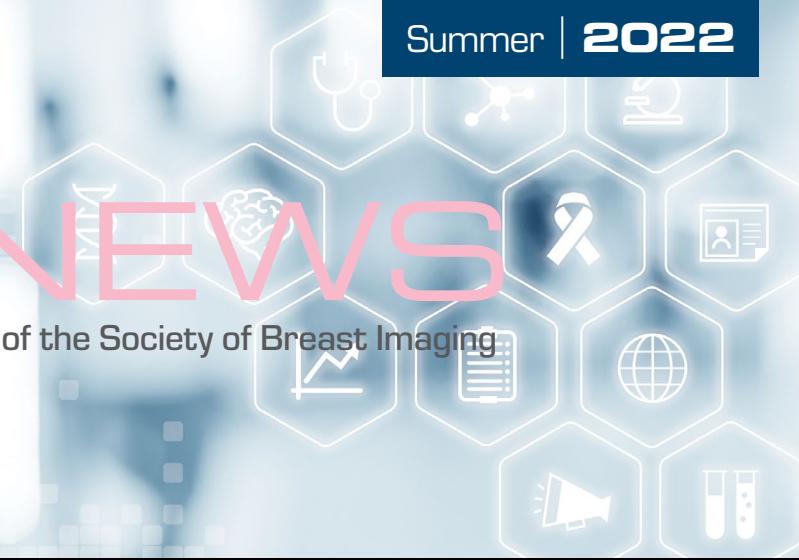




SBI NEWS

The Member Newsletter of the Society of Breast Imaging



INSIDE THIS ISSUE:

- SBI 2022 Meeting Highlights
- Legislative and Advocacy Update: The Future Is Now
- Highlights From the ARRS 2022 Meeting in New Orleans

SBI New Fellows Inducted May 2022

Michael Plaza, MD, FSBI



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Table of Contents

- 3 | President's Column
- 4 | Editor's Note
- 5 | Legislative and Advocacy Update:
The Future Is Now
- 6 | Technologists' Column: Staff Shortages in Breast Imaging: Where Do We Go From Here?
- 9 | Enhancing Wellness: The Importance of Effective Feedback
- 11 | What's New in the News: Exploring Image-Guided Ablation for the Treatment of Breast Cancer: A Natural Progression to Less-Invasive Surgical Options
- 13 | Mentorship Committee Update
- 14 | Member-in-Training Column:
Tips & Tricks for Trainees in Breast Interventions:
Ultrasound-Guided Biopsy
- 17 | Young Physician Section: Learning From Experience
- 20 | RAD-AID Column
- 21 | SBI New Fellows Inducted May 2022
- 23 | Highlights From the ARRS 2022 Meeting in New Orleans
- 25 | The Patient's Perspective: Tracy Lloyd
- 27 | SBI 2022 Meeting Highlights
- 29 | Upcoming Events

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Claudia Cotes and Sarah Jacobs

THE PATIENT'S PERSPECTIVE:

Hannah Perry and Danielle Sharek

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Amy Patel

OTHER MEMBERS:

Jean Seely

President's Column

OUR SBI MISSION:

To save lives and minimize the impact of breast cancer

OUR SBI VALUES:

Patient-centered and evidence-based care

Excellence in education

Scientific integrity

Collaboration and collegiality

Respect for diversity and inclusiveness



John Lewin,
MD, FACR, FSBI
President of the SBI

As I write my first column as president of the SBI, I must start by expressing how incredibly honored and humbled I am to hold this position. I joined the SBI as a resident and went to my first meeting as a fellow in 1996. The SBI has been a big part of my professional life, and I have many fond memories of interactions with mentors, mentees, and other colleagues at SBI meetings through the years. I want to thank the many people who worked to make our recent meeting in Savannah such a success. This group includes the program planning committee, the faculty, SBI staff, and quite frankly, all the attendees, especially those who braved the threat of connecting flights, understaffed departments, and COVID-19 to attend in person. You all contributed enormously to the great spirit that was felt throughout the meeting. And yes, the first SBI gala was amazingly fun, beyond my expectations. It was great to see everyone relax after being cooped up for two years due to the pandemic.

Next, I want to give some idea of what I see as the SBI's key areas of emphasis for the next year. The responses to the recent diversity, equity, and inclusion survey that the SBI Board of Directors distributed, with the help of our consultants at Nika White Consulting, revealed a broad range of opinions about where the society's strengths currently lie and where we should make improvements. One consistent theme, however, was that our membership wants to be more involved in society activities and decision-making. This conclusion is very heartening as it is a sign that the work of the society is seen as important and relevant. To address this important issue, the board will continue to consider different ways to expand opportunities for member participation. Changes already made include an expansion of the criteria for fellowship so that members who are leaders in private practice, but may not

have published many papers, can become SBI fellows. You may have also noticed an increased number of non-fellows who participated as faculty during the recent symposium. Both moves are designed not only to increase participation but also to keep the meeting somewhat fresher. Additional opportunities for members to teach (and for members to learn from fresh faces) lie in our SBI webinars, which have been a huge success. Our 2022 Summer Webinar series is currently under way and is off to a great start.

As part of our efforts to broaden participation, we will continue to increase transparency in all of our activities but primarily in how we choose people for leadership positions at both the committee level and the board level. Even before the survey went out, the board had recognized the need for change in this area and had made some changes in the way we choose members and fellows for committees and leadership positions. Our most recent committee and board openings were filled after an open call for applications. While we should all be happy with the results of those efforts, we also learned a lot and will be working to further improve the process to make it more inclusive as well as more transparent.

Finally, I would like to give my thanks to two of our amazing board members who will be leaving during the coming months, Dr. Elizabeth Morris, chair of fellows, and Dr. Jennifer Harvey, the founding editor of the *Journal of Breast Imaging*. There is nothing I can say about these two super-accomplished physician-scientists that could capture even a fraction of their contributions to the field. Both are leaving in part so they can concentrate on their positions as chairs of departments of radiology, part of a growing list of SBI members who are in that position.

Both Liz and Jennifer are irreplaceable, but we have no choice but to do just that. Keeping in mind our goals of inclusion and transparency, we have formed a committee to choose the next editor of the *JBI* and are finalizing the selection criteria. The next editor will inherit a journal that is growing in submissions, citations, and social media mentions and will almost certainly become indexed in PubMed in the next year. It is a great opportunity for the right person to make a huge impact on our field. The call for applications should be soon and I would encourage every member and fellow who meets the criteria to consider applying.

Best wishes for a great summer,

A handwritten signature in black ink that reads "John Lewin".

John Lewin, MD, FACR, FSBI
President, Society of Breast Imaging

Editor's Note

By Vilert Loving, MD, MMM, FSBI

Humans are social animals. Whether one is an introvert or extrovert, some degree of regular social interaction is vital for one's well-being. When people are socially isolated, they experience psychological and physical repercussions. Social isolation is associated with increased risk for early mortality.¹ For diagnostic radiologists specifically, burnout is prevalent, and isolated time in reading rooms is an important contributing factor to this trend.² Unfortunately, the omnipresent COVID-19 pandemic has only worsened social isolation and the resultant psychological and physical stressors on the global population.³



Vilert Loving, MD, MMM, FSBI

Organizations may combat social isolation by fostering a sense of belonging or community. For breast imaging radiologists and staff, the SBI is a community. In May 2022, I attended the SBI/ACR annual symposium in person and was acutely reminded how pleasant it was to interact with like-minded colleagues. In this *SBI News* edition, Dr. Claudia Cotes and Dr. Sasha Kurumety nicely highlight the symposium. For those who could not attend the conference, as you read their article, I encourage you to envision yourself as a conference attendee. As physicians in a subspecialty field, breast radiologists frequently experience the same trials and tribulations: breast cancer screening controversies, new technologies (artificial intelligence is everywhere!), burnout, workplace shortages, and the list goes on. When discussing best practices and challenges with others, we often develop a “swarm intelligence” that surfaces creative solutions.⁴ At the very least, it was nice to know that I wasn’t the only one with unique breast imaging-specific problems!

The SBI has developed many resources to cultivate the breast imaging community, and I encourage you to search the SBI website for solutions that might best fit your personal situation. In addition to the annual symposium, *SBI Connect* has blossomed into a vibrant online discussion forum. Similarly, the SBI social media accounts are possible venues for interacting with the wider breast imaging community. The SBI mentorship committee, as discussed in this *SBI News* edition, is another resource that will generate networking opportunities catering to early-career breast radiologists. Debuted in 2019, the

Journal of Breast Imaging has evolved into one of the premier forums for presenting and discussing the scientific, educational, and practice-oriented issues relevant to our field. Even this newsletter is a forum for sharing conversations and thoughts with the breast imaging community, particularly those touching on the “art of medicine” topics that are critical for breast radiology.

I invite you to revel in the breast imaging community, join the conversation, and participate in any of the aforementioned SBI initiatives. Contributing to *SBI News* is potentially easier than you may believe. If you have any stories, questions, ideas, or breast imaging-related personal passion projects, I invite you to write to me: vilert.loving@bannerhealth.com. The SBI Newsletter Committee will consider any article idea for publication. Thank you for reading this edition of *SBI News*. Please have a pleasant summer, and don’t forget your sun protection!

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Legislative and Advocacy Update: The Future Is Now

By Amy K. Patel, MD

Off the heels of the ACR Annual Meeting followed by the SBI/ACR Breast Imaging Symposium, radiology political advocates (radvocates) are reinvigorated with a renewed sense of activism for our patients and profession.



Amy K. Patel, MD

At the ACR Annual Meeting, the typical Capitol Hill Day, when radiologists meet with federal elected officials to lobby for important radiology legislation, did not occur because of security concerns. However, a virtual Capitol Hill Day is scheduled to take place later this year. Hopefully Capitol Hill Day can again occur in person at the ACR Annual Meeting in 2023.

Nevertheless, advocacy endeavors at the 2022 Annual Meeting marched on and included the unveiling of a new initiative of collaboration between the three branches of ACR Government Relations: the Radiology Advocacy Network (RAN), the Radiology Political Action Committee (RADPAC), and State Government Relations. With this new endeavor, the three bodies will take a more collaborative approach when tackling advocacy issues when there is overlap with legislative and regulatory issues and will eliminate duplicative efforts. The full plan of this new endeavor will be unveiled in the coming months. A task force representing all three bodies has been devised to ensure a smooth transition into the future of radiology government relations. However, within these three bodies, changes are occurring as follows.

The Radiology Advocacy Network

Advocacy is one of the fundamental missions of the ACR and includes the RAN.¹ The RAN is composed of over 200 trainees and attending radiologists representing their training programs, practices, or institutions. The RAN leader serves as the point person between their training program, practice, or institution and the ACR. Currently, each state has a main RAN leader as well as a residency program. However, a Young and Early Career Professional Section (YPS) RAN is currently being developed, with almost 30 states represented. The goal is to have the main RAN leader work in concert with the YPS RAN leader and the residency program RAN leader to ensure that efforts are collaborative and synergistic and to promote pipeline creation and sustainment. These RAN leaders ensure that federal legislative calls to action and other RAN communications on federal issues are being disseminated to their peers.

Additionally, I am honored to now assume the role of chair of the RAN, having been passed the torch by Dr. David Youmans, who did a tremendous job during his five years as chair. We have now devised an inaugural RAN Board composed of members of all levels of training, practice type, and government relations representation. We are

also going to implement increased communication via digital media and boots-on-the-ground efforts, including providing state support on pressing policy issues if needed (ie, state calls to action). Involvement in the RAN is crucial to tackle state and federal policy issues affecting our patients and profession, so this expansion of the RAN, known as RAN 3.0, will propel us into the next era of advocacy.

Radiology Political Action Committee

Together with advocacy efforts at the federal level comes RADPAC, the nonpartisan, multicandidate political action committee of the American College of Radiology Association. RADPAC focuses on the political influence of radiology in Washington, DC, and contributes to campaigns of candidates based on their ability to best represent the interests of radiology. As of the first quarter of 2022, RADPAC has disbursed funds to 46.5% of Democrats and 53.5% of Republicans, highlighting its nonpartisan nature and commitment to supporting pro-radiology candidates. RADPAC has been instrumental in championing continued moratoria in the Protecting Access to Lifesaving Screenings Act to extend annual screening mammography coverage beginning at age 40 years with no copay, largely due to stalwart relationships with mammography champions such as Representative Debbie Wasserman Schultz (D), a breast cancer survivor. This form of advocacy is incredibly crucial to ensure our patients' voices are heard on Capitol Hill. In recent years, RADPAC has fallen to fourth place in terms of dollars raised by subspecialty PACs (anesthesiology, orthopedic surgery, and dentistry are in the first three positions).² To provide a more long-term presence at the highest levels of RADPAC leadership, a new chair who will fulfill a multiyear term will be chosen by November 2022. Previously, the RADPAC Board chair was the chair elect of the ACR Board of Chancellors. There will be an open application process to serve in this role and on the RADPAC Board as a general member. Please be on alert as the application submissions will open in the summer of 2022.

State Government Relations

The ACR State Government Relations Committee is imperative to ensure that state policy issues are being addressed in a timely fashion and that the states have a voice in legislative and regulatory issues. The current chair of this committee, Dr. Bonnie Litvak, took over from Dr. Loralie Ma, a dedicated leader who served in

Continued on page 8 >



Staff Shortages in Breast Imaging: Where Do We Go From Here?

By Robyn Hadley, RT(R)(M); Sarah Jacobs, BS, RT(R)(M)(CT)

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RID:2668

Organizations across the country have suffered from staffing challenges during the past couple of years. It is no surprise that breast imaging teams have also felt this strain. This situation is largely due to the COVID-19 pandemic, which has contributed to retention problems, burnout, overwhelming workloads, and departure of senior staff. Staffing shortages have led to unprecedented employee disengagement and burnout, potentially negatively impacting image quality and access to breast imaging services. Now more than ever, it is essential that we focus on maintaining healthy work environments to optimize image quality and access for breast health examinations.

Prior to the challenges brought about by the COVID-19 pandemic, the *American Journal of Roentgenology* published a study aimed at developing forecasts for the future supply of radiologists and mammography technologists.¹ The study included basic mammography workforce statistics to provide context for these forecasts using an age cohort flow model based on data from the ACR and American Society of Radiologic Technologists (ASRT). At that time, concerns about future workforce adequacy prevailed. Forecasts showed that rates of production of new mammography professionals would result in a significant reduction in mammography professionals between 2009 and 2025. The supply of radiologic technologists was forecasted to decline approximately 22% by 2025. The number of radiologic technologists per 1000 women over age 40 years was forecasted to decline by 23% by 2015 and decline again by 40% by 2025. In 2022, it is alarming to observe the accuracy of these forecasts created before the pandemic.

Area Health Education Center (AHEC) recognized that staffing shortages are being reported in many different ways on the internet and social media outlets.² To assess the staff shortage of radiologic technologists within imaging departments, AHEC surveyed participants from 34 states. The survey results showed the following:

- 81% of facilities were experiencing staffing shortages.
- 35% of the total positions not filled were within the mammography modality.
- 49% of participants reported that their imaging departments were still maintaining regular schedules.
- 74% did not change imaging service delivery.
- 56% of facilities were authorizing overtime to cope with the shortage.



Robyn Hadley, RT(R)(M)



Sarah Jacobs, BS,
RT(R)(M)(CT)

- 57% of participants stated that heavy workloads and staff burnout were factors that contributed to the shortage.
- 30% of the facilities were receiving applications for the open positions.

Hadley conducted a similar survey in 2022 to assess staff shortages specific to breast imaging departments (unpublished). Despite the limitations in the number of responses, the Mammography Technologist Workforce online survey targeting breast imaging professionals reported similar results:

- 72% of facilities were experiencing staffing shortages.
- 71% were still maintaining regular schedules.
- 66% did not change imaging service delivery.
- 29% of facilities were authorizing overtime to cope with the shortage and 45% reported no changes made.
- Over 50% of participants stated that staff burnout and staff retirement were factors that contributed to the shortage.
- 23% of the facilities were receiving applications for the open positions.
- 39% of respondents reported considering leaving the profession or moving to a new modality.

While both surveys reported similar results, Hadley's survey revealed that a startling 39% of participants considered leaving their career in the breast imaging profession. Additionally, in 2019, the ASRT reported that departments were understaffed by 5.6% in mammography before the COVID-19 pandemic.³ Given the stressed prepandemic working environment, the current breast imaging workplace is in a critical state. Nonetheless, optimism and promise can be found in the remaining 61% who reported a desire to remain in the profession.

Effects of Staff Shortages on Image Quality

Decreased resources and pressure to maintain overloaded schedules can lead to a breakdown in image quality. When inadequate time is provided to complete examinations, staff members may subconsciously submit images of inadequate quality. Research examining mammographic positioning identified five factors contributing to inadequate breast positioning⁴ and technical recall rates⁵:

1. Reluctance to repeat images of suboptimal quality because of insufficient time, increased radiation dose, patient reluctance, and difficulty explaining the procedure to the patient (Figures 1 and 2)

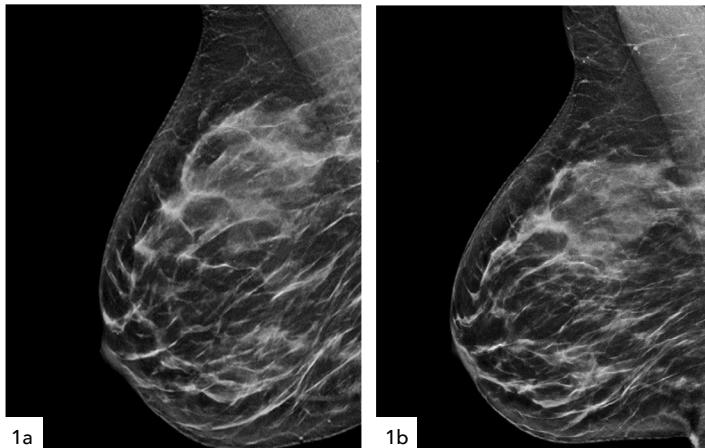


Figure 1. Right mediolateral oblique image of suboptimal quality because of reluctance to repeat (A). Repeated right mediolateral oblique image with improved image quality (B).

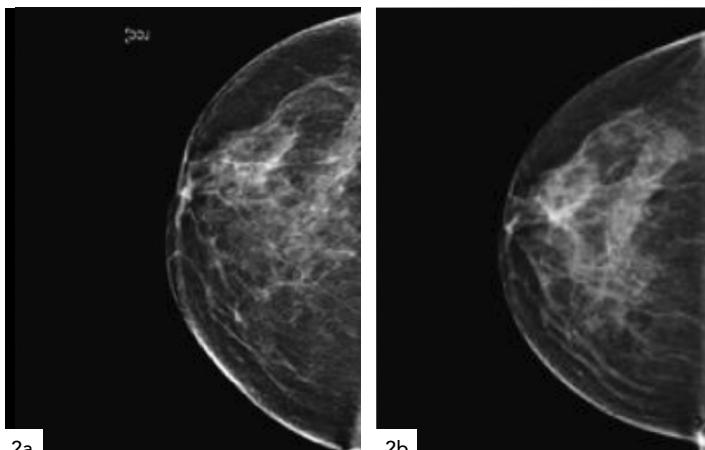


Figure 2. Right craniocaudal image of suboptimal quality because of reluctance to repeat (A). Repeated right craniocaudal image with improved image quality (B).

2. Difficulty with challenging patient circumstances such as patient physical limitations, patient discomfort, and fear
3. Inconsistencies in image evaluation and analysis due to subtlety or disagreement of criteria, no standardized positioning training, and insufficient new hire training
4. Insufficient time for patient care as a result of limited examination time and room resources, along with repeat examinations and images requiring added time
5. Lack of technologist engagement in building connections with their work and patients, low accountability, and stressful environment

It is evident that sufficient time for patient care is essential since insufficient time allotted for patient care leads to poor image quality. Adequate professional education and training improves the technologist's examination proficiency, image evaluation skills, and quick, efficient troubleshooting abilities. Continuing hands-on education and routine skill development are essential and should be important aspects of all imaging departments. This type of continuing education can help ensure that staff remain engaged and confident, which can extend assurance to primary care providers, patients, and interpreting radiologists.

Staffing Supply and Healthy Workplace System Resources

Educational Institutions and Mentorship

Working with local educational institutions by offering career-shadowing opportunities can be an excellent way to draw prospective new graduates into your facility. Promoting the profession at career and job fairs locally can also attract potential technologist candidates. In addition, mentorship programs can increase supply and interest in the field and can be important to one's success.

The ACR recognizes mentorship programs as a tool to promote well-being and reduce burnout. Although the ACR's well-being programs were created directly to reduce the impact of burnout on breast radiologists, many of these tools for mentorship and well-being can be modified to implement a practice for technologists and other imaging staff as well.⁶

Workflow Efficiency and Communication

Identifying inefficient workflow processes provides an opportunity for team members to work together to redesign processes that improve efficiency and ease of everyday tasks. Searching for methods of effective communication is key to continuous workflow efficiency and ensuring that staff members are able to relay ideas and be heard.

Artificial Intelligence

Artificial intelligence (AI) is gaining a significant amount of attention from breast radiologists for earlier cancer detection. However, from a technologist's perspective, there is also value in implementing an AI program to ease the burden of image quality assessment while decreasing subjectivity. Time spent assessing images can be decreased because AI systems can help troubleshoot and assess issues associated with image quality. Breast imaging professionals can use this saved time to focus on exceptional patient experiences.

Retention and Well-being of Imaging Personnel

Retention of breast imaging staff is essential to increasing and maintaining access to lifesaving screening services. It is critical that breast imaging organizations place more emphasis on technologist retention and engagement. Technologists are the first line of contact with patients and act as liaisons between radiologists and patients. A higher perceived level of care will likely follow when technologists are able to build connections with patients through engaging conversation and effective patient care. With higher levels of burnout and stress in the imaging department,⁷ creating a peer-led wellness curriculum based on team needs can be an effective method to

Continued on page 8 >

Technologists' Column: Staff Shortages in Breast Imaging: Where Do We Go From Here? (continued from page 7)

improve well-being and combat low engagement.⁸ Four key factors of wellness can be used as pillars for improving well-being and engagement in the workplace:

1. Physical well-being
 - a. Take a break: As challenging as it may be to step away from the department when work is piling up, taking a break even for a few minutes can ensure higher levels of focus. Encourage technologists to take breaks throughout the day or eat their lunch outside the department.
 - b. Activities: Take a few moments throughout the day to practice physical and wellness activities to promote a more serene and focused work environment. Physical activities may include short walks out of the department, stretching, or deep breathing exercises.
2. Emotional well-being
 - a. Gratitude: Gratitude practices and personal connections are excellent means for improving departmental resilience and extending compassionate levels of appreciation to colleagues.
 - b. Activities: Supply cards for handwritten thank-you notes and encourage your team to use them. Creating a gratitude board that all can contribute to is an easy way to promote sociability. Encourage more personal conversations among your team and take note of each other's well-being.
3. Intellectual well-being
 - a. Creativity: Considering the intellectual demands placed upon individuals in the workplace, intellectual well-being remains most valuable when viewed creatively. Explore avenues that stimulate creativity and critical thinking while developing knowledge and skill sets.
 - b. Activities: Read articles on new technology, stay current with legislation that affects screening mammography, register for a class or training session on a topic of interest, or read for pleasure.
4. Spiritual well-being
 - a. Connection: Workplace spirituality thrives when individuals are able to experience connection to something larger than themselves and find meaningfulness and purpose while working.
 - b. Activities: Stay positive and connect work to values. The time given to serve others should be carefully balanced with personal time. Spend quiet time in reflection and learn to find value in silence through meditation and disconnection from technology.

With staff burnout at an all-time high, dedicating time and resources to creating a breast imaging team that is engaged and resilient is more important than ever. Revisiting scheduling templates to provide efficient durations for high-quality examinations will increase both patient and employee satisfaction. To maintain adequate access to breast health services and high-quality imaging, it is essential for imaging departments to prioritize retention, wellness, and the

well-being of all team members. These efforts will help organizations navigate through the challenges of burnout and staffing shortages.

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Legislative and Advocacy Update: The Future is Now (continued from page 5)

this role for many years.³ Additionally, the ACR has hired a specific government relations staff member, Dillon Harp, to focus on state advocacy and legislative issues, particularly scope of practice. Dillon joins with a wealth of experience and has already proven himself an integral part of the team.

In an increasingly competitive and passionate health care environment, radiology political advocacy is imperative, now more than ever. It will take a concerted effort from all in the house of radiology, regardless of practice type, to contend with the many challenges that will be facing us, including reimbursement and, most importantly, equitable access to care for our patients. The days of being siloed and not being actively involved are over. We must all rise to ensure a stable and prosperous tomorrow. The future is now. So please join us as we enter this new chapter of radiology political advocacy to ensure a brighter tomorrow for our patients and profession.

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Enhancing Wellness: The Importance of Effective Feedback

By Sarah Jacobs, BS, RT(R)(M)(CT)

Enjoyment can be found when breast imaging teams use individual strengths and resources to strategically improve performance¹ while contributing to a healthy work environment. You may be surprised to learn that one of the key elements to creating this vision is feedback.

In many fields, feedback is often viewed as an individual assessment or report. However, feedback is defined as “information about reactions to a product, a person’s performance of a task, etc, which is used as a basis for improvement.”² The critical word in this definition is *improvement*.

The idea of someone having an opinion about our work can be terrifying, bringing up fears that managers may perceive our work as lacking or needing improvement.³ Whether warranted or not, these concerns may impact our mental health and response to others. During clinical site visits each month, I often ask mammography technologists how often they receive feedback from the interpreting radiologists who view their images. A simple “never” is the answer 8 out of 10 times. Often, individuals say, “I only get feedback when I need to correct something.” In a recent survey completed in February 2022, a social media platform that offers quality educational resources to mammography technologists created a poll asking technologists how often they receive positive feedback from their interpreting physicians. The poll revealed that an alarming 50% of the technologists only received feedback if there was a problem with their images (Figure). Unfortunately, positive feedback is not provided often enough in the breast imaging setting.

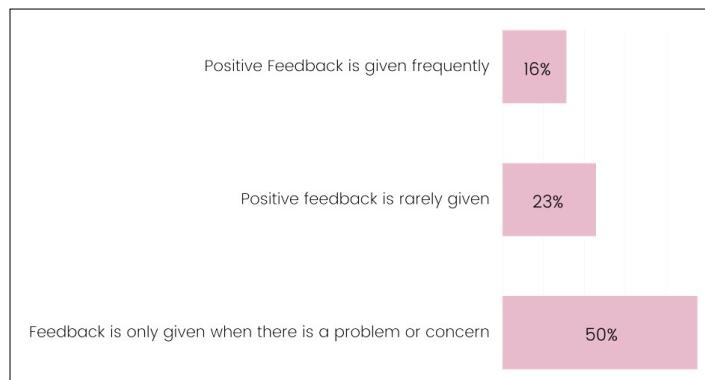


Figure. Results of Facebook poll on feedback in breast imaging.
Source: Jacobs S. Quality Breast Imagers Facebook page. February 2022.
<https://www.facebook.com/groups/qualitybreastimagers>

Rethinking the definition of feedback is needed now more than ever. Tamra Chandler, nationally recognized thought leader and author, has provided a useful definition: feedback should be defined as “clear and specific information that’s sought or extended for the sole intention of helping individuals or groups improve, grow, or advance.”⁴



Sarah Jacobs,
BS, RT(R)(M)(CT)

Why Feedback Is Important

When leaders embrace this redefined method of offering feedback to their colleagues, it demonstrates attentiveness and care about an individual team member’s contributions to the team. When staff members work in an environment where actions matter to others, they will likely feel more fulfilled, engaged, and healthy overall.

Consistent feedback increases employee engagement and job satisfaction. The mental and physical benefits of working in a feedback-rich culture are extraordinary¹:

- Enhanced immunity
- Decreased burnout
- Decreased depression
- Less physical illness over one’s lifespan
- Greater longevity

Feedback can be delivered in several ways depending on the individual receiving the feedback and the desired outcome. Social scientist and speaker Dr. Therese Huston recognizes three methods of delivering feedback. Placing focus on the method that those receiving feedback connect with the most will drive the opportunity for mutual understanding. It’s important to note that at some point in time, individuals will need all three methods of feedback to sustain engagement in their work.^{5(p42)} According to Huston, the three kinds of feedback that drive results are as follows:

- Appreciation: often the first method of delivering feedback and the one that should be used the most. Use appreciation when you want to see more of a specific behavior.

Continued on page 10 >

- Coaching: advice offered with the intent of making a change in behavior. Coaching inspires action and will help the individual find the courage to adapt, improve, and learn.
- Evaluation: lets the individual know where they stand relative to expectations within their role.

Tips for Delivering Feedback Effectively

- Before delivering any feedback, it's important to state your good intentions aloud and let individuals know how you feel without assumptions. Stating your intentions will remind the individual that you support them and that you want them to succeed.
- Timing is everything. Ask the individual when they prefer to have a feedback discussion, as the end of a busy day will likely produce a conversation that doesn't go as planned.
- To show support, ensure that you use words that aim to side with the person, not the problem. This is especially helpful when it is necessary to deliver feedback to correct an action or when improvement is needed. Corrective action feedback can be easily communicated with a few simple steps:
 - Ensure the space is safe and private to give this feedback.
 - Always start with positive feedback whenever possible to show that you recognize and appreciate their previous effort.
 - If there has been a change in performance or image quality, ask why the change occurred and what you can do to ensure their success at getting back on track; then provide them with the resources to do so.
- Critical feedback, given honestly and sensitively, will often lead to the development of improved skills and behaviors.⁶
- Listen, then listen again. Give the individual the opportunity to correct any inaccurate feedback that you've delivered. Ask questions to reiterate that you are learning by listening. Ask "What are your thoughts?" and "How do you feel you performed?" as this will lead to a higher level of trust. Learning and listening will encourage trust and will facilitate feedback conversations.
- To ensure the individual understood your intent, ask "What did you feel were the most valuable parts of our discussion?" Then be sure to follow up on any action items within two weeks.

Trust plays an essential role in giving feedback. If the recipient of your feedback doesn't trust you, they are not likely to receive that feedback meaningfully. Instead, they may dismiss it as a complaint. Building trust within your team must be a priority. A great way to build trust is to give feedback more often. This is especially effective when the feedback you deliver is appreciation.

Ways to Improve Wellness Through Feedback

- Ask others to provide you with the type of feedback (appreciation, coaching, or evaluation) that motivates you the most. Then offer to give others the type of feedback that motivates and engages them. To open these conversations, ask questions such as "What type of feedback are you looking for right now?" or "Would it be helpful to hear what I appreciate about your work?"
- Regular feedback results in significantly higher engagement.⁶ Schedule feedback conversations in advance.
- Real-time feedback is best. Support an increase in honest conversations between colleagues about what's working and what could be improved.
- Offer recognition and acknowledgment of hard work through feedback. Support others when difficulties arise, then acknowledge perseverance.
- Make it safe to provide feedback, ensuring the feedback doesn't feel punitive but rather is constructive and motivating.
- Get to know team members beyond their job description to create connections among your team.
- Double the amount of positive feedback that you would normally provide.

Simply put, feedback should be viewed as a two-way street, not a dead-end road. If the conversation is one-sided, meaning the individual offering the feedback is doing all of the talking, then it's really not a conversation. Making a conscious effort to listen when offering feedback, with the intention of learning what the individual's perspective is, will create trust and more meaningful feedback conversations. This deeper meaning and understanding has the power to elevate engagement and wellness in your work environment. Small, daily attempts to increase the frequency of feedback delivery and the style in which you offer this feedback will compound over time, improving mental health and resiliency for you as well those receiving your feedback.

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Exploring Image-Guided Ablation for the Treatment of Breast Cancer: A Natural Progression to Less-Invasive Surgical Options

By Anita K Mehta, MD; Anam Salman, MD

There is an overall trend toward less-invasive procedures for the diagnosis and treatment of breast cancer. Surgical excisions have been replaced by image-guided percutaneous biopsies and surgical treatment has shifted from radical mastectomy to breast conservation therapy (BCT) in patients with early-stage cancer.¹ With advances in imaging techniques along with widespread screening, we are not only improving our cancer detection rates but also finding smaller, node-negative cancers. Naturally, thoughts on how to treat these early cancers are shifting: what minimally invasive techniques could adequately remove small lesions without the need for surgery?

Recently, percutaneous thermal ablation techniques have evolved as a minimally invasive option for treating small breast cancers. The ability to pair image guidance with percutaneous thermal ablation offers an approach that is precise and well tolerated. Energy is directed into the tumor percutaneously, which raises or decreases the temperature of the cell and results in cell death. These techniques have been studied for the treatment of non-small cell lung cancer, renal cell carcinoma, and oligometastatic bone and liver disease, with promising early results.² In the setting of breast cancer, the goal of image-guided ablation is to achieve similar survival outcomes as BCT with the benefits of decreased morbidity, shorter hospitalization, and improved cosmetic outcomes.³ Overall, the benefits are expected to result in health care cost savings as well.³ Preliminary data on thermal ablation for breast cancer are mixed; however, the most promising results are in patients with small tumor size and little to no *in situ* component. Techniques discussed here are cryoablation, radiofrequency ablation (RFA), and high-intensity focused ultrasound (HIFU) ablation.

Cryoablation

Cryoablation is based on the cytotoxic effects of alternating freezing and thawing cycles in the breast tissue using liquid nitrogen or argon gas.⁴ Cryoablation can be used to treat breast cancers by placing one or multiple probes percutaneously into a breast lesion and creating an ice ball that can be monitored under ultrasound, computed tomography, or magnetic resonance imaging (MRI) guidance.^{5,6} Criteria for cryoablation include tumor size less than 2 cm, location at least 1 cm deep to the skin surface, and lack of an *in situ* component.⁴ Studies examining the ability of cryoablation to achieve local control demonstrate recurrence rates equal to or less



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than that of BCT. Sabel et al reported 100% destruction of invasive breast cancers 1.0 cm or smaller that underwent ultrasound-guided cryoablation followed by surgical resection. Poplack et al demonstrated an 85% success rate in negative margins for invasive tumors measuring up to 1.5 cm treated with ultrasound-guided cryoablation followed by surgical excision.^{4,5,7,8} Two ongoing trials in the United States are investigating long-term outcomes of cryoablation, with the primary end point assessment of 5-year local recurrence rate (Freezing Alone Instead of Resection Of Small Breast Tumors [FROST], activated in 2016, and Cryoablation of Low Risk Breast Cancer Less Than 1.5 cm [Ice3], activated in 2014).^{5,9,10} Cryoablation has also shown benefits in gaining local control of a primary breast tumor in patients with stage IV metastatic disease.^{11,12}

The major benefit of cryoablation is that it can be performed as an outpatient procedure under local anesthesia because freezing provides additional analgesia.⁵ The procedure time is relatively short, with two 10-minute freezing cycles with 5 to 10 minutes of interval thawing.⁵ The procedure can also be repeated in cases of local relapse or incomplete ablation.⁵ Complications reported with cryoablation include skin burns, hematomas, fat necrosis, and, rarely, infection.⁵ A disadvantage of cryoablation is its cost, especially when multiple probes are used.⁴ However, long-term cost savings may be possible if surgery and hospitalizations are eliminated.

Radiofrequency Ablation

RFA uses an electrode with an alternating current that is inserted into a breast lesion, resulting in friction, heat, and cell death.^{13,14} The ideal tumor size for successful RFA treatment is less than 2 cm with little to no intraductal component.⁴ Ultrasound and MRI can both be used for RFA-guided therapy. However, ultrasound is limited in its ability to monitor the ablated tissue since both the targeted

Continued on page 12 >

What's New in the News: Exploring Image-Guided Ablation for the Treatment of Breast Cancer: A Natural Progression to Less-Invasive Surgical Options (continued from page 11)

tissue and the surrounding tissue become echogenic following treatment.⁴ MRI is superior in monitoring the ablated tissue during the procedure and in assessing residual tumor following RFA.¹⁵

Studies investigating the efficacy of RFA are ongoing, but results are promising. A retrospective study conducted by the Breast Cancer Society for Minimally Invasive Therapy demonstrated tumor recurrence-free rates 5 years after RFA of 97% in patients with initial tumor sizes less than 1 cm and 94% in patients with tumor sizes 1.2 to 2 cm.¹⁶ García-Tejedor and colleagues conducted a prospective, randomized phase 2 clinical trial comparing the efficacy of ultrasound-guided RFA versus lumpectomy in 40 patients with invasive cancers smaller than 2 cm.¹⁷ Results demonstrated positive margins in the lumpectomy group in 55% of patients, as opposed to only 20% in the RFA group.¹⁷

The benefit of RFA, as with cryoablation, is that it can be performed under local anesthesia and sedation.¹³ Complications are uncommon and mild but include skin burns, muscle burns, ecchymosis, skin puckering, and fat necrosis at the RFA site.¹³ Current limitations of ablation include the inability to determine the optimum zone of ablation and accurately assess tumor margins during and after the procedure.¹⁶

High-Intensity Focused Ultrasound Ablation

HIFU is unique in that it is a completely noninvasive ablation technique without insertion of a needle or probe into the breast. HIFU uses a piezoelectric ultrasound transducer to create a focused ultrasound beam with high-frequency pressure waves to target a small volume of tissue.⁴ The beam raises the temperature of the targeted zone, leading to cell death with preservation of the surrounding tissue.⁴ HIFU ablation can be performed with ultrasound or MRI guidance, but with both modalities, the ability to identify the kill zone is crucial. With ultrasound guidance, the ablated tissue becomes hyperechoic immediately after the beam is administered.³ Integrated MRI-HIFU systems use heat-sensitive sequences to identify the treated zone. Advantages of an integrated MRI-HIFU system include superior anatomical detail and increased sensitivity in defining tumor extent and treatment response following therapy.¹⁸

The data on HIFU show mixed results. Early studies demonstrated complete ablation rates ranging from 20% to 100% for patients who underwent HIFU followed by surgical resection; however, some of these studies included tumor sizes up to 5 cm.⁴ Additional studies looked at MRI-guided HIFU in patients who were not surgical candidates, and resection margins were evaluated with core-needle biopsies. For example, Gianfelice et al found negative biopsy results in 19 of 24 patients 6 months after treatment.¹⁹ Wu et al looked at long-term outcomes and found a 5-year disease-free rate of 95% and a recurrence-free survival rate of 89% in patients who received HIFU followed by adjuvant therapy.²⁰

The greatest advantage of HIFU is its noninvasive nature. There are minimal posttreatment adverse effects, and studies have reported excellent cosmetic outcomes.⁴ Disadvantages include long treatment time and pain during the procedure, leading to the need for at least moderate sedation.⁴

Limitations

Percutaneous ablation is an exciting technique; however, limitations exist that need to be addressed before it can be fully integrated into clinical practice. Most importantly, we need a reliable way to assess tumor margins without a surgical specimen; only then can we assure local control.⁴ Second, how do we assess lymph node status if the patient does not undergo surgical excision of a sentinel node?⁴ Last, adjuvant therapy is often based on pathologic analysis of the surgical tissue. If no specimen is obtained, therapy will have to rely on the core biopsy analysis.¹⁸

Conclusion

There are clearly many potential benefits of thermal ablation for the treatment of small breast cancers. Although there have been significant advances, as of now thermal ablation for breast cancer still has limitations, and until it proves to be equal to or better than the standard of care, it cannot be fully integrated into clinical practice. However, there are subsets of patients in whom thermal ablation may be extremely useful, including patients who are poor surgical candidates or patients who have metastatic disease but need treatment for local control. Other potential clinical applications include image-guided thermal ablation for management of atypia and high-risk lesions in which tumor margin is not a concern. Continued development and larger clinical trials are needed to establish its full clinical utility.

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Continued on page 19>



Mentorship Committee Update

By Lisa Mullen, MD; R. Jared Weinfurtner, MD

The delicate balance of mentoring someone is not creating them in your own image but giving them the opportunity to create themselves.



Lisa Mullen, MD



R. Jared Weinfurtner, MD

Historically, mentorship has played a vital role in medicine for the transfer of knowledge, skills, and wisdom from experienced to early-career physicians. Studies over the past two decades demonstrate that mentored physicians have better success in research, professional opportunities, and overall career satisfaction.¹⁻⁵ However, despite the benefits, many radiology departments lack a formal mentoring program.^{6,7} Many cite confidentiality issues and a lack of dedicated time, financial support, and access to appropriate senior-level mentors as potential barriers.^{4,7,8} Given these difficulties, the SBI formed the Mentorship Committee with the goal of developing a formal mentorship program to address the mentorship needs of its members.

After a call for volunteers in November 2019, the Mentorship Committee was formed in April 2020 under the leadership of committee chair Dr. Laurie Margolies. The committee had its first virtual meeting in late April 2020, just as the COVID-19 pandemic was causing significant global disruptions. Despite the challenges, the committee members worked diligently to develop a mentorship program for our SBI community. To begin, four areas of focus were chosen for subcommittee assignments. These included (1) creation, distribution, and analysis of a needs assessment survey; (2) development of the Mentorship Committee mission, goals, purpose, and charter; (3) development of a mentorship program curriculum; and (4) creation of an outcomes survey for mentorship program participants. Committee members were divided into subcommittees to address each task.

The first task was to develop a needs assessment survey to guide formation of the program according to the needs of the SBI members. Subcommittee members drafted an institutional review board (IRB) protocol outlining the proposed survey and anonymous analysis. This protocol received IRB exemption shortly thereafter. The survey was distributed to all SBI members in March 2021 and closed in May 2021. The committee then analyzed the survey results. A total of 598 SBI members responded. Results analysis was submitted in manuscript form to the *Journal of Breast Imaging* and in abstract form to the SBI annual meeting. The manuscript was published in the *Journal of Breast Imaging* in the March/April 2022 issue, with all committee members listed as contributing authors.⁹ The abstract was also presented at the

SBI annual meeting as an electronic poster in May 2022. Survey results demonstrated demand for an SBI-sponsored mentorship program, especially among members who are young or from underrepresented populations. Work-life balance and leadership were the most popular choices for mentorship guidance needs.

Guided by the survey results, a mission statement was developed: “The mission of the SBI Mentorship Committee is to foster goal-driven mentor relationships in order to promote the career development and professional growth of its members.” The goals of the committee were also developed: “Create pairings between mentors and mentees with complementary needs and goals, continuously evaluate mentorship relationships, facilitate leadership skills of mentors and mentees, and increase engagement from SBI members early in their careers.”

Subsequently, the subcommittee developed a mentorship curriculum with a training document titled “How to be an Effective Mentor.” The curriculum was developed into a training presentation, which was pilot tested on the committee members in April 2022 and will be used to train the first group of mentors.

To evaluate the mentorship training program, prementorship and postmentorship training program assessment surveys were developed. These were included in an IRB protocol submission titled “Mentorship Training Program Survey Results for the Pilot Mentorship Program in the Society of Breast Imaging,” with exemption approval received in May 2022. These surveys will be administered to the pilot mentors to assess the training program’s effectiveness and highlight areas for improvement.

The committee is now actively recruiting mentors and mentees through an application process for a pilot 12-month mentorship program to begin later this year. For the pilot program, 25 mentor-mentee pairs will be matched. Subcommittee-developed surveys for midpoint and program completion administration will facilitate further program improvement. Once the pilot program is complete, the goal will be to expand the program to a larger group of SBI members and provide our community with this additional resource for success.

Continued on page 19>



TIPS & TRICKS FOR TRAINEES IN BREAST INTERVENTIONS: ULTRASOUND-GUIDED BIOPSY

By Wenhui Zhou, MD; Sophia O'Brien MD

The multiple modalities of image guidance for targeted breast biopsies include stereotactic, ultrasound (US), and magnetic resonance imaging (MRI) guidance. Although it is best to use the modality that optimally demonstrates the lesion, the numerous benefits of US support the recommendation to attempt to identify an US correlate for most lesions first seen on other modalities (except for suspicious calcifications, which are usually targeted mammographically) before deciding on the modality to use for biopsy guidance.

This three-part Member-in-Training series provides a brief overview of the modes of imaging guidance for breast biopsies and includes trainee-focused tips and tricks. This article, the second in the series, is devoted to US-guided breast biopsies. Please see the discussion of stereotactic-guided breast biopsies in the spring 2022 issue and stay tuned for the discussion of MRI-guided breast biopsies in the fall 2022 issue.

The Basics

Whenever feasible, US is the preferred modality for biopsy guidance if a correlate is noted because it offers many advantages over stereotactic and MRI guidance. These advantages include the following:

- Real-time visualization of the biopsy target and sampling
- Increased patient comfort due to supine positioning and lack of breast compression
- Lack of ionizing radiation or intravenous contrast material
- Only modality capable of guiding the biopsy of axillary or other locoregional lymph nodes

As for all procedures, preprocedure informed consent is obtained. Benefits and risks of the procedure, including bleeding, infection, pneumothorax, and implant rupture if the target is near an underlying implant, should be discussed with the patient.

Equipment and Technique

See the Figure for an example of an US-guided biopsy. US-guided biopsies can be performed with either vacuum-assisted or spring-loaded devices, depending on the characteristics of the patient and lesion and the radiologist's preference.



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- Spring-loaded devices generally take smaller samples (causing less trauma to surrounding tissue) but require more accurate needle placement. Additionally, spring-loaded devices take only one sample at a time, requiring multiple passes into the breast. However, this feature can be ideal for trainees because trainees can take one or two passes and an attending physician can take one or two additional passes as needed. Some spring-loaded devices allow the option of inserting the biopsy needle with an open-trough or closed-trough technique. With an open-trough technique, the biopsy sampling trough is placed through the lesion and the sample is obtained by firing the outer cutting cannula over the trough, collecting tissue without advancing the needle. This technique is particularly useful for sampling deep axillary lymph nodes in close proximity to vital neurovascular structures. With a closed-trough technique, the biopsy needle is positioned just proximal to the targeted abnormality and then fired within the breast, resulting in both the sampling trough and the outer cutting cannula being deployed sequentially through the targeted abnormality to collect tissue.
- Vacuum-assisted devices generally take larger samples (causing more trauma to surrounding tissues), but multiple contiguous specimens can be obtained within a single pass. These devices are typically used for intraductal or small obscure masses and are usually avoided in patients with small breasts or a mass near an underlying implant.

As with all procedures, the positioning of both the patient and the radiologist is key. Accounting for the radiologist's handedness (left or right) is also important for the approach and the placement of the equipment tray table.

- For lesions in the superior, lateral, or inferior breast, the patient is placed supine and oblique on the table. A wedge or rolled-up towel can be placed under the patient's shoulder and back to bring the target lesion as close to perpendicular with the floor as possible.
- The biopsy needle is best positioned parallel to the transducer. This parallel approach facilitates the best visualization of the target lesion and minimizes complications such as pectoralis muscle injury or iatrogenic pneumothorax. If the target is better visualized in an oblique plane, the positioning can be based on the optimal visualization of the mass. It is important to confirm mass visualization in both orthogonal planes before beginning the biopsy.
- For inferior lesions in very large breasts, it may be necessary to use paper tape or ask the assisting nurse/technologist to hold the breast in a good position for the biopsy.

Once satisfactory patient positioning and target visualization have been achieved, perform sterile cleansing of the breast and anesthetize the skin entry site and biopsy path with lidocaine.

- The entry site is usually 1 to 2 cm from the edge of the transducer. Deeper anesthesia is then delivered around the lesion and along the biopsy path.
- For lesions abutting the chest wall, a plane of lidocaine can be used to lift the lesion off of the pectoralis muscle.
- Similarly, lidocaine can be used to increase the distance between a superficial lesion and the skin surface.

The probe is held between the radiologist's thumb and index finger such that the transducer is perpendicular to the floor.

- If needed, the radiologist's third through fifth fingers can be used to hold or move the breast as the needle is advanced.
- Be aware that breast tissue is very pliable, and a long distance can be covered with pressure from the needle and counter-pressure from the radiologist's hand.

The needle should be visualized whenever it is moved within the breast.

- If you cannot see your needle, then adjust the position of your transducer or angle your needle, but do not move both at once.
- Take a deep breath, calm yourself, and look down at your hands for hand-eye coordination to see what movement is needed to bring your transducer and needle back into parallel alignment.

- When you find your needle with your transducer, bring your probe back to the lesion and determine what adjustment needs to be made. For example, if the lesion is superior to the needle, you need to swing your arm inferiorly so that the needle tip moves superiorly. It is best not to move both the hand and the needle to make the adjustment. Stabilizing the probe with the edge of the palm resting on the patient's body and adjusting the needle or reintroducing the needle in the correct plane may be more beneficial.
- Early trainees often make smaller adjustments in the breast than required and may need to remind themselves to make larger adjustments than they would expect.

As with stereotactic and MRI-guided biopsies, at the end of an US-guided biopsy a marker clip is placed directly into the lesion. A postprocedure mammogram is then obtained to document clip placement.

- If obtaining a biopsy from a mammographically apparent lesion, confirm appropriate target sampling on the postbiopsy mammogram.
- If the target lesion is a lymph node, preference should be given to a sonographically apparent biopsy clip that can be identified if needed for future US-guided placement of a localizing device before excision. If a patient undergoing neoadjuvant chemotherapy has a significant anatomic response resulting in normalization of previously abnormal lymph nodes, it would be very difficult for the radiologist to accurately place a localizing device to guide excision if there is no sonographically apparent biopsy clip.
- If your institution does not have sonographically apparent biopsy clips, consider placing an internal localizing device into the abnormal lymph node prior to neoadjuvant chemotherapy.

Conclusions

Trainees should expect that their skill, autonomy, and confidence with US-guided breast biopsies will grow over time. Practice using phantoms can help familiarize trainees with hand-eye coordination and US scanning. Carefully planning the patient's position, biopsy path, and choice of biopsy device, clip, and/or localizer before procedures is key to performing safe and successful breast biopsies. After each biopsy, remember to review the results to perform radiologic-pathologic correlation and help guide management recommendations. As always, trainees should not be afraid to ask questions or ask for help. Let your attending physician know what you are comfortable doing and also alert them when you encounter difficulties and need their guidance.

Continued on page 16>

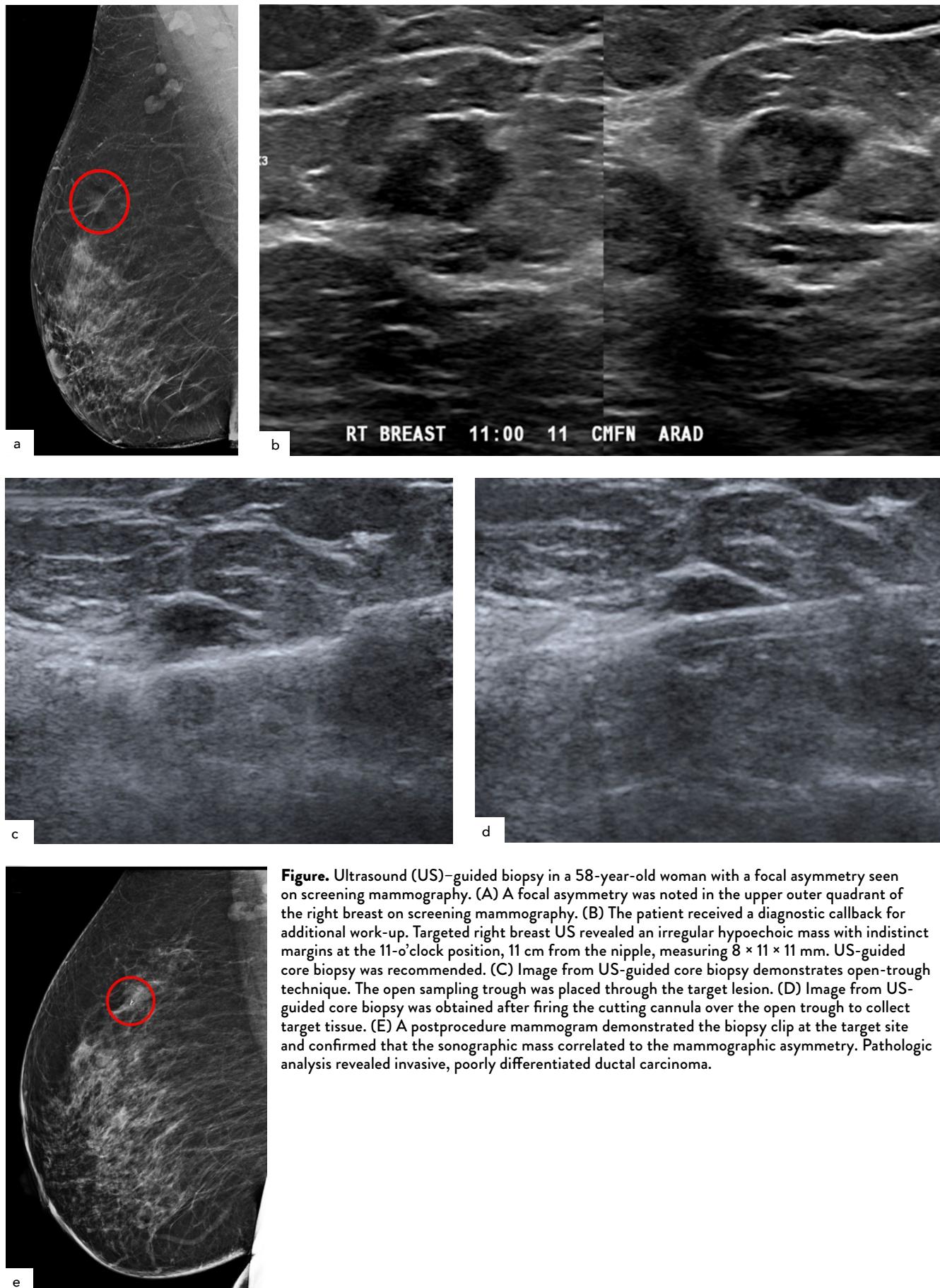


Figure. Ultrasound (US)-guided biopsy in a 58-year-old woman with a focal asymmetry seen on screening mammography. (A) A focal asymmetry was noted in the upper outer quadrant of the right breast on screening mammography. (B) The patient received a diagnostic callback for additional work-up. Targeted right breast US revealed an irregular hypoechoic mass with indistinct margins at the 11-o'clock position, 11 cm from the nipple, measuring $8 \times 11 \times 11$ mm. US-guided core biopsy was recommended. (C) Image from US-guided core biopsy demonstrates open-trough technique. The open sampling trough was placed through the target lesion. (D) Image from US-guided core biopsy was obtained after firing the cutting cannula over the open trough to collect target tissue. (E) A postprocedure mammogram demonstrated the biopsy clip at the target site and confirmed that the sonographic mass correlated to the mammographic asymmetry. Pathologic analysis revealed invasive, poorly differentiated ductal carcinoma.

Learning From Experience

By Sarah Pittman, MD, FRCPC

Since starting my position as junior faculty at Stanford University in 2019, I have felt incredibly fortunate to work with experts in the field who have become my mentors and friends. I have learned so much from my colleagues' expertise and professional experiences. Working on this article was a delight for me, as it gave me the opportunity to learn even more from two of these colleagues: Dr. Wendy DeMartini and Dr. Debra Ikeda. Many common themes arose during my interviews with Drs. DeMartini and Ikeda. And so I present to you the words of wisdom and experience imparted to me.

Biographies



Dr. Wendy DeMartini is a professor and the division chief of breast imaging in the Department of Radiology at Stanford University School of Medicine. Her work is focused on high-quality patient care, research, and education. She has more than 100 research presentations, abstracts/publications, review articles, or book chapters. She lectures nationally and internationally on a spectrum of breast

imaging topics, with emphasis on evidence-based utilization and breast magnetic resonance imaging (MRI). She is codirector of the ACR Education Center Breast MRI With Biopsy course. She was elected an SBI Fellow in 2009 and served as SBI President from 2017 to 2018.



Dr. Debra Ikeda was a tenured professor at Stanford University until 2022, when she became professor emerita. Dr. Ikeda served as breast imaging section chief from 1992 to 2016, is an SBI and ACR Fellow, leads the California Breast Imaging Information Group, was lead author of the first ACR BI-RADS MRI Lexicon, authored 3 editions of *Breast Imaging:*

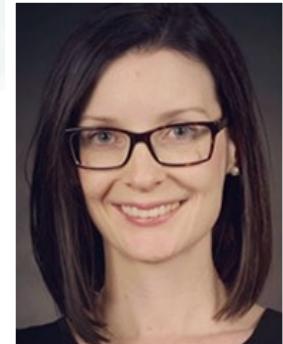
The Requisites, published over 130 original/scientific articles and over 180 scientific and educational abstracts, and gave over 325 educational presentations nationally and internationally. Her leading research interests include image quality, tomosynthesis, diffusion-

weighted MRI, breast density, and interval cancer.

On changes in career trajectory over time:

DI: As you go through your life, and as you go through your jobs, you find out you can ask yourself what Marie Kondo would ask—what brings you joy? Learn what it is that you like to do, and you pursue that. The other thing that I learned as a kid from my parents is that you have to trust yourself; you know what you like and what feels good for you, not what other people think. You can really tell what is true for yourself by examining your heart of hearts. I realized that I loved surgery but I wasn't going to be a surgeon because I needed sleep and couldn't take the night call; I loved OB/GYN [obstetrics/gynecology] but I couldn't take OB/GYN night call; I loved pathology but when I looked in the microscope it made me dizzy and want to throw up. And then I found radiology and I was like, "Oh I love this! I'm going to be a radiologist."

Sarah Pittman, MD, FRCPC



WD: There are many times when my career has taken different paths than I anticipated. For example, I initially completed a fellowship in neuroradiology but knew from my later residency experience and mentors that breast imaging was my true calling. So I completed a breast imaging fellowship with the amazing Dr. Constance (Connie) Lehman. This allowed me to have the productive and fulfilling academic career in breast imaging that I have today. Also, when my twins were small, I reduced my work schedule for around a year. It was very necessary and important. I then transitioned back to full time when they were older. It is vital to be open and willing to change, to not be afraid to modify your path. Circumstances and priorities will change. We all feel that now more than ever with the major upheavals we've had in the last few years. Allow yourself to take a different path. There will always be new opportunities and other directions. Don't be afraid to make a change.

On finding mentors:

WD: It's interesting because I think that it's a combination of having the right people together at the right time, and some of that we can control and foster and some of that is serendipity.

Continued on page 18 >

Young Physician Section: Learning From Experience (continued from page 17)

Finding mentors through formal programs and from other avenues can each be successful and important. Remember that you will likely benefit from different mentors for different aspects of your career and at different stages of your career. A great mentor is one who is modeling the way for what you would like to achieve and who is generous with you in their time and providing opportunities. That was a tremendous thing that I learned from Connie Lehman, to really work to promote the careers of others, especially as things come up that you recognize would be good opportunities for your mentees and sponsors.

DI: It's always somebody you run into, isn't it? Somebody that you know and you like. I ran into Ingvar Andersson and worked with him and trusted him. And I asked him "Who should I work with?" and he suggested people who he knew I would get along with and who would teach me.

When you are around people, see who you would like to emulate. Who would you like to be, and do you get along with them? Can you be truthful with them? And can they be truthful with you? And then you can ask them a trial balloon, some kind of general question. And see where that leads you. Does it feel comfortable and good for you to go in that direction with them as a mentor and friend. Are they giving you good advice, does it feel right? It's like being friends with somebody; a mentor is just a friend who knows more than you, right?

On best advice received in training/early career:

WD: Overall, the advice to be a kind and considerate human being, including as a practitioner and colleague. It can be easy for that to not be emphasized or to get lost in the hullabaloo of everything that's going on. I am far from perfect at it, but I think trying to hang on to that core of decency in attitudes and interactions is helpful. Also, the advice to focus on the science. We are so lucky in breast imaging to have robust science and data to support our practices, and we remain strong and relevant as a subspecialty by relying on evidence to guide our practices.

DI: I was told to try and get the best advice/training you can. Go to places and be with people that care about you and want to teach you, promote your career. Stanford does care about its faculty, and it cares about the people who work for Stanford. You want to be someplace where somebody's got your back, you want to be at "Cheers" where everyone knows your name and where people really count.

On imposter syndrome:

WD: I have experienced it, and I continue to experience it. When I know I am feeling it, having negative self-talk, I try to cultivate self-compassion. I ask myself if I would think or say something like that to someone else with similar accomplishments. You

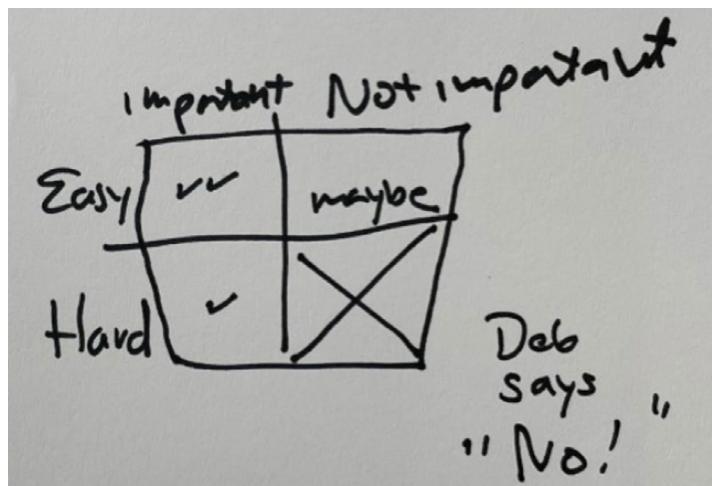
realize this negative self-talk is really just that, as opposed to reflecting reality. I have also recognized how much more prone to imposter syndrome I am when I am stressed or tired. This is among the many reasons to prioritize taking care of oneself mentally and physically.

DI: Early in my career I did have imposter syndrome once briefly. I was offered to chair a session at ISMRM [International Society for Magnetic Resonance in Medicine] and didn't think I could do it. But of course I could have done it! Duh. I always regretted turning that down. It was an opportunity and I turned it down, somebody else got it, and they went to the moon with it. And then I realized I could have done a great job and I thought, if they asked me again, I will look deep inside myself and ask: do I have the bandwidth to do it? Do I want to do it? And if I think yes I want to do it, I will say yes, do the work to do a good job. And then, as far as imposter syndrome goes, I think you just view whatever grandiose job offered to you as an opportunity and say if they made a mistake asking me even though I am not as qualified as someone else—too bad! Their mistake! I'm taking advantage of it—it's mine now! You walk through that door. If the door opens, you walk through it. You walk through and believe you can do it. Because you can!

On setting boundaries and saying no:

WD: We have to be okay with saying no. We all have limited time, and each yes comes with an opportunity cost of something else. I consider whether the "ask" is from a person/group and/or system and/or priority that I think will be enjoyable and/or important. The colleagues/collaborators component is often critical. And people do understand when you say no. And, if you can and it's appropriate, suggest someone else, particularly your junior faculty or other great colleagues that you have who might really be an excellent alternative.

DI: You only have so much time and you have only so much water in the well. When the well is full, it's good. When the well is empty, nobody's happy. So, you have to make sure to try and keep your well full. I would think about my career and my life and I try and



think: is this hard or easy, is it important or not important, and just do one or two hard/important things.

Anything that was not important and was hard I wouldn't do. The other piece of advice for young women: if people ask you to do something, the first thing you say is, "Let me think about it. Can I get back to you tomorrow," and don't answer right away. Because otherwise you can make a mistake. But anyone would give you 24 hours. You don't have to answer right away, just think it over.

On succeeding in academics:

DI: I think the most important thing that I learned is that I had to find out what it was I wanted to achieve. Then I asked, what are the goals of the organization? For me to get ahead, do my goals align with the organization and the chief? Because the chief is the captain of the ship. If that ship is going one way, and you have decided that in your life you want to go another way, get off that ship. Go to a ship that is going in the same direction that you want to go. When you start with an organization or when you start with a new job, find out what is their goal and what is their mission, what do they value, what are the milestones you have to hit in order to get ahead. Then you can get ahead.

WD: Finding a mentor or mentors is critical. These can be for different components of your career. Perhaps someone is your science/research mentor and someone else is your education mentor.

Developing a professional niche or emphasis can be helpful. It is useful in organizing your activities and in the opportunities that you might be given when you are seen as someone who has an emphasis or expertise in that area.

Be an active member of the SBI! Make the really amazing connections that we have with the SBI and other professional societies. These relationships are so important to share our ideas and our opportunities, to continue to strengthen our field, and to sustain us through challenging times.

What's New in the News: Exploring Image-Guided Ablation for the Treatment of Breast Cancer: A Natural Progression to Less-Invasive Surgical Options (continued from page 12)

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Mentorship Committee Update (continued from page 13)

The success of the mentorship program is made possible by the diligent work of the committee members and engagement with the SBI membership community at large. Please contact us with any

ideas or opportunities you'd like to discuss. Dr. Lisa Mullen can be reached at lmullen1@jhmi.edu and Dr. Jared Weinfurter can be reached at robert.weinfurter@moffitt.org.

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RAD-AID COLUMN

By Erica B. Pollack, MD; Genevieve Abbey, MD; Amina Farooq, MD; Daniel J. Mollura, MD; John R. Scheel, MD, PhD, MPH



Erica B. Pollack, MD



Genevieve Abbey, MD



John R. Scheel, MD, PhD, MPH



Amina Farooq, MD



Daniel J. Mollura, MD

What Is RAD-AID International?

RAD-AID International is a 501c3 nonprofit organization that works to increase access to imaging services worldwide with programs at over 90 health care facilities in 40 countries. The breast imaging section of RAD-AID focuses on reducing breast cancer mortality in low-resource settings by downstaging disease through earlier detection. In partnership with local health care providers, we improve access to high-quality imaging and image-guided procedures in low- and middle-income countries (LMICs) as well as medically underserved communities in high-income countries (HICs). We collaborate with partner organizations that work across the continuum of care to ensure that women diagnosed with breast cancer have access to treatment and posttreatment surveillance. To achieve our goals, we also support community outreach, navigation, and patient education.

Why Is Global Health Breast Imaging Important?

Breast cancer is currently the leading cause of cancer death for women worldwide, and its incidence continues to increase, particularly in LMICs.¹ While early-stage breast cancer (stages I and II) is largely curable with appropriate therapy, late-stage breast cancer (stages III and IV) has much higher morbidity and mortality rates.^{2,3} Without structured population screening programs or easily accessible imaging and intervention for tissue diagnosis, breast cancer in LMICs is more commonly diagnosed at a late stage compared with diagnoses in HICs.¹ The challenge for LMICs is compounded by lack of the more advanced breast cancer therapy required for treatment of advanced disease. This creates a disproportionate burden of breast cancer in LMICs, where mortality from breast cancer is relatively higher than in HICs.

What Are Some Examples of RAD-AID's Work?

RAD-AID breast imaging programs have been implemented in the United States, Latin America, Africa, Asia, and Europe. Our methods are tailored to best suit the resources and goals of our local partners. In keeping with international guidelines, each collaborative program begins with a thorough assessment of our target population and the local availability of breast cancer services.

Education and training are always a cornerstone of our process as we work to develop breast imaging leaders that may go on to scale breast cancer services locally and nationally. Our interdisciplinary

teams of RAD-AID volunteers have the expertise to mentor radiologists, primary care providers, nurses, technologists, and informatics specialists through in-person “hands-on” skills training workshops and didactic educational sessions. We have developed comprehensive educational programs in Ghana, Kenya, Tanzania, Ethiopia, India, Bangladesh, Peru, and Guyana.

RAD-AID’s online learning management platform of prerecorded lectures allowed an easy transition to remote education during the pandemic, and we have supplemented our archived resources with live webinars and ongoing regular virtual classrooms with read-out sessions of recent cases. For sites where RAD-AID has donated picture archiving and communication systems—Guyana, Nigeria, and Laos, for example—image sharing for case consultations and real-time clinical teaching have also been implemented. We are helping develop advanced fellowship-level breast imaging programs in Ethiopia, Kenya, and Ghana.

In the United States, RAD-AID launched a longitudinal program to address long-standing health care disparities in medically underserved women.⁴ The RAD-AID USA Women’s Health Program is a collaboration with the Black Women’s Health Imperative, National Alliance for Hispanic Health, and Hologic’s Project Health Equality. We have partnered with Federally Qualified Health Centers, which are primary care centers partially funded by the federal government for the purpose of reducing health inequities, and with tertiary centers and imaging centers to address disparities across the continuum

Continued on page 22>



Inducted May 2022

Michelle Lee, MD, FSBI

Michelle Lee is an associate professor of radiology and section chief of breast imaging at the Medical College of Georgia. She attended the University of Wisconsin as an undergraduate and received her medical degree from Northwestern University School of Medicine, which included a research year funded by a Radiological Society of North America (RSNA) Research

and Education Medical Scholars Grant. She pursued an internal medicine internship at MetroHealth City Hospital, Cleveland, and a radiology residency at Mallinckrodt Institute of Radiology (MIR). From 2010 to 2013, she served as the cochair of Northwestern Medicine Lake Forest Hospital's Breast Health Center, only to return to MIR until 2020. She served as assistant program director of the diagnostic radiology program and program director of the breast imaging fellowship.

In 2020 she moved to the Medical College of Georgia, where her clinical interests include high-risk screening and providing care to the underserved. She enjoys committee work on the American Board of Radiology Certifying Exam Committee, the Breast Screening Leadership Group, the SBI Fellowship Match Committee, and the RSNA Educational Exhibit Awards Committee.

Outside of work, she spends as much time as possible with her family, Geneva (24), Grace (21), and her dog, Glimmer (9), and cheering on her favorite team, the Packers.

Michael Plaza, MD, FSBI

Dr. Michael Jonathan Plaza, originally from Charlotte, North Carolina, received his medical school training at Wake Forest University. This was followed by a residency in diagnostic radiology at the University of Miami and a breast imaging fellowship at Memorial Sloan Kettering Cancer Center.

Following fellowship he returned to Miami, where he works as the director of magnetic resonance imaging (MRI) for Diagnostic Center for Women and has an academic appointment with Lake Erie College of Osteopathic Medicine, regularly teaching radiology residents from Larkin Community Hospital. His research interests include abbreviated breast MRI, breast cryoablation, and new approaches to breast cancer screening. He has served as a local site principal investigator for the ECOG-ACRIN 1141 trial and the FROST trial and is currently a local site principal investigator for the WISDOM trial. He is a volunteer with the RAD-AID breast imaging Peru team. During his time off he enjoys playing soccer and spending time with his wife and three children.

Jessica Porembka, MD, FSBI

Dr. Jessica Porembka is an associate professor in the Division of Breast Imaging, Department of Radiology, University of Texas Southwestern Medical Center. She serves as the medical director of Parkland Breast Imaging and the medical director of quality for Parkland Radiology. Dr. Porembka has focused her clinical and research endeavors on

reducing disparities in cancer screening since the early years of her career working with underserved communities through Dallas County's large safety-net hospital, Parkland Health and Hospital System. She has also participated in and organized efforts to increase breast cancer screening access and education throughout the Dallas–Fort Worth area.

Dr. Porembka maintains an active clinical practice specializing in breast imaging. While her clinical practice focuses on the early detection and diagnosis of breast cancer in underserved communities, her long-term career goal is to foster health equity through patient-centered care and research.

Continued on page 22>



Dana H. Smetherman, MD, MPH, MBA, FACR, FSBI

Dr. Dana Smetherman is a diagnostic radiologist who specializes in breast imaging. She is chair of the Department of Radiology and an associate medical director for the medical specialties at Ochsner Medical Center, New Orleans. Dr.

Smetherman is currently the secretary/treasurer for the ACR and serves on the organization's Board of Chancellors. She has also served as chair of the ACR Commission on Breast

Imaging. In addition to these roles, Dr. Smetherman has served as president of the Radiological Society of Louisiana, ACR councilor from Louisiana, board member for the National Accreditation Program of Breast Centers, chair of the Technical Exhibits Committee of the RSNA, advisor to the Current Procedural Terminology Panel of the American Medical Association, chair of the ACR Breast Economics Committee, and physician director on the Board of Directors of Ochsner Health. Dr. Smetherman has given numerous presentations and has multiple publications in the areas of breast imaging and health care economics.

RAD-AID Column (continued from page 20)

of care.⁵ The care model used at each program site is tailored to best meet the needs of the specific target population.

In Guyana, Kenya, and Peru, we have implemented breast radiology artificial intelligence (AI) tools that provide real-time educational feedback for physicians and technologists using the teach-try-use model. These programs integrate education, infrastructure, and gradual implementation of AI in low-resource health institutions.⁶ These efforts have been supported by several pro bono contributions of breast imaging AI software, such as by Koios and Densitas. Since the success of any AI tool in a specific setting depends on the applicability of the database from which its algorithms are trained, we anticipate that implementation of AI in low-resource settings will lead to continued development of AI tools that are able to serve patients everywhere.^{7,8}

How Can SBI Members Volunteer With RAD-AID?

RAD-AID International and the SBI have partnered to form the RAD-AID/SBI Global Breast Imaging Program, which is a collaboration to increase access to medical imaging services for breast imaging globally. This partnership creates unique volunteer opportunities for SBI members within RAD-AID's established global health programs. Volunteer roles include working in-country with RAD-AID teams to develop and optimize breast imaging programs or providing educational content and hosting web conferences to facilitate distance learning within RAD-AID's existing global network. The RAD-AID breast imaging team is

eager to welcome new volunteers with expertise in any aspect of breast cancer care who are interested in promoting high-quality care for underserved patients. Attending-level physicians and radiologists in training are welcome to apply, as are physician assistants, technologists, nurses, physicists, and informatics specialists. We invite you to learn more on the RAD-AID website at www.rad-aid.org and to sign up at <https://portal.rad-aid.org/survey/general-volunteer-survey> or email breastimaging@rad-aid.org with inquiries. Remember to indicate that you are an SBI member when you sign up!

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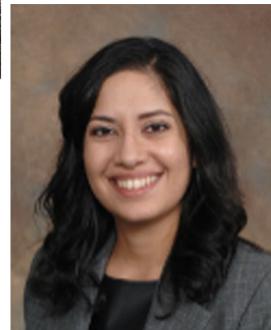
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HIGHLIGHTS FROM THE ARRS 2022 MEETING IN NEW ORLEANS

By Rifat Wahab, DO, FSBI, FAOCR



The American Roentgen Ray Society (ARRS) annual meeting was held May 1-5, 2022, and it featured a hybrid format of in-person and on-demand access. Watching the conference in pajamas did seem tempting, but there were perks of attending the in-person ARRS 2022 meeting, one being the connection quad! The quad hosted exhibitors, refreshments during breaks, and lunches for attendees. This was a great way to network, reconnect with colleagues, and explore advancements in radiology. Even the name urged attendees to make connections in a low-key environment. Another perk of attending in person was the experience of New Orleans culture and the delicious cuisine.



Rifat Wahab, DO, FSBI, FAOCR



Our very own SBI members reconnecting over lunch in the connection quad!

The meeting kicked off with a great opening ceremony and sessions geared toward career development. Dr. Andrew Rosenkrantz had a particularly helpful session on publishing in the “yellow journal” (*the American Journal of Roentgenology*). Attendees obtained a better understanding of what topics interest the journal and the logistics of publication. This session was followed by a fantastic panel of radiologists, including SBI member Dr. Amy Patel, in “Early Career Advice for Young Professionals: What I Wish I Knew Earlier.” Topics included “Professional Society Participation by Private and Academic Practice Radiologists,” “Personal and Practice Finance: The Essentials,” “Relationships: A Key to Success,” “Building Your Practice and Personal Brand,” and a panel discussion.

The conference hosted numerous breast imaging sessions organized into instructional courses, scientific sessions, and categorical courses. Several members and fellows of the SBI shared their expertise by presenting at these courses.

On day 2 of the conference, all three categorical courses on breast imaging were offered. “Breast Cancer: Background

History, BI-RADS, and Ultrasound,” presented by Dr. Debra Copit, Dr. Sarah Friedwald, Dr. Melissa Durand, and Dr. Donna Plecha, focused on the benefits of tomosynthesis, interval cancer detection, and the ACR BI-RADS audit. The next session, “Breast Cancer: BI-RADS and Tomosynthesis,” presented by Dr. Hannah Gilmore, Dr. Emily Conant, Dr. Regina Hooley, and Dr. Jordana Phillips, included a deep delve into breast pathology, a closer look at implementing abbreviated breast magnetic resonance imaging (AB-MRI), benefits of screening with ultrasound, and the future of contrast mammography. Rounding out the categorical courses was the session “Breast Cancer: MRI, AI, and Pathology,” presented by Dr. Jessica Leung, Dr. Stephanie Patterson, Dr. Dana Smetherman, and Dr. Michael Fishman. Patient anxiety and disparities were covered in the first half of the session, followed by economics and artificial intelligence in breast imaging.

The instructional course director, Holly Marshall, MD, developed a comprehensive program that provided refreshers, updates, and optimization in breast imaging that stretched over 4 days. Common “hot topics” among the instructional courses were auditing across breast imaging modalities and implementing new technologies. The “Abbreviated Breast MRI” course, provided by Dr. Emily Conant and Dr. Linda Moy, informed attendees about interpretation, advancement in ultrafast MRI, auditing, and how to overcome common adversities in implementing AB-MRI. Dr. Sora Yoon, Dr. Rifat Wahab, and Dr. Jay Parikh tackled “Optimizing Breast Cancer Mammography Screening.” This session included the benefits and drawbacks of online screening interpretation, interpretation of challenging cases, and how to interpret the breast imaging audit. The course “Implementing New Techniques” gave fantastic pointers on starting a contrast mammography program (Dr. Jordana Phillips), maximizing

Continued on page 24>

Highlights From the ARRS 2022 Meeting in New Orleans (continued from page 23)

clinical time with wireless localizations (Dr. Donna Plecha), and the new frontier of breast cryoablation (Dr. Robert Ward). Dr. Karen Johnson, Dr. Robert Weinfurtner, and Dr. Lilian Wang walked us through improving the patient experience during biopsies and the pearls and pitfalls of breast intervention. The last instructional course to conclude the conference was “Diagnostic Updates” in special patient populations: Dr. Holly Marshall discussed male breast disease, Dr. Sarah Pittman reviewed imaging in pregnant and lactating patients, and Dr. Katerina Dodelzon delved into imaging of the symptomatic patient.

The conference featured three breast imaging scientific sessions. Dr. Katherine Klein opened abstract presentations on postmastectomy imaging and posttreatment imaging, and Dr. Dana Ataya discussed “Radiomics of DCIS” in a keynote presentation to conclude the first session. The second session featured several intriguing abstracts focused on breast imaging tomosynthesis and patient diversity. Dr. Manisha Bahl provided

the keynote presentation on digital breast tomosynthesis, and Dr. Jay Parikh presented “Patient Diversity in Breast Imaging.” The final breast imaging scientific session focused on breast biopsy, intervention, and emerging technologies. This session featured challenges of artificial intelligence, presented by Dr. R. Cody Mayo, and emerging MRI techniques, presented by Dr. Lilian Wang. Along with great abstract presentations, this was the perfect scientific session to end the course.

The 2022 ARRS conference was a phenomenal showcase of breast imaging expertise and advances in research presented by many senior, midcareer, and junior faculty. To see presentations by a wide array of diverse speakers is commendable and a great accomplishment by the ARRS planning team! The sessions addressed many day-to-day challenges breast radiologists face and also provided insight on how to implement and use advancing technologies. Overall, it was a well-rounded conference not to be missed next year!



Dr. Holly Marshall, Dr. Emily Conant, and Dr. Linda Moy speaking at the ARRS 2022 instructional course on abbreviated breast MRI.

Tracy Lloyd

By Hannah Perry, MD

HP: Please tell me about yourself and your background.

TL: I was born in New York City and have been living in Mesa, Arizona, now for almost four years. My sister was diagnosed with breast cancer in her thirties and passed away at 38. I started getting mammograms in my twenties.

How were you diagnosed with breast cancer?

I went in for my yearly screening exam and was not having any pain or issues. After that, I was asked to come in for some additional views. At that time, I thought that it was nothing, as I had been called back for additional views when I was younger and was told that everything was fine.

How did you feel when you learned of the news?

I was very scared. I did not want to go through what my sister had been through.

What was your treatment process? Did you face any treatment obstacles? How did you overcome them?

My first reaction was, am I going to be able to afford to save my life? Treatment can be very expensive! Fortunately, I had the best doctors in the world guiding me through my diagnosis, and I cannot thank them enough. They explained everything so that I could understand and so I could explain to my family.

Currently, I am on tamoxifen. I have to say, it's not an easy pill. There have been times when I have wanted to stop due to the side effects. I used to have terrible anxiety, hot flashes, and cramps, but fortunately those symptoms have improved. There are good and bad days. I'm just taking it one day at a time.

What motivated you during your diagnosis and treatment process?

My cancer was caught early, and my doctor talked me through everything. The best advice that I have is to not skip your

mammogram appointments and to go get checked if you feel anything or have any concerns. Early detection is the key.



Hannah Perry, MD

What did you learn from your experience?

I have learned how important genetic testing is. I was once fearful of getting tested, because I didn't want to worry about the "what ifs." But the benefit of genetic testing is that it can show you what types of cancers you and your children may be at risk for. My testing revealed that I am BRCA2 positive. My daughter was tested as well and also has the BRCA2 gene mutation. I now worry about my son, because his father passed away at 49 from cancer, and we are not sure what type. I have encouraged him to undergo genetic testing, and if something comes back positive, I know that we will face it together as a family.

How has this diagnosis impacted your life?

I try to share my story with everyone on social media and with patients in the office. In 2022, I also shared my story with the Arizona Diamondbacks and helped Banner Health Foundation win a Ken Kendrick Grand Slam Award of \$100,000, which was used to support a new mobile mammography unit called the Big Pink Bus.

Are there any lessons that you think the breast imaging community can learn from your experience?

As a patient, even though you may have been told in the past the lump you were feeling was nothing to worry about, things can change. Never be afraid; just figure out what is wrong so that you can get proper treatment and be there for your family.

Continued on page 26>

What advice would you give to other patients who are going through the diagnosis and treatment process for breast cancer?

I hope that patients receiving a breast cancer diagnosis have an amazing team like I had. I can't thank them enough. My advice is listed below:

1. Try to receive your mammograms at the same breast imaging center.
2. Consider genetic testing.
3. Go to all of your follow-up breast imaging and clinical appointments.



Tracy Lloyd



SBI 2022 MEETING HIGHLIGHTS

By Claudia Cotes, MD; Sasha Kurumety, MD

The SBI/ACR Breast Imaging Symposium returned to live sessions in beautiful Savannah, Georgia, on May 16-19, 2022. In its hybrid form, the symposium attracted 566 in-person and 989 virtual attendees from nearly 50 countries. Through multiple lectures and educational and scientific sessions, renowned speakers discussed high-yield topics based on clinical and scientific data, which were beneficial for attendees at all levels of training.

The symposium kicked off with talks that covered the basics of breast imaging, serving as a nice refresher for deeper topics throughout the week. Dr. Sally Friedewald started with a great reminder of why we do what we do. Looking at the data, she described the importance of all women knowing their breast cancer risk by age 30 years. This critical point was supported by Drs. Murray Rebner, Beth Burnside, and Gabriel Hortobagyi, who covered the use of personalized breast cancer screening and treatment to improve late-stage diagnoses in all patient populations. A great comparison of digital breast tomosynthesis versus 2-dimensional digital mammography, a review of screening ultrasonography, and tips for interpreting magnetic resonance imaging (MRI) were given by Drs. Debra Monticciolo, Wendie Berg, and Linda Moy, respectively. These presentations led to interesting questions related to modality-specific techniques and improving interpretation. A sneak peek of the updated BI-RADS manual, which is expected to be released in 2023, was also delivered; stay tuned!

Dr. Beatriz Adrada and Dr. Jennifer LaRoy provided a comprehensive review of the evaluation of neoadjuvant therapy response and new enhancing abnormalities on MRI following therapy. The postsurgical breast was beautifully covered by the guest speaker, Dr. Mark Clemens, and a subsequent review of the expected imaging findings in the postoperative breast was given by Dr. Debra Ikeda. These talks were complemented by a simplification of the evaluation of the axilla by Dr. Ana Lourenco. The current use of ultrafast MRI and contrast-enhanced mammography were common topics throughout the symposium lectures and scientific sessions. Contrast-enhanced mammography was emphasized as a promising alternative to MRI, serving as an examination with higher sensitivity than digital mammography in high-risk and underserved populations. It was exciting to learn how this imaging technique could be easily



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implemented in any breast imaging facility. Additionally, through a fun and didactic discussion, a panel of experts demonstrated the variation in categorization of MRI findings among readers and the importance of standardizing the interpretation of MRI examinations.

These lectures provided innumerable cases that covered many of the dilemmas we face as breast radiologists in our daily practice and can apply to our workflows. They also highlighted a question and common goal: can we improve and make interpretations even more consistent among breast radiologists across modalities? Would these needed improvements come in the form of artificial intelligence (AI)? The current utilization rate of AI in screening mammography is only 9%, as pointed out by Dr. Fernando Collado-Mesa and Dr. Linda Moy, highlighting the room for growth in this field. They demonstrated how different types of computer programs can be used and offered advice on factors to be considered when implementing AI into practices of different sizes. AI is promising for decreasing physician workload, as demonstrated by Dr. Bibb Allen and Dr. Emily Conant, who also discussed the basics of AI ethics and the importance of quality control to ensure that models are generalizable. It will be interesting to see how new innovations in this field will make diagnoses and interpretations more consistent among radiologists in the future.

Improving care to underserved and underrepresented populations was a recurrent and important topic throughout the symposium. Dr. Cindy Lee and Dr. Rachel Brem revealed recent data from the COVID-19 pandemic demonstrating how decreased screening levels disproportionately affect women from underrepresented populations. It is necessary that breast radiologists acknowledge these disparities and address barriers to

Continued on page 28 >

screening because this is a key step to decreasing breast cancer mortality for women of all races in urban and rural settings. For those interested in international outreach, a comprehensive discussion of the SBI partnerships with RAD-AID International and Radiology Across Borders described how one can volunteer for the global reduction of breast cancer mortality.

The symposium had impressive coverage of the topic of leadership in breast imaging. It is crucial for experienced breast radiologists to lead and lead well because this will impact younger generations. This idea was impeccably delivered by Dr. Vilert Loving and Dr. Donna Plecha. Of course, important components of good leadership are productivity and efficiency, as explained by Dr. Stamatia Destounis and Dr. Amy Lynn Conners. They offered tips on how to improve workflow in academic and private settings. However, providing our teams with a sense of belonging and fairness is equally as necessary. The discussion about diversity, equity, and inclusion by Dr. Meshell Johnson provided insight into our implicit biases and how to mitigate these biases to reach this objective. Strategies to aid with physician burnout, which has significantly increased because of the pandemic, were also delivered by Dr. Jay Parikh. For those in leadership positions, these lectures were not only helpful but also necessary to overcome the current challenges we are facing as breast radiologists.

There also was space for networking and fun at the SBI symposium. Dr. Jessica Leung entertained the attendees with a review of the SBI Connect hot topics with responses from experts in the audience, highlighting the usefulness of this feature of the society's website. The Q&A sessions were helpful and permitted live and online interaction with the presenters.

The SBI's new president, Dr. John Levin, was inducted, and we were able to celebrate and thank our honorary fellows and past president, Dr. Emily Conant, while fund-raising for the SBI Research and Education Fund in a music-filled President's Gala. The exhibit hall, with its vendors and sponsors, served as the best meeting point during the breaks for networking and learning about the latest developments in our sector.

The SBI symposium is an event that all breast radiologists, practicing or in training, must experience. Although in-person attendance permits full involvement in the multiple activities, the virtual and on-demand format is available for those who decide to experience it in the comfort of their homes. We are excited for next year's symposium in National Harbor, Maryland, and hope to see you there!



MARK YOUR CALENDAR

Upcoming Events

Some events may be tentative, depending on the status of the COVID-19 pandemic.
Please check event websites for updates.



#SBI SUMMER SERIES

WEDNESDAYS

JUNE 22 - AUGUST 17

7 PM ET



2022 Summer Live Webinar Series

JUNE 28: Hindsight: What We Can Learn from Missed Breast Cancers

JULY 26: Breast Imaging in the ER

AUGUST 2: Contrast-Enhanced Mammography

AUGUST 16: Imaging the Reconstructed Breast

AUGUST 23: Transgender Breast Imaging

Visit the [SBI website](#) for details and registration information.