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# Amico Yasna Pars

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**“Life is either a daring adventure or nothing at all.”**

Helen Keller, *The Open Door*

Dear Valued Partners;

Many of us are aware of the great journey of ophthalmology from the beginning till now. The known history of ophthalmology starts in early days of written history and over the ages, the understanding of the eye has been developed and several major milestones happened.

- . Georg Joseph Beer introduced Beer’s operation as a treatment for cataract.
- . Ernst Abbe is renowned for the development of various optical instruments used in the field of ophthalmology.
- . Hermann von Helmholtz invented the ophthalmoscope in 1851.
- . Sir Harold Ridley successfully implanted the first intraocular lens in 1949.
- . Charles Kelman developed the ultrasound and mechanized irrigation and aspiration system for phacoemulsification, first allowing cataract extraction through a small incision in 1967.

Each step took slowly only for one great purpose, to improve the quality of vision, to provide people with the best possible quality of life.

Today, the responsibility lies with the ophthalmic community to continue this long journey and use its best endeavors to give people the best possible vision.

In Amico Yasna Pars, we believe that our role is to provide new and advanced technologies, and the role of surgeons is to use them for their patients. The result is helping people to improve their quality of vision and accordingly the quality of life. We know that sometimes this will be a challenge, like many of the new technologies when they were supplied for the first time, but also we know that those surgeons are the pioneer who come up with such challenges.

We are speaking about premium IOLs. There is no doubt that such IOLs give the patient much better vision, but unfortunately many surgeons still worry about using these kind of lenses which of course make people lose the chance to enjoy superior vision.

This led us to emphasize once more that by providing the best generation of premium IOLs and high level support, Amico Yasna Pars is ready to provide all kinds of cooperation in this field.

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# GUIDING CHOICES

Help patients understand extended-depth-of-focus, multifocal, and accommodating lenses.

BY D. REX HAMILTON, MD, MS



As cataract surgeons in 2017, we are blessed to have a variety of premium IOLs available. With this blessing comes a responsibility to adequately explain the pros and cons of these technologies to our patients prior to surgery.

## CHOOSE YOUR APPROACH

The first step is to choose how to approach the educational process. Will you make a strong recommendation based on your clinical assessment, or will you present each of the IOLs with its pros and cons and allow the patient a more active role in determining which one to use? My style is to make a recommendation based on a comprehensive clinical history, patient-reported desires for visual function and needs, the slit-lamp examination (including dilated fundus), corneal topography, and often (but not always) macular optical coherence tomography imaging. I prefer this approach to asking the patient to make an “educated” choice that is often biased by the experience of a loved one, friend, or neighbor or an angry blog post on the Internet.

I present multiple options to the patient and explain the reasons behind my recommendation of a specific IOL. For example, if a patient has an epiretinal membrane causing obvious distortion on Amsler grid testing, I will show him or her the macular optical coherence tomography findings. I will then explain that monovision is probably not the best option, despite his or her sister-in-law’s never having to wear glasses after monovision cataract surgery. Similarly, if a patient has a history of radial keratotomy surgery, I will explain that the optics associated with a multifocal IOL are not “compatible” with the optics associated with his or her cornea. I will state that a monovision approach is a better choice, even if his or her neighbor threw away his or her glasses after receiving multifocal IOLs last year.

## CONTRAST THE OPTIONS

There are similarities and differences in the conversations I have with patients when discussing extended-depth-of-focus (EDOF) versus multifocal lenses. Regarding EDOF IOLs (Tecnis Symfony and Tecnis Symfony Toric; Abbott), I describe a continuous range of high-quality vision from a distance to just inside arm’s length. Menus, price tags, cell phones, computers, and tablets will be visible without

glasses. Smaller-print items such as nutritional labels and drug package inserts may require some low-powered readers from the drugstore. The wonderful new aspect of EDOF is the phenomenal computer-range vision for folks whose jobs and careers revolve around monitors, tablets, and laptops.

I contrast these outcomes with the multifocal experience, which also includes an excellent useful range of vision. Multifocal IOL patients may be able to see items by holding them closer than with an EDOF IOL, I explain, but they will likely need to make more adjustments in working distance and lighting when viewing computer screens, laptops, and tablets, a feature that may frustrate those whose occupational and leisure environments do not allow for such changes.

## PREPARE THE PATIENT

It is important to explain the pros and cons of each IOL without alarming the patient. I often hear surgeons over-emphasize the negative aspects of certain IOL technologies to their patients, in effect scaring them off from an option that might have been ideal for their lifestyle needs. This conservative approach probably minimizes chair time during a surgeon’s early experience with new technologies, but ultimately, it may limit the volume of patients for whom the surgeon can provide the most desired outcome.

With EDOF IOLs, there is no question that near vision will be farther out than patients have been used to. This will strike them as odd and bothersome at first, particularly if they have been myopic. It is therefore important to point out to myopic patients that, immediately after receiving an EDOF or multifocal IOL in the first eye, they will still feel like they are reading out of the unoperated eye. I provide this information prior to surgery on the first eye so that patients are not surprised on postoperative day 1. I explain that, just because they are reading out of the unoperated eye, it does not mean that the operated eye cannot see up close. The brain defaults to normality. Once surgery on the second eye is complete, there will be a new norm that includes a new night vision experience and, especially with an EDOF IOL, a new near viewing distance that is farther away from the body.

For myopic patients concerned about this change in unaided near vision, I point out that, with the monofocal option, they will lose the unaided near vision they have had their

entire life and gain unaided distance vision they never had. With the EDOF/multifocal option, they will largely maintain the unaided near vision to which they are accustomed while gaining unaided distance vision that they have never had.

Night vision symptoms are present with both EDOF and multifocal lenses. It is just as important to discuss night vision with EDOF IOL patients as it is with multifocal IOL patients. In the AMO Multicenter Clinical Trial of Symfony Intraocular Lens, the incidence of moderate to severe night vision symptoms with the Tecnis Symfony IOL was lower than that seen in the multifocal IOL clinical studies, but the types of night vision symptoms differed. EDOF IOL patients talk more about starburst effects than halos, although they can see both. Neural adaptation is real and occurs with both EDOF and multifocal IOLs, and it should be discussed upfront. I like to point out that, much as the new working distance with EDOF IOL becomes the new norm, so does the presence of nighttime starbursts. The brain will adapt and stop noticing them in time.

### TREAT ASTIGMATISM

Another wonderful aspect of EDOF IOLs is their ability to treat astigmatism of up to 2.00 D at the corneal plane with the toric version. In my opinion, manual corneal relaxing incisions are less predictable than toric IOLs for treating astigmatism above about 1.25 D. Prior to the introduction of the toric EDOF IOLs, surgeons in the United States had to rely on corneal relaxing incisions to treat astigmatism at the time of cataract surgery with multifocal IOLs. With toric EDOF IOLs now available, I feel confident that I can significantly reduce spectacle dependence in a new segment of patients, namely those with significant astigmatism.

In my experience, patients have almost always heard of astigmatism and are very happy to be offered an intraocular solution. A great way to explain how a toric IOL treats astigmatism is to pull up the patient's topography on the electronic medical record. I then take the gummy toric IOL model provided by Abbott, place it over the topography, and slowly align it with the bowtie astigmatism.

### DISCUSS ACCOMMODATING LENSES

When explaining accommodating lenses, I find it important to limit patients' expectations for spectacle independence. Because the lens moves to some degree inside the eye, its resting point is less predictable than the standard one-piece lens design used for today's multifocal and EDOF IOLs. I make sure patients understand monovision concepts and that, due to the variability in refractive outcomes of the currently available accommodating lens (Crystalens AO; Bausch + Lomb), the need for a LASIK or PRK "fine-tuning" procedure is higher than it would be with a multifocal or EDOF IOL. In addition, even if unaided distance vision is excellent, near vision without glasses may be inadequate.

Computer-range vision is typically excellent with the accommodating lens, and this implant offers a reasonable solution for patients with previous corneal refractive surgery who desire some reduction in spectacle dependence.

### USE EDUCATIONAL TOOLS

Whichever option I recommend to a patient, I use several tools to help illustrate the postoperative experience so as to remove mystery and reduce fear.

#### IOL Models

All of the IOL manufacturers can provide jumbo-sized models of the IOLs they manufacture. I carry these around in my coat pocket and pull them out as I explain surgery, improving the efficiency of the discussion. For example, I can fold a model in front of the patient as I say, "The lens is foldable, allowing me to insert it into the eye through a very small incision that does not require a suture." To help explain the EDOF IOL, I can point out the rings while saying, "You see the rings on this extended-depth-of-focus lens. We are changing the optics your brain is used to in an instant. Your brain needs to adapt to the new optics. During the first few months, you will notice some combination of glare, halos, and starbursts around lights at night. These won't be debilitating like what you experience now with your cataracts, but they will seem unusual. After a time, you will notice these aspects less often. You are wearing a watch, necklace, bracelet, earrings, but you don't notice them. Your brain is used to them and ignores them. In much the same way, your brain will adapt to the new norm of these amazing optics and ignore the glare and halos."

#### Video Simulations

There are various video simulation packages provided by IOL manufacturers and other third parties (eg, Rendia, Patient Education Concepts) that are excellent for educating patients. My office has put together "Cataract Overview" and "Premium Choice" sequences of videos. After my optometrist has seen a new cataract patient, she will activate the "Cataract Overview" sequence, which walks the patient through the visual effects of cataract development, the cataract surgical process, laser options, IOL choices, and the postoperative visual experience. This not only provides vital educational information to the patient, but it also seems to shorten the time waiting for the surgeon to enter the exam lane. Once I have examined the patient and made my recommendation, I will activate the "Premium Choice" option, if appropriate, while the patient waits for my counselor to arrive and review the next steps in the process (eg, scheduling, finances, etc.). We incorporate some videos with my voice-over, together with stock videos from the third party, to add a personal touch to the educational experience.

## Discussion

### Physical 3-D Eye Model

It is old school, but I still like the 3-D eye model when talking directly to patients. It is something they can touch, rotate, and take apart. I find a 3-D eye model to be engaging for patients, and it serves as a foundation for the aforementioned discussions. It allows me to face the patient, make eye contact, and not turn away from him or her to fiddle around with the mouse and keyboard that would be required if I were using the video simulation to educate him or her.

In summary, today's refractive cataract surgeon is blessed with outstanding IOL technology that affords an unprecedented opportunity to provide spectacle independence to patients. Along with this opportunity comes the responsibility to adequately prepare them for the process. Addressing

concerns using visual aids, using simple language, and setting appropriate expectations will result in happy patients, more word-of-mouth referrals, and a prosperous refractive cataract surgical practice. ■

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## Posterior corneal astigmatism can be incorporated into toric IOL selection

Since before the turn of the 20th century, we recognized that there was a mismatch between anterior corneal astigmatism and refraction, although we were unable to pinpoint the cause. However, a new look with the aid of modern technology has shown us that posterior corneal astigmatism, or PCA, is also a significant player in the overall picture.

### Why PCA?

In 2009, Ho and colleagues published a study of 493 subjects comparing the keratometric corneal astigmatism with the total corneal astigmatism derived by double-angled vector analysis of both corneal surfaces with the Pentacam (Oculus). They reported that in 28.8% of eyes, total corneal astigmatism differed from anterior corneal astigmatism by more than 0.5 D and that, overall, PCA reduced total corneal astigmatism by an average of 13.4%.

Furthering our understanding of the impact of PCA, my colleagues and I published data on 715 corneas of 435 consecutive patients in 2012 with several useful observations. First, the mean magnitude of PCA was  $-0.3$  D. Second, the posterior cornea is steeper along the vertical meridian in more than 80% of eyes, creating against-the-rule (ATR) refractive astigmatism. Third, we demonstrated that in eyes with increasing amounts of anterior with-the-rule (WTR) astigmatism, there is a corresponding increase in PCA that tends to partially compensate for the WTR astigmatism of the anterior cornea. Fourth, mean PCA stays relatively constant in eyes with increasing amount of ATR anterior astigmatism.

Overall, we understood that not measuring PCA would lead to overcorrection of WTR astigmatism and undercorrection of ATR astigmatism. We confirmed this in a follow-up case series that measured corneal astigmatism using five different devices

before and after cataract surgery in which a toric IOL was placed. WTR prediction errors of 0.5 D to 0.6 D were caused by all devices in WTR eyes. In ATR eyes, the WTR prediction errors varied from 0.2 D to 0.3 D when using all devices except the Placido dual Scheimpflug analyzer (Ziemer Ophthalmic Systems). Now our attention turned to how to measure PCA.



<https://www.amoeasy.com/>

### Determining PCA

Direct measurement of each eye is the most accurate way to determine PCA; however, this is not always feasible due to a variety of factors such as equipment limitations and logistical barriers. Currently, there are a variety of ways to measure posterior corneal curvature: Scheimpflug technology, OCT and, with increasing popularity, the Cassini multicolor LED shape analyzer (i-Optics). Intraoperative aberrometers such as ORA (Alcon) and Holos (Clarity Medical Systems) also incorporate PCA into their calculations by measuring the refractive power of

## Discussion

the entire eye in an aphakic state. All of these devices calculate refraction and astigmatism of an aphakic eye from both the anterior and posterior corneas, which is not a direct measurement of PCA.

All of these factors are precursors to the idealistic state in which we can measure everyone individually without reliance on population-based means. But until we can actually measure on a patient-by-patient basis in an accurate way, we need to have formulas that can predict and closely approximate PCA.

Starting from what we discovered from the 715 eyes in our 2012 study and the 57 eyes in our case series, we sought to develop a formula that would take into account PCA. Scientists at Abbott Medical Optics in conjunction with Joseph Ma and myself have developed a hybrid algorithm, which is based on the Baylor nomogram and clinical outcomes of trials of Abbott lenses. Now integrated into the Abbott toric calculator with PCA (Abbott Medical Optics), we can easily factor in the estimated PCA for each patient to maximize the accuracy of astigmatic correction with toric IOLs. Optimized for use with the Tecnis family of IOLs (Abbott Medical Optics), the calculator offers an elegant method to select toric IOLs by taking into account PCA, IOL power and pseudophakic anterior chamber depth — the key factors to understanding the effective toricity of the IOL (Figure 1).

Including PCA as a standard of care

Cataract surgery is the most frequently performed and successful surgical procedure in the U.S., but we still have room to improve by increasing predictability of residual astigmatism and consistently achieving zero residual astigmatism. Better astigmatism management starts by incorporating PCA into our preferred method, which reduces the systematic ATR error observed when only

anterior corneal data are used for toric IOL power calculations. Another important consideration is the tendency for corneal astigmatism to drift in an against-the-rule direction. When PCA is ignored, the result is an overcorrection for WTR eyes or undercorrection for ATR eyes, leaving the patient with ATR astigmatism that worsens over time and erodes long-term vision quality. When we understand how PCA affects the eye, theoretically, we can leave patients slightly with-the-rule (0.25 D, if possible). When we use this comprehensive strategy, we give our patients many years to enjoy excellent uncorrected vision with little or no astigmatism.

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Disclosure: Koch reports he is a consultant for Abbott Medical Optics, Alcon and Bausch + Lomb and receives research support from i-Optics and Ziemer.



## The TECNIS® Toric IOL

Secure rotational stability.  
Deliver precise outcomes.





**Dr. Donnenfeld shares highlights of the Tecnis Symfony clinical trial results**

In July, the U.S. Food and Drug Administration approved the first extended range of vision IOL, the Tecnis Symfony (Abbott Medical Optics, Abbott Park, Illinois). This lens works differently from other presbyopia-correcting IOLs in that it provides a wide range of continuous vision while minimizing and even eliminating most of the disadvantages that have been associated with multifocal IOLs. Using diffractive echelette technology and achromatic optics, the lens spreads out light along a range, rather than splitting it between two distinct points.

The U.S. clinical trial for the lens was a prospective, randomized, subject- and evaluator-masked study conducted at 15 U.S. sites, including our practice. In all, 148 subjects were bilaterally implanted with the Symfony lens and 150 with the ZCB00 Tecnis monofocal lens. In reviewing the results from the clinical trial, four key features stand out to me.

**Quality vision at all distances**

The subjects implanted with the Symfony lens achieved mean binocular uncorrected vision of 20/20 for intermediate distance and between 20/25 and 20/32 for near (Figure 1). But even with these gains in near vision, they still had a high quality of vision at distance. Monocular and binocular distance visual acuity were clinically comparable to that of the monofocal control group. This is better distance vision than I have observed with multifocal IOLs.

At our practice, we even had a number of patients who saw better than 20/20 uncorrected at distance, which is unusual with a presbyopia-correcting IOL. I think that this high quality of vision is due in part to the fact that the lens material and

**New IOL provides high quality vision over extended range**

by Eric Donnenfeld, MD, EyeWorld chief medical editor

design correct for both spherical aberration and chromatic aberration.

**Night vision**

A major obstacle in the adoption of presbyopia-correcting IOLs has been the concern of visual disturbances under night vision conditions. We have been particularly conservative with those patients who have a high need for good vision in dim light, such as those who drive long distances at night.

Although we counseled patients in the study to expect that they might develop glare and halo, we found a very low incidence of night vision symptoms. On a non-directed symptom questionnaire, the vast majority of subjects implanted with the Symfony lens reported no halo, glare, or starbursts, and of those who did report symptoms, most experienced only mild or moderate symptoms, with less than 3% classifying their symptoms as “severe” (Figure 2).

We know that reading vision is always easier with good illumination. But the Symfony lens functions much like a monofocal lens, with a high degree of pupil independence. In addition, the difference in contrast sensitivity (CS) with the Symfony is not clinically significant compared to CS with an aspheric monofocal IOL.

In the past, we have judged presbyopia-correcting IOLs primarily by the quantity of vision or Snellen acuity they provide. Quality of vision discussions were framed mostly as a negative, for example, “Can the patient tolerate the expected decrease in visual quality?” Now, we can begin to shift our thinking because we have a presbyopia-correcting lens that is likely to perform well for night driving and for more demanding visual tasks where CS matters more than acuity.

**Functionality for patients**

Spectacle use was sharply reduced. As I previously noted, the study subjects achieved very functional near vision and 20/20 intermediate—exactly what they need to perform most daily tasks without glasses. About 85% of the Symfony subjects reported wearing glasses “none” or “a little bit” of the time (Figure 3), and 92% said they would select the same IOL again. The weakness of

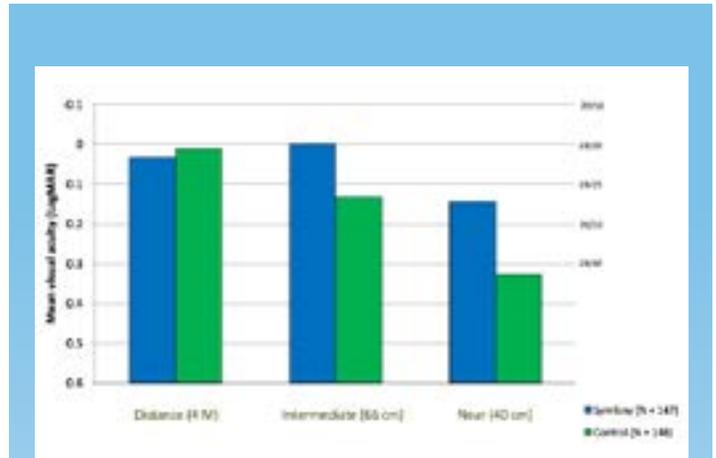


Figure 1. In the U.S. clinical trial, Symfony subjects achieved uncorrected binocular vision at distance and intermediate of approximately 20/20 and near vision between 20/25 and 20/32.

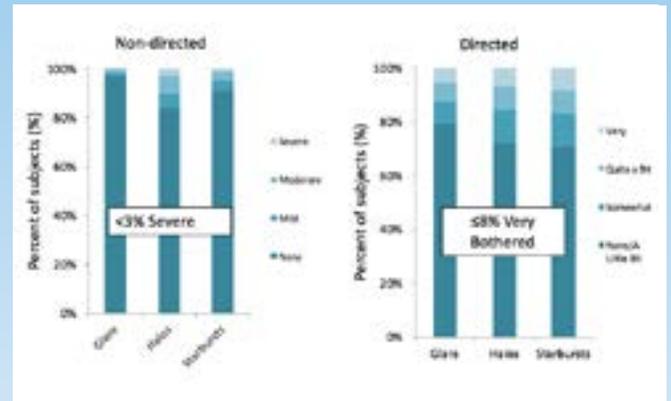


Figure 2. Complaints of glare, halo, and starbursts were low in both the Symfony and monofocal groups.

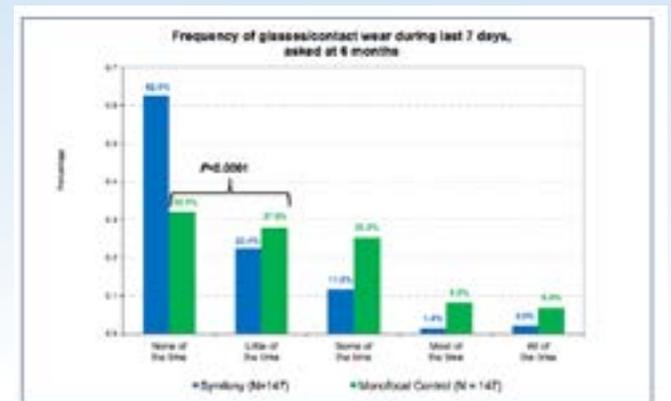


Figure 3. A statistically significantly greater proportion of Symfony subjects compared to control subjects reported wearing glasses “none/a little of the time,” and a majority of Symfony subjects reported never wearing glasses.

Source: U.S. Food and Drug Administration

## Discussion

this lens is the near point. It is very good for mid-range activities, but for fine reading, I counsel patients that they may need to wear glasses.

In my opinion, the Symfony lens provides what patients have wanted: They don't have to give up good distance vision or driving at night for excellent range of vision at near and intermediate; they can see the menu in a restaurant, the dashboard in their car, and comfortably use their computers and smartphones.

I had an interesting thing happen among my study patients. A group of them was in the waiting room together for their first day postop exams. It quickly became clear which patients had gotten the Symfony lens because they were so thrilled with their near vision. After the study, one of the monofocal patients had his lenses explanted due to dissatisfaction with reading. I implanted bilateral multifocal lenses instead. I have participated in a number of FDA trials and this is the first instance I can recall where I have needed to explant a control lens.

### Peace of mind for surgeons

Another aspect of the Symfony lens I like is that it is very forgiving of residual refractive error. It delivers 20/20 vision even in the presence of up to a diopter and a half of astigmatism. Because it extends the range of useful vision, patients will still have good outcomes even if the refraction is off by +0.25 or +0.50 D. They may not get as much near vision as intended, but they won't lose distance acuity as they would with the same amount of error in the presence of a multifocal IOL.

For surgeons who have been waiting for a presbyopia-correcting lens that minimizes visual disturbances yet offers a full range of near vision in refractive cataract surgery, Symfony is a good opportunity. I feel confident recommending it for a wider range of patients than before—patients who are more demanding, who drive a lot at night, or who are post-LASIK, for example. I am also excited about the toric version.

I have found that Symfony is more patient-friendly than previous generations of presbyopia-correcting

IOLs. This also makes it a surgeon-friendly lens because it gives us the opportunity to provide our patients with excellent quality of vision with a lower risk of dissatisfaction. **EW**

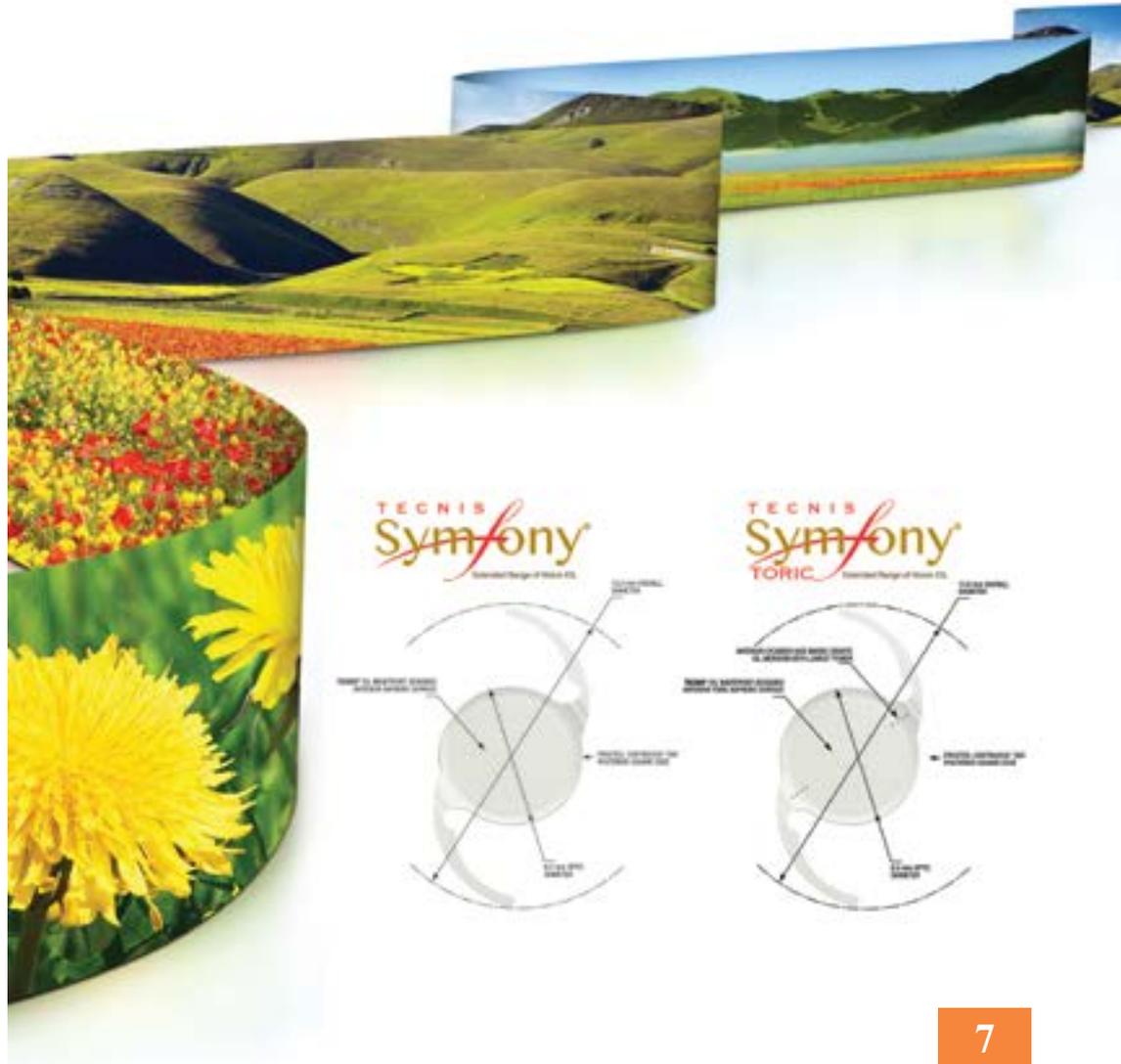
*Editors' note: Dr. Donnenfeld has financial interests with Abbott Medical Optics, Alcon (Fort Worth, Texas), and Bausch + Lomb (Bridgewater, New Jersey).*

### Contact information

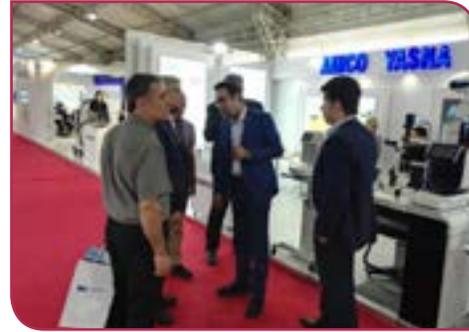
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The first and only presbyopia-correcting  
Extended range of vision IOL



## Events



### 23<sup>rd</sup> Annual Farabi Seminar

The 23rd annual seminar of Farabi Eye Hospital has been held in the Olympic Hotel in Tehran from 26 to 28 April 2017. The seminar was organized by Farabi Eye Hospital and a large number of ophthalmologists from all over the country participated. Among many of the scientific and practical programs, the side exhibition was considered as one of the attractive topics of the seminar.

As in previous years, Amico Yasna Pars had a great presence in the exhibition and tried to introduce the latest technology achievements to the participants. Amico Yasna Pars is the exclusive distributor for many world-renowned ophthalmic equipment companies including the American Abbott Company.

### First Spring Ophthalmology Meeting

A new title on the Iranian ophthalmic congresses calendar. The first Spring Ophthalmology meeting has been held in the IRIB conference center in Tehran from 11 to 14 April 2017 as a joint planning of the ophthalmology departments and research centers of Shahid Beheshti and Iran Universities of Medical Sciences. Although the program was the first of its kind, it was successfully conducted in the presence of a significant number of ophthalmologists. During the four days of the meeting, the

latest advances and achievements in the field of ophthalmology were reviewed and discussed. Like other similar events, ophthalmic equipment companies had a strong presence in the meeting. Amico Yasna Pars, based on its mission of supporting the ophthalmology community, actively participated in the event. In addition to Abott, Amico Yasna Pars represents many other well-known ophthalmic equipment companies in Iran.

### Upcomming Events

10-12 May 2017

25<sup>th</sup> Annual Seminar of Ophthalmology of Shiraz medical Science university

Tehran, Iran

12-13 May 2017

Royal Australian and New Zealand College of Ophthalmologists NZ Branch Annual Scientific Meeting 2017

Waitangi, New Zealand

17-19 May 2017

9<sup>th</sup> Annual meeting of Iranian society of ophthalmic plastic and reconstructive surgery (IrSOPRS)

Shiraz, Iran

24-26 May 2017

10<sup>th</sup> International meeting of update on cataract surgery

Mashhad, Iran

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