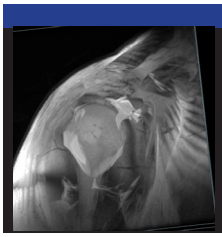


Radical Views...

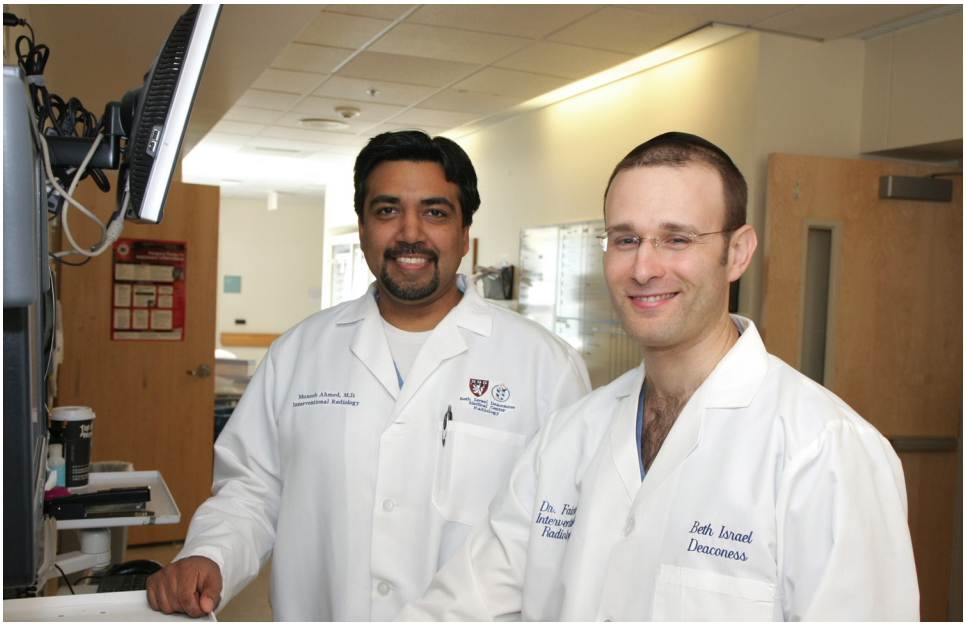
from the Department of Radiology

Volume 8, Number 3

SEPTEMBER 2015

Beth Israel Deaconess Medical Center

HARVARD MEDICAL SCHOOL TEACHING HOSPITAL



It gives me great pleasure to make the following announcements:

As of this month, **Dr. Sal Faintuch** has been appointed the Clinical Director of Interventional Radiology. In this position, he will take an active leadership role in the day-to-day operations of the clinical IR service, working closely with Marge, Bridget, and myself on improving workflow, standardizing practices and equipment, working closely with resource staff, coordinating educational sessions for techs/nurses, developing our IR clinic, and expanding our clinical service lines. I am very excited that Sal has agreed to take on this role, and ask you all to join me in congratulating him on his new appointment.

Dr. Felipe Collares received the de Groot Award from the American College of Phlebology. This award reflects his extensive interest in lower extremity venous disease, and supports his travel to another center, the Santa Casa Hospital in Belo Horizonte, Brazil, an important academic institution and referral center, to learn specific and advanced techniques in venous disease treatment. Please join me in congratulating him on this award.

- Muneeb Ahmed, MD
Chief, Vascular & Interventional Radiology
Vice Chair for Interventional Services | Radiology

Radiology's "Wow" Moment

How our IR team once again went above and beyond to provide the best possible patient care and service

On the evening of July 8th, the IR service was faced with three simultaneous complex patients (all around 4-5 pm) who needed urgent/emergent care: a pancreatic transplant AV fistula leading to an acute GI bleed, a renal transplant artery thrombosis, and a patient with hemoptysis requiring a bronchial artery embolization. Recognizing the critical nature of these cases, three separate IR teams volunteered to stay (4 attendings, 3 fellows, numerous techs and nurses) and neurosurgeon Ajith Thomas graciously postponed a non-urgent diagnostic cerebral to give us the INR room (Interventionalist Ammar Sarwar even went down to the cafeteria to get this patient a chicken sandwich as a consolation prize). All three cases were successfully completed to the patients' benefit (the transplant pancreas has done well, the renal artery is being thrombolyzed and has improved flow, and the bronchial patient is no longer bleeding). Each of the three teams finished after 11 pm, and one additional team stayed to do an emergent pelvic trauma embolization – finishing at 2 am.

These efforts highlight the continued significant effort that all members of the IR service make to prioritize patient care (often at their own expense) – and particularly to ensure that the complicated surgeries being done by partner services are supported to the greatest possible extent. Often the on-call team will stay until 10 pm to accommodate patients waiting for access to IR.

Radiology Calendar SEPTEMBER 2015

Check for the most up-to-date schedule at: **https://apps.bidmc.org/departments/radiology/residency/conferences/displayMonth.asp**

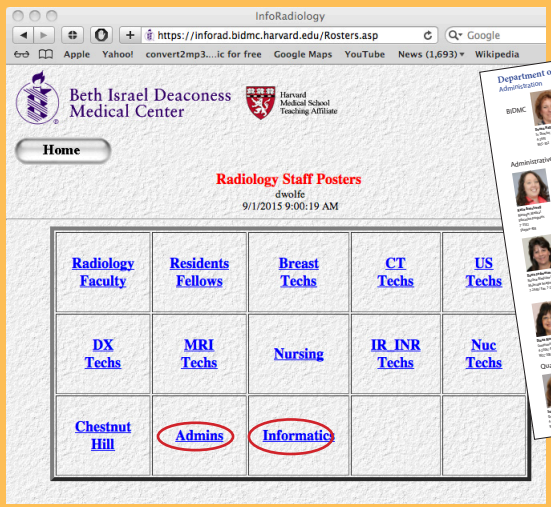
Mon	Tues	Wed	Thurs	Fri
Weekly Mon Section Meetings: 3:00-4:00 ED section meeting [ED annex, WCC]		Weekly Wed Section Meetings: 11:00-12:00 MSK clinical conference 12:00-1:00 CardioThoracic, GI/GU Oncology 3:00-4:00 Mammo [TCC-484]	Weekly Thurs Section Meetings: 12:00 - 1:30 Abd [WCC-354] 12:00-1:00 MSK	Friday Grand Rounds: 12 noon Sherman Auditorium, East Campus (unless stated otherwise)
	1 7:30 - 8:15 Parathyroid imaging (Kevin Donohoe) 8:15 - 9:00 Nucs Jeopardy (Kevin Donohoe)	2 7:30 - 9:00 Neuro (TBD)	3 7:30 - 8:15 Sentinal node imaging (Kevin Donohoe) 8:15 - 9:00 Nucs Jeopardy (Kevin Donohoe) 3:00-4:00 West MedRads - West Body Senior	4 7:30 - 8:15 Peer observation (Priscilla Slanetz) [Education Session]
7 Labor Day	8 7:30 - 8:15 Pelvic imaging cases (Girish Tyagi) 8:15 - 9:00 TBD (Leo Tsai) 10:30-11:30 NMMI meeting [GZ-103]	9 7:30 - 9:00 Neuro (TBD) 7:15-8:00 US meeting [WCC-304A]	10 7:30 - 8:15 Grey scale and Doppler imaging - technique pearls (Jonathan Kruskal) 8:15 - 9:00 Imaging of liver transplant complications (Jonathan Kruskal)	11 12:00 - 1:00 Chiefs Rounds - Ammar Sarwar [HUS, DEL, NLU, CHE]
14 7:30 - 9:00 MSK (TBD) 12:00-1:00 MRI Meeting [Ansin 2]	15 7:30 - 9:00 MSK (TBD) 8:00-9:00 IR Meeting [West Recovery]	16 7:30 - 9:00 Communicating errors (Steve Brown, BCH)	17 7:30 - 9:00 Physics (Matthew Palmer) 3:00-4:00 West MedRads - West Body Senior	18 7:30 - 8:15 The revenue cycle - how a dictation becomes a dollar (Annamarie Monks)
21 7:30 - 8:15 ICU III (Paul Spirn) 8:15 - 9:00 Cases (Paul Spirn)	22 7:30 - 8:15 Lung nodules (Alexander Bankier) 8:15 - 9:00 Cases (Alexander Bankier) 10:30-11:30 NMMI meeting [GZ-103]	23 7:30 - 8:15 Large airways (Phillip Boiselle) 8:15 - 9:00 Small airways (Philip Boiselle)	24 7:30 - 8:15 TBD (Janneth Romero) 8:15 - 9:00 TBA (Ronald Eisenberg)	25 7:30 - 8:15 Quality improvement (Justin Kung)
28 7:30 - 8:15 Bronchial interventions (Seth Berkowitz) 8:15 - 9:00 Y-90 (Ammar Sarwar)	28 7:30 - 9:00 MSK (TBD)	28 7:30 - 9:00 Neuro (TBD)		

Updated Radiology Staff, Trainee & Technologist Posters

are available on InfoRadiology in pdf format for viewing, downloading, and printing.

New this year are **Administrative** and **Informatics** posters, with **Support Staff** coming soon!

Log in to the portal:
https://portal.bidmc.org/
Click on InfoRadiology → Staff Posters



Please contact Donna Wolfe or Michael Larson if you would like to update your or any other information on these posters

DEPARTMENTAL NEWS: Guidelines for Contrast Reactions - Contrast Badge Update

Suzanne Swedeen, RN
MSN CNIV
Quality Improvement Specialist

Our guidelines for treating contrast-related events were updated and revised in Nov 2014 based on the 2013 ACR recommendations. ***For easy reference, these guidelines have been made into badges that can be worn with your hospital ID and are available at WCC-302, Dr. Kruskal's outer office. Please pick one up.***

These guidelines are for use in any section that administers contrast, and have been written broadly to help guide you in your assessment, triage and management of the patient. Included are the ACR recommendations on what should be included in your assessment of a patient experiencing an adverse contrast event. See below, the changes outlined in red that were made to the new Contrast Badges.

Guidelines for Managing Contrast Reactions

Urticaria

Asymptomatic: No treatment needed
Mild or Moderate: AND **NO** ride home*
Fexofenadine HCL (Allegra) 180mg PO
Mild or Moderate: AND patient HAS a ride home*
Diphenhydramine (Benadryl) 25mg-50mg PO/IV
Severe: As above, consider Famotidine 20mg IV over 2 minutes
*Due to the potential sedative effect of Diphenhydramine, Fexofenadine should be used for patient's that will be driving.

Facial or Laryngeal Edema

Mild to Severe: Consider calling Code 2-1212, Oxygen 6-10L facemask, Administer EpiPen (IM) may repeat 5-20 minutes (transfer to ED required if outpatient)

Bronchospasm

Mild: Oxygen 6-10L facemask, 2 puffs of Albuterol Inhaler
Moderate: Oxygen 6-10L facemask, Albuterol Nebulizer Solution, EpiPen (IM), may repeat 5-20 minutes (transfer to ED required if outpatient), consider calling a Code 2-1212
Severe: Consider calling a Code 2-1212, Oxygen-Ambu patient, Albuterol Nebulizer Solution, EpiPen (IM), may repeat 5-20 minutes (transfer to ED required if outpatient)

Hypotension with Tachycardia (Anaphylactoid Reaction)

Mild to Moderate: Oxygen 6-10L facemask, IV fluid
Severe or Unresponsive: Call a Code 2-1212, Administer Basic Life Support; Oxygen 6-10L facemask, IV fluid, EpiPen (IM) (transfer to ED required if outpatient)

Hypotension with Bradycardia (Vasovagal Reaction)

Mild to Moderate: Oxygen 6-10L facemask, IV fluid, consider brief elevation of legs
Severe or Unresponsive: Atropine 0.5-1mg IV, repeat q 3-5 minutes as needed (total 3mg), Oxygen 6-10L facemask, IV fluid, consider brief elevation of legs

Unresponsive Patient

Call a Code 2-1212, Administer Basic Life Support

To better aid you in your assessment, the ACR's Classifications of Contrast Reactions along with our Documentation and Patient Education Requirements are now included on the back of the badge.

Classification of Contrast Reactions

Mild: Signs and symptoms are self-limited without evidence of progression.
Limited urticaria, pruritus, edema
Limited flushing, warmth, chills
Limited itchy, scratchy throat
Nasal congestion, sneezing, rhinorrhea
Limited nausea, vomiting
Headache, dizziness, anxiety
Vasovagal reaction that resolves spontaneously
Bronchospasm - patient in no apparent distress
Mild hypertension

Moderate: Signs and symptoms are more pronounced and commonly require medical management.
Diffuse urticaria, pruritus, erythema–stable vital signs
Facial edema, throat tightness or hoarseness without dyspnea
Wheezing, bronchospasm, mild or no hypoxia
Protracted nausea, vomiting
Isolated chest pain
Vasovagal reaction that requires and is responsive to treatment
Hypertensive urgency

Severe: Signs and symptoms are often life threatening.
Diffuse edema or facial edema with dyspnea
Diffuse erythema with hypotension
Laryngeal edema with stridor and/or hypoxia
Wheezing, bronchospasm, significant hypoxia
Anaphylactic shock (hypotension + tachycardia)
Vasovagal reaction resistant to treatment
Arrhythmia, convulsion, seizures
Hypertensive emergency

Documentation Requirements:

All contrast related events, regardless of severity, must be reported in the Patient Safety Feedback System
If Allergic Reaction: Update patient's allergy profile in OMR to include allergy
A note must be documented in OMR or the chart (inpatient) describing assessment, treatment and disposition
Document event in the dictated exam report

Patient Education:

Discharge instruction to patient/caregiver should include:
Instruction for what to do should the reaction return
Instructions to inform their health care providers about this reaction

All patients should receive patient education sheet: Reaction to Contrast Agent LC 0161
All patients should receive wallet size allergy card

* *Coming soon: wallet-sized allergy cards*

Beth Israel Deaconess Medical Center
Department of Radiology
Tel. 617-754-2306

Name _____

Experienced a _____ Mild _____ Moderate _____ Severe
_____ Adverse event _____ Allergic Reaction

Contrast media _____

Route: Oral _____ IV _____ Date: _____

You have experienced an adverse/allergic reaction to contrast media (X-ray dye). This card should be with your other personal healthcare ID information.

Should you need future radiologic studies that require contrast media (x-ray dye), please present this card to and inform the technologist before any procedure requiring contrast media (x-ray dye).

Pre-medication recommended _____

Pre-medication NOT recommended _____

DEPARTMENTAL NEWS: *Introducing our Nurse Practitioners (NP) and Physician's Assistants (PA) in Radiology*

Nurse Practitioners (NPs) and Physician's Asisstants (PAs) are integral partners in radiology, facilitating throughput and collaborating with the physicians' practice so efficiently that they are nearly invisible. In this issue, I am pleased to increase their visibility ***and our appreciation*** by highlighting the role of our NPs/PAs in radiology through Radical Views. Following our profiles of Breast Imaging NP, **Nancy Littlehale**, and Abdominal Imaging NPs **Sarah Ghanem** and **Kate Schmid**, we introduced/updated everyone on IR PA, **Jon Underhill** and now on IR NP, **Devon O'Connel**l.

Introducing Devon O'Connell, MSN, FNP-BC - Nurse Practitioner in Interventional Radiology:

As the newest Nurse Practitioner in Interventional Radiology, I recently celebrated my 1-year anniversary in Radiology. How time flies! Although new to Radiology, I have been at BIDMC for five years having worked as a Nursing Assistant for one year and a Nurse for three years.

Currently, my primary responsibility is coordinating and preforming pre-procedure work-up of outpatient CT-guided procedures including biopsies, drainages, and fiducial seed implantation for patients preparing for radiation treatment.

I also am involved in coordinating the treatment and follow-up of our Interventional Oncology patients including **TACE** (trans-arterial chemoembolization), **RFA** (radiofrequency ablation), and **Y-90** (Yttrium-90).

When I am not doing the above, I also round on all of our inpatients that have received ultrasound or CT-guided drains while they are in-house and work closely with the inpatient teams responsible for these patients. I also carry the Radiology pager (not to be confused with Jon Underhill's pager!), so I triage the requests for inpatient biopsies and drainages, which require ultrasound or CT guidance.

Since I am a Family Nurse Practitioner (FNP), I also teach Graduate Pediatric Health Assessment at Simmons College where I enjoy interacting with the pediatric population of patients and their parents as well as helping educate future Nurse Practitioners.

When I am not at work I enjoy traveling, decorating my new apartment, skiing, playing tennis, and spending time with family and friends. I have had a great first year in Radiology and I look forward to learning more from my colleagues.

*Introducing Our **Sonographer Practitioners***

The Society of Diagnostic Medical Sonography (SDMS) has long supported efforts to create advanced sonographer career opportunities.

Following the positive feedback on the introduction of our Nurse Practitioners and Physician's Asisstant in Radiology, we are pleased to introduce our Sonographer Practitioners **Laurie Sammons** and **Lisa Napolitano** and to welcome and congratulate our newest US Practitioner **Kelsey Worcester**!


Kelsey Worcester

Kelsey Worcester: Although I have been a Sonographer at BIDMC since 2010, my training goes back to 2008, when I earned a B.S. in Biology from Salve Regina University and then I graduated from the BIDMC School of Diagnostic Medical Sonography in 2010. Now I am thrilled to transition from Sonographer to Sonographer Practitioner (officially on August 1st) but I am still getting to know my way around this dynamic and interesting role of being responsible for assisting the Radiologists with the dictation of ultrasound cases that come through the west campus and our off-site locations. As exams are performed, I check them for completeness, discuss any findings with the sonographer, and read-out with the attending radiologist. On technically difficult cases, I assist the sonographer to gather the diagnostic information needed. Some of the day is spent keeping the flow of the department steady, helping our wonderful NPs organize our IR procedures, and scheduling ultrasound-guided OR cases.

In my free time I volunteer at the Angell Memorial MSPCA in Jamaica Plain and I enjoy jogging, snowboarding, hiking, travelling, and entertaining Harvey, my one-year-old Lab mix.

*Introducing Our **Sonographer Practitioners** (cont'd)*

Lisa Napolitano: I have been at BIDMC for two years as a Sonographer Practitioner and I absolutely enjoy my time here. I relocated to the Boston area from South Portland, Maine having earned my degree in Radiologic Technology from St. Joseph's College in Maine and my ultrasound training at the Florida Institute of Ultrasound in 1988. I have been practicing in Ultrasound for 27 years in multiple specialties as a Lead Sonographer and Technical Director. I am ARDMS registered in OB/GYN, abdomen, breast, vascular, and Adult Echocardiography. I am also certified in Nuchal Translucency.


Lisa Napolitano

I serve as a liaison between the patient and attending and my primary responsibilities include checking ultrasound examinations for adherence to protocol, completeness of examinations, and technical factors from both the TCC and multiple offsite locations. I often will rescan an area of interest and take additional images. Upon reading out the examination with the attending radiologist, I dictate the preliminary report to be reviewed and signed by the attending and provide referring clinicians with any pertinent emergent findings at the time of the exam. I attend OB/GYN operative cases that require ultrasound guidance. Other duties have included assistance with QC cases, development of OB/GYN templates for Fluency and assistance with 3D rendering techniques. I also enjoy working with medical students and residents. When not at work, I enjoy spending time with my teenage kids, travelling back to Maine to see family, exploring the Greater Boston area, reading and music.

Laurie Sammons: I was the second Sonographer Practitioner in the Ultrasound section and the first on the West Campus. The role had been pioneered in the outpatient Ultrasound Shapiro Clinical Center with Gail Birch and Dr. Deborah Levine. It was very successful and I thought the role would be stimulating and challenging to adapt to the West Campus workflow. I had been doing clinical work and thought this would be a great opportunity to become involved in a different aspect of Ultrasound. I began my new role on April 1, 2007 and it has been an interesting journey.


Laurie Sammons

In 2015, Laurie celebrated 25 years at BIDMC!

I began with a BA in History and an AAS in Radiologic Science and am registered by the ARDMS in the Abdomen and Obstetric/Gynecology Specialties. Today, my primary responsibilities include reviewing cases with sonographers and helping with difficult scans. I interpret cases with the radiologists and assist in daily workflow of the Ultrasound reading room. We have a large volume of interventional cases and I assist in daily workflow organizing and communicating to clinical staff any information pertaining to the procedures. I assist in the education of the sonographers and residents while reviewing cases and share helpful tips and techniques to improve imaging.

Outside of work I'm an aspiring artist. Pastel painting is my current obsession. I'm also a hobby accordionist and I spend a lot of time with my three terriers, Maude, Baby Drip and Christopher.

Ultrasound Practitioners*

By Joyce Ward, CNMT, RT(N)

With the rapid growth in the number and types of ultrasound procedures being conducted, a growing number of experts believe there is a need for someone to perform and/or interpret ultra sound examinations.

Anticipating that an "ultrasound practitioner" could fill this role, the Society of Diagnostic Medical Sonographers (SDMS) established an Ultrasound Practitioner Commission (UPC) to explore the viability of such a position, suggest suitable didactic education and clinical training programs for it, and work with interested universities.

"...the practitioner would work as part of the team with physicians to enhance the whole practice, much like a nurse practitioner or physician's assistant. Indeed, educated at a master's degree level, the ultrasound practitioner would be a mid-level provider whose scope of practice would be similar to that of nurse practitioners or physician assistants," said Rebecca Hall, PhD, RDMS, vice president of SDMS and chair of the UPC.

Excerpted from https://smarthealthscreening.com/?p=1083

*At BIDMC, we prefer the title **Sonographer Practitioner**

Introducing MRI on Facebook

We just want to introduce the BIDMC radiology community at large to the Body MRI section's educational Facebook page (like "Division of Body MRI at BIDMC") that on a weekly basis provides an "unknown" body MRI case. This case is then discussed in full detail the following week. The site also has a trivia section, MRI-spy section, body MRI journal club, and advertises upcoming educational events in the Department. The primary case presenters are BIDMC residents and fellows who are thanked for their efforts and enthusiasm in contributing to this initiative! We are currently approaching 1,500 followers around the world and would appreciate your participation and feedback!

– Koenraad Mortele, MD

Unknown Body MRI Case #16

MRI Findings

- T2-WI: isointense mass with hyperintense central scar
- Late arterial hyperenhancement with non-enhancing central scar
- Retained lesional contrast on delayed (20 minutes) imaging with gadoxetate disodium)

ANSWER to Unknown Body MRI case of the week (#16):

62- year-old woman with a history of ulcerative colitis with an incidental liver lesion seen on abdominal CT, further evaluated by gadoxetate disodium-enhanced MRI.

Case Presenter: J Steinkeler

BIDMC Body MRI Staff

Koenraad Mortele, MD - MRI Chief
Karen Lee, MD
Marty Smith, MD
Maryellen Sun, MD
Leo Tsai, MD
Jesse Wei, MD

Body MRI Fellows

Kate Troy, MD
Kristy Lee, MD

Diagnosis

- Focal nodular hyperplasia (FNH)

Pearls & Perils

- Benign "tumor" of liver
- Hypothesized etiology: hyperplastic response of hepatocytes to localized vascular malformation or injury
- Second most common benign hepatic tumor (most common hemangioma)
- Most common demographic: young women ~ mean age 42
- 80% incidentally detected
- 80% solitary
- No proven association with oral contraceptive use
- Pathognomonic macroscopic features: central stellate scar with fibrous septa
- Differential diagnoses include adenoma, fibrolamellar hepatocellular carcinoma, hemangioma, hypervascular metastasis
- Most specific test for diagnosis: gadoxetate-enhanced MRI, retained contrast with this hepatobiliary agent as lesion is comprised of functioning hepatocytes and aberrant bile ducts

Reference

Mortele KJ, et al. CT and MR Imaging Findings in Focal Nodular Hyperplasia of the Liver Radiology- Pathologic Correlation. AJR 2000; 175: 687-692.

Community Radiology: Chestnut Hill 1-year Anniversary

On Wed., Aug. 5th, we celebrated our Chestnut Hill facility's 1-year anniversary. This NEW offsite outpatient Radiology department is located in a multi-disciplinary medical office building located at 200 Boylston Street. This site is designed to support Sports Medicine and Orthopedics , OB/GYN, Primary Care and medical specialties as well as a 12-bed Urgent Care on site for services to the broader BIDMC patient. The Radiology department provides state-of-the-art imaging in Screening Mammography with a 3D system, General Diagnostic with digital radiography, Ultrasound, Bone Densitometry and a 64-slice CT Scanner.

Chesnut Hill Radiology Clinical Manager Bob Butler

Our spacious, light filled outpatient Radiology Department has thrived in its first year of existence. Providing a wide range of state-of-the-art imaging services, the department has performed over 21,000 exams since opening last July. We are delivering world class care while allowing patients to enjoy the qualities of BIDMC right in their own neighborhood.

This new, highly innovative workspace was designed for the comfort and convenience of all patients. With plenty of free, accessible parking, it eliminates some of the unnecessary stress patients may feel when trying to commute to the Main Campus.

Board certified radiologists, who are also on staff at BIDMC, will interpret all studies. These images are immediately available at Chestnut Hill and in town on our PACS system, where doctors can consult and assist one another.
This truly is a remarkable site for the people of Newton and its surrounding communities!

- Bob Butler
  Radiology Clinical Manager, Chestnut Hill

Chesnut Hill Radiology staff (L to R): Yolette Thelusma, Hannah McArdle, Sarah Alosco, Beth Nolan, Erin Gayne, Ann Marie Baggs, Cathy Melchin and Christina Coyle.

[Not shown: Norah Call, Ivan Geshev, Christopher Clarke, and Jackie Gattonini]

Tammy Lynch

In Memorium: Robin Young *(1941-2015)*

Robin Young began her career in Radiology as a transcriber in April 1991 and even after her illness, she came back to BIDMC in June 2014 to apply her skills in PACS/RIS as our Application/Data Analyst working with the new Fluency voice recognition product. Robin passed away peacefully on the evening of August 14, 2015 at the Tippett Hospice in Needham, MA and a memorial service and celebration of Robin's life was held at St.Luke's Episcopal Church in Scituate on Saturday August 29th followed by brunch in the church hall. In lieu of flowers, contributions in Robin's memory were made to St. Luke's Episcopal Church or South Shore Hospice. Thanks to her family for sending us notice of her passing. She will be missed.

extracted from facebook

Dear friends and family,

I was able to reach out to some of you but not all. So I'll resort to social media, where Mom loved to poke around, after the girls gave her a Facebook lesson. Mum (Robin Young) passed away last night, after a long hard battle with cancer where she defied all odds and pretty much kicked cancer's ass. Her last days were peaceful with many friends and family visiting her at The Tippet House (Hospice). The memories created will never be forgotten but lived over and over. So if we haven't touched base, whether we've never spoken before (as mum's friends ran deep) feel free to inbox me with any questions. Mum's in a good place now, smiling down. Love you Mum.

– Andrew Young

Dear friends and family,

First I'd like to thank you for your outpouring of love, sympathy and support. We've done our best to keep everyone posted, but it's hard to do for a lady that touched so many people. So for those who I may have missed, apologies, here's the details for Mum's services (we decided to wait a wait until next week so that Mums friends and family could make their way down from her first home, Canada...eh?)

Mum's door was always open, so "her" doors are open to any who wish to attend. Anyone I may have missed please feel free to share. Much love, The Youngs

– with Robin Young and Jennifer Damron Young

I am saddened by the news of Robin's passing, but I know she was a fighter right up until the end. Her strong will to live and devotion to her family made her such a special person. Robin was always smiling and definitely looked at the world in the most positive way. She will be greatly missed by her family and her many friends. I am sure she is looking down upon us with a smile on her face. Rest in peace, Robin.

- **Jim Brophy, Radiology PACS/Informatics Manager**

I worked with her in Transcription for many years. Descriptive words: Kind, friendly, droll, socially adept, welcoming, intelligent, insightful, tactful, entertaining, family oriented, helpful. Robin personally helped several of us when we were ill with visits, rides to appointments, and moral support. We will miss her. Gail and I, as well as many other folks who worked in Transcription throughout the years, will remember her fondly.

– Jean Petree, Radiology Transcription/Radiology Support

Dr. Jonathan Kruskal remembers Robin in transcription and as the go-to person for every time the RTAS system broke down - she went all over to fix the microphone problems always with a smile!

Gail Johnson: "Robin was a wonderful person and a good friend." She met Robin in 1994 in transcription and they worked together side by side, continuing their friendship even when Robin retired in 2014. "In spite if her own health issues, Robin called to wish me a great holiday in Alaska this July." Gail is most pleased that Robin called her often because Gail could always able to make her laugh.

Andrea Baxter: I came in 1997 and Robin was the first person I met. We worked closely for a year in transcription and enjoyed a million laughs. I can't say enough about her kindness and big heart!

Robin and I had the fortunate opportunity to share office space together. She was a joy to work with given her strong work ethic, sense of humor and good nature. She had an infectious laugh that always made the day a little brighter. I will remember her for her kindness and concern she demonstrated towards others. I will miss her dearly.

– Jeffrey Bernard, RT
Manager, Community Radiology Network Services

AIDEEN SNELL ON THE PATIENT EXPERIENCE

Aideen Snell, MSW
Manager, Service Excellence Program
x72570 asnell@bidmc.harvard.edu

The Patient-Centered In the Moment Recognition Program

This past month we kicked off a pilot in the department, ***The Patient-Centered In the Moment Recognition Program*** which has been created to recognize all Radiology Caregivers for their contribution to service excellence when they show exemplary customer service, empathy and compassion.

Radiology Action Planning Committee's Patient Engagement

SEPTEMBER TIP OF THE MONTH:

"I have learned that people will forget what you said, people will forget what you did, but people will never forget how you made them feel."

– Maya Angelou

It has been a very busy summer in the department and at times it feels like we are always putting out fires… we have no choice when a problem arises, right? Do what it takes to make things better for the patient! That's what we are really good at in Radiology. But there is something else that we could do better such as taking the time to point out when someone is doing a good job. Too often those moments are lost in the craziness and our face-to-face communication disappears, replaced by an email a few weeks after the fact (if that).

US Supervisor **Juanita Cook** acknowledges "in the moment" positive feedback from a patient to US Director **Dr. Maryellen Sun** and US Practitioner **Laurie Sammons** by giving them a small gift from the Radiology Service Excellence Team. The patient commented on her experience in ultrasound, "I am patient of Dr. Maryellen Sun. I want to thank her and Ms. Laurie Sammons (tech) for their great service and warm heart."

This program is aimed to encourage more face-to-face communication and recognition in the moment. What is positive reinforcement? Any consequence that follows a behavior and increases its frequency in the future. The fact is that most of what motivates us day to day are the little things that people do or don't do that make a big difference. The most available form of created reinforcement is social reinforcement which involves doing or saying something to another person. You do not have to budget for it; you do not need permission to give it; and, when given correctly, people never get tired of it. So why don't we do more of it? This program is aimed to help us take the time to give that social reinforcement and we have paired it with a tangible reinforcer as a thank you for all that you do!

Keep your eyes peeled because with this initiative getting CAUGHT IN THE ACT is a good thing!

Warm hearts clean hands!!

Everyone Smiles in the Same Language

In my role as Program Leader for Patient and Family Engagement, I have the pleasure and privilege of recruiting BIDMC patients and family members to be volunteer advisors, to participate on numerous improvement projects, councils, committees, and focus groups throughout the medical center. Patient and family advisors have made an enormous impact on the medical center; their voices of experience and unique perspectives have helped to inform facility redesign, signage, policies and procedures, staff training protocols, patient education materials, and much more.

As they share their stories with me, patients and family members express immense gratitude for our compassionate staff members who go above and beyond each and every day to deliver on our mission "to provide extraordinary care where the patient comes first". They also candidly share the emotions involved with the inevitable hardships of being a patient: everything from feeling lost in our facility, not understanding the language, long waiting times, getting a new diagnosis, coping with painful symptoms, having to choose between treatments, life-changing health circumstances that impact their families, their finances, their independence, and their futures. But it never ceases to amaze me, when I am listening to their powerful stories, how grateful they are for the simplest of gestures, that can have the most powerful and lasting impact on the patient experience.

AIDEEN SNELL ON THE PATIENT EXPERIENCE *(cont'd)*

Recently I emailed our advisors to help me out with a project related to improving customer service excellence at BIDMC. "What would it take?" I asked, "Please send me your tips." Instantly, outlook notifications started cascading down my screen. I braced myself, expecting to see everything from "free parking" to "hire more staff" to "renovate this aging facility". What was remarkable was that not a single advisor suggested a "fix" that would cost money, or demand resources that didn't already exist. Similarly striking was the common thread that ran through their suggestions. Here are just a few, direct quotes, pulled from a long list of echoing advisor comments:

- In the event that there has been a line or a waiting time to be greeted, in addition to making eye contact, smile, thank the patient for waiting and ask "How can I help you today?"
- Do not be so into procedures that need to be done today, and so aware of the ticking clock, that you can't take a moment to smile and sincerely ask how I am doing or if I have questions and concerns.
- My tip is, you are the window of the hospital - smile with compassion to people.
- For older adults - remember to smile and greet the patient as well as the caregiver. Older people feel invisible too often - they should be acknowledged kindly and compassionately, no matter what their condition appears to be. Approach them with friendly demeanor, smiling, using eye contact and a calm tone.
- I was waiting for an appointment and a person sitting in the waiting room was clearly nervous. When the technician came out to get her, she smiled at the patient and the patient smiled back and that seemed to change the patient's demeanor.
- There is a saying that everyone smiles in the same language. I have found that to be true when I see staff interacting with people who don't speak English. A smile - more than one - goes a long way.

Some days, things that are beyond our control can make it challenging to deliver on our mission to provide extraordinary care, where the patient comes first: technology or equipment that is not behaving, longer than usual wait times, winter blizzards that tie us up and leave us exhausted and short-staffed. But what our patients want us to know is, no matter what our role, or what the circumstances are, we all have in our power the ability to make a positive impact on the patient experience, and to make each and every patient feel welcomed, respected, and valued. It is as simple as a smile.

– Caroline Moore, MPH
Program Leader - PFAC
Patient Care Services

RADIOLOGY PEER SUPPORT

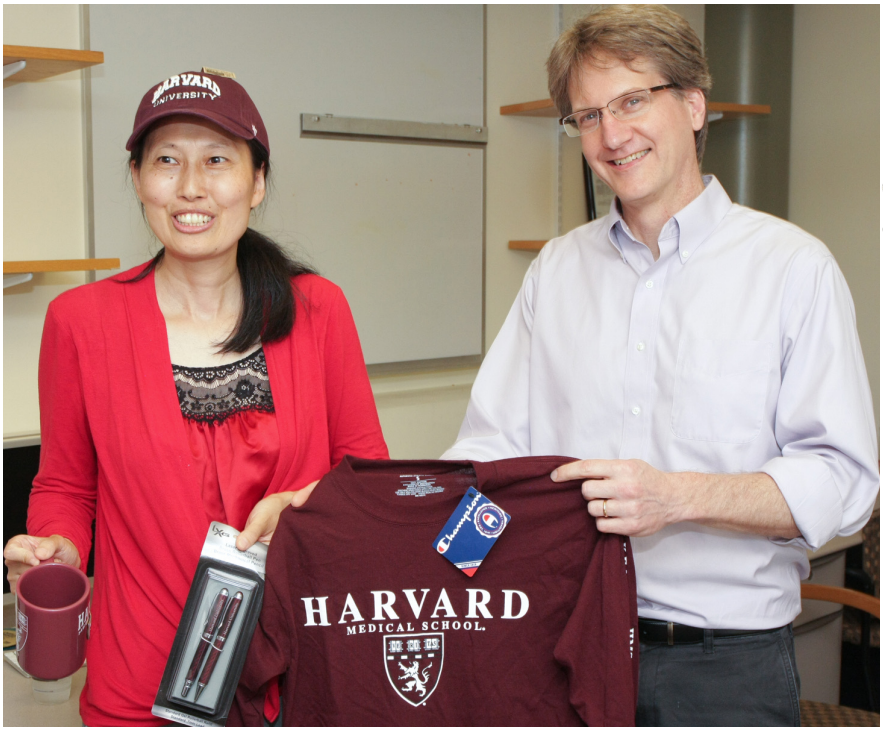
Suzanne Swedeen, RN
MSN CNIV
Quality Improvement
Specialist

Over the last decade, there has been a growing body of literature describing the experiences health care workers face when they are part of or witness an adverse event or other upsetting situations. Sometimes, impacted health care workers in these situations are described as "second victims," because these are challenging events to deal with, especially alone. Often, those who can be most supportive in these circumstances are peers.

Departments around the country, including our own anesthesia residency program, have developed peer support programs that have been crucial to enhancing staff wellness. A BIDMC team has come together to help create a culture that emphasizes peer support. Our hospital has piloted a Peer Support program in nearly all inpatient units throughout the medical center and developed well functioning support programs in several departments. The hospital is getting ready to roll out the program in Radiology.

In the coming weeks you will receive an email link to an anonymous survey asking that you help us identifying a peer in your environment that you think may be helpful in a difficult situation (participation in the program is voluntary for the nominees). We hope that with this program we can further strengthen the culture of peer support that is already so highly developed by guaranteeing easy access for all staff.

DEPARTMENTAL NEWS: *Farewell Weiying Dai, PhD*



(Left) Dave Alsop, Director of MRI Research and Co-investigator of numerous projects with Weiying Dai, bestows upon his departing colleague a number of useful souvenirs of her 8.5 years at HMS such as a Harvard baseball cap, pens, coffee mug and sweat shirt.

Above is the tasty cake created by MRI Administrative Associate (and ace party organizer) Lois Gilden with an MRI magnet made of rice crispies covered in fondant which Weiying will be taking to New York with her to tide her over until her new department gets their own magnet!

On Friday August 21st, MRI bid farewell to **Weiying Dai, PhD**, who has been part of the MRI Research Division for almost nine years – initially as a Research Fellow and then as a staff member. Weiying will be leaving BIDMC to take a position at SUNY Binghampton in New York, known for its high level of research activity. Although we are sad to see her go and will greatly miss her, we are happy that she and her husband will finally be able to work together in the same university, and wish her well as she continues her research career in arterial spin labeling and perfusion and permeability studies.

- Lois Gilden

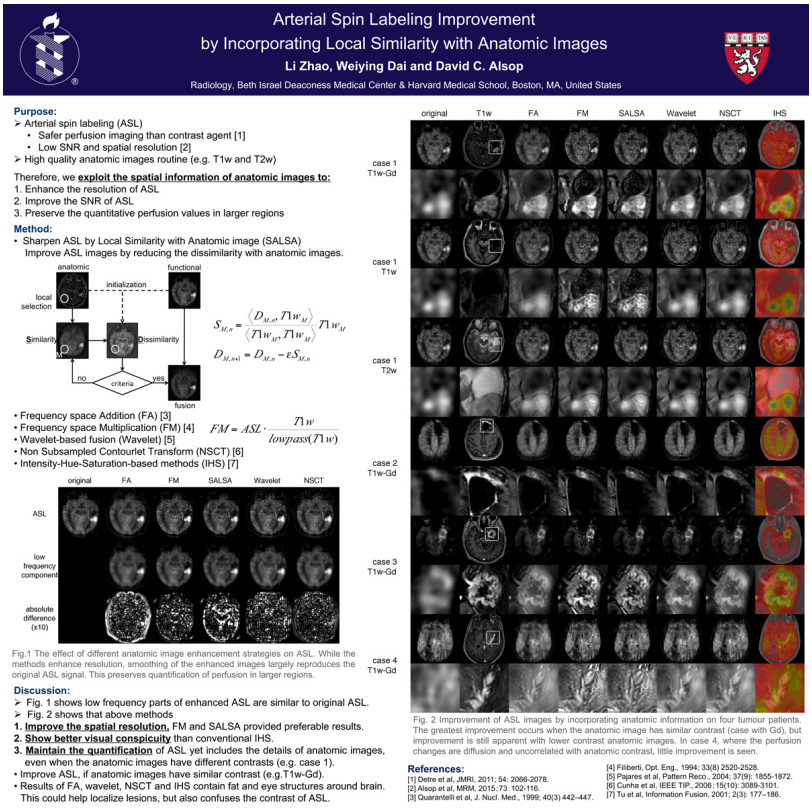
DEPARTMENTAL NEWS: *Welcome Li Zhao, PhD*

In the July issue of Radical Views, we introduced our incoming residents and fellows but missed one Research Fellow who came to BIDMC in September, 2014. It is perhaps fortunate that we waited to introduce him as he has been quite productive! Please welcome MRI Research Fellow Li Zhao, PhD.

Li Zhao earned his PhD in Biomedical Engineering at the University of Virginia with a thesis on the accuracy and acceleration of arterial spin labeling in MRI as well as Master's and Bachelor's degrees in Engineering from Tsinghua University in China. He has also served as an intern at the General Electric Co. in the MRI Pulse Sequence Development Group.

Currently, he has authored 6 publications and has 6 patents pending; he has presented or co-authored more than 20 conference presentations and serves as a reviewer for the Journal of Magnetic Resonance Imaging.

Most recently, he presented a poster with his BIDMC mentors Weiying Dai and David Alsop entitled *Arterial Spin Labeling Improvement by Incorporating Local Similarity with Anatomic Images* and he was awarded a *Summa cum laude* for ***Dynamic 3D ASL in 20 Seconds Per Frame with Model-Based Image Reconstruction*** and a *Magna cum laude* for ***Reduced Field-Of-View Single-Shot Spiral Perfusion Imaging*** all of which were presented at this year's ISMRM annual conference in Toronto 30 May - 05 June, 2015.



BIDMC at the 101st RSNA

While it is hard to believe that RSNA 2015 is already upon us, did you know that the services of a full-time Medical Editor are available to Radiology Faculty, Staff and Trainees? **Donna Wolfe, MFA** assists in editing, writing, proofreading and creation/preparation/assembly/submission of your scientific presentations - text, slides, posters, e-posters. ***Donna also creates the annual Program of BIDMC contributions at RSNA so please send her your acceptance e-mails to be included in the program guide.***

Please allow ample time for poster production, particularly for RSNA

RSNA	Nov. 29 - Dec. 4, 2015 Chicago, IL
STR	Mar. 13-16, 2016 Scottsdale, AZ
ARRS	Apr. 17-22, 2016 Los Angeles, CA
ASNR	May 21-26, 2016 Washington, DC
ISMRM	May 7-13, 2016 Singapore
SNMMI	June 11-15, 2016 San Diego, CA
RSNA	Nov. 27-Dec. 2, 2016 Chicago, IL

KUDOS – Each month, we share the positive feedback we receive about staff members and ask you to join us in congratulating them; as always, we are especially proud to acknowledge an unprecedented constellation of staff for providing outstanding care and service!

Support Services

Alina Khudaverdyan only recently started in the department, less than 6 month ago. During this period she has excelled, her standard of work is good, very attentive to our customers, displays good service excellence by being compassionate and very approachable. She has also been very reliable/ dependable, stepping up when needed to cover off shift due to sick calls and scheduled vacations.

Kudos to **Mary Finley** and teammate **Scott Gillespie** for achieving a perfect score (5 out of 5) during our last mystery shop conducted in June. This is a quote from the mystery shopper "During the course of my visit, I observed 4 patients being checked in. Both receptionists were inviting, friendly and helpful. They worked well as a team".

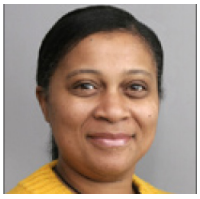
Nuclear Medicine

Thanks to patient representative **Diane Valentine** for her willingness to spend time contributing to the service excellence training video, working on the script, and sharing her personal experience as a patient.

DX

(L to R:) **Marie Farrar** and **Sara Ross** observed a van attendant attempting to assist a woman who was on the ground. Evidently the woman has been discharged from the medical center and was getting a ride home via the van. The woman appeared to need medical assistance, but was refusing to go to the ED. Marie got her in a wheelchair with the attendant's assistance, and she brought the patient into the Rosenberg lobby. Sara called a medical emergency since the woman didn't appear well, but was refusing to go to the ED. We learned later that the patient was admitted, and a central line was placed .

Chestnut Hill Square



Recently a patient let me know how impressed he was with **Tammy Lynch**. He said her warm smile and calming demeanor really set him at ease before going in for his CT scan. He said we were lucky to have her on staff and I couldn't agree more.

The Gallery at WCC-304B presents Edinburgh, London & Paris

Katie Armstrong

Manager, Medical Education Programs in Radiology

shares her passion for architectural elements she captured in Edinburgh, London and Paris

As always, please contact Donna Wolfe if you, too would like to share your photos, paintings or sculptures: dwolfe@bidmc.harvard.edu or 4-2515

HARVARD MEDICAL SCHOOL
COMMUNICATIONS AND EXTERNAL RELATIONS

In the News

VIR Fellow Edward Ahn was featured in the Washington Post as reported by HMS In the News.

Health & Science

What happens when doctors turn into patients?

By Bob Kirsch July 27

Like all of us, doctors sometimes wind up as patients. When facing difficult decisions about the best treatment for themselves and close relatives, what questions do they ask? What risks do they consider? What calculations do they make?

If we heard their stories, could we learn from them?

Four years ago, when he was 72, Bill Clark, an internal medicine physician in Bath, Maine, had a hip replacement that did not heal well. The prosthesis had to be replaced. About a month after that operation, a serious infection developed in the hip.

To deal with that complication, Clark's surgeon recommended further surgery (followed by intravenous antibiotics) but offered no guarantee that this would eliminate the infection. An infectious-disease specialist had a more drastic suggestion: Remove the artificial hip for six weeks, an approach certain to wipe out the infection if pathogens were hiding in the prosthesis or in adjacent tissue. But being without a hip meant not walking for weeks.

Despite all his medical knowledge — Clark is a lecturer at Harvard Medical School and past president of the American Academy on Communication in Healthcare — he had trouble deciding what to do.And it was his decision.

He found himself a bit upset that his physicians had not been better at helping him make the choice.

"I wished what had happened was that both of these doctors had said to me, 'Well, what's more important to you? Either you can have surgery to wash out the hip but then be left with risk of recurrent infection. Or you can have surgery to remove the prosthesis, with 100 percent certainty of infection cure but not having normal walking for many weeks, followed by surgical placement of another prosthesis.' I wish they had said clearly, 'This is a tough decision and these are the options.'"

Clark's main goal was to have a functioning, infection-free hip. For some patients, that might have been the only goal that mattered. For Clark, not to be sitting around for weeks partially incapacitated also mattered a great deal. He understood that not taking out the artificial hip right away involved some risk, as the infection might persist as long as the device remained in place.

He decided to leave the prosthesis in place and go with the surgery to clean out the infection. Part of what motivated him to make that choice was that "while both physicians knew their stuff, one guy works on hips and the other guy works on bacteria." Things turned out fine. "Such decisions should be made by patients on the basis of what's most important to them," he said. "People need to find a way to talk about what their goals are."

When advising a relative with advanced cancer, he said, he told her that some medical decisions reside within a realm filled with uncertainty and ill-defined risks. In such situations, he said, "information is important but is not the answer. It's not about the math."

Some patients want to prolong life at all costs. Some want to avoid extreme pain and be as comfortable as possible. Some want to hold on to life long enough for an old friend to visit.

Clark told his relative that if her physicians were not asking about her goals, then she should initiate that discussion. "And if you can't have that kind of discussion with your oncologist or your surgeon," he told her, "then you should change doctors or ask for a consultation with a doctor with whom you can have that kind of discussion."

When Edward Ahn's father fell off a ladder, the older man suffered a spinal cord injury and experienced paralysis. His "biggest fear," Ahn explained, "was that he would be completely dependent upon other people forever." Knowing what his father was most afraid of gave Ahn, then the chief neurosurgical resident at Maryland Shock Trauma and now a pediatric neurosurgeon at Johns Hopkins, a clear therapeutic goal to pursue.

Ahn had assisted in the treatment of similar patients, but his immediate reaction was aversion to the idea that his father might need surgery. "Surgery is invasive. His spine was going to be reconstructed. We were going to be inside his neck and around major structures and major blood vessels. I don't think you can get more invasive than that," he said.

His emotional involvement clouding his judgment, Ahn knew he could not offer dispassionate advice. He sought the opinion of colleagues who would "look at what was happening from the outside," impartially and without the heat of strong emotions.

Asking colleagues

Two neurosurgeons offered different recommendations. One recommended surgery that same day: With two herniated discs pressing on the spinal cord, delay might further injure Ahn's father. The other advised letting him recover for a few days, because performing surgery before the swelling had gone down might make things worse.

By that point, Ahn's father — a gynecologist/obstetrician experienced in performing surgical procedures — was starting to notice improvement. His strength started to return and he decided to wait. His surgery was done on the fifth day, with a follow-up procedure months later. Ahn, overcoming anxieties about how well he would do given the emotional stresses, assisted in both surgeries.

About 18 years ago, Lars Svensson, chairman of the Cleveland Clinic's Heart and Vascular Institute, having developed angina, searched for a heart surgeon. He wanted someone who had achieved low mortality rates, low complication rates and excellent long-term outcomes; who used the latest operative techniques; and who possessed what Svensson called "great empathy."

Health & Science

What happens when doctors turn into patients? *(cont'd)*

He wanted that surgeon to be practicing within an excellent program — where cardiologists and surgeons worked well together with good support from their hospital.

He asked colleagues for recommendations — other patients should ask their own doctors for recommendations. Anyone can search the database of the Society of Thoracic Surgeons, but it may be best to rely on a "medical adviser — preferably a physician, a nurse, or someone like that," he said.

A medical advisor might also offer information on mortality rates, side effects and adverse reactions. "The question is: What does that number mean? It is easy to get to a 1 percent mortality rate by avoiding patients who require high-risk operations."

Svensson chose a medical center where doctors worked together across the lines of medical specialties. They put him on aggressive medical treatment. He recovered without surgery.

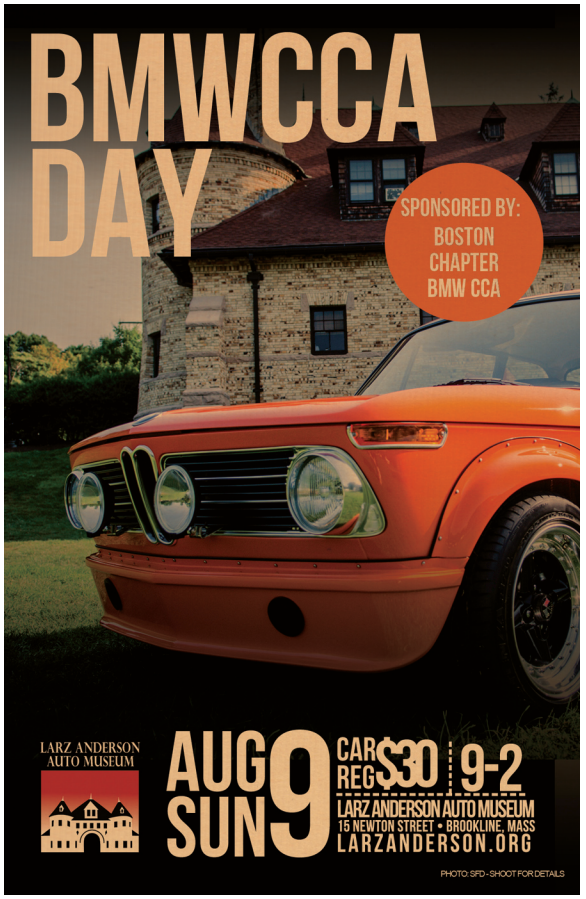
"At a hospital that did not have as much coordinated care by my medical team," he said, "I could have ended up having surgery."

Kirsch is a freelance medical and health writer.

http://www.washingtonpost.com/national/health-science/what-happens-when-doctors-turn-into-patients/2015/07/27/732e52da-f35c-11e4-b2f3-af5479e6bbdd_story.html

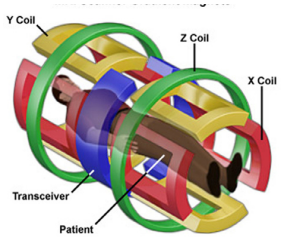
DEPARTMENTAL NEWS: Radiology in the Community

Drs. Rob Sheiman and **Abd Imaging Fellow Moon Justaniah** both showed their BMWs at a car show at the LarzAnderson Auto Museum in Brookline in early August. Below are the two of them in front of Dr. Sheiman's BMW M6 which he exhibited. Thanks to **Chief Resident Amanda Rigas** for this photo!



The Larz Anderson Auto Museum is home to "America's Oldest Car Collection". For more than 85 years the Larz Anderson Auto Museum has been supporting the community through a variety of educational programs, exhibits, and lectures.

Today the Museum's primary goal is its continued support of the community through educational outreach and the preservation of our permanent collection of early automobiles. The Larz Anderson Auto Museum hopes to serve as a resource for your automotive and cultural interests.

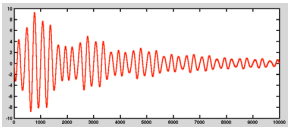


National High Magnetic Field Laboratory

BIDMC

Radiology Residents & Fellows

MRI Physics Course



2015-2016 Academic Year

Purpose:

To provide fellows and residents with a basic understanding of MR physics, with emphasis on practical aspects of image acquisition such as protocol optimization and troubleshooting. A brief overview of fundamentals of nuclear magnetic resonance will provide an introduction to sources of image contrast in MRI. Techniques for image formation will be described, followed by an overview of the major families of MR pulse sequences. Topics such as accelerated imaging, fMRI, and diffusion tensor imaging will be discussed.

Format:

All sessions will be held on Wednesdays, 5-6pm at the MRI Learning Lab, Ansin 220, starting on August 5th.

Text and Topics:

The recommended textbook is ***"MRI in Practice," 4th Edition (2011)*** by Catherine Westbrook. Supplementary reading from review articles will be recommended for advanced topics.

For more information, contact Aaron Grant, PhD: 7-3265

TOPICS

August 5: The origin of the NMR signal. Nuclear magnetism. Nutation, precession, signal reception. Chemical shift. Relaxation, T1, T2. Spin dephasing, impact of gradients and magnetic field inhomogeneities.

August 12: Sources of contrast in MRI: T1 and T2 weighting, magnetization transfer, diffusion.

August 19: Overview of MR hardware, Tour of MR equipment room.

August 26: Image formation (1). Phase and frequency encoding. Basic k-space concepts.

September 2: Image formation (2), Field-of-view, and resolution. k-space sampling for given imaging parameters, and effects of undersampling (aliasing, pseudo-noise). Accelerated imaging methods.

September 9: Signal-to-Noise: Image parameters that govern SNR. Trade-offs in image optimization.

September 16: Pulse sequences. Gradient echo, spin echo, steady state, EPI. STIR/FLAIR/IR etc. Fat suppression. Spectroscopy with PRESS, STEAM, CSI.

September 23: Effects of flow and diffusion. Flow compensation, time-of-flight, phase contrast, intro to diffusion.

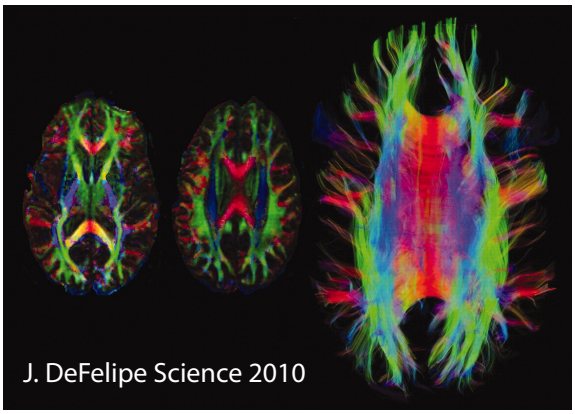
September 30: Contrast-enhanced MRI. Types of magnetic materials. Relaxivity and image contrast as a function of dose, TR, TE. Dynamic contrast enhanced imaging, angiography. BOLD effect, fMRI.

October 7: Accelerated imaging. Parallel imaging and compressed sensing.

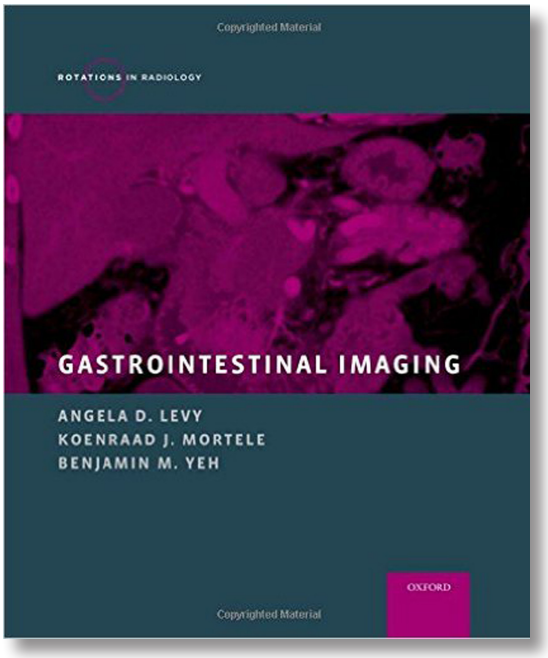
October 14: Diffusion-weighted imaging and DTI in neuro applications.

October 21: Arterial spin labeling in the brain and body.

November 4: Artifacts and troubleshooting.


J. DeFelipe Science 2010

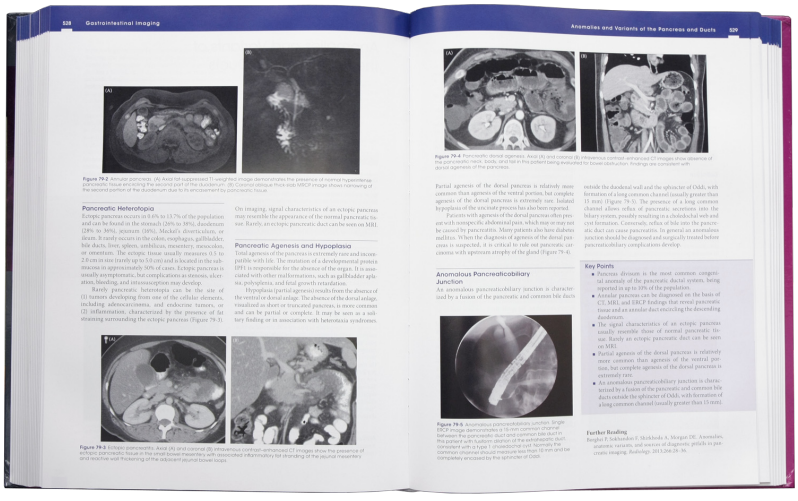
PUBLICATION CALL OUT:
Koenraad Mortele's Newest Textbook



Angela Levy is a Professor of Radiology at Georgetown University Medical Center in Washington, DC. Koenraad Mortele is an Associate Professor of Radiology at Harvard Medical School in Boston, Massachusetts. Benjamin Yeh is a Professor of Radiology at the University of California, San Francisco, California.

This book sets itself apart from others on GI imaging because its covers pathological entities using "vignettes" that are grouped by organ and disease entities. Therefore, it is very easy to find a comprehensive review on a particular GI disease that covers all aspects, including anatomy and embryology, clinical features, multimodality imaging features, differential diagnoses, management, further reading, and key facts. We were also very fortunate to convince some of the "masters in GI radiology", such as Drs. Gore and Levine to contribute material to the book!

- Koenraad



Oxford University Press; 1 edition (August 12, 2015)
760 Pages | 1246 illustrations • Also available on Kindle

Gastrointestinal Imaging presents a comprehensive review of gastrointestinal pathologies commonly encountered by practicing radiologists and residents in training. Chapters are organized by organ system and include the Pharynx and Esophagus, Stomach, Small Bowel, Appendix, Colon, Anorectum, Liver, Gallbladder, Bile Ducts, Pancreas, Spleen, Peritoneum, Mesentery, and Abdominal Wall, and a chapter on multisystem disorders. Part of the Rotations in Radiology series, this book offers a guided approach to imaging diagnosis with examples of all imaging modalities complimented by the basics of interpretation and technique and the nuances necessary to arrive at the best diagnosis. Each pathology is covered with a targeted discussion that reviews the definition, clinical features, anatomy and physiology, imaging techniques, differential diagnosis, clinical issues, key points, and further reading. This organization is ideal for trainees' use during specific rotations and for exam review, or as a quick refresher for the established gastrointestinal imager.

2015 BIDMC Radiology Publications - *A PubMed search for new BIDMC publications is made each month; however, if we miss your paper, please send the reference to dwolfe@bidmc.harvard.edu. Note that Epub dates are included only in publications where the Epub and paper publication dates occur in different years, i.e., Epub in 2014 and paper publication in 2015.*

Acord M, Shaikh R. Predictors of diagnostic success in image-guided pediatric soft-tissue biopsies. Pediatr Radiol. 2015 May 10. PMID: 25958250.

Agarwal MD, **Levenson RB**, **Siewert B**, Camacho MA, **Raptopoulos V**. Limited added utility of performing follow-up contrast-enhanced CT in patients undergoing initial non-enhanced CT for evaluation of flank pain in the emergency department. Emerg Radiol. 2015 Apr;22(2):109-15. doi: 10.1007/s10140-014-1259-4. Epub 2014 Aug 1. PMID: 25082439.

Ahmed M, Kumar G, Navarro G, Wang Y, Gourevitch S, Moussa MH, Rozenblum N, Levchenko T, Galun E, Torchilin VP, **Goldberg SN**. Systemic siRNA Nanoparticle-Based Drugs Combined with Radiofrequency Ablation for Cancer Therapy. PLoS One. 2015 Jul 8;10(7):e0128910. doi: 10.1371/journal.pone.0128910. eCollection 2015. PMID: 26154425; PMCID: PMC4495977.

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Alessandrino F, Ivanovic AM, Yee EU, Radulovic D, Souza D, **Mortele KJ**. MDCT and MRI of the ampulla of Vater (part I): technique optimization, normal anatomy, and epithelial neoplasms. Abdom Imaging. 2015 Aug 26. [Epub ahead of print] PMID: 26306515.

Alessandrino F, Souza D, Ivanovic AM, Radulovic D, Yee EU, **Mortele KJ**. MDCT and MRI of the ampulla of Vater (part II): non-epithelial neoplasms, benign ampullary disorders, and pitfalls. Abdom Imaging. 2015 Aug 26. [Epub ahead of print] PMID: 26306516.

Alessandrino F, Millo N, Yee EU, **Mortelé KJ.** The "peripheral washout sign" in focal hepatic lesions: not always an MRI sign of malignancy. Clin Imaging. 2015 Apr 20. pii: S0899-7071(15)00097-2. doi: 10.1016/j.clinimag.2015.04.005. PMID: 25951769.

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Barr RG, Ferraioli G, Palmeri ML, Goodman ZD, Garcia-Tsao G, Rubin J, Garra B, Myers RP, Wilson SR, Rubens D, **Levine D**. Elastography Assessment of Liver Fibrosis: Society of Radiologists in Ultrasound Consensus Conference Statement. Radiology. 2015 Sep;276(3):845-61. doi: 10.1148/radiol.2015150619. PMID: 26079489.

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Boiselle PM, Choe YH, Leipsic J, Pugliese F, Schoepf UJ, Vliegenthart R. Expert Opinion: How and When to Perform CT Myocardial Perfusion Imaging. J Thorac Imaging. 2015 May;30(3):167-8. doi: 10.1097/RTI.0000000000000156. PMID: 25844977.

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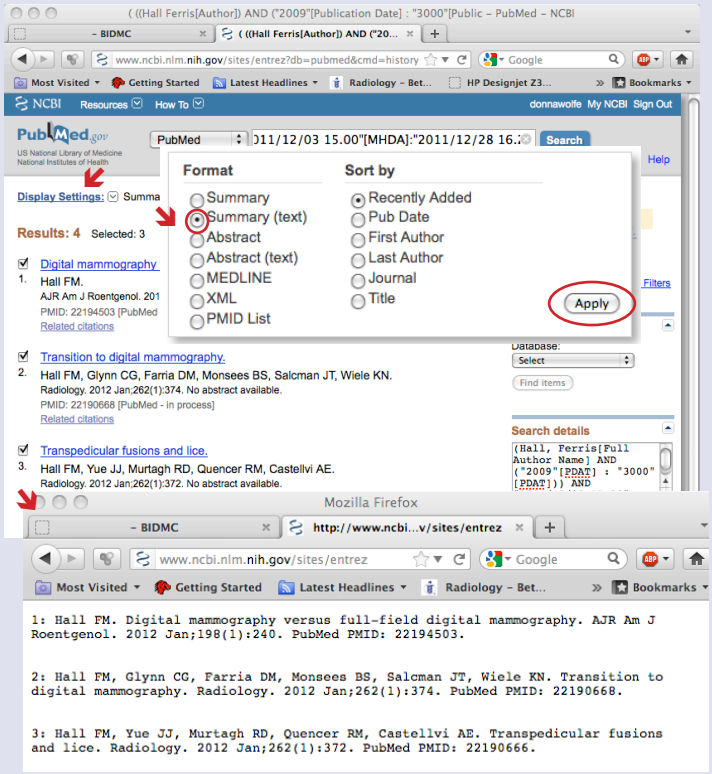

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