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INSIDE THIS ISSUE

Radiology - Marketing and Turf erosion - Viral Parekh

Hi Namaskar friends,

Wish you all a very happy Durga Puja and Navratri.

Radiology is still the most sought after stream of Medicine. Only the best students can opt for Radiology in Post graduate entrance examinations. But irony is that in our country you don't require a post graduate qualification to practice Radiology. Doctors without any post graduate qualifications are doing ultrasound all over the country. Even the big Multispeciality hospitals are hiring non Radiologists to do Ultrasonography. Many of them are self designated "Consultant Ultrasonologists" . This is really astonishing. In last 1-2 decades, lot of diagnostic centres owned by businessmen have cropped up where most of the non-Radiologists practice as so called Ultrasonologists. These diagnostic centres have strong marketing team and have created a so called "Brand" for themselves. Most of the patients like to go to these "branded" diagnostic centres. It does not matter to them that what is the qualification and experience of Doctors performing various diagnostic procedures. That is the power of marketing.

A qualified and experienced Radiologist without any marketing team struggles to keep his/her Radiological diagnostic centre afloat. So, is Radiology all about marketing? I hope it is not so. Many of Radiologists running their private X-ray and Ultrasound clinics have closed down their clinics in Kolkata and are now working for these "branded" diagnostic centres. Is this the best student who opted for Radiology deserve? There is no clear cut action form Medical authorities in India and in fact a few states of India have tried to legalise the so called Ultrasonologists by introducing an exam. However, this qualification of CBET is not recognised by National Medical Council. So, there is lot of confusion and on our part we Radiologists are not united and our associations are also struggling to fight this menace. I don't foresee any change in existing system.

Turf erosion is a big Problem and since Radiology is a cash cow, people from other streams are interested in practicing various branches of Radiology. Lot of Gynaecologists have also started doing Ultrasonography. Though they restrict themselves to G&O ultrasounds. Cerebral and carotid angiography and interventions are also performed by Neurologists and so on. Over and above that there is a fake MD degree provided by some overseas as well local institutions, where you don't have to do any Residency and acquire any Radiological skills and they conduct a so called exam and any MBBS graduate can appear in this exam, {of course by paying a certain amount}. Everyone passes this exam and becomes MD in Radiology. Voila!. This qualification is also not recognised by Medical council but people with qualifications are practicing without impunity.

So, it is high time that we get united and save Radiology from encroachments. United we stand and divided we fall. Let us hope better sense prevails and we Radiologists and Medical authorities try to protect our beloved stream from encroachers.

This issue would not have been possible without the help of Dr. Bhavin Jankharia, Dr. Rajesh Botchu, and Dr. Indraneil Makela. I sincerely thank all of them.

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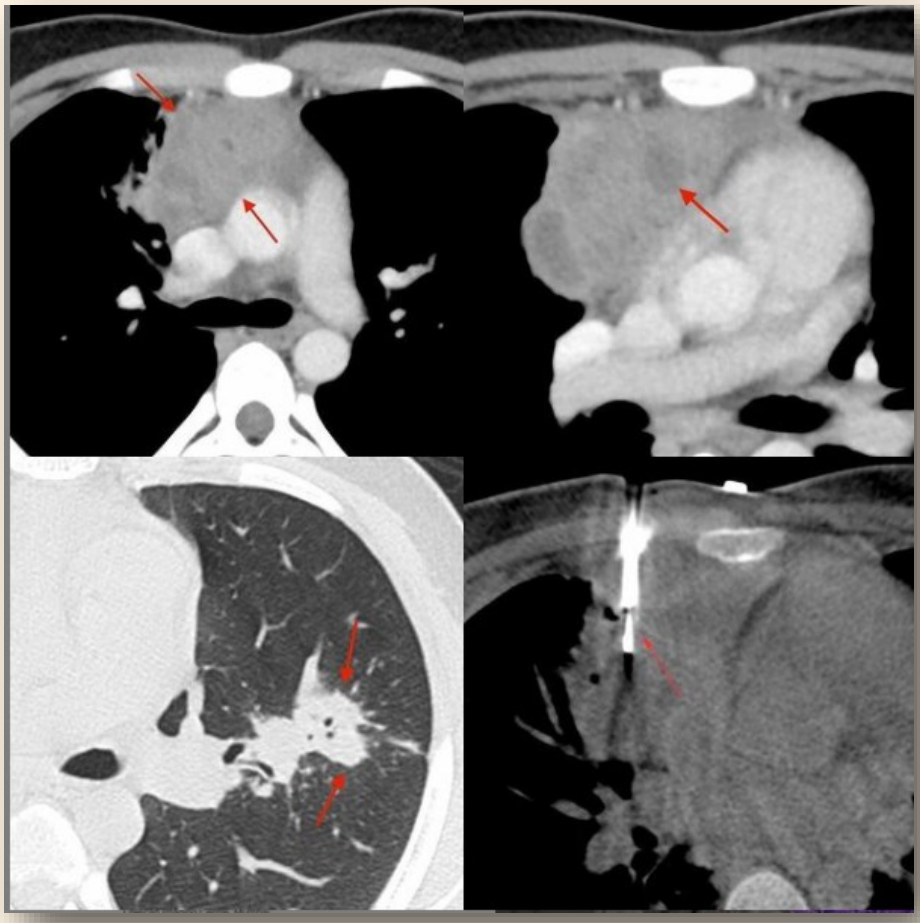
Dr. Bhavin Jankharia needs no introduction to the Radiology fraternity. As you all know he is a renowned Radiologist and academician and has contributed immensely in propagating Radiology education. Presently, he is a Consultant Radiologist at Picture This by Jankharia. He is also a Trustee of Radiology Education Foundation. He has consented to share some of his work with us, which will help all the Residents as well as practicing Radiologists. Here is some information about him in brief.

- **He has written 5 books, 35 chapters, 57 articles (PubMed listed)**
- **Presented 32 posters**
- **More than 1500 invited lectures over 27 years**
- **Editor-in-Chief, Indian Journal of Radiology & Imaging (2007-2012)**
- **Latest Book (2019): Computed Tomography of Interstitial Lung Diseases**
- **Hon. Visiting Consultant – Radiology – Tata Medical Centre, Kolkata**

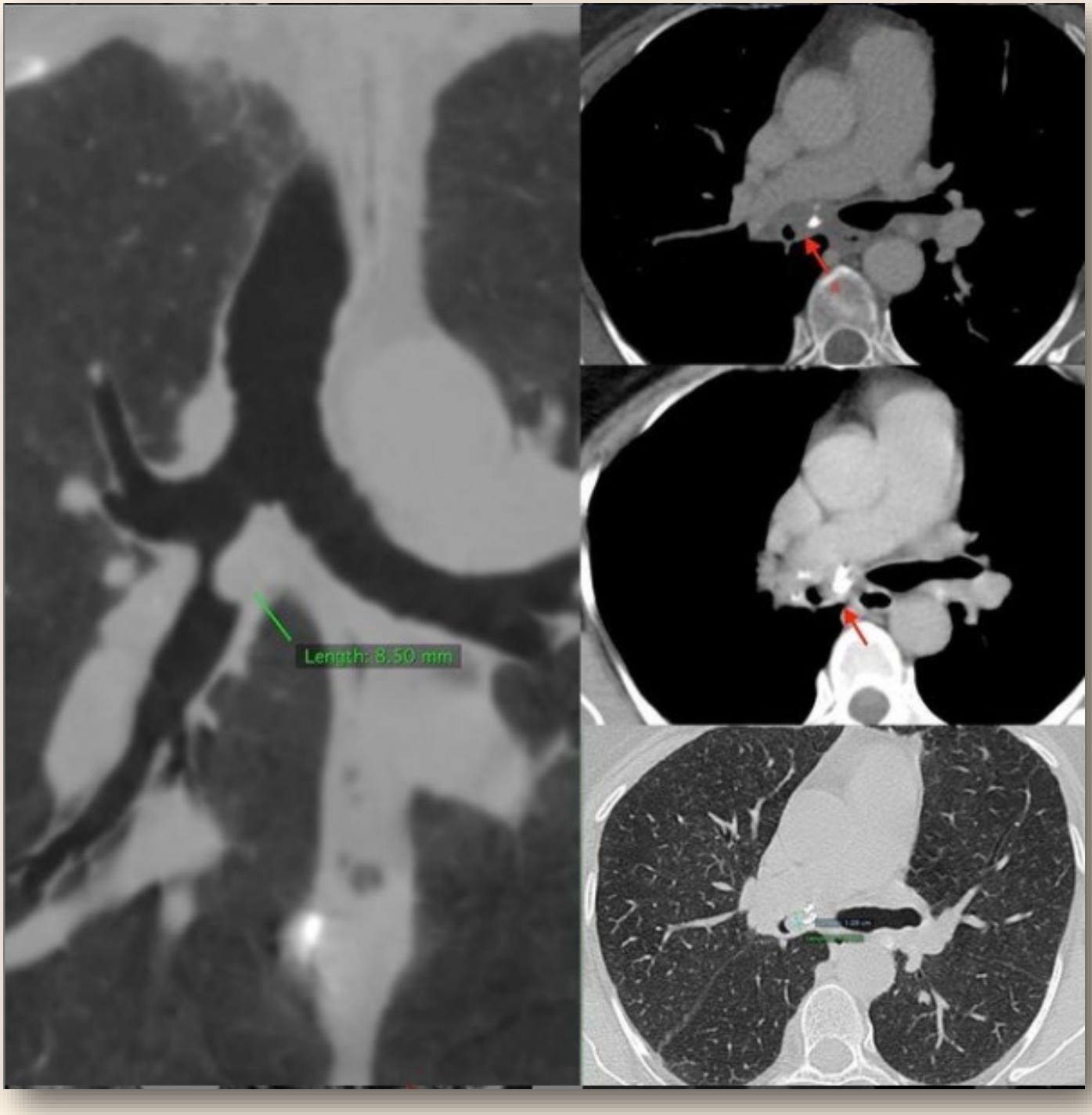
Case I - Prevascular space mediastinal mass - TB the great mimic



This is a 20-years old man who presented with fever and breathlessness. The chest radiograph (not shown) showed mediastinal widening. The CT scan shows a prevascular space mass that is suspicious for a thymic tumor, lymphoma or germ cell tumor. Though there are some areas of necrosis (right upper image with arrow), this amount of necrosis can occur in any kind of situation and does not necessarily imply tuberculosis. There was also a worrisome lung lesion with spiculated margins in the left upper lobe.

A biopsy was done as should be done in all such cases using an 18G coaxial biopsy gun. The PCR and culture and histopathology were all confirmatory for a diagnosis of tuberculosis. The patient responded to treatment and a follow-up study (not shown) after 6 months showed regression of disease and symptoms.

Case II—Endobronchial TB - The Power of MinIPs



This is a 64-years old lady with chronic cough. She had an earlier CT in 2008 showing calcified mediastinal nodes.

The current CT shows that the subcarinal node is calcified and causes narrowing of the intermediate bronchus. The minIP image in the coronal plane shows it the best and makes it very easy to appreciate and understand the pathology.

Bronchoscopy showed endobronchial nodules, positive for active tuberculosis.

Dr. Bhavin Jankharia, MD

Case III - The Lost Art of Plain Radiograph Interpretation

This 56 years old man was referred for a CT guided biopsy on the basis of an MRI report of an osteolytic lesion at D10 with abnormal soft tissue.
The MRI showed a fracture extending from the anterior to the posterior elements. I then looked at the radiographs, which showed frank ankylosing spondylitis.
This has never been picked up. The patient effectively had a fracture through D10, essentially a pseudarthrosis / Andersson lesion and he did not need a biopsy.

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Uncommon case of lateral midfoot pain – Cuboid tunnel syndrome

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The peroneal tendons are peroneus longus and peroneus brevis. The peroneus longus course lateral to the calcaneum and makes a sharp turn to enter the cuboid tunnel where it travels obliquely into the plantar aspect of the foot, inserting on the base of 1st metatarsal and medial cuneiform. The fibres that traverse from the cuboid tuberosity to the anterior part of the cuboid form the floor. The fibrous tissues of the cuboid tuberosity form the roof of the cuboid tunnel. The position of the peroneus longus is altered with the movement of foot. There may be subluxation of peroneus longus on dorsiflexion, which reduces to lie in the centre of tunnel on plantar flexion. The commonest site of peroneus longus tendinopathy and tear is the cuboid tunnel due to the acute change in orientation of the tendon. Tendinopathy is seen as thickened tendon with increased T2W high signal on fluid sensitive sequences. Reactive edema of the adjacent cuboid is not an uncommon finding. Osseous edema of the bone adjacent to the tendon with tenosynovitis and tendinopathy is well known. In cuboid tunnel syndrome there is tendinopathy with or without tenosynovitis with marked osseous edema involving the plantar part of the cuboid. The differential diagnosis of the osseous edema of the cuboid would include osteoid osteoma, infection, stress response and stress fracture. The involvement of edema of the plantar aspect of the cuboid with abnormal peroneus longus tendon is the key to clinch the diagnosis. These can be managed symptomatically with ultrasound-guided injection of peroneus longus tendon in the cuboid tunnel. One needs to be aware of this when evaluating patients with lateral midfoot pain.

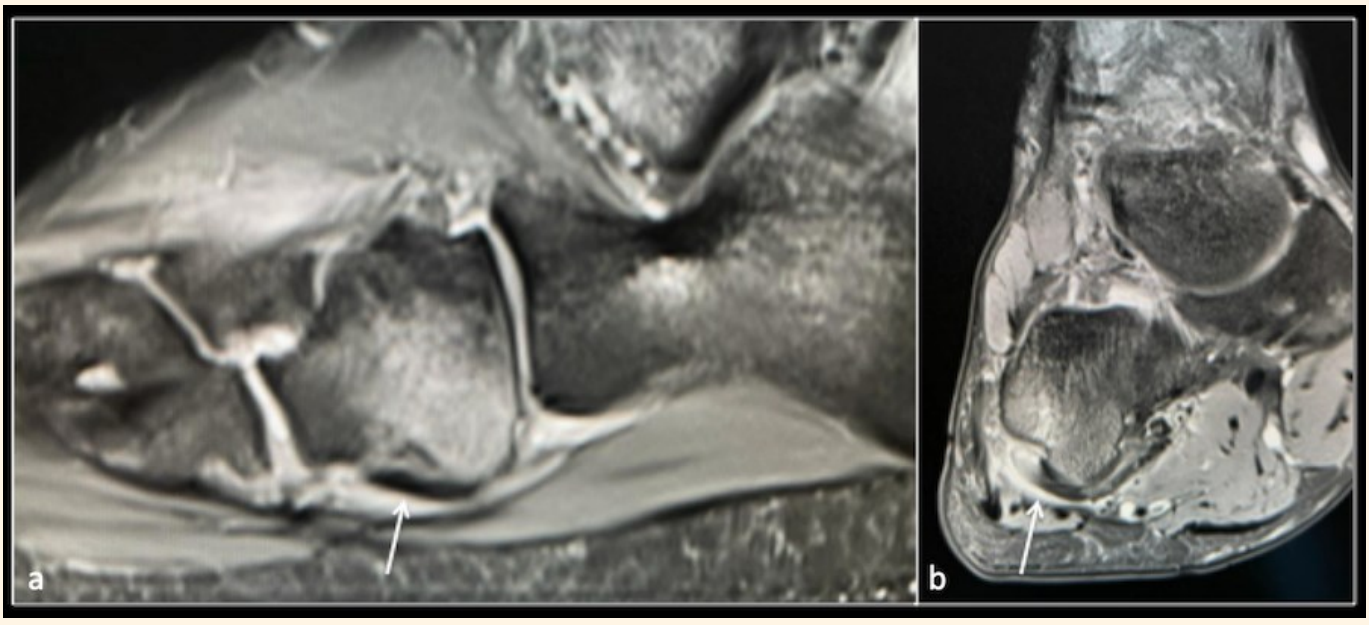

Figure 1. PDFS (proton density fat suppressed) sagittal (a) and coronal (b)showing tendinopathy and tenosynovitis of peroneus longus with moderate osseous edema of the adjacent cuboid. (arrow)

Uncommon case of lateral midfoot pain – Cuboid tunnel syndrome

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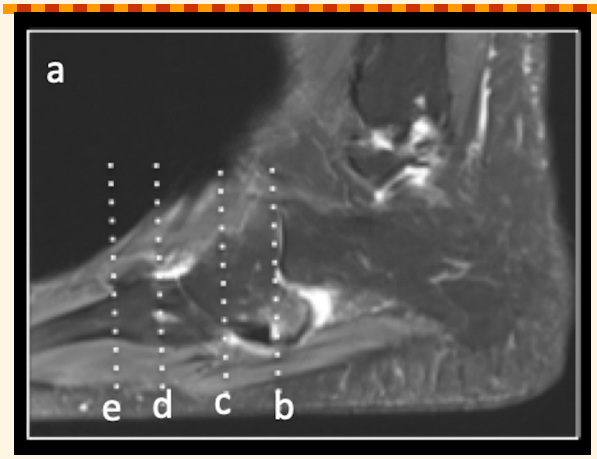
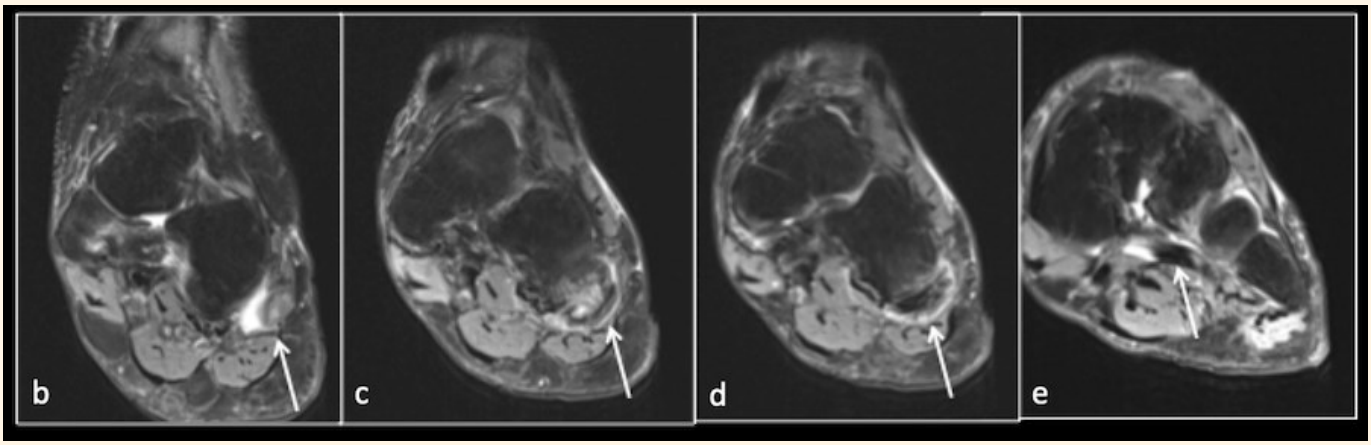


Figure 2. PDFS (proton density fat suppressed) sagittal (a) and coronal at different levels (b-e) showing tendinopathy and tenosynovitis of peroneus longus with moderate osseous edema of the adjacent cuboid. (arrow)



References

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Choudhary S, McNally E. Review of common and unusual causes of lateral ankle pain. Skeletal Radiol. 2011 Nov;40(11):1399-413.

Hallinan JTPD, Wang W, Pathria MN, Smitaman E, Huang BK. The peroneus longus muscle and tendon: a review of its anatomy and pathology. Skeletal Radiol. 2019 Sep;48(9):1329-1344.

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Subcapital insufficiency fractures of the Femur - unusual cause of hip pain

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Insufficiency fracture (IF) is defined as a fracture due to transmission of physiological load or normally applied stress through abnormal bone. Insufficiency fractures (IFs) are a subtype of stress fractures. IF of femoral necks are more common in elderly with female preponderance and those with co morbidities, which include diabetes, osteoporosis, rheumatoid arthritis. These nontraumatic fractures often occur in the pelvis and spine. IF of femoral neck account for 5% of IF and common in those who are on steroids, bisphosphonates, chemotherapy, or immunosuppressive therapy. Unilateral IF of femoral neck are not uncommon but bilateral IF of femoral neck are rare. These fractures can even be seen following activities of daily living (ADL) due to underlying weakness of the bone. Diagnosis of IF can be challenging and can result in increased morbidity if not detected early. Initial radiographs can be normal with subsequent development of sclerosis and subsequent collapse. On CT linear foci of sub capital or subchondral sclerosis can be easy to delineate. MRI demonstrates florid osseous edema of the femoral head and neck with linear low signal on T1 corresponding to the IF. Avascular necrosis is the differential diagnosis for IF of femoral neck however in AVN there is geographic, linear or crescentic pattern with predominant subchondral involvement. A classic double line sign can be seen in AVN, which is seen on fluid sensitive sequences at the interface of necrotic and viable bone.

Four case reports of bilateral subcapital IF of femoral necks have been described. Three were females (18, 22, 78 years) and one was male (50 year). These can be managed with internal fixation or arthroplasty depending upon whether there is secondary arthropathy. These should be treated in conjunction with medications following a metabolic physician review.

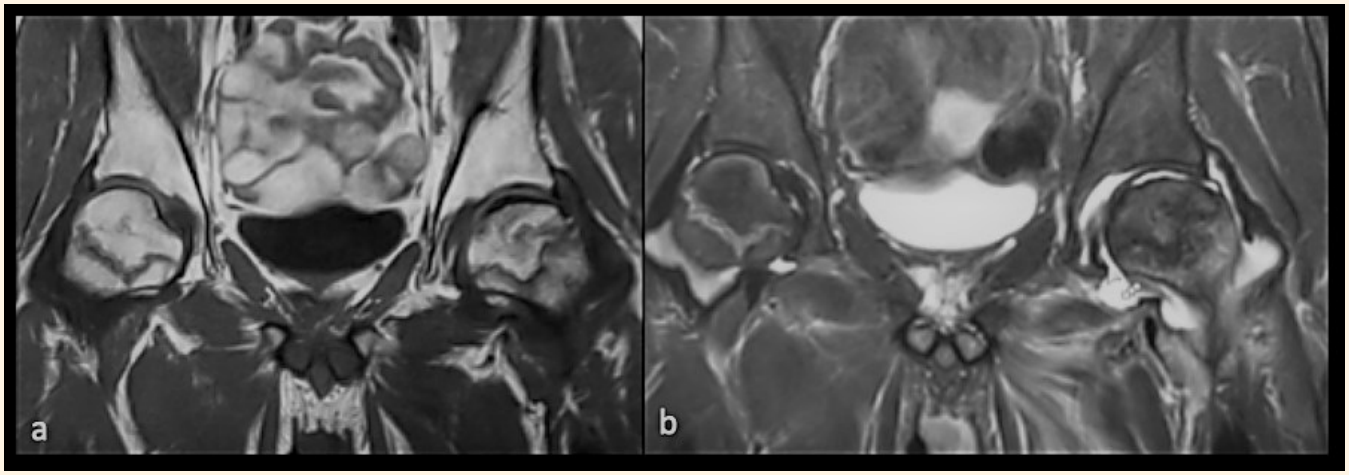

Figure 1

Coronal T1(a) and STIR(b) showing bilateral subcapital insufficiency fractures with subchondral insufficiency fracture of femoral head in a 65 year old male

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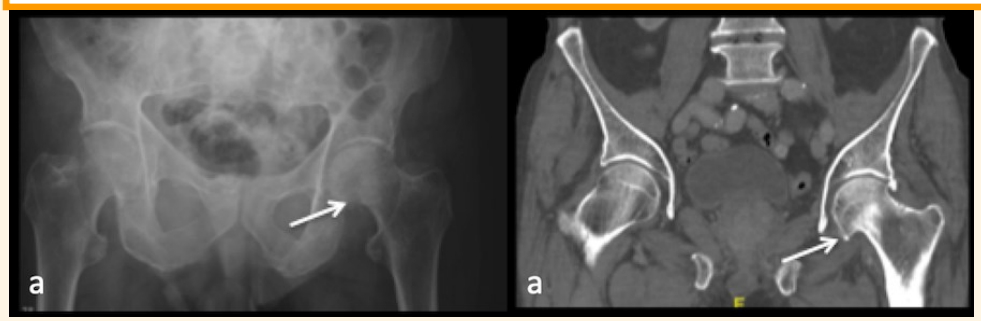

Figure 2
AP pelvis (a) and coronal CT (b) showing left subcapital insufficiency fracture (arrow) in a 70 year old male.

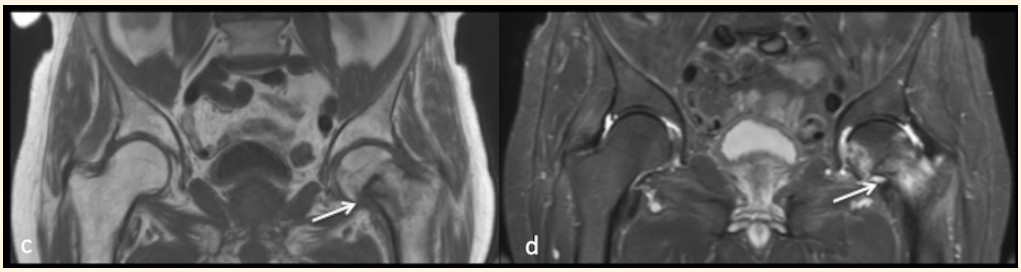

Figure 3
Coronal T1 (a) and STIR (b) showing left subcapital insufficiency fracture (arrow) in a 70 year old male.

Figure 4
AP left hip (a) , coronal CT (b), STIR (b) and bone scan showing left subcapital insufficiency fracture (arrow) in a 75 year old male.

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6	CAR - Case of the week - Case 2 - Adenocarcinoma of terminal ileum - Dr. Viral Parekh
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23	CAR - Case of the week - Case 18 - Langerhans cell histiocytosis - Dr. Sayan Sarkar
24	CAR - Case of the week—Case 19 - Hepatic angiomyolipoma - Dr. Viral Parekh.
25	CAR– Case of the week - Case 20 - Cirsoid aneurysm - Dr. Viral Parekh

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Link is here

We are on YouTube

You can send your good case to us. We will publish it in our channel.

COVID 19 pandemic and nonaccidental injury in children

Anup K Sadhu

Non accidental injury in children is grossly under -reported in India.

A radiologist is the first person to point out the menace in children with physical abuse.

Unfortunately, due to various legal formalities, radiologists, too, are reluctant to report such incidents.

Covid 19 pandemic has increased the incidence of domestic violence and child abuse.

The author here mainly deals with physical abuse leaving aside sexual, social, psychological abuses.

There are rules ,regulations, guidelines, standards to safeguard and protect children, which have lowered mortality. However, despite this, the subtle, initial presentations can be missed, and COVID-19 presents the perfect storm for the escalation of NAI. The silent pandemic, becoming even more silent and deadly, in the face of this new, viral pandemic.

Non- accidental injury (NAI) is often considered to be a silent pandemic. At its most extreme, this leads to the death of the child, and worldwide, there are estimated to be 50,000 deaths each year1. We have come a long way since Caffey2 first described the phenomenon of parental maleficence associated with multiple fractures, subdural and retinal hemorrhages, in the 1940s.

NAI is on the rise

Already departments are reporting an increasing number of NAI cases, and when the risk factors for NAI are examined, this comes as no surprise.

Social isolation is a risk factor intrinsic to the perpetrator of abuse and intrinsic to the family structure. We have all been asked to limit our social contact in the light of COVID-19, the support that normally comes with socialising with friends and wider relatives is lost. The sudden withdrawal of schools, playgroups, youth programmes and time with other relatives takes away not only the respite of childcare, but also the early warning system that these places would normally provide. Children with developmental delay and additional needs are at particular risk of abuse.

Social isolation to many families means confinement, often with multiple children, in small dwellings with no access to outdoor spaces in which families can relive the stress of lockdown. These conditions make for a tense and volatile environment. The parents become hostile and the children restless. The brunt of insecurity of the parents falls of the child.

NAI is more prevalent in families with lower incomes, and financial uncertainty has been further associated with increasing this risk. This was seen during the last economic recession, where there was a substantial increase in abuse and mortality from non-accidental head trauma4. Through financial uncertainty, COVID-19 further adds an element of stress to a precarious situation for many children, and this effect will be long lasting.

Another known risk factor for NAI is the lack of access to healthcare. We are actively encouraging patients to stay away from hospitals to minimise the risk of spreading COVID-19, however ,we may also be inadvertently heightening the risk of NAI in the process. Child abuse and neglect will continue to happen, but behind closed doors; we just won't know about it. Children with early stage of disease come to the hospital much late and in incurable stage.

Any member of the household may have mental health issues, including substance abuse, which may be less well supported in these challenging times, and this poses a risk to the child living with them.

COVID 19 pandemic and nonaccidental injury in children

Anup K Sadhu

Risk factors heightened by COVID-19

Social isolation
Lack of early warning system
Loss of support systems
Low income and financial uncertainty
Lack of access to healthcare
Healthcare system itself under stress

NAI may go unnoticed in covid -19 situation

Not only are many families under extremely stressful circumstances, but healthcare systems are too. The increasing burden of COVID-19 presents a real challenge to maintain the standards that are normally in place. Staff are working out with their normal roles and may not be as familiar with the presentation of NAI.

The presentation of NAI/related issues as observed at Medical College Kolkata

1. majority of children came with perforating eye injuries with sequele
2 .Late presentation of a particular disease e.g., Lymphoproliferative disorders, Retinoblastoma, neuroblastoma—due to nonavailability of transport, high cost of permitted transport and absence of treating clinician/team members
3. altered characteristics of a disease due locally available alternative therapy
4 .utter indifference of the parents regarding outcome
5. parents are not afraid of legalities/punishments
6. Skeletal injuries less frequent/not so common as we observed

Challenges of managing NAI during the pandemic

Once recognized, the child should be admitted to the hospital, even with the current risks of viral transmission. It is only in the hospital that the child can be considered in a place of safety. Unfortunately, we failed to take care of these sick children as the priority was to admit Covid infected patients
The processes to investigate NAI, such as the discussion between healthcare providers, social workers came to a halt.
Discharge planning for the child will be challenging(if the child gets a chance to get admitted). Under normal circumstances, the child may be discharged with additional supervision, discharged under care of another member of the family. All of these options are currently compromised by COVID-19 and a longer admission may be required to protect the wellbeing of the child.

Conclusion

Non-accidental injury in the Covid 19 era is the tragic outcome of a complex interplay between the individual, relationship, community, and society. It must be a diagnosis which we seek to actively dismiss, to safeguard the children under our care. Failure to recognize the abuse that often leads to the child's demise.

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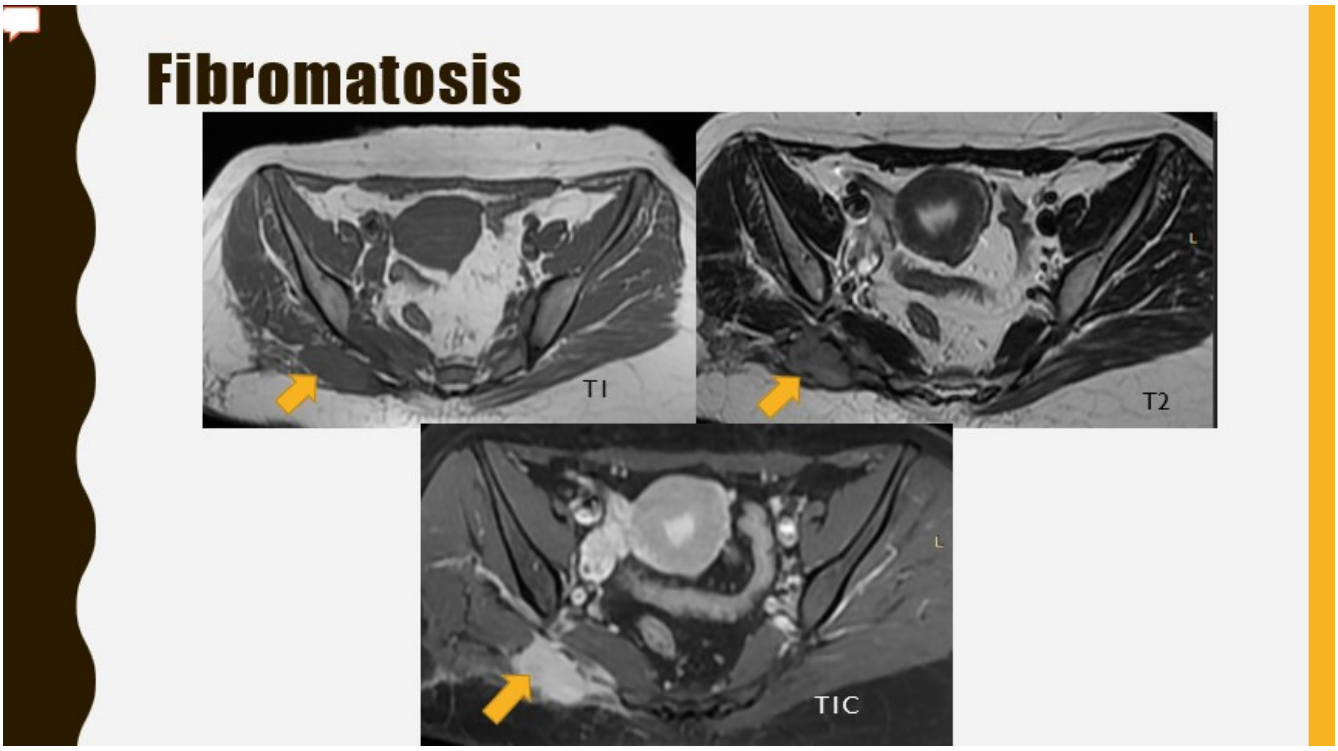
Back to basics - Why do we use Gel for an ultrasound exam?

To understand this concept the term 'Impedance' must be understood first. It is actually a self -explainable plain English word which means to hinder / impede. We all can experience the difference when we jog on a concrete pavement and on a sandy beach. There is a lag or resistance offered by sand when we jog on a beach.

In terms of Physics, Acoustic Impedance denoted by the letter Z is the resistance offered to sound when it travels in a medium. It is measured in rayls and is a characteristic feature of that particular medium.

Sound beam encounters different values of impedance as it travels through different media such as soft tissue, muscle, fluid, bone etc. Whenever there is a difference of impedance between two media (which it invariably will be) a portion of sound beam reflects. The fraction of sound beam that reflects depends on the degree of difference between the Acoustic Impedances of the two media, i.e., higher the difference more the return (reflection) and lower the difference, lesser the return. The impedance difference between the piezo-electric crystal and the body (soft tissue) is very high and to alleviate this difference a 'mediator' in the form of matching layer is used in the probe. The Z of matching layer is in between that of the crystal and the soft tissue and whose thickness is made to be 1/4th of the wavelength (called as Quarter Wave Matching). However, this helps only to a certain extent, and we need something else to further lower the differences; especially the difference is worsened when air comes in between the probe-body interface as air has a much lower Z. Ultrasound beam cannot travel / be transmitted efficiently because of this. Hence in order to alleviate the differences further another 'mediator' in the form of coupling gel is used to 'smoothen' the journey and for gradual transition of this difference.

Consider this analogy - The Z of a crystal is very high somewhere on the 50th floor of a building and the Z of soft tissue near ground floor. Ultrasound wave cannot simply "jump" from 50th floor so it needs a "Matching Layer elevator" to slowly climb down to 10th floor and then a "Gel ladder" to reach down to the skin of patient. If there is no 'Gel ladder' it cannot simply jump into the "air" to reach the skin of the patient. The Matching layer and the gel are such mediators. (The floor numbers are used for analogy purposes and are not real...the differences are actually much higher!!)

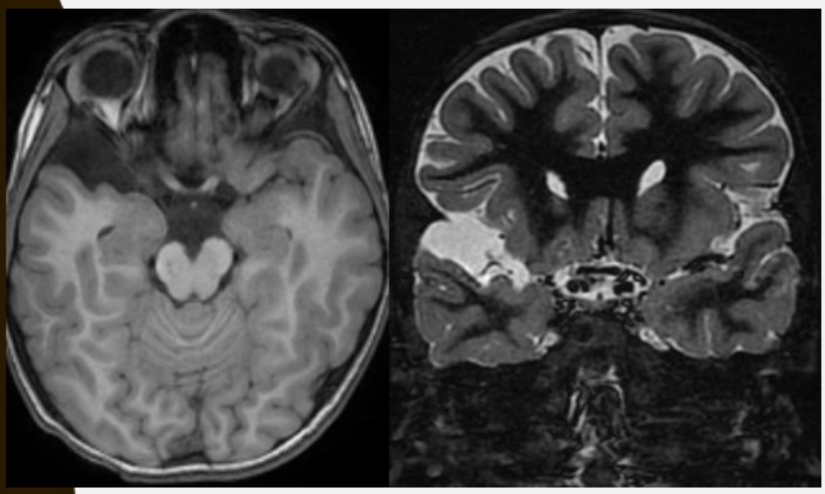


Fibromatosis

- The fibromatoses are a diverse group of soft-tissue lesions that occur at different ages and anatomic locations and that have common histopathologic features.
- They are composed of spindle-shaped fibrous cells that are separated and surrounded by abundant collagen material with rare mitoses.
- Their biologic behaviour is intermediate in aggressiveness between benign fibrous lesions and fibrosarcoma.
- There is a strong tendency toward local recurrence; however, these lesions never metastasize.
- The lesions have a well circumscribed or infiltrative margin, and the degree of cellularity is widely variable.
- The fibromatoses are commonly divided into two major groups: superficial (fascial) and deep (musculoaponeurotic).
- The superficial fibromatoses are usually small, slow-growing lesions that arise from fascia and aponeuroses.
- The superficial group includes palmar fibromatosis (Dupuytren disease), plantar fibromatosis (Ledderhose disease), juvenile aponeurotic fibroma, and infantile digital fibromatosis.
- The deep fibromatoses are larger and may grow rapidly.
- They are more aggressive and likely arise from the deep fascia about muscle and aponeurotic tissue.
- The most common types of deep fibromatoses are infantile myofibromatosis, fibromatosis colli, extraabdominal desmoid tumor, and aggressive infantile fibromatosis.

Back to Basics - Dr. Viral Parekh, DMRD, DNB.

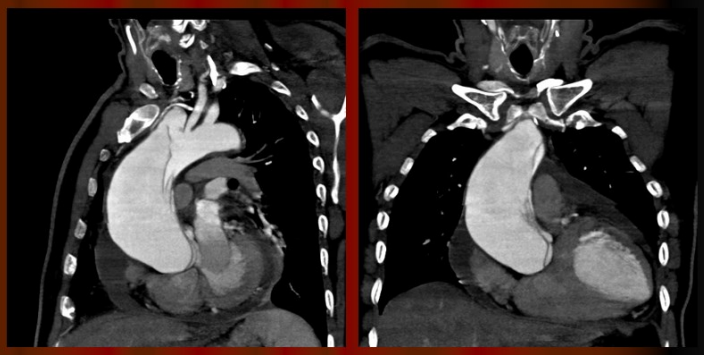
ARACHNOID CYST



Classification

- **Type I**
  - small, spindle-shaped
  - limited to the anterior portion of the middle cranial fossa, below the sphenoid ridge
  - free communication of subarachnoid space
- **Type II**
  - superior extent along the Sylvian fissure
  - displacement of the temporal lobe
  - slow communication with subarachnoid space
- **Type III**
  - large
  - fills the whole middle cranial fossa
  - displacement of not only the temporal lobe but also the frontal and parietal lobes
  - often results in midline shift
  - little communication with subarachnoid space

AORTIC DISSECTION

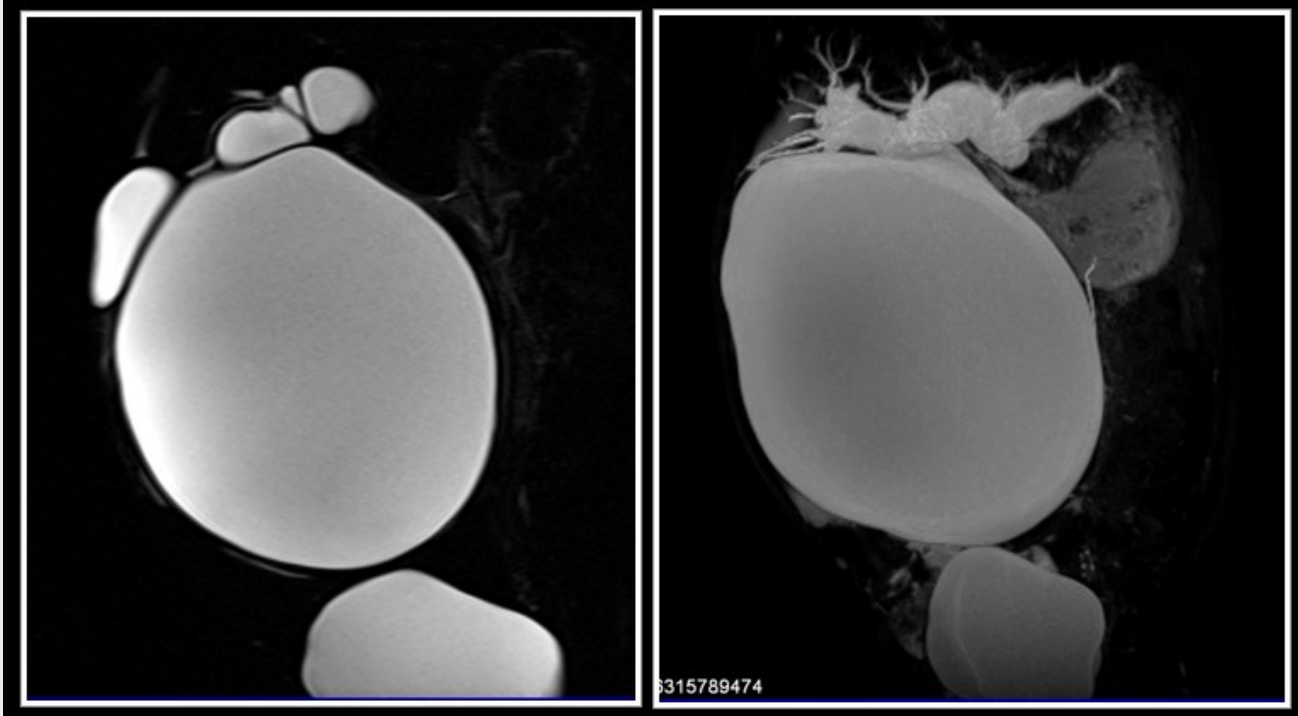


Check list for aortic dissection

- Stanford type A or type B?
- Signs of rupture?
- Mural Haematoma?
- Thrombosis of true or false lumen?
- Compression of true or false lumen?
- Aortic valve incompetence?
- Stenosis, compression or occlusion of aortic side branches (including the coronaries)
- Concomitant involvement of aortic branches
- Impaired perfusion of abdominal organs
- Location of intimal tear- Entry or re-entry

Back to Basics - Dr. Viral Parekh, DMRD, DNB.

Choledochal Cyst



Choledochal cysts

- Type 1
  - 77-90%
  - 1a - Cystic dilatation of CBD
  - 1b - Focal segmental dilatation of distal CBD
  - 1c – Fusiform dilatation of both CHD and CBD.
- Type 2
  - 2%
  - Choledochal cysts are true diverticulae
- Type 3
  - Choledochocele
- Type 4
  - 10%
  - 4a – Multiple intra and extrahepatic cysts
  - 4b – Multiple extrahepatic cysts only
- Type 5
  - Caroli' s disease

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A Platform For Radiology Education & Interaction

Calcutta Academy of Radiology was formed on international day of Radiology in 2019, that is on 8th. November, 2019 to promote Radiology education, keeping in mind Residents as well practicing Radiologists.

Since then we are on WhatsApp and Telegram, where thousands of cases have been discussed by members from all over the world and in the process we are sharing our experiences and helping each other. These social media platforms have turned out to be great learning tools.

We had organized a half day CME also on GI Radiology in February, 2020. We have plans to organize more such CME programmes in future when world recovers from this ongoing pandemic.

We are on YouTube also where we regularly post teaching videos and in the process try to propagate Radiology as much as possible.

We are on WhatsApp and Telegram

Next issue will be published in December 2021

We will be bringing out such Newsletters with a frequency of one issue every two months. So, next issue will be published in December, 2021.

We are hereby inviting good interesting cases and original work from our fellow Radiologists, which will be published on merit basis.

So, I request all of you to contribute to this Newsletter. Please send your material in Word format with good quality images. Please send your photograph and details of your place of work with email address also.

Your material should reach us by 15th. Of November, 2021. You can send the word file to our abovementioned email address or you can WhatsApp it to above-mentioned three phone numbers.

On our YouTube channel, we are presenting a new case every week and there is good response to such teaching videos. I hereby request all Radiologists to share their teaching videos with us and if they contain good teaching material, we will surely publish it on our channel. So friends, during this trying time , stay away from depression by engaging yourself in academic activities.

Our Telegram group is lagging behind in academic activities as compared to two WhatsApp groups, so I request all of you to join our Telegram group. Since, WhatsApp restricts the number of members to 256 only, whatever activity going on there is not helping the whole Radiology community.

Telegram can add up to whopping 200,000 members. So, if we post our study material there; it will reach to and benefit huge number of members.

So friends, take care and be safe.

So, see you all in next issue of CAR newsletter.

So long,

Anup Sadhu, Bijon Kundu and Viral Parekh.

We are thankful to all the contributors for sharing their experiences and literature with us and in the process helping the Radiological fraternity.