Calcutta Academy Of Radiology

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INSIDE THIS ISSUE

Pandemic of virus and conferences - Viral Parekh

Hi Namaskar friends,

Wish you all a very happy Christmas.

We are yet to recover completely from the Delta variant of Corona Virus and there is already a new strain, Omicron aka B.1.1.529 variant of Corona virus, which is supposed to be much more virulent than the delta variant. Once again, we are staring at Global lockdown and I hope it is contained fast and there is no significant damage to the humanity.

As we are going through a pandemic of a deadly virus, there is pandemic of conferences and webinars in the field of Radiology. When, I became a Radiologist, we used to have one or two major conferences in a year and we used to look forward to attending the conference and listen to and see something new. Now, we have at least 4-5 webinars in a day. I don't know what is the method behind this pandemic of educational events. Do we really need so many webinars? How many people are really interested in attending such webinars daily? We don't know the logic behind so many educational events. I hope doubting Thomases are wrong and these webinars are really serving a purpose.

There is lot of buzz around HiP CT- that is Hierarchical Phase-Contrast Tomography (HiP-CT). It is an X-ray technique which promises to separate field of view and resolution to image any organ in the human body with cellular resolution. The technique will enable the scanning of whole bodies with a resolution of 25 microns, thinner than a human hair and ten times the resolution of a medical CT scanner. Areas can then be selected to be zoomed in on, achieving local micron resolution, or one hundred times the resolution of medical CT. The project to develop such a system is going on. Developments like this keeps interest in field of Radiology alive and we all look forward to work on a scanner like this. I hope I am able to see projects like this to come to reality in my lifetime.

This issue would not have been possible without the help of Dr. Bhavin Jankharia, Dr. Rajesh Botchu, Dr. Bhaskar Golla, and Dr. Bhabani Prasad Chattopadhyay. I sincerely thank all of them.

The next issue of our newsletter will be published on 1st. Of February, 2021. Till then take care and stay safe.

I wish you all a life of contentment and sheer happiness in coming New Year, 2022.

Dr. Bhavin Jankharia,
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Consultant Radiologist.

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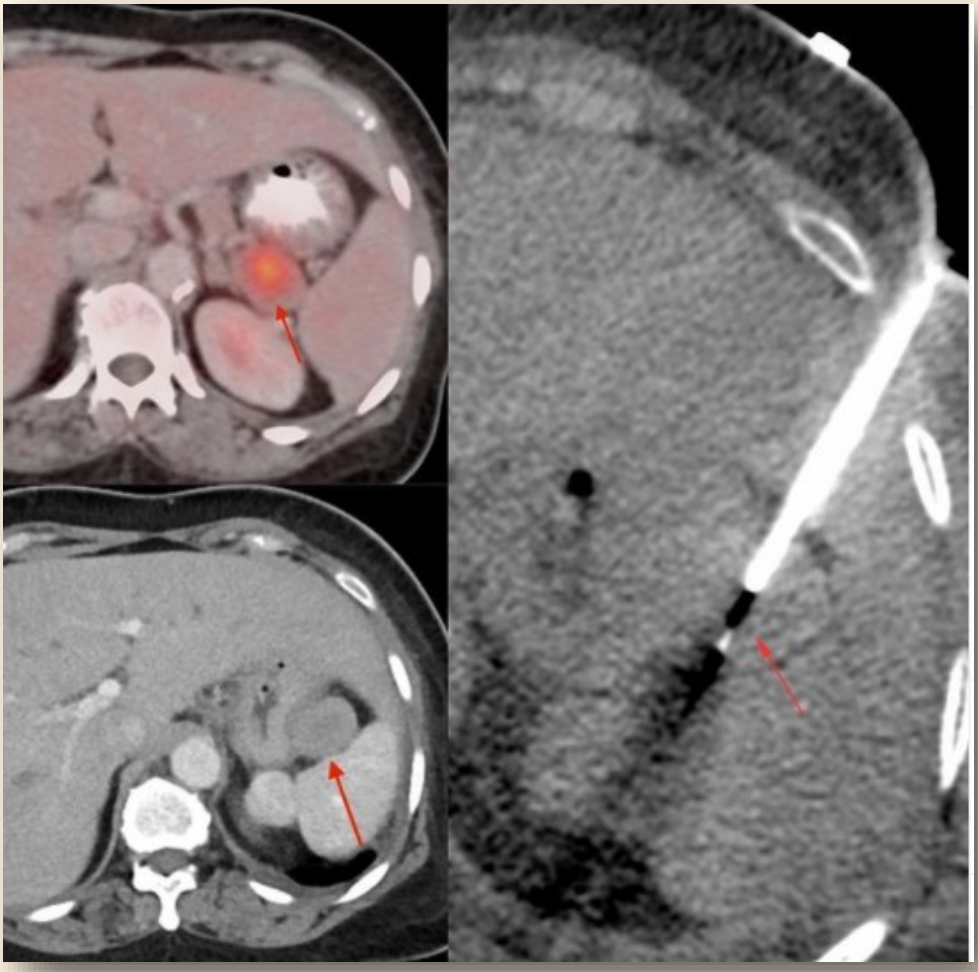
Dr. Bhavin Jankharia needs no introduction to the Radiology fraternity. As you all know he is a renowned Radiologist and academician and has contributed immensely in propagating Radiology education. Presently, he is a Consultant Radiologist at Picture This by Jankharia. He is also a Trustee of Radiology 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**

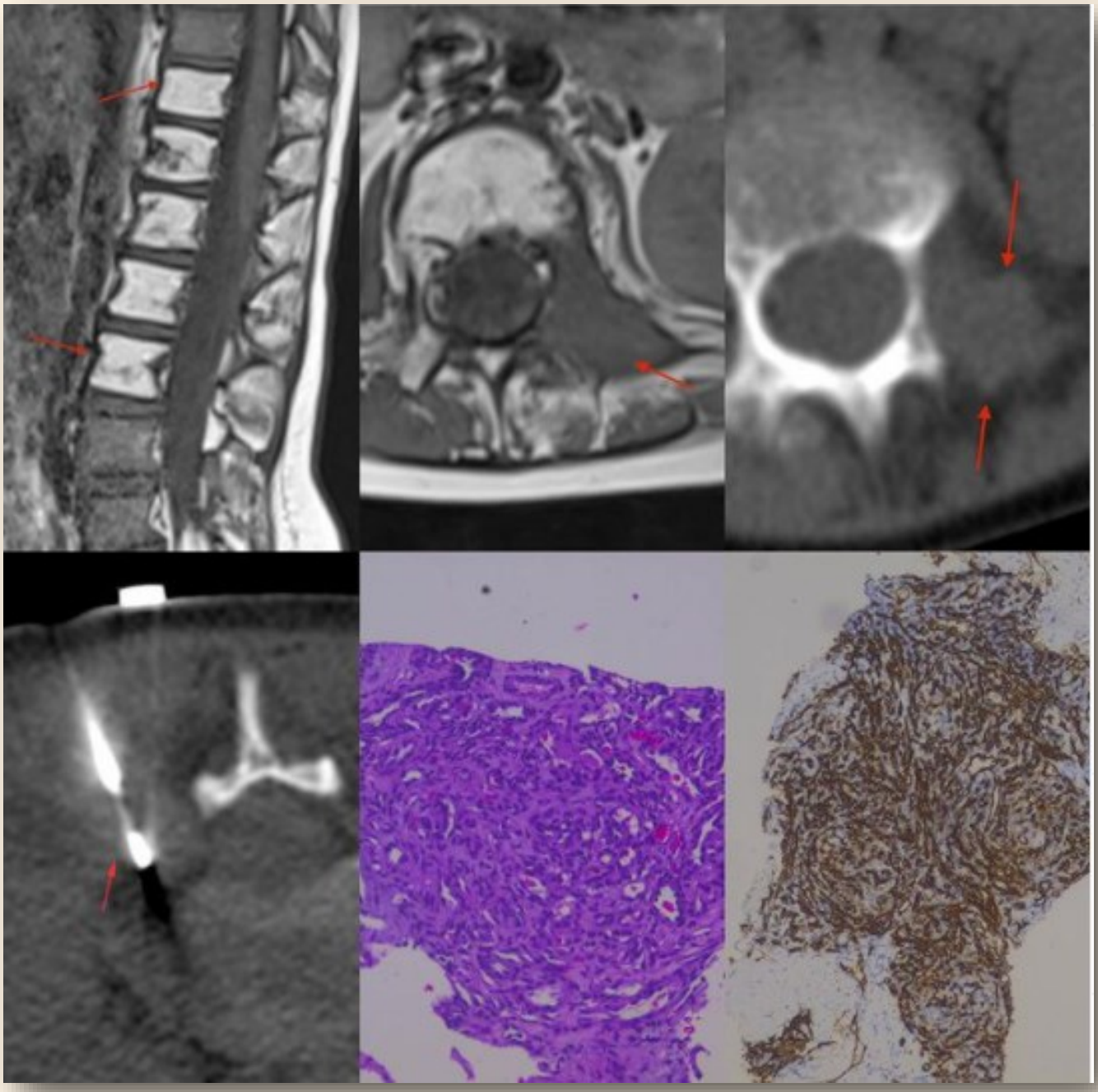
Case I - Trans-Organ Biopsy - Trans-Hepatic Biopsy of a GIST



his is a 61-years old lady who came for a CT guided biopsy. She had a PET/CT showing a focal mass with mild uptake, the lesion located posterior to the stomach, with a prominent left lobe of the liver. I envisaged doing a trans-hepatic, trans-gastric biopsy. On the day of the biopsy however, and as often happens in such circumstances, the mass was now peri-gastric, rather than retro-gastric, which meant I would have to go through just the liver, instead of both the liver and the stomach.

The biopsy was simple using a 20G coaxial biopsy gun. The diagnosis as expected was gastrointestinal stromal tumor (GIST). It is usually fine to go through other organs to get to the lesion.

Case II - Simple Biopsy Tough Diagnosis - Kaposiform Hemangioendothelioma Spine



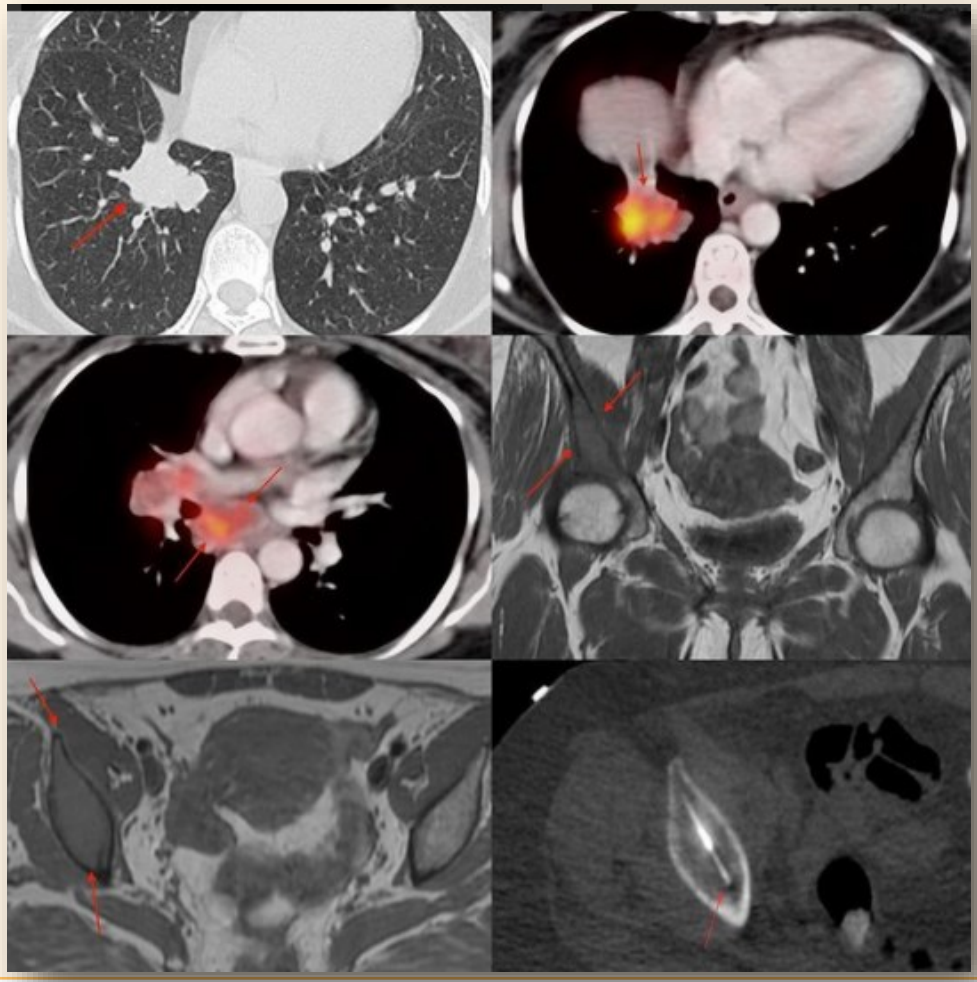
his 5 years old boy had backache and pain.

The MRI showed T1 bright marrow change from D11 to L3. The left L2 pedicle showed a T1 dark area, which was scheduled for a biopsy. The CT scan showed that this was a soft tissue component scalloping the bone, rather than intra-osseous.

The biopsy was performed under sedation with an 18G coaxial biopsy gun. It was very simple and straightforward. The biopsy result however took a few days and was a tough diagnosis to make. The fin al diagnosis was a Kaposiform hemangioendothelioma (KHE), CD34 and D2 40 positive.
KHE normally presents with corresponding skin changes. This patient didn't have any. KHE without skin changes is a rare diagnosis.

Dr. Bhavin Jankharia, MD

Case III - What Does One Biopsy - Bone or Lung



This 46 years old lady had an active lung mass, with active, necrotic subcarinal nodes and a lesion in the right iliac bone. Her initial presentation was pain in the right hip region and after the MRI a PET was done to look for other lesions in the body and this is what we found.

There are some oncologists who only want material from the primary site of the malignant neoplasm. There are others who are fine with material from a metastatic site. In this case, assuming this to be metastatic stage IV lung cancer, we would need material for EGFR, ALK, ROS1, PDL1, etc as well and in this patient, it would be easy to get a lot of material from the bone lesion without any complication.
I did a bone biopsy through the antero-inferior iliac spine with an 18G coaxial biopsy gun. This is a simple biopsy to do and she had adenocarcinoma metastasis from carcinoma lung and the material was enough for EGFR and ALK, which is what was asked for at that time. However, we would have to do what is asked for. If the physician or oncologist insisted on a lung lesion biopsy then that is what I would have done. But if we assume that doing the simplest biopsy where the chance of a complication is the lowest and the material obtained is good enough, is also an acceptable dictum, then the iliac bone biopsy was fine as well.

Dr. Bhavin Jankharia, MD

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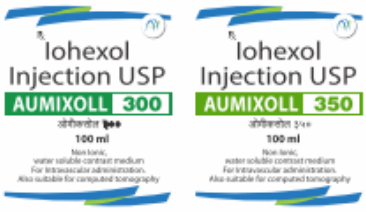

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Satisfaction of search - problem and solution

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Satisfaction of search (SOS) in diagnostic radiology is a well known phenomenon. This involves satisfaction by the reporting radiologist on identifying an abnormality on a study with subsequent decrease in relative concentration resulting in overlooking findings on the rest of the study. This can be seen on all modalities in imaging from radiographs to CT and MRI. SOS can occasionally result in under diagnosing the full extent of disease/pathology, interpreting one finding only rather than a conglomerate of findings. This can result in increased morbidity and in some cases mortality. Botchu et al had demonstrated a series of 5 cases where SOS had resulted in significant progression of disease (not reported due to SOS on initial imaging) on the subsequent imaging.

Every radiologist should be aware and develop their own plan to mitigate this phenomenon of SOS. Some of the strategies that have been used include- making diagnosis on one series of MRI or CT and using the other series to confirm or refute the diagnosis noted on first series. Re reviewing study before verifying the report is another tactic. Using theory of compartmentalization of brain can also help to mitigate SOS- this involves parking the first finding noted in one part of the brain and evaluating the subsequent imaging as if no abnormality was noted. This can be repeated with multiple findings being deposited/parked in brain. These can be assimilated together at the end of the report to ensure no finding has been missed. These are only some of the strategies that can help to minimise discrepancies due to SOS.

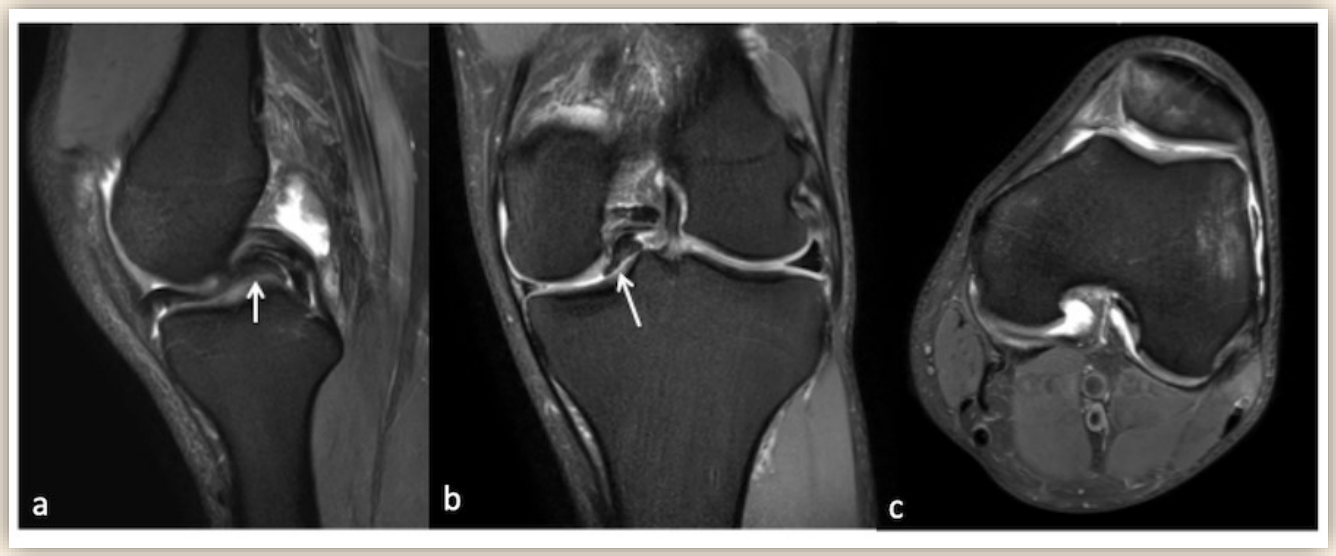

Figure 1: PDFS sag(a), coronal(b) and axial (c) -20 year old male with bucket handle tear of medial meniscus (arrow) and kissing contusion of the medial part of the patella and lateral femoral condyle in keeping with recent reduced patellar dislocation.

Satisfaction of search - problem and solution

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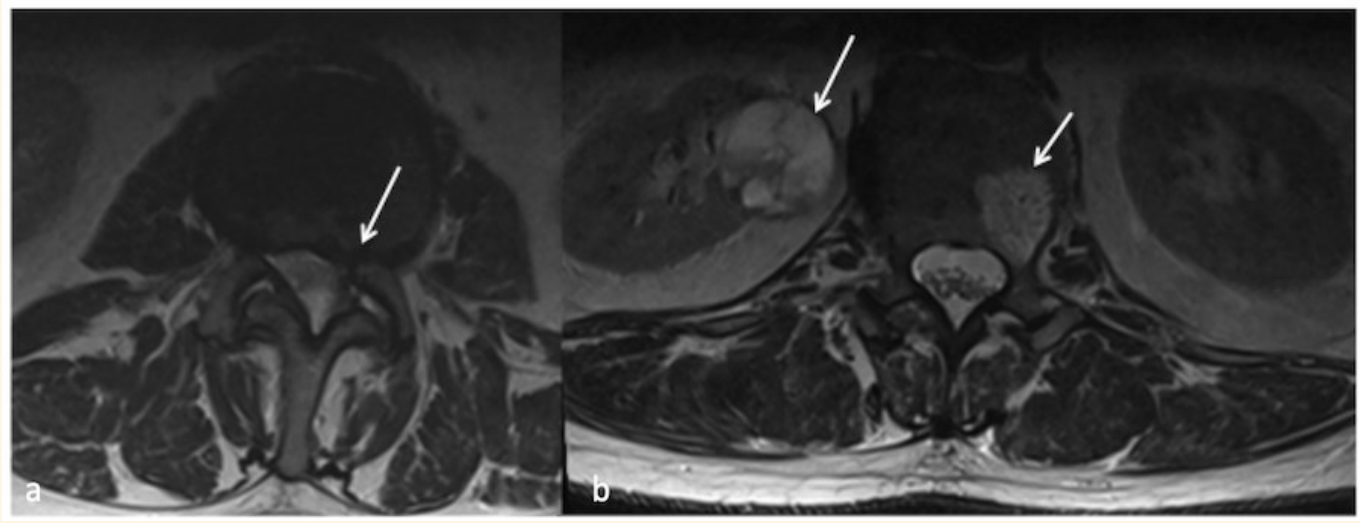


Figure 2

Axial T2(a and b) - 60 year old male with impingement of left L4 nerve root in the left lateral recess due to left paracentral disc protrusion (a), incidental vertebral hemangioma (small arrow) and right renal cell carcinoma (arrow)

References

Botchu R, Rao B, Tyagi R. MDCT of the abdomen: missed diagnoses due to satisfaction of search. AJR

Adamo SH, Gereke BJ, Shomstein S, Schmidt J. From "satisfaction of search" to "subsequent search misses": a review of multiple-target search errors across radiology and cognitive science. Cogn Res Princ Implic. 2021;286(1):59

Amyand's Hernia

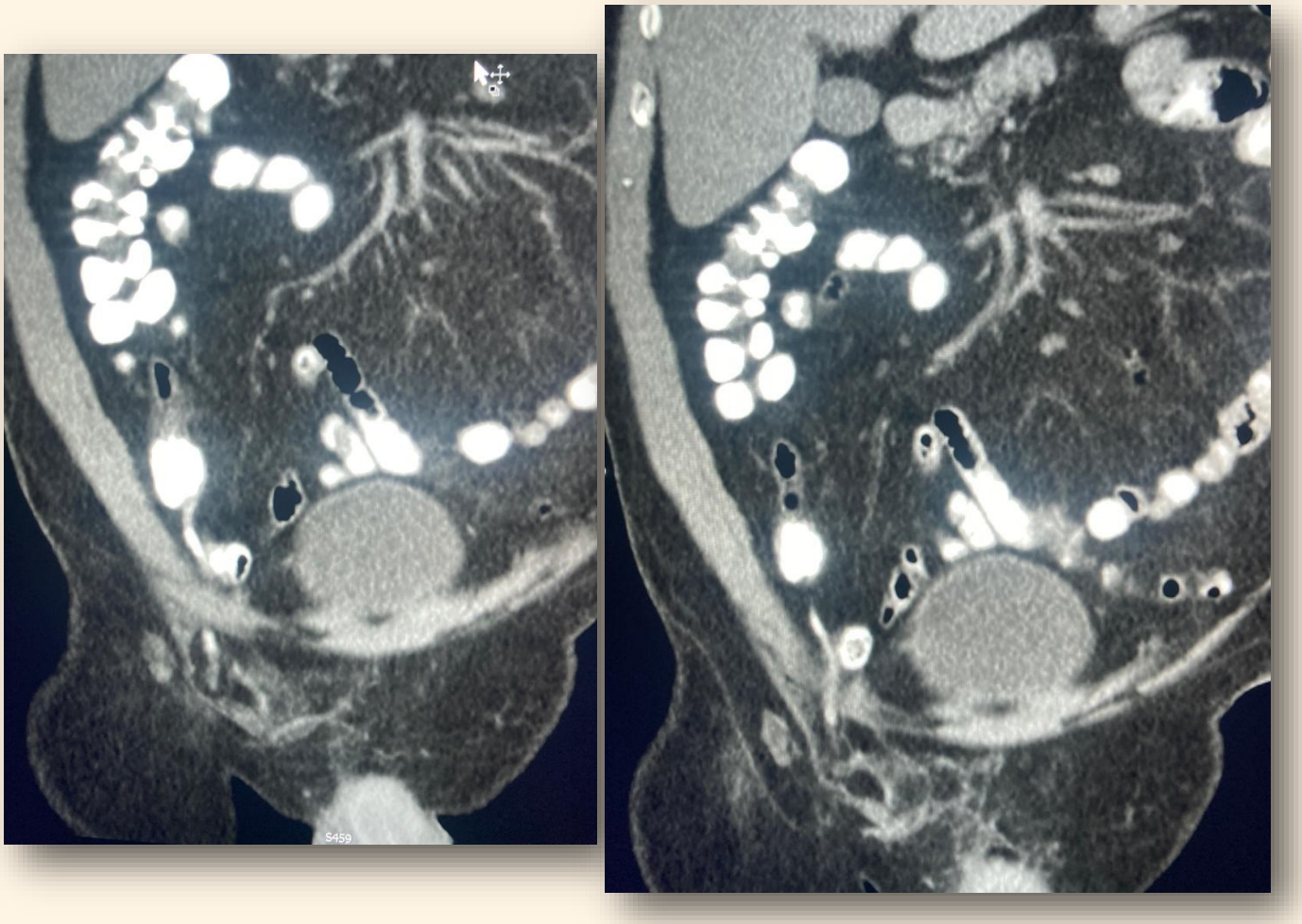
Amyand's hernia is an unusual condition characterized by the presence of a normal or inflamed appendix located within an inguinal hernia.

It is named after Dr. Claudius Amyand, who performed the first appendectomy where the appendix happened to be located in the inguinal canal.

An Amyand's hernia can become inflamed, infected, or perforated, or be incarcerated and completely healthy.

They are seen in less than 1% of inguinal hernias. It should not be confused with an appendix-containing femoral hernia, known as a De Garengeot hernia.

Amyand hernia is usually found on the right side and more common in males. The most common presentation is an indirect inguino-scrotal hernia. The right side location is attributed to the presence of the appendix on the right. Left sided Amyand hernia has also been reported, due to gut malrotation, situs inversus totalis, and very mobile cecum. Few cases of Amyand hernia also had been reported in females.

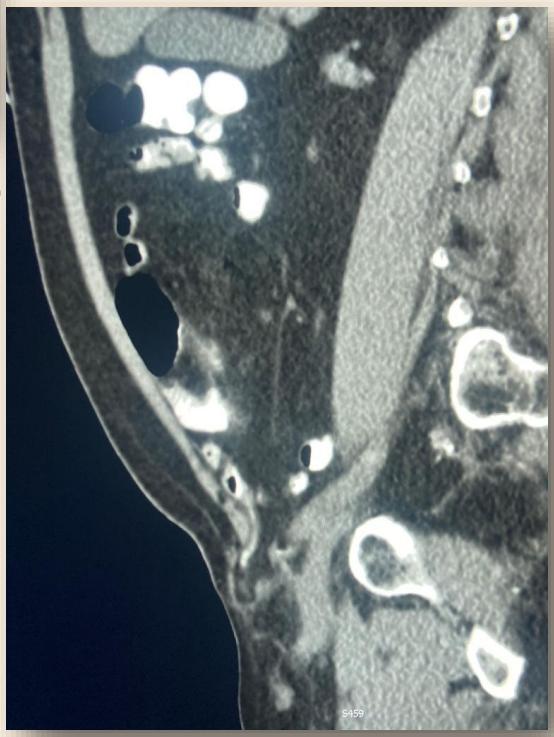


Dr. Bhaskar Golla, MD.
Dr. Viral Parekh, DMRD, DNB

Amyand's Hernia

Amyand hernia is classified into four types based upon the presence of appendicular inflammation, associated peritonitis, or any other abdominal pathology by Losanoff and Basson.

Losanoff and Basson classification of Amyand's hernia.	
Classification	**Description**
Type 1	Normal appendix in an inguinal hernia
Type 2	Acute appendicitis in an inguinal hernia, without abdominal sepsis
Type 3	Acute appendicitis in an inguinal hernia, with abdominal wall or peritoneal sepsis
Type 4	Acute appendicitis in an inguinal hernia, with abdominal pathology



Sometimes appendix can herniate through the defect in the previous incisional site. Appendix is the content of the sac in the post-operative incisional hernia. It is added as a new fifth type in the Losanoff and Basson classification of Amyand hernia. This is further classified into three subtypes, namely VA, VB, and VC based upon the presence of appendicular inflammation or any other associated intraabdominal pathology.

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CARDIOLOGIST'S EXPECTATION FROM RADIOLOGIST

DR BHABANI PRASAD CHATTOPADHYAY
PROFESSOR ,DEPARTMENT OF CARDIOLOGY, MEDICAL COLLEGE ,KOLKATA

Very recently my residents were in trouble in the Cath lab in completing one coronary angiography because of severe pressure dampening and ventricularisation with JL 6 F catheter in a patient with left Main Coronary Artery Disease with severe Triple Vessel CAD. To complete the procedure Multiple downsized catheters available were used but the Left Main ostial stenosis was so severe that there was dampening of pressure even with 4 F JL Catheter. Sinus shots and brief selective injection of contrast by hit and run approach helped in finally completing the picturisations. But discontent prevailed in visualisations in entirety due to brevity of contrast injection time. I contacted my mentor Radiologist about the discontent considering the patient's actual necessity of better imaging without indulging in the fatal haemodynamics. He bailed me out by excellent quality MDCT coronary Angiography with the exact details required for planning the grafts for CABG.

On several other occasions in our high-volume center the anomalous site of origin and uncomfortable take off of the coronaries were limiting the stable engagement of the coronary catheters for appropriate imaging needed for decision making. My expectation as a Cardiologist was not denied but fulfilled by the Radiologist who virtually bailed out sometimes of the crucial dilemma in decision making.

Cardiac imaging is an upcoming branch in the field of radiology . Cardiovascular causes are up there among the top 3 causes of mortality globally. Cardiac imaging constitutes a novel noninvasive modality of cardiac risk stratification and aids in reducing the cardiovascular disease burden .The 2 most upcoming aspects in the field of cardiac imaging are cardiac CT including CT coronary angiography and cardiac MRI . CT technology has advanced rapidly since its inception in the 1970s. Coronary CT angiography has emerged as a noninvasive alternative to coronary angiography in recent times. The information given on the coronary lumen by CCTA is almost similar to invasive coronary angiogram . CT angiography helps to assess the presence , extent , angiographic severity, and composition of atherosclerosis. This imaging modality has an extremely high negative predictive value. It has one drawback - it fails to give an idea on the physiological assessment of a lesion . Radiologists can play an extremely key role in this era of coronary artery disease in identifying the coronary anatomy , evaluating coronary artery calcium scoring and assessing the angiographic severity in chronic coronary syndrome . Cardiac CT is also an important imaging modality in identifying anomalous coronary anatomies like anomalies of origin and course , anomalies of intrinsic coronary arterial anatomy and anomalies of coronary termination . Cardiac CT also is an important aid in diagnosing complex congenital heart disease . With improvement of spatial and temporal resolution in CT imaging modality ,this has become a valuable tool in diagnosing complex congenital heart disease along with ECG, chest Xray and echocardiography .

CARDIOLOGIST'S EXPECTATION FROM RADIOLOGIST

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CT has also evolved to become an important imaging modality for pre-operative guidance and follow up for many interventions of structural heart diseases like transcatheter heart valve replacement , left atrial appendage occlusion and arrythmia ablation . Specific to the novel modality of TAVR , CT scans help to provide valuable information regarding aortic annular size and calcification , prediction of TAVR deployment angles ,coronary ostial heights ,aorto-iliac size and atherosclerotic burden ,and post-procedural evaluation of TAVR devices for evidence of leaflet thickening suggestive of thrombosis.

Cardiac CT can also be useful in patients of atrial fibrillation as it can give a detailed morphologic characterization of the left atrium, left atrial appendage and pulmonary veins.
Yet another novel advancement in the field of cardiac radiology is the field of nuclear cardiology which includes SPECT myocardial perfusion imaging . A good radiologist must understand that the information derived from such imaging procedure must enhance the physician's decision-making process for proper diagnosis and management of a patient. SPECT MPI can give valuable information regarding myocardial blood flow at rest , size of infarct , myocardial viability, and assessment of myocardial perfusion during stress.

Cardiac MRI helps in diagnosing an array of cardiovascular diseases like varieties of cardiomyopathies like sarcoidosis, amyloidosis, ARVD and hypertrophic cardiomyopathy.
Cardiologists and radiologists have their own shortcomings - for cardiologists , it is difficult to understand the nuances of imaging physics and interpret the artifacts during a CT imaging , and this applies to radiologists as well who lack training in invasive angiograms. Proper coordination between the 2 fields can optimize the potential of cardiac imaging and can certainly add years to life in hundreds of patients across the globe.

Hyperlinks of academic material published on YouTube by Calcutta Academy of Radiology	
1	Imaging of acute Pancreatitis—Dr. Anirudh Kohli
2	USG of rotator cuff - Dr. P. K. Srivastava
3	PET CT Physics - Dr. Sikandar Sk.
4	PET CT in Neurology - Dr. Sikandar Sk.
5	CAR - Case of the week - Case 1 - Megalencephalic leukoencephalopathy with subcortical cysts. - Dr. Viral Parekh
6	CAR - Case of the week - Case 2 - Adenocarcinoma of terminal ileum - Dr. Viral Parekh
7	CAR - Case of the week - Case 3 - Stener lesion - Dr. Nivedita Chakraborty
8	CAR - Case of the week - Case 4 - Anterior shoulder dislocation - Dr. Nivedita Chakraborty
9	CAR - Case of the week - Case 5 - Secondary intracranial hypotension. - Dr. Viral Parekh
10	CAR - Case of the week - Case 6 - Intramyocardial Dissection - Dr. Ritu Agarwal
11	CAR - Case of the week - Case 7 - Radiation Necrosis and BT - RADS - Dr. Nivedita Chakraborty
12	CAR - Case of the week - Case 8 - Undisplaced right ulnar styloid base fracture - Dr. Nivedita Chakraborty
13	CAR - Case of the week - Case 9 - Hypoglycaemic encephalopathy. - Dr. Viral Parekh
14	CAR - Case of the week - Case 10 - Myocardial annular dysjunction - Dr. Ritu Agarwal
15	CAR - Tribute to Wilhelm Conrad Roentgen - Immortal Roentgen.
16	CAR - Case of the week - Case 11 - Dacryocystocele with anatomy of Nasolacrimal apparatus. - Dr. Viral Parekh
17	CAR - Case of the week - Case 12 - Tubercular osteomyelitis - Dr. Nivedita Chakraborty
18	CAR - Case of the week - Case 13 - Marchiafava Bignami disease - Dr. Viral Parekh
19	CAR - Case of the week - Case 14 - Parosteoal Sarcoma - Dr. Nivedita Chakraborty
20	CAR - Case of the week—Case 15 - Adrenal haemangioma - Dr. Viral Parekh

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21	CAR - Case of the week - Case 16 Patellar GCT - Dr. Nivedita Chakrabarty
22	CAR - Case of the week - Case 17 - MEN Syndrome - Dr. Sayan Sarkar
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

We have a new blog , where we publish cases, quizzes and various other education materials. Please follow the blog.

Link is here

We are on YouTube

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

From the pages of History - The early journals of Radiology

Compiled by Dr. Anup K Sadhu

In the development of any new branch of science or medicine, it is essential to develop channels of communications among the investigators and the practitioners. In Radiology , organizations and periodicals of high quality were established sob after Roentgen's discovery.
American Roentgen Ray Society (ARRS)began 3 yrs before its founding with an x-ray pioneer Heber Roberts of St Louis.
In 1897 Roberts launched The American X Ray Journal.---- a monthly journal devoted to practical X ray work and allied arts and sciences.
It was his idea to give the readers and thinkers a faithful resume of all x-ray work done in any part of the globe.

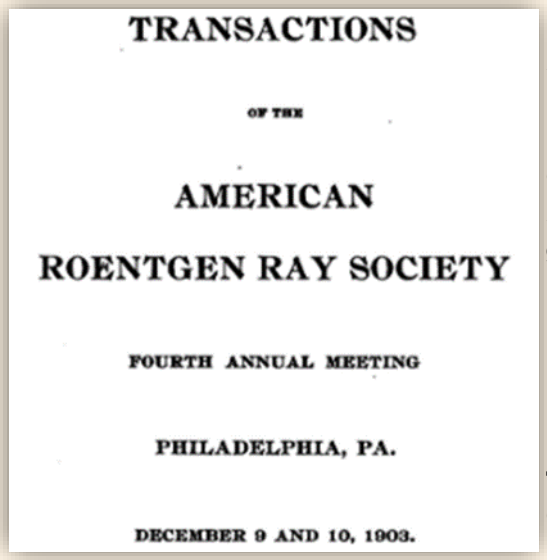
Archives of Clinical Skiagraphy was the first radiology scientific journal and appeared in May 1896. Its founder and editor was Sydney D. Rowland (1872-1917), a medical student at St. Bartholomew's Hospital in London. The first issue comprised 16 pages with an article by Rowland on the method of taking a radiograph, or skiagram as he called it, and six photographic plates. Seven months later the journal became Archives of Skiagraphy. Skiagraphy was a term proposed by Rowland that literally means "shadow writing," derived from the Greek terms skia (σκια) and grapho (γραφω). His first editorial stated, "The object of this publication is to put on record…the most striking applications of the new photography to the needs of medicine and surgery." In 1897, the journal was renamed, again: British Journal of Radiology.

The earliest radiology journals that appeared in the United States were the precursors of the present American Journal of Roentgenology (AJR) and Radiology. Dr. Heber Robarts (1852-1922), a surgeon for the Great Northern Railway, established a laboratory in St. Louis for the further study of the x-ray phenomenon. His ambition was to establish an American periodical devoted to the interests of this new medical specialty. His American X-ray Journal was initially a monthly magazine, first published in May 1897, devoted to practical x-ray work and allied arts and sciences. Robarts noted that the application of the "new rays" allowed for "the ease and certainty of aiding diagnosis which has advanced more in the past 12 months than any previous hundred years." He went on to say, "that no advertisements shall appear in this journal that savor of quackery, deception, or fraud," an early manifestation of the intended integrity of a medical journal. In 1900, Robarts organized "the Roentgen Society of the United States" and was chosen as the first president of the society. The ranks soon became infiltrated by commercial interests, and Robarts disposed of the journal's control.

In 1906, the American X-ray Journal's editorship passed to Dr. Preston Manasseh Hickey (1865-1930) of Detroit, a pathologist, otolaryngologist, and skilled amateur photographer who, with a colleague, purchased one of the first x-ray machines in Michigan. In 1922, Hickey was appointed chair of radiology at the University of Michigan; he is counted among the founding members of the American Roentgen Ray Society (ARRS). ARRS started publishing the scientific presentations at its meetings as Transactions, and after 1906, in the American Journal of Roentgenology and Radium Therapy, AJR's predecessor. Hickey was editor from 1906 until 1916, and he was responsible for the terms "roentgenology," "roentgenogram," and "radiograph." He was also instrumental in standardizing radiographic nomenclature and report structure.

From the pages of History - The early journals of Radiology

Compiled by Dr. Anup K Sadhu


TRANSACTIONS

OF THE

AMERICAN

ROENTGEN RAY SOCIETY

FOURTH ANNUAL MEETING

PHILADELPHIA, PA.

DECEMBER 9 AND 10, 1903.

At this point, a new radiology society gave rise to a second credible journal. ARRS was considered an "Eastern" society with most of its meetings held in that part of the country. Attendance for Hickey's colleagues west of the Alleghenies was difficult, and many "Western" radiologists were ineligible for membership according to ARRS' professionally elitist criteria. Some sensed that there should be a place in organized radiology where young physicians were encouraged to develop, so Dr. Edwin C. Ernst (1885-1969) of St. Louis convened a meeting in St. Louis in 1915. His organization was originally known as the Western Roentgen Society, and in 1922, its name was changed to the Radiological Society of North America (RSNA). RSNA's 1923 articles of incorporation included a plan "to maintain a journal in order that legally the society should own and control, RADIOLOGY," which was then beginning publication. Dr. Maximilian John Hubeny (1880-1942) was editor from the journal's inception until his departure in 1931. Under Hubeny's editorship, Radiology was immediately established as a quality medical journal, and he supervised its first 16 volumes. AJR and Radiology remain the flagship publications of our profession.

In more recent decades, as sub-specialization and significant technologies like CT reshaped the profession, diverse types of radiology journals appeared, the predecessors of today's several respected publications targeted to particular imaging techniques and specific anatomic areas or diseases of an organ system. In 1977, once CT had advanced past its initial novelty and rarity to become widely accepted, Journal of Computer Assisted Tomography was first published by Raven Press as a technique-oriented journal dedicated to emission and transmission tomography, under the editorship of Dr. Giovanni Di Chiro (1926-1977) of the National Institutes of Health. Soon after in 1980, Dr. Melvin Figley (1920-2010) at the University of Washington, editor of AJR, helped establish the sub-specialized American Journal of Neuroradiology (AJNR) as a joint project of ARRS and American Society of Neuroradiology (ASNR). Dr. Juan Taveras (1919-2002), a founder of ASNR in 1962 before moving to Massachusetts General Hospital, was AJNR's first editor. Selected articles were reprinted in AJR a month after they appeared in AJNR, elevating neuroradiology's academic credibility among the various neurosciences and setting a precedent for successful organ system-oriented radiology journals in other sub-specialties.

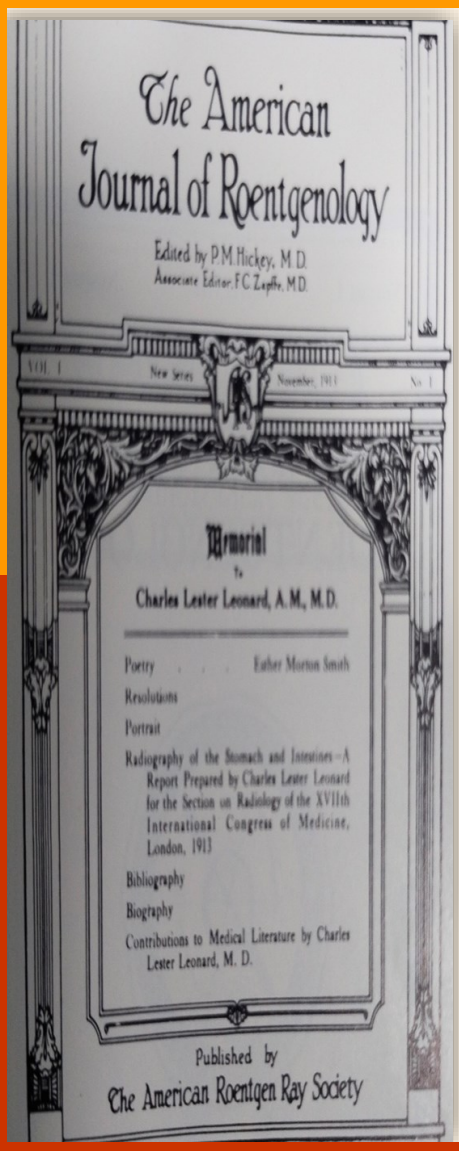
The long history of responsible medical journalism is the pride of radiology. Ethical conduct by editors and reviewers is mandatory in academic journals, and authors are always responsible for honest conduct of research. Conclusions are evaluated based on credible data.

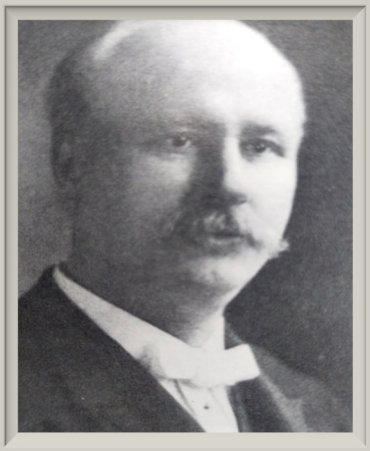
There is, admittedly, a recent proliferation of for-profit journals, many of which are internet-based, which charge authors a fee for publication, have questionable peer review, and draw advertising away from established academic journals.

From the pages of History - The early journals of Radiology

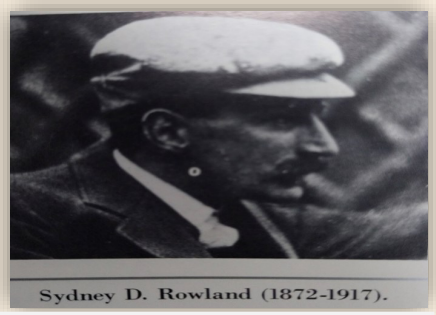
Compiled by Dr. Anup K Sadhu

It is increasingly our responsibility as radiologists, particularly in the rapidly changing times COVID-19 makes so immediately familiar, to respect and protect the legitimate journals our specialty has so long esteemed—the traditional publications highlighted in this article and the many recent efforts space limits my mentioning—as the primary sources of information for our practices in an era when expansive, even sensational, mass-media coverage of new techniques, cures, and devices rushes all of us ahead.



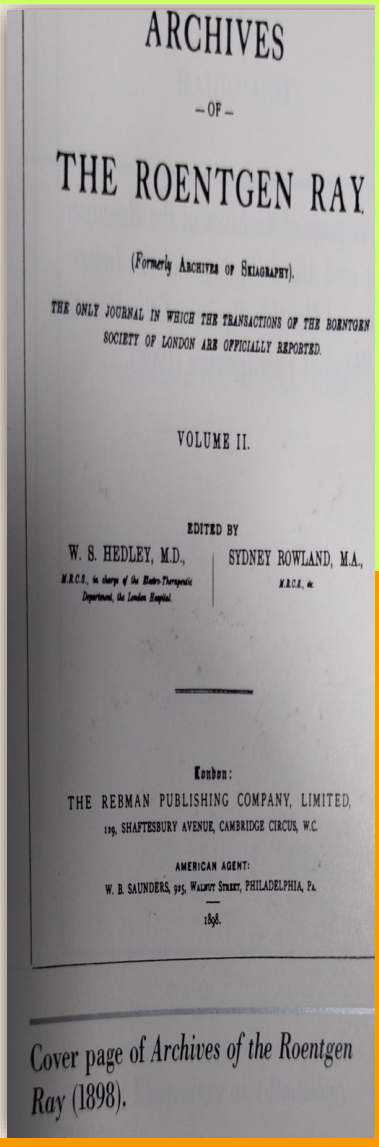


Heber Roberts



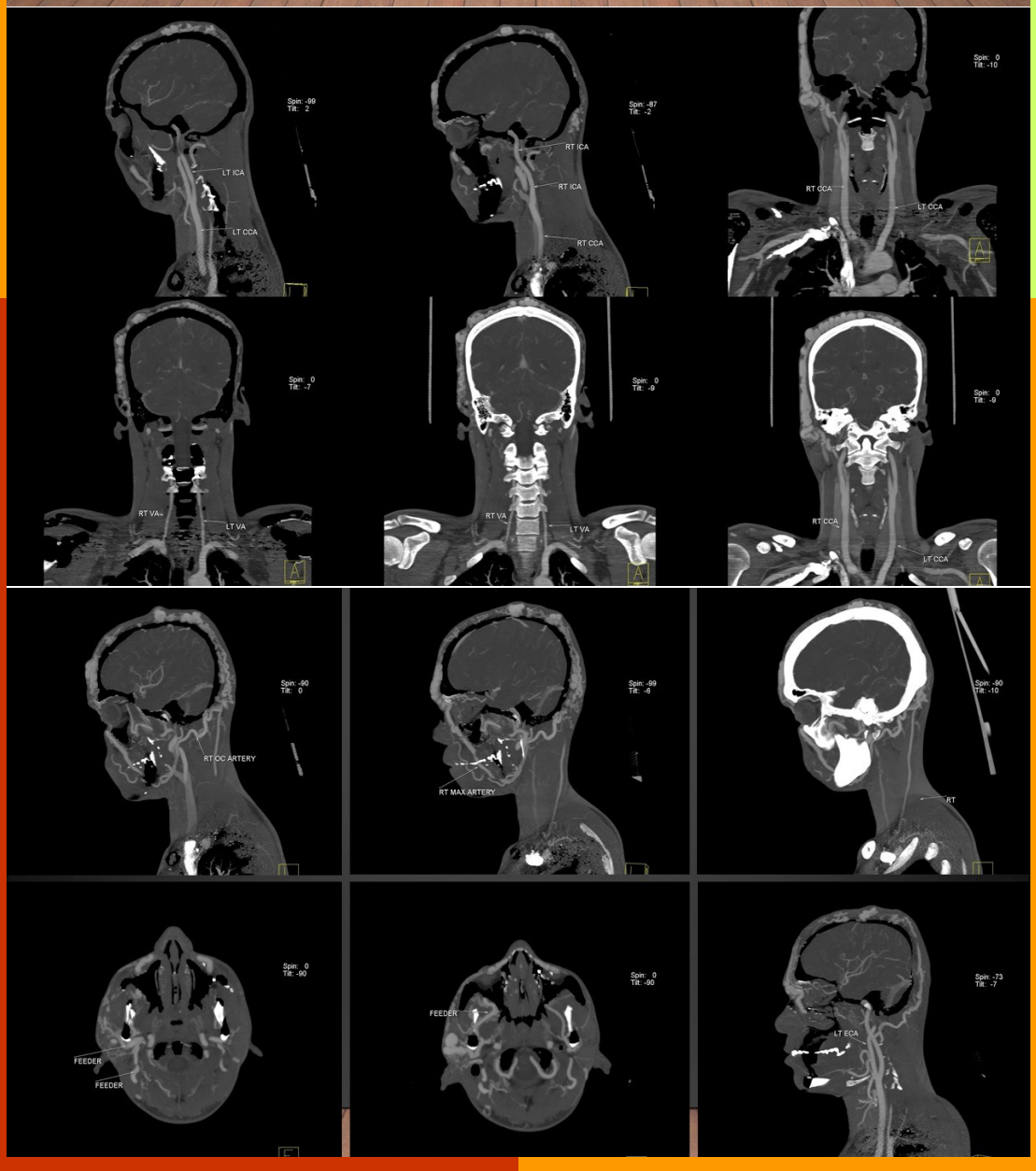
Sydney D. Rowland (1872-1917).

Rowland, the major force behind Archive later named British Journal of Radiology

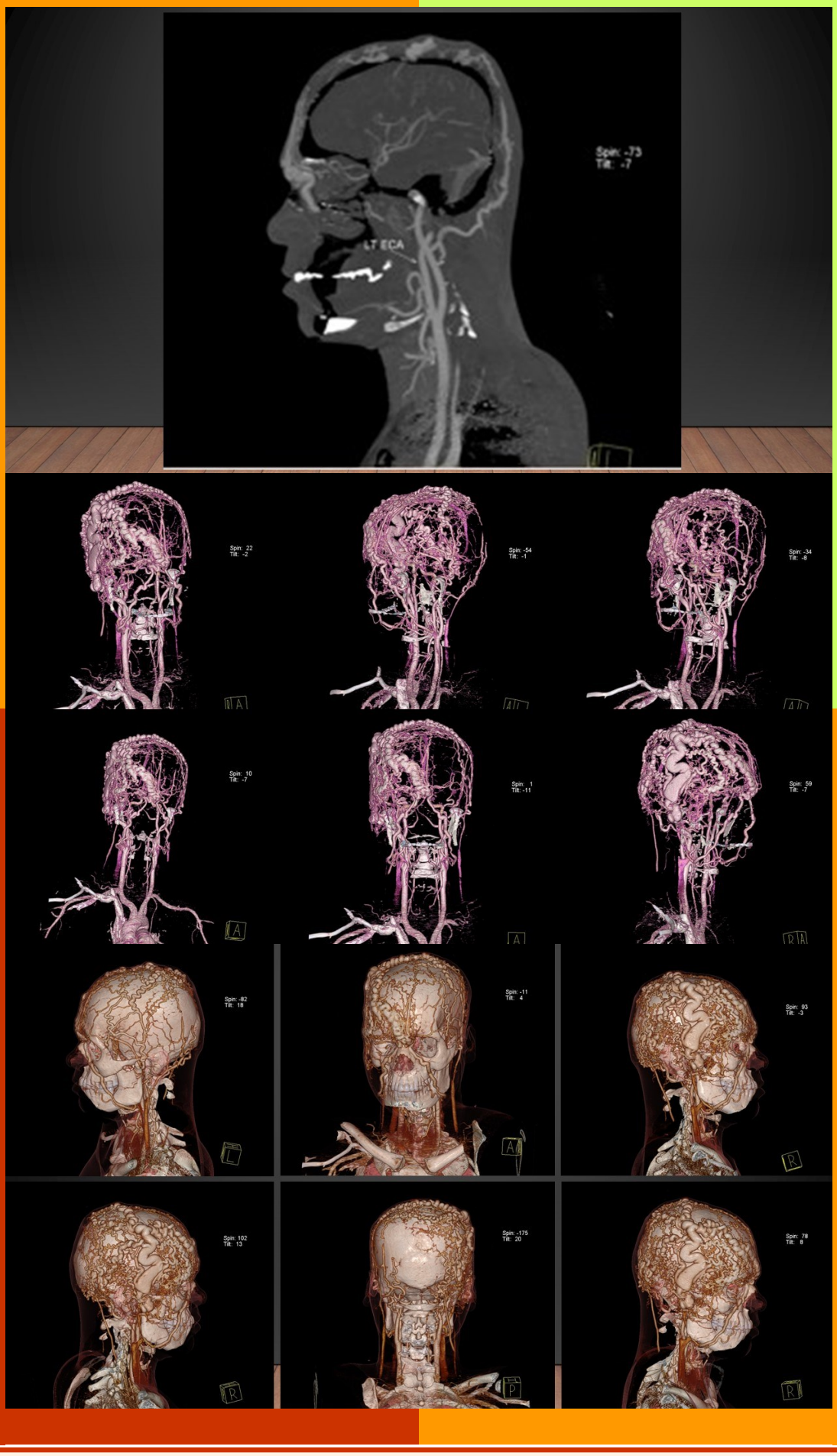


Cover page of *Archives of the Roentgen Ray* (1898).

A 33year old male presented to OPD complaining of gradually progressive pulsatile scalp swelling. A CT angiography was advised.



Dr. Viral Parekh, DMRD, DNB.



Dr. Viral Parekh, DMRD, DNB.

Final Diagnosis

Cirsoid Aneurysm

- Cirsoid aneurysms (CAs) of the scalp are rare with scanty reports available in the radiological literature. Breschet first described them in 1833, who coined the term "aneurysme cirsoide".
- Cirsoid means resembling a varix – referring to the characteristic variceal dilatation of the draining veins (Greek kirsos means varix).
- They have been previously also referred to as aneurysma serpentinum or aneurysma racemosum, but the term cirsoid has been accepted in English literature as a descriptive term for these lesions.

- CAs are either congenital or traumatic in origin and occur due to abnormal vascular connections (arterio-venous shunts) within the scalp between the external carotid artery and the scalp veins.
- The superficial temporal artery is the most commonly involved.
- The congenital form can present at birth or more commonly, may remain asymptomatic until puberty or the third decade of life.
- The traumatic form develops months or possibly years following scalp injury. Often these are trivial traumatic episodes.
- The patients usually present with a gradually progressive pulsatile scalp swelling. Headache, bleeding and tinnitus are other uncommon presenting complaints.
- The noticeably tortuous subcutaneous vessels can lead to progressive cosmetic deformity in untreated cases

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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 February, 2022

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 January, 2022. 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.