Dear Sir,

We read the article "Technical note: MRI lymphangiography of the lower limb in secondary lymphedema" by Kamble et al., published recently in your journal with great interest. [1]

We concur with the authors that the investigation of secondary lymphedema has been enigmatic with direct lymphangiography being too invasive and lymphiscintigraphy having poor spatial and temporal resolution. The authors have rightly pointed out that indirect contrast-enhanced MRI lymphangiography offers excellent visualization of the lower limb lymphatics in secondary lymphedema. The greatest advantage of this technique is the absence of radiation exposure, the multiplanar capability of MRI allowing for precise compartmental localization (epifascial/subfascial/intramuscular) and accurate depiction of the extent of abnormality. We would like to point out that one of the major limitations of the technique is poor visualization of inguinal lymph nodes after intradermal injection of contrast in the feet. We would also like to share our experience of indirect MRI lymphangiography with a newer MRI contrast agent with high relaxivity, gadobenate dimeglumine (0.5 mmol/L MultiHance, Bracco, Milano, Italy). We have found gadobenate dimeglumine to provide more detailed depiction of the lymphatic anatomy in the small number of patients that we have done [Figure 1A and B]. Lohrmann et al.[2] have demonstrated frequent visualization of inguinal lymph nodes after injection of gadoteridol (ProHance, Bracco-Altana, Konstanz, Germany) one of the newer contrast agents. The use of newer contrast agents with higher relaxivity thus offers the possibility of simultaneous depiction of the lymphatic channels and the lymph node groups.

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References

Authors’ reply

Dear Sir,

We agree with Parihar et al.[1] that this technique of MRI lymphangiography is relatively noninvasive and useful in depicting lymphatic channels of the lower limb in...
Letters to the Editor

Radiology education needs a revamp

Dear Sir,

Radiology as a subject has come a long way. Behind the curtains and overshadowed by their clinical colleagues, radiologists now play a significant role in patient management. And it is not just diagnostics anymore. However, sadly the training pattern of post-graduate radiology students has failed to evolve with modern times. In good old days when radiology was synonymous with X-ray, there was a lot of emphasis on physics. It is true even today. I strongly feel that radiology students should not be burdened with too many technical details, especially when there are many more important things to learn and remember. Practically, it is not a knowledge of physics that one requires to have in day-to-day practice, but a good clinical acumen, to make the right diagnosis. The technical jargon is best left to engineers, and we should focus on medicine. An orthopedics student is never asked to write a short note on manufacturing of Austin Moore's prosthesis, neither is a surgeon asked about the physics of a laparoscope. However, a radiology student is invariably asked about a Dry View camera. Is there nothing better to ask? Radiology curriculum needs a revamp. It should be redesigned so as to give our post-graduate students a better perspective of a subject that is essentially clinical. A 6 months official posting in a surgical or medical department during post--graduation would be a good idea to start with. This will create a genre of clinically sound radiologists that clinicians will find difficult to bully. Radiology is not mere medical photography or simple image interpretation where you just have to tell black from white. We are better than that, much better.

It is the need of the hour to make imaging more clinically relevant. We have given away too many things, including echocardiography and endosonography, simply because radiology is not considered a clinical branch. We have only ourselves to blame. Only those species that learn to adapt and evolve will ultimately survive. If we are not careful enough, the day is not far when CT scan and MRI will go the same way as X-ray and USG have,, i.e., to the clinicians. Let us wake up before it is too late.

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References


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We have used gadopentate dimeglumine (Magnevist, Bayer Schering Pharma, Berlin, Germany) for injection which is different from gadobenate dimeglumine (MultiHance, Bracco, Milano, Italy); Magnevist has low viscosity (2.9 vs 5.3) and low T1 relaxivity (4.1 vs 8.3 at 1.5T) as compared to MultiHance.[3,4] We were not able to demonstrate inguinal lymph nodes probably because Magnevist gets washed away early as it reaches the groin due to low viscosity and low relaxivity. We completely agree with the authors that newer contrast media like MultiHance may be a better option to visualize lymphatic channels along with visualization of inguinal lymph nodes in secondary lymphedema due to the higher relaxivity, which may help improve the quality of the technique.

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