



The Annual Meeting of the Society of Radiologists in Training 2014
May 8th-9th, W12 Conferences, London

Welcome!

Welcome to the annual meeting of the Society of Radiologists in Training 2014. I would first and foremost like to thank all of you for your interest and attendance to this conference and hope that over the next two days you find it both educational, enjoyable and come away having made new radiology friends from various training schemes!

This year we have strived hard to build on the feedback given to us from last years conference. We have overhauled the old SRT website to create a brand new, easier to navigate site for trainees. We do hope that you all take the opportunity to contribute articles and topics for discussion so that we can help to maintain a useful resource for all radiology trainees.

This year we have introduced two fun SRT radiology quiz prizes. One of them is an interactive and fun ice-breaker game to enable trainees to start talking to one other! We have also created a SRT conference app to ensure that all the vital conference information can be at your fingertips at anytime without searching our website, your old emails or fumbling through papers!

As always, any meeting would not be able to go ahead without the great support of our valued sponsors. Several of them have contributed to our meeting for many years and have a wealth of knowledge on latest advances in radiology. Please do make the effort to visit their stalls and their websites for further information.

I finally would like thank all the current committee members for their hard work over the last year. With several members leaving the committee, it is with great sadness that we have to say goodbye to them. I sincerely hope that this enables an influx of fresh faces and ideas onto our new committee to take the SRT forward and continue to succeed in all its future endeavors.

I look forward to meeting all of you during the next two days.
Have fun and enjoy yourselves!

Susie Shelmerdine
SRT President 2013-14

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Sponsor Adverts

ALSO IN YOUR DELEGATE FOLDER:

SRT Radiology Images Quiz Answer Sheet

SRT Radiology Badge Quiz Answer Sheet

New Committee Voting Ballot

SRT Conference Feedback Form

New Committee Member Applicant Personal Statements

SRT COMMITTEE MEMBERS 2013 - 2014

Please do come and speak to any of the members of the committee during the course of the conference if you have any queries. We will all be wearing our committee shirts so you can easily spot us!

President

Susan Shelmerdine, ST4, London

Vice President

Magdalena Szewczyk-Bieda, ST5, Dundee

Treasurers

Natasha Gardiner, ST2, Portsmouth

Ruo Lei Chen, ST3, London

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Oliver Hulson, ST3, Leeds

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Oliver Hulson, ST3, Leeds/ Bradford

Media & Public Relations

Walid Al Deeb, ST3, North Wales

Committee Member Without Portfolio

Tinu Purayil, ST4, Plymouth

A special thanks to Dr. Jeremy Lynch, ST1 London for his help and contribution in creating the SRT Conference App

CONFERENCE QUIZ & VOTING

SRT Radiology Badge Quiz

Behind your name badges you will notice one or more radiology images relating to a condition or syndrome. Each delegate will have one of a possible 5 different conditions/syndromes on their name badges.

Your task is to try to meet as many trainees as possible and see if you can figure out the case. Once you have met enough trainees and seen all 5 cases and think you have worked them out, fill out your answers on the quiz answer sheet provided.

No team entries – just individual submissions! The trainee with the most correct answers wins a prize. This will be announced at the prize giving ceremony at the end of the conference.

Please submit your answer sheet into the quiz answers box before Friday lunchtime.

SRT Radiology Images Quiz

Within your programme booklet you will find the questions for the radiology images quiz. This quiz has 3 parts, all of which are related to radiology and images in one way or another.

Please fill out your answers to this quiz on the answer sheet provided in your pack. You may join forces with other trainees but no more than up to 3 members in one team please! The team with the most correct answers wins a prize. This will be announced at the prize giving ceremony at the end of the conference.

Please submit your answer sheet (you only need to submit the one sheet per team) into the quiz answers box before Friday lunchtime.

New SRT Committee Voting

This year we are trying to make the voting system for entering the SRT committee more transparent and fair by asking all interested parties to submit a short personal statement for delegates to read to help them make a more informed voting decision.

Please read the enclosed personal statements and complete the enclosed voting ballot with the names of the top 3 trainees you would like to see on the SRT committee 2014-2015. The highest

number of votes for each candidate will be counted and announced at the AGM on Friday morning. Please submit the ballots into the voting box by the Friday coffee break (11.15am) at the very latest.

All potential committee entrants are also allowed to participate in the voting as well.

Prize Awarding Ceremony

The prize awarding ceremony will close the SRT annual conference. Here we will announce the winners of the poster and quiz prizes. Winners can choose a book prize from a varied selection of books sponsored by JP Medical and CRC Press.

If a delegate is not present at the ceremony to collect their prize for the SRT quiz (es), this will then be awarded to the next highest scoring entree present at the ceremony.

A delegate not present for the poster prize award will be posted their certificate and sent a book selected by the committee based on remaining prizes not chosen by the other winning candidates present.

Oral presentation prizes will be awarded at the end of the oral presentations on Friday morning.

SRT Conference Feedback

Finally, please do ensure you complete the feedback forms included in the delegate pack. You will be given a certificate of attendance to the SRT conference only upon handing in your completed feedback form.

If you need to leave the conference early or are only attending for one day, then please still hand in the feedback form to a member of the committee for your certificate.

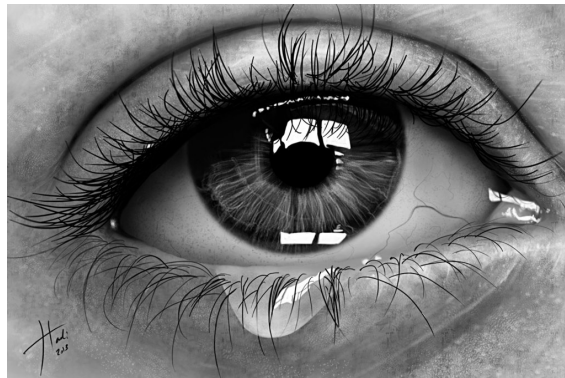
SRT RADIOLOGY IMAGES QUIZ

PICTURE QUIZ PART 1 – WHAT IS THE DIAGNOSIS?

1) A type of fracture



2) A type of injury



3) A type of fracture



PICTURE QUIZ PART 2 – FAMOUS FACES

Who are these famous 'radiology related' faces?

A



B



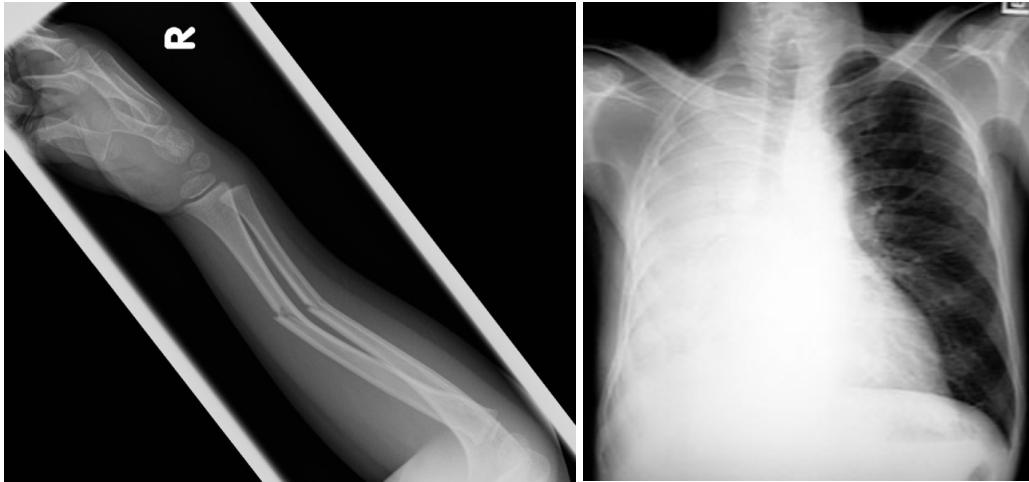
C



D

PICTURE QUIZ PART 3 – COMMON THEMES

What theme do these radiographs have in common?
Name the sign or diagnosis + the common factor.

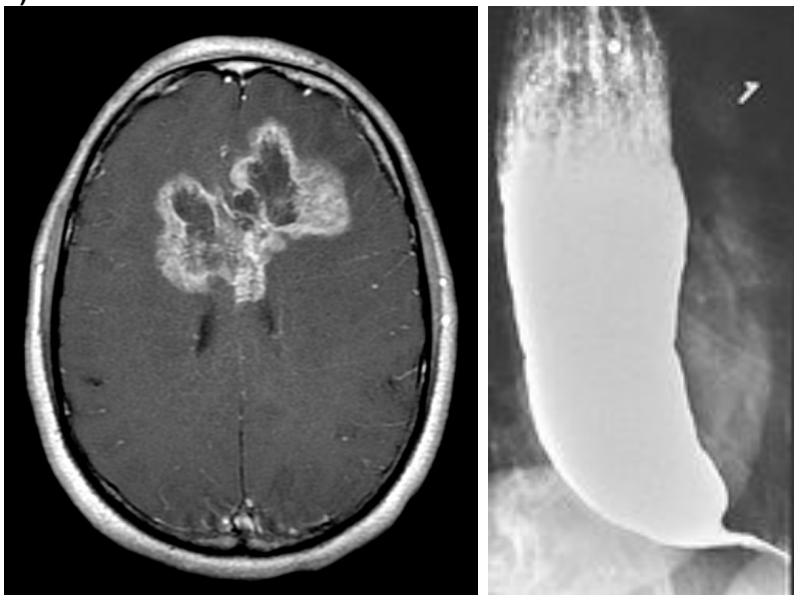


e.g. **GREEN** stick fracture & **WHITE** out = COLOURS!

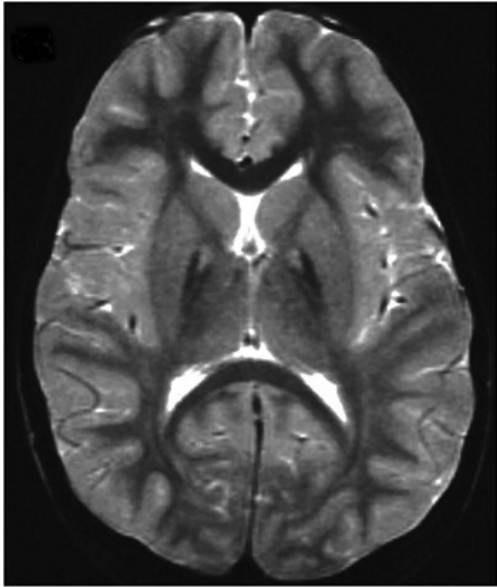
1)



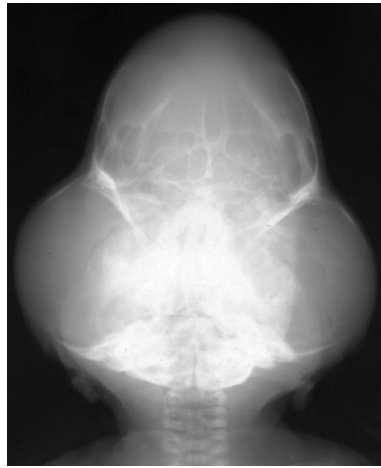
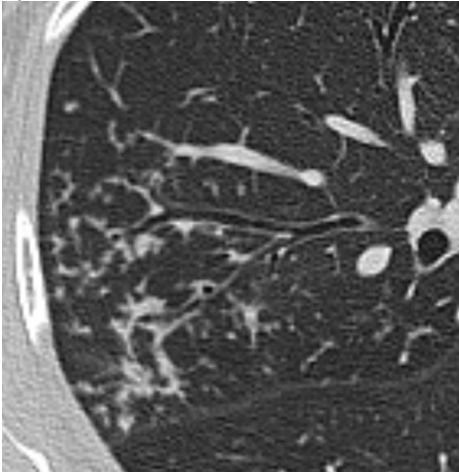
2)



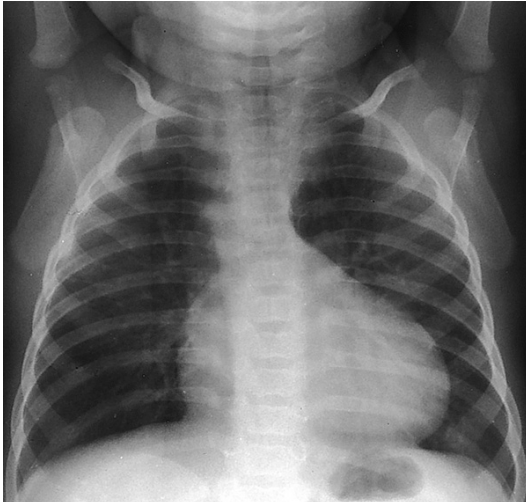
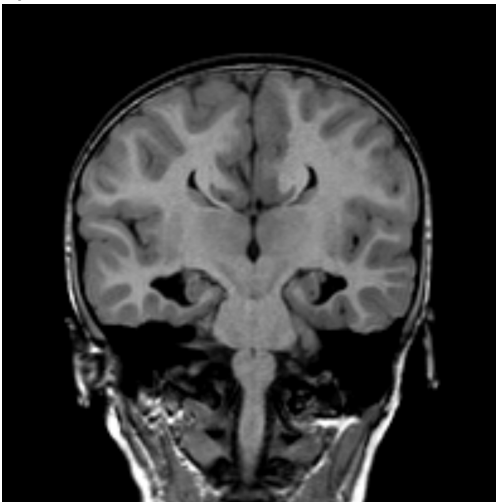
3)



4)



5)





CONFERENCE DINNER MENU

May 8th, Tiger Tiger, 29 Haymarket, London SW1Y 4SP

The annual conference dinner will be taking place at Tiger Tiger this year. Included in the conference fee is a glass of bubbly on arrival from 19.30 onwards.

Dinner will start at 20.00 and includes a 3 course meal, half a bottle of wine and free entry into the dance venue/club afterwards! The dinner will take place in the Cloud Lounge – please do make your way to this area of the venue on arrival.

Your meal choices should have already been emailed to the SRT committee before 28th April 2014. Dinner place settings with your name and choices will be available on arrival at the venue. If you did not send us your choices beforehand, you have been allocated the vegetarian options (highlighted by **).

STARTERS

- Herb & Spice Crumbed Chicken Fillets with Romaine and corn chip salad, ranch dressing
- Breaded Camembert with wild roquette and cranberry sauce
- Creamy Tomato Soup with shredded basil and rustic bread **
- Traditional Prawn Cocktail with brown bread
- Smoked Haddock and Applewood Fishcake with Caesar dressed baby leaf salad

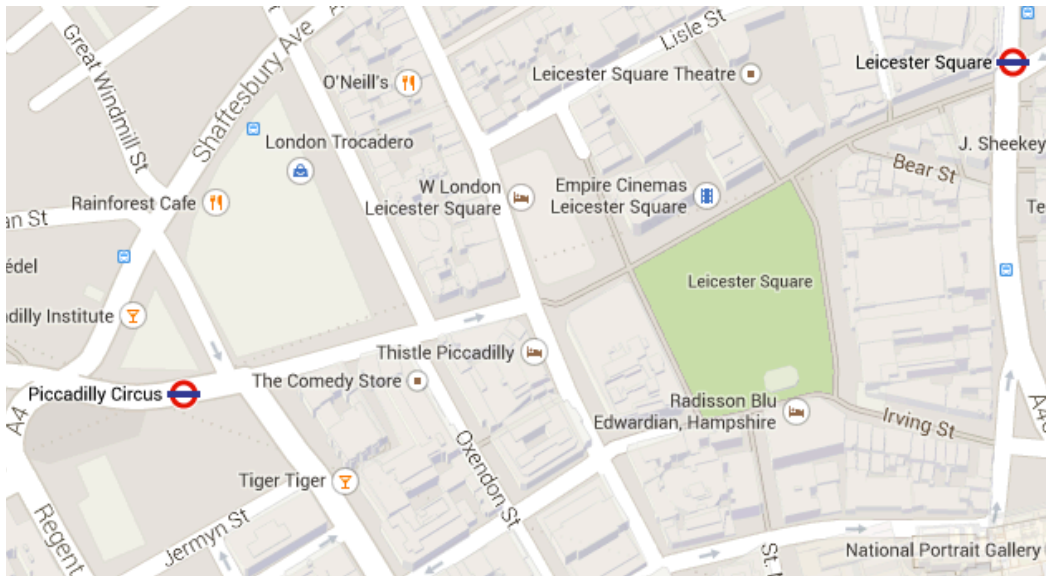
MAINS

- Roast Chicken Breast with wild roquette, creamed potato and pesto dressing
- Steak, Mushroom and Irish Stout Pie with grain mustard mash, Chantenay carrots and mange tout
- Award winning Cumberland Sausage and Mash with caramelised onion gravy and sage crisps
- Cajun Spiced Salmon Steak with crushed new potatoes & fresh zesty avocado salsa
- Spicy Crushed Tomato Penne Pasta with fresh chillies and ripped basil **

DESSERTS

- Rich Chocolate Fudge Cake with Anglaise Sauce
- Tarte au Citron with raspberry coulis
- Traditional Jam Sponge with custard **
- Baked New York Cheesecake with raspberry coulis
- Selection of Ice Creams with Florentine wafers

GETTING TO THE SRT ANNUAL CONFERENCE DINNER VENUE TIGER TIGER, 29 THE HAYMARKET, LONDON SW1Y 4SP



Public Transport – Underground:

The nearest underground tube stations are:

Picadilly (Picadilly line, 0.1m, 3min walk) or Leicester Square (Northern Line, 0.3m, 5 minute walk).

Further transport details are available from the venue website at:

<http://www.tigertiger.co.uk>

If you would like advice on the best form of public transport to take from your hotel or workplace, the 'Transport for London' website has useful advice on the best routes: www.tfl.gov.uk

SRT ABSTRACT SUBMISSIONS

ORAL ABSTRACT SUBMISSIONS

Oral:

1. Follow-up of suspected scaphoid fractures with scaphoid series, MR, CT and BS: diagnostic accuracy and cost-effectiveness. Evidence based practice approach. Olga Shaw

Purpose/aims:

To determine how the repeat scaphoid series compares with MR, CT and BS in terms of diagnostic accuracy and cost-effectiveness in patients with suspected scaphoid fractures.

Methods:

Evidence based practice approach, developed at the Centre for Evidenced Based Medicine at the University of Oxford, UK and the McMaster University, Canada. Five steps of the evidence based practice were followed: 1. ASK answerable question, 2. SEARCH for best evidence, 3. APPRAISE evidence for validity, 4. APPLY results in practice, 5. ASSESS performance.

Results:

The answerable question was formulated using the PICO method. The evidence was searched on the 6S hierarchy of evidence in a systematic manner. Appraisal of the validity of the evidence was performed using the appropriate critical appraisal tools, such as AGREE II instrument for guidelines, and the SIGN checklists for economic evaluations, systematic reviews and meta-analyses. Action plans were developed for application of the results and evaluation of the performance.

Conclusions:

1. MRI is most sensitive and specific out of scaphoid series, CT and BS for detecting scaphoid fracture, and other wrist injuries.
2. After initial negative scaphoid series, if clinical suspicion of scaphoid fracture remains, immediate MRI is cost-effective, if using a limited protocol, and if considering total cost of presumptive care and loss of productivity.

2. Diffusion-Weighted Imaging in the Abdomen and Pelvis: Nononcologic Applications. Ajay Sahu

Learning Objectives:

Diffusion-weighted imaging (DWI) has become an important and widely used tool in abdominal and pelvic MRI, but its use has been primarily applied to oncologic questions.

After this exhibit the learner should be familiar with the underlying physics of DWI, recognize common pitfalls and artefacts in abdominal and pelvic DWI, have an up-to-date understanding of useful nononcologic applications of DWI in the abdomen and pelvis, and be able to identify situations in clinical practice where information provided by DWI sequences would be of diagnostic value.

Description:

We will cover multiple organ systems and diverse nononcologic processes in the abdomen and pelvis as depicted by DWI MRI. Some of these include inflammatory diseases such as vasculitis, autoimmune pancreatitis, and inflammatory bowel disease; infectious processes such as appendicitis, pyelonephritis, and abdominal abscesses; granulomatous disease including sarcoid; metabolic diseases such as amyloidosis and glycogen storage disorders; and problematic congenital

abnormalities such as an intrapancreatic accessory spleen. We present nononcologic applications of DWI in the abdomen by class (inflammatory, infectious, etc.) and organ system, providing representative imaging and discussing the value of DWI sequences in making or rejecting specific diagnoses in these situations. Global and specific pitfalls as well as common artefacts when using DWI are presented.

Conclusion:

DWI has become an established technique in abdominal MRI due to its value in oncologic problem solving. We present numerous nononcologic situations in the abdomen and pelvis where the technique adds value to the diagnostic process.

3. Breast cancer detection rates in patients with B3 breast lesions: a 12 year retrospective review. Nadia McAllister

Purpose/aims:

B3 lesions comprise a heterogeneous group of breast lesions with an increased risk of subsequent breast malignancy.¹ Surgical excision of such lesions is being replaced by large volume core needle biopsy and 5 yearly mammographic follow up.² This study aims to establish the incidence, nature and timing of malignancy associated with B3 lesions, and to assess whether such mammographic surveillance programmes are appropriately targeted.

Methods:

Retrospective, single centre, review of all screen detected B3 lesions (identified on core or diagnostic excision biopsy) between 1995-2008.

Results:

188 B3 lesions identified. Average age was 55 years (range 48-74). Each patient had a median of 6 follow-up mammograms (range 0-9). 16 cases (9%) subsequently developed breast cancer (13 invasive, 3 high grade DCIS). Median time-to-diagnosis was 5 years (range 1-18yrs). 4 patients were diagnosed after 1 year (3 at the original site, 1 contralateral nodal metastasis). 12/16 cancers were in the ipsilateral breast, but only 7/12 were at the same site as the index lesion. The spectrum of initial B3 diagnoses that subsequently developed into cancer varied.

Conclusion:

The observed cancer detection rate of 9% is higher than expected for a screened population. However, in this cohort, subsequent cancer occurred either early, representing a failure of initial assessment, or much later, consistent with studies suggesting that the presence of B3 lesions are a risk factor for breast cancer development.¹ We propose a more appropriate and cost effective follow-up strategy of a single mammographic review at one year followed by return to the routine NHS breast screening programme, in conjunction with regular self examination.

References:

1. **Heywang-Köbrunner SH, Nährig J, Hacker A, Sedlacek S, Höfler H. B3 Lesions: Radiological Assessment and Multi-Disciplinary Aspects. *Breast Care (Basel)* 2010; Aug;5(4):209-217.**
2. **S. Rajan, A.M. Shaaban, B.J.G. Dall, N. Sharma. New patient pathway using vacuum-assisted biopsy reduces diagnostic surgery for B3 lesions. *Clin Radiol* 2012; Mar;67(3):244-9.**

4. A review of Image-guided Acoustic Haemostasis: an emergent technology for haemorrhage control in combat casualty care. Georgina Blenkinsop

Learning Objectives:

To increase awareness of the therapeutic potential of Image-guided Acoustic Haemostasis.

To understand applications and limitations of Image-guided Acoustic Haemostasis.
To review current and future progress in this area.

Description:

Modern advances in the ability to harness technology have seen vast improvement in the field of therapeutic ultrasound. High Intensity Focused Ultrasound (HIFU) is one such evolving modality. Applicable to trauma audiences is the promising use of HIFU for haemorrhage control in occult bleeding. Despite huge advances in military medical care, early mortality rates remain only marginally changed since the Crimean war, which is partly attributable to the failure to prevent death from occult haemorrhage. Currently, the only developing technology for the rapid detection and intervention of life threatening occult haemorrhage is Image-guided Acoustic Haemostasis. Imaging ultrasound detects the site of haemorrhage then a transcutaneous HIFU beam is delivered, causing localised cauterisation and arrest of haemorrhage, without damaging intervening tissues. A portable device could be used to rapidly and accurately cauterise active bleeding without need for facilities capable of performing invasive procedures.

Conclusion:

Military contingency planning necessitates preparation for being unable to reach advanced medical care within NATO medical evacuation timelines. HIFU, now successfully integrated with ultrasound imaging to produce a system of image-guided therapy, brings sophisticated technology to forward echelons. Extensive animal studies have shown this system has potential to deliver a new approach to life saving care on the battlefield. Importantly, however, further development is critical to create a robust clinical tool.

POSTER ABSTRACT SUBMISSIONS

Educational:

1. Post-Cryoablation CT Appearances in Renal Cell Carcinoma, R Williams
2. Overview of Cholescintigraphy, M Bushara
3. Intussusception reduction by air enema – how it's done. Experience from a busy tertiary centre, A Gupta
4. Abdominal films; useful or just a pain in the backside? Would we even know? A Gupta
5. Imaging of Soft-Tissue Fibrous Lesions: What the Radiologist Needs to Know and How Imaging Can Help Guide Clinical Management, K Pearce
6. Extra thoracic manifestations of amyloidosis, K Pearce
7. Imaging of Adult Patients Presenting to the Emergency Department With Acute Drug-Induced Musculoskeletal Complications, K Pearce
8. The Anatomy and Associated Pathologies of Neck Spaces, A Kamalasanan
9. Extracorporeal membrane oxygenation (ECMO) - What the radiologist needs to know, O Westerland
10. Acute CT head imaging – What not to miss on-call! O Westerland
11. Common imaging manifestations of Crohn's disease on MR enterography. R Chen
12. Frozen' shoulder- what does it look like on MRI? D Stavrou
13. A Pictorial Review of Creutzfeld-Jakobs Disease (CJD) on MRI Brain. R Kassamali

Case Report/Series:

1. NHS staff stunned after oxygen tank flies "like a rocket" into £2million MRI scanner, S Tenant
2. Musculoskeletal (MSK) Cases of the Day: Hot Topic for the FRCR 2A and 2B, P Yeap

Research:

1. Early carotid endarterectomy (CE) is effective secondary prevention for non-disabling carotid territory stroke or Transient Ischaemic Attack (TIA) patients with a moderate/severe carotid stenosis. Carotid Doppler ultrasound (CDU) is used to assess carotid stenoses in such patients. M Rodrigues
2. Computational Fluid Dynamics applied to Coronary CT Angiography: an emerging technique for non-invasive calculation of Fractional Flow Reserve for assessment of physiologically important coronary arterial stenosis, R Alcock
3. Evaluating the use of a negative D-dimer and modified low Wells score in excluding above knee deep venous thrombosis in an outpatient population, assessing need for diagnostic ultrasound. M Rahiminejad
4. To assess the safety of heart rate optimisation using solely intravenous Beta-Adrenergic blockade prior to CT coronary angiography. R Kassamali
5. The Sensitivity of CT-Colonography at Leeds Teaching Hospital, A Koo
6. Surgery for Cauda Equine Compression Following Requests for Urgent Spinal MRI. T Minett

Audit/ Service/ Quality Improvement

1. Creating a vascular reporting template for CT Aortas, R Williams
2. Audit of Diagnosis and Follow Up Recommendation of Lung Cancer on Chest Radiography, N Schembri
3. An Audit of Sample Adequacy using the Biopince needle for ultrasound guided liver biopsies in a London District General Hospital, A Begum
4. Referring to Radiology: A Completed Audit of Access to Imaging Referral Guidelines in North East Thames. T Gaunt
5. Patient Consent in Interventional Radiology, T Gaunt
6. IV Contrast Reactions: An audit of radiologists' knowledge, S Tenant
7. The Appropriateness of Carotid Ultrasound imaging in a large teaching hospital. L McCarthy
8. EVAR surveillance within the first year: Rationalizing the need for a pre-discharge and a 6 month follow up CT. R Alchanan
9. Audit of Voice Recognition Accuracy in Radiological Reports. J Hartley
10. SonoVue (sulphur hexafluoride microbubbles) clinical audit. N McAllister

11. An audit on the quality of percutaneous renal biopsy obtained specimens by radiologists at Worcestershire Royal (WRH) and Kidderminster Hospital (KTC), N Davendralingam
12. Radiological Investigation of Renal Colic in an Emergency Department of a Teaching Hospital, A Koo
13. The positive pick up rate of CTPAs, and the proportion of requests with pre test probabilities carried out. A Syeed
14. Developing the role of undergraduate radiology: the RCR approach. F Pathiraja

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