13th Annual BSGAR Meeting

2nd - 4th February 2011 • The Lowry Hotel, Manchester

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Creative Conferences has had the pleasure of organising the BSGAR Annual Meetings since the inception of SIGGAR in 1999. We hope we'll see you next year in Cardiff.

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Chairman's Welcome

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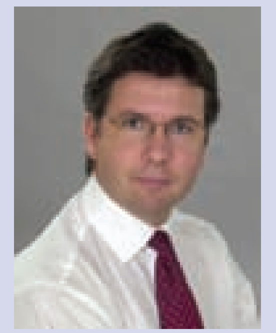

Dear Colleagues,

On behalf of the organising committee I have the privilege of welcoming you to the Lowry Hotel in Manchester for the 13th Annual Meeting of the British Society of Gastrointestinal and Abdominal Radiology.

The Committee has worked hard to develop this year's programme which I hope you agree contains a number of interesting, scientifically relevant topics again based on suggestions received following recent BSGAR meetings. No successful meeting occurs without a sustained effort from many people and I am profoundly grateful to everyone who has contributed to the event including importantly all the participating speakers and chairpersons.

In particular I would like to welcome Professor Celso Matos from The Hôpital Erasme-Université Libre de Bruxelles who will deliver the 2011 Richard Farrow memorial lecture as well as updating us on the latest developments in MRCP technique.

After due consideration we have kept the overall format of the meeting similar to last year's popular programme and thus the Committee very much look forward to greeting you at our opening BSGAR welcome reception as well as at the annual dinner.

I do hope that you enjoy the 13th BSGAR Annual Meeting which as always promises to deliver both excellent education combined with the usual BSGAR hospitality!

Dr Simon Jackson
Chairman, BSGAR

Meeting Programme

Wednesday 2nd February 2011

18.30 - 20.00 Welcome Reception

Thursday 3rd February 2011

08.30 - 08.55 Registration and Coffee

08.55 - 09.00 Welcome and Introduction
Dr Simon Jackson, Chairman, BSGAR - Derriford Hospital, Plymouth

09.00 - 10.30 **Session: Multidisciplinary IBD Management**
Chairman: Dr Andrea Phillips - Royal United Hospital, Bath

Update - What's new for the GI radiologist?

09.00 - 09.15 Medical Management
Speaker: Dr Alistair Makin - Manchester Royal Infirmary

09.15 - 09.30 Surgical Management
Speaker: Mr Jim Hill - Manchester Royal Infirmary

Imaging markers of disease activity/severity:

09.30 - 09.50 Assessment With US
Speaker: Dr Anthony Higginson - Queen Alexander Hospital, Portsmouth

09.50 - 10.10 Role of MRI/CT
Speaker: Dr Stuart Taylor - University College Hospital, London

10.10 - 10.30 Panel Discussion

10.30 - 11.15 Coffee and Exhibition

11.15 - 12.40 **Session: Developments in Abdominal Trauma Radiology**
Chairman: Dr Simon Jackson - Derriford Hospital, Plymouth

11.15 – 11.35 Setting the Scene - Lessons from Afghanistan
Speaker: Surg Cdr Ewan Armstrong - Derriford Hospital, Plymouth

11.35 - 11.55 Optimising Cross Sectional Imaging Algorithms
Speaker: Lt Col Andrew West - University Hospital of Birmingham

Thursday 3rd February 2011

11.55 - 12.15 Interventional Radiology - Where and When?
Speaker: Dr Iain Robertson - Greater Glasgow and Clyde

12.15 - 12.40 Panel Discussion

12.40 - 14.00 Lunch and Exhibition

14.00 - 15.10 **Debate: "This House Supports Delegation of the Radiologists Role to Radiographers."**
Chairman: Dr Hans-Ulrich Laasch - The Christie, Manchester
For: Dr Clive Kay - Bradford Royal Infirmary
Mrs Jane Smith - St James University Hospital, Leeds
Against: Dr David Richardson - Royal Victoria Infirmary, Newcastle-Upon-Tyne
Dr Peter Rodgers - Leicester Royal Infirmary

15.10 - 15.30 BSGAR Related National Trials and Audits - Members Update
Speakers: Dr Stuart Taylor - University College Hospital, London
Dr Andrew Lowe, Bradford Royal Infirmary

15.30 - 16.15 Tea Break and Exhibition

16.15 - 17.00 **THE RICHARD FARROW MEMORIAL LECTURE**
Chairman: Dr Ashley Guthrie - St James University Hospital, Leeds

Differentiating inflammatory from neoplastic disease of the pancreas
Speaker: Prof Celso Matos - Hôpital Erasme-Université Libre de Bruxelles, Brussels

17.00 Meeting Ends

17.00 - 18.00 Annual General Meeting (BSGAR members only)

19.00 Meet at Reception of The Lowry for Coach Pick-up

19.30 Drinks Reception and Winter Barbeque at Great John Street Hotel

Friday 4th February 2011

08.30 - 08.45	Coffee
08.45 - 09.50	**Session: Interesting Cases Presentation** Chairman: Dr Damian Tolan - Leeds General Infirmary
09.50 - 10.00	National Registries - Members Update Speaker: Dr Hans-Ulrich Laasch - The Christie, Manchester
10.00 - 11.00	**Session: Staging GI Tumours - Tips and Tricks** Chairman: Dr Andrew Lowe - Bradford Royal Infirmary
10.00 - 10.15	The Oesophagus/Stomach Speaker: Dr Brinder Mahon - University Hospital of Birmingham
10.15 - 10.30	The Solid Pancreatic Mass Speaker: Dr Maria Sheridan - St James University Hospital, Leeds
10.30 - 10.45	Anal Cancer Speaker: Dr Rohit Kochhar - The Christie, Manchester
10.45 - 11.00	Peritoneal Tumours Speaker: Dr Ben Taylor - The Christie, Manchester
11.00 - 11.30	Coffee and Exhibition
11.30 - 11.35	Prizes
11.35 - 13.15	**Session: Challenging Topics for the GI and Abdominal Radiologist** Chairman: Dr David Breen - University Hospital of Southampton
11.35 - 12.00	Liver DWI - The Prerequisites Speaker: Dr Ashley Guthrie - St James University Hospital, Leeds
12.00 - 12.25	Secretin Enhanced MRCP Speaker: Prof Celso Matos - Hôpital Erasme-Université Libre de Bruxelles, Brussels
12.25 - 12.50	The Incidental Splenic Mass Speaker: Dr Simon Freeman - Derriford Hospital, Portsmouth
12.50 - 13.15	The Difficult Pancreatic Biopsy Speaker: Dr Nick Carroll - Addenbrookes Hospital, Cambridge
13.15 - 13.20	Close of Meeting

Social Events

Wednesday 2nd February 2011

18.30 - 20.00	Welcome Reception The Library - first floor

Thursday 3rd February 2011

19.00	Meet at Reception of The Lowry for Coach Pick-up transfer to The Great John Street Hotel
19.30	Drinks Reception at The Oyster Bar (pictured) and Winter Barbeque at Great John Street Hotel

Delegate List

A

Dr Kirsty Anderson
Freeman Hospital, Newcastle upon Tyne

Surg Cdr Ewan Armstrong
Derriford Hospital, Portsmouth

Dr Janice Ash-Miles
University Hospitals, Bristol

Dr Sheila Augustine
Royal Albert Edward Infirmary, Wigan

Dr Dina Awad
Royal Preston Hospital

B

Dr Clive Bartram
Princess Grace Hospital

Dr Christine Baudouin
Freeman Hospital, Newcastle upon Tyne

Dr Maggie Betts
John Radcliffe Hospital, Oxford

Dr Sean Blake
Airedale NHS Trust

Dr Tony Booth
Hinchingbrooke Hospital, Huntingdon

Dr David Breen
University Hospital of Southampton

Dr Robert Briggs
Huddersfield Royal Infirmary

Dr John Brittenden
Mid Yorks NHS Trust

Dr Ingrid Britton
University Hospital, North Staffs

Dr David Bruce
University Hospitals of Leicester

Dr John Brush
Western General Hospital

B

Dr Timothy Bryant
Southampton General Hospital

Dr Simon Burbidge
Leeds General Infirmary

Dr Hugh Burnett
Salford Royal Foundation Trust

Dr Briony Burns
Western Sussex NHS Trust, Chichester

C

Dr Shona Campbell
University Hospitals of Leicester

Dr Nick Carroll
Addenbrookes Hospital, Cambridge

Dr Peter Chowdhury
Singleton Hospital, Swansea

Dr D Christodoulou
Guys Hospital

Dr Joanne Corkan
Wigan Royal Infirmary

Dr Conor Corr
Wrexham Maelor Hospital

Dr Nicholas Cross
Nevill Hall Hospital, Abergavenny

D

Dr S Desai
Royal Albert Edward Infirmary, Wigan

Dr Rajpal Dhingsa
Queens Medical Centre, Nottingham

Dr Nick Dodds
Royal Cornwall Hospital

E

Dr Derek Edwards
The Christie Hospital, Manchester

E

Dr Julian Elford
Royal Hampshire County Hospital

Dr Sarah Evans
Kingston Hospital

F

Dr Neil Fairlie
Northampton General Hospital
NHS Trust

Dr David Fleming
Royal Gwent Hospital, Newport

Dr Simon Freeman
Derriford Hospital, Portsmouth

Dr Roger Frost
Salisbury District Hospital

G

Dr John Garrett
Kent and Sussex Hospital, Kent

Dr Stephen Glancy
Western General Hospital

Dr Edmund Godfrey
Addenbrooke's Hospital, Cambridge

Dr Catherine Grierson
Southampton General Hospital

Dr Alan Grundy
St George's Hospital

Dr Ashley Guthrie
St James University Hospital, Leeds

H

Professor Steve Halligan
University College Hospital

Dr John Hancock
Royal Cornwall Hospital

Dr Ian Harris
Lancashire Teaching Hospital
NHS Trust

H

Dr Keith Harris
Leeds General Infirmary

Dr Stephen Hayward
Royal United Hospital, Bath

Dr Eryl Hicks
Royal Glamorgan Hospital

Dr A. Higginson
Queen Alexander Hospital, Portsmouth

Dr Jim Hill
Manchester Royal Infirmary

Dr Rob Holmes
Royal Victoria Infirmary, Newcastle

Dr Fuad Hussain
Royal Surrey County Hospital

Dr Rachel Hyland
Leeds General Infirmary

J

Dr Simon Jackson
Derriford Hospital, Portsmouth

Dr Yatin Jain
North Manchester General Hospital

Dr J Craig Jobling
Nottingham University Hospital

Jackie Johnson
Salford Royal

K

Dr Mathew Kaduthodil
Bradford Royal Infirmary

Dr M Kamal
Lincoln County Hospital

Professor Sung-Gwon Kang
Seoul National University
Medical College

Dina Kasir
Salford Royal

K

Dr Clive Kay
Bradford Royal Infirmary

Dr Rohit Kochhar
The Christie, Manchester

L

Dr Hans-Ulrich Laasch
The Christie, Manchester

Dr Amanda Law
Royal Bolton Hospital

Dr Kathryn Lawrence
Dorset County Hospital

Dr Stephen Lee
Manchester Royal Infirmary

Dr Amanda Liddicoat
Royal Cornwall Hospital

Dr. Andy Lowe
Bradford Royal Infirmary

M

Dr Peter Maclean
Western General Hospital

Dr Jenny MacPherson
North Devon District Hospital

Dr Brin Mahon
University Hospital of Birmingham

Dr A Makin
Manchester Royal Infirmary

Dr Richard Mannion
York DGH

Dr Michele Marshall
St Mark's Hospital

Dr Giles Maskell
Royal Cornwall Hospital

Prof Celso Matos
Hôpital Erasme-Universite
Libre de Bruxelles, Brussels

M

Dr Rod Mawhinney
Harrogate Foundation Trust

Dr Alan McCulloch
Ninewells Hospital, Dundee

Dr Shaun McGee
Salisbury District Hospital

Rajiv Menezes
Southport and Ormskirk NHS Trust

Danielle Murphy
Salford Royal

O

Dr Sarah O'Shea
Manchester Royal Infirmary

P

Dr Delia Peppercorn
North Hampshire Hospital

Dr Dan Petty
York DGH

Dr Andrea Phillips
Royal United Hospital, Bath

Dr Kate Potter
Royal Surrey County Hospital

Dr Deepak Prasad
Bradford Royal Infirmary

Dr Samad Punekar
Bradford Royal Infirmary

R

Dr Sridharan Ramachandran
Wigan Infirmary

Dr Catherine Ramsey
West Middlesex University Hospital

Dr Rubeena Razzaq
Royal Bolton Hospital

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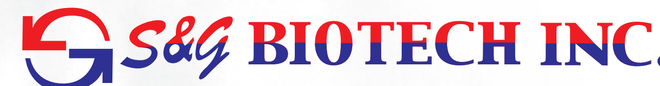

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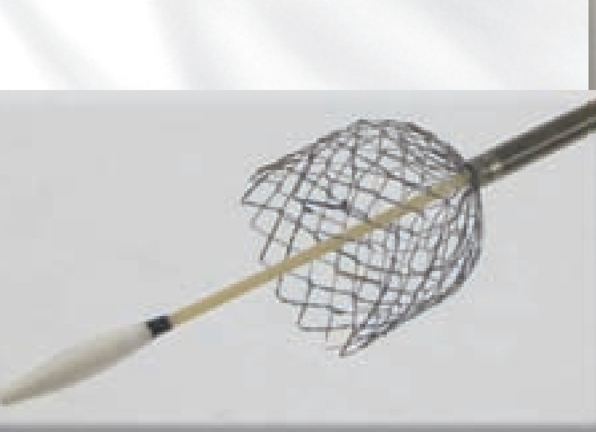
- Colorectal
- Oesophageal



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Lisa Renaut
Salford Royal

Dr Ian Renwick
Scarborough Hospital

Dr Paul Rice
Cragavon Area Hospital, Co Armagh

Dr David Richardson
Royal Victoria Infirmary
Newcastle-Upon-Tyne

Dr Huw Roach
University Hospitals Bristol

Dr Ashley Roberts
University Hospital of Wales, Cardiff

Dr Catherine Roberts
Huddersfield Royal Infirmary

Dr Ian Robertson
Glasgow Royal Infirmary

Dr Lili Robinson
Leicester Royal Infirmary

Dr Mark Robinson
Royal Gwent Hospital, Newport

Dr Peter Rodgers
Leicester Royal Infirmary

Dr V. Rudlingam
University Hospital South Manchester

S

Dr Milan Sapundaeski
Fairfield Hospital, Bury

Dr John Scott
Freeman Hospital, Newcastle

Dr David Scullion
Harrogate DGH

Dr Rishi Sethi
Manchester Royal Infirmary

S

Dr Vikas Shah
Charing Cross Hospital, London

Dr Maria Sheridan
St James University Hospital, Leeds

Dr Tony Sheridan
Warrington Hospital

Dr John Shirley
Plymouth Hospital

Dr Phil Shorvon
Central Middlesex Hospital

Dr Andrew Slater
John Radcliffe Hospital, Oxford

Dr David Steele
Wishaw General Hospital

Dr Rob Stockwell
Chorley and South Ribble DGH

Dr Madeline Strugnell
Royal Cornwall Hospital

Dr S.A.Sukumar
University Hospital of South
Manchester

T

Dr Eddie Tam
North Manchester General

Dr Ben Taylor
The Christie, Manchester

Dr S Taylor
University College Hospital, London

Dr Sue Tebby-Lees
East Cheshire NHS Trust

Dr A.M.Thompson
Downe Hospital, Northern Ireland

Dr Andrew Thrower
North Hampshire Hospital

T

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Dr Carolyn Tweed
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U

Dr Ken Uzoka
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V

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George Elliott Hospital, Nuneaton

Dr Ragu Vinayagam
Sheffield Teaching Hospitals

Dr Vivek Vohra
Bedford Hospital

Dr Alireza Vosough
Aberdeen Royal Infirmary

W

Dr Sharan Wadhwani
Manchester Radiology Training Scheme

Lt Col Andrew West
University Hospital of Birmingham

Dr Mark White
Airedale NHS Foundation Trust

Dr Siobhan Whitley
Cambridge University Hospitals

Dr Luke Williams
Hope Hospital Salford

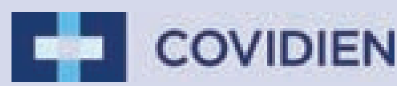
Dr Peter Wylie
Royal Free Hospital

Z

Dr Ian Zealley
Ninewells Hospital Dundee

Sponsors & Floorplan

Bayer have kindly agreed to sponsor the course dinner.



Exhibitor Attendees

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Nicole Farmer
Suzanne Jarvis
Bracco
Debbie Hallam
Liz Hodge
BVM
Alan Atkinson
Eddie Mahon
Covidien
Richard Waddington
Cook Medical
Gill Ashworth
Coleen Jones
Phillip Pickles
Guerbet
Noel Powell
Barbara Suggitt
Hitachi Medical Systems
Stephen Brookes
Jonathan Clode
Kurt Lauriers
Keymed
Michael Harwood
Manatech
Chris Bolter
Andrew Maxwell
Medicsight
Dylan Griffiths
Novartis
Howard Caseley
Sean Graham
Ian Lloyd
Sanochemia Diagnostics
Denis Underwood
UK Medical
Robert Bardsley
Paul O'Brien
Prof K Volonec
Vygon
Graham Milward
Irwm Javed

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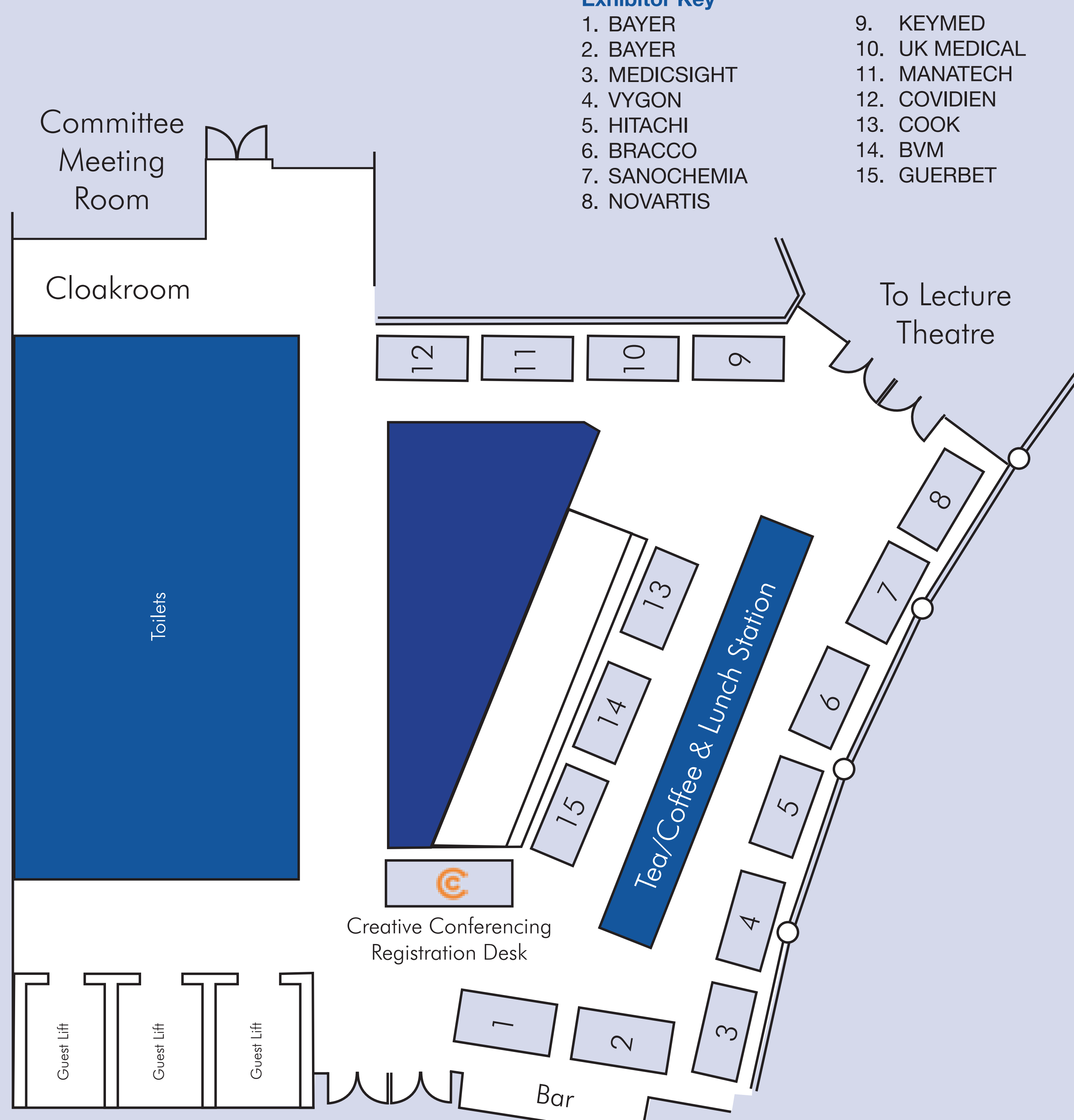
10. UK MEDICAL
11. MANATECH
12. COVIDIEN
13. COOK
14. BVM
15. GUERBET



THE DIFFICULT PANCREATIC BIOPSY

12.50 - 13.15 Friday 4th February

Dr Nick Carroll - Cambridge University Hospitals NHS Foundation Trust

Pancreatic biopsy

- Why bother?
- Which method
- What makes it difficult
  - Location
  - Tissue
  - Lesion visibility
  - Access
  - CBD Stent
  - Chronic pancreatitis
- Processing/analysis of material
- Cytology v histology
- What makes it difficult for cytologist/histopathologist

C.P and stenting

- CP can cause cellular atypia closely mimicking well-differentiated pancreatic adenocarcinoma and can make the diagnosis difficult
- The presence of CP lowers the sensitivity, PPV, and accuracy of EUS-FNA for a pancreatic cancer diagnosis only in the subset patients with obstructive jaundice and who have a biliary stent in place at the time of EUS-FNA.

THE INCIDENTAL SPLENIC LESION

12.25 - 12.50 Friday 4th February

Dr Simon Freeman - Derriford Hospital, Portsmouth

- The spleen has been named “the forgotten organ” because:
  - Focal lesions of the spleen are relatively rare
  - Splenic pathology is frequently clinically silent
- Incidental splenic lesions will however regularly be encountered by abdominal radiologists
- Benign splenic lesions are slightly more common than malignant lesions
- Splenic lesions are often difficult to characterise based purely on their imaging appearances, however correlation with clinical findings and laboratory data frequently allows a presumptive diagnosis to be made

This talk will:

- Review normal splenic variants that may be confused with disease
- Illustrate a variety of benign and malignant focal splenic lesions
- Discuss an approach to diagnosis of an incidental splenic lesion that will emphasise the value of conventional and microbubble contrast enhanced ultrasound
- Review the indications, technique and safety of targeted splenic biopsy comparing fine needle aspiration with core biopsy

STAGING OF ANAL TUMOURS - TIPS AND TRICKS

10.30 - 10.45 Friday 4th February

Dr Rohit Kochhar - The Christie, Manchester

Introduction

- Anal cancer is an uncommon malignancy
  - 1.5% of all GI cancers
  - 800 new cases in the UK per year

- The primary tumour size, location and depth of penetration at presentation are the most important prognostic factors

- Anal sphincter preservation with radiochemotherapy (CRT) is the standard of treatment for most patients with anal cancers

- Anal cancer is characterised by a high-risk of local relapse: 25 to 30% of cases relapse and require radical salvage surgery

Conclusion

- MRI including DWI has a key role to play both in primary staging and post treatment assessment
- Response assessment after treatment of primary anal cancer with CRT is particularly challenging and involves
  - correlation with pretreatment MRI
  - recognition of serial changes related to treatment effect on MRI
  - need for EUA and identification of recurrence
  - eligibility for salvage
- Post therapy FDG PET CT response is a better outcome predictor than pretreatment tumour size or nodal status
- Imaging and treatment of anal cancer requires specialist multi-disciplinary care and should be centralised

ROLE OF MRI/CT

09.50 - 10.10 Thursday 3rd February

Dr Stuart Taylor - University College Hospital, London

Crohn's disease activity on MRI & CT

- Wall thickness (MRI & CT)
- Increased mural signal
- Layered enhancement (MRI and CT)
- Absolute enhancement - complex relationship
- Ulceration
  - ? Comb sign
  - Lymph node enhancement

Imaging markers of disease activity - Role of CT/MRI

- Learning objectives
  - To briefly describe the subtypes of Crohn's disease
  - To present MRI and CT protocols optimised to Crohn's disease
  - To discuss the literature pertaining to the assessment of disease activity and highlight weakness or inconsistencies
  - To present validated makes of disease activity on CT and MRI

STAGING PANCREATIC ADENOCARCINOMA – LEARNING POINTS

10.15 - 10.30 Friday 4th February

Dr Maria Sheridan - St James University Hospital, Leeds

1. Describe TNM staging and other clinical systems that inform patient management
2. Revise absolute and relative criteria for non – resectability
3. Discuss borderline resectability

- **Locally invasive (AJCC stage III)**
  - Peripancreatic structures (small bowel mesentery & transverse mesocolon)
  - Peripancreatic veins (SMV, PV, SV)
  - Peripancreatic arteries (HA, CA, SMA)

- **Metastatic disease (AJCC stage IV)**
  - Liver
  - Distant lymph node (beyond surgical resection planes)
  - Peritoneum
  - Lungs & bone

Borderline Resectability

- Vascular resection
  - Severe unilateral invasion of SMV/PV
  - Tumour abutment on SMA
  - Gastroduodenal artery involvement upto HA
  - Limited IVC involvement
  - Short segment SMV occlusion (proximal & distal patency

STAGING PERITONEAL TUMOURS –TIPS AND TRICKS

10.45 - 11.00 Friday 4th February

Dr Ben Taylor - The Christie, Manchester

- CT is accurate in the majority of patients, but CE-MRI has a higher sensitivity for detection of small deposits. DW-MRI may further increase sensitivity.
- CT tumour detection is optimal with oral contrast – but beware calcified deposits.
- The most common sites of involvement are the greater momentum, Pouch of Douglas, sigmoid mesentry, paracolic gutters and subphrenic spaces, but the supracolic momentum, gastrohepatic ligament and small bowel mesentry are important review areas.
- Overall tumour volume is predictive of operability, but infiltration of the small bowel and mesentry are the most important individual factors.
- Pseudomyxoma peritonei (PMP) typically presents with mixed solid and low density (mucinous) peritoneal deposits, with scalloping of the liver being a characteristic feature. The condition usually arises from an appendiceal mucinous tumour, which may be visible as a tubular cystic structure, often with wall calcifications.

- Levy AD, Shaw JC, Sobin LH. Secondary tumors and tumorlike lesions of the peritoneal cavity: imaging features with pathologic correlation. Radiographics. 2009 Mar-Apr;29(2):347-73. Review.
- Coakley FV, Choi PH, Gougoutas CA, Pothuri B, Venkatraman E, Chi D, Bergman A, Hricak H. Peritoneal metastases: detection with spiral CT in patients with ovarian cancer. Radiology. 2002 May;223(2):495-9.
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- Low RN, Barone RM, Gurney JM, Muller WD. Mucinous appendiceal neoplasms: preoperative MR staging and classification compared with surgical and histopathologic findings. AJR Am J Roentgenol. 2008 Mar;190(3):656-65.
- Kyriazi S, Collins DJ, Morgan VA, Giles SL, deSouza NM. Diffusion-weighted imaging of peritoneal disease for noninvasive staging of advanced ovarian cancer. Radiographics. 2010 Sep;30(5):1269-85.

LIVER DWI - THE PREREQUISITES

11.35 - 12.00 Friday 4th February

Dr Ashley Guthrie, St James's University Hospital Leeds

- With DWI contrast is generated by differences in the random (Brownian) motion of protons
- This motion becomes "restricted" by the presence of macromolecules, cell and organelle membranes
- The greater the motion - the lesser the restriction - the smaller the signal
- An old concept but to produce abdominal images of acceptable quality this has required the development of hardware eg parallel imaging, to eliminate other sources of motion
- Diffusion gradients are modified (b values) to vary the sensitivity to diffusion motion, if at least 3 values are generated the apparent diffusion coefficient (ADC) can calculated
- ADC is an index of signal intensity: b value and can produce an image (map). Diffusion restriction reduces signal on the ADC map ie the converse of the DWI images
- The sequence is T2 weighted – tissues with long T2 times (bright on T2) demonstrate high signal intensity on DWI - "T2 shine through"
- Mistaking high T2 signal for DWI restriction can be overcome by the use of ADC maps and conventional T2 images
- A major clinical role is the detection of lesions particularly those less than 1cm in diameter in the non-cirrhotic liver
- Cysts can be differentiated from solid lesions, but characterization of other lesions is limited
- DWI should be seen an adjunct rather than replacement for contrast agents
- DWI can also be used to detect responses of metastases to chemotherapy prior to changes in size, and to some extent assessing parenchymal liver disease

References

1) Koh DM, Collins DJ. Diffusion weighted MRI in the body: Applications and Challenges in Oncology. AJR. 2007. 188:1622-1635.

2) Coenegrachts K, Matos C, Ter Beek L, et al. Focal liver lesion detection and characterization: comparison of non-contrast enhanced and SPIO-enhanced diffusion- weighted single-shot spin echo echo planar and turbo spin echo T2-weighted imaging. European Journal of Radiology. 2009. 72(3):432-439.

3) Low RN, Gurney J. Diffusion-weighted MRI (DWI) in the oncology patient: value of breathhold DWI compared to unenhanced and gadolinium-enhanced MRI. Journal of Magnetic Resonance Imaging. 2007. 25:848–858.

4) Sandrasegaran K, Akisik FM, Lin C, Tahir B, Rajan J, Saxena R, Aisen A. Value of Diffusion-Weighted MRI for Assessing Liver Fibrosis and Cirrhosis AJR 2009; 193:1556-1560

INTERVENTIONAL RADIOLOGY - WHERE AND WHEN?

11.55 - 12.15 Thursday 3rd February

Dr Iain Robertson, Greater Glasgow and Clyde

- Current services not fit for purpose
- Significant variation in care from 5 unexpected survivors to 8 unexpected deaths
- Lack of effective access to CT & IR
- New national trauma guidelines, CT in ATLS
- Designated major trauma centres & networks
- CT within 30 minutes; IR in 60 minutes
- IR in trauma: preserve or occlude vessels
- Technical challenges: poor coagulation - use different agents eg glue
- Technical challenges: speed
- Damage control IR
- How to assess quality in trauma IR
- Increasing scrutiny for diagnostic and interventional radiology

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- Per-polyp CAD sensitivities were 90.1% and 96.0% at 6 and 10mm threshold sizes, respectively.[1] Average of 4.7 CAD false-positives per image series 13Ø/ ' 461+').[1]
- CAD marked an additional 15 polyps of 6 mm or larger, missed by an expert but found at a subsequent colonoscopy.[1]

1. Lawrence EM, Pickhardt PJ, Kim DH, Robbins JB. Colorectal Polyps: Stand-alone Performance of Computer-aided Detection in a Large Asymptomatic Screening Population. Radiology (2010) 256, 791-798

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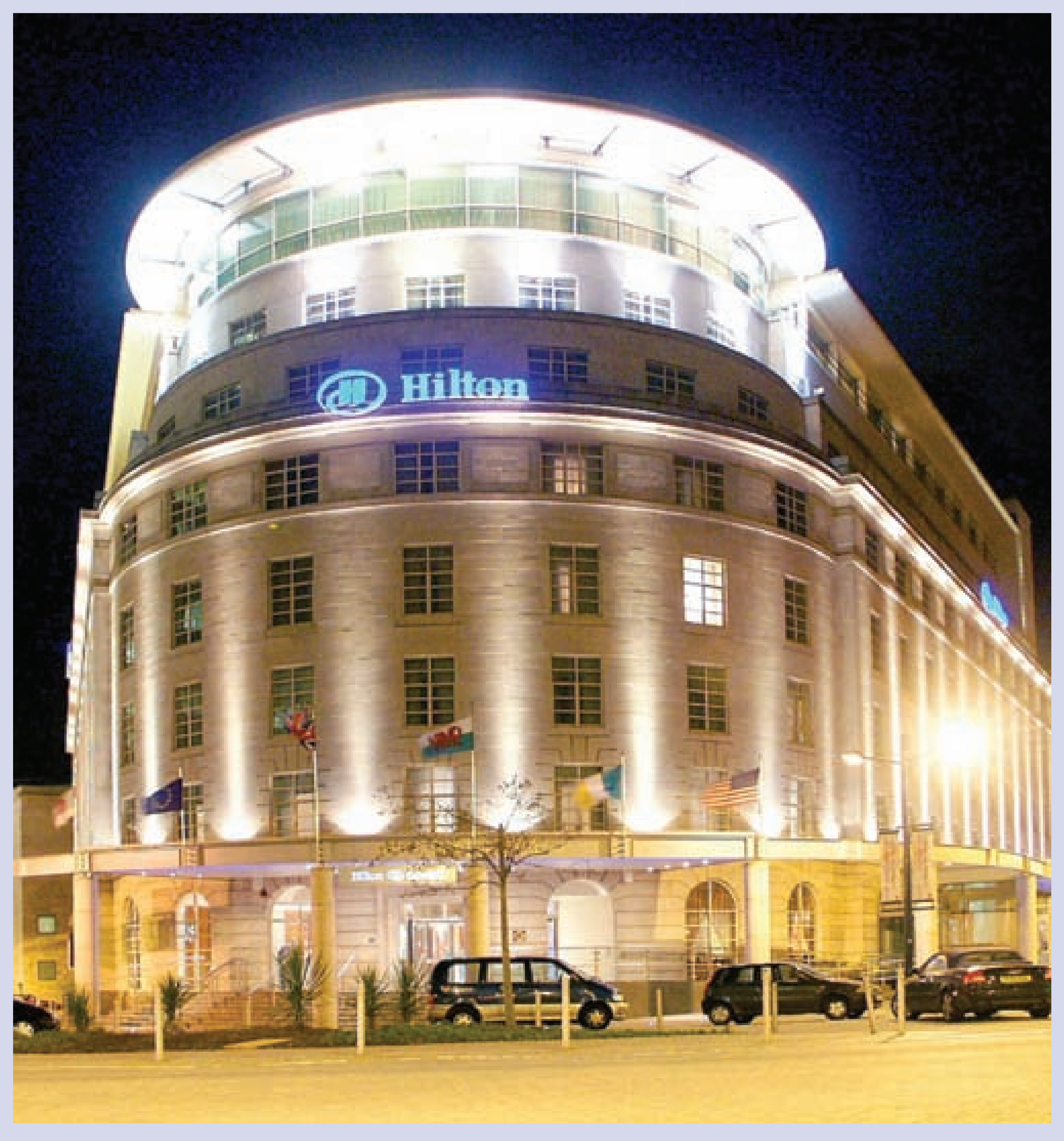
BSGAR Stand 3

Join us at Cardiff's Hilton Hotel for BSGAR 2012

Wednesday 1st February - Friday 3rd February 2012



CME certificates will only be supplied once your evaluation form has been handed in to Creative Conferences on Friday

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