SOMnews
University of Maryland School of Medicine
March 2008 Vol.9 No.7

DEAN'S MESSAGE: What's On My Mind

What's on my mind this month is the School of Medicine's research roadmap. In my research vision letter and in my September State of the School address, I outlined my goals and objectives for our outstanding research enterprise. I emphasized that we are not only compelled but indeed obligated to increase the impact of research and discovery on human health. It is not enough to simply increase the amount of research we do, but rather we must increase the impact that research has on human health. We propose to do this in a number of ways: by increasing new magnet areas, expanding current magnet areas, recruiting and retaining productive faculty, emphasizing translational research, working in a more collaborative environment to enhance interdisciplinary research, and, ultimately, achieving a top-15 ranking within five years.

Our research roadmap will help us achieve these goals and objectives. The roadmap is unique because it harnesses the individual excellence of the School of Medicine's departments, programs, institutes and centers in achieving institutional goals using tools for measuring organizational success and accountability. It also provides incentives for encouraging and rewarding interdisciplinary collaborations and entrepreneurship. For example, it combines traditional business metrics, such as return on investment, with institutional development objectives, workforce planning and cultural change.

Let us focus on just one of our goals—achieving top-15 status for national biomedical research funding over the next five years (FY2008-FY2012). As you know very well, the competition is fierce for funding from federal, state and private sources for grants and contracts for biomedical research. Thus, achieving this status will require a sustained commitment of time and energy from all sectors of the School of Medicine. Our roadmap is critically important to this process because it provides a structured, interdependent framework for clarifying and achieving the specific goals that will lead to achieving this vision. More importantly, it mobilizes resources to focus on maximizing opportunities for success across departments, programs, institutes and centers toward a common goal. We must remember that funding level is a surrogate for and an effective measure of excellence in research programs since funds are secured by rigorous competition of program content, progress and success.

The roadmap includes several key elements with distinct strategies:

- Foster a more collaborative research community by fully accounting for collaborative efforts and establishing measures of research productivity for clinical faculty.
- Support existing and emerging centers of clinical-translational research excellence and ensure their continued growth by building and maintaining translational research excellence. For example, over the next five years, at least half of our clinical departments will have an area of excellence that meets the criteria for an established "center of clinical-translational research excellence."
- Prioritize the recruitment of established (funded) principal investigators and development of a steady pipeline of exceptional new investigators by such measures as enhancing the recruitment process to identify and review the best candidates, increasing the number of endowed chairs, and staying ahead of the curve in investing in new core technologies.
- Encourage and support existing research faculty by protecting them from the growing burdens of the administrative component of research, strengthening the research infrastructure to enhance their research capabilities, and assisting them in identifying sources of funding and in developing grant proposals.
- Increase state, federal, philanthropic, school and medical center investment in research by aggressively and relentlessly pursuing existing, new and novel sources of funding.
- Identify and strengthen core facilities/infrastructure by focusing on space management, building new research space, and keeping pace with the latest research laboratory designs.

I am very optimistic and energized by our research roadmap. The plan is practical. It is highly dynamic and most adaptable, in that it can change as research evolves. Furthermore, it touches on the entire organizational infrastructure including policies, processes, structure and research direction, and is designed to improve the entire research enterprise from the bottom up.

There are so many opportunities that already exist for the School of Medicine to continue to enrich and expand its research enterprise. **The research roadmap is the thread that ties together all those who are committed to soaring to new heights. I encourage you to talk with your chair and/or director and your colleagues about this roadmap and about how you can become involved in achieving our goals, so that together, we will indeed soar to greater heights.**

You can access the research roadmap at http://medschool.umaryland.edu/researchroadmap.asp. In the relentless pursuit of excellence, I am

Sincerely yours,

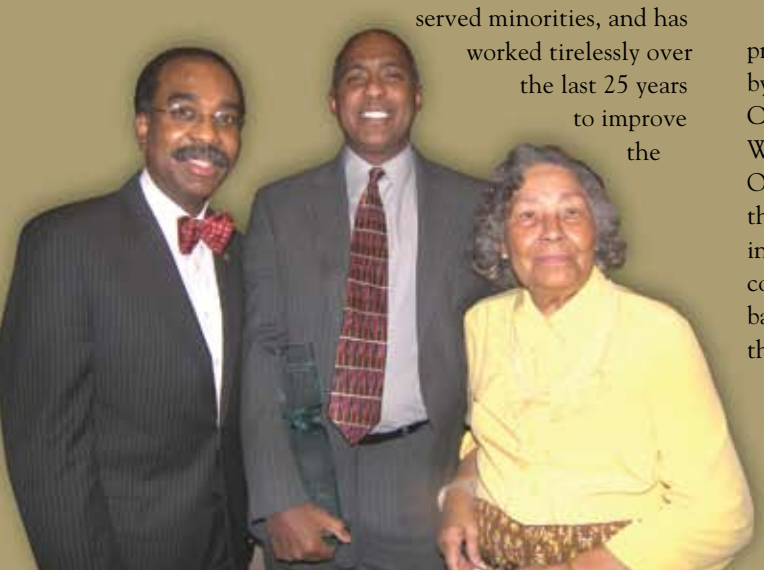
E. Albert Reece

E. Albert Reece, MD, PhD, MBA
Vice President for Medical Affairs, University of Maryland
John Z. and Akiko K. Bowers Distinguished Professor and Dean, School of Medicine

Dr. Hugh Mighty Receives UMB MLK Diversity Recognition Award

At the annual UMB Martin Luther King, Jr. Diversity Awards program, UMB President David Ramsay, Dean E. Albert Reece and Baltimore City Mayor Sheila Dixon, who was the event's keynote speaker, presented the Outstanding UMB Faculty/Staff Award to Hugh Mighty, MD, FACOG, MBA, associate professor and chair, Department of Obstetrics, Gynecology & Reproductive Sciences.

Dr. Mighty has devoted his life as a leader in medicine to the provision of necessary medical care for underserved minorities, and has worked tirelessly over the last 25 years to improve the quality of and access to health care for pregnant women, especially those at high-risk, throughout West Baltimore. It is his mission to provide medical care to underserved women who have prenatal complications, such as diabetes. Because of his specialized certification and training in high-risk maternal-fetal medicine and critical care medicine, he has brought to the community a unique set of talents that has resulted in many lives being saved. Dr. Mighty has been a pioneer and role model, demonstrating what open access health care delivery should be.



(L-R) Dean Reece, Dr. Hugh Mighty and his mother Gwendolyn Mighty pose at the UMB MLK Diversity Recognition Awards ceremony.

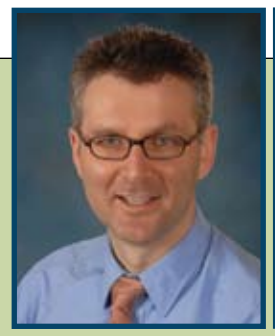
Dr. Mighty has further demonstrated his interest in providing equal access to medical care for at-risk women by not only championing the establishment of the Tamar Child and Chrysalis House Healthy Start programs in West Baltimore but by establishing the Department of Obstetrics, Gynecology & Reproductive Sciences as their principal medical provider. These programs allow incarcerated pregnant women to deliver their babies in a community setting and allows them to remain with their babies for the first year of the baby's life. As a member of the Governor's Perinatal Task Force, he has spearheaded a project of high-risk maternal-fetal telemedicine outreach throughout the state of Maryland, reaching women in areas that are underserved by maternal-fetal medicine specialists. Dr. Mighty has been a continuous force seeking improved access and facilities to support the delivery of medical care to a population often ignored.

The Honorable Sheila Dixon, mayor of Baltimore City, speaks at the event about the importance of change through diversity.

Dr. Mighty is a champion of diversity, inclusiveness and caring. Since his appointment as chair in September 2002, 75 percent of recruited faculty members have been underrepresented minorities and/or women. As a leader in the School of Medicine, Dr. Mighty continues his encouragement of underrepresented minorities and female medical students to pursue careers in obstetrics and gynecology.

The Diversity Recognition Awards are presented for individual and group achievements in the areas of diversity and inclusiveness. Each year, UMB schools and administrative units are asked to select an individual or group who has played a leadership role or been an integral part of the diversity effort at UMB. The awards represent equality, justice and opportunity for all people; the recipients serve as models of the ideals epitomized by the life and work of Dr. King.

Study Finds Advanced Imaging Enhances Treatment of Heart Rhythm Abnormality



Timm-Michael L. Dickfeld, MD, PhD

Stephen R. Shorofsky, MD, PhD

University of Maryland School of Medicine cardiologists are among the first in the world to combine advanced three-dimensional PET/CT imaging with standard techniques to treat ventricular tachycardia, a life-threatening electrical disorder that causes the heart to beat too fast. The imaging component offers the potential to improve precision and patient safety, reduce treatment time and boost the success rate of ablation therapy, which uses high-energy radio waves to redirect the heart's electrical pathway to prevent abnormal heart rhythms.

The usefulness of this sophisticated technology is confirmed in a University of Maryland School of Medicine study that was published in the January 2008 issue of the *Journal of the American College of Cardiology's Cardiovascular Imaging*. The study is the first to compare the combination of advanced high-resolution PET (positron emission tomography) and CT (computed tomography) images with traditional catheter-based electrical mapping of the heart to guide the ablation treatment.

"With this advanced imaging, before patients come for treatment, I know where the scar tissue causing the abnormal rhythms is located," said principal investigator Timm-Michael L. Dickfeld, MD, PhD, assistant professor, Department of Medicine. "The PET/CT imaging has the potential to reduce the time patients spend in the electrophysiology lab by several hours," said Dr. Dickfeld, who is a cardiologist with expertise in image-guided electrophysiological procedures. "Additionally, the imaging should make the procedures more precise and more successful."

Medications are typically the first line of therapy for ventricular tachycardia, but their use is often limited by side effects and a reduction in effectiveness over the long term. Most patients diagnosed with ventricular tachycardia are given internal cardiac defibrillators that shock the heart to correct electrical abnormalities. Dr. Dickfeld indicates that while the electrical jolt does restore normal heart rhythm, some of these patients, who may require multiple shocks each day, live in fear of the next shock. He says radiofrequency ablation is an appropriate treatment for many of these patients. The goal is to reduce or eliminate the need for the defibrillator's jolts.

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Scars, which often form in the heart muscle after a heart attack, cause most of the spiraling electrical signals characteristic of ventricular tachycardia. The current "gold standard" method to determine scar location is called electrical or voltage mapping. A catheter with an electrode is inserted into an artery through the groin and guided to the beating heart. The probe detects variations in electrical signals as it is moved a few millimeters at a time. High voltage indicates normal cardiac tissue. Low or no voltage is associated with dead scar tissue. A computer compiles the data into a map which shows where to apply ablation to eliminate cardiac tissue in and near the scars.

CT imaging shows the heart's anatomy while PET imaging distinguishes between healthy and abnormal cardiac tissue by keying in on cellular function and metabolism. The combined result is revealed in 3-D images of both the inner and outer surfaces of the heart muscle and the coronary arteries. The imaging is currently used in combination with electrical mapping. Once the scars are defined, the imaging also helps improve the accuracy and efficiency of the ablation process.

The study looked at 14 patients who had PET/CT imaging prior to ablation for ventricular tachycardia. The goal was to determine its accuracy and feasibility compared to the traditional electrical mapping.

The study concluded that PET/CT imaging can accurately predict the location and extent of left ventricular scar tissue and the border between scarred and normal heart tissue. It also found that integration of a 3-D scar map into a clinical mapping system is feasible and shows additional scar data not available from voltage maps alone.

"Electrical mapping is a technique that helps us figure out what is going on with the heart's electrical system," said the study's senior author, Stephen R. Shorofsky, MD, PhD, professor, Department of Medicine. "The heart is a rather big place when you're down at the millimeter level trying to measure the electricity. The clarity and accuracy of PET/CT imaging may one day replace a major part of electrical mapping," said Dr. Shorofsky.

"What Do We Do?" The MD/PhD Program

The MD/PhD Program was established in 1985 with the purpose of educating physicians who would be equally comfortable in both basic science and clinical settings.

"Fast forward to 2008 and it's clear the MD/PhD Program is even more necessary when you take into account the results of a June 2007 *Journal of the American Medical Association* study that revealed a critical unmet need for physician scientists in the United States. The goal of our program is to train talented students to become physician scientists, where they can translate discoveries at the research bench and bring them into the clinical arena," explained Terry Rogers, PhD, director of the MD/PhD Program, and professor, Department of Biochemistry & Molecular Biology.

More than 100 students apply for the five MD/PhD spots available at the School of Medicine each year. Those who are accepted are able to complete their medical degree and a PhD in one of five fields: Biochemistry and Structural Biology, Molecular Medicine, Molecular Microbiology and Immunology, Neuroscience, or Epidemiology. "It's a long program, about eight years," Dr. Rogers said. "Typically they enter as medical students and take the two years of their pre-clinical course work. They then leave the medical school track to become PhD students for a period of usually three or four years. After defending their PhD theses they return to medical school to complete the last two years of their clinical training before continuing on to residencies and fellowships."

Nancy Malson, coordinator, (second from the left) and Terry Rogers, PhD, director, (third from the left) pose with current MD/PhD Program students Carl Deetz, PhD, MSIV, (far left), Aparna Kishor, MSII, Julie Brownley, MSII, and Amanda Mason, GSIII.

Dr. Rogers has made it a priority during his 11 years as head of the MD/PhD Program to put activities in place to help students see the relationship between research and clinical care. For example, in a longitudinal clinical rotation during the PhD years, students are teamed with clinical faculty to examine clinical problems related to their research. This experience provides an essential link between the students' ongoing research and clinical careers. Program Coordinator Nancy Malson manages this complex program which requires extensive interactions with many diverse groups, including medical school applicants, faculty, staff and administration in the School of Medicine and UMB's Graduate School.

Such training is very expensive, but the cost of that education is not taken on entirely by the MD/PhD students. "We pay their tuition and fees for medical school and graduate school and give them a stipend," said Dr. Rogers.

It is crucial that these students aren't so burdened with debt that they have to choose the more lucrative area of private practice. "The typical medical student has about $100,000 of debt. If they go to graduate school as well, that debt is even more," said Dr. Rogers. "Post-graduation these students will have a difficult time financially, pursuing research fellowships or going through the kind of apprenticeship that one needs in academia. We realized early on that if we are going to have a cohort of physician scientists who are going to populate these types of physician scientist positions, we need to level the playing field so they have minimal debt. Then they can pursue those research opportunities, which pay less than clinical careers."

Dr. Rogers admits he is sometimes asked if it's worth the money. "The return on investment from these talented students is very real," he declared. "They write and receive their own grants, thus paying for their own education through their grants. Frequently they make key new discoveries, allowing their principle investigators (PIs) to submit patent applications or write new grants. So even though we invest $240,000 in each student, the trickle-down effect of them receiving their own grants or their PIs getting a new million-dollar grant would more than cover that amount. And we've seen that happen many times. So the return on investment is palpable."

Discovering Success

One of the MD/PhD program's most recent successes is Joseph Markowitz, a 2007 graduate. "He came here as a first-year medical student and in his first summer rotation he exploited a computer program, a structural biology-based program called a docking program, capable of identifying chemicals as potential drugs for a target protein," explained Dr. Rogers. "Over the summer he screened 750,000 different chemicals, and he found a few of them that bound with high affinity. So subsequently, as a PhD student, he studied those candidates and showed through NMR [nuclear magnetic resonance] studies how they interacted with a protein target. Then, in cell biology experiments he showed that one chemical could actually stop cancer cells from dividing in the lab. That discovery led to the idea that this could be used as a drug in the treatment of melanoma."

Joseph Markowitz, MD, PhD

The drug Dr. Markowitz used in his research was already FDA-approved, but as a treatment for pneumonia, not cancer. "That led to submission of a fast-track request to the National Cancer Institute for a Phase-II clinical trial. It can go right to Phase-II because it's already an approved drug," said Dr. Rogers. "As a fourth-year medical student, at the end of his academic lifetime here, Markowitz's research was already translating into a clinical trial. That he went from a computer discovery all the way through the structural and cell biology to a new patent application for the school—and a grant—in his academic time here is rather remarkable. That's the kind of intellectual impact these students can have on the research and clinical enterprise. Put these talented, ambitious students into the right translational environment like that, and exciting things are going to happen."

New Breast Center Features All-Digital Equipment

Deirdre Coll, MB, BCh

The University of Maryland Breast Center opened with all-digital imaging technology and a staff of specialists who focus solely on breast health, including diagnosing and treating a full range of cancerous and benign breast conditions.

The center provides screening and diagnostic mammography, ultrasound and MRI (magnetic resonance imaging), genetic counseling for women who are at high risk for breast cancer and the latest treatment options for cancer and other disorders, such as benign breast tumors and breast pain.

The University of Maryland Breast Center is also one of the few centers to use exclusively all-digital mammography. This technology provides sharper images with greater contrast and has been shown to be better at detecting cancer in some women while emitting lower levels of radiation.

"We feel using all-digital mammography provides the best option for breast imaging, both in terms of accuracy and convenience for women. Digital mammography has been shown to be superior to traditional film mammograms in detecting breast cancer in women with dense breasts and women under the age of 50," said Deirdre Coll, MB, BCh, associate professor, Department of Diagnostic Radiology & Nuclear Medicine, and director of Breast Imaging at the University of Maryland Medical Center.

"Our multidisciplinary team approach allows us to make the best use of the technology at the Breast Center. We are committed to providing the best possible care to women who come in for routine screening and those needing diagnosis or follow-up for breast cancer," said Jean Warner, MD, assistant professor, Department of Diagnostic Radiology & Nuclear Medicine.

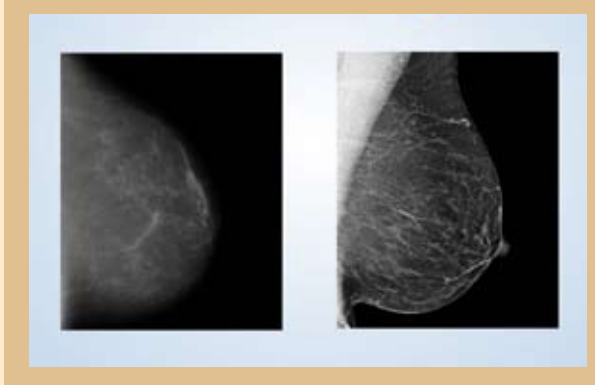
Dr. Warner says patients may prefer digital mammography. It takes less time than traditional mammograms since the technologist no longer has to wait for film to develop to confirm the image quality. With digital mammography, the images are viewed instantly on a computer.

"Digital mammography allows the radiologist to get a better look at the X-ray with the ability to optimize the image, such as magnifying it—the same benefits people see with images from their digital cameras. Digital mammograms are also stored electronically, so they take up less storage space," added Dr. Coll.

The Breast Center staff can scan and digitize a patient's previous film mammograms, so the radiologists can compare the images in the same digital format. The digital mammography system features computer-assisted detection software that looks for patterns of very small calcifications, masses or lumps in the breasts, another aid that may help catch cancer earlier.

"Digital mammography's computers can detect microcalcifications that form in the breast tissue of about half the women with breast cancer, often before tumors can be seen any other way. The computer cannot diagnose cancer, but it can provide a second pair of eyes, alerting the radiologist where to look more closely," said Reuben Mezrich, MD, PhD, professor and chair, Department of Diagnostic Radiology & Nuclear Medicine.

Film vs. Digital



A traditional film mammogram on the left, compared to a sharper, more detailed digital mammogram of the same breast, at right.

ultrasound equipment includes elastography, a non-invasive technique that shows promise in differentiating cancers from benign lesions. Elastography measures the elasticity of tumors, examining how the tumors move and stretch. Cancerous tumors react differently than benign lesions.

"In early tests, elastography has been nearly 100 percent accurate when compared to needle biopsy. For the 80 percent of women whose biopsy comes back as benign, elastography may spare them the pain and inconvenience of the needle biopsy," said Dr. Warner.

While elastography shows promise, the Breast Center will use it for now in conjunction with needle biopsy and will study its potential benefits for breast cancer diagnosis. In the future, Breast Center researchers will study tomosynthesis, a new technology similar to computed tomography (CT) that can rapidly take multiple pictures of breast tissue and reconstruct three dimensional images.

Women diagnosed with cancer at the Breast Center receive coordinated care from a multidisciplinary team of physicians from the University of Maryland Marlene and Stewart Greenebaum Cancer Center, which includes medical oncologists, radiation oncologists and breast surgeons. This collaboration ensures patients will be evaluated by a team of specialists to determine the best, and the fastest, treatment.

"Early detection of breast cancer improves the chances of better outcomes for breast cancer patients and increases cure rates. Working closely with the imaging specialists at the Breast Center, we are able to develop individualized treatment plans, which may include chemotherapy, surgery, radiation or a combination of therapies," said Katherine Tkaczuk, MD, associate professor, Department of Medicine, and director of the Breast Evaluation and Treatment Program at the Greenebaum Cancer Center.

The Breast Center staff also works with women diagnosed with benign breast conditions to find the best treatment options.

This technology provides sharper images with greater contrast and has been shown to be better at detecting cancer in some women while emitting lower levels of radiation.

Approximately 90 percent of women have a normal screening mammogram. Only about five in every 1,000 women screened are found to have cancer, and even in those with cancer, early detection can lead to a cure.

For women who need additional evaluation for breast cancer or other breast issues, the Breast Center offers a comprehensive array of testing, including ultrasound, MRI and the most advanced, minimally invasive imaging-guided biopsy techniques.

The Breast Center team will also investigate new techniques for diagnosing breast problems. The Breast Center's

Researcher Studies Genetics and Environmental Risk Factors for Breast Cancer

One dreadful reality of inheriting a genetic predisposition to breast cancer is that there is often no known cause of what would trigger the onset of the disease. BRCA1 (breast cancer susceptibility) is the name of one such gene that is altered in certain families with an inherited susceptibility to breast cancer. Women who have mutations in this gene often have particularly aggressive forms of breast cancer and very few treatment options. Several lines of experimental evidence suggest that certain chemicals in polycarbonate plastics can also increase the risk of breast cancer development. Laundette Jones, PhD, assistant professor, Department of Pharmacology & Experimental Therapeutics, is examining how the environment and certain genes affect a woman's chances of developing breast cancer. She anticipates that this line of research will lead to predictions about breast cancer risk from exposures to environmental compounds.

"In our lab, we are working to understand how mutations in BRCA1 in the mammary gland affects the body's response to synthetic estrogenic compounds found in the environment," said Dr. Jones. "Although the estimates for lifetime breast cancer risks among carriers of BRCA1 mutations is high, not every woman with BRCA1 mutations develops breast cancer. So that brings in environmental factors that might play a role. Being able to identify environmental factors as modifiers of breast cancer risk to predisposed populations is a key step to prevention. It's feasible that there are certain things women with this predisposition can do to lessen their risk of eventually developing these particularly aggressive forms of breast cancer."

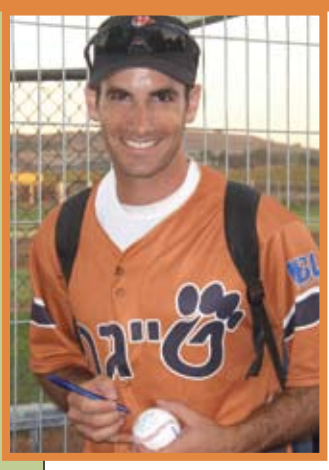
Laundette Jones, PhD

Animal studies done during her postdoctoral fellowship at Georgetown University indicated that BRCA1 mutant mice treated with estrogen tended to develop cancerous tumors more quickly than a control group of mice. "That finding made me realize that many synthetic chemicals in the environment called 'xenoestrogens' that mimic the effects of estrogen may also work with BRCA1 deficiency to accelerate breast cancer development," said Dr. Jones.

With funding from the Building Interdisciplinary Research Careers in Women's Health (BIRCWH) K12 program at the University of Maryland, Baltimore, Dr. Jones opted to investigate a common synthetic xenoestrogen called Bisphenol A (BPA). "Human exposure to this compound largely occurs through leaching from a variety of food packaging and consumer products, including polycarbonate plastic bottles, the lacquer inner coating of cans and restorative dental materials," she said. "Specifically, heating of cans to sterilize food, the presence of acidic or basic food or beverages in cans or polycarbonate plastics and repeated washing of polycarbonate products have all been shown to increase leaching of BPA. There is much to debate about the role of BPA in the development of breast cancer as well as many other xenoestrogens in the environment. Are these xenoestrogens safe or a potential threat?"

Dr. Jones's goal is to identify gene/environmental interactions that may help identify groups of women who may be at higher risk for breast cancer when exposed to certain chemicals. She also hopes to identify clues for new therapeutic treatments for these aggressive BRCA1 breast cancers.

PT Student is a Baseball Pro



Benjamin Engelhart

Benjamin Engelhart was only five years old the first time he picked up a baseball mitt, and in the years since he often dreamed of making it as a professional player. His talent caught the attention of local all-star teams, but when they tried to recruit Engelhart he more often than not had say no. "Being Sabbath-observant basically meant not being able to play on any of these teams," explained physical therapy student Engelhart, whose Jewish faith precludes him from participating in sports on Saturdays.

He managed to find teams that were specifically scheduled not to play on Saturdays, and even initiated the creation of a baseball team at his high school, the Hebrew Academy of Greater Washington (now the Melvin J. Berman Hebrew Academy), so he could keep playing. The schedule-juggling grew more complicated when Engelhart headed to the University of Maryland College Park, though, and he sometimes had to play softball rather than baseball in order to keep his faith and still play competitively. Yet he never gave up. "I always dreamed of playing professionally and even had a running joke about my obsession for baseball in the column I wrote for my high school newspaper," Engelhart revealed.

So Engelhart instead channeled his athletic interests into sports medicine, enrolling in the Department of Physical Therapy & Rehabilitation Science at the School of Medicine. Then an unexpected opportunity came his way via the newly formed Israel Baseball League, actually located in Israel itself. Engelhart went to open tryouts in Massachusetts, where he competed against star collegiate players and minor leaguers. "I received a letter after the tryouts telling me that my performance was good enough to be called back for another tryout," he recalled. "Then, out of the blue, I received an email with a contract attached. It was a great feeling!"

The Israel Baseball League started play in June 2007. It consisted of six teams, all newly put together, representing the Israeli cities of Netanya, Tel Aviv, Petach Tikva, Modiin, Raanana and Beit Shemesh. Players were collected from tryouts in Massachusetts, Miami, Los Angeles, Israel and the Dominican Republic. Not all were Jewish and not all were Sabbath-observant, although the league was. Engelhart played for Netanya. "We lost in the playoffs to the team that went on to win the championship," he said.

Engelhart had to take a leave of absence from school to play in the Israeli league, but he is now back working on his physical therapy internships. "When I came back I was one internship behind," he explained. "Currently I am completing the last three internships with my class and then making up my first one with next year's class in order to graduate in December 2008, only six months behind my classmates."

Fortunately, his time in Israel offered some opportunities to keep his skills up. "I spent time with the team physical therapist and trainer in order to maintain my knowledge base," Engelhart said. "I even visited a neuro clinic in Israel, which was an educational experience. Turns out, although they speak a different language, Israeli patients and treatments are very similar to ours here in the States."

Despite his experience, Engelhart plans to remain in the US rather than head back to Israel for another season. "I will announce my retirement," he joked. "This experience was the fulfillment of my childhood dream. I will always remember it and be grateful for the opportunity and leave it at that."

VIP Reception and Advance Screening of "21"

This event will benefit the University of Maryland School of Medicine and will feature a special appearance by the author, Ben Mezrich, son of Reuben Mezrich, MD, PhD, professor and chair of the Department of Diagnostic Radiology & Nuclear Medicine.

Thursday, March 27, 2008

5:00–7:00 pm VIP Reception • 7:30–9:00 pm Movie Screening

The Charles Theatre, 1711 N. Charles Street, Baltimore, MD

"21" was adapted from Ben Mezrich's nonfiction book *"Bringing Down the House: The Inside Story of Six M.I.T. Students Who Took Vegas for Millions."* It stars Jim Sturgess, Kate Bosworth, Laurence Fishburne and Kevin Spacey, who is also a producer.

Tickets are available for purchase by the UMB community; $150 apiece for the VIP reception and $50 apiece for the movie screening. For more information and to purchase tickets, contact Mary Cain, director of Special Events and Board Relations, at mcain@som.umaryland.edu or 6-3901.

SOMnews

University of Maryland School of Medicine March 2008 Vol.9 No.7

SOMnews is produced by the University of Maryland School of Medicine, Office of Public Affairs
▲ E. Albert Reece, MD, PhD, MBA, Vice President for Medical Affairs, University of Maryland, and Dean, School of Medicine ▲ Jennifer Litchman, Executive Editor ▲ Heather Graham, Managing Editor ▲ Sharon Boston, Caelie Haines, Becky Ceraul and Bill Seiler, Contributors ▲ Brushwood Graphics Design Group, Design ▲ Submitting information to SOMnews: Please email your submission six weeks prior to the month you wish to see your submission included to Jennifer Litchman, Assistant Dean for Public Affairs, at jlitchman@som.umaryland.edu. ▲ Printed using environmentally-responsible low VOC inks.

ANNOUNCING . . .

the return of Get Fit Maryland™! Mark your calendars for September 2008 for the start of this award-winning walking and fitness program! More details will follow in future issues of this publication.