

The Newsletter of The Executive RegistrySM Health News

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What's Inside

It's Never Too Late to Exercise	2
Oh My Aching Legs: Why Vein Problems Occur and What You Can Do About Them	3
Science May Be on the Brink of Breakthroughs in Alzheimer's Disease	5
Your Membership	5

A Specialty of Looking at the Bigger Picture

Physiatry is a specialty that aims to improve and restore function and quality of life to people with physical impairments or disabilities, such as injuries to the muscles, bones, connective tissues, and nervous system. The discipline was pioneered by Dr. Frank Krusen in the late 1930s and was recognized as a specialty by the American Medical Association in the late 1940s, when the field was growing in response to the need for rehabilitation techniques for injured soldiers returning from World War II.

A physiatrist's training is very wide and includes a lot of sub-specialty training within it. Physiatric residents go through multiple rotations covering spinal cord injuries, sports medicine, amputee service, musculoskeletal medicine, orthopedic medicine, *pediatric* disorders and rehabilitation, and neurologic disorders, including post-stroke rehabilitation. Electrodiagnostics are also part of the training. Electrodiagnostics provide information about nervous system function for diagnosis and prognosis of various neuromuscular disorders. Within this type of test, nerve conduction studies (NCS) measure nerve response to electrical stimuli, while electromyographies (EMG) reveal the electrical potential of muscle fibers and the sufficiency of the nerve supply to the muscle.

Some physiatrists may follow their residency with a fellowship in sports medicine, pain medicine, *pediatric rehabilitation*, or neurorehabilitation. Physiatry is a specialty that is focused on rehabilitation and achieves that focus by looking at all aspects of the patient's care. Approximately 60 percent of physiatrists work in the area of general rehabilitation, while the rest get additional training to specialize.

Those who practice in general rehabilitation will often team up with other specialists to provide patient care. These doctors are

sometimes called primary care doctors for disabled patients, referring as necessary to other sub-specialists for coordinating care, evaluations, or tests. Physiatrists practicing in a sub-specialty also use the team approach to ensure the best patient outcomes. For example, a pain doctor will work together with the patient's orthopedic doctor, primary doctor, physical and occupational therapists; in the case of someone with a spinal cord injury and at the same time a brain injury, the team might consist of a physiatrist, psychiatrist, psychologist, neurologist, physical and occupational therapists, and a social worker.

Treating the Whole Person

Physiatry is not a holistic approach in the sense that "holistic" is assumed to incorporate nontraditional medicine, but it is in the sense that the whole person is viewed as the treatment target rather than just the broken finger, the damaged knee, or the injured back. Whole body rehabilitation also includes nutrition and mental health issues.

For example, all of these issues would be addressed in a patient with a spinal cord injury: the injury itself, treatment of symptoms, treatment of related symptoms like problems with the skin, problems with the bowels, nutrition, physical/occupational

therapy issues, and prescriptions for wheelchairs and different devices the patient may need for long-term home care. In the case of a patient with chronic pain, the physiatrist addresses not only the site of pain and its treatment, but also possible causes of the pain, the different rehabilitation approaches possible through a multidisciplinary team, improving function, mental health, and general well-being.

The website of the American Academy of Physical Medicine and Rehabilitation (www.aapmr.org) is an excellent place to find more information on this topic.

Methods of Pain Treatment

Pain in one location can change the body's alignment, generating additional problems. When a physiatrist treats a patient with chronic pain, the pain itself is addressed, perhaps with an injection (epidurals, nerve blocks, or injections into arthritic joints) or medication, but physical therapy and occupational therapy are also prescribed. The aims of these therapies might be to *decrease pain*, to strengthen muscles to better support a painful joint, to prevent additional damage from misalignments, to *improve overall function*, or to learn new ways to do everyday tasks that cause less physical stress and *coping skills to deal with the pain problem*. Wide exposure during training to working together with physical therapists and occupational therapists enables us to know exactly what they do and how they do it, so we are very comfortable prescribing physical and

(continued on page 2)

It's Never Too Late to Exercise



It's almost impossible to miss—on a regular basis we all see articles, newscasts, and television and online doctors touting the importance of exercise. If you're not already exercising, the question you should be asking yourself is not "Should I?" but rather "How should I get started?" The truth is it's never too late to start exercising. You may already know them, but a review of the top benefits of exercise may encourage you to start a program. Exercise increases your strength and ease of movement by strengthening muscles, bones, and joints; it also improves posture and balance, and promotes more independent living. It helps to control blood pressure and blood fats (lipids), and assists in blood glucose control. Exercise increases the efficiency of the heart and lungs by strengthening the heart and circulatory system (all of which include muscle), in addition to helping to prevent respiratory and circulatory problems like pneumonia or blood clots (problems often resulting from inactivity). Further benefits include helping to maintain a healthy weight, reducing stress, increasing energy, and improving one's sense of self and well-being.

Now that you have the "why," let's discuss the "what." Exercise recommendations refer to many different types of exercise, but for ease of discussion we'll group them into three main categories: strengthening/resistance exercise, flexibility/stretching exercise, and cardiovascular/aerobic exercise. In truth, each type also provides at least a little of the benefits associated with the other types. Strengthening/resistive exercise uses resistance to increase muscle strength (and sometimes size). Examples are lifting weights, using resistance bands, or even lifting a body part against gravity. Often, when performing exercises to increase strength, many people do fewer repetitions of an activity with more resistance.

Flexibility/stretching exercise helps maintain and increase the range of motion around a particular joint, usually by putting parts of the body into positions that will lengthen the muscles and soft tissues around the joints. Examples of this are reaching for your toes, reaching for the sky, or even arching your back.

Lastly, cardiovascular/aerobic exercise makes the heart and lungs work harder to meet the body's increased need for oxygen, which improves the functioning of the cardiovascular and respiratory systems. Examples of this type of exercise include

walking, running, biking, and swimming. With this type of exercise, it's common to do more repetitions of an activity with less resistance.

So, how and when should you start? Before starting a formal exercise program, it's important to check with your physician about any specific guidelines he or she may want you to follow. When you begin exercising, don't overdo; start slow and gradually increase your workout.

The most recent recommendations by the American College of Sports Medicine (ACSM) and American Heart Association (AHA) can be found on the website, www.acsm.org, under the section "Physical Activity & Public Health Guidelines." Here is a brief summary of their recommendations, which are based on age groups: Moderately intense cardio/aerobic exercise 30 minutes a day, five days a week OR vigorously intense cardio/aerobic exercise 20 minutes a day, three days a week AND eight to ten strength training exercises of varying repetitions dependent upon your age group, 2 to 3 times per week. Additionally, for the over 65 group, they recommend performing balance exercises if you are at risk of falling.

During exercise you should expect to see your heart rate and blood pressure go up. You should discuss specific target ranges with your physician. Your breathing (respiration) rate should also increase; it's normal to feel a bit winded, but you should not find yourself gasping for air. A good unofficial test for this is to see if you can exercise and

talk without gasping. Lastly, you should feel a little warm.

If you experience chest tightness; chest, jaw, or arm pain; difficulty breathing (beyond a normal exercise response); dizziness; or an upset stomach with nausea or vomiting you should immediately stop exercising and call your doctor or go to the emergency room. You may recognize these signs and symptoms—they're some of the typical and atypical signs of a heart problem and need to be addressed immediately.

My hope is that you now see there are good reasons to start exercising. Remember to check with your doctor before beginning a formal exercise program. Here are some tips that will hopefully keep you exercising regularly: Try to set realistic goals for yourself and keep things simple. (The truth is that some of your daily activities and chores—sweeping, vacuuming, walking to the store or work—are exercise, too.) Try to make it a part of your regular routine and choose exercise you enjoy so you're more apt to stick with your program. Consider exercising with a buddy or joining a gym or exercise group—it's harder to skip a day when someone else is waiting or relying on you. Finally, one of the most important things you can do is to HAVE FUN and remember . . . it's never too late to start exercising!

Golda Widawski, PT, MPT

Senior Physical Therapist

Perelman Heart Institute

New York-Presbyterian Hospital

A Specialty of Looking at the Bigger Picture

occupational therapies and knowing what therapies a patient may need. We are familiar with psychological issues and their treatments, biofeedback, and know exactly how and when to use them.

Gary I. Polykoff, M.D.

Massachusetts General Hospital Pain Medicine

Center; Spaulding Rehabilitation Hospital/

Medford Center; Harvard Medical School

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Oh My Aching Legs: Why Vein Problems Occur and

Most people take their veins for granted. We all learn that veins return blood to the heart, but beyond that, their structure and function do not get much attention in science classes or even in medical school. However, disorders of the veins, particularly in the lower extremities, are among the most common problems in humans and can lead to substantial quality of life issues.

Venous disease can be divided into acute and chronic conditions. Acute venous disorders are primarily related to thrombosis, or clotting, in the veins. Chronic disorders are usually related to leaking valves or, less often, blocked veins after prior thrombosis.

Varicose and spider veins are the most commonly known chronic venous disorders. Many people consider them to be only an aesthetic concern, but patients with varicose veins frequently complain of aching, throbbing, and heaviness in their legs. These symptoms are worse at the end of the day, particularly after a day standing.

Legs ache because of gravity. Since we spend a large portion of our lives standing or sitting, leg veins must work against gravity to move blood upward to the heart. Calf muscle contractions push blood up toward the pelvis. Veins have one-way valves to keep blood from flowing back down when the contractions relax. If those valves do not perform properly, or if the calf muscles do not contract well or for some time, blood pools in the legs. The pressure in the vein increases, causing it to stretch. The veins close to the skin do not tolerate the pressure well and get longer and larger in diameter, resulting in what we recognize as varicose veins (from the Latin word for twisted).

As many as 60 percent of Americans, mostly women, but a significant number of men as well, will suffer this form of vein disorder at some point in their lives. Although the prevalence of varicose veins increases with age, 40 percent of women will suffer from abnormal leg veins before reaching their fifties. No one knows exactly why some valves malfunction when they do. Heredity plays a big role; spending a great deal of

time sitting and standing without moving adds to the risk, as does being overweight. Obesity is also a major negative predictor for success and durability of the various minimally invasive treatments available.

Hormonal changes accompanying pregnancy account for the higher incidence of varicose veins among women. These hormones relax the muscles found in vein walls resulting in vein dilation, which pulls apart the valves, causing them to leak. The effect of the hormones occurs primarily during the first trimester, so abnormal veins develop early and usually worsen throughout the pregnancy. Varicose veins usually improve a few weeks or months after delivery, though they are less likely to completely disappear after several pregnancies.

In the minority of cases, leaking valves associated with varicose veins can cause skin sores or ulcers. This is especially true near the ankles, where the skin's normal ability to clear byproducts of metabolism is impaired after long-term exposure to high vein pressures. This process often begins with a darkening of the skin in this area. Sores or a rash on the leg near the ankle may develop later and require medical attention.

Varicose or spider veins cannot be prevented, but you can reduce the risk of developing them by avoiding standing or sitting in one position for longer than 30 minutes. If you must do so, periodically walk around the room or stand on your toes to contract the calf muscles, to keep blood circulating.

Walk, run, or do other leg-strengthening and stretching exercises regularly. Wearing graduated support socks can reverse the pressure caused by leaking valves, can improve symptoms, and may slow down any progression. These socks are tightest around the foot and ankles, and less tight over the calf to help move blood upward.

If your symptoms are affecting the quality of your life, it may be reasonable to speak with a Phlebologist, a physician who specializes in vein disorders. These physicians are super-specialists who are usually also board certified in Interventional Radiology,

Vascular Surgery, Vascular Medicine, or Dermatology.

An ultrasound exam can determine the location of the vein segments with the abnormal valves. Often, the vein that runs along the inside of the leg from the ankle to the groin, the great saphenous vein (GSV), is the source of the abnormal blood flow. This vein is too deep to see without an ultrasound. Treatment begins by eliminating the leakage, if present. Endovenous thermal ablation, with either an endovenous laser or a similar tool that generates heat, has become the most common procedure to seal an abnormal GSV. This office-based procedure is performed in about one hour with local anesthesia and minimal recovery time; patients can return to work the same day.

Once the saphenous vein is sealed closed, there are also two choices to close the varicose veins themselves. Sclerotherapy is a very quick ambulatory procedure that closes down small and medium-sized spider and varicose veins by irritating them with a medication that is injected with a tiny needle. This procedure usually needs to be repeated every few weeks to eliminate all of the abnormal veins.

The alternative for medium and larger varicose veins is microphlebectomy, also known as miniphlebectomy or ambulatory phlebectomy. This procedure can also be performed in the office as a walk-in, walk-out procedure using only local anesthetic at the same time a laser elimination of the GSV is performed. Tiny 3mm skin nicks are created over the abnormal veins that are then painlessly removed using an instrument similar to a mini crochet hook. There is essentially no recovery time after this procedure and patients can return to work immediately. Patient satisfaction with the cosmetic and symptomatic improvements after these minimally invasive treatments for veins is very high.

Acute deep venous thrombosis (DVT) is a serious, and unfortunately relatively common medical condition that occurs most often in the lower extremities. Clots in the deep veins pose two risks. Clots prevent blood

What You Can Do About Them

from draining freely from a leg. As a result, the legs swell and become painful. In cases when the blockage involves the larger veins of the leg and pelvis, the degree of swelling can threaten the leg itself.

A potentially life-threatening concern with deep vein thrombosis is that a clot could break off like an iceberg from a glacier and then travel through the pelvic and abdominal veins, through the right side of the heart, and lodge in the blood vessels of the lungs. This is known as a pulmonary embolism (PE). If a large enough clot or enough smaller clots pass to the lung they can affect the ability of the heart to move and oxygenate blood, resulting in the sense of air hunger and a drop in blood pressure. Pulmonary embolism can be quite serious and is a common cause of sudden death.

Long term risks of deep vein thrombosis include persistent vein blockage and leaking valves. This can result in severe elevations in venous pressure and result in chronic leg pain and swelling known as the post-phlebotic syndrome (PTS), which can be quite debilitating. PTS is thought to occur in about 50 percent of patients who have had a DVT within 2 years of the event, especially DVTs that involve the femoral and iliac veins together, known as iliofemoral DVT (IFDVT).

Another type of acute vein problem,

superficial vein thrombosis (SVT) (also known as a superficial phlebitis), is venous clotting in superficial veins close to the skin. This usually presents as painful and palpably hard, tender and red areas on the leg, often over previously known varicose veins. When limited in extent, these are often treated conservatively with warm compresses and over-the-counter pain medications. However, cases that involve a large number of veins, especially those that extend to the thigh, can extend into and cause a DVT.

Avoiding long periods of immobility is crucial in the prevention of vein thrombosis. Getting up to walk during periods of immobility, such as an airflight or after an operation are crucial. Since airflights also dehydrate you, drinking a lot of water and avoiding alcohol on airflights is very important. Physicians are aware of the risks after surgery and use a variety of strategies to minimize the risk, including the use of calf compression devices and blood thinners.

Treatment of deep vein thrombosis depends on the extent of the clot and condition of the patient. For uncomplicated clots in the leg, an oral blood thinner, graduated knee-high compression stockings, and ambulation are most commonly used. IFDVTs, which often produce the most significant swelling of the leg, are more serious. Recently,

aggressive treatment of such clots by Interventional Radiologists with catheters and blood clot dissolving medications (mechanicochemical thrombolysis) have helped to rapidly alleviate the pain and swelling associated with the clot.

Preliminary data also suggest that it has the ability to minimize the likelihood of PTS.

Venous disorders are commonly thought of as problems in the elderly and ailing. Although it is true that these populations are at a higher risk, younger active and otherwise healthy people are at risk for these problems as well. Lest you think you are immune, recall that the 2012 Olympic, Wimbeldon, and US Open champion Serena Williams had a DVT and PE in 2011 at age 30. Summer Sanders, the 40-year-old former Olympian and mother of two, recently underwent treatment for painful varicose veins. Fortunately, most vein problems can be easily diagnosed and treated with minimally invasive procedures with very high patient satisfaction and a quick return to a full lifestyle.

Neil Khilnani, M.D.

Director, Weill Cornell Vascular; Associate Professor of Clinical Radiology, Weill Cornell Medical College; Associate Attending Radiologist, New York-Presbyterian Hospital

Science May Be on the Brink of Breakthroughs in Alzheimer's Disease

(continued from page 5)

carbohydrates, sugars and salt in the diet; increase intake of fruits and vegetables; eliminate excess body fat; and increase exercise. Getting regular exercise may be the single most important thing we can do.

This disease strains our society and our health care system. If we fail to solve this problem as the population continues to age, Alzheimer's alone has the potential to bankrupt Medicare. The Alzheimer's Association says 75 percent of those afflicted will be admitted to nursing homes by age 80, compared with only 4 percent

of the general population.

Alzheimer's also has an all-consuming impact on families. According to surveys cited by the Alzheimer's Association in its "2012 Alzheimer's Disease Facts and Figures" article, 65 percent of caregivers recently said they had to take time off work; 20 percent had to take a leave of absence; 13 percent dropped to part-time work; and 11 percent had to give up working entirely.

I know about these effects on family from first-hand experience. I watched as my mother, a bright, retired schoolteacher,

lost her ability to communicate, care for herself, or recognize her family. She died from Alzheimer's earlier this year. I was helpless to intervene for her, but I believe we soon will have therapies in place for our kids' and our grandkids' generations.

Keith L. Black, M.D.

Chair and Professor, Department of Neurosurgery at Cedars-Sinai Medical Center; Director, Maxine Dunitz Neurosurgical Institute; Director, Johnnie L. Cochran, Jr. Brain Tumor Center; Ruth and Lawrence Harvey Chair in Neuroscience

Science May Be on the Brink of Breakthroughs in Alzheimer's Disease

Our ability to detect, diagnose, and treat Alzheimer's disease is not much better than it was in 1906 when Dr. Alois Alzheimer found unusual clumps and fibers of proteins in the brains of patients who had died after suffering a specific type of mental confusion and deterioration.

But the battlefield is changing. I believe we will start winning the war against Alzheimer's within a very few years.

We now diagnose the disease when people develop memory loss, but changes in the brain begin 10, 15, or 20 years earlier. When symptoms emerge, patients already have lost 40 to 50 percent of their brain cells and the disease is at its end stage. Also, our diagnostic tools and methods are poor, so what we call Alzheimer's may not always be; other disorders and disease processes can cause cognitive issues that look like those of Alzheimer's.

Complicating diagnosis, the sticky substances Dr. Alzheimer found—plaques consisting of beta-amyloid protein and neurofibrillary tangles of tau protein—do not show up on CT or MRI scans. We still have no practical, humane, or accurate way to view these plaques while a patient is living.

But in our laboratories at Cedars-Sinai, we recently discovered that beta-amyloid protein plaques occur not only in the brain, but also in the retina in the back of the eye. Our research shows they can be seen in the retina before they begin to accumulate in the brain of experimental models.

With this discovery, we developed a device that enables us to look through the eye—just as an ophthalmologist examines the eye to diagnose retinal disease—and see amyloid plaques in the back of the eye. This may give us a quick, inexpensive, noninvasive way to screen patients for Alzheimer's early in the destructive process.

Based on promising results in laboratory studies, we are testing this technology in patients, collaborating with major pharmaceutical companies that recognize

the value of early detection: Potential treatments have a much better chance of working if they can be started earlier rather than later.

A good example of a preemptive strike is our approach to diabetes. If it is detected early, you can take steps to control your blood glucose level, which is likely to prevent progression to kidney failure, vision loss, and other potential effects of long-term high sugar levels. But if you go to your doctor after having uncontrolled diabetes for 10 or 20 years and you already have kidney failure, you might be able to gain control of your blood sugar, but you cannot reverse the damage that has been done.

Similarly, we are trying to move the focus of Alzheimer's disease to the early stage where intervention may be able to help.

In a sense, ending the threat of Alzheimer's may be an easier objective than defeating malignant brain tumors, which has been my lifetime research focus. In cancer treatment, we essentially have to remove or kill 100 percent of cancer cells. If we leave even 1 or 2 percent of these cells behind, they can divide and the cancer can grow back.

With Alzheimer's, the only thing we must do is slow the destruction it causes. Keep in mind that damage begins years before symptoms start to emerge. A person whose disease process covertly begins at 50 may start to have memory loss when they are 75. If we can slow that process by half, memory loss would begin at 100 rather than 75. Most patients with Alzheimer's would live out their natural lives without suffering the disease's consequences rather than spending their final four years to two decades in a nursing home, unable to recognize family members and loved ones.

We know that the protein deposits of Alzheimer's kill nerve cells in the brain, and we think that by reducing the amount of plaque we can lessen the effects of the disease. Pharmaceutical companies are focusing their research on developing

drugs to prevent this accumulation.

But we also know that Alzheimer's is a complex disease: an intense inflammatory cascade takes place. I think the immune system is at the center of the basic mechanisms of the disease and will play a critical role in the solution, and I believe we will see treatments that can stop the inflammatory process in just a few years.

Research scientists in our laboratories are studying three methods of manipulating the immune system, and in preclinical models—laboratory and laboratory animal studies—we see that if we regulate the inflammation occurring in the brain, we can significantly slow disease progression.

But until a treatment or cure emerges, there are lifestyle changes many of us can make to improve our odds against Alzheimer's. We are beginning to understand that what is good for heart disease, diabetes, and stroke also may be good for Alzheimer's: Reduce fats, simple

(continued on page 4)

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