Report on IAPM activities in a period February 2017 – May 2018
13th meeting of

INTERNATIONAL ACADEMY OF PERINATAL MEDICINE

17-19 February 2017 – Khartoum (Sudan)

Venue: Police Conference Centre

Friday, 17th February
Administrative and Ceremonial meeting

Saturday, 18th February

Scientific Symposium

Recent Advances in Perinatal Medicine
Under The Patronage of His Excellency
The Sudan vice President Bakrie Hassan Salih
PAPERS PUBLISHED IN ACADEMY CORNER
Published in 2016/2017

• **Kurjak**, First ten years of International Academy of Perinatal Medicine – Which lessons we have learned and what are future challenges. J. Perinat. Med. 2016; 44(7): 733–735

• Ferraz T, **Matias A.** Late pregnancy – a clue to prolonging life? J. Perinat. Med. 2017;45(4):399.401


Academy's Paper

Mitroslaw Wielgos, Bronisława Pietrzak, Natalia Mazanowska and Bożena Kochszewska-Najman*

Neonates of mothers who have had kidney or liver transplantation

DOI 10.1515/jpm-2016-0070

Introduction

The first reports of pregnancy in kidney and liver recipients come from years 1963 [1] and 1978 [2] and since then thousands of babies have been delivered by solid organ graft recipients worldwide. This paper concentrates on the largest groups of post-transplant pregnant patients those who are kidney and liver graft recipients. The chance for childbearing is regarded as an additional important benefit of undergoing transplant procedure in young women with end-stage organ failure. Nevertheless, pregnancy in a female after transplantation is a high risk one and the successful outcome is possible only with a multidisciplinary approach with the cooperation of obstetricians, specialists in transplantation medicine, and anaesthesiologists. Likewise, the neonates born from post-transplant pregnancy require particularly attentive medical care as they can often burdened with prematurity and/or intrauterine hypotrophy. The optimal management of post-transplant pregnancy and newborns as well as effect of immunosuppressant's exposure in utero on the child's health remains to be established. The data from prospective studies are very limited and the knowledge on obstetric and neonatal outcomes comes mainly from reports on national transplant registries, single-center studies or published case series.

*Corresponding author, Bożena Kochszewska-Najman, lst Department of Obstetrics and Gynecology, Medical University of Warsaw, Pius Street 1/3, 02-015 Warsaw, Poland, E-mail: boznajman@wp.pl

Prematurity and low birth weight

According to two meta-analyses published recently by Deshpande et al., the overall live birth rate in the post-transplant kidney and liver population is high, reaching 73.9% and 73.5%, respectively [3]. Nevertheless the complication rate is also high, with preterm delivery observed in about 46% of pregnancies (45.6% and 36.6% in kidney and liver recipients, respectively) [4]. The preterm and/or the small-for-gestation neonate is a vulnerable patient and the long-term consequences of these conditions seem to reach far beyond early childhood. The acute risks of prematurity may include but are not limited to respiratory distress syndrome, necrotizing enterocolitis, invasive infections, and central nervous system injury [5]. It is agreed that the risks are more pronounced in the kidney post-transplant population. The mean birth weight as well as mean gestational age at delivery are in general distinctively lower in kidney recipients, which most probably depends on the underlying condition with higher frequency of arterial hypertension [6]. According to a recently published prospective report concentrating on pregnancy outcomes in the current setting of medical care of the UK post-transplant kidney population, premature birth occurred in 52% of cases, with 48% of infants having low birth weight (<2500 g), and 24% being small for gestational age [7]. Very preterm birth (<32 weeks of gestation) occurred in 9% of cases. The same group also gathered prospective data on neonatal outcomes in UK liver recipients showing that low-birthweight infants occurred in 37% and small for gestation in 21% of cases. None of the liver recipients in this cohort experienced very preterm birth (<32 weeks of gestation) with 42% of infants born before 37 weeks of gestation [8].

Fetal effects of immunosuppressive medications

All the immunosuppressants administered to the mother cross the placenta and are transported by the umbilical vein.
First 10 years of the International Academy of Perinatal Medicine – which lessons we have learned and what are future challenges

Any academy in the world is a society of people of significant intellectual achievements (learned people), who are institutions of intellectual authority who are trying to advise decision makers, to provide views on different issues of science and to advise their members on issues related to science. Academies can and should have a presence in the life of society, without treading part of it, but should provide expert advice when summoned and express competent opinions and recommendations to events of global importance.

The IAPM was founded in 2009 on the initiative of presidents of four scientific societies: the World Association of Perinatal Medicine (WAPM), the European Association of Perinatal Medicine (EAPM), and the International Society “The Future of a Patient” (ISFAPC) and its journal. The IAPM contains four main scientific areas: all over the world, for scientific progress, and published discussions on current topics of perinatal research and patient care from a global point of view.

The aim of the IAPM is to provide a place for study, reflection, discussion, and for the promotion of perinatal medicine, especially in aspects such as obstetrics, the appropriate use of technological advances, and the sociological and humanistic dimensions of the field.

The IAPM should be responsible for research, education, standards. It has the potential of being a leading influence in the world of perinatal medicine.

A permanent advantage of the Academy is the continuous availability of its contacts and acting experts. This is a compensatory potential that is compared with societies where relatively frequent changes of leading experts is common.

Future challenges

The importance of perinatal medicine is growing rapidly and is making great and social scientific progress. More and more evidence now indicates that perinatal life is a major determinant of adult health and disease. So for instance the increasing realization that newborns are exposed to disease and illness, as well as premature delivery, can have their origins in environmental factors experienced during intrauterine life. We see our discipline in a much greater importance than anyone ever dreamt possible. Therefore, I believe that patients, families, colleagues and governments are ready to recognize that a major revolution is now taking place.

But, there is something else. One of the most disappointing fields in Perinatal Medicine is the lack of significant success in preventing prematurity. Indeed, the advances in the care of preterm neonates in the last
Academy's Paper

Tiago Ferraz* and Alexandra Mattas

Late pregnancy – a clue to prolonging life?

DOI: 10.1555/16-100001

Abstract: The relation between fertility and longevity has always been a subject of study and controversy. Indeed, life expectancy extension is found to be tied to late births. This conclusion can be drawn from social-observational studies like the Long Life Family Study in New England and the New England Centenarians Study on which was found that women whose last birth was after 40 years of age are more likely to live longer. Recently, a group in Israel published a review on animal and human studies that shed some understanding on the cellular mechanisms behind the association between pregnancy and tissue regeneration and repair. These studies shed some understanding to draw biological plausibility on the association between late pregnancy and life expectancy.

Keywords: Anthropology; late pregnancy; regeneration; tissue repair.

Introduction

Prolonging life has always been a hot subject of research in many different areas of medicine.

Regarding the effect (if any) of pregnancy on longevity and tissue regeneration, we may consider the social/demographic studies as well as animal tests.

In fact, the importance of life course on health and mortality differentials in later life is increasingly recognized, both because past experiences exert strong influences on current circumstances and because accumulated stresses may have long-term influences.

*Corresponding author: Tiago Ferraz, 175 - Innovation in Health and Intervention Institute, University of Porto, Porto, Portugal; and Department of Gynecology and Obstetrics, Faculty of Medicine, University of Porto/Center Hospital S. João, Porto, Portugal. E-mail: tiago.ferraz@fe.up.pt

Alexandra Mattas: 175 - Innovation in Health and Intervention Institute, University of Porto, Porto, Portugal; and Department of Gynecology and Obstetrics, Faculty of Medicine, University of Porto/Center Hospital S. João, Porto, Portugal.
Academy's Paper

Isaac Blickstein*

Antenatal corticosteroids: current controversies

DOI 10.3355/pjm-2015-0605

Introduction

Treatment with antenatal corticosteroids (ACS) has been known for decades and became standard care following the 1994 consensus published by the American National Institute of Health (NIH). The NIH published an amendment in 2000 [1] with three main recommendations, namely (a) women who are expected to deliver within 7 days, between 24+0 and 34+6 weeks’ gestation, are considered as candidates for ACS treatment, (b) a single course includes two intramuscular injections of 12 mg betamethasone given 24 h apart or dexamethasone, four doses of 6 mg, 12 h apart; and (c) repetitive doses should be reserved for clinical trials. This standard of care has been endorsed almost unanimously and endured the last 15 years of practice.

The initial indication for ACS was reducing the incidence of neonatal respiratory distress syndrome (RDS) – a clinical approach which was confirmed in a comprehensive Cochrane review by Roberts and Daniel [2], and was subsequently extended to generally reduce neonatal morbidity and mortality. Regardless of being an integral part of managing preterm labor, ACS treatment presents new controversies that need answers and primary, one may ask how, after so many years of using the standardized protocol, and as will be shown below under ‘Question of timing’, only about half of the patients receive a complete course of treatment. Hundreds of articles were published on issues related to ACS treatment in the last few years and this review updates and discusses some of the newer controversies, the order of which are not related to their importance.

ACS before and after the ‘window of opportunity’

Numerous studies [3] confirmed that ACS treatment reduces infant mortality by 31%, risk of developing RDS by 46%, and the risk of developing intraventricular hemorrhage (IVH) by 46%. In addition, ACSs reduce the risk of developing necrotizing enterocolitis (NEC), the need of respiratory support, incidence of intensive care admissions, and sepsis during the first 48 h of life. Not surprisingly, it was questioned whether these beneficial effects should be restricted to the ‘window of opportunity’, namely after 24 and before 35 weeks’ gestation.

Laboratory studies have shown that corticosteroids accelerate structural as well as functional changes in the fetal lung between 22 and 24 weeks’ gestation (at the canalicular stage) and several cohort studies showed that ACS decreased the mortality and cerebral palsy rates of infants born between 21 and 25 weeks’ gestation [3]. These data led to the idea to extend the lower limit of gestational age for ACS to 23 weeks.

Evidently, cohort studies are not entirely suitable to exclude confounders such as the possibility that women who received ACS very early in pregnancy also received closer follow-up, and delivered in a more favorable environment. In addition, the safety of ACS at such gestational ages has not been established yet, especially the potential effect of ACS on fetuses that eventually remain undelivered until a late stage in pregnancy.

In general, ACS are not given beyond 34 completed weeks. However, in light of the increasing incidence of near term birth combined with the higher incidence of respiratory morbidity in infants born by elective cesarean section before 39 weeks’ gestation, it was suggested that ACS might be indicated in pregnancies scheduled for an elective abdominal birth at <39 weeks.

The first study on Antenatal Steroids for Term Elective Caesarean Section (ASTEGS) found in 2006 that ACS in such circumstances decreased by 59% the incidence of transient tachypnea of the newborn (TTN) [4]. A more recent study [5] found that the neonates had less respiratory morbidity after elective cesarean when the mother
Perinatal critical care and ethics in perinatal medicine: the role of the perinatologist

Introduction

Critical care management of life-threatening conditions during pregnancy is an indispensable component of perinatal medicine [1, 2]. Ethics is an essential dimension of perinatal critical care [3]. Like other aspects of critical care medicine, perinatal critical care is an area of clinical practice with considerable potential for ethical conflicts. Rather than wait for such conflict to occur, it is far better for patients, their families and perinatologists to anticipate and seek to prevent ethical conflicts. In this paper, we therefore emphasize a transcultural, transnational and transreligious preventive ethics approach that appreciates the potential for ethical conflicts and adopts ethically justified, clinically applicable strategies to prevent those conflicts from occurring. Preventive ethics helps to build and sustain a strong physician-patient relationship [4], which is especially important in perinatal critical care [1-3]. We first define ethics, medical ethics, and the fundamental ethical principles of medical ethics beneficence and respect for autonomy. Second, we define the ethical concept of the fetus as a patient. Third, we define critical care as a trial of management, with short-term and long-term goals. Fourth, we provide an ethical framework for a preventive ethics approach to perinatal critical care to guide perinatologists in patient care.
ACADEMY PAPERS

Published in

2018

Peripartum cardiomyopathy – from pathogenesis to treatment

Introduction

At the beginning of the 21st century, cardiac diseases remain the main cause of death in pregnant women in many countries. One of the most common cardiovascular diseases associated with pregnancy is peripartum cardiomyopathy (PPCM) [1]. The etiology of this disease is unknown, but factors such as infection, inflammation and autoimmune processes may underlie the pathogenesis of its development [2]. The symptoms of this pathology are typical for left ventricle (LV) cardiac insufficiency, however, due to the specific physiological condition during pregnancy and peripartum, its first signs may be masked by complaints typical for normal pregnancy [3]. Furthermore, its clinical course may differ, one course being cardiac failure, with abrupt deterioration of the patient's condition and mortality rate reaching up to 28% and another course being normalization of cardiac insufficiency parameters in 23% of the patients after 6 months [3–5].

PPCM is a rare condition, however, it represents a serious risk of death and therefore, it is crucial to have current knowledge of it to enable its differentiation and treatment. In this publication, we present the most recent reports on the etiopathogenesis, diagnosis and treatment of patients with PPCM.

Definition

According to the definition by the European Society of Cardiology from 2011, PPCM is an idiopathic cardiomyopathy occurring at the end of pregnancy or several months after delivery and presenting with cardiac insufficiency secondary to systolic dysfunction of the LV in a previously healthy woman [4, 6]. Its diagnosis is made based on exclusion because other causes of cardiac insufficiency should be excluded before a diagnosis of PPCM is considered [4].

Epidemiology

Although PPCM is a rare condition, complicating 1 in 300 to 1 in 4000 pregnancies, it is associated with a very high mortality rate for mothers, reaching up to 28% after 6 months of therapy [4]. Of those patients who survive, 27%–52% develop cardiac insufficiency (New York Heart Association (NYHA) class III or IV) [7]. Most of the PPCM cases occur after delivery, in 49% of the patients within the 1st month, in 36% of the patients in the 2nd or 3rd month and in 15% of the patients in the 4th or 5th month [3].

Predisposing factors include parity, diabetes, smoking, arterial hypertension, pre eclampsia, undernourishment, mother's age (advanced age, teenage pregnancy), the use of tocolytic agents, and anemia in pregnancy [4]. Furthermore, according to the EUF Observeral Research Programme, the increased use of assisted reproduction and an increased incidence of multiple pregnancies increases the likelihood of PPCM [8–10].
Introduction

The incidence of malignant disease increases with age and reaches its peak after 50 years of age. But, on the other hand, there is a significant number of children and young women in reproductive age who suffer malignancies. In the last few decades, treatment of malignant disease has improved significantly. Thus, there is a significant increase in children, adolescents and young people who reach the first 5 years, with a realistic chance of survival. Around 80% of patients in whom malignant disease is diagnosed before age 15 will survive the first 5 years, and 70% of them will survive 10 years after being diagnosed [1]. Carcinoma occurrence in children has increased in the last decades. But it is encouraging that survival rates have increased as well. In Europe, children's cancer survival rates are higher in Northern countries and lower in Eastern ones. In Great Britain, children's survival rate within 10 years is about 75%. This figure is more than double that of 50 years ago [2]. Unfortunately, in developing countries, this rate is still very low; 10% for a 5-year period [3]. Child malignancies are different from adult ones. The most frequent tumors affecting children are as follows: leukemia (the most frequent, accounting for 30%), brain and spinal cord tumors, Wilms tumor (nephroblastoma), neuroblastoma and lymphoma (both Hodgkin and non Hodgkin). Patients being diagnosed between 15 and 19 years of age account for 8% of all invasive cancers in the United States, which is about 700,000 new cases every year. It is also estimated that over 1,000,000 women of reproductive age have suffered cancer. In Europe, the estimated number is 130,000 annually [4-6]. Longer life expectancy is the main reason for the increased number of young women surviving cancer who are considering motherhood in the future.

With regard to future pregnancies, some questions that should be addressed when facing cancer in children, adolescents and young women are discussed in the following.

How is fertility preserved when treating malignant disease?

When a patient is facing a malignancy, the main objective is healing. But at the same time, the treatment plan should be carefully selected and should take into account the patient's reproductive future.

Most oncologic treatments imply specific gonadotoxic effects. Chemotherapy with alkylating agents and abdomen pelvic irradiation may produce a reduction in primordial follicles that, in turn, causes temporary or permanent ovarian function loss. This may manifest as acute ovarian insufficiency either during treatment, shortly thereafter or later as premature-early menopause, even before 40 years of age [7, 8].

The gonadotoxic effect depends on the age of the patient (her ovarian reserve [ORI]), the chemotherapeutic agents used and their dosage. If the treatment plan includes pelvic irradiation, this may worsen the patient's reproductive function in the future.

Five groups of alkylating agents are the first line of chemotherapy, although they have the most potent gonadotoxic effect, especially if they are used in combination. Some of such agents are cyclophosphamide, temozolamide, melphalan, busulfan and chlorambucil, and these are the agents with a higher risk (cisplatin and carboplatin, with low cumulative doses, and Adriamycin, use of intermediate risk). Treatment protocols with belotecna, actinomycin II, vincristine, methotrexate and fluouracil, without alkylating agents, are of low risk [9].

The gonads are very sensitive to radiotherapy, and the extent of damage that it may cause depends on the dose and irradiation field. High radiation doses on the hypothalamus and pituitary, as well as total body irradiation,
IAPM
co-organizer of meetings
24. Međunarodni simpozij
24th International Symposium

Znanost i religija – 2000 godina suradnje i osporavanja

Science and Religion – 2,000 Years of Cooperation and Controversies

27-29. travnja 2017. godine
27-29 April 2017

Pod pokroviteljstvom / Under auspices:
predsjednice Republike Hrvatske gospode Kolinde Grabar Kitarović
Grada Zagreba gradonačelnika Milana Banića
President of Republic of Croatia Mrs Kolinda Grabar Kitarović
City of Zagreb mayor Milan Bandić

ISLAMSKI CENTAR ZAGREB
Prilaz Sufyet-Bega Bašagića 1, Zagreb, Hrvatska

30 GODINA OTVORENJA ISLAMSKOG CENTRA ZAGREB
Erich Saling World School of Perinatal Medicine

15-16 May 2017
Moscow, Russia
Международная научно-практическая школа
«Всемирная школа перинатальной медицины
имени профессора Эриха Залинга».
Тема: «Клинические рекомендации по профилактике и
тактике ведения преждевременных родов»

Erich Saling World School of Perinatal Medicine
Topic: “Discussing Clinical Protocols on Term
and Preterm Birth”

15-16 мая 2017 года
1st EUROPEAN CONGRESS OF IAN DONALD SCHOOLS
16-18 June 2017
Cagliari, Italy
1st EUROPEAN CONGRESS OF IAN DONALD SCHOOLS

17th - 18th June 2017
Regina Margherita Hotel, Cagliari, Sardinia, Italy

Congress President: Giovanni Monni - Ian Donald School Europe Director
Honorary Presidents: Asim Kurjak & Frank Chervenak - Ian Donald School World Directors

Under the Auspices of:
October 26 - 29, 2017
Sava Center, Belgrade, Serbia

14.45-17.30

**SYMPOSIUM IAPM**
Chairpersons: Erich Saling, Germany, Asim Kurjak, Croatia and Miroslaw Wielgos, Poland

14.45-15.00
Fetal ultrasound as a window into maternal health
Asim Kurjak, Croatia

15.00-15.15
Is 3D ultrasound the best method for detection and assessment of fetal anomalies?
Eberhard Merz, Germany

15.15-15.30
Neonatologist made significant progress in the past. What does the future bring?
Ola Saugstad, Norway

15.30-16:00
COFFEE BREAK

16.00-16.15
Pulmonary hypertension of the newborn: where are we now?
Manuel Sanchez Luna, Spain

16.15-16.30
Complement system is a key factor in preterm and term labor
Javier Mancilla Ramirez, Mexico

16.30-16.45
Immunosuppressive therapy during pregnancy – effects on mother and offspring
Miroslaw Wielgos, Poland

16.45-17.00
Prediction of preeclampsia
Bernat Serra, Spain

17.00-17.30
Discussion
<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
<th>Chairpersons</th>
</tr>
</thead>
<tbody>
<tr>
<td>16.15-16.30</td>
<td>SPONSORED LECTURE&lt;br&gt;PRENATAL genetics diagnostic at CENTOGENE&lt;br&gt;Aina Maksimovic, Germany</td>
<td></td>
</tr>
<tr>
<td>16.15-16.45</td>
<td>COFFEE BREAK</td>
<td></td>
</tr>
<tr>
<td>16.45-19.00</td>
<td>PARALLEL SESSION Session of Young Scientists&lt;br&gt;Chairpersons: Asim Kurjak, Croatia and Panos Antsaklis, Greece</td>
<td></td>
</tr>
<tr>
<td>16.45-17.00</td>
<td>Fetoplacental Growth and Maternal Obesity&lt;br&gt;Kelly Yamada, USA</td>
<td></td>
</tr>
<tr>
<td>17.00-17.15</td>
<td>Congenital diaphragmatic hernia in prenatal life: assessment and management&lt;br&gt;Nicola Volpi, Italy</td>
<td></td>
</tr>
<tr>
<td>17.15-17.30</td>
<td>Long-term outcome and subsequent fracture risk after pregnancy-associated osteoporosis: Data from the first systematic study&lt;br&gt;Ioanna Kyvernitaki, Germany</td>
<td></td>
</tr>
<tr>
<td>17.30-17.45</td>
<td>Gestational diabetes mellitus - understanding natural course of the disease&lt;br&gt;Josep Juras, Croatia</td>
<td></td>
</tr>
<tr>
<td>17.45-18.00</td>
<td>Hypo- and Hyperplasia of corpus callosum&lt;br&gt;Sonula Pashaj, Albania</td>
<td></td>
</tr>
<tr>
<td>18.00-18.15</td>
<td>Clinical application of KANET test&lt;br&gt;Panos Antsaklis, Greece</td>
<td></td>
</tr>
<tr>
<td>18.15-18.30</td>
<td>Smoking in pregnancy: prevalence and cessation policies. A prospective observational study in Northern Greece and review of the literature&lt;br&gt;Themistoklis D. Dagkis, Greece</td>
<td></td>
</tr>
<tr>
<td>18.30-18.45</td>
<td>Near-Infrared spectroscopy (NIRS) monitoring in NICU as a diagnostic tool in perinatal pathology&lt;br&gt;Olga Brezhnevska, Russia</td>
<td></td>
</tr>
<tr>
<td>18.45-19.00</td>
<td>Brainstem evoked auditory response and Bilirubin induced neurologic dysfunction score in detecting acute bilirubin encephalopathy in term neonates in a tertiary hospital in Kano Nigeria&lt;br&gt;Fatima Usman, Nigeria</td>
<td></td>
</tr>
<tr>
<td>19.00-19.15</td>
<td>Ultrasound and management of specific complications in monochorionic twins&lt;br&gt;Costin Bereanu, Romania</td>
<td></td>
</tr>
<tr>
<td>19.15-19.30</td>
<td>Transport of critically ill neonates with commercial airline&lt;br&gt;Jadon Haric, Malta</td>
<td></td>
</tr>
<tr>
<td>19.30-19.50</td>
<td>Discussion</td>
<td></td>
</tr>
<tr>
<td>19.50-20.00</td>
<td>Asim Kurjak: DELIVERY OF TWO AWARDS TO THE YOUNG SCIENTISTS</td>
<td></td>
</tr>
</tbody>
</table>
Saturday, 28th October 2017

Hall 6

11:30-13:00
PARALLEL SESSION Newcomers
Chairpersons: Asim Kurjak, Croatia and Eberhard Merz, Germany

11.30-11.45
Advanced ultrasound in the detection and assessment of fetal syndromes
Lara Spaldi, Croatia

11.45-12.00
Early development (normal and abnormal) of fetal face
Selma Porovic, B&H

12.00-12.15
Gestational diabetes
Sertac Esin, Turkey

12.15-12.30
Sonographic detection of fetal syndromes with limb defects
Sonia Pashaj, Albania

12.30-12.45
Congenital diaphragmatic hernia. Management and Polish experience
Przemyslaw Kosinski, Poland

12.45-13.00
Discussion

13.00-14.00
LUNCH BREAK
Global Congress of Perinatal Medicine

16-17 February 2018
Aswan, Egypt
Global Congress Of Perinatal Medicine
Egyptian Association of Neonatology
Upper Egypt Society of Minimal Invasive Surgery
Aswan, Egypt
Congress: 15-17 Feb 2018

Endorsed By
International Academy of Perinatal Medicine
Ian Donald School of Ultrasound
Fetus as patient society

Neonatology Group
Prof. Nadia Badawi
Prof. Magdy Badawy
Prof. Mona El Hossary

Obs/Gyn Group
Prof. Abdou Hassan Swisy
Dr. Abdelhalim Hone
Dr. Mostafa Fahem

Prof. Asim Kurjak
Prof. Frank Chervask
Prof. Milan Stanojevic
Prof. Alaa Ebrashy

Global Congress Of Perinatal Medicine
The 2nd Annual Conference of Upper Egypt of minimal invasive surgery
Egyptian Association of Neonatology
Helnan Aswan Hotel - Aswan, Egypt
Date: 15-17 Feb 2018

Upper Egypt Society Of Minimal Invasive Surgery

Scientific Program

Prof. Abdou Hassan Swisy
Head of the society
Dr. Hossam Abdalrahim
Executive director of the society
Dr. Assem Badawy
Secretary General of the congress
Dr. Ali Elsayed El Gohary
Secretary General of the congress
FUTURE MEETINGS SPONSORED BY IAPM
7th IAN DONALD ADVANCED COURSE OF FETAL-PERINATAL ULTRASOUND
Inter-University School of Medical Ultrasound

7th - 8th - 9th JUNE 2018
Hotel Regina Margherita, Cagliari
President Giovanni Monni

UNDER THE AUSPICES OF:
Ian Donald Inter-University School of Ultrasound in Medicine
in cooperation with
- DEGUM-German Society of Ultrasound in Medicine
- Fetal Medicine Foundation Germany
- Croatian Society of Ultrasound in Medicine
- International Academy of Perinatal Medicine
- World Association of Perinatal Medicine

3rd World Congress on 3D Ultrasound in Obstetrics and Gynecology

CONGRESS ORGANIZERS:
Eberhard Merz (Germany) and Asim Kurjak (Croatia)

21-24 March 2019 - Dubrovnik, Croatia

www.dubrovnik3Dcongress2019.org
SEE YOU IN DUBROVNIK!

3rd World Congress on 3D Ultrasound in Obstetrics and Gynecology

Organizers:
Eberhard Merz (Germany) and Asim Kurjak (Croatia)

21-24 March 2019 - Dubrovnik, Croatia
jadranka.cerovec@yahoo.com