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Society of Radiologists in Ultrasound

President's Letter

Peter Doubilet, MD, PhD
President

My prior president's letter, in the December 2009 issue of the newsletter, focused on activities and developments that took place at the October 2009 annual meeting in Chicago. SRU activities don't lie dormant between annual meetings, and much has transpired over the past several months.

The Program Committee, with Deb Rubens as Chair and Mindy Horrow as Vice-Chair, held a meeting via conference call on January 27, 2010, to decide on the format and content of the October 2010 Advances in Ultrasound course, and committee members were assigned sessions to organize and moderate. Following the call, committee members invited speakers to their sessions, and the program has now been finalized. The course will begin with a plenary session on practice management, followed by sessions on ultrasound imaging in each of the following areas: ob/gyn, oncology, women's imaging, vascular imaging, pediatric and musculoskeletal imaging, and abdominal imaging. The course will also include, once again, two sessions devoted to the popular "Head to Toe" ultrasound program. As in past years, the faculty will be first-rate, and we expect an excellent attendance at our Las Vegas location.

The location itself has been a work in progress over the past few months. The SRU had contracted with the Cosmopolitan Resort and Casino as the site of the meeting at a time when the facility was under construction. In January, we were informed that due to construction delays the facility would not be ready to open in time for our meeting. Thanks to excellent work by Justine Wood and Susan Roberts, the venue has been changed to another hotel on the Las Vegas Strip. As soon as the contract is finalized we will notify the membership by e-mail of the name of the hotel.

In April 2010, we received the excellent news that the consensus statement resulting from the 2009 preconvention conference on management of ovarian cysts imaged on ultrasound has been accepted for publication in the journal *Radiology*. The conference, which was superbly organized and run by SRU Fellows Debbie Levine and Rusty Brown and included an expert panel of radiologists, gynecologists, and pathologists, addressed the thorny and sometimes controversial topic of how to report, follow, and manage ovarian/adnexal cysts in asymptomatic pre- and postmenopausal women. When the consensus paper comes out in print, it will provide much-needed guidance, both to ultrasound practitioners and to those who refer women for pelvic sonography, on how to interpret and manage ovarian/adnexal cysts. In doing so, it will follow in the footsteps of prior SRU consensus conferences that have dealt with clinical issues – postmenopausal bleeding, internal carotid artery stenosis and thyroid nodules – the consensus statements from which have proved to be useful and influential and have elevated the stature of the SRU in the medical community.

The SRU Executive Board met on March 26 in San Diego, at the site of the annual meeting of the American Institute of Ultrasound in Medicine. Much of the meeting was devoted to the difficult task of addressing a major budget gap that has resulted from relatively flat revenues but substantially

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INSIDE HIGHLIGHTS

President's Letter (continued)

increased expenses over the past few years. Food and beverage service alone cost over $130,000 at the 2009 annual meeting, a strikingly high number that is due to hotel charges for soda, coffee, bagels, meal entrees, etc., that far exceed conventional retail charges for such items (see "The $6.48 Coke" elsewhere in this newsletter). The Board's goal was to try to balance the budget by increasing revenues and decreasing expenses, without harming the educational and scientific missions of the SRU. Some of the changes that you will see on the revenue side include institution of registration fees for the Fellows meeting; allowing corporate representatives to attend the Fellows Meeting as observers for a fee; institution of registration fees for trainees (to cover the major expenses for food and beverage consumed by these attendees); and institution of a fee for guests who attend the Fellows' dinner. On the expense-cutting side, we will be eliminating food and beverages at committee meetings, eliminating the members' business and resident luncheons, and decreasing the food choices at breakfasts and other meals and breaks. We, the Executive Board members, are no happier than you, the Fellows and general members, are about many of these changes, but they are unfortunately necessary for the survival of the SRU. As I said (with only slight hyperbole) to an SRU member recently when he complained about cuts in food and beverages: "you can have food or the SRU, but not both". I hope that all of you, at next year's meeting, will enjoy the educational, scientific, and social aspects of the meeting while understanding that the revenue enhancement and cost cutting measures were necessary to allow you to maintain those wonderful aspects of the SRU.

There is another, more positive, financial matter to report. As you may know, the SRU has established the SRU Foundation, a charitable arm of the society whose purpose is to support our important missions, including ultrasound research and consensus conferences. In the last newsletter I reported that we had applied to the Internal Revenue Service for recognition of the SRU Foundation as a 501(c)(3) tax-exempt organization. I am now pleased to report that we have been granted this status by the IRS, which means that contributions to the Foundation are tax-deductible. Please give generously to the Foundation to allow the SRU to maintain and expand its activities in advancing the science and practice of ultrasound.

On behalf of the SRU, I would like to thank Bob Bree for his service as SRU Councilor to the American College of Radiology. He was our alternate councilor from 2000 - 2005 and our councilor from 2005 - 2009. In this role, he attended the ACR Annual Meeting and Chapter Leadership Conference, held each spring in Washington, DC, and produced a written report about the meeting that was included in the newsletter each year. Now that Bob's tenure is complete, Faye Laing has generously agreed to take over this important role.

On a personal note, I will be performing my duties as SRU president from my bicycle from April 20 – July 11, 2010. My wife, Carol Benson, and I will be cycling across the United States and stopping en route at 13 medical centers – Brown, Columbia, Cornell, Penn, Chicago, Mayo Clinic, Portland (Oregon), and others – to teach and lecture on ultrasound. With our computers in waterproof, shockproof cases and our cell phones in our pockets, you'd never know that we were away from home – unless you check out the pictures and postings on our trip blog: pdoubilet.blogspot.com. ●

Welcome To New Members

The SRU welcomes the following physicians to membership:

Randal L. Aschenbeck, MD	Temple, TX
Lawrence A. Cicchiello, MD	New Haven, CT
Yoshimi Endo, MD	New York, NY
Anil N. Kurup, MD	Rochester, MN
Adil A. Muhammad, MBBS, MCPS, FCPS	Karachi, Pakistan
Joseph Rosado, MD	Lodi, NJ
Lauren F. Stein, MD	Ann Arbor, MI ●

What It Means to Be a Fellow of the SRU

Edward I. Bluth, MD, FSRU, Chair, Fellowship Committee

Fellowship status in the Society of Radiologists in Ultrasound (SRU) is perhaps the highest honor that those who specialize their practice in ultrasound can receive. When the Society was founded in 1976, it was strictly made up of Fellows, and limited to a maximum of 50. In 1993, the society decided to expand to include not only a Fellowship category but also general membership and member-in-training categories. However, the Fellowship category remained as a distinct entity within the society.

According to the society bylaws, "To be nominated for Fellowship in the Society, the candidate must have been a General member for at least five years by the date of the annual Fellows' meeting of the year of nomination and must be certified by the American Board of Radiology, the American Osteopathic Board of Radiology or certified in radiology by the Royal College of Physicians and Surgeons of Canada or other Board that in the judgment of the Fellowship Committee is of equivalent rank; have a minimum of three years experience post-residency training in diagnostic ultrasound; have two letters of recommendation from Fellows of the Society; have demonstrated special interest, effort and accomplishment in diagnostic ultrasound; have contributed substantially to the goals of the Society; and have submitted a formal curriculum vitae (CV) to the Fellowship Committee."

Potential new Fellows are generally approached by other Fellows in the Society to determine their interest. However, it would certainly be appropriate for a general member who feels that he or she meets the criteria for elevation to Fellowship to discuss their candidacy with current Fellows in order to obtain letters of recommendation. The deadline for nomination of new Fellows to be voted on during the October Fellows' business meeting is August 27, 2010.

The most beneficial component of Fellowship is the privilege of attending the Fellows' meeting, which takes place on the Thursday before the annual meeting and postgraduate course. For most Fellows, this is the highlight of their academic year. Fellows are asked to make brief presentations on new research or areas of special interest. These presentations are informal, and provide an opportunity for peer review at its highest level. New ideas can be proposed, merits debated, and suggestions for improvement discussed. There is an expectation that all Fellows will give presentations on a regular basis. As such, one of the criteria for election to Fellowship is special accomplishments in diagnostic ultrasound.

Nominations for Fellowship are reviewed by the Fellowship Committee, which consists of three current Fellows. Up to five new Fellows can be elected each year, and elections take place annually at the Fellows' business meeting. To be elected, a candidate must receive votes from more than 50% of the Fellows attending and voting. Voting is by secret written ballot. As a requirement for continuity of Fellowship status, Fellows must attend either the Fellows' meeting or the general membership meeting at least once every two years.

In addition to the active Fellow membership category, an Emeritus Fellow category is available for those Fellows who choose to no longer remain active in the society due to retirement, long-term disability, or similar reasons. An existing Fellow may request Emeritus status by submitting a letter to the chair of the Fellowship Committee. Emeritus status is granted by a majority vote of the Fellows at the annual Fellows' business meeting.

In summary, Fellowship in the SRU is a significant honor to those who specialize in ultrasound. The process of become a Fellow involves nomination and letters of recommendation by two active Fellows. If general members have a desire and feel they have the appropriate qualifications for elevation to the Fellowship level, they may approach present Fellows and ask for nomination and letters of recommendation. Applications, which should include a curriculum vitae, will be reviewed by the Fellowship Committee and a recommendation regarding qualifications will be made to the Fellows at the next Fellows' meeting. There is an expectation that Fellows will remain invested in ultrasound, presenting new research and ideas about the advancement of the field. ●

Update on Guidelines for Management of Thyroid Nodules

Mary C. Frates, MD

The American Thyroid Association (ATA) recently released a revised version of its publication "Management Guidelines for Patients with Thyroid Nodules and Differentiated Thyroid Cancer"[1]. This commentary will compare the new ATA guidelines to the SRU Consensus Conference Statement for Management of Thyroid Nodules Detected at Ultrasound, published in 2005[2].

Both the ATA guidelines and the statement were composed by teams of physicians including endocrinologists and endocrine surgeons. However, unlike the SRU, the ATA group did not include radiologists. The ATA guidelines are an exhaustive compilation of recommendations for the optimal care of patients with thyroid nodules and differentiated thyroid cancer, with two specific recommendations related to the role of fine needle aspiration (FNA) in the evaluation of thyroid nodules. The majority of the 47 recommendations in the document deal with management of thyroid cancer patients. When evaluating the ATA guidelines, please note that Table 3, Sonographic and Clinical Features of Thyroid Nodules and Recommendations for FNA, is incorrectly formatted as it appears in the November issue of *Thyroid* (S. Mandel, personal communication). When looking at Table 3 in the online version of the article, be sure that you are looking at the corrected version.

Both the ATA and the SRU panels attempted to use evidence-based medicine whenever possible for decision making. The ATA strongly recommends thyroid sonography for all patients with known or suspected thyroid nodules, and the SRU statement is directed to nodules detected at ultrasound. Both groups agree that certain characteristics place patients into the category of high risk of malignancy, including family history, history of head/neck irradiation, and prior history of thyroid cancer. In this high-risk group, the ATA strongly recommends biopsy of all nodules >5 mm in size with suspicious sonographic characteristics (hypoechoic, internal vascularity, irregular margins, microcalcifications, absent halo, or taller-than-wide shape). The ATA believes that there is insufficient evidence to recommend FNA of nodules without suspicious features between 5 and 10 mm, even in patients with a high risk history. The SRU recommendations are general, and specifically exclude those patients with historical, physical or other features that suggest that they are at increased risk for cancer.

The following criteria apply to those patients without a high risk history.

Calcifications

- In the presence of microcalcifications, the ATA recommends FNA of all nodules ≥1.0 cm and the SRU strongly considers FNA at the same size.
- The SRU also strongly considers FNA for solid nodules with coarse calcifications ≥1.5 cm.

Solid Nodules

- The ATA recommends FNA of nodules ≥1 cm if hypoechoic, and ≥1-1.5 cm if solid AND iso-or hyperechoic.
- The SRU strongly considers FNA for solid nodules ≥1.5 cm, but does not distinguish between hypo-, iso-, or hyperechogenicity.

Mixed Cystic and Solid Nodules

- The ATA recommends FNA ≥1.5-2 cm for a mixed cystic and solid nodule if any suspicious features are present and ≥2.0 cm if no suspicious features are present.
- The SRU strongly considers FNA for a mixed cystic and solid nodule ≥2.0 cm, or nodules that are mostly cystic with a mural nodule, or nodules that have shown substantial growth.

Spongiform Nodules

- The ATA recommends FNA at ≥2 cm for a spongiform nodule.
- The SRU does not consider a spongiform nodule as a separate category, and these nodules are treated as mixed cystic and solid nodules as described above.

Purely Cystic Nodules

- The ATA and the SRU agree that FNA is not indicated in the purely cystic nodule.

Abnormal Cervical Nodes

- If abnormal nodes are present, the ATA and the SRU both strongly recommend FNA of ipsilateral nodules of any size.

Both groups agree that in patients with multiple nodules of similar sonographic characteristics, if no nodule has suspicious characteristics, observation alone is reasonable and

Update on Guidelines for Management of Thyroid Nodules (continued)

FNA can be deferred. Both groups recommend repeat FNA if nodule growth occurs, defined by the ATA as >50% change in volume, or 20% increase in at least two dimensions; however, the amount of time allowed for growth is unclear. Both groups agree that a repeat FNA under ultrasound guidance is indicated for any nodule with initial non-diagnostic results.

All in all, the two sets of guidelines are very similar. For both groups, more worrisome sonographic (and clinical) characteristics prompt FNA at smaller nodule sizes. Both sets of guidelines have some flexibility built in, to allow decision-making to be based on individual patient circumstances. Whichever guideline is chosen, following these recommendations should allow diagnosis of the majority of clinically significant thyroid cancers while avoiding FNA in nodules that are highly likely to be benign.

References

1. Cooper DS, Doherty GM, Haugen BR, et al. Revised American Thyroid Association guidelines for patients with thyroid nodules and differentiated thyroid cancer. Thyroid 2009: 19: 1167-1214.
2. Frates MC, Benson CB, Charboneau JW, et al. Management of thyroid nodules detected at ultrasound: Society of Radiologists in Ultrasound consensus conference statement. Radiology 2005;237: 794-800.
3. New version of ATA thyroid guidelines Table 3 (in erratum) in press.

Recommendations for Fine Needle Aspiration of Thyroid Nodules

	ATA	SRU
High Risk History Including: Hx head/neck irradiation Prior history thyroid cancer Positive family history 18FDG avid on PET scanning Multiple Endocrine Neoplasia Rapid growth and hoarseness	With suspicious sonographic characteristics: >5 mm Without suspicious sonographic characteristics: >5 mm Insufficient evidence to address	Not addressed
Abnormal Cervical Nodes	All	All
Microcalcifications	≥1 cm	≥1 cm
Solid Nodule AND hypoechoic AND iso- or hyperechoic	 ≥1 cm ≥1-1.5 cm	 1≥.5 cm ≥1.5 cm
Mixed Cystic and Solid	With suspicious sonographic characteristics: ≥1.5-2.0 cm Without suspicious sonographic characteristics: ≥2.0 cm	≥2.0 cm
Spongiform Nodule	≥2.0 cm Or sonographic monitoring without FNA	≥2.0 cm
Purely Cystic Nodule	Not indicated	Probably unnecessary
Substantial Growth Since Prior	If ≥50% change in volume or 20% increase in at least 2 dimensions at 6-18 month: Repeat FNA	Substantial growth of nodule requires repeat FNA
Nondiagnostic sample	Repeat	Repeat
Multiple nodules, with no suspicious characteristics and multiple sonographic similar coalescent nodules	FNA largest nodules only	FNA likely unnecessary ●

Society of Radiologists in Ultrasound 2010 Member-in-Training Research Award

General Information

In accordance with the mission of the Society of Radiologists in Ultrasound (SRU) to advance the science, practice and teaching of the subspecialty of ultrasound in radiology, the SRU announces the 2010 member-in-training research award.

The $1,000 award will be given to an SRU in-training member for a paper on original research in ultrasound. The award-winning paper will be presented at the 2010 annual meeting in Las Vegas, NV by the first author (the in-training member submitting the work).

The abstract will be submitted by the SRU to *Ultrasound Quarterly*, the official journal of the SRU, for possible publication.

Requirements

- The work must be primarily about clinical ultrasound imaging. The in-training member submitting the work must be the first author and must have contributed the majority of the work for the study.
- The submission shall consist of an abstract not to exceed 500 words, containing the following four elements in separate paragraphs:
  - Purpose or objective of the study
  - Materials and methods
  - Results
  - Conclusion
- The applicant must submit a current curriculum vitae and a letter from his or her program director attesting that he/she is a radiology resident or fellow in good standing and that the work has been done primarily by the applicant and has not been previously submitted for publication, published or presented at another venue prior to its presentation at SRU.
- Each candidate is limited to one submission.

Submission Instructions

The required materials must be submitted to the SRU **by July 2, 2010.** Applicants will be sent an acknowledgment of receipt of their application via email, but should not contact members of the Research Committee or Executive Board regarding activity on their applications. The SRU Research Committee will review the proposals and submit its recommendation for the award-winning paper to the Executive Board for final approval. The review process will be completed by August 13, 2010, and the candidates will be notified of the final decision on their proposals shortly thereafter. Applications should be sent as e-mail attachments to sroberts@acr.org.

ASK THE EXPERT
The Emperor's Old Clothes
Does the Common Bile Duct Dilate After Cholecystectomy?

R. Brooke Jeffrey, MD

Some things just never die. The fact that this topic is even open for discussion after 30 years of intensive clinical investigation is remarkable in itself, but even to the most casual observer the volume of contradictory published literature in this area raises doubts as to whether there will ever be a definitive resolution to the controversy. While merely reviewing this conflicting scholarship is not likely to lead us to a firm conclusion, what I hope to do in this response is to deconstruct some of the reasons for the controversy, and to step back and look at the larger clinical context and put this question in some perspective.

The controversy originated in 1887, when Oddi reported dilatation of the common bile duct in three dogs that had undergone cholecystectomy.[1] Parulekar first reported measurements of the common duct by ultrasound in 1979[2], and from that time forward, sonographic measurement of the common duct has been the subject of a vast array of medical literature. On the surface, the basic components of this question appear to be straightforward. Most studies describe the measurement of the common duct preoperatively and repeat that measurement at various intervals after surgery. What could be more straightforward? In fact, nothing about it is straightforward. The first problematic area concerns the accuracy and reproducibility of the measurement, and in addition a whole array of patient-related factors may impact the measurement. Sonography cannot reliably identify the site of insertion of the cystic duct with the common hepatic duct to form the common bile duct. Therefore, there is some question at the outset as to which portion of the duct we are identifying. Most authorities would agree that when measuring in a parasagittal plane the portion of the bile duct anterior to the right portal vein is in fact the common hepatic duct and not the common bile duct. It quickly becomes apparent on reviewing the methodology of numerous papers that there has been no standardization of where the measurement is taken or precisely how the measurement is obtained. Secondly, there have only been a few studies that looked at inter-observer variability in the measurement of this small structure, but these studies suggest that there is a variability of 1-2 mm in the reproducibility of the measurement.[3] Studies that have looked at the standard deviation of the measurement also reflect standard deviations >1 mm.[3] Thus, it immediately becomes apparent that there are both anatomic issues that impact the measurement as well as human error in terms of its reproducibility that suggest that achieving highly precise measurements may in fact be problematic.

Another fascinating dimension to this debate is the whole host of factors that may impact the size of the bile duct. These include the patient's state of respiration, body mass index, age, and medications such as nitroglycerine, opiates, and calcium antagonists, as well as the presence of common duct stones, Sphincter of Oddi dysfunction, and post-cholecystectomy state.[4] To summarize, there is no uniform standard for measuring the bile duct, and studies vary widely in where that measurement is taken. There is undoubtedly a finite degree of inter-observer variability in obtaining the measurement, which calls into question the precision of reproducibility, and finally there is a host of patient-related factors that may influence the bile duct size.

An interesting insight into this entire dilemma is whether the common bile duct dilates with age as a natural phenomenon. The theory here is that the loss of smooth myocyte bands in the reticulo-elastic framework of the duct may lead to dilatation over time. Anyone who has been to their 25th high school reunion can attest to the appreciable effects of the loss of elastic tissue. That said, this is still a matter than generates some controversy, as there are contradictory articles in the literature stating that the bile duct does and does not dilate with age.[5,6] In part this reflects the difficult nature of clinical research, as there are undoubtedly multiple confounding variables in doing these types of studies. In an aging population that is taking nitroglycerine or calcium antagonists, perhaps the bile duct dilates a bit. Perhaps inevitably in patients who are not on these medications the bile duct does not dilate. In some patients there is Sphincter of Oddi dysfunction following cholecystectomy, which may be related to either an organic ampullary stenosis or a physiologic abnormal motility of the sphincter.

What are we to make of this mystery wrapped in an enigma? A back-of-the-envelope meta-analysis would suggest that, prior to the age of 75 at least, the normal bile duct is rarely >7 mm. In most, but not all patients following chole-

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ASK THE EXPERT (continued)

cystectomy, the bile duct does not dilate appreciably. While many noted authorities might take issue with the above statement, let's stop at this juncture and ask a more basic question: who cares what the size of the bile duct is? One incontrovertible fact that has been known since the early 1980s is that patients with "normal bile duct size" may have significant pathology, most notably small common duct stones, which may lead to devastating consequences such as the onset of gallstone pancreatitis. So, if it is entirely possible to have significant pathology with a normal duct, is the converse true, that dilated ducts in fact may not have any compelling clinical sequela? The answer to that is yes, as numerous studies have shown that, particularly in elderly patients, ducts >10 mm may in fact have no accompanying pathology and could possibly be related to benign, age-related changes.

What in fact is the relevance of common bile duct size following cholecystectomy? As it turns out, not much. We have noted that a normal bile duct size does not exclude significant ductal pathology, and conversely the simple size cut-off for normal and abnormal isn't all that clinically meaningful. What is meaningful is whether the patient has symptoms or biochemical abnormalities of the serum liver enzymes. The gamma-glutamyl transpeptidase is far more sensitive than biliary sonography in the detection of common duct stones, and is abnormal in over 90% of cases.

Here are some practical guidelines that are imperfect and perhaps only moderately controversial:

1. Patients with either clinical symptoms or liver enzyme abnormality post-cholecystectomy should be thoroughly worked up regardless of common bile duct size. If ultrasound does not demonstrate definitive pathology such as a common duct stone, then MRCP, pancreatic MR or CT, or ERCP with manometry are indicated.
2. Conversely, patients with a "dilated" common duct (7-10 mm) after cholecystectomy who are asymptomatic and who have normal liver enzymes can be observed without further investigation.

References

1. Oddi R. D'une disposition a sphincter speciale de l'ouverture du canal choledoque. *Arch Ital Biol 1887*; 8:317-22.
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4. Daradkeh S, Tarawneh E, Al-Hadidy A. Factors affecting common bile duct diameter. *Hepatogastroenterology* 2005; 52(66):1659-61.
5. Horrow MM, Horrow JC, Niakosari A, Kirby CL, Rosenberg HK. Is age associated with size of adult extrahepatic bile duct: sonographic study. *Radiology* 2001; 221(2):411-4.
6. Bachar GN, Cohen M, Belenky A, Atar E, Gideon S. Effect on aging on the adult extrahepatic bile duct: a sonographic study. *J Ultrasound Med* 2003; 22(9):879-82; quiz 883-5.
7. Pereira-Limâ JC, Jakobs R, Busnello JV, Benz C, Blaya C, Riemann JF. The role of serum liver enzymes in the diagnosis of choledocholithiasis. *Hepatogastroenterology* 2000; 47(36):1522-5.

We invite all members to submit questions to Ask the Expert regarding the practice of radiology. Questions can be technical, clinical, political or socioeconomic in nature. We will refer your question to the right person and publish an answer. If we can't answer your question in print we will try to obtain an "off-line" answer for you. ●

Future Meeting Dates

October 22-24, 2010
Las Vegas, NV

October 21-23, 2011
The Westin Michigan Avenue
Chicago, IL

SRU Members in Haiti during the January Earthquake

Robert D. Harris, MD and Douglas L. (Rusty) Brown, MD

Two SRU members were on separate medical mission trips in Haiti at the time of the January 12, 2010 earthquake. Although the earthquake devastated the capital city of Port-au-Prince and the immediate area, both members were in the northern part of the country, where the earthquake was felt but there was little damage. They provided the following reports.

Robert D. Harris, MD

Tuesday, January 12, 2010, 4:53 pm EST. Do you remember where you were then? This was the official occurrence of the devastating earthquake in southern Haiti, and I found myself waiting at a small northern Haitian hospital in Limpe, 10 miles west of Cap Hatien, as our hosts tried to wrangle a rental car for the drive to Port-au-Prince. My 20-year-old daughter Chelsea and I were just starting our trip home after spending a week performing sonographic exams on a donated Sonosite 180 machine in a small regional hospital in Le Borgne, about 30 miles west of Cap Hatien. The weather had been foggy and rainy most of the previous week and our flight to Port-au-Prince, scheduled to depart at 2:30 that day, had been cancelled due to poor visibility,. Had the flight not been cancelled, we would have landed in Port-au-Prince about an hour before the quake. We count ourselves as having used one of our nine lives - we felt the tremors but experienced no damage to structures or humans.

Upon our arrival in Port-au Prince on January 5, our group went to the Hotel Montana for a brief respite from travel, and we shared the magnificent views from this expensive hotel. Now, of course, the hotel lies in ruins, the site of much loss of life and property.

Our introduction to life in rural Haiti began on the first morning after arrival, when some natives brought in a post-partum patient in distress lying on a door, having no money for stretcher, after carrying her for several hours over muddy trails. She was hemorrhaging heavily, and we took her into the labor and delivery ward where I got out my compact ultrasound machine to see if I could see anything in her pelvis. Color Doppler, such as it is on the old Sonosite 180, showed a boggy post-partum uterus and some increased vascularity. Meanwhile, the general practitioner examined the patient and found the umbilical cord sticking out from her vagina. Three physicians, including me, manually extracted her placenta over the next half hour, performing uterine massage and heavy manual traction.

In general, the week went well, I scanned patients with the providers from about 9:00 am to 4:00 pm on work days. As those of you who have worked in undeveloped countries know so well, the work ethic is quite different from that of the Western world. If something doesn't get accomplished today, there is always tomorrow and the next day…and the next day. If something is unavailable, you make do, or wait a couple of weeks for it to be obtained or resolved. The whole pace is considerably more sluggish, and the resources very constrained. Doctors would inexplicably disappear at odd times, with patients waiting in the exam room for them to return. I found myself wanting to interact more, to provide more hands-on teaching, but none of the three physicians had included time for learning ultrasound in their daily schedule. So, I saw patients with them, scanned where indicated, and delivered a couple of lectures on the basics of the ultrasound machine knobology and basic physics, and a primer on OB ultrasound. These were well received, and I jumped at every chance to show them how to use the machine. All in all, it was a very worthwhile trip, we received a lucky break, and my heart aches at the death and destruction we just missed but goes on seemingly uninterrupted.

Douglas L. (Rusty) Brown, MD

I travelled to Haiti with a team of 15 people on a one-week medical mission to the Univers Medical Center in Ouanaminthe, Haiti, arriving the Saturday before the earthquake. We flew into the Dominican Republic, driving across the border at Dajabon. The small medical clinic and a school are sponsored by the Coalition of Children in Need Association (COCINA). The team I traaveled with included two general surgeons, anesthesiologists, and nurses who performed general surgical procedures in the one operating room at the clinic. A refurbished compact ultrasound machine had been donated to the clinic and my role was to teach the two local physicians to do some basic ultrasound exams. One of the physicians spoke some English, but we had interpreters to help translate between English and Creole. We concentrated on basic exams like the gallbladder, kidneys, pelvis, and basic obstetrics. While we felt the earthquake, there was little damage in Ouanaminthe. The saddest part was that most of the local people we came to know had families in Port-au-Prince and were unable to contact them.

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SRU Members in Haiti during the January Earthquake (continued)

Unfortunately, before we left many of them found out that their family members and friends had been killed. There has now been an influx of people into the town, straining the already limited capacity of the school and medical clinic.

Haiti is a country of extreme poverty, unlike anything I have ever seen. The country has a long and complicated history that contributes to this. We were fortunate to meet many caring and appreciative people during our trip. Despite the healthcare problems in this country, we are very fortunate compared to those in Haiti. The healthcare providers there learn to get by on limited resources, though it is far from ideal. I learned that if you don't have a linear transducer, a transvaginal transducer isn't too bad for an ultrasound of the thyroid or a superficial mass. I also learned that goat tastes pretty good, but that's another story. ●

SRU Foundation

The SRU recently received notice from the IRS that the application for tax--exempt status for the SRU Foundation has been approved. The Foundation is now a 501(c)(3) organization. The SRU gratefully acknowledges receipt of donations to the SRU Foundation from the following members:

$20 - $250

Gregory J. Allen, MD
Teresita L. Angtuaco, MD
Rochelle F. Andreotti, MD
Gordon H. Beute, MD
Marcela Bohm-Velez, MD
Brian D. Coley, MD
Anne P. Dunne, MD
Paul Ellenbogen, MD
Rick I. Feld, MD
Claudia A. Goodwin, MD
Lennard D. Greenbaum, MD
Michael Hinz, MD
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Cheryl Kirby, MD
Alfred B. Kurtz, MD
Errol Lewis, MD
Erlinda S. McRea, MD
Dolores H. Pretorius, MD

$20 - $250 (continued)

Sheshagiri Rao, MD
Shuchi K. Rodgers, MD
Caryl G. Salomon, MD
Leslie M. Scoutt, MD

$251 - $500

John M. Benson, MD
Robert L. Bree, MD
Edward G. Grant, MD

$501 and Above

Carol B. Benson, MD and Peter M. Doubilet, MD, PhD
Raymond E. Bertino, MD
Douglas L. Brown, MD
John J. Cronan, MD
Ulrike M. Hamper, MD
Philip W. Ralls, MD

To make a donation to the Foundation, please contact Heidi Salkeld of the membership department (hsalkeld@acr-arrs.org). ●

The $6.48 Coke: What It Costs to Put on a Meeting

Susan Roberts, SRU Staff

Registration fees for an educational conference are established to help cover the costs to the organization to run the meeting. The largest expense to the SRU, and to most organizations, is generally the obligation to the venue where the meeting is held.

When the SRU contracts with a hotel for space to hold its annual meeting and postgraduate course, there are a number of variables that factor into the terms of the contract. Because of the number of sleeping rooms that are used during the meeting, the SRU meeting management staff is able to negotiate a waiver of meeting room rental fees. If the number of sleeping rooms that was negotiated when the contract was signed are not used, the society would be obligated to pay attrition fees to the hotel, which can be significant. The SRU has been very fortunate over the past several years to meet or exceed its sleeping room obligation and therefore has not been faced with paying attrition fees.

The highest cost to the society in conducting a conference at a hotel is food and beverage. In addition to utilizing a certain number of sleeping rooms, a hotel contract also includes an obligation to spend a certain amount of money on food and beverage during the course of the meeting. At the SRU meeting, food and beverage events include the opening reception on Friday evening, breakfasts, and breaks, as well as any lunch or committee meetings at which food is served. If you have ever ordered anything from room service in a hotel you have probably noticed that the total amount of the meal exceeds the price of the actual food item by a fairly large amount. This is because food and beverage items are priced by what is termed "plus plus", which means the cost of the actual item plus a taxable service charge and state tax. Service charges can be quite high, often 20% or more of the actual cost of the food item. The "plus plus" method of pricing applies to catered events as well. Food and beverage charges vary by hotel, but as an example, the base price of a can of soda served during a break is usually about $5.00. When a service charge of 20% and tax of 8% are added, the total cost of the can of soda is $6.48. If you compare this with what you might spend to purchase the same item in a supermarket, it will help you to understand why food and beverage expenses for a meeting are so high.

Individually packaged items are charged "on consumption", meaning that costs are calculated by the hotel based on the number of individual units that are consumed. Every time an attendee decides to take a couple of bottles of water served at a break to their room, thinking that they are free, they have in fact cost the society about $13.00. Items such as coffee and tea are charged by the container, regardless of how much is actually consumed. Individual meals are charged based on how many are ordered, regardless of whether they are all consumed.

Following is a list of common items that might be served at an SRU event, with prices based on catering menus provided by the hotel in Las Vegas, and priced before the service charge and tax are added. Tax on food items in Nevada is currently 8.1%. In other locations, such as Chicago, both the base cost of food and beverage and the tax are considerably higher.

Coffee	$84.00 per gallon (approximately 16 individual servings)
Orange or other breakfast juice	$36.00 per pitcher (approximately 8 individual servings)
Yogurt	$6.00 per individual container
Bottled water	$4.75 per bottle
Canned soda	$5.00 per can
Cold buffet lunch	$45.00 per person
Hot, three-course dinner	$89.00 per person (without beverage)

Audiovisual services are another large meeting expense, particularly for an organization such as the SRU where presentations are very image-intensive and must utilize state-of-the-art equipment. In addition to labor fees for the people who set up and operate the audiovisual equipment, there are also equipment rental fees. Some sample costs from the 2009 meeting follow:

Projectionist	$135.00 per hour, $202.50 overtime, $270.00 weekends
Audio engineer	$145.00 per hour, $217.50 overtime, $290.00 weekends

continued on next page

The $6.48 Coke: What It Costs to Put on a Meeting (continued)

Projector, screen, VGA cable, LCD data monitor	$1245.00 per meeting room per day
Microphones (wired and hand-held)	$325.00 per room per day
Speaker timer	$325.00 per room per day
Laser pointer	$35.00 per room per day
Power supply	$125.00 per location

Justine Wood, Senior Meeting Manager at the ACR and the manager of the SRU annual meeting, is very proactive in negotiating the best rates and fees that can be obtained. However, in cities with very strong unions, it is difficult to negotiate reductions in standard rates.

When you attend the 2010 meeting in Las Vegas, the information provided in this article may help you to have a better understanding of the challenges of putting on a cost-effective, efficient and enjoyable meeting. ●

Members in the News

Vikram Dogra, MD was awarded honorary membership in the Turkish Society of Radiology and the Turkish Society of Ultrasound at the 2009 annual convention in Antalya, Turkey. The honorary membership was conferred for his contributions to the advancement of radiology and ultrasound in Turkey. The Turkish society has been in existence for 86 years and this is the first time that the award has been conferred on any radiologist.

Harvey Nisenbaum, MD was presented as the Annual Oration Honoree at the Philadelphia Roentgen Ray Society meeting on March 4, 2010. In his honor, Barry B. Goldberg, MD gave an informative and prescient oration entitled "Ultrasound: A Look Into the Future". Dr. Nisenbaum has been a tireless advocate for both radiology and diagnostic ultrasound.

Mindy M. Horrow, MD will receive the Philadelphia Roentgen Ray Society's Mary S. Fisher Outstanding Educator Award on May 6, 2010. In the words of a colleague, Dr. Horrow is "an outstanding physician, mentor, and teacher...one whose knowledge, skills, and ability to transmit information in a way that simplified the most complicated of cases" is outstanding.

Members in the News is a new feature of the newsletter. Any member who has professional news to share should send the information to sroberts@acr.org for publication in a future issue. ●

Advances in Sonography

20th Annual Meeting & Postgraduate Course

October 22 – 24, 2010
Las Vegas, NV

Program includes:

- Plenary Session: Ultrasound, Where We Have Been and Where We Are Going
  Barry B. Goldberg, MD, Keynote Speaker
- Practice Management and Continuous Quality Improvement
- Ultrasound in Oncology
- Ultrasound in Obstetrics and Gynecology
- Ultrasound in Women's Imaging
- Ultrasound in Abdominal Imaging
- Ultrasound in Vascular Imaging
- Ultrasound in Pediatric Imaging
- Ultrasound in Musculoskeletal Imaging

A detailed program will be available in early July.
For additional information, contact sroberts@acr.org or visit www.sru.org

Head-To-Toe Ultrasound

Two half-day sessions on the essentials of ultrasound practice