Association of Vascular and Interventional Radiographers

Interventional Informer

PRESIDENT'S MESSAGE


Melissa Post

The annual AVIR meeting always promises great venues, speakers, topics, and networking opportunities. This past meeting in Chicago not only provided this, it also offered top notched attendees! I was so pleased to see the room full of folks every morning (even early in the morning!); the attention given to every speaker and moderator; but mostly I was impressed with the caliber of questions each of you came up with at the end of each session and during the panel discussions.

This premier level of attendees offers the opportunity to be challenged. I work best when faced with a challenge. With our membership's increasingly savviness we are faced with the challenge to exceed your expectations again next year. How can we do this, especially with the rough economic time that surrounds the AVIR, specifically the decrease in vendor support, and decrease in membership?

Many Hands

"Many hands make for light work" is the motto I am coining for this challenge. Despite our numbers, we have received outstanding information from the evaluations forms and speaker forms. Actually we are well lined up with topics and speakers for next year, Yahoo!

Subsequently, the number of members who signed up for the Member Committee also promises success with our objective of staying in-tuned with our members. This avenue allows members to voice multiple perspectives and view points. Your feedback is critical to the success of our organization – If we don't listen what value are we offering you?

Lines of Communication

Our understanding from the surveys, is that we are proud to be aligned with SIR. With that in mind, we asked to meet SIR's new Executive Director, Susan Holzer. During our Board meeting specific questions were asked regarding our relationship (AVIR and SIR), the lines of communication as well as what the future looks like. It was nice to hear Susan's response confirming those same questions as she is expected to ask the SIR board exactly that. We should learn more regarding those questions as they are planning a strategic meeting this summer.

Finally and most importantly, our focus this year is to invest in our main line of communication by providing a new and improved website.

Some of you mentioned your skills are web design and development; we will use you. Also, the committee will be key at aligning this project to your needs and desires. So keep talking!

Again, all the above ideas are great but without your voice we will be short with executing our promises. In order to exceed your expectations we need to know them. Use your Member Committee, get involved in your local chapter happenings and volunteer for next year's annual event in San Francisco!!

AVIR
www.avir.org

Summer 2011

Interventional Informer Editor:
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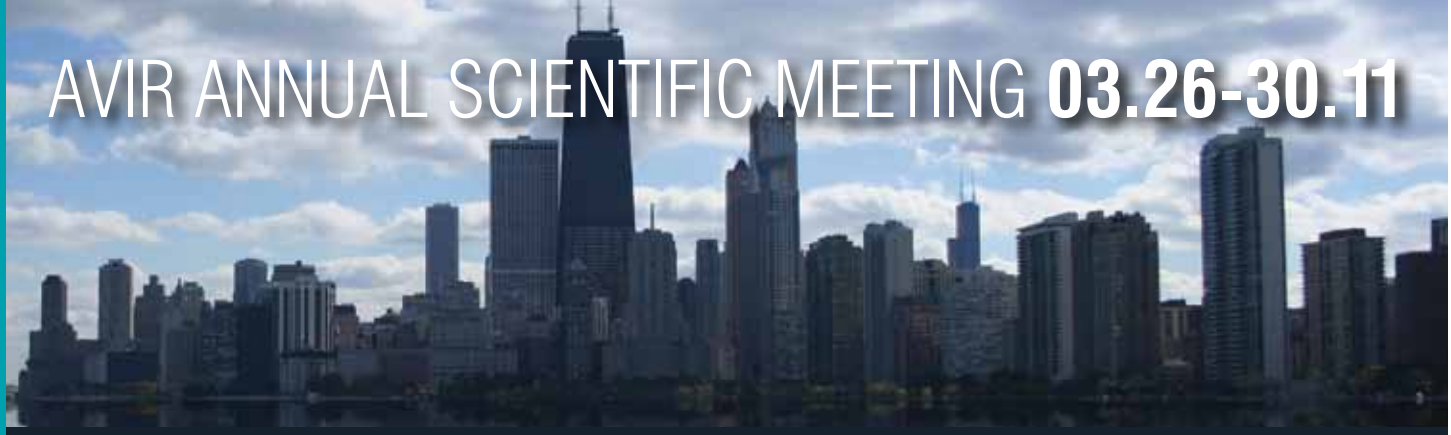
Inside this Issue

AVIR ANNUAL SCIENTIFIC MEETING **03.26-30.11**



McCormick Place Convention Center | Chicago, Illinois | *Held in Conjunction with SIR*

The AVIR Annual Scientific meeting was scheduled March 26-30th, 2011 in Chicago, IL. The Chicago McCormick Center was a great place for a meeting. Chicago is a fun city and there was really something for everyone. The bus system for transporting to and from the hotels ran smoothly overall. The program was diverse and well-rounded and the attendees seemed to really enjoy the topics, speakers and the new panel discussions.

The McCormick Center was really an amazing complex and the meetings were conducted in the brand new West Building. There was ample space for everyone, the exhibit halls was central and easy to access and there were restaurants and coffee stands available. The floor plan was very well designed as far as meeting space, transportation options, restaurants and shopping. The AVIR meeting was conducted on the 4th floor.

The program committee included Joni Schott, Program Chair, Anita Bell, Esma Campbell, Karen Finnegan, John Furtek, Jeanie Rhoten, Anne Oteham and Mark Veigl. The goal was to provide a fun, educational experience. We tried a new concept in Chicago with two panel discussions/presentations. One panel discussion was on acute stroke and intervention and the second was on the management of renal artery stenosis. Other topics will included neurointervention, ablations, venous and arterial disease and treatments, patient care, musculoskeletal procedures, IR veterinary care, UAE, and new procedures and technology on the horizon. Dr. Buddy Connors was honored and presented 2011 Gold Medal Lecture. Dr. Connors is an excellent speaker and continues to be an advocate for educating technologists and nurses.

The pre-meeting workshops included a four hour PICC workshop and a four hour ARRT advanced registry review. The SIR meeting was also highly successful and included lectures on oncology and palliative care, liver tumor therapy, carotid/stroke interventions, women's health, embolics, lung tumor therapy, nanotechnology, renal tumor therapy, biliary interventions, vascular imaging, hemodialysis, and peripheral arterial interventions. As in past years, the SIR program included plenary, symposia, categorical course, workshops and scientific sessions.

The meeting hotels were all located within the same general vicinity. Chicago was a great meeting spot because it is known for Michigan Avenue or the Magnificent Mile, Wrigley Field, Millennium Park, Lincoln Park Zoo, Frank Lloyd Wright's home and studio, John G. Shedd Aquarium, the Art Institute, the Museum of Science and Industry, and the Field Museum. The restaurant selection was remarkable and as far as night life, there were many options including Broadway shows, Navy Pier, comedy clubs, and many other musical venues.

Plans are already underway for the 2012 Annual Meeting in San Francisco.

SURGPRO

Speaking of many hands, a large part of our successful meeting is due Surgpro. This Medical Company supported us in many facets. Let me just say, President & CEO, Bill Porter, is one fun dude. His hands-on involvement included giving an inspiring leadership and team building talk (last minute), funding an after hours reception for meeting attendees, a dinner party at Gino's which included a big Hummer Limo ride there and multiple of other surprises following that—if you can imagine.

Dana Bridges, our Associate Representative, needs some kudos too. She basically is responsible for roping Bill into all this! Ha! And for that we are really grateful.

Best thing is, Dana is on the board for next year too. Just for your info, I have already identified the spot for our next reception in San Francisco. See you there!

Melissa Post

AVIR ANNUAL SCIENTIFIC MEETING **03.26-30.11**

22nd Annual AVIR Scientific Meeting

David S. Douthett, RT(R)(CV), Editor

San Francisco

"Here We Come – Right Back Where We Started From"

Yes around 20 years ago we had one of our annual meeting in San Francisco and it a blast. We were in the Marriott Hotel and only half the size at that time, but educational and very eventful. Joni Schott, this year's Program Chair is setting us up for a very memorable meeting this year. I would set my schedule now and start working with your hospitals to work out the educational value that is brought forth at this meeting. Last year's meeting over 30 CEUs in a broad range of subjects all pertaining to Interventional Medicine. That is hard to beat, all focused around our world and all in one place.

So set your sails for the far west and come join us on **March 22 -29, 2012** in San Francisco!

AVIR Annual Meeting 2011

Jeanie Rhoten, RT(R)(CV)

Product Showcase

We would like to express a special thank you to those who have graciously contributed to the success of our association. Without the support of our vendors it would be impossible to have our annual meeting and lend a helping hand to our chapters throughout the country. Below is a list of many items that were showcased at this years annual meeting, along with some helpful information for those members that were unable attended and those that attended.

Covidien announced that it has received Premarket Approval (PMA) from the FDA for the Pipeline embolization device, indicated for the endovascular treatment of adults (22 years of age or older) with large or giant wide-necked intracranial aneurysms in the internal carotid artery from the petrous to the superior hypophyseal segments.

Pipeline is a new class of embolization device designed to divert blood flow away from the aneurysm in order to provide a complete and durable aneurysm embolization while maintaining patency of the parent vessel.

PEVAR - Miniaturisation of EVAR heralds percutaneous era

An exciting opportunity awaits interventional radiologists with the miniaturisation of EVAR devices. The new-generation devices have shown a trend towards being lower in profile and some are designed for an entirely percutaneous approach.

Earn CEUs with **Stanley InnerSpace**

It was great seeing you at AVIR in Chicago! As we mentioned during our SpaceTRAX symposium, we'd like to give you the opportunity to earn some CEUs. InnerSpace's Lean course "Using Lean Strategies to Reduce Supply Costs" is now available online at no charge:
www.StanleyInnerSpace.com/LeanStrategies

Earn 2.0 CEUs with Stanley InnerSpace! Please be sure to fulfill all course requirements to earn your credits.

SpaceTRAX® Inventory Management System

We're excited that you want to learn more about Lean in healthcare and SpaceTRAX! SpaceTRAX is a web-based inventory management solution offering the flexibility to manage 100% of your inventory with a barcode scanner and/or manage your high-dollar implants and devices with RFID carts. Save millions of dollars by reducing inventory, eliminating waste, and improving charge capture.

If you have any questions about CEUs or Stanley InnerSpace inventory or storage solutions, please contact us at **800.467.7224** or visit **StanleyInnerSpace.com**

Bard introduced the LifeStent® FlexStar and FlexStar XL Vascular Stent

Based on a multi-dimensional helical architecture which enables it to meet the unique performance characteristics of the SFA. The device has completed a comprehensive clinical trial in the U.S. and Europe which demonstrated superiority over PTA, and was PMA approved for an SFA & Proximal Popliteal indication.

The **Artis zee®** family of interventional imaging systems from **Siemens Healthcare** was originally unveiled in December of 2007. Featuring the **Artis zeego®** multi-axis system, the new platform is available in a number of different stand configurations to address clinical specialties within body and neuro intervention delivering imaging excellence, enhanced workflow and investment confidence.

More recently, Siemens Healthcare has announced that all installed Artis zee systems will be upgraded, at no additional charge, to include the very latest in CARE (Combined Applications to Reduce Exposure) features. Further, these features will be included as standard items on new Artis zee systems that are sold and installed. These include specific functionalities driving towards dose reduction, monitoring and reporting.

To learn more about Artis zee and Siemens CARE features, please visit us at:
www.usa.siemens.com/low-dose

Trellis™
8 Peripheral Infusion System Isolated Pharmacomechanical Thrombolysis for the Treatment of DVT

When Deep Vein Thrombosis (DVT) occurs, a strategy for early clot removal is critical to avoid potential long-term sequelae, including recurrent DVT, and Post-Thrombotic Syndrome. And while systemic application of thrombolytic drugs may be the currently accepted practice, most interventionalists agree that the potential for serious complications make it far from ideal.

There is a better way to treat DVT. The Trellis System is an FDA-cleared, catheter-based procedure that isolates the blood clot and delivers focused treatment to the targeted area. This allows for early thrombus removal, and is a significant step in preventing chronic consequences associated with DVT."

SurgPro is a privately held medical device dealer founded in 2001 in Raleigh, North Carolina. We service the Southern United States, Caribbean, and Central American markets. Our products consist of a full line of vascular and interventional devices that are sold into interventional radiology departments. In addition to these product lines, we are proud that we help develop next-generation products as well as keep an eye open for new markets and technologies.

We also believe in core philosophies that reverberate throughout the organization. These include overall product value, reliable delivery, and outstanding service. Our team espouses to the highest integrity and standards knowing that our customers put their faith and trust in us. We welcome the challenge to never let our customers down and continually strive to do better in all facets of the organization.

Many of the products we sell are oncology-focused including single and dual lumen CT-rated port-a-caths and bone marrow biopsy needles. One of our new family of products that is utilized in the oncology market is Asept Pleural and Peritoneal Drainage Systems. Asept is intended for long term, intermittent drainage of symptomatic and recurrent pleural effusions and malignant ascites. The name "Asept" is derived from the self-sealing valve which eliminates the need for end caps and allows for a more secure, "aseptic" connection between the catheter and the receptacle for fluid collection. Additionally, the connector is a universal luer lock which provides multiple drainage options for patients. For more information on Asept or any other products offered by SurgPro, please visit our website at **www.surgpro.com**.

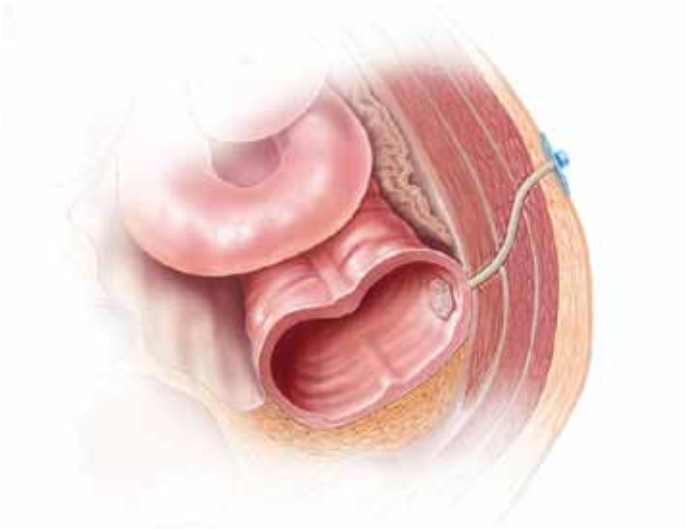
Cook Spectrum®
Technology: Infection Control Solutions "Beyond Soap and Gloves"

Maximal sterile barrier precautions are an essential part of patient care, but aren't always enough. Spectrum antibiotic impregnated catheter technology, with its unique combination of minocycline plus rifampin (M+R),is the only PICC recommended by the CDC or any other organization for reducing catheter-related bloodstream infections (CRBSIs). Spectrum catheters are five times more effective in reducing catheter-related bloodstream infections than maximal sterile barrier precautions alone.

Two decades of evidence, including over 21 peer-reviewed studies and meta-analyses, confirm that minocycline plus rifampin catheters are the most effective tool available to provide broad-spectrum protection against gram positive and gram negative organisms in both short- and long-term use. Over 10 years of clinical use has shown no evidence that M+R catheters lead to bacterial resistance, and a 7 year study

of over 500,000 catheter days confirms these results. Data indicate that facilities using M+R catheters have a decreased need for systemic antibiotic use. This is evidence of protection no other process or technology can match.

The facts are clear. Spectrum technology improves patient care and can bring down costs by helping to prevent CRBSIs and the associated expense of treating them. Cook Medical offers a full line of Spectrum catheters, including power injectable Turbo-Ject® catheters and standard silicone options. Your patients deserve the best care possible. Win the fight against CRBSIs in your facility with Spectrum.



Biodesign® Enterocutaneous Fistula Plug

Biodesign®
Enterocutaneous Fistula Plug: New Hope For Patients Suffering From Enterocutaneous Fistulas

Enterocutaneous fistulas can significantly affect patient health and quality of life. Designed to provide closure of an enterocutaneous fistula tract, Cook Medical's Biodesign Enterocutaneous Fistula Plug has been specifically developed as an interventional method to correct this notoriously difficult-to-treat and often debilitating condition.

The enterocutaneous fistula plug incorporates Biodesign technology and has a distally attached polyurethane flangethat contains a radiopaque nitinol marker. The flange is dual purpose, designed to create a seal that restricts enteric fluids from entering the fistula tract while also providing a method of visualization for the physician. Biodesign is a breakthrough technology that combines the best attributes of synthetic materials and biologic grafts, providing signals and support for the body to restore itself. Once the enterocutaneousfistula plug is in place, adjacent tissues grow across the Biodesign scaffold, which has been shown to remodel into strong, fully vascularized natural tissue, thus closing the fistula tract.

Spectrum® Turbo-Ject® Double Lumen Catheter

Renegade® HI-FLO™ Fathom®
Pre-Loaded System

The Renegade® HI-FLO™ Fathom® Pre-Loaded System consists of the Renegade® HI-FLO™ Microcatheter, preloaded with a Fathom® -16 Steerable Guidewire. It combines the turn-for-turn torque response, flexibility, support and high visibility of the Fathom -16 Guidewire with the proven performance of the Renegade™ HI-FLO™ Microcatheter, all in one, convenient to use, pre-loaded system.

Fathom-16 Guidewire – The outer micro-cut nitinol sleeve is designed to transmit turn-for-turn torque for enhanced maneuverability. In addition, the stainless steel core provides excellent support, while the platinum/tungsten tip delivers visibility, tip shape retention and memory.

Renegade HI-FLO Microcatheter – The large-lumen (.027" ID) offers a combination of high flow rates and excellent distal access. The VORTEC® Plus Fiber and platinum braiding provides excellent kink resistance and visibility. The 3F proximal OD tapers to 2.8F polished distal tip with platinum RO marker.

AVIR Annual Meeting 2011 Product Showcase (con't)

The Interlock™
35 Fibered IDC™ Occlusion System

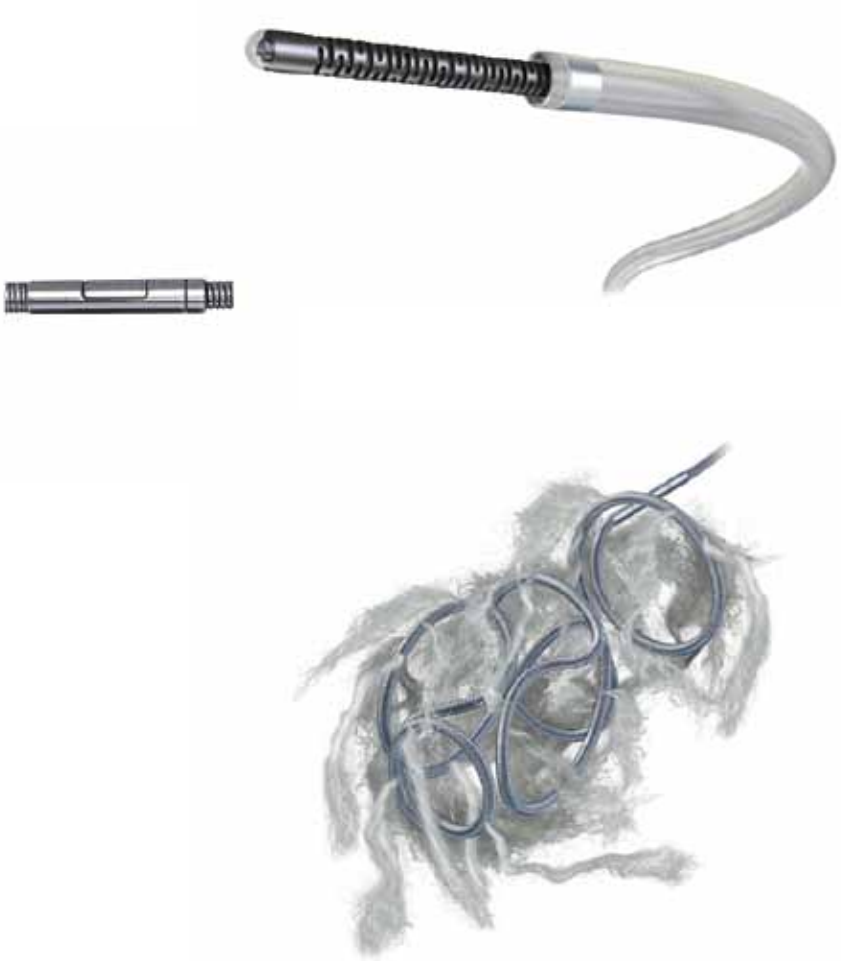
The Interlock™ - 35 Fibered IDC™ Occlusion System is a heavily fibered, detachable 0.035" coiling system that is available in a wide array of shapes, diameters and lengths. These features, combined with a simple detachment mechanism, allow you to Lock-In Accuracy, Power and Precision with every coil placed.

Accuracy: Unlike other systems that require complex equipment for deployment, the Interlock 35 Fibered IDC Occlusion System features a simple interlocking connection between the pusher wire and the coil. Accurate and reliable detachment is achieved by simply pushing the connection beyond the distal end of the catheter.

Power: The system's dense fiber configurations are specifically designed to promote rapid thrombogenicity, without the wait. In addition, the coil is available in lengths up to 40cm, enhancing the potential impact of each coil that is placed.

Precision: The Interlock 35 Fibered IDC Occlusion System is available in a traditional 2D Helical shape, as well as Cube and Diamond configurations. This array of shapes allows you to better manage the unique challenges of the peripheral anatomy.

If you have an opportunity to speak to any of the vendors please express your thanks for there support. And please let them know that we look forward to working again with them next year.



Billing for the Embolization Agent Used for UFE

37210	Uterine fibroid embolization
99217	Observation care discharge day management

In 2007, the all-inclusive CPT code 37210 was established for uterine fibroid embolization (UFE). This code specifically includes percutaneous access to the vessel, vessel selection, embolization and all radiologic supervision and interpretation as well as all imaging needed to complete the procedure. The agent used for embolization is not separately billable. Any additional selective catheterization that is needed to perform the uterine artery embolization is also included, such as catheterization of the ovarian artery and embolization from this site.

Physician billing and reimbursement is based on fee schedules that are directly linked to current procedural terminology (CPT) codes. In-facility fee schedules refer to those procedures performed on an outpatient basis or on an inpatient basis in a hospital or hospital-associated ambulatory surgical center. UFE is most frequently performed in a hospital setting, though it has now been approved as a procedure that can be performed in a freestanding facility. The most common scenario is for the patient to be admitted to the hospital under observation status, as the anticipated hospital stay will be less than 24 hours. In this typical scenario, the hospital is reimbursed under the Ambulatory Payment Classification (APC) group. (The current APC code for UFE is 0229.) Under the APC rules, some items can be charged for separately. These items are specifically stated as "pass-through" items; a listing can be found at www.cms.gov/HospitalOutpatientPPS/Downloads/DeviceCats_OPPSUpdate.pdf. Embolization agents are not on this listing and are considered included with the value placed on the procedural code.

If the interventional radiologist performs a UFE at a freestanding facility, the APC code used is the same; however, the place-of-service modifier indicates that this site is a nonfacility site and the reimbursement rates are adjusted to take into account the typical practice expense.

It is expected that the diagnosis of leiomyoma of the uterus is already known before the UFE procedure. This diagnosis is usually established and a treatment plan prescribed at the time of the initial clinic visit with the interventional radiologist. Evaluation and management coding is very appropriate in this setting and will fall under either the consultation code (if the patient has been referred by another physician) or the initial encounter code (if the patient is self-referred or referred by a nonphysician).

Documentation on the initial visit requires three key elements: history, examination and medical decision-making. The only exception to this rule of the three key elements is where the majority of the time (greater than 50 percent) is spent face-to-face with the patient in counseling and coordination of care. This time spent must be specifically documented in the visit note. There are many available guides to teach physicians how many elements of the history, physical exam, review of systems and complexity of clinical care are required for each level of E&M coding. All interventional radiologists should become familiar with these levels of service. With the increasing availability of electronic medical records, templates with the specific requirements for level of service already built in are very helpful in ensuring that one captures all of the information needed for the appropriate level of billing.

UFE has a global period of zero days. This means that the initial surgical package includes one related E&M service that occurs after the decision for surgery (usually the history and physical examination performed immediately before the procedure), the surgical procedure, itself, immediate postoperative care (including the procedure note and orders) and an evaluation in the recovery area. Since the global period is zero days, other procedures or services provided (even if related to the procedure) are separately reportable. If the patient is observed overnight and then discharged from observation status, the appropriate observation care discharge code (99217) may be used if there is documentation of a discharge summary that includes a discussion of the hospital stay, a final examination and a discharge plan. ❖

Chapter Happenings

Tony Walton, RT(R)

Below are the most current contacts for the active AVIR Chapters. The AVIR is dedicated to developing new and supporting existing state and regional chapters. From my experience with AVIR, activities at the Chapter level are rewarding and a great resource for networking, both locally and nationally.

Developing New Chapters

New chapters are being formed in Massachusetts, Pennsylvania, Idaho and Florida! Below is the contact information for each chapter:

Massachusetts

Robert Sheridan RT(R)
rmsheridan@partners.org
Hoping to restart the chapter in Boston

Pennsylvania

Maria Niblock RT(R), BS
mmflyers@comcast.net
Wants to start a chapter in Philadelphia

Idaho

Terry Newsom RT(R)
xrayhunter@cableone.net
Wants to start a chapter in Boise

Florida

Izzy Ramaswamy MS, RT(R)
izzyr@baptisthealth.net
Will start the Miami chapter

As the incoming *Director at Large* and *Chairman of the Chapter Committee*, I believe that encouraging existing chapters to grow and the development of new chapters is a priority. Chapter and regional meetings provide educational opportunities that allow our members to serve locally, regionally and hopefully nationally. Below are the most current contacts for active AVIR chapters.

North Carolina AVIR

Diane Koenigshofer MPH, BSRT (R)(CV), FAVIR
dianek@nc.rr.com

Orange County California AVIR (OCAVIR)

Brett Thiebolt RT(R)
thieboltbh@stjoe.org

North California Chapter

Darlene Crockett RT(R)(CV)
maildarlene@juno.com

Los Angeles Chapter

Jeane Rhoten RT(R)(CV)
jrslife@aol.com

Seattle AVIR

Leona Benson RT(R)(CV) FAVIR
seattleavir@hotmail.com

Lone Star State Chapter

Alan Seeley RT(R)(VI)
aseeley@petersonrmc.com
aseeley61@windstream.net

North Texas AVIR

Sven Phillips BS, RT(R)(VI)
sven427@yahoo.com

SE Wisconsin Chapter

Julie Malkowski RT(R)(CV)
Jmalkowski5@wi.rr.com

Baltimore Chapter

Sharon Misler RT(R)(CV) FAVIR
angiosm@aol

Virginia Chapter/ VA AVIR

Rita howard RT(R)(CV)
Rhoward709@aol.com

Christopher Shaver RT(R)
christophershaver@msn.com

New York Capital AVIR

Kevin Berry RT(R)
kbxray@yahoo.com

NE Connecticut AVIR

Meredith Gaiter-Brown BSN, RT(R)(CV)(MR)(M)
mrcvm@aol.com

Buckeye State Chapter (Ohio)

Jamie Hiott RT(R)(CV)(M)(CT)(VI)
jshiott@gmail.com

South Carolina / SCAVIR

John Furtek RT(R)
jfurtek@comcast.net
www.scavir.org

Metro Atlanta Chapter

Thomas Staton RT(R)(CV)
tlstanton@bellsouth.net

Great Lakes Chapter (Michigan)

Michelle Denomme
denomme@beaumonthospitals.com

Rocky Mountain Chapter

Erik Stein RT(R)
ekdstein@yahoo.com
diane.mudd@uhcolorado.edu

A few members expressed a willingness to help in their areas…

Renee Tossell PhD RT(R)(CV)(M)
rtossell@pima.edu
Willing to help with membership in the southern Arizona area

Patti Payne
patti.payne@ge.com
Willing to start a chapter

Associated Sciences Program at RSNA 2011

Associated Sciences Courses

Sponsored by the Associated Sciences Consortium
(This Live activity has been approved for *AMA PRA Category 1 Credit™* and Category A+ credit for technologists)

RSNA® 2011 Celebrate the Image

November 27– December 2 | McCormick Place, Chicago

Monday, November 28

MSAS21 8:30 AM - 10:00 AM

Implications of the Changing Face of Health Care: Aging and the Shift of Population

Claudia A. Murray, *Moderator*
David R. Gruen, MD
Robert M. Kulis

MSAS22 10:30 AM - 12:00 PM

Implications of the Changing Face of Health Care: Delivery and Regulatory Impacts

Charles Stanley, RT(R)(CT)(MR), *Moderator*
Abraham Seidmann, PhD
Christine J. Lung, CAE

MSAS23 1:30 PM - 3:00 PM

Changes in the Scope of Practice: Gaps and Overlaps

Steve Vogt, MSRS RT(R)(MR)(CT)(BD), *Moderator*
Donna T. Long, MSM, RT(R)(M)(QM)
Linda Gough, M.R.T.(R.)
Lynne Roy, MBA, MS, CNMT, FSNMTS

MSAS24 3:30 PM - 5:00 PM

Medical Imaging Radiation Exposure Origins, Consequences, and Control: Optimization of Radiation Dose

Ellen Lipman, MS, RT(R)(MR), CAE, *Moderator*
Rob Goodman, MB BChir
Kathlyn A. Slack, BSC

Tuesday, November 29

MSAS31 8:30 AM - 10:00 AM

Ethics in the Era of Health Care Reform

Karen J. Finnegan, MS, RT(R)(CV), FAVIR, *Moderator*
Richard Duszak Jr, MD
Frank J. Lexa, MD

MSAS32 10:30 AM - 12:00 PM

Understanding Health Literacy and the National Standards on Culturally and Linguistically Appropriate Services (CLAS)

Ellen Lipman, MS, RT(R)(MR), CAE, *Moderator*
Michael D. Ward, PhD, RT(R)
Brenda A. Battle

MSAS33 1:30 PM - 3:00 PM

Impacts of Emerging Practice Models

Donna Blakely, MS, RT(R)(M)(CRA), *Moderator*
Shay Pratt
Patricia Kroken, FACMPE, CRA

MSAS34 3:30 PM - 5:00 PM

Picking Up the Pieces: Forensic Radiography Following Mass Disasters

Susan Crowley, BAppSc(MI), MRT(R) MA Ed, *Moderator*
Gerald J. Conlogue, MHS, RT

Wednesday, November 30

MSAS41 8:30 AM - 10:00 AM

Imaging Facility Design in an Age of Diminishing Resources

Morris A. Stein, BArch, *Moderator*
Bill Rostenberg, FAIA, FACHA
Ronald L. Arenson, MD
Steven C. Horii, MD

MSAS42 10:30 AM - 12:00 PM

Creative Strategies for Marketing: Keeping It Legal

Donna Blakely, MS, RT(R)(M)(CRA), *Moderator*
Peggy Martin, CRA
W. K. Davis Jr, JD

Also on Monday:

AAPM/RSNA Basic Physics Lecture for the Radiologic Technologist

(Approved for 1.25 *AMA PRA Category 1 Credits* and Category A+ credit for technologists)

Monday, November 28, 1:30 PM – 2:45 PM

CT Dose Control and Optimization

Douglas E. Pfeiffer, MS, *Moderator*
Dianna Cody, PhD
James M. Kofler, Jr, PhDd

RSNA is an ARRT®-approved Recognized Continuing Education Evaluation Mechanism Plus (RCEEM+) and will provide Category A+ continuing education credits for technologists and radiologist assistants.

Registration Information

Registration is required to attend the Associated Sciences programs at *RSNA2011.RSNA.org*.

Advance discounted registration for the RSNA annual meeting ends November 4, 2011. Register now to get the hotel of your choice.

If you would like a copy of the published Associated Sciences Proceedings, please call 1-877-776-2227.

Sponsoring Organizations

- AHRA: The Association for Medical Imaging Management
- American Institute of Architects – Academy of Architecture for Health (AIA-AAH)
- American Society of Radiologic Technologists (ASRT)
- Association for Radiologic & Imaging Nursing (ARIN)
- Association of Educators in Imaging and Radiologic Sciences, Inc (AEIRS)
- Association of Vascular and Interventional Radiographers (AVIR)
- Canadian Association of Medical Radiation Technologists (CAMRT)
- The College of Radiographers (CoR)
- International Society of Radiographers and Radiological Technologists (ISRRT)
- Radiology Business Management Association (RBMA)
- Section for Magnetic Resonance Technologists (SMRT-ISMRM)
- Society of Nuclear Medicine Technologists Section (SNMTS)

Member Committee

Melissa Post, MBA, CRA, RT(MR)(CV)

Becoming an AVIR Fellow can be a daunting task especially after reading the application. However, don't fret; you are well on your way to being fellow just by being a member and becoming involved in the Member Committee.

Historically, when the AVIR membership numbers were large, we were able to have multiple people for each specific committee (financial, program, education, ethical, members, etc.). Well, with smaller numbers come frugal ways to do business. This year we are going to have one Committee to help with all of these tasks. Again, at first blush, it seems to be too big of a task, but just like becoming a fellow you breakdown the steps one at a time and before you know it you've filled out your entire obligation.

That's how we plan to utilize this committee. Each of you has talents and gifts (and time) for particular topics. When they come up please don't be shy – chime in. For example, VP, Tony Walton, just asked for educational help from those who enjoy reading JVIR journal articles came up with a quiz for continuing education credits. If 15 of the 30 committee members respond to this request we will have that many more CEUs available to the rest the association. FREE CEUs is an identified benefit of being a member.

Do you see how many hands make light work?! I love this philosophy — can you tell?

Those of you in Northern California get ready. This next year is your year to show us your stuff.

Hello Northern California AVIR Members:

Paula Baker
Christina Caridis
Theresa Castillo
Edward Clunies-Ross
Wade Cobb
Darlene Crockett
Francisco Diaz
Anne Edwards
Melody Halbert-Riley
Martha Higgins
M. Kiely
William Knapp
Deborah Lent
Joseph Librizzi
Lisa McNamare
Annette Mello
Timothy Mihora
James Olry
Ann Parrino
Juan Pedroza
Kathleen Peterson
Maricarol Rodgers
Edward Rodriguez
Barbara Rousseau
Zoilo Saavedra
Larissa Smith
James Stokes
Garry Thomson
Jon Van Brocklin
Samuel Wells

We will be tapping into you and your labs. Actually we are looking for a showcase lab to spot light for our annual meeting. This will offer a unique opportunity to network and demonstrate team building between and among caregivers. ***Are you interested? Let me know!***

From left to right: Robert Sven Phillips, Karen Finnegan, David S. Douthett, Tony Walton, Melissa Post, Jeffrey Kins, Bill Greear, Dana Bridges, and Joni Schott

2011-2012 AVIR Board of Directors

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2011–2012 AVIR Board of Directors

Jeffrey Kins, RT(R)(VI), Nominations Chair

The incoming AVIR Board of Directors for 2011-12 will have a very familiar look to it. With the exception of *Director-at-Large*, all the *Board of Director* positions have been filled with members who have previous AVIR Board experience.s

As per the association by-laws, Jaime Nodolf RT(R) will transition from *President* to *Immediate Past President*.

In turn, Melissa Post MBRT(R) (CV), FAVIR will transition from *Vice President/President Elect* to *President*.

William "Tony" Walton RT(R) will serve as *Vice President/President Elect*. Tony had served as *Director-at-Large* for the 2010-11 term.

Bill Greear MHA, MBA, RT(R) (CV) has agreed to continue in his position as *Secretary/Treasurer* for an additional year.

The sole new incoming Board member is Robert Sven Phillips BSRT(R) (VI) from Carrollton, TX, serving as the *Director-at-Large*. Sven is a graduate of Odessa College and Texas Tech University and is currently the Chief Technologist of Special Procedures/ Interventional Radiology at the Medical Center of Plano, TX. He has previously served on the local as well as state level where he completed terms as vice president and education committee chair. Sven also has experience on the AVIR chapter liaison, education, ethics and finance committees.

Welcome Sven, and congratulations!

Interview with Past President, Jeff Kins

Melissa Post, MBA, CRA, RT(MR)(CV)

Let's meet the Past President, Jeff Kins!

Jeff thanks for taking the time to meet with me. I have to say I am intrigued by you and thus looking forward to our chat. I don't know you too personally, however I have seen you in your distinguished black hat. Tell me about that hat.

Ha ha! Well, there's really not much to tell. I have several in different colors including a panama hat that I just got in San Juan, but the black fedora is my favorite for traveling. It can get shmushed in a suitcase and still hold its shape. It's a classic look that keeps my head warm.

Ok, enough of the goofy stuff, what are most proud of (so far) in your IR career?

I was involved in what is believed to be the first ever angiogram at sea. It was on the USNS Comfort during the Gulf War in 1990, using the old puck Elema-Schonander film changers with the punch cards. They sounded like a machine gun going off!

Where did you start your career?

I graduated from X-ray school at the Naval School of Health Sciences in Portsmouth, VA in 1983 and went straight to a Marine Corps field unit. I didn't get a lot of x-ray experience there, but I had a great time.

How long have you been in IR?

I started in IR in 1987 at the National Naval Medical Center in Bethesda, MD. They had a great OJT program there for all the different modalities, but IR was always the one I wanted.

Interview with Past President Jeff Kins (con't)

Do you have a favorite procedure in IR?

I like pretty much any interventional procedure where you can actually fix the patient's condition, and not just diagnose what the problem is. UFE, TIPS, AAA stent grafts. It's very satisfying when the patient leaves the suite with an improved quality of life.

Jeff, I admire you because you are almost through with your AVIR commitment as President. How was your experience?

It was invaluable to me. Although it can be a lot of work at times, it's all worth it when you talk to the members and see how much education, networking and enjoyment they get out of the national and regional meetings.

What do you feel is your biggest accomplishment?

Without a doubt, it's getting the AVIR accepted as a RCEEM (Recognized Continuing Education Evaluation Mechanism) by the ARRT. This allows us to certify category A credits for continuing education for our own as well as other organizations.

Why do you feel this is a beneficial thing?

This gives the AVIR more value as an organization. Members that attend local or even facility-based learning sessions (like grand rounds) can potentially get CE credit. The application can be downloaded from the AVIR website and we have a very streamlined process. Assuming all the criteria is met, the Education Committee will determine the number of CE's and assign the session an ID number. In the future, we hope to market this service to corporate events as well.

Along with the continual work towards that, there is some play time. Do you have a fond memory while being the President?

I would have to say the Global Embolization Symposium and Technologies (GEST) meeting in San Francisco in May of last year. This was our first time certifying credits for another organization, and it really went well. The reception was held at the Exploratorium Museum where they have hundreds of hands-on exhibits. I got the biggest kick out of watching some of the brightest innovators and IR physicians in the world playing with giant soap bubbles and magnets like they were little kids. It still makes me laugh to think about it.

If I may, what was a disappointment during your term?

I would like to have increased membership and awareness among IR techs. Membership has remained somewhat flat for the past several years, even though AVIR members make up only a fraction of technologists working in the IR field. I hope our organization can continue to grow in the next few years.

Now that you have completed the Past President role, do you have advice for the upcoming presidents?

Stay vigilant and stay focused. Great ideas for improvement always come up at the annual meeting and you really have to stay on top of things to keep them from falling through the cracks and getting lost. Also, know how to delegate and use your committees.

Thanks so much Jeff, you are such a good sport.
I can't wait to hang out with you more in San Francisco!

Thanks Missy, I'm looking forward to it!

High Mortality, Heart Attack And Stroke Rates Accompany Peripheral Arterial Disease

David S. Douthett, RT(R)(CV), Editor

In an effort to increase awareness of peripheral arterial disease (P.A.D.), a common cardiovascular disease that affects as many as 12 million Americans, the United States Senate passed a resolution, in 2007, designating September as National Peripheral Arterial Disease Awareness Month.

P.A.D. is characterized by blockages in the arteries that supply blood to the legs and is a warning sign that other arteries, including those in the heart and brain, may be blocked as well. Thus, while P.A.D. is known to cause leg muscle fatigue, cramping or pain when walking and lead to disability, amputation, or a poor quality of life, it is also associated with a high risk of heart attack and stroke. New clinical research published in 2007 documented P.A.D..s serious consequences. The international REACH registry evaluated cardiovascular outcomes in 68,000 individuals to define their risk. This registry demonstrated that one in five patients with P.A.D. will have a heart attack or stroke, be hospitalized or die due to cardiovascular complications within one year. Patients with P.A.D. had higher one-year death rates than patients who previously had a heart attack or stroke.

The survival rate for individuals with undetected peripheral arterial disease is worse than the outcome for many other serious diseases, including many common cancers,. noted Senator Crapo. Despite the grim statistics, P.A.D. is often undiagnosed. By informing Americans about the seriousness of P.A.D. and its risk factors and symptoms, we aim to reduce the burden of this devastating disease.

Who is at risk for P.A.D.?

Everyone over 50 is at risk for P.A.D. However, your risk is increased if you:

- Smoke, or used to smoke
- Have diabetes
- Have high blood pressure
- Have abnormal blood cholesterol
- Are African American
- Have a personal history of coronary heart disease or stroke

The most common warning signs and symptoms of P.A.D. include one or more of following:

- **Claudication –** the symptom of fatigue, heaviness, tiredness or cramping in the leg muscles (calf, thigh or buttocks) that occurs during activity such as walking and that goes away when you rest.
- Skin wounds or ulcers on the feet or toes that are slow to heal (or that do not heal for 8 to 12 weeks).

For almost half of affected individuals, P.A.D. is a silent disease, causing no recognizable symptoms. Many individuals who do have leg muscle discomfort often think it is a natural part of aging and do not tell their health care provider.

P.A.D. is one of the most dangerous cardiovascular diseases that no one has ever heard of,. said Alan T. Hirsch, M.D., Chair of the P.A.D. Coalition, Professor of Epidemiology and Community Health at the University of Minnesota School of Public Health, and Director of the Vascular Medicine Program at the Minneapolis Heart Institute. By increasing awareness of P.A.D. and assuring patient access to therapies that are proven to save lives and limbs, we can reduce unnecessary suffering and improve the nation.s vascular health.

High Mortality (con't)

To address this serious and growing health problem, the P.A.D. Coalition and the National Heart, Lung, and Blood Institute (NHLBI) of the National Institutes of Health are conducting a national awareness campaign titled Stay in Circulation: Take Steps to Learn About P.A.D. The campaign provides tools for consumers, community groups, medical professionals and health organizations to inform Americans about the risks, symptoms and treatment of P.A.D. New Stay in Circulation resources are available online at **www.aboutpad.org**.

In September, the P.A.D. Coalition and its member organizations will disseminate P.A.D. information through special partnerships and activities. In addition, many hospitals and medical centers will offer free screenings for P.A.D. Visit www.padcoalition.org to find a P.A.D. screening site.

About the P.A.D. Coalition

The Peripheral Arterial Disease (P.A.D.) Coalition is an alliance of leading health organizations, vascular health professional societies, and government agencies united to raise public and health professional awareness about lower extremity P.A.D. Established in 2004, the P.A.D. Coalition is coordinated by the Vascular Disease Foundation (www.vdf.org), a national, not-for-profit section 501(c)(3) organization.

The P.A.D. Coalition seeks to improve the prevention, early detection, treatment, and rehabilitation of people with, or at risk for, P.A.D.

Guidelines Promote Early Detection, Treatment of Arterial Disease

David S. Douthett, RT(R)(CV), Editor

Treatment Of Arterial Disease Of The Legs And Feet, Kidneys, Intestines, And Aorta

(BETHESDA, MD)—More than 12 million Americans suffer from peripheral arterial disease (PAD), prompting the American College of Cardiology (ACC) and the American Heart Association (AHA) to release the Peripheral Arterial Disease Guidelines to help physicians and all healthcare professionals better treat this alarmingly common condition.

PAD is generally defined as diseases of the arteries that supply blood to the arteries outside the heart, including those that supply the legs, feet, kidneys, and intestines. These arterial diseases can impair physical health by diminishing an individual's ability to walk. PAD can lead to amputation of the extremities, rupture of an aortic aneurysm, severe hypertension, kidney failure, as well as contribute to current rates of heart attack, stroke, and cardiovascular death.

The Guidelines, representing best practices for managing diseases of the aorta—the body's main artery—and the arteries that supply blood to the legs, feet, kidneys, and intestines, were developed in collaboration with and approved by the American Association for Vascular Surgery/Society for Vascular Surgery, Society for Cardiovascular Angiography and Interventions, Society of Interventional Radiology, Society for Vascular Medicine and Biology, and the ACC/AHA Task Force on Practice Guidelines.

"These Guidelines provide a concise diagnostic and treatment guidebook for patients suffering from PAD and for physicians, physicians assistants, nurse practitioners, and nurses who are now offering care to treat them," said Alan T. Hirsch, M.D., F.A.C.C., chairman of the writing

Guidelines Promote Early Detection (con't)

committee. "Our important collaborations with our professional partners in SVMB, SIR, SVS and SCAI make these Guidelines more valuable to all practicing health professionals. We have provided access to the best available evidence that can guide best care. A key source of the power of these recommendations is that they are so broad-based in their origin from every vascular specialty, as they attempt to reach a broad-based audience of clinicians. Everyone can use these Guidelines and a large segment of the public can benefit from them."

The PAD Guidelines strongly emphasize the fact that early detection and treatment of peripheral arterial disease can prevent disability and save lives.

Highlights of the guidelines include:

- Recommended questions and observations that can uncover hidden signs of peripheral arterial disease;
- Clinical clues that a patient may have renal artery stenosis, a narrowing of the arteries that supply blood to the kidney—and a possible cause of poorly controlled high blood pressure or kidney failure;
- Recommendations on when an aneurysm—a weakening and bulging of the arterial wall—should be treated with surgery or catheter-based therapy, as well as when "watchful waiting" is the best course;
- A critical analysis of the strengths and weaknesses of vascular imaging tests and other diagnostic methods;
- An emphasis on therapeutic choice, including the role of exercise, diet, smoking cessation, and medications, and an objective review of the benefits and drawbacks of surgical and catheter-based therapies; and
- Clinical pathways and treatment algorithms to guide clinical decision-making.

The Guidelines have been developed not just for specialists who perform the complex procedures used in the treatment of peripheral arterial disease, but also for primary care physicians, nurse practitioners, and physician assistants, all of whom make the initial diagnosis and initiate therapy.

The full text of the Guidelines will be published online at www.acc.org and www.heart.org. An executive summary of the Guidelines will be published in the Journal of the American College of Cardiology and in Circulation: Journal of the American Heart Association.

The Consistency, Accuracy, Responsibility and Excellence (CARE) in Medical Imaging and Radiation Therapy Bill

David S. Douthett, RT(R)(CV), Editor

CARE BILL

Introduction of the bill will be early next week. The ASRT will send a template to the Alliance to use for action alerts and call-to-actions. There are approximately 20 original co-sponsors; evenly balanced (Democrats and Republicans).Support from MITA, ACR and GE. Other supporters are Toshiba, Siemens, Varian and Elekta which all give good representation on Capitol Hill.

FINDINGS

Whereas, the provision of imaging services by unqualified and/or untrained medical personnel results in costly duplication of services and subjects patients to unnecessary risk including exposure to radiation, the federal government has a responsibility to the taxpayer to make cost-efficient, medically prudent, and safe purchases of health care services.

Whereas, for purposes of determining an individual's qualification to provide medical imaging or radiation therapy services, federal health programs will rely on state requirements for defining licensure, certification, registration and the scope of practice. In the absence of applicable state licensing or certification standards, the Secretary shall rely on the standards and certifications offered by national certification organizations.

Whereas, imaging services may also have non-medical applications, nothing in this Act shall establish qualifications for personnel performing non-medical imaging services.

Whereas, the States traditionally regulate the practice of medicine, nothing in this Act will preempt the states' authority to license or regulate the practice of medicine.

Update from the ARRT

ARRT exams were busy this year, with the CQ2011 coming, it seemed everybody showed up to get credentialed before the deadline. Over 40,000 candidates signed up for exams and an average of 83% pass rate with average scores of 81%. CT exams led the way with a 114% increase in candidates with a 110% increase in Cardiac-Interventional Radiography and a 100% increase in Vascular-Interventional Radiography.

The numbers were:
CT = 11,000
CI = 163
VI = 744

Overall pass rate for the VI was only 67% and we led with this low rate. Oh well, just goes to show how challenging, our profession is.

Academic Degree Requirements Effective 2015: Professionalism is the Goal.

ARRT is now requiring a degree to be eligible for a certification in Radiography – effective day one of 2015. ARRT believes that the general education courses required for an academic degree will provide a firm foundation to support the evolving role of the technologist and the lifelong learning necessitated by the increasing rate of technological change.

The degree will not need to be in radiologic sciences, and it can be earned before entering the educational program or after graduation from the program. The degree requirement will apply to graduates **on or after January 1, 2015.**

Individuals who complete a recognized non-degree granting program prior to that date will not be subject to the degree requirement.

ARRT (con"t)

Then Coming in 2016: Structured Education Requirements For Our Post – Primary VI Certification

So on the heels of ARRT's degree requirements for the primary certification, they now have enacted a structured education requirement for post-primary certification that will be effective January 1 2016.

The structured education requirements will be in addition to the clinical experience requirements that already help candidates demonstrate "experiential" education. The addition of this structured education addresses cognitive learning. Overlapping experiential and cognitive education requirements will provide the most comprehensive preparation for examination.

This requirement definitely raises the educational bar in helping to ensure excellence in patient care.

Details of the requirements include:

- A total of 16 hours of structured education earned with a 24 month period immediately preceding submission of an application for certification will be required. This time will be calculated the same as for CE (i.e. one credit will be awarded for 50-60 contact minutes, 12 credits for each academic quarter credit, 16 credits for each academic semester credit).

CE activities used to fulfill the requirements MUST be approved by a RCEEM.

What Happened Here? San Francisco Knowledge Cards

Dona Budd

1 Columbus Ave on April 18, 1906

Amadeo Giannini rescued the assets of the Bank of Italy. When the fire caused by the Great Earthquake approached Giannini's business, the Bank of Italy, his background in produce paid off. He stuffed $2 million in gold, coins, and securities under a wagon load of vegetables and drove to safety. Two years earlier, he had left the board of North Beach bank whose directors refused to do business with the working class. Giannini converted a saloon into the first back that did not exclusively serve businessmen and the wealthy. The bartender became his assistant teller. When the other banks closed after the earthquake, Giannini propped a plank on two barrels and extended credit to individuals and small businesses so they could get back on their feet. Giannini's bank became the giant Band of America. It is just as well that he never heard San Franciscans call the granite sculpture in the Bank of America plaza "the Banker's Heart"

1434 Grant Avenue on June 7, 1974

In the Savoy Tivoli restaurant's back room, *Beach Blanket Babylon*, an outrageous musical revue that has been selling out for 30 years, was first performed.

What do you get when you cross a dancing Christmas tree with a *Jeopardy* champion? The team of the late Steve Silver, who created *Beach Blanket Babylon*, and his wife, Jo Schuaman Silver, who produces and continuously renews the surreal spoof with gags about the latest news. In 1975, needing more space, the show moved to its current venue, Club Fugazi. BBB combines zany comedy, wit, first-rate performers and costumers so excessive they are worthy of the city that perfected the art of drag. The Show's signature hats include an 8x12-foot San Francisco skyline, complete with operating cable car. BBB is named after *Beach Blanket Bingo*, a 1965 teen movie featuring Annette Funicello and Frankie Avalon bopping by the sea. Both boppers, as well as Queen Elizabeth, have attended a BBB performance.

Tributes to William A. Cook

Many Thanks from the AVIR

Interventional radiologists such as Barry Katzen, Matthew S. Johnson and Jim Benenati, join senior staff from Cook including John Brumleve, and Joe Roberts to pay tribute to the well-respected entrepreneur, who died in April this year.

The passing of Bill Cook is a major milestone in the field of interventional radiology and all of less-invasive medicine. Bill was a giant in our field, who was as passionate about the value and importance of interventional procedures and improving care as any practitioner in the field. More importantly, he supported the development of new technology when the pioneers of our field were creating new ideas about treating patients using image guidance, but had no tools or medical devices. His contributions to our field were recognized with Gold Medals from many professional societies including SIR and CIRSE, and he was awarded the Distinguished Career Recognition by ISET several years ago. No one practicing any aspect of interventional medicine and no patient undergoing an interventional procedure has not been affected and benefitted in some way from Bill's accomplishments in developing Cook Medical and all of the other components of Cook Group. Bill and his family (which included his entire company), were extremely generous to our field though providing philanthropic support, to physicians, institutions, and societies who were trying to improve patient care through less-invasive therapies or multidisciplinary collaborative efforts. Bill was a giant of a man, who lived an incredibly modest and generous life, and never forgot where he came from. Those of us who met and knew him will have memories which will keep us smiling, and feel fortunate to have known one of the iconic figures in medical history. For those of us who have not, your lives and those of our patients have been enriched by his innumerable accomplishments. We will all miss him greatly.

Barry Katzen
Baptist Cardiovascular Institute
Florida, USA

I met Bill Cook on his private jet about 16 years ago. He flew 15 or 20 Indiana University doctors and administrators and me, at that time a young interventional radiologist, fresh out of fellowship, down to Miami, to tour what is now the Baptist Cardiovascular Institute. Bill thought that Barry Katzen's practice was the paradigm of successful interdisciplinary cooperation, the perfect example of what could be possible for us. I did not know then, but know now, that unparalleled effort was typical of him. He was a tireless supporter of Indiana, of Indiana University, and of interventional radiology. He ran his company with integrity, and he ran it well. I know that he always held the best interests of interventional radiology in his heart, and I like to believe that he always had the best interests of Indiana there as well. It always seemed that way, anyway. All of us at Indiana University, in Indiana, and certainly in interventional radiology, will miss him.

Matthew S. Johnson
Indiana University School of Medicine, USA

Tribute to William A. Cook (con't)

Bill will be sorely missed by all those in interventional radiology. Perhaps those who did not know him suffer the greatest loss. Bill was an innovator, a pioneer and a genuine friend and supporter to all those who have participated in the explosive growth in endovascular care over the past forty years. The Cook name and brand will remain ingrained in the minds of endovascular physicians, not just because of the quality products produced over a generation but because of the trust and loyalty that Bill fostered in the interventional community.

James Benenati
Baptist Cardiovascular Institute Florida, USA

Bill Cook was as much a father figure to me as my own father was. Both were great men, but in very different ways. Bill Cook was an entrepreneur in its truest sense. He saw opportunities where other "business people" would not have thought to look. I can cite several medical procedures in which he, along with my colleagues, collaborated with physicians to develop new minimally invasive therapies. This in turn developed into hundreds of new medical procedures in-conjunction with over 42 different medical specialties. I can only guess how many patients we helped physicians and clinicians to treat over the past 48 years.

Another very important aspect is how he personally inspired each employee to strive to reach a higher level of performance than you thought possible. This always came with the statement of, "do the right thing" because a patient is to always benefit with the use of a product that we develop or manufacture.

A final thought from Bill relates to an evening two years ago when I attended a local Historical Society event in Bloomington, Indiana, which featured Bill as a speaker. He commented that, "people look at me as a great genius because I have 50 separate companies but look at myself, I do not just reflect on the 50 or so current companies that I have started, I remember the other 95 companies that did not make it." He dared to risk failure for the opportunity to achieve success. He was a generous, self-effacing man that made this world a better place to live in.

John Brumleve
Physician Societies Corporate Liaison
Cook Medical

When I began working for the company in 1979, Bill Cook took me out to shoot basketball followed by sharing a pizza. Little did I know that this man was creating what would become the largest private medical device company in the world. Thinking back on that night, I can see the uncommon man with the common touch which was part of everything he did. His commitment to every patient, physician, employee and every member of the international community's he touched was a consistency running through his life's work. The last time I saw him he was eating lunch in the company cafeteria surrounded by people who had become part of his dream. That is how I always will remember him.

Joe Roberts
Vice President of Corporate Development
Cook Medical

In Memoriam

David S. Douthett, RT(R)(CV), Editor

Dr. Hawkins showed us things that we would have never imagined. Thanks Doc for all you did and left for us in the world of Interventional Medicine.

Dr. Irvin Franklin "Dick" Hawkins, Jr., MD, Professor of Radiology and Surgery, passed away suddenly on June 8, 2011. He was a longtime resident of Micanopy and Gainesville, Florida. He also lived in Naples, Florida.

Dr. Hawkins was born October 9, 1936, in Baltimore, Maryland. His parents preceded him in death, Irvin F. Hawkins, Sr., and Dorothy Hawkins. He is survived by, the love of his life, wife, Kitty Stewart Hawkins, sister, Janet Terry and husband Peter. He leaves his beloved children, Mark Hawkins, Jeff Hawkins and wife Bonnie, Kim Kazman and husband John. Their mother, Mrs. Jean Wilson and husband Hal, survives her former husband. His step children are Sydney Mading, and husband Ian, and Delaney Stewart. His grandchildren are Kristie, and husband Bryan Vande Walker, Karrie and fiancé Jorge Menendez, Kaitlynn, Megan, Stephanie, Natalie, Sara, Scott, and Cash.

Dr. Hawkins received a Bachelor of Science at the University of Maryland in 1958. His Medical Degree was from the University of Maryland, in 1962. He then completed an internship at the prestigious Mercy Hospital in San Diego, California. He was a Captain in the United States Air Force from 1963-1965. He completed his residency in Diagnostic Radiology at Ohio State University from 1965-1968.

Dr Hawkins began his career at the University of Florida, College of Medicine in 1968, as the NIH Fellow and Special Trainee in Cardiovascular Radiology and was the advanced to Chief of Interventional Radiology in 1969, a position he held for 30 years. He advanced to professor of Radiology in 1976, as well as professor of Surgery in 1981.

Dr. Hawkins was one of the Elite Founders of Interventional Radiology. Dick is renowned throughout the world for his accomplishments in pioneering techniques and innovations. His goal has been to improve patient care through reduced complication rates. He has received a Lifetime Achievement Award as well as the Gold Medal from His Societies. His passion for teaching, and his special educational style, left fond memories on all residents, fellows and staff. He shared businesses in medical devices with his children, and his close friend Eamonn Hobbs. Dick enjoyed many extracurricular activities. He was a former nationally ranked water skier, and continued to ski until the time of death. He loved traveling with his wife, scuba diving, playing the piano, singing, and playing racquetball with his friends.

2011 VA AVIR Symposium for Vascular-Interventional Radiographers and Nurses | October 8 , 2011 | Great Wolf Lodge

Please join the Virginia AVIR for a fun-filled and informative Saturday at the Great Wolf Lodge to discuss new procedures and concepts for Vascular interventions.

Our program will provide up to 8.0 CEU's as well as breakfast, lunch and access to vendors with their latest product demonstrations.

Great Wolf Lodge | 549 East Rochambeau Drive | Williamsburg, VA 23188

MEETINGS AROUND THE WORLD

MEETING	FOCUS	WEBSITE	LOCATION	DATE
Complex Cardiovascular Catheter Therapeutics	Peripheral/ Cardiac C3	www.c3conference.net	Orlando, FL	June 26–30, 2011
PICS & AICS 2011		picsymposium.com	Westin Waterfront Boston, MA	July 24–27 2011
Chicago EndoVascular Conference (CVC)		cvcpvd.com	Swiss Hotel Chicago, IL	July 28–30, 2011
SNIS 8th Annual Meeting		snisonline.org	Colorado Springs, CO	July 25–28, 2011
Solaci ' 11		solacicongress.com	Santiago, Chile	August 3–5 2011
Japan Endovascular Symposium (JES)		japanendovascular.com	Tokyo, Japan	August 25–27, 2011
Association for Medical Imaging Management		arrt.org	Dallas, TX	August 14–17 2011
Midwestern Vascular 2011 (MVSS)		vascularweb.org	Chicago, IL	September 15–17, 2011
38th Annual New England Society for Vascular Surgery		vascularweb.org	Westin Providence, RI	September 16–18 2011
Diabetic Limb Salvage		disconference.com	JW Marriott Washington, DC	September 15–17, 2011
Cardiovascular and Interventional Radiological Society of Europe (CIRSE)		cirse.org	Valencia, Spain	October 2–6 2011
40th Annual South East Angiograpic and Interventional Society Conference (SEAS)		SIR.org	Napa, CA	October 15–19, 2011
CiDA (Controversies in Dialysis Access)		dialysiscontroversies.org	Washington, DC	October 10–11 2011
Catheter Lysis of Thromboembolic Stroke (CLOTS)		sirweb.org/meetings/clots.shtm/	Dallas, TX	October 23–27 2011
VIVA 2011		vivapvd.com	Wynn Las Vegas, NV	October 18–21 2011
All That Jazz		AllThatJazz.org	New Orleans, LA	October 31–Nov 2, 2011
Transcather Cardiovascular Therapeutics		tctconference.com	San Francisco, CA	November 7–11 2011
Radiological Society of North America (RSNA)		rsna.org	Chicago, IL	November 27 – Dec 2, 2011
2012				
International Symposium on Endovascular Therapy (ISET)		ISET.ORG	Fontainebleau Hotel Miami Beach, FL	January 15–19 2012
36th SIR Annual Meeting (SIR)		SIR.org	San Francisco, CA	March 24–29, 2012
21st Annual AVIR Scientific Meeting		avir.org	Chicago, IL	March 22–29, 2012

WHAT IS AVIR?

The Association of Vascular and Interventional Radiographers (AVIR) is the national organization of healthcare professionals within Vascular and Interventional Radiology and involved in standard of care issues, continuing education and related concerns.

Who Can Become a Member of AVIR?

ACTIVE | DUES $75 PER YEAR
Radiographers with a primary focus in Vascular and/or Interventional Radiology. Active members must be ARRT registered or have Canadian equivalent. Submit copy of certification with application.

ASSOCIATE | DUES ARE $65 PER YEAR
Related healthcare professionals working with or having a special interest in Vascular and/or Interventional Radiology, including Nurses, Medical/Cardiovascular Technologies and Commercial Company Representatives.

STUDENT | DUES ARE $45 PER YEAR
Students in certified programs for Vascular and/or Interventional Radiographers.

INTERNATIONAL | DUES ARE $85 PER YEAR
Healthcare professionals working or having special interest in CIT and who reside outside of the United States and Canada. This category includes, but is not limited to, medical technologists, radiologic technologists, registered nurses, licensed practical nurses, Physicians and commercial company representatives.

All memberships are renewable annually each January.

Why Is Joining AVIR Important?

The AVIRis dedicated to you and is a powerful advocate for the special interest and concerns of healthcare professionals working in Vascular and Interventional Radiology. We acknowledge the importance of continuing education, establishing high standards of practice and care, certifying Vascular and/or Interventional Radiographers, and establishing a nationwide network for obtaining information and/or employment opportunities.

What Opportunities Does AVIR Offer?

- Professional growth
- Society of Interventional Radiographers (SIR) Annual Meeting
- Exchange of information and ideas
- AVIR Annual Meeting
- Continuing education opportunities
- Quarterly newsletter
- Local chapter involvement
- National membership directory

The Association of Vascular and Interventional Radiographers (AVIR)

12100 Sunset Hills Road
Suite 130
Reston, VA 20190

www.avir.org

JOIN AVIR TODAY
and become an influential force in the future of health care policies!

ASSOCIATION OF VASCULAR AND/OR INTERVENTIONAL RADIOGRAPHERS
12100 Sunset Hills Road, Suite 130, Reston, Virginia 20190 | 703.234.4055 | Fax 703.435.4390 | Email: info@avir.org

MEMBERSHIP APPLICATION

FULL PAYMENT MUST ACCOMPANY COMPLETED APPLICATION FORM

Membership Category — Select only one | Please print or type

❍**ACTIVE** — $ 75/yr* ❍**CLINICAL ASSOCIATE** — $ 65/yr ❍**CORPORATE ASSOCIATE** — $ 65/yr

❍**STUDENT** — $ 45/yr ❍**INTERNATIONAL** — $85/yr *ACTIVE – *Submit ARRT certification or Canadian equivalent*

NAME ❍Mr ❍Mrs ❍Ms FIRST M.I. LAST GENERATION *(JR., SR., II, III)*

CREDENTIALS LICENSURE

DEGREE/S REGISTRATION/S

Preferred Address ❍Home ❍Work

HOME STREET

CITY STATE ZIP

PHONE FAX EMAIL *(for official avir business only)*

WORK INSTITUTION NAME DEPT.

STREET *(include department, room number, mail stop codes, etc., if appropriate)*

CITY STATE ZIP

PHONE FAX EMAIL EMAIL *(for official avir business only)*

Length of Time as Tech Area of Expertise: _____

Size of Institution (*# of beds*): _____
_____❍Private _____❍Academic

Number of Exams Performed at this Institution: _____
_____❍Vascular _____❍Interventional

Are You a Member of: ARRT ❍Yes ❍No **ASRT** ❍ Yes ❍No
(*If YES, please attach photocopy of membership card/s)*

Other Professional Organizations of Which You Are a Member:

_____

_____

_____

_____

Related Interests (*CQI, Teaching, Publishing, etc.*):

_____

_____

Payment Information: ❍Check Enclosed
Credit Card: ❍AmEx ❍MasterCard ❍Visa

_____
ACCT NUMBER

_____ / _____ / _____
EXP DATE

_____
NAME ON CARD

_____
SIGNATURE

STUDENT MEMBERS ONLY

_____
DIRECTOR

_____
PROGRAM ADDRESS

_____
CITY STATE ZIP

_____
PHONE

07.2010