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SNM Names Officers, Awards Honors

Frederic H. Fahey, D.Sc., director of nuclear medicine physics at Children's Hospital Boston and associate professor of radiology at Harvard Medical School, was named president of the Society of Nuclear Medicine (SNM) during its recent annual meeting in Miami Beach, Fla. Other SNM officers elected for 2012-13 are Gary Dillahay, M.D., professor of radiology at Northwestern Memorial Hospital in Chicago, president-elect; and Peter Herskovich, M.D., director of the PET Department at the National Institute of Health (NIH) Clinical Center in Bethesda, Md., vice-president-elect. Abhao Alavi, M.D., and Steven Larson, M.D., known for his substantial research and contributions to the field of nuclear medicine, were awarded SNM's Benedict Causse Prize. Dr. Alavi is a professor of radiology and director of research education at the University of Pennsylvania School of Medicine in Philadelphia. Dr. Larson is an attending physician in the Department of Radiology at Weill Cornell University Medical Center and a professor in the Department of Radiology at Memorial Sloan Kettering Cancer Center, both in New York. He is also chief of nuclear medicine service, vice-chairman for radiology research, and director of the Laurent and Alberta Gerschel Positron Emission Tomography Center, and Donna & Benjamin M. Rosen chair in radiology in the Department of Radiology at Memorial Hospital in New York. Dr. Larson chairs the SNM's Molecular Imaging Committee, is a member of the Public Information Advisors Network, and was named SNM Outstanding Researcher in 2004. Daniel S. Berman, M.D., professor of medicine at the University of California, Los Angeles (UCLA), was awarded the Georg Charles de Hevesy Nuclear Pioneer Award for his contributions to the nuclear medicine profession. Dr. Berman is director of nuclear medicine/cardiac imaging, professor of imaging, attending physician in the departments of Imaging and Medicine, and co-director of the Artificial Intelligence in Medicine Program at the Cedars-Sinai Medical Center in Los Angeles. The Paul C. Asherfield Award was given to Mark M. Goodman, Ph.D., a program director of the Center for Systems Imaging (CSI) and professor of radiology and imaging sciences, psychiatry, and hematology and oncology at Emory University in Atlanta.

New Interventional Radiology/Diagnostic Radiology Certificate Available from ABR

The American Board of Medical Specialties has approved an application from the American Board of Radiology (ABR) for a new Dual Primary Certificate in Interventional Radiology and Diagnostic Radiology. The new certificate is available to those who have completed both specialties, and this may be of particular interest to those interventional radiologists in training who wish to pursue training in diagnostic radiology. The completion of both specialties also increases the job market for those with these skills. ABR supported the creation of this primary certificate based on the need to ensure that future trainees acquire the requisite combination of clinical, procedural and interpretive skills necessary for the safe and competent practice of interventional radiology. The new certificate is available to those who have completed both specialties, and this may be of particular interest to those interventional radiologists in training who wish to pursue training in diagnostic radiology. The completion of both specialties also increases the job market for those with these skills. ABR supported the creation of this primary certificate based on the need to ensure that future trainees acquire the requisite combination of clinical, procedural and interpretive skills necessary for the safe and competent practice of interventional radiology.

Donaldson Awarded Stanford's Prestigious Dean's Medal

2013 RSNA President Sarah S. Donaldson, M.D., was awarded the Stanford University Medical Center's Dean's Medal at an October ceremony at the university in Stanford, Calif. Dr. Donaldson, the Catharine and Howard Avery Professor at Stanford, is one of three recipients of the medal, the medical school's highest honor.

RSNA IS LARGEST MEDICAL MEETING

RSNA tops the annual list of the 50 largest U.S. medical meetings released by the Healthcare Convention & Exhibitors Association (HCEA). RSNA reported average attendance of 53,789 attendees at RSNA 2011. In second place was the Greater New York Dental Meeting, with 53,789 attendees. In its report, HCEA noted that average reported professional attendance at medical meetings increased 3.2 percent over 2010, while average reported total attendance increased 2.2 percent. HCEA aims to increase the efficiency and effectiveness of healthcare conventions and exhibits as an educational and marketing medium and fosters understanding and cooperation between industry and healthcare associations.

BIR Hounsfield Biography Marks 40th Anniversary of CT

A mild-mannered and pleasant but determined genius, Sir Godfrey Hounsfield made a great breakthrough in medical imaging with CT in 1972. Read how this mostly self-taught country boy became a global laurate and changed the world in the new biography, “Godfrey Hounsfield: Intuitive Genius of CT,” published by the British Institute of Radiology (BIR) in celebration of the 40th anniversary of Hounsfield’s landmark announcement of CT at the BIR Congress. Written by Stephen Bates, Liz Beckmann, Adrian Thomas and Richard Waltham, the book includes many recollections from the inventor’s family and colleagues. All proceeds go to BIR, as designated in Hounsfield’s will.

To order, go to BIR.org.UK and click Publications/Book Shop.
RSNA Board of Directors Report

At its September meeting, the RSNA Board of Directors considered new RSNA programs, enhanced collaborations with other radiologic and medical societies and appointed volunteers to RSNA committees for the coming year.

Committee Members, R&E Trustees Appointed
In consultation with the committee chairs, the RSNA Board approved appointments to the Society’s many committees. The Board thanked the boards of dedicated volunteers who help RSNA to meet its mission.

In the committee appointment process, RSNA aims to maximize volunteer participation in the Society and involve members in training to help ensure that RSNA products, services, programs, and activities meet the needs of trainees now and as they develop professionally. More than 900 members are serving the Society on committees and editorial boards, and as representatives to other organizations.

James P. Bongsted, M.D., will assume the position of chair of the 2013 Research & Education (R&E) Foundation Board of Trustees. Richard D. White, M.D., and Valerie P. Jackson, M.D., were reappointed. G. Scott Gauntle, M.D., Ph.D., and Burton R. Drucker, M.D., were appointed as secretary and treasurer, respectively.

The RSNA New Editorial Board welcomes 2007 RSNA President R. Gilbert Jost, M.D., as its new Research & Education Foundation Contributing Editor.

Ongoing Collaboration Supports Molecular Imaging
RSNA is once again a co-sponsor of the World Molecular Imaging Congress (WMIC), to be held Sept. 18-21, 2013, in Savannah, Ga. RSNA support includes appointment of two representatives, Paul Knahan, Ph.D., and King Li, M.D., to the WMIC planning committee.

RSNA also reiterated its commitment to encourage radiology department chairs to consider establishing more medical imaging physics residencies.

New Quality Improvement Certificate
The Board authorized creation of an advanced level certificate in principles of quality improvement. More details about the new certificate will be available at RSNA.org/quality.aspx.

RSNA currently offers Quality Essentials Certificates of Completion to annual meeting attendees who successfully participate in Session II and/or Session III of the Quality Improvement Symposium. The Quality Essentials Certificate: Quality Improvement in Your Practice can also be obtained by scoring 80 percent or higher on the online self-assessment module from this session.

The second Quality Essentials course will be available online by June 2013.

I’m excited, as I know you are as well, about what lies ahead for RSNA and our specialty in the coming year.

My Turn
Professionalism Vignettes Spark Discussion of Daily Dilemmas

As one of the specialty’s core competencies, professionalism is essential to achieving the central goal of every radiologist: providing patient-centered care.

In 2005, RSNA endorsed the Physicians’ Charter stating that “professionalism demands placing the interests of patients above those of the physician, setting and maintaining standards of competence and integrity, and providing expert advice to society on matters of medicine’s contract with society.” This is essential to maintaining the public’s trust in physicians and represents the basis of medicine’s contract with society.

Although radiologists are called upon to demonstrate professionalism in their day-to-day activities, few have had formal instruction on the topic in programs on teaching and evaluating professionalism among radiology residents have only recently been introduced. Educational innovation is particularly important for teaching professionalism, because standard teaching methods, by themselves, do not promote active audience participation or facilitate retention of learned material. One such educational innovation is the use of vignettes that describe specific situations and require the learner to inquire more closely into the dynamics of those situations.

The RSNA Professionalism Committee has developed a series of web-based vignettes that provide thought-provoking scenarios, based on published literature, in an interactive question-and-answer format. Professionalism Committee Chair Marilyn Goske, M.D., says the vignettes “seek to engage radiologists in a meaningful way to consider the importance of professionalism in their daily practice.”

Each vignette illustrates a realistic situation with a professional dilemma, followed by a series of multiple-choice questions that draw attention to important, specific teaching points on professionalism. For teaching purposes, we have minimized detail in order to elicit the relevant principles of professionalism in an online format. Therefore, the answers provided in these vignettes should be considered as “educational beacons” and starting points for discussion rather than policies appropriate to all, or the only legally appropriate alternatives.

The vignettes will be issued bimonthly and cover such diverse topics as “ Disclosure of Radiologic Error” to a patient, “The Disruptive Physician,” and “Sexual Harassment in the Workplace.”

It is our hope that these vignettes will increase radiologists’ awareness of important issues and principles in professionalism in preparation for facing such difficult professional problems in real life.

Peruse our professionalism website and access the vignettes at RSNA.org/Professionalism. We welcome your feedback.

Renew RSNA Membership Now
RSNA membership renewal is due by December 31 to avoid interruption of your subscription to RSNA News and many other benefits:

- Access to Radiology and RadioGraphics
- Access to the myRSNA personalized Web portal
- Free tools to help with continuing medical education
- Renew online at RSNA.org/renew or by mail with the invoice sent to you early in October. For more information, please contact membership@rsna.org or 1-877-RSNA-EM (1-877-776-2636) or 1-630-571-7973 outside the U.S. and Canada.

Meaningful Use Stage 2 Criteria Finalized; Effective Date Postponed
The Centers for Medicare and Medicaid Services (CMS) recently published a final rule that specifies the Stage 2 criteria that eligible professionals, eligible hospitals, and critical access hospitals must meet in order to continue to participate in the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs. All providers must achieve meaningful use under the Stage 1 criteria before moving to Stage 2.

Stage 2 criteria become effective in 2014, one year later than originally called for in the American Recovery and Reinvestment Act. Stage 2 criteria include using secure electronic messaging to communicate with patients on relevant health information, recording electronic notes in patient records, making imaging results accessible through certified EHRS technology and reporting cancer and other cases to specialized registries.

For more on Meaningful Use and the Stage 2 criteria, go to www.cms.gov/Regulations-And-Guidance/Legislation/EHRIncentivePrograms/Stage-2.html. Read about radiology’s reaction to Stage 2 in the September 2012 issue of RSNA News and an update on the final rule at rsnaonline.rsna.org.
Clot-retriever Devices May Improve Acute Ischemic Stroke Outcomes

Approximately 85 percent of strokes are ischemic. A new generation of devices that remove clots from blocked brain arteries while restoring blood flow could dramatically increase survival and recovery rates for acute stroke patients, according to new research.

While clot-busting thrombolytic drugs are often the first treatment option in acute ischemic stroke, they are not suitable for all patients and aren’t always effective. In those cases, mechanical clot removal is another option.

The standard mechanical clot remover, the Merci Retriever System, from Stryker in Kalamazoo, Mich., uses a small, coil-shaped wire to remove blood clots. However, a new generation of devices that rely on a self-expanding stent are outperforming the mechanical system, according to two studies published in the August 26 online edition of The Lancet.

In the new generation of systems, the stent is inserted into the blocked artery via a thin catheter and compresses and traps the clot. The entire device is then removed—and with it, the clot—thereby reopening the blocked blood vessel.


In findings published in the June 21, 2012 online issue of the American Journal of Neuroradiology, Dr. Pasquale Mordasini, M.D., of the Department of Diagnostic and Interventional Neuroradiology, University of Bern in Bern, Switzerland, and colleagues studied the device in 14 patients with basilar artery occlusion (BAO), a type of stroke associated with a poor clinical outcome and high mortality.

Successful recanalization was achieved in all patients in the study. Median procedure time to maximal recanalization was 47 minutes and there were no device-related complications, he said.

“Other studies and our other research has shown a procedure time of less than 60 minutes with recanalization success in 80 percent to 100 percent of cases, which has not been achieved with previous mechanical devices,” Dr. Mordasini said. “Therefore, I think stent retrievers will become a mainstay of mechanical thrombectomy in acute stroke treatment.”

Solitaire Enables Quick, Successful Recanalization

Another researcher who investigated Solitaire also discovered the device to be highly effective. “A main advantage of the Solitaire is that it enables fast recanalization with a high success rate,” said researcher Pasquale Mordasini, M.D., of the Department of Diagnostic and Interventional Neuroradiology, University of Bern in Bern, Switzerland.


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Patient Selection is Focus of New Study

While Solitaire is becoming more common in practice as interventionists receive training, additional studies are needed, researchers say. A second-stage study by Dr. Jahan and colleagues will use multi-modality imaging techniques to learn more about patient selection for the device.

In our next study, SWIFT PRIME, we’re going to use multi-modality CT-MR imaging to select patients who might benefit from Solitaire, just as we would in everyday practice,” Dr. Jahan said. “If the at-risk area of the brain has died, it’s too late to intervene with Solitaire. However, if the area of the brain is still viable, that’s a patient we would want to treat.”

WEB EXTRAS

To access abstracts of the studies from The Lancet cited in this article, go to:

- Trevo Versus Merci Retrievers for Thrombectomy Revascularisation of Large Vessel Occlusions in Acute Ischemic Stroke (TREVO 2): a Randomised Trial—www.thelancet.com/journals/lancet/article/PIIS0140-6736%2812%2961244-9/fulltext
- To access an abstract of “Experimental Evaluation of Immediate Recanalization Effect and Recanalization Efficacy of a New Thrombus Retriever for Acute Stroke Treatment” (Trevo), published in the American Journal of Neuroradiology, go to apnr.org/content/early/2012/05/06/ajnr.A3272.prev/arctex.html
- To view a video of the Solitaire Flow Restoration Device in use at the UCLA Stroke Center, go to cinescape.rsna.org.

MOBILE STROKE UNIT SPEEDS DRUG TREATMENT TO PATIENTS

Stent retrievers are just one way that medical researchers are working to speed lifesaving treatment to stroke victims.

German researchers have demonstrated the effectiveness of Mobile Stroke Units (MSUs)—specialized ambulances equipped with a CT scanner, a point-of-care laboratory and a telemedicine connection that transmits information to the hospital—in getting critical treatment to stroke victims within an hour of the emergency site.

A study examining MSUs in the May 2012 issue of the Lancet Neurology found a dramatic advantage of pre-hospital stroke diagnosis work-up and treatment. “Treatment success is strongly dependent on the time frame of drug administration,” said lead researcher Silke Walter, M.D., senior physician in the Department of Neurology at the University Hospital of the Saarland in Homburg, Germany. “The earlier the therapy is applied, the more patients can be saved from permanent disability.”

To that end, MSUs have the potential to cut the time from the initial emergency call to treatment decision in half, according to new research.

In the study of 100 patients, Dr. Walter and colleagues found that median time from the emergency call to the therapy decision was 35 minutes for stroke patients who had pre-hospital treatment in MSUs compared with 16 minutes for patients who received conventional hospital treatment. Safety endpoints were similar across the groups.
Technology Takes Imaging to New Level at London Olympics

Radiologists who worked around the clock treating athletes at the 2012 London Olympics left with a clear picture of the increasingly critical role the specialty will play in providing imaging services to competitors at future Olympic Games.

Advances in state-of-the-art technology and imaging techniques have propelled radiology into a central role on the medical teams working to treat athletes and return them to their sport as quickly as possible, said Philip O’Connor, M.D., director of the NIHR Leeds Musculoskeletal Biomedical Imaging Unit, Chapel Allerton Hospital, Leeds, West Yorkshire, England.

“Radiology is not only essential to medical services for the Olympics, it’s likely that radiologists will become incorporated into the medical teams that some of the larger countries take to future games,” Dr. O’Connor said.

Dr. O’Connor served as imaging leader for a team of about 100 volunteers including sports radiologists, radiographers and radiographic assistants who operated MR, CT and ultrasound scanners and X-ray equipment in the Olympic Village Polyclinic sponsored by GE Healthcare. In terms of sheer output, radiology dramatically increased its role since the 2008 Beijing Olympics, Dr. O’Connor said.

Radiologists performed more than 800 MR imaging exams, 400 ultrasound, 372 X-ray, and 80 CT exams during the London Games. By the end of the closing ceremony, radiologists had performed more than 1,400 imaging exams in all—twice the number of the 2008 Olympics, Dr. O’Connor said.

“The workload was huge, with scanners running constantly from 7 a.m. to 11 p.m.,” said Dr. O’Connor, who spent nine weeks in London serving as the only full-time Olympic radiologist for the games, which hosted 10,000-plus athletes from 200 countries.

Along with the satisfaction gained from aiding athletes, radiologists’ Olympic experiences will also serve as the basis of future research. A diagnostic and therapeutic impact study conducted at the games will be used for a series of research papers, as well as lectures for the Royal College of Radiologists, the British Institute of Radiology and the International Society for Magnetic Resonance in Medicine (ISMRM) technologists section, Dr. O’Connor said.

Dr. O’Connor also worked with British Journal of Radiology Editor Prof. Charles Hutchinsom, M.D., and Philip O’Connor, M.D., lead imager for the London 2012 Olympics, to read an Olympic special feature editorial by Prof. Charles Hutchinson, M.D., and Philip O’Connor, M.D., lead imager for the London 2012 Olympics, the issue features research on imaging muscle injury in elite athletes, radiological interventions for soft tissue injuries and tendon and ligament imaging, among other topics.

To read an Olympic special feature editorial by Prof. Charles Hutchinson and Dr. O’Connor and access abstracts of the research, go to bj.jrpub.com/contents/005/0106/index.cfm

Radiologists at the 2012 London Olympics performed more than 1,400 imaging exams in all—twice the number of the 2008 Olympics, said Philip O’Connor, M.D., (above) imaging leader for a team of about 100 volunteers on Dr. O’Connor, who spent nine weeks in London, enjoyed a rare bit of downtime between scans.

Portable Ultrasound, Electronic Health Records Aid Athletes

Since the last Olympics, advances in state-of-the-art medical technology allowed radiologists to diagnose potential injuries earlier and monitor treatment more efficiently—a huge asset for imagers and athletes alike.

Equipment such as handheld ultrasound and flat-panel detectors for radiographic systems have improved dramatically in terms of size, portability, wireless capabilities and price, according to Lori Webb, a clinical analyst with MD Buyline, which provides healthcare organizations with objective, evidence-based information for their acquisition and management of medical technology.

Webb, who worked in sports medicine as a contracted radiographer for an NFL team in the late 1990s, found “the depth and breadth of imaging modalities” in the Olympic Village Polyclinic to be “a far cry from the portable X-ray unit, film processor and view box I used 15 years ago during the Atlanta Falcons’ home games.

“Despite this, the goal has remained the same,” Webb said. “Get the medical imaging procedure done quickly and accurately, get the results to the right people and get the athlete back in the game if the results support that decision.”

David Connell, M.D., a musculoskeletal radiologist at the Olympic Park Medical Centre in Melbourne, Australia, who treated many gold medalists at the London games, said the athletes were surprised by the quality of the imaging equipment.

“For many athletes, this was the first time they had experienced this level of imaging sophistication,” Dr. Connell said. “Many teams were bowled over by the high-quality service.”

The 2012 games also ushered in the transition to electronic medical records, marking the first time in Olympic history that paper charts were not used for U.S. athletes. Electronic imaging records were stored in the GE Healthcare Centricity Practice Solution, a RIS/PACS system that is in compliance with meaningful use guidelines.

“Using electronic medical records has given radiologists and other physicians simultaneous access to the athletes’ medical information when needed, enhancing their ability to care for the athletes,” said Webb.

Radiologists Learn Value of Teamwork

The intensity of the polyclinic and sheer number of athletes and athletes treated by the radiologists taught volunteers a number of lessons on everything from techniques to teamwork.

“Seeing such a broad spectrum of injuries was amazing,” Dr. O’Connor said. “And seeing the injuries that athletes could compete with was amazing.

“We also got a real feel for sport-specific injuries, having days when we would see four or five of the exact same injury because a new sport had come into the program,” he added. “For example, during the judo and weightlifting, we saw 14 acute ulnar collateral ligament injuries of the elbow.”

Although they’re not athletes, Dr. O’Connor said he also realized “how well radiologists can get on when they come together as a team with a common non-competitive aim.”

“Radiologists acted in a volunteer capacity and helped engender a lot of goodwill to the spirit of the games,” Dr. Connell agreed.
PET/CT imaging has been the standard for lung cancer staging, but a new pilot study reveals that PET/MR imaging could provide comparable diagnostic image quality while cutting radiation dose by 75 percent compared with diagnostic contrast-enhanced PET/CT.

“Our preliminary data indicate that simultaneous PET/CT offers an alternative modality in thoracic imaging and reduces radiation dose by 75 percent, from about 28 mSv with standard-dose contrast-enhanced whole-body PET/CT—including an additional CT scan of the lung in inspiration—to about 7 mSv with whole-body PET/MR,” according to Nina F. Schwenzer, M.D., an assistant professor, Department of Radiology, Eberhard-Karls University, Tübingen, Germany, and lead author of the study published in the August 2012 issue of Radiology.

In the study, 10 patients who had or were suspected of having lung cancer underwent standard clinically indicated fluorine 18 fluorodeoxyglucose (FDG) PET/CT with a whole-body scan from the skull base to mid-thigh level and underwent whole-body PET/MR imaging immediately afterward.

Results showed that local tumor staging was feasible with simultaneous PET/MR imaging. “In seven out of 10 patients, a similar tumor stage was found at PET/CT and PET/MR imaging,” according to researchers. “In all patients, higher tumor-to-liver ratios were found in PET at the later time point, probably because of increasing FDG uptake in the pulmonary masses.”

PET/MR Effective for Staging Lung Cancer, Reducing Radiation Dose

“Especially where superior soft tissue contrast is needed, innovative sequences with parallel imaging offer MR imaging an increasing role in the clinical practice of tumor staging,” said Christina Schraml, M.D., a study co-author and a radiologist in the Department of Radiology at Eberhard-Karls University. “Especially where superior soft tissue contrast is needed, innovative sequences with parallel imaging offer MR imaging an increasing role in the clinical practice of tumor staging.”

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RSNA Image Share Enrolls Just Over 2,000 Patients, Expands Sites

Three years since its launch, the RSNA Image Share project that was designed to help patients take control of their medical images and reports is expanding its reach by deploying systems to new facilities and enrolling patients to use the network.

The Image Share network is in use at five pilot academic institutions and could expand to nearly two dozen additional sites in the coming months, said David S. Mendelson, M.D., a professor of radiology at the Mount Sinai School of Medicine in New York and principal investigator on the Image Share project.

The project was launched through a $4.7 million National Institute of Biomedical Imaging and Bioengineering (NIBIB) contract to build a secure, patient-centric medical image sharing network based on open standards. RSNA was charged with developing a system to enable patients to share images with physicians free of the limitations of CDs. Patient participation is voluntary and participating clinicians are spreading the word to their patients.

“Now we have just over 2,000 patients enrolled in the program and have been awarded an additional two-year $5.5 million contract from the National Institute of Biomedical Imaging and Engineering to extend the number of patients and participating sites,” Dr. Mendelson said. “The contract includes two additional option years, with an additional $5.5 million to move Image Share from a demonstration project to a nationally adopted set of standards.”

While the initial sites in the network—Mount Sinai Medical Center, the Mayo Clinic in Rochester, Minn., the University of Maryland Medical Center in Baltimore, the University of California, San Francisco, and the University of Chicago Medical Center—have been enrolling patients, a growing number of other institutions have been joining the network as well.

“In the coming months, we expect to have more than 25 sites in the network from across the country,” said Dr. Mendelson, a member of the RSNA Radiology Informatics Committee (RIC) that developed the Image Share concept, chair of the RIC subcommittee for Structured Reporting.

New sites include additional large research institutions like Stanford University and the University of California, Davis, and sites such as Advanced Radiology, a multisite radiology provider in Stanford, Conn.; Gillette Children’s Specialty Healthcare in St. Paul, Minn., and Texas Children’s Hospital, Houston, where 2012 RSNA president George S. Bisset III, M.D., serves as chief of pediatric radiology and the Edward B. Singleton Professor of Radiology at Baylor College of Medicine, in the Texas Medical Center.

Participating sites install a device called an Edge Server that connects local radiology systems to the network infrastructure. “We have a consultant who’s available to these sites to assist with implementation at no charge,” said Dr. Mendelson. “We visit our new sites at are at varying points in the implementation process.”

Sites use the Edge Server to enroll patients in the network. Patients receive a secure password that enables them to retrieve their radiologic images and reports. Patients sign into the network using personal health record (PHR) accounts provided by commercial vendors, currently Dell and lifeIMAGE. They retain secure access to the information and can share it with care providers when needed.

“Patients will be surveyed about their experiences with the network,” Dr. Mendelson said. “A health policy group here at Mount Sinai has produced a survey that we’ll provide to patients asking them to return it after they have had a chance to really experience the network with multiple providers.”

Storing Dose among Future Uses for Edge Server

Beyond its image sharing function, a variety of secondary initiatives are planned for the Edge Server in the second phase of the contract, Dr. Mendelson said. “We want to enable the Edge Server to house radiation dose information that can be used by local dose monitoring applications and to submit to the American College of Radiology’s (ACR) Dose Index Registry as well,” he said.

The Edge Server will also be enhanced to gather and share data for clinical decision support. These data can be used to help sites demonstrate compliance with practice guidelines and to enhance those guidelines through comparative effectiveness research, Dr. Mendelson said.

“We will feed anonymized data back from our Edge Server to organizations such as the ACR to aid their guideline development efforts. This will help to close the loop regarding how ordering patterns reflect best practices,” Dr. Mendelson said.

RSNA also plans to work with vendors and standards bodies including the appropriate DICOM (Digital Imaging and Communications in Medicine) working groups to refine transfer of DICOM data and improve network performance. “The intent is to expedite the adoption of new technologies,” Dr. Mendelson said.

The Image Share network will also foster clinical trial research. The team has incorporated the RSNA Medical Clinical Trial Processor (CTP) with the Edge Server. “We're in the process of releasing that as a way of moving around clinical trial data which have been de-identified,” Dr. Mendelson said.

RSNA Encourages Vendor Involvement

Because the participation of healthcare equipment and software developers is essential to widespread adoption of image sharing, RSNA is inviting vendors of radiology systems to link to the Image Share network by providing the same capabilities offered by the Edge Server.

“We will continue to provide our reference model system directly, but increase vendors’ ability to incorporate the capabilities of the Edge Server within their own products,” Dr. Mendelson said.

The computer code behind the Edge Server has been publicly released as open source so that program developers can easily integrate their products with commercial systems. During the IHE Image Sharing Demonstration at RSNA 2012, vendors had the opportunity to test and demonstrate their capability to link to their systems to the network.

“We hope the Image Share project leads to a standards-based, national infrastructure that makes this kind of service easily available at a reasonably convenient cost to any patient, anywhere, anytime.”

David S. Mendelson, M.D.

Developers expect the Image Share Network, designed to help patients take control of their medical images and reports, to expand to as many as 25 sites in the coming months. RSNA was charged with developing a method for patients to control access to their information through personal health records (PHR) without relying on CDs (bottom).

Expanding the project to as many patients as possible remains the central goal of Image Share, Dr. Mendelson said.

“We’re grateful to NIBIB for recognizing the importance of healthcare interoperability and for sponsoring development of a solution for image sharing,” Dr. Mendelson said. “Our primary focus is on patient engagement. We hope this leads to a standards-based, national infrastructure that makes this kind of service easily available at a very reasonable cost to any patient, anywhere, anytime.”

To learn more about the RSNA Image Share project, visit rsna.org/Informatics.
To preview the patient experience in using an image-enabled personal health record, try the RSNA Online Demo at http://www.rsna.org/Image_Share.aspx.
Radiology Compensation Rates Drop Slightly in 2011

After experiencing modest compensation increases for two consecutive years, radiologists saw their incomes dip slightly in 2011.

Of the 30 specialties surveyed for the 2012 American Medical Group Association (AMGA) 25th Annual Medical Group Compensation and Financial Survey, nearly 3 in 4 saw increases in compensation, averaging 2.8 percent above the previous year. But while radiologists remain some of the best compensated specialists, diagnostic and interventional radiology were among the five specialties that experienced a slight decrease in compensation from 2010 to 2011. AMGA mailed the survey questionnaire to medical groups across the country in January 2012 and received responses from 225 groups representing more than 55,000 providers.

The survey showed that the median compensation level for interventional radiologists was $485,277, a 1.39 percent decrease from 2010 to 2011, while median compensation for diagnostic radiologists fell by 0.45 percent to $459,186. In terms of compensation, radiologists ranked fourth and fifth respectively among specialties surveyed.

Among other factors, experts say radiology may have reached a cooling off point after years of being considered a “hot” specialty.

“Whenever you see a big increase in a hot specialty like radiology, you will eventually hit periods that are a bit flatter,” said Brad Vaudrey, M.B.A., C.P.A., principal at Sullivan, Cotter & Associates, Inc., which administered the AMGA survey. “Now, a plateau is occurring.”

A number of factors are affecting the lower than expected compensation levels for radiologists any time soon. First, they are cath lab cardiologists with a median of $524,731, a 4.09 percent increase, and orthopedic surgeons with a median of $515,759, a 2.78 percent increase from the year before.

Specialties that recorded the biggest increases in annual compensation were hematology and medical oncology (up 7.13 percent to a median $348,157), hypertension and nephrology (up 6.99 percent to a median $287,794), and urgent care (up 5.17 percent to a median $242,145).

Cardiac/thoracic surgeons remain the best-compensated specialty with a median compensation of $554,087, which was a 2.16 percent increase from the previous year. Following them are cath lab cardiologists with a median of $524,731, a 4.09 percent increase, and orthopedic surgeons with a median of $515,759, a 2.78 percent increase from the year before.

“Confusion about mammography recommendations and the impact of the poor economy leading to fewer elective procedures performed, Dr. Yousem said.

Factors that may have contributed to the drop in RVUs for diagnostic radiologists include the declining number of CT procedures, due in part to public and industry-wide emphasis on radiation safety, and the impact of the poor economy leading to fewer elective procedures performed, Dr. Yousem said.

“Endocrinologists experienced the biggest drop in compensation, from a median $233,000 to $221,400, a 4.98 percent decrease,” said David Yousem, M.D., M.B.A., a professor in the Department of Radiology, vice-chair of program development and director of neuroradiology at Johns Hopkins Hospital in Baltimore, and a nationally recognized expert on radiology economics.

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“Confusion about mammography recommendations and the impact of the multiple procedure 50 percent reduction for image interpretation made by CMS in its reimbursement calculations in 2011 may also have led to the decrease in RVUs,” Dr. Yousem said. CMS decreased the multiple procedure payment reduction for interpretation of imaging from 50 to 25 percent in 2012.

Radiology Compensation Likely to Remain Flat

Vaudrey said that 2013 should show an overall increase in compensation of about 3 percent but he doesn’t expect to see a dramatic increase in compensation levels for radiologists any time soon.

“The growth of therapeutic procedures performed by interventional radiologists in oncology and gynecology may explain the increase in RVUs for interventional radiologists,” said David Yousem, M.D., M.B.A., a professor in the Department of Radiology, vice-chair of program development and director of neuroradiology at Johns Hopkins Hospital in Baltimore, and a nationally recognized expert on radiology economics.

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The RSNA Foundation has collaborated with the Association of University Radiologists (AuR) to jointly fund a biennial scholarship for radiology residents and fellows. The first named grant will be awarded in 2013.

MOC News
ABR Expands Activities Accepted as Self-Assessment CME

Beginning January 1, 2013, separate requirements for CME credits and self-assessment modules (SAMs) will no longer be necessary to fulfill Part II of American Board of Radiology (ABR) Maintenance of Certification (MOC). These activities will be combined into a single requirement of 75 CME credits every three years, 25 of which must be self-assessment activities. In addition, the ABR’s definition of self-assessment activity to include more than just SAMs created by societies and other providers. SAMs were previously approved in the future, will continue to count as self-assessment CME.

As in the case of teleconferences, webinars or other “live” activities, AMA Category 1 CME activities that are performed in person or remotely do NOT automatically count as self-assessment CME because they may not be required to incorporate all the necessary criteria. Contact the ABR to learn whether an activity is considered self-assessment CME.

Organizations that want their “live” CME activities approved as SAMs must submit them for review by the ABR. All previously approved SAMs, as well as those approved in the future, will continue to count as self-assessment CME.
Networks can use.

**Journal Highlights**

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

**Performance of FDG PET/CT in the Clinical Management of Breast Cancer**

PET with fluorine 18 (18F) fluorodeoxyglucose (FDG) has an important role in oncology while its role in the management of patients with breast cancer continues to evolve.

In a State-of-the-Art review in the January issue of Radiology (RSNA.org/Radiology), David Grotheer, M.D., Ph.D., of Saint Louis Hospital, Paris, and colleagues examine the principles of FDG PET/CT focusing on breast imaging and assess the advantages and limits of this approach at diagnosis, initial staging, follow up and evaluation of response to therapy in breast cancer. Specifically, the authors discuss the following regarding FDG PET/CT:

- Its usefulness in differentiating malignant from benign breast lesions
- Whether it can replace sentinel node biopsy for axillary staging
- Its role in initial staging of inflammatory or locally advanced breast cancer and in initial staging of clinical stage II A and II B and primary operable stage IIIA breast cancer
- Its role in the assessment of early response to neoadjuvant therapy and of response to therapy for metastatic disease

Combined PET/CT is more sensitive and specific than either of its constituent imaging methods, according to the authors.

“Facilitates distinguishing normal physiologic uptake from pathologic FDG uptake, allows accurate localization of functional abnormalities and adds the incidence of false-positive and false-negative results of imaging studies,” the authors write. “The factors that influence FDG uptake by breast tumors have an implication on how to interpret FDG PET/CT scans and who is the appropriate patient for imaging.”

**Complications of Aortic Valve Surgery: Manifestations at CT and MR Imaging**

Because postoperative complications of aortic valve surgery remain a substantial source of morbidity and mortality, routine surveillance of prosthetic heart valves with transthoracic echocardiography (TTE), transesophageal echocardiography (TEE) and fluoroscopy is critical. However, MR and CT are emerging as diagnostic tools complementary to conventional imaging for detecting and monitoring complications after aortic valve replacement, according to an article in the November-December 2012 issue of RadioGraphics (RSNA.org/RadioGraphics). Along with discussing that emerging role, Nancy Pham, M.D., of the Cleveland Clinic, and colleagues present CT and MR imaging appearances of a broad spectrum of prosthetic heart valve complications, including:

- Paravalvular or valvular regurgitation
- Valve dehiscence
- Prosthetic valve endocarditis (PVE) and abscess formation
- Obstruction (thrombosis versus pannus)
- Structural failure
- Pseudoaneurysm formation

The choice between CT and MR imaging depends on individual patient characteristics, the type of prosthetic valve, and the acuity of the clinical situation, according to the authors.

“In general, screening with TTE followed by TEE is recommended,” the authors write. “When results of TTE and TEE are inconclusive, cardiac CT and MR imaging should be considered. The choice between these imaging techniques depends on the presence of patient-specific contraindications to CT or MR imaging.”

**Invasive ductal carcinoma of the left breast in a 61-year-old woman who had undergone aesthetic breast surgery, with bilateral breast prosthesis, 10 years earlier. Before PET/CT, the tumor was classified as a T2N0 lesion (primary tumor of 45 mm with an ovoid and lobulated shape) and a T2N+M0 lesion (lymph node metastases). (a) PET/CT image shows high FDG uptake in the primary tumor (SUVmax 15.7). (b) PET/CT image also shows FDG uptake in axilla, level I (arrowhead), as well as in infracostal nodes (arrow). (c) PET/CT image shows optimized PET/CT fusion (superimposition of PET and CT images). Tumor is well defined and shows high FDG uptake. (d) Axial contrast-enhanced MR image shows mixed hypointense and hyperintense lesion with heterogeneous enhancement. (e) Axial T2-weighted MR image shows hyperintense lesion with heterogeneous signal intensity. (f) Axial diffusion-weighted (DW) image shows hyperintense lesion with heterogeneous signal intensity. DCE-corrected 2.5D MIP (maximum intensity projection) images (g) and (h) show heterogeneous enhancement and homogeneous washout characteristics. (i) Axial T1-weighted image shows hypointense lesion. (j) Axial T2-weighted image shows hyperintense lesion. (k) Axial T1-weighted image, 30 min after contrast injection, shows heterogeneous enhancement. (l) Axial T1-weighted image, 60 min after contrast injection, shows homogeneous enhancement. (m) Axial T1-weighted image, 240 min after contrast injection, shows homogeneous enhancement. (n) Axial T1-weighted image, 360 min after contrast injection, shows heterogeneous enhancement.”

**Comparison of Digital Screening Mammography and Screen-Film Mammography in the Early Detection of Clinically Relevant Cancers: A Multicenter Study**

In a study, an international collaboration compared digital and screen-film mammography on a prospective basis. Digital mammography was implemented in December 2006 at the London Breast Unit and in February 2007 at the Academic Medical Center in Amsterdam. The study compared the number of detected cancers, the malignancy of these cancers, and the number of recall rates. The study showed that the number of cancers detected was 31.2% higher on digital mammography. The study also showed that the number of cancers detected was 41.9% higher on digital mammography.
RSNA 2012 Courses to be Posted Online

At each RSNA annual meeting, the RSNA Education Center records several courses and, in the coming months, will post these presentations online as enduring educational materials for RSNA members.

The RSNA Education Center thanks the faculty who agreed to have their courses recorded at RSNA 2012, as well as those who presented self-assessment modules (SAMs) at the annual meeting. As part of presenting a SAM, faculty must write SAM questions for their course and provide references for each question. With the help of SAM faculty, the Education Center was able to provide more than 40 SAM courses at RSNA 2012. Visit RSNA.org/education to view the current catalog of products. For information on educational products, contact the Education Center at ed-ctr@rsna.org or 1-800-272-5220.

ARLM Awards First Certificates of Achievement

RSNA congratulates Amilcare Gentili, M.D., and Lisa H. Lowe, M.D., on earning the first Academy of Radiology Leadership and Management (ARLM) Certificates of Achievement awarded since ARLM was launched in 2011.

The certificates recognize dedication to furthering leadership and management skills by participating in a wide array of ARLM-approved leadership courses offered through its sponsoring organizations: RSNA, the Association of University Radiologists (AUR); American Roentgen Ray Society (ARRS); Society of Chairs of Academic Radiology Departments (SCARD); and the Association of Administrators in Academic Radiology Departments (AAARD).

To earn a certificate, individuals must earn 50 education credits—at least 30 in person—across a spectrum of core learning domains including financial skills, human resources, professionalism, legal contracting, academic mission and general management. A minimum of three credits in each domain is required.

Visit more and explore courses at www.radleaders.org.

RSNA Receives ABR Deemed Status, CAR Accreditation

Further solidifying its reputation as a quality medical education provider, RSNA has received deemed status from the American Board of Radiology (ABR) for its self-assessment modules (SAMs) and accreditation by the Canadian Association of Radiologists (CAR) for its in-person and online SAMs in support of the Royal College of Physicians and Surgeons of Canada’s (RCPSC) Maintenance of Certification (MOC) program.

RSNA’s record of high-quality educational products and services prompted application for deemed status with the ABR in 2012. Deemed status indicates a favorable history of ABR-approved SAM offerings and will allow RSNA to develop and implement SAM courses without prior ABR review. “We are pleased and honored to receive ABR deemed status for SAM courses,” said David Armit, M.D., Ph.D., chair of RSNA’s Education Committee. “This success illustrates RSNA’s dedication to quality education for our members.”

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RSNA looks forward to a continued partnership with CAR to further the value of its educational resources.

Education and Funding Opportunities

Writing a Competitive Grant Proposal

Registration is being accepted for the Writing a Competitive Grant Proposal workshop designed for researchers in radiology, radiation oncology, nuclear medicine and related sciences who are interested in actively pursuing federal funding.

A limited number of slots are available for this 1½-day intermediate-level program that combines didactic and small group interactive sessions designed to help radiologic researchers understand and apply the key components of writing a competitive grant proposal. Topics to be covered include the National Institutes of Health grant review process, developing specific aims, and funding opportunities.

Guided by a faculty of leading researchers with extensive experience in all aspects of grant applications and funding, the program will focus on developing realistic expectations and providing tools for getting started. Faculty includes: G. Scott Gazelle, M.D., Ph.D., M.P.H., of Massachusetts General Hospital in Boston; Ruth Carlos, M.D., of the University of Michigan in Madison; and Francis Blankenberg, M.D., of Lucile Packard Children’s Hospital at Stanford University in Palo Alto, Calif.

The course fee is $175. Registration forms can be found at RSNA.org/CGP. Contact Fiona Miller at 1-630-590-7741 or femill@rsna.org for further information.

Derek Harwood-Nash Fellows Announced

RSNA has named the recipients of its Derek Harwood-Nash International Fellowship for 2013:

- Celeste Anabel Garcia de Rodriguez, M.D., of Instituto Salvadoran Del Seguro Social in El Salvador, will complete a fellowship at Brigham and Women’s Hospital in Boston from July to September 2013.
- Naeem Mohamed, M.D., of Chir Hari Hospital in Pretoria, South Africa, will complete a fellowship at Children’s Hospital, Boston, from September to November 2013.
- Nicolas Meza Toussaint, M.B.B.C.H., of Universidad Gran Mariscal de Ayacucho-Hospital Pedro Carreno in Venersa, will complete a fellowship at University of California, San Diego, from June to August 2013. The Derek Harwood-Nash International Fellowship allows international radiologists three to 10 years beyond training to complete a six- to 12-week fellowship at a North American institution. Learn more at RSNA.org/Derek_Harwood-Nash_International_Fellowship.aspx.

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RSNA News | RSNA News

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- November 27: Deadline for international badge mailing
- December 1-6: RSNA 99th Scientific Assembly & Annual Meeting

Media Coverage of RSNA

In August, media outlets carried 292 RSNA-related news stories. These stories reached an estimated 379 million people.


Radiotherapy in Public Focus

Continued from page 18

Continued from page 18

Coronary Vessel Wall 3-T MR Imaging with Time-resolved Acquisition of Phase-Sensitive Dual Inversion-Recovery (TRAPD) Technique: Initial Results in Patients with Risk Factors for Coronary Artery Disease

Time-resolved acquisition of phase-sensitive dual-inversion recovery (TRAPD) imaging of coronary arteries improves arterial wall visualization and quantitative assessment by increasing the success rate of obtaining good- to excellent-quality images and sections orthogonal to the longitudinal axis of the vessel. The technique also resulted in vessel wall thickness measurements that show a more distinct difference between healthy subjects and those with CAD risk factors, new research shows.

In the study of 12 healthy subjects and 26 with at least one CAD risk factor, Khaled Z. Abd-Elmoniem, Ph.D., of the National Institute of Diabetes and Digestive and Kidney Diseases, National Institutes of Health, and colleagues developed the TRAPD coronary vessel wall imaging sequence and validated it with a flow phantom. Researchers obtained time-resolved coronary artery wall images at three to five cine cases in all subjects and made qualitative and quantitative comparisons between TRAPD and conventional single-image wall measurements.

Use of three to five frames increased the success rate of acquiring at least one image of good to excellent quality from 76 percent in single-image acquisitions to 95 percent with the TRAPD sequence, results showed. The difference in vessel wall thickness between healthy subjects and CAD risk factor subjects was significant with the TRAPD sequence, according to the authors. "Preliminary experience with the TRAPD sequence in healthy subjects and subjects with risk factors for coronary artery disease suggests improved ability to distinguish coronary wall thickness between the two groups compared with that with single-frame dual-inversion-recovery imaging," the authors write.

On December 1-6: RSNA 99th Scientific Assembly & Annual Meeting

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December Outreach Activities Focus on MR Imaging

In December, RSNA’s 60-Second Checkup radio program focuses on the potential of MR imaging to pinpoint children at risk for dyslexia.

RSNA Wins Marketing & Communication Gold Award

RSNA recently received a Gold MarCom Award from the Association of Marketing & Communication Professionals for its 2011 Annual Meeting Press Kit. The international competition recognizes outstanding creative achievement by marketing and communication professionals. The 2012 competition drew more than 6,000 entries from the U.S., Canada and several other countries.

Continued from page 18

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The Value of Membership

R&E Foundation Grants Impact Investigators Throughout Their Careers

RSNA members can take an active role in moving the specialty forward by supporting—or applying for—the Research & Education (R&E) Foundation grants that represent the future of radiology and related scientific disciplines.

R&E Foundation grants are available for medical students, residents, fellows and faculty at all levels. Applicants must be RSNA members at the time of application. From hypothesis-driven basic science, translational and clinical studies to development of new strategies for teaching methods, the Foundation supports projects that are changing the way radiologists practice and learn.

In 2012, the Foundation funded 79 grant projects totaling $2.9 million—and that’s just the beginning. Surveys show that for every dollar funded by the Foundation, grant recipients will receive an additional $30 from sources such as the National Institutes of Health (NIH) for further research. The $37 million funded by the Foundation since its inception in 1984 equates to more than a billion dollars in subsequent research dollars channeled into the radiologic sciences.

“I was fortunate to receive an R&E Foundation Research Seed Grant that helped me prepare and transition to NIH-level funding proposals. The experience gained during that study allowed me to secure a basic science research grant from the American Cancer Society, which will help me prepare and transition to NIH-level funding proposals. Visit RSNA.org/foundation for more details or to submit an application.

Read about the redesigned R&E Foundation homepage including a new feature listing grant recipients and their abstracts on Page 24.

Residents & Fellows Corner

New Features Enhance myPortfolio Experience

Residents accessing myPortfolio—RSNA’s Web tool designed to assist with tracking goals, progress and accomplishments—can now explore a number of new online features created to expand the user experience.

In addition, new features now available on myPortfolio include:
- Tablet Ready—Now optimized for tablet viewing to provide users with the best experience possible.
- New Site/Menu Layout—A streamlined, user-friendly layout provides quicker access to the tools used most frequently.
- Tagging Files and Activities—Add tags to each file or activity uploaded to myPortfolio to organize content.
- Integration of ACGME Competencies—Use the tagging feature to assign Accreditation Council for Graduate Medical Education (ACGME) core competency categories to any myPortfolio entry. Use the enhanced search feature to filter entries by competency.
- ACR In-Training Exam Scores—Residents can now access their American College of Radiology (ACR) In-Training exam scores from myPortfolio.

Access myPortfolio at myRSNA.org.

DEADLINES FOR 2013 GRANT APPLICATIONS

The application process for 2013 R&E Foundation grants opens this month. Deadlines are:
- January 10, Education Grants
- January 15, Research Grants
- February 1, Research Medical Student Grant
- April 15, Research Medical Student Grant

To spotlight the growing number of researchers who have received Research & Education (R&E) Foundation grants, the R&E website now links users to a list of grant recipients and their research abstracts as part of the redesigned RSNA.org.

Posted on the R&E homepage under Things to Know, the list of 2012 grant recipients features each researcher’s name/photo, an abstract of the research and links to more activities associated with each grant recipient. Users can narrow their search by keyword.

The fresh new look of the R&E Foundation homepage also features a prominent “Donate Now” button and a link to the R&E quarterly newsletter, Foundation Focus. Other highlights include:

- About the Foundation: Learn about the mission, history, Board of Trustees, committees and more, and view a video about the Foundation featuring testimonials from grant recipients.
- Foundation Resources: Your connection to a host of information, including:
  - Grants and Awards: Review detailed information, application process and deadlines.
  - Your Donations in Action: Learn how your donations fuel bright ideas for investigators.
  - Giving to the Foundation: Support the advancement of radiologic research, education and practice.
  - Guide to Planned Giving: Leave a Legacy by including RSNA in your estate plans.
- Volunteer for a Committee: Become an active member in support of the Foundation’s mission.

COMING NEXT MONTH

Workplace stress and burnout continue to increase for the majority of physicians—including radiologists. As the New Year begins, we ask experts to share their most effective tips and strategies for transforming stress into empowerment.
Riverain Technologies Introduces
ClearRead +Confirm™

Become more efficient reading portable chest X-rays with the use of ClearRead +Confirm. ClearRead +Confirm identifies and highlights lines and tubes, significantly reducing portable reading time.

See for yourself! Request a demo at RSNA 2012.
South Hall Booth #5917

*Pending 510(k), not available for sale within the United States