Also Inside:

Failure to Order Imaging Tests Not a Major Driver of Malpractice

Imaging Advancements Aid in Sleep Apnea Therapy, Detection

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Stereotactic Body Radiation Therapy Highly Effective Lung Cancer Treatment

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DISTINGUISHED HONOREES AND LECTURERS

The RSNA Board of Directors has announced the distinguished award recipients to whom the Society will pay tribute at the 99th Scientific Assembly and Annual Meeting. They are:

GOLD MEDALISTS
Theresa C. McLoud, M.D. Boston
Harvey L. Neiman, M.D. Boston, Va.
J. Frank Wilson, M.D. Milwaukee

HONORARY MEMBERS
Gabriel P. Krestin, M.D., Ph.D. Rotterdam, Netherlands
Anne W. Lee, M.D. Shanghai, China
Malgorzata Szczerbo-Trojanska, M.D. Lublin, Poland

PROGRAM DEDICATION
RSNA will dedicate its 2013 annual meeting program to the memory of Philip E.S. Palmer, M.D.

Numbers in the News

7
Percentage of adult Americans who could be affected by obstructive sleep apnea syndrome (OSAS). See Page 9 to find out how advancements in dynamic CT and MR imaging are proving successful in diagnosing and treating OSAS.

50
Percent chance a radiologist has of being a defendant in at least one malpractice lawsuit by age 60, according to a recent study. Turn to Page 5 to learn about this study and another, both published in the February issue of Radiology, that examined the frequency with which radiologists are sued, and the reasons why.

53
Patients with acute stroke whose CT brain scans were simultaneously interpreted by radiologists at the hospital and by telestroke doctors with smartphones, for a recent study. The level of agreement between reviewers was 92 to 100 percent. Learn more about the smartphone app used in the study and the implications of the results on Page 7.

60
Three-year survival rate for patients with inoperable non-small cell lung cancer treated with stereotactic body radiation therapy (SBRT), according to a recent study. Learn more about the potential for SBRT to become the standard treatment for early stage, medically inoperable non-small cell lung cancer on Page 13.

2012 RSNA President George S. Bisset III, M.D. (center), received honorary membership in the European Society of Radiology (ESR) from 2013 European Congress of Radiology President José Ignacio Bilbao, M.D., Ph.D. (left), and 2013 ESR President Gabriel P. Krestin, M.D., Ph.D. (right). RSNA News

ESR Honors Dignitaries at Annual Meeting

2012 RSNA President George S. Bisset III, M.D., was named an honorary member of the European Society of Radiology (ESR) at the European Congress of Radiology (ECR) in Vienna, Austria, in March. Dr. Bisset is chief of pediatric radiology at Texas Children’s Hospital and Edward B. Singleton Professor of Radiology at Baylor College of Medicine in Houston.

Also receiving honorary ESR membership were Tarek A. El-Diasty, M.D., a professor of radiology and chair of the radiology department at the University of Maryland, Baltimore, and Gary M. Glazer, M.D., who served as chair of the Department of Radiology and the Emma Pfieffer Memorial Professor of Molecular Medicine at Stanford University School of Medicine, California, for more than 20 years. RSNA awarded Dr. Glazer its Gold Medal in 2009. He passed away in 2011. Gold Medals were also bestowed at ECR 2013:

• José Cáceres, M.D., a professor and former head of diagnostic radiology at H.G.U. Vall d’Hebron Universidade Autonoma, Barcelona, Spain.
• Johannes Lammer, M.D., vice-chair of the Department of Radiology and director of cardiovascular and interventional radiology at the Medical University of Vienna.
• Maximilian F. Reiter, M.D., a professor of radiology, chair of the Department of Clinical Radiology and dean of medicine at Ludwig Maximilians University of Munich. RSNA awarded Honorary Membership to Dr. Reiter in 2008. He is a member of RSNA’s Public Information Advisors Network.

IN MEMORIAM
John M. Dennis, M.D.

John M. Dennis, M.D., a nationally renowned radiologist and former dean of the University of Maryland School of Medicine (UMSMM), Baltimore, passed away January 17, 2013. He was 90.

Dr. Dennis began his career in 1951 at UMSM as an instructor in the radiology department. Two years later, he was named professor and the first full-time chair of the department, a position he held until 1973 when he was appointed acting dean of the medical school. He was named dean in 1974, vice-chancellor for health affairs in 1975 and vice-president for academic affairs in 1983. Dr. Dennis was named dean emeritus in 1990 and professor emeritus in diagnostic radiology in 1995.

Dr. Dennis earned his medical degree from UMSM in 1945. He served in the Air Force from 1946 to 1948 as chief of radiology at the Station Hospital, Langley Air Force Base in Virginia. Dr. Dennis served as president of the American College of Radiology (ACR) and chair of its Board of Trustees. His many honors include gold medals from ACR and the American Roentgen Ray Society.
RSNA Board of Directors Report

At meetings in January and March, the RSNA Board of Directors updated the Society’s 2013-18 Strategic Plan, looked ahead to the 2013 International Day of Radiology and approved more plans for RSNA 2013.

Strategic Plan

The updated RSNA Strategic Plan refines the Society’s goals within the radiological sciences, foster the development of new technologies, offer education in a variety of media, facilitate information strategies to improve the efficiency and effectiveness of healthcare and serve as a worldwide leader in radiology. Read the plan at RSNA.org/RSNA_Strategic_Plan.aspx.

Ronald L. Arenson, M.D.
Chairman, 2013 RSNA Board of Directors

Collaborations

Plans are underway for the next International Day of Radiology, a collaborative effort of RSNA, the European Society of Radiology and American College of Radiology (ACR) launched in 2012. Activities on this year’s International Day of Radiology, scheduled for November 8th, will focus on lung imaging. This event’s Facebook page, facebook.com/internationalradioday, will feature updates throughout the year. The Board extended an invitation to the ACR Resident and Fellow Section (RFS) to appoint a liaison to RSNA’s Resident and Fellow Committee. An RSNA liaison will also serve on the ACR RFS and this reciprocal relationship will facilitate cooperation between the two groups to more effectively serve the interests of radiology residents.

RSNA 2013

The Board of Directors selected the Special Interest and Controversies Sessions for this year’s annual meeting. These sessions enable meeting attendees to discover radiology-related topics that present point-counterpoints on a controversy in imaging (Controversies), or programs the RSNA Board deemed of particular importance (Special Interest). This year’s sessions are:

Special Interest
- Update on Image Wisely
- Quality: Getting Radiologist-Friendly Right

Hot Topic Sessions that enable meeting attendees to discover radiology-related topics that are late-breaking will be announced at a later date. In other news, the Pediatrics and Nuclear Medicine/Molecular Imaging camps will be offered once again at RSNA 2013. The separate camps feature many components—including refreshers and series courses, scientific presentations, and education exhibits—of these subspecialties, to facilitate focused study during the week.

Advance registration for RSNA 2013, with its theme of The Power of Partnership, is underway for members. General registration opens June 5 and course enrollment begins July 10. I look forward to seeing you in Chicago as we experience together the science, education and technology that no one else can offer quite like RSNA.

Ronald L. Arenson, M.D.
Chairman, 2013 RSNA Board of Directors

My Turn

Amyloid Imaging Offers Opportunities, Requires Caution

Amyloid beta is the most widely recognized marker of Alzheimer Disease (AD), and many even believe it is a causal factor. Amyloid plaques are associated with neuronal damage that can eventually lead to profound dementia in a subset of patients. For patients with dementia, the standard imaging workup has been MR and FDG-PET imaging of the brain. These diagnostic studies often help to establish the diagnosis of AD by distinguishing it from other conditions such as fronto-temporal dementia. However, these studies are less useful early on in the disease, at a time when treatment modifications may still be effective.

Clinical guidelines require the presence of dementia to make the diagnosis of AD. However, by then, it may be too late to halt or even delay the progression with treatments aimed at reducing amyloid deposition. The recent FDA approval of F18-Florbetapir, an amyloid tracer and imaging biomarker, is a giant leap forward.

As with any diagnostic test, amyloid imaging carries with it the expectation of increased diagnostic certainty, or at least the potential to alter medication choices and regimens, and/or improve patient understanding and motivation. The strength of amyloid imaging lies in its high negative predictive value. Its best use is when the presentation is atypical and objectively verified cognitive decline.

This is where MR imaging and FDG-PET fall short. Amyloid scanning should rather be the front-line imaging study for elderly patients with cognitive decline or a screening test for AD.

It is important to emphasize that amyloid deposits in the brain do not automatically equate to Alzheimer disease. With the appropriateness criteria and indications for amyloid scanning now established, CMS should work swiftly to approve reimbursement. Research can then be appropriately directed at drug development strategies for amyloid removal or perhaps even methods for preventing amyloid deposition in the first place.
According to recent research showing that diagnostic errors far outpaced any other source of malpractice lawsuits, radiologists are highly unlikely to be sued for failing to recommend imaging tests.

In a separate study, those researchers also determined that the likelihood of a radiologist being the defendant in at least one malpractice lawsuit is 50 percent by age 60, yet the difference in frequency and average number of lawsuits accrued varies widely by sex and state of residence.

Researchers. Fear of being sued is often cited as a reason for ordering additional imaging—a phenomenon known as defensive medicine. While not in line with frequently held notions about radiology malpractice, this new data could assuage the fears many radiologists have to some degree.

A study conducted at the University of Medicine and Dentistry of New Jersey in Newark, the study of 4,793 cases filed against 2,680 radiologists in 47 states found that the primary allegation that failure to order additional imaging represented only 0.41 malpractice claims per 1,000 person-years. By contrast, the study found that a significant source of lawsuits against radiologists is a failure to communicate important radiographic findings.

“While the number of malpractice lawsuits alleging failed radiographic communication has not yet reached epidemic proportions, nonetheless they are indeed increasing in number,” said Leonard Berlin, a radiologist at Skokie Hospital and a professor of radiology at Rush University and the University of Illinois College of Medicine.

“In fact, failure to communicate results of radiologic examinations is the second most common cause of malpractice lawsuits filed against radiologists, said Dr. Berlin, who delivered an Annual Oration in Diagnostic Radiology, “To Disclose Radiologic Errors—Should ‘Patient First’ Supersede Radiologist Self-Interest?, at RSNA 2012.

An American College of Radiology (ACR) survey conducted earlier this year found that 23 percent of the 3,400 radiologists responding admitted having been sued for failing to communicate findings. Forty-nine percent said they have not and 28 percent declined to respond. Sixty percent of failed communication malpractice lawsuits were resolved in favor of the plaintiff, either through settlement or trial verdict; 29 percent were resolved without payment to the plaintiff and no information was given regarding the remaining 11 percent.

Dr. Berlin says the problem is exacerbated by the disparity between how radiologists communicate urgent versus significant, unexpected findings. While malpractice lawsuits rarely allege failure of communication of an urgent finding such as a hem- orrhexis or tension pneumothorax, virtually all of the failed communication lawsuits dealt with failure to directly communicate significant unexpected findings.

“Nevertheless, from the courts’ perspective, all radiologic findings that could be adverse to a patient’s health fall into the same category: they require direct communication,” Dr. Berlin said. While he agrees that malpractice lawsuits arising from radiologist negligence for failing to order additional imaging examinations have been, and remain, extremely rare, lawsuits alleging failure to order imaging tests filed against non-radiologic physicians are not rare. Data from Cook County (greater Chicago area), Illinois indicate that failure to order all recommended examinations across a variety of medical specialties has become a trend.

“The fact that radiologists themselves are not commonly sued for ‘failure to order’ an imaging test should not pull them into a false sense of security,” Dr. Berlin said. Both Drs. Berlin and Baker urge radiologists to follow the ACR Practice Guidelines for Communication of Diagnostic Imaging Findings, which are often invoked by plaintiff lawyers making cases that a particular defendant radiologist failed to meet such an obligation.

One Company Offers Significant Database
While numerous studies have examined malpractice trends in radiology, the One-Call Medical database offered a much larger pool of data, said Dr. Baker, whose research grew out of his longtime work as a consultant for the company.

“As the company grew and grew, I thought, this is a huge data source that can give us insights into malpractice cases,” Dr. Baker recalled. “This study group is 10 times bigger than those of previous studies, and the radiologists enrolled represent more than 25 percent of the radiologists in the country.”

Of the 4,793 cases filed against radiologists in the study, Dr. Baker and colleagues were able to derive an alleged cause of the lawsuit in 4,043.

After breast cancer, non-vertebral fractures and spinal fractures, lung cancer and vascular disease were the most frequently missed diagnoses. Procedural complications represented the second most common category of malpractice suits after errors in diagnosis, with 1.78 claims per person-years.

The same research team mined this data for a separate study examining demographic characteristics of malpractice claims against the same group of radiologists. Researchers found radiologists had a 50 percent likelihood of being the defendant in at least one suit by age 60.

Information on settlements and jury verdicts were available for 2,758 cases. Claims were settled before trial in the vast majority of cases, with only 99 listed claims ending in a court-directed judgment. The majority of completed claims were settled in favor of the plaintiff, with an average award of $411,112 paid on behalf of radiologists in court-directed cases. For claims settled out of court, the mean payment was $295,993.

“The chances of a radiologist getting sued are not huge,” said Dr. Baker. “However, the chance of losing is well above 50 percent, because we can’t hide our mistakes.”

Data showed that male radiologists were about 1.37 times more likely than women to be sued during their careers. “I have a hunch that in the case of breast imaging, women are less likely to sue women,” Dr. Baker said. “It’s also possible that while younger women are working in the same areas as men, the older ones are being segregated into areas less likely to be subject to malprac- tice.”

The outcome of cases and average award amounts differed markedly by state. Median payment awards ranged from a low of $24,105 in Colorado to a high of $350,000 in Maine. Mean payments varied from $74,373 in Nebraska to $715,707 in Oregon. The higher mean payments reflect the disproportionate effect of a few very large awards.

The likelihood of a radiologist being the defendant in at least one suit is 50 percent by age 60, yet the difference in frequency and average number of suits accrued varies widely by state of residence and sex, according to research by Stephen R. Baker, M.D., and colleagues. About 60 percent of the claims filed against radiologists in each state who have ever been sued. The District of Columbia and 14 states had fewer than 50 radiologists enrolled with One-Call Medical at the time of the study and were therefore excluded from this analysis. Though individual states varied greatly in the likelihood for a radiologist to have been sued, malpractice ac- tions against radiologists were not concentrated in any region of the country.
Smartphone App Successful in Telestroke Evaluation

The phrase "time is brain" represents the recognition that a stroke is a time sensitive neurological emergency.

But many patients, particularly those who live in remote and medically underserved areas, have limited access to neurologists. Although telemedicine is a possible solution in those situations, neurologists are still tied to a desktop or laptop computer that require a reliable Internet connection.

A recent study by Bart Demaerschalk, M.D., and colleagues from the Mayo Clinic in Phoenix, has determined that telemedicine can, as Dr. Demaerschalk puts it, "fit in our pockets." The study, published in the September 2012 issue of Stroke, found that the U.S. Food and Drug Administration (FDA)-approved ResolutionMD™ Mobile smartphone app, from Calgary Scientific, can be used successfully to evaluate medical images during the course of a complete telestroke evaluation.

"Every second that elapses between the onset of stroke and diagnosis, management and institution of treatment means that more neurons die and patients have a greater possibility of neurological deficit, disability or death," said Dr. Demaerschalk, a professor of neurology and medical director of Mayo Clinic Telestroke, a network connecting the Mayo Clinic Hospital in Phoenix to a dozen rural hospitals, most of which are in Arizona. "But with electronically images as sophisticated as it is, there are still instances when there can be delays."

Smartphones, however, give neurologists immediate access to patients brain imaging. Dr. Demaerschalk and colleagues evaluated 53 patients who presented at Yuma Regional Medical Center with symptoms of stroke. He pointed out that his own institution in Phoenix provides telestroke care to the Maricopa Medical Center, a busy urban hospital that has neurologists on staff but is still challenged when it comes to finding emergency neurological care.

"We’ve also learned that it’s not just remote rural hospitals that are underserved," Dr. Demaerschalk said. "There are a number of urban hospitals that are underserved as well." He pointed out that his own institution in Phoenix provides telestroke care to the Maricopa Medical Center, a busy urban hospital that has neurologists on staff but is still challenged when it comes to finding emergency neurological care.

Dr. Demaerschalk and colleagues also conducted a companion study, published in Stroke, in which they determined that high-quality video teleconferencing using smartphones to conduct neurological exams for stroke are "reliable, easy to use, affordable...and [yield] high physician satisfaction."" Ultimately, Dr. Demaerschalk would like to test the validity of the two studies in one combined study, to determine whether smartphones remain a reliable and safe tool, before the technology is adopted for routine clinical practice.

ON THE COVER
Mayo Clinic researchers demonstrated the feasibility of the ResolutionMD™ Mobile smartphone app from Calgary Scientific can be used successfully to evaluate medical images during the course of a complete telestroke evaluation.

Smartphones like ResolutionMD™ by Calgary Scientific, right, offer the considerable advantage of giving physicians immediate access to patients and providing telemedicine benefits to patients in remote, rural hospitals that are often underserved. Image courtesy of Calgary Scientific.

WEB EXTRAS
• To view an abstract of the study, “Smartphone Telestroke Technology Application Is Successfully Incorporated Into a Telestroke Network Environment,” go to stroke.ahajournals.org/content/43/12/3098.
• To view an abstract of the study, “A New Support System Using a Mobile Device (Smartphone) for Diagnostic Image Display and Treatment of Stroke,” go to stroke.ahajournals.org/content/43/12/3098.
• To access SYNAPSE ERm at the Apple store in iTunes, go to www.apple.com/itunes/download/
• To view a video of Bart Demaerschalk, M.D., demonstrating the ResolutionMD™ smartphone app, go to http://www.youtube.com/watch?v=CPoRI4

SYSTEM USES SMARTPHONE TO EXCHANGE STROKE IMAGES

Smartphones were used by neurologists at Jikei University School of Medicine (JUSM) in Tokyo to develop a system for exchanging diagnostic images and clinical and management information to rapidly diagnose and treat stroke victims.

In their pilot study, co-inventors and authors Hiroyuki Takao, M.D., an instructor at JUSM, and Yuichi Murayama, M.D., director for the Center of Endovascular Surgery at JUSM, developed the “I-Stroke” system to transfer hospital-generated patient, clinical and imaging information from a hospital’s “stroke server” to a physician’s smartphone. The system, since renamed SYNAPSE ERm, is able to transfer clinical data, CT, MR, angiographic, intraoperative images and expert opinion in real time. The consultation occurs via Twitter direct messages seen only by the recipient.

The study was published in the October 2011 issue Stroke and presented at the 2012 Society of Neuro-Interventional Surgery annual meeting.

Dr. Takao sees smartphones as part of the solution in continuing efforts to rapidly diagnose and treat stroke victims. "We can’t use a personal computer anytime and anywhere, but we can use smartphone devices for stroke on anyone, anytime anywhere."

In addition to delivering images, the system can alert hospital staff to the imminent arrival of stroke patients and the amount of time elapsed after the stroke and patient’s condition on arrival. By allowing physicians to view imaging results and other tests in real time, SYNAPSE ERm encourages swift reaction and saves precious time.

The system also allows neurologists outside the hospital to view surgical and other procedures in real time, making them available for guidance and expert assessment of treatment progress.

"The system may be available for free patient management in neurology and neurosurgery," said Dr. Takao, adding that the system can improve the outcome in many patients by facilitating diagnosis and treatment of stroke. He also believes SYNAPSE ERm can help cut healthcare costs by improving physician efficiency and reducing misdiagnosis and the unnecessary transfer of patients.

SYNAPSE ERm is available for free download at the Apple store in Japan. Licensed by FUJIFILM Corp, the system is now in place in approximately 25 hospitals in Japan, Dr. Takao said. Trials are underway in the U.S. and Europe to evaluate the technology and pave the way for possible regulatory approval.
Researchers detected three patients with severe OSAS and four with mild OSAS and imaged the computerized models of the girls’ upper airways while they were awake. Images of the severe cases revealed the upper portions of the airway constricting during one part of the breathing cycle and at the same time expanding lower down in the airway. Cases of mild OSAS revealed more synchronous motion of the entire airway. “In the more severe patients, we can see an abrupt change in the timing of the airway motion going from the velopharynx into the oropharynx, precisely at the site of restriction in the severe cases,” Dr. Wagshul said. “Other studies in the group have shown that such motion may be due to activation of the muscles surrounding the airway, likely compensation for change in airflow due to the airway constriction.” Dr. Wagshul continues to examine data from the study.

**Multislice craniofacial CT imaging can aid otorhinolaryngologists and maxillofacial surgeons in detecting soft tissue and skeletal factors that can alter the mechanical properties of the upper airway and its tendency to collapse during sleep, according to researchers.**

**Cine MR imaging offers complete coverage of the entire upper airway with isotropic resolution, allowing image reformatting in any plane you desire.**

Mark Wagshul, Ph.D.
Amyloid PET Imaging Plays Pivotal Role in Alzheimer’s Care

Often referred to as the next frontier in Alzheimer disease (AD), amyloid PET imaging holds tremendous promise as a tool to aid in the early detection of AD or cognitive impairment—potentially even before the onset of dementia.

Nevertheless, the modality faces a number of barriers to widespread use. Medicare does not yet cover brain amyloid imaging with PET, and out-of-pocket fees for the test can cost several thousand dollars. Other limiting factors include patients’ access to dementia experts who can effectively use amyloid PET imaging information as a part of their diagnostic workup and radiologists who can accurately interpret the scans.

Although wider clinical use will take time, the wheels are already in motion. Used in Alzheimer’s research for more than a decade, amyloid PET imaging has been clinically available only since April 2012, when the U.S. Food and Drug Administration (FDA) approved the first radiopharmaceutical for brain amyloid PET imaging (Amyvid by El Lilly and Company), opening the door for approval of similar PET tracers. And patients are already beginning to ask physicians about the benefits of the new modality.

“The test is not in general use yet, but there are going to be a lot of questions about amyloid PET imaging and physicians need to be prepared,” said Dean H. Hartley, Ph.D., director of science initiatives, Medical and Scientific Relations Division, at the Alzheimer’s Association.

To offer guidance to patients, physicians affected by AD and the public, the Society of Nuclear Medicine and Molecular Imaging (SNMMI) and the Alzheimer’s Association jointly published the first criteria for the appropriate use of amyloid PET imaging to aid in the diagnosis of those with suspected AD. The criteria appeared in the January 2013 online editions of The Journal of Nuclear Medicine and Alzheimer’s & Dementia: The Journal of the Alzheimer’s Association.

“Our primary goal is to provide healthcare prac- titioners with the information and options available to provide patients with the best possible diagnosis and care in a cost effective manner,” said Maria Cas- rillo, Ph.D., Alzheimer’s Association vice-president of medical and scientific relations.

Drafted by SNMMI and the Alzheimer’s Asso- ciation’s Amyloid Imaging Taskforce, consisting of dementia and imaging experts from across the globe, the criteria are designed to help physicians determine who is—and is not—an appropriate can- didate for amyloid PET imaging.

Task force members stress that amyloid PET imaging is not the equivalent of clinical diagnosis of Alzheimer disease or dementia and is only one tool that clinicians should use to judi- ciously manage patients. “Currently, amyloid PET imaging can aid in the determination of someone having Alzheimer disease but cannot replace a full clinical evaluation,” Dr. Hartley said.

Criteria Determine Appropriate Use for Amyloid PET Imaging

In amyloid PET imaging, the radiophar- maceutical is introduced into the body by injection into a vein and binds specifically to the amyloid protein, enabling visualiza- tion of areas in the brain where amyloid has clumped together into plaques—one of the defining pathologic features of AD.

However, patients with normal cogni- tion can also have elevated levels of these plaques, as do people with conditions other than AD. Therefore, the potential clinical use of amyloid PET imaging requires careful consideration so that its proper role may be identified, according to criteria authors. Because definitive research only with the limitations outcomes of amyloid PET imaging isn’t yet available, task force members analyzed peer-reviewed, published literature to develop a consensus of expert opinion. “Basically, the task force reached 10 indications for use of amyloid PET imaging,” Dr. Hartley said. “Three were determined as appropriate; seven were not.”

According to the task force, amyloid PET imaging should be limited to the following:

- Patients with persistent or progressive unexplained mild cognitive impair- ment who have had a confirmed assessment of impairment
- Patients who may have Alzheimer disease but lack a clear clinical presenta- tion (either an atypical clinical course or an etiologically mixed presenta- tion)
- Patients with progressive dementia who are aged 65 or younger, which may indicate early onset.

The task force determined that amyloid PET imaging is inappropriate in the following situations: Patients age 65 or older who meet standard defini- tions for Alzheimer disease; to determine dementia severity; based solely on family history of dementia or presence of the apolipoprotein E type 4 (APOE 4), a genetic factor associated with Alzheimer’s disease; to aid in the diagnosis of dementia; or for presymptomatic screening.

“Of the critical indications of PET amyloid imaging will be to aid in the diagnosis of Alzheimer’s in patients whose clinical presentations are atypical or unexplained," said Satoshi Minoshima, M.D., Ph.D., co-chair of the task force and professor and vice-chair of radiology at the University of Washington, Sea- ttle. "Examples include atypical symptoms, atypical age of onset and presence of comorbidities. If anti-amyloid treatments are determined effective in the future, amyloid PET imaging could be used for better therapeutic evaluations.

Although Dr. Minoshima says the PET amyloid imaging procedure itself is relatively straightforward, the interpretation can be challenging if physicians are not familiar with the scan. For that reason, the task force recommends that the scans be read by physicians certified in nuclear medicine or nuclear radiology who have adequate specific training in amyloid PET imaging interpretation, and that imaging procedures be performed by a qualified nuclear medicine technologist with appropriate training and certification.

New training resources are available or in the works. When the FDA approved Amyvid, the agency mandated that El Lilly provide specific training in amyloid PET interpretation. (See sidebar) SNMMI will soon be releasing an education program for those referring patients and reading the scans along with technical procedure guidelines for ensuring performance quality. Use of beta amyloid imaging and computer-aided analysis software for amyloid PET imag- ing is also in development, according to the task force.

CMS to Rule on Amyloid PET Imaging Coverage

Although insurance coverage is critical to use of amyloid PET imaging, the Medicare Evidence Development and Coverage Advisory Committee (ME- DAC) ruled in late January that adequate evidence does not exist to determine whether amyloid PET imaging changes health outcomes in suspected cases of AD. Committee members also expressed concern about possible inappropriate use of the test and the possibility of false-positive results.

SNMMI and the Alzheimer’s Association issued statements expressing disap- pointment in the opinion, stressing that those concerns had been addressed by the task force criteria and recommending that the Centers for Medicare & Medicaid Services (CMS) cover brain amyloid PET imaging according to those criteria. CMS, which is expected to vote on the issue this summer, generally follows committee recommendations; private payers tend to follow CMS’ lead.

Whatever the CMS decision, Dr. Hartley stressed that the task force will continue to update the criteria to reflect changes in the evolving issue. “This is a working document and it will be modified and updated to reflect any new information we receive. We are still convening and still discussing this issue.”

"One of the critical indications of PET amyloid imaging will be to aid in the diagnosis of Alzheimer’s in patients whose clinical presentations are atypical or unexplained."

Satoshi Minoshima, M.D., Ph.D.
Stereotactic Body Radiation Therapy
Highly Effective Lung Cancer Treatment

New research has added to the growing body of evidence demonstrating the potential of stereotactic body radiation therapy (SBRT) to become the standard treatment for early stage, medically inoperable non-small cell lung cancer.

Investigators who presented findings of a Phase II trial by the Japan Clinical Oncology Group (JCOG) at the 2012 American Society for Radiation Oncology (ASTRO) annual meeting determined that SBRT for early stage, medically inoperable non-small cell lung cancer doubled overall survival rates, as compared to conventional radiation treatment.

“SBRT should be the new standard replacing conventional radiotherapy for patients with early inoperable lung cancer,” said Yasushi Nagata, M.D., lead author of the JCOG research and a radiation oncologist at the Department of Radiation Oncology at Hiroshima University in Hiroshima, Japan. “SBRT is not only effective but is well tolerated and has only mild toxicity, making it a suitable alternative to other therapies. SBRT is also painless and non-invasive, which are big advantages.”

Surgery still holds one advantage: physicians have tissue samples to determine whether the cancer has spread to the lymph nodes. But patients are increasingly interested in less invasive treatment as the evidence for their efficacy becomes more solid, said Chance Matthiesen, M.D., assistant professor of radiation oncology at the University of Oklahoma Health Sciences Center (OUHSC) and lead author of “Stereotactic Body Radiation Therapy (SBRT) for Early Stage Medically Inoperable Non-Small Cell Lung Cancer,” presented at RSNA 2012.

“In this day and age, patients are very smart and read about their options, coming to clinics more educated than ever before,” Dr. Matthiesen said. “They will be asking whether they can have this therapy.”

The devices focus radiation very tightly on the tumor, with minimal radiation exposure to surrounding normal tissue. SBRT can be accomplished in as little as a single treatment, as compared to several weeks with conventional fractionated radiation therapy.

In some cases, tumors were inoperable due to location but most patients had comorbid conditions such as impaired pulmonary function that made them ineligible for surgery. The median patient age in that study was 66.

Three-year Survival Rate Doubles over Conventional Therapy

Dr. Nagata’s 2012 study, the companion to a similar study conducted previously among operable lung cancer patients, examined the safety and efficacy of SBRT for 100 inoperable lung cancer patients treated between July 2004 and November 2008. Median patient age was 78; median tumor size was 21 mm. About half of the patients had adenocarcinomas and 40 percent had squamous cell carcinomas. Patients received an average of 48 Gy in four fractions.

Results showed patients’ overall three-year survival rate was 60 percent. Earlier studies on conventional radiation in inoperable patients showed overall three-year survival rates ranging from 31 to 39 percent. Side effects for SBRT were mild and included dyspnea, hypoxia, pneumonitis chest pain and cough, Dr. Nagata said.

SBRT Exhibits Minimal Toxicity

In their research examining clinical outcomes and retrospectively reviewed 49 patients diagnosed with early stage, medically inoperable non-small cell lung cancer treated with SBRT from 2006 to 2011. In some cases, tumors were inoperable due to location but most patients had comorbid conditions such as impaired pulmonary function that made them ineligible for surgery. The median patient age in that study was 66.

Just over 73 percent of the group had tumors with a median maximum diameter of 2 cm, and 26.5 percent had a median maximum diameter of 4.3 cm. Approximately 53 percent of patients had squamous cell carcinomas and about 29 percent had adenocarcinomas. The median SBRT treatment was 60 Gy in three to five fractions.

At median follow-up of 16 months, 28 of the 49 patients were alive and 26 had no local recurrence or systemic cancer progression. Of those who had died, only nine patients died of recurrence or progression of lung cancer. Nine patients experienced complications from SBRT including their wall pain and rib fractures.

“The encouraging thing about SBRT is its low toxicity,” Dr. Matthiesen said. “Acute effects are minimal for the overwhelming majority of patients.” Because SBRT can be accomplished in a much shorter timeframe, this treatment could offer a significant advantage to patients in rural states, he added.

“Sometimes we see patients here who live three hours away who may have a full-time job and a family depending on them,” Dr. Matthiesen said. “A lung cancer diagnosis might mean stopping their life for weeks to get treatment. A week of SBRT is a stressor, but it’s manageable. And it would ease the burden on treatment centers; if you can treat people in five sessions, you can see a lot more patients in a lot less time.”

SBRT should be the new standard replacing conventional radiotherapy for patients with early inoperable lung cancer.

Yasushi Nagata, M.D.
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**RSNA.org/donate.**

The RSNA R&E Foundation provides the research and development that keeps radiology in the forefront of medicine. Support your future—donate today at RSNA.org/donate.

**Failure to Order Imaging Tests Not a Major Driver of Malpractice**

Alabama radiologists experienced the lowest malpractice rate with less than one lawsuit per 100 practice-years for both men and women, while New York had the highest rate with 56 lawsuits per 100 practice-years for men and 41.3 for women.

Caps on Awards Impact State Malpractice Rates

One possible reason for the different malpractice rates among states is tort reform, which often caps awards for non-economic damage to plaintiffs in malpractice suits. “In states where there are limited awards for pain and suffering, plaintiffs’ lawyers might be reluctant to take cases,” Dr. Baker noted.

**Caps on Awards**

Caps on awards are not the only factor in malpractice rates. For instance, an Alabama case involving caps on malpractice awards was overturned by the state Supreme Court, yet the state has the lowest legal malpractice rate in the country. In the 2008 study in the *Journal of Health & Biomedical Law*, aggressive defense of malpractice claims by insurers, positive juror attitudes toward physicians, and the propensity of the state Supreme Court to overturn plaintiffs’ verdicts on appeal all played a role in limiting the number of suits in Alabama.

Dr. Baker’s research team continues to pore through the data on radiology malpractice, focusing on malpractice rates in spine versus non-spine fractures, breast imaging cases and elderly patients. 

**Your Donations in Action**

With a grant from the RSNA Research & Education (R&E) Foundation, Linda Chu, a body MRI imaging fellow at Johns Hopkins University in Baltimore, MD, is developing the project, “Cardiac MR Imaging Evaluation of Early Disease Markers of Hypertrophic Cardiomyopathy.” This project is made possible through the generous support of Siemens Healthcare.

“My project will investigate the use of novel cardiac MR imaging techniques [4D phase contrast and T1 mapping] to quantify structural and functional abnormalities in patients with hypertrophic cardiomyopathy,” Dr. Chu said. “We hope the quantitative measures from these techniques will identify patients who may benefit from early intervention.”
Intracranial Vasa Vasorum: Insights and Implications for Imaging

Unlike extracranial vasa vasorum, intracranial vasa vasorum are rare and develop with age, predominantly on the proximal portions of the intracranial arteries. Advanced contrast material-enhanced imaging techniques can help detect and even grade intracranial vasa vasorum, which may provide new insights into our ability to diagnose and assess the risk of intracranial vascular lesions such as atherosclerosis, aneurysms, dissections and vasculitis.

In a Review and Commentary in the June issue of *Radiology*, Anthony Portanova, B.S., of the University of Rochester, N.Y., and colleagues review the published literature on intracranial vasa vasorum and interpret the findings in a radiologic context. The authors offer radiologists a concise framework for analyzing diseases of the intracranial arteries on the basis of the presence or absence of vasa vasorum.

The unique structure and environment of intracranial arteries may explain their relative lack of vasa vasorum, according to the authors. This distinctive feature of intracranial arteries may serve as an important diagnostic characteristic on imaging studies, since vasa vasorum and the presence of a variety of vascular pathologic processes can be detected by using contrast-enhanced imaging techniques.

“Contrast-enhanced imaging modalities, including MR imaging, CT, and ultrasound, can depict vasa vasorum by showing wall enhancement, which enables the identification and characterization of intracranial vasculoopathies such as atherosclerosis, aneurysms, dissections, and vasculitis that would not be achievable with conventional angiography,” the authors write.

Diffusion-weighted MR Imaging of the Gastrointestinal Tract: Technique, Indications, and Imaging Findings

Diffusion-weighted MR imaging is emerging as an important tool in the evaluation of gastrointestinal tract tumors and inflammatory disorders and is used to depict complications and monitor tumors and inflammatory bowel disorders to assess response to treatment.

In an article in the May-June issue of *RadioGraphics (RSNA.org/RadioGraphcs)*, Rakesh Sinha, M.B.B.S., M.D., F.R.C.R., F.I.C.R., of Warwick Hospital, South Warwickshire NHS Foundation Trust, England, and colleagues review the technique, indications and imaging findings of diffusion-weighted imaging and its role in depicting disease processes that affect the gastrointestinal tract. The authors also discuss artifacts and an approach to image optimization with examples of pitfalls of interpreting diffusion-weighted images of the bowel.

“Complications, such as a malignant change, abscess, and fistula, may also be depicted, and it is particularly useful in assessing gastrointestinal tract conditions in patients with contraindications to the use of intravenous contrast material,” the authors write. “Quantitative measurements of signal intensity at diffusion-weighted imaging may help differentiate actively inflamed bowel from normal bowel, and ADC values provide useful information about disease activity and response to treatment.” An Invited Commentary on Dr. Sinha’s article by Alyia Qayyum, M.B.B.S., M.R.C.P., F.R.C.R., also appears in the issue.

Journal Highlights

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

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Thalamic Atrophy is Associated with Development of Clinically Definite Multiple Sclerosis

Measurement of thalamic atrophy and increase in ventricular size in clinically isolated syndrome (CIS) is associated with clinically definite multiple sclerosis (CDMS) development and should be used in addition to the assessment of new T2 and contrast agent-enhanced lesions, according to new research.

Robert Zivadinov, M.D., Ph.D., of the Buffalo Neuroimaging Analysis Center, University at Buffalo, N.Y., and colleagues used contrast-enhanced MR imaging for initial assessment of 216 CIS patients. Follow-up scans were performed at six months, one year, and two years. Over two years, 92 of 216 patients, or 42.6 percent, converted to clinically definite MS. Decreases in thalamic volume and increase in lateral ventricle volumes were the only MR imaging measures independently associated with the development of clinically definite MS.

Development of thalamic and central atrophy is associated with conversion to clinically definite multiple sclerosis (CDMS) over two years, and measurement should be used in addition to the assessment of new CE lesions and T2 lesions, according to the authors. “Use of these MR imaging biomarkers may be relevant for identifying patients who are at high risk for conversion to CDMS in future clinical trials involving CIS patients,” the authors write.

RadioGraphics

The Journal Highlights section in the April issue of *RadioGraphics* included Doctor Radio (Sirus XM), KFI-AM (Los Angeles), WLS-TV (Chicago), WMAQ-TV (Chicago), WHDH-TV (Boston), WXIA-TV (Atlanta), WPXI-TV (Pittsburgh) and KCBS-AM (San Francisco). Online coverage included The Wall Street Journal, The Huffington Post, NPR.org, Yahoo! News, WebMD, iVillage and FOXNews.com.

Media Coverage of RSNA

In March, 1,175 RSNA-related news stories were tracked in the media. These stories reached an estimated 729 million people.


Broadcast coverage included Doctor Radio (Sirus XM), KFI-AM (Los Angeles), WLS-TV (Chicago), WMAQ-TV (Chicago), WHDH-TV (Boston), WXIA-TV (Atlanta), WPXI-TV (Pittsburgh) and KCBS-AM (San Francisco). Online coverage included The Wall Street Journal, The Huffington Post, NPR.org, Yahoo! News, WebMD, iVillage and FOXNews.com.

RSNA.org/RadioGraphics

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Corrections

The Journal Highlights section in the April issue of *RSNA News* incorrectly identified the journal in the citation for the study, “Breast Reconstruction: Review of Surgical Methods and Spectrum of Imaging Findings.” The journal is RadioGraphics. The Radiology in Public Focus section in that issue incorrectly identified the page numbers in the citation for the study, “Body CT Scanning in Young Adults: Examination Indications, Patient Outcomes and Risk of Radiation-induced Cancer.” The page numbers are 460-469.
RSNA/AUR/ARRS Introduction to Academic Radiology Program

Applications due: July 19

Sponsored by RSNA, the American Roentgen Ray Society (ARRS) and Association of University Radiologists (AUR), the Introduction to Academic Radiology program:

• Exposes second-year residents to academic radiology
• Demonstrates the importance of research in diagnostic radiology
• Illustrates the excitement of research careers
• Introduces residents to successful clinical radiology researchers

Successful applicants will be assigned to either a seminar held during the RSNA Scientific Assembly in Chicago, December 1-6, 2013 or the AURS Scientific Meeting in San Diego, May 4-9, 2014.

More information and the nomination form for this program are available at rsna.org/Introduction_to_Academic_Radiology.aspx

Final Call to Apply for RSNA Clinical Trials Methodology Workshop

January 11-17, 2013
Scottsdale, Ariz.

Applications due: June 19

Over the course of this 10-day workshop, each trainee will be expected to develop a protocol for a clinical study, ready to include in an application for external funding. Participants will learn how to develop protocols for the clinical evaluation of imaging modalities. A dynamic and experienced faculty will cover topics including:

• Principles of clinical study design
• Statistical methods for imaging studies
• Design and conduct of multi-institutional studies
• Sponsorship and economics of imaging trials
• Regulatory processes

Applicants will undergo a competitive selection process for course entrance. Once admitted, trainees will participate in advance preparation, didactic sessions, one-on-one mentoring, small group discussions, self-study and individual protocol development. Familiarity with basic concepts and techniques of statistics and study design is required of all applicants.

Online application and additional information can be found at rsna.org/CT2013.

RSNA Advanced Course in Grant Writing

Applications are now being accepted for this course designed to assist participants—generally junior faculty members in radiology, radiation oncology or nuclear medicine programs—prepare and submit a National Institutes of Health, National Sciences Foundation or equivalent grant application. The course, to be held at RSNA Headquarters in Oak Brook, Ill., will consist of four two-day sessions: September 27-28, 2013; February 7-8, 2014; March 21-22, 2014; and April 25-26, 2014.

For more information and an application, go to rsna.org/AGW. Questions can be directed to Fiona Miller at 1-630-590-7741 or fmiller@rsna.org.

2013 CORE Workshop

Registration deadline: September 28

The 2013 Creating and Optimizing the Research Enterprise (CORE) workshop will be held Friday and Saturday, Oct. 25 and 26, 2013, in Oak Brook, Ill. The workshop will focus on strategies for developing and/or expanding research programs in radiology, radiation oncology and nuclear medicine departments. The CORE program features a combination of presentations, case studies and group discussions. More information and registration is available at rsna.org/Creating_and_Optimizing_the_Research_Enterprise_Workshop.aspx.

RSNA Derek Harwood-Nash International Fellowship

Applications due: July 31

The Derek Harwood-Nash Fellowship program enables international scholars pursuing a career in academic radiology to study at North American institutions. Accepted participants will receive a stipend of up to $10,000 from RSNA to be used toward travel, living expenses and educational materials for the six- to 12-week fellowship period. The application for this program is available at rsna.org/Derek_Harwood-Nash_International_Fellowship.aspx. For more information e-mail CIRE@rsna.org.
Course Enrollment Begins July 10
The RSNA 2013 Advance Registration, Housing and Course Enrollment brochure will be mailed in late June to all RSNA members and 2013 meeting registrants. On July 10, the brochure will be available online at RSNA.org/Attendees.aspx. Those registering for RSNA 2013 prior to June 15 who wish to view course enrollment information online only can “opt out” of receiving the copy by mail during online registration. Use this brochure to make the most of your RSNA 2013 experience. The information is organized to help you complete your enrollment in just a few steps, find the courses you need, build your schedule and enroll quickly and easily online or via the print form.

RSNA 2013 Registration
How to Register
There are four ways to register for RSNA 2013:
1 INTERNET (fastest way) Go to RSNA.org/register
2 FAX (24 hours) 1-630-772-9988
3 TELEPHONE Valid 8 a.m. – 5 p.m. (CT) 1-866-430-7018
1-847-996-5676
4 MAIL Experient/RSNA 2013 P.O Box 4088 Frederick, MD 21705 USA

RSNA 2013 Registration

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Important Dates for RSNA 2013
- June 5: General registration and housing opens
- July 10: Course enrollment opens
- October 25: International deadline to have full conference badge mailed
- November 8: Final housing and discounted registration deadline
- November 27: Deadline to guarantee a seat for all ticked courses
- December 1-6: RSNA 99th Scientific Assembly & Annual Meeting

Buy Bistro RSNA Tickets Now
Avoid long lines by purchasing Bistro RSNA tickets now. Advance tickets to Bistro RSNA—which provides a comfortable setting for attendees to eat, meet and network during the annual meeting—are only $20.

Guarantee Your Seat!
Tickets are required for various meeting components, including refresher, multisession, informatics workshops and RSNA tours and events.

International Visitors
Personalized invitation letters to RSNA 2013 are available by request during online registration. In addition, the International Visitors section of RSNA.org/Attendees.aspx includes important information about the visa application process. Visa applicants are advised to apply as soon as they decide to travel to the U.S. and at least three to four months in advance of their travel date. International visitors are advised to begin the visa process now.

Spouse/Family Member Badges
Full-conference professional registrants are entitled to one complimentary spouse/family member badge; each additional badge is $50. This badge is intended for use by a spouse or family member 16 and over accompanying a full-conference professional registrant to the meeting. It allows access to technical exhibit halls, Lakeside Learning Center and classrooms–space permitting–after all professional registrants have been seated. CME credit is not tracked or awarded. A co-worker or industry associate is not eligible for this badge and must register as a professional and pay the applicable registration fee.

For more information about registering for RSNA 2013, visit RSNA.org/Attendees.aspx, e-mail reginfo@rsna.org, or call 1-800-381-6640 x7862.
RSNA 2012 Refresher Courses Now on Sale

For a limited time, RSNA is offering discount pricing on selected refresher courses from past annual meetings. These collections are available at a 25 percent discount until October 31, 2013. The discount price is $60 for members; $90 for nonmembers. Each collection includes an audiovisual presentation, a line-by-line transcript and offers AMA PRA Category 1 Credits® for each successfully completed CME test.

- Breast Imaging/New Technologies: Two CDs, “Mammographic Interpretation” and “Computer-assisted Decision Systems in Breast and Lung Imaging” explore the effect of new technologies on breast imaging and their implications for clinical practice. The Breast Imaging/New Technologies Collection offers 5.0 AMA PRA Category 1 Credits®.
- Musculoskeletal: Three CDs, “Emerging Techniques in Musculoskeletal Imaging,” “Imaging of Upper Extremity Entrapment Neuropathies” and “Osteoporosis: Clinical and Imaging Features,” provide a comprehensive review of the hottest areas of musculoskeletal radiology. The Musculoskeletal Collection offers 4.5 AMA PRA Category 1 Credits®.

To purchase these collections at the discounted rate, go to the RSNA Education Center catalog at RSNA.org/education or call 1-800-272-9290.

RSNA Staff Retirements

In March and April, RSNA said goodbye to two employees who retired after nearly 50 years’ worth of combined service to the Society.

Al Simonaitis, 24 years

When Al began his employment with RSNA in September 1988 as a manuscript editor in the Publications Department, Radiology and Radiographics were available in print form only. As the journals evolved, so too did Al’s job—he became a managing editor in August 1990 and eventually took responsibility for the journals’ burgeoning online presence. From the very first articles available as text only to RSNA members via the Internet, to the podcasts, image datasets and other enhanced content that now accompany Radiology and Radiographics articles, Al oversaw considerable change in the way RSNA shares cutting-edge science and radiology education.

“One of the hallmarks of the many years of Al’s work at RSNA was his willingness to take on new challenges,” said Roberta E. Arnold, M.P.H., RSNA assistant executive director for publications and communications, who hired Simonaitis and served as his supervisor through his RSNA career. “He was the first managing editor of JMRI (Journal of Magnetic Resonance Imaging), when RSNA helped the Society of Magnetic Resonance Imaging to develop that journal, and he was the managing editor of the ahead-of-its-time, totally online journal, RSNA EJ, founded and edited by Dr. Laurens Ackerman. These journals could not have moved forward without Al’s skill and enthusiasm.”

Ken Schulze, 24 years

Ken also played a significant role in developing RSNA’s online presence. Like Al, Ken began his employment with the RSNA as a manuscript editor when he was hired in May 1989. After a promotion to Managing Editor—Electronic Information, Ken ultimately became RSNA’s first Webmaster. Ken’s experience ranges from the very first announcements shared via RSNA Link to the recent redesign of the RSNA.org website. Ken was also instrumental in developing RSNA News online available.

“Ken is one of the most professionally ethical individuals I have ever met,” said Schulze’s supervi- sor, John W. Basco, M.S., RSNA managing director of web operations. “He knows a little bit about everything. One day Ken could be building HTML forms for RSNA.org. The next he could be teaching a class on the proper way to use a semi-colon. In our department, the rule of thumb is ‘If you don’t know something—any- thing—ask Ken Schulze.’ After 24 years, we’ll really feel his absence.”

RSNA.org

AUR, SCARD Websites Get a Brand New Look

In addition to seeing an eye-catching new look, visitors to the redesigned Association of Radiology (AUR) and the Society of Chairs of Academic Radiology Departments (SCARD) websites will experience improved navigation and streamlined organization in a tablet-friendly format. The websites offer visitors simpler, more direct paths to the wide array of content they have long relied on to fill their membership needs.

On the SCARD site, for example, content including past SCARD announcements, training resources, society links and more is now located under one Resources tab on the top of the page. All AUR content is now organized in colorful, easy-to-read categories anchoring the home page.

Both revamped home pages also feature new Spotlight sections highlighting important news and announcements. The SCARD site has also added a Google-powered search function.

We invite users to experience the revamped sites at www.AUR.org and www.SCARDweb.org.

Residents & Fellows Corner

New York Times Examines Change in Outlook for Radiology Residents

Declining salaries and dwindling job opportunities for radiology residents have attracted the attention of the New York Times, which explored the issues in a March 27 article.

“Job Prospects are Dimming for Radiology Trainees” looks at why residents are finding it increasingly difficult to find jobs, let alone those well-compensated enough to cover debt accumulated during training. Medicare reimbursement cuts, teleradiology, public scrutiny of the value of medical specialties, and the increase in the number of radiology graduates all affect resident job prospects.

“The RSNA Resident and Fellow Committee will meet this month at RSNA Headquarters in Oak Brook, Ill. One of the committee’s responsibilities is to develop content for the Residents and Fellows Committee. This meeting is an annual meeting. Each committee meeting sessions look at issues including career planning and legal aspects of working in radiology. Committee members also provide feedback to RSNA regarding how the Society can best meet the changing needs of radiology trainees. A report detailing the committee’s latest activities will be published in the August issue of RSNA News. Learn more by clicking Committees at RSNA.org/Leadership.aspx and selecting Resident and Fellow Committee.

COMING NEXT MONTH

From patient testimonials to videos of patients describing various radiologic procedures and programs, we report on some of the unique ways radiology departments and practices are using online tools to improve the patient experience.
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For more info, contact ed-ctr@rsna.org