been previously described as an alternative route for transvenous pacemaker placement but the experience is limited. Long term follow up of transfemoral intracardiac defibrillators (ICD's) and biventricular defibrillators (BIVICD's) have not been previously reported.

Methods: This study is a single center retrospective systematic clinical review of patient records who received permanent devices using the transfemoral route from 2006 to 2013.

Results: A total of seven patients with nonischemic cardiomyopathy (4), complete heart block (2), sudden cardiac arrest (1) and sustained ventricular tachycardia (1) were identified (2 BIVICD's, 2 dual chamber ICD's, 2 single chamber ICD's and one dual chamber pacemaker). The average age of the patients was 60 (49-83) years. The indications for femoral approach were bilateral subclavian vein occlusion and presence of AV fistula or indwelling catheters.

The follow up interval averaged 32 (2.3 - 83.4) months for a total of 18 patient-years. The average threshold for right atrial, right ventricular and left ventricular pacing at the time of implant and follow up was 1.5 V and 0.8 V ($P=0.06$); 0.83 V and 0.86 V ($P=0.8$) and 1.1 V and 1.375 V respectively. The sensing threshold and impedances of the right atrial and right ventricular leads remained stable throughout the follow up

period. Defibrillation threshold in ICD patients was successfully tested at 25 J. During the follow up period only one device related complication in the form of a pocket hematoma resulting in hospitalization was successfully drained. No cases of lead dislodgement, re-positioning or deep vein thrombosis were recorded. There were no device related deaths during the follow up period; however two patients had expired from unrelated causes.

Conclusion: From our single center experience, the use of the transfemoral route for device implantation including for resynchronization therapy when the subclavian access is inaccessible is safe and effective.

Single Center Experience with Fluoroscopy-Free Atrial Flutter Ablation

Mehran Attari, MD

Introduction: Radiation exposure during electrophysiology (EP) procedures places physicians and patients at increased health risks. Specifically, the deterministic and stochastic effects of ionizing radiation (IR) increase the risk of malignancy. Technological and procedural innovations have managed to decrease overall exposure to IR. An example is the use of 3-dimensional electro-anatomic mapping systems (3D-EAM). Complete abandonment of fluoroscopic imaging, in favor of full reliance on 3D-EAM systems, has been attempted by some operators. Significant data on safety and clinical outcomes from such techniques are lacking.

Methods: 41 patients with documented typical cavo-tricuspid isthmus (CTI) atrial flutter (AFL) underwent radiofrequency (RF) ablation. Ablation was performed using irrigated catheters (Safire Blu, St Jude Medical). No fluoroscopy was used during the procedure. Catheter

placement/movement and application of RF lesions were completely guided by a 3D-EAM (Ensite Velocity, St. Jude Medical). Quadripolar recording catheters were placed at the His and right ventricular apical positions. A duo-decapolar catheter was placed along the tricuspid valve annulus with the distal catheter electrodes inserted into the proximal coronary sinus. Patients were followed clinically and with 30-day event monitors (or implantable cardiac rhythm devices) post-ablation for evidence of arrhythmia recurrence. Complications, if any, were recorded.

Results: All patients (mean age 67 years) had acutely successful AFL ablation with bidirectional block across the CTI. Five patients were lost to follow-up. At a mean 127 days of follow-up, none of the other patients had recurrence of typical AFL. Arrhythmias noted on follow-up were atrial fibrillation (15 cases, 41%), atypical AFL (1) and typical AVNRT (1). Only 1 complication was noted (groin bleeding treated conservatively). Mean procedure time (80 minutes) was similar to cases done with standard fluoroscopy technique.

Conclusion: Ablation of typical AFL without use of fluoroscopy is safe, efficient and effective. Such technique should be further refined to allow its use in other ablation procedures. Benefits include reduction in operator/patient IR exposure and in use of heavy lead outfits.

Recurrence patterns and prognostic factors in patients with hepatocellular carcinoma in noncirrhotic liver: a multi-institutional analysis.

Arnaoutakis DJ, Mavros MN, Shen F, Alexandrescu S, Firoozmand A, Popescu I, Weiss M, Wolfgang CL, Choti MA, Pawlik TM.

Background: Hepatocellular carcinoma (HCC) primarily affects patients with a cirrhotic liver. Reports on the characteristics of patients with HCC in noncirrhotic liver, as well as predictors of recurrence and survival, are scarce.

Methods: Between 1992 and 2011, 334 patients treated for HCC in noncirrhotic liver were identified from three major hepatobiliary centers. Clinicopathological characteristics were analyzed and independent predictors of recurrence and overall survival were identified using Cox proportional hazards models.

Results: Median patient age was 58 years and 77 % were male. Most patients had a solitary (81 %) and poorly or undifferentiated tumor (56 %); median size was 6.5 cm. The majority of patients (96 %) underwent liver resection (microscopically negative margins in 94 %), whereas a few had transarterial chemoembolization or transplantation (4 %). Median recurrence-free survival (RFS) was 2.5 years, and 1- and 5-year RFS was 71.1, and 35 %, respectively. Elevated alkaline phosphatase levels [hazards ratio (HR) = 1.82], poor tumor differentiation (HR = 1.4), macrovascular invasion (HR = 2.18), and the presence of satellite lesions (HR = 1.9), or intrahepatic metastases (HR = 2.59) were independently associated with shorter RFS; in contrast, an intact tumor capsule independently prolonged RFS (HR = 0.46). Median overall survival was 5.9 years, and 1- and 5-year overall survival was 86.9, and 54.5 %, respectively. Tumor size ≥ 5 cm (HR = 2.27), macrovascular (HR = 2.72) or adjacent organ invasion (HR = 3.34), and satellite lesions (HR = 2.18) were independently associated with shorter overall survival, whereas an intact tumor capsule showed a protective effect (HR = 0.51).

Conclusions: Following resection of HCC in the setting of no cirrhosis, more than one-half of patients were alive after 5 years. However, even among patients with no cirrhosis, recurrence was common. Factors associated with RFS and overall survival included tumor characteristics, such as tumor capsule, satellite lesions, and vascular invasion.

Impact of sarcopenia on outcomes following intra-arterial therapy of hepatic malignancies.

Dodson RM¹, Firoozmand A, Hyder O, Tacher V, Cosgrove DP, Bhagat N, Herman JM, Wolfgang CL, Geschwind JF, Kamel IR, Pawlik TM.

Background: Assessment of patient performance status is often subjective. Sarcopenia--measurement of muscle wasting--may be a more objective means to assess performance status and therefore mortality risk following intra-arterial therapy (IAT).

Methods: Total psoas area (TPA) was measured on cross-sectional imaging in 216 patients undergoing IAT of hepatic malignancies between 2002 and 2012. Sarcopenia was defined as TPA in the lowest sex-specific quartile. Impact of sarcopenia was assessed relative to other clinicopathological factors.

Results: Indications for IAT included hepatocellular carcinoma (51 %), intrahepatic cholangiocarcinoma (13 %), colorectal liver metastasis (7 %), or other metastatic disease (30 %). Median TPA among men (568 mm(2)/m(2)) was greater than women (413 mm(2)/m(2)). IAT involved conventional chemoembolization (54 %), drug-eluting beads (40 %), or yttrium-90 (6 %). Median tumor size was 5.8 cm; most patients had multiple lesions (74 %). Ninety-day mortality was 9.3 %; 3-year survival was 39 %. Factors associated with risk of death were tumor size (HR = 1.84) and Child's score (HR = 2.15) (all P < 0.05). On multivariate analysis, sarcopenia remained independently associated with increased risk of death (lowest vs. highest TPA quartile, HR = 1.84; P = 0.04). Sarcopenic patients had a 3-year survival of 28 vs. 44 % for non-sarcopenic patients.

Conclusions: Sarcopenia was an independent predictor of mortality following IAT with sarcopenic patients having a twofold increased risk of death. Sarcopenia is an objective measure of frailty that can help clinical decision-making regarding IAT for hepatic malignancies.

**Treat your superior as
a father, your equal as
a brother, and your
inferior as a son.**

Updates On Heart Failure for Primary Care Physicians

Freidoon Ghazi, MD

Heart failure remains the leading cause of death and hospital admissions in the industrialized and developing countries. Aging, diabetes, Hypertension and obesity are among the major risk factors for development of heart failure. Both systolic and diastolic heart failure have equal incidence and mortality rate.

Despite major improvements in early diagnosis and treatment, mortality remains high. Aggressive treatment of diabetes and hypertension as well as smoking cessation has shown to play a major role in preventing heart failure. Improved survival after myocardial infarction by emergent myocardial revascularization and prevention of sudden cardiac death by implantable defibrillators have reduced the number of patients progressing into heart failure. Contemporary treatment options and future directions will be discussed

FIVE UNDENIABLE FACTS OF LIFE

1. Don't educate your children to be rich. Educate them to be Happy. So when they grow up they will know the value of things not the price.
2. Best awarded words in London... "Eat your food as your medicines. Otherwise you have to eat medicines as your food."
3. The One who loves you will never leave you because even if there are 100 reasons to give up he or she will find ne reason to hold on.
4. There is a big difference between a human being and being human. Only a few understand it.
5. You are loved when you are born. You will be loved when you die. In between, You have to manage!

BAM Medical Center Update

It is my pleasure to report the advances of IAMA project in Bam, Iran. As you may know IAMA administration in Iran rented IAMA Medical Center to the University of Bam for providing free medical services to the needy people in the area & academic use. At the same time IAMA NGO was established after almost 3-4 years of investigation of its members & routine official work, which finally approved this year. Subsequently they filed for the deed of the land to be owned by this IAMA NGO. As this land was donated by the City Council of Bam for offering medical services they had to get a certificate from the University of Bam in this regard. This has been done now & Kerman land administration office accepted the request, which should follow its usual routine procedures in different committees to issue the deed which will be under the name of the IAMA NGO. I have to thank all

members of the IAMA Boards in Iran for all of these very tiresome and time consuming works & efforts especially Dr. Abass Esmaeili, Dr. Ali Maghsoudi & Engineer Vahid Sabaghian. As soon as this last procedure is done then we can make arrangements to go there and offer our specialty services to the needy people there. Your help in any way including donations of money to advance the Center and offering your medical services is greatly appreciated. At the same time if you want to make plans to serve & present paper or offer your clinical expertise to the universities in Iran you may contact the Iranian Society of Surgeons through IAMA. If you have any constructive comments or questions please don't hesitate to let us know.

Amir Ganchi, MD

**If you just want to Walk Fast,
Walk Alone!**

**But if you want to Walk Far,
Walk Together!**

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THE GOAL OF UNITY.**

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