Calcutta Academy Of Radiology

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INSIDE THIS ISSUE

Art of writing a Radiology Report - Viral Parekh

Hi! Namaskar friends, colleagues, juniors & seniors,

We Radiologists might be having a very good training, we might be very knowledgeable or we might be experienced; but, everything comes to naught if we are not able to express ourselves properly in the written report which we provide. Report writing is also an art and is the most critical component of the service provided by a radiologist. A major cause of litigation against radiologists is failure to effectively communicate results.

A radiology report must be concise and to the point. The language used should be grammatically correct but simple so that every physician/care giver can understand what a Radiologist wants to convey. The use of difficult or ambiguous terms should be avoided. Redundant words can be omitted from the report without a loss of meaning.

A standardized report should follow certain steps, which are as follows:

1. Title: It should convey name of the study, like - CHEST RADIOGRPAH - PA VIEW.
2. Indication: A short history or purpose of the examination should be mentioned, though it is not mandatory.
3. Procedure: For most studies the procedure is implied by title, like CHEST– PA & LATERAL Views. In MRI, many radiologists like to mention the sequences used in the study.
4. Findings: This sections of the report describes the radiological findings observed in the study. The statements in this section should be clear and concise. Long, wordy reports are less likely to be read by referring physician.
5. Impression/Conclusion: It should summarise the report. Froom my experience, I have come to a conclusion that a referring physician most of the time reads only the impression section of the report. So, this is the most important part of the report and should be written carefully. One should avoid to write "?" in the impression. If a Radiologist is not able to come to the final diagnosis, then it should be honestly conveyed and what should be done next to come to a conclusion should be conveyed unambiguously.

Every Radiology teacher must teach his/her students, the art of writing a radiology report. It is as important as teaching finer nuances of radiological features and findings.

This issue would not have been possible without the help of Dr. Bhavin Jankharia, Dr. Rajesh Botchu and his team and our own Dr. Bijon Kundu. I sincerely thank all of them.

WISH YOU ALL A VERY HAPPY DOCTOR'S DAY

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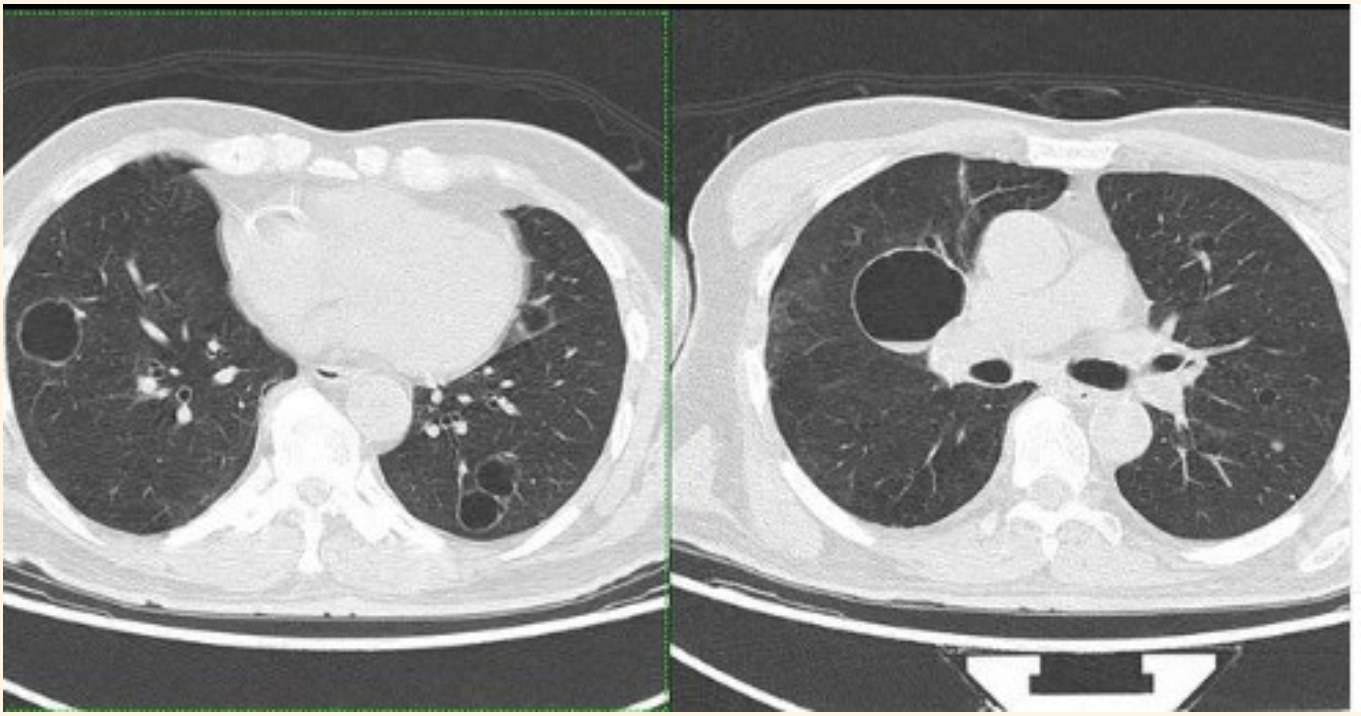
Dr. Bhavin Jankharia needs no introduction to the Radiology fraternity. As you all know he is a renowned Radiologist and academician and has contributed immensely in propagating Radiology education. Presently, he is a Consultant Radiologist at Picture This by Jankharia. He is also a Trustee of Radiology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



Cysts in the lungs. Thought they were an unusual cystic lung disease. Patient turned out to have scalp angiosarcoma. The one condition where we get cystic lung metastases like this.

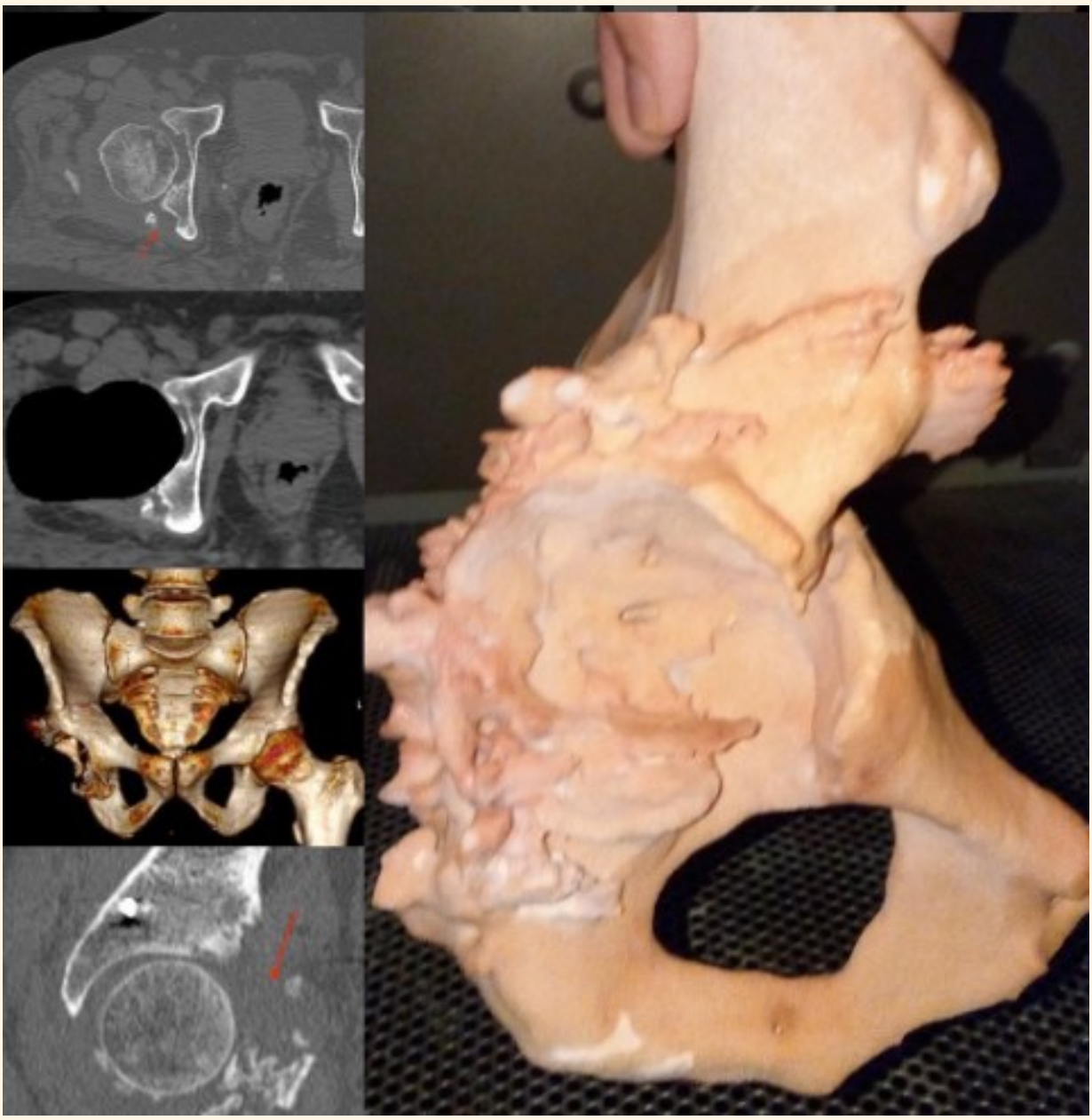
Case II - Failed Back

When a Pacemaker Forces Us to Think Differently in Failed Backs
This 55-years old man with a pacemaker came in July 2014 with back-pain and intermittent claudication. Since an MRI could not be done, a CT myelogram was done, which shows canal stenosis at L4/5 (red arrow) and mild disease at L3/4 (blue arrow). He had a laminectomy, but in Sept 2015, he started getting pain and claudication again. We repeated a CT myelogram, which shows that L4/5 (red arrow) is now capacious, but the canal stenosis at L3/4 (blue arrow) has progressed significantly.

This is a known phenomenon. Often after a laminectomy, the immediately superior, non-operated level, progresses rapidly, if there was mild disease to begin with. This is one of the causes of a failed back.

Dr. Bhavin Jankharia, MD

Case III - 3D Models - Understanding Complex Acetabular Fractures



This is a 55-years old man with a complex right acetabular fracture predominantly involving the posterior wall and roof with comminuted fragments. He has been operated in the past. To plan surgery now, it is necessary to understand the current status in detail. While 3D images help, there is nothing to beat a 3D model that can be held in one's hand and rotated. The surgery itself can also be planned on the model.

This model was created using a Projet 660 printer after subtracting the head from the acetabulum.

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Synovial osteochondromatosis

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Introduction

Synovial osteochondromatosis (SOC) refers to the cartilaginous loose bodies within the intra-articular space which may or may not be ossified. The origin of this condition can be primary (Reichel syndrome) or secondary to other joint pathologies (1).

Primary SOC is typically an idiopathic condition that was known to involve chondroid metaplasia and proliferation of synovial membrane. However, it's now considered to be a benign neoplastic process (2). It is commonly a mono-arthritic condition that predominantly affects the knee (up to 70%) (2)(3)(4). Moreover, primary SOC has a prevalence of 1 in 100,000 and, it tends to be more common in men aged 20-50 years (5).

Secondary SOC is a more common condition, which occurs as a result of intra-articular hyaline cartilage damage. On the whole, it is related to osteoarthritis, inflammatory arthritis, trauma, neuropathic arthritis, or previous joint infection (2).

History and physical examination

As previously mentioned, in primary SOC typically one joint is affected. Whereas a multi-articular pattern can be present in secondary SOC.

Similar to most common pathologies that affect the joint, the main complaint of patients with SOC is joint pain. Other associated presentations are joint swelling and locking (3).

The onset of these clinical symptoms is usually insidious and gradually progresses.

On examination, the affected joint may have a limited range of motion, articular crepitus, and palpable nodules (2).

Imaging evaluations

Owing to the ambiguity of clinical presentation, imaging plays a paramount role not only in diagnosis but also in the management of SOC.

Plain radiograph and CT

The degree of ossification/calcification determines the appearance of SOC in radiographs.

In the absence of calcification which accounts for up to 30% of cases, radiographs tend to be normal or show non-specific changes including bone erosions, soft tissue mass, joint space widening, or osteoarthritis changes (4).

In higher degrees of calcification, radiographic features of mineralisation such as chondroid ring-and-arc calcification may be visible. Further maturation and endochondral ossification results in a trabecular centre with a peripheral rim of cortex. Rarely, Chondral bodies unite to form a large, mineralised mass seen as conglomerate areas in radiographs.

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The most distinctive appearance typically consists of multiple small, round, and smooth bodies of similar size scattered throughout the joint space (2)(4)(6).

In the late stages of the disease, secondary degenerative changes including joint space narrowing and osteophytes may also be detectable (6).

Computerised tomography can identify both calcified and non-calcified bodies in addition to confirming their intra-articular location. Nodules in SOC tend to form a soft-tissue mass which raises the capsule and has a water density in CT. This modality allows distinguishing bone erosions caused by pressure (e.g., SOC) from aggressive destruction. Adjunct arthrography may also be used to further evaluate the nodules (4)(6).

Radiographic features help to differentiate primary SOC from secondary SOC. If secondary SOC is suspected, the underlying joint pathology needs to be identified (3).

MRI

MRI features of patients with SOC are divided into 3 categories; Pattern A shows intra-articular lesions that are hypointense to muscle in T1 or hyperintense to muscle in T2 which is typically seen in patients with no visible calcifications in the plain radiograph. Pattern B which accounts for the majority of cases is most commonly seen in patients whose plain radiograph shows calcification of nodules. The features of this pattern include the presence of signal-void in all pulse sequences. This feature is much more visible when Gradient Echo (GE) sequence is used which shows blooming artefact (4)(6). This represents the calcification of the nodules. Pattern C is seen in patients whose plain radiograph reveals both calcification and ossification. Due to the central fatty marrow and cortical peripheries of these nodules, MRI shows a high central signal accompanied by a low peripheral signal (6).

Treatment, complications, and prognosis

In long term, SOC can develop into other conditions. For instance, the intra-articular loose bodies can result in injury to the cartilage and lead to secondary osteoarthritis. Ultimately, when joint space becomes fully occupied, the loose bodies can penetrate surrounding tissues and cause further damage (7).

Development of chondrosarcoma from SOC is relatively rare, and there is a chance of approximately 1-6% that cases of SOC transform into malignant neoplasia (8)(2).

However, these complications can be prevented if SOC is managed. It is predominantly managed by arthroscopic surgery for the removal of loose bodies and partial synovectomy. It is worth mentioning, that open surgery is sometimes necessary.

Surgery not only results in reduction of pain and swelling, but also improves mechanical function in most cases (3).

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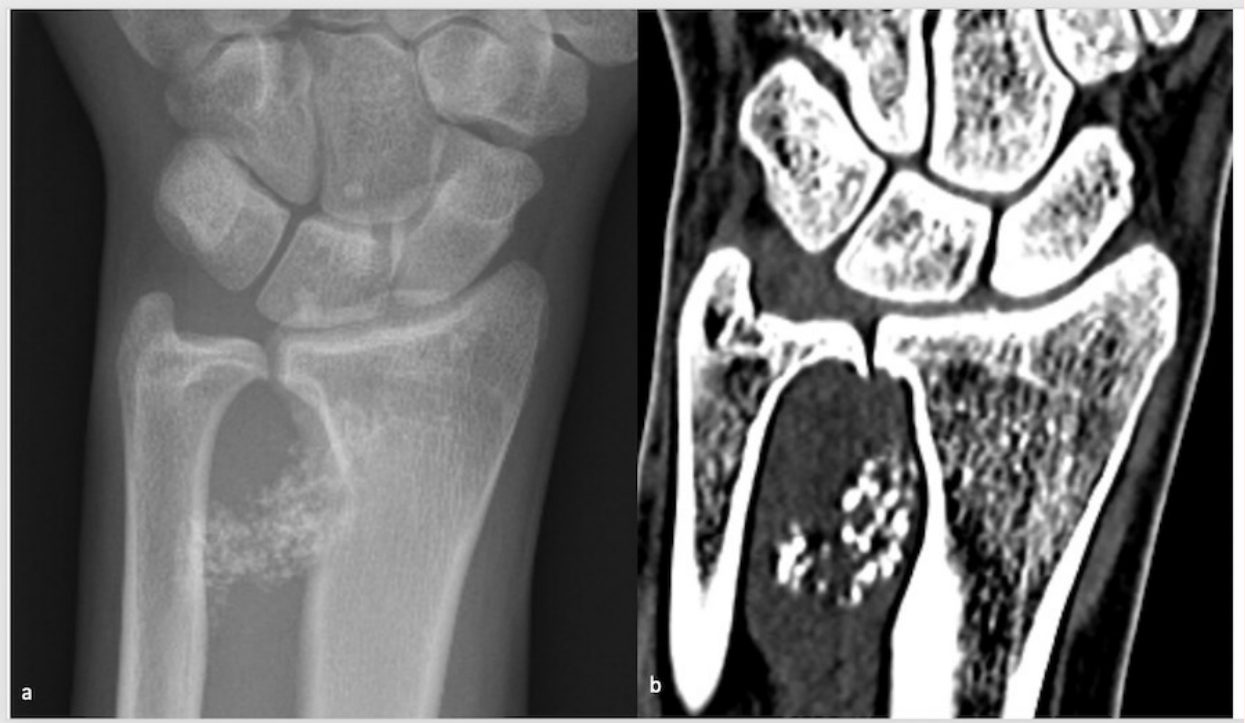
Figure 1

AP radiograph of wrist (a) and coronal CT(b) showing synovial osteochondromatosis of distal radioulnar joint (DRUJ)



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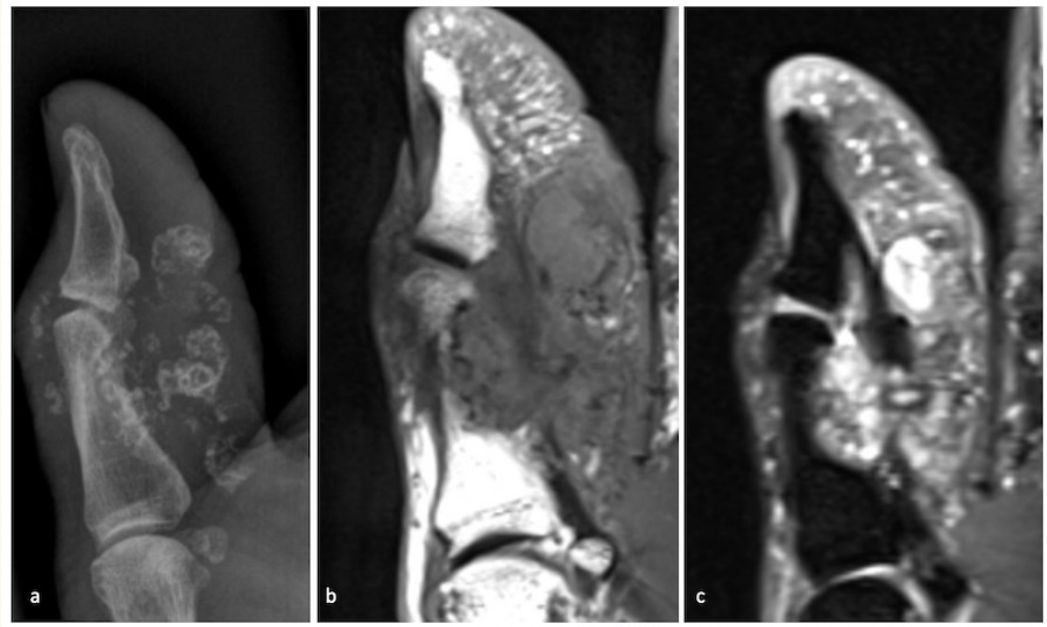

Figure 2

Lateral radiograph of thumb (a), sagittal T1 (b) and STIR (c) demonstrating synovial osteochondromatosis of interphalangeal joint of thumb

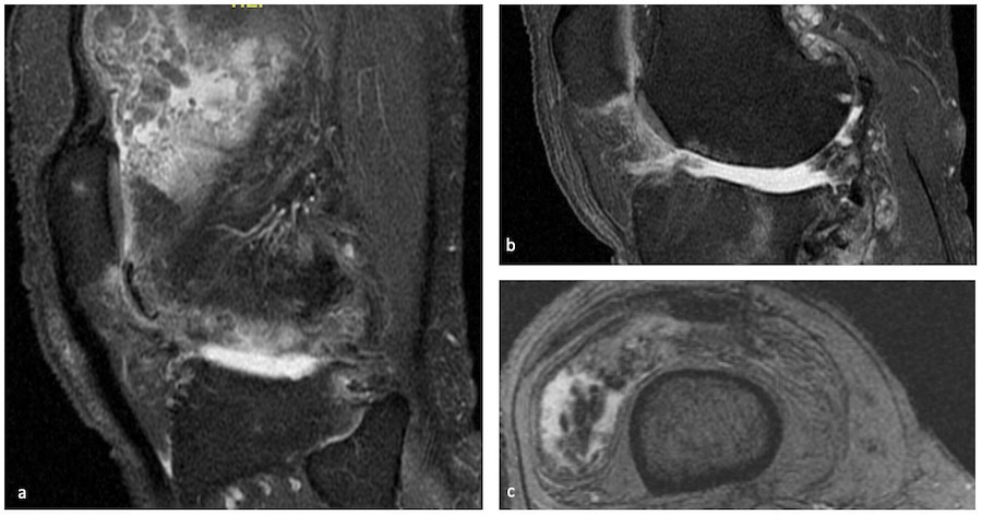

Figure 3

Sagittal PDFS (a and b) and axial gradient echo of knee demonstrating synovial osteochondromatosis of knee joint

Figure 4

Lateral radiograph of ankle demonstrating synovial osteochondromatosis predominantly in the anterior recess of the ankle

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Parsonage Turner Syndrome: an uncommon cause of shoulder pain

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Parsonage Turner Syndrome (PTS), also known as acute idiopathic brachial neuritis, brachial plexus neuropathy or acute brachial radiculitis is a clinical entity characterised by sudden onset non-traumatic shoulder pain and/or weakness of the upper extremity. Its etiology, although unknown, is hypothesised to be immune mediated as there is usually a preceding history of viral illness or immunization. It can be bilateral in upto one-third cases, although presentation can be asymmetric. The management is symptomatic, and the disease is usually self-limiting, although there are incidences of recurrence.

MRI is the imaging modality of choice for establishing the diagnosis. It can help not only in excluding other causes of shoulder pain such as cuff or labral tears but may be instrumental in suggesting this diagnosis in unsuspected cases.

MRI reveals denervation edema in the shoulder girdle muscles affecting one or multiple nerve distributions. The most commonly affected nerve is suprascapular followed by the axillary and thus affliction of the supraspinatus and infraspinatus muscles (supplied by the suprascapular nerve) is usual followed by deltoid (supplied by the axillary nerve). MRI changes are evident about two to four weeks after onset of symptoms and thus may be absent or very subtle if patients are imaged too early or too late. The affected muscles show hyperintensity on the fat suppressed fluid sensitive (PDFS or STIR) images. However, abnormalities may not always be striking and changing the viewing window settings helps in making the findings more conspicuous.

Whenever denervation edema is detected, one needs to rule out structural causes of neuropathy such paralabral cysts, masses, or varicosities in the spinoglenoid notch, suprascapular notch, and quadrilateral space. Also, detection of edema in muscles supplied by different nerves should alert the radiologist to the possibility of PTS as multifocal involvement is not uncommon.

The imaging findings usually resolve on follow up, but in chronic cases, muscle atrophy with or without fatty infiltration of the denervated muscles can be seen, best depicted on the T1 images. The degree of these changes correlates with permanent loss of muscle strength and thus need to

be reported.

Differential needs to be made from other causes of muscle edema such as muscle strain. Usually, a history of trauma can be elicited in these cases and presence of perifascial, or subcutaneous edema essentially rules out a PTS.

Cervical disc disease can also present with shoulder pain and sometimes denervation edema may be seen due to nerve root impingement, but it would be confined to the distribution of the affected nerve root. It would thus also be prudent to rule out cervical spine disease if muscle edema is demonstrated on MRI of the shoulder.

To conclude, although PTS is predominantly a clinical diagnosis, MR imaging can be a problem-solving tool in cases of clinical confusion. In fact, in many cases, the radiologist may be the first to suggest this diagnosis which is crucial in-patient management and obviates unnecessary interventions. The trick to diagnose subtle alterations in signal intensity is to change the window settings by increasing the contrast of the images which makes the abnormality conspicuous and increases the confidence of reporting.

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Parsonage Turner Syndrome: an uncommon cause of shoulder pain

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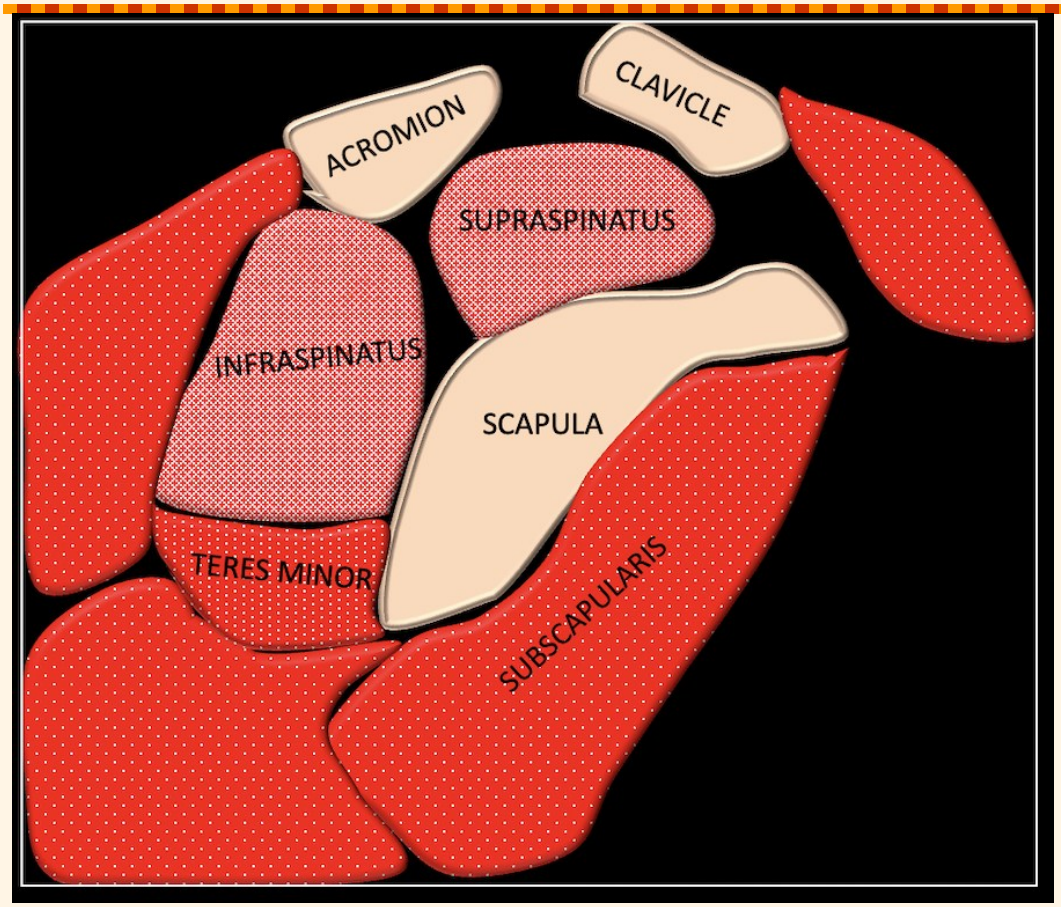
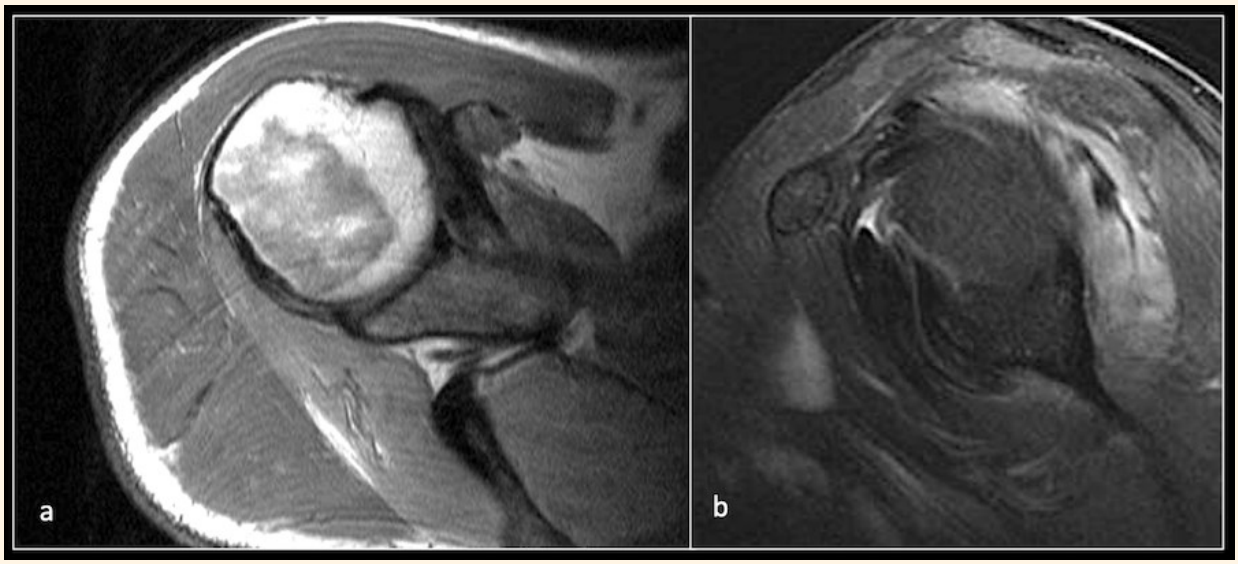


Figures 1

Schematic of sagittal of the shoulder edema involving the supraspinatus and infraspinatus.

Figure 2

PDFS axial (a) and sag (b) showing edema involving the supraspinatus and infraspinatus.



Parsonage Turner Syndrome: an uncommon cause of shoulder pain

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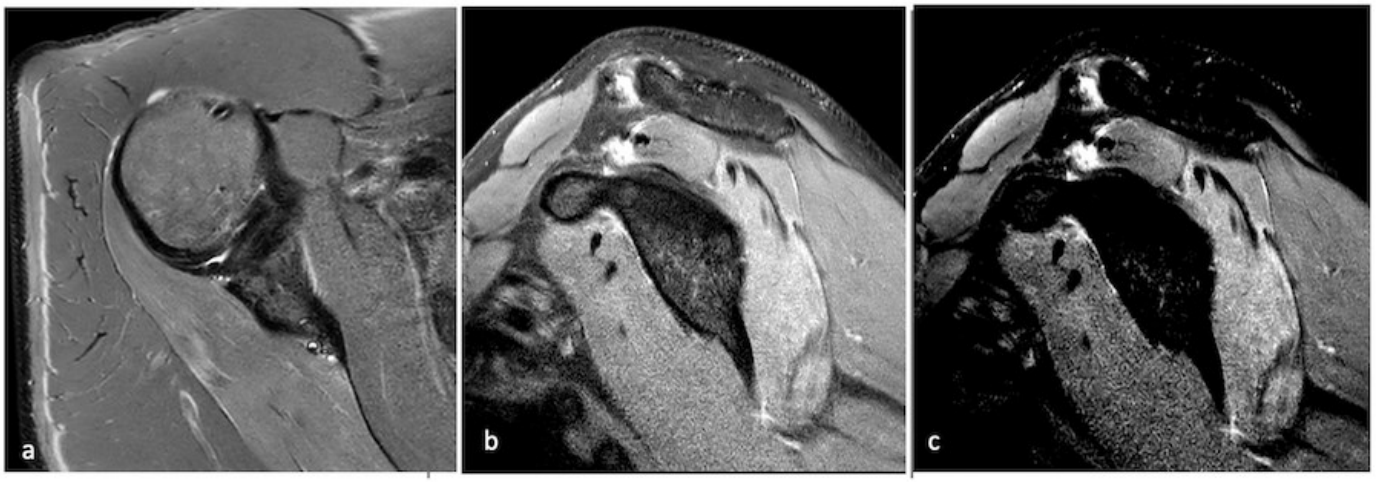
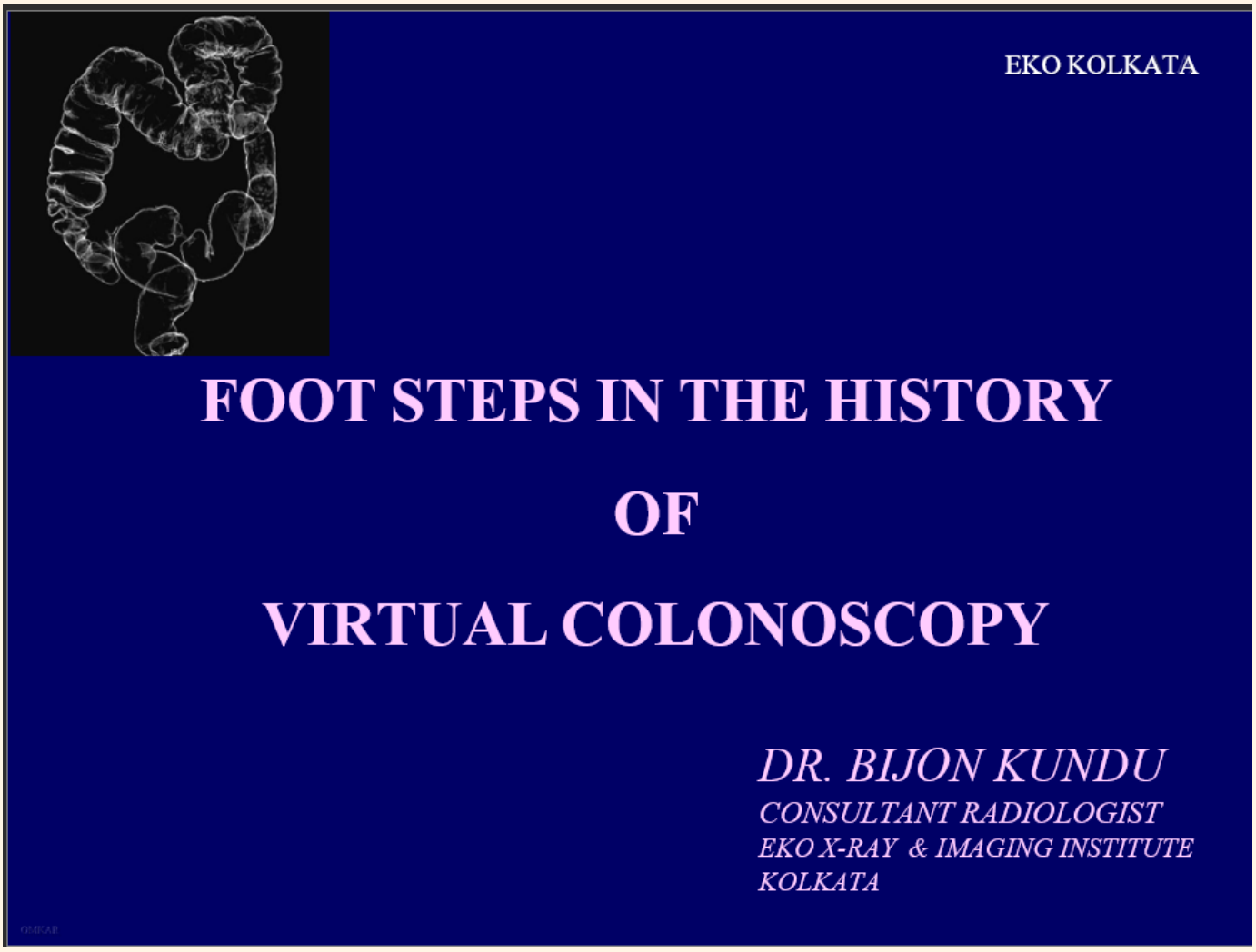


Figure 3

PDFS axial (a), sag (b) and sag (c with increased contrast) showing edema involving the infraspinatus and teres minor.

Figure 4

PDFS sag (a) and (b) (with increased contrast) showing edema involving the supraspinatus and infraspinatus.


EKO KOLKATA
FOOT STEPS IN THE HISTORY
OF
VIRTUAL COLONOSCOPY
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COLORECTAL CANCER IS THE SECOND LEADING CAUSE OF CANCER-RELATED DEATH IN UNITED STATES AND THE THIRD MOST COMMON CANCER OVER ALL

INDICATIONS OF C T VIRTUAL COLONOGRAPHY

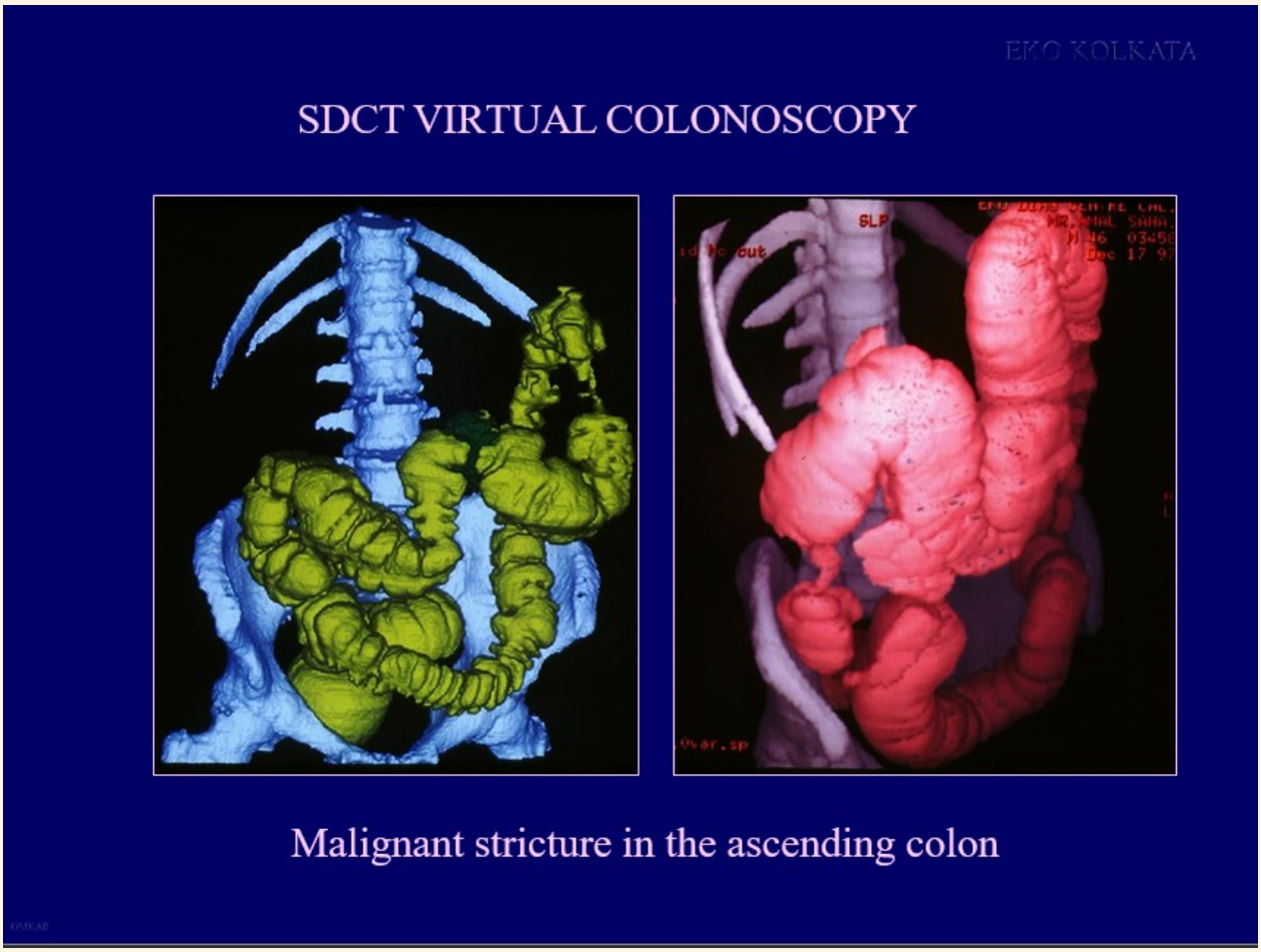
1. **SCREENING OF THE LARGE GUT**
2. **FAILURE TO PERFORM FIBROPTIC COLONOSCOPY**
3. **EVALUATION OF LARGE GUT LESION EXCEPT INFLAMMATORY BOWEL DISEASE**

EKO KOLKATA

COMPUTED TOMOGRAPHY (C T) IMAGING OF COLON FOR POLYP DETECTION INITIALLY WAS DESCRIBED IN 1983

VIRTUAL COLONOSCOPY (CTC) STARTED IN 1994 WITH THE ADVENT OF SPIRAL CT – SINGLE HELICAL

MULTISLICE (16 MDCT) NOW IN 2004 FOR VIRTUAL COLONOSCOPY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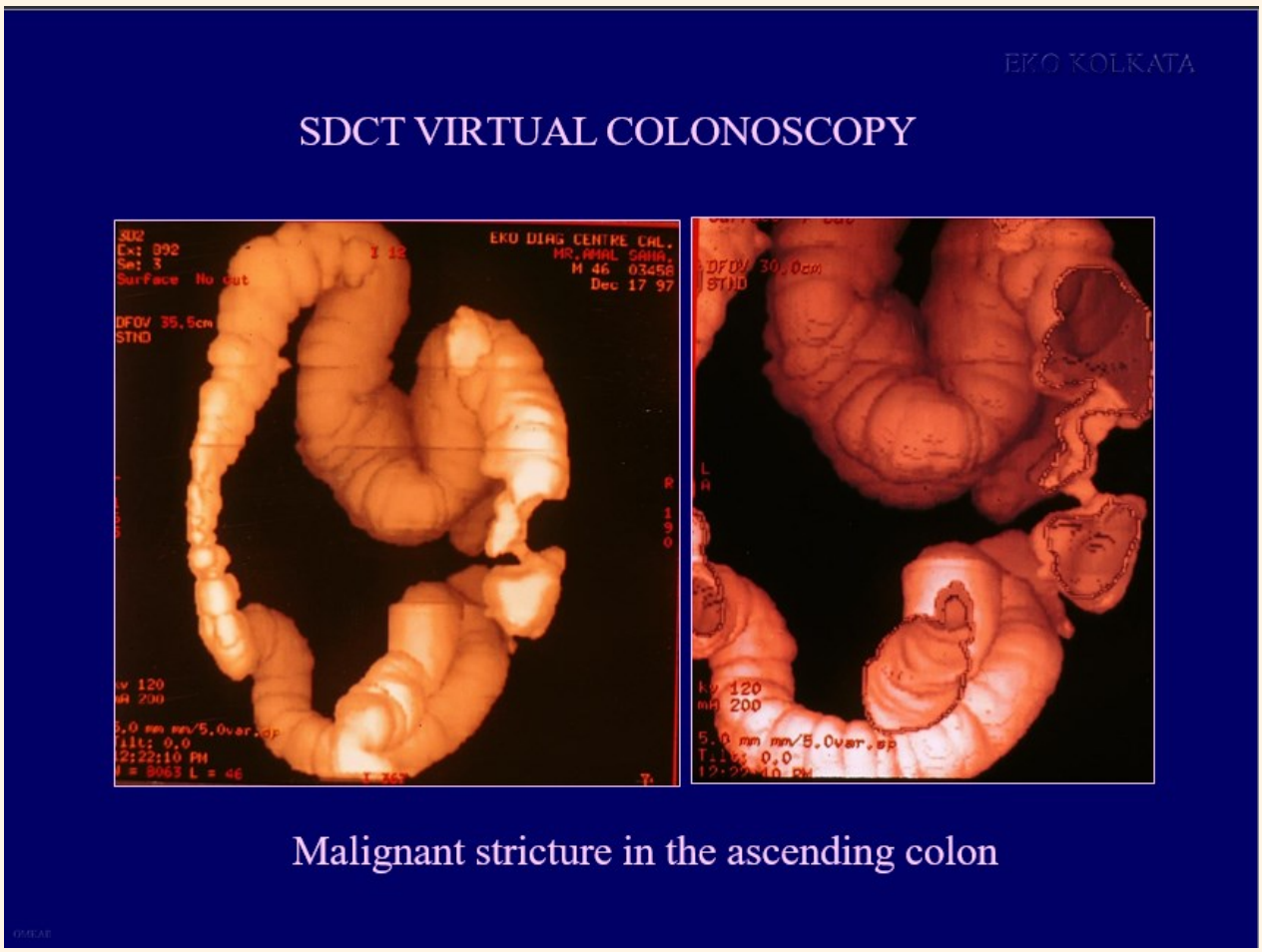
SDCT VIRTUAL COLONOSCOPY
SLP
Malignant stricture in the ascending colon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SDCT VIRTUAL COLONOSCOPY
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Malignant stricture in the ascending colon

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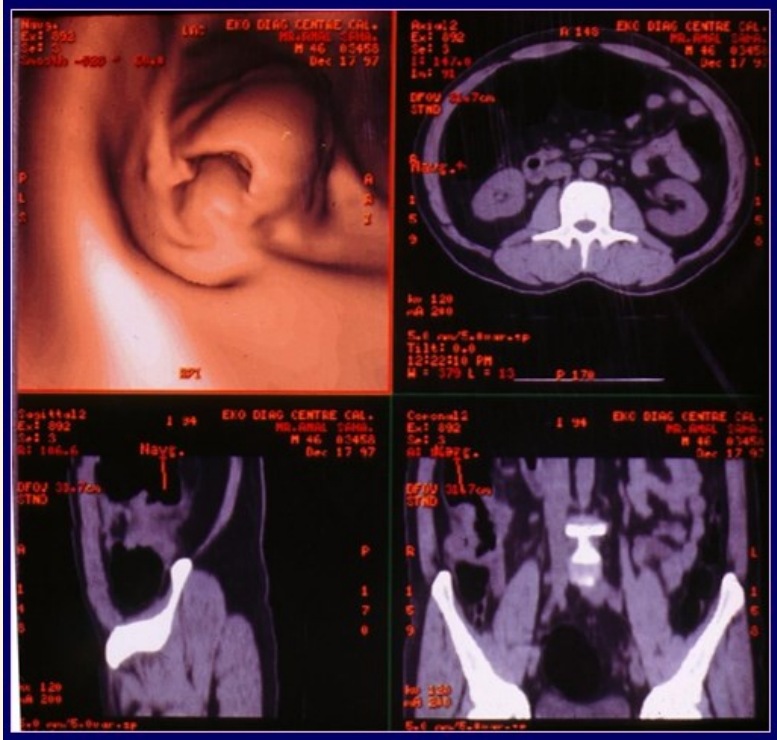
SDCT VIRTUAL COLONOSCOPY



Malignant stricture in the ascending colon

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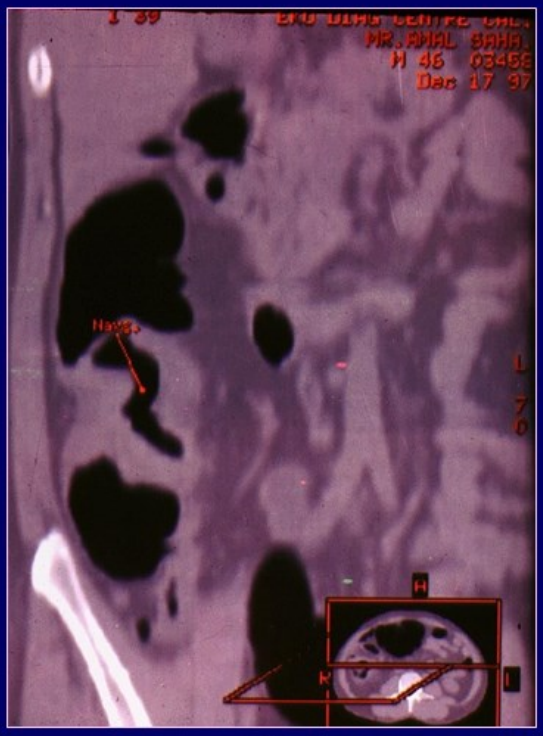


SDCT VIRTUAL COLONOSCOPY

Malignant stricture in the ascending colon

SCREENING FOR COLORECTAL CANCER IN AVERAGE RISK INDIVIDUALS AT THE AGE OF 50

1. ANNUAL FECAL OCCULT BLOOD TEST (FOBT).
2. FLEXIBLE SIGMOIDOSCOPY EVERY 5 YEARS.
3. COMBINATION OF ANNUAL FOBT AND FLEXIBLE SIGMOIDOSCOPY.
4. DOUBLE-CONTRAST BARIUM ENEMA EVERY 5 TO 10 YEARS.

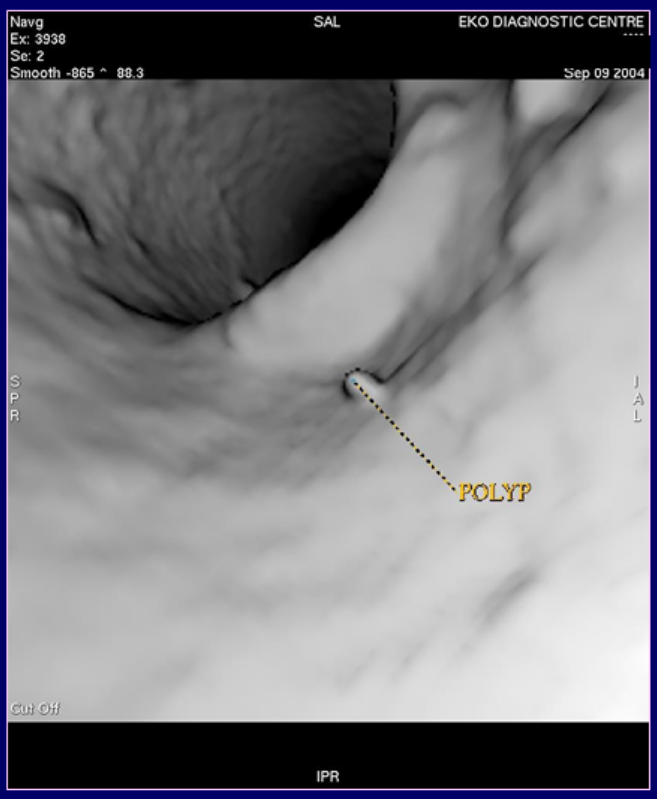
AMERICAN CANCER SOCIETY WITH AMERICAN COLLEGE OF GASTRO-ENTEROLOGY

BOWEL PREPARATION

1) LIMIT PATIENT'S DIET

2) BOWEL CLEANSING THE DAY BEFORE STUDY
   - A) POLYETHYLENE-GLYCOL (PEG) – ELECTROLYTE LAVAGE.
   - B) MAGNESIUM CITRATE – KIT.
   - C) BISACODYL TABLETS & SUPPOSITORY IN CONJUNCTION WITH CATHARTICS – ACT AS A CONTACT LAXATIVE.
   - D) GLUCAGON (ANTI-SPASMODIC AGENT) – CONTROVERSIAL.

3) COLON DISTENSION – ROOM AIR / CO_2 — MANUALLY & ELECTRONICALLY



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Fly through navigation Image shows a small benign polyp about 10mm in size.

MDCT VIRTURAL COLONOSCOPY

MDCT COLONOSCOPY

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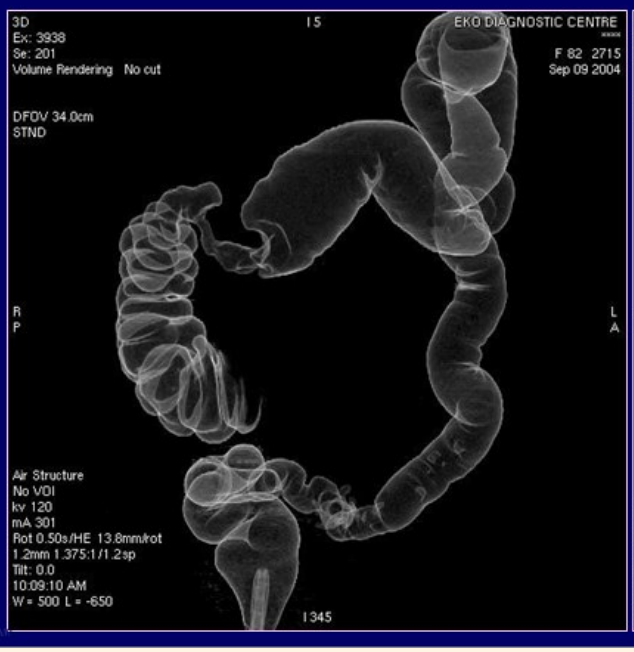
82 y/f presenting with pain in the abdomen and bleeding per rectum.



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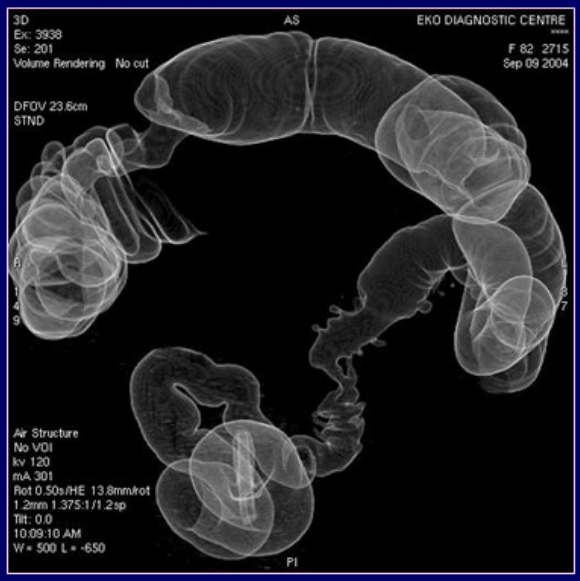
MDCT COLONOSCOPY



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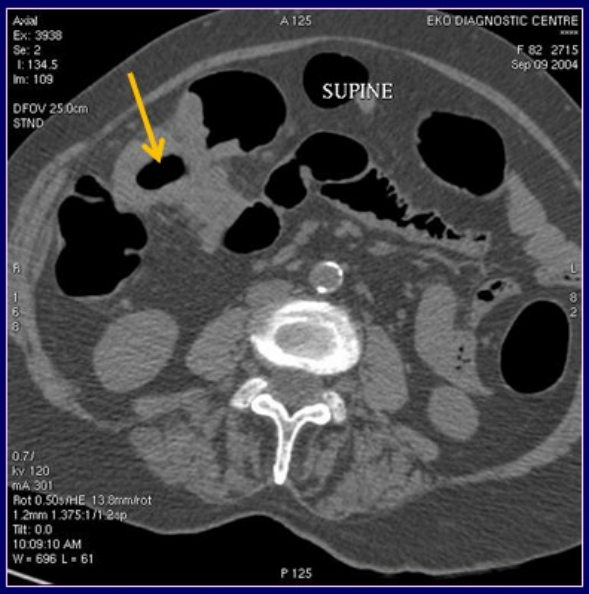
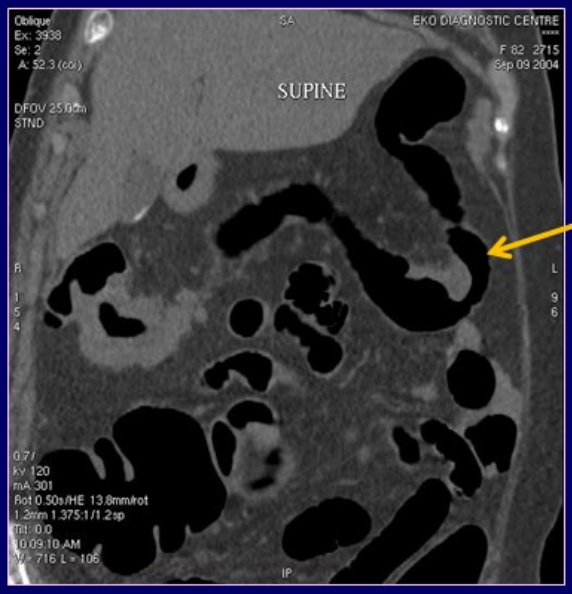
MDCT COLONOSCOPY



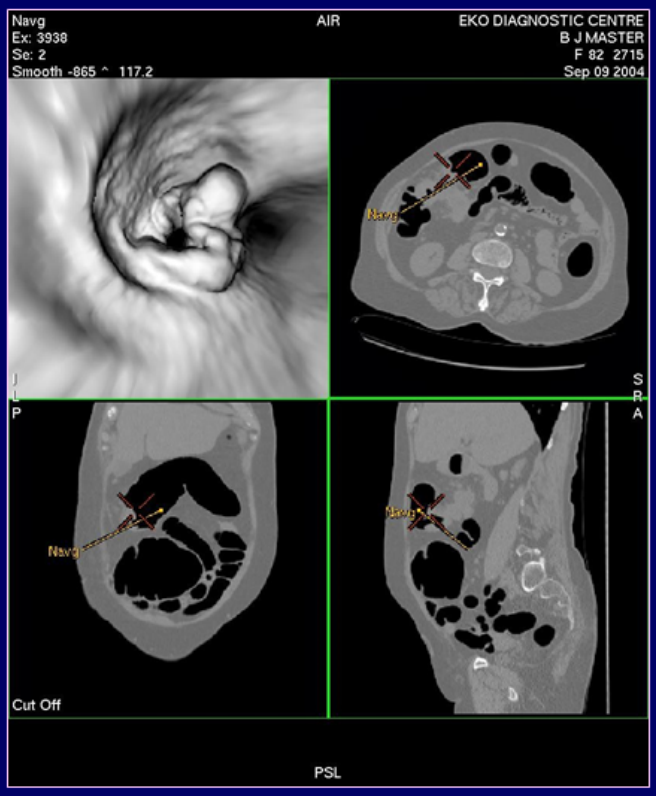
Mass lesion in proximal transverse colon



Another mass in the distal transverse colon

MDCT COLONOSCOPY

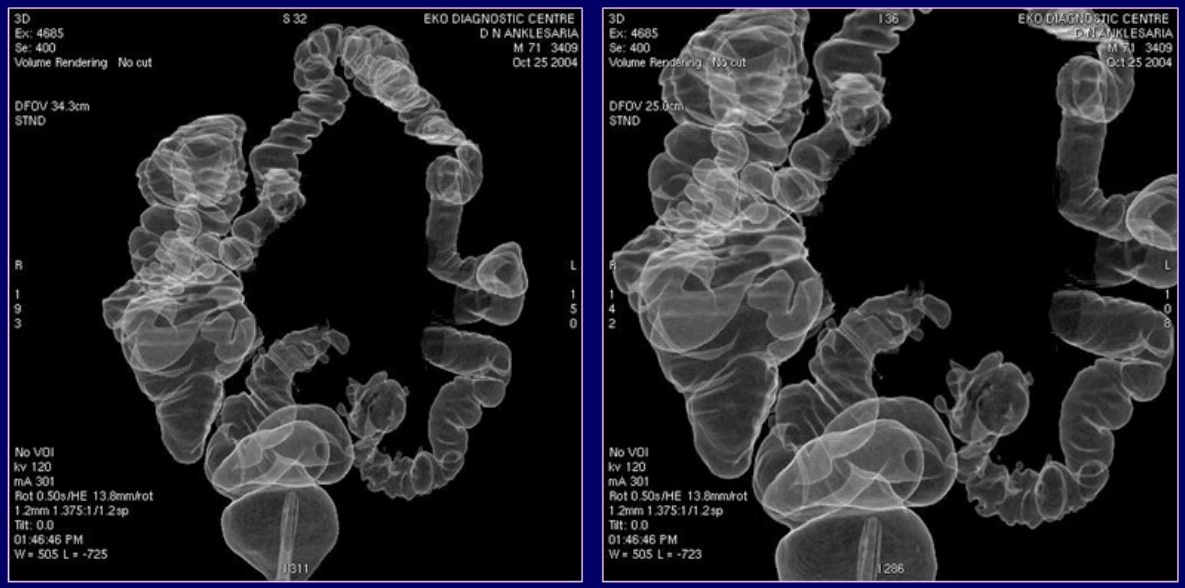
EKO KOLKATA



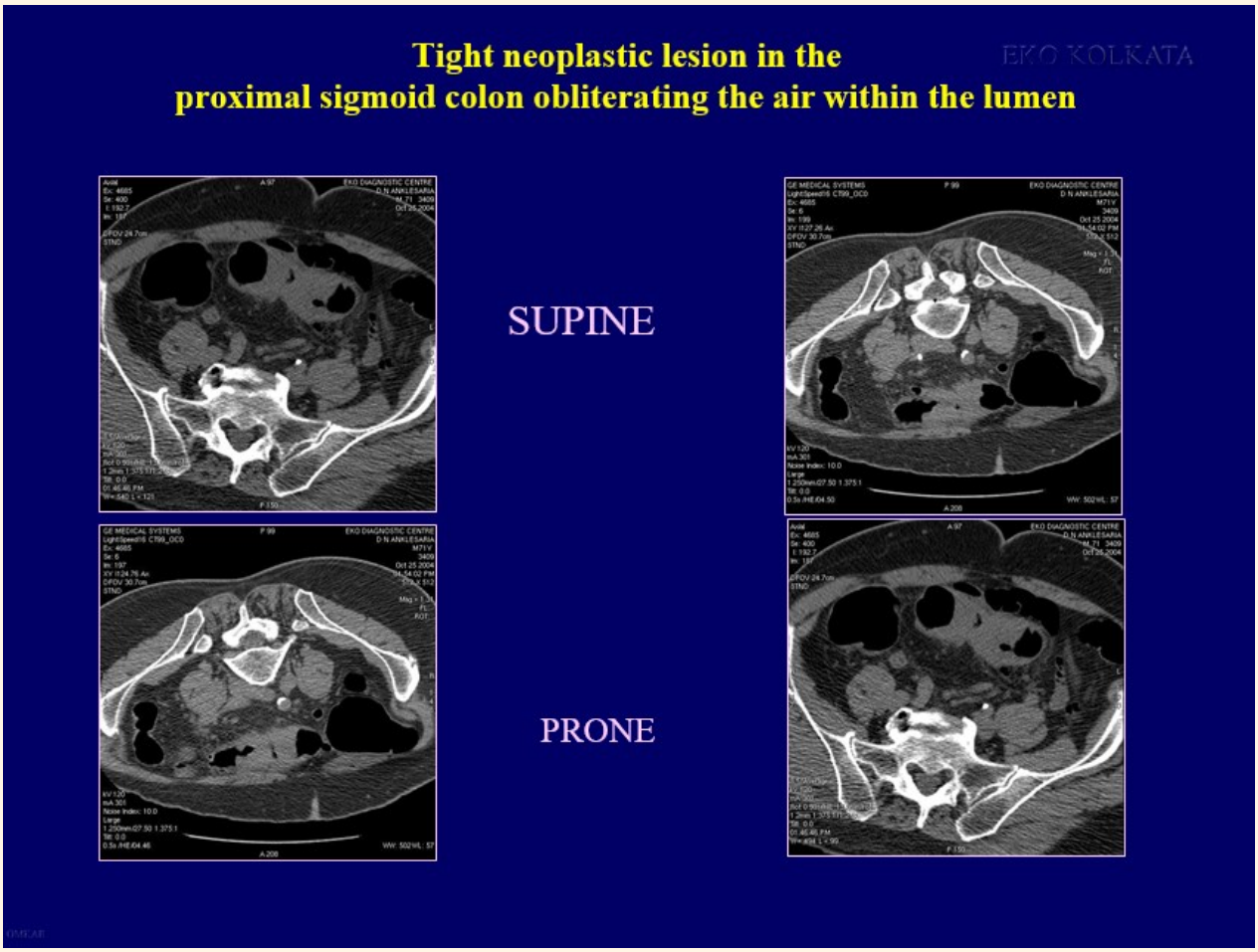
Fly through navigation
Image shows a neoplastic mass in the proximal transverse colon.

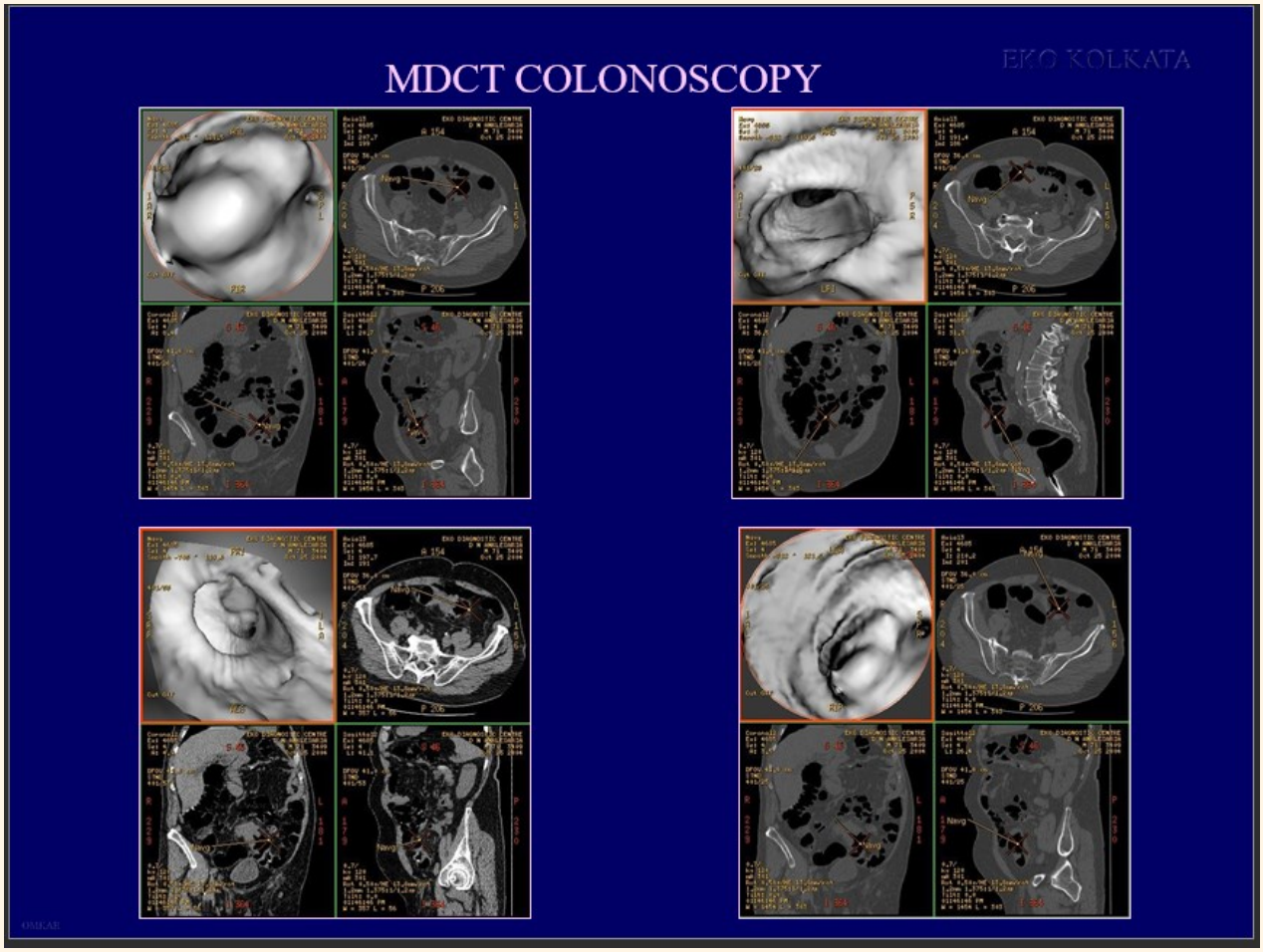
MDCT COLONOSCOPY

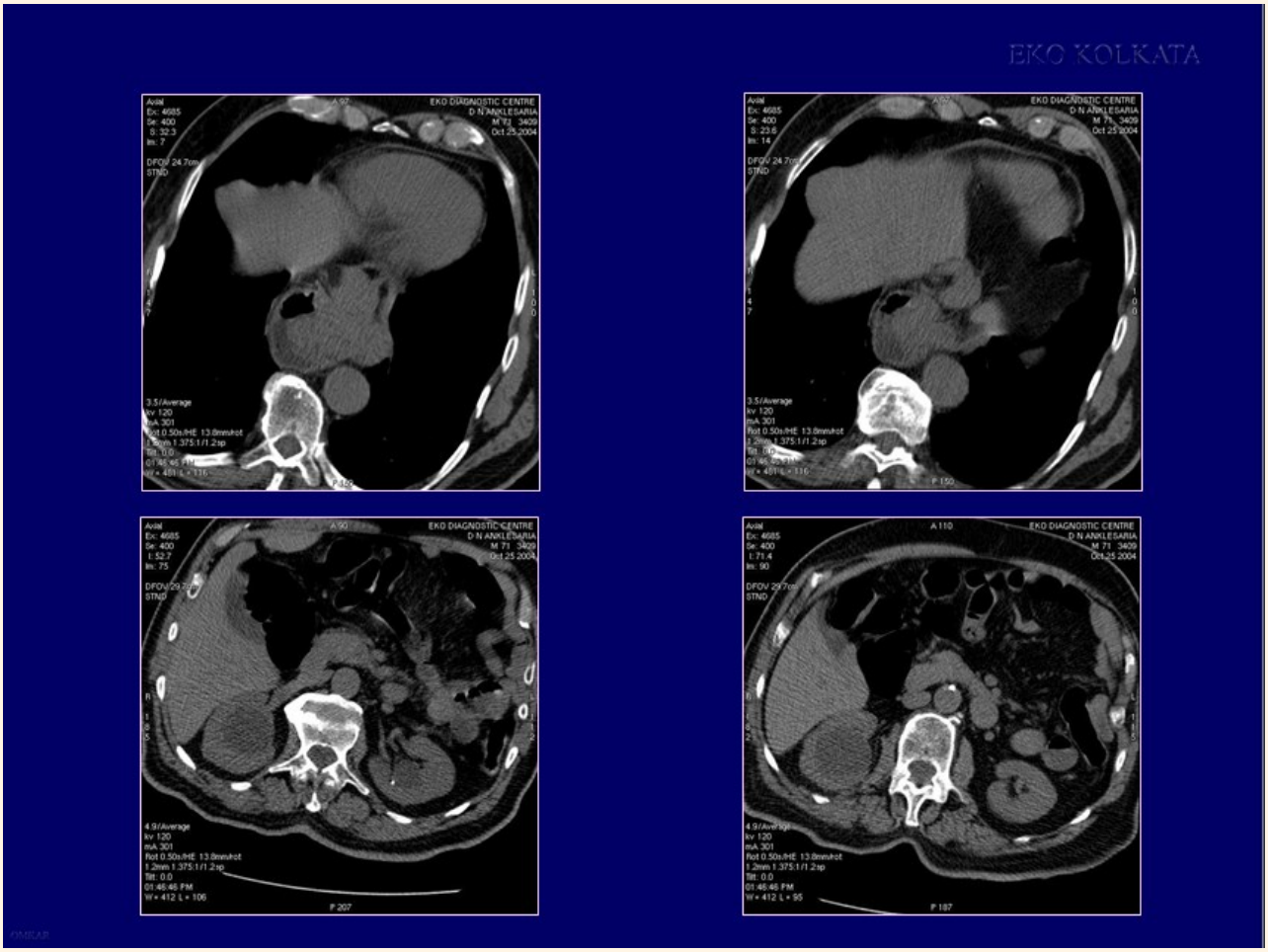
EKO KOLKATA



Tight neoplastic stricture in the proximal sigmoid colon


Tight neoplastic lesion in the
proximal sigmoid colon obliterating the air within the lumen
EKO KOLKATA
SUPINE
PRONE


MDCT COLONOSCOPY
EKO KOLKATA



EKO KOLKATA

69 y/m presenting with bleeding per rectum

Fibreoptic Colonoscopy was done 3 times demonstration a large polyp in the distal transverse colon.

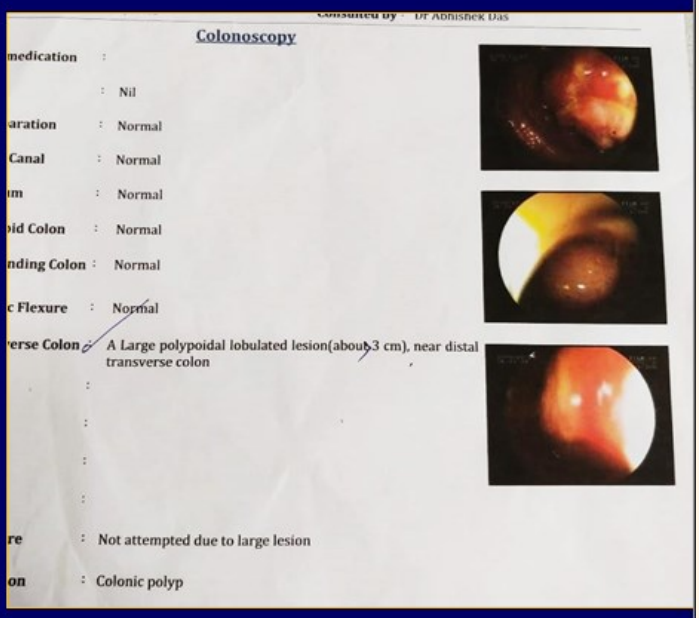
Biopsy done every time proved no malignancy.

CT virtual colonoscopy was done to evaluate this lesion and rule out any aggressive neoplasm.

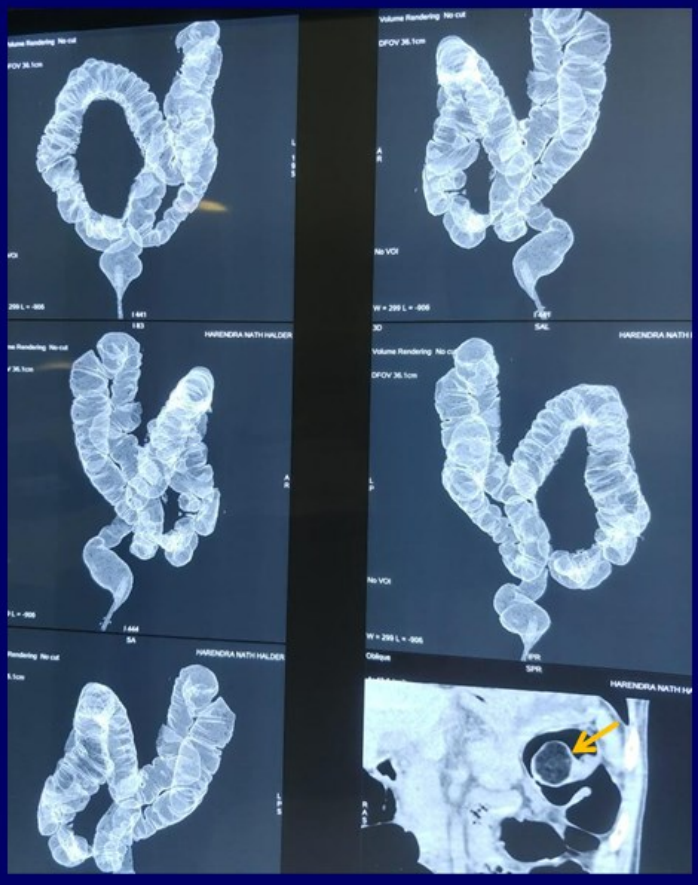
Fibre optic Colonoscopy

EKO KOLKATA

Study -1

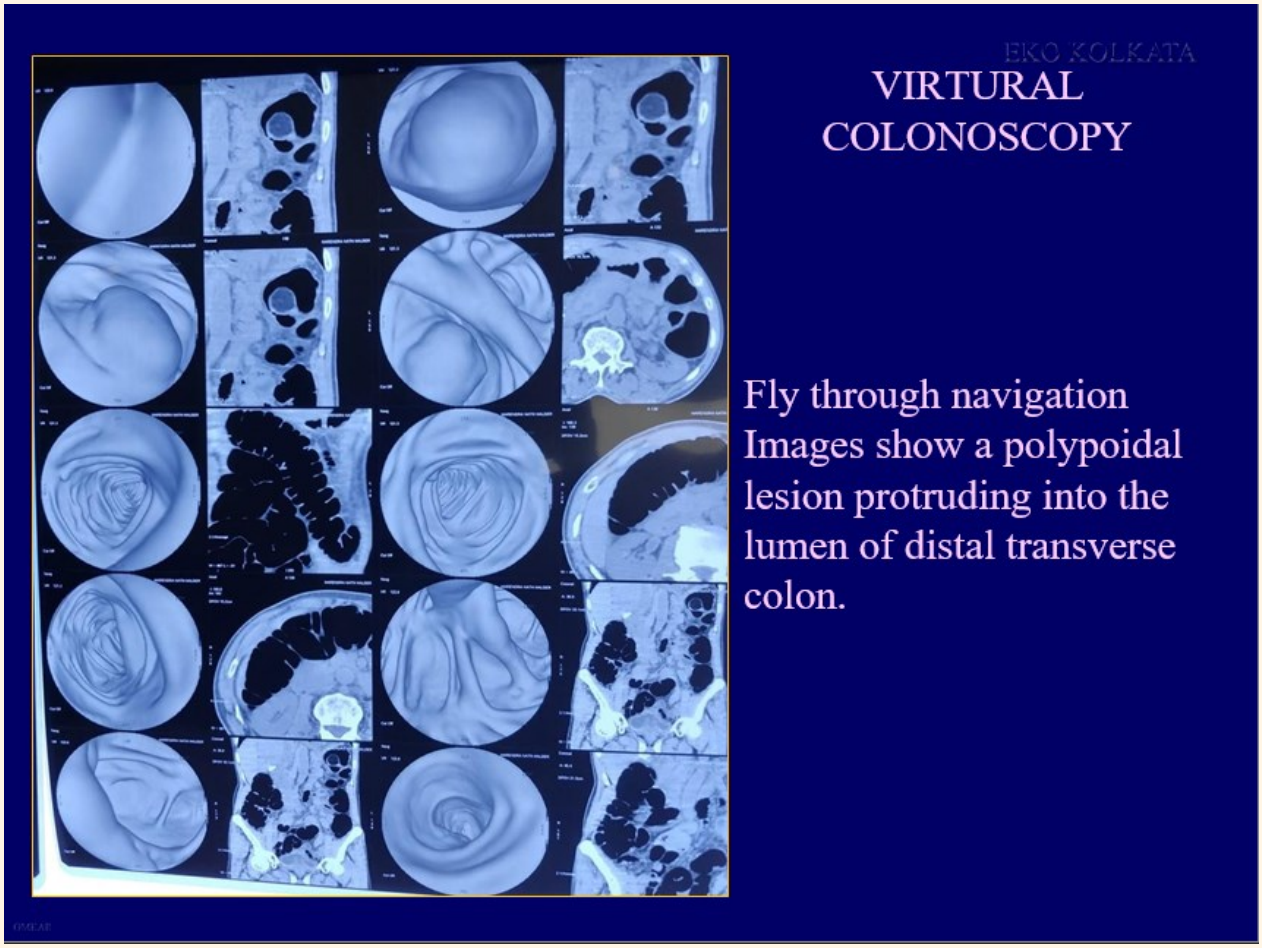


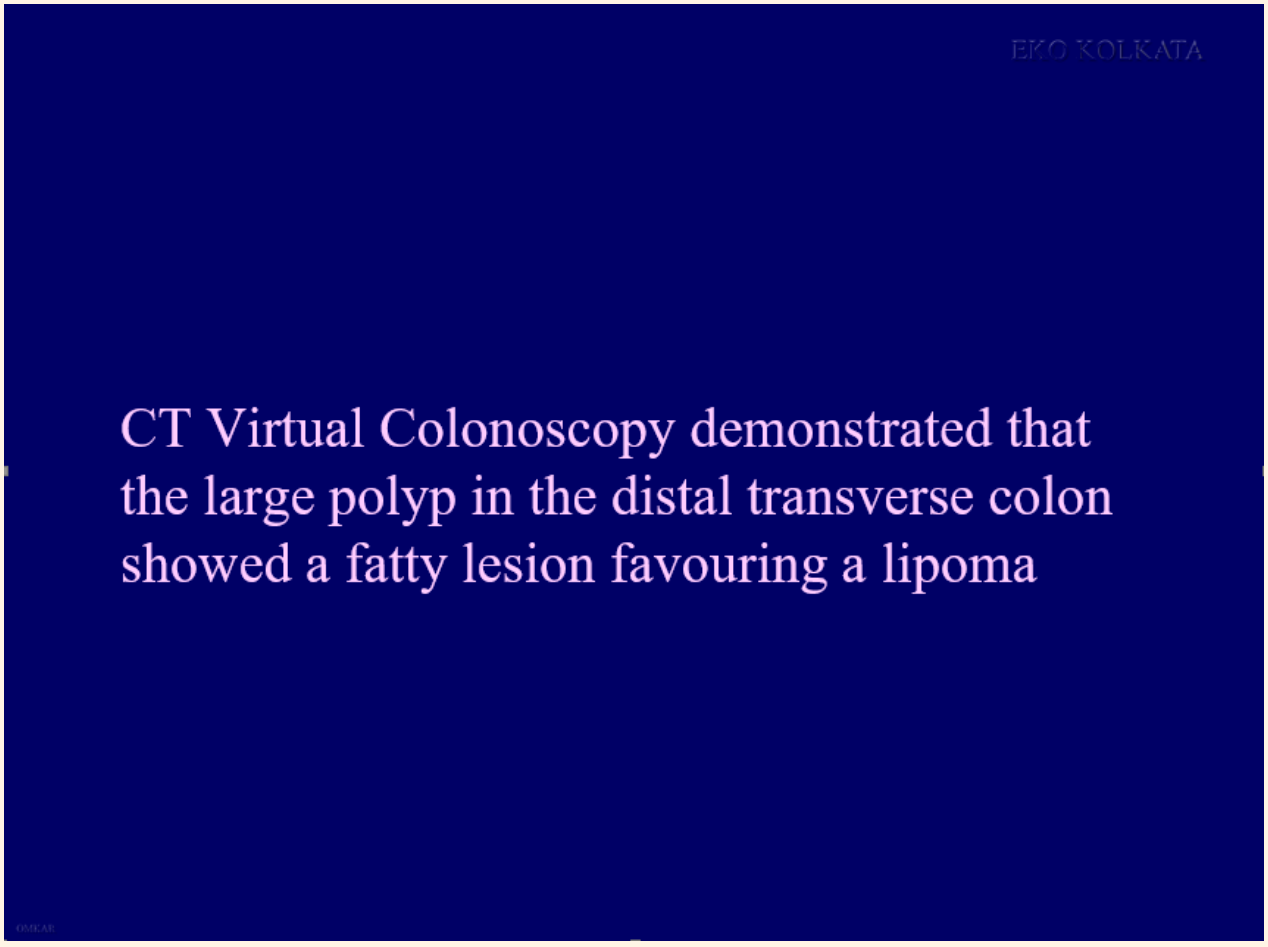
Study -2



EKO KOLKATA

VIRTURAL COLONOSCOPY


EKO KOLKATA
VIRTURAL COLONOSCOPY
Fly through navigation Images show a polypoidal lesion protruding into the lumen of distal transverse colon.


EKO KOLKATA
CT Virtual Colonoscopy demonstrated that the large polyp in the distal transverse colon showed a fatty lesion favouring a lipoma

CT Colonography performance for the detection of 10 mm or large polyps

Study	Patient type	CT Type and Collimation	Sensitivity (By patient)	Specificity (By patient)	Sensitivity (By patient)
Yee. 2001	300 (204 high risk)	SDCT 3mm	100%	-	90.2%
Fletcher, 2000	180 High risk	SDCT 5 mm	85.4%	93%	75.2%
Fenlon, 1999	100 High risk	SDCT 5 mm	96%	96%	91%
Hara , 2001	237 High risk	77 SDCT 160 MDCT 5mm	78-100%	90-93%	80-89%
Macari,2002	105 High risk	MDCT 1mm			

Radiologic Clinics of North America – Vol.42. No. 4, July 2004

AJR FOCUS ON:

CT Colonography Performance for the Detection of Polyps and Cancer in Adults ≥ 65 Years Old: Systematic Review and Meta-Analysis

Perry J. Pickhardt[1]
Loredana Correale[2]
Silvia Delsanto[2]
Daniele Regge[3]
Cesare Hassan[4]

Keywords: colorectal cancer screening, CT colonography, Medicare, meta-analysis, virtual colonoscopy

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P. J. Pickhardt is cofounder of VirtuoCTC, an advisor to Check-Cap and Bracco, and a shareholder in SHINE, Elucent, and Cellectar Biosciences. C. Hassan is a consultant for Fujifilm, Olympus, Norgine, and Cosmo. Supported in part by a grant from Bracco Diagnostics.

OBJECTIVE. We sought to perform a systematic review and meta-analysis of published CT colonography (CTC) studies assessing lesion detection in senior-age (≥ 65 years old) cohorts.

MATERIALS AND METHODS. We conducted a systematic review of CTC studies published between January 1994 and August 2017 containing data on senior-age adults. The primary endpoint was the CTC-positive rate for large colorectal polyps (≥ 10 mm) and masses. Secondary endpoints included lesions ≥ 6 mm, proven advanced neoplasia, and colorectal cancer (CRC). Study authors were contacted for additional missing data. Random-effects and meta-regression analyses were used to generate pooled estimates and explore contributing factors.

RESULTS. A total of 34 studies with 41,680 (18,798 senior-age) subjects were included. Pooled CTC-positive rates among senior-age patients using the 10-mm size threshold were significantly lower in cohorts of patients with no symptoms (8.2%; 95% CI, 6.0–11.1%) compared with cohorts of patients with positive fecal occult blood tests (32.8%; 95% CI, 15.4–56.7%) and other symptoms of CRC (14.0%; 95% CI, 12.0–16.1%). However, a uniformly high positive predictive value for advanced neoplasia at colonoscopy was seen for all senior-age cohorts using a 10-mm threshold (84.3%; 95% CI, 79.3–88.3%; $I^2 = 0.0$) where such data were available. CTC sensitivity for CRC was 93.0% (95% CI, 89.0–95.0%) in senior-age patients compared with 92.0% (95% CI, 84.0–93.0%) in younger patients. Overall, CTC detection rates were higher in senior-age adults compared with younger adults.

CONCLUSION. On average, one in every 12 senior-age adults without symptoms of CRC who underwent screening would be referred to colonoscopy using the 10-mm threshold, with a high yield for advanced neoplasia and high sensitivity for cancer detection. As expected, CTC-positive rates were higher in cohorts of patients 65 years old or older with symptoms of CRC. These results should help inform the Centers for Medicare & Medicaid Services regarding coverage determination of CTC screening for Medicare beneficiaries.

LIMITATIONS

1) POLYP SIZE – LESS 10 MM.. UNABLE TO DETECT EFFECTIVELY AS WELL AS FLAT NEOPLASMS
   NO "CUT-OFF" SIZE GIVEN AS YET
2) NO PUBLISHED STANDARDS BY A GOVERNING RADIOLOGY BOARD FOR PERFORMANCES, INTERPRETATION OR REPORTING
3) ACCEPTANCE OF THE PATIENT FOR THE ARDOUS BOWEL PREPERATION
4) INADEQUATE BOWEL PREPARATION
5) THE EXAMINATION IS DIAGNOSTIC ONLY
6) COST EFFECTIVENESS

CONCLUSION

MDCT COLONOSCOPY HAS BEEN FOUND TO BE EFFECTIVE FOR THE DETECTION OF LARGE POLYPS AND CANCER IN HIGH RISK OR SYMPTOMATIC PATIENTS

IT HAS THE ABILITY TO EXAMINE BOTH SIDES OF THE BOWEL WALL WITHOUT SEDATION

IT HAS A BETTER PATIENT COMPLIANCE THAN CONVENTIONAL FIBROTIC COLONOSCOPY AS WELL AS IS LESS RISKY.

THE DIAGNOSTIC ABILITY OF MDCT COLONOSCOPY IS COMPARABLE TO CONVENTIONAL COLONOSCOPY AND FUTURE DEVELOPMENTS OF COMPUTER AIDED DETECTION AND FECAL TRAGGING PROMISE TO IMPROVE ITS TECHNIQUE SIGNIFICANTLY.

RADIOLOGISTS AND GASTROENTEROLOGISTS NEED TO WORK TOGETHER FOR SIGNIFICANTLY BETTER RESULTS.

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

Hyperlinks of academic material published on YouTube by Calcutta Academy of Radiology	
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
26	CAR CME - Heart Anatomy

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.

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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 August, 2022

We will be bringing out such Newsletters with a frequency of one issue every two months. So, next issue will be published in August, 2022.

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 July, 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.