Association of Vascular and Interventional Radiographers

Interventional Informer

President's Message

Jeff Kins, RT(R)(VI)

Ah, springtime! A time for reawakening; for rebirth; a time to re-energize. A time to shake off the doldrums of winter. A time for renewal – of your continuing education credits, perhaps? If this is the case, you're in luck. The AVIR is offering a wide range of credits on both the east and west coasts in addition to the credits available to our members online.

First and foremost, there is the 2010 AVIR Annual Scientific Meeting being held in Tampa, FL from March 13-17. Once again we will be holding this in conjunction with the Society of Interventional Radiology's annual meeting, giving our members and attendees access to the latest innovations and brightest minds in the IR field. This also marks a milestone for our organization, as this will be the first time the AVIR will be evaluating and approving our own category A CE's for submission to ARRT. A+ credits will also be approved through the ASRT, as has been the case in the past.

In addition to our annual meeting in Tampa, for the first time AVIR will partner with the Global Embolization Symposium and Technologies (GEST) meeting, which will take place for the first time in North America from May 6-9 in San Francisco, CA. The GEST meeting is the original embolization meeting which focuses upon a truly global and unique educational experience. It delivers the 'total' educational experience, by merging signature live demonstrations, master classes, hands-on attendee events, in-depth technical sessions, evidence-based review, satellite symposia, research presentations, and case-based teaching. This is a unique opportunity for AVIR members to attend sessions side-by-side with physicians and other health care professionals from around the world while earning up to 23 CE's through AVIR.

On another note, I would like to introduce the 2010-11 AVIR Board of Directors. As I move into the position of Immediate Past President, Jaime Nodolf RT(R) of the University of Wisconsin Medical Center will be taking over as President. Melissa Post MBRT(R)(CV)FAVIR, also from University of Wisconsin Medical Center and currently serving

Continued

Winter 2010

Interventional Informer Editor:
David S. Douthett, RT(R)(CV)

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President's Message

Continued

as our Director-at-Large, will assume the duties of Vice-President. Bill Greear, MHA MBA RT(R)(CV) will begin his second year as Secretary Treasurer. And newcomers to the Board, Tony Walton RT(R) from the Medical College of Virginia Hospital in Richmond, VA, and Dana Bridges, Director of Sales for SurgPro LLC will be serving as Director-at-Large and Associate Representative respectively.

I look forward to serving with the new Board of Directors, and I'm certain Jaime will lead this organization to even greater heights and accomplishments.

In addition to those I have already mentioned, I would like to recognize the rest of our current Board: Anita Bell RT(R) RCIS FAVIR(Immediate Past President), Leona Benson RT(R)(CV) FAVIR(Website Chair), Dave Douthett RT(R)(CV) (Publications Chair), Connie Groves RN (Associate Representative), Karen Finnegan MS RT(R)(CV) FAVIR (Past Presidents Chair), Joni Schott MBA RT(R)(CT) and Greg Phillips BS RT(R)(CV) (Program Co-Chairs). I would like to thank them for all of their help and support throughout this past year.

CEUs Are Our Back Bone
Do Not Forget the Changes

CE Credit for "A" Only, No More "B"

All 24 CE credits required in a biennium or for CE probation must be approved by a RCEEM and designated as Category A.

Category B credits, which have been allowed since the CE program began in 1995, will not be counted for ARRT CE requirements if they are completed on or after January 1, 2008.

Category B credits meet all of the criteria for Category A activities except they have not been approved by a RCEEM, ARRT allowed Category B credits initially to assure that sufficient opportunities existed for R.T.s to earn 24 credits each biennium.

Today's wealth of CE opportunities eliminates the need for Category B credits.

Laughter Is the Best Medicine

A patient was admitted to the Emergency Department because her Non-tunneled Dialysis Catheter was removed, and needed to be replaced by the IR department. In the chart was a copy of the police report. It quoted the patient saying: "I was at a gas station tonight and a lady came up to me and pulled out my catheter and then drove off!"

This man looks *nothing* like a 30 year old woman.

On a busy day in a Louisiana Hospital, we had a new admission into ICU from the ER. She was admitted for weakness and pain of the lower extremity. She was 150 Kilograms and little short of breath. On examination in the morning by the nurse on duty, they noticed that her ECG did not look quite normal. While checking leads on the left side a biscuit came rolling out from under her left breast. I corrected the lead placement and handed it back to her. The patient took the biscuit and put it back under her breast. I had to leave the room to compose myself. I returned to her room. I couldn't help but ask, " why do you put that biscuit under your breast?" She went on to explain that in this hot weather, she puts a fresh biscuit each day under her breast to sop up her sweat. There you have it, necessity.

Be Prepared - Interventional Radiology Disaster Planning

Concetta R L Groves, RN, BSN and Karen Finnegan, MS, RT (R) (CV), FAVIR

For what it is worth, no matter how hard we try, there will always be things that we have no control over. So, when expecting the unexpected, the best thing to do is "Be Prepared!"

Every hospital or medical center should have its own Disaster Plan, covering not only hospital-wide planning and preparation, but also unit level planning and readiness. All hospital staff are considered essential personnel, so in any internal/external emergency, how does the IR department conduct itself for "Business as Usual" in the midst of hurricanes, tornadoes, snow storms, earthquakes, H1N1, and mass disasters?

Responding to any emergency is dictated by several factors:

1. The type of emergency – internal or external
2. The extent of disruption to facility operations
3. The duration of disruption of services

When looking at the weather or environmental emergencies, the medical center/hospital will initiate an "Internal/External Emergency" which would be announced throughout the medical center. Hospital managers/supervisors activate their unit specific emergency/disaster plans, and designated charge personnel will coordinate efforts to account for all staff, patients, and visitors. The safety of every person entering and leaving the hospital is the primary goal on any given day, and this is heightened during any disaster event. Supply departments within the hospital will ensure adequate inventory for a minimum duration of three days. Food, linen, scrubs, disposables, medical supplies, and pharmaceuticals are a few items that are necessary for the hospital to continue functioning.

The IR department individualizes departmental emergency plans that are used in conjunction with the hospital-based emergency plan:

- Staff call list – An IR staff call-down is initiated to see how many staff members are available. This list consists of Radiologists, technologists, nurses, and receptionists.
- Personnel on duty report to the charge/manager for their assignments.
- Personnel cannot leave without permission from their supervisor.
- Phones and paging are restricted to essential business during the emergency.

Interventional Radiology has the responsibility to continue providing patient services. The staff expectations include:

- Reporting to work as scheduled
- Open communication with the "Designated IR Operations" Charge
- Having sufficient staff to run the department adequately
- Taking inventory to insure that products needed for Interventional procedures are in adequate supply
- Preparing your home and family for the possibility of not leaving the hospital for an undetermined period of time (i.e., alternative care for family members and/or pets)
- If you are not scheduled to work, would you be available in an emergency situation
- Returning to work at your scheduled time (if you are able to leave the hospital)
- Evaluating patients for rescheduling their appointment; will they be able to safely return home (outpatient)?
- Planning how to best utilize space in the IR department

As health care workers, we are dedicated to delivering safe care to patients on a daily basis. In any emergency we may be given roles outside of our current job functions, which may be necessary for continuing operations in the hospital as well as the IR department. Through teamwork and focusing on our delivery of care under "extenuating" circumstances, we strive to support each other, and all staff members, to keep the IR department and medical center operations moving smoothly and safely. Having a Disaster Plan in place will help facilitate these expectations.

Chapter Happenings

Melissa Post, MBRT (R)(CV), FAVIR

Are you looking for ways to develop yourself in the career you love? The AVIR offers a number of growth opportunities.

Participate in one (or more) of the AVIR standing committees:

Nominating Committee
Prepares the ballot for the general election.

Ethics/Judicial Committee
Considers any ethical or judicial question regarding the policies of the association or Local Chapters or actions of the members of the Association.

Education Committee
Responsible for policies concerning continuing education programs; for reviewing and approving the educational program of meetings/seminars endorsed by the national Association; and for assisting other organizations, including local chapters, in planning the content of educational meetings/seminars in which the Association will be endorsing (e.g. Regional AVIR Meetings).

Fellowship Committee
Reviews applications for admission as a Fellow of the AVIR and elects as Fellows those applicants who satisfy the relevant criteria. Fellowship Committee members are required to have AVIR Fellowship status.

Award of Excellence Committee
Reviews nominations for the Award of Excellence and elects the most qualified nominee who satisfies the relevant criteria. Award of Excellence committee members shall be recipient's of the Award of Excellence.

Membership Committee
Reviews membership concerns and supervises membership recruitment efforts. Committee Members should include the Associate Member Representative.

Finance Committee
Seeks contributions from outside sources to fund the projects of the Association.

Annual Program Committee
Plans and conducts the Annual Meeting of the Association.

Publications Committee
Develops and implements policies and guidelines regarding the relationship between the Association and publishers of professional journals and other publications in the field of Cardiovascular and Interventional Radiology.
The committee oversees the newsletter and other publications of the Association.

Associate Members Committee
Reviews associate member concerns and supervises associate membership recruitment. Committee members shall have associate membership status.

Web Site Committee
Reviews and recommends to the AVIR Board content to be placed on AVIR Web site.

Chapter Committee
Members are known as Chapter Liaisons. Each Chapter Liaison is assigned a regional area where they shall be responsible for helping new Chapters get started or helping existing chapters with problems and/or questions. This committee is chaired by the Director-at-Large. All local chapter liaisons must submit a bi-monthly report on the activities for the past two months and future activities of their assigned chapters.

…or Check out and get involved in your local Chapter. Here are their latest reports:

California
Los Angeles AVIR
Jeanne M. Rhoten RT(R) (CV)
951-845-7522
jrslife@aol.com

No new news reported at this time.

Maryland
Baltimore AVIR (BIRT)
Sharon Misler RT(R) (CV) (FAVIR)
410-605-7400 - work
angiosm@aol.com

BIRT recently held a weekend seminar offering 16 CEUs.

North Carolina
North Carolina AVIR
Diane Koenigshofer BS RT(R)
919-966-1820-work
dianek@nc.rr.com

NCAVIR is having a one day seminar offering 8 CEUs. This will be held on February 27 at the Embassy Suites in Concord, NC. Registration for AVIR members is $40. Sign up today!

South Carolina
SCAVIR
John Furtek
843-813-6446
jfurtek@comcast.net

SET is offering a quality education at an affordable price. Check this program out. Because the meeting is focused on team learning—Physicians, (yes, that is pleural consisting of Surgeons, Cardiologists and Radiologists) nurses and technologists will come away with something unforgettable. This is scheduled on February 18-29th at the Sanctuary Resort on Kiawah Island. For more details go to http://www.setmeeting.org/ or call John.

Texas
Lone Star State
Alan Seeley
830 258-7357
aseeley@petersonrmc.com

No new news reported at this time.

Wisconsin
Southeast Wisconsin AVIR
Julie Malkowski RT(R) (CV)
414-647-7488-work
julie.malkowski@aurora.org

The SEW AVIR is hosting an all day seminar on April 10 at the Clarion Airport Hotel in Milwaukee, WI. This is a great opportunity to network and gain 8CEUs while having fun.

Virginia
Virginia AVIR
Rita Howard RT(R) (CV)
757-594-2892-work
Rhoward709@aol.com

The Virginia Chapter of the AVIR last seminar was held Oct 9 2009 at the The Great Wolf Lodge in Williamsburg VA. We had 9 speaker which were physcians, nurses and rad tech.

The participants received 8 ceu that was approved by the arrt. We had OVER 75 in attendance with 15 new members. This annual event is our main event for the year and this last one turned out to be very rewarding. We are planning to have our 8th annual meeting this coming fall at the GREAT WOLF LODGE in Williamsburg VA.

The Virginia Chapter is currently working on a one day CIT Review course for any RT looking to sit for their VI this year as CQ2011 becomes a reality. Other information is in this issue or you can contact me.

2010 Meetings Around the World

Meeting/Society	Acronyms	Website	Dates	Location
Association of Vascular Interventional Radiographers	AVIR	www.avir.org	March 13-17, 2010	Tampa, FL
Society of Interventional Radiology	SIR	http://www.sirweb.org/	March 13-17, 2010	Tampa, FL
Vascular & Endovascular Controversies	Xcharing Cross	www.cxsymposium.com	April 10-13, 2010	London UK
Angioplasty Summit: TCT Asia Pacific 2010	TCTAP2010	www.summit-tctap.com	April 28-30, 2010	Seol, Korea
International Vein Congress: Office-based Venous Surgery	IVC	www.ivcmiami.com	May 13–15, 2010	Miami Beach, FL
ASNR 48th Annual Meeting	ASNR	www.asnr.org/2010	May 15–20, 2010	Boston, MA
ALL THAT JAZZ	JAZZ	www.allthatjazz.org	May 21 - 23, 2010	New Orleans, LA
11th Annual New Cardiovascular Horizons		www.newcvhorizons.com	June 2–5, 2010	New Orleans, LA
Multidisciplenary European Endovascular Therapy	MEET 2010	www.meetcongress.com	June 17–19,2010	Marseille, France
Society of Vascular Surgery	SVS	www.vascularweb.org	June 10-14, 2010	Boston, MA
PICS & AICS 2010	PICS	picsymposium.com	July 18–21,2010	Chicago, IL
Latest Advances in interVentional Techniques	LAVA	http://radiologycme.stanford.edu/	July 26-29, 2010	Maui, Hawaii
SNIS 7th Annual Meeting	SNIS	www.snisonline.org	July 26–30, 2010	Carlsbad, CA

Virginia AVIR Presents:

Vascular Interventional Registry Review

Mark your Calendars!
May 1, 2010
VCUHS Alumni House
Paul Gross Conference Center

Prep Lectures designed for preparing for the registry. Everything you need to know and how to prepare, including test breakdown, physics review, pharmacology, anatomy, pathology and procedures.

8 ECU's applied for. Lunch Provided.

For any additional information, please contact Tony Walton at tonywalton.avir@gmail.com or 804-244-1792.

Va AVIR Chapter Registry Review Notice

There has been an increase in the number of interested individuals seeking advanced certification through the ARRT, specifically in the VI discipline. To promote the advances in our field of practice and to obtain certification before the 2011 "grandfathering" deadline, the Virginia Chapter of the AVIR will be holding a one day seminar covering the essentials in taking the advanced certification. The date is May,1st, 2010, and will be located at the Alumni Hall around the Virginia Commonwealth University Medical College campus. (VCUMC)

Please RSVP with your interest at this time, a conference schedule and topics/speakers will be released soon. If you know of any other technologist's or Interventional Radiology Departments in the Mid Atlantic area, that would be interested please pass this on and help promote our specialty. Thanks for your continued support.

William "Tony" Walton RT (R) ARRT
VCU Medical Center
Interventional Radiology
tonywalton.avir@gmail.com

Award of Excellence Winner

Stephen Haug

Every year the AVIR awards one outstanding Interventional Radiographer the Award of Excellence. This award is given to that special technologist that continually goes the extra mile and maintains a high level of competency and professionalism with their patients and families, peers, physicians, and hospital staff. The prestige of this award is that fact that the recipient is nominated by their peer.

This year the Award of Excellence goes to **Stephen Haug**. Steve works for the University of Virginia Health Systems. While trying to balance between caring for a large family and work, he is still able to keep his passion for the field of Interventional Radiology. He is involved in community outreach to help attract high school students to the field of radiology, leads recruiting trips and seminars to recruit IR students to the UVA program, and is helping put together a 6 hour registry review with several others from the local Virginia AVIR chapter. One of his coworkers had this to say, "Steve treats every patient with the utmost respect and compassion. He is the most passionate tech I've ever encountered; his skills are superb, physicians will listen to his suggestions because of his well thought out suggestions and respectful manner."

Steve will accept his award in Tampa, FL at the AVIR Annual meeting on Monday, March 15, 2010 at 10:00am. Congratulations Steve!!!

AVIR Fellows Award Winner: Juan Mancera

What is an AVIR Fellow? Like many organizations we have an established fellowship category for members that have made significant strides in the Interventional field and organization. They have dedicated themselves to being leaders, educators, authors, and committee members striving for quality and improvement in the field of interventional radiology.

The Fellows award is based on a point system. Points are given for Personal Qualifications (education and experience), Contributions to the AVIR (national and local chapters), and Contributions to the Profession (other than AVIR); once the required points are met an application can be sent to the Fellowship Committee for review.

This year Juan Mancera will receive the Fellows Award. He will be presented his award at the AVIR Annual Meeting in Tampa, FL on Monday, March 15, 2010 at 10:00 am.

Juan received his Associates Degree for Radiologic Technology from Mt San Antonio College in 1998 and his Bachelor of Science in Radiologic Sciences from Florida College Health Sciences in 2005. Juan has worked in the Special Procedures Department at USC University Hospital since 2000. Through the years he has been actively involved with the AVIR on the national and local levels, is a member of multiple allied health care organizations, given lectures and written articles pertaining to the Interventional field, and has attended multiple vascular and interventional conferences. Congratulations Juan!!

Letter to the Editor

David Douthett, RT(R)(CV)

The director of your lab is a key opinion leader for one of the stent companies that are used in your lab. Does this mean you cannot or should not buy this stent to use in the lab? Does this mean the doctor cannot perform a procedure with this stent because he has a perceived conflict of interest? Of course not, but it is important to understand and work with our industry and the conflicts of interest which inevitably occur in most businesses, including the business of interventional medicine.

Let's evaluate a few things. Easiest way is to start with some questions. So shall we start with how is your relationship between the industry and lab personnel?

In the last few years, major universities and hospital systems have limited or prohibited relationships of any kind with industry to demonstrate and avoid undue industry influence on patient care. While this process has now moved to the far side of the reasonable spectrum, prohibiting minor amenities like donuts and coffee for the lab, with supposedly no doubt that the industry presence influences medical decisions. Simple proof is the observation that a company spends millions supporting its product representatives in the field. However, in many ways, the lab and our patients remain the beneficiaries of this corporate expense.

There is a need for representatives to bring the new products into the lab and teach us how and why these products work. The decision to use the product is always reserved for the physician in charge of the patient's care. Every lab has relationships with their industry suppliers. The industry suppliers, of course, depend on the lab to use their products. The representative thus has two goals: 1) to promote sales, and more importantly, 2) to direct the appropriate (and of course identify inappropriate) use of their product for the patient's best care. These two goals should not be mutually exclusive. Good representatives should always advocate appropriate product selection (to the best of their knowledge) to obtain the best outcome for the situation. When the "xyz" stent representative is asked the question, should I use this product, the "xyz" stent, in an aneurismal vessel when the "abc" stent is known to be better, the answer should be a clear "no," despite the fact that the representative would lose a sale. Experience has most representatives have high integrity and understand that the needs of patients trump sales. If representatives are not performing in this capacity, a career change is in order.

While much has been said about the use and abuse of industry as advocates for clinical use of their products, sometimes with limited evidence of benefit, the lab must balance the convenience of having a representative around during procedures against the possible undue influence at the expense of best clinical practices.

Next question will be how much influence does a representative have in the lab?

A lot if you believe in an abstract presented at TCT; however it was focused on cath lab and coronary artery Stenting only. Titled "Does the Presence of a Corporate Representative Affect Choice of Coronary Stent?" by HoHai Van et al, examined the influence of representatives from stent manufacturers on stent selection. It came forward to demonstrate that the presence of stent manufacturer representatives significantly increases stent utilization from their respective companies. It is part of human nature and should be no surprise that the presence of a representative with whom the staff and the physicians have favorable relationship would influence the selection of equipment, given all other clinical factors being equal.

However, this is in the coronaries where you are working on two vessels with clinical variance at a minimum.

In the periphery where there are miles of more vessels to be treated all with a different clinical variance and special conditions appear, the use of specific appropriate device should always be the first consideration for the clinical need of the patient with second or distant consideration for the representative present.

How about should industry representatives be banned from the interventional lab?

This question is very difficult. Personally, I do not believe this should be the case. I feel the representatives bring new information, new products, discussions of how things are done in other labs, the how-what and where to use the product, and indirect communications among labs in the community about who is doing what. However, some labs find the conflict of having representatives in the lab during their procedure too great, and have gone so far as to restrict access to interventional suites, staff and physicians during working hours in the lab. Does this ban from the lab really reduce the unwanted influence? It certainly changes the attitude of the lab personnel to their industry partners for the worse. They are visitors versus partners now.

Should the representatives participate in the procedures in any other way than in a "hands off" advisory capacity?

Probably, the answer is "no." No non-hospital sanctioned person should ever be permitted to touch any equipment related to the patient care. However, this is clearly not the case for many of the Clinical representatives. Like the pacemaker representatives who are requested to program and check the pacemaker devices, and perhaps even assist in the implantation of AICDs, their specific hands-on participation is a big question mark. The AAA representative is directly involved with measuring and positioning of the device prior to and while in the procedure. The Atherectomy representatives showing and explaining the fundamentals and pieces of their device while the cases are going on. There are many others and especially when we start getting into the neuro interventional procedure. But let's face it, in terms of good practices, if an error should occur due to their activity, the brunt of criticism will fall on hospital team members and not directly on the 'hands-on' representative, who is not part of catheterization team. The liability belongs to the hospital. But not sure how you cannot have them involved.

Should manufactures' representatives provide lunch for the lab staff?

Those days appear to be over in many places. Because of the perception and perhaps reality of undue influence, major universities and health delivery systems have prohibited "gifts" of any kind to the employees of the institution. Inducements like lunch, innocuous as it may seem, can bias the users' selection of equipment. However, these important industry/ lab interactions, in the right setting, can provide valuable interactions and educational opportunities. Our medical industry can and should sponsor educational symposia, free of bias presentations, so that the members of the lab team can be educated, physicians can receive information on latest procedures and techniques, and best care can be provided through this knowledge. Industry relationships should not be penalized or demonized, but conflicts of interest should be acknowledged and identified. Major professional societies have established guidelines with regard to both participation in studies, holding of equity, disclosure of relationships when performing procedures, and use of appropriate vendors with whom the physicians and labs have relationships.

So, overall, the evolution of the important contributions of the medical industry to the care of our patients has been highly beneficial, if not exceptional. The role of the manufacturers' representatives in assisting the lab staff and physicians should lead to the use of the best techniques for the best outcomes with the least bias at the most reasonable cost for our healthcare system.

ATTENTION ALL WRITERS

The Interventional Informer is offering $100 to the best article. This is awarded four (4) times a year. The articles should be originals. No limit in size, but they must pertain to Interventional Radiology. Just submit your article with name and address for the AVIR Board of Directors to review.

Best of luck!

EDITORS AWARD WINNER

AVIR would like to acknowledge the following writer for their publication in the past issue.

DEBBIE SEPANSKI

for her article on

"Reaching Into the Future: IR Today and Tomorrow"

Newsletter Advertising Rates and Production Schedule

Type	Dimensions *Inches*	Ad Rate
Classified Ad	1 column inch	$ 125.00
1/8 page black/white ad	2¼ x 3¾	$ 225.00
1/4 page black/white ad	4½ x 3¾	$ 425.00
1/2 page black/white ad	4½ x 7½	$ 800.00
Full page black/white ad	9 x 7½	$ 1,500.00
Full page color ad	9 x 7½	$ 2,000.00

Full payment must accompany ad order.

Issue	Close Date	Mail Date
2010 Spring	April 20, 2010	May 20, 2010
2010 Summer	July 20, 2010	August 20, 2010
2010 Fall	October 20, 2010	November 20, 2010
2011 Winter	January 20, 2011	February 20, 2011

Welcome to GEST 2010

The 4th Annual Global Embolization Symposium and Technologies (GEST) Meeting is coming stateside to California in 2010.

After three successful years in Europe, GEST, the ORIGINAL AND LARGEST EMBOLIZATION MEETING, is bringing its interactive educational experience to San Francisco, a city renowned for its physical beauty, cultural resources and excellent facilities. We are proud to be hosting the meeting in San Francisco, one of the world's most popular international destinations. The city is famous for its gorgeous scenery and landmarks including the Golden Gate Bridge, Fisherman's Wharf, cable cars, Victorian architecture, diverse city neighborhoods and world-class restaurants. Our Gala evening event will take place within the San Francisco Exploratorium at the Palace of Fine Arts, arguably one of the world's best interactive science museums.

GEST 2010 will build upon the success of past years' events, merging signature live demonstrations, Master Classes, Hands-On attendee events, in-depth technical sessions, evidence-based reviews, satellite symposia, research presentations and case-based teaching. Covering all disciplines in embolization, GEST San Francisco aims to provide the highest level of scientific and technical education about the use of new materials and devices, their results, relevance for patient care and imaging. This year's congress will once again feature a large international expert faculty, from all corners of the world, which is an integral part of delivering the global and unique educational GEST experience.

We look forward to seeing you in San Francisco, May 6-9.

The GEST 2010 Team

Directors Jafar Golzarian, Ziv J Haskal and Marc Sapoval

NOT TO BE MISSED - MAY 6-9, 2010



REGISTER NOW!

The GEST Directors:
Jafar Golzarian, US; Ziv J Haskal, US and Marc Sapoval, FR

GEST 2010 Scientific Committee: Yasuaki Arai, JP; Jose I Bilbao, ES; James P Burnes, AU; Mike Darcy, US; Thierry de Baere, FR; John Kaufman, US; Keigo Osuga, JP; Sang Joon Park, KS

NEW FEATURES FOR 2010 will include the Hands-On Village, Ablation Alley and much more. Full registration, abstract/case submission and hotel information available on www.gestweb.org

GEST 2010

Global Embolization Symposium and Technologies

The World's Largest Embolization Meeting
www.gestweb.org
May 6-9, 2010 | San Francisco

SOCIETY OF INTERVENTIONAL RADIOLOGY
Enhanced care through advanced technology

AVIR

AVIR attendees can earn
24 Category A credits

GEST 2010 and SIR Accredidation

This activity has been planned and implemented in accordance with the Essentials and Standards of the Accreditation Council for Continuing Medical Education (ACCME) through joint sponsorship of the Society of Interventional Radiology (SIR) and the Global Embolization Symposium and Technologies Meeting (GEST).

The Society of Interventional Radiology is accredited by the ACCME to provide continuing medical education for physicians. The Society of Interventional Radiology designates this educational activity for a maximum of 25.00 AMA PRA Category 1 Credits™. Physicians should only claim credit commensurate with the extent of their participation in the activity.

GEST 2010 Nurses and Technologists Delegate Registration

GEST 2010 is pleased to be able to offer technicians and nurses the opportunity to join GEST San Francisco and earn CE credits. Participation in GEST includes networking opportunities, presence at original research presentations and original live demonstrations given by a renowned international faculty and more. Content and credit at GEST are specifically directed to radiological technologists, physician assistants, interventional technologists and technicians.

GEST 2010 and the Association of Vascular and Interventional Radiographers (AVIR) are partnering to offer a special rate of registration to nurses and technologists, available as follows:

AVIR Members: $375
Non AVIR Member*: $500

Online registration available at www.gestweb.org

*Please note that the non member registration fee is inclusive of 2010 AVIR membership.

Annual AVIR Meeting | Tampa, FL | March 13-17, 2010

IR Innovation - Something for Everyone!

Joni Schott, MBA, RT (R) (CT), FAVIR
2010 AVIR Program Co-chair

The AVIR Annual Meeting is right around the corner. The theme for the meeting this year is IR Innovation. The program committee and the Board of Directors have done a phenomenal job planning the Tampa meeting. There is truly something of interest for everyone. We feel confident that you will enjoy listening to the leading edge cryoablation, RF ablation and chemoembolization techniques, stroke and carotid treatments including trauma, diseases, and stenosis as well as the latest MRA and CTA imaging techniques, venous lectures including IVC filters, dialysis access, central venous access and the latest techniques for treating varicose veins. The last day of the conference includes AAA treatments, renal artery interventions, UFE, and a look at Interventional Radiology historically with the past, present and future of the field.

The meeting this year will be conducted from Saturday, March 13th through Wednesday, March 17th. Attendance on Thursday mornings has been very low in the past, so in an effort to contain costs for attendees and the organization, the decision was made to only schedule the program through Wednesday.

On Saturday, we have wide variety of workshops to chose from that include a PICC workshop, neurointerventional workshop, and a three hour registry review. During the program, there will be several symposiums offered during lunches, breaks, and at the end of the regularly schedules lectures.

Dr. Wayne Yakes will present this year's Gold Medal Lecture on Tuesday morning. Dr. Yakes has a prestigious reputation and has been a strong supporter of the AVIR. Dr. Brian Stainken will present a talk on treating and caring for oncology patients in Interventional Radiology. Eamonn Hobbs will be back by popular demand and enlighten the audience with an overview of the past, present and future of the Interventional Radiology field.

The goal this year was to design a program that would be interesting and stimulating for professionals that are both new to the field and those with years of experience.

The Tampa Marriott Waterside Hotel and Marina is a beautiful setting to host the annual meeting. The AVIR sessions are not scheduled at the conventional center this year due to space constraints. To learn more about the hotel, you can access their web site at http://www.marriott.com/hotels/travel/tpamc-tampa-marriott-water-side-hotel-and-marina/

The SIR exhibit hall and lecture halls is located directly across the street. This year, the AVIR will not participate in a joint meeting with ARIN on the opening day. ARIN will be hosting their meeting in the Marriott as well.

Networking is always an important component of the meeting. It's fun to greet friends at the SIR Opening Reception, as well as enjoying a cup of coffee or tea with other radiographers and interventional professionals. As always, we encourage attendance at the annual business meeting and chapter meeting.

AVIR will not be applying for nursing CEU's this year due to low usage in the past. All lectures will provide Category A ARRT credits for attendees.

It's always fun to support the vendors to see hands-on demonstrations of the latest devices and products. As always, box lunches are available daily for attendees in the exhibition hall.

Tampa is located in west central part of the state and is known for its beautiful weather and fun opportunities. Activities include the beaches, shelling, fishing, and if you travel with your family, you may chose to take a couple of extra days and take advantage of Disney World, which is just a short drive away. Recommended sites include Ybor City, which is known as Tampa's Latin Quarter and yields an exotic, eclectic mixture of sounds, aromas, flavor foods, and sights. Tampa is considered the business hub of the west coast and has several museums as well as Busch Gardens, a popular theme park.

We are excited about the program and upcoming meeting and look forward to seeing you in Tampa. For additional information and schedules, please access the AVIR web site at www.avir.org.

Tampa AVIR Meeting 2010
Program Schedule

Saturday, March 13, 2010

8:00 - 8:30 am	Continental Breakfast
8:30 - 9:30 am	PICC Workshop
9:30 - 10:30 am	PICC Workshop
10:30 - 10:45 am	Break
10:45 - 11:45 am	PICC Workshop
11:45 am - 12:45 pm	Lunch
12:45 - 1:45 pm	Neurointerventional Workshop
2:00 - 3:00 pm	Anatomy & Physiology review
3:00 - 4:00 pm	Update on Neuro procedures
4:00 - 4:10 pm	Break
4:10 - 5:00 pm	Neurointerventional final review
12:45 - 1:45 pm	CIT Review
2:00 - 3:00 pm	CIT Review
3:00 - 4:00 pm	CIT Review
4:00 - 4:10 pm	Break
4:10 - 5:00 pm	CIT Review

Sunday, March 14, 2010

7:00 - 8:00 am	Continental Breakfast
8:00 - 8:15 am	Presidents' Welcome
8:15 - 9:15 am	Treating the Oncologic Patient in Radiology
9:20 - 10:20 am	RF/Cryo Ablation
10:20 - 10:30 am	Break
10:30 - 11:30 am	Hepatic Chemo Embolization
11:30 am - 1:00 pm	Imaging Device Symposium
1:00 - 2:00 pm	TAA treatment
2:00 - 3:00 pm	Venous Disease and Emergency Treatment
3:00 - 3:15 pm	Break
3:15 - 4:15 pm	SFA and Tibial Treatment and Revascularization

Monday, March 15, 2010

7:30 - 8:00 am	Continental Breakfast
8:00 - 9:00 am	Acute Stroke Imaging
9:00 - 10:00 am	Carotid Disease and Stroke
10:00 - 10:30 am	Break - Business Meeting
10:30 - 11:30 am	Treatment vs.Intervention for Carotid Stenosis
11:30 am - 1:00 pm	Imaging Device Symposium
1:00 - 2:00 pm	Acute Stroke Angioplasty and Stenting (focus on imaging and new technology supplies)
2:00 - 3:00 pm	CTA/MRA new imaging techniques and software
3:00 - 3:15 pm	Break
3:15 - 4:15 pm	Carotid Injury and Repair
4:15 - 5:15 PM	AVM treatment

Tuesday, March 16, 2010

7:30 - 8:00 am	Continental Breakfast
8:00 - 9:00 am	Planning and Evaluation for Dialysis Access
9:00 - 10:00 am	IVC Filters
10:00 - 10:30 am	Break
10:30 - 11:30 am	Renal Artery interventions
11:30 am - 1:00 pm	Imaging Device Symposium
1:00 - 2:00 pm	Management of Central Venous Access
2:00 - 3:00 pm	AAA Endovascular Treatment Options
3:00 - 3:15 pm	Break
3:15 - 4:15 pm	DVT Update Imaging, Recommendations and Treatments
4:15 - 5:15 pm	Varicose Veins Treatment and Updates

Wednesday, March 17, 2010

7:30 - 8:00 am	Continental Breakfast
8:00 - 9:00 am	UFE
9:00 - 10:00 am	Fallopian Tube Interventions
10:00 - 10:30 am	Break
10:30 - 11:30 am	TIPS
11:30 am - 1:00 pm	Imaging Device Symposium
1:00 - 2:00 pm	Percutenous Lung Ablation
2:00 - 3:00 pm	MSK Bone Lesion Ablations
3:00 - 3:15 pm	Break
3:15 - 4:15 pm	Kyphoplasty
4:15 - 5:15 pm	Vertebroplasty

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CQ 2011

Distinguishing the Profession Through Demonstration of Continued Qualifications for ARRT Registration

What the heck is this?

This is a continued Qualifications program that ARRT is implementing on January 1, 2011.

So, any new certifications awarded in 2011 or thereafter will fall under the CQ/2011 requirements. All certifications awarded prior to 2011 and maintained as registered are exempt from the CQ/2011 requirements. If you earn new certifications after that point, you will be issued a time-limited certificate for that category, even though the certifications earned earlier do not fall under the requirements. Make sure you read that last sentence twice.

Again, any certificate that is earned before January 1, 2011, is exempt from the CQ/2011 requirements – provided that registration is maintained. If you fail to maintain your certification after 2011 you will be required to fall under the CQ/2011 requirements.

Post-primary certificates all fall under this also and if you are planning on taking one, I would think you might want to consider this before the end of 2010. The actual test must be taken for it to qualify.

Anyhow the bottom line is if you are coming into the field after next year, the ARRT is implementing an Assessment Component that will have you have Continued Qualifications and tailored to your practice pattern. This means for us the CQ will be focused on Cardiovascular, and your activities will be cardiovascular-specific.

None of this will preclude, any of us from getting the 24 CEUs we need for our Biennium. Plus folks even if you do take a test or need to retest, none of the requirements at the earliest will be enforced till 2021.

Hmm, not even sure how to picture what our profession will look like then.

Inside a Broken System

Dr. Noel Parent, Virginia Beach

EVERY TIME I TREAT A PATIENT, I am aware of the presence of an invisible third party, the health insurance company. As Congress reconciles the health care bills, I am unaware of any provisions that reduce the ability of insurance companies to interfere with the doctor-patient relationship.
I have a patient who is plagued with an ulcer of the leg due to long-standing varicose veins. He is independently employed as a hairdresser, standing 12 to 16 hours a day. Over many years he developed more veins, and these led to a recurrent ulcer. Because he had already undergone multiple vein-stripping surgeries, I recommended a laser vein ablation treatment that could be done safely at low cost in the office using local anesthesia. An older treatment method is open surgery to tie off the veins. This is very expensive and medically risky, as it is done under anesthesia in a hospital operating room. This laser vein procedure is well-proven, I have good experience with it, and it is approved by the FDA and Centers for Medicare and Medicaid Services, i.e., it is not experimental.

A prominent health insurance company denied pre–authorization for the vein ablation, so I appealed the decision. I had several "peer to peer reviews" with a "medical director" who stated the proposed procedure was experimental and therefore did not meet the company's guidelines for medical necessity. I requested a review by a vascular surgeon "peer" who has experience with vein treatments, and this request was denied.

Due to the lengthy delay of these appeals, the patient was unable to work, had trouble paying his bills and then his mortgage. Ironically, he continued to pay his health insurance premiums.

The insurance company never got back to me.

When the condition of the patient's leg deteriorated, I was forced to admit him to a hospital for IV antibiotics. After a surgical wound debridement, two weeks' hospitalization, a skin graft and six more weeks of IV antibiotics, he had to get a lawyer to help him declare personal bankruptcy. As the country prepares to enroll more patients into private insurance plans, be aware the system is still broken.

New Members

Active Members

Doran Akers	Ashland, VA
Elissa Arnheim	Seattle, WA
Nooi Blanco	Miami, FL
Ryan Butler	Puyallup, WA
Patrick Capasso	Ballston Spa, NY
Katherine Crittenden	Deltaville, VA
Ashley DuCoin	Reading, PA
Jason Fox	Rome, NY
Stasha Fulton	Grand Island, NE
Matthew Gilly	Cedar Park, TX
Michael Gross	Tulsa, OK
Joan Hagen	Burnsville, MN
Danielle Hardin	Richmond, VA
Genevre Kane	Merchantville, NJ
Anne Kubasiak	Averill Park, NY
Jennifer Matuszewski	Pewaukee, WI
Michael Metz	Blacksburg, VA
Lacey Moore	Woburn, MA
Isaac Olivarez	Mesa, AZ
Brian Palmiscno	Avonmore, PA
Deborah Pastrich	New York, NY
Jeanette Primich	Williamsburg, VA
Sarah Ragsdale	Dinwiddie, VA
Audrey Reynolds	Meridian, ID
Melanie Ridenhour	Knightdale, NC
David Scola	Providence, RI
Daniel Sharrock	New Kensington, PA
Jesse Tate	Easton, PA
Lynne Teixeira	Pawtucket, RI
Chanthakham Thammavong	Winthrop, MA
Angelica Velazquez	Des Plaines, IL
Donna Vroom	Zimmerman, MN
Michael Wejkszner	Hull, MA
Charlotte Williams	Newport News, VA

Clinical Associate Members

Roland Anderson	Richmond, VA
Dori Braithwaite	Virginia Beach, VA
Karen Brown	Carlsbad, CA
Anne Gardner	Virginia Beach, VA
Judith Goodwin	Virginia Beach, VA
Yvonne Harris-Morris	Chester, VA
Lane Mosher	Midland, MI
Kristin Nunes	Smithfield, VA
Shannon Saner	Virginia Beach, VA
Thomas Smail	Leechburg, PA
Bradley Turner	Seattle, WA
Mary Wideman	Midland, MI
Jeff Winters	Allen Park, MI

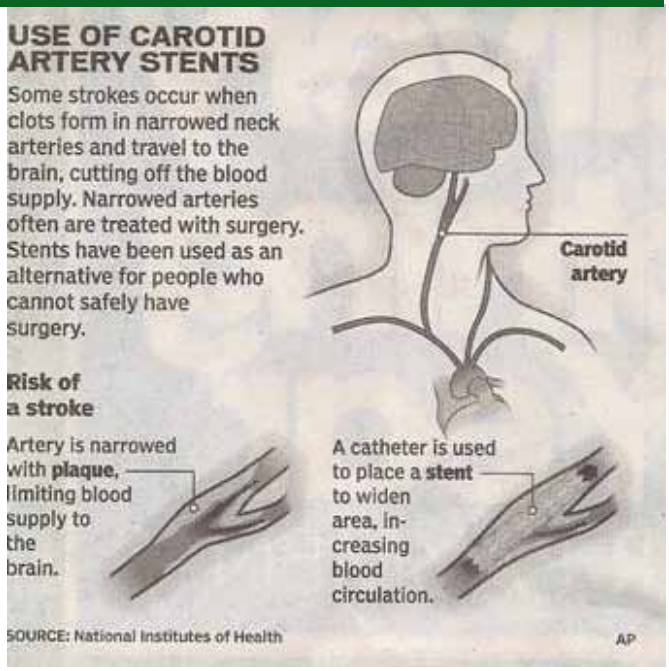
International Members

King Keung Leung	Hong Kong, China

Study: Stents Safe for People with Narrowed Neck Arteries

The nine-year CREST trial compared surgery vs carotid artery stenting in 2,502 patients with or without a previous stroke and found both were just as safe and effective.

CREST Trial Update



Stents, surgery both prevent strokes-study

* Stents better in younger people
* Surgery slightly better at preventing second stroke
* Stents help prevent future heart attacks

CHICAGO, Feb 26 (Reuters) - A newer, less invasive approach to preventing strokes using a device called a stent proved to be as safe and worked just about as well as surgery, U.S. researchers said on Friday, a finding that may be a boon to medical device makers.

Crest Trial Update
- A newer, less invasive approach to preventing strokes using a device called a stent proved to be as safe and worked just about as well as surgery, U.S. researchers said on Friday, a finding that may be a boon to medical device makers.

For many years, surgery has been the preferred way to clear away dangerous fatty deposits in neck arteries that can cause strokes.

But newer, less invasive approaches using angioplasty and stents have been approved for use in higher-risk patients, stirring debate over which approach is best.

Carotid artery stenting involves threading a wire mesh coil called a stent in the neck artery to widen the blocked area and capture any dislodged plaque that could travel to the brain and cause a stroke.

They compared the treatment with surgery, in which doctors cut open the neck, scrape away the fatty deposits in the artery, and sew it back up.

Several medical device makers sell carotid stents, including Boston Scientific Corp <BSX.N>, Abbott Laboratories <ABT.N>, Cordis, Johnson & Johnson <JNJ.N>, Ev3 Inc <EVVV.O> and C.R. Bard Inc <BCR.N>.

The nine-year trial, dubbed the Carotid Revascularization Endarterectomy vs. Stenting Trial or CREST trial, compared the safety and effectiveness of surgery versus stenting in 2,502 patients with or without a previous stroke.

It showed that both approaches were safe and effective overall at preventing stroke, but they did find some differences between the two approaches.

They found that patients who had had surgery had lower rates of subsequent strokes, while those who had gotten a stent were less likely to have a heart attack after the procedure.

"Although the purpose of the study was to compare the two procedures, we were pleased to find that both (surgery) and stenting have become extraordinarily safe," Dr. Gary Roubin of the Lenox Hill Hospital in New York City, who presented his findings at the International Stroke Conference in San Antonio, said in a statement.

A year after the procedure, those who had suffered a stroke reported that the effects had a greater impact on their quality of life than those who had suffered a heart attack.

Age also appears to matter. People who were age 69 or younger appeared to fare slightly better if they got a stent, while those over 70 fared better with the surgical treatment.

For stroke prevention alone, the team said surgery has proven to be safest.

"It is when heart attacks are added that the results of the two procedures become similar," Dr. Wesley Moore of the University of California at Los Angeles, who helped lead the study, said in a statement.

Data from CREST, a prospective, multicenter RCT comparing carotid artery stenting (CAS) to surgical carotid endarterectomy (CEA) for asymptomatic or symptomatic patients with obstructive carotid artery disease, was presented(finally after 10 years) at the International Stroke Conference 2010 in San Antonio, Texas.

The primary composite endpoint (death, stroke, or MI within 30 days and ipsilateral stroke up to 4 yr of follow-up) was similar for the 2 therapies and did not demonstrate superiority for CAS or CEA (7.2% vs 6.8%, HR 1.11; 95% CI: 0.81 – 1.51; p = 0.51, respectively).

For age, there were differences between the therapies that showed slightly better primary endpoint outcomes for CAS in patients 70 years old or younger, and slightly better outcomes for CEA patients over age 70. These trends became statistically-significant in favor of CAS for patients under 48 years old and in favor of CEA for patients over age 79.

For the peri-procedural period, patients receiving CAS had a higher frequency of stroke and CEA patients had a higher frequency of MIs. For all stroke, rates for CAS and CEA favored surgery (4.1% vs 2.3%, HR 1.79; 95% CI: 1.14-2.82); for MI (defined by symptoms or EKG evidence of ischemia + CPK-MB or troponin elevation) rates favored CAS (1.1% vs 2.3%, HR 0.50; 95% CI: 0.26-0.94). In addition, the rate of cranial nerve injury resulting in S/S similar to a minor stroke (swallowing, facial weakness) are reported as 0.3% for CAS vs 4.8% for CEA, HR 0.07; 95% CI:0.02-0.18.

What we learned from CREST overall:

CAS performed equally well as CEA in CREST with no significant difference in the primary endpoint (prevention of stroke, MI, and death) compared to CEA with a low event rate for both therapies.

Therapy differences appear in stroke rates (CAS) and MI/cranial nerve injury (CEA). CREST provides good documentation of these complications of surgery in a normal risk population.

All things equal, revascularization by less invasive means is a viable therapy to treat carotid artery disease.

In conclusion, CREST is evidence that CAS is a reasonable alternative to CEA for the treatment of symptomatic or asymptomatic carotid artery disease for conventional risk patients.

CE Opportunity

"The Alliance of Cardiovascular Professionals is pleased to support professionals in their quest for information, skills, and tools to better support patients. Towards this end, we are the recipients of a generous grant from CORDIS® CARDIAC and VASCULAR INSTITUTEsm to develop and provide a website dedicated to online learning and continuing education. ACVP welcomes all professionals to participate in classes. Online learning is a great way to build skills, test knowledge, and acquire information to better serve you in your role as a healthcare professional.

Classes are provided with continuing education units from a variety of sources depending upon the course content. ACVP is a direct provider for technologists and nurses. ACVP also works with ASRT and ACHE for continuing education for radiology technologists and hospital executives. If you need specific continuing education recognition for courses that do not list provision accordingly, please contact ACVP at info@acp-online.org. ACVP will be pleased to pursue recognition accordingly. This website is updated regularly as new courses are being added frequently. Please visit often to ensure you have access to the latest online learning opportunities in the field." You can access the website here http://www.cvceu.org/Main/Pages.aspx?pagetypeid=14.

The University of Virginia Health System

is looking for highly motivated radiologic technologists in search of a fast-paced, challenging career.

The Charles J. Tegtmeyer School of Interventional Radiology is a twelve-month postgraduate program dedicated to interventional radiology, cardiac catheterization, and special procedures. This advanced program includes the latest exams in peripheral, neuro, and cardiac intervention.

Eight individuals will be selected to train in this rapidly developing field of radiology. Upon completion of our postgraduate school, you will be knowledgeable in percutaneous transluminal angioplasty, thrombolysis, biliary drainage, central venous access, vertebroplasty, embolization, intravascular ultrasound, stenting, IVC filters, stent grafts and much, much more. Graduates from our program are all registry eligible and are in demand nationwide.

For more information regarding the program or application requests please call or write Stephen B Haug at:
(434) 924 - 9401
Angio/Interventional Radiology
Box 800377
Department of Radiology
University of Virginia Health System
Charlottesville, Virginia 22908

From left to right: Jaime Nodolf, Anita J. Bell, Bill Greear, Joni Schott, Connie Groves, Jeffrey Kins, Karen Finnegan, Leona J. Benson, Greg A. Phillips, Viki Allenbach, David S. Douthett. Image right: Melissa Post

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ASSOCIATION OF VASCULAR AND/OR INTERVENTIONAL RADIOGRAPHERS

Membership Application

For January 1– December 31

payment **must** accompany this completed application

Please print or type

Membership Category – Select only one, see reverse side for category descriptions/requirements

○ **Active** – $ 75/yr* ○ **Clinical Associate** – $ 65/yr ○ **Corporate Associate** – $ 65/yr

○ **Student** – $ 45/yr ○ **International** – $85/yr

ACTIVE – Submit ARRT certification or Canadian equivalent.

○ Mr ○ Mrs ○ Ms

Name 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 _____
Email addresses are used only for official AVIR business

Work Institution Name _____ Dept. _____

Street _____
Include department, room number, mail stop codes, etc., if appropriate

City _____ State _____ ZIP _____

Phone (_____) _____ Fax (_____) _____ Email _____
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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***

List 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 _____ / _____ / _____

Name on Card _____ Signature _____

Student Members Only

Director _____ Program Address _____

City _____ State _____ ZIP_____ Phone (____) _____

09.07.20

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AVIR

12100 Sunset Hills Road
Suite 130
Reston, VA 20190

Address Service Requested

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: 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.

Dues are $75 per year. Membership renewable annually each January.

Associate: 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.

Dues are $65 per year. Membership renewable annually each January.

Student: Students in certified programs for Vascular and/or Interventional Radiographers.

Dues are $45 per year. Membership renewable annually each January.

International: 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.

Dues are $85 per year. Membership renewable annually each January.

Why Is Joining AVIR Important?

The AVIR is 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

Join AVIR today... and become an influential force in the future of health care policies!