

RSNA *News*



Burton P. Drayer, M.D., Joins the RSNA Board of Directors

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- Differences Found in Results of Screening Mammography in U.S. and U.K.
- Support Builds for Medical Malpractice Reform
- Radiologists Can Help Prevent Contrast-Related Nephropathy
- Online Searchability Faster, More Comprehensive for RSNA Journals
- RSNA 2003 Meeting Moments

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Lentle New RSNA President

Brian C. Lentle, M.D., was inaugurated on December 4 as RSNA's 89th president.

Dr. Lentle is a champion of radiology education and is dedicated to building international and domestic relationships to promote radiology.

Dr. Lentle has been a member of RSNA since 1993. He has served as a member of the Ethics Committee as well as the Futu-Rad Committee. In 1998, he was elected to the RSNA Board of Directors as the Liaison for Education. In 2002, he served as the chairman of the Board and was the primary advocate for the Society's strategic plan.

It was also Dr. Lentle who developed the theme for the 2004 RSNA Scientific Assembly and Annual Meeting—Radiology's Global Forum.

"It has been a great privilege to serve RSNA alongside so many distinguished colleagues," Dr. Lentle notes. "Radiologists in North America are fortunate in being so well served by strong organizations such as RSNA, the American College of Radiology (ACR), the Mexican societies and the Canadian Association of Radiologists (CAR). RSNA brings to our specialty a necessary mixture of vision and commitment to education and research. Our future will be determined by success in developing the next generation of radiologists and by the research needed to ensure the vitality of imaging as central to medical practice."

Dr. Lentle is a professor emeritus and former head of the Department of Radiology at the University of British Columbia.

He recently retired as chairman of the Department of Radiology at Vancouver General Hospital and is currently a consultant radiologist responsible for densitometry service at the Women's and Children's Health Centre of British Columbia.

Prior to moving to Vancouver, Dr. Lentle was a professor of radiology at the University of Alberta and director of the Department of Nuclear Medicine at Cross Cancer Institute in Edmonton.

Dr. Lentle has served as a reference radiologist for several national and international trials of osteoporosis treatment. His areas of interest and expertise include nuclear medicine, radiology, osteoporosis and the history of medicine.

He has published more than 130 peer-reviewed articles, has jointly edited three books and has

written 17 book chapters. He is currently a reviewer for *Canadian Association of Radiologists Journal*, *Canadian Medical Association Journal*, *The Journal of Rheumatology*, *The Journal of Bone and Mineral Research* and *Radiology*.



Brian C. Lentle, M.D.
2004 RSNA President

Dr. Lentle has received numerous awards including the Exhibit Gold Award from CAR, the Exhibit Silver Medal from the Society of Nuclear Medicine, and the Silver Jubilee

Medal from the Governor General of Canada.

In addition to his RSNA activities, Dr. Lentle is past-president of CAR and of the Pacific Northwest Radiological Society. He has specialty qualifications in radiology and nuclear medicine from the Royal College of Physicians and Surgeons in Canada and is an ACR fellow.



2004 RSNA President Brian C. Lentle, M.D., received the presidential gavel from 2003 RSNA President Peggy J. Fritzsche, M.D.

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Hattery Named RSNA Chairman

Robert R. Hattery, M.D., is the 2004 RSNA chairman of the Board.

Dr. Hattery, who was elected to the RSNA Board of Directors in 1998, is the executive director of the American Board of Radiology (ABR), a position he assumed in July 2002.



Robert R. Hattery, M.D.
2004 RSNA Chairman

Dr. Hattery has been a familiar face at national meetings, with numerous presentations of papers and education exhibits. He has made many contributions to peer-reviewed literature, book chapters and syllabi, focusing on urography, com-

puted tomography, ultrasound and diseases of the urinary tract.

"I finished my residency training in 1970 and had several excellent mentors," Dr. Hattery recalls. "I was advised repeatedly to get involved in organized radiology at the national level to learn, to contribute to the specialty, to share knowledge through investigation, to meet current and future leaders, and to

network with other radiologists who shared my passion for urology."

For more than three decades, Dr. Hattery taught, administrated and served at Mayo Clinic, Mayo Medical School and Mayo Graduate School of Medicine in Rochester, Minn. Dr. Hattery advanced from an instructor in 1973 to professor of diagnostic radiology in 1982. From 1981 to 1986, he was chairman of the Department of Diagnostic Radiology. Before accepting the position at ABR, he held more than a dozen administrative positions at Mayo, including serving as a member of the Mayo Foundation Board of Trustees, and was chairman of the Board of Governors and CEO from 1994 to 1998.

"Although I am a diagnostic radiologist by training and experience, I am first a physician," Dr. Hattery notes. "I believe strongly in radiology by radiologists, not for the sake of our specialty or us as individuals, but for the needs of our patients. In the final balance, the needs of our patients come first."

Dr. Hattery was the RSNA Board's Liaison for Publications and Communications, a position that includes chairmanship of the Publications Council and membership in the Society's Public

Information Advisors Network, and which oversees the Public Information Committee and the Public Information Web Site Committee, a joint effort with ACR (www.RadiologyInfo.org). He also has served on the editorial board for RSNA's journal *RadioGraphics* and was a scientific reviewer for the journal *Radiology*.

"The opportunity to be involved with the RSNA leadership has allowed me to gain a broader perspective of radiology, experience first-hand the wisdom of my mentors and reinforce the opinion that I'm lucky to have chosen this specialty for a career," Dr. Hattery says. "I have the desire to give back to radiology some measure of payment for what I have been given. RSNA has helped me do that."

Dr. Hattery received his bachelor's and medical degrees from Indiana University. He interned at Parkland Memorial Hospital in Dallas and was subsequently a fellow in diagnostic radiology at the Mayo Graduate School of Medicine in Rochester, Minn. In 1970, he was the chief resident in diagnostic radiology at Mayo.

Hussey Becomes RSNA President-Elect



David H. Hussey, M.D.
2004 RSNA President-elect

David H. Hussey, M.D., will serve as the Society's president-elect in 2004.

Dr. Hussey, who was elected to the Board in 1998, is a clinical professor in the Department of Radiation Oncology at the University of Texas Health Science Center in San Antonio. He had previously been director of the Division of Radiation Oncology at the University of Iowa College of Medicine and professor of radiotherapy at the University of Texas M.D. Anderson Hospital and Tumor Institute in Houston.

"I was one of the last radiation oncologists to be trained as a general radiologist," says Dr. Hussey. "Shortly after I completed training, the two specialties split and radiation oncologists started their own society."

Dr. Hussey notes that over time, the number of radiation oncologists in RSNA has diminished and the size of the radiation oncology program at RSNA has gone down proportionately. "However, in recent years the two specialties have come closer together and there is a need for

cross-fertilization between the two," he says. "In the coming year, I would like to increase involvement of radiation oncologists at our annual meeting, in participation and attendance, and their membership in RSNA."

Dr. Hussey said he would also like to help strengthen RSNA's strategic planning process, developed by the Board of Directors in 2001. Goals for the Society were established and objectives were written for each goal. Strategies were then developed to accomplish the objec-

tives, to be evaluated each year as part of RSNA's planning process.

"During the coming year I would like to develop a more sophisticated system of assessing what is being accomplished for each objective within the strategic plan," Dr. Hussey says.

Dr. Hussey's other areas of interest include graduate medical education, altered radiotherapy fractionation schedules, early and late normal tissue radiation injury in large animals, head and neck and genitourinary cancer, and fast neutron radiotherapy. He has published more than 120 peer-reviewed papers and authored more than 38 chapters and textbooks.

He has served as president of the American Radium Society, the American Society for Therapeutic Radiology and Oncology, and the Gilbert H. Fletcher Society. Dr. Hussey was a trustee of the American Board of Radiology. He has also served on a variety of committees for the American College of Radiology and has been a member of the radiation study section for the National Cancer Institute.

Dr. Hussey has served on several RSNA committees, including the Scientific Program Committee Subcommittee on Therapeutic Radiology and Radiobiology, which he chaired from 1992 to 1995, Inter-Society Council for Radia-

tion Oncology (ISRO), Meeting-related Publications Committee, Refresher Course Committee and Ad Hoc Strategic Planning Committee.

Dr. Hussey graduated from the Washington University School of Medicine in St. Louis. After completing his internship and residency at the University of Iowa Hospitals and Clinics, he was named a fellow in radiotherapy at the University of Texas M.D. Anderson Hospital and Tumor Institute, and was in charge of the fast neutron radiotherapy program using the Texas A&M Variable Energy Cyclotron.

Drayer Joins RSNA Board of Directors

One of the world's leading authorities on the use of CT and MR imaging for the diagnosis of neurological disorders has been elected to a six-year term on the RSNA Board of Directors.

Burton P. Drayer, M.D., is the Board Liaison-designate for Annual Meeting and Technology.

"I am truly honored to have the opportunity to serve my fellow radiologists," says Dr. Drayer. "I hope as a Board member I can enhance the educational and research missions of RSNA, as well as share my zeal for clinical excellence, technical innovation, financial responsibility, and interspecialty collaboration and translation."

Dr. Drayer is the president of Mount Sinai Medical Center in New York City and the executive vice-president for hospital and clinical affairs. He is also the Dr. Charles M. and Marilyn Newman Professor and chairman of the Department of Radiology at Mount Sinai.

His specialties are diagnostic radiology and neurology. His interests range from imaging neurodegenerative and demyelinating disorders and the aging brain, to contrast media safety and utilization of CT and MR imaging for functional brain imaging. He is board certified in both radiology and neuroradiology, and has a certificate of added qualification in neuroradiology.

In addition to his multiple publications describing the pathoanatomic applications of CT and MR imaging, he has played a seminal role in the creation and development of unique metabolic and physiologic techniques using CT and/or MR imaging to measure cerebral blood flow and volume, cerebrospinal fluid circulation, blood-brain barrier permeability, phosphorus metabolism, brain iron accumulation and MR angiography.

He received his undergraduate degree in political science from the University of Pennsylvania in Philadelphia. He earned his M.D. degree at the University of Health Sciences/The Chicago Medical School in Chicago. After completing an internship and neurology residency at the University of Vermont in Burlington, he entered a radiology residency and neuroradiology fellowship at the University of Pittsburgh.

An RSNA member and dedicated volunteer since 1980, Dr. Drayer has been the chairman of the Public Information Committee and has participated in numerous public information activities. He was the 2003 RSNA first vice-president.

Dr. Drayer is a past-president of the American Society of Neuroradiology (ASNR), a founder of the Neuroradiology Education and Research Foundation of ASNR, and a fellow of the American College of Radiology and the American Academy of Neurology. He is past-president of the New York Roentgen Society.

He is a dedicated teacher and a sought-after lecturer in North America and throughout the world.

Dr. Drayer has published more than 200 journal articles, 39 book chapters and two books. He is or has been a manuscript reviewer for nine medical journals, including *Radiology*, *New England Journal of Medicine*, *American Journal of Neuroradiology* and *Journal of Magnetic Resonance Imaging*. Dr. Drayer has been the consulting editor of *Neuroradiology Clinics of North America* for the past decade.



Burton P. Drayer, M.D.
2004 Board Liaison-designate for Annual Meeting and Technology.

RSNA Grant Recipient Earns NCI/NASA Contract

Gang Zheng, Ph.D., a 2002 RSNA Research Seed Grant recipient, has been named the principal investigator of a three-year, \$2 million contract from the National Cancer Institute (NCI) and the National Aeronautics and Space Administration (NASA). The contract was awarded to the University of Pennsylvania for "Fundamental Technologies for Development of Biomolecular Sensors."

"My RSNA grant played a significant role in helping us to get this project," says Dr. Zheng. "The support from my RSNA project, 'Receptor-Targeted NIR Fluorescent Imaging of Tumors with Reconstituted Low-Density Lipoprotein (LDL),' enabled us to acquire critical preliminary data for this contract, which will provide targeted delivery of MR imaging agents, NIR fluorescence probes and photodynamic therapy agents to tumors via LDL receptors and glucose transporters."



Gang Zheng, Ph.D.

Dean Steps Down as Deputy Director of NIBIB

Donna J. Dean, Ph.D., deputy director of the National Institute of Biomedical Imaging and Bioengineering (NIBIB), has stepped down to become a senior scholar in residence at the National Academy of Engineering (NAE).

"It was my great privilege to work with a stellar group of staff who built a firm foundation for NIBIB's future. I will always be proud of the pivotal role that I played in creating a new institute at NIH that has unlimited potential to foster new arenas of research. I have never had so much fun in my career, nor worked so hard, as in the past three years. ... It truly was a stimulating and exciting endeavor," said Dr. Dean.

Belinda Seto, Ph.D., will be her replacement. More information on Dr. Seto will appear in the February issue of *RSNA News*.



Donna J. Dean, Ph.D.

New NIH Deputy Director for Extramural Research

Norka Ruiz Bravo, Ph.D., has been named deputy director for extramural research at the National Institutes of Health (NIH). Her official title is director of the NIH Office of Extramural Research. The office is NIH's focal point and voice for all policies and guidelines for extramural research grants, which represent approximately 85 percent of the NIH budget.

Dr. Ruiz Bravo has been with NIH since 1990. Her most recent role was as associate director for extramural activities at the National Institute of General Medical Sciences.



Norka Ruiz Bravo, Ph.D.

Hanson Earns ACS Award

Wayne R. Hanson, Ph.D., director of the RSNA Department of Research, is the recipient of the 2003 St. George National Award from the American Cancer Society (ACS).

Dr. Hanson has been an ACS volunteer for 15 years, and is the immediate past-president of the ACS Illinois Division Board of Directors.

"With this award, we take great pleasure in recognizing your distinguished and exemplary leadership, your years of service and your commitment to the American Cancer Society," said ACS Chairman David M. Zacks.



Wayne R. Hanson, Ph.D.

Keusch Leaves Fogarty International Center

Gerald T. Keusch, M.D., director of the Fogarty International Center (FIC) and associate director for International Research at NIH,

has resigned his position to become the assistant provost for global health at the Boston University Medical Campus and associate dean

for global health at Boston University School of Public Health.

Sharon Hrynkow, Ph.D., who has served as FIC

Deputy Director since 2000, is now acting director of the center.

RSNA News

Send your submissions for *People in the News* to rsnanews@rsna.org, (630) 571-7837 fax, or *RSNA News*, 820 Jorie Blvd., Oak Brook, IL 60523. Please include your full name and telephone number. You may also include a non-returnable color photo, 3x5 or larger, or electronic photo in high-resolution (300 dpi or higher) TIFF or JPEG format (not embedded in a document). *RSNA News* maintains the right to accept information for print based on membership status, newsworthiness and available print space.

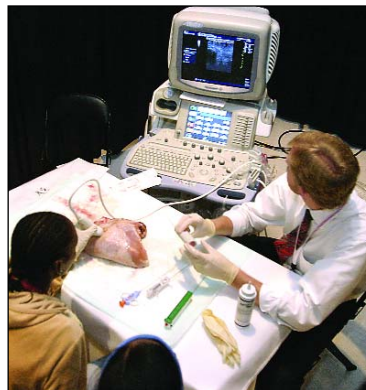
Chicago Teenagers Learn about Careers in Radiology

Forty Chicago Public High School students participated in the RSNA 2003 “Exploring Your Future in Radiology” program. The high school juniors spent the day at McCormick Place listening to a series of lectures and taking part in a hands-on workshop with William E. Shiels II, D.O. They also toured the technical exhibits and learned about different career opportunities from:

- Robert A. Novelline, M.D., professor of radiology at Harvard Medical School
- Kate Little, R.N., president of the American Radiological Nurses Association
- Becky Kruse, R.T.(R), director of continuing education for the American Society of Radiologic Technologists
- James C.H. Chu, Ph.D., chairman of the Department of Medical Physics at Rush University

These students will now compete for scholarships.

Three students who participated in the inaugural program at RSNA 2002 were each presented with a \$1,000 scholarship from RSNA. They are Rhoda Faye T. Tomines from Sullivan High School, Annie Lam from Sullivan High School and Brittany Briggs from Kenwood Academy. The scholarship winners prepared an essay about their experience at RSNA 2002 and completed a 100-question quiz.



(top and bottom left) The high school students used ultrasound to find an olive in a turkey breast. (bottom left) The students were given Geiger counters to examine during their introduction to the world of radiology.

ARRT to Launch RA Certification Program

The American Registry of Radiologic Technologists (ARRT) says it plans to launch its certification program for radiologist assistants (RAs) in the fall of 2005.

The comprehensive RA certification program is being developed by a committee of physicians and radiologic technologists. ARRT President Edward I. Bluth, M.D., says the committee is charged with putting “all the pieces in place to assure that the RA is appropriately educated,

credentialed and accepted by the healthcare community and regulatory bodies.”



ARRT’s program will be built on the education-ethics-examination model that characterizes its other certification programs in radiologic technology.

More information is available in the RA Update section of www.rrt.org.

A focus session at RSNA 2003 addressed the RA issue. A feature article will appear in the February issue of *RSNA News*.

RSNA 2003 Materials Available Online

For a limited time, some of the scientific materials from RSNA 2003 will be available online at www.rsna.org/rsna/. This includes some of the digital scientific sessions, Mobile Computing Pavilion presentations, Sunday Image Interpretation Session, and links to handouts from some of the refresher courses. The posted material is not available for AMA PRA category 1 credit.

In early spring, the RSNA 2003 Cases of the Day and some of the refresher courses will be available for AMA PRA category 1 credit via InteractED (www.rsna.org/education/interactive/index.html).

To check on the availability of the RSNA 2003 syllabi, CD-ROMS and Internet programs, go to the RSNA Online Catalog at www.rsna.org/education/catalog.

Guglielmi Completes RSNA Editorial Fellowship

The 2003 RSNA Editorial Fellow, Giuseppe Guglielmi, M.D., from San Giovanni Rotondo, Italy, completed his one-month fellowship in early December.

He worked closely with *Radiology* Editor Anthony V. Proto, M.D., *RadioGraphics* Editor William W. Olmsted, M.D., and the RSNA publications, advertising, and marketing and communications staff to learn about the editorial process as well as journal production.



Giuseppe Guglielmi, M.D.

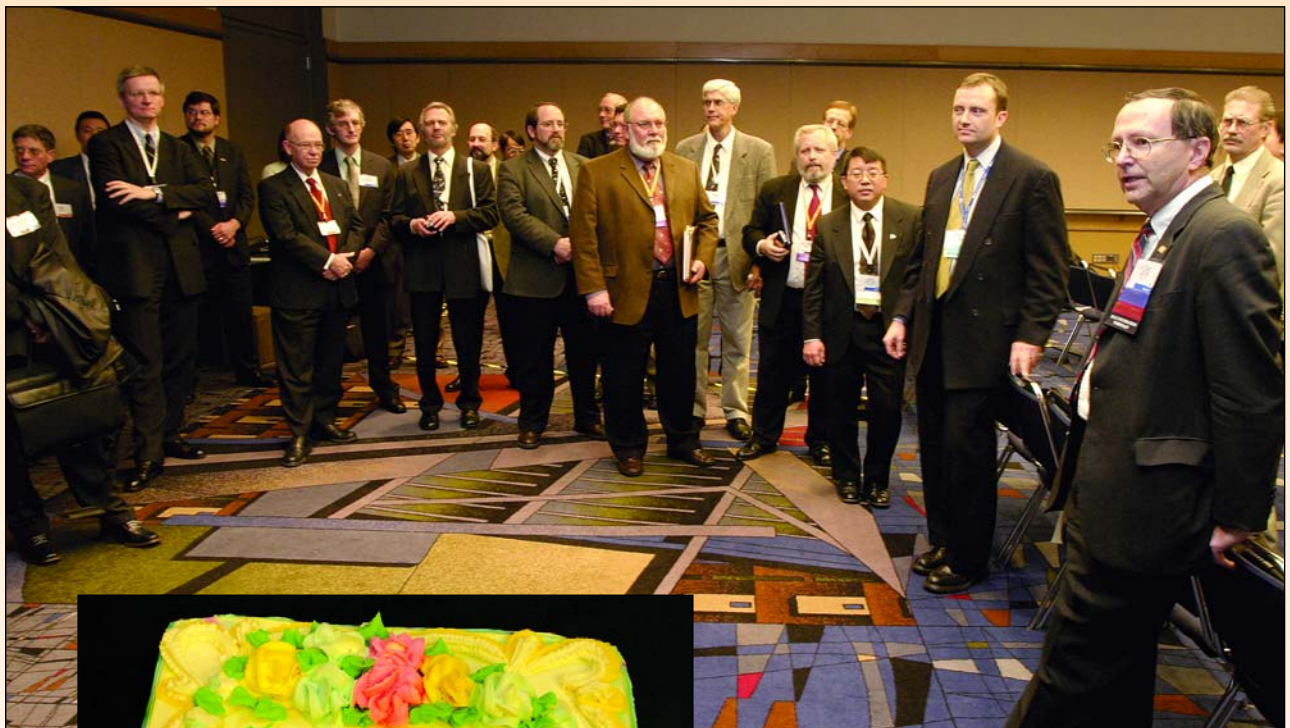
HIPAA Complaint Form Available

The American Medical Association (AMA) has launched a HIPAA Complaint Form (HIPAACF) designed to collect information from physicians about non-compliance by health plan and third-party payers with the Transaction and Code Set Standards of the Health Insurance Portability and Accountability Act (HIPAA).

The American College of Radiology is among the 16 specialty, state and county medical societies promoting the use of HIPAACF.

For more information, go to www.ama-assn.org/ama/noindex/category/11149.html.

DICOM Celebrates Anniversary



R. Gilbert Jost, M.D. (right), RSNA Board Liaison for Annual Meeting and Technology, helped celebrate the 20th anniversary for the Digital Imaging and Communications in Medicine (DICOM) standard. Twenty years ago, representatives for medical professionals and medical equipment manufacturers sat down for an historic meeting to develop standards to assure interconnectivity of electrical equipment used for medical imaging. The first standard was published 10 years later. Over the years, the range of applications of the DICOM standard has expanded dramatically, and its acceptance has spread around the world.

 **DICOM**SM
Digital Imaging and Communications in Medicine

Differences Found in Results of Screening Mammography in U.S. and U.K.

Breast cancer detection rates are similar in the United States and the United Kingdom, but the costs in terms of callbacks, noninvasive testing and surgical biopsies are significantly higher in the United States, according to a study in the October 22-29 issue of *The Journal of the American Medical Association*.

“We’re finding cancer the same way, but in order to find those cancers, we do a lot more non-invasive tests—a lot more ultrasounds, diagnostic ultrasounds, diagnostic mammograms and biopsies,” says lead author Rebecca Smith-Bindman, M.D., an associate professor of radiology, epidemiology and biostatistics at the University of California, San Francisco (UCSF). “In addition, in every category we looked at, the recall rate is about twice what it is in the U.K.”

The researchers also found that British physicians are more likely to use less-invasive needle biopsies, while American physicians are more likely to use surgical biopsies. “When we probed a little further, it turned out that the surgical biopsies that result in cancer—the positive ones—were the same in the two countries, but the negative surgical biopsies were two to three times higher in the United States,” explains Dr. Smith-Bindman.

For the study, Dr. Smith-Bindman and her colleagues compared data from three large-scale mammography registries or screening programs: The Breast Cancer Surveillance Consortium and the National and Cervical Cancer Early Detection Program in the United States; and the National Health Service Breast Screening Program in the United Kingdom. A total of 27,612 women,

age 50 years and older, were diagnosed with breast cancer—invasive or ductal carcinoma in situ (DCIS)—within 12 months of screening.

British women undergo screening mammography about every three years, while American women undergo screening mammography about every 18 months. The authors project that if you screen a thousand women over 10 years in the United States, nearly half will be recalled. In the U.K., the rate would be about 17 percent. The difference in the recall rate is due to both higher rates of recall at each mammographic examination as well as the more frequent screening in the United States. What was interesting, she says, is that total cancers detected and types of cancers detected were very similar.

Dr. Smith-Bindman says more frequent screening likely translates to smaller average cancer size at diagnosis, as evidenced by the slightly lower rates of invasive cancer of 10 mm or more, and the higher rates of in situ cancer diagnosed in the United States. “We’re diagnosing more DCIS in the United States,” she says. “DCIS is very easy to see and it’s easy to detect calcifications, but that’s not what we’re supposed to be finding. The biggest benefit of mammography is in finding more small, invasive cancers, and that was not very different between the two countries.”

Dr. Smith-Bindman gives several possible explanations for the differences in recall rates, including the litigious atmosphere that permeates American medicine. But she says she believes the primary force behind the U.K.’s improved screening efforts has been the implementation of a central-



Rebecca Smith-Bindman, M.D.
University of California, San Francisco

ized quality assurance program that carefully monitors data to enable a comparison of their recall and cancer detection rates with other programs.

“I would argue that even if medical malpractice is one reason we’re performing in this way, perhaps having an organized quality control program where we say, ‘look, these are the targets we need to hit,’ would almost certainly improve the quality of mammography.” Dr. Smith-Bindman says, adding that British radiologists interpret more mammograms and do more double-readings than do American mammographers.

A Difference of Opinion

The UCSF study is drawing strong disagreement from the president of the Society of Breast Imaging, D. David Dershaw, M.D. “The quality of breast cancer screening cannot be measured by the recall rate or the cancer detection rate. Although these are important

Continued on next page

Continued from previous page

considerations, it is the rate of detection of small, early stage, node negative tumors that translates into saved lives," he says. "DCIS plays the same role in the breast that adenomatous polyps do in the colon."

Furthermore, Dr. Dershaw believes that moving closer to a U.K.-style system would be the last straw for many radiologists who are already disenchanted with mammography screening. "To be totally practical about the whole thing, if you further regulate screening mammography and add more requirements that need to be met, the way medicine is organized in the United States, screening mammography will disappear because nobody's going to do it," he says.

"Malpractice does help to drive the callback and biopsy rates," acknowledges Robert Smith, Ph.D., director of cancer screening for the American Cancer Society. "We are practicing in an environment that makes achieving the sensitivity that we're achieving with a lower callback rate very difficult. If you've got a very, very sensitive screening tool like mammography, and if you take a more aggressive approach to periodic screening, which results in an average interval of about 18 months in this country—you're going to find more DCIS. Your only option to avoid detecting DCIS is not to be screened, or to not act on lesions that you think have a high probability of being DCIS. But some of those are going to be invasive cancers or aggressive DCIS lesions. Now, they may make that decision in the United Kingdom, but we're very reluctant to make that decision here."

In two studies recently published in the *European Journal of Cancer*, Dr. Smith and his colleagues reported that

The quality of breast cancer screening cannot be measured by the recall rate or the cancer detection rate. . . . It is the rate of detection of small, early stage, node negative tumors that translates into saved lives.

—D. David Dershaw, M.D.

most of the reduction in mortality from mammography screening occurs as a result of the early diagnosis of invasive carcinoma and that the detection of DCIS within a screening program, while worthwhile, contributes in only a minor way to the mortality reduction gained by screening.

"Some people have actually postulated that as mammography becomes increasingly sensitive, we will be able to go further beyond down-staging from advanced disease to localized disease and move from local disease to in situ disease. You would then have a model very similar to cervical cancer, and you would be trying to find disease before it became invasive," Dr. Smith says. "But the data dispute that because the duration that breast cancer remains

as a detectable DCIS lesion is very short. You don't get a lot of bang for the buck from finding DCIS in terms of reducing mortality."

Dr. Smith advocates treating breast cancer screening as a public health program, as it is done in Great Britain and British Columbia, but agrees that placing additional requirements on radiologists without improvement in incentives in today's environment would be counterproductive. "Yet, imagine a model where radiologists who were really interested in doing mammography were well rewarded," he hypothesizes. "These higher rewards would come as a result of demonstrated proficiency and a multispecialty approach to breast cancer that resulted in much better patient outcomes than we see today. Imagine also that we could link this degree of specialization and accuracy to a reduced risk of malpractice and, even more to the point, imagine how much greater the advantages would be to women in this country." □

Estimated Number of Women With at Least 1 Recalled Examination, Cancer Diagnosis, or Biopsy During 10 Years *

	Rate per 1000 (95% Confidence Interval)		
	BCSC	NBCCEDP	NHSBSP
No. of women screened	1000	1000	1000
Time between screening examinations, mean, mo	18	19	36
Aged 50 to 59 years			
Cancer detected	24.5 (19.9-30.7)	23.8 (19.1-28.9)	19.4 (17.5-21.4)
In situ	5.8 (5.0-8.3)	7.4 (5.2-9.9)	3.8 (3.3-4.5)
Invasive	19.0 (15.0-24.1)	16.4 (12.9-20.7)	15.3 (13.9-17.0)
Women recalled	476.6 (441.7-515.1)	432.8 (402.4-469.1)	174.5 (164.9-183.8)
Biopsy	79.0 (69.2-89.8)	113.2 (102.7-129.7)	49.3 (45.8-52.0)
Open surgical biopsy †	29.0 (23.5-35.8)	‡	14.5 (13.4-15.6)
Aged 60 to 69 years			
Cancer detected	31.5 (26.3-37.8)	26.6 (20.7-34.2)	27.9 (24.1-32.3)
In situ	7.0 (5.3-9.2)	9.2 (5.9-12.9)	5.2 (4.0-6.7)
Invasive	24.7 (20.5-30.0)	18.0 (13.4-23.5)	22.7 (19.7-26.6)
Women recalled	396.0 (354.9-435.4)	333.7 (302.7-365.5)	132.6 (122.6-144.8)
Biopsy	71.7 (63.0-82.0)	83.9 (74.8-95.4)	43.4 (36.9-48.7)
Open surgical biopsy †	26.9 (22.4-32.8)	‡	12.4 (10.9-14.4)

Abbreviations: BCSC, Breast Cancer Surveillance Consortium (US); NBCCEDP, National Breast and Cervical Cancer Early Detection Program (US); NHSBSP, National Health Service Breast Screening Program (UK).

* The time between mammograms was assumed to be the mean interval observed in each setting. Data are estimated intervals in variation around these estimates and were calculated for the cancer detection, recall, and biopsy rates and varying the screening interval from 16 to 20 months (BCSC), 17 to 21 months (NBCCEDP), and 33 to 39 months (NHSBSP).

† Open surgical biopsies are a subset of all biopsies.

‡ The type of biopsy could not be determined from the NBCCEDP data and for 3 of the BCSC sites.

(JAMA 2003;290:2129-2137) Copyrighted ©2003, American Medical Association. All rights reserved. Printed with permission.

Support Builds for Medical Malpractice Reform

Having almost made it over the congressional hump last session, advocates of medical malpractice tort reform are ready for victory in 2004.

Radiology groups will be pushing hard for the bill to pass because radiologists who fail to diagnose breast cancer on a mammogram are among those facing the most malpractice lawsuits, according to Leonard Berlin, M.D., chairman of the department of radiology at Rush North Shore Medical Center in Skokie, Ill.

The Physicians Insurers Association of America (PIAA) does not keep statistics on the number of malpractice lawsuits filed against radiologists or any other specialty. Nor does it compute average jury awards. The American College of Radiology (ACR) doesn't collect those numbers either. But Dr. Berlin cites somewhat dusty PIAA statistics from a survey of insurance company payouts to medical malpractice plaintiffs between the years 1985-1995. During that period, the total of all the average indemnifications for all specialties doubled, from \$87,000 to \$180,000. For radiologists alone, average indemnification nearly tripled from \$46,000 to \$133,000.

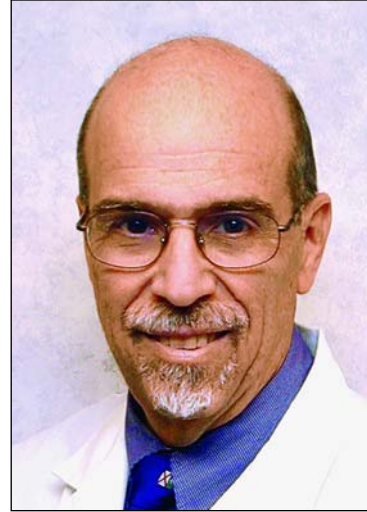
The frequency with which radiologists get caught in the crosshairs of a malpractice lawsuit explains the answer ACR General Counsel Bill Shields, C.A.E., received when he made a phone call in 2002 to The Doctors Company, an insurance company formed by surgeons.

Shields asked if the company would set up a malpractice insurance program for ACR. "I was told they were not interested in radiology," he states.

Joan Bristow, vice-president of risk management services at The Doctors



Bill Shields, C.A.E.
American College of Radiology



Leonard Berlin, M.D.
Rush North Shore Medical Center

Company, explains: "Radiologists are reviewing a high volume of x-rays, mammograms, etc. With such high volume come mistakes."

She adds that teleradiology is making the situation more complex. "Take the instance where a California radiologist reads at his home or office computer in California, but it's a New York patient being treated in New York. Guess which court he gets dragged into? Yes, New York. Say goodbye to the California insurance caps, fast track, etc.," she explains.

The legal assault against radiologists stems, in good part, from public misperceptions about the accuracy of mammography, according to Dr. Berlin. He says organized medicine has oversold mammography. "It is not unusual to hear physicians tell patients that mammograms can reveal existing cancer 90 percent of the time. So women become understandably angry and litigious when a physician discovers a lump and it proves cancerous even though the woman had a recent, osten-

sibly clear mammogram," he explains. "In up to two-thirds of the cases when a later mammogram shows a cancer and the woman brings in an earlier mammogram, at least a suggestion of the tumors can be found in retrospect."

"Mammography is an art, not a science, and the public needs to understand that," says Dr. Berlin. "Tissue calcifications can be very fine and difficult to see and architectural distortions can be very nebulous. There are varying degrees of tissue density in the breast," he says.

Patients First Act

A bill that moved to the Senate last July after passing the House in March would reduce the size of malpractice judgments against radiologists. The Patients First Act of 2003 (S.11), sponsored by Senator John Ensign (R-Nev.), was supported by 49 senators and opposed by 48. Because of parliamentary rules, 60 votes were needed for the bill to overcome a threatened filibuster

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that would have undermined passage.

The Patients First Act of 2003, called the HEALTH Act (H.R. 5) in the House, would cap awards by limiting non-economic damages, such as pain and suffering, to \$250,000, and punitive damages to twice the amount of economic damages or \$250,000, whichever is greater.

Punitive damages would be further constrained by limiting the circumstances under which they may be sought. Economic, or compensatory, damages would not be limited. Attorney fees would be restricted based on the size of the award. The bill would impose a statute of limitations requiring that lawsuits begin within three years after the occurrence of the injury alleged to have happened as a result of malpractice or one year after the claimant discovers—or should have discovered—the injury, whichever occurs first. The liability of each defendant would be limited to the share of damages attributable to his or her responsibility.

The bill is based on California's Medical Injury Compensation Reform Act, which was signed into law by Democratic Governor Jerry Brown.

According to data of the National Association of Insurance Commissioners, the rate of increase in medical professional liability premiums in Califor-

nia since 1976 has been a very modest 167 percent, compared to the rest of the United States, which experienced a 505 percent increase.

The main sticking point in the Senate was the \$250,000 limit on pain and suffering. Senator Dianne Feinstein, (D-Calif.) proposed a compromise figure of \$500,000, but Donald J. Palmisano, M.D., J.D., president of the American Medical Association (AMA), says, "We've never seen any evidence that a \$500,000 cap would stabilize premiums."

Democrats said they opposed the Ensign bill mainly because they disputed the notion that big judgments for pain and suffering were the cause of the precipitous increase in malpractice premiums. However, a General Accounting Office (GAO) report published in August to which senators had access during their floor debate, said that in seven states studied, the greatest contributor to increased premium rates since 1998 appeared to be increased losses for insurers on paid medical malpractice claims. The report also substantiated that malpractice premiums rose less dramatically in states with \$250,000 caps on pain and suffering.

"For example, from 2001 through 2002, average premium rates rose

approximately 10 percent in states with noneconomic damage caps of \$250,000, compared with approximately 29 percent in states with more limited tort reforms," the report said.

However, the GAO report disputed claims by the AMA that escalating malpractice rates were forcing physicians to get out of medicine or to relocate to states with better tort climates.

For supporters of medical malpractice liability reform, their job this year will be to do a better job of linking high malpractice premiums to loss of medical services for people beyond just a few rural communities.

Dr. Berlin was the instructor of a refresher course at RSNA 2003, titled "Malpractice Lawsuits: What Gets You Into Them, What Keeps You Out of Them, and What is Their Economic Impact?" He was also the moderator of a Special Focus Session, titled "Is Malpractice Tort Reform Really Necessary?"

RSNA and ACR have each contributed \$25,000 to the Fund for America's Liability Reform, spearheaded by the AMA, in support of federal tort reform efforts. □

Mammography is an art, not a science, and the public needs to understand that.

—Leonard Berlin, M.D.

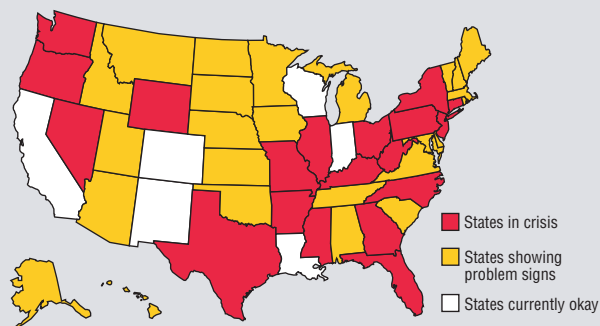
AMA Survey Shows Medical Students Not Immune to Medical Liability Crisis

A first-of-its-kind survey by the American Medical Association (AMA) finds America's medical liability crisis is forcing a majority of medical students to seriously consider whether they want to practice a high-risk specialty or apply for a residency in one of the 19 states currently in crisis.

The survey of nearly 4,000 medical students found that 86 percent of students consider the

issue of medical liability to be a crisis or a major problem. Half of the respondents indicated the current medical liability environment was a factor in their specialty choice and 39 percent said it was a factor in their decision about a state in which they would like to complete residency training.

For more on the survey, go to www.ama-assn.org/ama1/public/upload/mm/31/ms-mlrhighlights.pdf.



American Medical Association Division of Market Research and Analysis. November 2003

Radiologists Can Help Prevent Contrast-Related Nephropathy

As the medical research community works on methods to better define and prevent contrast-induced nephropathy, radiologists can take steps to protect those who are known to be at high risk, namely, those who already have renal dysfunction.

“Radiologists have recognized contrast-related renal failure for 50 years,” says Michael A. Bettmann, M.D., a professor of radiology at Weill Medical College at Cornell University in New York City and chairman of the Department of Radiology at New York Methodist Hospital in Brooklyn. “As contrast agents have improved and other complications related to contrast have diminished in frequency, their effect on renal function has drawn more attention.”

The current definition of contrast nephropathy is variable. Dr. Bettmann says that may be part of the problem. “Serum creatinine is used both to define risk and define occurrence,” he says.

Creatinine clearance is estimated by using a fairly simple formula that takes into account patient age, sex and weight, which may be a more accurate reflection of how the kidneys are functioning than a simple serum creatinine measurement. “By following this formula and getting an estimated creatinine clearance, we will achieve a better understanding of contrast nephropathy,” he says. “Researchers have been lumping together patients who may have widely divergent renal function, which may have clouded our understanding of contrast nephropathy over the years.”

According to Dr. Bettmann, serum creatinine is an inexact indicator of renal function. “Normal serum creatinine is up to either 1.2 or 1.5 mg/dL



Michael A. Bettmann, M.D.
Weill Medical College



James H. Ellis, M.D.
University of Michigan

depending on the lab. Serum creatinine is a reflection of glomerular filtration rate and therefore of renal function. It is also a function of how much creatinine is produced,” Dr. Bettmann explains. “As people age, the rate decreases, while their muscles produce less creatinine. An 80-year-old patient with a creatinine of 1.2 mg/dL has a very different creatinine clearance than a patient who is 20 years of age with the same serum creatinine. Patients who are muscular, male and young have greater muscle mass and therefore produce more creatinine.”

Research Highlights

Research on preventing contrast-induced nephropathy has ranged from hydration to drug prophylaxis. Hydration has been shown to be helpful in preventing contrast-induced

nephropathy; however, there are no prospective randomized studies of hydration versus no hydration. Dr. Bettmann says that the hydration studies used a fixed volume of infusion, or

There is no evidence that non-ionic contrast agents have caused widespread renal failure. These are extremely safe drugs for people who have normal renal function.

— James H. Ellis, M.D.

volume per kilogram, rather than hydration to a certain point of serum osmolality or urine specific gravity.

A second technique that recently has been found to be useful is administration of n-acetylcysteine. A number of studies have concluded that n-acetylcysteine—given either intravenously 30 minutes prior to contrast and continuing for four hours after contrast, or orally two doses the day before and two doses the day of contrast—is at least somewhat effective.

There have been two prospective randomized studies looking at iodixanol as a contrast agent compared to

Continued on next page

Radiologists Can Help Prevent Contrast-Related Nephropathy

Continued from previous page

iohexol. Iodixanol does seem to have a benefit, according to Dr. Bettmann, although the extent is not entirely clear and needs further evaluation.

“There are a number of other medications that have been studied. Fenoldapam, a dopamine agonist, has been looked at in a few fairly small studies, but has not been proven to have a significant positive effect,” he explains. “There are also some promising medications, such as an endothelin antagonist that blocks vasoconstriction and a prostacyclin analogue that is a renal vasodilator.”

“We still need to get a better understanding of what contrast nephropathy is, what the exact mechanism of action is and its real natural history,” says Dr. Bettmann.

He recommends screening patients carefully and using calculated creatinine clearance rather than just serum creatinine. He also suggests administering n-acetylcysteine either orally (600 mg twice daily on the day before and the day of the exam) or intravenously, 150 mg/kg over the 30 minutes prior to the exam and 50 mg/kg over four hours after the contrast administration, each in 500 ml normal saline.

Dr. Bettmann also stresses the importance of hydration. “If patients can, they should drink plenty of fluids before the exam. If conscious sedation is necessary, then intravenous hydra-



Comparison CO2 and contrast aortograms demonstrate bilateral renal artery stenosis and very poor intra-renal perfusion. This is the type of patient who would be at risk of developing nephrotoxicity because of baseline compromise in renal function.

Photos courtesy of Michael A. Bettman, M.D.

tion will be necessary, at least over the last few hours” he says.

Knowledge Gap

Still, it must be stressed that non-ionic contrast material can be safely administered to the vast majority of patients without concern for renal toxicity.

“There is no evidence that non-ionic contrast agents have caused widespread renal failure. These are extremely safe drugs for people who have normal renal function,” says James H. Ellis, M.D., a professor of radiology at the University of Michigan in Ann Arbor.

Steps to Reduce Contrast-induced Nephropathy

- Screen patients carefully using calculated creatinine clearance rather than just serum creatinine
- In high-risk patients, consider administering n-acetylcysteine either orally or intravenously
- In high-risk patients, consider the use of an iso-osmolality contrast agent
- Hydrate the patient

The incidence of clinically important renal failure from contrast agents is very low. However, a small number of patients will develop permanent renal function changes. These patients primarily come from the group of patients who have renal dys-

function before the contrast test. The combination of renal dysfunction and diabetes increases this risk even further.

Although research is ongoing, Dr. Bettmann says that radiologists can take steps to protect at-risk patients from contrast-induced nephropathy.

“There are clearly high-risk patients who need to be identified and protected,” says Dr. Ellis. “There are many people who have mild degrees of renal insufficiency. The degree of risk in this borderline group is less well understood. We need larger and better studies to more completely define the risk factors so that we can focus our efforts on patients who are truly at a higher risk for contrast nephrotoxicity.”

Drs. Bettmann and Ellis presented the refresher course, “Radiographic Contrast Agent Nephrotoxicity and Other Adverse Events,” at RSNA 2003. □

Online Searchability Faster, More Comprehensive for RSNA Journals

RadioGraphics Online has a new look and some new features that make it simple and easy to perform complex literature searches in very little time. The September launch of the improved *RadioGraphics Online* comes on the heels of a redesign for *Radiology Online*.

Part of the new and improved functionality of *Radiology Online* (radiology.rsnaajnl.org) and *RadioGraphics Online* (radiographics.rsnaajnl.org) is a Quick Search box on the home page and all subsequent pages.

"RSNA members and subscribers no longer have to weave their way into another layer to begin a search of *Radiology* or *RadioGraphics*," explains Al Simonaitis, manager of RSNA's online journals. "From the Quick Search box, users can type in an author's last name, a keyword or phrase, then add a year, volume or page number if they want to narrow the search results."

For example, ❶ if you type the word sarcoma in the Keyword box and type 2003 in the Year box, when you click on Go, you get 52 articles that appeared in *Radiology* and *RadioGraphics* in the year 2003 that included the word sarcoma. The search results will show the journal, article title, author and a few sentences in which the word sarcoma appears.

To make this search even more effective, a new technology called Vivísimo assists in searching *Radiology* and *RadioGraphics*. Vivísimo clustering and meta-search technology

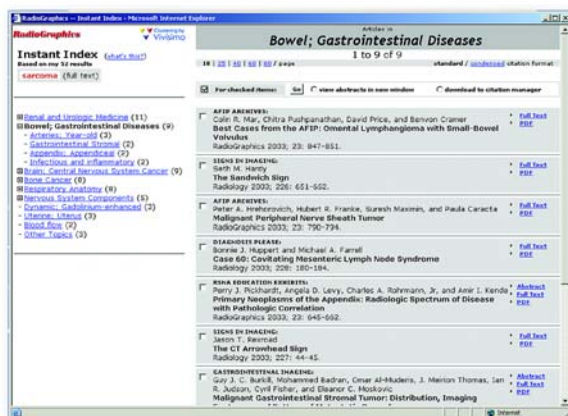
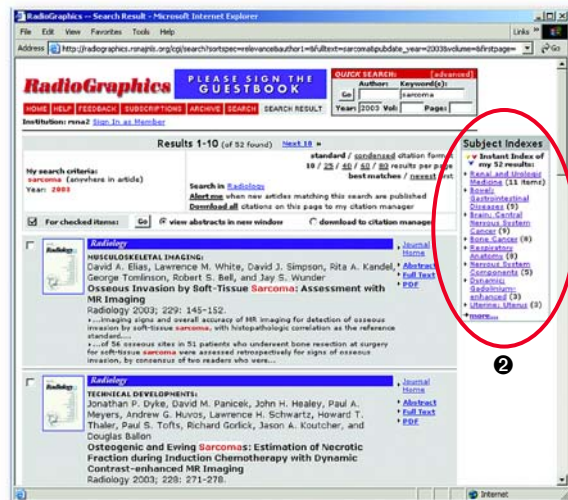
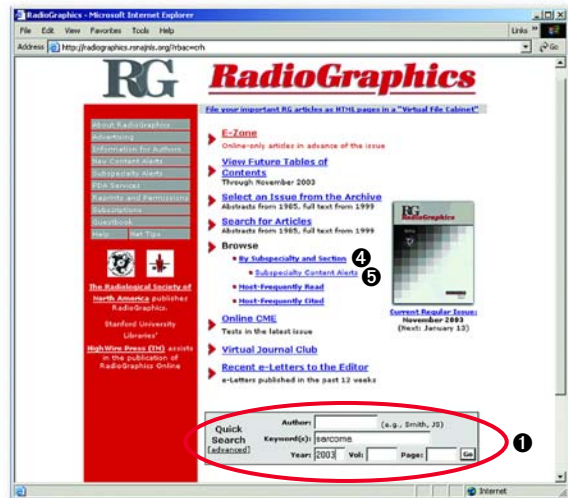
improves the way search results are organized.

While you won't see the word Vivísimo, the technology operates through the box called Subject Indexes that appears on the right side of your search results offering instant indexing by topic. ❷

"From that box users can get the results of their search for sarcoma organized by category, such as bowel or bone cancer," explains Simonaitis. "It's a nice feature because you don't have to scroll through all 52 articles to find your area. You can click on bowel and find the nine articles containing the word sarcoma in 2003 that are in the gastrointestinal imaging category." ❸

A recent addition to *RadioGraphics Online* is the Browse by Subspecialty category (*RadioGraphics Collections*) ❹ that is a topic-specific archive of articles from 1999 to the present. For example, if you click on Musculoskeletal Radiology, you will get a list of 76 articles that are available in *RadioGraphics Online* in that area. The most recent articles are listed first. This feature is also available on *Radiology Online*.

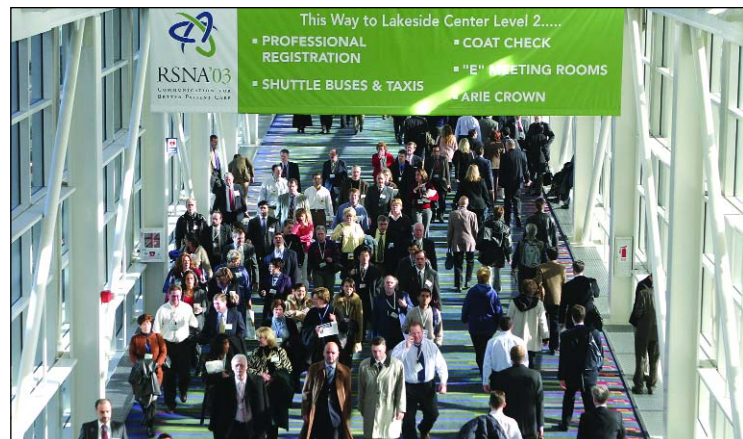
Another new feature is the Most-Frequently Read section, which lists the 50 most-read articles archived on *RadioGraphics Online*. There is also a Most-Frequently Cited section that lists the 50 most-frequently cited articles archived on *RadioGraphics Online*. Both lists are updated monthly.

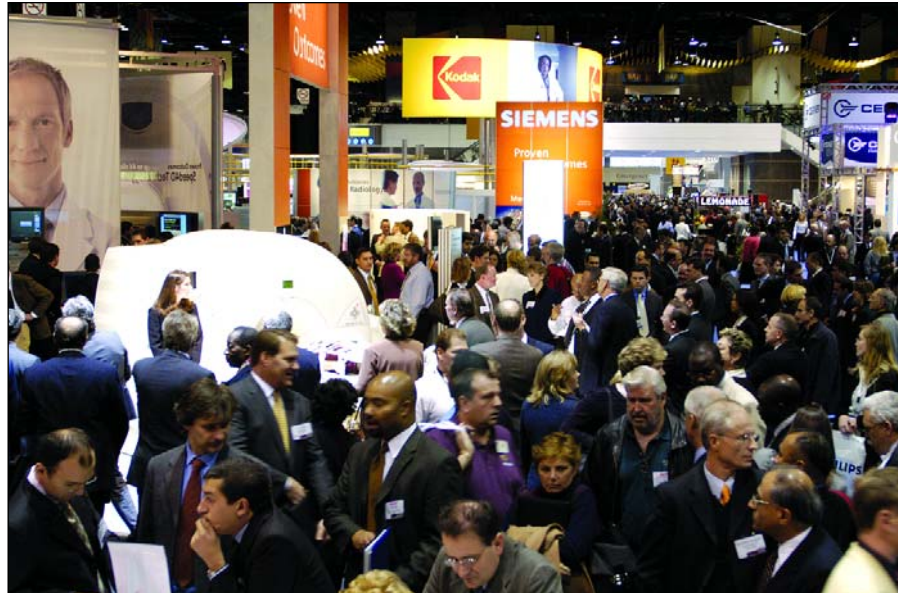
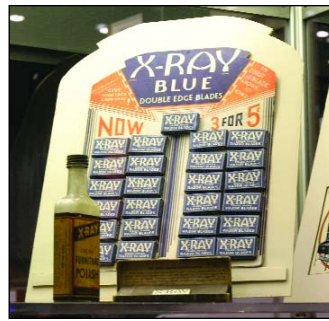


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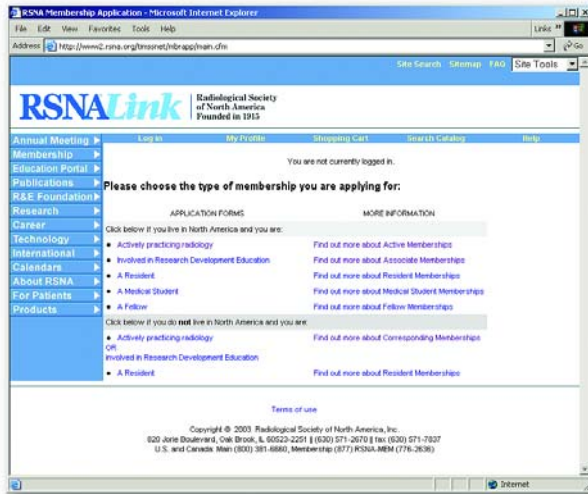
RSNA 2003 Meeting Moments

The February and March issues of *RSNA News* will provide in-depth coverage of some of the sessions at RSNA 2003. Topics will include whole-body screenings, health issues for radiologists in the workplace, the radiologist's assistant, workstation auditing tools, emergency radiology and radiation dose.





Working For You



Membership Application Online

Applying for RSNA membership is as easy as a mouse click. Membership applications are now online at www2.rsna.org/timssnet/mbrapp/main.cfm. In addition to the application, information is available about each membership type and the many benefits that RSNA provides to its members.

Easier Way to Request Permissions

If you would like to request permission to use material from *Radiology*, *RadioGraphics* or *RSNA News*, the e-mail address is now easier to remember—*permissions@rsna.org*. Written requests may also be sent by fax to (630) 590-7724, or by mail to RSNA Publications, Attn: Permissions, 820 Jorie Blvd., Oak Brook, IL 60523.

A request for permission should include the author, title and citation (journal name, year, volume and page numbers) of the article. The request should also include the figure or table

numbers, an explanation of how you will use the material, and your mailing address and a fax number.

Authors of articles published in *Radiology* and *RadioGraphics* since April 2003 receive an image license agreement that allows them to reuse their images without requesting permission from RSNA.

A signed copy of the image license must be returned to RSNA for the license to be valid.

SERVICE TO MEMBERS:

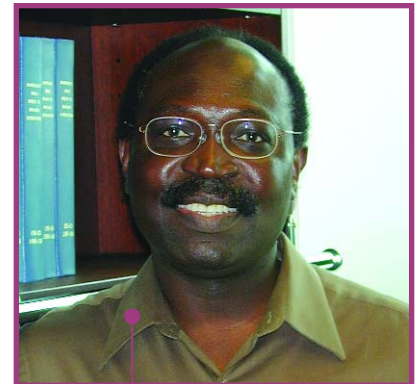
I see my primary responsibility as helping to create a viable Department of Data Management at RSNA. In July 2003, the department assumed the majority of the membership data entry and management activities of the Department of Membership & Subscription Services. Our mission is to develop into a comprehensive data entry and management arm of RSNA. This means that, whenever the opportunity arises from here on, we will assume more and more of the data entry and management activities of the Society.

A centralized data management structure creates many opportunities for detecting linkages in data that are critical for decision-making by the executive staff and board of directors.

The Department of Data Management is also responsible for the survey research and data analysis activities of RSNA, including the analysis of the evaluation forms frequently completed by course participants.

WORK PHILOSOPHY:

“It is not about me,” “Time flies when you are busy,” and “There is always room for improvement”—these form the foundation of my work ethic. None of what I do can be effectively and efficiently accomplished without working in a team. To the extent possible, I try to do whatever it takes to get the job done and be a team player. I am continuously engaged in self-evaluation and in looking for ways to learn and elevate my work to the next level.



NAME:

Francis Kwakwa

POSITION:

Assistant Director,
Department of
Data Management

WITH RSNA SINCE:

December 2002

If you have a colleague who would like to become an RSNA member, you can download an application at www.rsna.org/about/membership/memberapps.html, or contact the RSNA Membership and Subscription Department at (877) RSNA-MEM [776-2636] (U.S. and Canada), (630) 571-7873 or membership@rsna.org.

Wrong Site Protocol

The RSNA Board of Directors has endorsed the Joint Commission on Accreditation of Healthcare Organization's (JCAHO) Universal Protocol for Preventing Wrong Site, Wrong Procedure, Wrong Person Surgery.

The universal protocol

draws upon, expands and integrates a series of existing requirements under the 2003 and 2004 National Patient Safety Goals. One of the goals is to create and use a preoperative verification process, such as a checklist, to confirm that appropriate

documents, including medical records and imaging studies, are available.

The universal protocol will be implemented July 1, 2004, for all JCAHO accredited organizations that perform surgical or other types of invasive procedures.

For more information, go to www.jcaho.com/accredited+organizations/patient+safety/universal+protocol/wss_universal+protocol.htm.

Radiology in Public Focus

A press release has been sent to the medical news media for the following scientific article appearing in the January issue of *Radiology* (radiology.rsna.org):

"Small Bowel Findings: Comparison of Capsule Endoscopy, Barium Studies and CT"

A new FDA-approved technology using wireless capsule endoscopy (CE) displays more small bowel disease than barium exams or CT studies in patients without evidence of a small bowel stricture.

Amy K. Hara, M.D., and colleagues from the Mayo Clinic in Scottsdale, Ariz., retrospectively studied the CE exams of 52 patients who, within the past six months, had undergone barium small bowel follow-through (SBFT), enteroclysis and/or contrast-enhanced CT scans of the abdomen and pelvis—most (43 of 52) for gastrointestinal bleeding.

Of the 40 patients who had undergone a barium exam, one patient (three percent) had positive findings. That compares to 22 patients (55 percent) who had positive findings with CE. Of

the 19 patients who had undergone a CT scan, four (21 percent) had positive results. That compares to 12 patients (63 percent) who had positive results with CE.

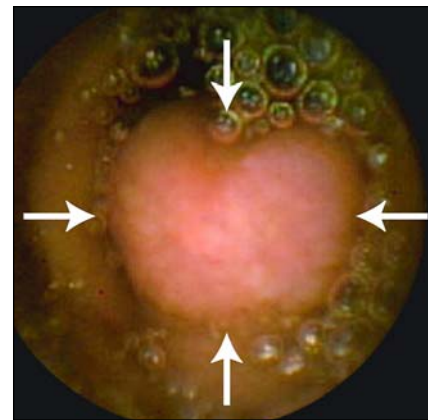
Among the CE findings were angioectasias, ulcers and surgically confirmed masses.

"CE's main advantage is the ability to provide a more complete endo-

sopic evaluation of the small bowel than has previously been available. Other advantages include relatively low risk for the patient, absence of radiation and minimal patient discomfort," the researchers write. "CE, while demonstrating many findings not seen with imaging,

is not a perfect technique. In this study, two jejunal tumors and a coloenteric fistula were not detected by CE."

They add, "In the future, CE is



CE image in 69-year-old man with obscure gastrointestinal bleeding shows carcinoid tumor (arrows). Tumor was not detected at SBFT examination or CT.

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likely to play an important role in small bowel imaging but further prospective comparison studies with barium and CT are needed."



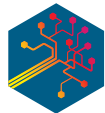
RSNA press releases are available at www2.rsna.org/pr/pr1.cfm.

Program and Grant Announcements

Register for BIROW 2

Online registration is under way for the 2004 Biomedical Imaging Research Opportunities Workshop (BIROW 2) at www.birow.org. The workshop will identify and explore new opportunities for basic science research and engineering development in biomedical imaging, as well as related diagnosis and therapy.

It will be held February 25-26 at the Bethesda Marriott Hotel. It is the second in a series being sponsored by RSNA, American Association of Physicists in Medicine, Biomedical Engineering Society, Academy of Radiology Research and American Institute for Medical and Biological Engineering.



**Biomedical
Imaging
Research
Opportunities**
WORKSHOP 2

Leadership Strategies for Radiology Practices

Future and current leaders in academia and private practice are invited to attend this 2 1/2 day RSNA course that will focus on administrative challenges including financial matters, strategic planning, billing, compliance, contracts and legal matters.

The course will be held in Chicago, July 23-25, 2004, at the Chicago Marriott Downtown.

Didactic lectures are followed by separate interactive breakout sessions for academic and private practice participants. At the completion of this leadership course, participants should be able to:

- Develop strategic plans for either academic or private-practice departments
- Describe the critical components for selecting and implementing PACS systems
- Discuss key points of group member, hospital and managed care contract negotiations
- Summarize methods used to analyze and respond to business opportunities
- Assess the major components of a successful radiology practice

For more information, go to www.rsna.org/shortcourses or contact the RSNA Education Center at (800) 381-6660 x3747.



NCI/CSR Host Workshop for New Grantees

Imaging investigators, who recently received their first funding from the National Institutes of Health (NIH), were treated to a workshop designed to help them succeed in renewing their funding and building their research careers.

The Promising Cancer Imaging Investigators Workshop was sponsored by the Cancer Imaging Program at the National Cancer Institute (NCI) and the NIH Center for Scientific Review (CSR). The workshop was held in October at NIH in Bethesda, Md.

During the one-and-a-half day Promising Cancer Imaging Investigators Workshop, participants learned about NIH policies and procedures, participated in a mock study session, and attended a session on career development, led by volunteer senior investigators who provided advice and led discussion about developing and maintaining an academic career, including balancing family and professional activities.

GE Pledges \$1.5 Million to R&E Foundation



GE Medical Systems has signed an agreement to donate \$1.5 million over the next 10 years to the RSNA

Research & Education Foundation. The endowment will establish the GE Medical Systems/RSNA World Wide Web-based Educational Program Grant.

The purpose of the grant is to give scientists/physicians the opportunity to develop educational materials specifically for widespread distribution through the World Wide Web.

“Diagnostic imaging has been and will continue to be an essential part of patient care,” says Paul Mirabella, president and chief executive officer of GE Medical Systems Americas and Healthcare Services. “At GE, we are committed to the development of innovative solutions that allow physicians to better see and treat diseases, and provide overall better patient care. This educational grant is another example of that dedication and commitment.”

The GE announcement was made during RSNA 2003.

GE has sponsored eight RSNA Research Scholars since becoming a member of the Foundation’s Vanguard Group of companies in 1990.

“GE is among the industry leaders who recognize the importance of investing in the future of radiology,”

says Seymour H. Levitt, M.D., chairman of the 2003

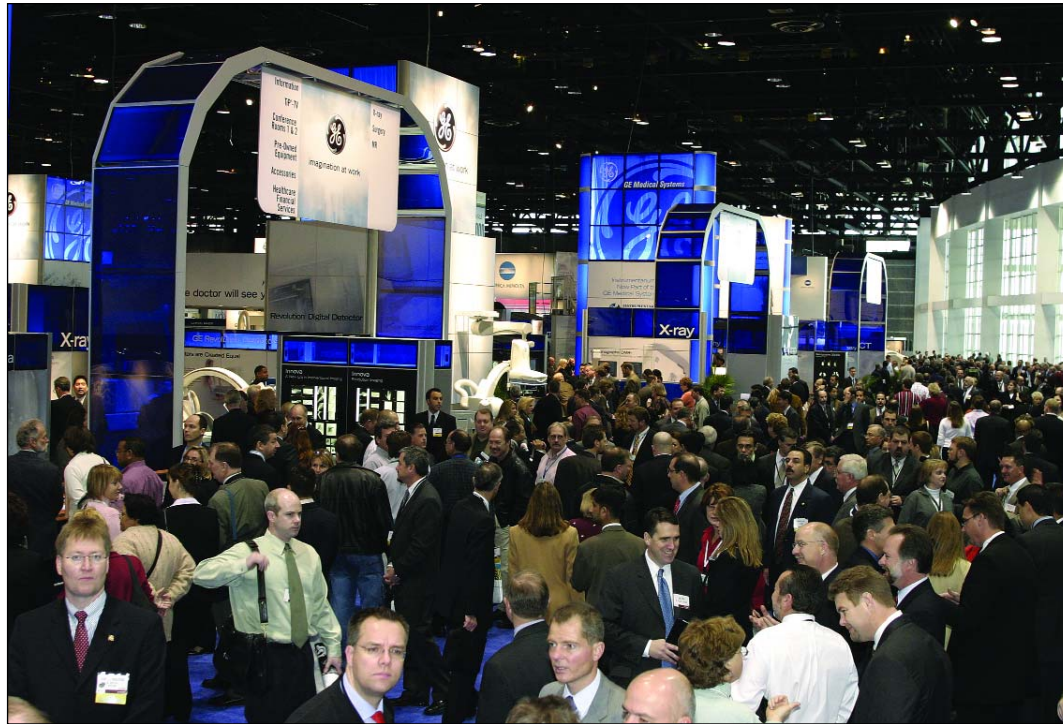
R&E Foundation Board of Trustees.

“GE recognizes that tomorrow’s practice will be shaped by today’s research. We are pleased to have the company’s support.”

The first recipient of the GE Med-



**Smita Patel, M.B.B.S.,
M.R.C.P., F.R.C.R.**



ical Systems/RSNA World Wide Web-based Educational Program Grant will be announced later this year.

Each grant is up to \$75,000 for a one-year project. Applicants do not

need to be a citizen or resident of a North American country, and the principal investigator must be in the radiologic sciences. Co-investigators can be from other fields.

The 2003 recipient of the GE Medical Systems/RSNA Research Scholar Grant is Smita Patel, M.B.B.S., M.R.C.P., F.R.C.R., from the

Department of Radiology at the University of Michigan Health System in Ann Arbor. Her research project is “ECG-gated 16-slice CT Coronary Angiography: Comparison with Catheter Coronary Angiography.”

At RSNA 2003, GE was the largest exhibitor of the 668 exhibiting companies, occupying 30,000 square feet. GE had seven booths on the technical exhibits floor, including space in the new Mobile Computing Pavilion.

Diagnostic imaging has been and will continue to be an essential part of patient care.

—Paul Mirabella, President and CEO,
GE Medical Systems Americas and
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News about RSNA 2004

Submit Abstracts for RSNA 2004

A new online abstract submission system will be activated this month, making it easier than ever to submit an abstract for the RSNA Scientific Assembly and Annual Meeting. This new system, which will be available through *RSNA Link* (www.rsna.org), will also make it more efficient for the Scientific Program Committee to evaluate submissions.



The direct link is: www.rsna.org/rsna/abstracts.html

Electronic submission of scientific abstracts for the annual meeting was first offered in 1997. Submissions have been online only since 2001.

All abstracts must be received by April 15, 2004.

Abstracts are required for scientific papers, scientific posters, education

exhibits, radiology informatics and *infoRAD* exhibits.

Scientific presentations can be made in either oral or poster format. Oral presentations will be delivered at an assigned date and time and will be limited to seven minutes followed by three minutes for discussion. Attendees of oral presentations are awarded category 1 CME credit. An author of a poster will be assigned to a one-hour scientific session in which attendees will earn category 1 CME credit. Posters will be on display during the entire week for independent review by attendees who can claim self-study credit.

For more information, contact (877) RSNA-ABS [776-2227] or programs@rsna.org.

Important Dates for RSNA 2004

April 15	Deadline for abstract submission
April 26	Registration and housing opens for RSNA and AAPM members
May 24	General registration and housing opens
June 21	Refresher course enrollment opens
Oct. 29	Final advance registration deadline
Nov. 28– Dec. 3	RSNA 90th Scientific Assembly and Annual Meeting

■ For more information about RSNA 2004, call (800) 381-6660 x7862 or e-mail reginfo@rsna.org.

Online Searchability Faster, More Comprehensive for RSNA Journals

Continued from page 13

Subspecialty Content Alerts

Two new services are available for RSNA members and subscribers to *RadioGraphics Online*. By signing up for the Subspecialty Content Alerts, users will be notified about articles in their area of interest. ⑤

“A chest radiologist can click on Chest Radiology, and the system will send an e-mail when an article is posted in that area,” says Simonaitis.

Radiology readers can also sign up to be notified of new content in their specified area of interest.

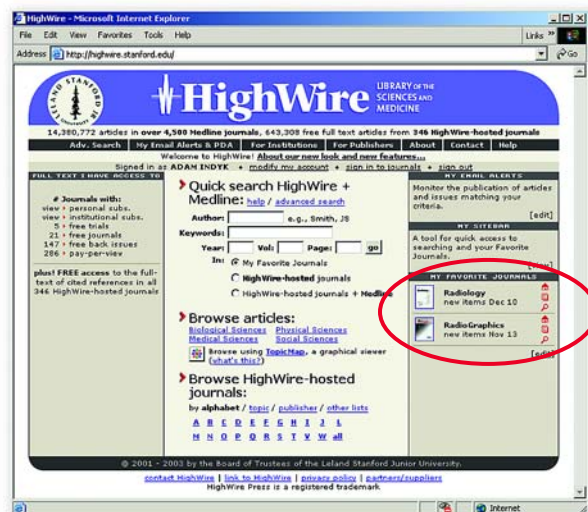
The recently expanded PDA Service provides free downloads of tables of contents, abstracts and selected full-text material from *Radiology Online* and *RadioGraphics Online*. Both Palm OS and PocketPC are supported.

Expanded Searching

HighWire has also updated its Web site with enhancements to make it easier and faster to perform a comprehensive, targeted search of the medical literature.

From the HighWire home page, highwire.stanford.edu, users can use the Quick Search Box to search the nearly 350 journals hosted on the HighWire site, as well as through MEDLINE, provided by the world's largest medical library—the National Library of Medicine.

“Not only are you searching through *Radiology* and *RadioGraphics*, but you are also searching through the largest archive of free life science arti-



cles in the world—in one click of the mouse,” Simonaitis says. “RSNA members can personalize the HighWire home page by clicking on My Favorite Journals in the right-hand column, and adding *Radiology* and *RadioGraphics*.” ⑥ □

RSNA 2004 Exhibitor News

RSNA 2004 Exhibitor Meeting

All RSNA 2003 exhibitors are invited to attend the RSNA 2004 Exhibitor Planning Meeting on March 3 at Rosewood Restaurants and Banquets near O'Hare International Airport. The meeting is intended to review RSNA 2003 and plan for RSNA 2004. More information will be sent to each exhibitor's official contact in mid-January.

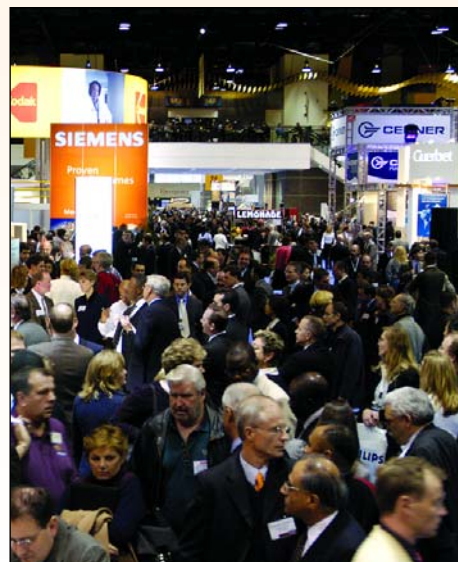
Important Exhibitor Dates for RSNA 2004

March 3	Exhibitor Planning Meeting
April 5	Exhibitor Prospectus Mails
June 22	Exhibitor Planning/Booth Assignment Meeting
July 6	Technical Exhibitor Service Kit Available Online
Nov. 28–Dec. 3	RSNA 90th Scientific Assembly and Annual Meeting



November 28 – December 3, 2004
McCormick Place, Chicago

■ For more information, contact RSNA Technical Exhibits at (800) 381-6660 x7851 or e-mail: exhibits@rsna.org.



www.rsna.org

RSNA 2003 Syllabi Available Online

The two syllabi from RSNA 2003 are available for purchase in a variety of formats.

■ Categorical Course in Diagnostic Radiology Musculoskeletal Imaging: Exploring New Limits

Co-Editor: *Kenneth A. Buckwalter, M.D.*

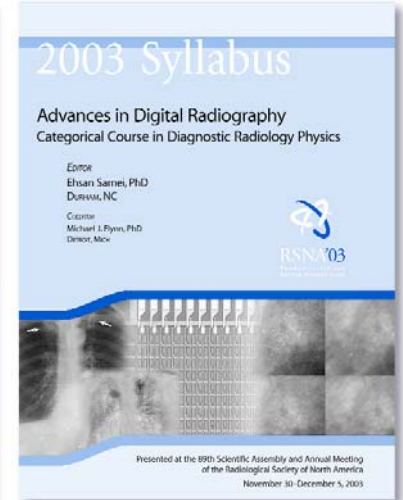
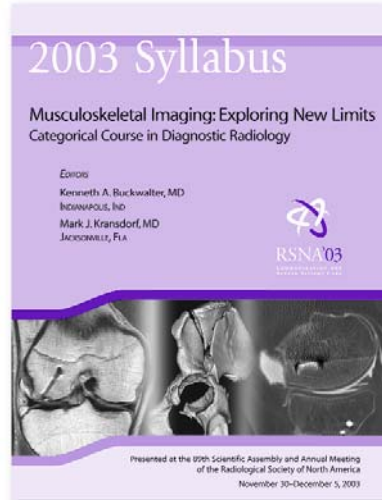
Co-Editor: *Mark J. Kransdorf, M.D.*

■ Categorical Course in Diagnostic Radiology Physics: Advances in Digital Radiology

Editor: *Ehsan Samei, Ph.D.*

	Print	CD	PDF
RSNA members	\$75	\$45	\$69
Non-members	\$85	\$55	\$79

To order either version, go to www.rsna.org/education/syllabi/.



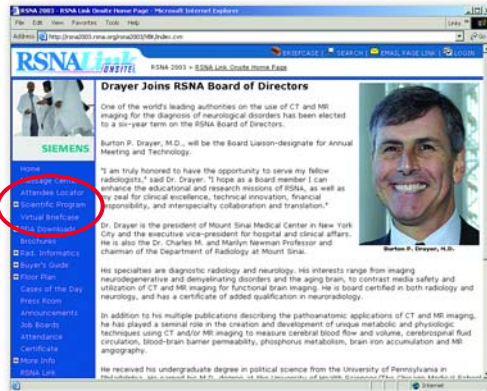
Award Winners at RSNA 2003

Lists of award winners from RSNA 2003 are available on *RSNA Link Onsite* (rsna2003.rsna.org).

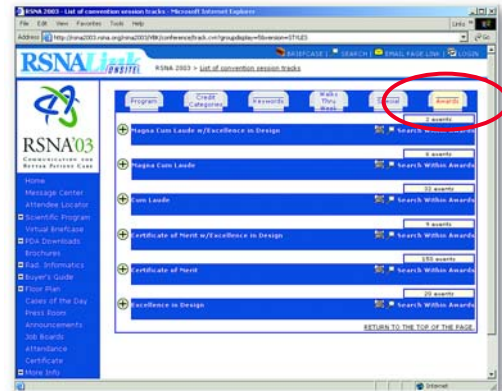
These include outstanding exhibits, fellow award presentations and resident award presentations.

To view the exhibit award winners, click on the Scientific Program link in the left-hand column. ❶ Then, click on the Awards tab in the top right-hand section. ❷

The Special section features



❶



❷

links to the virtual presentations, hot topics presentations and supporters of the RSNA Research & Education Foundation.

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Medical Meetings

February – May 2004

FEBRUARY 4–8

Sociedad Mexicana de Radiología E Imagen (SMRI), Annual Meeting, Mexico City • www.smri.org.mx

FEBRUARY 5–8

Society of Nuclear Medicine (SNM), Mid-Winter Meeting, Disneyland Hotel, Anaheim, Calif. • www.snm.org

FEBRUARY 13–15

American Institute of Ultrasound in Medicine, Practical Aspects of Obstetric and Gynecologic Ultrasound, Four Seasons Hotel, Las Vegas • www.aium.org

FEBRUARY 22–26

Healthcare Information and Management Systems Society (HIMSS), 2004 Annual Conference and Exhibition, Orange County Convention Center, Orlando • www.himss.org

FEBRUARY 25–26

Biomedical Imaging Research Opportunities Workshop (BIROW 2), Bethesda Marriott Hotel, Md. • www.birow.org

MARCH 5–9

European Congress of Radiology, ECR 2004, Vienna, Austria • www.ecr.org

MARCH 7–10

Society of Skeletal Radiology (SSR), Annual Meeting, Loews Ventana Canyon Resort, Tucson, Ariz. • www.skeletalrad.org

MARCH 7–12

Society of Gastrointestinal Radiologists (SGR) and Society of Uroradiology (SUR), Abdominal Radiology Course, Westin Kierland Resort, Scottsdale, Ariz. • www.sgr.org

MARCH 22–26

Society of Computed Body Tomography & Magnetic Resonance (SCBT/MR), 27th Annual Meeting, Lake Las Vegas Resort, Henderson, Nev. • www.scbtmr.org

MARCH 25–30

Society of Interventional Radiology (SIR), 29th Annual Scientific Meeting, Phoenix Civic Plaza, Phoenix, Ariz. • www.sirweb.org

MARCH 28–31

Academy of Molecular Imaging (AMI), Annual Conference, Gaylord Palms Resort & Convention Center, Orlando • www.ami-imaging.org

MARCH 28–APRIL 1

Society of Thoracic Radiology (STR), Annual Meeting, Westin Mission Hills Resort, Rancho Mirage, Calif. • www.thoracicrad.org

APRIL 8–10

Japan Radiological Society (JRS), 63rd Annual Meeting, Pacific Convention Plaza, Yokohama, Japan • www.radiology.or.jp/english/index.htm

APRIL 21–24

Association of University Radiologists (AUR)/Society of Chairmen of Academic Radiology Departments (SCARD)/ Association of Program Directors in Radiology (APDR)/ American Association of Academic Chief Residents in Radiology (A³CR²), 52nd Annual Meeting, San Francisco Marriott, San Francisco • www.aur.org

APRIL 21–24

Sociedade Paulista de Radiologia e Diagnóstico por Imagem (SPR), 34th Sao Paulo Radiology Meeting, ITM Expo Convention Center, Sao Paulo, Brazil • www.spr.org.br

APRIL 24–25

American Osteopathic College of Radiology (AOOCR), Mid-Year Conference—Mammography, Hilton Chicago O'Hare Airport, Chicago • www.aocr.org

APRIL 24–27

Radiation Research Society (RRS), 51st Annual Meeting, Adams Mark Hotel, St. Louis • www.radres.org

APRIL 27–MAY 1

Society for Pediatric Radiology (SPR), Westin Savannah Harbor, Savannah, Ga. • www.pedrad.org

APRIL 28–MAY 1

Asian Oceanian Congress of Radiology, 10th Annual Meeting, Raffles City Convention Centre, Singapore • lennytan@nus.edu.sg

MAY 2–7

American Roentgen Ray Society (ARRS), 104th Annual Meeting, Fontainebleau Hotel Resort and Towers, Miami Beach • www.rrs.org

NOVEMBER 28–DECEMBER 3

RSNA 2004, 90th Scientific Assembly and Annual Meeting, McCormick Place, Chicago • www.rsna.org