

THE SOCIETY FOR
VASCULAR TECHNOLOGY OF
GREAT BRITAIN AND IRELAND

NEWSLETTER

Issue 93 Summer 2016

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News from the President of the SVT



I wanted to keep you informed of the work the committees have been doing so far this year and a few changes that have happened.

In April this year the Vascular Society vacated their office at the Royal College of Surgeons in London in order to outsource their administration to Fitwise, the company which also organises the VS conference. Up until this point, the SVT had been able to take advantage of the administrative support the VS office provided and the executive committee had to make a decision about how we would proceed. BMUS have kindly agreed to provide the SVT with postal support and we will continue to use the dedicated email addresses the SVT have always held which are available on the website. There will be no dedicated telephone contact for the SVT but officers of the

committees can be contacted through the designated email addresses. The new registered address for the SVT can be found on the website footer on the home page.

A new SVT website was launched on the 18th July. This has a new modern look and will make the administration of the SVT more streamlined. Each member will be emailed with a link to login and update personal details. The username will now be the registered email address and you can select your password at the initial login. One of the benefits of the new website will be the member's 'locker'. This is a personal facility for each member and can be used to store

President: Tracey Gall • **Vice President:** Helen Dixon • **Past President:** Tanyah Ewen • **Membership Secretary:** Sara Causley
Conference Secretary: Dominic Foy • **Treasurer:** Tanyah Ewen (acting) • **Newsletter Editor:** Helen Dixon (acting)
Web Site Manager/ Job Adverts: Lee Smith • **SVT Website:** www.svtgbi.org.uk

CPD evidence. There is also an online CPD activity facility so that members can earn CPD through answering questions on the website.

The professional standards committee has been very busy drafting new policies for social media, complaints and code of conduct. We have also been discussing some minor changes to the constitution upon which the membership will need to vote and will be able to do so through the balloting facility of the new website. Further details will be circulated soon.

Following increasing demand from other organisations to give input to research developments, a new SVT research committee has been

created, chaired by Richard Simpson from Nottingham. The aim of this committee is to development documents for helping our members to conduct research and representing the SVT with other groups such as VERN and RCS Vascular Research Committee. The SVT will also make available a fund for education and research applications from our members. Once again, all the details can be found on the website.

Our alliance with the American Registry of Diagnostic Medical Sonography continues to move forward and we are still on target for the delivery of electronic exams for 2017.

It has been a busy year so far and all the committee members have been working hard to ensure all these projects come to fruition. There will be some vacancies on the committees in November and the Society does rely on its members to ensure it continued success. If you think you could spare some of your time please do get in touch to find out what positions are available and have an informal chat about what is required. I have thoroughly enjoyed my time whilst I have been involved with SVT and would definitely recommend it!

Tracey Gall
SVT President

Would you like to be more involved in the SVT?

The SVT relies on the good will and dedication of its members to support and promote the development of our profession. Although we are a relatively small society we have always been extremely fortunate to attract new enthusiastic and willing volunteers every year to help run and influence our society. This continual cycle of refreshing our committees and working groups ensures that there is always an assortment of opinions, skills and knowledge leading our profession into the future.

SVT roles are wide and varied; they may be very specific organisational tasks such as arranging practical examiners and recording exam results or a more responsive role such as reviewing new NICE guidelines or surveying members on a particular topic.

Typically members attend 3-4 meetings per year in London (expenses are paid). Being involved is interesting, great team work and a really fantastic opportunity to make new contacts and learn from colleagues. You will also be awarded CPD points for being on a committee. Committee members do not require full accreditation but we do ask that you have passed the theory exams and are preparing to sit the practical.

As usual there will be opportunities available on the committees from November 2016. At this time we are just asking for your "expression of interest". Further details will then be available during November on the specific roles available.

Please email the following details to h.dixon@nhs.net by October 31st:

Name:
Membership number:
Hospital/department:

Helen Dixon
SVT Vice President





The Vascular Societies'
Annual Scientific Meeting
 in conjunction with the Vascular Society of Great Britain and Ireland, the Society of Vascular Nurses, and the Society for Vascular Technology of Great Britain and Ireland. **2016**

30 November – 2 December
Manchester Central Convention Complex

The Vascular Societies Annual Scientific Meeting encompassing the **Vascular Society**, **Society of Vascular Nurses** and the **Society for Vascular Technology** into one single integrated event will take place from the 30 November – 2 December at the Manchester Central Convention Complex.

The conference will take place in the iconic Manchester Central Convention Complex (MCCC), which is located in the heart of the city. Being located in the centre of the UK, Manchester has excellent transport links to the rest of the UK and further afield.

Make sure you put the ASM meeting date in your diary. Online delegate registration will open on the 1 September 2016, when the programme will also be made available.

1 September 2016 online registration opens



The Vascular Societies Annual Scientific Meeting 2016

Tel: 01506 292042

Web: <https://fitwise.eventsair.com/vsasm2016/abstract-submission>

Email: asm@vascularsociety.org.uk

IICMS Conference

On Friday 6th May 2016 the Irish Institute of Clinical Measurement Science held their annual Scientific Conference at the Sheraton Hotel in Athlone. Following some email correspondence with Tanya Byrne, the IICMS Chairperson and lead for the Vascular Faculty, about how the SVT could support our Irish members I was invited to attend the conference and to speak in the vascular faculty break out session.

The IICMS is the representative body for professionals working in the field of physiological or clinical measurement science in Ireland. It has five faculties including Cardiac, GI physiology, Neurology, Respiratory and Vascular. The morning of the conference was a general session open to all faculties and we heard from some really interesting speakers on topics relevant to all specialities. The first was Dr Conor Kerely, who spoke about some of the work he had done for his PhD on 'Nutrition for Prevention and Treatment of Chronic Disease'. There was a lively debate titled, 'The Institute should focus on Advancing Clinical Science rather than Pseudo-scientific concepts such as Leadership and Risk'. For the motion was Dr Gerard King who felt the 'science was being watered down' and that the Institute should not include professional issues in a scientific conference. Against the motion was Mr Paul Nolan who felt it was important to use this meeting as a forum to discuss those issues affecting the working environment of the physiologist.

Professor Sherif Sultan, Consultant vascular and Endovascular surgeon from the Galway Clinic gave his presentation on some of the cardiovascular innovations he

has developed and consulted on including the cyber knife and his perspective of the future of hospital care. After lunch the delegates divided into their relevant faculties and the vascular faculty had a good turn out with approximately 20 attending. The first speaker was Elaine Doran from the Galway Clinic speaking about her experience of training junior staff. Most trainees in Ireland are now graduates of the Dublin Technical Institute. Trainees continue to learn whilst working in the vascular lab, can access PgC courses in the UK and work towards achieving AVS. This talk prompted a discussion about measuring competency and how many scans a trainee should do or be audited on before being deemed competent to practice independently. Sarah Clarke from Mater University Hospital presented the results of a study looking at the patency of the ICA following CEA at 2, 5 and 10 year post –operation and there was an update from the faculty committee on topics such as CPD. Richard Pole gave an overview of IQIPS and whilst this accreditation is not offered in Ireland discussing the process did prompt some discussion about improving lab services.

The IICMS are able to secure funding for members to attend courses and conferences and asked for the SVT's help in running some study days in the future, particularly for upper limb/ fistula scanning which we hope to organise for 2017.

Overall, the day was really informative both in the clinical respect and learning about working away from the NHS.

Tracey Gall
SVT President

PLEASE NOTE Membership Fee Increase

New members £50 Renewal £40

Due to increasing costs we have reluctantly decided we will need to increase the new member fee and renewal fee from June this year. The current fees have been the same for many years now and are small in comparison to most. I'm sure you will agree we still represent excellent value for money.

Action required NOW.

For those who pay your renewal fee by **standing order on the 1st September** you will need to amend the amount you pay. **We CANNOT do this for you. Please check your account and make this change now. Don't wait until September.**

Your help in this is appreciated to ensure all renewals run smoothly again this year. Thank you.

Sara Causley, Membership Secretary

Ann Donald Scientist of the Year Award 2016

Call for Nominations

An annual award for the scientist who has performed the best original research or been the most innovative in the promotion of vascular ultrasound.

The annual prize of £500 will be awarded to 'the scientist who has performed the best original research or been the most innovative in the promotion of vascular ultrasound during the year'.

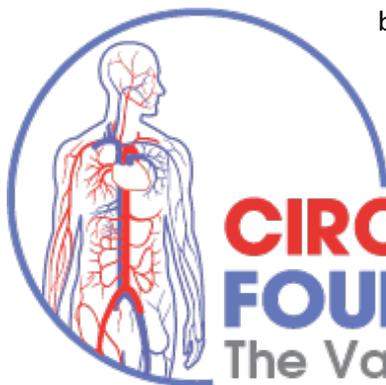
How to nominate someone for the award: Nominations for this award can be made in writing using the application form on the SVT website. You may either nominate yourself or another, in recognition of achievements over the past year or so. Applications must be completed in full, with supporting evidence and two others to support your nomination.



The deadline for nominations is 31st October 2016, and the prize will be awarded at the 2016 ASM if we receive an appropriate nomination.

Vascular Awareness Month

September 2016



This year the Circulation Foundation's 'Vascular Disease Awareness Month' will be taking place throughout the month of September. The main aim of the awareness month is to provide an opportunity for supporters of the charity, from healthcare professionals, to individuals with vascular disease and their families and friends, to create awareness of vascular disease and the charitable work of the Circulation Foundation.

Create your own event during the awareness month. Your event can take any shape or form, and if you need any ideas please go to the 'getting involved' page on the website www.circulationfoundation.org.uk When you have decided on your event, register your event online, and we will send you a 'fundraising'

pack. This will contain T-shirts, collection boxes, balloons and charity ribbons. You can also print off any patient information you think will help you with your event.

On the day of your event, take some photographs so that you can send these, along with some information about yourself and your event, to be displayed on the website and the next Newsletter. The easiest way to send us any money you raise during your event, is via 'Virgin Money' giving or 'Just Giving', both of which can be accessed via the website.

As always, the Circulation Foundation is very appreciative of the time and effort you are putting into supporting us, and we hope you have an enjoyable and successful event. We look forward to hearing about your event.

Case Study: An unusual case of upper limb DVT and vein compression

Alison Elcott, Clinical Vascular Scientist, Watford General Hospital

A 48, year old male patient was referred from the DVT (deep vein thrombosis) clinic to the Vascular Laboratory at Watford General Hospital for a query left upper extremity DVT (UEDVT) following a long-haul transatlantic flight. He presented with symptoms of a swollen, painful arm and signs included prominent dilated veins over his upper arm. No history of trauma to the arm or strenuous activity had occurred prior to this incident. This patient was a pilot and had undergone an EASA (European Aviation Safety Agency) class 1 medical examination earlier in the year. This confirmed that he had been certified medically fit by the civil aviation authority. No predisposing factors or medical problems could be attributed to a UEDVT.

The referring clinician reported that two weeks prior to this appointment whilst on flight deck sleep rotation this patient slept for approximately eight hours sitting upright in an unusual position (see figure 1).

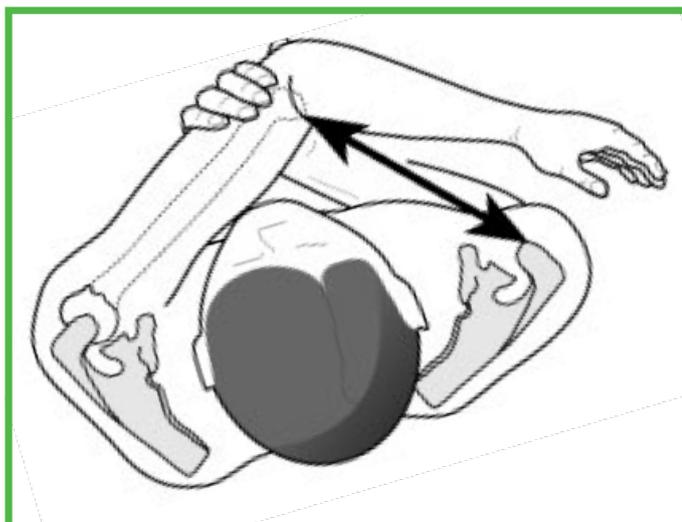
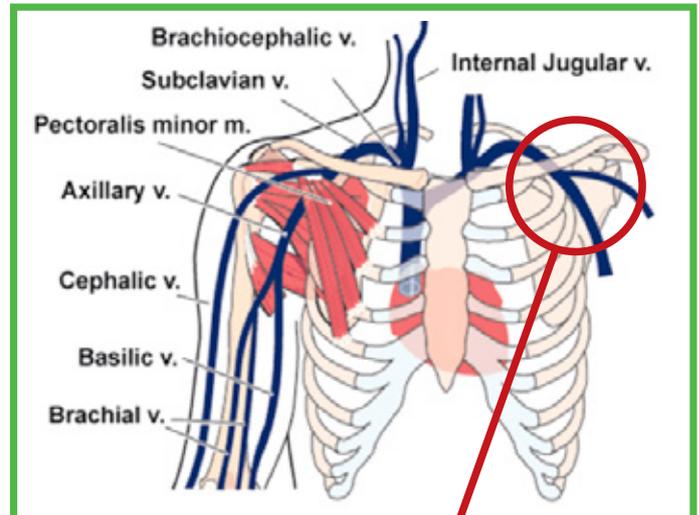


Figure 1: Patient position (Matsen, F 2011)

The patients' upper body was leaning towards his left side with his elbow flexed and arm adducted across his body, compressed against his chest.

Upon performing his left upper limb venous duplex scan, acute thrombus with low echogenicity was identified occluding the basilic vein, axillary vein and distal subclavian vein (infraclavicular) (see figure 2). The results were explained to the patient and reported. The patient returned to the DVT clinic whereby the consultant ruled out the option of catheter- directed thrombolysis and initiated anticoagulation treatment with Rivaroxaban that same day. This patient was also referred to the anticoagulation clinic for further investigations and a follow up.



Axillary and subclavian vein [brachial plexus] compressed during cross body adduction of arm.

Figure 2. Diagram of anatomy of venous system of the neck, thoracic inlet and arm.

(Chin, E et al 2005 Journal of Ultrasound in Medicine)

The consultant referred the patient for a chest x-ray which ruled out any P.E. (pulmonary embolism) or mass lesions that may be causing compression of the veins. In clinic the consultant explained to the patient that this was an unusual case and the cause was likely to be as a result of abnormal compression on the veins running between the pectoralis muscles and/ or brachial plexus. Although similar in mechanism those less common primary forms of UEDVT were ruled out because there was no evidence of muscle atrophy to support Paget Schroetter disease and no evidence of repetitive strain injury to support Thoracic Outlet Syndrome.

This was an unusual presentation of UEDVT. Although more common due to the increased use of pacemakers, defibrillators and central venous catheters, only 10% of all DVT are upper limb (Hollberg, J. 2011). This patient was not offered interventional treatment despite the fact active interventions such as thrombolysis have been associated with increased vein patency and decreased post-thrombotic syndrome (Hollberg, J. 2011). As a result of this case subsequent eligible patients that present with UEDVT are offered a choice of catheter-directed thrombolysis or anticoagulation. Furthermore, a topic for further research and discussion is the use of ultrasound-assisted thrombolysis which disaggregates fibrin strands and disperses thrombolytic drugs through acoustic microstreaming.

From previous page:

References

Chin E., Zimmerman, p. & Grant, E., 2005. Sonographic Evaluation of Upper Extremity Deep Venous Thrombosis. *Journal of Ultrasound in Medicine*; vol 24 (6), pp 829-838.

Hollberg J., 2011. What is the best approach to treat an upper-extremity DVT? *The Hospitalist*; October 1, pp 1-10.

Matsen F., 2011. Shoulder arthritis/ rotator cuff tears causes of shoulder pain [online]. Washington. Available from :http://shoulderarthritis.blogspot.co.uk/2011_08_01_archive.html [Accessed 01/07/2016].

bubbles

Matt Slater, Chair of the Professional Standards Committee

Contrast sonovenography - Is this the answer to complex deep vein thrombosis imaging.

Smith, A. Parker, P. Byass, O. Chiu, K. (2016). Ultrasound, 24 (1), pp. 17-22.

Background: Deep vein thrombosis (DVT) is a potentially fatal condition with complications such as pulmonary embolism and PE and debilitating post-thrombotic syndrome. Currently duplex ultrasound is the investigation of choice for DVT as it is widely available and does not involve ionising radiation. The overall specificity of thrombus detection for ultrasound is ~94%, reducing to 64% in the distal lower extremity. Image resolution and depth can be suboptimal in certain populations such as the obese or those suffering from significant peripheral oedema. This will limit the ability to identify deep vessels and provide accurate diagnosis in these patients.

Ways to improve the sensitivity and specificity of distal lower extremity DVT detection is both beneficial to the patient and healthcare system. In recent years contrast ultrasound has become an increasingly accepted enhancement for ultrasound. It is well tolerated, non-nephrotoxic and is substantially cheaper than investigations such as CT and MRI. The aim of this study was to see if it is feasible to use contrast enhanced

ultrasound (CEUS) in identifying deep leg veins.

Methods: Fifteen patients deemed high risk for thromboembolic disease as determined by clinical decision algorithm (wells score) and or raised D-Dimer were identified for this study. All patients had a previously negative ultrasound.

Ultrasound of the lower limb was performed with the patient in a supine position, using B-mode compression sonography along the transverse plane. Colour/Power Doppler analysis was used down to the distal calf.

After initial ultrasound assessment a single bolus of contrast agent was given intravenously via a cannula in the upper extremity. Identification of deep veins with contrast was correlated with deep identification without. The extent to which each vein was clearly seen was documented.

Results: Twelve of the 15 patients recruited were included in this study. Of the three excluded, one was excluded due to failure to obtain IV access, another because there was optimal deep vein imaging on standard ultrasound and a third because of patient pain.

For the CFV in 100% of cases it was

visualised fully pre contrast, the SFV demonstrated a pre-contrast visualisation of 67% and the Pop V 83%. Contrast administration improved visualisation to 100% for both veins. In total 60 veins (5 veins in each patient) were imaged, of these 43 (71.6%) were fully visualised pre contrast and 55 (91.6%) post contrast. No anatomical variants or DVTs were identified with either baseline ultrasound or contrast ultrasound.

CEUS provided significant improvement in calf vein visualisation extent. There was improved visualisation of the PT veins in all of the candidates with a mean gain in the distance visualised of 18.8cm. Increased full visualisation of Peroneal veins was demonstrated improving from 25% to 58%.

Conclusion and Comment: This is the first study using a second generation contrast agent more suitable for real time scanning to detect DVT. It appears to have demonstrated that CEUS improves deep venous visualisation compared to colour flow. The paper does not state who performed the ultrasound examinations and their level of experience. Of particular concern would be the fact that in 2 of the 12 patients the Popliteal vein could not be imaged. Even in obese patients with significant oedema it is unusual to not be able to visualise the

Popliteal vein fully. It may therefore be the case that experienced scientists/sonographers/Radiologists with the ability to fully optimise colour flow and B-mode imaging would have seen much more of the deep venous system on the baseline ultrasound.

It is however a small study pilot study and further studies are needed to confirm if contrast does indeed enhance deep venous visualisation in this difficult patient group and more importantly if it enhances DVT detection.

Comparison of portable ultrasound system and high end ultrasound system in detection of endoleaks.

Zimmermann, H. Rubenthaler, J. Rjosk-Dendorfer, D. Helck, A. Reimann, R. Reister, M. Clevert, D.A. (2016) *Clinical Haemorrhology and Microcirculation*, Epub.

Background: EVAR is less invasive than open surgery but has a higher complication rate indicating lifelong surveillance. Endoleaks are the most common complication after EVAR and are defined as the persistence of blood flow outside the lumen of an endoluminal graft but within the aneurysm sac. Endoleaks are cause for concern because they can lead to aneurysm sac enlargement with associated risk of rupture.

Type I and Type III endoleaks are characterised as high flow endoleaks which are likely to need further intervention after detection. Currently CT, Colour ultrasound and Contrast enhanced ultrasound (CEUS) are used to detect endoleaks. Despite the different imaging techniques available it is still sometimes difficult to tell whether or not there is an endoleak and which type it is. Ultrasound technology is continuously evolving and portable systems have been improving, such

that many may now be equivalent to older larger high end systems.

Methods: In this retrospective study 25 patients underwent both standard examination (b-mode and colour flow) using a portable ultrasound (Philips VISIQ) system and a second standard examination using a high end ultrasound system (Phillips EPIQ 7). The examinations were performed by an experienced sonographer (15 years of experience). The examination using the portable system was carried out first followed by examination with the high end system. Finally the contrast enhanced examination was carried out using the high end system. It is not clear from the methods whether these were all carried out on the same day or if there was an interval between the scans.

Results: Of the 25 patients CEUS detected endoleaks in 20/25 cases (80%). Using the portable system endoleaks were detected in 6/25 (24%) patients in B-mode and 7/25(28%) patients using colour flow. Using the high-end system endoleaks were detected in 8/25 patients (32%) using B-mode alone and 9 of 25 patients using colour flow. Of the 20 endoleaks 19 were type II and one was type III which was identified by both machines. Sensitivity for endoleak detection on Colour Doppler for the high end system was 45% and specificity was 100%. For the portable system sensitivity was 35% and specificity 100%. Diameter measurements were comparable on both machines.

Conclusion and Comment: In this study, the high end ultrasound system does not seem to have an additional advantage in the measurement of the aneurysm diameter. More endoleaks could be detected on B-mode and colour Doppler using the high-end system. The level of endoleak detection and thus the sensitivity of Colour Doppler on both systems in this study seems

rather low (45% on the high end system). In order to detect low flow endoleaks colour flow needs to be optimised and the low sensitivity in this study may suggest that this has not been carried out effectively by the "experienced" sonographer. In fact 11 type II endoleaks were not detected compared to CEUS.

Rather bizarrely the authors compared B-mode only on the two systems for endoleak detection. While a good EVAR ultrasound scan should always include using B-mode as a guide to look for less echogenic areas where there may be an endoleak, it should never be used in isolation to diagnose endoleak without Colour flow.

The study does appear to show however the relatively comparable results of a high end system and tablet based portable system. Nevertheless within the methods it does not describe the time frame between which the portable and high end scans were performed and the high end scan seems to have been performed after the portable scan. If an endoleak was detected using the portable system inherently the sonographer would be looking for that same endoleak with the high end system possibly introducing bias.

It is a relevant question however to ask if portable equipment is as sensitive and specific as high end equipment for endoleak detection and EVAR scanning, particularly as vascular labs expand and perhaps purchase portable equipment as a cheaper option. This study goes some way to exploring the idea that portable systems may be as effective in EVAR surveillance but more research is needed.



CPD Questions

Summer 2016

The questions below are in relation to the following paper: [GRANATA. A et al 2009. Doppler ultrasound and renal artery stenosis: An overview. Journal of Ultrasound, 12 133-143.](#)

Questions

1. State two pathological causes of RAS
2. In one study, what was the prevalence of RAS in hypertensives found in the general population?
3. Name the four criteria used to detect a significant stenosis or occlusion within the proximal renal artery.
4. What PSV and RAR values should be obtained from a normal (non-stenosed) proximal renal artery?
5. Under what conditions should the RAR be disregarded?
6. What is the equation for calculating resistive index?
7. Name three conditions that can increase RI values.
8. What is the name of the dampened waveform commonly found within the distal renal artery in the presence of a significant renal artery stenosis?
9. In relation to the answer provided in question 8, state two characteristics of this waveforms.
10. Approx. what percentage of patients have one or more accessory renal arteries?
11. Why might it be better to image the right renal artery using the flank approach?

Submission deadline: **31st October 2016**

Please forward answers to heather@vascularsolutions.co.uk. Don't forget to include your SVT membership number.

Answers: Winter 2016 Newsletter

1. Answer: 2.9 million
2. 75%
3. Localised injury to skin and/or underlying tissue below the ankle.
4.
 - i. Neuropathy
 - ii. Limb ischaemia
 - iii. Ulceration
 - iv. Callus
 - v. Infection/inflammation
 - vi. Deformity
 - vii. Gangrene
 - viii. Charcot arthropathy
5. Podiatrist
6. Diabetology, podiatry, diabetes specialist nurse, vascular surgery, microbiology, orthopaedics, biomechanics and orthotics, interventional radiology, casting and wound care.
7. Annually for low risk patients, when foot problems arise any admission to hospital or if any change in status whilst in hospital.
8. 2-4 weeks.
9. A wagner classification.



Trainee Competition Summer 2016

1. Can you list the different carotid criteria available for grading carotid disease?
2. Can you discuss the different criteria and what is currently recommended by the Society of Vascular Technology?
3. Can you list and briefly explain current treatments available for significant carotid disease?

Please send answers to Siobhan Meagher, Chair of the Education Committee on Siobhan. meagher@luht.scot.nhs.uk. The winner will receive a £25 book token and have their answers printed in the Autumn newsletter:-Closing date: 15th of September

SVT Wordsearch

S J S Q H U K Z A R T Z F Y C
 O R I X U T B N I A M E C C I
 M E S N F I R E T L J C I N L
 D C O O I C A M I U T N L E A
 S U R I S A C U T G H A O U H
 T D E T T L H L N U R D T Q P
 E S L A U I I A E J O E S E E
 N N C C L P A Q V A M P Y R C
 O A S R A E L K D S B M S F O
 S R O U G R K U A R O I W P I
 I T R F N C I L O T S A I D H
 S T E I C I M E A R E P Y H C
 F R H B X V E I N L D Z Q Z A
 T A T T E N U A T I O N A S R
 Q Y A E U Q A L P E G Y W U B

ADVENTITIA	HYPERAEMIC
ATHEROSCLEROSIS	IMPEDANCE
ATTENUATION	JUGULAR
BIFURCATION	LUMEN
BRACHIAL	PLAQUE
BRACHIOCEPHALIC	STENOSIS
CALIPER	SYSTOLIC
DIASTOLIC	THROMBOSED
FISTULA	TRANSDUCER
FREQUENCY	VEIN

Theory Exam Report

The Society for Vascular Technology exams took place on the 6th of June. There were three exam locations, in London, Manchester and Ireland. Final exam candidate numbers were as follows.

- 43 in total were registered to sit the Physics exam
- 45 in total were registered to sit the Technology exam

Broken down by geographical location:

For the Physics Exam:

- 6 were registered in Ireland
- 25 were registered in London
- 12 were registered in Manchester

For the Technology Exam:

- 4 were registered in Ireland
- 29 were registered in London
- 12 were registered in Manchester

Overall 40% failed the physics and 60% passed which is an improvement on last year which had a pass rate of 55% and for the technology exam 13% failed the technology and 77% passed which was also an improvement on last year which had a pass rate of 72%.

Unfortunately due to a printing issue there was a delay to the start time of the physics exam at the London venue and this had a knock on affect for the afternoon with a delayed start time to the technology exam. This will hopefully be avoided in the future with the instigation of the online exam system.

Exam certifications were issued in July, with the introduction of the new website exam certification should be able to be directly applied to each exam candidate's membership account.

Resit exams will be on the 5th of September. Registration for the resits will be available late July to mid August. Please check the website for more details. Only candidates who sat their exams in June can apply to do the resit exams.



Welcome to the Summer 2016 edition of the SVT Newsletter...

I hope you are all enjoying the Summer and more importantly have visited the new SVT website, you may have noticed there has also been an update to the SVT logo to go with our new website design. The website will make all the administrative processes within the SVT more streamlined and I hope we can develop it further to include more educational, teaching and CPD resources. We welcome your feedback so please feel free to send comments and suggestions to the committee email addresses which you will find at the end of the newsletter.

As always I would like to extend thanks to all contributors who sent in articles for this season's issue.

The Newsletter is continually looking for original contributions, so please email me any case studies, reviews, your experiences or any comments

that you think would be of interest to members of the society, contributions may also be eligible for CPD points. I would also welcome any comments on articles published in this edition.

As always a £25 prize is offered to the individual chosen for sending in the article or letter of the month. The prize this issue is awarded to Alison Elcott for her case study on an unusual presentation of upper limb DVT.

The next Newsletter will be the Autumn Issue, and the closing date for receiving articles will be 7th October.

Helen Dixon
Newsletter Editor
newsletter@svtgb.org.uk

DATES FOR THE DIARY 2016

SVT Theory Exam Resits, King's College Hospital, London
 5th September

VASBI AGM, Queens Hotel, Leeds
 22nd/23rd September

VS ASM, Manchester Central Convention Complex
 30th November –
 2nd December

SVT ASM, Manchester Central Convention Complex
 1st December

BMUS ASM, York
 7th-9th December

Committee Members 2016

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Past President

Tanyah Ewen

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Members

Mary Ellen Williams
Richard Craven
Lila Elliott
Alison Charig

RESEARCH COMMITTEE

Chair

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Members

Steven Rogers
Laura Scott