This past year for the AVIR, not unlike many other organizations, has weathered the economic storm. Measures were implemented which stopped the bleeding; now we have to ask ourselves, “Can we maintain?”

Getting ahead
Past President Jaime Nodolf executed tough decisions the board never had to make or face before (they weren’t exactly crowd pleasers either). Such as: reducing the number of board meetings everyone travels (1 instead of 4); reduce regional meetings; begin sharing hotel rooms; capping the Presidents Dinner, etc.

Staying ahead
My role this year was to continue to look for those trees while keeping the forest as beautiful as ever. My approach was to prune— not cut out an entire tree. Why? Well, based on our member surveys, we all are pretty proud of the AVIR and what we stand for. So the trick was to re-examine the value of each expense and ask is this bringing value back to the members? Does this align with our team building efforts with the Nurses? How can we reconnect with the executive office of the SIR? Is the annual meeting the correct route to offer education? Does this align with our team building efforts with the Nurses? How can we reconnect with the executive office of the SIR? Is the annual meeting the correct route to offer education? Are there other avenues we should entertain?

It’s amazing how things pull together—many hands make for light work, right? Our team building efforts have made steps towards working with the ARIN association again. With the latest RCEEM accreditation of A+ status, we now offer value to the SIR executives—next year we will work with them on their clinical associate’s path. Joining forces with the Advance Imaging & Radiation Oncology we are able to offer annual webinars. Reorganizing the policies allowed us to identify different ways of doing things. For example, our member committee has been vocal and instrumental in assisting the board put together a great annual meeting in San Francisco without filling the program chair. For the first time ever, we invested in a contributions manager to manage and stay on top of all the grant/educational funds that are available (this has improved our collections this year by 20%—another sign we are rebounding from this economic deficit). We also have to make sure we tout the work everyone has been adding to the new website!! This is another initiative that will provide tremendous value to you. The information age is chock full of avenues, but how is one to know where to spend their time looking? With our new website, we will come looking for you! Each member will be able to have their own page and will be able to connect via your local chapters etc.

Speaking of connections, the AVIR is building one with GEST (Global Embolization Symposium and Technologies). This year, May 03 - May 06, 2012, this symposium will be in New York where we will be offering a reduced members fee. We are expecting to go and support the newest Chapter addition too!!

I am not one to predict the future, though I am sure we will have to continue our frugality. We are on the right path (or it feels like we are) we still need to be prudent and at least acknowledge of the “other” path. I am not going to talk about it here, but am willing to discuss this further with anyone who has more questions after reading the rest of this article.

I hope to see you in San Francisco!

Sincerely,
Melissa J. Post
West made this fake head, to place in his bed, in anticipation of the 1962 escape. He, together with the Anglin Brothers and Frank Morris, planned the escape. However, West did not make it out of his cell in time. The head was carefully constructed of cotton sheeting, soap, paint, and human hair. www.alcatrazhistory.com/rs2.htm

Making a head

The most famous attempt at escaping from Alcatraz was carried out by Frank Lee Morris and brothers, Clarence and John Anglin. In 1962, a fellow inmate named Allen West helped the trio to devise a clever plan that involved constructing a raft and inflatable life vests to navigate the Bay waters, and human decoys to fool the guards during the routine counts. Over the course of a several months, the inmates used special tools stolen from various prison work sites to chip away at the vent covers in their cells, meanwhile carrying on with the creative fabrication of the dummies and decoys.

The vents were located at the rear of each cell, and were covered with 10x6-inch thatch-patterned metal grills. The true ingenuity of the plan lay in the prisoners’ methodical camouflaging of the vent grills to hide the chipped paint and cement from detection, and their creation of lifelike decoys that would deceive the guards up-close during inmate counts. The quality of the faked grills and dummies was remarkable. The inmates utilized paint kits and a soap and concrete powder to create the lifelike heads, which were decorated with human hair collected from the Barbershop. The preparations took over six months of planning and fabrication.

On the night of June 11th, 1962, immediately following the 9:30 a.m. count, Morris and the Anglins scaled the utility shafts to reach the roof. Allan West, whom the FBI would later suspect of masterminding the whole plot, had spent the majority of his time over the past six months in building the decoys, and hadn’t been able to make as much progress as the others in widening the concrete vent opening in his cell. His accomplices therefore had no choice but to leave him behind. Once they reached the roof, they climbed through a ventilator duct where they had spread apart the thick metal bars, and made their way to the edge of the roof. After descending utility pipes attached to the cement cellhouse wall, all three scaled a fifteen-foot fence, and hurried down to the island shore where they inflated their rafts and life vests. The inmates ventured out into the freezing Bay waters, and were never seen again. Back at the cellhouse during the morning count, a guard probed his club into one of the inmates’ cells, and the dummy head rolled off the bed and onto the floor.

Decades later, it is still unknown whether the inmates ever succeeded in making their escape. The story was dramatized in several books, and in the famous motion picture “Escape from Alcatraz,” starring Clint Eastwood and Fred Ward. The FBI actively pursued the case for several years, but never came across any effectual leads. They did, however, make a final determination that the attempt had been unsuccessful.

AVIR Annual Scientific Meeting
March 24-28, 2012

San Francisco Marriott Marquis | San Francisco California
Held in Conjunction with SIR
2012 AVIR Fellow Award Recipient

Israel Ramaswamy RT (R) (CV) M.S.

Israel Ramaswamy, or as he is known to us all “Izzy” has been an active Interventional Technologist since his graduation in 1991 from Hudson Valley College in Troy, New York. From academia to clinical practice, he first started as a special procedures technologist at Albany Medical Center that same year, and after several years found himself as a CVIR Lead Technologist at Brigham’s Women and Children in Boston. Then, in 1999, directed his career path into the hospital management and leadership direction, returning to Albany Medical Center as the VIR Manager. In 2011, Izzy accepted the Operations Manager role for Interventional Services at Baptist Cardiac and Vascular Institute in Miami, Florida and is an integral part of the leadership team.

Mr. Ramaswamy has continued to excel, completing his Bachelors and his Master’s Degree in Healthcare Operations and Leadership. Professionally, Izzy attained his CV status in 1995, has served on the ARRT VI Board Exam Committee and is state licensed in New York and Florida. He has been a member of AVIR since 2000. Within the AVIR organization, he activated the Eastern New York Region Chapter, organizing numerous educational opportunities and publishing papers and articles, in his efforts to bring pride and support to those in our professional. Since his relocation to the Miami area, Izzy has been instrumental in the establishment of the Miami AVIR Chapter, and will be serving as the Vice-President of the AVIR for the 2012–2013 term. Izzy considers this role, serving the mission of the AVIR, critical to both the profession and those who serve in it.

2012 Shari Ullman Gold Medal Award Recipient

Dr. Alan H. Matsumoto, M.D. FSIR, FACR, FAHA

Dr. Alan H. Matsumoto, M.D. FSIR, FACR, FAHA, received his Bachelor’s and Master’s Degrees from the University of California at Santa Barbara, where he was elected to Phi Beta Kappa and Sigma Xi Honor Societies. After completing his Medical Degree in 1980 from Bowman Gray School of Medicine of Wake Forest University and being elected to the Alpha Omega Alpha Honor Society, Dr. Matsumoto completed Residencies in Internal Medicine at the University of Massachusetts and Diagnostic Radiology at the University of North Carolina. He also had additional Fellowship training in Vascular and Interventional Radiology at Georgetown University. Dr. Matsumoto is Board Certified in Internal Medicine, Diagnostic Radiology, and Cardiovascular & Interventional Radiology.

His clinical practice includes image-guided, minimally invasive therapy for arterial occlusive and aneurysmal disease inclusive of abdominal and thoracic aortic stent grafts; peripheral, and mesenteric vascular disease; fibromuscular dysplasia of the renal arteries; DVT and PE thrombolysis and thrombectomy; IVC filters; embolization and MR guided focused ultrasound therapy for fibroids and other tumors.

He is a Professor of Radiology and Chair of the Department of Radiology at the University of Virginia. He has pioneered many novel and innovative, minimally invasive, image-guided procedures during his 20 years at the University of Virginia, many of which have become incorporated into practice at many nationally recognized medical facilities. He has published more than 180 articles and

continued on page 5
The Association of Vascular and Interventional Radiographers
Presents The 2012 AVIR Award of Excellence To:

David Baires RT R(CV) ARRT

Congratulations David! For a job well done, you now join an elite group of past winners that include:

1996 – Joyce Moses
1997 – Richard Cless
1998 – Gara Colelli
1999 – David Hall
2000 – Gene Maziarski
2001 – Marie Schodle
2002 – Sharon Misler
2003 – Leona Benson
2004 – Sandra Dixon & Amber Mitchell
2005 – Viki Allenbach
2006 – Jaime Nodolf
2007 – Patricia Crane
2008 – Rebecca Lassiter
2009 – Juan Mancera
2010 – Stephan Haug
2011 – Heidi Apfel

Congratulations!
Award Recipients

from page 3

book chapters and has trained more than 100 Residents and Fellows. His patient-oriented, multidisciplinary collaboration with other medical specialists has led to optimization of care in patients with complex diseases. A great supporter, educator and contributor, he helps this organization move forward as the “2012 Shari Ullman Gold Medal Awardee”.

This is the third year since the AVIR renamed the Gold Medal Lecture in honor of Shari Ullman. After Board approval, the AVIR presented this honor to Shari in 2008 and she was really touched. In fact to quote Shari: “this means the world to me.”

The first annual Shari Ullman Gold Medal Award was given at our 19th Annual Meeting in San Diego. Unfortunately, Shari past away before she could present the first Gold Medal Award named in her honor.

However, Shari’s family was able to attend the first awarding of the Shari Ullman Gold Medal Lecturer Award to Dr. John Aruny. A duplicate crystal was presented to her family, in remembrance of Shari.

This year it is being presented to Dr Alan H. Matsumoto.

REGULATORY NEWS

FDA CDRH Ombudsman Releases 2011 Report

The FDA’s Center for Devices and Radiological Health (CDRH) has released its ombudsman report for 2011, the first year the office’s electronic tracking system has been used to facilitate record-keeping and trending.

The data show a total of 461 new contacts for the year, up from 414 in 2010 and 250 in 2009.

The ombudsman’s office fielded 201 inquiries, 202 complaints, 43 disputes and 15 uncategorized contacts in 2011. Some 278 of the contacts were initiated by industry, with the balance coming from consumers (105), healthcare providers (33), CDRH employees (23) and other individuals (22).

As for reasons stakeholders reached out to the CDRH ombudsman in 2011, the report shows contact counts as follows:

- 151 Policies and Procedures;
- 111 Miscommunication/Lack of Communication;
- 29 Practice of Medicine;
- 27 Data/Testing Requirements;
- 26 510(k) Not Substantially Equivalent;
- 21 510(k) Request for Additional Information;
- 16 Level Playing Field;
- 14 Registration and Listing;
- 13 PMA Not Approvable;
- 6 Complaints about CDRH Employee; and
- 47 Other.

Also included in the CDRH report are data showing which CDRH offices were contacted and how frequently in 2011; what sorts of inquiries, complaints and disputes were filed; and the year-end status of inquiries, complaints and disputes. The report also presents comparative data from 2009 and 2010.

CDRH’s current ombudsman is David S. Buckles, PhD, a former cardiology researcher and industry CTO.

Elsewhere on its website, FDA points out that the CDRH ombudsman investigates complaints from outside FDA and facilitates the resolution of disputes between CDRH and the industry it regulates. “The CDRH ombudsman is a good starting point if you have a complaint, question or dispute of a scientific, regulatory or procedural nature,” reads a statement on the site. “He can answer questions, follow up on a complaint, discuss appeal and dispute resolution options or mediate a dispute. While providing this assistance, he maintains his impartiality and neutrality. The ombudsman advises the center director, to whom he reports, on ways to assure that our procedures, policies and decisions are of the highest quality and are fair and equitable.”
She’s ready to take center stage, are you?

Get the flexibility to see more in just six seconds.

www.siemens.com/artis-zeego-club

After just a few stretches, she’s ready to take on her next performance with flexibility and speed. For you, though, it takes more than stretching your body. You need to stretch your capabilities with a solution that will enable you to see more, faster in your interventional suite. Meet Artis zeego® and syngo® DynaCT 360.

Use syngo DynaCT 360 with your Artis zeego and you can acquire large-organ, soft-tissue images in just six seconds—faster than with any previous syngo DynaCT application. You’ll have better image quality, fewer motion artifacts, greater patient comfort, and use less contrast agent.

Imagine how a broader field of view could impact your patient care. Visualize the entire tumor anatomy and feeding vessels to support interventional oncology during abdominal and thorax applications. Or detect endoleaks and improve precise graft positioning during vascular treatments of the abdomen. You’ll have the flexibility to see more, which, ultimately, can enable you to do more.

Stretch your possibilities for case management—in just six seconds with syngo DynaCT 360.

Answers for life.
Obtaining a Post Primary/Advanced Certification is an excellent way for an individual to build on their radiography experience and background to advance their careers and support today’s interventional practices. As R.T.s, they are already in compliance with ARRT rules and standards. Adding a CI or VI credential, they demonstrate clinical experience and cognitive knowledge that qualifies them for the range of vascular-cardiac interventional radiography procedures. Some employers require it, for most it is a preferred certification. Certification can also be an advantage in professional development by influencing evaluations, wages, and clinical ladder promotions.

A look at the numbers

Since it’s inception in the early 1990’s, the CV post primary certification has had the greatest numbers and by the 2011 ARRT census totaled 4,037. Of the over 5,900 combined CV/VI/CI technologists, most reside in Pennsylvania, Florida and California. In 2003, When the VI and CI Certifications were implemented and the CV designation discontinued there were less than 100 first time candidates for the two combined. Since then, the number of certifications incrementally increased, until 2011, when the number of first time examinees dropped 50% in both CV and VI. The ARRT Annual report outlines these numbers in detail. They can be found at the link below.

www.arrt.org/Publications/Annual-Report

It will be interesting to see if these numbers continue to decline for 2012, considering the legislative environment surrounding health care reform. Some of this legislation deals with the training and certification of imaging personnel. HR 2104, The CARE bill dealing with imaging personnel, can greatly add to the integrity of our profession, requiring and enforcing accredited training. To see more regarding the CARE bill go to the link below:

www.frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=112_cong_bills&docid=f:h2104ih.txt.pdf

Do You know the process and requirements for Post-Primary Certification?

The application process is the same as for the primary certification, with a few extra items. Go to the ARRT website to order your Post Primary Handbook at www.arrt.org Certification. Inside you will need the following items:

- Agreement of Candidates
- Application form (in back of the handbook)
- Perform the procedures
- Document your performance
- Apply for Certification
- Maintain your records
- Photo /ID Requirements (note: 6 month limit on pictures & signatures, and no nicknames)
- Application Fees now $200
- Allow up to 4 weeks for CSR
- 90 day window to schedule at Testing Centers
- You can change your window (see booklet)
- Documenting your required exam performance

53 vascular-interventional procedures form the basis of the clinical experience requirements. Candidates must complete and document the performance of a subset of these 53 procedures according to the following rules:

- Candidates must complete a minimum of 10 of the 53 procedures; more than 10 procedures may be selected for completion.
- Each selected procedure must be performed a minimum of 5 times (repetitions) in order for the candidate to receive credit for that procedure.
- Each procedure may be counted a maximum of 20 times.
- Each candidate must complete a total of 200 repetitions across all procedures selected for performance.
- All submitted examinations must be signed off by a registered technologist or physician as noted on the Verification Identification page.

continued on page 8
What study materials/courses are available?

If you are a technologist who has set your goal on becoming an VI or CI registered technologist finding study material and resources is rare. In the years since the ARRT divided the Cardiovascular (CV) examination into two separate exams it has been difficult to find resources to assist technologists in preparing for the examination. Some test specific material can be found at HEALS Education Website.

www.healsreview.com/vi.html

Available paper and electronic materials are geared more towards the CIT or CI Certification. The following have links to Amazon for your review.

ARRT Examination in Cardiovascular Interventional Technology: New Rudman's Questions and Answers on the CIT 2004
www.amzn.com/0837358175

Appleton & Lange’s Review of Cardiovascular Interventional Technology Examination 1995
www.amzn.com/0838502482

www.amzn.com/0971113726

www.amzn.com/1438221835

WANT TO CONTACT THE ARRT?

Online: www.arrt.org

Phone: 651-687-0048

Concern about:

- extension 8540  Education & Registration
- extension 8580  Ethics
- extension 8560  Examination & Certification
- extension 8530  Psychometrics

ARRT Recognized Radiologist Assistant Educational Programs

- Bellevue College | Bellevue, WA
- Bloomsburg University | Bloomsburg, PA
- Loma Linda University | Loma Linda, CA
- Midwestern State University | Wichita Falls, TX
- Quinnipiac University | Hamden, CT
- Ohio State University | Columbus, OH
- University of Medicine/Dentistry of New Jersey Newark, NJ
- University of Arkansas for Medical Sciences Little Rock, AR
- University of North Carolina at Chapel Hill Chapel Hill, NC
- Virginia Commonwealth University | Richmond, VA
- Weber State University | Ogden, UT
Chapter Happenings
Sven Phillips RT (R) VI Director at Large

CHAPTER BENEFITS
Any questions concerning the formation of new chapters or existing ones please call the AVIR office at 703-234-4097
OR the Director at Large Jeff Kins at jdkins@gmail.com
OR Sven Phillips at Sven427@yahoo.com
Again, thank you for your support!

Developing New Chapters
New chapters are being formed in Massachusetts, Pennsylvania, Idaho, and Florida!
Following is the contact information for each chapter:

Massachusetts
Robert Sheridan RT(R) (CV)
is hoping to restart the chapter in Boston
rmsheridan@partners.org

Pennsylvania
Maria Niblock RT(R), BS
wants to start a chapter in Philadelphia
mmflyers@comcast.net

Idaho
Terry Newsom RT(R)
is in Boise and wants to start a chapter
Xrayhunter @cableone.net

Los Angeles Chapter
Jeane Rhoten RT(R)(CV)
jrslife@aol.com

Seattle AVIR
Leona Benson RT(R)(CV) FAVIR
seattleavir@hotmail.com

Lone Star State Chapter
Alan Seeley RT(R)(VI)
aseeley@petersonrmc.com
aseeley61@windstream.net

North Texas AVIR
Sven Phillips BS, RT(R)(VI)
Sven427@yahoo.com

SE Wisconsin Chapter
Julie Malkowski RT(R)(CV)
Julie.maldowski@aurora.org

Tampa, Florida
Christopher Sheridan RT R (CV)
christopher.sheridan@moffitt.org

North Carolina AVIR
Diane Koenigshofer MPH, BSRT (R)(CV), FAVIR
dianek@nc.rr.com

Diane has averaged about 60 attendees per meeting. They hold 1 Saturday seminar a year and try to provide 8 CEs. Other CE activities have been offered at Carolina Medial. Visit the NC AVIR Chapter page on the new website for updates. The next meeting in Carolina will be in the Fall of 2012.

Orange County California AVIR (OCAVIR)
Brett Thiebolt RT(R)
thieboltbh@stjoe.org

This Chapter has approximately 65 active members, and are a combination of RT’s, CVT’s and RN’s. Dates to be announced.

North California Chapter
Darlene Crockert RT(R)(CV)
maildarlene@juno.com

North Carolina AVIR
Diane Koenigshofer MPH, BSRT (R)(CV), FAVIR
dianek@nc.rr.com

Diane has averaged about 60 attendees per meeting. They hold 1 Saturday seminar a year and try to provide 8 CEs. Other CE activities have been offered at Carolina Medial. Visit the NC AVIR Chapter page on the new website for updates. The next meeting in Carolina will be in the Fall of 2012.

Orange County California AVIR (OCAVIR)
Brett Thiebolt RT(R)
thieboltbh@stjoe.org

This Chapter has approximately 65 active members, and are a combination of RT’s, CVT’s and RN’s. Dates to be announced.

North California Chapter
Darlene Crockert RT(R)(CV)
maildarlene@juno.com

Los Angeles Chapter
Jeane Rhoten RT(R)(CV)
jrslife@aol.com

Seateel AVIR
Leona Benson RT(R)(CV) FAVIR
seattleavir@hotmail.com

Lone Star State Chapter
Alan Seeley RT(R)(VI)
aseeley@petersonrmc.com
aseeley61@windstream.net

North Texas AVIR
Sven Phillips BS, RT(R)(VI)
Sven427@yahoo.com

SE Wisconsin Chapter
Julie Malkowski RT(R)(CV)
Julie.maldowski@aurora.org

Julie Chairs the SEW_AVIR chapter in Wisconsin. The Chapter has been around for a long time, at least 15 years if not more. Julie has been involved sith it for the last 10 years. This year the SEW will hold a one day seminar on May 12th in Milwaukee, WI. Check the SEW chapter on the new website.
Chapter Happenings (con’t)

Baltimore Chapter
Sharon Misler RT(R)(CV) FAVIR
angiosm@aol

Virginia Chapter / VA AVIR
Rita Howard RT(R)(CV)
Rhoward709@aol.com
Christopher Shaver RT(R)
christophershaver@msn.com
The Va-AVIR Chapter is the largest of all the active chapters, totaling over 100 members. Last year they held an 8 CE conference in November in Williamsburg, VA. Over 80 technologists and nurses attended. This year, plans are already in motion to have the 9th Annual conference in October again at the Great Wolf Lodge in Williamsburg. Contact Rita and Chris for further details. Check out the VA AVIR Chapter section on the new Website.

New York Capital AVIR
Kevin Berry RT(R)
kbxray@yahoo.com
This chapter was previously chaired by Izzy Rasaswamy, who has since relocated to the Miami area. Kevin Berry will be the point of contact in central New York region. This chapter features educational sessions combined with regional Angio clubs. Their last meeting was in November, and featured presentations by the local vascular surgeons.

New York, NY
Andrew Amorossa RT (R)
Amorosso43@gmail.com

NE Connecticut AVIR
Meredith Gaiter-Brown
BSN, RT(R)(CV)(MR)(M)
mrcvm@aol.com
Meredith expressed her concerns for the past lack of interest by regional members, but would still like to see the chapter active once again. Interested individuals in that region are encouraged to contact her to assist promoting renewed interest in the educational process.

Buckeye State Chapter (Ohio)
Jamie Hiott RT(R)(CV)(M)(CT)(VI)
jshiott@gmail.com

South Carolina / SCAVIR
John Furtek RT(R)
jfurtek@comcast.net
www.scavir.org
SCAVIR recently held the Sanctuary of Endovascular Therapy (SET) at the Sanctuary Resort, Kiawah Island, SC. For future meeting details please look to their website www.setmeeting.org

Metro Atlanta Chapter
Thomas Staton RT(R)(CV)
tlstanton@bellsouth.net

Great Lakes Chapter (Michigan)
Michelle Denomme
denomme@beaumonthospitals.com

Rocky Mountain Chapter
Erik Stein RT(R)
edstein@yahoo.com
diane.mudd@uhcolorado.edu

A few members expressed a willingness to help in their areas:
Renee Tossell PhD RT(R)(CV)(M)
rtossell@pima.edu
Willing to help with membership in the southern Arizona area

Patti Payne
Patti.payne@ge.com
Willing to start a chapter

Living close to these metropolitan areas?
Contact the above individuals to express your support and ideas. Active Chapters need active members. The following areas and regions need active chapters.

• Idaho
• Pennsylvania
• Massachusetts
• Colorado
• Georgia

If you live in these areas, there are numerous AVIR members who will benefit from organized educational activities, such as those an active Chapter can provide. Are you interested in joining the AVIR or getting involved in rewarding Chapter activities? Contact your area/regional Chapter representative. It’s a great way to start!
Chapter Happenings (con’t)

Involved in a Chapter and need better exposure, let the AVIR help you by getting the word out about upcoming events. Email blasts and website events notices, even Facebook notices can increase your attendance, and spark more interest. Contact the AVIR office or any board member for assistance.

Why are Chapters so important?
At the grassroots level, Chapters help foster local and regional educational opportunities and increase the overall visibility of the AVIR. Membership had decreased over the last few years, which could be due to the national economy, and the restructure of the membership term. Several Chapters faded into obscurity. But there has been a resurgence, new members, renewing members, and most important new Chapter interest. A Chapter's activities enables its members, and vice versa. Every technologist needs to obtain CE's to maintain their respective certification, why not achieve this goal, by offering network opportunities and industry exposure? Providing education is a win-win for everyone involved.

Getting local physicians involved speaking on current therapies and procedures, enhances not only an Institution's image, but also exposes attendees to innovations and techniques to take back to their own practices. Talk to your interventional radiologists about supporting the AVIR and its activities, whether it’s providing a lecture locally, regionally or assisting staff members in attending the Annual Meeting.

How Can You Start a Chapter in your State or Region?
Depending on where you live, there may be a Chapter already, but you can still be involved. The Chapter listings have been updated with current contact information, so feel free to e-mail the Chapter Representative in your area or region to inquire about upcoming meetings or events. New interests in New York City and Tampa, Florida are also listed, along with their respective contacts.

The process of starting a Chapter has a few requirements. Evaluating interest amongst your peers, whether within your institution, city or region is a first step. Networking this interest through the AVIR and industry sponsors can help promote an increased awareness, and potential members. The AVIR has a Chapter Committee, lead by the Director at Large, to help facilitate your needs. Reviewing the AVIR Chapter manual will also be necessary, as there are reporting requirements, CE application, and sponsorship information essential in having successful events. Selecting leadership, and organizing formal or informal meetings to discuss possible events and delegating the tasks that go along with AVIR sponsored CE presentations is important. Communicating those discussions and events to your constituents is important as well. Visit the AVIR website to access the Chapter Manual, and find the contacts of those who can help you be a success. The current website (www.avir.org) is being upgraded in the very near future. The AVIR is also hosted on Facebook, where meetings and events are posted, as well as blogs regarding practice and industry ideas. Visit us there as well.

Membership Breakdown
AVIR membership has reached its lowest period in the last decade in 2011, several factors I feel there are 2 major contributors to this.

• The Economy, plain and simple. Job market, home values, gas prices, etc. All affect how we see value in our daily lives. The AVIR wants to give you more bang for your buck, by offering educational opportunities (in various formats) and promoting the profession world-wide.

• Membership renewal period, in mid 2009, the renewal went from, July 1 to Jan 1, and a sharp decline happened as a result. Some members just didn't renew. If you know somebody like this. Please remind them.

Going forward the organization need to consider several options, dissolving the association, restructuring management/expectations, and membership expectations going forward. You can only run a non-profit in the red for so long, so offering more membership advantages, easy CE opportunities, up to date conferences and seminars, will hopefully drive membership up. As we begin to offer more features, study-guides, and resources, a cost increase will be suggested for 2013. The AVIR wants to be your main resource for CE and informational resources across the industry.

Unfortunately there were numerous areas that decreased in census; around 35% from 2010 to 2011. In that regard, members are needed everywhere. Our membership even stretches out to areas as far as Saudi Arabia, Hong Kong and Uruguay and Canada as well. Increasing our membership numbers, allows the AVIR to offer different on-line educational opportunities, as well as plan and develop regional meetings as well as the Annual Meeting with SIR and ARIN. Help promote the AVIR, in your labs and amongst your peers. Thank you for your continued support.
2011–2012 AVIR Board of Directors

Melissa Post, MBA, CRA, RT(MR)(CV)(CT), FAVIR
President
1706 Cumberland Ct
Waunakee, WI 53597
Work Phone: (608) 262-7549
Home Phone: (608) 335-3868
Email: mpost@uwhealth.org

Jaime Nodolf, RT(R)
Immediate Past President
3121 Prospect Drive
Sun Prairie, WI 53590-7010
Work Phone: (608) 890-6994
Home Phone: (608) 332-4425
Email: jnodolf@uwhealth.org

William “Tony” Walton RT(R)
Vice President/President Elect
8398 Windsor Drive
Mechanicsville, VA 23111
Work Phone: (804) 828-6986
Work Fax: (804) 828-7926
Cell Phone: (804) 244-1792
Email: Tonywalton.avir@gmail.com

Bill Greear, MHA, MBA, RT(R), (CV)
Secretary/Treasurer
11926 Red Sorrel Lane
Huntersville, NC 28078
Work Phone: (704)-304-5867
Fax: (704)-304-5197
Home Phone: 704-947-7002
Email: Bill.greear@carolinasehealthcare.org

Sven Phillips BS, RT(R)(VI)
Director at Large
2213 Canyon Trail
Carrollton, TX 75007
Work Phone: (972) 519-1426
Home Phone: (214) 483-6509
Email: sven427@yahoo.com

Jeffrey Kins, RT(R)(VI)
2010 Board Member
4201 White Heron Pt.
Portsmouth, VA 23703-5359
Work Phone: (757) 866-6520
Home Phone: (757) 686-9578
Email: jdkins@gmail.com

David S. Douthett, RT(R)(CV)
Marketing Chair
1304 Murray Drive
Chesapeake, VA 23322
Work Phone: (800) 447-7585 x1271
Fax: (757) 482-0473
Home Phone: (757) 620-2989
Email: ddouthet@its.jnj.com

Dana Bridges, RN
Associate Representative
1509 Fox Hollow Rd.
Greensboro, NC 27410
Work Phone: (336) 312-0095
Home Phone: (336) 856-7790
Email: dbridges@surgpro.com

Joni Schott, MBA, RT (R)(CT)
Program Chair
W3209 Schaefer Rd
Belleville, WI 53508-9660
Work Phone: (608) 263-4099
Fax: (608) 263-8297
Home Phone: (609) 424-6901
Email: JSchott@uwhealth.org

Karen Finnegan, MS, RT(R)(CV), FAVIR
2010 Board Member
1321 Elm Road
Baltimore, MD 21227
Work Phone: (410) 328-3694
Fax: (410) 328-2213
Home Phone: (410) 242-9242
Email: karenfinn12@aol.com
Our Board of Directors consists of President-Elect, Secretary/Treasurer, Director-at-Large, Past President, and Associate Representative. A requirement to be nominated for a Board position consists of being a current AVIR member and must have served on an AVIR committee for at least one (1) year. The following are a brief explanation of some of the responsibilities and commitments.

**President: Tony Walton.** This position is a non-voting position (unless there is a tie). Your second year responsibilities would include being the Chair of the Ethics and Judicial Committee, a member of the Finance Committee, a correspondent with all external organizations, and presidential correspondence. You are responsible for writing the “Presidents Message” for the newsletter, work with Immediate Past President on projects thus enabling a smooth transition. You conduct the Annual Business Meeting and are responsible for the agenda for all of the Board of Director meetings and conference calls. This year Tony Walton will move in as our new President as he transition out of VP and prior to that the Direct at Large. This will make Tony’s 3rd year on the board and we value his experience and knowledge as he carries on the torch.

**Vice President: Izzy Ramaswamy.** This is a voting position. Israel “Izzy” Ramaswamy was voted in by you all and comes to us from Miami, Florida where he works in the well known and prestige’s Baptist Hospital South Florida. Izzy has a Master of Science and has taken his CV when it was still with that title. He is currently working in leading within the Cardiovascular lab at Baptist. His resume is outstanding and has been involved with the AVIR in some status for the last 6 years. His first year responsibilities as VP would include being the Chair of the Education Committee, Chair of the Fellowship Committee, and a member of the Finance Committee. Will also attend all Board Meetings and conference calls, write newsletter articles, work closely with President for a smooth transition, and stand in for President whenever needed. This year will be exciting, for Izzy as he gets to get broke in with Tony.

**Past President: Missy Post.** This is a voting position. Your third and last year of commitment include being the Chair of the Nominating Committee, a member of the Finance Committee, and are responsible for the AVIR External Liaisons. You will write newsletter articles, work with President on projects from previous years, and attend all Board Meetings and conference calls. Missy Post after her years on the board will move into the Past President slot. She has a wealth of experience and has helped us thru these past couple years and we look forward to her continued management skills and direction for this board of directors.

**Secretary/Treasurer: Rob Sheridan.** One (1) year commitment. This is a voting position. Your responsibilities include chairing the Finance Committee and the Membership Committee. You will work closely with the home office on all Financial Reports, write newsletter articles, present a Finance report at Annual Business Meeting, and attend all Board Meetings and conference calls. This year Rob Sheridan was elected and is looking to carry out the mission to create a solvent organization.

**Director-at-Large: Jeff Kins.** One (1) year commitment. This is a voting position. Your responsibilities include being the Chair of Chapters Committee, a member of the Education Committee and the Finance Committee, assist with local chapter committees by answering questions and corresponding with local chapter members. You will write newsletter articles, present the Director-at-Large report at Annual Business Meeting, and attend all Board Meetings and conference calls. This year we welcome in Jeff Kins,
AVIR Board of Directors & Committees (con’t)

who comes to us with just a massive amounts of experience. He just recently and still actively supporting the educational Committee, where he was instrumental and getting us the RCEEM status. He has held the position of President of this organization once and now he is back with us. Helping get the Chapters in order and providing them with an outreach program.

**Associate Representative: Dana Bridges. One (1) year commitment.** This is a non-voting position and your responsibilities would include Chairing the Associate Representative Committee and attend all Board Meetings and conference calls. This position represents non-RT members. Dana Bridges will be this year’s Associate Representative.

These commitments might of seemed a bit more than what you were capable of at this time; so, there are Committees that need a strong representation of members. Please consider joining one or more of these committees. It is a great way to be involved in the decisions of the association.

Annual Program Committee: Andrew Amorossa chairs this committee. Plans and conducts the Annual and Regional Meetings of the Association.

Publications Committee: David Douthett chairs this committee. Develops and implements policies and guidelines regarding the relationship between the Association and publishers of professional journals and other publications in the field of Cardiovascular and Interventional Radiology. The committee oversees the newsletter and other publications of the Association.

Membership Committee: The Membership Committee is composed of active members who volunteer each year to serve as a sounding board for Association matters including, but not limited to membership, educational programs, sponsor relations, marketing and website assistance and chapter relations.

What is New, Be-Labored or Interesting!
David S Douthett RT R CV AVIR Editor

NOT SURE I BELIEVE THIS

**JACC: SPECT, PET & CTA have little impact on pre-cath patient testing**

Although post-imaging use of cardiac catheterization and medical therapy increased in proportion to the degree of abnormality findings, noninvasive testing had only a modest impact on clinical management of patients referred for clinical testing, according to the SPARC trial published in the Jan. 31 issue of the Journal of the American College of Cardiology.

**AR: Cardiac CT slices ED costs for patients with chest pain**

Cardiac CT (CCT) in the emergency department (ED) is more cost effective in evaluating patients with suspected acute coronary syndrome than the standard of care involving multiple tests and a stress SPECT scan, even when the downstream costs of CCT are considered, according to a study published in the March issue of Academic Radiology.

JACR: Is CT dose reduction optimal for RT planning?

In complying with CT dose reduction programs, radiologists should be aware that reduced-dose CT techniques may not be appropriate for all patients, particularly for radiotherapy planning CT scans, according to an article published in the February issue of the Journal of the American College of Radiology.

Radiology: Digital subtraction CTA gets high marks for assessing intracranial aneurysms

Digital subtraction CT angiography (CTA) should be the preferred noninvasive modality for evaluating intracranial aneurysms given the fact it has a high sensitivity and specificity, and is less invasive and time-consuming than 3D rotational digital subtraction angiography, according to a study published in the February issue of Radiology.

---

**continued on page 32**
# OUR NEWEST MEMBERS

## ACTIVE MEMBERS

<table>
<thead>
<tr>
<th>Name</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Laurence Assip</td>
<td>Bellerose, NY</td>
</tr>
<tr>
<td>Shanna Bandy</td>
<td>Coweta, OK</td>
</tr>
<tr>
<td>James Black</td>
<td>Schenectady, NY</td>
</tr>
<tr>
<td>Dondi Bondy</td>
<td>Thompson, ND</td>
</tr>
<tr>
<td>Christopher Boyer</td>
<td>Winter Park, FL</td>
</tr>
<tr>
<td>Crystal Broihahn</td>
<td>Madison, WI</td>
</tr>
<tr>
<td>Lisa Brooks</td>
<td>Pasadena, MD</td>
</tr>
<tr>
<td>Heather Causey</td>
<td>Wilmington, NC</td>
</tr>
<tr>
<td>Heidi Chermak</td>
<td>Topeka, KS</td>
</tr>
<tr>
<td>William Clark</td>
<td>Cooperstown, NY</td>
</tr>
<tr>
<td>Rachel Dagit</td>
<td>Metamora, IL</td>
</tr>
<tr>
<td>Donna Davidson</td>
<td>Coatesville, IN</td>
</tr>
<tr>
<td>Michelle De Palma</td>
<td>Phoenix, AZ</td>
</tr>
<tr>
<td>Valentine Domingo</td>
<td>Burbank, CA</td>
</tr>
<tr>
<td>Amber Graf</td>
<td>Racine, WI</td>
</tr>
<tr>
<td>Emily Grasmick</td>
<td>Shakopee, MN</td>
</tr>
<tr>
<td>Kimberly Henricksen</td>
<td>Pittsboro, CA</td>
</tr>
<tr>
<td>Ashley Hester</td>
<td>Pasadena, MD</td>
</tr>
<tr>
<td>Michael Idio</td>
<td>Burlingame, CA</td>
</tr>
<tr>
<td>Stephanie Jemmott</td>
<td>Glens Falls, NY</td>
</tr>
<tr>
<td>Ulene Jensen</td>
<td>Mapleton, UT</td>
</tr>
<tr>
<td>Lindsay Karl</td>
<td>Doylestown, PA</td>
</tr>
<tr>
<td>Sean Keating</td>
<td>Minneapolis, MN</td>
</tr>
<tr>
<td>Dawn Kesler</td>
<td>Pesotum, IL</td>
</tr>
<tr>
<td>Timothy Lambright</td>
<td>Everett, WA</td>
</tr>
<tr>
<td>Bruce Landau</td>
<td>Cream Ridge, NJ</td>
</tr>
<tr>
<td>Rebecca Levario</td>
<td>San Bernardino, CA</td>
</tr>
<tr>
<td>Allison Lofton</td>
<td>Minneapolis, MN</td>
</tr>
<tr>
<td>Angelo Lynch</td>
<td>Elk Grove, CA</td>
</tr>
<tr>
<td>Amy Maloney</td>
<td>Charlestown, MA</td>
</tr>
<tr>
<td>Sandi McInerney</td>
<td>Bremerton, WA</td>
</tr>
<tr>
<td>Nelly Moronta</td>
<td>Ridgewood, NY</td>
</tr>
<tr>
<td>Christine Nabbs</td>
<td>Medina, OH</td>
</tr>
<tr>
<td>Christopher Patnode</td>
<td>South Glens Falls, NY</td>
</tr>
</tbody>
</table>

## CLINICAL ASSOCIATE MEMBERS

<table>
<thead>
<tr>
<th>Name</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marilou Cicero</td>
<td>Madison, WI</td>
</tr>
<tr>
<td>Michael Daras</td>
<td>Scotland, MD</td>
</tr>
<tr>
<td>Agnes Larke</td>
<td>Madison, WI</td>
</tr>
<tr>
<td>Ackhadej Phoxay</td>
<td>Chicago, IL</td>
</tr>
<tr>
<td>Carrie Smeltzer</td>
<td>Elm Grove, WI</td>
</tr>
<tr>
<td>Kari Tilkens</td>
<td>Glendale, WI</td>
</tr>
</tbody>
</table>

## CORPORATE ASSOCIATE MEMBERS

<table>
<thead>
<tr>
<th>Name</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clarence Stueve</td>
<td>Lynnwood, WA</td>
</tr>
</tbody>
</table>

## STUDENT MEMBERS

<table>
<thead>
<tr>
<th>Name</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lauren Gross</td>
<td>Oak Creek, WI</td>
</tr>
</tbody>
</table>
CE Activities

Tony Walton RT(R)

There are lots of CE activities to choose from, conferences, directed readings, webinars, study programs, etc. Choosing what fits your lifestyle and professional needs usually determines a combination of CE methodologies that will help us meet our various registry requirements. Here is a rundown of some of the CE opportunities that are available. This information is also available on the new AVIR website at www.avir.org which has been re-designed with today’s education and professional resources in mind.

AVIR Chapters are also conducting CE activities. The Southeast Wisconsin Chapter (SEW) is having a one day, 8 CE conference on May 12th, and Virginia will hold one in the fall, see the Chapter News for more details and points of contact. Utilize the new website, which has separate chapter sections and resources to help in organizing these activities. If you need any assistance, contact either me or any board member.

Other methods of attaining CE’s are more labor intensive, but more flexible, like directed readings or study programs. Webinars are also available from Advance and VIVA 2012 is Offering 8 A+ CE Credits October 9–12, 2012 | www.vivapvd.com
Who is more special than those of us who work in Interventional Radiology? Seriously, as the decades of more formal angiography and interventional radiology have developed, IR physicians and technologists have been among the most flexible and creative practitioners. In the 1970’s, we were all about any “special‘ imaging”. Those were the years of myelograms, ventriculograms, sialograms, arthrograms, lymphangiograms, and, oh, yes, angiograms. We were all about these “grams”. Imaging was our thing. The quality of our film images were our trademark, and that’s how we were evaluated; on the quality of our diagnostic images and how well we could do subtractions. About the only thing we did to “fix” anything were those brachial cut-downs for IVC filter insertions! Some larger centers and university hospitals were beginning to embolize bleeds. Still, we were creative! We cut and hubbed catheters. We put forms in the tips and sent them to be sterilized, hoping that the process would mold the tip shape. We sharpened reusable needles on sandpaper. We washed our own trays, assembled them, and delivered them to central sterile.

When the 80’s rolled around, we started to think about fixing things. Those were the early years of angioplasty, stent development, non-vascular interventions particularly in the biliary tree and in kidneys. We started to ablate and embolize tumors. We experimented with lasers in the vascular tree. Toward the end of the decade, we started dilating lesions in dialysis fistulas, giving us a new population of patients to help. Our practice began the slow turn away from “grams” to interventions. Many of our grams (arthrograms, myelograms, etc) went away to other parts of radiology as we focused our sights on how to fix problems through the tubes we’d been using for imaging in earlier years.

The 90’s expanded that interventional spirit. Stent development was a huge focus, including the beginnings of stent grafts. Ablations continued to develop. TIPS, once an extensively long procedure, became common and much shorter. Urokinase became a commonly used drug for thrombolytic therapy. At the end of the decade, Urokinase was pulled from the market over concerns about production technique, shaping the way the next decade would develop. We created new arterial pathways when the original became impassible (SIR). New devices were hitting the market almost faster than we could keep up with them. Atherectomy devices and thrombectomy devices went through so many iterations, it was mind-boggling. Lasers hit the field again, with not much more success than in the 80’s. As CT and MR developed, there were those who predicted the end of our field. The reality was that even though we became even less about “grams”, CT and MR gave us more diagnoses to do interventions on. With the advent of digital image acquisition and PACS systems, we moved even more away from imagers and became interventional specialists in radiology.

As the year 2000 came around, we worried about how our computerized equipment would handle the change of the century. Having recovered from that very unimpressive crisis, we moved on again. TPA became our new thrombolytic drug. Device development slowed a bit in the 2000’s, and finesse became the name of the game. Better performing and smaller devices came out. Removable IVC filters changed the way we practiced prophylactic interventions. Stent Grafts received FDA approval. Oncological interventions for treatment and palliative care gained momentum. Theraspheres, Sirspheres, Chemoembolization, and central lines for pain management received our attention. Balloon-occluded retrograde transvenous obliteration (BRTO) became an alternative to TIPS. Oh yes, and we tried lasers, again! Now we’re in the 2010’s. Life as an interventional technologist is again changing. Collaboration across fields is common. We work not only with radiologists, but it is also common to work with surgeons, urologists, endoscopists, cardiologists, Nuclear Medicine professionals, and oncologists. We use many imaging formats including, but not limited to, ultrasound, CT, MR (IMRIS & Focused Ultrasound), many times in conjunction with our standard imaging equipment. We have articulated C-arms (Zeego) that allow us views we could never before obtain.
Procedurally, the door is also wide open. While we don’t convert many stent graft procedures, the setup to do so has allowed us to do amputations, jump grafts, and other surgical procedures in the IR suite. The limits of what we can become involved with seem endless. Who would have ever thought we would be involved with birthing babies? (Be sure to hear Dr. Sabri’s Placenta Accreta presentation at the Annual Meeting on Sunday!)

So, I ask you, now that we’ve reviewed all the changes that our field has gone through in recent history, would you not say we are “special”? Is there another modality in Radiology who has experienced so many changes, been as flexible, or survived so much culture change? Yes, we are special. And the procedures that we do are special. Our roots as “Special Procedures” are far extending and are the soul of who we are and what we do.

Anita J. Bell, MSM, BSRS, RT(R), FAVIR
Manager, Interventional Radiology
University of Virginia Health System
ajb2m@virginia.edu
office 434-982-3455
Blackberry 434-465-4967
Fax 434-243-5194

AVIR Launches New Website
www.AVIR.org

Featuring Your Membership hosting and new designs offering up-to-date features to enhance the AVIR Mission!

— Member Profiles
— Chapter Sites
— CE Opportunities (Conferences, readings, quizzes, etc.)
— Forums and Social links (Facebook and LinkedIn)
— Daily updates and news feeds
— Sponsor Links/Resources, and more!
The formation, development, or existence of a clot within the vascular system is referred to as a thrombosis. When a thrombus detaches from its original site, it is referred to as an embolus. A pulmonary embolus (PE) or thromboembolism occurs when a blood clot forms or becomes lodged in a pulmonary artery. The embolus is carried through the bloodstream and can ultimately occlude a vessel at a distance from its origin. Most commonly this occurs from a thrombus originating in a lower extremity known as deep vein thrombosis (DVT). The embolus migrates through the inferior vena cava, through the right atrium, right ventricle, and pulmonary trunk into a pulmonary artery and becomes lodged, resulting in an obstruction of blood supply to the lungs. The embolus may partially or completely occlude the artery, resulting in symptoms such as chest pain or shortness of breath. Pulmonary embolism is a life-threatening condition. In addition to clotted blood, an embolus can be formed from fat, air or tumor tissue.

A pulmonary embolus can change the pulmonary hemodynamics and the gas exchange capabilities of the lungs. Prolonged periods of inactivity or bed rest increase the risk for pulmonary embolism. Symptoms generally occur abruptly and include a sudden onset of coughing, chest pain and acute shortness of breath.

A laboratory test known as D-dimer enzyme-linked immunosorbent assays (ELISA) can play a valuable role in the workup for possible PE. This inexpensive blood test can be used as a screening tool for suspected PE. If D-dimer values are within the normal range, there is a very low likelihood of PE. Unfortunately, an abnormal D-dimer value does not confirm the presence of PE as many other causes may result in elevated D-dimer assays, including cancer, myocardial infarction, pneumonia, sepsis, and pregnancy. Therefore, this test is usually done with the understanding that an elevated value indicates the necessity for further diagnostic tests.

Pulmonary angiograms and nuclear perfusion and ventilation lung scans (VQ scan) have been commonly used in the diagnosis of a PE; however multidetector CT (MDCT) has proven to be a timesaving and cost-effective imaging modality for diagnosis of pulmonary emboli. MDCT technology allows scans to be obtained much faster, it also allows images to be obtained while contrast media in the pulmonary arteries is at its peak. In recent years MDCT angiography has become an imaging mainstay in the diagnosis of pulmonary embolism. MDCT scanners have expanded this trend with improved image quality and thinner slices to promote enhanced postprocessing reconstruction, excellent CT angiographic capability, and more rapid imaging to assist in scanning the distressed patient. CT pulmonary angiography is considered by most to be much better than traditional catheter or invasive pulmonary angiography. With traditional invasive pulmonary angiography the number of projections that can be obtained is limited as well as the potential of vessel overlap occurring and obscuring pathology.

A disadvantage of MDCT in the diagnosis of PE has to do with breathing motion artifacts. Breathing motion affects the peripheral and smaller arteries more than the bigger central arteries, although the central and segmental arteries can still usually be evaluated even in studies limited by...
patient breathing. Most institutions do their PE scanning protocols in the caudal-to-cranial direction. Respiratory motion, which is greatest at the lung bases, can make interpretation difficult. Patient breathing creates more motion at the diaphragm, but relatively little motion at the lung apices. Therefore, in cases in which the patient is unable to hold their breath for the entire scan, it is best to start the scan at the lung bases. Scanning in a caudal-to-cranial direction minimizes respiratory artifacts.

The prognosis is dependent on the size and location of the PE as well as the patient’s prior cardiovascular status. Thrombolytic therapy such as streptokinase, urokinase or tissue plasminogen activator (tPA) and placement of inferior vena cava filters may be used in the treatment of PE. Sometimes a pulmonary embolectomy may be necessary.

Anticoagulant therapy such as heparin or warfarin after the initial episode will be indicated because it decreases the probability and intensity of recurrent pulmonary emboli. Approximately 50% of patients who survive the initial PE will demonstrate a recurrent episode.

Thrombolytic therapy (streptokinase, urokinase) is used in life-threatening cases, and the administration of thrombolytic therapy is performed in the cardiovascular or interventional area of the department. In less severe cases, patients may be treated with anticoagulation medications. A severe pulmonary embolism is the 3rd leading cause of death in hospitalized patients. PE is a relatively common condition. At least 100,000 cases of PE occur each year in the United States. Untreated PE’s result in a 30% death rate. After diagnosis and treatment, the death rate drops dramatically. Compared with PE, DVT is less difficult to diagnose, and alone it very rarely causes death.

References:

CMS: More Data Needed on Best Management of Blocked Carotid Arteries

The Centers for Medicare & Medicaid Services (CMS) held a meeting Jan. 25 with the hope of strengthening carotid atherosclerosis management. During said meeting, the Medicare Evidence Development & Coverage Advisory Committee (MEDCAC) voted on evidence, procedures and the most beneficial strategies for the management of atherosclerosis to prevent stroke, with most members agreeing that more data are necessary.

Currently, CMS covers carotid artery stenting for patients at a high risk of adverse events from carotid endarterectomy (CEA) for:
- Symptomatic patients with a stenosis greater than or equal to 70 percent;
- Symptomatic patients with a 50 to 70 percent stenosis when procedures are performed in FDA approved category B Investigational Device Exemption (IDE) trials or FDA approved post approval studies;
- In asymptomatic patients with greater than 80 percent stenosis when procedures are performed in FDA approved trials.

Members looked at both symptomatic and asymptomatic patient populations to discuss whether carotid artery stenting (CAS), CEA and optimal medical therapy (OMT) improved outcomes in atherosclerotic patients. Additionally, CMS looked to understand whether previously published data on the topic are generalizable to the Medicare population.
Members voted on six questions and used the following responses: low confidence, intermediate confidence or high confidence. Questions dealt with whether CAS or CEA is the favored treatment strategy in certain patient populations, previous data outlining the benefits/risks of CAS or CEA as opposed to OMT and what should be done in the future, among others.

During the meeting, William A. Gray, MD, associate professor of Medicine at the Columbia University Medical Center in New York City, said the “concept of a ‘low-risk’ patient has not clearly been defined, nor identified.” Additionally, Gray said that to date, there are no trials that assess patients who are at a high surgical risk, and that post-trial CEA outcomes cannot be generalizable to those who were not enrolled in the trial.

Gray said that in symptomatic patients, CEA and CAS “appears equivalent” in terms of outcomes and stroke in the CREST trial, but noted women did better with CAS compared with CEA in the EVA-3S and ICSS trials.

Lastly, Gray said that the “correct cocktail of medical class” is missing in asymptomatic patients to determine the most optimal medical therapy to treat those with carotid artery disease. “The role of medical therapy remains a tantalizing but unproven alternative to revascularization in patients with established severe carotid stenosis,” Gray said in a statement.

Meanwhile, Robert M. Zwolak, MD, PhD, of the Dartmouth-Hitchcock Medical Center in Lebanon, N.H., looked at the real-world results of CAS and CEA during a presentation at the meeting, and concluded that real-world results are not always comparable to what is found in randomized controlled trials.

Zwolak used 30-day stroke and death rates post-CAS and CEA from the SVS Registry as an example. Of 1,450 CAS patients and 1,368 CEA patients, the combined rates of stroke, death and MI were nearly 6 percent for CAS patients compared with nearly 3 percent in CEA patients. The 30-day stroke rates for CAS and CEA for asymptomatic patients were 2.11 percent vs. 1.28 percent, and 5.27 percent vs. 2.37 percent in symptomatic patients. Based on a Nationwide Inpatient Sample analysis, Zwolak reported that stroke and death rates in high surgical risk patients to be nearly two times higher after CAS vs. CEA.

“Even after risk-factor adjustment, stroke risk is likely greater after CAS in population-based studies,” Zwolak said.

When asked to vote on whether there is accurate evidence to determine whether or not CEA or CAS is the favored treatment as compared to optimal medical therapy in the Medicare population, the majority of the voting body said they had low- to intermediate- confidence about the data. This question was asked about asymptomatic patients not considered high risk for adverse events with CEA.

All voting members said that they had low confidence that CAS would be the favored treatment strategy in asymptomatic carotid atherosclerosis patients who were not at high risk for stroke. However, many said they had high confidence that optimal medical therapy alone should be the favored treatment strategy in this patient population.

All in all, the majority of the panelists agreed that more data are necessary to better define the best treatment strategy—CEA, CAS or OMT—for atherosclerotic Medicare patients.
The CARE Bill 2012

Karen Finnegan

The CARE bill was reviewed in August, 2011 by the Alliance for Quality Medical Imaging and Radiation, which is a coalition of 25 other health care organizations, including the AVIR. Over 500,000 health care professionals are represented by the Alliance. The ASRT has taken the lead in this effort and has shouldered the majority of the financial burden of trying to pass this bill; however, if it does not pass this year they may not be so generous next year.

The purpose of this review was to tweak the bill in preparation for submission to the House of Representatives. This continuing review insures that the bill stays current with all the new technologies and professions that have emerged over the 25 year history of this piece of legislation.

The House Bill (H.R. 2104) was introduced by Rep. Edward Whitfield (R-KY) and has 66 co-sponsors. The Bill has been referred to the following committees:

- House Energy and Commerce
- House Energy and Commerce, Subcommittee on Health
- House Ways and Means
- House Ways and Means, Subcommittee on Health

To reiterate the purpose of the Care Bill is: To amend the Public Health Service Act and title XVIII of the Social Security Act to make the provision of technical services for medical imaging examinations and radiation therapy treatments safer, more accurate, and less costly. In reality, that means the public will benefit from being cared for by properly educated and certified radiologic personnel. The current lack of uniform educational standards nationwide for operators of radiologic equipment poses a hazard to the public states the ASRT.

The Joint Commission is also taking a firm stand on the radiation risks of diagnostic imaging through a Sentinel Event Alert published in August, 2011. This Alert focuses on diagnostic radiation and does not cover therapeutic radiation or fluoroscopy. As a result of the potential dangers associated with ionizing radiation, the Centers for Medicare & Medicaid Services (CMS) will require the accreditation of facilities providing advanced imaging services (CT, magnetic resonance imaging (MRI), positron emission tomography (PET), nuclear medicine) in non-hospital, freestanding settings beginning January 1, 2012.

Download the article here on the AVIR website: Sentinel Event Alert www.avir.org

VDF: Vascular Disease Foundation
Taking on the Current Issues in Vascular Disease

This new formed group is a combination of several groups that have come together to jointly take a stake in vascular disease. This multidisciplinary nonprofit organization is dedicated to public education and the promotion of awareness of vascular diseases, as well as to development of initiatives that improve the health and care of patients afflicted with arterial or venous disease. The two main groups that have come together with this new VDF are the PAD Coalition and the Venous Disease Coalition.

PAD Coalition is actually an alliance of more than 80 professional societies (one which is the AVIR) along with health organizations, government agencies and corporations. They together have developed many different things, but most recently have come up with an online interactive patient workbook (www.myPADguide.org) The group is active in lobbying on Capitol Hill and has had luck lately with evaluating reimbursement for ABI testing. They are creating a national awareness campaign for CLI and reduce the impact of limb-threatening, late stage PAD.

Venous Disease Coalition, an alliance of health professional societies and patient advocacy groups that have united to improve the survival rates and quality of life for individuals with, or at risk for, venous disease, also has developed online patient resources. The coalitions’ efforts have led to develop a public awareness program educating the public on venous disease.

VDF is undergoing reorganization and revamping of its Web site and the introduction of a new logo. VDF provides numerous resources for public education, including its newsletter, Keeping in Circulation, as well as many online resources.
Peripheral artery disease (PAD) may have a lower public profile than coronary heart disease (CHD), but like CHD, PAD affects women at high rates. And like CHD, PAD left unmanaged contributes to morbidity, mortality and high healthcare costs, according to a scientific statement published online Feb. 15 in Circulation. “There was a time when people thought PAD was a disease of men,” Alan T. Hirsch, MD, chair of the writing committee that summarized current evidence and challenges of PAD in women, said in an interview. “That myth is busted.”

“A Call to Action: Women and Peripheral Artery Disease” was commissioned by the American Heart Association (AHA) to shed light on the impact of PAD on women and facilitate efforts to better inform clinicians, women, healthcare policy-makers and payors. The statement includes a summary of the epidemiological burden of PAD on women, the associated cardiovascular risk of ischemic events, symptom classes and clinical presentations/treatments. It also highlights the gaps in gender-specific knowledge and lack of awareness among women, and concludes with a list of recommendations.

More women than men in the U.S. who are 40 years old or older have PAD, but neither they nor physicians may be aware of their disease burden, according to the statement. The authors noted that in the past, failure to recognize the impact of coronary disease on women left women uninformed that they were at risk of CHD. Unaware and unmanaged, those women were exposed to potentially preventable sickness and death. Campaigns to educate the healthcare community, women and their families about gender-related aspects of cardiovascular disease and stroke have helped boost research, diagnosis and treatment of women.

“Every cardiovascular practitioner is probably embarrassed in retrospect that we all, men and women alike, are now aware that for decades women were under-informed regarding heart disease risk,” said Hirsch, a professor of medicine, epidemiology and community health at the Lillehei Heart Institute at the University of Minnesota Medical School in Minneapolis. “That gender bias and lack of knowledge regarding heart disease presentations in women occurred in a disease that was in the spotlight—heart attacks. Therefore, it certainly was not surprising to consider that for an equally common but less well known disease—PAD—such gaps would coexist.”

PAD affects approximately eight million Americans and is associated with significant morbidity and mortality. PAD is considered a marker for systemic atherosclerotic disease and while it shares many risk factors with CHD, smoking and diabetes mellitus are stronger risk factors for PAD than CHD (Circulation 2011;123:e18-e209).

Gaps in scientific knowledge continue to vex the healthcare community, including an incomplete evaluation of gender-specific prevalence of PAD. The authors noted the need for PAD research to tease out gender-based differences in disease development, clinical presentation, diagnostic testing and treatments.

Among their recommendations, they called for clinical trials that include women participants at rates that reflect prevalence of PAD in the patient population. The authors noted that many studies were inadequately powered for detecting gender-based differences in outcomes or rates of adverse events.

“There shouldn’t be 20 or 30 percent women in a PAD clinical trial; there should be more than 50 percent,” Hirsch pointed out. “Their sample size should represent the population and be large enough that if a woman had a different preference than a man—hypothetically, for example, a greater focus on exercise than on stenting—then it could be known by asking.”

Other research-related recommendations included:

- Basic research on the impact of gender on the vascular biology of atherosclerotic and aneurysmal disease;
- Prevalence studies with clearly defined methodology and gender-specific analyses; and
- Studies on diagnostic tools with sample sizes to evaluate sensitivity, specificity and accuracy.

Public awareness of PAD is low, impeding prevention and early treatment opportunities. Earlier campaigns rallied women to help amplify messages about the prevalence and...
risk of heart disease in women, Hirsch said, an approach that may be effective for PAD as well. The AHA’s Go Red for Women is participating in dissemination efforts, he added.

The authors also targeted clinical settings, recommending that:

- Primary care physicians and gynecologists follow current national guidelines on the use of the ankle-brachial index to identify women at risk of PAD;
- Healthcare professionals educate women about PAD risk factors, including cardiovascular risks, and symptoms;
- Heart health initiatives add PAD to their awareness and prevention campaigns; and
- Ensure women at risk of PAD receive appropriate testing.

“Beyond Go Red for Women, will health systems, medical societies, government agencies and payors take the task seriously?” Hirsch asked. “This has yet to be determined. As a hallmark lesson from the work of this writing committee, it should be impressive to women, payors and health systems that currently there are more than one million women seeing clinicians for PAD care—that is equal to stroke—at a time that we know simultaneously that only one fourth of women are aware of PAD’s risk. This burden is high.”

Hirsch added that a societal push to lower exposure to PAD risk factors such as smoking and obesity was feasible.

“A Call to Action: Women and Peripheral Artery Disease” was endorsed by the Vascular Disease Foundation and its Peripheral Artery Disease Coalition. The authors contributed on behalf of numerous cardiovascular councils, including nursing, radiology and intervention, surgery and anesthesia, clinical cardiology and others.

What Goes Around, Comes Around…. By Bill Greear, RT-R (CV), FAVIR

Once again we find ourselves gathering for our Annual AVIR Meeting and this year’s location is in beautiful San Francisco. San Fran has seen the likes of many historic events ranging from the mighty Gold Rush to more recently becoming one of the most diverse and eclectic city in the U.S. Similarly the AVIR has a little bit of history in that it has seen a lot of change. Along with our nation and government the AVIR has experienced a bit of a downswing and now the future is looking much brighter. At this years conference I think you will see and feel a new passion for the AVIR and its mission. New members on the board and a new energy surrounding the organization. As an “Old Timer” I am encouraged to see new board members joining the ranks of Secretary Treasurer and Director at Large among others. It is with this new passion that the AVIR will continue to expand and reach out to new members and continue its professional growth.

Recently I think the AVIR has become very aware of how volatile our little society really is… With the economic strains come lesser funding from our vendors, fewer registrations at the annual conference and a decline in membership. With this comes concern and responsibility. I can say with little hesitation that the AVIR Board of Directors has adjusted many goals and objectives to meet these demands. The AVIR continues to look for ways to do things differently now than we did 5-10 years ago. A lot of these changes you will see and hear about at the annual meeting. A new website, new CEU opportunities, ways to inform others about our profession and how to become a member are all areas that a lot of energy is being spent to improve.

One area that we are thankful to see is a bit of an increase is our Vendor Educational Grants. For many years the AVIR enjoyed the luxury of having successful fund raising efforts and aligning ourselves with many Interventional Product companies that had a common interest. Through the years and through acquisitions and mergers the funding almost became non-existent. Many lean years were experienced and new partner relationships had to be formed to re-align the allegiances that once lead to a stable source of educational funding for the AVIR. This year I am proud to announce that the Vendor support is trending up again and the AVIR is once again seeing stability. Please take every opportunity to thank your local vendors and sales representative for their support. If they do not know about the AVIR please take the time to educate them on how important our educational needs are to our members and attendees. Without their support there would be no AVIR. I am encouraged and delighted to report that we are stepping back on stable ground.

If you are attending the annual conference please look to program schedule and attend the Annual Business Meeting. At this session you will have a chance to meet the new Board Members, hear a little about the financial status and see a number of new things that will be coming out in 2012. Personally I am encouraged and grateful that we have weathered what we hope is a passing storm and we are poised to look to the future which is extremely bright.

Hope you have fun in San Francisco!!
SATURDAY, MARCH 24, 2012
8:00 AM – 8:30 AM  Continental Breakfast
8:30 AM – 11:30 AM Back to the Future… Basic I.R. Workshop*
Stephen B. Haug, RT(R)(CV)
Bob Grouden
11:30 AM – 12:30 PM Imaging Device Lunch Symposium
12:30 PM – 3:30 PM Back to the Future… I.R. Workshop and Beyond*
Stephen B. Haug, RT(R)(CV)
Bob Grouden

SUNDAY, MARCH 25, 2012
7:00 AM – 8:00 AM  Continental Breakfast
8:00 AM – 8:15 AM  President’s Welcome
8:15 AM – 9:15 AM  Research Initiatives in IR
John F. Angle, MD
Andrew Amorosso, RT
10:15 AM – 10:30 AM Break
10:30 AM – 11:30 AM CCVIS
Kenneth Mandato, MD
11:30 AM – 1:00 PM Imaging Device Lunch Symposium
1:00 PM – 2:00 PM Placenta Accreta
Saheer S. Sabri, MD
2:00 PM – 3:00 PM Pediatric IR
Speaker TBA
3:00 PM – 4:00 PM BRTO of Gastric Varicies: Concepts and Techniques
Wael E. Saad, MD, FSIR
4:00 PM – 4:15 PM Break
4:15 PM – 5:15 PM SIRs
Constantinos T. Sofocleous, MD, PhD, FSIR

MONDAY, MARCH 26, 2012
7:30 AM – 8:00 AM  Continental Breakfast
8:00 AM – 9:00 AM  Gold Medal Lecture
Alan H. Matsumoto, MD, FSIR, FACP, FAHA
9:00 AM – 10:00 AM Spot Light Lab – A Hybrid Suite
Robert M. Sheridan, RT(R)
10:00 AM – 10:15 AM Break
10:15 AM – 11:15 AM Y90 Room Set-Up
Sanjeeva P. Kalva, MD
11:15 AM – 12:15 PM Techs, RNs, MDs
Panel Discussion
TUESDAY, MARCH 29, 2011

7:30 AM – 8:00 AM  Continental Breakfast
8:00 AM – 9:00 AM  Radiation Dose Management and Operator Protection
                    Robert G. Dixon, MD
9:00 AM – 10:00 AM  The New Health Plan and How It Will Affect Our Jobs
                    David Rosman, MD, MBA
10:00 AM – 10:30 AM  AVIR Business Meeting
10:30 AM – 11:30 AM  Embolization
                    Gary P. Siskin, MD, FSIR
11:30 AM – 1:00 PM  Imaging Device Lunch Symposium
1:00 PM – 2:00 PM  Vendor Compliance
                    Tammy Leitsinger
2:00 PM – 3:00 PM  CIT Review (continued)
                    Deborah Scroggins, MSRS(R)(CT)(CV)(M)
2:00 PM – 3:00 PM  Manager Talk
                    Michael Tom, RT(R)(CV), FAVIR
3:00 PM – 3:15 PM  Break
3:15 PM – 4:15 PM  CIT Review (continued)
                    Deborah Scroggins, MSRS(R)(CT)(CV)(M)
3:15 PM – 4:15 PM  Non-Surgical Treatment of Cerebral Aneurysms
                    Alexander Norbash, MD
4:15 PM – 5:15 PM  CIT Review (continued)
                    Deborah Scroggins, MSRS(R)(CT)(CV)(M)
4:15 PM – 5:15 PM  Stroke
                    Lora Cheek, RN

WEDNESDAY, MARCH 30, 2011

7:30 AM – 8:00 AM  Continental Breakfast
8:00 AM – 9:15 AM  Bone & Lung Ablations
                    Majid Maybody, MD
                    William Alago, Jr., MD
9:15 AM – 10:15 AM  Pet Guided Ablations
                    Ronan Ryan, MD
10:15 AM – 10:30 AM  Break
10:30 AM – 11:30 AM  Extreme IR – A Trip Through the Doctor’s Mind
                    Paul Christy, MD
11:30 AM – 1:00 PM  Imaging Device Lunch Symposium
1:00 PM – 2:00 PM  Trauma
                    Seyhan O. Senler, MD
2:00 PM – 3:00 PM  Vascular Interventions
                    Rahul S. Patel, MD
4:00 PM – 5:00 PM  IV Therapy in Radiology
                    Kimberly DuBore, RN, BSN
AVIR ANNUAL SCIENTIFIC MEETING SPONSORS

**GOLD MEDAL SPONSORS**

- COVIDIEN
- SIEMENS

**SILVER MEDAL SPONSORS**

- BARD PERIPHERAL VASCULAR
- BRACCO LIFE FROM INSIDE
- COOK MEDICAL

**BRONZE SPONSORS**

- Abbott Vascular
- Owens & Minor
- Creative Technologies Worldwide
- CMS IMAGING INC
- GORE
- Cordis CARDiac & VASCULAR INSTITUTE
- ANGIODYNAMICS
- GE

**FRIENDS OF AVIR SPONSORS**

- Boston Scientific
- BIBRAUN
- CAREfusion
- St. Jude Medical
- CELO NOVA BIOSCIENCES
- SurgPro Medical Device Distributor
CE Activities (con’t)

GE. There are numerous resources, some being more cost effective than others. ASRT, Advance, Gage and others offer partial and full courses of study. The AVIR recently received the RCEEM A+ rating from the ARRT, allowing us to accredit educational courses and programs. I envision offering a choice of 20 plus readings online, online quizzes, webinars, CE tracking, and industry sponsored CE’s, all free to active and associate memberships. Increasing the educational value and providing profession oriented networking capabilities, will help the AVIR support it’s members and further the profession.

Coding Update for AV Grafts

All balloon angioplasty of the AV dialysis access is coded with one set of angioplasty codes, no matter how many focal stenosis are treated within the AV dialysis circuit. The majority of the time, this is a venous angioplasty code and would be reported using 35476/75978. However, if the stenosis in the AV fistula or graft that is treated is at the arterial anastomosis, it may be coded with arterial angioplasty codes 35475/75962. This code would then apply to all other stenoses treated within the AV dialysis “vessel.” In other words, all angioplasty within the AV dialysis circuit (considered from the peri-anastomotic vessels near the arterial anastomosis through the axillary vein) would be coded with either 35475/75962 or 35476/75978. The appropriate code is chosen on the basis of whether a true arterial anastomotic stenosis is treated.

The 2012 AVIR Annual Conference will be Offering Over 30 A+8 CE Opportunities

www.avir.org

GEST 2012 will be Offering over 25 A+* CE Credits

www.gestweb.org
**ARRT Designates AVIR as RCEEM+**

(February 2, 2012) – The Association of Vascular and Interventional Radiographers (AVIR) has been designated a RCEEM+ by the American Registry of Radiologic Technologists (ARRT), making it the fourth Recognized Continuing Education Evaluation Mechanism Plus (RCEEM+) that is authorized to review and approve CE activities for A+ credit. AVIR was originally designated a RCEEM in July 2009.

The A+ designation is awarded to CE activities at the level of and intended for mid-level providers such as Registered Radiologist Assistants (R.R.A.s) or Nuclear Medicine Advanced Associates. Category A+ CE credits are also open to Registered Technologists (R.T.s), who are permitted to report as many A+ CE credits as they wish.

RCEEM and RCEEM+ organizations follow ARRT continuing education policies and assist ARRT during investigation of any inconsistencies regarding CE. Any RCEEM+ designee must first meet the standard requirements for becoming a RCEEM (e.g., national, not-for-profit, radiology based) and have a proven track record as a RCEEM.

To become a RCEEM+, organizations must further demonstrate:

1. The need for an additional RCEEM+;
2. Thorough understanding of the scope of practice for the R.T., the radiologist extender, and the physician; and

A complete list of RCEEMs and RCEEM+s can be found at [www.arrt.org/registration/RCEEMs](http://www.arrt.org/registration/RCEEMs). In addition, ARRT recognizes the evaluation processes (for Category A CE credit) of the following states that have continuing education requirements in their licensing laws: Florida, Illinois, Iowa, Kentucky, Massachusetts, New Mexico, Oregon, and Texas. For more information, see ARRT’s [Continuing Education Requirements for Renewal of Registration](http://www.arrt.org/registration/RCEEMs).

About ARRT

The American Registry of Radiologic Technologists promotes high standards of patient care by recognizing qualified individuals in medical imaging, interventional procedures, and radiation therapy. Headquartered in St. Paul, Minn., ARRT evaluates, certifies, and annually registers more than 300,000 radiologic technologists across the United States. For information, visit [www.arrt.org](http://www.arrt.org).
An Addition to the Lower Extremity Solutions Portfolio

Cordis SLEEK® Over-The-Wire PTA Dilatation Catheter

An 0.014” catheter with excellent pushability and a small crossing profile!

Available in:
• **1.25 - 5mm diameters**
• **15 - 220mm lengths**

Access the AVIR Website www.avir.org
Articles and tests are posted under Members Only
Mail or fax the completed test to AVIR
12100 Sunset Hills Road
Suite 130 Reston, Virginia 20190
FAX 703.435.4390 PHONE 703.234.4055 E-MAIL info@avir.org
If you have suggestions for other AVIR projects, please let us know!
<table>
<thead>
<tr>
<th>MEETING</th>
<th>ACYRN</th>
<th>WEB SITE/ PHONE</th>
<th>LOCATION</th>
<th>DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Houston Aortic Symposium: Frontiers in Cardiovascular</td>
<td></td>
<td>promedicacme.com</td>
<td>Westin Oaks Hotel, Houston TX</td>
<td>March 22-24 2012</td>
</tr>
<tr>
<td>36th SIR Annual Meeting</td>
<td>SIR</td>
<td>SIR.org</td>
<td>San Francisco</td>
<td>March 24-29, 2012</td>
</tr>
<tr>
<td>21st Annual AVIR Scientific Meeting</td>
<td>AVIR</td>
<td>avir.org</td>
<td>San Francisco</td>
<td>March 22-29, 2012</td>
</tr>
<tr>
<td>34th Charing Cross International Symposium</td>
<td>CXS</td>
<td>cxsymposium.com</td>
<td>London UK</td>
<td>April 14-17 2012</td>
</tr>
<tr>
<td>2012 AUIM Annual Ultra Meeting</td>
<td>AUIM</td>
<td>auim.org</td>
<td>Phoenix, AZ</td>
<td>March 29-April 1, 2012</td>
</tr>
<tr>
<td>2012 ATA Annual TeleHealth &amp; mHealth Meeting</td>
<td>ATA</td>
<td>ata.org</td>
<td>San Jose, CA</td>
<td>April 29-May 1 2012</td>
</tr>
<tr>
<td>ISRRRT World Congress</td>
<td>ISRRRT</td>
<td>2012isrrt.org</td>
<td>Toronto, Canada</td>
<td>June 7-10 2012</td>
</tr>
<tr>
<td>PICS &amp; AICS 2012</td>
<td>PICS</td>
<td>picsymposium.com</td>
<td>Marriott Downtown, Chicago, IL</td>
<td>April 12-15 2012</td>
</tr>
<tr>
<td>Chicago EndoVascular Conference</td>
<td>CVC</td>
<td>cvcpvd.com</td>
<td>Marriott Downtown, Chicago, IL</td>
<td>July 19-21, 2012</td>
</tr>
<tr>
<td>SNIS 10th Annual Meeting</td>
<td>SNIS</td>
<td>snisonline.org</td>
<td>New York, NY</td>
<td>April 27-28 2012</td>
</tr>
<tr>
<td>Concepts in Contemporary Cardiovascular Medicine Symp</td>
<td></td>
<td>cardiovascularconcepts.org</td>
<td>Hilton of Americas; Houston TX</td>
<td>May 1-3 2012</td>
</tr>
<tr>
<td>GEST 2012</td>
<td>GEST</td>
<td>gestweb.org</td>
<td>Sheraton New York Hotel, New York</td>
<td>May 3-6 2012</td>
</tr>
<tr>
<td>Vascular Access for Hemodialysis</td>
<td>VASA</td>
<td>vasamd.org</td>
<td>Ritz Carlton; Orlando, FL</td>
<td>May 9-11, 2012</td>
</tr>
<tr>
<td>Cardiovascular and Interventional Radiological Society of Europe</td>
<td>CIRSE</td>
<td>cirse.org</td>
<td>Lisbon, Portugal</td>
<td>September 15-19 2012</td>
</tr>
<tr>
<td>VIVA 2012</td>
<td>VIVA</td>
<td>vivapvd.com</td>
<td>Wynn, Las Vegas</td>
<td>October 9-12, 2012</td>
</tr>
<tr>
<td>Transcather Cardiovascular Therapeutics</td>
<td>TCT</td>
<td>tctconference.com</td>
<td>Miami Beach FL</td>
<td>October 22-26 2012</td>
</tr>
<tr>
<td>Radiological Society of North America</td>
<td>RSNA</td>
<td>rsna.org</td>
<td>Chicago, IL</td>
<td>Nov. 26-Dec 1, 2012</td>
</tr>
</tbody>
</table>
JACC: CT trumps 2D echo for valve replacement

There could be a new gold standard for aortic annular evaluation before transcatheter aortic valve replacement (TAVR) as 3D CT imaging has been shown to be superior to 2D transesophageal echocardiography (TEE), according to a study published Feb. 22 online in the Journal of the American College of Cardiology.

ANYBODY THAT HANGS OUT IN CATH LABS MAY BELIEVE THAT YOU COULD GET RADIATION POISON AT LEAST

JACC: What are the real dose risks with cardiac imaging?

With the growth of cardiac imaging, there has been heightened concern about the resulting increased exposure to ionizing radiation. Andrew J. Einstein, MD, PhD, of Columbia University Medical Center and New York-Presbyterian Hospital in New York City, outlined the currently available research on radiation exposure in cardiac imaging in the Feb. 7 issue of the Journal of the American College of Cardiology and concluded that while strong data specifically addressing the risks of cancer from cardiac imaging don’t exist, increased risks can be projected from studies involving similar levels of radiation exposure.

SURE THIS WILL HAPPEN! RIGHT

HIMSS: ICD-10--ready or not?

Amidst the evolving timeline for a transition to ICD-10, the prospect of postponement is a plus, Robert S. Gold, MD, CEO of DCBA in Atlanta, said during a Feb. 20 session focused on documentation improvement at the 2012 Healthcare Information Management and Systems Society (HIMSS) annual conference.

MAYBE NOT:

AMA to House Speaker Boehner: Stop ICD-10

American Medical Association CEO James L. Madara, MD, wrote to House Speaker Boehner (R-Ohio) to urge him to take action against the implementation of ICD-10, informing him that the transition to ICD-10 as mandated by HIPAA would place a heavy burden on physicians without offering a direct benefit to individual patient care.

SO:

AHIMA recommends providers keep working on ICD-10 implementation

The American Health Information Management Association (AHIMA) urged the healthcare community to continue preparing for the transition to the ICD-10 classification system, warning that the U.S. Congress may not act on requests to stop ICD-10 implementation and let stakeholders design and adopt a new classification system to replace ICD-9-CM.

WATCH YOUR BACK – SOMEONE MAYBE WATCHING – now even the FDA has to be careful

Alleging internal spying, six whistleblowers take FDA to court

Six current and former employees of the FDA—all scientists and physicians who worked on reviewing medical devices—have filed suit against the agency, accusing it of spying on their computer activities. The six allege that they were placed under secret surveillance because they had warned Congress that FDA was hastily approving risky devices.

Sen. Grassley asks FDA for details on employee monitoring

Sen. Chuck Grassley (R-Iowa) wrote to FDA Commissioner Margaret Hamburg, MD, asking her why the agency accessed an alleged whistleblower’s emails in an instance that appears to be an act of retribution.

WHO, that is that has had one, WOULD LIKE TO QUIT GETTING ENDOSCOPED?

GE invests in ingestible imaging capsule maker

GE Capital and GE Healthcare have invested in Check-Cap, developer of an ingestible imaging capsule that may help detect colorectal cancer.
Radiology: Virtual colonoscopy effective screening tool in older patients

CT colonography, also known as virtual colonoscopy, can be used as a primary screening tool for colorectal cancer in adults over the age of 65, according to a study published online Feb. 23 in Radiology.

REALLY! TELL ME IF YOU THINK THIS WILL REALLY WORK? GIVING MORE MONEY TO AN ALREADY ….. well you get my point.

Device makers agree to pay double for better FDA performance

Manufacturers of medical devices have agreed to pay substantially higher fees to the FDA in exchange for speedier and more predictable reviews, according to a news release from the agency. The deal, which needs to be approved by Congress, would double the dollars kicked in by industry—to $595 million over the next five years, up from $295 million over the past five years, according to multiple sources.

AND JUST A LITTLE MORE ON POURING MORE MONEY INTO A SYSTEM THAT HM MMMM I THOUGHT THE GOVERNMENT WAS ALREADY PAYING THEM. WELL NOTHING LIKE GETTING PAID TWICE. Oh this is Obama Care at its best.

FDA and Industry Reach Agreement in Principle on Medical Device User Fees

February 1, 2012—The US Food and Drug Administration (FDA) announced that the agency and representatives from the medical device industry have reached an agreement in principle on proposed recommendations for the third reauthorization of a medical device user fee program. The industry associations that have reached the agreement with the FDA include the Advanced Medical Technology Association (AdvaMed), the Medical Device Manufacturers Association, and the Medical Imaging and Technology Alliance.

The recommendations would authorize the FDA to collect $595 million in user fees over 5 years plus adjustments for inflation. Details of the agreement, such as the fee structure, are expected to be finalized soon, the FDA stated.

According to the FDA, under a user fee program, industry agrees to pay fees to help fund a portion of the FDA’s device review activities while the FDA agrees to overall performance goals such as reviewing a certain percentage of applications within a particular time frame.

The FDA advised that when the final details of the agreement with industry are completed, the agency will develop a package of proposed recommendations and give the public an opportunity to comment before they are submitted to Congress. The date of the public meeting has yet to be determined.

AdvaMed noted that in addition to reducing the total review time on a premarket approval (PMA) application or a 510(k) submission, the performance goals in the agreement would:

• Achieve significant performance improvements for PMA and 510(k) applications relative to current performance;
• Leave “no submission behind” by requiring the FDA to meet with companies if a performance goal on a PMA or 510(k) is missed and work out a plan for completing work on the submission;
• Provide a substantive interaction with applicants halfway through the targeted time for completion of review, thus ensuring that a company can have time to properly respond to appropriate questions; and
• Implement an analysis of the FDA’s management of the review process by an independent consulting organization, coupled with an FDA corrective action plan to address opportunities for improvement.

NOW SHOULD WE PUT UP BILLBOARDS

Webinar: Providers should more readily adopt social media

The healthcare industry as a whole has been slow to adopt social media tools and to join online social networks, but the presenters of a HealthWorks Collective webinar said hospitals that aren’t utilizing the modern mode of communication are making a mistake and encouraged them to start now.
FOR SOME ITEMS STRAIGHT OFF THE LINE

Control Medical’s Aspire Max Thrombus Aspiration System Cleared by FDA

February 28, 2012

Control Medical Technology (Park City, UT) announced that the US Food and Drug Administration has granted clearance for the company to market its Aspire Max thrombus aspiration system. The Aspire Max is described by Control Medical as a high-performance aspirator with integrated handles and valves that allow clinicians to instantly create, increase, decrease, slow, stop, or “pulse” aspiration force.

According to a company press release, the FDA clearance allows Control Medical to market the Aspire Max thrombus aspiration catheter system including an Aspire aspirator and a Max catheter in one package and/or Max aspiration catheters alone in multiple sizes with an indication to remove soft fresh thrombi, and emboli, from vessels in the peripheral vasculature.

The Max thrombus large-lumen catheters are available in multiple outer diameters and lengths and are designed to improve aspiration speed, force, and control.

SERIOUSLY?

THE RENAL RENAISSANCE: Will advances in renal denervation and stenting trials bring renewed clinical interest?

In recent years, a shadow has loomed over vascular intervention in the renal arteries. Questions regarding trial designs and data and the potential overuse of stents seemed to pause progress with the procedure, then reverse it. However, the downturn has not merely corrected the situation to include only appropriate use; it seems to have obscured the fact that there are still large numbers of patients who need revascularization of their renal arteries, particularly those with resistant hypertension. The good news is we may be witnessing a new era in renal therapy. If we dedicate ourselves to good science and effective collaboration, the current signs of resurgence could mark the start of a true renaissance.

One of the hottest topics in all of vascular therapy is renal denervation for the treatment of resistant hypertension.

OTHER POTENTIAL INDICATIONS FOR RDN

Activation of the sympathetic nervous systems contributes to insulin resistance and is associated with central obesity, and an increased risk of diabetes mellitus and metabolic syndrome. Early results indicate that the glucose metabolism can be favorably influenced by RDN. In a study of 50 patients (37 of whom underwent RDN), significant BP reduction was accompanied by substantial glucose and insulin concentration decrease and distinct improvement in insulin sensitivity.

Evaluating the effects of this procedure on BP and sleep apnea severity in 10 patients with resistant hypertension and sleep apnea. At 6 months, a decrease in the apnea-hypopnea index in polysomnography was noted. Interestingly, significant decreases were also observed on plasma glucose concentration 2 hours after glucose administration and in hemoglobin A1c level.

RDN could also probably be beneficial in patients with congestive heart failure characterized by increased sympathetic activity. In previous studies, muscle sympathetic nerve activity assessed on microneurography was related to heart failure severity. A preliminary case report demonstrated substantial reduction of muscle sympathetic nerve activity in a patient with resistant hypertension after RDN. Similarly, a single report indicated a potential benefit from RDN in individual patients with heart failure and concomitant life-threatening ventricular arrhythmia resistant to conventional pharmacotherapy.

WELL LOOKS LIKE WE MAYBE ABLATING EVERYTHING PRETTY SOON

WELL HERE WE GO with some good stuff

Cryo Extends Lives in Ovarian Cancer Study

Killing tumors by freezing them can add time to the lives of women with ovarian cancer that has spread to other parts of the body, according to cyroablation research presented at the fourth annual Symposium on clinical Interventional Oncology, in collaboration with the International Symposium on Endovascular Therapy. This study adds to the evidence that cyroablation is an effective option for patients who can’t have surgery. As Dr Hyun Bang, author, points out this procedure is often overlooked, but based on the high survival rate, cost-effectiveness, consistent local control, and safety of the procedure, we should be taking a closer look at cyroablation as an option before these women enter the latter stages of their disease.
# Membership Application

**ASSOCIATION OF VASCULAR AND/OR INTERVENTIONAL RADIOGRAPHERS**  
12100 Sunset Hills Road, Suite 130, Reston, Virginia 20190 | 703.234.4055 | Fax 703.435.4390 | Email: info@avir.org

**Full payment must accompany completed application form.**

## Membership Category
— Select only one | Please print or type

- **ACTIVE** — $75/yr *
- **CLINICAL ASSOCIATE** — $65/yr
- **CORPORATE ASSOCIATE** — $65/yr
- **STUDENT** — $45/yr
- **INTERNATIONAL** — $85/yr  

*ACTIVE – Submit ARRT certification or Canadian equivalent

---

### NAME
- Mr
- Mrs
- Ms
- FIRST
- M.I.
- LAST GENERATION (JR., SR., II, III)

### CREDENTIALS

### DEGREE/S

### LICENSURE

### REGISTRATION/S

---

### Preferred Address
- **Home**
- **Work**

#### HOME STREET

- CITY
- STATE
- ZIP
- PHONE
- FAX
- EMAIL (for official avir business only)

#### WORK

- INSTITUTION NAME
- DEPT.
- STREET (include department, room number, mail stop codes, etc., if appropriate)

- CITY
- STATE
- ZIP
- PHONE
- FAX
- EMAIL (for official avir business only)

---

### Length of Time as Tech Area of Expertise: _________________

### Size of Institution (# of beds):
- Private
- Academic

### Number of Exams Performed at this Institution:
- Vascular
- Interventional

### Are You a Member of: ARRT
- Yes
- No

### Are You a Member of: ASRT
- Yes
- No

*(If YES, please attach photocopy of membership card/s)*

### Other Professional Organizations of Which You Are a Member:

### Related Interests (CQI, Teaching, Publishing, etc.):

---

### Payment Information:
- Check Enclosed
- Credit Card:
  - AmEx
  - MasterCard
  - Visa

- ACCT NUMBER
- EXP DATE
- NAME ON CARD
- SIGNATURE

---

**Student Members Only**

### DIRECTOR

### PROGRAM ADDRESS

- CITY
- STATE
- ZIP

### PHONE

---

Join AVIR today... and become an influential force in the future of health care policies!
What Is AVIR?
The Association of Vascular and Interventional Radiographers (AVIR) is the national organization of healthcare professionals within Vascular and Interventional Radiology and involved in standard of care issues, continuing education and related concerns.

Who Can Become a Member of AVIR?
ACTIVE: Radiographers with a primary focus in Vascular and/or Interventional Radiology. Active members must be ARRT registered or have Canadian equivalent. Submit copy of certification with application.
   Dues are $75 per year.

ASSOCIATE: Related healthcare professionals working with or having a special interest in Vascular and/or Interventional Radiology, including Nurses, Medical/Cardiovascular Technologies and Commercial Company Representatives.
   Dues are $65 per year.

STUDENT: Students in certified programs for Vascular and/or Interventional Radiographers.
   Dues are $45 per year.

INTERNATIONAL: Healthcare professionals working or having special interest in CIT and who reside outside of the United States and Canada. This category includes, but is not limited to, medical technologists, radiologic technologists, registered nurses, licensed practical nurses, Physicians and commercial company representatives.
   Dues are $85 per year.

All Memberships are renewable annually each January.

Why Is Joining AVIR Important?
The AVIRs dedicated to you and is a powerful advocate for the special interest and concerns of healthcare professionals working in Vascular and Interventional Radiology. We acknowledge the importance of continuing education, establishing high standards of practice and care, certifying Vascular and/or Interventional Radiographers, and establishing a nationwide network for obtaining information and/or employment opportunities.

What Opportunities Does AVIR Offer?
• Professional growth
• Society of Interventional Radiographers (SIR) Annual Meeting
• Exchange of information and ideas
• AVIR Annual Meeting
• Continuing education opportunities
• Quarterly newsletter
• Local chapter involvement
• National membership directory