



SRT 2015

THE SOCIETY OF RADIOLOGISTS IN TRAINING

BANGOR, NORTH WALES



FINAL PROGRAMME

22nd ANNUAL POSTGRADUATE CONFERENCE

MAY 14-15



The Annual Meeting of the Society of Radiologists in Training 2015
May 14th-15th, Bangor, North Wales.



Welcome! Croeso!

Thank you for being part of our **22nd annual conference**, which for the first time is being held in Wales.

We have organised a series of great speakers to teach on a diverse selection of topics. We have also mixed in some politics by inviting the Chief Scientific Officer for Wales. We anticipate future politicians in our events, so watch this space.

Our community has grown vastly over the last year. We currently have over 64,000 followers on twitter. **This is by far the largest radiology community on social media in the world!**

This is followed by the Radiological Society of North America (RSNA) with just under 20,000 followers.

We use our social media presence to interact with trainees globally by sharing with them interesting radiological cases, relevant courses and issues pertinent to our training. We therefore encourage you to participate in our posts and help put the British perspective of Radiology at the forefront on an international scale. We already have Radiopaedia, RCR, RCANZR, RSNA, ECR, ACR and many other great radiological societies liking, sharing and tweeting our posts, as well as following us.

This is testament to the fact that the SRT plays a significant role in the lives of many radiologists globally.

Because of our international recognition, the SRT will soon also introduce speakers from outside the UK. Dr Amy Juliano who is a renowned lecturer from Massachusetts Eye and Ear hospital has expressed her excitement and interest in joining us in 2016.

The **BEST Trainer of the year awards** were introduced across the United Kingdom and have proven to be very successful. The SRT committee want to honour, acknowledge and encourage outstanding support and participation in teaching among trainers, be they radiologists, radiographers or sonographers.

We recognise the fact that there are many inspirational radiologists that don't necessarily work in tertiary centres but contribute immensely to training. Their work must be acknowledged and therefore these awards will and must continue.

On another note, I would like to mention that the SRT is providing courses in alliance with **Radiology Recipes International**. We have worked closely with Dr Kshitij Mankad and would like to thank him wholeheartedly for his inspiration, support and dedication to our community.

On behalf of the committee I would also like to thank The President of the Royal College of Radiologists Dr Giles Maskell, Wales Deanery (including The Head of School for Radiology, Dr Sian Philips and our training programme director Dr Senthil Muthu), Bangor Hospital's postgraduate centre, and all our speakers and sponsors for their immeasurable support.

I would also like to thank the delegates and my beloved committee members to whom I owe so much for helping make this event possible.

I look forward to meeting you during the next couple of days.

Radiology is certainly an amazing speciality.

Enjoy

A handwritten signature in black ink, appearing to read 'Walid Al-Deeb', enclosed within a large, loopy oval shape.

Dr Walid Al-Deeb
SRT President 2014-15

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1. SRT COMMITTEE MEMBERS 2014 - 2015

Please do come and speak to any of the committee members 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

Dr. Walid Al-Deeb, ST4, North Wales

Vice President

Dr. Tinu Purayil, ST5, Plymouth

Treasurers

Dr. Natasha Gardiner, ST3, Portsmouth

Dr. Neal Larkman, ST4, Leeds

Secretaries

Dr. Phey Ming Yeap, ST4, Dundee

Dr. Oliver Hulson, ST4, Leeds

Web Blogger

Dr. Dina Hikmat, ST2, Mersey

Webmaster

Dr. Neal Larkman, ST4, Leeds

Media & Promotions

Dr. Phil Touska, ST2, London

Event Organiser

Dr. Rahil Kassamali, ST4, Birmingham

Dr. Jeremy Lynch, ST2, London

Committee Member without Portfolio

Dr. Samantha Choi, ST2, Dundee

Consultant Advisor

Dr. Kshitij Mankad, Consultant Neuroradiologist, London



2. CONFERENCE PROGRAMME

The Annual Meeting of the Society of Radiologists in Training 2015
May 14th & 15th, Bangor, North Wales

Thursday, 14th May

8.30 - 9.00	Registration
9.00 - 9.15	Welcome message Dr. W. Al-Deeb SRT President Dr P Birch Assistant Medical Director of Bangor Hospital
9.15 - 10.00	CT colonography in Wales Dr. E. Favill
10.00 - 10.45	Head & Neck Snapshot for the FRCR 2A Exams (to include 2B images) Dr. S. Muthu
10.45 - 11.00	Coffee Break
11.00 - 11.45	Cardiac Radiology Differentiating cardiac pathology on MRI Prof. M. Rees
11.45 - 13.00	New Technologies and their benefits in portable ultrasound <i>Sponsored talk by Siemens</i> followed by Lunch & Poster Reviewing (BSGAR to award best GI poster)
13.30 - 14.15	Interventional Radiology An interactive QUIZ sessions Dr. O. Rees
14.15 - 15.00	Chief Scientific Officer for Wales Christine Morrell
15.00 - 15.45	MRI Shoulder Reporting Step-by-step approach Dr. R. Proctor
15.45 - 16.00	Coffee Break
16.00 - 16.50	The Royal College of Radiologists Updated from the President on fellowships (abroad&local) Dr. G. Maskell
19.00	Evening Dinner @ Château Rhianfa Beaumaris, Menai Bridge LL59 5NS

Friday, 15th May

8.30 - 9.00	Morning coffee
9.00 - 10.15	Registrar Scientific Presentations Panel: Dr. S. Shamshuddin, Dr K.Mankad Dr. J Curtis, Dr. R. Proctor
10.15 - 11.00	OsiriX (use in Radiology training) Dr S. Shamshuddin & Dr. J. Curtis
11.00 - 11.15	Coffee Break
11.15 - 11.55	Chest Radiology HRCT & Interstitial lung diseases (interactive session): Dummies Guide Dr. J. Curtis
11.55 - 12.30	Radiological Findings in the Mesentery, Omentum and Peritoneal Cavity Dr. C. Corr
12.30 - 13.00	Lunch & Poster Reviewing
13.00 - 14.00	Grand Rounds Dr. H. Godfrey
14.00 - 14.20	Coffee Break & Poster Reviewing
14.20 - 15.05	Musculoskeletal Quiz Anatomy, FRCR 2A and 2B Interactive pad voting participation Dr. H. Aniq
15.05 - 15.45	Neuroradiology: Non-accidental head injury Dr. K Mankad
15.45 - 16.00	Coffee Break
16.00 - 16.40	Announcement of prize winners for oral/poster presentations
16.40 - 17.00	New committee members' positions announced
17.00 - 17.10	Feedback

WORKSHOPS BASED IN THE RADIOLOGY DEPARTMENT

	Time	Title	Places
Thursday 14th	11.00 - 12.00	US shoulder (A. Kraus)	Max 5
Friday, 15th	10.15 - 11.00	Basic guide to MRI knee reporting (Dr. R. Proctor)	Max 10
Friday, 15th	10.15 - 11.00	US Biopsy	Max 4
Friday, 15th	15.05 - 16.00	US Biopsy (R. Dixon)	Max 4

*These sessions will take place DURING THE LISTED TALKS. Not all participants will be able to register for all classes. **Early attendees** will get their choices first. Max ONE workshop per attendee.*

Note:- We may have an additional slot for **US Abdomen** for 5 candidates on Friday morning. To be led by Dr Sean Flannigan.

Prize Awarding Ceremony

This will close the SRT annual conference. Here we will announce the winners of the oral/poster and quiz prizes. Winners can choose a book prize from a varied selection of books.

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 conferee present at the ceremony.

In the event that a delegate cannot be present for the oral/poster prize award we will post their certificate and send a book, selected by the committee, based on remaining prizes not chosen by the other winning candidates present.

This year, we also have two additional awards

- The best interventional poster award: Funded trip to BSIR (British Society of Interventional Radiology) trainee conference (awarded by BSIR)
- The best GI poster: £50 awarded by BSGAR (British Society of GI and Abdominal Radiology)

SRT Conference Feedback

Finally, please ensure you complete the feedback forms included in the delegate pack (See part 13). You will be given a certificate of attendance to the SRT conference only upon handing in your completed 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.

Thank you!



3. CONFERENCE DINNER MENU

Thursday May 14th, Chateau Rhianfa, Beaumaris Road, Menai Bridge, Anglesey, LL59 5NS.

The annual conference dinner will be taking place at Chateau Rhianfa, a 5 star luxurious castle.

Dinner will start at 7.00pm and includes a 3-course meal. Your meal choices should have already been emailed to the SRT committee.

Dinner place settings with your name and choices will be available on arrival at the venue.

STARTERS

Ham hock terrine with piccalilli and toasted brioche

Heritage beetroot and goats cheese sa.ad

MAINS

Chicken breast and confit leg, fondant potato and crushed cob nuts

Hake fillet, candied aubergine and sweet and sour peppers

Chilli marinated halloumi, sweet & sour peppers with Thai basil foam

DESSERT

Chocolate torte, orange and cardamom ice cream

Coffee with home made fudge

KEEP BLANK



4. CONFERENCE QUIZ

A. Case of The Day

TWO cases of the day will be displayed in the seminar room screen/s.

Your task is to write your answers with as few words as possible. No long answers please!

Please submit your answer sheet into the quiz answers box before 2pm on Friday. Dr Mankad will go through these cases with the answers during Friday afternoon session.

Tear Here

FRIDAY

ANSWER CASE 1:

ANSWER CASE 2:

Tear Here

THURSDAY

ANSWER CASE 1:

ANSWER CASE 2:

KEEP BLANK



4. CONFERENCE QUIZ

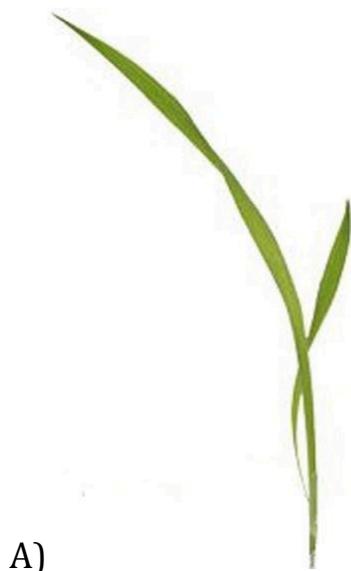
B. SRT Radiology Images Quiz

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

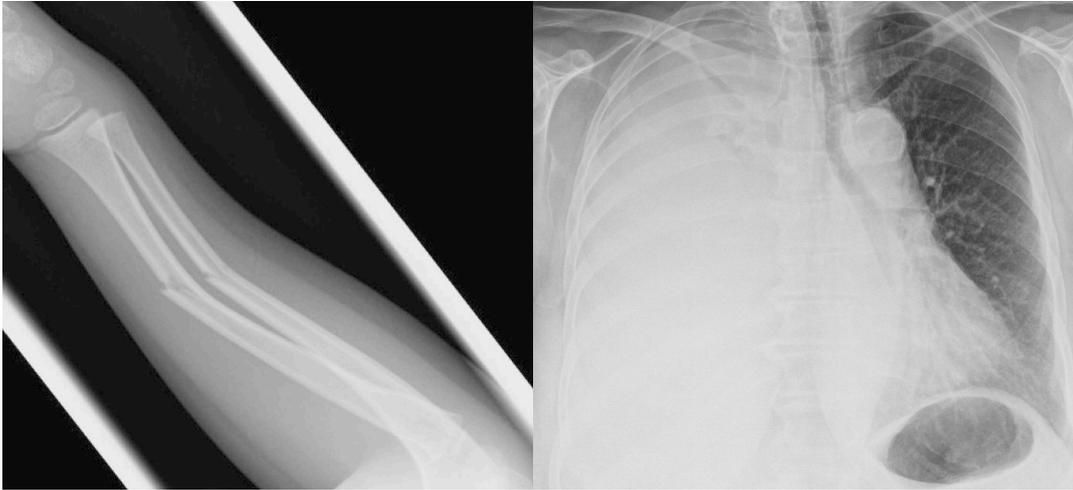
PART 1

Name the diagnosis based on the sign



PART 2

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

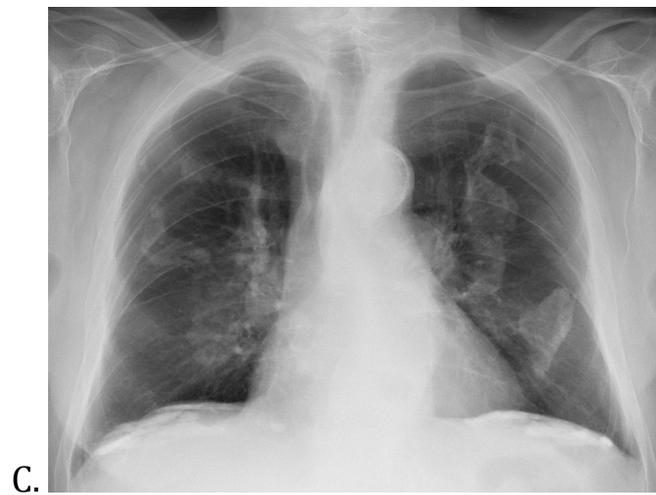
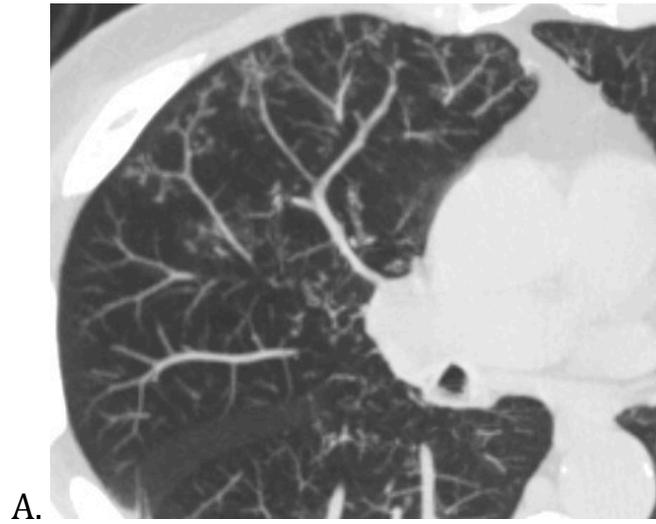


e.g. GREEN stick fracture & WHITE out = COLOURS!

Quiz 1.

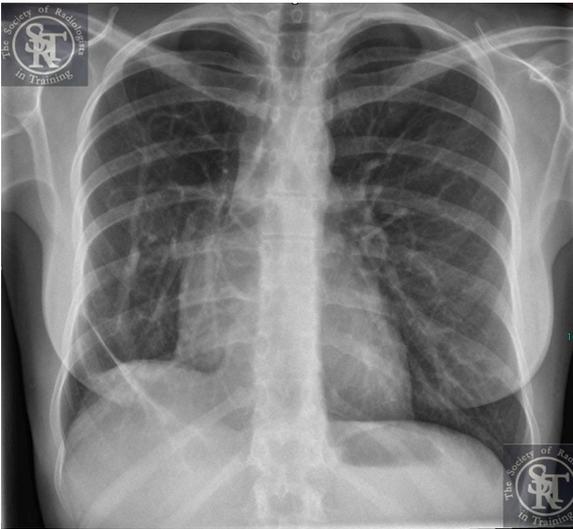


Quiz 2.

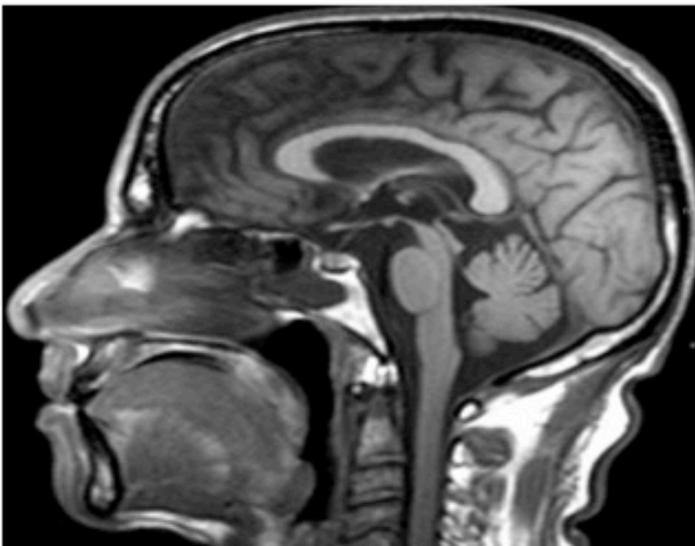


Quiz 3.





Quiz 4.





5. CONFERENCE VOTING

SRT Committee Voting

To make the voting system for entering the SRT committee more transparent and fair, all interested parties were asked 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 2015-16. The highest number of votes for each candidate will be counted and announced at the AGM on Friday afternoon. 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.

We will use an electronic system to vote but in case this does NOT work ***please select in order of preference i.e. 1, 2 and 3. If you have only one choice please put a tick box or number 1 in the side box.***

-----**TEAR HERE**-----&-----**PLACE IN BALLOT BOX**-----

REENA AGGARWAL	
SRIVIDYA AVULA	
SARAH SHARP	



NEW COMMITTEE MEMBER APPLICANT PERSONAL STATEMENTS

Dr Reena Aggarwal



"My name is Reena Aggarwal and I am a ST2 in the East Midlands South training scheme. As a SRT member and having used the website for the last few years, I am keen to become part of the committee this year and help to promote radiology, improve education/training and widen participation so that we can all benefit. I have experience from being involved in numerous committees previously and have many ideas for the society including:

- 1) Widening networking opportunities with both current and past trainees to share experiences and advice on exams, research, fellowships and career choices through the online forum and organising more events.
- 2) More input from trainees for books and courses reviews and information for doctors applying to radiology.
- 3) Seeking more sponsorship to ensure AGM prices are as low as possible for you and maximise opportunities to get your posters presented.
- 4) More publicity for the society and social media pages to ensure easy access to online forums and learning resources/interesting cases.
- 5) A forum to raise issues which are affecting training schemes and share ideas for solutions/examples of good practice to improve your training locally.
- 6) Have more subsidised socials (because we all love socialising!)

I am committed to attend meetings, liaise between trainees and the committee and passionate about improving our training experience. I feel that my enthusiasm, excellent organisational and team working skills will make me an active SRT committee member.

Dr Srividya Avula



A Loyal Dog Found

Dear SRT Team Members and My Dear Colleagues,

I am Srividya Arya, ST1-Clinical Radiology-North Wales Training Program me.

Why I want to be in SRT:

SRT is a non-profit making organization, run by radiology trainees specifically to promote radiology training and education in the UK. This role presents the opportunity to represent the interest of the candidates training in Radiology, thereby gaining insight into current issues. I will also gain valuable experience by participating in the SRT's events and meetings. I can liaise with other Radiology trainees from different training programs.

What I can give to SRT:

I am a good team member.
My commitment and initiative.
My openness, approachability and diplomacy while retaining trainee confidentiality.
Leadership qualities and Management expertise
Excellent written and oral communication skills and interpersonal skills
IT literate, including email skills
Motivational skills
Proactive wherever I see a place to contribute to the improvement of training, either generally or specifically.

Dr Sarah Sharp



“The SRT is the principal organisation in forming a national community of radiology registrars for the purposes of providing education and improving training. I wish to be a committee member as in my career I intend to have a significant input into medical education, and I have considerable teaching and organisation skills to help develop the SRT's aims further.

Prior to my medical career, I undertook a PGCE and was employed as a secondary school Science teacher, during which I was involved with curriculum development. During medical school I jointly ran a mentoring programme to assist students through preclinical exams. In my foundation years I organised and presented a lecture series to medical students on the student assistantship programme at Warwick Medical School. During this time I was also the foundation representative at the AoMRC's UKFPO board, providing feedback on the foundation years, which gained me experience in management and bureaucracy! In 2013-2014 I worked as an anatomy demonstrator at Manchester University. These roles developed ample organisational skill, which I feel would be of value to the SRT. My teaching experience allows me insight into creating and organising educational programmes, and my managerial experience can easily be applied to the SRT's work.”



6. THE SRT BEST TRAINER OF THE YEAR AWARD 2014-15

To celebrate the ongoing commitments of trainers, this year the SRT has introduced this award in deaneries that has an elected official member. The results are follows

Best Radiologist Trainer of the Year

East of Scotland: Dr. Thomas Taylor

London: Dr Dominic Yu (Royal Free); Dr Jeevan Kumaradevan (UCH); Dr Kathryn Wessley (Chelsea& Westminster); Dr Pamela Allen (King's)

Mersey: Dr. Edu Anosike

Peninsula: Dr. Richard Riordan

Wales: Dr. Rebecca Dixon

Wessex: Dr. Adam Wallis

West Midlands: Dr. Alison Page

Yorkshire: Dr. Andrew Grainger

Best Radiographer/Sonographer/AHP Trainer of the Year

East of Scotland: Mr. Scot Dundas

Mersey: Ms. Samantha Lacey

Peninsula: Mr. Pete Cantin

Wales: Mr. John Rees

Wessex: Mr. Ashley Andrews

West Midlands: Ms. Angie Heeney

Yorkshire: Ms. Terry Humphrey



(Photo on the left) **MERSEY Deanery:** Dr Dina Hikmat, the SRT committee member, handed over the certificate to Ms Samantha Lacey.



(Photo on the right) **WESSEX Deanery:** Dr. Natasha Gardiner, the SRT committee member, handed over the certificate to Dr Adam Wallis



YORKSHIRE Deanery: Dr Neal Larkman, the SRT committee member, handed over the certificate to Dr Andrew Grainger (photo on the left) and Ms Terry Humphrey (photo on the right).



EAST OF SCOTLAND Deanery: Dr Phey Ming Yeap, the SRT committee member, handed over the certificate to Dr Thomas Taylor (photo on the left), and Dr Samantha Choi, the SRT committee member, handed over to this Mr. Scot Dundas.



(Photo on the left) **WEST MIDLANDS deanery:** Dr Rahil Kassamali, the SRT committee member, handed over the certificate to Dr Alison Page.

(Photo on the right) **WALES Deanery:** Dr Walid Al-Deeb, the President of SRT, handed over the certificate to Mr. John Rees (Senior Radiographer).



7. SRT ABSTRACT SUBMISSIONS

ORAL ABSTRACT SUBMISSIONS

TITLE	PRESENTER
1) CTPA Detecion Rate: What is it in Spinal Cord Injury	Dr. Samer Alabed
2) Clear as mud: readability of radiology journal articles	Dr. Katy Edmonds
3) Type B or not type B, that is the question! What radiology registrars need to know about CT of the aorta	Dr. Lyn Zimmo
4) Incidentalomas on radiology trainee inter-USS scanning	Dr. Ebrahim Palkhi
5) 'The accuracy of ultrasound scanning in detecting the presence of axillary lymph node metastasis in patients presenting with symptomatic breast cancer'	Dr. John Sammut

1) CTPA Detection Rate: What is it in Spinal Cord Injury?

Alabed S

Background: Spinal cord injury (SCI) carries the highest risk of pulmonary embolism (PE) of all patient groups (4%-10%). These patients rarely have clear symptoms and radiologists often have to justify computer tomography pulmonary angiograms (CTPA) requests based on minimal clinical suspicion. This study compares CTPA detection rates of patients with and without spinal cord injury and compares them to the results of PIOPED II study. PIOPED II suggests that the detection rate of CTPA should be at least 20%. This study reviews the database of The National Spinal Injuries Centre at Stoke Mandeville Hospital; one of the largest specialist spinal units in the world.

Objective: To review CTPA detection rates in patients with and without SCI.

Methods: This retrospective study reviewed all CTPAs for spinal patients between 2008 and 2013. CTPAs for other patient groups in October 2008 and October 2013 were also reviewed and CTPA detection rates calculated.

Results: 91 SCI patients had a CTPA in the 6 year study period. There were 116 CTPAs in the other patient group in October 2008 and 132 CTPAs in October 2013. The detection rate of CTPA in SCI patients was 12.5%. The CTPA detection rate in other patients was 20% in 2008 and 18% in 2013.

Conclusion: The CTPA detection rates in spinal patients is significantly lower than other patient groups. This reflects the difficulty in diagnosing PE in spinal patients.

2) Clear As Mud: Readability of Radiology Journal Articles

Edmonds KM, Moore KS, Zealley IA, White RD

Introduction: Readability tools are commonly used to establish the comprehensibility of text. Flesch Reading Ease score (FRES) is one of the most commonly used. For example, FRES <30 is very difficult (understood by 4.5% of the population), 50-60 fairly difficult (54%), 60-70 standard (83%; Reader's Digest is ~65). The aim of this study is to assess the readability of mainstream radiology journals (Clinical Radiology - UK; and Radiology - USA). We will also highlight the utility of readability tools in radiology, include examples and provide tips and tricks for readers to help improve the readability of their own articles.

Method: All original scientific articles from Radiology journal (n=81) and Clinical Radiology (n=51) for a three month period (October to December 2014) were assessed using a commercially available readability calculator, (<http://www.read-able.com>).

Results: Mean FRES for Clinical Radiology was 31.6 +/- 11.0 (mean +/- stdev) and for Radiology was 32.4 +/- 9.2. These were not significantly different (P=0.6, unpaired t-test). Examples of extremely difficult to read papers were identified (as low as FRES 1.9 in Clinical Radiology), with the most readable paper having FRES 58.6 (Radiology).

Conclusion: The readability of radiology journals is similar in the UK and USA and is equivalent to that reported in the general medical literature (BMJ 31.5, JAMA 28.7) [1]. Whilst complex jargon is both inevitable and necessary in medical journals, there is no need to overcomplicate matters. It is important to get key messages across in a sufficiently clear manner, reducing the potential for misinterpretation by both medical professionals and others who read the journals (including press and lay people).

[1] BMJ 2002;325:1451-2

3) Type B or not type B, that is the question! What radiology registrars need to know about CT of the aorta

Zimmo L

Learning objectives: -To depict the spectrum of aortic pathologies on CT, with reference to clinical relevance -To highlight pearls and pitfalls of evaluation of the aorta on CT, including indications for different contrast phases

Description: Using cases from our centres, we provide a pictorial synopsis of aortic pathologies that radiology trainees may encounter when reporting CT scans, particularly in the emergency setting. These include: acute aortic syndromes (dissection, intramural haematoma, penetrating ulcers); aneurysms and pseudoaneurysm; rupture and impending rupture; coarctation and pseudocoarctation; aortitis and periaortitis; trauma; post-endovascular repair complications; and the surgical aorta. Pearls and pitfalls will be reviewed and guidance given on the contrast phases required in evaluating aortic pathologies.

Conclusion: Aortic pathologies can present in numerous ways and can mimic other pathologies. As such, the aorta forms an important review area on all body CT scans. Even on dedicated aortic CT scans, the range of pathologies is vast and their clinical significance can be unclear to the uninitiated. Is a non-contrast phase needed? Are there signs of impending rupture? Does this need urgent consultant review? Review of this exhibit should improve the confidence of registrars who may encounter these scans at 3am while alone in the department.

4) Incidentalomas on radiology trainee inter-USS scanning

Palkhi, E. Koo, A.

Medical imaging, which is increasingly used in research and teaching involves patients and healthy volunteers. Radiology trainees, in particular, routinely partake in inter-trainee scanning as part of their curriculum to master the dynamic skill required for ultrasound imaging. This may highlight an ethical dilemma resulting from the discovery of incidental abnormal findings (incidentalomas), which can represent up to 30% in body imaging (1). Researchers are expected to exercise reasonable care towards their participants, including feedback of information on any incidental findings. However, radiology trainees are not performing ultrasound imaging within the scope of research but with the objective of improving their skill. Most radiology trainees who perform inter-trainee scanning are often still relatively junior, especially when they are in process of honing these skills. This would imply that their diagnostic ability is limited and may result in either being unnecessarily or inadequately concerned about incidentalomas. In situations where being unnecessarily concerned, this would generate extra workload in a busy radiology department. More importantly, the latter could potentially result in adverse outcomes if the practitioner unknowingly disregards a serious pathology.

Within a small cohort of first year radiology trainees (n=12) in West Yorkshire radiology academy, pathologies that were demonstrated included 3 fatty livers, 2 thyroid cysts, 2 gallbladder polyps, 1 splenic cyst, 1 liver haemangioma, 1 scrotal varicocele and 1 pelvic kidney. Senior radiologists or sonographer consultants reviewed these findings and only 1 required follow-up (FNA of thyroid cyst - benign).

Overall, there is a lack of clarity, awareness or consistency in managing these incidentalomas amongst radiology trainees. The subject of incidentalomas in inter-trainee scanning leads rise to ethical issues regarding inter-trainee autonomy, beneficence as well as non-maleficence. We suggest that during inter-peer scanning, mutual consensual agreement must be made due to a risk of discovering incidentalomas. In order to avoid potential adverse outcomes, expert opinion and senior support should be readily available. (1) Management of incidental findings detected during research imaging. https://www.rcr.ac.uk/sites/default/files/docs/radiology/pdf/BFCR%2811%298_Ethics.pdf

5) The accuracy of ultrasound scanning in detecting the presence of axillary lymph node metastases in patients presenting with symptomatic breast cancer

J. Sammut¹, C. Sirianni¹, C. Barwick²

Affiliations:

¹Department of General Surgery, YsbytyGwynedd, BetsiCadwaladr University Health Board, North Wales

²Department of Radiology, YsbytyGwynedd, BetsiCadwaladr University Health Board, North Wales

Abbreviations: USS – Ultrasound Scan; ANMD – Axillary Nodal Metastatic Disease; FNA – Fine Needle Aspirate; SLNB – Sentinel Lymph Node Biopsy; RCR – Royal College of Radiologists

Introduction: Patients with breast complaints are often assessed in the rapid access breast clinic. For palpable breast lumps, an ultrasound scan (USS) forms part of the ‘triple’ assessment. An USS is useful not only for differentiating benign from malignant lumps but also, for the latter lesions, in helping determine if the cancer has spread to the nodes in the axilla. If axillary nodal metastatic disease (ANMD) can be identified (i.e. by USS-guided fine needle aspiration (FNA) and/or biopsy) at this assessment stage, then patients will often undergo an axillary clearance at the time of their primary surgery. Otherwise, patients will have a sentinel lymph node biopsy (SLNB) at the time of their primary surgery and then, if the SLNB shows ANMD they will often then have a second procedure to remove the axillary nodes at a later date. **Methods:** We conducted a retrospective audit of all patients who presented to the rapid access breast clinics serving North West Wales (i.e. Llandudno General Hospital and YsbytyGwynedd) during the year 2014. Patients were excluded if their cancer was diagnosed through the national breast screening programme. Any patient who had a diagnosis of cancer and had an axillary procedure (i.e. SLNB, axillary sampling or an axillary clearance) was included. We used the two standards set by the Royal College of Radiologist (RCR) as our outcomes for assessment. These are: 1) USS should identify patients with ANMD in 50% of patients; and 2) USS guided FNA/biopsy should be accurate in the identification of metastatic disease in nodes which appear abnormal on USS. The accuracy (i.e. sensitivity) of the second standard should be at least equal to the prevalence of ANMD in first time presenters to the local symptomatic breast service. **Results:** 80

patients were identified as having had an axillary procedure as part of the staging for breast cancer, having initially presented to a rapid access breast clinic. 32 (40%) of these patients were found to have ANMD. 22 patients were considered to have abnormal looking nodes on USS: 11 classed as likely involved with cancer (i.e. U4 or U5) and 11 having an indeterminate USS appearance (i.e. U3). All of the former patients were subsequently shown to have ANMD; 6 of the 11 patients with U3 nodes were subsequently shown to have ANMD – 3 of these 6 patients did not have a positive USS-guided FNA for cancer but a subsequent surgical procedure showed there to be ANMD. Thus, USS was accurate in identifying patients with ANMD in 17 of the 32 patients (i.e. 53.1%) - so standard 1 was met. 13 of the 32 patients who were subsequently found to have ANMD had a normal pre-operative USS appearance; in the final two patients no comment on the axillary nodes was made on the assessment USS at presentation. However, for both of these patients it was an indeterminate primary breast lesion (one U3 and another U4). 14 patients were confirmed pre-operatively (i.e. by USS-guided FNA and/or biopsy) as having ANMD. This is equivalent to 43.8% of all patients subsequently diagnosed with ANMD, which is higher than the prevalence of ANMD in the first time presenters in our patient group (i.e. 40%) – so the second RCR standard was also met. **Conclusions:** We identified that the local practice at our hospitals met both of the RCR standards for the 12 month period assessed in this audit. When the USS appearances were highly suspicious for ANMD, it was 100% specific but the specificity was around 55% for indeterminate lesions. Although the FNA did not reveal ANMD in 3 patients, all these 3 patients had indeterminate (U3) appearances of the axillary nodes and although subsequently found to have ANMD it is very likely that a relatively small proportion of the relevant nodes were replaced by cancerous tissue (i.e. the FNAs were most likely technically accurate). One negative finding from this audit was that there was no comment on the axillary appearances for four patients, two of whom were subsequently found to have ANMD. This will be highlighted by internal review and can be assessed by re-auditing in six months time. Overall the radiological performance has been found to be good.



8. SRT ABSTRACT SUBMISSIONS

POSTER ABSTRACT SUBMISSIONS

Scientific

TITLE	PRESENTER
1) Association of pre-treatment PSA, Gleason Score and MRI staging in newly diagnosed prostate cancers	Dr. Ashok Bhuvanagiri
2) Optimization of CT pulmonary angiography by applying cardiac CT techniques	Dr. Imran Yousuf
3) Role of Transrectal prostate biopsy and Bone Scan in patients presenting with high PSA in advanced prostate cancers.	Dr. Ashok Bhuvanagiri
4) The incidence of contrast induced nephrotoxicity (CIN) amongst inpatients undergoing CT scans	Dr. Nigel Khoo
5) The use of computer aided diagnosis (CAD) system in CT colonography:-- Experience from a tertiary centre	Dr. Bhosekar T
6) Precision of (18)F-fluoride PET skeletal kinetic studies in the assessment of bone metabolism	Dr. Yosra Albeyatti
7) Diagnostic outcomes of highly suspicious masses on GP-requested chest radiographs	Dr. Sana Ali
8) Data analysis consideration for diffusion kurtosis imaging	Dr. Caryl Richards
9) Assessing head and neck tumour heterogeneity with MRI	Dr. Mustafa Anjari
10) Accuracy of CT requests in patients with renal impairment	Dr. Natalia Levchenko
11) Assessing the quality of the Hysterosalpingography service at UHL	Dr. Reena Aggarwal
12) Improving the patient journey - diagnosis and management of Crohn's disease with small bowel MRI	Dr. Kate Thomas
13) Which thyroid nodules need fine needle aspiration	Dr. David Bell

14) Evaluation of current algorithms for segmentation of scar tissue from late Gadolinium enhancement cardiovascular magnetic resonance of the left atrium: an open-access grand challenge	Dr. Yosra Albeyatti
15) Implementing WHO's surgical checklist in Interventional Radiology in St Peter's Hospital	Dr. Yosra Albeyatti
16) How robust is our follow up of patients	Dr. Amit Gupta
17) Evaluation of plain radiographs as an imaging method in assessing blunt trauma patients with a suspicion of cervical spine injury	Dr. Garner Megan

Educational/Case report/series

TITLE	PRESENTER
18) Simulated based teaching in radiology	Dr. Horea Craciun
19) Incorporating radiology into simulation teaching for final year medical students	Dr. Vincent Lam
20) Foundation doctors' knowledge of radiation legislation and exposure	Dr. Bina Vekaria
21) How to unlock 2A modules with minimum effort	Dr. Ayyaz Mahmood
22) A pictorial review of neonatal pneumoperitoneum	Dr. Gana Kugathanan
23) A pictorial review of intra-abdominal calcifications prompted by a curious case of traditional Chinese medicine	Dr. Sarah Eljamel
24) A pictorial review of neonatal pneumothorax	Dr. Gana Kugathanan
25) A pictorial review of paediatric emergencies on ultrasound	Dr. Asha Omar
26) A forgotten cause of abdominal pain: a clinical radiological and pathological review of meckle's diverticulum	Dr. Andrew Cumming
27) Cronkhite Canada Syndrome, a pictorial review	Dr. Amit Gupta
28) Tuberos Sclerosis, a pictorial review	Dr. Amit Gupta
29) Pictorial representation of upper GI surgery on CT	Dr. Kirsten Pearce
30) Review of MERS-Cov Chest X-rays and interesting A&E Radiological Images at Our Tertiary Centre, King Fahad Hospital in Jeddah, Kingdom of Saudi Arabia	Dr. Sultan Al Marzouqi
31) ECMO: What do radiologists need to know	Dr. Amy Barrett

32) Radiology trainees guide to interstitial lung diseases	Dr. Hind Saffar
33) Investigation and management of biloma formation in a case of gall bladder perforation	Dr. Sorah Tomas
34) Missed complete absence of iliac arteries in the left hemipelvis in a case of deceased donor renal transplantation!	Dr. EbrahimPalkhi
35) Giant faecaloma - a rare cause of life threatening gastrointestinal haemorrhage.	Dr. Flavius Parvulescu
36) Prostate artery embolisation: an educational overview	Dr. Rachael Manning
37) Anatomy and pathologies of the superior mesenteric artery and its branches: Pictorial synopsis and clinical implications	Dr. Lyn Zimmo
38) Vascular Anatomy of the abdomen and variants	Dr. SrividyaArya
39) Recognition of emphysematous pancreatitis	Dr. Rebecca Spruce
40) Radiological detection of intussusception	Dr. Rebecca Spruce
41) CT imaging in patients on extracorporeal membrane oxygenation	Dr. Naveen Sharma
42) Fluoroscopy of the genito-urinary tract: not dead yet, and still very useful in the post operative evaluation of the urology patient	Dr. Mustafa Anjari
43) Management of persistent orthostatic headache: the value of CT myelography and cisterography	Dr. Mustafa Anjari
44) An atlas of the ultrasound machine	Dr. Charles Bishop
45) WHO checklist for interventional radiology	Dr. Thomas Puttick
46) The many faces of stroke	Dr. Kirsten Kind
47) Muscle not mass	Dr. Nick Heptonstall
48) Great impersonators – Benign mimics of breast malignancy on mammography and ultrasound	Dr. Olga Shaw
49) Requesting lumbar radiographs in patients with back pain	Dr. Ibrahim Niematallah
50) Risk management in Radiology	Dr. Amoolya Mannava

Audit/Service/Quality Improvement

TITLE	PRESENTER
51) Audit on NICE Clinical Guideline 169, entitled 'Acute Kidney Injury'	Dr. David James Thompson
52) Audit of ultrasonography findings and documentation in cases of abnormal MRCP in biliary pathology	Dr. Subra Nachiappan
53) An audit exploring reasons for repeat nephrostomies and compliance with the use of prophylactic antibiotics at the Royal Liverpool Hospital	Dr. Wee Ping Ngu
54) Audit on prevention of contrast induced nephropathy in patients undergoing contrast-enhanced CT	Dr. Brooke Lawson
55) Re-audit: Exclusions of the lens of the eye in routine ct head examinations at Lewisham hospital	Dr. Rebecca Spruce
56) An audit of the practices of reporting staging CT scans in primary malignancies	Dr. Sana Ali
57) An audit of our skeletal survey practise for non-accidental injury	Dr. Amit Gupta
58) Fluoroscopic assessment for complications following Laparoscopic adjusted gastric band. An Audit of radiation dose	Dr. Rosanna Frost
59) The length of time for pediatric USS scans to be examined and reported from time of vetting	Dr. Rebecca Spruce
60) CT head Injury audit, are we following guidelines?	Dr. Amit Gupta
61) Auditing the diagnostic adequacy of CT guided chest and abdominal biopsy and their complications against newly defined local standards	Dr. Idris Badreddine