Note from Editor

Dear friends, it gives me immense pleasure to send you the third issue of the newsletter of our society.

In order to make a beginning, however humble it may be it was decided to bring forth the issue, as an MS word document, and to be sent as an email newsletter. This is the third issue.

We intend to make this newsletter, a voice of our society, a medium of exchange of ideas, events, interesting cases, new products so on and so forth. The success of this newsletter in achieving its objectives will to a large extent depend on the participation and contribution of our worthy members.

There has been a significant contribution from the members. I am thankful to members who have contributed the cases and news.

I hope that the contribution from members will increase further in future issues, and we will be able to bring out the issues more frequently.

I sincerely hope that this newsletter will serve a source of good reading and with fruitful contributions from all members will grow with time to come.

With best wishes

Gp Capt Hirdesh Sahni

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The ISNR has accepted the THE NEURORADIOLOGY JOURNAL, formerly Rivista di Neuroradiologia, as its official journal.

Many international societies that have similarly accepted this journal as their official journal. These societies are
- AINR - Associazione Italiana di Neuroradiologia
- Malaysia College of Radiology Neuro Interested Group
- The Neuroradiologists of Alpe-Adria
- Neuroradiology Section Pakistan Psychiatry Research Center
- ANRS - Albanian Neuroradiological Society
- Neuroradiology Section of Singapore Radiological Society
- Section of Neuroradiology Polish Radiological Society
- PANRS – Pan Arab NeuroRadiology Society
- ISNR - Indian Society of Neuroradiology
- Romanian Scientific Committee
- Section of Neuroradiology of Serbia and Montenegro
- Indonesian Society of Neuroradiology
- Neuroradiology Section of the Radiology Society of Iran
- SILAN - Sociedad Ibero Latino Americana de Neurorradiologia

ISNR members on scientific committee of The Neuroradiology Journal representing our society are
- N.K. Mishra, Chairman
- Arun K. Gupta
- Shrinivas B. Desai
- Rakesh K Gupta
- Sanjeev Handique

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Chair of Neuroradiology, University of Bologna
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The web link for this journal is
“www.centauro.it/theneuroradiologyjournal/editorial.htm"
THE NEURARADIOLOGY JOURNAL
formerly Rivista di Neuroradiologia

Founded by
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Alberto Calabro, Aristide Carella,
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Section of Neuroradiology
of Serbia and Montenegro
**Forth Coming Events of ISNR**
The major annual event of the society, the **12th Annual Conference** of the Indian Society of Neuroradiology. This year it is being held at Chennai. It is incorporating the prestigious and popular RAIN 2009, as a one day program on interventional neuroradiology on 12 Oct 2009, from 13th to 15th October, 2009.

**Conference web site:** [www.isnr2009.com](http://www.isnr2009.com)

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**Message from Organisers:**

Dear Colleagues & Friends

It is our great privilege and honour to invite you to the ISNR 2009. — The 12th Annual National Conference of Indian Society of Neuroradiology, to be convened jointly by Apollo Hospitals & Sri Ramachandra Medical College, Chennai.

We are fortunate that International Society for Magnetic Resonance in Medicine (ISMRM) is supporting us in their out reach program this year as well.

The ISNR Annual Conference is a great way for friends and colleagues from the Neuro Radiology Society (ISNR), Society for Magnetic Resonance in Medicine and allied professional communities to get together and share their knowledge.

The conference will cover a host of diagnostic neuroradiology and neurointerventional topics. A one-day workshop on Neurointerventional procedures with live case demonstration and interactive discussion is planned. Topics such as non surgical interventional management of aneurysms, arteriovenous malformations, stroke and spinal lesions will be dealt with.

The theme for the diagnostic radiology will be from “ Morphology to Molecule” and will cover brain tumors, some aspects of stroke, paediatric neuroradiology, neurodegenerative disorders, neuroinfections, neurotrauma and several recent advances in neuroimaging. Leading national and international faculty will deliver the talks and adequate time will be provided for interaction with the invited experts. Ample opportunity will be available for students to imbibe the basics, discuss their difficulties and explore the advances in the field of Neuroradiology. Sessions like morning physics lectures, evening film reading sessions, proferred oral scientific papers presentations, and poster presentations are some of the features planned.

Many experienced and talented members of our profession will support us to make the conference a grand success.

We are eagerly looking forward to welcome you in Chennai

**ORGANISING CHAIRMAN**
Dr N Chidambaranathan

**ORGANISING SECRETARY**
Dr. Swatee Halbe

**SCIENTIFIC COMMITTEE CHAIRMAN**
Dr. Santhosh Joseph
Forth Coming International Neuroradiological conferences

ASNR 2010

http://www.asnr.org/2010/

ASNR 48th Annual Meeting & NER Foundation Symposium 2010

May 15 - 20, 2010 | Hynes Convention Center | Boston Massachusetts

Abstract Submission site is now open. CLICK HERE to Submit.

SUBMISSION DEADLINE: Friday, December 11, 2009 – 5:00pm Pacific Standard Time (PST)

This deadline applies to the following Presentation Categories:

- Scientific Paper (Oral Presentation)
- Excepcia Extraordinaire (Oral Presentation)
- Scientific Poster (Printed)
- Scientific Exhibit (Printed)
- Electronic Scientific Exhibit (eSE)

Submission Topics
Click here to view and download the list of Submission Topics.

Submission Instructions
Download complete detailed ASNR Abstract Instructions. Click here to view instructions.

For preliminary information on the ASNR 48th Annual Meeting and NER Foundation Symposium 2010, click one of the following links.

Boston 2010 » (Quicktime movie, ~15mb)
2010 Overview » (MS PowerPoint, ~5mb)
Program Overview »
Preliminary Brochure »

The Executive Committee of the ASNR invites you to the 48th Annual Meeting, May 15 - 20, 2010, an event that features an historic location and an excellent educational program. Our meeting venue is the Hynes Convention Center in downtown, Boston.

Key Programming Deadlines:

- September 2009 – Preliminary Program and Call for Abstracts available.
- December 11, 2009 – Abstract Submission Deadline.
- January 2010 – On-line registration and housing will be available.
LINNC 2010
The LINNC 2010 is organized jointly with the Anatolian Course of Interventional Neuroradiology (ACINR).

www.linnc-acinr.com/index.php?option=com_frontpage&Itemid=1

LINNC 2010
The LINNC 2010 is organized jointly with the Anatolian Course of Interventional Neuroradiology (ACINR) and will propose more cases, induce more debates to finally lead to progresses within Interventional Neuroradiology field.

The LINNC 09 was a success not only because we had 800 participants, but also because the fusion between the Interventional Neuroradiology and Neurorsurgery has appeared obvious and mandatory. This was the aim of the first LINNC "double hit" and the goal was achieved. The LINNC-ACINR 2010 meeting will continue to make the "fusion" work for the best.

With the close collaboration of the Neurorsurgery Department of Helsinki University (Prof. Juhana Heiskanen – Prof. Miia Jokela), the Interventional Neuroradiology department of Hacettepe University Hospitals – Ankara (Prof. Suatcan Celiktepe – Prof. Bilgin), the Department of Neuroradiology of Istanbul University, Corağusma Medical Faculty (Prof. Nad Kocak – Prof. Orhan Esas), The Interventional Neuroradiology department of Baylor College of Medicine – Houston (Prof. Michel Mandai) and the Interventional Neuroradiology Department of Fondazione Rizzoli Hospital, Parma – Oderzo University – Parma (Prof. Jacques Moret – Dr. Michel Brout – Dr. Laurent Spelle – Dr. Raphael Blanc), we will continue to emphasize the complementarities between the two disciplines and enable the faculty to other very famous surgical and endovascular teams from USA and Europe.

The goal is to stimulate as much as possible open debates on updates regarding knowledge of the diseases, and impact of long term follow up regarding:

- "Flow Diverters": when are we? Different architecutres, clinical experiences, results.
- Management of neurosurgical procedures in patients with antithrombotic treatment and in emergencies: advices and rules.
- IE versus SA in acute stenosis pros and cons; what about the future?
- Giant aneurysms: what is the role of high flow bypass surgery versus "flow diversion" stenting?
- Self expandable stents: a true impact on endovascular long term follow up? Should we abstain most of the aneurysms?
- Predictive factors after HGA to follow and decide endovascular treatment of evolving aneurysms in operated patients.
- New imaging modalities in vascular pathology: pre, peri and post endovascular treatment.

Neuroradiologists and ISA Doctors will provide support and controversy to "transaxial therapy" and debates on medical treatment evolution.

The live cases are the aim of the course and will remain so, just because techniques and skill are indivisibles in our daily practice. The selection of the cases is always done in a way that it demonstrates either the "state of the art", or a specific indication for a given technique, or use of a new technique. Anesthesia is frequently chosen on live demonstrations of technique and practical training, but one should never forget that a "surgical" act has a manual component which needs years of practice to be ethically proposed to a patient. It is often easy to speak about science. It is frequently much more difficult to apply it.

Interactivity between panelists and attenders is another major goal of the course. Discussions will be promoted as much as possible in order to give equal chances to debate on the topics of the lectures and live during live cases.

Finally "evidence based medicine" will be approached through open debates on studies which are deeply inrolled with our daily practice, specially the TEAM study on aneurysms.

Because science is linked with creativity and arts, the magic place of the Louise museum will host the meeting for the pleasure of everybody.

The LINNC-ACINR 2010 meeting will seal for the future a new discipline (whose name has to be found), uniting Neurorsurgery and Interventional Neuroradiology.

Chan Isik on behalf of organizing committee

Jacques MORET  Orhan ESAS  Juhana HEISKANEN  Michel MANDAI  Miia JOKELA  Michel BROUT

Editorial:
LINNC & ACINR
2nd Joint Meeting
June 2-4, 2010
Istanbul, Turkey - Hilton Istanbul Convention Center

Dear friends and colleagues,

The LINNC has mixed, for the very first time, Interventional Neuroradiology and Neurorsurgery live cases. This format has definitely stimulated free and constructive debates but also some refinement on both sides. Many of the comments we got after the first meeting have pointed out the fact that despite the two disciplines work in close relationships, we still don’t know how to appreciate completely how fancy, efficient and beneficial for the patients both techniques can be.

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Chan Isik on behalf of organizing committee
11th congress WFITN
World Federation of Interventional Therapeutic Neuroradiology
http://www.wfitn2011.org/
MEMBER NEWS: (As contributed by members)

Dr Prof Rakesh K Gupta, SGPGI Lucknow
Please note my personal achievements:

1. I have become a member of program committee of ISMRM for three years wef April 2009.

2. I have been inducted as member of editorial board of AJNR for 2 years wef September 2009

Note from Editor: Heartiest Congratulations for these great achievements.
Dr. Hima Pendharkar,
Assistant Professor,
Department of Imaging Sciences & Interventional Radiology,
Sree Chitra Tirunal Institute for Medical Sciences & Technology, Trivandrum, Kerala, India.

International conferences attended-
1) LINNC at Paris in May 2009.
2) WFITN at Montreal, Canada, July 2009. Here I presented 4 posters in the conference, two of which were selected for the "Best poster" award. I however did not make it to the top.

Note from Editor: Congratulations for getting two posters in the award category. Keep it up.

Dr. Prashant Bhatt, Tripoli, Libya

Dear ISNR members

Regards from Tripoli.

I am sending to you a brief report of some activities which I have been undertaking in Libya-Mediterranean region.

My background
A graduate of Maulana Azad-Delhi and post graduate of KEM Hospital Mumbai (under Professor Ravi Ramakantan) at present I am incharge of Radiology in Libyan Swiss Medical Centre, Tripoli, Libya.

Our department has a 1.5 Tesla MRI (GE), Dual slice spiral CT, Conventional radiology and Ultrasound-Doppler.

Pediatric Neurology Association in Libya
Majority of outpatients Pediatric Neurology consists of epilepsy and developmental problems. Particular to Libya is the frequency of recessive disorders, enhanced by the tradition of marriages between relatives (national average: 24% of all couples).

From 22-25 October—we had an extensive review of these cases along with a Dr. Olivier Dulac (OD), Professor of Neurology, Saint Vincent De Paul Hospital, Paris at the Sbia Neurosciences Institute, Libya.

Scientific blogs—
I write weekly in IRADIX since October 2008 www.iradix.in/prashant+bhatt in which I have covered different issues relating to life and science in the day of a working radiologist.

With warm regards
Dr. Prashant Bhatt, MD
Consultant Radiologist
Libyan Swiss Medical Centre
Tripoli, Libya.
A Problem case
From:
Dr. Prashant Bhatt, MD
Consultant Radiologist
Libyan Swiss Medical Centre
Tripoli, Libya.
drpbhatt@gmail.com

Hyperintense areas in dentate nuclei and medulla
Possibility of Mitochondrial disease was discussed. The lack of supratentorial lesions is striking in this case. Any suggestions please.

Note from editor: Please send your suggestions by email to Dr Prashant Bhatt, at drpbhatt@gmail.com, with a copy to drhsahni@gmail.com, so that the discussion can be shared with all later.
Case Report 1:
NEUROSARCOIDOSIS
Dr. D. Ravi Varma
Consultant Neuroradiologist, Krishna Institute of Medical Sciences, Secunderabad

Case History
A 32 year old female with 4 weeks of diplopia and right sided facial paralysis. She also reported having occasional holocranial headaches. Examination revealed left oculomotor palsy and right lower motor neuron facial paresis.
MR brain (Figures 1 – 6) revealed a heterogenous lesion in the dorsal pons on right side of midline. The lesion showed minimal perilesional edema and intense nodular enhancement. The ventral surface of the brainstem, bilateral oculomotor nerves and the left trigeminal nerve demonstrated nodular foci of intense enhancement. Nodular enhancing lesion was also seen involving the hypothalamus and infundibulum of pituitary gland. There were multiple other foci of nodular enhancement within the convexity sulcal spaces and in the right Sylvian fissure.

CSF - elevated proteins, mononuclear pleocytosis, and normal sugar levels. CSF angiotensin converting enzyme levels were elevated. There were no organisms on Gram stain, Zeihl Neelson stain and India ink preparation. There were no malignant cells.

Chest radiograph revealed reticular pattern in the lung fields on either side.

Taking into consideration, the clinical presentation, brain imaging, chest radiographic features and findings on CSF analysis, she was diagnosed to be suffering from neurosarcoidosis. The patient was treated with corticosteroids and has reported significant improvement in symptoms.

Discussion

Sarcoidosis is multisystemic granulomatous inflammatory disorder of unknown etiology. While clinical involvement of the central nervous system is seen in 5 – 15% of patients suffering from sarcoidosis, the incidence of subclinical neurosarcoidosis is thought to be higher.

Virtually any part of the nervous system can be affected. Cranial neuropathy – on presentation occurs in up to 75% of patients. Facial palsy is the single most common neurologic manifestation, seen in 25% to 50% of neurosarcoidosis patients. The eighth cranial nerve is involved in 10% to 20% of cases. Optic neuropathy is an uncommon but serious manifestation of neurosarcoidosis, seen in about 15% of cases. Other common modes of presentation include aseptic meningitis (10-20%), hydrocephalus (10%), endocrinopathies (10-15%), mass lesions (5-10%), encephalopathy (5-10%), psychiatric symptoms (19%). and seizures (5-10%).

Those with an acute presentation usually present with isolated cranial neuropathies or aseptic meningitis, and those with chronic onset usually present with parenchymal involvement, hydrocephalus, multiple cranial neuropathies, or peripheral nervous system manifestations.

MR imaging with gadolinium contrast enhancement remains the preferred imaging technique for neurosarcoidosis. Leptomeningeal involvement is the most commonly reported imaging abnormality (40% of cases). There is thickening and diffuse or focal/multifocal enhancement of the leptomeninges on contrast-enhanced T1-weighted images. There is a distinct predilection for involvement of the basal meninges and along the cranial nerves. Neurosarcoidosis with predominant dural involvement may be seen as pachymeningeal thickening and enhancement or even dural based masses simulating meningiomas. Thickening and enhancement of the pituitary infundibulum and hypothalamus can be seen either as an extension of leptomeningeal involvement or in isolation.

Parenchymal lesions of neurosarcooidosis are seen multiple periventricular lesions that may or may not enhance. These lesions are frequently associated with leptomeningeal involvement in the proximity and are thought to represent spread along the perivascular spaces. Central necrosis is absent in these lesions. Larger lesions may appear dark on T2 weighted images and mimic intraaxial mass lesions.
Communicating hydrocephalus is reported in 5% to 12% of patients. It results from altered cerebrospinal fluid (CSF) resorption secondary to dural or leptomeningeal involvement. Adhesions or loculations in the ventricular system may cause obstructive hydrocephalus.

Spinal involvement may occur in a variety of locations, including the cord or nerve roots, the intradural-extradurally space, the extradural space, or the vertebral bodies and disks. Spinal cord involvement can appear as a focal enhancing lesion with cord enlargement, focal or diffuse enhancement, or regional cord atrophy. Thickening, nodularity and matted nerve roots may be seen in the cauda equina.

Differential diagnosis of neurosarcoidosis includes primary neurologic diseases, such as multiple sclerosis, lymphoma, primary CNS neoplasia, primary CNS infections including tuberculosis, neurosyphilis, and toxoplasmosis, Whipple’s disease, and autoimmune diseases (including systemic lupus erythematosus, Sjogren syndrome, Behcet’s disease, Vogt-Koyanagi-Harada disease, lymphocytic hypophysitis, pachymeningitis, and isolated angiitis of the CNS).

The diagnosis of neurosarcoidosis may be challenging as the disease mimics other infectious, demyelinating, granulomatous, neoplastic, and connective tissue disorders affecting the nervous system. The diagnosis is particularly difficult when neurological complications precede other systemic manifestations of sarcoidosis affecting lungs, lymph nodes, skin, or eyes. Though several laboratory investigations such as elevated serum angiotensin enzyme or serum immunoglobulins, hypercalcemia, or hypercalciuria, may suggest the diagnosis of sarcoidosis, none of these tests is confirmatory. Apart from histopathological demonstration of noncaseating granulomas in the central nervous system, the diagnosis of neurosarcoidosis is largely by exclusion.

References:


Case series 2
Oesophageal Stenting
Dr. DS Dhiman,
Professor and Head, Dept. Of Radio-Diagnosis, IGMC Shimla.

IGMC SHIMLA has started oesophageal stenting recently and five cases are performed in this institution.
The following members were in the team:- D.S. Dhiman, Anupam Jhobta, Sanjiv sharma, Suresh Thakur and Prof Brij Sharma (Gastroentrologist)
Patients with malignant esophageal stricture were selected and preliminary barium swallow study was done to locate the exact site and extent of the esophageal stricture. After that under fluoroscopic guidance 1st of all a guidewire was passed to the stomach then strictures dilatation was done and then self expanding nitinol esophageal stent was placed with the help of endoscope across the strictures. Barium is given to the patient to look for the right positioning of the stent and competency of the lumen of the esophagus.
In one case complication there was complication of oesophageal perforation.

Indications
1) Palliation of malignant dysphagia in inoperable tumors.
2) Dysphagia due to extra esophageal tumors such as lung cancer/malignant lymphadenopathy.

Benefits
Improvement of quality of life is the most important objective.
Dysphagia has been effectively and reliably relieved

Risks and complications

Intraprocedural complications
Conscious sedation, Aspiration, Malpositioning of the stent, esophageal perforation.

Early post-procedural complications
Chest pain, foreign body sensation, Bleeding, Tracheal compression, with resultant airway compromise and Respiratory arrest

Late complications
Distal stent migration, esophageal fistula, Bleeding, Perforation and Stent occlusion

The oesophageal stenting should be done cautiously where the stricture is tight and slow dilation should be performed before placing the stent in position.

OESOPHAGEAL STENTING TEAM AT IGMC SHIMLA

Lt.to Rt:- Dr. Anupam Jhobta Asst Prof
Radio-Diagnosis. Dr.Brij sharma Asst Prof
(GASTRO);Prof.& Head Dr. DS Dhiman
Radio-Diagnosis, Dr. Sanjiv Sharma
Associate Prof. Radio-Diagnosis.
Barium study to define stricture location, length, angulations, and presence of tracheoesophageal fistulas

The delivery device is pre-mounted over the guide wire

As the outer sheath is retracted, the stent slowly expands. Once the stent is fully deployed, the guide wire and delivery device are

Esophageal perforation leading to hydropneumothorax in one of the patients
A 29 year old agriculture laborer from West Bengal who presented with 3 months history of Lt eye proptosis and chemosis of 1 month duration following road traffic accident. Type1 CCF of Lt ICA treated using 4x16mm Jomed stent graft. Post procedure patient improved in symptoms but has developed Lt 6th cranial palsy which we believe is due to acute thrombosis.