Mid-year convention on July 30

The annual PCR Mid-Year Convention will be held on Saturday, July 30, 1988 at the Philippine Columbian Clubhouse at Plaza Dilao in Paco, Manila. The whole day affair will start at 8:00 AM with the registration of participants and will continue until the evening with the delivery of the First Dr. Paterno Chikiamco Memorial Lecture by Dr. Bienvenido Lapuz.

Dr. Jaime Samaniego, Chairman of the Mid-Year Convention announced that registration fees of P150.00 for Fellows and P100.00 for Residents will be charged to cover expenses which will include lunch and dinner.

PCR President Dr. Jaime Tomas is appealing to all Fellows to find time to attend this very important scientific meeting and expressed hope that participants would be punctual.

An “Afternoon Tea Social” would precede the Mid-Year Convention. This will be held on Friday, July 29, 1988 also at the Philippine Columbian Clubhouse. This social event would serve as an opportunity for fellowship among the Fellows and Residents prior to the convention, aside from generating funds for the PCR.

Fund drive on

The PCR Fund Drive is on.

Realizing that the PCR is financially strapped and that many activities may not be accomplished, the Board of Directors decided to launch a fund campaign this year.

It will take the form of an “Afternoon Tea”, a social activity which will consist of a show with contributions coming from the radiology staffs of different Metro Manila hospitals. During the show, door prizes will be given to lucky ticket holders.

Prizes include a Betamax Video Camera, colored television set, Nintendo Computer Game sets and many others. Each ticket will cost P100.00.

If plans pull through, the PCR hopes to sell about 2500 tickets through the members and the residents.

(continued on page 2)
PBR exams set

The Philippine Board of Radiology through its Chairman Dr. Antonio Garcia recently announced the date and venue of the certifying examinations.

The exams will be held on Saturday, December 3 and Sunday, December 4, 1988 at the Lung Center of the Philippines. The deadline for submission of applications will be on Saturday, September 3. All applications should be submitted to PBR Secretary Dr. Roberto Ramos at the Institute of Radiology of St. Luke’s Medical Center along E. Rodriguez Avenue in Quezon City.

Meanwhile, the PBR proposed as minimum requirement for qualification to take the specialty board examination in Radiotherapy a 2-year cumulative training in the subspecialty. This would affect residents who start their training in January 1989. After December 31, 1990, the requirements would include 6 months in Diagnostic Radiology, 3 months in Radiation Physics and 3 months in any subspecialty in addition to the 2 years cumulative training in Radiotherapy.

The PBR intends to meet with the Radiation Oncology Section of the PCR to iron out details.

<table>
<thead>
<tr>
<th>SCHEDULE OF SCIENTIFIC MEETINGS</th>
</tr>
</thead>
<tbody>
<tr>
<td>(AUGUST-NOVEMBER)</td>
</tr>
</tbody>
</table>

Saturday, August 27...San Juan de Dios Hospital
(in conjunction with the Ultrasound Society of the Philippines)

Friday, September 30...Metropolitan Hospital
Friday, October 28...Philippine Heart Center
Saturday, November 26. Cardinal Santos Memorial Hospital

All meetings start at 5:30 P.M.

FUND DRIVE ON. . . . (continued from page 1)

Each member will be given a certain number of tickets for disposition.

The Afternoon Tea will be held at the Philippine Columbian Clubhouse on July 29 at 4:30 in the afternoon. This will be the day before the Mid-Year Convention and will likewise serve as a fellowship affair for all participants.

Dr. Jaime Tomas issued an appeal to all members and residents to actively participate in this activity and to sell as many tickets as possible to help boost the dwindling coffers of the PCR.

PCR dialogues with DOH

The PCR and the Department of Health have finally met in an informal dialogue last March. The PCR was represented by President Dr. Jaime Tomas and First Vice-President Dr. Manuel Mejia in talks with Assistant Secretary of Health Dr. Antonio Periquet.

In this dialogue, Dr. Periquet informed the PCR that the DOH would want to enlist the help of the PCR in formulating a rational training program for rural health physicians in Radiology.

As a result, an Ad Hoc Committee chaired by Dr. Gaudencio Vega was formed to study the matter and make the proper recommendations to the Board of Directors. Composing the membership of the committee are Dr. Jose Gaffud, Dr. Antonio Garcia, Dr. Justo Dañiguil, Dr. Paul Matriano and Dr. Manuel Mejia.

Meanwhile, it has been learned that the 6-week crash course in Radiology for rural health physicians has been temporarily suspended pending monitoring and evaluation of the performance of the recent “graduates”.

A second meeting with Dr. Antonio Periquet is scheduled sometime in July after he comes back from an official trip to China. It is expected that in this meeting, the PCR could finalize its position vis-a-vis the DOH request.

Fil-American radiologists organize

Filipino-American radiologists have organized themselves early this year. The new organization has been baptized the Philippine Radiological Society of North America.

Its membership comes from Filipino radiologists in active practice in the United States and Canada.

The president of this organization is noted radiologist Dr. Manuel Madayag, an interventional radiologist based at the Illinois Masonic Medical Center in Chicago. The secretary is Dr. Max Basco, also a Chicago-based radiologist.

Dr. Madayag expressed plans of helping establish a supplementary training program for interested Filipino radiologists. Tentatively, the plan is to bring into the Philippines consultants who would help train radiologists mainly in interventional radiology. This, he said, would be less expensive than acquiring the same training abroad considering that more local radiologists would be benefited. Dr. Madayag likewise expressed the hope that the PRSNA could coordinate with the PCR in activities that would be mutually beneficial.
Ultrasound Society of the Philippines

— A coming

April 30, 1988 marked another milestone in the history of the Philippine College of Radiology. The Ultrasound Society of the Philippines, the first of its kind in the country, after having been painstakingly organized by Dr. Vicente Romano, held its first national convention. The venue was the Makati Medical Center where Dr. Romano heads the Ultrasound Section. The affair was well attended by its members from Metro Manila as well as those from the provinces. Before the event, the officers of the organization had collected and compiled voluminous data sent earlier by the members.

The evening started with the welcoming of the members by the officers, then cocktails and dinner thereafter. Dr. Romano, being the president and organizer of the society, presided over the meeting. The insignia agreed upon was presented to the audience to be recognized as the symbol of the society from then on.

Dr. Romano then proceeded to read the constitution of the organization, subsequently discussed and debated upon by those present. This clarified membership among fellows and practitioners and included a grandfather’s clause. The officers of the organization are: President - Dr. Vicente Romano, Vice President - Dr. Roberto Ramos, Secretary - Dr. Mercy Go, Treasurer - Dr. Emilio Baltazar, Jr., and PRO - Dr. Emmanuel Carandang.

One of the issues discussed for the night, among others, was the professional fee of the ultrasonologist. As among the clinicians, the ultrasonologist will also examine his patients, analyze other laboratory data and correlate them with his findings and, therefore, should receive a compensation for these services rendered. Everyone hopes that this will be realized in the near future.

This was followed by a slide presentation and discussion, much like a CPC, of some of Makati Medical Center’s interesting cases, with contributions coming from Dr. Liza Mercado and from as far as Cagayan de Oro City from Dr. Rito Nangcas. The discussion proved to be very informative with new ideas gathered, and at the same time very lively (after those bottles of beer) with quite polar ideas coming out.

The climax of the affair was the distribution of the precious certificates of membership, with each member coming up to have himself/herself recognized, accepted and applauded. To say the least, the undertaking was a resounding success. Before goodbyes were said, it was agreed upon that the society shall now hold regular meetings, date and time of which will be announced beforehand, so stay tuned.

Nievera bares plans for Radiation Oncology Section

Dr. Eduardo V. Nievera, newly elected Chairman of the Radiation Oncology Section (ROS) of the PCR announced his plans for the year during the 1st meeting of the section held at a Japanese Restaurant in Makati last March. In attendance were officers of the PCR board headed by Dr. Jaime G. Tomas, Jr. and some PCR fellows who are currently active in the practice of Radiation Therapy.

Nievera envisions that the ROS will eventually become a society under the umbrella of the PCR in the same manner that the newly organized Ultrasound Society of the Philippines (USP) has become. He plans to have a formal presentation of specialty certificates to members of the section during the Mid-Year Convention in July. The original membership is composed of PCR fellows who have trained abroad and locally at the UP-PGH Cancer Institute. Creating a Radiation Oncology section will be in keeping with the concept of the Philippine Society of Oncologists, a growing society involving all physicians who are oriented and trained in Oncology. Further, the ROS will define more clearly the membership among PCR fellows who will also become fellows of the ROS. As it stands there is an overlapping membership among PCR fellows in subspecialties such as Ultrasound and Radiotherapy.

Another main agenda for the ROS will be to endorse the inclusion of Medical Physicist as a regular staff in a Radiology Dept., a drive being spearheaded by the Radiation Health Service of the DOH. The role of the physics section would encompass radiation protection (personnel & equipment monitoring), overseeing the repair & maintenance of equipment and giving assistance to the Radiologist in treatment planning.

In keeping with the PBR resolution that requires 2 years of RT training prior to qualifying for the board Exams in Radiation Therapy, the ROS has also supported this program. As such starting 1990 a 4 year residency training program in Radiology (to include 2 years of RT) shall be implemented at the UP-PGH. A 3 year straight Residency training in Radiation Therapy has already begun at the Jose Reyes Memorial Medical Center in the Department of Radiotherapy (formerly NCCC).

As a parting shot, Dr. Nievera lamented that the practice of Radiation Oncology has not been perceived clearly by other medical practitioners in the fight against cancer. “I strongly feel that we should launch an information campaign to define exactly our role in the multidisciplinary approach to cancer - especially in the triumvirate - "Surgery - Radiation Oncology - Medical Oncology".”
Radiology started out quite simply. It started with the visualization of the bones of the hand of Roentgen's wife in 1898. Since then, imaging of body organs has undergone an evolution that now borders on the sensational. Necessarily, with more sensitive modalities at hand, clinicians and patients have become more demanding and have greater expectations of the specialty of Radiology. How then may the consultants and resident staff of the Department of Radiology, UP-PGH, anticipate and, more importantly, match these expectations?

Looking back at the development of the specialty in the developed countries, it becomes obvious that the trend common to all is SECTORIZATION. With the marriage of electrons, sound waves, gamma rays and electromagnetic waves with computers, various subspecialties were born. The knowledge and skills required for the interpretation of the images sent back by ultrasound are quite distinct from nuclear imaging as they are distinct from CT scans. In the background of all these sophisticated subspecialties are the ubiquitous plain radiographs of the various parts of the body. Therefore, it behooves the resident in Radiology, if he is to ably compete in the limited market of the specialty, to have superspecial skills and knowledge over and above the basic requirements. The body of knowledge is at present tremendous owing to the research that is going on in CT scan and MRI. Three years are too short to accommodate all.

The preceding paragraphs have largely dealt with Diagnostic Radiology. But what about Radiologic Oncology? In the making is a Center of Oncology where there will be a section of Radiotherapy. UP-PGH has the cobalt, cesium and radium sources. Surely, any resident of the department must have a working knowledge of radiotherapy as well.

Generally speaking, the first 3 years of the proposed 4 year program are still largely as they are conducted at present with a few modifications. At the end of 3 years, the resident physician must have completed 2 years of diagnostic radiology and 1 year of radiotherapy. The 4th year is reserved for pursuit of superspecialization in either ultrasound, interventional radiology, musculoskeletal radiology, pediatric radiology, CT scan or radiotherapy. Aside from polishing the skills, the setup will insure that there will always be able manpower in these various subspecialties. In fulfillment of the requirements of the Boards of Diagnostics and that of Therapy the resident qualifies to take the board examinations only after the 4th year.

The idea of increasing the number of years of training finds favor among the resident staff collectively and with me personally. It will satisfy our intellectual and professional needs. It will equip us with many skills. It will provide us more opportunities for research. And more important from my standpoint, it will make work more organized and more manageable on a day to day basis.

Through all these, caution has been advocated. It is easy to be dazzled by the wonders of high technology but let's face it: our economy cannot sustain so many subspecialists. Our country does not have that luxury. The 4 year program, therefore, is tempered to find the happy compromise between two excesses. The specialty must undoubtedly diversify if we have to keep the respect of our colleagues in the clinics. But we must not spread ourselves too thinly, either. Herein lies the challenge. The residents and consultants of the department of Radiology of the UP-PGH are working towards the development of our specialty to the heights of excellence and service we are all committed to.
A Case of McCune Albright’s Syndrome

Jerome A. Gaerlan, MD
2nd Year Resident
JRRMMC

This is a case of E.G., 27 year old, female, single, from Isabela, admitted at JRRMMC on April 13, 1988 because of a left temporal mass. The present condition apparently started 2 years PTA, when the patient while walking, suddenly felt a cracking sensation over the right leg. She consulted at the National Orthopedic Hospital where a biopsy of the right tibia was done. She was discharged asymptomatic. Five months PTA, the patient started to experience on-and-off vertigo. She likewise noted a gradually enlarging mass over the left temporal area and also from the external auditory canal of her left ear. This was accompanied by diminished hearing on that ear. She consulted at the Ilagan Hospital, where radiographs of the skull were done. These radiographs were interpreted as consistent with bony metastases. This prompted referral to JRRMMC.

Pertinent Physical Findings

Physical exam revealed a 9 x 6 cm. mass, doughy, round, non-tender over the left temporal area. Otoscopy of the left ear disclosed a reddish mass filling up the auditory canal which bled easily on manipulation. Hypertelorism and prominent zygomatic bones were also appreciated. The skin showed non-elevated irregular brownish patches scattered throughout the left half of the thorax, both front and back.

Pertinent Laboratory Results:

\[ T_4 - 107 \text{ n mol/L} \quad \text{(N.V. - 60-160 n mol/L)} \]
\[ T_3 - 1.8 \text{ n mol/L} \quad \text{(N.V. - 1-2.4 mmol/L)} \]
\[ \text{Phosphorus - 1.77 mmol/L (N.V. - .97-1.29 mmol/L)} \]
\[ \text{Calcium - 1.92 mmol/L (N.V. - 2.35-2.75 mmol/L)} \]

Skeletal Survey (done at JRRMMC on 4-21-88)

Irregular and thinned out cortical margins with areas of bony rarefaction and sclerosis are seen at the ribs as well as the leg, pelvic, and skull bones (See Figs. 1-3). Some of the vertebrae show similar changes. There is a break at the spinal lamina and process of L₅ which is fused to S₁. The left 12th rib is missing.

Imp: (1) Osteitis fibrosa disseminata (polyostotic fibrous dysplasia) is the primary consideration, r/o bony metastases and multiple myeloma.
(2) Spine bifida, L₅
(3) Sacralization of L₅

Histopath Result (biopsy of right tibia done at NOH on 11-6-86)

Section shows irregular C-shaped immature bony trabeculae dispersed in a proliferating fibrous connective tissue stroma. No evidence of malignancy seen.

Diagnosis: Fibrous Dysplasia, right tibia.

(continued on page 6)
McCUNE ALBRIGHT’S SYNDROME
(continued from page 5)

Discussion:

Fibrous dysplasia is a condition marked by local, expanding lesions within bone in which the normal bony structure is replaced by fibrous tissue and poorly formed, woven bone trabeculae. Such lesions appear in three distinctive patterns: (1) involvement of a single bone (monostotic), (2) multiple lesions within several bones (polyostotic), and (3) Albright’s syndrome representing the concurrence of polyostotic fibrous dysplasia, melanotic pigmentation of the skin and a variety of endocrinopathies.

Approximately half the females with polyostotic disease have the McCune-Albright’s syndrome. The skin pigmentation generally appear as dark to light brown macules having irregular serpiginous borders. Although precocious puberty in females is the most typical endocrine anomaly present, other endocrinopathies may prevail such as gigantism, acromegaly, dwarfism, Cushing’s disease and so on. Albright’s syndrome is also seen, although less commonly, in males.

Fibrous dysplasia pursues an unpredictable course. The patients with monostotic lesions often remain asymptomatic throughout life. In some instances, sufficient destruction of cortical bone leads to fracture. This is seen particularly in the disseminated type where associated skeletal deformities occur. In general, the earlier the age of onset, the more progressive the condition. In less than 1% of cases, the lesions of fibrous dysplasia undergo sarcomatous change.

Roentgenologic Picture of Fibrous Dysplasia

The medullary portion of the long bone usually have a homogenous ground-glass appearance that blends with cortical bone without sharply demarcated edges. The medullary trabeculae are frequently obliterated, and the endosteal cortex is thinned and scalloped. Areas or bands of endosteal sclerosis may produce a multilocular appearance. The diaphysis may be expanded or widened. The expanded lesions are always covered by a thin shell of bone. Deformity of bone is common. Coxa Vara-Shepherd's Crook - is sometimes seen. Occasionally sclerotic changes dominate the picture. Diaphyseal and metaphyseal areas are most often involved, although in children lesions may extend to the epiphyses. In the skull, lucent and/or sclerotic lesions can be appreciated. Cystic lesions may be found in the calvarium and may be surrounded by a sclerotic zone. The sclerotic lesions usually involve the base of the skull, the sphenoid ridges, and the facial bones (leontiasis ossae).

An interventional radiologist at work. Invasive Radiology has come of age and is properly the turf of the radiologist. There is an air of concern among radiologists who feel strongly about what belongs to the specialty.

EDITORIAL... (from page 8)

The training programs in many of our centers have, on account of the many new developments, gone through a review and as a consequence the training curricula face expansion. Some training institutions are still hampered by many handicaps, principally that of lack of equipment. Some of our colleagues have, on their own, gone for further training elsewhere either for full residency programs or short-term fellowships. Whatever the mode of training, it looks like this area of concern is not neglected.

As far as practice goes, it seems that there is a steady increase in the workload of our radiology departments. Radiology is still one of the top earners in any medical center. If the number of referrals to a department were the gauge of confidence in our equipment and our abilities - and necessarily of our performance standards - then we can say that we are responding magnificently.

Many of our colleagues in the clinics have come to depend on us in varying degrees for the diagnosis and management of their cases. We have to respond to them by continually updating ourselves. No radiologist in his right mind can proclaim that he has mastered all the niceties of the specialty. Let us not rely on an exaggerated sense of self-importance and carelessly put down our guard. The radiologist - old or young, urban or rural based, teaching or non-teaching - cannot afford to stop learning. Otherwise, he will reap the whirlwind of his own complacency.

Back then to the question of how the Filipino radiologists are responding to the challenge of technological advancement. There can be no single answer for all. The answer of how well we are doing lies within our own individual selves. And if we are to advance in the rapidly expanding world of Medicine, the answer better be good.
The Contrast is Clear.

With Schering Contrast Media

- **Angiografin**
  pure meglumine diatrizoate for angiography and CT

- **Urograin**
  sodium and meglumine diatrizoate in a range of concentrations to best suit individual requirements

- **Urovision**
  high sodium diatrizoate content for excellent results in diagnostic urography

- **Biloptin**
  sodium iopodate rapidly absorbed produces optimal visualization, and excellently tolerated

Compliments of
Berlimed Philippine Corporation
subsidiary of
Schering AG • West Germany

For further information please consult our scientific literature or contact:
Berlimed Philippine Corp.
P.O. Box 331/Commercial Center
Makati - Metro Manila D-708
The "technological imperative"

There is no denying the fact that Radiology has changed. As early as perhaps two or three decades ago, technical miracles have been happening in advanced countries which drastically changed the face of radiological practice. It was a phenomenon that would eventually reach Third World Radiology a few years later.

Dr. Theodore Tristan, a former president of the Radiological Society of North America, observed that "our discipline is changing dramatically because of the technological imperative. Our professional functions are being altered in an extraordinary manner, placing new and unaccustomed burdens on our traditions and performance specifications."

How are the Filipino radiologists responding to these "new and unaccustomed burdens"?

In dealing with this question, it is important to remember that ours is a specialty which relies heavily on technology and equipment — much of which is beyond the financial reach of a battered economy still slowly on the upturn. Let us take a cursory look at the Philippine situation as far as three areas are concerned: acquisition of equipment, training of competent personnel and practice of the specialty.

There is a perceptible trend of modernization in many radiology departments. Many centers are updating their hardware, some slowly, others faster. There is a concentration of these modernizing centers in the bigger cities and among privately owned institutions. The corporate structure, the presence of enlightened hospital managers and the aggressiveness of our radiologists in these areas have hastened the process of modernization. Juxtaposed however against other countries, even among our ASEAN neighbors, our upgrading efforts still pale.

In the rural setting where the corporate structure is not as evident, the radiologist has to proceed with his upgrading scheme more slowly and painfully, mainly because the burden of finance is his. But despite the many constraints facing the rural radiologist, he has managed to embark on the venture albeit on a more modest scale. His purchases are limited to basic diagnostic radiological and ultrasonographic units.

(continued on page 6)

A battle for turf

Many of us may not be acutely aware of it, but there is a battle going on among some medical specialties. It is a battle for turf.

The advent of ultrasonography and vascular and interventional radiology has brought our specialty into the war zone, so to speak. Many of the procedures properly belonging to the province of Radiology are being performed by other practitioners, much to the chagrin of our fellows and residents.

There are those of us who believe that these examinations should be performed by competent specialists in Radiology. The reasons advanced are two-fold: that they are competent and that they have a better sense of quality control.

How do we go about winning this battle?

First, we in Radiology must show our colleagues that we are capable of doing the procedures better than they. This will entail a lot of training and hard work on our part.

Second, the leaders of Radiology departments must be able to fight for concentrating imaging equipment under one department. It would not be wise, for instance, to put an ultrasound unit in an OB-GYN department where only pelvic sonograms will be performed. In a setting where there is a dearth of such equipment, it is only proper that all such apparatus be placed in a central diagnostic imaging department (Department of Diagnostic Imaging would be a good name) where its use can be maximized to include other anatomic regions. Besides, what will become of the training of resident radiologists if the equipment were in another territory?

Thirdly, we in Radiology must practice a very high level of diplomacy if we are to entice our colleagues in the clinics to refer to us rather than to perform the procedures themselves. This may be a difficult balancing act but it will be necessary to win the battle.

Meanwhile, as specialty chauvinism pervades, the battle goes on. It may never be completely resolved in the near future but its presence is something worth thinking about and doing something about.