

RSNA *News*



Dunnick Joins RSNA Board of Directors

Also Inside:

- Radiologists Brace for Effects of DRA Cuts
- Giving and Receiving Part of Experience for Visiting Professors in Chile
- Active Aging Population Drives Knee Imaging Innovations
- RSNA 2006 Meeting Moments

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Jost is 2007 RSNA President

R. GILBERT JOST, M.D., a physician recognized globally for using information technology to improve diagnostic radiology practice, is the RSNA president for 2007.

Dr. Jost is the Elizabeth Mallinckrodt Professor of Radiology, chair of the Department of Radiology at Washington University School of Medicine, director of the Mallinckrodt Institute of Radiology and radiologist-in-chief at Barnes-Jewish Hospital in St. Louis. He was elected to the RSNA Board of Directors in 1999 as the liaison-designate for communications and corporate relations.

An early participant in the RSNA Integrating the Healthcare Enterprise (IHE®) Planning Committee and the IHE Strategic Committee, Dr. Jost has been influential in the adoption of the DICOM standard.

Dr. Jost has been with the Mallinckrodt Institute for more than 30 years. After attending Yale



R. Gilbert Jost, M.D.

Medical School in New Haven, Conn., Dr. Jost worked as a research associate at the National Institutes of Health in the Laboratory of Neural Control. He then conducted his residency at Mallinckrodt and in 1985 became a professor of radiology, an affiliate professor of computer science and chief of diagnostic radiology at Washington University. He assumed the chairmanship of the department in 1999.

Dr. Jost became a member of the RSNA Electronic Communications Committee in 1993 and was appointed its chair five years later. Dr. Jost's other RSNA endeavors include the Strategic Planning Committee, the Education Council, Publications Council and Medical Imaging Resource Center (MIRC) Committee. On the Board of Directors, he has served as the chair, president-elect and liaison for annual meeting and technology.

McLoud is RSNA President-Elect

THERESA C. MCLLOUD, M.D., is the RSNA president-elect for 2007.

Currently the associate radiologist-in-chief and director of education for the Department of Radiology at Massachusetts General Hospital in Boston, Dr. McLoud is also a professor of radiology at Harvard Medical School.

Beginning her term on the RSNA Board of Directors in 2000, Dr. McLoud has also worked on the Scientific Program Committee for the annual meeting, serving as its chair in 1998. As president-elect, she plans to continue the work she began last year as Board chair, focusing on needs in the international radiology arena and quality improvement initiatives as they pertain to adult education and the preeminence of the RSNA annual meeting.

Dr. McLoud's primary research interests are interstitial lung disease, CT of the thorax, lung



Theresa C. McLoud, M.D.

cancer imaging and occupational lung disease. She is the author of *Thoracic Radiology: The Requisites*, a widely read introductory text.

Dr. McLoud obtained her medical degree from the McGill University Faculty of Medicine in Montreal and completed a thoracic imaging fellowship at the Yale University School of Medicine in New Haven, Conn. She currently serves on the advisory committee for the National Lung Screening Trial conducted by the National Cancer Institute.

Awarded the gold medal of the American Roentgen Ray Society (ARRS) in 2004 and the Marie Curie Award of the American Association for Women Radiologists in 2003, Dr. McLoud is a past-president of the Fleischner Society, the Society of Thoracic Radiology and ARRS.

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Becker Becomes Board Chair

GARY J. BECKER, M.D., is the 2007 chair of the RSNA Board of Directors.

A professor of vascular and interventional radiology at the University of Arizona College of Medicine, Dr. Becker is also associate executive director for diagnostic radiology and subspecialties at the American Board of Radiology in Tucson.

One of Dr. Becker's goals as RSNA chair is crystallizing the Society's role in quantitative imaging. His leadership at RSNA began with an appointment to the Refresher Course Committee, followed by service on the Public Information Advisory Board and Planning Committee for the Office of Research Development. He has also participated in various research development committees and the RSNA Research &



Gary J. Becker, M.D.

Education Foundation's Distinguished Roster of Grant Reviewers. Since 2002 he has served as Board liaison for science.

Dr. Becker earned his medical degree from the Indiana University School of Medicine. He has served as director of interventional radiology and medical director of research and outcomes at the Miami Cardiac & Vascular Institute at Baptist Hospital in Florida. He was also branch chief of image-guided intervention for the Cancer Imaging Program at the National Cancer Institute (NCI).

Founding editor of the *Journal of Vascular & Interventional Radiology*, Dr. Becker served as its editor-in-chief from 1990 to 1995.

Dunnick is New RSNA Board Member

N. REED DUNNICK, M.D., is the newest member of the RSNA Board of Directors. Elected at RSNA 2006, Dr. Dunnick will serve as the liaison-designate for publications and communications.

He will work with current liaison, Hedvig Hricak, M.D., Ph.D., until she becomes chair of the RSNA Board at the conclusion of RSNA 2007.

Dr. Dunnick is the Fred Jenner Hodges Professor and chair of the Department of Radiology at the University of Michigan Health System in Ann Arbor. Founding president of the Radiology Research Alliance and recipient of several grants from the National Institutes of Health, Dr. Dunnick has investigated functional adrenal disease, hypertension, renal masses and the percutaneous approach to urolithiasis.

Dr. Dunnick's expertise in publications includes service on the editorial boards of 12 peer-reviewed journals, including *Radiology*, *American Journal of Roentgenology*, *Journal of the*



N. Reed Dunnick, M.D.

American College of Radiology, Academic Radiology and Journal of Women's Imaging.

An RSNA member since 1978, Dr. Dunnick is currently the president of the Academy for Radiology Research, a trustee for the American Board of Radiology and president of the Association of University Radiologists. He is also past-president of the American Roentgen Ray Society (ARRS), Society of Uroradiology, Society of Computed Body Tomography, Society of Chairmen of Academic Radiology Departments and the Michigan Radiological Society.

Dr. Dunnick received his M.D. degree from Cornell University Medical College in New York. Among the numerous honors he has received throughout his career is the 2006 ARRS gold medal.

ESR Launches European School of Radiology

The European School of Radiology (ESOR), a new project of the European Society of Radiology (ESR), aspires to raise radiology standards through global e-learning initiatives and train young radiologists with an eye on tomorrow's requirements.

The overall goals of the ESOR are to develop tools in the international language of radiologic education, expand existing programs into long-term educational support and design

specific education programs to meet the needs of individuals, groups and national societies.

ESOR plans to offer schools and scholarships throughout Europe, as well as in-house courses, fellowships, teach-the-teacher courses, visiting professorships, tutorials and electronic teaching and e-learning modules.

More information about ESOR is available at www.ecr.org/pages/e-learning/esor.php?sub=64.

RADIATION SAFETY

Tip of the Month

The imaging dose delivered during image-guided radiation therapy may be high enough to impact treatment planning.



American Association of Physicists in Medicine

Imaging Utilization Detailed in NEMA Report

MEDICAL imaging advances have changed not only how physicians measure, manage and diagnose disease, but also how they think about it, according to a report released last month by the National Electrical Manufacturers Association (NEMA).

“Changing the Landscape: How Medical Imaging Has Transformed Health Care in the U.S.,” concludes that with patient-centered changes like the modernization of cardiovascular care and virtual elimination of exploratory surgery, medical imaging has radically changed the way medicine is practiced and medical delivery is structured.

The report details the impact of medical imaging on nearly all aspects of

healthcare delivery, including diagnosing and treating stroke, heart disease, and cancer. Better visualization and information from imaging have also led more types of physicians to use imaging in more clinical situations and for more diseases and more patients, according to the report.

This broad applicability of imaging, the report concludes, is one of the primary factors in its increased utilization—attributing growth in utilization primarily to financial motives of medical providers ignores deep, patient-centered changes, the report states.

The report is available at www.medicalimaging.org.

MEDICAL IMAGING COMPANY NEWS

Primedex Now RadNet

Outpatient imaging center operator Primedex Health Systems, Inc., of Los Angeles, has changed its corporate name to RadNet, Inc. The new name reflects the name of the operating entity, RadNet Management, Inc., under which Primedex has been operating since 1992. At the time of the name change, the company also announced a one-for-two reverse split of its outstanding common stock.

As of late 2006, RadNet owned and operated 134 outpatient imaging facilities in California, Colorado, Florida, Kansas, Maryland, Minnesota and New York. The company performs approximately 2,500,000 diagnostic imaging procedures annually.

PEOPLE IN THE NEWS

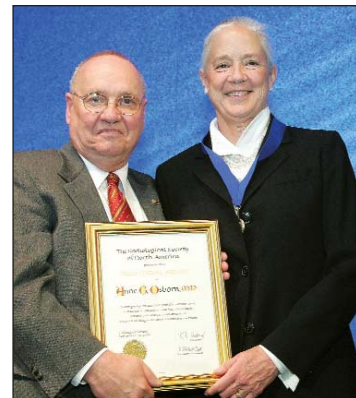
Mexican Federation Honors Osborn

THE Federación Mexicana de Radiología e Imagen (FMRI) will present its Award of Radiological Merit to **Anne G. Osborn, M.D.** this month.

Representing 30 Mexican radiologic societies, FMRI presents the award every two years to one Mexican recipient and one foreign recipient.

Dr. Osborn is a distinguished professor of radiology at the University of Utah

School of Medicine, where she holds the William H. and Patricia W. Child Presidential Endowed Chair in Radiology. She received the RSNA Gold Medal at RSNA 2006 and also recently received the gold medal of the Asian Oceanian Society of Radiology (AOSR). Dr. Osborn is also the new chair of the RSNA Research & Education (R&E) Foundation Board of Trustees.



Anne G. Osborn, M.D., received the RSNA Gold Medal from RSNA 2006 President **Robert R. Hattery, M.D.**

RSNA Grant Leads to Defense Department Funding

Christopher D. Willey, M.D., Ph.D., recipient of two Holman Pathway Research Resident Seed Grants from the RSNA Research & Education (R&E) Foundation, has received a related grant from the U.S. Department of Defense (DoD).

Dr. Willey said his current RSNA-funded project, “The Role of Membrane Derived Second Messengers and Bmx/Etk in Response to Radiation Treatment of Lung Cancer,” helped qualify him for the DoD funding to investigate Bmx in prostate cancer tumor models.



Christopher D. Willey, M.D., Ph.D.

French-Canadian Society Recognizes Schoepf

The 2006 Dr. Jean A. Vezina Award in Innovation and Excellence, presented by the French-Canadian Society of Radiology, went to **U. Joseph Schoepf, M.D.**

Dr. Schoepf is an associate professor in the Departments of Radiology and Medicine at the Medical University of South Carolina, which he joined in 2004.



U. Joseph Schoepf, M.D.



Dave Fellers, C.A.E.

Fellers Named to PCMA Board

RSNA Executive Director **Dave Fellers, C.A.E.**, has begun a 3-year term on the board of directors of the Professional Convention Management Association (PCMA).

Fellers became RSNA's fifth executive director in 2001. He has more than three decades of experience in association management

with organizations including the American Association of Neurological Surgeons and the American Society of Plastic Surgeons.



David B. Fraser, M.D.

Fraser is Distinguished Dalhousie Alumnus

David B. Fraser, M.D., 1998 RSNA president, has received an alumni achievement award from Dalhousie University in Halifax, Nova Scotia.

Chair of the Radiology Department at Dalhousie for 17 years, Dr. Fraser also was president of the medical staff in 1985. Now retired, he continues to contribute to the university through the David B. Fraser Learning Resource Centre in the Department of Radiology.

Dr. Fraser also is known for bringing the first MR imaging machine to Nova Scotia and for establishing Dalhousie's Department of Radiology Research Foundation in 1983.



Send news about yourself, a colleague or your department to rsnanews@rsna.org, 1-630-571-7837 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.

MY TURN

As Communication Evolves, So Must Communicators

"NOTHING IS PERMANENT EXCEPT CHANGE" HERACLITUS (540-475 B.C.)

THE ACCELERATING pace of change we as radiologists are witnessing today is mesmerizing. To thrive, one has to embrace this change and recognize new opportunities.

Our environments and habits have been transformed, as the mountain of slides we used to carry has been replaced with a memory stick. Huge, dusty file rooms have been replaced with filmless and paperless departments, rows of file cabinets with a few drawers and a powerful computer.

Powerscribe, by making reports available immediately, is improving patient care. PACS allows more efficient information exchange and better oversight of workflow—no more lost films or films unread for days. Carefully composed letters have all but vanished in a whirlwind of telegraphic SMS and e-mails. The way we find and store information and the way we communicate is changing who we are. Ask someone for the time, and you can tell

their age. Young people look at their cell phones, while others still look at their watches.

In the world of medical publication, the biggest change has been the shift to online. One cannot simply post a conventional textbook-style article online—the design and information users seek are vastly different. Not long ago, we tore the pages from journals and kept them in manila folders. Today, we download journal articles, search through thousands with a few keystrokes and link from one to another in a matter of seconds.

A single dimension in anything no longer meets our standards. We communicate via multiple media—voice, photography, video, text—using just one device, so it's not surprising that we also seek multiparameter displays of anatomy and function on a single machine. Image fusion and integration are here to stay.



Hedvig Hricak, M.D., Ph.D.

Technological changes are also helping us learn more effectively. Traditionally, most teaching has been done through didactic lectures and reading, even though we absorb only 5-10 percent of the information conveyed that way. Now, with interactive teaching—aided by video displays, online chat rooms and Webcasts—we engage in discussion and even participate in image interpretation from a distance. Using these modes of learning, we retain more information.

The spectrum of what we can now do, and the dynamism of how we do it, is exciting. Information overload may be a problem, but the electronic age has arrived. We'd better learn how to manage—and enjoy—the change.

Hedvig Hricak, M.D., Ph.D., is the RSNA Board Liaison for Publications and Communications. Dr. Hricak is the Carroll and Milton Petrie Chair of the Department of Radiology at the Memorial Sloan-Kettering Cancer Center in New York.

My Turn
ONE
RADIOLOGIST'S
VIEW

Radiologists Brace for Effects of DRA Cuts

DESPITE THE vigorous eleventh-hour efforts of advocacy groups such as the American College of Radiology (ACR), the Deficit Reduction Act of 2005 (DRA) went into effect on January 1, 2007, cutting outpatient imaging reimbursements in a way that some forecast to be profoundly devastating for radiologists.

Created by Congress during a late-night session in December 2005, the controversial act imposes Medicare payment caps on imaging and computer-assisted services in physicians' offices, limiting technical component reimbursement to the lesser of what would be paid under the Hospital Outpatient Prospective Payment System (HOPPS) or Medicare fee schedules.

The cuts come on the heels of other provisions recently implemented. The multiple imaging payment reduction reduced payments on contiguous body parts by 25 percent and the fee schedule payment increase lowered payments to 2005 levels.

Lobbying efforts by ACR and other organizations failed to persuade Congress to adjust the provisions of the DRA before it adjourned in mid-December. However, radiologists—along with physicians in other specialties—will reap some benefits from a Congressional decision not to reduce the Medicare Physician Fee Schedule.

Although the effects of the DRA on individual radiologists are difficult to predict, many in the industry foresee troubling consequences for radiology and, ultimately, patient care.

Patient, Payer Mix Will Determine Impact

One early indicator of the DRA's potential impact is a survey of practicing radiologists commissioned by ACR.



John Patti, M.D.
North Shore Medical Center, Salem, Mass.



Jonathan Breslau, M.D.
Radiological Associates of Sacramento

Released in October 2006, the survey reported that nearly half of the responding radiologists have some technical-component income, either directly or as a percentage of global billing. The survey also found that for all payers across those practices, the technical component represented 35 percent of their income, while Medicare made up approximately 13 percent. However, these averages conceal the disparities in effects of the cuts on individual radiologists. Those hit hardest will be physicians with significant portions of income from technical components or global billing and those with more Medicare patients.

"Clearly a practice that is completely hospital-based is not going to be affected at all, while a practice with five MR imaging units is going to be affected severely," said John Patti, M.D., chair of the ACR Commission on Economics and a radiologist at North Shore Medical Center in Salem, Mass.

Jonathan Breslau, M.D., of Radio-

logical Associates of Sacramento in California, said that implications for radiologists will also hinge on their payer mix.

"If you do not see any Medicare patients, this will not directly affect you immediately," said Dr. Breslau. "However, ultimately it will affect everyone because payers will cut their reimbursement in line with Medicare."

MR Imaging Hit Hardest

Of the 524 radiology codes that have a technical component, only 145 are affected by the DRA, according to a report by The Moran Company, a Washington-based healthcare research and consulting firm. Of those 145, however, 126 (87 percent) are paid at a rate below the estimated cost of performing the procedure in an office setting.

"The DRA affects only certain codes, and a practice may or may not use a large preponderance of those codes," Dr. Patti said.

Continued on next page

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The survey also found that nearly nine out of every 10 imaging procedures affected by DRA cuts are reimbursed below what it costs physicians to provide the exam.

Not all procedures are affected equally. Based on an article published in the October 2006 issue of the *Journal of the American College of Radiology*, MR imaging is the modality hardest hit by the payment reductions. Average aggregate payment reduction on the technical component for MR imaging is estimated at approximately 35 percent.

Other affected codes include ultrasound (predominately cardiac codes), which decreases approximately 30 percent. MR angiography decreases 25 percent and CT angiography goes down 37 percent. CT will decrease only 9 percent.

Patient Access Could Be Lost

Perhaps the leading concern, say experts, is the effect the imaging cuts will have on patient care. Many worry the cuts will force outpatient radiology practices to cut back on Medicare patients to make up lost revenue.

“The Moran Company report shows that the DRA provisions focus on procedures that Medicare patients often need, such as in the diagnosis and treatment of brain cancer, heart problems and osteoporosis,” Arl Van Moore, M.D., chair of the ACR Board of Chancellors said in a press release.

This could result in less patient access, particularly in rural areas, as well as increased wait and travel times for imaging procedures. If outpatient access is affected, Medicare patients with less access may end up going for procedures at a hospital that may not be able to handle the workload.

“The cuts will cause radiologists to look critically at whether they can afford Medicare beneficiaries if they don’t have other income to cover their losses,” said William T. Thorwarth Jr., M.D., past-chair of ACR’s Commission on Economics, ACR past-president and

a radiologist at Catawba Radiological Associates in Hickory, N.C. Dr. Thorwarth is also a member of the RSNA Research & Education Foundation Board of Trustees.

The reality of the DRA cuts may force affected radiologists to rethink their business practices.

“Radiologists will need to operate more efficiently, whether that means reading more studies in a day or having fewer radiologists on staff, but everyone will have to seriously look at cutting costs,” Dr. Breslau said.

Dr. Breslau does not think belt-tightening is necessarily a bad thing. In some cases, he said, “it might be good for the long-term health of a practice.”

Access to procedures commonly known to be loss-leaders, such as mammography and CT angiography, may be affected as well.

“If you have an imaging facility that is doing mammography and MR, and it’s using MR to subsidize mammography, and your MR gets cut by 40 percent, it may not be cost-effective to deliver these mammography services,” said Dr. Patti.

Another concern is that radiologists may delay technical or computer upgrades as decreased revenue slows a practice’s larger expenditures. Dr. Breslau predicts his practice will tighten capital expenditures after doing its own DRA-related financial analysis.

DRA Possibly a Glimpse into Future

Ultimately, however, some think the DRA cuts may be a harbinger for future trends in radiology.

“Basically, what’s happening on a macro level is a continuation of increasing utilization of imaging in all healthcare,” said Dr. Breslau. “Imaging costs are a bigger and bigger target for payers and regulators.”

Reducing inappropriate utilization is complicated, and Dr. Breslau worries

that Congress will continue to focus on simple solutions.

“Just saying ‘we’re going to cut across the board with the stroke of a pen’ is very simple,” he said. “I’m concerned that the simple fix will be the way that they continue to approach this complex problem.”

One thing radiologists can do, he said, is support ongoing research in technology for new imaging techniques. Then, as cuts in more established technologies are made, new technologies can help preserve radiologists’ position in medical care, he said.

ACR has joined other patient advocacy groups, medical manufacturers and providers to form the Access to Medical Imaging Coalition (AMIC) and has drafted two bills (HR 5704 and S 3795) calling for a 2-year moratorium on technical component payment caps.

Ultimately, however, there are no easy fixes. Dr. Patti urged each individual practice to do its own analysis to determine what the DRA’s impact will be.

“I think we’re going to have to wait and see if there’s any relief from this or not,” said Dr. Patti. □

Radiologists will need to operate more efficiently. Everyone will have to seriously look at cutting costs.

Jonathan Breslau, M.D.

■ The full text of the Deficit Reduction Act of 2005 is available at thomas.loc.gov/cgi-bin/query/z?c109:S.1932.ENR:

Giving and Receiving Part of Experience for Visiting Professors in Chile

JUST A MONTH after returning from Chile as part of an international visiting professor team, Thomas Lee Pope, M.D., was ready to go again.

A clinical professor of radiology/orthopedics at the Medical University of South Carolina in Charleston, Dr. Pope said he waited three years to be a part of the program.

“I would do it again in a heartbeat. I had a great time and I met some people that I now consider friends,” said Dr. Pope, who went to the South American country in October to lecture at the Chilean Congress of Radiology and visit with local radiology residents.

Along for the 16-day trip that included stops at hospitals in the capital city of Santiago and Concepción as well as the conference in Viña del Mar, was John Gilbert Strang, M.D., an associate professor of radiology at the University of Rochester School of Medicine in New York. Remarking on the vast differences between radiology in the U.S. and in Chile, both physicians said they were also able to receive as much as they gave during the trip.

Established in 1986, the RSNA International Visiting Professor Program annually sends teams of North American professors to lecture at national radiology society meetings and visit with radiology residency training programs at selected host institutions in developing nations. The goal is to foster teaching and a cultural exchange between radiology departments in the U.S. and those in other countries. The RSNA Committee on International Relations and Education administers the program.



Image courtesy of Thomas Lee Pope, M.D.

Thomas Lee Pope, M.D., and John Gilbert Strang, M.D., visited the Andes east of Santiago during a trip to Chile as part of the RSNA International Visiting Professor program.

Chile occupies a long and narrow coastal strip wedged between the Andes mountain range and the Pacific Ocean and is the longest country in the world at more than 2,600 miles long.

Gap Exists Between Private and Public Hospitals

Drs. Pope and Strang spoke with at least 50 radiology residents at hospitals in Santiago and Concepción, the only Chilean cities with radiology teaching programs. Dr. Strang said he saw big differences between the cities.

“Santiago is a modern city of around 5 million people and it has

about anything a person could need,” he said. “Concepción, on the other hand, is an industrial city with about a million people.”

You have to keep going out and seeing what others are doing and bringing it back.

We made improvements to our practice based on what we saw there.

John Gilbert Strang, M.D.

The doctors also observed clear differences between imaging centers in Santiago’s private teaching hospitals—which employed technology similar to that available in the U.S.—and the public health system.

“Mainly they have public hospitals, which do 80 percent of the care,” Dr. Strang said. “They are entirely paid for by the state and they are limited. So

Continued on next page



John Gilbert Strang, M.D. (above, second from right, and in other photos) accompanied **Thomas Lee Pope, M.D.**, on a trip to Chile that involved stops in Santiago, Concepción and Viña del Mar.



Images courtesy of Thomas Lee Pope, M.D.

Continued from previous page

they don't have the most modern technology."

Little interventional radiology is practiced in Chile, he added. "They do have MR at the bigger and better hospitals, but not at most public hospitals," Dr. Strang said. "And in Chile, nuclear medicine is an entirely separate field."

Education Focuses on Diagnostic Radiology

The residency standards, as well as the technology, differ from those in the U.S. "Their residents do three years of training. Here we do four years of radiology and a year of internship," Dr. Strang said. "And they do mostly diagnostic radiology, since they don't do interventional or nuclear medicine."

As for the residents themselves, Dr. Pope said he saw quite a bit of variation in skill. "Most of my discussions were musculoskeletal tutorials," he said. "In Concepción, I left them with 350 slides of my cases to help them with future cases they might see."

While Chilean radiologists face challenges due to a lack of technology, the government is beginning to invest in the public hospitals, Dr. Strang said.

"The Chilean economy is doing quite well now because they are the largest copper mining country in the world," he said. "They have begun to

invest in multidetector CT." As radiology has gained popularity in Chile, he said, the government has identified CT as offering the greatest benefit to the healthcare system at the least expense.

"The private teaching hospitals already had that, but this is a major investment in their public teaching hospitals and it will dramatically alter their practice," he said.

Professors Gain Experience

For all the knowledge and experience he and Dr. Strang shared, said Dr. Pope, the Chilean radiologists had something to teach as well.

"By not doing MR, they do much more musculoskeletal ultrasound and I saw good examples of how that can benefit some patients," he said. "I want to go back there to learn more about their ways of doing that."

The doctors also took some time out, touring the Andes, sightseeing in the port city of Valparaíso and visiting the former home of the poet Pablo Neruda, which is now a museum.

"It is a beautiful country," said Dr. Strang. "The weather was mid-spring when we were there and because the country is narrow, wherever you are

you can see the Andes."

Dr. Pope praised his hosts Gloria Soto, M.D., president of the Chilean Radiological Society, and John MacKinnon, M.D., the society's past-president. "Culturally I learned a lot and the camaraderie with the radiologists at the meeting where we spoke was great," he said.

Dr. Strang said he learned how essential it is to keep up with the ever-changing practice of medicine—close to home and globally.

"You have to keep going out and seeing what others are doing and bringing it back," he said. "We made improvements to our practice based on what we saw there."

In 2006, RSNA also sent visiting professors to India, Malaysia, Lithuania and Mexico. In 2005 professors traveled to Sri Lanka, Thailand, Mexico and Brazil. For more information on the program, go to RSNA.org/International/CIRE/ivpp.cfm. □

Active Aging Population Drives Knee Imaging Innovations

AN AGING U.S. population wanting to stay active longer and steady improvements in imaging quality are changing not only how musculoskeletal radiologists look at the knee and what they look for, but also why they are looking.

As the average age of the U.S. citizen increases, doctors are seeing more patients with osteoarthritis, which in turn creates a bigger healthcare cost burden, said Timothy J. Mosher, M.D.

“We’re also seeing that people want to stay more active later in life—they want to get out there and maintain a level of activity and exercise,” said Dr. Mosher, an associate professor of radiology and orthopedics, vice-chair for clinical radiology research and chief of musculoskeletal and MR imaging at Penn State University College of Medicine in Hershey.

People are also seeking shorter recovery periods and requesting imaging at an earlier stage, Dr. Mosher added. “They are demanding a higher level of function from their bodies and they are looking for that in the diagnosis of their injuries as well.” All of this, he said, is helping drive the growth of musculoskeletal MR imaging.

Seeking Underlying Disease

In response, said Dr. Mosher, more musculoskeletal radiologists are seeking ways that imaging can help not only treat knee disease and injury symptoms, but also go after the fundamental disease process. In the case of osteoarthritis, that means slowing the rate of damage to knee cartilage, which requires better ways of looking at the knee and determining its structural integrity, said Dr. Mosher.

Knee imaging is indeed moving in



Timothy J. Mosher, M.D.
Penn State University



Levon N. Nazarian, M.D.
Thomas Jefferson University



William B. Morrison, M.D.
Thomas Jefferson University Hospital

a preventive direction, said William B. Morrison, M.D., director of the Division of Musculoskeletal and General Diagnostic Radiology Department at Thomas Jefferson University Hospital in Philadelphia. He pointed to the example of identifying meniscal extrusion in the knee, where the fibrocartilage support structure becomes dysfunctional, often accompanied by certain types of meniscal tears—a primary risk factor for the development of knee osteoarthritis.

Rather than treating meniscal tears by debriding them, more doctors are seeking to restore the functional meniscal structure, preserving as much of the tissue as possible in order to prevent osteoarthritis, said Dr. Morrison. Radiology can help facilitate this type of preventive treatment by imaging meniscal dysfunction in the knee, potentially under weight-bearing conditions, he said.

Functional Imaging Innovation Mirrors that of Brain, Heart

This type of research has been made possible in recent years by vast improvements in MR imaging, including the development of the 3.0 Tesla scanner. Knee cartilage is very thin tissue, said Dr. Mosher, and using 3.0 Tesla has allowed radiologists to “make more confident diagnoses of cartilage

injury than we were able to five years ago.”

In addition to the usual anatomic imaging, radiologists now need to consider the functional properties of the knee and how various tissues respond to pivotal and biochemical loads.

“In the future,” said Dr. Mosher, “we’re going to be looking at MR imaging

as a way of seeing how the tissue is reacting to what is being asked of it, much as we currently do with functional brain imaging or functional cardiac imaging.”

And it’s certainly not just MR

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People are demanding a higher level of function from their bodies and they are looking for that in the diagnosis of their injuries as well.

Timothy J. Mosher, M.D.

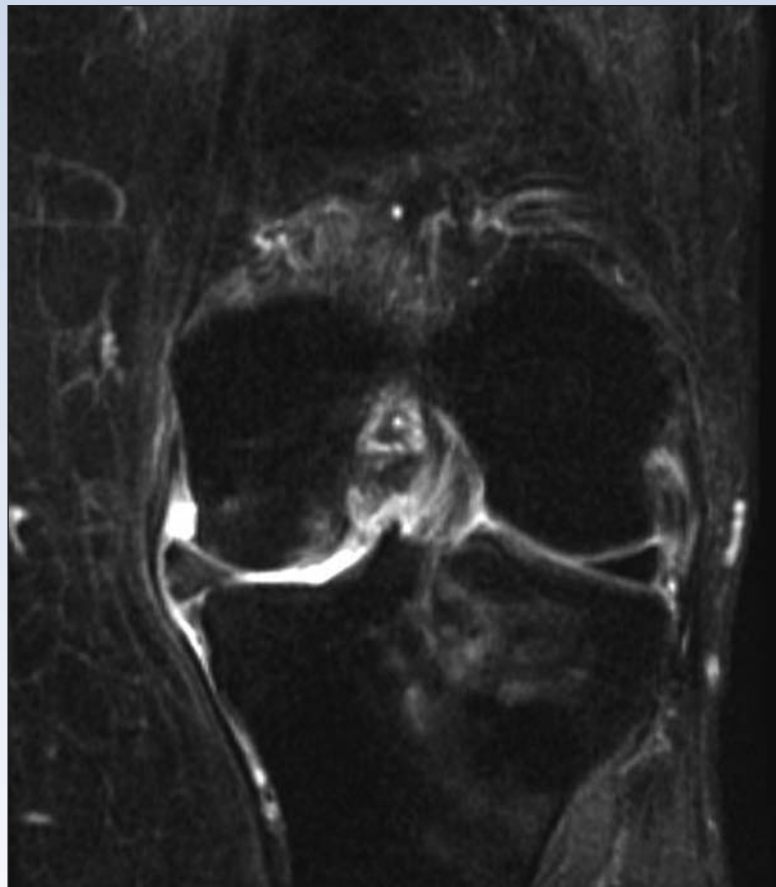
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imaging that's moving rapidly into new areas of musculoskeletal and knee research. Improvements in imaging quality are making ultrasound a very important part of the process as well, said Levon N. Nazarian, M.D.

"The resolution with ultrasound is so superb that I'm finding you can detect abnormalities that may be difficult even for MR imaging," said Dr. Nazarian, a professor and vice-chair for education in the Department of Radiology at Thomas Jefferson.

Ultrasound is particularly well suited to detecting knee issues that can only be seen dynamically, such as "popping" or "clicking" symptoms when a patient makes a certain type of knee motion, said Dr. Nazarian. However, he said, the U.S. lags behind Europe in applying ultrasound to these types of knee diagnoses. "We write articles on ultrasound appearances of the knee tendons and the Europeans say 'What are you talking about? We've been looking at these things for the past 15 years.'"

Dr. Nazarian said ultrasound does have its limitations—for example, its inability to penetrate bone makes certain areas of the knee hard to see. Still, while MR imaging provides superior evaluation of bone marrow, ligaments and abnormalities deep in the knee joint, ultrasound provides better resolution of the superficial knee structures and adds the benefit of dynamic evaluations. "I think ultrasound needs to have a more central role in musculoskeletal imaging in general," said Dr. Nazarian. "It really should have a complementary role to MR imaging."



Coronal T2-weighted fat-suppressed MR image of the knee shows medial meniscal extrusion with associated diffuse medial compartmental cartilage loss.

Image courtesy of William B. Morrison, M.D.

Ultrasound Aids Accurate Interventional Procedures

Ultrasound also plays a key role in guiding interventions, said Dr. Nazarian. He noted that, given the complexity of the knee structure, injection treatments hit the intended target only about three-quarters of the time. In the past few years, said Dr. Nazarian, the use of ultrasound to improve the accuracy of injections and procedures around the knee—such as the drainage of Baker cysts—has greatly increased.

Looking ahead, Dr. Nazarian sees great potential for the use of new 3D technology in improving the efficiency of ultrasound for diagnosing knee disease and injuries. "As ultrasound tech-

nology continues to advance," he said, "so does the application of ultrasound to the evaluation of the musculoskeletal system."

Dr. Mosher sees similar potential for MR imaging in the future and noted that imaging will play an important role in understanding how exercise affects the older athlete in a society in which many people see staying fit and mobile longer as a priority. □

■ For descriptions of sessions on knee imaging and other courses at RSNA Highlights: Clinical Issues for 2007, go to RSNA.org/HighlightsConference.



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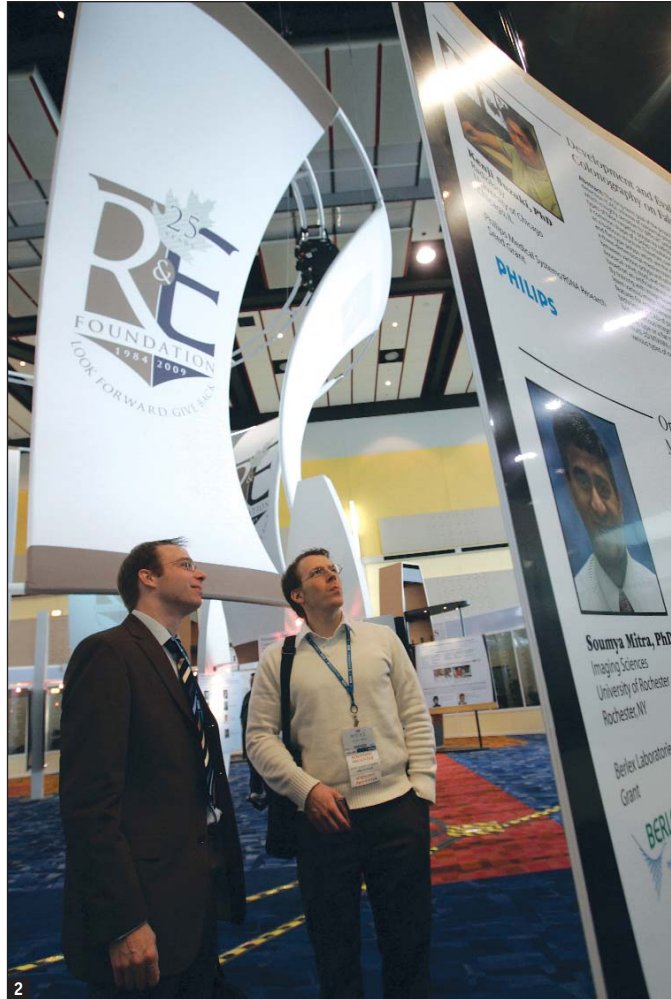


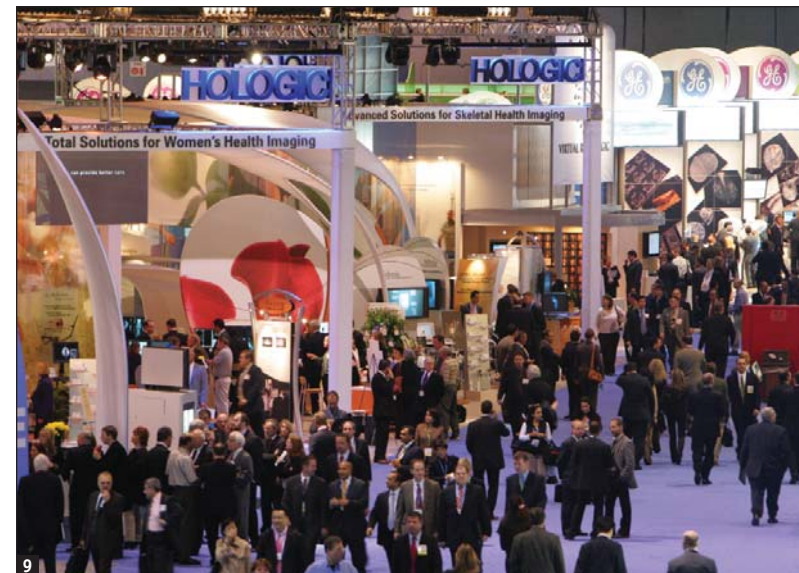
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A Look Back at RSNA 2006

IN ITS 92nd year, the RSNA annual meeting marked the debut of several new features, as well as enhancements to many existing offerings. While attendees took advantage of a new layout for scientific posters and education exhibits and records were being broken in the technical exhibit hall, the RSNA Research & Education Foundation found new ways to entertain and inform.





1. In the Cases of the Day area, participants submitted diagnoses for unknown cases in different categories.
2. In the RSNA Research & Education (R&E) Foundation area, attendees learned about grant recipients and their projects.
3. RSNA 2006 attendees could purchase such resources as refresher courses on CD-ROM and syllabi in the Education Center Store.
4. Kofoworola Oluwatoyin Soyebi, M.B.Ch.B., of Lagos, Nigeria, was presented with RSNA honorary membership.
5. More than 750 exhibitors made up the RSNA 2006 technical exhibition.
6. Theodore S. Lawrence, M.D., Ph.D., delivered the Annual Oration in Radiation Oncology at RSNA 2006.
7. RSNA enhanced the WiFi and Internet Zones available at McCormick Place during RSNA 2006.
8. Chefs freshly prepared authentic selections from Chicago neighborhoods.
9. The RSNA 2006 technical exhibition was a record-breaking 519,900 square feet.
10. An R&E skit depicted the past, present and future of radiology research.
11. Computer workstations in the Lakeside Learning Center were arranged so attendees could gather for discussion.
12. At hands-on workshops, attendees learned from industry representatives about their proprietary computer systems.

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 Brijesh Reddy, M.D.
 William D. Reed, M.D.
 Shawn S. Reinhart, M.D.
 Marta & Carlos S. Restrepo, M.D.
 James T. Rhea, M.D.
 Joe C. Rice, M.D.
 Dan H. Rich, M.D.
 Ilene & Yale Richmond, M.D.
 Milly & Paul A. Riemenschneider, M.D.
 George T. Ripeckyj, M.D.
 Jacqueline & Leroy Roberts Jr., M.D.
 Russell L. Roberts Jr., M.D.
 Hugh James F. Robertson, M.D.
 Davene & Berthland S. Rodney, M.B.B.S.
 David M. Roelke, M.D.
 Lisa & Neil M. Rofsky, M.D.
 Anna Rokhlenko, M.D.
 Elizabeth S. Burnside, M.D., M.P.H. & Patrick Rollins
 Ayala T. Rosenbaum, M.D.
 William F. Rosner, M.D.
 Patricio G. Rossi, M.D.
 Lauren H. & Richard D. Rossin, M.D.
 Allen J. Rovner, M.D.
 Scott J. Rowen, M.D.
 Anna D. & Thomas G. Rudd, M.D.
 Marilyn J. Goske, M.D. & Richard A. Rudick
 Marwan H. Saab, M.D.
 Norman L. Sadowsky, M.D.
 Ayesha & Maqbool A. Salam, M.D.
 Kenneth V. Salce, M.D.
 Anthony F. Salvo, M.D.
 Robert G. Schiff, M.D.
 Amy L. & Brian J. Schiro, M.D.
 Alan E. Schlesinger, M.D.
 Andrew M. Schneider, M.D.
 Paul W. Schneider, D.O.
 Stefan H. Schneider, M.D.
 James A. Schnur, M.D.
 U. Joseph Schoepf, M.D.
 Stephanie A. Schwartz, M.D.

Sheryl & Mark E. Schweitzer, M.D.
 Leslie M. Scoutt, M.D.
 Lewis I. Segal, M.D.
 Leon S. Serchuk, M.D.
 Rodney G. Shaffer, M.D.
 Julie & Martin M. Shaperman, M.D.
 R. Kendall Shelton, M.D.
 John P. Shoosmith, M.D.
 Gary E. Simmons, M.D.
 Julian T. Simmons, M.D.
 Destiny Kinal & Barry P. Skeist, M.D.
 Michael L. Sloan, M.D.
 Ellie & Thomas L. Slovis, M.D.
 Bonnie R. Smith, M.D. & Forrest M. Smith
 Herschel H. Solomon, M.D.
 Virginia & Edward A. Solomon, D.O.
 Sat Somers, M.D.
 Daniel N. Sommers, M.D.
 Rahul A. Somvanshi, M.D.
 Swithin J. Song, M.B.B.S.
 Karen & Andrew H. Sonin, M.D.
 Suzanne & Richard N. Southard, M.D.

Eric R. Sover, D.O.
 Shelley J. Spaner, M.D.
 Jennifer & Michael S. Stecker, M.D.
 Richard P. Stewart, M.D.
 Donna & Randall H. Stickney, M.D.
 Steven J. Strober, M.D.
 Kenneth P. Sullivan, M.D.
 Deborah A. Summa
In memory of A. Francis Summa, Ph.D.
 Chris C. Sung, M.D.
 John H. Sutphen, M.D.
 Gordon K. Sze, M.D.
 S. Murthy Tadavarthy, M.D.
 Kristian Talle, M.D.
 Akihiro Tanimoto, M.D.
 Chariya & Preecha Tawjareon, M.D.
 Nina L. J. Terry, M.D., J.D.
 Carol & Thomas R. Thompson, M.D.
 Linda P. Thomas, M.D.
 Mariam Thomas, M.D.
 Stanford B. Trachtenberg, M.D.
 Bradley R. Trotter, M.D.

Michael R. Tryhus, M.D.
 Sidney Ulreich, M.D.
 Frances M. Unger, M.D. & Lawrence M.
 Unger
 Debera & Jonathan J. Uy, M.D.
 Nagendram & Rajendra P. Valiveti, M.D.
 Donald T. Van de Water, M.D.
 Marla & Paul E. Van Dyke, M.D.
 Francisco C. Vargas, M.D.
 Kavita Rajkotia & Murugusundaram
 Veeramani, M.B.B.S.
 Peter Vock, M.D.
 Aparna Vootkur, M.D.
 Mark S. Wadina, M.D.
 Claire M. Waite, M.D. & Justin Waite
 Edwin Yen Wang, M.D.
 Michael P. Wang, M.D.
 Ruth M. L. Warren, M.D.
 James H. Watt, M.D.
 Susan & James R. Weeks Jr., M.D.
 Jeffrey P. Weingardt, M.D.
 Meredith & Benjamin A. Wendell, M.D.

Donald B. Wheeler Jr., M.D.
 William M. Whetsell, M.D.
 Paul R. White, M.D.
 Judy G. & Tom W. White, M.D.
 Scott D. Wiedenmann, M.D.
 Robert G. Wilson, M.D.
 George E. Wislo, M.D.
 Robin & Clifford R. Wolf, M.D.
 Jason T. Wong, M.D.
 William L. Woodard Jr., M.D.
 Robert E. Woods, M.D.
 Christine W. Wu, M.D.
 Hiraku Yodono, M.D.
 Richard S. Young, M.D.
 Marilyn & David M. Yousem, M.D.
 Yvonne M. DeCuir, Ph.D. & Robert K. Zeman,
 M.D.
 Peter T. Zimmerman, M.D.
 Olga & Christoph L. Zollikofer, M.D.
 Karel J. Zuiderveld, Ph.D.

Program and Grant Announcements

Oncologic Image-Guided Interventions: Opportunities for Collaboration

February 1–2, 2007 • Bethesda North Marriott, Maryland

This meeting is designed to encourage collaboration among industry, academia and federal agencies in oncologic image-guided interventions (IGIs) such as clinical trials of IGI cancer therapies and procedural and systems simulation for imaging guidance and therapy delivery. Also addressed will be ideas such as a “plug and play” environment to improve intraoperability among guidance and therapy modalities. For more information, go to <https://cms.palladianpartners.com/cms/1154973321/index.shtml>.

Tools for Success in the Practice of Radiology

June 29–30, 2007 • RSNA Headquarters, Oak Brook, Ill.

Designed for current and future leaders, this course will be directed by Claire E. Bender, M.D., of the Mayo Clinic College of Medicine. The course will be customized so that participants not only learn about but also discuss proven tools for creating and sustaining success in the practice of radiology. Sessions on financial issues, strategic planning, staff development, compliance and legal matters will help participants confidently navigate the obstacles that radiology practices face.

Early registration is encouraged, as participation in this personalized interactive course will be limited. For more information on course registration and housing, go to RSNA.org/education or contact the Education Center at 1-800-381-6660 x7772.



Revitalizing the Radiology Research Enterprise

Applications Now Being Accepted

RSNA is now accepting applications for the Revitalizing the Radiology Research Enterprise (RRRE) program site visits to evaluate the departmental and institutional research environment. The RRRE program is designed to help academic radiology departments improve their ability to support and conduct radiologic research. Six departments will be selected from applications made by departments of radiology, radiation oncology and nuclear medicine.

In addition, an RRRE 1½-day workshop planned for October in Oak Brook, Ill., will focus on challenges to and strategies for conducting research in radiology and radiation oncology departments. To obtain an application or information about the site visits or workshop, please contact Tracy Schmidt, M.S., at tschmidt@rsna.org or 1-630-368-3751.



World Conference on Interventional Oncology and Society of Thermal Medicine Joint Annual Meeting

May 14–18, 2007 • Washington Hilton Hotel

Looking globally at the role of image-guided interventions in cancer treatment, this conference will also take advantage of its proximity to federal agencies like the National Institutes of Health and the U.S. Food and Drug Administration. RSNA is co-sponsor of this conference. More information is available at www.wcio2007.com.

Journal Highlights

The following are highlights from the current issues of RSNA's two peer-reviewed journals.

The National Institute of Biomedical Imaging and Bioengineering and NIH Grant Process: An Overview

NEWCOMERS to the process of applying for a grant from the National Institutes of Health (NIH) may find it to be a formidable undertaking. Even to veterans the serious effort needed and the volume of writing and other work required can seem daunting.

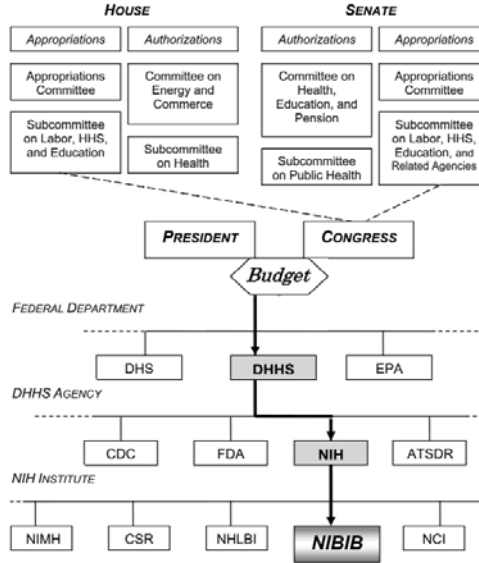
Radiology

In a review article in the January issue of *Radiology* (RSNA.org/radiologyjnl), Anthony B. Wolbarst, Ph.D., and William R. Hendee, Ph.D., of the University of Kentucky, describe the procedures by which investigators may obtain research funding from the National Institute of Biomedical Imaging and Bioengineering (NIBIB) and other NIH institutes and centers.

"The process of applying for a research grant is demanding for an applicant and, not infrequently, leads initially to disappointment," writes Dr. Wolbarst. "But an idea that is novel, potentially of substantial importance, and well and appropriately presented has a good chance of ultimate success."

Information available on the Internet is quite scattered and can be too highly detailed for someone just starting the process, said Dr. Wolbarst. His intention, he writes, is to provide a linear overview, with references to sites where readers can find more information. Among the topics he addresses:

- Categories of NIH grants and award mechanisms
- Imaging research areas supported by the NIBIB
- Life cycle of an R01 grant



Funding of NIBIB and its grants.

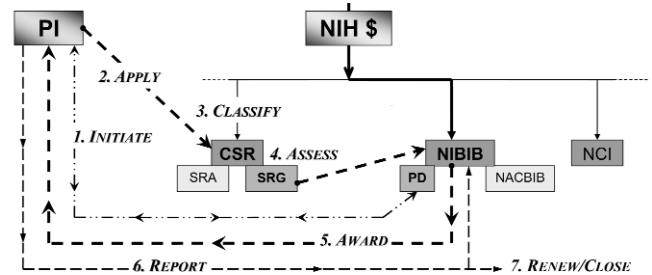
Each year the President proposes a budget for the Department of Health and Human Services (DHHS) and the other federal agencies. The White House and relevant congressional committees together work out the details, from DHHS, through NIH, down to the level of NIBIB (arrows). ATSDR = Agency for Toxic Substances and Disease Registry, CDC = Centers for Disease Control and Prevention, DHS = Department of Homeland Security, EPA = Environmental Protection Agency, FDA = Food and Drug Administration.

(*Radiology* 2007;242:32-55) © RSNA, 2007. All rights reserved. Printed with permission.

Schematic of life cycle of grant application, showing essential features.

From the outset, the principal investigator (PI) remains in contact with the appropriate NIBIB program director (PD).

The PI submits a grant application to NIH Center for Scientific Review (CSR), where it is classified and assigned to a particular Scientific Review Group (SRG). After peer review of the application's scientific and technical merit, SRG gives it a priority score, which the scientific review administrator (SRA) forwards to NIBIB. The National Advisory Council on Biomedical Imaging and Bioengineering (NACBIB) provides a second level of scientific and technical review of applications. Based on the NIBIB budget allocation from NIH and its current program objectives, the application's priority score and NACBIB approval, NIBIB makes a funding decision that, if positive, results in an award. In that case, the PI must submit an annual progress report that demonstrates that the project is on track. To continue after expiration of the funding, the PI can submit a competitive renewal application.



- Animal and human subjects
- Peer review assessment of an application by a scientific review group
- Annual progress report for a funded application

The process of applying for a grant can be arduous, writes Dr. Wolbarst, but it also "provides the researcher with a

rare opportunity to crystallize his or her thinking on all aspects of the project—the basic science behind it, the validity of the hypotheses, the advantages of different ways of carrying out the experiments, and the implications of the results. While some of this may seem like drudgery, it is the essence of good science."

Cardiovascular MR Imaging in Neonates and Infants with Congenital Heart Disease

WHEN echocardiography does not provide sufficient information in neonates and infants with congenital heart disease (CHD), cardiovascular MR imaging offers an established, less invasive alternative to angiocardiology that does not involve **RadioGraphics** catheterization or ionizing radiation.

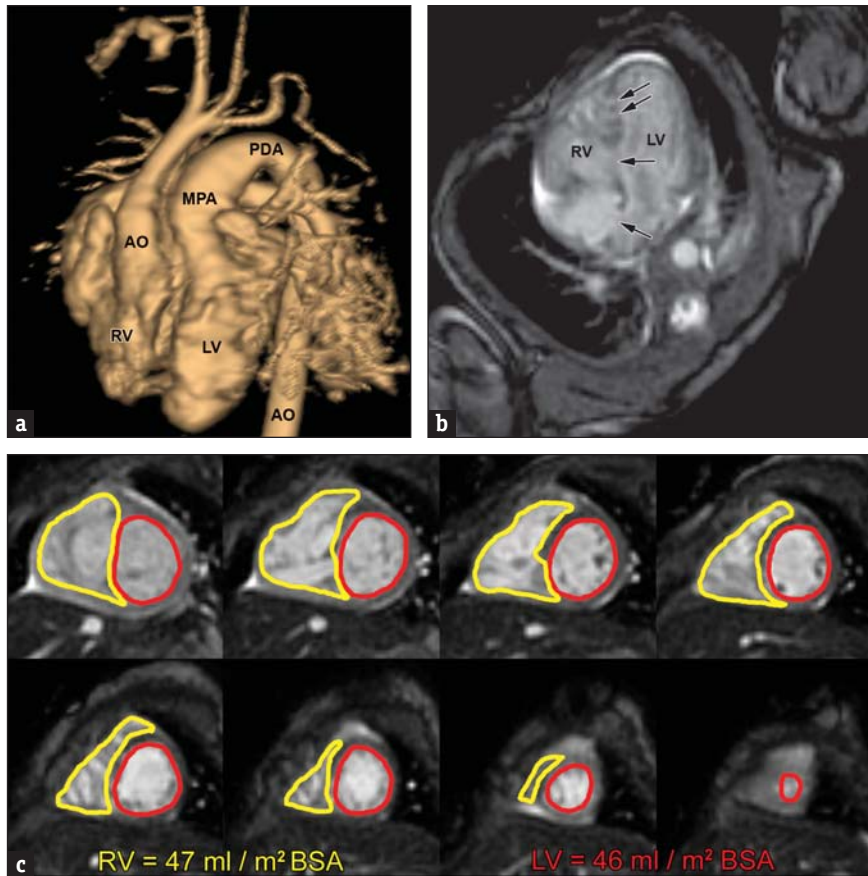
In an article in the January-February issue of *RadioGraphics* (RSNA.org/radiographics), Christian J. Kellenberger, M.D., of University Children's Hospital in Zurich, Switzerland, and colleagues discuss the increasing use of cardiovascular MR imaging in neonates and infants for the initial investigation of CHD or as follow-up after surgery or catheter-guided intervention.

Specifically, the authors:

- Illustrate MR imaging techniques including contrast material-enhanced MR angiography, cine imaging and phase-contrast velocity mapping
- Address the technical adjustments necessary for imaging small babies with high heart rates
- Enumerate common indications for cardiovascular MR imaging in the neonate and infant population, including abnormalities of the aorta and pulmonary vasculature, complex CHD, borderline hypoplastic left heart syndrome and tumors

This article meets the criteria for 1.0 AMA PRA Category 1 Credit.

“Cardiovascular MR imaging provides both morphologic and functional information that can be decisive in the treatment of neonates and infants with CHD,” Dr. Kellenberger and colleagues conclude. “The capacity of MR imaging to accurately demonstrate complex abnormalities of the entire thoracic vasculature can obviate potentially harmful cardiac catheterization in many cases.”



Interrupted aortic arch in a 3-day-old girl with transposition of the great arteries, ventricular septum defects (VSDs), and an atrial septum defect (ASD).

Severe aortic coarctation and a hypoplastic right ventricle were suspected at echocardiography. (a) Volume-rendered (VR) MR angiographic image demonstrates a type A interrupted aortic arch. Transposition of the great arteries, with the aorta (AO) arising from the right ventricle (RV) and the pulmonary trunk (MPA) from the left ventricle (LV), is clearly depicted. PDA = patent ductus arteriosus. (b) Horizontal long-axis cine image shows multiple VSDs and the ASD (arrows). (c) Short-axis cine images with measurement of the end-diastolic volumes shows equal-sized ventricles, thereby helping rule out right ventricular hypoplasia. BSA = body surface area.

(*RadioGraphics* 2007;27:5-18) © RSNA, 2007. All rights reserved. Printed with permission.

RadioGraphics Has New Cover

STARTING WITH the January-February 2007 issue, images reflecting the content in each issue of *RadioGraphics* will be featured on the cover. The new design, the third since Editor William W. Olmsted, M.D., began in 1990, is intended to emphasize the journal's mission and the advances made in radiology.

“*RadioGraphics* is the educational journal of the Society and is heavily image-based,” said Dr. Olmsted. “This will be a great way of recognizing the journal's terrific content.”

A question about the images will also be posed on the new *RadioGraphics* cover, directing the reader to the relevant article for the answer. In January 2006, images were featured on the cover of *Radiology* for the first time in the science journal's 83-year history.



Radiology in Public Focus

Press releases have been sent to the medical news media for the following articles appearing in the November issue of *Radiology* (RSNA.org/radiologyjnl):

Importance of Comparison of Current and Prior Mammograms in Breast Cancer Screening

COMPARING current mammograms with prior mammograms significantly improves overall reading performance, researchers in The Netherlands have found.

Such comparison can reduce referrals due to nonlesion locations, however limiting the availability of prior mammograms to cases selected by the reader reduces the beneficial effect, according to A.J. Roelofs, Ph.D., of the Radboud University Nijmegen Medical Center.

For the study, 12 experienced radiologists read 160 soft-copy screening mammograms—once with prior mammograms and once without. The radiologists reported 1,935 findings when prior mammograms were unavailable, versus 1,715 findings when they were available.

The transition from screen-film to full-field digital mammography prompted Dr. Roelof's study. Use of

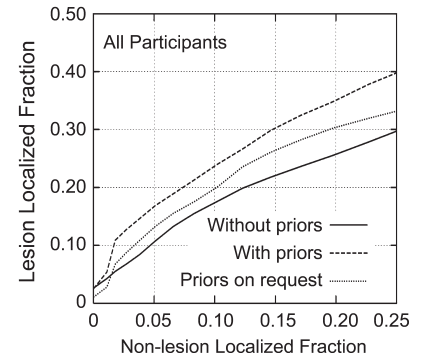
Localized receiver operating characteristic (LROC) results for reading with and reading without prior mammograms.

The availability of prior mammograms led to a considerable improvement in detection performance. Reading with prior mammograms available on request resulted in increased performance compared with reading without prior mammograms. However, reader performance in the session in which prior mammograms were available by request was lower than that in the session in which prior mammograms were always available.

(*Radiology* 2007;242:70-77) © RSNA, 2007. All rights reserved. Printed with permission.

prior mammograms amidst this transition will be particularly challenging, he writes, as reading digital images in combination with film images is difficult to organize and may lead to a loss of efficiency. Dr. Roelof notes that while these challenges could support a strategy of allowing radiologists to decide on a case-by-case basis whether to retrieve prior mammograms from patient files, his findings encourage reading prior mammograms in all cases where they are available.

“Our results suggest that prior mammograms help radiologists interpret suspicious abnormalities but have



no effect on the initial detection of these abnormalities,” writes Dr. Roelof. “In principle, this makes viable a strategy in which prior mammograms are reviewed only when radiologists deem it necessary. However, overall performance may become worse when prior mammograms are not always available, and it may be the case that prior mammograms are not requested frequently enough in clinical practice because of the additional workload involved.”

Media Coverage of Radiology

In November, 279 media outlets carried news stories generated from articles appearing in *Radiology*. These stories reached an estimated 64 million people.

Radiology press releases highlighted findings from a study on cardiac MR imaging with remote control (*Radiology* 2006;241:528-537) and a study on CT colonography screening covered by third-party payers (*Radiology* 2006;241:417-425). The CT colonography study was also the focus of a video news release.

These and other *Radiology* studies were covered by FOX News (national), Univision (national), WLS-TV (Chicago), WPVI-TV (Philadelphia), *The Sunday Telegraph* (Washington, D.C. bureau), *Washington Times*, *The Independent* (London), *American Medical News*. Stories also were carried by the Reuters and United Press International wire services, as well as Healthday, *CNN.com*, *MSNBC.com* and *Docguide.com*.



Working For You

RSNA Committees

This month *RSNA News* continues its series highlighting the work of RSNA's volunteer committees with a look at the Public Information Committee.

Public Information Committee

WORKING WITH the RSNA Public Information and Media Relations Department, the Public Information Committee helps the Society increase public awareness and understanding of radiology and the role of radiologists. The committee recommends activities to the Board of Directors based on needs assessments, the RSNA Strategic Plan and evaluations of existing public information programs.

Public information activities include press releases regarding studies appearing in *Radiology*, radiology-focused radio public service announcements and video news releases featuring high quality video of radiology procedures. During the RSNA annual meeting, the committee also helps oversee the newsroom, which assists medical

reporters covering the meeting, and hosts a career day and scholarship program for Chicago public high school students.

It's more important than ever that members of the public—especially those

who receive imaging services—know the many contributions that radiologists make to their healthcare," said Philip O. Alderson, M.D., committee chair. "The more ways and more times we can deliver that message, the better our patients and the public will understand and appreciate our efforts."

The committee also oversees a program to personally contact health editors



Philip O. Alderson, M.D.

at national media outlets and the Public Information Advisors Network (PIAN), an assembly of more than 130 radiology experts available to participate in media activities throughout the year.

RadiologyInfo.org, the public information Web site co-sponsored by RSNA and the American College of

Radiology, is another component of RSNA's public information program.

More information about the Public Information Committee, including current members and the 2006 committee chair report, can be found at RSNA.org/About/whoswho/committees/publicinformation.cfm. To learn about all committees and opportunities to volunteer, go to RSNA.org/About/volunteer.cfm.

Working for you
COMMITTEE PROFILE

MOC Resources Available

More MOC Brochures Released

RSNA has released two more titles in its series of brochures regarding the American Board of Radiology (ABR) maintenance of certification (MOC) process.

"Lifelong Learning: How Do You Find CME That's Right For You?" and "Education Plans: How Do You Create One?" are now available online at RSNA.org/Education/pdf.cfm.

Brochures will be mailed to people participating in the MOC registry, an online feature designed to assist members in participating in the



MOC process who have completed a practice profile. To participate in the MOC registry go to RSNA.org/Education/moc.cfm.

All brochures will also be available at the new RSNA Highlights conference to be held February 26–28 in Phoenix.

Radiologists who received time-limited certification are now required to complete the MOC process in 10-year cycles.

SAMs Offered Online

Now available at RSNA.org/education are self-assessment modules (SAMs) qualified by the American Board of Radiology (ABR) in meeting the criteria for self-assessment toward the purpose of fulfilling requirements in the ABR maintenance of certification program. Each module qualifies for 1 SAM credit, in addition to 2.5 *AMA PRA Category 1 CME Credits*™.

SAMs available are:

- Assessment of the Pulmonary Vessels
- MRI & Vertebrae
- Intervention in Hepatic Malignancy

Continued on next page

If you have a colleague who would like to become an RSNA member, you can download an application at RSNA.org/mbrapp or contact the RSNA Membership and Subscriptions Department at 1-877-RSNA-MEM [776-2636] (U.S. and Canada), 1-630-571-7873 or membership@rsna.org.

RSNA Highlights: Clinical Issues for 2007

Advance Registration Deadline February 5

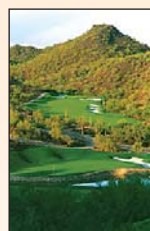
RSNA Highlights: Clinical Issues for 2007 will be held February 26–28 at the J.W. Marriott Desert Ridge Resort & Spa in Phoenix.

RSNA Highlights is a concentrated educational package, offering four refresher courses in each of these topic areas—cardiac imaging, PET/CT, breast imaging and sports injuries. Two hot topics courses, “Comprehensive Imaging for Acute Stroke Treatment” and “Optimal Techniques for Multidetector CT and MR of the Liver,” also will be offered.

Highlights attendees will also be able to access to select electronic education exhibits from RSNA 2006. Physicians can earn up to 19 *AMA PRA Category 1 Credits™* at RSNA Highlights and three self-assessment modules (SAMs) will be offered.

Get \$100 off the onsite registration rate when you register by Feb. 5. The advance housing registration deadline is Jan. 26.

United.com offers RSNA Highlights attendees a 10 percent discount on select United Airlines, United Express and TED qualifying flights. Use the electronic certificate number 553SB to make your discounted airline



Registration

	Advance Registration Deadline: Feb. 5, 2007	Onsite Registration
RSNA Member	\$550	\$650
Non-Member	\$700	\$800
RSNA Resident Member	\$150	\$150
Non-Member Resident	\$550	\$650

reservation online at *United.com*. If you prefer, call United at 1-800-521-4041 or your personal travel agent and mention the United discount ID number 553SB to be eligible for the discounted fares.

For more information about RSNA Highlights—including detailed course descriptions—and to register, visit RSNA.org/HighlightsConference.

MOC Resources Available

Continued from previous page

- The Urethra
 - Unusual Pulmonary Vascular Disease
 - Uncommon Causes of Cystic Pulmonary Disease
 - A Spectrum of Interstitial Lung Disease
 - The Role of Ultrasound in Transplant Assessment
 - FDG PET Imaging & Cancer
- Most SAMs consist of articles from

RadioGraphics, a test and a listing of additional available resources. For more information, call 1-800-381-6660 x3733.

RSNA 2006 Syllabi Available

Two new syllabi are available for purchase in print (with companion CD), as a CD-ROM only or online:

Categorical Course in Diagnostic Radiology: Genitourinary Radiology

- 22 AMA PRA Category 1 CME Credits available.

Categorical Course in Diagnostic Radiology Physics: From Invisible to the Visible—The Science and Practice of X-ray Imaging and Radiation Dose Optimization.

To order: call 1-800-272-2920 or go to RSNA.org/education.

Product News



NEW PRODUCT

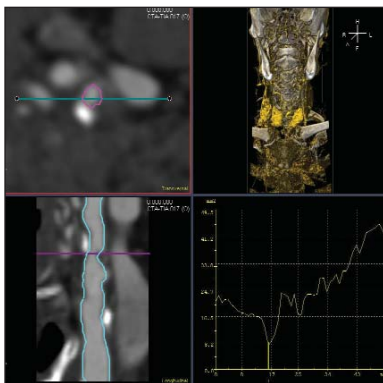
Disposable Protective Drape

THE X-DRAPE from AADCO Medical, Inc. (www.aadcomed.com) is a sterilized disposable surgical drape that addresses the issue of high-level scattered radiation emanating from a patient's body. Made from AADCO's proprietary non-lead composite radiation absorbing material, X-Ban®, the X-Drape works within the sterile field to reduce scatter radiation up to 98 percent.

NEW PRODUCT

CT Angiography Software

Medis Technologies Ltd. (www.medis.nl) has introduced QAngio® CT, a software solution for the quantification of coronary and peripheral arteries in CT angiography studies. The software enables quick detection of vessel abnormalities and assessment of severity. Independent of CT scanner brand or type, QAngio CT is designed to minimize time spent on interpreting CT angiography data. The software is the CT equivalent of Medis' solution for coronary angiograms, QAngio® XA.



NEW PRODUCT

Dual-Tier Desk Cart

The dual-tier Banana Corner Desk Cart from AFC Industries (www.afcindustries.com) is designed to maximize accessible work area and minimize footprint while providing streamlined height adjustment. By creating less stress, strain and repetitive movement than a conventional rectangular or L-shaped unit, the desktop shape allows access to a greater work area. Both tiers of the cart independently adjust up and down, with the rear accommodating as many as six display mounts and a film illuminator.



NEW PRODUCT

Automatic MR Imaging Shielded Door

ETS-Lindgren (www.etslindgren.com) has introduced the Auto-Seal® II (AS-II) shielded door with an automatic opening and closing system for MR imaging applications. Intended to be a maintenance-free radiofrequency (RF) sealing system, the AS-II has a pneumatically operated, bladderless and gasketless design. The AS-II is available in three door configurations: RF shielded, acoustic and fire-rated. The automated opener/closer system can be activated in several ways.



News about RSNA 2007

Submit Abstracts for RSNA 2007

THE ONLINE abstract submission system for RSNA 2007 is now available. **The submission deadline is April 15, 2007.**

Abstracts are required for scientific papers, scientific posters and education exhibits. To submit an abstract online, go to RSNA.org/abstracts.

For more information about the abstract submission process, contact RSNA at 1-877-776-2227 within the U.S. or 1-630-590-7774 outside the U.S.

Important Dates for RSNA 2007

April 15	Deadline for abstract submission
April 23	RSNA/AAPM member registration and housing opens
May 21	Non-member registration and housing opens
June 18	Refresher course enrollment opens
Nov. 25– Nov. 30	RSNA 93rd Scientific Assembly and Annual Meeting

Exhibitor News

Access RSNA 2006 Exhibitor List Online

A list of exhibitors that participated at RSNA 2006 will be available all year at rsna2006.rsna.org/showcase. An excellent resource for viewing and comparing companies when contemplating an equipment purchase, the list can be searched alphabetically and by various product categories.

Learn About New Products Highlighted at RSNA 2006

Information about more than 150 new products and services showcased at the RSNA 2006 technical exhibition can be found in the New Products sections of the *Daily Bulletin*, the official newspaper of the RSNA annual meeting. Find the *Daily Bulletin* online by going to rsna2006.rsna.org and clicking Daily Bulletin. Please note that information for new product announcements was provided by the manufacturers. Inclusion of a product in the publication should not be construed as an endorsement by RSNA.



Technical Exhibition Quick Fact

■ With a record 520,000 square feet of exhibit space, the RSNA 2006 technical exhibition covered nearly 12 acres of McCormick Place.

RSNA.org

RSNA 2006 Image Interpretation Session

THE RSNA 2006 Sunday Image Interpretation Session is available on-demand at RSNA.org.

One of the most popular events at the RSNA annual meeting, the 2006 session was moderated by Anne C. Roberts, M.D.

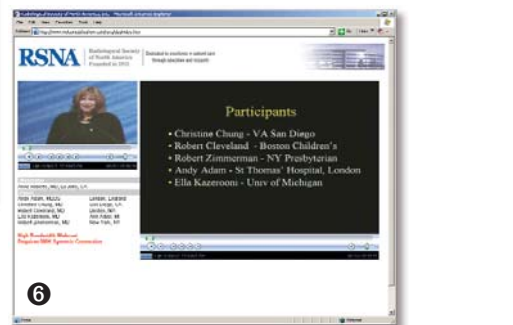
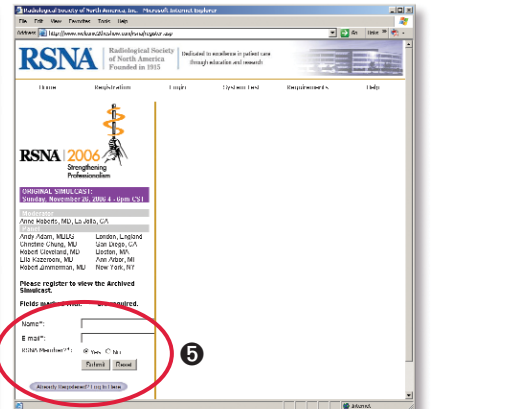
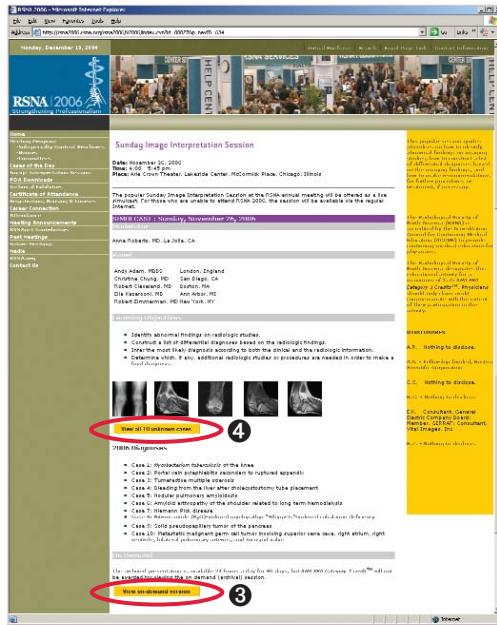
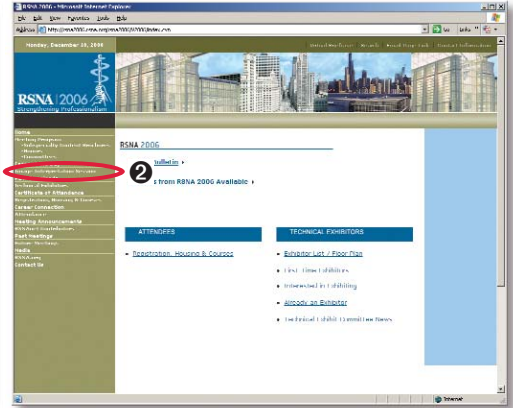
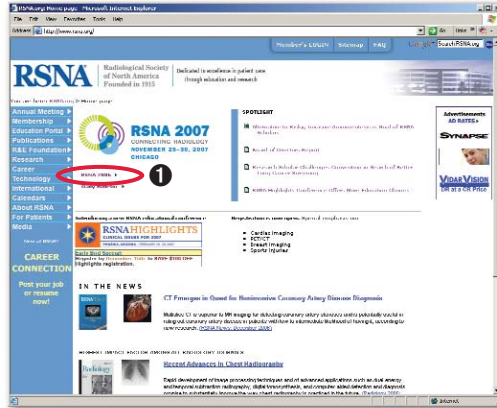
The session will be available 24 hours a day through February, however *AMA PRA Category 1 Credit™* is not awarded for viewing the on-demand session.

To access the on-demand session, click on RSNA 2006 underneath the RSNA 2007 logo on the RSNA.org front page ❶. Click on Image Interpretation Session in the left-hand navigation bar ❷.

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The session is free, but you must register by entering your name and e-mail address ❺. If you return to the session another time, you may click Already Registered? Log In Here and enter your e-mail address.

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Medical Meetings

February – April 2007

JANUARY 31–FEBRUARY 4

Sociedad Mexicana de Radiología e Imagen (SMRI), 41st Annual Radiology and Imaging Course, Hotel Sheraton Centro Histórico, Mexico City • www.smri.org.mx

FEBRUARY 1–2

Advanced Medical Technology Association (AdvaMed)/Medical Device Manufacturers Association (MDMA)/National Electrical Manufacturers Association (NEMA), Oncologic Image-Guided Interventions: Opportunities for Collaboration, Bethesda North Marriott, Maryland

• <https://cms.palladianpartners.com/cms/1154973321/index.shtml>

FEBRUARY 1–4

Radiation Therapy Oncology Group (RTOG), Annual Meeting, Tampa Marriott Waterside Hotel, Florida • www.rtog.org

FEBRUARY 10–11

International Cancer Imaging Society and Hong Kong College of Radiologists, Joint Meeting, Hong Kong Academy of Medicine Jockey Club Building • www.hkcr.org

FEBRUARY 11–15

International Society for Magnetic Resonance in Medicine (ISMRM), MR Physics & Techniques for Clinicians Workshop, Fairmont Chateau Lake Louise, Alberta, Canada

• www.ismrm.org/workshops/MRPhysics/index.htm

FEBRUARY 15–18

Society of Nuclear Medicine (SNM) Mid-Winter Educational Symposium, Hyatt Regency San Antonio • www.snm.org

FEBRUARY 17–18

Armed Forces Institute of Pathology (AFIP), 22nd Annual Washington Neuroradiology Course, Hyatt Regency Bethesda Hotel, Maryland • www.afip.org/Departments/edu/upcoming.htm

FEBRUARY 25–28

ISMRM, Non-Cartesian MR Imaging Workshop, Enchantment Resort, Sedona, Ariz.

• www.ismrm.org/workshops/Non_Cartesian_MRI/index.htm

FEBRUARY 25–MARCH 1

Healthcare Information and Management Systems Society (HIMSS), Annual Conference and Exhibition, Ernest N. Morial Convention Center, New Orleans • www.himss07.org

FEBRUARY 26–28

RSNA Highlights: Clinical Issues for 2007, J.W. Marriott Desert Ridge Resort & Spa, Phoenix
• RSNA.org/HighlightsConference

MARCH 1–6

Society of Interventional Radiology (SIR), 32nd Annual Scientific Meeting, Seattle • www.sirmmeeting.org

MARCH 5–9

Society of Computed Body Tomography and Magnetic Resonance (SCBT-MR), 30th Annual Course, Portofino Bay Hotel at Universal Orlando, Florida • www.scbtmr.org

MARCH 9–13

European Congress of Radiology (ECR), Annual Meeting, Austria Center, Vienna • www.ecr.org

MARCH 15–18

American Institute of Ultrasound in Medicine (AIUM), Annual Convention, Marriott Marquis, New York • www.aium.org

MARCH 25–28

ISMRM, Advances in High Field MR Workshop, Asilomar Conference Center, Pacific Grove, Calif.

• www.ismrm.org/workshops/HighField/venue.htm

APRIL 5–7

ISMRM/Turkish Society of Magnetic Resonance (TSMR), International Cardiovascular MR Imaging Symposium, Maritim Pine Beach Resort, Antalya, Turkey

• www.ismrm.org/workshops/turkey07.htm

APRIL 12–15

São Paulo Society of Radiology and Diagnostic Imaging, 37th Meeting, Transamerica Expo Center, Sao Paulo, Brazil

• www.spr.org.br

APRIL 13–15

Japan Radiological Society (JRS), 66th Annual Meeting, Pacifico Yokohama, Japan • www.radiology.or.jp

APRIL 14–17

Society of Breast Imaging (SBI), 8th Postgraduate Course, Westin Diplomat Resort & Spa, Hollywood, Fla.

• www.sbi-online.org

NOVEMBER 25–30

RSNA 2007, 93rd Scientific Assembly and Annual Meeting, McCormick Place, Chicago • rsna2007.rsna.org

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