SCBT-MR Spotlight

SCBT-MR Quarterly Newsletter
Editors: SCBT-MR Communications Committee

Spring | 2013

IN THIS ISSUE

- President's Address
- Case of the Quarter
- Physics Tip
- Ask the Experts
- Call for Abstracts
- Committee Updates
- Upcoming Events

President's Address

Dear Society Members and Fellows,

Our country is currently going through a tumultuous time of fiscal cuts, some of which promise to irrevocably change the way we practice medicine. Below please find a passionate article by Past-president Bill Shuman, encouraging us all to advocate for the value of expert cross sectional imaging in advancing health care and to share our expertise with our patients and with policy makers.

As our snowy winter winds up, I wish you all a sunny and happy springtime.

Best wishes,
Leslie Quint, President

Body CT and MR: Why We must Advocate Locally and Nationally

William P. Shuman, MD

Many of you likely saw and read the article from March 4 TIME magazine entitled "Why Medical Bills are Killing Us" by Steven Brill. In that article, the author argues that medical bills in the USA are much higher than other countries in part because our charges are not closely related to costs, arbitrarily set too high. Throughout the course of that 32 page article, CT and MR are cited no less than 17 times as examples of high charge healthcare expenses. It is clear that our imaging modalities are lightning rods and high voltage lightning is striking.

Regardless of how you feel about relative charges, there is danger in this scenario for patients and for radiologists. The danger is that, in the recurring rhetoric about charges, the positive benefit of modern digital imaging may get lost, overlooked, buried.

The one biggest challenge to healthcare in the USA for the next 7 years is to dramatically increase value – by up to 30% - if we are going to insure many more citizens who currently are uninsured, plus provide them better quality healthcare at lower cost. Value is defined as impact (or quality) divided by cost. The lightning strike scenario is hitting only cost, obscuring the profound positive impact on disease processes from CT and MR.

Fellowship Directory

NEW

Residents

- **View** directory of body imaging fellowships

View Fellowships

Program Directors

- Post your program's **body/cross-sectional fellowship** on our online directory.

Submit a Fellowship Listing

SCBT-MR SPOTLIGHT has the following submission deadlines:

WINTER – November 30
SPRING - February 28
SUMMER - May 31
FALL - August 31

SCBT-MR 1891 Preston White Drive
Reston, VA 20191
703-476-1117 info@scbtmr.org

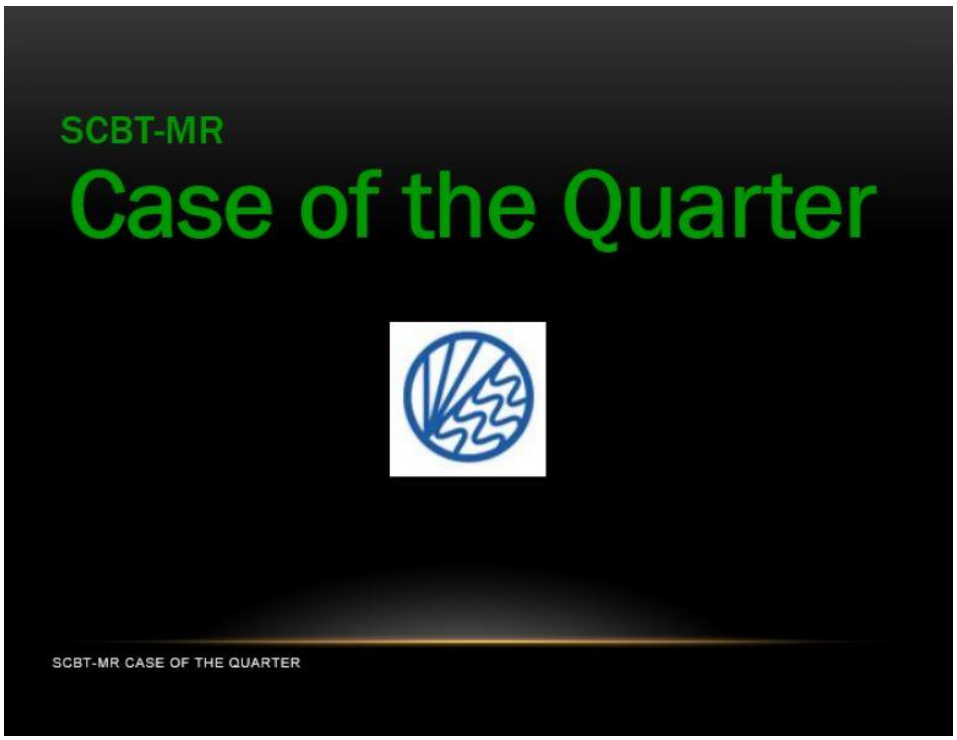
Overlooking this positive impact is where patients and radiologists may suffer from the shock waves as the Accountable Care Act and sequestration roll out.

While we in Radiology have been relatively quiet about such broad-sweeping political matters in the past, there is something we can do today to educate patients and government about the high value of CT and MR: advocate. We must, simply must, advocate for the ability of CT and MR (in the hands of knowledgeable radiologists) to quickly discover correct diagnoses, enabling precision therapy, and thus lower both cost and patient suffering. There are good studies which we can cite that document the positive impact of imaging on outcomes, on time lines, and on cost – we should cite them at every opportunity, in every venue.

Just three weeks ago, fifteen of our radiology residents took a midweek day to go to our State Capitol and talk with legislators about the role of radiology in healthcare. They came back stunned. They were surprised that legislators on the whole were not evil ogres, but were civic-minded public servants trying to do what is best for the citizens of the state – though their perspectives may differ. They discovered that the same was true for staffers and state employees. Our residents were also amazed at how little legislators knew about radiology and about CT and MR – other than cost. Yet those legislators spoke with our residents, listened, engaged, absorbed, digested, and were moved to a better understanding of value, as opposed to just cost.

You too can advocate – and each of us should. In your local community and hospital governance, you can speak up about the positive impact of CT and MR on disease outcome and on cost. You can learn how to contact your state and federal Representatives and Senators. You can write or – better yet – make appointments to go talk with your legislators or their staff. And you may be surprised to find they listen and learn. Further, because you belong to the ACR (you certainly do, don't you??) you can be sure that our professional educational/advocacy organization speaks to the world about value, insuring an understanding that radiologists care about much more than just income. And you can contribute to RADPAC, generously, till it hurts.

When the country is blinded by repeated lightning bolts which strike at high-cost imaging, it is time for each of us to use reason, logic, and data to speak thoughtful words of wisdom to those who chart the future course of healthcare. Let us support more of the CT and MR outcomes research which documents the substantial healthcare value which we all know is very real. And let us all advocate, broadly.



Case of the Quarter

Click on Link Above to view.

TOP

"Like" SCBT-MR on Facebook

Did you know that SCBT-MR has a Facebook page? Like SCBT-MR and be a part of the body imaging conversation.

HELP SCBT-MR to build its social media presence

Drawing will take place **May 31, 2013** with winner announced in the June issue of SPOTLIGHT.

** - All users who "like" the SCBT-MR page, will be considered.
*** - Users names may be submitted to the drawing no more than 3 times.

WIN a Meetings-by-Mail 2012 Annual Meeting DVD-Rom

with 27.5 *AMA PRA Category 1 Credits™*

LIKE and/or Comment on the SCBT-MR Facebook Page and have your name entered into a prize drawing.

"**Liking**" the page gets your name in the drawing, leaving a "**Comment**" increases your changes by having your name entered more than once into the drawing***.

TOP

SCBT-MR Member News

- Check out this high impact article published in Radiology in October 2012:

  Recommendation for the management of subsolid pulmonary nodules detected at CT: a statement from the Fleischner Society

  Naidlich DP, Bankier AA, MacMahon H, Schaefer-Prokop CM, Pistolei M, Goo JM, Macchiarini P, Crapo JD, Herold CJ, Austin JH, Travis WD.
  Radiology 2013 Jan; 266(1):304-17. Doi: 10.1148/radiol.12120628. Epub 2012 Oct 14

- **Dr. James A. Brink** has been appointed Chief of the Massachusetts General Hospital (MGH) Department of Radiology, effective February 1, 2013.

- Have you received a recent promotion?
- Or a new appointment at your institution?
- Have you received an Award or professional recognition?

SEND US YOUR MEMBER NEWS!

SCBT-MR Physics

TIP of the DAY

When scanning pediatric patients, make sure you "child-size" your scan parameters to reduce the dose to the patient. Scanning a pediatric patient with adult scan parameters will increase the dose to the pediatric patient significantly.

Remember to use these Important Website Resources:

- Ask the Experts – Ask SCBT-MR's most experienced Fellows questions that you come across in your daily practice. Click Ask the Experts to submit a question: yours may be chosen for the next newsletter!
- Ask the Physicist – Click Ask the Physicist to submit a question: yours may be chosen for the next newsletter!
- Member News - Have you been promoted, moved to a new position, etc. – help us to inform your colleagues in the field, submit your news here: Member News
- Post your Fellowship on our new Directory: We are currently implementing an online fellowship directory to provide detailed information on available fellowship programs in Body Imaging. You can now post your program's body/cross-sectional fellowship on our online directory by clicking here Submit a Fellowship
- News Feed - Let SCBT-MR rustle through numerous RSS feeds finding the articles and news you need to know. Come to the SCBT-MR homepage at www.scbtmr.org to read all the latest news.
- Protocols – Suggested links to protocols on other relevant sites as well as updates of those already listed on the SCBT-MR

***** Do you have protocols you would like to share?**

Send a link to your protocols on a website to rlevine@acr.org for consideration.

TOP

QUESTION

"Given the more common pitfalls of CT and rare caveat of MR, why not use MRI as the first-line approach to the characterization of renal masses?"

ANSWERS

Fellow Responses

Stuart G. Silverman, MD - Harvard Medical School/Brigham & Women's Hospital

Since MRI does not involve ionizing radiation, it is reasonable to consider using MRI as the 'first-line' test.

Regarding our ability to use MRI to diagnose the cause of renal masses, there are additional reasons. Among cystic masses, MRI has been shown to demonstrate more structural findings than CT (e.g., more septations) and has been shown using the Bosniak classification to result in 'upcategorizing' some lesions. The one principal finding that is not typically seen with MRI is calcification. However, calcifications by themselves are not predictive of malignancy. Although MRI may show more findings in cystic masses, CT findings alone are often predictive of the diagnosis. The identification of more findings and a different Bosniak category does not necessarily translate to a different or more correct diagnosis.

Among solid masses, T1, T2, diffusion, fat suppression, and chemical shift imaging each yield features that expand upon those that CT alone demonstrates. However, most solid masses are malignant and typically resected or ablated. However, it is important to identify fat to minimize the chances that an angiomyolipoma is resected inadvertently. MRI can be helpful in identifying fat poor angiomyolipoma (AML). MRI may also be used to help to determine the subtypes of renal cancer, something that will become more important as different therapeutic options evolve.

Most renal masses are found incidentally on CT and most are diagnosed fully with CT. As a result, there is often no reason to examine the patient with MRI. Relative to CT, MRI is more expensive and not as available as CT in some communities. Therefore, in clinical practice, rather than applying a general recommendation that applies to all patients with renal masses, it is better to understand the relative merits of MRI and CT and apply specific indications for using MRI to evaluate a renal mass. In our practice, we reserve MRI for patients with iodinated contrast media allergy, Bosniak IIF and III cystic renal masses, hyperdense enhancing renal masses (to differentiate fat poor AML from clear cell RCC) and young patients, particularly those that need serial follow-up. We also use MRI selectively in pregnant patients and after percutaneous ablation because of the need for multiple examinations and long term follow-up.

Jeffrey C. Weinreb, MD – Yale University

Either CT or MRI can be used as the next exam to characterize a renal mass when a suspicious finding is seen on US. For depicting and staging solid renal tumors, they are usually equivalent. Occasionally, MRI is better than CT for differentiating very small cysts from small enhancing malignancies (i.e. TSTCs), for differentiating between different types of solid renal neoplasms, for showing septations, and for detecting solid enhancing components in calcified or hemorrhagic masses. Occasionally, CT is better for characterizing a mass because a small amount of "macroscopic" fat may be easier to detect on CT, thus clinching a diagnosis of AML. Of course, CT is less expensive and image quality is not as variable as it is on MR.

However, if a patient has hematuria (a common clinical scenario) it is much easier to see renal, ureteral, or bladder calculi (which are usually calcified) with CT. Furthermore, because of the varying appearances of gadolinium contrast agents (depending on concentration) in the renal pelvis, there is a concern that a small (and sometimes even a large) uroepithelial tumor can be missed on MR. While there are ways of overcoming these

TOP

limitations, given the ease of performance and interpretation, not to mention the cost and predictability of image quality, CT is usually preferred.

Isaac Francis, MD - University of Michigan Hospitals

MR could be a good replacement for CT.

Issues are:

1. Inability to detect calcium- in most cases this is not used as a feature of malignancy- so may not be a big issue.

2. In Michigan, MR exams are more expensive, but this may not be true in other parts of the US.

3. In Michigan, access to MR is an issue: a patient may have to wait for 3-4 weeks to get an MRI - because of demand for neurologic and musculoskeletal imaging - Michigan is a "certificate of need state" - access is limited to high end scanners - MR and PET.

4. Technical expertise is more demanding on MR: Motion artifacts, need for optimal technique, ability to perform subtraction for detection of subtle enhancement, etc. So a high level of expertise in both the scanning end and interpretation have to be available - this is not available in many mid-level and smaller hospitals. CT is more forgiving, as it is easier to perform and interpret and also is more readily available.

5. The urologists are more comfortable "interpreting" CT than MR - so they tend to order tests that they can also "interpret."

Gary Israel, MD – Yale University

I feel it is acceptable to use MRI as the first-line approach to the characterization of renal masses, as long as the MRI is of good quality. I feel that MRI is superior to CT in characterizing small renal masses and for those lesions, it should be the first line approach. The better contrast resolution of MRI allows us to see more septa in cystic mass and at times the septa/wall may appear thicker when compared to CT. Therefore, for Bosniak IIF/III lesions, CT is likely a better first line test (since there is more experience with these lesions with CT and the Bosniak criteria are primarily based on CT findings).

Do you have a question to Ask the Experts?

Click Ask the Experts to submit a question for consideration for the next newsletter.

Brian Herts, MD – Cleveland Clinic

This is an excellent question. My first response is "absolutely no reason, we should use MR more" but a recent case I saw illustrates why MR hasn't replaced CT (yet) in the evaluation of renal masses. A 62 yo male had a 5 cm mass identified on ultrasound in a solitary kidney. The contralateral kidney was removed. A renal MR was performed because of contrast allergy. The MR showed a mass with soft-tissue signal on T1WI, slightly hyperintense on T2WI, and signal drop between in- and opposed-phase images, and heterogeneous enhancement after contrast. No area with signal suppression on the fat-saturated T1WI. This case was shown at a weekly MR contrast and a heated discussion ensued regarding the significance of the signal drop on the opposed-phase images, and the difficulty diagnosing AMLs on MR. The patient went on to non-contrast CT just to look for gross fat (there was none).

Reasons MR has not replaced CT as the primary modality to characterize renal masses have to do with exam consistency and familiarity. Tri-phasic CT exams of the kidneys are relatively easy to do, quick, and extremely reproducible. Multi-planar images are now also available with helical CT scanners, one earlier advantage for MR. Importantly, radiologists and urologists have grown to be quite facile interpreting CT images. Criteria for enhancement and the classification of complex cystic lesions at CT are described in the literature (1). CT also has the advantage of easier identification of fat diagnostic of AML and better identification of calcifications, although calcium has become less important in the assessment of complex cystic masses.

MR is typically used to image patients with contrast allergy issues and to characterize indeterminate renal masses at CT. MR is better than CT for characterizing small renal lesions and indeterminate

TOP

intra-parenchymal lesions due to better soft tissue resolution and sensitivity to contrast. Small simple cystic lesions are much easier to confirm with MR than with CT, although one could state that the characterization of a sub-10 mm lesion is a moot point. Complex cystic renal lesions on CT often look even more complex on MR, which can be confusing. Enhancement on MR is based on either a subjective review, including use of subtraction images, or signal attenuation increases greater than 15% over baseline (2); but defining reproducible enhancement of a solid renal mass is much harder with MR than with CT. And as we experienced, RCC can be mistaken for an AML if someone is not aware of the fact that RCC can have intracellular lipid and signal drop on opposed-phase imaging (3). Unfortunately, a good MR is harder to perform than a good CT; and a poorly done MR can be confusing.

One final comment is that imaging should never just stop at characterizing renal lesions – but should also gather information for staging, surgical planning and prognosis, which further complicates the decision. Bottom line: Until urologists are more comfortable reviewing and operating from MR images, and until MR quality can become more consistent at centers that are not major tertiary care centers, CT will still rule the renal mass roost.

1. Silverman SG, Israel G, Herts BR, Richie JP. Management of the incidental renal mass. Radiology 2008; 249: 16-31

2. Ho VB, Allen SF, Hood MN, Choyke PL. Renal masses: quantitative assessment of enhancement with dynamic MR imaging. Radiology 2002; 224:695-700.

3. Outwater EK, Bhatia M, Siegelman ES, Burke MA, Mitchell DG. Lipid in renal clear cell carcinoma: detection on opposed-phase gradient-echo MR images. Radiology 1997; 205:103–107.

SCBT-MR
Society of Computed Body Tomography & Magnetic Resonance

MEMBERSHIP RENEWALS DUE APRIL 1

To keep receiving the SCBT-MR SPOTLIGHT, along with all your other membership benefits, make sure to renew your membership by APRIL 1.

If you haven't already done so, renew by clicking here:

RENEW

If you wish to receive an electronic or hard copy invoice, email info@scbtmr.org

Do you have TOPIC IDEAS for the NEWSLETTER?

Would you like to write an article?

Send us your topic ideas and/or article thoughts by clicking HERE

TOP

Call for Abstracts 2013

Society of Computed Body Tomography and Magnetic Resonance (SCBT-MR) welcomes the submission of original scientific abstracts related to Body CT or MR and imaging sciences for its **36th Annual Meeting, October 12 - 16, 2013 at the Hilton El Conquistador in Tucson, Arizona** via its online system (www.SCBT-MR.org). Authors will access the system to submit abstracts for Scientific Presentations and Educational Exhibits.

Each abstract will be eligible for one of the following major awards:

- Resident or Fellow in Training Award (no restriction to type of research)
- Junior Faculty Award (candidate not more than 5 years beyond either residency or fellowship training; no restriction to type of research)
- Hounsfield Award (best CT paper)
- Lauterbur Award (best MR paper)
- Poster Awards (first, second and third place)

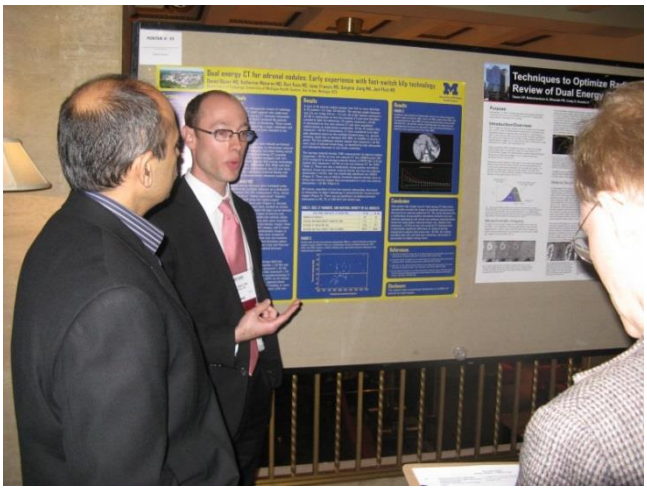
In an effort to have greater institutional representation at the Scientific Session, the number of abstracts that can be presented by a given department section is limited. There will be no restriction on the number of abstracts that can be submitted by a department; however, the Research Awards-Scientific Committee has been asked to accept only the two highest ranked abstracts from any individual department section.

The Scientific Session will be held on **Saturday, October 12, 2013**. The Scientific Session abstract presenters will be allowed approximately 9 minutes for their presentation followed by 3 minutes for questions and discussion.

2012 Research Committee Chair Scott Reeder, MD awards a certificate to Scientific Session Cum Laude Awardee – Ajit H. Goenka, MD

DEADLINE: June 15, 2013, 11:59 p.m. EST

- ► Submission Guidelines
- ► Submission Form
- ► Timeline
- ► Oral Presentations
- ► Posters



Daniel Glazer, MD presents his poster at the 2012 Oral Poster session.

NOTE: SCBT-MR recognizes there may be concerns about the eligibility to submit a scientific abstract to both the SCBT-MR and to the RSNA for inclusion in both programs. RSNA has confirmed that presentation at the SCBT-MR Annual Course Members Only Scientific Session (a closed meeting) does not preclude individuals from submitting the same abstract for consideration for presentation at RSNA. You must disclose this information when you submit your abstract to RSNA, but it will not influence the RSNA selection process.

TOP

MEET the Committees

Communications

Eric P. Tamm, MD, Chair

(Bio featured in last issue as New Fellow).

Committee Highlights:

The SCBT-MR Communications Committee has a variety of responsibilities to the society. These include the newly created newsletter, management of the society website, and to facilitate communication within the society and from the society to the radiology community.

Our committee consists of 10 members working on a variety of projects. These include a review of the society website to make sure that all materials are current, in particular an in-depth review of the website section that includes imaging protocols. We are developing a database of imaging fellowships to aid our trainees. The committee has added several new features for the newsletter including "Case of the Quarter," "Physics Tip of the Day," "Ask the Physicist," and "Ask the Expert." These features are designed to make the expertise of the society available to its members, to facilitate communication and to aid the dissemination of new ideas. Our committee also posts regularly to Facebook interesting news items, and we encourage members to subscribe to the society Facebook link.

Committee Members:

Ihab R. Kamel - Johns Hopkins Hospital
Kalpana M. Kanal - University of Washington
Katarzyna Macura - Johns Hopkins University
Tara Catanzano - Baystate Medical Center
Andrew Rosenkrantz - New York University
Gaiane M. Rauch - MD Anderson Cancer Center
Garrett K. Andersen - South Texas Radiology
Priya Bhosale - MD Anderson Cancer Center
David Dreizin - Johns Hopkins University

Membership

Jill E. Jacobs, MD, FACR, Chair

Dr. Jacobs is a Professor of Radiology at the New York University School of Medicine and the Associate Director of Quality and Patient Safety for the Radiology Department at the New York University Langone Medical Center. She currently serves as the Section Chief of Cardiac Imaging and as the Director of the Advanced Cardiovascular Imaging Fellowship. Dr. Jacobs is a fellow of American College of Radiology, the Society of Computed Body Tomography and Magnetic Resonance and the North American Society for Cardiac Imaging, and currently serves as the Vice President of the North American Society for Cardiovascular Imaging. She is a member of multiple additional national and local radiologic societies including the Radiological Society of North America, the American Roentgen Ray Society, the American Heart Association, the Society of Abdominal Radiology, the American Association for Women Radiologists, and the New York Radiological Society, serves on many national scientific committees, reviews for several prominent radiologic journals, and frequently lectures at national and international radiologic meetings. Dr. Jacobs has authored many articles and chapters on cardiac CT and abdominal imaging.

Committee Highlights: The SCBT-MR Membership Committee reviews the membership trends of the Society and identify strategies to increase retention as well as recruit new members. Certain initiatives of focus:

- Evaluate current member benefits and recommend new benefits
- Identify opportunities for members to participate in society activities

TOP

The June issue of SCBT-MR **SPOTLIGHT** will feature an overview of the membership in the first 6 months of this year.

Committee Members:

Reginald F. Munden - MD Anderson Cancer Center
Jurgen Futterer - University Medical Centre Nijmegen
Rendon Nelson - Duke University Medical Center
John Thomas - University of Alabama at Birmingham
Sudhakar Venkatesh - Mayo Clinic Rochester
David N. Bolus - University of Alabama at Birmingham
Nikki Tirada - Mount Sinai Medical Center

Fellow Membership

Erik K. Paulson, MD, Chair

(Bio featured in last issue as Board Member)

Committee Highlights:

The Fellow Membership Committee is tasked with recruiting nominations for new fellows to the SCBT-MR, evaluating new fellow applications, and presenting endorsements to existing fellows at the business meeting at the annual meeting.

Committee Members:

Dominik Fleischmann- Stanford University Medical Center
Desiree E Morgan - University of Alabama Birmingham
Philip Costello - Medical University South Carolina
Kimberly Applegate - Emory University
Lynne Steinbach - University of California-San Francisco

Volunteer Opportunity

SCBT-MR is looking for volunteers to staff a new PQI Committee. If you are interested, click below:

PQI Committee

Research and Scientific Committee

Daniel Boll, MD, Chair

Daniel T. Boll, MD, Associate Professor of Radiology at Duke University Medical Center also serves as Medical Director of the Duke Multi•Dimesional Imaging Post-Processing Laboratory. His sustained academic and clinical interest focuses on the visualization of hemodynamic phenomena and the assessment of its impact on dependent parenchymal structures in cross-sectional MR and MDCT imaging. The primary focus of his clinical activities has been cross-sectional abdominopelvic and cardiovascular imaging with emphasis on implementation of latest Dual-Source/Spectral MDCT and Ultra-High Field MR imaging modalities into the daily standardized routine.

Committee Highlights:

The research committee of SCBT-MR is responsible for reviewing all abstracts submissions and selecting those that will be presented during the Scientific Session and in poster format at the annual meeting. During the meeting, the committee convenes to determine which oral and poster presentations will receive recognition of excellence from the SCBT-MR. SCBT-MR received over 110 abstract submissions for last year's meeting. The committee hopes to increase this number for 2013. The deadline for submission is **June 15, 2013**. (See the Call for Abstracts on page 8)

Committee Members:

Ivan Pedrosa - MD Anderson Cancer Center
Mukesh Harisinghani - Massachusetts General Hospital
Edward A. Carter - San Luis Valley Regional Medical
David P. Mayer - Mercy Health System
Vikas Kundra - MD Anderson Cancer Center
Koenraad Mortele - Beth Israel Deaconess Medical Ctr.
Matthew Davenport - University of Michigan
Kartik Jhaveri - University of Toronto

TOP

Writing Committee

Lincoln L. Berland, MD, FACR Chair

Lincoln L. Berland, MD, FACR serves as the Vice-Chair for Quality and Safety in the Department of Radiology at the University of Alabama at Birmingham and is a past president of the SCBT-MR. He is the lead author of a 2010 white paper in the JACR on incidental findings on imaging studies. Virtually all of the members of the ACR Incidental Findings Committee he chairs also are members or Fellows of the SCBT-MR. A new set of white papers on incidental findings are in preparation from this committee. However, he also leads an SCBT-MR writing committee on dual-energy CT, which is expected to complete a white paper on this topic in 2013.

Committee Highlights

The SCBT-MR has formed a writing committee of Fellows and members of the Society who are experienced with dual-energy CT to draft a white paper on this topic. The Society believes that this technology is underutilized because it is confusing and intimidating, even to many of those who are using it. So, this work will have a different character and purpose from existing publications and will intend to help provide a new way to bring value to both practicing radiologists and researchers in dual-energy CT. Among the objectives of this effort will be to describe the varied implementation of the technology and of the many current and future applications of dual energy CT, to propose a standardization of terminology, to help influence vendors regarding technical innovations, especially addressing software usability and workflow, and to suggest fruitful areas for further research. Specific topics will include radiation exposure, tissue characterization, Iodine extraction and the promise of contrast dose reduction, metal and other artifact reduction, dynamic analysis (e.g. cardiac and perfusion dual-energy CT) and examination protocols.

Committee Members

Marilyn Siegel - Washington University School of Medicine
Dennis Foley - Medical College of Wisconsin
Beth McFarland - SSM St Joseph Health Center
William P. Shuman - University of Washington
Donald P. Frush - Duke University Medical Center
Erik K. Paulson - MD Anderson Cancer Center
Joel Platt - University of Michigan Medical Center
Ben Yeh - University of California-San Francisco
U. Joseph Schoepf - Medical University of South Carolina
Desiree E. Morgan - University of Alabama Birmingham
Dushyant Sahani - Massachusetts General Hospital
Alec Megibow - New York University Medical Center
Rendon C Nelson - Duke University Medical Center
Daniel Boll - Duke University Medical Center
Ravi Kaza - University of Michigan Medical Center
David N. Bolus - University of Alabama Birmingham

Corporate Relations

Neil M. Rofsky, MD

(Bio featured in last issue as Board Member)

Committee Highlights

The SCBT/MR Corporate Relations Committee has traditionally functioned as the “raise the money” committee to help support our annual meeting. This has often been a last minute scramble, consisting of desperate calls requesting that those with connections to a given company, reach out to their contacts. I know, because I have been quite involved in the scramble over the last years! A bit stressful and at times, a bit fun, this approach admittedly is not particularly strategic. While this remains a core function of the Committee, it is important to consider how recent changes impact our perspective.

With the increasing expenses required to support a continuing medical education (CME), the large number of existing courses and the increasing propensity for physicians to peruse online educational activities, societies with an educational mission are

TOP

struggling to expand all sources of support, including funding and resources from the corporate sector.

Given the threat of continued cuts in corporate support for CME looming, and the increased competition for this support, a new imperative to understand how to develop and maximize corporate collaborations in this uncertain funding environment is critical. We must move beyond the prior conceptualization that corporate sponsors function as donors to our society and morph to a newer conceptualization that sponsors function as investors in our society.

While I don't claim to have all the details for a new strategy, it is clear that we can start by 1) improving our committee's organization, 2) establishing more frequent contact with our corporate supporters, and 3) launching a purposeful inquiry to identify areas of mutual benefit between SCBT/MR and our corporate sponsors. I predict that those societies that figure out and optimize society-industry relations will be the ones to excel in CME activities in the upcoming years.

In this spirit I have prepared a suggested outline of the goals and responsibilities for the corporate relations committee for the upcoming. I offer the draft that follows and welcome your input.

Goals:

1) To provide a formalized structure and set of procedures to garner the maximum support for the SCBT/MR

a. Offer a value proposition to existing and potential sponsors

b. To seek feedback from sponsors

i. Satisfactions

ii. Dissatisfactions

iii. Opportunities for improvement

2) To provide an opportunity for Society fellows and Corporate Sponsors to collaboratively network and share ideas at the annual meeting.

Responsibilities:

1) Create and Maintain an SCBT/MR resource and Corporate membership network made up of current corporate supporters, past corporate supporters and non-supporters with interests related to the mission of the Society.

2) Work in conjunction with the Treasurer and SCBT/MR staff to solicit annual Corporate support

3) Render recommendations and guidelines to all programmatic committees in SCBT/MR regarding corporate donations

4) Act as a "Clearinghouse" for all members to report, request, or inquire about any societal involvement with corporations

5) Submit an informative article or update to corporate sponsors via a periodic SCBT/MR newsletter

6) Prepare and submit an annual report to the Board of Trustees by August 1st which summarizes the committee's activity during the year.

7) Meet with corporate representatives at the annual meeting to discuss their impressions of the value they receive by being corporate sponsors of the SCBT/MR, and to solicit a verbal commitment to support for the next year's meeting in the context of each sponsor's budget cycle.

In closing, it is my honor to serve as the Chair of the Corporate Relations Committee of our Society and hope that together, we can leverage this committee to strengthen our ability to satisfy our mission and our unique niche in the world of imaging.

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*Some of the ideas I have presented in this writing were inspired by materials offered by the The Network of Academic Corporate Relations Officers (NACRO) and I encourage interested readers to peruse their website: http://www.nacroonline.org/

Committee Members

Lincoln L. Berland - University of Alabama Birmingham
U. Joseph Schoepf - Medical University of South Carolina
William P. Shuman - University of Washington
Ihab R. Kamel - Johns Hopkins Hospital
Shreyas Vasanawala - Packard Children's Hospital Stanford

TOP

Upcoming Events

2013 Annual Meeting

Call for Abstracts

DEADLINE: June 15

October 12 – 16, 2013
Hilton Conquistador Golf & Tennis Resort
Tucson, AZ

The preliminary program is now online!

View Program

Meeting Information

Book your hotel room

www.scbtmr.org