


# BULLETIN

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**Iranian American Medical Association**

I A M A

# IAMA Bulletin

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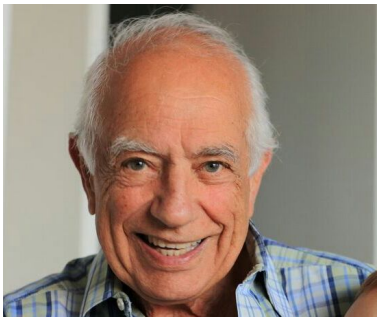
1. *Please type or write legibly.*
2. *The social and scientific views of the authors are not necessarily IAMA's views.*
3. *The IAMA Bulletin has the right to edit and/or shorten submitted articles.*
4. *Please enclose the original manuscript as well a translation.*
5. *Pictures and sketches should be sent separately.*
6. *Quoting from IAMA's Bulletin is permissible.*

# A Note from the Editor

I hope this new edition of the Bulletin will be informative and brings you up to date as to what is going on in IAMA as a whole. Someone said "lazy people are usually astronomers, poets or philosophers!" Astronomers sit on their butts all day, poets and philosophers do not move from their desks much.



We, members of IAMA, are none of those - some of use work 80 hours per week or more. We are all physicians or related to medical science. We do not look at the stars much and if some of us make poems it is for fun.

Along with this hard work, we still have to find time to donate to IAMA because it is a bond with our colleagues. It refreshes our lives and reveals another side of living. We know that our organization should last for years to come so we are working to build a strong infrastructure for future generations.

So my friends, do not wait to be called. See by yourselves what you are able to provide for your group. Let me plagiarize John F. Kennedy "do not ask what IAMA can do for you, ask what you can do for IAMA."

**My 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.**

**You may donate through 'IAMA.ORG, PAYPAL' or simply mail it to**

**IAMA**
**PO Box 8218**
**Haledon, NJ 07538**

# President's Message

Dear Members

First of all, I would like to wholeheartedly thank Dr. Ganchi, Founder of the association for his enthusiasm, persistence and dedication. He has made sure that IAMA has continued to improve in its mission from its inception.



We just finished our 24th Annual Meeting in the beautiful city of San Diego. The venue was excellent and liked very much by all participants. Thanks to our local organizing committee, chaired by Dr. Ashouri, who did a wonderful job to see that this event was a success. In spite of a few last minute legitimate cancelations (sickness and death in the family); we were able to deliver a high quality CME course (as evaluated by participants), thanks to our dedicated members who kindly filled in for these canceled spots.

The CME event was very interactive and there was ample time for questions & answers. We had 97 registered participants and out of 55 CME qualified registrants for the course, only 35 turned in their evaluations. These members will receive their CME certificate soon. For those who forgot either to turn in or fill out their evaluations, please call IAMA office for the form to fill out and return them if you need a CME certificate.

This year we were honored to have three distinguish guest speakers Drs. Gharib, Ronaghy, and, Akbarnia and each of them touched upon very important subjects of interest for our audience. Our keynote speaker Mr. Mohammad Ehteshami, First Vice President of G.E., gave a fascinating, enlightening, and state of the art lecture that really defined for us the meaning of "Engineering the Impossible". He and his wife stayed during the entire meeting and made a close bond with IAMA family. Mr. Ehteshami graciously accepted to be an honorary member of IAMA. Thanks to Dr. Ghazi who made it happen.

Everyone enjoyed the hospitality of Dr. Javedani, his wife and his personnel at Sufi Restaurant on Saturday night. The restaurant's atmosphere, entertainment, taste, and quantity of food was excellent and liked by all of us.

During our Young Investigator Luncheon, three top young presenters (medical student Arash Ataie, Dr. Pooria Hosseini, and Dr. Sara Aria) were awarded with a certificate and $500 each. Seven other young investigators received travel grants and reimbursement for their hotel expense, young investigator luncheon award session and Gala dinner.

This year's generous donors for this great cause were Dr. Masood Khatamee and Dr. Mehrnaz Hadian. The reason for this is to make sure that our young colleagues who may not have the opportunity of staying at the main venue can be there so they will receive the maximum benefit from all the activities, enjoy networking, and get to know their senior colleagues. I encourage our other senior members to consider contributing to this great cause.

Our cultural speaker, Dr. Nasser Engheta, gave a wonderful talk on "Philosophy of Life". We concluded the event with our Gala, which was a great success. During the Gala we opened our hearts and pockets and our generous members donated $29,000. Donations ranged from $1,000-$10,000 for different causes that included BAM project, website, etc..

One of the highlights from our meeting was when Arman Raesian-Nejad, a young volunteer became impressed with this altruistic attitude of our members, he raised up and donated 1 week of his earnings to IAMA. I was touched very much by his selfless action and I encourage other members who were not present in the Gala or did not contribute, do so now and specify what purpose they want their donation to be used for.

IAMA's business meeting was held Sunday afternoon when Dr. Ganchi oriented members on Bam project. Our hard working treasurer, Dr. Ataei gave a detailed report on the financial status of the association. The report is available for anyone who wants to see it.

The Monday morning rap-up session included board members, trustees and chapter Presidents. Houston was chosen for next year's meeting. This will be the 25th anniversary of our beloved organization IAMA, already a very talented and committed local organizing committee is in full force to prepare another excellent meeting for our members.

Please get yourself ready it is Memorial Day weekend, 2018 "mark your calendar"

During the meeting we celebrated birthdays and anniversaries of several of our members.

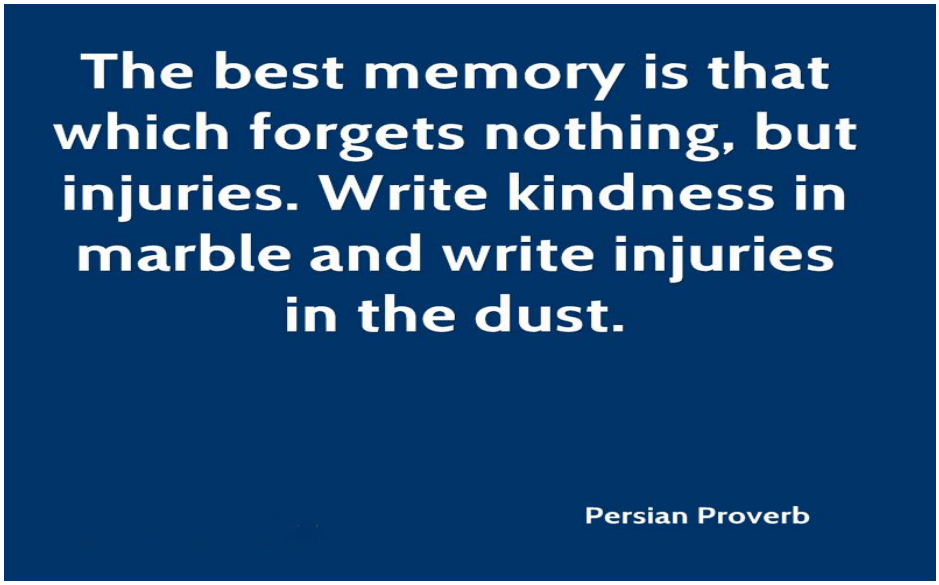
IAMA Javaan elected Anahita Hadioonzadeh as their President and Dr. Shahab Kahzanedari as Vice President. Congratulations to them and the rest of their board, we hope for a very active and energetic IAMA Javaan for future.

I cannot finish without thanking our wonderful volunteers for making this easy for everyone during the meeting.

On behalf of the new Board of Directors.

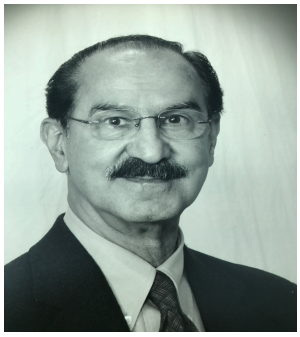
Your humble friend

Hosein Shokouh-Amiri, MD



# Be In IAMA with IAMA
# Bam Update

It is my great pleasure to report the detailed activities of the administration of IAMA in Iran who are actively working hard on the related issues of IAMA Medical Center in Bam, Iran.



Trustees of IAMA NGO in Iran are: Dr. M. A. Mirzaei, Chair; Dr. A. Emaeili, Engineer V. Sabbaghian, Dr. A. M. Mirfakhraee, Dr. A. Abasahl, Dr. R. Farid Hosseini, Dr. J. Moshirpur, Dr. A. Ganchi, , Dr. A Maghsoudi. Board of Directors: Dr. A. Ganchi, Dr. A. Esmaeili, Engineer V. Sabbaghian, Dr. A.M. Mirfakhraie, Dr. A. Abasahl, Dr. J. Mirfakhraie, Dr. J. Baharmast

1. Cooperation with the authorities of the Bam University, Medical School, which is subordinate of IAMA to equip the building to become operational in 2 months.
2. IAMA, NGO in Iran was approved after going through many lengthy investigations, including security and police check of all members of the trustees and the Board of Directors. Thanks to the hard work of Dr. Ali Maghsoudi, Secretary General & Trustee, and Dr. A. Esmaeili, Vice President & Trustee, of IAMA in Kerman – Bam in Iran. Dr. A. Esmaeili Trustee and Vice President of IAMA NGO in Bam following the affairs of the IAMA Medical Center in BAM and at the same time helping Dr. A. Maghsoudi Secretary General of IAMA NGO, who was actively following the legal aspects of the NGO and now following the process of the deed of donated land by the City Council of BAM chaired by Dr. A. Esmaeili at that time under the name of IAMA NGO in Bam, Iran. This one also has gone through a very long and hard process. There were 11 inquiries from different governmental and non-governmental offices to the other organizations to be answered, which took more than 3 years to get the result. Finally, those 11 inquiries are finished and now a letter should be sent to the Office of Registration in Kerman that the land and building to be owned by IAMA, NGO in Iran.
3. Now the authorities of Bam University, Medical School are working hard on the part of the vacant building to install a dental unit and at the same time equip the other spaces for counseling and medical clinic in the next few months to be operational. IAMA pledged to pay $15,000 for the cost of the dental unit to be installed.
4. The other half of the building is equipped with all state of the art machinery equipment for the water and food lab to serve 3 vicinity counties.
5. All the services of dental and medical clinic will be free of charge for the needy people in the area.
6. At the same time in the US, we have been trying to get the license from OFAC (Office of Foreign Assets Control) to send the money allocated to BAM for a long time, which was donated by you, the loyal members of IAMA ($130,000). Finally it was approved by the help of Mr. Ramin Asgard, attorney.

Please notice the recent agreement regarding the equipment of the medical center to be operational is about 2 months. Hope to arrange a group trip to Iran, BAM soon after that.

**Amir Ganchi, MD**

# U.S. DEPARTMENT OF THE TREASURY
# OFFICE OF FOREIGN ASSETS CONTROL
# LICENSING DIVISION

**From:** The Licensing Division
Office of Foreign Assets Control
U.S. Department of the Treasury
1500 Pennsylvania Avenue, N.W.
Washington, D.C. 20220

February 16, 2017

**To:** Dr. Amir Ganchi
Iranian American Medical Association
32 Bodie Rd.
Wayne, NJ 07470

**Subject:** **Certain Services in Support of NGO Activities in Iran**

**Case #** **IA-2017-339680-1**

**COMMENT:**

This is in reply to your letter dated January 5, 2017, to the Office of Foreign Assets Control (OFAC), on behalf of the Iranian American Medical Association, seeking authorization related to the transfer of funds to or from Iran. On September 10, 2013, OFAC issued **General License E** pursuant to the Iranian Transactions Sanctions Regulations, 31 C.F.R. Part 560 (ITSR), which generally authorizes the exportation of services and funds transfers of up to USD500,000 per annum in support of certain not-for-profit activities, including activities related to humanitarian projects to meet basic human needs in Iran, activities related to non-commercial reconstruction projects in response to natural disasters in Iran for a period of up to two years following the natural disaster; activities related to environmental and wildlife conservation projects in Iran; and activities related to human rights and democracy building projects in Iran.

Further, the ITSR authorize United States depository institutions or registered brokers or dealers to process transfers of funds to or from Iran, or for the direct or indirect benefit of persons in Iran or the Government of Iran, if the transfer arises from, and is ordinarily incident and necessary to give effect to, an underlying transaction that has been authorized by a general license, such as General License E of the ITSR, and does not involve debiting or crediting an Iranian account. ITSR, § 560.516. Please be advised further that the ITSR do not authorize transactions that would be prohibited by a different sanctions program administered by OFAC, such as current restrictions under the Weapons of Mass Destruction Proliferators Sanctions Regulations (31 C.F.R. Part 544) (WMDPSR) or the Global Terrorism Sanctions Regulations (31 C.F.R. Part 594) (GTSR).

To the extent that transactions related to your proposed activities in Iran fall within the scope of General License E, or section 560.516, of the ITSR, you may proceed without further authorization from OFAC. Please note that any transactions that fall outside the general licenses would still need to be specifically authorized by OFAC.

If you have any additional questions, you may refer to the OFAC website at www.treasury.gov/ofac or call our office at (202) 622-2480.

۹۶/۱/۳۰
۹۶/ر/۳۸٤

به نام خداوند یکتا

« صورتجلسه »

خداوند متعال توفیقی عطا فرمود که پنج شنبه مورخ سی ام فروردین ماه ۱۳۹۶ جلسه ای با حضور آقای دکتر اصغر مکارم ریاست محترم دانشگاه علوم پزشکی بم و آقای دکتر عباس اسماعیلی و آقای دکتر قندچی نماینده انجمن پزشکان و پیراپزشکان ایرانی مقیم آمریکا و آقای دکتر محمد رضا عرب معاونت محترم درمان دانشگاه و آقای دکتر فروتن تشکیل شده و مسائل مربوط به کلینیک یاما در بم و راه اندازی آن و مشکلات موجود مورد بحث و بررسی قرار گرفت و در نتیجه جناب آقای دکتر مکارم ریاست محترم دانشگاه وعده فرمودند با وجود مشکلات مالی و در عین حال نیاز ساختمان به تعمیرات اساسی و برای خدمت به مردم زلزله زده بم به شرح ذیل آن را راه اندازی نمایند.

۱- کلینیک پزشکی با یک اتاق عمل برای جراحی های کوچک و سرپایی و سالن انتظار
۲- کلینیک دندانپزشکی با یک ماشین دندانسازی (یونیت) و عکسبرداری و تعمیرات لازم این قسمت که مقرر شد به امید خداوند یکتا دندانپزشکان آمریکا مخارج این کار را عهده دار شوند
۳- محل کافی برای مشاوره روان درمانی با در نظر گرفتن کلیه ضوابط حریم خصوصی روانکاوی
۴- محلی که هم اکنون توسط دانشگاه آماده بهره برداری شده برای آزمایشگاه آب و مواد غذایی چند شهرستان منطقه

مدت زمانی که برای انجام این منظور در نظر گرفته شده سه الی چهار ماه می باشد. آقای دکتر قندچی از طرف انجمن پزشکی و پیراپزشکی یاما از این همه مراتب کمک و همراهی سپاسگزاری کرده و امید است به لطف پروردگار یکتا و سروران گرامی در دانشگاه بم این مهم سرانجام یابد و در نتیجه اعضاء انجمن پزشکی و پیراپزشکی ایرانیان مقیم آمریکا مجدداً با کمال علاقه و اشتیاق خواهان مسافرت به میهن عزیزمان ایران و دادن خدمات آموزشی ، درمانی و کمکهای فنی و انتقال یافته های جدید علمی در جهت ارتقاء سطح علمی دانشگاه بم برای ارائه خدمات بهتر به بازماندگان زلزله و مردم بم هستند.

لازم به ذکر است خدمات درمانی و روابط اینترنتی مستمر برای بالابردن سطح علمی و پیاده کردن یافته های جدید پزشکی نیز جزئی از این خدمات خواهد بود.

**اعضاء جلسه:**

دکتر اصغر مکارم
رئیس دانشگاه علوم پزشکی بم

دکتر قندچی
نماینده انجمن پزشکان و پیراپزشکان ایرانی مقیم آمریکا

دکتر محمدرضا عرب
معاون درمان دانشگاه

دکتر عباس اسماعیلی

دکتر رضا فروتن
قائم مقام جلب مشارکتهای اجتماعی دانشگاه




**This plaque is mounted in the hallway of the entrance area of the BAM Medical Center in appreciation of the donors who helped establish the Center.**

# CONGRATULATIONS! SUSMA JOINED IAMA

**SHIRAZ UNIVERSITY SCHOOL OF MEDICAL SCIENCES ALUMNI ASSOC., USA, INC. (SUSMA)**

The Shiraz University School of Medical Sciences Alumni Association (SUSMA) was founded over thirty years ago by a group of graduates from that university. The aim of the society was to bring together alumni and medical professionals from Iran to promote the rich Iranian cultural heritage and their common goals for each other, their children and the Iranian Society.

To achieve its objective, the Board of Directors decided to organize a yearly reunion for the alumni in the month of March that coincides with the "Nowruz" Persian New Year. They worked diligently to arrange and prepare for a memorable Alumni weekend.

Every March friends from distant States would arrive on Friday to relax, socialize, sight see and get ready for the festivities.

On Saturday night the Nowruz Celebration will recognize and honor prominent colleagues for their accomplishments and contributions to the science of medicine.

On Sunday morning a scientific medical conference was organized to promote medical knowledge and awareness, followed by a luncheon to complete the weekend reunion.

Since its inception as a not-for-profit organization, SUSMA, through its Board of Directors, has been instrumental in providing various services and making contributions by giving scholarships, helping students and needy Iranians through placement in different positions and assistance in providing medical treatment.

It has also assisted Earthquake victims in Iran by providing blankets, medication and purchasing and donating an Ambulance to transport the sick from rural areas to distant hospitals.

SUSMA purchased and maintained the supply of medical journals and books for Shiraz University Library, contributed to the Eye Institute in Shiraz, supported advancement of Encyclopedia Iranica, contributed funds to New York City for victims of 911 and to United Nations for Somali victims of war, just to name a few.

SUSMA has also sponsored a chair in the United States in the name of an Iranian physician and the publication of a book written by the Dean of Shiraz University.

Today we can proudly state that through hard work and dedication we have achieved and even surpassed the goals we set thirty years ago, our accomplishments in society are recognized and our contributions lauded.

Now the Board of SUSMA is pleased to accept the invitation of IAMA to join in as a section of IAMA.

# IN BALBOA PARK, SAN DIEGO

## House of Iran is for human rights, religious freedom.



In October of 2004, the House of Iran completed their $350,000 cottage and donated it to the City of San Diego as a gift from the Iranian American Community in appreciation of the opportunities they have found in our great city.

As part of this project the House of Iran installed a piece of rock carrying the replica of the "Cyrus the Great" Cylinder as the First Official Declaration of Human Rights in the World. This declaration is proudly displayed outside of the House of Iran cottage for the public to see.

Inscribed in cuneiform on a clay cylinder discovered in 1879, now on display in the British Museum Cyrus the Great (585-529 BC) the Iranian Emperor defined the first Declaration of Human Rights on this cylinder.




*I hereby abolish slavery; my governors are ordered to prohibit exchanging men and women as slaves within their ruling domains. Such a tradition should be exterminated the world over.*

*If anyone oppresses others, should it happen, I will take his/her right back and penalize the oppressors.*

*Today I declare Freedom of Religion. All are free to choose any religion, live in all regions and take up any job provided that they never violate other's rights.*

**These proclamations ring true today in our times as they did in 538 BC.**





**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. Please be sure to include your topic and your information.

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



**Sad news from Stanford University.**

# Maryam Mirzakhani, Stanford mathematician and Fields Medal winner, dies

**Stanford mathematics Professor Maryam Mirzakhani, the first and to-date only female winner of the Fields Medal since its inception in 1936, died Friday, July 14, after a long battle with cancer. Mirzakhani was 40 years old.**

BY ANDREW MYERS AND BJORN CAREY

Stanford mathematics Professor Maryam Mirzakhani, the first and to-date only female winner of the Fields Medal since its inception in 1936, died Friday, July 14. She had been battling breast cancer since 2013; the disease spread to her liver and bones in 2016. Mirzakhani was 40 years old.



Professor Maryam Mirzakhani was the recipient of the 2014 Fields Medal, the top honor in mathematics. *(Image credit: Courtesy Stanford News Service)*

The quadrennial Fields Medal, which Mirzakhani **won in 2014**, is the most prestigious award in mathematics, often equated in stature with the Nobel Prize. Mirzakhani specialized in theoretical mathematics that read like a foreign language by those outside of mathematics: moduli spaces, Teichmüller theory, hyperbolic geometry, Ergodic theory and symplectic geometry.

Mastering these approaches allowed Mirzakhani to pursue her fascination for describing the geometric and dynamic complexities of curved surfaces – spheres, doughnut shapes and even amoebas – in as great detail as possible. Her work was highly theoretical in nature, but it could have impacts concerning the theoretical physics of how the universe came to exist and, because it could inform quantum field theory, secondary applications to engineering and material science. Within mathematics, it has implications for the study of prime numbers and cryptography.

Mirzakhani joined the faculty of Stanford University in 2008, where she served as a professor of mathematics until her death.

“Maryam is gone far too soon, but her impact will live on for the thousands of women she inspired to pursue math and science,” said Stanford President Marc Tessier-Lavigne. “Maryam was a brilliant mathematical theorist, and also a humble person who accepted honors only with

the hope that it might encourage others to follow her path. Her contributions as both a scholar and a role model are significant and enduring, and she will be dearly missed here at Stanford and around the world."

Despite the breadth of applications of her work, Mirzakhani said she enjoyed pure mathematics because of the elegance and longevity of the questions she studied.

A self-professed "slow" mathematician, Mirzakhani's colleagues describe her as ambitious, resolute and fearless in the face of problems others would not, or could not, tackle. She denied herself the easy path, choosing instead to tackle thornier issues. Her preferred method of working on a problem was to doodle on large sheets of white paper, scribbling formulas on the periphery of her drawings. Her young daughter described her mother at work as "painting." "You have to spend some energy and effort to see the beauty of math," she told one reporter.

In another interview, she said of her process: "I don't have any particular recipe [for developing new proofs]. … It is like being lost in a jungle and trying to use all the knowledge that you can gather to come up with some new tricks, and with some luck you might find a way out."

Mirzakhani was born in Tehran, Iran, and – by her own estimation – was fortunate to come of age after the Iran-Iraq war when the political, social and economic environment had stabilized enough that she could focus on her studies. She dreamed of becoming a writer, but mathematics eventually swept her away.

She attended an all-girls high school in Tehran, led by a principal unbowed by the fact that no girl had ever competed for Iran's International Mathematical Olympiad team. Mirzakhani first gained international recognition during the 1994 and 1995 competitions. In 1994, she earned a gold medal. In 1995, she notched a perfect score and another gold medal.

After graduating college at Sharif University in Tehran, she headed to graduate school at Harvard University, where she was guided by Curtis McMullen, a fellow Fields Medal winner. At Harvard, Mirzakhani was distinguished by her determination and relentless questioning, despite the language barrier. She peppered her professors with questions in English. She jotted her notes in Farsi.

McMullen described Mirzakhani as filled with "fearless ambition." Her 2004 dissertation was a masterpiece. In it, she solved two longstanding problems. Either solution would have been newsworthy in its own right, according to Benson Farb, a mathematician at the University of Chicago, but then Mirzakhani connected the two into a thesis described as "truly spectacular." It yielded papers in each of the top three mathematics journals."The majority of mathematicians will never produce something as good," Farb said at the time. "And that's what she did in her thesis."

Iranian President Hassan Rouhani said the "unprecedented brilliance of this creative scientist and modest human being, who made Iran's name resonate in the world's scientific forums, was a turning point in showing the great will of Iranian women and young people on the path towards reaching the peaks of glory … in various international arenas," according to Iranian state media.

"What's so special about Maryam, the thing that really separates her, is the originality in how she puts together these disparate pieces," said Steven Kerckhoff at the time of her Fields Medal award. Kerckhoff is a professor at Stanford who works in the same area of mathematics. "That was the case starting with her thesis work, which generated several papers in all the top journals. The novelty of her approach made it a real tour de force."

After earning her doctorate at Harvard, Mirzakhani accepted a position as assistant professor at Princeton University and as a research fellow at the Clay Mathematics Institute before joining the Stanford faculty. "Maryam was a wonderful colleague," said Ralph L. Cohen, the Barbara Kimball Browning Professor of Mathematics at Stanford. "She not only was a brilliant and fearless researcher, but she was also a great teacher and terrific PhD adviser. Maryam embodied what being a mathematician or scientist is all about: the attempt to solve a problem that hadn't been solved before, or to understand something that hadn't been understood before. This is driven by a deep intellectual curiosity, and there is great joy and satisfaction with every bit of success. Maryam had one of the great intellects of our time, and she was a wonderful person. She will be tremendously missed."

In recent years, she collaborated with Alex Eskin at the University of Chicago to answer a mathematical challenge that physicists have struggled with for a century: the trajectory of a billiard ball around a polygonal table. That investigation into this seemingly simple action led to a 200-page paper which, when it was published in 2013, was hailed as "the beginning of a new era" in mathematics and "a titanic work." "You're torturing yourself along the way," she would offer, "but life isn't supposed to be easy." Mirzakhani is survived by her husband, Jan Vondrák, and a daughter, Anahita. The university will organize a memorial service and an academic symposium in her honor in the fall, when students and faculty have returned to campus.

# CHAPTER ACTIVITIES

**California**

President: Omid Ashouri, MD
Vice President: Maryam Hagh, MD
Treasurer: Susan Morvaridi, PhD
Secretary: Noushin Afrookhteh, MD
Members at Large: Hamid Shidban, MD Mehran Motamed, MD, Alireza Noorian, MD, Reza Pakdaman, MD

The 24th Annual Conference was held in San Diego, CA this year. The IAMA CA Chapter helped organize this very successful event. Future events will be public education and conferences for health care professionals.

**Massachusetts**

President: Khosro Farhad, MD
Vice President: Mahta Samizadeh, MD
Treasurer: Mahnaz Zeinali, MD
Secretary: Nahal Panah, MD
Members at Large: Sara Ansari, DPT and Reza Madani, MD
Board Member: Badrieh Edaltppour, MD

The quarterly scientific meeting was held at Crowne Plaza Hotel in Newton, MA on September 30th, 2017. Up to 90 people attended the talk by Dr. Dariush Mozaffarian on "Food and Policy Priorities on Nutrition: Are All Calories Created Equal?"

The feedback from audience was strongly positive on the topic and also speaker.

We also had 2 young investigator award winners: Dr. Afsaneh Amouzegar, who presented her work on " Mesenchymal Stem Cells Modulate the Differentiation of Immature Myeloid Cells in Ocular Inflammation". The second winner was Dr. Amir Sheikhi, who presented his work on "Engineering natural colloidal systems for advanced environmental and biomedical applications".

They presented their work on a poster and were present at their posters for the entire meeting from 6 to 10 PM. The young investigator winners were awarded $250 kindly sponsored by Dr. Sharifzadeh for this time. We have other volunteers to continue this trend in future. We also advertised about IAMA and made it mandatory for young investigators to be IAMA member before submitting their abstract.

The next conference to be held on December 2nd, 2017. Our distinguished lecturer will be Professor Reza Dana. He will talk on the Dry Eye Disease, as the most common ophthalmic condition. We will also have 2 young investigator award winners. The abstracts will be reviewed by our scientific board and 2 winners will be announced to present their work as a poster. They will be awarded $250 each with a certificate.

**New Jersey**

President: Shervin Mortazavi, MD
Vice President: Pegah Ameri, DMD
Secretary: Ali Tabarroki, MD
Treasurer: Shahram Lashgari, DMD
Member at Large: Payam Torrei
Advisors: Masood Khatamee, MD, and Hoseinali Shahidi, MD



During the past year IAMA New Jersey continued the chapter Board meeting on a monthly basis, also, the chapter had active participation at the annual conference in San Diego, with 100% presence of all the board members and advisors.

As part of IAMA's mission in public education and awareness, NJ chapter continued the Public Awareness sessions on a bimonthly basis. Topics were selected based on suggestions from the audience and voting on the topics. During the past year presented topics were as followed:

Pain management, Vahid Grami, MD
GI disaorders, Mohammad Erfani, MD
Hypnosis and Meditation, Shervin Mortazavi, MD

Oral Hygiene and Dental Care, Pegah Ameri, DMD and Shiva Ameri
Immunotherapy in Cancer, Hosein Tirgan, MD

**New York**

President: Reza Hedayati, MD
Vice President: Haleh Yarmohammadi, MD
Secretary: Reza Peymani, MD

The most recent activity of New York chapter was Public Medical Awareness Seminar on Diabetes. By Tooraj Zahedi, M.D. on September 2017.

The next New York Chapter Public Medical Awareness Seminar will be held on November 19, 2017 on Immunotherapy for cancer patients . By Hossein Tirgan , M.D.

**Ohio**

President: Freidoon Ghazi, MD
Secretary: Homayoon Mesghali, MD
Treasurer: Mohammad Motekallem, MD

Ohio Chapter meets quarterly. A Persian night gala took place on September 30th in Cincinnati arranged by KARMA under the auspices of IAMA.

**Texas**

President: Shahin Tavackoli, MD
Vice President: Tannaz Armaghany, MD
Treasurer: Homayoun Ataei, MD
Secretary: Ehsan Arabzadeh, MD
Members at Large: Neda Ghedami, MD and Homayoon Mohajer, MD
Monthly Asheghaneh medical articles to expand medical knowledge of the general population are produced.

Two quarterly meetings held this year with general population and invited speakers, to expand the medical knowledge of the attendees.

We had a free clinic/low cost laboratory evaluation for those without means on in September

Attended and represented IAMA-TX at the Nowruz celebrations in Houston.

A luncheon was held to re-introduce IAMA to the Iranian population of Houston in April of this year and delivered three scholarships, each for $2000 to qualifying candidates.

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Save the Date

25 YEARS

# IAMA

## 25th Annual Meeting of

## *Memorial Weekend ~ May 25-28, 2018*




## Meet old friends …. Make new friends

## Show the power of your organization

# SCIENTIFIC ABSTRACTS PRESENTED AT THE 24th ANNUAL MEETING OF IAMA

# May 26 - 29, San Diego, CA



*Professor H. Shokouh-Amiri, President, welcoming all to CME presentation.*

**Dr. Hosein Shokouh Amiri**

## Minimally Invasive Versus Open Surgery In Treatment Of Liver Lesions

**Background**

Laparoscopic and robotic surgeries are considered alternative to open surgeries to manage liver lesions. These methods are underutilized and we report our experience.

**Aim**

To compare the outcomes, morbidity, mortality and survival of patients who had minimally invasive vs open surgeries on liver lesions at our center

**Materials & Methods**

From 621 liver surgeries that have been performed in our center between 1998- 2016 we analyzed the data that were collected prospectively With IRB approval in patients who underwent minimally invasive liver surgery (n=109) and compared them to matched patients with open liver surgery (n=109). Demographic data, blood loss, operation time, hospital stay, professional fee, morbidity and mortality were studied.

**Results**

We performed 109 minimally invasive (26 robotic and 83 laparoscopic) surgeries (22 HCC, 34 liver metastasis, 3 cholangiocarcinoma, 3 neuroendocrine tumor, 1 hepatoblastoma, 1 GIST and 45 benign lesions). These were compared with 109 matched open surgeries (22 HCC, 34 liver metastasis, 5 cholangiocarcinoma, 3 neuroendocrine and 45 benign lesions). Estimated blood loss (257.5±128.2 vs. 637.6±458, P-value 0.0001) and hospital stay (5.5±3 vs. 8.7±5.7 days, P-value 0.0001) were significantly lower in favor of minimally invasive surgery. Professional fee(p-value=0.54), Operation time(p-value:0.73), Peri-operative mortality (p-value=0.73) and R0 resection margin( p-value=0.79) were comparable in both groups. 17.4% of patients with minimally invasive vs. 14.7% of patients with open surgery had peri-operative morbidity (p-value=0.58). Mean survival time in minimally invasive and open surgeries were 37.8±33.1 vs. 48.4±30.1 months (P-value 0.062) respectively.

**Discussion**

There has always been a great concern about oncological safety, ability to achieve negative resection margin and survival of patients who undergo minimally invasive surgeries. Recent studies have revealed comparable oncological outcomes, rate of negative resection margin and survival between patients with minimally invasive liver resection vs open resection. Our study findings reveal similar results regarding rate of resection margin, oncological outcomes and overall survival of patients between the two groups.

**Conclusion**

Considering the limitation of the study which is not randomized, we can conclude that robotic and laparoscopic liver surgeries can

be performed safely with significantly lower blood loss and shorter hospital stay in comparison with open surgeries.

## Dr. Hosein Shokouh Amiri

## Minimally Invasive Versus Open Surgery In Treatment Of Distal Pancreatic Lesions

**Background**

Laparoscopic and robotic pancreatic surgeries are gaining popularity and considered alternatives to open surgeries in management of benign and malignant pancreatic lesions.

**Aim**

To assess outcomes, morbidity, mortality and survival of patients underwent minimally invasive versus open surgery on distal pancreatic lesions.

**Materials & Methods**

Patients who underwent minimally invasive distal pancreatectomy (MIDP,n=56) and matched patients with open distal pancreatectomy (ODP, n=56) were analyzed retrospectively with IRB approval. Hospital stay, morbidity, professional fee, narcotic dose, mortality and survival were studied.

**Results**

MIDP were utilized in 56/487 patients with pancreatic lesions and 56 patients with ODP matched for age, sex, race, tumor size, and type of surgery were used for comparison. Malignant lesions accounted for 27 vs. 22 in MIDP vs. ODP group. Patients with MIDP had significantly less blood loss than ODP (239±174 vs 637±622 ml, p-value: 0.007). 14.8% vs 18.2% of patients with MIDP vs ODP had positive resection margin (p-value:0.75). No differences were identified between OR time, hospital stay, professional fee, narcotic usage, tumor size, stage, morbidity and survival time. The mean survival time was 31.4±25.3 vs 34.4±26.4 months (p-value: 0.74) in malignant patients with MIDP vs ODP respectively. In comparison, patients with pancreatic adenocarcinoma who underwent MIDP vs. ODP had only significantly less estimated blood loss (268.2±115 vs 619.12± 611 ml, p-value: 0.033). Mean survival time in patients with pancreatic adenocarcinoma who underwent MIDP vs. ODP was 23.3±21.5 vs 26.2±23.6 months ( p-value: 0.75).

**Discussion**

The data on minimally invasive distal pancreatectomy suggest that it may bring some advantage but true comparison to open approach is hard due to the deficiency of randomized study. If studies can prove that minimally invasive surgeries can at least match the results of open pancreatic surgeries this can introduce significant development as it will avoid large incisions.

**Conclusion**

Considering the limitation of this study MIDP can be performed safely with significantly lower blood loss compared to open surgery in distal pancreatectomy.

## Dr. Pooria Hosseini



## Do surgeons need to rescrub during operations that last longer than three hours?

**Co-Authors'**

Gregory M. Mundis Jr.,
Robert Eastlack,
Jeff Pawelek,
Stacie Nguyen,
Behrooz A. Akbarnia

**Background**

Despite advances in infection control, surgical site infection remains a substantial cause of morbidity especially in long operations (>3 hours). There is evidence that the efficacy of the scrubbing material fades away after three hours. Hence, it can be postulated that the surgeon's hands may become a progressive source of contamination during surgery. We aimed to determine the level of hand contamination after operations lasting more than 3 hours.

**Aim**

Is there a correlation between surgical duration and hand contamination at the end of surgery?

**Materials & Methods**

Three spine surgeons used the same scrubbing technique and material enrolled. Exclusion criteria: procedures less than three hours, and operations with perforated gloves. Twenty consecutive spine surgeries were included.

Hands were swabbed with 5 ml sterile 75 mM Phosphate Buffered Saline with 0.1% Triton-X at prior to hand scrubbing (pre-scrub), immediately following hand scrubbing (post-scrub) and immediately following surgery (post-operative).

**Results**

With a longer duration of surgery, more colony-forming units are recovered from gloved hands at the end of surgery ($R = 0.94$, $R2 = 0.89$, $p = 0.005$). The receiver-operating characteristic curve suggested that 5 hours is the cutoff point for hand recolonization. At 5 hours, contamination reached or exceeded prescrub levels (area under the curve, 0.66; 95% CI, 0.23–1.0), whereas before 5 hours, there was no contamination detected at the end of surgery.

**Discussion**

Our results show that duration of surgery correlates with hand recontamination and at 5 hours, recolonization of a surgeon's hands becomes detectable. Recolonization may have started even earlier than 5 hours. However, these levels are not detectable in the laboratory at earlier times.

**Conclusion**

Based on this pilot study, rescrubbing is highly recommended before the fifth hour of an operation, ideally at some point between the fourth and fifth hours.

## Major Pancreas Resection for Adenocarcinoma in the Elderly Patients; Does Age Impact the Outcome?



**Alireza Hamidian Jahromi, MD[1]; Gazi B. Zibari, MD, FACS, FICS[2]; Quyen Chu, MD, FACS[1]; Gregory P. Wellman, MD, FACR[3]; Runhua Shi, MD, PhD[4]; Hosein Shokouh-Amiri, MD, FACS, FICS[2].**

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The current aging in the general population will ultimately result in an increase in incidence of cancers like pancreatic adenocarcinoma which are more common in the elderly. While major pancreatic resection is considered as a high-risk procedure, evaluating the survival benefit in the elder population undergoing curative resection (CR) is gaining increasing relevance. We evaluated the safety and survival benefit of CR of borderline resectable pancreatic adenocarcinoma in the elderly patients (≥70 years age) compared to a younger group of patients.

**Methods:** In this IRB approved retrospective cohort study, patients who had pancreatic surgery (N=274) between 1998-2012 were reviewed. Patient's outcome and survival were compared between seventy patients (age <70 years) who underwent major pancreatic resection for pancreatic adenocarcinoma (group-I) with the elderly patients (age≥70 years) (group-II) (N=27). Demographics, pre-op tumor marker levels, operative and follow-up data, were reviewed.

**Results:** Type of the operations were: Standard Whipple (N=53), pylorus-sparing-Whipple (N=41), total pancreatectomy (N=3). The grades were: 1 (xx%), 2 (50.4%), 3 (32.2%), and 4 (6.1%). The stages were: 1A (5.2%), 1B (8.2%), IIA (24.7%), IIB (48.5%), III (11.3%), and IV (2.1%). Stages IIB-IV had a significantly lower median OS than stages I-IIA (p=xxxx). The 5-yr OS for the entire group was XXX%. The 5-year OS for N0 and N (+) was XX% and XX% (p<0.05), respectively, and for R0 and R1 the 5-year OS

was XX% and XX% (p<0.05), and for PST (-) and PST (+) were XX% and xx% (P<0.05) respectively. The median OS for Groups 1, 2 were XX months, and XX months, respectively (p=XX). The risk of intra-operative and post operative complications were not different between the groups (P>0.05 for both). Cox regression analysis demonstrated that while grade (Hazard Ratio=2.7), peri-pancreatic soft tissue involvement (PST) (Hazard Ratio=2.3), margin status (Hazard Ratio=1.9) were independent predictor of mortality (P<0.05 for all), age was not an independent predictor of outcome (P>0.05).

**Conclusion:** While pancreatic major resection in the elderly patients seems to be feasible and safe and is not associated with significant risk of intra-operative and post operation complications; the survival of the elderly patients undergoing pancreatic adenocarcinoma is poor. Age is not an independent predictor of outcome in the elderly patient with pancreatic adenocarcinoma.



## Dr. Sara Arian



## Demographic Characteristics Of Women With Uterine Factor Infertility Seeking Information On Uterine Transplantation

**Background**

uterine factor infertility (UFI) was considered an incurable problem. Mayer-Rokitansky-Kuster-Hauser (MRKH) syndrome is the predominant congenital cause of UFI, with a prevalence of 1:4000 women (1). Some acquired cases of UFI are the results of surgery or uterine damage. Gestational surrogacy and adoption have historically been the only reproductive options for women with UFI. However, these choices may be limited by religious, ethical, legal, or cultural factors. Uterine transplantation is not fertility preservation, per se; however it could be considered a method of fertility restoration in a population with otherwise irreversible infertility. This procedure may therefore provide women with congenital or surgical absence of the uterus with an opportunity to experience the gestational component of motherhood as well as to carry their own biological child.

**Aim**

women with uterine factor infertility (UFI) who were screened as candidates for a uterine transplantation clinical trial at our institution.

**Materials & Methods**

This is a descriptive study.

Reproductive-aged women with UFI contacted our institution starting 4/2015 regarding our uterine transplantation clinical trial. Descriptive and demographic characteristics of screened patients are reported below.

**Results**

Over 250 women contacted our institution and 239 women with UFI were screened for our uterine transplantation protocol. The mean age was 31 years (range 18-52). 32% (n=78) had UFI secondary to Mayer-Rokitansky-Kuster-Hauser (MRKH) syndrome versus 64% (n=154) with acquired UFI secondary to prior hysterectomy. One patient had an intersex diagnosis. There were 5 male to female transgender applicants (2%) and one case of androgen insensitivity syndrome. The mean age in the MRKH group was 28 versus 33 in the acquired UFI group. 15% of patients with MRKH had a single kidney. The most common cause for seeking uterine transplantation was prior hysterectomy, with indications for surgery including 50% benign conditions (fibroids, endometriosis), 25% obstetric complications (post-partum hemorrhage, placenta abnormalities) and 25% gynecological malignancies (Table 1).

67% of candidates were Caucasian. 94% of women lived in the United States and 6% were international. 64% of screened women

were legally married, 29% in a stable relationship and 7% were single. 17% of the screened candidates had at least one child.

**Discussion**

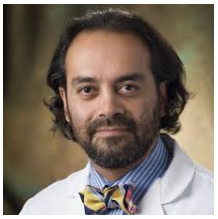
condition that affects approximately 1.5 million women worldwide. Given recent reported live births, uterine transplant has now reached its clinical experimental stages at several institutions. Candidates are actively seeking uterus transplantation programs internationally and in the U.S. These women have wide-ranging ages, social and religious situations, and medical histories.

**Conclusion**

congenital UFI in our screened population was unexpected, as was the fact that half of prior hysterectomies were for non-oncologic indications. Careful consideration and screening of candidates including medical, surgical, social and cultural histories is a prerequisite to a successful transplant protocol. Prior to its routine clinical application, uterine transplantation requires extensive considerations of clinical, surgical, ethical and financial questions that need to be addressed.



**Dr. Alireza A. Shamshirsaz,**



## A survey of Obstetricians and Gynecologists responses to honor-related practices: Time to open Pandora's Box

**Co-Authors' Full Name(s) (if any)**

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**Background**

religions, and ethnicities family honor and societal beliefs related to women's chastity and sexual life put women and girls at risk of inappropriate procedures. Virginity testing, virginity restoration, and female genital mutilation (FGM) are three common procedures to which women and girls are often subject. Physical and psychosocial problems (e.g. urinary fistula, obstetric complications, depression, despair, suicidal feelings, and identity problems) often occur as a result.

**Aim**

experiences and attitudes of practicing Obstetrician-Gynecologists (OBGYNs) in the U.S toward requests for honor-related practices that are ethically controversial or unacceptable.

**Materials & Methods**

containing 42 questions on physicians' demographic and practice experience with honor-related practices and demographic characteristics were as sent to 1000 members of the American College of Obstetricians and Gynecologists, including members of the Collaborative Ambulatory Research Network

and non-Collaborative Ambulatory Research Network members. Stratified random selection was used to generate samples from both groups.

**Results**

were retired. A total of 288/909 OBGYNs responded to the survey for a response rate of 31.7%. In the 12 months prior to completing the survey, 29/288 (1.0%), 16/288 (0.56%), and 168/288 (58.6%) of physicians provided care to at least one patient who requested for virginity testing, virginity restoration or who had undergone female genital mutilation (FGM), respectively. Of all respondents, 10/288 (3.5%) and 3/288 (1.9%) perform virginity testing and restoration, respectively, upon request which were not limited to the foreign nationals or immigrant generations. Only 10/288 (3.5%) were aware of any institutional policies regarding receiving such requests. Only 95 of the 168 (56.7%) physicians who saw patients with a history of FGM were aware that federal laws prohibit FGM. Surprisingly, 3 respondents (1.8%) in this subgroup reported seeing patients who underwent FGM in the U.S.



**Discussion**

gynecologists, a considerable number have received requests for virginity testing or virginity restoration or to provide care for patients with a history of FGM. Despite our limited number of responses, our survey reported that more than 2/3 of OBGYNs care for patients who may or have experienced some form of honor-based practice, especially FGM. Given the perceived low prevalence in western countries, and the hidden nature of these practices, such a high number should create grave alarm. Honor-related practices are at least ethically suspect and at worst ethically impermissible because they violate human rights, are associated with significant physical and psychosexual consequences, are not scientifically validated.

**Conclusion**

who have been subjected to them, especially genital mutilation, may be greater than is commonly believed. Although these practices are either not ethically controversial or impermissible, a significant number of OBGYNs perform the practices and are not aware of any available guideline/law in managing these patients.

The man who speaks the truth is always at ease

~ Persian Proverb

## Dr. Soheil Hanjani



Good Samaritan Medical Center

### Female Genital Cosmetic Surgery – I'm too beautiful …. Everywhere!

**Background**

Female genital cosmetic surgery is increasingly utilized, and has become more popular and recognized by patients.

**Aim**

An understanding of the basics of Female genital cosmetic surgery and the options available is increasingly important in taking care of the female population.

**Materials & Methods**

Professional national female medical organizations in general remain skeptical and cautious about these surgeries. But a variety of Female genital cosmetic surgeries are being used nationwide. Most common are: Labioplasty, Hymenoplasty, Vaginoplasty and vaginal rejuvenation, Perineoplasty, and Clitoral hood reduction.

**Results**

Complications appear minor and acceptable to patients. There is little formal data available regarding outcomes and satisfaction post procedure. However the surgery does seem to fulfill the majority of patient's desires for cosmetic and functional improvement, as well as some enhancement of the sexual experience.

**Discussion**

The literature on this subject is almost entirely retrospective. Despite the fact that women's genitals naturally have a wide range of normal appearances that are anatomically correct, many patients desire to surgically correct perceived or functional issues in that region. A balanced counseling approach is warranted in these patients.

**Conclusion**

Women requesting Female genital cosmetic surgery often do so for cosmetic, and sometimes functional, reasons, with a high degree of satisfaction with the results.

## Zahra Nooshin Rezvani, MD

### Parkinson's disease, Suicidal Ideation and associated risk factors



**Co-Authors'**

Erik Barr, Ann Gruber-Baldini, Joseph Savitt, Rainer Von Coelln, Lisa Shulman

University of Maryland

**Background**

Although Depression is a common non-motor symptom in PD, suicide is relatively uncommon. Little is known about the prevalence of suicidal ideation (SI) in PD and its risk factors.

**Aim**

The aim of this study is to adequately diagnose and treat SI in patient with Parkinson's disease.

**Materials & Methods**

Cross-sectional analyses were performed in 1783 PD patients completed the Brief Symptom Inventory (BSI-18), including an item assessing the presence of SI. Logistic regression models were used to identify independent predictors of SI.

**Results**

SI was reported by 312 (18%) of PD patients. Logistic regression found that patients reporting SI were younger (66.6 (10.8) vs 69.4 (10.6) $p<0.001$), more depressed ($p<0.001$), more likely to be diagnosed with mood disorder ($p<0.001$), more cognitively impaired (MoCA 22.9 (5.4) vs 24.7 (4.3) $p=0.04$), had greater comorbidity (CIRS; $p< 0.001$), higher motor UPDRS (32.3+/- 1 v 29.4+/- 14.2, $p=0.008$), and greater disability (OARS, $p< 0.001$) than those without SI. In the multivariate model age mood disorder,

comorbidity, and disability remained significant.

**Discussion**

Suicidal ideation is reported by nearly one-fifth of PD patients. SI is more common in PD patients who are younger, more cognitively impaired, have greater disability or mood disorder diagnosis.

**Conclusion**

Evaluation of SI is necessary in patient with Parkinson's disease, specially in young patients with advanced disease.

**Ahmad Darvish, MD & Edward Glasscock, MD**



## Kv1.1 Potassium Channel Deficiency Reveals Altered ECG and Bradycardia in Isolated Langendorff Perfused Mice Heart.

Department of Cellular Biology and Anatomy, Louisiana State University

Health Sciences Center, 1501 Kings Hwy, Shreveport, LA 71130, USA.

Sudden Unexpected Death in Epilepsy (SUDEP) is a disease of neurological condition which results in 200-300 death each year in US alone. One of the most studied animal model of SUDEP currently use to study SUDEP is the Kv1.1 knockout mouse model. Mice lacking the voltage gated potassium channel alpha subunit Kv1.1 display frequent spontaneous seizures throughout their adult life. The three important organ system involved in the development of SUDEP are neuronal, respiratory, and cardiac. This disease has been extensively studied at the neuro-pathophysiological level. SUDEP is associated with altered neuronal electrical generation in amygdala, higher brain center. Although the alteration in neurogenic mechanisms has been extensively studied both in human and animal models of SUDEP, the role of cardiac system has not been studied thoroughly. Until recently, based on the pharmacology and expression data it was accepted that the cardiac abnormality observed in Kv1.1 deficient mouse were neuronal in origin. Previously we detected Kv1.1 protein by immunoblotting heart protein lysate samples which was believed to be from nodal pacemaker regions or intrinsic cardiac neurons. We as many others believed that Kv1.1 channels do not play a major role in altering cardiac function, but rather influence cardiac function via the autonomic nervous system. Recently using RT-PCR, immunocytochemistry, and immunoblotting, Kv1.1 mRNA and protein were detected in isolated mouse cardiomyocytes and human atria with the concomitant absence of mRNA and protein in Kv1.1 null animal. Recently number of in vivo studies had demonstrated an arrythmogenesis, tachycardia, atrioventricular blockage observed during seizure in Kv1.1 animal model. The cardiac abnormality observed in Kv1.1 deficient mouse in vivo were believed to be the result of altered autonomic nervous system in regulation of Kv1.1 mice heart. In this study we are recording Electrocardiogram (ECG) from WT and Kv1.1 potassium deficient isolated Langendorff perfused hearts. As well as testing the effects of Isoproterenol and Acetyl choline on isolated Langendorff perfused hearts from each group. Here we show that the Isolated heart of Kv1.1 null mice under Langendorff perfused system have a significant lower heart rate compared to aged match wild type group. Also the duration of P wave in the Kv1.1 null mice ECG is significantly increased with all the other components of the ECG reaming the same.



## Dr. Tooraj Zahedi



### Update on Fine needle Aspiration Biopsy of the thyroid nodules.

Nodules are frequently seen in the Thyroid Gland. The incidence has dramatically increased in the past ten years mainly due to increased use of imaging of the neck for various reasons.

Most thyroid nodules are benign but five percent could be malignant. Factors like size, shape, non homogeneous texture, irregular borders and presence of micro calcification would increase the risk of malignancy in a nodule but needle biopsy is the gold standard to determine the malignant potential and direct the approach to management of the thyroid nodules.

The result of a biopsy is reported as six different categories which are called Bethesda 1 through 6.

the meaning are as follows:

Bethesda 1: Insufficient material for diagnosis

Bethesda 2: Benign

Bethesda 3: atypia of undetermined significance

Bethesda 4: Follicular neoplasm or suspicious for follicular neoplasm

Bethesda 5: Suspicious for malignancy

Bethesda 6: Malignant

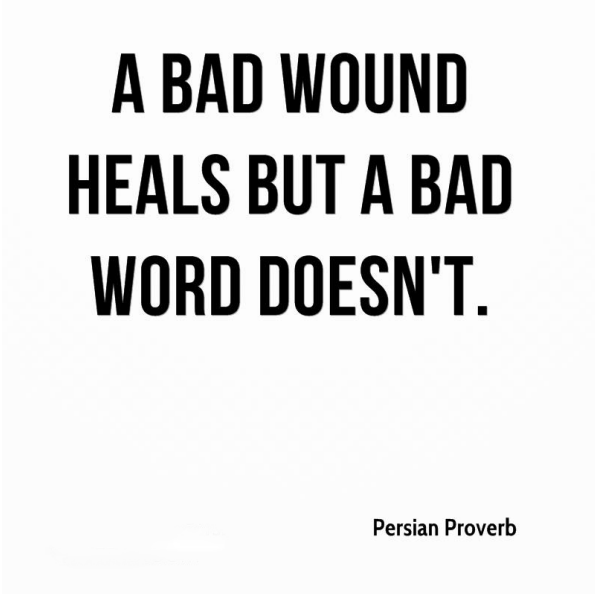
the approach for B1 is repeating the biopsy. for B2 observation, for B3 and B4 a sample is sent for genetic testing. If there were no mutations or translocations patient is usually observed. If there were mutations or translocations patient would be sent for surgery. B5 and B6 are surgical candi

## Dr. Bahram Ghassemi

### Orthodontic correction of Nasio-Labial angle can enhance the esthetic results of patients and may avert the need for rhinoplasty

Associate professor at orthodontic department at Tufts University School of Dental Medicine and Diplomate of American board of orthodontics.

The nasolabial angle is defined as the angle between the line drawn through the midpoint of the nostril aperture and a line drawn perpendicular to the Frankfurt horizontal while intersecting subnasale. An arbitrary range of 90 to 120 degrees for the nasolabial angle is usually stated in the literature. The purpose of this study was to objectively define the ideal nasolabial angle. Most of patients are seeking rhinoplasty to correct nasiolabial angle. The purpose of this presentation is to demonstrate how effective orthodontic treatment could help correction of the nasiolabial angle and enhance the esthetic of the patients.



**Pegah Ameri DMD**



## No-Preparation Porcelain Veneers

Direct resin veneers followed by porcelain veneers were introduced in the early 1980s, and have undergone an evolution of both techniques and materials. When veneers were first introduced, no preparation at all or conservative tooth preparation was suggested. When porcelain veneers were introduced as a treatment modality almost 30 years ago, there were concerns that a thin porcelain facing would fracture during function; this fear caused come clinicians to recommend routine tooth preparations of 0.5-1 mm without any evidence to support this view. However, long-term clinical studies confirmed excellent durability and success of the porcelain veneer restoration. Nevertheless, one of the most important considerations in the success of the veneers was tooth preparation.

Minimal-preparation to no-preparation veneers have resurfaced in the dental literature as topics for clinical discussion. Recent marketing and advertisements by dental manufactures and laboratories aimed at the public and the profession recommend no-preparation veneers as the optimum option to conserve the tooth structure and achieve the most esthetic results compared to conventional tooth preparation veneers.

No-preparation or minimally invasive veneers are veneers that have ultra-thin or "Contact lens" thickness of 0.3-0.5 mm.

It has been observed that many patients who have received veneers may not have been educated about more conservative treatment options before accepting ceramic veneers as a treatment

modality. Depending on the case and the desired results, the clinicians can provide a range of conservative treatments or combination of some of these conservative treatments: bleaching only minor orthodontics esthetic recontouring of teeth, esthetic recontouring of gingival tissue, directly placed resin composite veneers, no-preparation porcelain veneers, enamel only preparation veneers, varied levels of dentin veneer preparation and interproximal extensions.

**Advantages:**

1. Painless.
2. Lack of need for anesthesia.
3. Fast technique.
4. Conservation of the tooth structure.
5. No harm to the pulp and therefore elimination of post operative sensitivity.
6. Ease of impression, because tissue management is not needed.
7. No need for provisionals.
8. Permanently whiten teeth.
9. Bonding to enamel.
10. Longer-lasting restorations due to enamel bonding.
11. Minimal flexing stress due to bonding to enamel.
12. Higher level of acceptance by the patients, specifically patients with dental phobia or refuse to remove sound tooth structure.
13. Excellent esthetic.
14. Resistant to permanent staining.
15. Easy to clean and maintain when placed supragingivally.
16. Can be placed over unattractive crowns and bridges without replacing them.

This has been reported mostly as case reports and there is not much literature about this advantage.

17. Reversible (if necessary)

Lots of manufactures claim this advantage of no-preparation veneers of being reversible, but it is not easy to remove the veneer and resin cement without touching the enamel. Therefore, it may not be a true advantage that the no-preparation veneers are reversible. I think that this advantage is mostly a marketing claim to attract patients to seek the no-preparation veneer treatment. Moreover, the need to remove these veneers means that the patient wasn't satisfied with the results or that the case has failed.

**Disadvantages:**

1. Bulky appearance:

For no-preparation veneers, the esthetic results are variable; some of these restorations appeared too bulky and over contoured, while others have relatively acceptable esthetics. To maintain the original tooth shape, it often requires the clinician to remove a slight-to-moderate amount of enamel when making the tooth preparations. However, in order to avoid tooth sensitivity and pulpal death, tooth preparation should be made in enamel whenever possible. Nevertheless, bulky veneers should be avoided, because they appear false to the observers. Therefore, flattening of prominent cervical contours must be done to avoid overcontouring of the veneer. Some clinicians feel that there is a more optimum esthetic potential when teeth are prepared with a light chamfer especially at the gingival margin to prevent overcontouring in that region, which is a debatable view. When it comes to the laboratory work, it is very difficult to fabricate a veneer less than 0.3 mm thick.



2. Periodontal problems due to overcontouring of the veneer:

However, in a study done by Yu et al comparing teeth restored with porcelain veneers, both with and without preparation, it was reported that there were no differences in terms of periodontal health.

3. Teeth width being restored cannot be altered significantly.

4. Difficult to mask severe staining and discoloration with thin veneers (Such as severe tetracycline staining) without adding thickness to the veneer.

If thin veneers were constructed, the final result in these cases is often compromised because of the use of underlying opaque porcelains, the veneers will exhibit very high value and lack of vitality. The color discrepancy is due to the relative thinness of the veneer and the light passing through it can make the color of the underlying preparation show through. If the patient requests a significant shade change, the dentist must overcome that by increasing the thickness of the restoration by deepening the preparation. This will allow room for the technician to block out the underlying tooth color and achieve the desired color change.

A study was conducted in 2005 by Chen J et al, on tetracycline-stained teeth restored with Cerinate porcelain veneer on teeth reduced approximately 0.75 mm incisally and 0.25 cervically, and bonded using Den-Mat Ultra-bond, a dual-curing composite resin, which contains an opaque component. Cutting the labial enamel may give space for veneer restoration, which is important for color correction and maintaining arch form. The research indicated that Cerinate porcelain veneer restoration system is a reliable and ideal choice for the correction of tetracycline-stained teeth.

**Indications for No-Preparation or Minimally Invasive Porcelain Veneers:**

1. Upgrading and enhancing a patients' appearance is the primarily for the purpose of placing ceramic veneers.
2. Minor color changes.
3. Masking mild to moderate tooth discoloration and staining.

Eg: enamel hypoplasia, enamel hypocalcifications, discolorations due to endodontic staining, teeth with localized enamel malformations, flourosis with enamel mottling, tetracycline staining).

4. Masking exiting class III, IV, and V restorations.
5. Closing diastemas.
6. Restoring chipped or cracked teeth.
7. Reshaping peg-shaped and undersized teeth.

Small or lingually positioned teeth should be considered ideal candidates for techniques involving no or minimal preparation. Many patients may be satisfied with limited improvement in their smile to preserve as much of the original tooth structure as possible.
8. Correcting minor misalignments and rotations of anterior teeth.
9. Recontouring of teeth.
10. Revitalizing existing porcelain and porcelain-metal restorations.

However, as it was stated earlier in the advantages, this is not supported much by evidence. There are only few case reports regarding this advantage or indication.
Den-Mat recommends placing lumineers over all units of the existing bridge or crowns, because the results would be more satisfactory compared to placing a single lumineer over the defective existing unit. And care should be taken when matching the shade if a single lumineer is placed.
11. Worn dentition.
12. Adolescent dentition.

Damaged smile from childhood accidents can be improved.
13. Pre-adolescent teeth.

Chipping and cracking can be restored.
Generally, minority of cases are considered as ideal for no-prep cases. They are:
1. Individuals with pleasing teeth arraignments.
2. Minor tooth damage and discolorations that is able to tolerate an increase in tooth bulk.

And a larger group of patients presents as minimal-preparation cases. They are cases that are similar to no-preparation cases, but with minor space issues.
However, the majority group of people seeking smile alterations are people with excessive wear, large class III restorations, and space management issues.
**Contraindications:**
1. Severe discoloration or darkly stained teeth.
2. Protruding teeth or crowding that will require some reduction to achieve better esthetics and function.
3. Insufficient enamel remaining to provide adequate retention.
4. If teeth are significantly broken down or compromised. In this case, crowns are a better and stronger alternative than ceramic veneers
5. Large class IV defects, because of the large amount of unsupported porcelain and lack of tooth-colored backing.
6. In large diastemas, the amount of unsupported porcelain should be carefully evaluated.
7. Bruxer or clencher patients. Those patients have increased chance of veneer fracture even if incisal edge is not covered by porcelain.

## Dr. Shahram Lashgari



## Immediate implant placement in fresh extraction socket

Dental implants can be placed in fresh sockets immediately after tooth extraction. These are called "immediate" implants. "Immediate-delayed'" implants are those implants inserted after one or more weeks, up to a month or more, to allow for soft tissue healing. "Delayed" implants are those placed thereafter in partially or completely healed bone. The advantage of immediate placed implants is the shortened treatment time. Bone height will be maintained thus improving implant bone support and aesthetic results. The extraction socket can have an implant placed immediately after a CHRONICALLY infected tooth is removed, but needs to have the replacing implant anchored into bone and the site grafted at the same time will be better to have a membrane that excludes soft tissue, allowing the bone grafted socket site to heal normally with the newly placed implant

**Arash Ataei, medical student**



## *In-Silico* ADMET Profiles of Fusarochromanone and Analogs

How the human body absorbs, distributes, metabolizes, and excretes small molecules are key considerations in drug development, because a molecule's clinical efficacy can be compromised by its ADMET or pharmacokinetic profile. Being able to predict key pharmacokinetic properties of prospective drug candidates is thus a potentially valuable asset. Recently, in-silico pharmacokinetic prediction tools have demonstrated increasing reliability and are becoming good predictors of in vivo results.

We have performed an in-silico ADMET analyses of fusarochromanone (FC101), a lead compound that displays significant anti-cancer properties in early-stage testing against triple negative breast cancers. Using ADMET Predictor to measure the five above mentioned properties, a series of five new FC101 analogs were tested to predict if any of them may offer more promising therapeutic outcomes than the original parent compound.

The discovery that certain toxic chemicals can cure a variety of cancers ranks as one of the most significant discoveries in modern medicine. Over the past 75 years, more than 200 cancer drugs have been approved for cancer treatment.[2] The goal today is to find less toxic compounds that target cell specific signaling pathways in cancer.

There are currently close to 100,000 drugs in the World Drug Index (WDI), a list of agents shown to have positive attributes in the treatment of disease, including cancer. This index includes a myriad of alternative names, as well as the activity of the drugs within the body.[4] According to Connors, one of the fundamental problems of drug development is the lack of suitable laboratory models for prediction of drug effectiveness towards specific diseases. This challenge has been significantly surmounted using the recent innovation of *in-silico* modeling for predicting ADMET (Absorption, Distribution, Metabolism, Excretion, and Toxicity) properties.[2,5]

*ADMET Predictor* by Simulation Plus uses a focused group (fWDI) of approximately 2300 FDA-approved drugs from the WDI. The program compares the ADMET properties of these compounds for testing against those of the fWDI. Our goal was to use *in-silico* analyses to predict the best candidate of FC101 analogs as a potential drug for *in-vitro* testing.

Mahdavian et. al showed that FC101 had potent anti-cancer and anti-angiogenic activity in multiple cancer cell lines and mouse xenograft tumor models.[3] Future discoveries of ADMET properties using *in silico* analyses will expedite and make cancer research more time and cost-effective.

Simulations-Plus ADMET Predictor version 8.0 was used to predict ADMET parameters and molecular descriptors of FC101 and five analogs (Table 1). FC101 and analogs were sketched in three-dimensional space using SYBYL-X sketch mode. Molecules were saved individually in MOL2 format before being exported into a single 2D SDF file named Jupiter_multi20.sdf. Simulations-Plus ADMET Predictor's Physio-chemical and Biopharmaceutical Module and Toxicity Module were used to calculate predicted ADMET values of Jupiter_multi20.sdf. A robust computational filter, S+ADMET_Risk, was utilized to select analogs with the lowest liability- liability refers to problems with overall bioavailability and toxicity.

A general methodology for synthesis of FC-101 and analogs is included in Scheme 1.

Collectively, our predicted ADMET screen indicates the most liability risk is associated with analog 5. Analogs 1 and 2 are both very similar in liability with analog 2 being the most promising lead for cancer drug discovery.

## Dr. Tahaamin Shokuhfar

## Mynxgrip Vascular Closure Device Use in Pediatric Neurointerventional procedures

**Co-Authors' Full Name(s) (if any)**
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**Background**
The application of vascular closure devices remains off label in pediatric patients despite their validation and widespread use in adults.
**Aim**
To assess the efficacy and safety of Mynxgrip closure device use after neuroendovascular procedures in the pediatric population.
**Materials & Methods**
We performed a retrospective review of all pediatric patients undergoing diagnostic or interventional neurovascular procedures at our institution. Mynxgrip use was predicated by an adequate depth of subcutaneous tissue and common femoral artery (CFA) diameter. Patients remained on supine bedrest for 2 hours after diagnostic and 3 hours after therapeutic procedures. We recorded patient demographics, procedural details, hemostasis status and complications.
**Results**

Over 36 months, 83 Mynxgrip devices were deployed in 53 patients (23 male and 30 female, mean age 14.5 years) undergoing neuro-endovascular procedures through a common femoral artery access. Diagnostic angiography comprised 46% of procedures. Median CFA diameter was 6.6 mm and ranged from 4 mm to 8.5 mm. A single device failure occurred (1.2%) without sequela. No other immediate or delayed major complications were recorded.
**Discussion**
The Mynxgrip can be used safely in the pediatric population with effective hemostasis and the advantage of earlier mobilization.Intuitively, given the smaller size of the arteries in children, we would prefer an extra-luminal device that does not have an intraluminal component. Furthermore, the preference is also for a device that does not leave a percutaneous or non-reabsorbable element inside the body.
**Conclusion**
The Mynxgrip can be used safely in the pediatric population with effective hemostasis and the advantage of earlier mobilization.

**Mahsa Khanbabai**
Khanbabai Immigration Law



## Trumped: A Dissection of Immigration issues

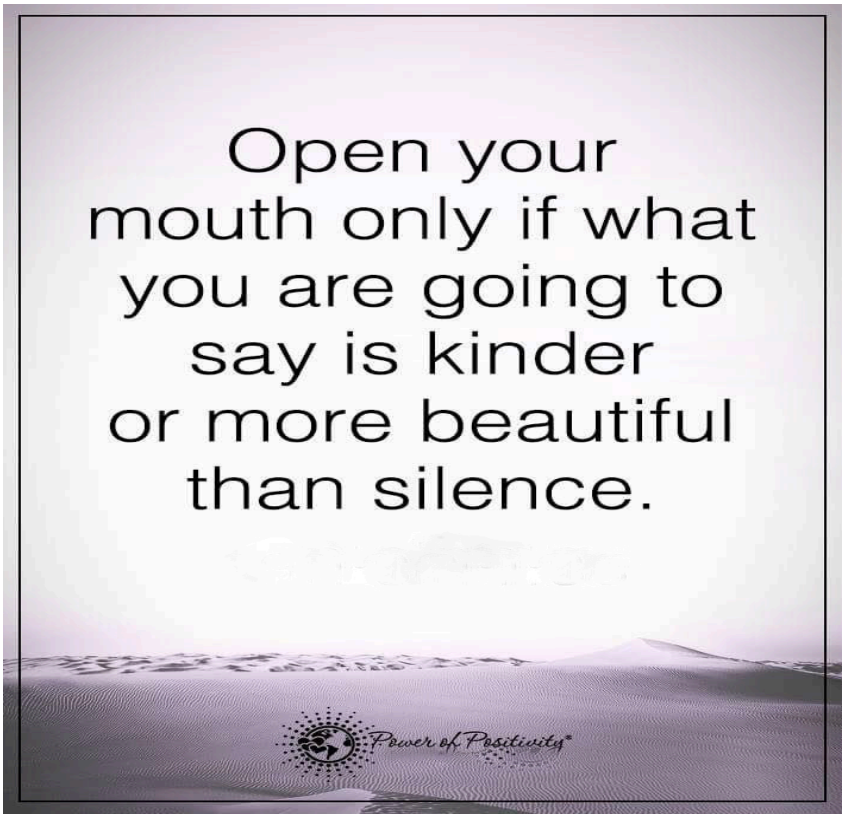
**Background**
Immigration rules may see some significant changes in the coming years.
**Aim**
To educate the audience regarding any new or proposed changes to the immigration laws, especially as they affect allied health professionals.
**Materials & Methods**
Power Point presentation.
**Results**
A better understanding of complex immigration rules and potential changes, especially as related to Allied Health professionals.
**Discussion**
How does one maneuver any new laws.
**Conclusion**
What one can do to help their case and effect more positive changes.

**Keyvan Nouri, MD**



## Lasers For Hair Growth

In the field of hair restoration, multiple modalities have evolved significantly over the past few decades. There is no cure for alopecia, but aesthetically pleasing results can be achieved with modern treatment. Available therapies for non-scarring alopecias include hair transplants, oral medications (systemic corticosteroids, finasteride, systemic immunosuppressants), topical medications (minoxidil, contact immunotherapy, topical corticosteroids, dithranol), intralesional corticosteroids, PUVA therapy, and platelet rich plasma. This lecture will focus on the more recent use of low-level laser therapy (LLLT) for the management of hair loss. LLLT has shown beneficial effects for various medical conditions such as wound healing, nerve regeneration, and joint pain relief among others. Due its ability to stimulate anagen re-entry in telogen hair follicles, prolong anagen phase duration, increase rates of proliferation in active anagen hair follicles and prevent premature catagen development, laser phototherapy has become an option for hair regrowth. We will review the various published studies that assess the efficacy and safety of LLLT for the treatment of androgenetic alopecia, alopecia areata, and chemotherapy-induced alopecia. At the end of this presentation, the audience will be familiar with the utility of different low level therapies for the induction of hair growth and the current research in this area.



# Pictures from IAMA 24th Annual Meeting



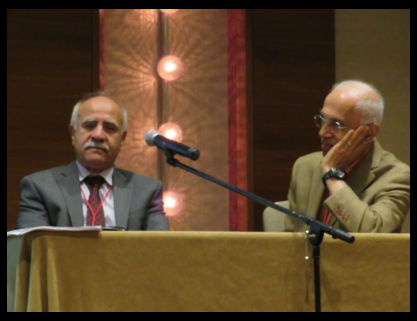













# Pictures from IAMA 24th Annual Meeting









































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