



Mankind is a vast ocean, which delving into his entire existential dimensions through any means other than a wisdom belonging to a higher realm of spirituality is deemed to be impossible. Human is a type of creature that has always been dependant on a truth beyond the earthly being that surrounds him and has, through all means possible, believed in it, even though this belief has manifested itself in different ways.

He has always contemplated that the earthly and material being, which is the cradle of his life, is somehow linked to a higher world: in the East, the material world of existence has never been perceived as an independent and separate reality from the higher realm of spirituality, and the concept of Matter has never been detached from the vision of its connection to «Nafs Al-Rahman»¹.


This notion is remarkably deep and human beings' lives particularly in the East, have been processed, analysed and transcended to

1. From Gnostics viewpoint; there is a single truth called Haq (God) and all creatures are manifestations of His existence; such manifested forms of existence is called «Nafs Al-Rahman».

philosophical and Gnostic spiritual ideas, in different forms. East has been indeed home to the emergence and the cradle of nourishment to great Divine religions, and the roots of self-realization and spiritually have always been strengthened and spread in this region.

Amongst all, Iran has possessed an outstanding thousands-year-old profound, insightful and incessant intellectual tradition particularly after Islam. In our culture, knowledge [science] has never been separate from religion, philosophy and Erfan (Gnosticism); in a way that this unity in their views is merged with scientific view along with Monotheism which have been attained for centuries, using the tremendous sources of culture, civilization, religion, philosophy and the highly rich Erfan of this land. The crucial point is how to make this intellectual tradition comprehensibly available for everyone; seeing that having access to this notion and its theoretical and practical knowledge sources, for human beings who are submerged in materialism, is vital nowadays.

According to the methodology of scientists



of our tradition, the material world of existence is like a ladder for ascending to the realms of rationalities as well as metaphysics. This notion believes that a unity reigns over the world that from existential aspect; has degrees and ranks which includes various physical and spiritual realms, and has a position in answering man's worldly as well as spiritual needs in practice. It also indicates that the material world of existence always displays a manifestation of the splendour of the higher realm of spirituality; which is beyond transformation [in comparison with the material world that is always in change and move] and exploration. This outlook has been also prevalent in all types of science including medicine, and traditionally our medical practitioners all had owned broad and wise philosophical, spiritual and aesthetic insights.

Today the West is confronting a severe crisis as a result of eschewing this notion and leaving it in oblivion, and despite developments in biological sciences and medicine, is entangled in a kind of intellectual impasse. For instance, for western biologists, once Darwin's book used to be a holy script and an unquestionable truth, whereas today, it is subject to scepticism and uncertainty. Without a doubt, this change of view in the West, is dramatically deep and critical, and in addition, will be followed by another crisis in the practical aspect.

In medical science -as a clear example of experimental sciences which has theoretical and practical aspects; human is turned into an

object which is almost equal to mere chemical elements that their reaction to medication has to be observed in a laboratory, instead of considering the unity of diverse dimensions of human being including body and soul, and considering «disease» as an event which is the direct result of lack of stability in an organization which all its existential elements and foundations are not necessarily physical. Consequently consumption of medicine has turned into a medical and economic problem and numerous other obstacles which made western doctors develop a doubtful look towards medical science.

Recently, western scientists have extremely criticized some aspects of the classic modern medicine and the famous book "Medical Nemesis" by Ivan Illich is the most outstanding and illustrative of all. This new movement was at least successful in reducing the monopoly of the conventional medicine to some extent, so that the investigation and analysis of other medical treatment doctrines, experiences and theories have become possible with a rational and realistic view and away from any prejudice. That is why Para-Medicine (Complementary and Alternative Medicine) is being seriously pursued and supported by the World Health Organization (WHO).

Nevertheless, considering the fact Iran has been noted as one of the most important medical centres of the world in past eras and has also nurtured the greatest medical doctrines such as Islamic medicine, we hope in this era

it would be able to proudly introduce a brand new treatment method to the world.

Exactly at the time that the West is vying to dispose of the impasses of the classic medicine, a ground-breaking and unique treatment method called “Faradarmani” has been founded in Iran, which is also completely based on experiment and rational arguments, and is intended to be introduced to the scientific and medical communities of the world. Faradarmani lies upon the unity and connection between different existential aspects/dimensions of human including body, psyche and Zehn (mind), additionally, it has transcended the treatment phenomena in to a reality which aims to recognize the consciousness encompassing the universe and the perception of His presence, which is in fact, benefiting from the Divine Communal Mercy.

Holy Quran explains the concept and the truth of the Divine Communal Mercy in Al-Araf Verse 156:

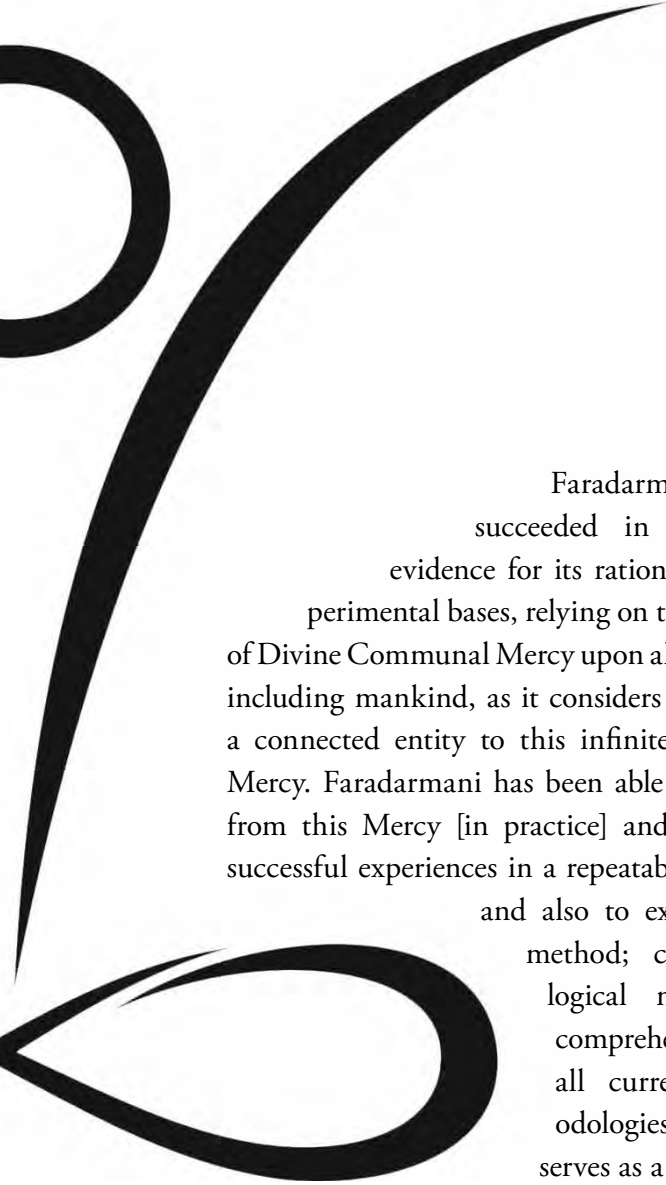
«And ordain for us that which is good, in this life and in the Hereafter: for we have turned unto Thee.» He said: «With My punishment I visit whom I will; but My mercy extendeth to all things...» (from Abdullah Yusuf Ali translation of Quran)

The great scholar, Allamah Tabatabai, ex-

plains this verse as: «From His part (God) nothing comes, but Mercy, for His Mercy is a Godly characteristic and necessitates His Divinity, whereas torment derives from the wrong deed of sinners, and its source is human’s transgressions, nevertheless, it will take place in accordance with His Godly wisdom and laws. However his vast and Communal Mercy which embraces everything, springs from His Divine essence and is not dependant on anything but His Divine essence.»

Thus God’s Mercy encompasses everything and in fact if such Mercy did not exist, the universe would not exist. God’s Mercy is the source of our being, thus every aspect of our life is inseparably intertwined with it and that is why the warp and weft of humans and other creatures are woven by Mercy, and “Faradarmani” is nothing but benefiting from the Divine Mercy and it is the responsibility of the Faratherapist practitioner to manifest that mercy.

In our experience, this method of treatment is highly effective; the contents of the current journal and the three previous volumes are evidence as tip of the iceberg.



Faradarmani has succeeded in providing evidence for its rational and experimental bases, relying on the lucidity of Divine Communal Mercy upon all creatures including mankind, as it considers human as a connected entity to this infinite ocean of Mercy. Faradarmani has been able to benefit from this Mercy [in practice] and to attain successful experiences in a repeatable manner

and also to expand this method; considering logical methodical comprehension in all current methodologies in science serves as a proof.

Accordingly, one of the prepared and accomplished proposals using the method of “Randomized Controlled Trial” (RCT) is the “Study of Faradarmani Effects on Bronchiectasis Patients Who Are Candidates for Lung Transplantation”, which aims to provide evidence on effectiveness of Faradarmani treatment to medical communities, and the reports have been presented to you in this issue.

With the help of God’s Mercy which has always accompanied us in our every effort, we continue our investigations, and in order to ac-

complish this heavy and crucial responsibility, we demand all our colleagues’ scientific and practical assistance.

Among our first collaborators was The Research and Investigation Unit of “Masih Daneshvari” Hospital; hardworking and broadminded doctors such as Dr Katayoun Najafzadeh and her colleagues provided the opportunity for research on this proposal which is immensely honoured and appreciated.

Also a number of dear colleagues helped us in this study, including Ms Sonia Zargari the respectable head nurse of the clinic and a caring and hardworking Faratherapist, Dr. Fariba Ghorbani, Dr. Shadi Shafaghi, Dr. Hamid Reza Khoddami Vishteh, Ms. Elham Rahmani, Ms Masoumeh Masoudnia and other colleagues in Masih Daneshvari Hospital, whose efforts we highly appreciate and are grateful for. We sincerely thank Dr. Maryam Asadi (Faratherapist) and Ms Sayeh Zargari, who actively accompanied us throughout the whole period of research, and finally Mr Ardeshir Shahnava and Ms Zahra Abbasi who helped us with their constant efforts. Some patients who participated in this research are introduced as case examples in this issue.

Dr. Vida Pirzadeh

Supervisor of Faradarmani Medical Research Group



Bronchiectasis is abnormal rigidity of lung bronchi which is associated with permanent inflammation and destruction of elastic tissues and muscular layers of the bronchial walls. Consequently, breathing gradually becomes extremely difficult. Typical symptoms include shortness of breath, persistent or recurrent cough, purulent odorous sputum, abnormal chest sounds, fatigue and possibly presence of blood in sputum. In classic conventional medicine there is no definite cure for Bronchiectasis and the final solution for patients is lung transplantation. This disorder is usually caused by severe chronic infections and is more common in middle and old ages, however it happens in younger patients when there are congenital defects. In summary Bronchiectasis can be caused by:

- a) Severe infections caused by microorganisms activities
- b) Congenital defects

'Faradarmani' positively affects this disease through different ways as follows;

A) Positive impact on body's immune system in cases of infection

A-1) Immune system invigoration through correcting patient's mental and psychological system arrangements

Experience has shown that '*Faradarmani*' increases the immune system strength which explains why infectious diseases respond well to '*Faradarmani*' intervention and are cured within shorter time.

From '*Faradarmani*' point of view, the body's immune system weakens whenever Zehn's¹

1. Zehn is also called Mental body. In Faradarmani, it is believed that the "body and cell management" which is a part of the "Mental Body", directs and delegates duties to the cells, and even controls brain function and its cells. Where is this manager of the body and is it a part of the brain or is it located somewhere else? This manager is not a part of the brain, as brain itself, only conveys orders and assigns duties to the neurons. In fact the management and control of hundred trillions of cells of which neurons are a part, is somewhere else. The anatomy of this part consists of hundred trillions of invisible branches which lead to each and every cell and thus relay their duties. The mental body itself consists of several subdivisions which in turn can be considered as separate bodies such as:

- Memory and archive of the everlasting data
- Memory management
- Management of data assembly (creation of thought)

(mental) energy is being wasted, for example when one is entrapped in a mental chaos,

agitation, or is struggling with confusion and uncertainty, the body's immunity weakens drastically and in such situations the functional integrity of the immune system is

disrupted and the chances of occurrence of infectious diseases comparatively increase.

'Faradarmani' through correcting the organization of 'Zehn', impacts the 'Zehn'(mind)

management which in turn is responsible for body and cellular management; thus will enhance

the feeling of well-being both mentally and emotionally, and increases hope which leads to improvement in patient's mental situation without a need for having

counselling and discussion, thus brings the immune system to its desirable status.

These are the main contributing factors in wasting *Zehn's*(mental) energy:

Over-involvement of this management in issues which are totally irrelevant to the individual and have no impact on their life, for instance making unnecessary judgments.

The individual's *Zehn* (mind) getting into conflict regarding the unity of the world of existence and seeing the world as separate parts instead of a whole, , dividing it and creating discrimination and multiplicity which

will lead to a higher consumption of *Zehn's* energy.

Furthermore, from '*Faradarmani*' point of view, the functioning of the body's immune system has direct relation with one's psychological state, and its capacity is severely undermined under the conditions of being in 'Negative Phase', that is having negative emotions such as fear, anxiety, distress, hopelessness, grief, and alike. Majority of patients are stricken by diseases after they go through a shock of 'Negative Phase'. Physicians have also realised through experience that those patients who are in higher spirits respond better to the treatment and recover faster in comparison with those whose spirits are low. Most of patients who have lost their hope and got depressed upon being informed that there is no definite cure for their disease and it can only be at best controlled for a limited time, are hardly open to any kind of advice; therefore it is not feasible for the '*Fara-therapist*' to help them improve their spirits through talking or counselling. Hence in order to achieve such results, an inner transformation should take place, something that is not achievable by counselling or giving advice. Through accessing various software in *Zehn* (mind) and psyche, and without the use of counselling or advising, '*Faradarmani*' is capable of bringing about positive changes in the software-based structures of patients and as a result boosts the

state of wellbeing. A common report received from patients who underwent 'Faradarmani', is the feeling of well-being and having good spirits. Being in such state is partly related to the inner arrangement of the 'Psychological Body' in which 'Faradarmani' brings about its optimum arrangement.

The 'Psychological Body' is one of the important bodies of human being that detects, examines and reveals one's passions and emotions. It considers the subjects related to the 'Step of Eshq²' and sends the relevant messages to the brain and the brain causes the necessary electro-chemical reactions to manifest and finally appear on Physical body. For example when confronted with a frightening scene, first the scene passes through a filter (the perception filter in Mental Body) where its intensity is analysed and determined. That's why an incident that causes fear in one person might not cause the same reaction in another. For example, one woman might faint upon seeing a mouse whereas another woman might react

2. All the human's interactions with the world of existence are based on one of these two types of approaches: Step of Logic (The world of device/the world of quantity) and Step of Eshq (The world free of device/the world of quality).

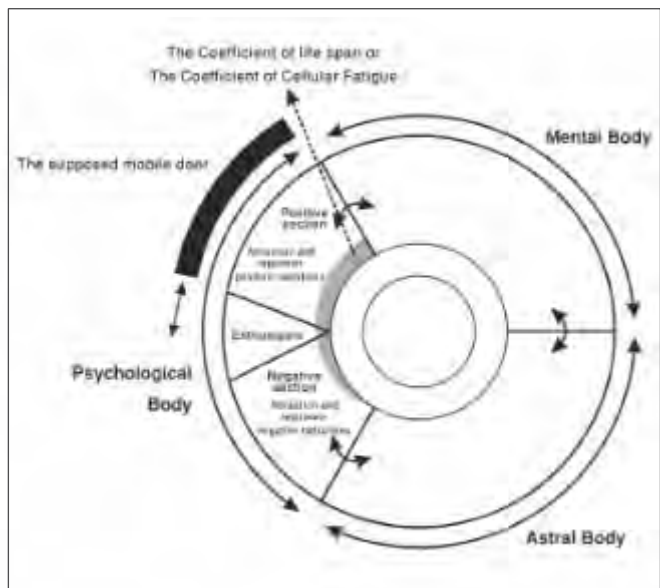
The world of Eshq, is the world of heart, and is not accepting technique and skill, it is going through its own special way where no advice and counsel would be effective. The world of Eshq is not accessible through struggle, endeavour and will power; for instance it is not feasible for someone to say he would try to fall in love within the next few hours, or a person in love cannot be convinced through advice, recommendations, reasoning and rationalization to give up his affection for his beloved. Also we cannot create talent in somebody through technique, science, knowledge or intellectual contemplation and make him to show some enthusiasm and passion that enable him to compose some poem.


normally.

Nevertheless after analysing the external events, the brain reacts and by sending chemical messages makes our physical body react in accordance.

This means that in confrontation with an external frightening event, first we become frightened and then chemical secretion (in this case Adrenaline) puts our body on the alert mode and thus the relevant signs appear on our face and body. Depending on how we are affected by external events (for instance if we are deeply affected), this message is sent to the brain which in turn secretes the associated chemicals that the symptoms of depression, for example, are revealed. The Psychological Body as shown in Figure 3 is composed of two sections, positive and negative, with the following characteristics:

Figure-3: The Psychological Body





The positive section discovers and perceives our positive emotions and is in charge of the absorption and emission of the positive radiations. This means that upon occurrence of positive emotions, the brain produces relevant favourable chemical messages and the positive section of the psyche emits positive radiation, and also absorbs positive radiation if being exposed to them. This state when one is using the positive section of their psyche, is referred to as 'being in the Positive Phase' whereby one can only send and receive positive radiation.

The negative section discovers negative feelings such as anger, revenge, hatred, meanness, jealousy and reveals them. Negative feelings make the brain produce the relevant response which upon execution on body leads to the generation of toxins. In addition, the negative section of our psyche creates negative radiation in which we expose others and ourselves to; in this case we are then in the 'Negative Phase'.

At any given time, one can only use one of the sections of the psyche; the positive or the negative. Thus one is either in the negative phase (where the positive section is blocked and only negative section is open) or in the positive phase (where the negative section is blocked and only positive section is open). It exactly simulates a hypothetical valve that can be opened only to one exit at a time and when

a section is obstructed there cannot be any exchange of the relevant radiations.

Our thoughts, deeds and behaviour hold and emit radiation accordingly. For example when we look at someone with affection, the person is exposed to positive radiation, whereas if someone is treated with anger and rage, he or she is exposed to negative radiation and as we will discuss, the person can be harmed. The influence of the positive and negative radiations is to the extent that the received radiations can affect the life expectancy of the individual (life span). The positive and negative radiations are not a function of space dimension, and distance, for example being far or close, has no effect on their intensity and strength.

While we are in the positive phase, if a negative radiation is directed towards us it will not be able to penetrate as the valve to our negative psyche is blocked. However, if we are in the negative phase this radiation can well affect us. The reverse holds true as well; if a positive radiation is coming on our way while we are in the negative phase, it cannot be absorbed as the valve to our positive psyche is blocked and we will be deprived of its benefits. Therefore, one must remain in positive phase as far as possible to prevent being affected by negative radiations.

Other software-based sections of man's Psy-

chological Body include:

- The section that determines man's life span which is called 'Life Span Coefficient'. The more one receives or emits positive radiation, the higher is this coefficient and the longer he may live. Accordingly Jesus Christ [Peace be upon him] has recommended to love even our enemies, because the harm one may experience when he or she is in negative phase is much greater than what one can imagine.

- The section that examines the positive and negative energies one receives, and under each emotional circumstance it is always exposed to a type of energy that can be absorbed or lost. For example when we are praised we receive energy so that our feelings of fatigue or even hunger or sleepiness may diminish. On the contrary, when we are criticised or blamed we lose energy and feel weak so that we may fail to move. This forms the underlying basis of the '**Psychological Warfare**' through which it is attempted to convince the enemy forces, by the use of some false information, that they do not have the necessary strength to fight the war. As a result their resistance and military capabilities will be undermined by damaging their national and militaristic pride.

- The section which measures our level of satisfaction and dissatisfaction, thus accordingly absorbs or loses energy. For example, after buying a second-hand car if we are told that

it is not worth the price, we will be drained of energy and might even get fever and become ill, but on the contrary if someone else tells us that we have made a real bargain we might get excited and not even feel tired and stay awake all night.

- 'Self- assessment' is done by means of another section; feeling popular and respected plays an important role in this case.

- Other important section evaluates our feelings of guilt or good-deed and then scores and rewards accordingly. This is followed by absorbing or losing energy and when energy is lost, our immune system weakens and we are more susceptible to diseases.

- The section which examines our needs and desires; when they are not fulfilled we lose energy, and vice versa.

- 'Being Idealistic' is measured by another section which contributes to gain or loss of energy. In a football match, for example, the fans of the team that has won receive a lot of energy, whereas the supporters of the team which has lost, lose energy and cannot even talk and feel exhausted and depressed. (Taking in to consideration that fans of both groups more or less were in similar state of spirit before the match.) In fact, reaching our ideal goals, itself, generates such energy that we totally forget the fatigue and struggle we went through. Otherwise, the feeling of tiredness

multiplies and that is why doing the same task over again consumes more energy and leads to fatigue.

The overall gained and lost energies are evaluated by a chief software, which ultimately determines the **'Coefficient of Life Span'** or the **'Coefficient of Cellular Fatigue'**. The more positive energy received, the greater the coefficient and the longevity. On the contrary, more negative energy decreases life span. Therefore maintaining a positive phase has a great impact on our health.

The Life Span Coefficient

As illustrated in Figure 3, the shaded section starts with minimum coverage in Negative Section and grows as it stretches into the Positive Section; the illustrated section is referred to as **Life Span Coefficient**. It shows how our life span increases as we use more of the positive section and how it is reduced when the negative section is more in use. That is to say that being in the positive section is an important factor in increasing longevity.

The Body's Immune Systems at the Times of Negative Emotional Involvement of the Psychological Body

Generally, when one is in Negative Phase, the brain produces poisonous chemicals, and in such situations the body's immune systems are weakened, as the integration of the Body and Cell's Management is disrupted and the

mental energy is wasted immensely. Evidence show that the majority of people who experience extreme Negative phase's emotions, become ill and even have heart attack.

'Faradarmani' causes a shift from negative phase to positive phase; thus creates feelings of peace and separation from negative emotions, consequently the body's immune system reaches its optimum condition, and finally cure will occur in the shortest possible time.

A-2) Causing microorganisms to become synchronized in human body's 'Consciousness Field' in order to eliminate their resistance and sabotage, and to achieve peaceful cohabitation (see 'Consciousness Immunity' – 3rd *Faradarmani* Special Issue)

In a "Consciousness field" the behavior of a [pathogen] microorganism is dependent on the common "Consciousness field" inbetween the microorganism and its carrier. This behavior is not necessarily in accordance with the known behavior of the microorganism, therefore some people are carriers of the microorganism but they don't become ill. For instance there are people who are carriers of HIV virus but they don't have AIDS, although they can infect others. Or for example people who are carriers of Tuberculosis however they are not affected by it.

The same applies to people who keep animals in their living environments very close to

them in a way that their contamination is almost certain, but they never catch the diseases caused by taking care of those animals. Also this applies to the doctors and members of the hospital health care services which are in direct contact with patients in the contagious infectious wards.

B) Treatment of Congenital Disorders

According to *'Faradarmani'* theories and several years of numerous experiments, *'Faradarmani'* through accessing the software-based information of the cells and organs, is capable of correcting the congenital disorders and bringing the affected organ to the normal status. One of the theories that is widely used in *'Faradarmani'* is the **'Theory of Defying the Role of the Genes in Incurability'**. Accordingly; the type of the disease and the fact that a disease is genetic -based do not affect its cure and is of no importance.

One of the mechanisms of Faradarmani is providing possibilities for penetrating, accessing and activating the different information levels within a cell. For instance, since common treatment methods are unable to pass through the gene's programme, the gene's software programme remains dominant and prevents the cure. Therefore, if we can pass through the gene's software, this barrier also will be broken. In Faradarmani the gene barrier is not considered as an obstacle and the fact that a disease is genetic based, does not affect its cure. In fact, through penetrating the

cell's information programmes we can access programmes which make any repair and correction possible.

Furthermore, through **'Reparability Function of Faradarmani'**, once the genetic disorder is corrected, the affected part will be also repaired.

One of the important theories in Faradarmani is the "repair ability and correction ability of different parts of human existence". According to this theory, every component of human existence has repair-ability. In Faradarmani this important phenomenon accomplishes through certain general ways as described below:

Repair Ability and Correction Ability

According to the following categorisation, the phenomenon of cell and organ repair and correction takes place in different ways:

- a) Repair and correction of cells and organs:
 - Histological (tissue repair)
 - Functional: Correction of the functions of the organs
 - Morphological: Repair of appearance and size
- b) Repair of cell and organ fatigue
- c) Repair of cell nonfunctionality
- d) Non-cell organic repair: Such as removal of blockage in the coronary arteries
- e) Software correction

Wishing you Divine Grace
Mohamad Ali Taberi

BRONCHIECTASIS DEFINITION

Harrison's Principles of Internal Medicine 2008

Bronchiectasis is an abnormal and permanent dilatation of bronchi. It may be either focal, involving airways supplying a limited region of pulmonary parenchyma, or diffuse, involving airways in a more wide-spread distribution. Recent studies have estimated there to be about 110,000 patients with bronchiectasis in the United States. It is a disorder that typically affects older individuals; approximately two-thirds of patients are women.

PATHOLOGY

The bronchial dilatation of bronchiectasis is associated with destructive and inflammatory changes in the walls of medium-sized airways, often at the level of segmental or subsegmental bronchi. Airway inflammation is primarily mediated by neutrophils and results in upregulation of enzymes such as elastase and matrix metalloproteinases. The normal structural components of the wall, including cartilage, muscle, and elastic tissue, are destroyed and may be replaced by fibrous tissue. The dilated airways frequently contain pools of thick, purulent material, while more peripheral airways are often occluded by secretions or obliterated and replaced by fibrous tissue. Additional microscopic features include bronchial and peribronchial inflammation and fibrosis, ulceration of the bronchial wall, squamous metaplasia, and mucous gland hyperplasia. The parenchyma normally supplied by the affected airways is abnormal, containing

varying combinations of fibrosis, emphysema, bronchopneumonia, and atelectasis. As a result of the inflammation, vascularity of the bronchial wall increases, with associated enlargement of the bronchial arteries and anastomoses between the bronchial and pulmonary arterial circulations. Three different patterns of bronchiectasis have been described. In cylindrical bronchiectasis, the involved bronchi appear uniformly dilated and end abruptly at the point that smaller airways are obstructed by secretions. In varicose bronchiectasis, the affected bronchi have an irregular or beaded pattern of dilatation resembling varicose veins. In saccular (cystic) bronchiectasis, the bronchi have a ballooned appearance at the periphery, ending in blind sacs without recognizable bronchial structures distal to the sacs.

ETIOLOGY AND PATHOGENESIS

Bronchiectasis is a consequence of inflammation and destruction of the structural components of the bronchial wall. Infection is the usual cause of the inflammation; microorganisms such as *Pseudomonas aeruginosa* and *Haemophilus influenzae* produce pigments, proteases, and other toxins that injure the respiratory epithelium and impair mucociliary clearance. The host inflammatory response induces epithelial injury, largely as a result of mediators released from neutrophils. As protection against infection is compromised, the dilated airways become more susceptible

to colonization and growth of bacteria. Thus, a reinforcing cycle can result, with inflammation producing airway damage, impaired clearance of microorganisms, and further infection, which then completes the cycle by inciting more inflammation.

Infectious Causes

Adenovirus and influenza virus are the main viruses that cause bronchiectasis in association with lower respiratory tract involvement. Virulent bacterial infections, especially with potentially necrotizing organisms such as *Staphylococcus aureus*, *Klebsiella*, and anaerobes, remain important causes of bronchiectasis when antibiotic treatment of pneumonia is not given or is significantly delayed. Infection with *Bordetella pertussis*, particularly in childhood, has also been classically associated with chronic suppurative airways disease.

Bronchiectasis has been reported in patients with HIV infection, perhaps at least partly due to recurrent bacterial infection. Tuberculosis, a major cause of bronchiectasis worldwide, can produce airway dilatation by a necrotizing effect on pulmonary parenchyma and airways and indirectly as a consequence of airway obstruction from bronchostenosis or extrinsic compression by lymph nodes. Nontuberculous mycobacteria are frequently cultured from patients with bronchiectasis, often as secondary infections or colonizing organisms. However, it has also been recognized that these organisms, especially those of the *Mycobacterium avium* complex, can serve as primary pathogens associated with the development and/or progression of bronchiectasis.

Impaired host defense mechanisms are often involved in the predisposition to recurrent infections. The major cause of localized impairment of host defenses is endobronchial obstruction. Bacteria and secretions cannot be cleared

adequately from the obstructed airway,

which develops recurrent or chronic infection. Slowly growing endobronchial neoplasms such as carcinoid tumors may be associated with bronchiectasis. Foreign-body aspiration is another important cause of endobronchial obstruction, particularly in children. Airway obstruction can also result from bronchostenosis, from impacted secretions, or from extrinsic compression by enlarged lymph nodes.

Generalized impairment of pulmonary defense mechanisms occurs with immunoglobulin deficiency, primary ciliary disorders, or cystic fibrosis (CF). Infections and bronchiectasis are therefore often more diffuse. With panhypogammaglobulinemia, the best described of the immunoglobulin disorders associated with recurrent infection and bronchiectasis, patients often also have a history of sinus or skin infections. Selective deficiency of an IgG subclass, especially IgG2, has also been described in a small number of patients with bronchiectasis.

The primary disorders associated with ciliary dysfunction, termed primary ciliary dyskinesia, are responsible for 5–10% of cases of bronchiectasis. Primary ciliary dyskinesia is inherited in an autosomal recessive fashion. Numerous defects are encompassed under this category, including structural abnormalities of the dynein arms, radial spokes, and microtubules; mutations in heavy and intermediate chain dynein have been described in a small number of patients. The cilia become dyskinetic; their coordinated, propulsive action is diminished, and bacterial clearance is impaired. The clinical effects include recurrent upper and lower respiratory tract infections, such as sinusitis, otitis media, and bronchiectasis. Because normal sperm motility also depends on proper ciliary function, males are generally infertile (Chap. 340). Additionally, since visceral rotation dur-

ing development depends upon proper ciliary motion, the positioning of normally lateralized organs becomes random. As a result, approximately half of patients with primary ciliary dyskinesia fall into the subgroup of Kartagener's syndrome, in which situs inversus accompanies bronchiectasis and sinusitis.

In CF (Chap. 253), the tenacious secretions in the bronchi are associated with impaired bacterial clearance, resulting in colonization and recurrent infection with a variety of organisms, particularly mucoid strains of *P. aeruginosa* but also *S. aureus*, *H. influenzae*, *Escherichia coli*, and *Burkholderia cepacia*. Bronchiectasis is associated.

Noninfectious Causes

Some cases of bronchiectasis are related with exposure to a toxic substance that incites a severe inflammatory response. Examples include inhalation of a toxic gas such as ammonia or aspiration of acidic gastric contents, though the latter problem is often also complicated by aspiration of bacteria. An immune response in the airway may also trigger inflammation, destructive changes, and bronchial dilatation. This mechanism is presumably important for bronchiectasis with allergic bronchopulmonary aspergillosis (ABPA), which is due at least in part to an immune response to *Aspergillus* organisms that have colonized the airway. In antitrypsin deficiency, the usual respiratory complication is in the early development of panacinar emphysema, but affected individuals may occasionally have bronchiectasis. In the yellow nail syndrome, which is due to hypoplastic lymphatics, the triad of lymphedema, pleural effusion, and yellow discoloration of the nails is accompanied by bronchiectasis in approximately 40% of patients.

CLINICAL MANIFESTATIONS

Patients typically present with persistent or

recurrent cough and purulent sputum production. Repeated, purulent respiratory tract infections should raise clinical suspicion for bronchiectasis. Hemoptysis occurs in 50–70% of cases and can be due to bleeding from friable, inflamed airway mucosa (Chap. 34). More significant, even massive bleeding is often a consequence of bleeding from hypertrophied bronchial arteries. Systemic symptoms such as fatigue, weight loss, and myalgias can also occur. When a specific infectious episode initiates bronchiectasis, patients may describe a severe pneumonia followed by chronic cough and sputum production. Alternatively, patients without a dramatic initiating event often describe the insidious onset of symptoms. In some cases, patients are either asymptomatic or have a nonproductive cough, often associated with “dry” bronchiectasis in an upper lobe. Dyspnea or wheezing generally reflects either widespread bronchiectasis or underlying chronic obstructive pulmonary disease. With exacerbations of infection, the amount of sputum increases, and it becomes more purulent and often more bloody; systemic symptoms, including fever may also be prominent.

Physical examination of the chest overlying an area of bronchiectasis is quite variable. Any combination of crackles, rhonchi, and wheezes may be heard, all of which reflect the damaged airways containing significant secretions. As with other types of chronic intrathoracic infection, clubbing may be present. Patients with severe diffuse disease, particularly those with chronic hypoxemia, may have associated cor pulmonale and right ventricular failure.

RADIOGRAPHIC AND LABORATORY FINDINGS

Though the chest radiograph is important in the evaluation of suspected bronchiectasis, the findings are often nonspecific. At one

extreme, the radiograph may be normal with mild disease. Alternatively, patients with sacular bronchiectasis may have prominent cystic spaces, either with or without air-liquid levels, corresponding to the dilated airways. These may be difficult to distinguish from enlarged airspaces due to bullous emphysema or from regions of honeycombing in patients with severe interstitial lung disease. Other findings are due to dilated airways with thickened walls, which result from peribronchial inflammation. These dilated airways are often crowded together in parallel. When seen longitudinally, the airways appear as “tram tracks”; when seen in crosssection, they produce “ring shadows.” Because the dilated airways may be filled with secretions, the lumen may appear dense rather than radiolucent, producing an opaque tubular or branched tubular structure.

CT, especially with high-resolution images 1.0–1.5 mm thick, provides an excellent view of dilated airways (Fig. 252-1). Consequently, it is now the standard technique for detecting or confirming the diagnosis of bronchiectasis. Examination of sputum often reveals an abundance of neutrophils and colonization or infection with a variety of possible organisms. Appropriate staining and culturing of sputum often provide a guide to antibiotic therapy.

When bronchiectasis is focal, fiberoptic bronchoscopy may reveal an underlying endobronchial obstruction. In other cases, upper lobe involvement may be suggestive of either tuberculosis or ABPA. With more widespread disease, measurement of sweat chloride levels for CF, structural or functional assessment of nasal or bronchial cilia or sperm for primary ciliary dyskinesia, and quantitative assessment of immunoglobulins may explain recurrent air-

way infection. Pulmonary function tests may demonstrate airflow obstruction as a consequence of diffuse bronchiectasis or associated chronic obstructive lung disease. Bronchial hyperreactivity, e.g., to methacholine challenge, and some reversibility of the airflow obstruction with inhaled bronchodilators are relatively common. Figure 252-2 illustrates a diagnostic approach based on clinical suspicion and radiographic findings. As the differential diagnosis for focal versus diffuse bronchiectasis is different, the radiographic distribution of disease can serve as a starting point of the diagnostic workup. This algorithm should not imply that all studies be obtained in all patients with bronchiectasis. Rather, the workup should be dictated by a careful assessment of the clinical scenario. In a patient with focal bronchiectasis, for example, documentation of a prior pneumonia in the same location may suffice. Evaluation for immunoglobulin deficiency and CF should be considered for young patients with bronchiectasis and sinopulmonary disease.

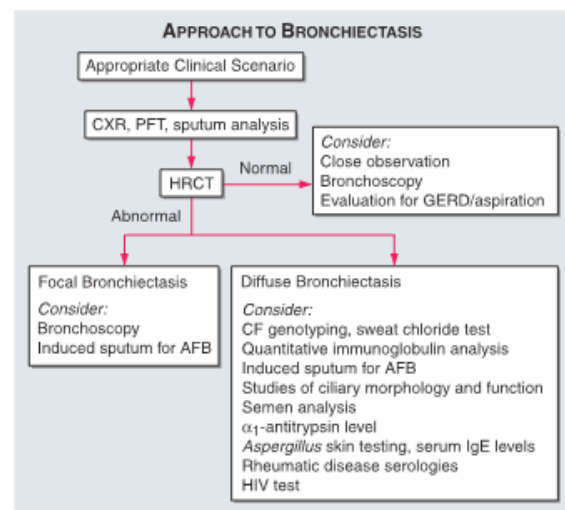


FIGURE 252-2 Diagnostic approach to bronchiectasis. AFB, acid-fast bacilli; CXR, chest X-ray; GERD, gastroesophageal reflux disease; HRCT, high-resolution computed tomography; PFT, pulmonary function testing.

TREATMENT OF BRONCHIECTASIS

Therapy has several major goals: (1) treatment of infection, particularly during acute exacerbations; (2) improved clearance of tracheobronchial secretions; (3) reduction of inflammation; and (4) treatment of an identifiable underlying problem. Antibiotics are the cornerstone of bronchiectasis management. For patients with infrequent exacerbations characterized by an increase in quantity and purulence of the sputum, antibiotics are used only during acute episodes. Although choice of an antibiotic should be guided by Gram's stain and culture of sputum, empiric coverage (e.g., with amoxicillin, trimethoprim-sulfamethoxazole, or levofloxacin) is often given initially. Infection with *P. aeruginosa* is of particular concern, as it appears to be associated with greater rate of deterioration of lung function and worse quality of life. When *Pseudomonas* is present, oral therapy with a quinolone or parenteral therapy with an aminoglycoside, carbapenem, or third-generation cephalosporin is appropriate based on antibiotic sensitivity patterns. There are no firm guidelines for length of therapy, but a 10–14 day course or longer is typically administered.

A variety of mechanical methods and devices accompanied by appropriate positioning can facilitate drainage in patients with copious secretions. Though commonly employed

and probably beneficial, these airway clearance techniques have been poorly studied, and their efficacy is not proven. Pharmacologic agents are also employed to promote bronchopulmonary hygiene. Mucolytic agents to thin secretions and allow better clearance are controversial. Aerosolized recombinant DNase, which decreases viscosity of sputum by breaking down DNA released from neutrophils, has been shown to improve pulmonary function in CF but may be deleterious and should be avoided in bronchiectasis not associated with CF. Bronchodilators to improve obstruction and aid clearance of secretions are particularly useful in patients with airway hyperreactivity and reversible airflow obstruction.

Although surgical therapy was common in the past, more effective antibiotic and supportive therapy has largely replaced surgery. However, when bronchiectasis is localized and the morbidity is substantial despite adequate medical therapy, surgical resection of the involved region of lung should be considered. When massive hemoptysis, often originating from the hypertrophied bronchial circulation, does not resolve with conservative therapy, including rest and antibiotics, therapeutic options are either surgical resections or bronchial arterial embolization (Chap. 34). Although resection may be successful if disease is localized, embolization is preferable with widespread disease.

Abstract

Background

Nowadays complementary medicine, as a group of diverse established medical and health care treatment methods, is considered for a significant number of diseases especially for the advanced illnesses which despite conventional treatment no considerable improvement is achieved. Faradarmani, as a new complementary medical treatment method in Iran, is based on Interuniversal Erfan (Halqeh) that proclaims the connection between the whole consciousness (the intelligence encompassing the universe) and the consciousness of parts, is able to cure diseases. The present study attempts to investigate the effectiveness of Faradarmani in the management of Bronchiectasis patients.

Method

A randomized clinical trial was administered on 34 Bronchiectasis patients who were on the lung transplantation waiting list in 2008-2009 at Masih Daneshvari Hospital in Tehran (11 patients in the control group and 23 in the treatment group). The spirometry, a six-minute walk test, estimated daily sputum amount and functional class were measured for each patient. The control group received only the standard prescribed treatment. After a brief general explanation about Faradarmani, the treatment group received Faradarmani treatment in addition to the standard prescribed

treatment. Faradarmani was administered by a trained practitioner (Faratherapist) and the recipient patients dispelled the distracting thoughts in their mind with their eyes closed for five minutes during the therapy. Faradarmani treatment was conducted by Faratherapist from a distant for the first two months. (The Faratherapist was not attending the hospital and was treating the patients via Long Distance –Faradarmani). Patients in the control group received a similar placebo procedure by a non-practitioner (non-Faratherapist). Participants were required to do this procedure at least once a day and afterwards they were followed up once a week by the Faratherapist via phone (the details of their treatment and the subsequent outcome and feelings were discussed). During the third month, Faradarmani treatment took place in the presence of the Faratherapist (Close Distance –Faradarmani), the performance tests were repeated and patients were questioned on their satisfaction with this new method.

Results

The illness duration was 16 years in average, the patients' average age was 31, and 74% of the patients (25 patients) were male. In comparison with base measurements, in treatment group a statistically significant and meaningful gain was observed in the distance traveled in the six-minute walk test, decrease in daily sputum amount, and improvement of functional class, all of which were not observed in the control group. Furthermore, oxygen requirement during the walking test was decreased in the treatment group. In addition, satisfaction and relief level in Faradarmani treatment group were higher than those of the control group. Nevertheless, FEV1 did not significantly change from the baseline.

Conclusion

The findings indicate that Faradarmani can be an effective complementary medical treatment method in Bronchiectasis patients to improve their clinical conditions and their quality of life and wellbeing. Therefore, further research is strongly recommended to investigate the effectiveness and degree of permanence of this treatment method on other health conditions.

Key words:

Bronchiectasis, Complementary Medicine, Faradarmani, Holistic View (Interuniversalism), Interuniversal Erfan

Introduction

Nowadays, international organizations and institutions recognize Complementary and Alternative Medicine (CAM) as a medical treatment approach and a great number of patients across the world are using these treatments. Furthermore, research funding for CAM has increased significantly; to the extent that only in the U.S.A it increased from 2 million US\$ in 1992 up to 68 million US\$ in 2000. Therefore, it is quite clear that complementary and alternative medicine has remarkably found an important status [1] and a popular footage in treatment of various medical conditions even in developed countries [2].

Complementary and alternative medicine constitutes five different subclasses one of which is mind-body intervention. In this type of CAM, various techniques are employed to enhance the performance of mind in order to override the body performance and diseases [3]. Research findings support the effectiveness of certain CAM methods in treatment of various conditions including pain and anxiety control, stress reduction and mood elevation, sleep and quality of life improvement and also treatment of various neurological conditions such as migraine, physical ache, neck and back problems, Carpal Tunnel Syndrome and Fibromyalgia [4, 5]. Generally, spiritual healing methods can be classified as this type of CAM. There are as many types of spiritual healing methods in the world as far as the religion, creed, and people's faith are concerned; including prayer, meditation, yoga and Ayurveda. Each method propose a certain

definition of health and disease, nevertheless they are qualitative treatment methods as they do not view human being as one-dimensional creature existing only in physical body. This type of treatment methods are very popular CAM methods [6] in a way that it was estimated 28.9% of Americans had used at least one of them for their well-being during the year 1999, of which prayer or spiritual healing was the most common [7]. Furthermore, according to the reports published by National Center for Disease Control and the National Prevention Center of the U.S.A in 2002, 62% of the surveyed people had used prayer as a type of CAM during the past year [8].

There are also some types of spiritual healing in Iran. Amongst them Faradarmani has been practiced lately in an organized way. According to the theory of Faradarmani, the world of existence comprises three elements of Matter, Energy and Consciousness or Awareness. From this perspective, human being is a collection of the physical body, Psyche, Mind (Zehn) and various other unknown bodies all of which have their own distinctive consciousness. From the collection of the Consciousness of parts, the consciousness of 'whole' is formed. The whole consciousness (The Inter-universal Consciousness) is the collection of awareness or consciousness encompassing the universe and is the main/core element of the existing world.

In Faradarmani in order to improve patient's condition, other existential dimensions of human being are deployed; without interfering with conventional medicine's quantitative treatments (prescribed medication). Disease in Faradarmani is defined as the occurrence

of disorder in any existential bodies, constituents and internal systems of human being. Therefore in this Gnostic outlook, viewing human being in its totality, is fundamental to the treatment. Faradarmani is based on the theory of "The Consciousness Bond" or "Parts Having Consciousness In Common". According to this theory, when a link is established between the "whole" consciousness and the consciousness of a "part"; the whole consciousness -via the consciousness of the mind- is capable of correcting, repairing and curing the consciousness of parts including mind, psyche and body thus healing and recovery take place. Once a connection is made between the whole consciousness and the consciousness of parts, the "The Consciousness Bond" will be formed. Following that, the consciousness distribution management centre of mind will be equipped and this centre will be in contact with all parts, thus all constituents will be scanned.

The Scanning stage is the process in which all existential constituents of the individual undergo scrutiny through the Consciousness Bond in order to detect any manifested or hidden defects or diseases. After this bond is established via Faradarmani, the patient automatically undergoes the scanning process and his defects and diseases are detected and revealed. The detected diseases are first prioritized, then the treatment process commences through a phase called 'discharge or externalization'. Discharge is a process after which a given cell reveals its present and past problems and diseases. By continuing Faradarmani treatment the disease symptoms gradually disappear; in accordance to the patterns

found experimentally in Faradarmani treatment graphs [9].

Since the mechanisms of complementary and alternative medical treatments are different from those of the conventional medicine, the effectiveness of CAM methods are always viewed with skepticism. Hence, a considerable amount of research is being conducted to investigate the effectiveness of different types of CAM throughout the world. The present study attempts to introduce Faradarmani as a new type of CAM and empirically investigate its effectiveness in ameliorating Bronchiectasis symptoms in afflicted patients.

Method

Research Design

The randomized clinical trial was conducted in 2008-2009 on Bronchiectasis patients on the lung transplantation waiting list at Masih Daneshvari Hospital in Tehran. The patients were presented with a brief orientation on the trial and were assured that the administration of the intervening treatment would not cause any side effect. Patients who could do pulmonary performance tests and who were not participating in other studies at the same time were selected and written consents were obtained from them. The research was ethically approved and certified by Masih Daneshvari Hospital authorities. There were 34 patients in total in the study. Once patients' demographic data were collected and the required pulmonary tests were taken, out of three patients two were randomly assigned to the treatment group and one was randomly as-

signed to the control group (overall 11 patients in the control group and 23 patients in the treatment group). Assignment was masked and the allocator had no knowledge of the patients' pre-test results. Post-tests and evaluations were administered at the end of the third month after the intervening treatment and all the evaluations were at the time that patients were stable. The two groups were only different in terms of the received intervening treatment (Faradarmani).

Research Variables

Patients' demographic data (age, sex, marital status, education) and the duration of their disease were registered at the onset of the study. Pre-test and post-test measurements included estimated daily sputum amount, patient functional class in four levels (Level I: generally in good condition, Level IV: unable to perform typical daily chores), six-minute walk test, and FEV1. Furthermore, a satisfaction survey was also conducted at the end of the experiment on a four-point Likert scale (I: satisfied, IV: not satisfied).

Interventions

The treatment group received Faradarmani intervention from four Faratherapists. A Faratherapist (Faradarmani practitioner) is an individual who has been trained in the field of Faradarmani treatment. After a brief general explanation about Faradarmani, patients underwent this CAM treatment method. In Faradarmani process, the patient receives 'Etesal' (connection) from Faratherapist. At the first time, the patient is asked to close his/her eyes for at least five minutes and manage to dispel the distracting thoughts, and

merely observe the feelings and experiences encountered during the Etesal impartially (state of becoming an observer). After that, the patient may recount their feelings and experiences. For subsequent treatments, there is no need for Faratherapist to be present at the place; rather the recipient and Faratherapist may reach an agreement over a certain time [of day or night] for Faradarmani treatment and to establish the connection from distance. Faradarmani is not dependent on time, place, individual and their idiosyncratic characteristics and may be administered from distance. The patients were required to undertake the treatment minimum once a day. The Faratherapist would make a phone call once a week to inquire about the occurrence of the connection and the feelings experienced by the patients and encourage them to keep on daily connections. In the third month of the treatment, the Faratherapist administered the treatment personally at the hospital. The control group received a placebo treatment by a non-Faratherapist with similar orientation, methods and follow-up.

Statistical Analysis

Data were analyzed using SPSS 13. The mean (standard deviation), median (inter-quartile range) and frequency (percent) were used to describe the variables. Statistical tests of significance employed were chi-square test, independent samples t-test, paired samples t-test, Mann-Whitney U test, Wilcoxon Signed Ranks test, and McNemar test. To enhance data analysis, patients' functional class and satisfaction level variables were converted into nominal dichotomous variables. The significance level (p value) was set at $p < 0.05$.

Case Presentation

Patient is a 21-year old single male, high school graduate living in Tehran who has been suffering from multiple flu and severe chronic infections since birth which have usually been along with asthma-like symptoms. Since about 2007, patient had dyspnea attacks along with severe hypoxia which after referral to his physician and chest radiography scans, Bronchiectasis was diagnosed and he was referred to Masih Daneshvari hospital where he was treated with routine treatments such as bronchodilator sprays and oral Prednisolone, recurrent infections were treated with Ciprofloxacin until the age of 18 when he went on the lung transplantation waiting list. Patient suffered from anxiety, palpitation, leg and hand tremor and bad temper since 2006 which continued until commencing Faradarmani treatment.

On 07/09/2008 Patient entered into “Faradarmani” research project at “Masih Daneshvari” Hospital Research Center. In his early Faradarmani connections/Etesal (three times a day), patient reported strong feeling of fear, and shivering throughout the body which by pursuing Faradarmani treatments his dyspnea and general wellbeing were improved, however he still needed oxygen for 18 hours a day. During Faradarmani connections/Etesal patient had a feeling of cold, intense trembling, dizziness and headache which after finishing the connections his breathing and general well-being were improved and his oxygen

requirement was reduced.

On 01/02/2009 according to patient’s report, for the first time the antibiotic treatment was stopped, there was a remarkable improvement in his anxiety, palpitation completely disappeared and the amount of sputum was considerably reduced.

In the next reports, patient’s dyspnea, coughing and sputum were gradually disappeared and dosage of Corticosteroids was reduced from 50 to 15 mg, oxygen requirement was remarkably reduced to almost zero during the days and it was limited to only a few hours at nights. Patient was even able to play (with ball) for an hour without having any breathing difficulty or needing oxygen. Patient’s physical pain was reduced and another important point to be considered was 12 kg weight gain until 20/06/2009 which during the next few months it reached up to 16 kg.

Now the patient is in a very good condition and the consumption of Cortone and antibiotics are stopped. All symptoms of nervousness, palpitation, anxiety, physical pain, fear and aggressiveness are totally resolved, and the amount of sputum is reduced to zero. Patient Test results have been gathered in several stages since the initiation of Faradarmani treatment and are registered in a table as following:

In walking test, distance walked in the first session was 127 meter with oxygen requirement, which in the 12th week reached to 476

meter without needing oxygen.

In Spirometry test in the beginning of the project, FEV1 was reported as 14% which after 6 months reached to 55%.

The ratio of FEV1/FCV was increased from 51.6% to 61.9%, and daily sputum reached from two glasses in the beginning of the project to negligible amount in 12th week.

Patient's functional class reached from III to I which means benefiting a better time perfor-

mance in carrying out personal tasks and outside responsibilities individually.

Patient's View

After Faradarmani treatment, patient shows a great interest in pursuing the this method of treatment due to resuming his normal condition which means the ability to do sports and outside tasks in addition to improvement of breathing condition, disappearance of sputum, coughing and nerve-related symptoms.



Faradarmani Project Questionnaire

Date: 07/09/2008

Patient's ID: 196812

File Number: 08-75-00

Gender and marital status:

Male x

Female

Single x

Married

Education:

Illiterate

Below High School Diploma x

Diploma or BSc

Higher Degrees

Age: 20

Illness Duration: 20 years

6 mw Test

% Secondary Sat O2	% Primary Sat O2	Oxygen Requirement	Distance Walked	Date	
81	85	18 hours a day	127 Meter	07/09/2008	Base (before the project)
60	90	Zero	365 Meter	26/10/2008	Project first referral
73	88	Zero	416 Meter	21/12/2008	Project second referral

Satisfaction Rate			Spirometry Test					
Bad	Average	Good	FEV (25-75) %	FEV/FVC %	FVC %	FEV1 %	Date	
	✓		13	51.6	40	25	07/09/2008	Base (before the project)
	✓		8	53	36	19	26/10/2008	Project first referral
	✓		7	69.1	27	26	14/12/2008	Project second referral

Sputum Volume for Bronchiectasis patients			
Functional Class	Sputum Volume ml	Date	
III	Two glasses	07/09/2008	Base (before the project)
II	Zero	26/10/2008	Project first referral
I	Zero	14/12/2008	Project second referral

Case Presentation

Patient is a 19 year-old single male who lives in Babol. In 2003 he was referred to a doctor due to having fatty stool and occasional night sweat. He went to Tehran to seek further medical advice as they were not able to assess his condition accurately in Babol. Sweat test was carried out at “Mofid” hospital where Cystic Fibrosis was diagnosed along with Bronchiectasis. Patient had recurrent symptoms of dyspnea and chronic cough until 2006; when he was swimming in the sea he had feeling of dyspnea, cyanosis and suffocation along with fever and chills. The physician diagnosed it as acute flu, prescribed antibiotic treatment, and he was intermittently under this treatment for 5 to 6 months. Patient was evaluated in hospital for another dyspnea attack in winter of 2006; Cystic Fibrosis along with Bronchiectasis was again diagnosed. This condition continued in the same manner until 2008 when the disease worsened and patient became bed rest at home; requiring 24 hours oxygen supply.

On 31/08/2008 patient participated in Faradarmani project at Masih Daneshvari hospital and started the treatment with three Faradarmani sessions a day. In his primary reports he had feeling of heaviness in the head, vision of suspended particles before his eyes, and the subsequent feeling of relaxation and lightness. In the next reports which distant connections were established at home, he had occasional feeling of heaviness in the head, heat and dizziness which all were gradually rectified. After a month, in the new assessment dyspnea was significantly improved and the oxygen requirement was reduced

to few hours a day and only during activities. Although the patient had carried out Faradarmani connections irregularly near the end of the project, nevertheless after Faradarmani connections, due to rapid improvement of his symptoms he had pleasant feelings, easier breathing, and had been able to work. Until April 2009 according to patient’s mother, he has achieved significant recovery in a way that there has been no oxygen requirement at all (during 24 hours), no sputum and no dyspnea. There are only slight signs of dyspnea and little sputum when he catches cold.

Laboratory Assessments

Patient Test results have been gathered in three stages with the frequency of 2 to 3 months since the initiation of Faradarmani treatment and are registered in a table as following:

In six minutes walking test, distance walked in the first session was 37 meter with oxygen requirement, which after 8 months reached to 432 meter without needing oxygen.

In Spirometry test, the amount of FEV1 reached from 18% to 25% and FEV1/FVC from 49.3% reached to 82.7% in the last session, which shows a decrease in obstruction disorder. Patient’s satisfaction level also increased. The amount of sputum reached from 1/3 of a glass in the beginning of the project, to only a slight amount 8 months after Faradarmani. Patient functional class reached from III to II.

Patient’s View

Despite patient’s erratic Faradarmani connections, he is content with the result of treatment and he owes his recovery to Faradarmani.

Faradarmani Project Questionnaire

Date: 21/09/2008

Patient's ID: 179636

File Number: 93971

Gender and marital status:

Male x

Female

Single x

Married

Education:

Illiterate

Below High School Diploma

Diploma or BSc x

Higher Degrees

Age: 18

Illness Duration: 6 years

6 mw Test

% Secondary Sat O2	% Primary Sat O2	Oxygen Requirement	Distance Walked	Date	
76	85	Yes	370 Meter	21/09/2008	Base (before the project)
75	85	Zero	422 Meter	15/02/2009	Project first referral
82	87	Zero	432 Meter	16/08/2009	Project second referral

Satisfaction Rate			Spirometry Test					
Bad	Average	Good	FEV (25-75) %	FEV/FVC %	FVC %	FEV1 %	Date	
	✓		7	49.3	32	18	21/09/2008	Base (before the project)
		✓	13	71.32	27	23	15/02/2009	Project first referral
		✓	10	82.7	31	25	16/08/2009	Project second referral

Sputum Volume for Bronchiectasis patients			
Functional Class	Sputum Volume ml	Date	
III	1/3 of a glass	21/09/2008	Base (before the project)
II	negligible	15/02/2009	Project first referral
II	negligible	26/04/2009	Project second referral

Case Presentation

Patient is a 50-year old married male, holds BSc and lives in Tehran. He has had a history of Bronchiectasis in the form of aggravation of breathing symptoms such as dyspnea, high amount of sputum, and lung infections (pneumonia) since 7 years ago. Patient participated in Faradarmani research project on 31/08/2008 and undertook Faradarmani treatment two times a day.

In walking test, distance walked in the first session was 66 meter with oxygen requirement, which 6 months later reached to 170 meter without needing oxygen.

In Spirometry test in the beginning of the project, FEV1 was reported as 14% which after

6 months reached to 55%.

The ratio of FEV1/FCV was increased from 47.1% to 96.95%, and daily sputum reached from half a glass a day in the beginning of the project to zero in the 6th month.

Patient's satisfaction level has significantly increased. In general, after Faradarmani treatment, dyspnea and chest pain have remarkably decreased and patient has had a feeling of calm and comfort. It should be mentioned that in the end of 2009 the patient had lung transplantation and this report has been presented only to demonstrate changes/ improvements which took place during Faradarmani treatment.



Faradarmani Project Questionnaire

Date: 31/08/2008

Patient's ID: 103462

File Number: 103462

Gender and marital status:

Male x

Female

Single x

Married

Education:

Illiterate

Below High School Diploma

Diploma or BSc x

Higher Degrees

Age: 50

Illness Duration: 7 years

6 mw Test

% Secondary Sat O2	% Primary Sat O2	Oxygen Requirement	Distance Walked	Date	
91	98	Yes	66 Meter	31/08/2008	Base (before the project)
91	95	Yes	140 Meter	07/12/2008	Project first referral
90	93	No	170 Meter	01/03/2009	Project second referral

Satisfaction Rate

Spirometry Test

Bad	Average	Good	FEV (25-75) %	FEV/FVC %	FVC %	FEV1 %	Date	
	✓		6	47.1	33	14	31/08/2008	Base (before the project)
		✓	17	50.9	26	16	07/12/2008	Project first referral
		✓	97	96.95	46	55	01/03/2009	Project second referral

Sputum Volume for Bronchiectasis patients

Functional Class	Sputum Volume ml	Date	
II	Half a glass	31/08/2008	Base (before the project)
II	Less than half a glass	07/12/2008	Project first referral
I	Zero	01/03/2009	Project second referral

Case Presentation

Patient is a 34 year-old married male living in Hamedan whose lung problem had existed since childhood and adolescence (about 20 years ago). During this period he has been repeatedly hospitalized due to severe acute purulent flu and shortness of breath; with no certain diagnosis he has been under variable treatment of Broad-spectrum antibiotics. Patient's problems in the form of wheezing symptoms and shortness of breath were intensified in 2001 in a way that he called on Tehran Allergy Clinic and upon Allergic asthma diagnosis, undertook medication and Corticosteroid sprays. Due to inconclusive results, after numerous referrals to different medical centers he was finally referred to Masih Daneshvari Hospital where after specific evaluations such as Spirometry and Six minutes walking test he was diagnosed as a Bronchiectasis case, became hospitalized and underwent bronchodilator spray and antibiotics treatment. After being hospitalized in Shariati Hospital since 2 years ago, specialist physicians confirmed that oxygen supply is essential for the patient. Since then he required oxygen supplement about 12 hours a day until 24/08/2008 that patient entered into "Faradarmani" research project at "Masih Daneshvari" Hospital Research Center.

In his early Faradarmani connections /Etesal (three times a day), patient reported feeling of heat and relief throughout his body and breathing improvement which by pursuing Faradarmani treatments gradually his dyspnea was rectified, nevertheless during Faradarmani connections coughs were initially intensified

which gradually disappeared after a month, sputum amount was remarkably reduced and his oxygen requirement was reduced to one to two hours a day with a lesser oxygen pressure in comparison with his previous condition (oxygen pressure reduction from 6 to 2).

In autumn 2009 patient was hospitalized as a result of severe flu and according to patient's words in spite of the cold season in his residence (Hamedan), his recovery speed was quick and his vital signs were not in emergency state in contrary to the past years.

Patient Test results have been gathered in three stages since the initiation of Faradarmani treatment and are registered in a table as following:

In walking test, distance walked in the first session was 182 meter with oxygen requirement. The distance gradually increased in the next referrals and after 8 months reached to 308 meter without needing oxygen.

In Spirometry test, level of FEV1 increased from 19% to 24%.

Daily sputum reduced from 1/3 of a glass (about 300 cc) in the beginning of the project to 100 cc at the end.

Patient's View

In the view of improvement of symptoms specially dyspnea, patient continued Faradarmani treatment and also considering that the illness symptoms used to aggravate every year; (nevertheless it didn't) during the past year he is optimistically undertaking the treatment and is very pleased with Faradarmani treatment effects on his recovery.

Faradarmani Project Questionnaire

Date: 24/08/2008

Patient's ID: reserved

File Number: reserved

Gender and marital status:

Male x

Female

Single

Married x

Education:

Illiterate

Below High School Diploma

Diploma or BSc x

Higher Degrees

Age: 34

Illness Duration: 20 years

6 mw Test

% Secondary Sat O2	% Primary Sat O2	Oxygen Requirement	Distance Walked	Date	
78	87	Yes	182 Meter	31/08/2008	Base (before the project)
67	82	No	225 Meter	14/12/2008	Project first referral
86	79	No	308 Meter	17/05/2009	Project second referral

Satisfaction Rate			Spirometry Test					
Bad	Average	Good	FEV (25-75) %	FEV/FVC %	FVC %	FEV1 %	Date	
			7	81	31	19	31/08/2008	Base (before the project)
			8	69.6	28	17	14/12/2008	Project first referral
			11	69	36	24	17/05/2009	Project second referral

Sputum Volume for Bronchiectasis patients			
Functional Class	Sputum Volume ml	Date	
II	300	31/08/2008	Base (before the project)
II	300	14/12/2008	Project first referral
II	100	08/03/2009	Project second referral

Case Presentation

Patient is a 60 year-old married retired male living in Tehran who has had non- acute breathing difficulties since 1985, which started in the form of dyspnea and progressive weakness and continued until 1996. He sought medical advice as an outpatient and pursued simple medical treatment such as oral antibiotics, vitamin supplement and various syrups (Expectorant) until 2009 when breathing difficulties were intensified in a way that he was referred to hospital with severe dyspnea and the feeling of suffocation. Acute allergy was diagnosed and patient was treated as an outpatient and was discharged from hospital along with some especial dietary regimen and anti-allergy spray. Nevertheless patient's problems continued and led to his retirement until after referral to a Pulmonologist and undertaking CT scan, Bronchiectasis was diagnosed at "505" Hospital. Afterward patient undertook treatment and monthly check ups at Masih Daneshvari Hospital. The patient was not using oxygen supply until 2007, but from this year on due to aggravated dyspnea, was in need of an oxygen generating machine for 3 to 4 hours a day.

Medication prescriptions were: 2 Endoxan tablets 50mg daily and since 2009 one Warfarin tablet a day.

Due to excessive sputum (about half a glass), patient wasn't able to carry out his daily tasks at home and as a result of gradual health deterioration, was referred to Masih Daneshvari Hospital Clinic on a monthly basis. On 28/12/2008 he participated in Faradarmani research project at Masih Daneshvari Hospital. Faradarmani sessions were carried out for 15 to 20 minutes a day after his daily prayers, and he reported feeling of

heat, tingling hands and (posterior) neck muscular spasm. In the next Faradarmani reports his general well-being and breathing conditions were improved, the required oxygen pressure was reduced from 6 to 4, knee and neck pain considerably reduced and he was able to do some personal activities at home such as tooth brushing, washing up and praying without oxygen requirement. Patient was also suffering from cataract, his poor eyesight also improved after Faradarmani treatment. On 14/06/2009 based on his testimony his spirit was lifted up, gained weight and the use of oxygen reduced to 2 to 3 hours a day and the oxygen pressure was reduced to 3 and he was able to drive without having company.

Laboratory Assessments

Six Minutes Walking Test was performed 4 times with frequency of 2 months in which the distance walked in the beginning of the project (before Faradarmani treatment) was 170 meter with oxygen requirement. The distance reached to 275 meter without needing oxygen after 6 months (after Faradarmani treatment).

In Spirometry Test before Faradarmani, FEV1 was 60% which shows average to extreme obstruction but in the last assessment after 6 months, reached to 76% which is in the minimum range. Ratio of FEV1/FCV, reached from 76.6% to 98.8% which shows a decrease in disorder severity.

Daily sputum reduced from half a glass in the beginning of the project to insignificant amount at the end and only after catching cold.

Patient's View

Patient is very content with the treatment process and the gained results of Faradarmani.

Faradarmani Project Questionnaire

Date: 28/12/2008

Patient's ID: reserved

File Number: reserved

Gender and marital status:

Male x

Female

Single

Married x

Education:

Illiterate x

Below High School Diploma

Diploma or BSc

Higher Degrees

Age: 60

Illness Duration: 10 years

Six Minutes Walking Test

% Secondary Sat O2	% Primary Sat O2	Oxygen Requirement	Distance Walked	Date	
56	69	Yes	170 Meter	28/12/2008	Base (before the project)
57	70	Yes	200 Meter	18/01/2009	Project first referral
59	93	No	275 Meter	14/06/2009	Project second Referral

Satisfaction Rate			Spirometry Test					
Bad	Average	Good	FEV (25-75) %	FEV/FVC %	FVC %	FEV1 %	Date	
			105	76.6	56	60	28/12/2008	Base (before the project)
			93	89.3	54	60	18/01/2009	Project first referral
			95	98.8	61	76	14/06/2009	Project second referral

Sputum Volume for Bronchiectasis patients			
Functional Class	Sputum Volume ml	Date	
III	Half a glass	28/12/2008	Base (before the project)
II	Half a glass	18/01/2009	Project first referral
II	insignificant	14/06/2009	Project second referral

Case Presentation

Patient is a 60 year-old married retired male living in Tehran who has had non- acute breathing difficulties since 1985, which started in the form of dyspnea and progressive weakness and continued until 1996. He sought medical advice as an outpatient and pursued simple medical treatment such as oral antibiotics, vitamin supplement and various syrups (Expectorant) until 2009 when breathing difficulties were intensified in a way that he was referred to hospital with severe dyspnea and the feeling of suffocation. Acute allergy was diagnosed and patient was treated as an outpatient and was discharged from hospital along with some especial dietary regimen and anti-allergy spray. Nevertheless patient's problems continued and led to his retirement until after referral to a Pulmonologist and undertaking CT scan, Bronchiectasis was diagnosed at "505" Hospital. Afterward patient undertook treatment and monthly check ups at Masih Daneshvari Hospital. The patient was not using oxygen supply until 2007, but from this year on due to aggravated dyspnea, was in need of an oxygen generating machine for 3 to 4 hours a day.

Medication prescriptions were: 2 Endoxan tablets 50mg daily and since 2009 one Warfarin tablet a day.

Due to excessive sputum (about half a glass), patient wasn't able to carry out his daily tasks at home and as a result of gradual health deterioration, was referred to Masih Daneshvari Hospital Clinic on a monthly basis. On 28/12/2008 he participated in Faradarmani research project at Masih Daneshvari Hospital. Faradarmani sessions were carried out for 15 to 20 minutes a day after his daily prayers, and he reported feeling of

heat, tingling hands and (posterior) neck muscular spasm. In the next Faradarmani reports his general well-being and breathing conditions were improved, the required oxygen pressure was reduced from 6 to 4, knee and neck pain considerably reduced and he was able to do some personal activities at home such as tooth brushing, washing up and praying without oxygen requirement. Patient was also suffering from cataract, his poor eyesight also improved after Faradarmani treatment. On 14/06/2009 based on his testimony his spirit was lifted up, gained weight and the use of oxygen reduced to 2 to 3 hours a day and the oxygen pressure was reduced to 3 and he was able to drive without having company.

Laboratory Assessments

Six Minutes Walking Test was performed 4 times with frequency of 2 months in which the distance walked in the beginning of the project (before Faradarmani treatment) was 170 meter with oxygen requirement. The distance reached to 275 meter without needing oxygen after 6 months (after Faradarmani treatment).

In Spirometry Test before Faradarmani, FEV1 was 60% which shows average to extreme obstruction but in the last assessment after 6 months, reached to 76% which is in the minimum range. Ratio of FEV1/FCV, reached from 76.6% to 98.8% which shows a decrease in disorder severity.

Daily sputum reduced from half a glass in the beginning of the project to insignificant amount at the end and only after catching cold.

Patient's View

Patient is very content with the treatment process and the gained results of Faradarmani.

Faradarmani Project Questionnaire

Date: 28/12/2008

Patient's ID: reserved

File Number: reserved

Gender and marital status:

Male x

Female

Single

Married x

Education:

Illiterate x

Below High School Diploma

Diploma or BSc

Higher Degrees

Age: 60

Illness Duration: 10 years

Six Minutes Walking Test

% Secondary Sat O2	% Primary Sat O2	Oxygen Requirement	Distance Walked	Date	
56	69	Yes	170 Meter	28/12/2008	Base (before the project)
57	70	Yes	200 Meter	18/01/2009	Project first referral
59	93	No	275 Meter	14/06/2009	Project second Referral

Satisfaction Rate

Spirometry Test

Bad	Average	Good	FEV (25-75) %	FEV/ FVC %	FVC %	FEV1 %	Date	
			105	76.6	56	60	28/12/2008	Base (before the project)
			93	89.3	54	60	18/01/2009	Project first referral
			95	98.8	61	76	14/06/2009	Project second referral

Sputum Volume for Bronchiectasis patients

Functional Class	Sputum Volume ml	Date	
III	Half a glass	28/12/2008	Base (before the project)
II	Half a glass	18/01/2009	Project first referral
II	insignificant	14/06/2009	Project second referral

Case Presentation

Patient is a 50 year-old married female living in Tehran who has had intermittent breathing difficulties since 1994. She consulted a general physician (GP) due to having dyspnea and flu in 2007; purulent flu was diagnosed, simple medication such as antibiotics and painkiller was prescribed, and also upon diagnosing Iron deficiency based on her blood test, she undertook the relevant medical treatment. Awhile later after having a chest radiography which was required upon undertaking a Plastic surgery, she was diagnosed as a Sarcoidosis case, was hospitalized and underwent Prednisolone treatment. Meanwhile due to having family issues and the subsequent mental distress, she encountered extreme dyspnea and face and body cyanosis. Upon referral to Masih Daneshvari Hospital, she was admitted with a high pulmonary pressure. Finally she was diagnosed as an extreme case of Bronchiectasis and was discharged with daily 50 mg Corticosteroid and oxygen requirement.

Patient had excessive sputum, wasn't able to do any activity without needing oxygen supply, was hospitalized for months in a regular basis at Masih Daneshvari Hospital and despite undertaking medical treatment unfortunately there was no recovery and in addition; she was requiring oxygen supply during sleep. Patient entered into Faradarmani project at Masih Daneshvari Hospital on 07/09/2008 and according to her first reports on Faradarmani treatment; she experienced anxiety and dyspnea with a subsequent feeling of comfort, relaxation and ease of breathing. The need of oxygen was gradually reduced in a way that she didn't need oxygen in her sleep and only during the day while do-

ing excessive activities it was required. Dosage of Cortone was reduced from 50 mg to 10 mg and then to 7.5 mg a day, patient had a feeling of wellbeing, and she only had very mild dyspnea and increased sputum while she had flu.

According to her reports during the next 6 months, patient enjoyed a great calmness, oxygen requirement dramatically was reduced, the strong state of depression that was observed in the beginning of the project improved significantly and she spent hours outside without needing oxygen.

Laboratory Assessments

The Six Minutes Walking Test was carried out in three stages and frequency of 2 to 3 months; distance walked in the beginning of the project was 312 meter with oxygen requirement. Following Faradarmani treatment and after 6 months, it reached to 420 meter without needing oxygen. Also in Spirometry, FEV1 from 46% reached to 48% at the end of the project which didn't have a significant change.

Patient's sputum amount wasn't noticeable in the beginning of the project but was completely eliminated in the end of the project. Patient functional class from class III, inability in doing household work and light activities, reached to rather normal ability in carrying out outside activities as well as inside tasks, class II.

Patient's View

After observing the effects of treatment on her recovery process, patient has started undertaking Faradarmani courses and is hopeful to continue Faradarmani connections until total eradication of her disease and she is very content with this treatment.

Faradarmani Project Questionnaire

Date: 28/12/2008

Patient's ID: reserved

File Number: reserved

Gender and marital status:

Male x

Female

Single

Married x

Education:

Illiterate x

Below High School Diploma

Diploma or BSc

Higher Degrees

Age: 60

Illness Duration: 10 years

Six Minutes Walking Test

% Secondary Sat O2	% Primary Sat O2	Oxygen Requirement	Distance Walked	Date	
81	96	Yes	312 Meter	07/09/2008	Base (before the project)
71	89	No	420 Meter	07/12/2008	Project first referral
70	90	No	420 Meter	01/03/2009	Project second Referral

Satisfaction Rate			Spirometry Test					
Bad	Average	Good	FEV (25-75) %	FEV/ FVC %	FVC %	FEV1 %	Date	
			64	98	45	46	07/09/2008	Base (before the project)
			70	95.6	43	48	07/12/2008	Project first referral
			124	97.73	41	48	01/03/2009	Project second referral

Sputum Volume for Bronchiectasis patients			
Functional Class	Sputum Volume ml	Date	
III	insignificant	07/09/2008	Base (before the project)
II	insignificant	07/12/2008	Project first referral
I	Zero	01/03/2009	Project second Referral

Case Presentation

Patient is a 27 year-old married male, illiterate and living in Karaj. History of his illness dates back to 12 years ago when he had recurrent infections, dyspnea and hypoxia. He was diagnosed as an allergy case and underwent the relevant treatment. He was referred to “Masih Daneshvari” Hospital since 2008 when symptoms were aggravated. Having a history of right Pneumothorax concerning Bronchiectasis, he was hospitalized twice (May and November) in 2009. Upon getting familiar with Faradarmani, he entered into “Faradarmani” research project on 02/11/2008. Before entering in the project he was treated with bronchodilator spray, Ciprofloxacin, Prednisolone (500 mg daily) and required oxygen supply.

According to his first Faradarmani report, he experienced a feeling of calm and dyspnea relief, according to the second report which was based on undertaking the treatment three times a day, he was able to walk for couple of hours, had no signs of dyspnea, amount of sputum was significantly reduced and he developed a general calmness and state of well-being. According to the next reports (based on patient testimony); the frequency of catching cold in winter time reduced from 4 to 5 times to once, and he experienced walks for as long as 2 hours a day. Furthermore the feeling of lightness, disappearance of sputum and dyspnea, and stopping antibiotics consumption are the most prominent recovery signs.

During the first year of Faradarmani treatment, patient gained 15 kilograms (from 59 to

74) and in recent weeks (December 2010) he was able to play football for half an hour after 2.5 years. According to the mentioned points and discontinuation of Cortone and antibiotics, we can conclude that in general, patient’s acute symptoms are totally eradicated.

Patient’s test results which have been taken in three stages and are registered in the chart are summarized below:

In Six Minutes Walking Test, the distance walked in the beginning of the project was 420 meters without oxygen requirement and in the second stage of the project increased to 559 meters.

In Spirometry Test, FEV1 was 25% in the beginning of the project which reached to 34% in the second stage and FVC increased from 35% to 55% which shows a decrease in obstructive disorders.

The amount of patient’s sputum after starting the project in the first stage was half a glass and in the second stage decreased to an insignificant amount. Patient’s satisfaction level reached from III to I which shows patient is in good state of health.

Patient’s View

According to patient’s words, after Faradarmani treatment, his general well-being and physical condition have improved greatly and the process of recovery is still continuing by following Faradarmani Etesal/connections. He is much content about getting familiar with and undertaking this method of treatment.

Faradarmani Project Questionnaire

Date: 02/11/2008

Patient's ID: 103225

File Number: 065411

Gender and marital status:

Male x

Female

Single

Married x

Education:

Illiterate x

Below High School Diploma

Diploma or BSc

Higher Degrees

Age: 27

Illness Duration: 12 years

6 mw Test

% Secondary Sat O2	% Primary Sat O2	Oxygen Requirement	Distance Walked	Date	
73	87	Zero	420 Meter	02/11/2008	Base (before the project)
67	88	Zero	546 Meter	14/12/2008	Project first referral
76	89	Zero	559 Meter	08/03/2009	Project second referral

Satisfaction Rate			Spirometry Test				Date	
Bad	Average	Good	FEV (25-75) %	FEV/ FVC %	FVC %	FEV1 %		
			12	58.7	35	25	02/11/2008	Base (before the project)
			15	59.7	45	32	14/12/2008	Project first referral
			14	63	55	34	08/03/2009	Project second referral

Sputum Volume for Bronchiectasis patients			
Functional Class	Sputum Volume ml	Date	
III	Half a glass	02/11/2008	Base (before the project)
I	Slight	14/12/2008	Project first referral
I	Negligible	08/03/2009	Project second referral

Case Presentation

Patient is a 62 year-old married male, educated below High School Diploma and lives in Tehran. He has had a history of the disease in the form of recurrent pulmonary infections and pneumonia since 12 years ago. Symptoms aggravated 8 years ago; as a result he was admitted -on numerous occasions- to “Pars” Hospital and based on the assessments, Congenital Syndrome including lack of Alpha-1 anti-Trypsin along with Bronchiectasis was diagnosed. Patient also underwent multiple lavage operations however without achieving definite recovery; common treatments such as Corticosteroid sprays and oral antibiotics were followed. Finally he was admitted to “Masih Daneshvari” Hospital for specialized assessments in 2005.

On 12/10/2008 patient entered into “Faradarmani” research project and according to his first report (after establishing Faradarmani Etesal/connection), he felt pain in the back of his neck and shoulders, heaviness of the chest and then a feeling of relief and lightness. According to the next reports he had more pleasant feelings and his dyspnea remarkably improved after a month. In addition, his oxygen

requirement decreased to minimum amount and sputum was reduced significantly. Based on patient’s latest reports, he undertakes two Faradarmani sessions a day and he feels his general wellbeing has improved 60% to 70%.

Patient’s Test results have been taken in three stages since the beginning of Faradarmani treatment as following:

In Six Minutes Walking Test, distance walked from a minimum of 448 meter reached to 472 meter and amount of primary oxygen saturation from 88% raised to 94%. In Spirometry Test patient’s FEV1 from 87% reached to 95% and also the ratio of FEV1/FCV from 83.2 reached to 92.5 which show a decrease in severity of expiratory tract obstruction and disorder.

The amount of sputum, from half a glass in the beginning of study, decreased to insignificant amount.

Patient’s View

Patient’s satisfactory level is extremely high and in general he is fond of his choice of treatment and he is seriously pursuing this treatment process.

Faradarmani Project Questionnaire

Date: 12/10/2008

Patient's ID: 149600

File Number: 08-03-66

Gender and marital status:

Male

Female

Single

Married

Education:

Illiterate

Below High School Diploma

Diploma or BSc

Higher Degrees

Age: 62

Illness Duration: 12 years

6 mw Test

% Secondary Sat O2	% Primary Sat O2	Oxygen Requirement	Distance Walked	Date	
80	88	Yes	462 Meter	12/10/2008	Base (before the project)
88	94	Zero	448 Meter	15/02/2009	Project first referral
90	94	Zero	472 Meter	16/08/2009	Project second referral

Satisfaction Rate			Spirometry Test					
Bad	Average	Good	FEV (25-75) %	FEV/FVC %	FVC %	FEV1 %	Date	
			83	83.2	83	87	12/10/2008	Base (before the project)
			113	86.35	86	94	15/02/2009	Project first referral
			132	92.5	81	95	16/08/2009	Project second referral

Sputum Volume for Bronchiectasis patients			
Functional Class	Sputum Volume ml	Date	
II	1/4 a glass	12/10/2008	Base (before the project)
II	Slight	15/02/2009	Project first referral
II	Zero	16/08/2009	Project second referral

Findings

Patients' Demographic Data

The mean (standard deviation) of patients' ages was 31 (13) yr and the age ranged from 11 to 62. There were 25 (74%) male participants. There were 17 (50%) married patients; 24 patients' (71%) education level were below High School Diploma. Disease duration ranged between 2-41 years with a mean (SD) of 16 (10) yr. No significant differences were observed in demographic variables and disease duration between two groups (Table 1).

Baseline Measurements

Before the administration of the intervening treatment, the distance traveled in Six-Minute Walk Test in the treatment group was significantly shorter than that of the control group (independent samples t-test, $p=0.030$). The number of patients in the treatment group requiring oxygen administration during the test was significantly more than that of the control group (Chi-Square Test, $p=0.016$). There were no significant differences between the two groups in terms of oxygen saturation drop during test, oxygen saturation percentage at pre-test, FEV1, estimated daily sputum amount, and functional class III or IV ($p>0.05$).

Post-test Findings

Significant positive changes were observed in the treatment group in terms of increase in distance traveled ($p=0.023$), decrease in estimated daily sputum amount ($p=0.014$), and decline in functional class ($p=0.031$) as compared to baseline levels (Table 2). Furthermore, the number of patients in the treatment group needing oxygen administration during walk tests decreased while the result was statistically mediocre (McNemar test, $p=0.063$). On the other hand, no statistically significant changes were observed in pulmonary performance tests and the functional class of the control group as compared to the pre-test measures ($p>0.05$). The estimated daily sputum amount in treatment group decreased significantly in comparison with that of the control group (Mann-Whitney U test, $p=0.028$). No other statistically significant differences (including the functional class) were observed in other measurements between the two groups ($p>0.05$). There were 21 patients in total (91%) in the treatment group who were satisfied with the treatment in comparison with the only one (9%) participant in the control group (Chi-square test, $p<0.001$).

Discussion

The findings of the present research indicate that Faradarmani has positive effects on Bronchiectasis candidates of lung transplantation (in the treatment group in comparison with the control group) in terms of:

- Increase in distance traveled in the six-minute walk test
- Decrease in need for oxygen administration during the test
- Reduction of daily sputum amount
- Improvement of patient functional class
- Patients expressed satisfaction regarding the received treatment and were at ease with the method

Mind-body interventions aim to heighten mind's power/capacity to influence body functions and ultimately to treat illnesses. Meditation, prayer, mental healing, art and music therapy are instances of mind-body intervention. Today, spiritual healing treatments are highly popular CAM methods [6].

Faradarmani can be classified as a type of spiritual healing. In this approach which is based on Iranian mysticism/Erfan, atten-


tion to human being's 'totality' [wholeness/inclusive of all existential constituents] forms the fundamental of the treatment. Therefore, similar to other mind-body interventions, Faradarmani is a type of "Holistic" treatment. In this approach, the awareness/consciousness encompassing the universe is considered as the treatment source; once a connection is made between the parts' consciousness and the whole consciousness, the process of diagnosis and treatment initiates. Therefore, Faratherapist (the practitioner) holds no role except establishing the connection between the patient and the whole consciousness, after which (if connection is maintained) diagnosis, prioritization of maladies, and their treatment are conducted by the Interuniversal Consciousness. The treatment proceeds through the process of discharge or externalization in which a cell manifests its past and present defects and diseases and gradually self-heals through the connection with the Interuniversal Consciousness and in accordance with the progress patterns observed experimentally in Faradarmani treatment Graphs [9]. Although science may be reluctant to accept such theories; they underlie many mind-body interventions which their competence can be proved through the ob-

served 'effects' rather than their underlying 'theories'. For instance, in Ayurveda, an ancient Indian medical practice, it is believed that an intelligent cosmic energy (cosmic consciousness) underlies man's existence and treatment proceeds through alignment of man's internal energies with environmental energy changes, and maintaining an equilibrium in natural energies [10, 11].

Although spiritual healing in many countries especially in Eastern countries dates back to ancient times, scientific achievements and advances in drug synthesis, surgical procedures and other conventional medications have become dominant and have deflected the significance of mind, psyche and spiritual dynamics as valuable means of healing and treatment. As long as through new scientific approaches patients were cured, prayer and spiritual healing were long forgotten. This view continued until 1950's when mind-body medical interventions became popular again to a degree that spiritual healing and prayer are now the major constituents in Americans health and treatment; [12] also receiving much attention from researchers. According to the reports published by the National Center for Disease Control and the National Prevention Center of the U.S.A in 2002, prayer was one of the most common

forms of CAM in which; prayer intended specifically for one's own health comprised 43%, prayers by others for one's own health comprised 24.4%, and participation in prayer groups for one's own health comprised 9.6% of CAM forms [8]. Furthermore, at present the majority of Americans acknowledge the power of prayer in treatment of illnesses. In a Time/CNN joint survey, 82% of Americans asserted that prayer could seriously improve illness conditions, 73% believed that prayer for others could improve their health and 64% had asked their physicians to pray for them [13].

Research on the effect of prayer has revealed positive findings. It has been shown that spiritual changes in patients are positively correlated with their life welfare, happiness, higher self-confidence in problem solving, and reduction in stress and anxiety [14]. Other studies have shown the effect of faith healers on decreasing the growth of cancerous cells, speeding wound healing, relieving pain from distance and improving other common health problems [15, 16]. Furthermore, research reports have also shown the therapeutic effects of intercessory prayer on treating infertility, pain, insomnia, vomiting and nausea caused by chemotherapy [17], relieving cardiac diseases [18], relieving stress



and consequently reduction in the severity of Psoriasis [19]. In addition, a study on the effects of distant healing on patients with AIDS showed that the frequency of physician visit and hospitalization, and the length of hospitalization decreased significantly [20]. In fact, it can be asserted that a new age has risen in which medicine and science have become objective; an era in which mental activities such as prayer have far-fetched observable effects. As the new paradigm in quantum physics helps us understand the relationship between Matter, time and space from a different perspective; the new medicine can as well help us discern the relationship between individuals and the events beyond the conventionally defined frontiers [12].

Indeed, it can be stated that spiritual health is the core element of human general health. Thus, fostering and promoting spiritual health could be an appropriate way to prevent diseases or cope with them [21]. Spiritual health, nevertheless, is a sophisticated and ambiguous aspect of human evolutionary process which creates a harmonic relationship between the internal energies of the individual and is characterized by attributes such as stability in life, peacefulness, and close relationship with God, self, society and environment which are all the dynamics that

determine the integrity of an individual [22]. Therefore, various forms of mind-body interventions, including Faradarmani, attempt in different ways to promote the spiritual health of an individual in order to understand the world of existence and consequently the process of formation and treatment of diseases.

Nevertheless, one should also contend that in spite of the fact that modern medical science is reluctant to accept the theories propounded by complementary and alternative medicine, many people, especially in the Western hemisphere, are using these treatment methods. Therefore, the paradox seems to lie in the effectiveness of such treatment methods. Today, a holistic approach towards medicine (in treatment of diseases) is gradually being accepted to such an extent that a study conducted in the U.S.A showed that dissatisfaction with conventional medical practice was not the reason behind the tendency towards CAM methods, rather the holistic view and maintaining health through natural ingredients and a philosophical view on life were the selling points of CAM methods. In this study, some proposed theories for using CAM methods were surveyed, such as dissatisfaction with conventional medicine, and the compatibility of CAM methods with respondents' beliefs, faith, and their outlook

on life. The findings indicated that only 4.4% of respondents inclined to CAM due to dissatisfaction with conventional medicine and the majority of respondents consider CAM in harmony with their beliefs, faith and outlook on life [23]. Another study conducted on physicians with different specialties in various areas of the U.S.A, showed that 60% of the physicians during the past year and 38% during the past month, had recommended their patients to resort to CAM methods. About 40% of physicians had used CAM methods on themselves and 23% of them practiced them on their patients [24].

Although the use of CAM methods is on the rise, obstacles such as the high cost, the need for special places or special people, medication prescription in some methods, and the need for trained practitioners at all stages of the treatment impede the spread and wide use of such methods. The advantage of Faradarmani, in comparison with other CAM methods, lies in the fact that it is a simple treatment requiring no special place, times, or medication and imposes no cost on the patient. Furthermore, it does not interfere with conventional medical treatments and can in fact proceed concomitantly with conventional treatments. However, the most prominent advantage Faradarmani offers is that the diagnosis and treatment processes are error free because it is the 'whole awareness' (Interuniversal Consciousness) that

detects, prioritizes, and treats diseases and the practitioner is just a mediator providing the connection between the patient and the whole consciousness. Other advantages include patient satisfaction and comfort. In addition, everyone can participate in the short term training courses to learn this treatment method.

A problem in the way of research on mind-body interventions, including Faradarmani, is their lack of standard and systematic procedures. Therefore, an attempt was made in this study to maintain an explicit and uniform treatment method for both the treatment and control groups. A challenge of concern was to make sure that participants in both groups would carry out the required tasks (daily connections/Etesal). Therefore, practitioners would call in to encourage patients to carry out their assigned daily tasks regularly. Nevertheless, this is the first double-blind study with standard research methodology in medicine on the effectiveness of Faradarmani on a chronic disease. More research is warranted to further investigate and support the effectiveness of this simple treatment method on various other ailments. (The existence of a control group in this study was a great advantage; otherwise the effectiveness and validity of the treatment method could be questioned.)

References

1. WHO Traditional Medicine Strategy 2002-2005. Available at: <http://apps.who.int/medicinedocs/en/d/Js2297e/>
2. Goldbeck-Wood S, Dorozynski A, Lie LG, Zinn C, Josefson D, Ingram M. Complementary medicine is booming worldwide. ; *BMJ*. 1996; 313:131-133.
3. National Center for Complementary and Alternative Medicine Available at: <http://nccam.nih.gov/> Jan 2010.
4. Carlson LE, Bultz BD. Mind-body Interventions in Oncology. ; *Curr Treat Options Oncol*. 2008 Jun; 9(2-3):127-34. Epub 2008 Aug 13.
5. Wahbeh H, Elsas SM, Oken BS. Mind-body Interventions: Applications in Neurology. *Neurology*. 2008 Jun 10; 70 (24):2321-8.
6. Abbot NC, Harkness EF, Stevinson C, Marshall FP, Conn DA, Ernst E. Spiritual Healing as a Therapy for Chronic Pain: a randomized, clinical trial. *Pain*. 2001 Mar; 91(1-2):79-89.
7. Ni H, Simile C, Hardy AM. Utilization of Complementary And Alternative Medicine by United States Adults: results from the 1999 national health interview survey. *Med Care*. 2002 Apr; 40(4):353-8.
8. Barnes PM, Powell-Griner E, McFann K, Nahin RL. Complementary And Alternative Medicine Use Among Adults: United States, 2002. *Adv Data*. 2004 May 27; (343):1-19.
9. Taheri, Mohamad Ali; *Human From Another Outlook: Tehran, Neda Publications, 2007*
10. Barnes PM, Bloom B, Nahin RL. Complementary And Alternative Medicine Use Among Adults And Children: United States, 2007. *Natl Health Stat Report*. 2008 Dec 10; (12):1-23.
11. Edwin L. Cooper. *Ayurveda is Embraced by eCAM. Evidence-based Complementary And Alternate Medicine*. 2008 March; 5(1): 1-2.
12. Dossey L. *Healing Words: The Power of Prayer and the Practice of Medicine*. San Francisco: Harper San Francisco 1993.
13. *Time/CNN*. *Time*. June 24, 1996:21
14. Kennedy JE, Abbott RA, Rosenberg BS. Changes in Spirituality and Well-being in a Retreat Program for Cardiac Patients. *Alternative Therapy Health Med*. 2002 Jul-Aug; 8(4):64-6, 68-70, 72-3.
15. Tsubono K, Thomlinson P, Shealy CN. The Effects of Distant Healing Performed by a Spiritual Healer on Chronic Pain: a randomized controlled trial. *Alternative Therapy Health Med*. 2009 May-Jun; 15(3):30-4.
16. Gerard S, Smith BH, Simpson JA. A Randomized Controlled Trial of Spiritual Healing in Restricted Neck Movement. ; *J Alternative Complement Med*. 2003 Aug; 9(4):467-77.

17. Benson H. *Timeless Healing: The Power and Biology of Belief*. New York: Scribner; 1996.
 18. Byrd R. *Positive Therapeutic Effects of Intercessory Prayer in a Coronary Care Unit Population*. *Southern Med J*. 1988;81(7):826–829.
 19. Kabat-Zinn J, Wheeler E, Light T, Skillings A, Scharf MJ, Cropley TG, Hosmer D, Bernhard JD. *Influence of a Mindfulness Meditation-based Stress Reduction Intervention on Rates of Skin Clearing in Patients with Moderate to Severe Psoriasis Undergoing Phototherapy (UVB) and Photochemotherapy (PUVA)*. *Psychosomatic Med*. 1998 Sep-Oct; 60(5):625-32.
- Sicher F, Targ E, Moore D II, Smith H. *A Randomized Double-blind Study of the Effect of Distant Healing in a Population with Advanced AIDS: Report of a small scale study*. *WJM*. 1998; 169(6):356–363.
20. Mc Clain CS, Rosenfeld B, Breitbart w. *Effect of Spiritual Well being on End of Life Despair in Terminally Ill Cancer Patients*. *Lancet*; 2003.361:1603-1607.
 21. Craven RF, Hirnle CJ. *Fundamental of Nursing: Human health and function*. 4th ed. Philadelphia Lippincott; 2003.p.1383,1392.
 22. Astin JA. *Why Patients Use Alternative Medicine: Results of a national study*. ; *JAMA*. 1998 May 20; 279(19):1548-53.
 23. Borkan J, Neher JO, Anson O, Smoker B. *Referrals For Alternative Therapies*. *J Famil Pract*. 1994; 39:545-550.

Table 1. Patients' demographic data and disease duration

	Treatment Group (Faradarmani)	Control Group	P value
Age, yr (mean, SD)	3115±	3210±	0.891*
Sex (male)	16 (70%)	9 (82%)	0.449**
Education (below Diploma)	16 (70%)	8 (72%)	0.850**
Marital status (married)	9 (39%)	8 (72%)	0.06**
Disease duration, yr (mean, SD)	1511±	178±	0.642*

* Independent samples t-test

**Chi-square test

Table 2. Test results for pulmonary function tests, sputum amount, and patient functional class*

	Treatment group (n=23)			Control group (n=11)		
	Pre-test	Post-test	P value	Pre-test	Post-test	P value
Six-min Walk Test Results						
Distance (m)	316134±	358120±	0.023 [§]	41993±	434148±	0.545 [§]
Oxygen saturation at beginning of test (%)	876±	877±	0.757 [§]	859±	848±	0.832 [§]
Oxygen saturation drop (%)	1410±	158±	0.362 [§]	1910±	126±	0.062 [§]
Oxygen requirement during test	12 (52%)	7 (30%)	0.063 [¥]	1 (9%)	1 (9%)	1.000 [¥]
FEV1 (%)	3420±	3421±	0.841 [§]	3619±	3717±	0.064 [§]
Estimated daily sputum amount (cc)	200 (0-300)	50 (0-200)	0.014 [§]	250 (50-400)	200 (30-400)	0.343 [§]
Functional class III or IV	9 (39%)	3 (13%)	0.031 [¥]	3 (27%)	4 (36%)	1.000 [¥]

** Estimated daily sputum amount was reported in median (IQR), oxygen requirement and functional class III and IV were reported in frequency (%), and other variables were reported in mean and SD.*

§ Paired samples t-test

¥ McNemar test

\$ Wilcoxon Signed Ranks test



The First Academic Research

Faradarmani Effects on Bronchiectasis

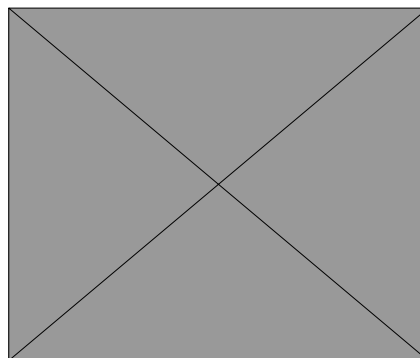
Interview by Mehdi Niroomanesh

Note

Dr Katayoun Najafizadeh, Internist and Pulmonary Diseases & ICU specialist, member of Scientific Board in Shahid Beheshti University of Medicine and chief of Transplantation Unit in Masih Daneshvari Hospital, started on an approved scientific proposal with the title of 'Faradarmani effects on Bronchiectasis patients on the waiting list for lung transplantation' in early 2009. This interview aims to clarify further details on this research.

Dr. Najafizadeh, How did you first get acquainted with Faradarmani?

The lung transplantation clinic which I am in charge of, has been established for about 9 years. Now, all patients in need of transplantation and also pulmonary experts know that they can call on the clinic on Sundays at 1 pm every week to carry out relevant tests/experiments. After going through some procedures, patients go on the lung transplanta-



tion waiting list. Unfortunately there are 200 patients on the waiting list right now whereas the capacity of lung transplantation is 8 to 10 cases in a year. I have to update the list every month because some patients are to be out of the list as they pass away and new patients go on the list, which is very disturbing. Therefore we have been looking for other methods to bring back hope to our patients.

Couple of months ago, accidentally, I came across a group who were using a method called «Faradarmani» to treat patients. Members of this group were physicians who had undertaken Faradarmani courses and were pursuing medical research in this area. Faradarmani is a subcategory of complementary and alternative medicine, and as I had some experiences in «Para Medicine» and I was familiar with acupuncture, I was offered to be in charge of this research.

With the help of this group we prepared a scientific research project titled «Effect of

Faradarmani on Bronchiectasis Candidate Patients for Lung Transplantation». I was in charge of the ailment part of the project and parts related to «Faradarmani» were set by our fellow Faratherapist physicians. Since then Faratherapists come to the clinic on Sundays and patients in addition to undertaking their routine clinical tasks, they also undergo Faradarmani treatment.

You mean you handed over the research procedures to Faratherapists?

Research had to be prepared and performed entirely in a scientific way and in accordance with the academic standards and criteria; so that there won't be any scientific objection



to the results. Hence we divided the volunteer patients into two groups; the «Control» group and the «Treatment» group. The treatment group was under the care of Faratherapists and followed Faratherapists instructions. Control group followed the exact same instructions except that; the individuals who were giving instructions were not Faratherapists. It means what happened to control group was an imitation of the process which Faratherapists instructed the treatment group. This was carried out following the scientific medical research criteria and was intended to prove whether the treatment could have other effects than the probable inculcation.

Another stage was carrying out various tests on each patient in control group as well as in treatment group, including breathing test, walking test and others. After patients in treatment group underwent Faradarmani and the control group underwent simulated placebo-like treatment, the tests were repeated. Physicians and scientists are generally familiar with these routine procedures. I just emphasize on details to clarify that the difference between Faradarmani treatment and conventional medicine didn't prevent us from following scientific principles

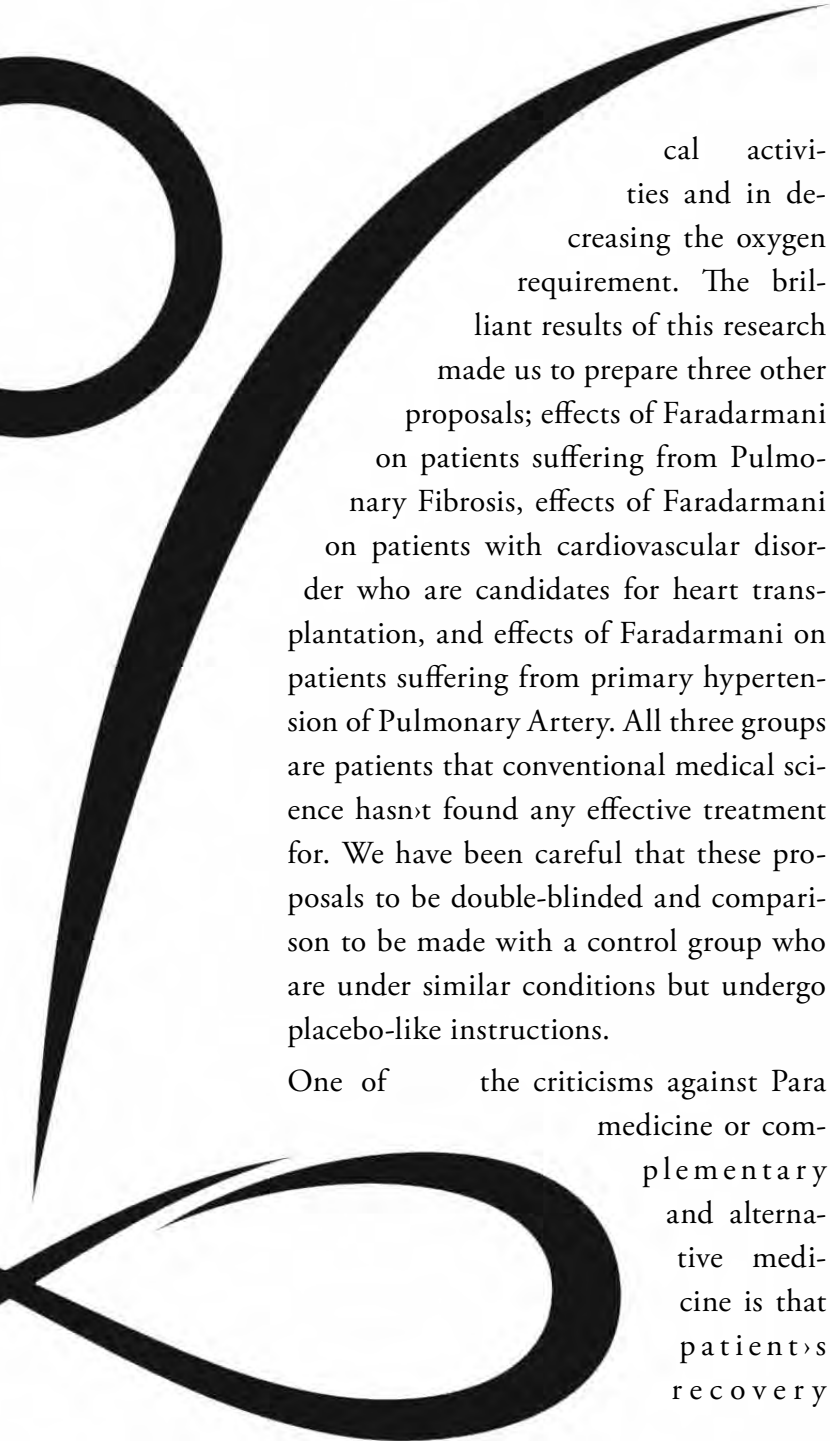
and medical research criteria.

How long did the research carry on?

We assessed the test results of treatment group about three months after the beginning of the research project. Results were noteworthy. Despite the fact that our research was double-blinded and didn't have any presumption, and personally I didn't have any knowledge or experience on efficiency of Faradarmani, patients' results showed improvement and recovery in an obvious and meaningful way. Bear in mind that all patients participating in this project were terminally ill and all were on the lung transplantation list; without which they didn't have any hope of recovery through common medical treatments. The problem which occurred during the research was that some of patients in treatment group experienced such recovery that they didn't intend to cooperate any further through the next stages of the research; some were attending the clinic while travelling from other cities -along with a lot of difficulties, and after 3 months that Faradarmani manifested its results they didn't agree to travel to Tehran or attend the clinic for a new set of tests upon our request to complete the research results.

Therefore in order to follow the scientific criteria, we had to omit their names from the treatment group (patients who had in fact a complete recovery but didn't cooperate until the end of project). Unfortunately also in control group, as patients didn't see any improvement in the usual course of their disease and it became aggravated day by day, some didn't cooperate with the research group and left. Finally we had to finish our research in that stage and assess the results.

Oxygen requirement during the walking test was reduced by 20% in treatment group while there was no change in control group, in addition, distance walked in the test increased meaningfully in treatment group in comparison with control group. The research conclusion was that Faradarmani has a positive effect on Bronchiectasis patients in reduction of sputum, in increasing the ability of physi-



cal activities and in decreasing the oxygen requirement. The brilliant results of this research made us to prepare three other proposals; effects of Faradarmani on patients suffering from Pulmonary Fibrosis, effects of Faradarmani on patients with cardiovascular disorder who are candidates for heart transplantation, and effects of Faradarmani on patients suffering from primary hypertension of Pulmonary Artery. All three groups are patients that conventional medical science hasn't found any effective treatment for. We have been careful that these proposals to be double-blinded and comparison to be made with a control group who are under similar conditions but undergo placebo-like instructions.

One of the criticisms against Paramedicine or complementary and alternative medicine is that patients recovery

could be related to inculcation. Therefore we are extremely careful not blotting the research result regarding this matter; especially that in Faradarmani there are no use of special means and medications, therefore it maybe more under expectation than other types of complementary medicine such as acupuncture.

Did the decline in patients number in «control» and «treatment» group hinder the research?

No; we had 91% satisfaction and recovery in the group who continued undertaking Faradarmani. This means we measured the distance walked in 6 minutes test, the sputum amount and their oxygen requirement and compared them to control group. In all three cases, there were remarkable and unexplainable improvements from medical point of view. We omitted those patients who didn't continue the treatment from our statistics, nevertheless we have been in contact with all of them via telephone and they have been all satisfied completely with their treatment; however because they didn't return to clinic we had to omit their results from our statistics. In control group only 9% were satisfied which proves statistically that the effects of Faradarmani

by no means are related to inculcation/placebo-like effect.

Patients' average age was 31, 74% were male, 50% married, 71% below Diploma Education, and the disease history was 16 years in average which after three months the positive results of Faradarmani treatment manifested in this group.

Does the result of this research indicate the elimination of the disease in treatment group?


You need to recall that patients in this group had an end stage disease and were terminally ill in such way that medical science was not able to offer them any other treatment except for lung transplantation. It is not possible for all of them to have lung transplantation nevertheless they are on the verge of death and they suffer from severe dyspnea and live with minimum activity; whatever brings recovery to some extent increases their hope to live. Faradarmani has had positive results on their recovery and this is remarkable.

Have you observed other effects from Faradarmani treatment except for results achieved through this research?

Yes; once there was a patient that a particular vein became narrowed during his lung transplantation surgery. It was obvious both

in CT scan and heart Echo that certain vein was narrowed, consequently blood in lungs wasn't drained properly and edema grew day by day. Patient was unconscious and was connected to a special medical apparatus. One day when Mr. Taheri, founder of Faradarmani was at hospital, I explained about this patient and he performed Faradarmani on him. The next day patient's edema disappeared and we disconnected him from the apparatus. Our colleague physicians had different speculations about this event however as I have some experience in complementary and alternative medicine; I believe the purpose overall is patient's recovery using any possible method. The purpose isn't the analyzability of the treatment process; maybe Faradarmani process is not explainable from medical science's point of view at present; but the important point is its positive effects on patient's recovery.

Also in another case a patient developed pulmonary edema 40 days after his lung transplantation. It wasn't possible to detach him from the apparatus and he was kept with minimized oxygen consumption with the help of sedatives. I had to travel to Belgium and on the night before my travel, I asked my Faratherapist physician friends, who would



visit the hospital every week, to put him under Faradarmani treatment and I explained there was not much hope for him to live.

The day I returned back to Tehran I saw the patient was disconnected from the apparatus. I didn't have any doubt that he had passed away, yet in my surprise I found out the patient had recovered. I assumed my colleagues had taken a new approach or had prescribed new medication but I understood patient was still under the same medical treatment. I asked my colleagues in the ward how he has possibly recovered but no one had an explanation. Finally a nurse said the patient was under Faradarmani treatment. It was just then I remembered I had personally asked Faratherapist physicians to treat him.

Did you encounter any problem or obstacle during the research?

When we set the control group, we had to assign individuals to instruct the group with simulated instructions that Faratherapists would give the treatment group. It was obvious to Faratherapist physicians that the patients in control group would not get any result by imitating Faradarmani process however this procedure was scientifically essential. I had to explain this process to Mr. Taheri, founder of Faradarmani, who super-

vised Faratherapist physicians remotely. This was very difficult for him, morally. He said when we can help these patients; it is immoral not to help them. I explained this is the only acceptable scientific method for statistic comparison in medical research. He said:” if you don't want us to precede Faradarmani treatment for this group, you must not give us their personal information and reports. Because if you give their information, our conscience won't let us deprive them from Faradarmani and this will ruin your statistic research results.” Hence we had to monitor the control group away from treatment group so that Faratherapists didn't know their names, information and reports which was a difficult task.

If Faradarmani has opened the dead-end area of Medical Science, how it can be expanded in the world of Medicine in your opinion?

The world of medicine should accept that not everything fit into analyzable scientific framework. This research has turned into articles and soon they will be presented in some credited international journals. I believe more articles like the results of this research should be published in credited medical journals and ultimately World Health

Organization recognizes Faradarmani.

Finally I would like to thank all our Faradarmani colleagues, especially Master Mohamad Ali Taheri and also Dr. Vida Pirzadeh, Dr. Shila Mirzadeh, Mrs. Zargar who have helped us sincerely. In addition I would like to show my gratitude to the hardworking transplantation team of Masih Daneshvari Hospital, Mr. Hamid Reza Khoddami Vishteh, Dr. Fariba Qorbani, Dr. Shadi Shafaqi and the honorable personnel of transplantation clinic. Endless support of Dr. Hamidreza Jabari is also appreciated greatly.