What does AVIR membership mean to you? What does the AVIR membership do for me? What are the advantages of belonging to the AVIR? Who is the AVIR? As the AVIR leadership pondered, dissected, and analyzed these very questions this year we came to a few realizations. This association is to interventional radiology techs what the Society of Interventional Radiologists (SIR) is to interventional radiology physicians. Yes, they can belong to RSNA and we can belong to ASRT and yes we can be educated, informed, and organized there. So why do we (SIR and AVIR) exist? Well, the obvious answer is because we are specialized and our fields are not well represented in those forums. We provide specialized care, what does that mean? It means nowhere else in radiology do technologists do what we do; nowhere else in radiology do physicians do what our colleagues do. Our IR physicians appreciated this a long time ago. RSNA was founded in 1915; twenty years after Roentgen discovered x-ray. A little over 50 years later in 1973 the Society of Interventional Radiologists was formed. Technologists have been there from the beginning but AVIR wasn’t founded until 1986. The purpose and the mission were clear then, but somehow became muddy. Now, here they are for your review:

MISSION: The AVIR is a nonprofit, national organization of radiologic technologists and allied health professionals deeply committed to improving health and the quality of life through the practice of vascular and interventional radiology, while providing leadership and the development of superior education for its members.

VISION: The Association of Vascular and Interventional Radiographers vision is to grow, advance, and continue education in the area of vascular and interventional radiology and to promote professional growth and the socioeconomic stature for AVIR members throughout the medical community.

PHILOSOPHY: The Association of Vascular and Interventional Radiographers philosophy is to establish and maintain a high level of professional performance of medical and ethical standards of all Cardiovascular Interventional Radiographers, to provide, promote and maintain continuity of and continuously improve patient care, to create a positive working relationship among all facets of the medical profession and to educate the public and allied health professionals in skills and awareness of vascular and interventional studies.

Two years ago, I had the privilege to meet Dick Steuve, the technologist that worked with Dr. Charles Dotter, the “Father of IR” and Melvin Judkins, as they developed from its infancy the specialty we call interventional radiology. It was a true honor and so great to hear the stories. It truly emphasized to me the important role we as technologists played then and still...
do today. Although times have changed and technology has improved so must we evolve. On a side note, if you have the chance, watch the made for TV movie Something The Lord Made, a story about the first heart surgery in America and the relationship between Dr. Blalock and his assistant Vivean Thomas. I’m sure it will strike a chord for many of you as it did for me.

Under the current leadership AVIR is evolving. We are transitioning from a membership based organization to a subscription based organization. What does this mean? Well it changes our focus to provide to our members that which is most important to them; Education. From this year forward we will keep a revolving 12 field relevant directed readings on our member page. We will also provide quarterly webinars on current and budding technology. Our annual meeting will provide at least 24 credits each year and include important topics such as radiation safety and vascular interventions board review. We will continually provide updates on evolving and controversial topics such as Renal Denervation and CCSVI, and make sure we cover all the basics for the new and budding technologists in our field. We will also record many of our lectures from the annual meeting and post them on the website so those of you that were unable to attend can still take part in the education that was presented there. With the subscription, our education will be easier to get reimbursed through education funds available at your workplace and if belonging to a professional organization is relevant to your career ladders, maybe you can ask your leadership to cover the subscription fee as well. AVIR will not look or feel any different but we are changing how we present you with the information and opportunities. The new website transitions are complete and we are ready now with a strong foundation for growth. We will keep the 30 day promotion alive so your colleagues can try us out; let’s get the word to them.

Wait there’s more: (sound like an infomercial?) AVIR is on the web, in the social setting through our blog LinkedIn, Facebook, and twitter. These forums really allow real time discussion of the hot topics, our LinkedIn page has over 1300 members and our Facebook page is a few hundred and growing. This year we discussed salaries, specifically how on call is paid, and I have to say, the variability was an eye opener. These discussions beckon your input, thoughts, and ideas.

We have also increased our partnerships and tied into IR meetings around the US like ISET in Miami and the GEST meeting this year being held in San Francisco. Thanks to IR physicians who truly understand the importance of our role like Dr. Katzen and Dr. Haskal, and so many others that we all work so close with, we have been able to partner up at these meetings and offer significant discounts to our subscribers.

Bill Gates said: “We will always overestimate the change in two years and underestimate the change in ten” I look forward to 2014, under Rob Sheridan’s guidance, I believe the Association of Vascular Interventional Radiographers will take some giant leaps forward and forge some new ground well into our future. We as technologists have a lot of work to do at the local level to help the leadership get the message out. Please go to your chapter meetings, and attend the angioclubs your docs have invited you to, be a part of the bigger picture. It’s more than just a job; it’s a life in one hand and our pride in the other. I leave you with these throwback pictures from my NY days, I miss them even though they just point and laugh as I tried to teach them and sometimes they just don’t want to hear it. I also want to give a shout out to my BCVI team of techs, nurses, and physicians; they have been so great and supportive, our Miami Chapter president Roberto Telleria has really taken charge of the local arena and we have had regular meetings with growing interest and attendance all around, I am very fortunate to be part of them. Let’s all make it a great year AVIR – CHEERS!!!!
Have any of you read “Who Moved My Cheese” by Dr. Stephen Johnson? It’s a story about four individuals (two simple mice and two little people) who run through a maze in search of cheese (which is a metaphor for whatever it is that people want to pursue in life which they believe will make them feel happy and successful). Life is cruising along just fine until one day something changes … the cheese is missing. How each of the four characters reacts to this change is what makes this simple story very enlightening.

Sniff & Scurry, the two mice, put on their running shoes and jogging outfits and head back out into the dangerous uncertainty of the maze to look for new cheese. Hem and Haw, the two little people, do what they’ve “always done” and keep going back to where they’re comfortable but guess what? No cheese reappears. Regardless, day after day, Hem and Haw go back to the same spot. Finally, one day Haw begins laughing at himself, “I keep doing the same things over and over again and wonder why things don’t get better. If this wasn’t so ridiculous, it would be even funnier.”

In the crazy pursuit of cheese, whether your “cheese” is a perfect job, a fancy car, a loving relationship, a huge mansion on a lake, etc., who do you relate to in the story? Are you Sniff & Scurry who simply go about finding an alternative to what has ALWAYS been, Hem who does what he’s always done even though he gains no reward or Haw who looks at his behavior and decides doing the same thing over and over is only leading to the same result … no cheese? An even better question may be who do you work with in your hospital? Do you embrace change while someone else in your department is stuck in a rut?

I’ve heard it said many times that the only thing constant is change so what can you do to look at change, understand it & ultimately embrace it? If you work in the healthcare industry in just about any capacity then change is inevitable. In fact, one would think that we would be surprised if our “cheese” actually stayed in the same place. In my opinion, healthcare “cheese” has been moved and changed more in the last few years than any time I can remember. The real question is what do you need to do to move and adapt to that change?

Throughout the book, Dr. Johnson offers several ways to embrace change including laugh at yourself, change your attitude, and appreciate that doing something new can make you feel young. He also suggests that you envision what is possible in order to move toward your goals. He points out that discomfort can lead to something even better than what you had before. Additionally, he writes that “sometimes … things change and they are never the same again. … That’s life! Life moves on. And so should we.”

While in the past hospitals may have wanted loyal employees, today they need flexible people who are not possessive about “the way things are done around here.” The biggest inhibitor to change lies within yourself, and nothing gets better until YOU change. Keep things simple, be flexible, and move quickly. When you change what you believe, you change what you do. New beliefs encourage new behaviors and when you move beyond your fear of change, you feel free.

One final lesson that we should all learn … although we may not like it at the time, change can turn out to be a blessing in disguise as it leads to finding better “Cheese.” Good luck as you encounter the inevitable change that we will all face and remember: Move with the cheese!
Dear AVIR Members,

Are you due to renew your membership? There are over 200 of you who are up for renewal this month and we want you to know why you shouldn’t hesitate. We, the AVIR have been working endlessly to ensure you are educated in the growing field of Interventional Radiology by providing you our members an opportunity to obtain all of your credits through our website. We have collaborated with the JVIR to offer you up to 20 credits, 5 per quarter right here on our website!

And that’s not all. Your membership also provides you with live webinars, discounted registration to the annual meeting, article reviews and much more! AVIR offers many levels of membership including students and international. So please don’t wait, renew today so you are up to date on all the upcoming excitement in the world of Interventional Radiology!!

Best,
Amanda Popovitch
AVIR Secretary/Treasurer

What an exciting venue for the Annual Meeting. No better weather can be had than southern California in the spring. Along with the amazing weather comes a meeting focused on education and clinical expertise.

If I had to choose a theme for this year, I would say “Convergence.” As we progress as an organization, it is important to remember our success is dependent upon the union of passionate technologists, and the invaluable resources, feedback, and interaction they provide to the AVIR. To quote Barry Katzen, MD, this year’s Gold Medal Lecturer, “These technologists provide incredible support to the team that is necessary to deliver the best clinical results”.

This year, we are excited to provide opportunities for interaction through sessions with clinical specialists that will allow our members the opportunity to simulate catheter manipulation, vessel selection, and endograft placement. Our speakers will compliment each other very well in a lot of cases. Giving you an in depth look at NeuroInterventions, Portal Interventions, and Interventional Oncology.

As the AVIR moves forward, my hope is that we continue to develop educational opportunities to advance our field, and continue to make us valuable resources within the IR suite.

As the Program Director, my hope is not only to provide these educational opportunities, but also to network with other individuals whose goal is to continue to grow an organization that provides relevant and exciting meetings, conversation, and continuing educational opportunities for their members.

I thank you for your continued support of the AVIR, and look forward to a great 2014. See you in San Diego!!

By David Nicholson RT(R)(CV), AVIR Program Chair
Did you purchase your Soiree tickets yet? 
You still can!

Join us Sunday March 23rd 2014 @ 7pm

The AVIR Board of Directors can’t wait to see you all looking your best at the Wine and Culinary Institute on Sunday night after the conference day. Get ready to indulge in the fine wine and food that San Diego has to offer.

**A semi-formal dress code is appreciated. See you there!**

The San Diego Wine & Culinary Event Center is located at the base of the Harbor Towers and the main entrance faces onto the Martin Luther King Promenade and to Hall A at the San Diego Convention Center.

From the Five Star Parking lot, cross J Street and walk through the arch that says “Galileo lol”. Follow the path to left to the main entrance.

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Sponsorship and Relationship

By Amanda Popovitch RT(R)

We, the AVIR Board and the AVIR a community would like to extend a sincere Thank You to all of our sponsorships for the past year. Without you our Annual National Meeting’s would not be possible. Through your generous donations, technologists here in the United States and abroad are given the opportunity to further their education in the ever so growing field of Interventional Radiology. At the annual meeting we are able to network, share what is happening at other institutions and learn about your current and new products. In addition to the annual meeting our website offers members directed reading to earn free credits and take part in blog discussions. This year will prove to be one of the most successful year’s the AVIR has ever seen. If you have not had the chance to check out our site please take a minute to see what we have been up! We appreciate your continued support and we look forward to seeing you in San Diego!
AVIR extends its appreciation to the following sponsors!
## Sunday, March 23

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
<th>Speaker(s)</th>
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</table>
| 8:00 - 8:15   | Presidents Welcome                                                   | Beth Hackett, President ARIN  
Izzy Ramaswamy, President AVIR                                            |
| 8:15 - 9:15   | Gold Medal Lecture                                                   | Barry T. Katzen, MD, FACP, FACC, FSIR  
Medical Director  
Baptist Cardiac and Vascular Institute Miami, FL                           |
| 9:15 - 9:30   | Break                                                                |                                                                            |
| 9:30 - 10:30  | Understanding and Improving Patient Satisfaction Scores              | Elvira V. Lang, MD, FSIR, FSCE  
President, Hypnalogics, LLC                                                  |
| 10:30 - 10:45 | Break                                                                |                                                                            |
| 10:45 - 11:45 | Affordable Care Act - The Present State of Health Care               | Donald F. Denny Jr., MD  
Princeton Radiology  
Princeton, NJ                                                                    |
| 11:45 - 1:00  | Lunch                                                                | Pick up lunches in Convention Center and return to hotel                    |
| 1:00 - 2:00   | Building a Better IR Team: RT’s, RN’s and NP’s                      | Gail Egan, MS, ANP  
Vascular and Interventional Radiology  
Albany Medical Center  
Albany, NY                                                                   |
| 2:00 - 3:00   | Communication, Teamwork, and Interprofessionalism in Healthcare     | Denise L. Davis, MD  
Associate Clinical Professor of Medicine  
University of California San Francisco  
San Francisco, CA                                                            |
| 3:15 - 3:30   | Break                                                                |                                                                            |
| 3:30 - 4:30   | The Anesthetized Patient in Interventional Radiology/Interventional Radiology Anesthesia | Mary F. Landrigan-Ossar, MD, PhD  
Boston Children’s Hospital  
Boston, MA                                                                    |
| 4:30 - 5:30   | Patient Safety. Team training and panel discussion on interesting case review | Karen Miguel, MM-H  
Patient Safety Officer  
Massachusetts General Hospital Imaging  
Boston, MA                                                                    |
| 7:00 - 10:00  | Soiree at the San Diego Wine and Culinary Center                    | Across the street from the Convention Center and Hotel                     |

## Monday, March 24

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<thead>
<tr>
<th>Time</th>
<th>Event</th>
<th>Speaker(s)</th>
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</table>
| 8:00 - 9:00   | Chronic Venous Insufficiency: from clinic to the room                | Sandra Schwaner, RN, ACNP  
University of Virginia Medical Center  
Charlottesville, VA                                                               |
| 9:00 - 10:00  | Endovascular Management of Femoropopliteal Disease                  | Minhaj Khaja, MD  
University of Virginia Medical Center  
Charlottesville, VA                                                               |
| 10:00 - 10:15 | Break                                                                |                                                                            |
| 10:15 - 11:15 | Portal Intervention                                                  | Hector Ferral, MD  
Northshore University Health System  
Chicago, IL                                                                       |
| 11:15 - 12:15 | Portal Hemodynamics                                                  | Wael Saad, MD, FSIR  
University of Michigan  
Ann Arbor, MI                                                                     |
| 12:15 - 1:15  | Lunch                                                                |                                                                            |
| 1:15 - 1:45   | AVIR Business Meeting                                               | Izzy Ramaswamy, Rob Sheridan,  
The AVIR Board of Directors                                                       |
### AVIR Schedule of Events

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
<th>Speaker(s)</th>
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<tbody>
<tr>
<td>1:45 - 2:45</td>
<td>Shoulda, Coulda, Woulda</td>
<td>Janice Newsome, MD</td>
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<td>Interventional Radiologist</td>
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<td>Riverside Regional Medical Center</td>
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<td>Newport News, VA</td>
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<tr>
<td>2:45 - 3:00</td>
<td>Break</td>
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<td>3:00 - 4:00</td>
<td>ROE- Radiology Order Entry</td>
<td>Rob Sheridan and Florian Fintelmann MD</td>
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<td>Director of Interventional Radiology</td>
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<td>Massachusetts General Hospital</td>
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<td>Boston, MA</td>
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<tr>
<td>4:00 - 5:00</td>
<td>Pulmonary Interventions</td>
<td>Nael Saad, MD</td>
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<td>Washington University Medical Center</td>
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<td>St. Louis, MO</td>
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**Tuesday, March 25**

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<thead>
<tr>
<th>Time</th>
<th>Event</th>
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<tbody>
<tr>
<td>8:00 - 9:00</td>
<td>Neuro Interventional - Stroke Therapy</td>
<td>Martin Radvany, MD, FSIR</td>
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<td>Neurological Surgery and Neurology Division of Interventional Neuroradiology</td>
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<td>Johns Hopkins Hospital</td>
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<td>Baltimore, MD</td>
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<td>9:00 - 10:00</td>
<td>Aneurysm Pipeline</td>
<td>Guilherme Dabus, MD</td>
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<td>Director of the Fellowship Program in Interventional NeuroradiologyBaptist Cardiac and Vascular Institute and Baptist Neuroscience Institute</td>
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<td>Miami, FL</td>
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<tr>
<td>10:00 - 10:15</td>
<td>Break</td>
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<td>10:15 - 11:15</td>
<td>Catheter Directed Oncology</td>
<td>Bulent Arslan, MD</td>
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<td>Rush University Medical Center</td>
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<td>Chicago, IL</td>
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<tr>
<td>11:15 - 12:15</td>
<td>Advancements in Tumor Ablation</td>
<td>Suvaranu Ganguli, MD</td>
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<td>Massachusetts General Hospital</td>
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<td>12:15 - 1:15</td>
<td>Lunch</td>
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<td>1:15 - 2:15</td>
<td>Pediatric Interventional Radiology</td>
<td>Ahmad Alomari, MD, MSc, FSIR</td>
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<td>Interventional Radiology Fellowship Director</td>
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<td>Boston Children’s Hospital</td>
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<td>Boston, MA</td>
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<td>2:15 - 3:15</td>
<td>The Role of Advanced Practitioners in IR from a PA Mindset</td>
<td>Melissa Chittle, PA-C</td>
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<td>Massachusetts General Hospital</td>
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<td>Boston, MA</td>
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<td>3:15 - 3:30</td>
<td>Break</td>
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<td>3:30 - 4:30</td>
<td>Update on Chronic Cerebrospinal Venous Insufficiency (CCSVI)</td>
<td>Michael D. Dake, MD</td>
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<td>Professor of Cardiovascular Surgery</td>
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<td>Stanford University</td>
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<td>Palo Alto, CA</td>
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**Wednesday, March 26**

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<tr>
<th>Time</th>
<th>Event</th>
<th>Speaker(s)</th>
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<tr>
<td>8:00 - 12:30</td>
<td>Vascular Interventional (VI) Board Review</td>
<td>Alisha Hawrylack RT(R)VI</td>
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<td></td>
<td>University of Virginia Medical Center in Charlottesville, VA</td>
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Interventional Radiology (IR) the Next Level

By Deb Sepanksi RT(R)(CV), FAVIR

I have been in IR for many years and have seen where we were and how to be successful and be where the procedures are. We must change to where the procedures are. In the past we were diagnostic in performing angiograms of vessels to see if there are occlusions in the carotids, aorta, and femoral. CT and MR came along, and they do the diagnostic procedures. Cardiology and Vascular Surgeons are doing what a lot of the IR physicians do. In order to survive this economy we all need to work together as a team.

Several years ago we moved into a new department and began marketing our service to our referring physicians and our dialysis centers. We have 25 dialysis centers that refer to us. We told them we would Declot a fistula within 24 hours, have one phone number to call (we have three hospitals that our dialysis centers refer to, one of their requests when we began marketing was a one call number, one fax number, plus electronic scheduling for all three hospitals.)

One of the areas IR is growing in is the Oncology field. We do biopsies to determine diagnosis, place Ports for chemotherapy, Ablations of tumors, chemo-embolization, and Y-90 for treatment of HCC of liver disease. We attend tumor boards to let referring physicians know IR is there to assist in treatment of disease and we are very successful.

Research is very important! Last year at SIR, Renal Denervation (RND) had several lectures, and this year at ISET, RND was the hot topic, this is the new cutting edge technology for IR.

Researchers have said that high blood pressure was caused by a faulty feedback loop in the nervous system. The loop starts in the arteries and then feed the kidneys and the renal arteries. The therapy is that if the nerves that line the renal arteries could essentially be electro-shocked, then the faulty messages they were sending would be stopped and the body would stop creating a high blood pressure scenario. The research papers have shown that patients treated with Renal Denervation have a lower heart rate, recover more quickly after exercise, and have overall improved heart function, which assists to improve the overall blood pressure of patients.

Patients going through the procedure should have first either an MRA or CTA of the renal arteries to check for stenosis. The patient then undergoes a Renal Arteriogram to check for stenosis where a RND catheter is placed in the renal arteries and the artery is ablated. The treatment lowered blood pressure in approximately 85% of the patients. Studies suggested that RND, using bi-polar technology, delivering energy between a pair of electrode poles placed closely together on the balloon. The unique bi-polar approach allows for more localized and precise energy delivery, treating only where necessary. To reduce the risk of injuring deeper tissue, the RND system delivers the lowest effective energy dose. Renal Denervation is cost effective which is obviously important when it comes to being adopted, developed, and used as an effective medical treatment.

Another research product we are involved in, and is also cutting edge technology, is the venous stent designed for ilio-femoral occlusive disease. We were the second facility in the country to place this stent. On February 5 our local TV station interviewed the twenty-two year old patient and the physicians involved in this successful procedure.

Cook Medical has launched the VIVO clinical research study to evaluate the
safety and effectiveness of the Zilver Vena Venous Stent in the treatment of symptomatic ilio-femoral venous outflow obstruction. This disease is characterized by leg pain, throbbing, swelling, and skin discoloration of the legs. The Zilver Vena Venous was designed specifically for the ilio-femoral veins.

This is an important trial which is intended to objectively assess the endovenous correction of symptomatic ilio-femoral vein stenosis with a stent designed for this specific purpose. This condition can arise for various reasons, including post-thrombotic syndrome in deep vein thrombosis patients. This stent provides flexibility, and has consistent radial force for venous disease. The news reporter described it as a cutting edge technology “Slinky.”

I am very proud of our team and IR needs to be aggressive in staying on top of the new treatments, new procedures, and new technologies to be successful.
Introducing the newest evolution of the GORE® VIABAHN® Endoprosthesis

Now with a streamlined delivery profile and the longest stent graft available, GORE® VIABAHN® Endoprosthesis offers more options for endoluminal bypass.

- 6 Fr delivery profile for 5 and 6 mm, 7 Fr delivery profile for 7 and 8 mm devices*
- 0.018” / 0.014” guidewire compatibility
- 25 cm length covers more lesion with one device
- Contoured proximal edge and Heparin Bioactive Surface

*The 8 mm x 25 cm device is not compatible with the 7 Fr COOK® CHECK-FLO® FLEXOR® Sheath.

EXTENDED USE / INDICATIONS: The GORE® VIABAHN® Endoprosthesis is indicated for improving blood flow in patients with symptomatic peripheral arterial disease in superficial femoral artery lesions up to 230 mm in length with reference vessel diameters ranging from 4.0 – 7.5 mm. The GORE® VIABAHN® Endoprosthesis is indicated for improving blood flow in patients with symptomatic peripheral arterial disease in iliac artery lesions up to 80 mm in length with reference vessel diameters ranging from 4.0 – 12 mm. Refer to Instructions for Use at goremedical.com for a complete description of all contraindications, warnings, precautions and adverse events.

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<table>
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<tr>
<th>Meeting</th>
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<th>web site/ phone</th>
<th>location</th>
<th>date</th>
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<tr>
<td>Intensive Vascular Ultrasound Interpretation Review and Registry Preparation 2014</td>
<td></td>
<td><a href="http://www.cfeme.org/VasUltrasound14">www.cfeme.org/VasUltrasound14</a></td>
<td>Cleveland Clinic, Cleveland, OH</td>
<td>April 12-13, 2014</td>
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<td>Save a Leg, Save a Life Foundation 2015 Annual National Conference</td>
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<td><a href="http://www.savealegsavealife.org">www.savealegsavealife.org</a></td>
<td>Disney Yacht &amp; Beach, Lake Buena Vista, FL</td>
<td>May 9-11, 2015</td>
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<td>American Roentgen Ray Society Annual Meeting</td>
<td>ARRS</td>
<td><a href="http://www.arrs.org">www.arrs.org</a></td>
<td>San Diego, CA</td>
<td>May 4-9, 2014</td>
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<td>SITE: International Symposium on Endovascular Therapies</td>
<td>SITE</td>
<td><a href="http://www.sitesymposium.org">www.sitesymposium.org</a></td>
<td>Barcelona, Spain</td>
<td>May 9, 2014</td>
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<td>Society For Imaging Informatics in Medicine Annual Meeting</td>
<td>siim</td>
<td><a href="http://www.siim.org">www.siim.org</a></td>
<td>Long Beach, CA</td>
<td>May 15-17, 2014</td>
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<tr>
<td>MEET Congress/Multidisciplinary European Endovascular Therapy</td>
<td>MEET</td>
<td><a href="http://www.meetcongress.com">www.meetcongress.com</a></td>
<td>Nice, France</td>
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W. L. Gore & Associates Congratulates
Anne Kubasiak, RT (R) VI

2014 recipient of The Association of Vascular and Interventional Radiographers

Award of Excellence

Thank you, Anne for going the extra mile in the field of interventional radiology, taking action to improve daily life for patients, peers, physicians and hospital staff. Your compassion and professionalism are an inspiration to those in your hospital and community.

Gore proudly sponsors the AVIR Award of Excellence. Founded in 1958, Gore Medical is devoted to exceeding expectations — through superb product design, a culture of collaboration and utmost dedication to customers. Gore knows excellence when it sees it, and sincerely appreciates others who are also always working for a better solution.
Anne Kubasiak is an Interventional Technologist at the Albany Medical Center in Albany NY. Anne is also an avid marathon runner with a passion for not only her professional growth but also for personal well being. Anne has won numerous Radiology Residents “best tech” award for her ability to take on the teaching role in the academic setting. Anne is also a senior technologist taking on many other leadership tasks at AMC. Her nomination has come from her peers and physician colleagues who speak very highly of her as a person and as a professional. In alignment with the nature of this award, Anne is exemplary in the manner in which she conducts herself both professionally and personally as shown by the comments below.

“Anne works with a very large group of physicians and nurses here at Albany Medical Center.

As she works with them you can see how strong many of the bonds have become especially with many physicians who really trust her to handle many responsibilities. The entire staff here knows that Anne is extremely capable in doing her job and that leads to a great working relationship with other staff.”

“Anne is an avid runner/marathoner. Anne participates in a host of running events that are for charity.”

“Anne always is the person that is willing to work to make sure everyone gets out on time.

Anne is always available to the entire department if they have a question day or night. She really does love her job and really always puts the patient first and I think many of us would benefit from imitating her attitude. Anne never stops and she should be rewarded for all of her hard work.”

“Anne is a special individual and one whose talents are unique and exceptional, which makes her an elite technologist quite worthy of this recognition. It is my pleasure and honor to recommend her for this award.” Dr. Gary Siskin, MD
This year’s fellowship award goes to President Robert Sheridan. Rob is the director of interventional radiology at the Massachusetts General Hospital. The MGH is a world class facility with the highest of grades in most measurable standards. With over 18 years in the field; Rob is an expert, a leader, a student, and an advocate to the community of interventional radiology at the local and national levels. He is a father, a son, and husband to his family and a role model to his peers. Rob is also your next AVIR President.

At the MGH Rob is responsible for the day-to-day operations and strategic management of Interventional Radiology, performing over 18,000 procedures annually. As Director of the Radiology Consulting Group, he brings a strong clinical background to the role with a focus on leadership development, charge capture, competency based training, inventory management - and application of RFID, operational efficiency and LEAN implementation and patient safety and HETT training.

With the AVIR, Rob has spent many years speaking at the local and regional level on many related topics. Rob has also been invited to speak at the national meeting for the last three consecutive years. Rob is currently the active Vice President / President elect. Prior to this position, Rob held the Secretary/Treasurer position with the AVIR. Rob has a genuine understanding of strategic business practices and brings his practical knowledge and experience to the table in AVIR business matters. We look forward to his leadership this year as he and the newly elected BOD take the AVIR to new and uncharted places.

The Vascular Imaging and Intervention Division of the Massachusetts General Hospital Department of Radiology provides advanced diagnostic exams and minimally invasive, image-guided procedures for diseases and injuries of the blood vessels.

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Gold Medal Award – Barry T. Katzen MD, FACR, FACC, FSI

Barry T. Katzen, MD, is the founder and Medical Director of Baptist Cardiac & Vascular Institute. At the Institute since 1987, he has been a leader in the development of interventional radiology and multi-disciplinary models for delivering cardiovascular care. Dr. Katzen is Voluntary Professor of Radiology at the University of Miami School of Medicine as well as Clinical Professor of Radiology at the University of South Florida College of Medicine, and most recently became Associate Dean for Clinical Affairs at the Florida International University Herbert Wertheim College of Medicine.

Dr. Katzen received his medical degree from the University of Miami School of Medicine. He completed his radiology residency at the New York Hospital-Cornell Medical Center, with fellowship in cardiovascular radiology at St. Vincents Hospital Medical Center in New York, as well as the University of Rome, Italy. He later trained in Europe on several occasions, developing a deep understanding of the delivery of healthcare in multinational settings.

Dr. Katzen is a longtime advocate of AVIR and everything we stand for. Throughout his years pioneering the field of interventional radiology he has continually supported the goals set by AVIR both nationally and locally. At BCVI, he and his colleagues fully support the role technologists play inside the procedure suites, outside managing workflow, and at the executive and leadership level supporting the mission he set in motion back in 1987. It is an honor to have him speak for us this year on the future of interventional radiology and the impact the changes in healthcare will have on us all.

Gold Medal Lecturer Award

This is the fifth year since the AVIR Re-named the Gold Medal Lecture in honor of Shari Ullman. After Board approval, the AVIR presented this honor to Shari in 2008 and she was really touched. In fact to quote Shari: “this means the world to me.” The first annual Shari Ullman Gold Medal Award was given at our 19th Annual AVIR Meeting in San Diego. Unfortunately, Shari passed away before she could present the first Gold Medal Award named in her honor. However, Shari’s family was able to attend the first awarding of the Shari Ullman Gold Medal Lecturer Award. A duplicate Crystal was presented to her family, in remembrance of Shari. Now 6 years later, we are back in San Diego and looking forward to this year recipient, as it is an honor to have this individual who has brought so much to our organization and represents every bit of how this was envision being. This year it is being presented to Dr. Barry T. Katzen.
Radiologic Technologists: Health Professionals On A Mission

By: Ashley Hester RT (R)

Introduction

Booker T. Washington once elegantly stated, “success is to be measured not so much by the position that one has reached in life as by the obstacles which he has overcome while trying to succeed” (Washington, 2009). Difficult economic times highlight problems throughout many facets of our country, including many areas within the health care system. Fiscal pressure on hospitals has resulted in hospitals setting wage and hiring freezes, reducing hours, cutting benefits, and trimming staff. Wage growth has slowed down between 2010 and 2013, demonstrating the repercussions of the economic recession (Agricola, 2013; pp. 44-45). Among the healthcare professionals affected by this are radiologic technologists (RT’s), the third largest group of healthcare professionals in the United States, behind physicians and nurses (Institute for career research, pp. 3).

Radiologic technologists may come from different educational backgrounds, but they still have the same basic knowledge needed to complete their job. Radiology is a large segment of the health field, so a technologist’s opportunities are endless. Basic x-ray technologists will find themselves employed within diagnostic radiology, yet there are multiple possibilities to cross train in other areas. Different radiology modalities include computed tomography (CT), magnetic resonance imaging (MRI), mammography, and interventional radiology (IR). Radiologic technologists are required to have knowledge in basic patient care, CPR, vital signs, sterilizing equipment, and keeping a facility aseptic (Institute for career research, pp. 10). Generally, successful RT’s have good overall reasoning and critical thinking skills and enjoy a profession where they will continue to learn (Institute for career research, pp. 20-21).

Overcoming Technologist Judgment

Often times, radiologic technologists are overlooked and underestimated. Joanne Greathouse, the director of a radiography program in Arizona suggests “most radiographers know far more in general than many give them credit for and clearly know a lot about radiographic procedures, radiographic imaging, and radiation protection that benefit the facilities for which they work” (Sheth, 2010). In order for physicians to correctly diagnose patients based upon their diagnostic tests, imaging technologists must stay knowledgeable and current within the field. Achieving a high level of patient protection and quality control is a daunting task, given budget constraints, overworked staff, and ever-changing technology, yet these professionals will strive to succeed (ASRT staff, 2013; pp. 28). X-ray examinations will continue to be a necessity for proper diagnostics, therefore technologists must find a way to project professionalism and pave the way for future professionals.

Although results will not be seen overnight, to overcome technologist judgment many distinct actions must be taken by various health professionals. By shaping others opinions, staying current with technology, and striving for independence, RT’s will find themselves in a better position within their respective environments. Although many health professionals work together seamlessly, knowledge gaps may pose a threat to certain technologists. In order to work more efficiently, communication is vital between health care workers. Physicians in particular may not always understand what a radiologic technologist encounters in a day’s work. A physician’s main priority in radiology is diagnosing the patient from different images. Technologists must find way to create a masterpiece of diagnostic quality from patients who are uncomfortable, uncertain, and impatient. In the same breath, these images must be acquired in a timely and efficient manner, allowing the radiographer to move on to their next task.

Physician’s are not the only guilty party in the judgment of radiologic technologists; nurses and administration easily find their position within this group. Nurses are a vital part of a patients venture through a health facility, and at times faulty communication may cause tensions to rise and teamwork to falter. In most scenarios, nurses do not have the background information necessary to form accurate opinions on radiologic technologists. Throughout the hospital it is not hard to hear people communicating that x-ray technologists simply push buttons and take pictures,
with the depth of the position completely misunderstood. In Interventional Radiology, many departments have a nurse as the manager, because they must advise over health professionals ranging from different backgrounds. When administration does not come from the same background as those they are directing, tensions may rise and certain people may feel unacknowledged. Interprofessional education is “advocated by the government as a strategy to help overcome difficulties in communication and team working” and may be the only way to get past certain misinterpretations (Forte & Fowler, 2009; pp. 58).

Furthermore, other health professionals are not the only people responsible for tackling the issue with overcoming technologist judgment. Radiologic technologists must take it into their own hands with the topic of staying current with health care. Charles Poling accurately states “R.T.s have to be knowledge sharks, swimming forward and consuming a steady diet of education” (2013; pp. 28). Every two years technologists are responsible for completing 24 category A or A+ continuing education credits in order to keep their licensure. Although this is a minimum, many RT’s go above and beyond this by continuing their education with a higher degree, or becoming certified in a different modality. Radiologic technologists must stay on top of their game in order for other health professionals to take them seriously and feel as though they belong to a higher crowd.

An important aspect of staying current with technology is networking within the field. The best way to overcome harsh judgment is to not allow other professionals to have any negative opinions about the field. Attending continuing education seminars such as the Society of Interventional Radiology is a great way of getting physicians, technologists, and nurses together in an environment where they can learn and grow from one another’s experiences. Emphasis on communication, quantitative skills, technology, and behavior are all the general skills that provide the background necessary for RTs in an ever-changing workplace (Poling, 2013; pp. 28). Finding common ground with other health professionals will help foster a more positive and healthy environment where individuals can work together for the patient’s well being.

Although radiologic technologists must work together with a varying team of health professionals in order to overcome judgment, it is equally as important to strive for a level of independence within their field. For years, using imaging equipment has fell under the scope of practice of only physicians and radiologic technologists. House bill 218 from Maryland is a new bill allowing physician assistants to take certain diagnostic images with a lower level radiation machine. This bill was passed after multiple failed attempts by groups of technologists to fight to maintain their level of independence. At certain immediate health care facilities, radiologic technologists lost their jobs in place of physician assistants who are now able to take low quality diagnostic x-rays. Instead of the intensive training that radiologic technologists receive on radiation safety and quality, physician assistants must simply pass an examination and perform radiographic examinations on at least 20 separate patients to be signed off and begin their new duty. In order to stand a chance at being taken seriously in the health care field, radiologic technologists must demonstrate that their job is not simply something that can be learned overnight (George, 2013; pp. 2).

The RT’s professional dignity is at high risk under the circumstances at hand. In order to build back the reputation that is deserved, technologists must step up and involve others in their expansive knowledge base. Once more professionals are under the impression that radiologic technologists are well trained individuals who are more than capable of doing their jobs, it will become increasingly difficult to stand up and pass these bills that go against forward movement within the field. A radiation therapy student declared, “by demonstrating your commitment to the profession, employers see your willingness to make a commitment to their organization” (2013; pp. 5). Students must find a way to stand out and find their way into a field where there is a continuous need for improvement and dignity.

Education/Credentials/Radiology Modalities
Radiologic technology students are a very important part of paving the way for new opinions on technologists. There are a few different ways to become an x-ray tech, but the most common program is 2 years, and results in an Associates degree. Bachelors and certificate programs do exist, but they are less common within the field. After class and clinical requirements are met, radiologic technologists must sit for a board examination to become certified in radiography. Depending on the state the technologist will work, they are also required to apply for a state license, and in Maryland this goes through
the Maryland Board of Physicians. The ASRT Scanner highlights that “beginning in 2015, [the] American Registry of Radiologic Technologists (ARRT) will require candidates to have a minimum of an associate degree from an ARRT-recognized accredited institution to be eligible for primary certification” (Poling, 2013; pp. 28). This degree demonstrates the importance of general education within the role of an RT, allowing individuals to develop their skills in communication, social behavior, science, math, and critical thinking. (Poling, 2013; pp. 28).

Obviously, organizations such as the ARRT are beginning to realize that in order for other health professionals to take the profession seriously, certain degree requirements should be met across the board. Coming to a consensus between different programs will promote a sense of stability within the profession, and hold the candidates for licensure up to a higher standard. Radiologic science programs need to advocate to students regarding the importance of dignity within the field, and prepare them to enter a field where continuing education is key. Students should be encouraged to continue their educations, not simply be happy with the status quo. Kevin Powers stated “increasing the minimum criteria for entry into the field has been needed for a long time, it’s not a metric for quality, but it shows the broader community that we see education as one of the benchmarks for coming into the field. As time goes on, we may find that the associate degree is not enough” (Poling, 2013; pp. 28).

Technology is continuously changing; therefore health professionals must be able to grow and adapt with these changes. Radiologic technologists have a compelling background in continuing education, and now is the time to step up and prove to other health professionals that RT’s are capable of growing and learning as needed. Degrees are not the only education a technologist may receive to further the idea that they are well-rounded health professionals. Radiology is full of different modalities, such as CT, MRI, IR, nuclear medicine, and mammography. Each of these individual modalities involves separate education in order to successfully work within the field. CT, MRI, and Nuclear medicine all have extra classes available that prepare the radiologic technologist to sit for another set of board examinations that give the RT more credentials.

Continuing Education

Continuing education does not simply involve going back to school or becoming certified in other modalities within radiology. Continuing education is an ongoing mandatory part of being a radiologic technologist. 24 category A or A+ credits must be documented every two years to maintain licensure, and there are different ways of receiving this type of credit. Attending different conferences is a great way to network while receiving credit and learning new processes. Organizations such as the Society of Interventional Radiology (SIR), and the American Society of Radiologic Technology (ASRT) are just some of those who hold conferences and classes for professionals to come and learn. RT’s who are enrolled in classes at accredited institutions working towards another degree receive continuing education credits for each credit involved in the course. Finally, a simple way to receive credit is through directed readings posted by organizations such as the ASRT, where articles are read and questions are answered to receive credit.

Organizational involvement for a radiologic technologist is a great way to further education and a career. Certain conferences held by these organizations demonstrate an interest in learning between technologists and physicians, and even allow learning to coincide with nursing education. Associations are the perfect way to bring a
group of individuals together from all over the country, who are working towards the same cause. Networking between different hospitals thousands of miles apart allows technologists to take ideas home, and better the environment based on the good and the bad discovered. The Association of Vascular Interventional Radiographers (AVIR) is one specific to those technologists working in Interventional Radiology. The AVIR is a perfect example of an organization with the mission to give radiologic technologists the recognition they deserve, and provide an area for communication and networking in a nonjudgmental environment. Building from within, technologists will gain confidence from each other, preparing their venture out to a world where others may need more education about the RT cause.

Patient Care and Safety
Patient care is at the forefront of a radiologic technologists role in health care. The main aspect of patient care within radiology is radiation safety. Radiation is a great tool when used in the proper manner, but can be deadly if not managed correctly. Radiologic technologists learn about radiation safety for months while in x-ray school to guarantee that the practice performed is up the standards necessary for quality patient care. The main principle used within radiology when radiation safety is concerned is “as low as reasonably achievable” or ALARA (Bradley, 2012; pp. 448). Technology has come a long way since radiation was first discovered in 1895, and the safety is miles ahead of where it once stood, but corners still should not be cut while using radiation. Radiologic technologists must manage a balancing act when it comes to radiation safety; using the correct amount of radiation to receive a quality image, while minimizing radiation to the patient and to themselves (Bradley, 2012; pp. 447).

Radiation safety is an often misunderstood area of radiology, simply because most do not understand the concept of radiation. The inverse square law states that time, distance, and shielding are the cardinal rules of radiation protection, and that by doubling the distance away from the radiation source; a technologist will decrease the dose by a quantity of four. Simply educating health professionals who do not receive formal education on radiation safety about the basics will increase the respect for the radiologic technologist, while increasing awareness for the importance of radiation safety. Radiologic technologists strive to protect patients from unnecessary radiation, and demonstrating the vast amount of information RT’s have on the topic will enable other professionals to increase their knowledge base as well (Bradley, 2012; pp. 454).

One of the accrediting bodies for hospitals is The Joint Commission (TJC). The mission of The Joint Commission is “to continuously improve health care for the public, in collaboration with other stakeholders, by evaluating health care organizations and inspiring them to excel in providing safe and effective care of the highest quality and value” (About the joint, 2014). Overcoming technologist judgment is an ongoing process that may involve using The Joint Commission as a set of guidelines to live by. Different states have varying outlines for a technologist’s scope of practice, but in order for other health care professionals to understand what an RT is capable of, The Joint Commission must be addressed to help give specific recommendations for how an RT can advance. Many technologists become ACLS certified while working in certain areas of the hospital, yet the distinct lines of scope of practice can get confusing. Concerns for technologists can stem from the state level all the way down to the departmental level. Within a healthy radiology department, teamwork becomes increasingly important and everyone must understand his or her role in order to foster an efficient environment. A “lack of communication is the number one cause of stress to health care workers,” and no matter which group one belongs to, hard workers are always present even when work techniques differ greatly (ASRT Staff, 2013; pp. 28-30). Once guidelines are set within a department demonstrating what each individual health professional's duties entail, it is important for these people to learn and respect each other's roles. Those who do not respect one another should fall to certain disciplinary action to keep the environment safe and effective for patient care. Radiologic technologists are an important part of these departments, hence the need for mandatory staff education involving everyone's background and responsibilities. Creating an environment where everyone realizes what each professional is held accountable for will allow differences in opinions to be more easily extinguished.

The Future of Radiologic Technologists
Only those directly involved with the field can control the future of radiologic technologists. New guidelines for education and constant opportunity to advance into other modalities are main reasons why RT’s always find a
way to advance their careers. Many people do not realize that those running the machine in an interventional radiography suite or MRI suite have an x-ray background. Information must be made readily available to other health professionals to ensure the future of radiologic technologists stays bright. Degrees in different areas such as “business management, health care management, public health and public administration all offer ways to broaden the playing field” of an RT’s career (Poling, 2013; pp. 29). Education and professional development are a great way to maintain leverage over an employer and increase earning potential over a longer period of time (Agricola, 2013; pp. 48). Individuals with these types of degrees may go on to become administrators, and once they reach this stage they have a greater opportunity to advocate for the profession. The more people who find ways to support radiologic technologists, the easier it will be to overcome judgment from other health professionals.

Technology is constantly innovating and upgrading to meet the needs of an aging population. Radiology departments, in particular, must constantly find ways to upgrade hardware and software to compete with other hospitals and offices. With new technology comes new learning opportunities, and radiologic technologists are some of the first to learn about the new ways to image and advance. The best way to stay current is to stay involved and network with other offices to ensure that a department is not falling behind competitors. Radiologic technologists have a unique opportunity to demonstrate their knowledge to the public through article publications read by different health professionals. The different association's available to a radiographer provides an array of opportunity to produce articles for publication. Broadcasting different information to health professionals not only advances a radiologic technologists career, but provides a medium for interesting facts as well. By stepping up and creating a new image for the profession, physicians, nurses, and administrators alike will be able to form new opinions about the background and education necessary to maintain a career as a radiologic technologist.

Obstacles for Technologists

Even with a bright future full of opportunities for radiologic technologists to overcome judgment, there are still other obstacles to conquer. Healthcare alone is battling issues with the recession and baby boomers aging quickly. The large groups of individuals who are at the high end of many professions are gradually finding their way into retirement, which means vacancies will be available for upcoming professionals, and more people will be added to the aging geriatric population in need of healthcare. An already overworked staff will need to find ways to continue achieving high levels of patient protection and quality control in a complicated health care field (ASRT Staff, 2013; pp. 28). The need to realize technologist importance will be at its highest, to continue to ensure that students pursue careers within the field of radiologic technology. More jobs will need to be created to keep up with the overwhelming need for healthcare, and maintaining a healthy respect for the field of radiologic technology will guarantee respect and interest.

Moreover, salary growth is an obstacle that many professions are struggling to deal with. Kim Agricola illustrates “wages haven’t been growing in health care, in particular where there's pressure to slow the rate of spending” (2013; pp. 45). The recession, paired with a growth in the number of RT’s in recent years has compounded the issues with salary growth. Interest in radiologic technology with students comes in waves, so it is expected that oversupply will eventually trickle back down to a short supply. Regardless of issues with salary, radiologic technologists have proven to be resilient and satisfied in their positions. Many realize that they are lucky to simply have a job, and the best way to maintain a happy environment is to improve the one to which they belong. At this point, it is easy to tell why many technologists find ways to learn more within their field, increasing their earning potential where it seemingly maxed out elsewhere (Agricola, 2013; pp. 46-48).

Education is easier than ever in the technology age, with online education allowing for professionals to achieve more. Online education “is a growing trend, especially in higher education, due in part to greater accessibility to the Internet and computers” (Kowalczyk & Copley, 2013; pp. 27). Students are able to learn at their own pace, and programs specific to radiology need to place emphasis on learning models good for adults, and instructor competency. When radiologic technologists reach their goals and achieve higher education, they need to be recognized the way that other professionals are recognized within the organization. Once more people realize the effort put forth by technologists, many others will judge less and understand more (Kowalczyk & Copley, 2013; pp. 27-29).
Conclusion

The possibilities in healthcare have proven to be endless, constantly innovating and finding ways to overcome economic issues. No one is sure of what the future will bring to the table when it comes to the economy, but healthcare professionals must be ready to embrace whatever comes their way. Radiologic technologists in particular have proven they are up to the challenge of staying open to change, staying current with technology, and continuously learning. They are “first and foremost problem solvers and patient advocates” who “will continue to seek the best images possible, using whatever technology is available, so their patients get the best care” (Poling, 2013; pp. 36). Continuing their efforts and broadcasting information is the best way to ensure that others have the same gleaming opinion on the profession, and believe their presence is necessary.

Radiologic technologists have chosen a career path that will never get boring, for the opportunities are boundless with the correct mindset. Keeping other health professionals educated is the best way to overcome judgment and create a more stable environment for upcoming technologists. Following in the footsteps of the bounty of successful individuals will be an easy task with the continuation in education and ability to find new ways to embrace the career of radiologic technology. All in all, by shaping healthcare professional opinions, staying current with technology, and continuing education, RT’s will create an unstoppable force that no one will be able to ignore. Kim Agricola brings it home with “by showing up – participating, volunteering, mentoring and working with one another – you’re making a difference for your patients and the profession. That’s success” (2013; pp. 5).
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As technology advances in healthcare, we continue to see changes in the techniques we use with endovascular treatment. As our techniques change, the vessel choice for artery catheterization remains constant. The Common Femoral Artery continues being the most common access for angiography.

In 1953, Dr. Ivar Seldinger developed the Seldinger Technique for vessel catheterization. This technique eliminated the need to surgically expose blood vessels for catheterization by allowing a guide wire to pass through a needle inserted in a vessel's inner lumen. The needle is inserted at a 45 degree angle at or above the inguinal crease; thus, entering the femoral artery at the medial inferior one third of the femoral head. Once the needle is in the vessel, a wire is then inserted through the needle until it enters into the artery (Fig.1). The Seldinger Technique continues to serve as the foundation of vascular access. However, there have been some technical modifications based on equipment advances and physician preferences. The use of a 21-gauge micro puncture needle system with a .018 guide wire has decreased the risk of hematoma and intra-luminal dissection. Along with the micro puncture technique, the use of ultrasound imaging guidance has helped reduce hematoma and needle side walling.

Once the procedure is completed and arterial access is no longer needed, the sheath is removed and a manual compression or femoral closure device is employed to achieve hemostasis. Manual compression requires pressure to be held over the entrance site for a minimum of 15 minutes or until hemostasis is achieved. Another option that has recently gained favor is the use of femoral closure devices. There are different methods of mechanical closure, but it usually involves the use of an implant material to seal off the puncture site in the vessel wall. The use of closure devices have shown decreased patient recovery times, while those treated with manual compression experience a longer period of recovery in order for the arteriotomy to heal.

The newest device on the market is called the Axera 2 by Arstasis. This device focuses on access in order to facilitate quicker hemostasis times resulting in shorter patient recovery times. The procedure begins by accessing the vessel using a modified Seldinger Technique. After access to the Common Femoral Artery is gained, a .035 locking wire (provided in the Axera 2 kit) is advanced into the Iliac Bifurcation. After confirmation of the wire's correct placement radiographically, the Axera 2 device is attached to the locking wire. The Axera 2 is then advanced into the lumen and the heel is deployed while simultaneously pulling the device snugly against the lumen wall (Fig 2). The Axera 2 then directs a second puncture that creates a shallow arteriotomy (Fig 3). This shallow arteriotomy creates an overlap of tissue on tissue. Once the femoral sheath is removed, manual femoral pressure is applied for 3-5 minutes. Once hemostasis is achieved, the patient can sit up at a 45-degree angle after fifteen minutes and then allowed to ambulate at one-hour. Finally, the patient can be discharged as early as two hours post hemostasis. The most important benefit of the Axera 2 is the fact that no implants are left behind in the body. With traditional closure devices, patients have an increased risk of infection and lower leg ischemia secondary to implants remaining in the body.
We have done a recent study at The University of Tennessee Medical Center in Knoxville comparing the Axera 2 access device to post procedure manual compression. The total sample size was 189 patients receiving diagnostic cerebral angiograms; 111 patients were treated with the Axera 2 while 78 received manual compression. We used standard guidelines of five minutes of manual compression with the Axera 2 and fifteen minutes of manual compression without the Axera 2. The results yielded a mean time of 7.5 minutes of manual compression when used with the Axera 2 as compared to 17 minutes of manual compression on those without the device. There were 9 technically unsuccessful Axera 2 procedures that were converted to normal sheath access without incident along with two small hematomas that were managed without incident. We recorded 9 hematomas for the manual compression group. The average discharge time for patients with the Axera 2 was 2.6 hours earlier than those who received only manual compression. We have seen great benefits with diagnostic outpatients because of the earlier sit-up, ambulate and discharge times.

In conclusion, as there are constant advancements in the field of vascular access, we continue to search for safer and more efficient ways to treat our patients. Even though new access techniques differ from the original, Seldinger’s pioneering footprint is still evident in today’s environment.

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Dimensions: Trim Size: 8.5”x11”

Live Area should be kept 1/4” from trim on all sides including gutter. Bleed extends 1/8” beyond trim on all sides.

**File Submission**

Digital files should be provided in high resolution PDF format, including crop marks and bleed if applicable. Although not recommended, we will accept the following formats: .eps, .tiff, or Adobe InDesign native files with all support links and fonts. The following file formats are not accepted: Corel, Microsoft Word, Powerpoint or Publisher documents.

All images must be 300dpi and in CMYK or Grayscale color format. All fonts should be embedded or in outlines where applicable. Artwork should be submitted at 100% scale.

Please contact AVIR for ad submission due dates. Full payment must accompany ad order.
In January 1992 the RSNA became the AVIR's Executive Office which was the start of a 10 year affiliation between the two organizations as well as friendships. I know the first boards can attest to the long hours spent together trying to hammer out the structure and direction of the AVIR. One of the key persons in those early years was Betty Rohr.

I can remember the first time I saw Betty Rohr- she was managing the registration tables for both AVIR and ARNA (now ARIN) single handedly with complete composure as the technologists and nurses rushed her with all sorts of questions. I admit I was intimidated by her professional demeanor and little did I know I would be sitting across from her at a Board meeting several years later, planning for RSNA's exit as our executive office. Fortunately, I had the unique opportunity to be mentored by Betty as she gave me a crash course in Robert's rules, how to conduct a Board meeting and how to write a Request for Proposal (RFP) for a replacement management association. Betty was invaluable to me that year as she had been for all the other previous Boards and I was sad that future Board members would not see firsthand the value that Betty brought to the table. But I truly believe that Betty and the early Boards were responsible for creating a solid foundation for the AVIR.

Betty worked for the Radiological Sciences of America (RSNA), which managed several of the Associated Sciences organizations. She was versed in managing organizations, writing policies and by-laws, conducting Board meetings and more importantly how to get a group of opinioned board members to consensus, which was no easy task. Often before Annual meetings you would see her working right beside the volunteers and her associates stuffing the bags for the techs and nurses. Then the RSNA decided that the physicians and education was their primary mission and the Associations that they managed need to find a new management group. Then Betty became the Director of Program Services and Data Management at the RSNA. She was still actively involved with the Associated Sciences Consortium which the AVIR is a member, so she was able to keep tabs on all the organizations she mentored.

Betty retired this year from the RSNA and although she is wintering in the Chicago area she will be spending the summer at her place in Door County. We wish her well.

Thanks for the time you spent with us!
Past Presidents and the AVIR Board of Directors

As the AVIR continues to rebuild our organization so does our commitment of educating you in our growing field of Interventional Radiology. We have shifted our focus from not only networking but to ensure that our technologists have the necessary tools and information needed to be successful technologists in the field. Your membership offers you 24 + credits per year, 20 of which are obtainable online as well as live broadcasts, articles from around the country and of course our annual meeting. Studying for your VI boards? This year at our annual meeting in San Diego we have a new presenter for the VI Board Review. Alisha Hawrylack from the University of Virginia will be presenting a 4 hour board review course in which she will give you all the information you need to pass your VI boards. Alisha received the University of Virginia Academic Excellence Award in 2007 and Clinical Instructor of the year in 2009 and 2011. If you aren't able to make it to San Diego there is also an option online. This is a comprehensive review utilizing a quiz format. Each time an answer is given (correct or incorrect) the correct answer is given along with a short explanation. Go to www.cvireducation.com for more information or go to the Advanced Certification tab on our website.
I am extremely pleased to share the most recent 2014 financial update with our membership! As many of you know, the board of directors embarked upon a crucial mission a couple of years back that aimed to ensure we not only were financially stable, but that we also had a plan in place for the AVIR to thrive for many years to come. This might seem like a simple mission; however our industry has been going through significant changes in recent years that directly or indirectly impact our association.

Through a series of productive board meetings over the past couple of years and newly formed partnerships with our new management team, I am thrilled to inform our membership that we have continued to make forward progress fiscally over the past year. Our significant reduction in operating cost coupled with new banking and management partnerships as well as shifting our models as we diversify what we offer has yielded solid return on investments for us this past year that will help ensure a healthy association for years to come.

As much as we are excited with the progress we have made fiscally with our current board and management team, we are not planning to sit idle with our fiscal management of the association! In fact, fiscal headwinds persist for us in the face of an ever changing fiscal environment; the ACA, the new medical device tax laws and more will continue to present challenges for associations like the AVIR. So we continue to work on adjusting our approach as we evolve our association under an ever changing environment. One tangible example is our shift towards an educational subscription model that offers our members a means to attain focused continuing education through the AVIR. There are 12 NEW directed reading quizzes, 10 NEW self-paced education modules and discussion forums for our members can be easily accessed on our updated webpage. The AVIR is also now a recognized provider of ACE credits and accepts submission for ACE credits directly through our enhanced website.

The board is particularly excited for the upcoming annual meeting in San Diego! The fantastic program we’ve built and new offerings such as simulation sessions for our membership will only be enhanced by networking of our members, new member attendance, and new board members.

We look forward to seeing you all in sunny San Diego!

Respectfully,
Rob Sheridan,
AVIR Vice President

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By Crystal Hanson, RT (R)

Get involved in your local chapter!

The AVIR Board wants to help if you are interested in starting your own Chapter. After the annual meeting the ambition to make a difference is the highest. For those of you that want to keep that momentum going, starting a local Chapter site might be for you.

The Board of Directors wants to help keep you interested. After the annual meeting if you feel you would like to become more involved, this is your chance. A conference call post annual meeting would be your chance to learn more about what starting a Chapter entails. On this meeting you are able to speak with the Board members and ask them questions, or express any concerns in regards to your medical site. If you feel you are interested in learning more about this, there will be more information to follow on the website after the meeting or please seek out one of the Board Members for more information.
2014 Spring Chapter Updates

Crystal Hanson, RT (R)  AVIR Director at Large
chansonAVIR@gmail.com

Baltimore Chapter
Contact: Sharon Misler RT(R )(CV) FAVIR
angiosm@aol.com
Contact: Karen Finnegan MSRT®CV FAVIR
KFINNEGAN@uminn.edu
Sharon has retired and is enjoying the time away. Between Karen and Sharon however they are looking for another meeting and moving BIRT back into action.

Boston Chapter
Contact: Robert Sheridan RT(R )(CV)
Contact: Amanda Popovich
Contact: Kimberly Mahoney
Email: rmsheridan@partners.org, Amanda.Popovitch@childrens.harvard.edu, KMAHONEY18@partners.org

Buckeye State Chapter (Ohio) > No Updates
Contact: Jamie Hiott RT (R ) (CV)(M)(CT)(VI)
Email: jshiott@gmail.com

Connecticut Northeast Chapter of AVIR
Contact: Meredith Gaiter-Brown BSN, RT (R )(CV) (MR)(M)
Email: mrcvm@aol.com
I miss having the meetings, but ASRT has taken a huge bite out of our conferences. But I would like to have one more before my co chair Bobbie retires. Any volunteers want to step up and help would be great.

Great Lakes Michigan Chapter-
Contact: Michelle Denomme
Email: mdnomme@beaumonthospitals.com
Please forward any comments and interest in a meeting or get together to

Lone Star State Chapter  > Updates forth coming
Contact: Alan Seeley RT (R ) (VI)
Email: aseeley@petersonrmc.com or aseeley61@windstream.net

Los Angeles Chapter
Contact: Jeane Rhoten RT(R )(CV)
Email: jrslife@aol.com
Still looking to do another meeting and would like to meet up with folks in San Diego to figure out our next move and location for it.

Miami Chapter (South Florida)
Contact: Roberto Telleria, RT R CV CT
Email: AVIR.MIAMI.RT@GMAIL.COM
The Miami AVIR Chapter is off to a great start this year. In January we affiliated with Dr. Katzen, Dr. Benenati and all the BCVI physicians to provide seven continuing education credits at the ISET Nurse/Tech Symposium and provide a four hour board review session for the ARRT vascular interventions advanced certification exam. With over 100 registrants it was a very successful event. We have also scheduled quarterly chapter meetings for 2014 which will be held in the BCVI conference center. Keep an eye on our chapter website and Facebook page for details on dates, times, and education topics being offered. Our first one is already scheduled for March 20th at 7pm.

NY Capital Region Chapter
Contact: Heather Fairchild, RT (R) (VI)
Email: FairchH@mail.amc.edu

New York City Chapter
Contact: Andrew Amorossa RT (R)
Email: amorosso43@gmail.com
To be honest, at this moment- we have nothing, but we are planning a registry review this fall. Follow ups to come. Will post soon.
Northern California Chapter
Contact: Darlene Crockett RT(CV)
Email: maildarlene@juno.com
I would like to get a chapter meeting if anyone has ideas
please contact me

North Carolina Chapter of AVIR
Contact: Diane Koenigshofer MPH, BSRT-R(CV), FAVIR
Email: diane@nc.rr.com
The NCAVIR has nothing planned for the spring, but
hopes to regroup in the fall and have a one-day seminar, but
there are no definite plans.

North Texas Chapter > No Updates
Contact: Sven Phillips RT (R) VI
Email: sven427@yahoo.com
The north Texas chapter of AVIR has been quiet since our
meeting in 2010...They are hoping to launch an online class
for taking the VI exam in the Fall of 2014.

Orange County California Chapter (OCAVIR)
Contact: Brett Thiebolt (R)
Email: thieboltb@stjoe.org
At this time there is nothing scheduled other than our
quarterly Angio Club meeting which is a case presentation
for the physicians, residents and RT’s. It is open to all
OC hospitals as well as LA. I currently do not have the
next date.

Seattle Chapter
Contact: Leona Benson RT (R)(CV) FAVIR
Email: seattleavir@hotmail.com
www.seattleavir.com
Unfortunately no activity at this time in Seattle. We want
to do a meeting need some volunteers to help us get this
active again.

South Carolina (SCAVIR)
Contact: John Furtek RT (R)
Email: jfurtek@comcast.net
www.scarvir.org
In mid February, 2014 the S.E.T. Symposium is held
in Kiawah Island, South Carolina. This year over 224
attended. It is designed to provide vascular surgeons,
interventional radiologists, cardiologists, podiatrists and
allied health professionals a unique interactive program
on the most current information and treatment options
available for endovascular disease.

South Coast, Lakewood, CA
Contact: Joseph Carfagno
email: irmaster@msn.com
We have it all going on in San Diego  Look forward to
seeing everyone soon.

Tampa, Florida
Contact: Christopher Sheridan RT (R) (VI) christopher.
sheridan@moffitt.org
Contact: Crystal Hanson AVIR chansonAVIR@gmail.com
This is a strong area for us and we are looking for moving
this chapter forward. Please reach out to me if anyone has a
big interest in making this happen soon.

Virginia Chapter VAAVIR
Contact: Rita Howard RT(R)(CV) rhoward709@aol.com
Contact: Christopher Shaver RT (R) christophershaver@
msn.com
We are currently planning the AVIR Virginia chapter
11th annual symposium at the Great Wolf Lodge in
Williamsburg, Virginia. We have a great group of speakers
with talks surrounding the world of Interventional
Medicine. The date this year is November 14-15, 2014.

And last but not least…from the Badger State….

Wisconsin Chapter
Contact: Jen Eklund.
Email: daisymay1210@yahoo.com
The Southeast Wisconsin chapter brings a
strong 8 credit symposium in the Spring of
2014. Saturday March 1st. It is to be held at the Clarion
Hotel located at 5311 S Howell Ave in Milwaukee
again this year. The Symposium covers a range from
Embolization of AV Fistulas, to Planning and Constructing
a Vascular Hybrid Operating Room, all the way to Coding
Regulations in IR. A great variety worth all 8 CEUs,
AVIR Local Chapter Has Benefits

In appreciation of those chapters providing Regional or Local Meetings with a minimum of 7 hours of continuing education for the chapter’s attendees, the AVIR is going to extend one FREE registration to the Annual Scientific Meeting of that year per year. The category A credit hours will have to be approved by a RCEEM recognized by the ARRT (AVIR being one of these) and will need to be submitted to the AVIR office prior to the AVIR/SIR registration deadline.

Attention All Writers

The Interventional Informer is offering $100 to the best article. This is awarded for each issue of the Informer. The articles should be originals. No limit in size, but they must pertain to Interventional Medicine. 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.

Fall 2013
Simulation Training in IR – It’s come a long way...
By Rob Sheridan

Any questions concerning the formation of new chapters or existing ones please call the AVIR office at 703 234-4055 or the Director at Large:
Crystal Hanson AVIR
Email: chansonAVIR@gmail.com
Phone: 608-732-7150
Again, thank you
For your support!

CIT Review

You may find the following book very helpful well trying to review for the PV exam. This book in the past has been one of the main contributing resources for that exam. The sample focuses on protocol and equipment. It explains how to perform all current interventional radiology procedures, including pulmonary angiography, vein embolization, biopsies, drainage, and stenting. Chapters will include a discussion of issues such as risk management, outpatient care, and drugs and dosages. You’ll find it in an outline format making the information easily by, review, and remember.

ISBN 9780781768160 Lipincott Williams & Wilkins
Presidents Welcome:
It has been my privilege to work with such an amazing and dedicated team of professionals this year. I look forward to continuing my partnership in my new role and with Rob’s leadership taking AVIR to new levels. We welcome new Team Members Alisha and Lora, we truly look forward to working with you now and well into the future, which has never looked brighter.
Izzy Ramaswamy, RT
2013 AVIR President

President: Robert M. Sheridan, RT (R)
Mr. Sheridan is the Director of Clinical Operations for Interventional Radiology at the Massachusetts General Hospital (MGH), a 900 bed academic medical center located in Boston. Massachusetts General Hospital is Ranked # 1 by US World News Reports and is the primary teaching hospital for Harvard Medical School.
Mr. Sheridan has 18 years experience in Interventional Radiology and is responsible for the overall strategic planning and operations for 15,000 image guided procedures for 6 IR divisions, and 4 clinical units.

Vice President: David Nicholson, RT (R)
I have worked at the University of Virginia Medical Center Interventional Radiology Department since 2000. For three years I was the Clinical Coordinator for the Charles J. Tegtmeier School of Interventional Radiology and Special Procedures. Over the past 10 years I have spoken at several regional and national conferences. I have also participated in research projects as well as book chapters, abstracts, and manuscripts. I hope my interests in teaching and education will go far on the AVIR board, and I am excited to see what the future holds for the organization.

Secretary/Treasurer: Alisha Hawrylack, RT(VI)
I am currently employed by the Division of Interventional Radiology at the University of Virginia, where I have been since graduating their IR program in 2008. Working in an academic institution has allowed me to pursue my passion for education. In addition to providing procedural support to physicians, I work to organize continuing education lectures for my colleagues, as well as teach Interventional Radiology students in both a clinical and classroom setting. I believe that in order to stay relevant and engaged, technologists should be provided with educational opportunities that mirror the dynamic challenges our field provides. As the field of Interventional Radiology continues to evolve, so should continuing education. As a member of the AVIR board, I look forward to the opportunity to network with other individuals whose goal is to continue to grow an organization that provides relevant and exciting meetings, conversation, and educational opportunities for their members so that they in turn may continue to provide excellent patient care.

Immed Past President: Izzy Ramaswamy, MS, RT(R)(CV)
A true IR advocate, currently on the leadership team at Miami’s Baptist Cardiac & Vascular Institute. We are an ever expanding combined services department always looking into the future both in a fiscally responsible and technologically revolutionary way. We bring the best of healthcare to the local community and share our best practices to the worldwide community through our participation in ISET, SIR, AVIR, TCT and the rest of the international symposiums available each year.

Director At Large: Crystal Hanson, RT (R)
I grew up knowing that I wanted to start a career helping people. At the UW Hospital in Madison I strive to put patient care first. I work first hand with physicians and RNs making sure their procedures go smoothly. Whether I am positioning or prepping patients, getting the physicians the correct wires and catheters, running equipment such as ultrasound, CT and fluoro, I am also using my anatomy background for good filming techniques. Interventional Radiology is constantly evolving and the ability to adapt to change is important. Being a young employee in Interventional Radiology, I feel that I am growing with the current technologies and could provide good leadership and advise to new technologists.

Annual Meeting Chair: Amanda Popovitch, RT (R)
Interventional Radiologist III at Boston Children’s Hospital, one of the leading pediatric institutions in the world. I have been working here for over eight years and prior to that I completed nearly four years as an Operating Room technologist at Children’s Hospital of Philadelphia. Since working at Boston Children’s in Interventional Radiology my interest in pediatric disease has become a passion with primary interest in Vascular Malformations and Cerebral Neuro work as well as Universal Protocol. I was an invited speaker to the New Orleans AVIR conference in March 2013 and it was at this time that my interest in becoming more involved in the AVIR community grew. I look forward to bringing my knowledge of pediatrics to our incredible community of technologists!

Associate Representative: Lora Cheek, RN, CNRN
I am a Registered Nurse who has been fortunate to have experienced 22 years of growth at The University of Maryland Medical Center in downtown Baltimore. I am honored to participate in the diverse evolution of AVIR as the Associate Representative. I believe we can accomplish amazing feats in healthcare with our clinical teams through situational awareness, mutual support, and open communication promoting every team members voice. My professional experience includes 14 years in the Neurocare ICU, 2 years as the UMMC Stroke Coordinator and the last 6 years as a Senior Clinical Nurse in the dynamic environment of Interventional Radiology. The treatment of acute Stroke and intensive care of the Neuro patient is one of my passions and I have been privileged to have participated as the UMMC onsite coordinator for the Closure clinical trial. Over the last 10 years I have also lectured on these subjects at Local, State and National conferences including AVIR and ARIN.

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Publication Chair: David S. Douthet, RT(R)(CV)
I have been involved in Interventional Medicine since X-Ray School when we were using Schonander Film Changers and had to pull the patients on a wood board, which was sitting on the X-ray table. It has been many Angios ago.

After working at 3 different Hospitals and several different clinics for 20 some years, I ended up in the commercial end of the business. Again 3 different commercial companies, to be currently working at W.L. Gore & Associates with in the Endovascular end of the business doing the EVARs and TEVARs. I keep my license current as you always want to leave a back up plan at hand.

I have been active in the AVIR since 1993 and have been the Publication Chair since 1995. I have had the pleasure of working with alot of great folks over the years and look forward to every year. This is hands down the best thing I have ever done and I love doing it.

Editor’s Note

By David S Douthett RT (R) (CV)

Well I find myself here again. Not sure how you want to take that, but the point is we are in this wonderful ever moving business of Interventional medicine and it keeps coming around to a lot of the same things but always moving. Now in some cases growing, some cases changing and some case shrinking. But not usually just staying the same. We are mandated to be moving because the nature of our business.

Tightening regulations and reimbursement paired with increasing competition are pushing IR towards doing something. Those that do nothing, are the ones that are shrinking. The ones consolidating are changing and the ones going to a larger organization are growing. We are constantly moving and we ALL need to be involved to help this happen. This moving has to come from Relationships. This emerging Relationship needs to start with us as we help the tele-radiology groups and hospital work better together, we need to be supportive of the radiologist and vascular surgeons, we need to be more knowledgeable about the procedure so that we are an intrigue part of the case and be a volunteer of a committee within the hospital. The IR sections will need to find new ways to support the practices at hand and how to find new ways to position and run our sections in the future, leaving some past standards behind.

Your question should be: Is there a case for redesigning the IR Section? We must analyze the following when considering this question:
• They moving more procedures to OP centers
• They moving more procedures to other departments
• Are we all in with Interventional Medicine
• Whether support staff size is right
• The overall hospital being served
• IR staff supporting the Radiology Infrastructure
• IR staff’s relationship with hospital
• IR staff’s relationship with physicians
• IR staff’s attitude towards Hospital
• We competitive with the practice we support
• - Within the hospital and the physicians
The evolving practice of Interventional Medicine is so dynamic I would think that in the same manner a new model of some sort would have to take place. You would have to take your situation and answer each of the 10 statements above. Through this, you would have an idea of what you look like, and from this, you could take the steps in making moves. Remember moving is progressing. In a short brief, let’s consider some modifications to your current design that may make sense. IR is a Unique Section

The differences in the IR section, compared to other sections in radiology, are vast enough, but really, where a lot of the attention has come from are the other Angio sections in or outside of the hospital in which they are competing with the same procedures you are doing. This is, in itself, a story to be told, and as you look at each statement above, and answer them, you can build stories around them. The facts in these stories are what you need to capitalize on. Each of these will bring you closer to understanding how to move.

Growing, shrinking and changing are all Moving and as I stated in the beginning this is mandated to survive in Interventional Medicine...

*Next issue will be some comments around each of the statements above that I have picked up.
### 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

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### CREDENTIALS

- **NAME**
- **FIRST NAME**
- **M.I.**
- **LAST NAME**
- **GENERATION**

### 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** (for official AVIR business only)

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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)

**Other Professional Organizations of Which You Are a Member:**

- [ ]

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

- [ ]

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### Payment Information: [ ] Check Enclosed

**OR** Charge Credit Card:

- [ ] AmEx
- [ ] MasterCard
- [ ] Visa

- **ACCT NUMBER**
- **EXP DATE**
- **NAME ON CARD**
- **SIGNATURE**

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**Student Members Only**

**DIRECTOR**

**PROGRAM ADDRESS**

- **CITY**
- **STATE**
- **ZIP**

- **PHONE**
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.

**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.

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

    Dues are $45 per year.

**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.

*All Memberships are 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

The Association of Vascular and Interventional Radiographers (AVIR)

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