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AHRA Annual Meeting Preview
The association for medical imaging management heads to the Mile High City – July 27-31

Glassware Insurance Programs
Can they take the shock out of CT tube replacement costs?

Bone Densitometers
Helping doctors find and treat osteoporosis

Single-Use Devices
Should they continue to be reprocessed and re-used?

Laser Camera Equipment
Sales are down, but not out

Mammography In Flux
Every imaging modality offers an answer – but which are best?
Tiger Takes a Timeout

One of the biggest sports stories of the year was Tiger Woods winning the 108th U.S. Open. (And while I’m a fan of Tiger’s, this time I was kind of pulling for “old” Rocco Mediate — being closer to his age.)

But perhaps an even bigger story is that Tiger did it with a torn ACL and double stress fractures in the tibia of his left leg.

I tore my ACL about 12 years ago (skiing, double black diamond, Aspen — at least it happened on the run of the last day) and had it repaired. I’m happy to say it feels about 99% fine all the time, and I’ve gone back to skiing and windsurfing with no trouble. So once Tiger’s out of rehab, he’ll be virtually good as new, we trust.

Among the many wonders of modern medicine is the reconstructive possibilities available today for so many sports injuries. But the fact that Tiger decided to ignore the recommendations of his doctor and try and make it through the season on such gimpy wheels, reminds us of the old adage, “You can lead a horse to water, but you can’t make him drink.”

But perhaps Tiger’s highly visible poor judgment in this case will help a great many people think twice about ignoring sound medical advice.

So while we’ll miss the charismatic Tiger on the Tour the rest of the year, he will have helped a lot of people from being benched themselves.

Robert Garment
Executive Editor
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Olympus Responds to DOTmed News
Endoscopy Report From May 2007

We ran a response in DOTmed’s Weekly Online News from Olympus to an Industry Sector Report on Endoscopy Sales & Service Companies that ran last year in DOTmed Business News. The response was posted online on 6-19-2008. You can read Olympus’s comments at this address: www.dotmed.com/dm6274

Below are two Letters to the Editor we received by email about the Olympus response. One from G. Wayne Moore, founder of Sonora Medical Systems, and one from a biomedical technician in a hospital in Indonesia.

July 2008 Events

GOG (Gynecologic Oncology) Semi-Annual Meeting
2008, July 17-20, Chicago, IL

AHRMM Annual Conference & Exhibition
July 20-23, San Antonio, TX

SCAI Pediatric & Adult Interventional Cardiac Symposium (PICS-AICS) 2008
July 20-23, Las Vegas, NV

AHWONN (Women’s Health, Obstetric and Neonatal Nurses) Annual Convention 2008
July 21-25, Los Angeles, CA

AHA Leadership Summit 2008
July 24-26, San Diego, CA

IAC 14th World Congress on Heart Disease 2008
July 26-29, Toronto, Canada

AHRA (Radiology Administrators) Annual Meeting and Exposition 2008
July 27-31, Denver, CO

July 28 - Aug. 1, Lake Tahoe, CA

SICP (Invasive Cardiovascular ) Annual Meeting 2008, July 31-Aug. 2, Las Vegas, NV

Dear Sir,
I work in a hospital in Indonesia and we face the same issues for scope repair here as are faced in America.

My experience with Olympus has been expensive repairs, long waiting times and little or no information regarding the root cause of the problem.

We started sending our scopes to an ISO in America for repair and got excellent service. Repairs were cheaper and turn around was quicker and the quality of repairs was excellent. We now send to an ISO in Malaysia who has also given us excellent service and because of their close proximity to us gives an even quicker turn around than if we send to America and has given us excellent feedback concerning the cause of the problems with our scopes and what we can do to minimize the recurrences of those problems.

At the end of the day, we have had cheaper repairs and LESS repairs since we started using the ISO’s.

Regards,

Myles Baker
Senior Manager Support Services
Gleni International Hospital
Medan, Indonesia

Correction:
Gary Midgen of Bay Shore Medical, LLC, and Joseph Sciarro of Marquis Medical, LLC, should have been included the Services Directory for Nuclear Medicine Companies in our June issue. We apologize to them.
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Philips Introduces the GEMINI TF, the first-ever large bore PET/CT, and the BrightView XCT, an integrated SPECT/CT

At the SNM in New Orleans last month, Philips showcased the first ever large bore PET/CT system — the Philips GEMINI TF Big Bore. With a full 85 cm bore for PET and CT scans, the new system allows for positioning flexibility, and has a rigid table design to meet the accuracy requirements for treatment planning. The GEMINI TF Big Bore allows clinicians to image patients in the same position they are treated, expanding PET/CT capabilities beyond diagnosis, staging and follow-up to include therapy planning.

The system combines Philips’ GEMINI TF time-of-flight PET imaging technologies with its Brilliance Big Bore CT localization to consolidate radiation oncology procedures, increase potential for greater accuracy and improve scheduling. It is the first system that offers tools and protocols to easily integrate PET functional images into radiation oncology, helping to consolidate procedures while maintaining premium image quality.

A GEMINI TF Big Bore will be installed later this year in the Perelman Center for Advanced Medicine as part of the University of Pennsylvania Health System in conjunction with the Abramson Cancer Center and the Roberts Proton Therapy Center.

Philips also announced the release of their new BrightView XCT, which integrates Philips BrightView SPECT in a co-planar design with advanced flat-detector X-ray CT technology to acquire low dose, high resolution CT images and to improve registration confidence. The system will ship in the first quarter 2009.

This is the first time a flat panel X-ray detector will be used for CT imaging in nuclear medicine. In addition, the co-planar SPECT and CT capabilities limit, and in some cases eliminate, the need to move the table between scans. Reduced movement can help improve patient comfort and allow for more confidence in image registration, the process of comparing, matching and superimposing the SPECT and CT images on one another for analysis.

For more on this equipment and Philips’s new NM software, see this story online.

Online: dotmed.com/dm6292

Experimental Camera Pill Could Replace Endoscope

Rather than having an endoscope thrust down their throats, patients with esophageal injury may one day swallow a so-called “camera pill,” no bigger than a piece of candy, and achieve images of the stomach and the esophagus.

The product, called a “Pillcam,” is being manufactured by Given Imaging in Israel.

Modifications to the camera are being made by The Fraunhofer Society, a non-profit organization in Germany, which encourages applied science and entrepreneurial spin-offs.

Dr. Frank Volke, a Fraunhofer researcher, says that the camera will be able to diagnose cancer of the esophagus, and Barrett’s esophagus -- a pre-cancerous condition-- at its earliest stages.

“In the future, doctors will be able to stop the camera in the esophagus, move it up and down, turn it, and thus adjust the angle of the camera as required.

Online: dotmed.com/dm6226

Hospitals Demand Feedback About Computed Radiography

Responding to healthcare provider demands for feedback on direct user experiences with CR systems and vendors, KLAS is investigating single-cassette, also known as single-plate, computed radiography (CR) in a groundbreaking study.

A research firm specializing in monitoring and reporting the performance of healthcare vendors, KLAS is working with executives from over 4500 hospitals and 2500 clinics on this particular effort.

CR equipment is a sizable market as a result of PACS technology. However, the potentially high costs associated with digital radiography (DR) systems casts a spell of uncertainty over its widespread use. Nearly 60 percent of the images acquired in hospitals still come from x-ray. Proponents say converting x-ray images to digital media for image capture and
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storage is a way for radiology departments and imaging centers to enhance workflow efficiency and control long-term cost.

But some healthcare facilities are unable to justify the jump to DR in the face of technology limitations and budgetary constraints. For the study, KLAS spoke with more than 140 individual healthcare professionals about the products and vendors they utilize. Respondents rated their products and vendors with an average performance score of 88 out of 100.

To learn more about the KLAS’s research visit DOTmed News Online.

- Online: dotmed.com/dm5954

**Standards Urged for Radiotracer Doses in Pediatric Nuclear Medicine**

Results of a recent survey of 13 pediatric hospitals in North America show a lack of universally applied standards for administering radiopharmaceutical doses to children undergoing nuclear medicine examinations, according to an article in the June issue of The Journal of Nuclear Medicine.

“Modern nuclear medicine procedures are sensitive, minimally invasive, painless, safe, and thus well suited for the evaluation of pediatric patients. They provide a wealth of unique and useful information that can be used to diagnose and treat many childhood diseases,” said S. Ted Treves, M.D., Chief of the Division of Nuclear Medicine at Children’s Hospital Boston and professor of radiology at Harvard Medical School.

In nuclear medicine, there are well-established guidelines for administering radiopharmaceutical doses to adults. For children, however, it’s much more of an inexact science. Physicians typically base dosages on the patient’s body weight, the nature and the type of problem being investigated, the equipment available, and their own experience. This has led to variations in dosages.

“This survey identifies a very important question: what are the lowest radiopharmaceutical dosage levels that are compatible with quality imaging in children?” said Dr. Michael Gelfand, M.D., President of SNM’s Pediatric Imaging Council. “Over the last few years, the imaging community successfully tackled the problem of computed tomography (CT) absorbed radiation doses that, in many cases, were higher than required for quality imaging. Although nuclear medicine scans are performed less frequently than CT scans and generally involve much less radiation, this report has identified a question that needs attention.”

- Online: dotmed.com/dm6218

**House of Representatives OKs Defibrillators for Schools Program**

The U.S. House of Representatives has established a grant program with the Department of Education to provide schools with funding for Automated External Defibrillators.


Sutton’s hometown is Barberton, OH, where Josh Miller, a 15-year-old high school student, died of cardiac arrest while playing football for his school’s team. Paramedics who arrived with an AED were unable to resuscitate him.

The HEARTS Act aims to reduce the number of American children who could suffer a similar fate, by supplying schools with AEDs and training staff to use them.

AEDs, according to Sutton, are the single most effective treatment for those suffering a sudden cardiac arrest. By ensuring that schools have access to these lifesaving devices needless deaths in communities across the country will hopefully be prevented. The program will cost $220 million, according to the Congressional Budget Office.

- Online: dotmed.com/dm6248

**The National Alliance for Health Information Technology Gets New Leader, Makes New Strategic Alliances**

At its recent membership meeting, the National Alliance for Health Information Technology (NAHIT) announced new leadership and a new strategic and operating framework for promoting and influencing the efficient and effective use of health information technology (HIT) to achieve safer, higher-quality, and more affordable healthcare.

The board of directors has recruited George Lynn, former Chief Executive and President of AtlantiCare and past Chairman of the American Hospital Association (AHA), and John Glaser, Vice President and Chief Information Officer of
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Partners HealthCare System Inc., and CHIME Fellow to serve as its co-chairs. The board also named Jane Horowitz, formerly NAHIT’s Vice President and Chief Marketing Officer, as its New Chief Operating Officer.

“With George, John, and Jane, we have put in place the right leadership to take NAHIT forward,” says Curt Selquist, who is stepping down as interim Chief Executive and board Chairman but will continue to serve as a board member.

To strengthen its efforts in addressing health IT as a strategic, rather than a purely technology issue for senior executives, NAHIT has established formal alliances with the AHA and College of Healthcare Information Management Executives (CHIME), both founding members of NAHIT in 2002. AHA is providing core staff, back-office support, and other services that offer connections to critical distribution and education channels and linkages, with leaders across the field. CHIME, too, will contribute full-time staff and functional support for key NAHIT member services such as education, communication, website, content development, and connections with over 1,200 information and technology leaders and providers of IT products and services.

Online: dotmed.com/dm6220

Multiple Studies Tout Healthy Effects of Vitamin D

Men lacking in Vitamin D have more than double the normal risk of a heart attack, a new study says. It’s just the latest in a series of studies suggesting the vitamin may be crucial to maintaining good health.

Medical researchers are examining the so-called “wonder drug” that may significantly reduce the risk of heart disease, cancer, diabetes, and many other diseases.

Prior to this latest study, another one found that low levels of Vitamin D increased the risk of diabetes. Yet, another study conducted earlier in the spring linked deficiencies of vitamin D to an increased risk of dying from breast cancer.

The findings join a growing body of evidence indicating that an adequate level of the vitamin, which many people can get from 20 minutes in the sun, is crucial to maintaining good health.

Not every scientist agrees that Vitamin D is so crucial to well-being, and there is controversy about what should be considered an adequate level of the compound in the blood. But, sentiment is gradually shifting toward a higher intake.

Online: dotmed.com/dm6249

Siemens SOMATOM Definition AS Receives FDA Clearance

Siemens Medical Solutions USA has received FDA 510(k) market clearance for the SOMATOM® Definition AS, the world’s first adaptive CT scanner. The Medical University of South Carolina (MUSC) in Charleston is one of the first facilities to install the scanner, adding to the SOMATOM Definition Dual Source MUSC installed in September 2006.

The SOMATOM Definition AS adapts to virtually any patient for complete dose protection, new dimensions, and adapt to the user’s space.

“The SOMATOM Definition AS goes beyond slices and detector rows to address the overall versatility and usefulness of a CT scanner,” said Dr. Joseph Schoepf, Associate Professor of Radiology and Cardiology, and Director of CT Research and Development at MUSC. “It truly allows to adapt the CT scanning to individual patients.”

Online: dotmed.com/dm6238

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Ed Sloan Sr. Named to DOTmed.com, Inc. Board of Directors

Ed Sloan Sr. has been appointed to the Board of Directors of DOTmed.com, Inc. DOTmed.com is headquartered in the financial district of Manhattan, and is the world’s leading public marketplace for buying and selling medical equipment, parts, and services.

Philip F. Jacobus, President of DOTmed.com, said, “we are extremely pleased and fortunate to have Ed on our board. He is an icon in the medical equipment industry, and he is highly respected for his business acumen and integrity. He will provide valuable guidance and direction as DOTmed continues its rapid growth in the near future.”

Mr. Sloan is considered to be one of the most knowledgeable professionals in the sales and service of high-end diagnostic medical imaging equipment, and he has over 20 years experience in the business. Mr. Sloan entered the medical equipment business in 1986 when he founded Reliable Medical Parts (ReMedPar). He grew the company into a leading equipment and parts provider for high-end diagnostic medical imaging equipment. The company now occupies a 100,000 sq. ft. facility just north of Nashville, TN. From its beginning until his retirement from ReMedPar in January of 2008, the business grew from its infancy to a $40-plus million enterprise with 65-plus employees.

Mr. Sloan also is President of his own consulting company, Ed Sloan & Associates, which is located in Goodlettsville, TN.

Online: dotmed.com/dm6269

Medicare Looks to Lower Cost of Durable Medical Equipment

Nearly four million people with Medicare living in ten communities across the nation will learn about a new program that lowers the costs for certain medical equipment and supplies.

The Centers for Medicare & Medicaid Services (CMS) will begin mailing letters explaining the new program, which begins July 1st, to beneficiaries later this month.

“Beginning July 1st, Medicare beneficiaries will see lower costs for some of their durable medical equipment and supplies — as much as a 43 percent savings for certain items — and the assurance they will have accredited and financially sound suppliers providing them with equipment and supplies,” said CMS Acting Administrator Kerry Weems. “It is important that people with Medicare who use certain medical equipment and supplies know they can call 1-800-MEDICARE or go to

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what’s new

Ed Sloan Sr., Co-founder of ReMedPar
www.medicare.gov to see if their current supplier is a Medicare-contract supplier or what they may need to do to find a new supplier approved by Medicare.”

Found in the package from CMS is a brochure about the new program and a list of Medicare contract suppliers in beneficiaries’ geographic areas. CMS is also sending similar information and its list of Medicare contract suppliers to local partner groups and durable medical equipment (DME) referral agents, such as hospital discharge planners, physicians’ office staff and home health agency social workers. The ten Round One communities include certain ZIP codes in the areas of Charlotte, NC; Cincinnati and Cleveland, OH; Dallas/Fort Worth, TX; Kansas City KS-MO; Miami and Orlando, FL; Pittsburgh, PA; Riverside, CA and San Juan, Puerto Rico.

ACP Provides “Policy Framework” for Universal Healthcare Coverage

A framework for policies that would enable all Americans to have access to affordable health insurance coverage has been released by the American College of Physicians (ACP). The updated position paper, “Achieving Affordable Health Insurance Coverage for All Within Seven Years: A Proposal From America’s Internists, Updated 2008,” is based on a 2002 position paper.

“Expanding health insurance coverage to all Americans is a moral imperative,” said Jeffrey Harris, M.D., FACP, President of the American College of Physicians.

Among ACP’s recommended reforms:
• States should have the option to expand Medicaid coverage to all residents up to 100 percent of the federal poverty level;
• Advance, refundable and sliding scale tax credits should be made available to uninsured working Americans with incomes up to 200 percent of the federal poverty level;
• Tax credit recipients should have the option of buying coverage through state purchasing group arrangements modeled after the Federal Employees Health Benefits Program;
• Small employers should have new options for obtaining coverage;
• Once coverage is affordable and available, national and/or state-based health plans should ensure that all individuals participate in the plan;
• An expert advisory commission should be created to recommend a core set of benefits.
• The federal government should provide dedicated funding to states that have requested federal support for efforts to redesign their health care delivery programs to expand coverage and organize care around a Patient-Centered Medical Home.

Many of the key elements of ACP’s framework already have been incorporated into a bipartisan bill, called the Health Coverage, Access, Responsibility and Affordability Act (HealthCARE Act - HR 2351).

DOTmed Auctions Now Translate Into 6 Universal Languages

With DOTmed.com fast-approaching 100,000 registered users worldwide and getting more than 12,000 unique visitors a day, the company has initiated a translation program, initially offering DOTmed Auctions in six languages.

Go to any Auction and at the top of the page are six flags representing French, Russian, Arabic, Spanish, Portuguese, and Chinese. Click on the flag of choice and the whole page is automatically translated into the selected language.

No two people ever translate a piece of text exactly the same way. Since the translations are done by a software program from WorldLingo, there could be some minor inconsistencies. This is just the initial phase of a program that will continue to unfold in the future.

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Undiagnosed Disease Program Launched by NIH

The National Institutes of Health (NIH) has launched a new clinical research program that aims to provide answers to patients with mysterious conditions that have long eluded diagnosis.

Called the Undiagnosed Diseases Program, the trans-NIH initiative focuses on the most puzzling medical cases referred to the NIH Clinical Center in Bethesda, MD, by physicians across the nation.

“A small number of patients suffer from symptoms that do not correspond to known conditions, making their care and treatment extraordinarily difficult. However, the history of biomedical research has taught us that careful study of baffling cases can provide new insights into the mechanisms of disease, both rare and common,” says NIH Director Elias A. Zerhouni, M.D. The goal of NIH’s program is two-pronged: to improve disease management for individual patients and to advance medical knowledge in general. With the program infrastructure now in place, patients will be accepted as of July 2008.

For more information about the Undiagnosed Diseases Program, go to: http://rarediseases.info.nih.gov/Undiagnosed. Physicians and patients with specific inquiries may call the NIH Clinical Center clinical information research line, at 1-866-444-8806.

Got Contrast Agent?

An item commonly found in many homes — whole milk — is just as effective, costs less and is easier on the patient than a diluted (0.1%) barium suspension, and is also commonly used as an oral contrast agent in conjunction with CT to examine the gastrointestinal tract, a new study finds.

The study included 215 patients undergoing abdominal and pelvic CT, said Chi Wan Koo, M.D., lead author of the study. All patients were given an IV contrast media; 115 were also given whole milk as an oral contrast agent; 100 received a 0.1% barium suspension. Two radiologists reviewed all the images and scored them based on degree of bowel distension and bowel wall visibility.

The study found that the images taken of patients who were given whole milk were just as useful as the images that were taken of patients given the diluted barium.

Varian Developing Systems Interface With Still River Systems

Varian Medical Systems and Still River Systems, Inc. have announced an agreement to develop an interface between the Varian ARIA™ Oncology Information System and Still River’s Monarch250™ Proton Beam Radiotherapy System.

Corey Zankowski, Varian’s Senior Director for Product Management, describes ARIA as a “powerful oncology infor-
information system that manages the clinical processes unique to radiotherapy treatments for cancer.” Varian is committed to creating connectivity between ARIA and most commonly used radiation delivery devices, including proton treatment systems, such as the Monarch250 proton therapy system.

The Monarch250 and ARIA interface will allow integration of proton therapy within existing radiation therapy practices, according to Skip Rosenthal, PhD, Still River Systems’ Vice President of Clinical Systems. The Monarch250 system has not yet been cleared by the FDA for commercial use in clinical therapy. Any new ARIA interface with new radiotherapy delivery technologies are subject to 510(k) clearance by the FDA, and will need the clearance prior to clinical deployment.

- Online: dotmed.com/dm6112

Echoserve Continues Expansion, Adds Multiple Offices

Ultrasound, x-ray and physiological monitoring equipment company Echoserve, Inc., has opened sales and service offices in metro New York, NY; Orlando, FL; Chicago, IL; and Detroit, MI. The company is also continuing to add engineering, repair and customer service personnel at its headquarters in Golden, CO.

“Our customers have asked us to bring Echoserve’s technical capabilities and expertise closer to them,” said Christopher M. Cone, Chief Executive Officer of Echoserve. “A direct presence in the largest U.S. metro areas allows us to serve the majority of the country with no more than two-hour travel times. We plan to open more regional offices in the near future.”

The additional resources should allow Echoserve to better serve the needs of third-party service organizations and clinical users of imaging and patient monitoring equipment. The company is investing heavily in the engineering expertise required to support many of the emerging technologies in the medical equipment industry. By leveraging technical personnel, Echoserve hopes to provide leading-edge repair and field service solutions in such areas as hand-carried ultrasound, ultrasound transducers, PACS networking, digital mammography and telemetric physiological monitoring.

- Online: dotmed.com/dm6244

GE Healthcare Clinical Systems’ Lunar Earns Top Scores

In its latest report on bone mineral densitometry equipment, MD Buyline, an independent medical technology and informatics intelligence firm, has ranked GE Healthcare number one for the second consecutive quarter. Not only did GE Healthcare’s GE Lunar bone mineral densitometry products achieve the highest overall user satisfaction composite rating from MD Buyline’s member network...
of more than 3,200 hospitals, but it also improved its previous scores in eight categories, including systems performance, reliability, installation and implementation, service response and repair time, among others.

This achievement is consistent with GE Healthcare’s own customer satisfaction polling, including its own customer advisory board, periodic surveys, and using feedback to seek continuous improvement. Latest scores reveal a 97-percent rate for customers who are not only satisfied, but often willing to recommend GE Healthcare Lunar Service to a peer.

Online: dotmed.com/dm6239

Summer Eating Habits Pose Potential Problems

Most people would rather not know what goes into the corndog they consume at the State Fair. But for the 12 million Americans with food allergies, awareness of ingredients is a must for safely eating their way through summer events, according to the American Academy of Allergy, Asthma & Immunology (AAAAI).

“People with food allergies must be extra vigilant when eating at summer fairs and festivals,” said Amal H. Assa’ad, M.D., FAAAAI and Chair of the AAAAI Adverse Reactions to Foods Committee. “There are many questions about ingredients, preparations and possible cross-contamination that if left unanswered could lead to an allergic reaction.”

The stakes are high. A single bite of the wrong food can induce anaphylaxis, a life-threatening reaction, in severely allergic people. The AAAAI estimates that hundreds of people die each summer from anaphylaxis caused by food allergies.

Learn more about food allergies at www.aaaai.org.

Online: dotmed.com/dm6240

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AHRA 2008 Annual Meeting and Exposition — A Full Slate of Programs for a Challenging Environment

It's also the AHRA’s 35th Anniversary
The AHRA — the association for medical imaging management — will host more than 1,000 professionals at their 2008 Annual Meeting and Exposition on July 27-31 at the Colorado Convention Center in Denver. This year marks AHRA’s 35th Anniversary, and the 2008 Annual Meeting — the premier educational and networking event for medical imaging leaders — promises to be the highlight of the association’s milestone year.

“We have developed a program that reflects medical imaging administration’s unique challenges and opportunities,” notes Jeffrey Palmucci, CRA, President of AHRA. “Today’s administrator is responsible for technology, budgets, staffing and customer safety and satisfaction—as well as a host of other areas. This meeting will provide a vast slate of educational sessions with practical information attendees at all experience levels will be able to use every day in their respective facilities.”

Dr. Paul Wolpe, Keynote Speaker
Among the keynote speakers is Paul Root Wolpe, Ph.D. He will address the impact of emerging neurotechnologies on brain imaging, privacy and ethics. Dr. Wolpe will discuss the implications on clinical practices in general and radiology in particular.

The AHRA Leadership Institute will present its Basic Management Skills Program in conjunction with the meeting. This five-day comprehensive program will focus on basic management skills, including human resources, communications, operations management, asset management, finance and budgeting for new supervisors and managers.

Special Events
Special events include the 9th Annual AHRA Education Foundation Golf Tournament on July 27. This event raises funds for educational programs and scholarship opportunities. The President’s Reception will provide another excellent networking opportunity, as will the breakfast for new members. According to President Palmucci, “whether you’re an experienced administrator or a new supervisor, the AHRA Annual Meeting will offer relevant educational sessions, solutions you can use in your specific work setting and connection with your peers on a wide scale.”

Off-hours in the Mile High City
If you’re looking for a chic and sophisticated outing, visit any of the hundreds of museums and galleries that make Denver the Arts Capital of the West. Or, if you’re feeling adventurous, take a bike ride throughout the city and explore the state’s biggest attraction, the Rocky Mountains, national parks and forests, and other amazing scenic views.

The Exhibit Hall
More than 200 medical imaging equipment and service providers will be on hand in the exhibit hall. A dedicated exposition schedule and perfect sized venue will ensure that attendees and vendors will have ample time to meet. There are no classes or other competing activities during the time the hall is open.

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Please drop by DOTmed.com’s Booth, #340. Our Trade Show Team will be on hand to answer any questions you have. Also ask about editorial and advertising opportunities in DOTmed Business News magazine — and in DOTmed’s Online Weekly News, already established as the go-to website for the latest news and information about the business of medical equipment.
Here is a perfect intersection of drugs and technology.

In the old days, there was little that doctors could do to treat osteoporosis. Tums and Tylenol were the only weapons in the armamentarium. Everything changed in 1999 with the approval of the first drugs to build bone mineralization. Examples include Merck’s Fosamax and GlaxoSmithKline’s Boniva, among others. The treatment has finally caught up to the diagnostic capability of bone densitometers.

“These are connected for sure,” said Gitte Andreasen, Director of Global Marketing, Lunar Division, GE Healthcare, Waukesha, WI. “When the first osteoporosis treatment received approval, we did see an increased interest in BMD [bone mineral density] testing, because the dilemma physicians had faced — ‘I would love to test you but I have no therapy available’ — now had a solution.”

Bone mineral density is measured by various types of equipment at various sites on the body, including the spine, hip, femur, forearm, heel, and fingers. DEXA or (DXA) scanners come in two main types — older pencil beam and the new fan beam designs that have tremendous diagnostic capability. The smaller or peripheral body parts are assessed with ultrasound or more compact X-ray units.

“Each device and each measurement site has its place. For a quantitative bone density measurement I would say go get a measure of your spine and hip to check for fractures,” said John Jenkins, Senior Director of Skeletal Health Division, Hologic, Inc., Bedford, MA. “The peripheral measures of the forearm or heel are for widespread screening — it’s a risk indicator but not a diagnostic tool.” The distinctions are important since they affect the cost of the equipment and the potential target market for it, which range from modest screening systems that might be utilized by private practitioners, up to cutting-edge technologies in hospitals.

“There are $10,000 systems [sold] around the world. These are less expensive, but also less advanced when it comes to clinical applications,” noted Andreasen. “They do have a smaller footprint … this is often an issue for primary care physicians.”

Compared to other capital investments, BMD testing is a bargain at a price range from about $50,000 to $150,000-plus for new equipment; with refurbished as low as $20,000 to $30,000, as a ballpark.

“Everybody knows CT, MR and nuclear medicine. But now more people are doing mammography or bone densitometry,” said Leon Gugel, President, Metropolis International, Long Island City, NY.
“Bone densitometers never really were big money makers like a CT or nuke med cameras, but they still brought in some decent money [for health care providers],” said John Cline, Vice President, Tritech Services, Louisville, KY. “The fact is that it’s still something that patients need.”

Huge unserved market
Bone densitometry is an extremely promising technology that has far from fulfilled its market potential.

BMD testing procedures are growing at a rate of 15 percent each year. Yet the market remains untapped since 70 percent of women over 60 years of age — prime candidates for the exam — are not tested. This suggests a very promising future for this specialized modality.

“If you have 20 to 30 patients a month that you can test based on the number of patients in the practice, then [a refurbished] system will pay for itself and generate revenue,” suggested said Jeffrey Rubinoff, Vice President of Marketing and Business Development, Complete Medical Services, Warren, MI. “We try to educate our dealers and end users that it’s a critical modality. It’s not a STAT test [of life-saving urgency], but it’s important if you look at the numbers.”

Osteoporosis is a major public health threat for an estimated 44 million Americans, or 55 percent of people 50 years of age and older. In the U.S. today, 10 million individuals are estimated to already have the disease and almost 34 million more are estimated to have low bone mass, placing them at increased risk for osteoporosis. As the population ages, those numbers will grow. While the disease is concentrated in women, men are also afflicted and represent a largely ignored patient base.

Costs associated with fractures argue for a more concerted effort to measure and treat osteoporosis. In 2005, osteoporosis-related fractures were responsible for an estimated $19 billion in costs. By 2025, experts predict that these costs will rise to approximately $25.3 billion, according to the National Osteoporosis Foundation.

Also favoring the market for bone densitometers is a diverse customer base of many medical specialties. They include orthopedists, rheumatologists, OB/GYN, endocrinologists, internal medicine, primary care and family practice, radiology, and even oncology.

Sales down in non-hospital settings
Despite the many factors favoring bone densitometry, reductions in Medicare reimbursement have put a damper on the market. (Note that as of this writing, legislation is pending in Congress that may reinstate higher funding levels. For updates as we get them, visit DOTmed.com’s Weekly Online News.) Meanwhile, many vendors are reporting that sales are flat for both new and pre-owned machines.

“A lot of bone density machines have already been sold, so there is a saturation factor in the last few years. Couple that with DRA [reimbursement cuts] and you have a flat if not slightly shrinking market,” said David Denholtz, CEO, Integrity Medical, Fort Myers, FL. “You hear gloom and doom but there is still a market there.”

“Demand is going to pick up [for pre-owned equipment]. As the economy is turning down, more people are going to buy used versus new equipment,” said Gugel.

In terms of new equipment sales, two separate markets — hospital versus non-hospital — have very different outlooks since the hospital market is not affected by cuts in reimbursement.

“When you are focused on selling to private practices, and their reimbursements start to get cut, everybody takes a wait-and-see approach. They don’t want to invest if there are going to be major negative changes,” said Hologic’s Jenkins. “So it’s been a shift from selling to the primary care physician and the specialties, to really renewed growth in radiology. We did hit a valley as far as [sales] performance, but are hiking back out and seeing increases in the U.S. as more hospitals purchase the units.”

GE has enjoyed steady sales growth (about eight percent in recent years) in the hospital market, but in non-hospital settings, Andreasen observed, “there’s definitely a lower uptake.” However she noted new markets are emerging for bone density testing. “We see new customers entering this market and we have a new focus on secondary osteoporosis, which is caused by breast and prostate cancer treatment. So we do see a new customer group as the awareness grows and scientific evidence becomes available stating how important it is to monitor bone density in cancer patients.”

Read exclusive briefings on bone densitometry from GE Healthcare and Hologic including state-of-the-art fan beam technology at www.DOTmed.com. Enter this story number into any search box: DM6272.
The service market is blossoming

Both GE and Hologic offer state-of-the-art fan beam DXA technologies that will replace the older designs like the pencil beam. The new units are amazingly capable and can even spot vertebral fractures, which might lead to another dimension of osteoporosis assessment. But the shift to cutting-edge approaches raises concerns over ongoing support for the installed base of older technologies, including the GE Lunar DPX and Hologic QDR 4500.

“We do still support our DPX product portfolio in terms of service, but we do recommend our customers start looking into newer technologies because at some point, it will ‘end of life,’” said GE’s Andreasen, referring to the service phase-out process. “DPX is one of the older technologies and as we introduce newer and better technology, we try to ‘end of life’ some of the old products. Otherwise we end up having 15 to 20 products and that is just not good business for anybody.”

Hologic, with an installed base of more than 15,000 bone densitometry systems worldwide, is also focusing on the future with its fan beam technology. “We no longer sell any pencil beam products. We felt the future was completely in fan beam because we can get very good images [and] the fastest throughput,” Jenkins said.

Regarding service, Jenkins also acknowledged an end-of-life strategy. “We never just say [to customers] that one day we can’t support your product. However, as technology changes, we have to make sure that we can continue to support products and give customers warning if we see that sometime down the road we may not be able to buy a certain part…. So we declared an end of life status on [QDR] 4500s manufactured before the year 2000…. End-of-life status means that we can’t guarantee support. Though we will continue to support the products as long as we possible can.”

When one door closes, another opens and refurbishers and independent service organizations are poised to maintain and repair older machines coming off OEM service contracts. So while sales have slowed, service opportunities abound in the aftermarket.

“In 2005, we put in a table every 10 days. Now it’s every 15 to 20 days. Sales are off 30 percent,” said Desmond Johnson, Service Manager, DEXAScanners, Inc., Lebanon, TN. “A huge number of pre-owned units are on the market and prices have dropped accordingly. But service has blossomed so revenues are the same.”

“It’s great for us because we’ve got literally tens of thousands of parts stocked for these machines. So when the manufacturers stop supporting them, that is when we can support those customers that don’t want to upgrade because they don’t need to and the machines are working great and are reliable,” Denholtz said.

Other players in the market

Smaller OEMs are also a factor in bone density testing, among them Norland, Sunlight, and Schick.
Alara, Inc.’s MetriScan® uses a simple, affordable design for screening patients. Technically, it’s not a DEXA scanner because the MetriScan uses digital radiographic absorptiometry of the hand. (DEXA or DXA stands for dual-energy X-ray absorptiometry.) The MetriScan brings bone density screening to the masses and is useful in family medicine and other healthcare settings, including a growing export market.

“There is definitely a big shift in the marketplace getting away from whole body DEXAs of the spine or hip to these smaller, compact machines,” said Kuldip Ahluwalia, Vice President of Sales and Marketing, Alara, Inc., Fremont, CA. “Two years ago, I got calls from people who said they were looking for a ‘real’ DEXA. Now they are asking why the big boys [large OEMs] aren’t talking about [lower-cost technology]. My rallying cry is: ‘For what you pay for a service contract on a whole body DEXA, you can buy my machine.’ Our retail is under $13,000.”

“Like every bone density test, it is one of the arrows in the quiver of the M.D. to help make a decision about how to treat a patient,” said Christopher R. Mitchell, Ph.D., Chief Scientific Officer at Alara. “We felt that if the machine was compact, easy to use and less expensive, it could go in the primary care physician’s office or the OB/GYN as part of a standard health workup.”

“In the future we will see many more primary care physicians taking on BMD testing,” GE’s Andreasen affirmed. “They are at the forefront of healthcare and they see patients first. So it makes a lot of sense for the physician to say: along with your mammogram and pap smear, you also need to have your bones tested. That would be our dream come true.”

Online: dotmed.com/dm6263
As the cost of medical supplies and devices continues to skyrocket, hospitals and medical treatment facilities are forever on the lookout to find ways to cut corners when it comes to saving money and reducing losses. Hence, the reprocessing and reuse of medical devices labeled “single-use” or “disposable” has become a popular, albeit controversial worldwide practice.

The facts
The U.S. Government Accountability Office (GAO) issued a report in January 2008 addressing the SUD reprocessing industry, the number of reprocessing establishments, the types of devices reprocessed, and the extent to which hospitals use reprocessed SUDs. The report also reviewed the steps the FDA has taken to strengthen oversight of reprocessed SUDs – on its own and in response to legislative requirements, as well as the safety of reprocessed SUDs compared with other types of medical devices. The GAO report concluded that FDA oversight has increased since 2000, and available information does not indicate that the use of SUDs presents an elevated health risk.

New measures by the FDA
In essence, the FDA has regulated the reprocessing of SUDs since 2000, calling for all SUDs to be cleaned, checked for functional integrity and sterilized according to the requirements applicable to OEMs. The FDA added new points of governance in 2006, including an order for any reprocessor to add its name to the reprocessed device. The only exception to that regulation is when the original device, or an attachment to it, does not prominently and conspicuously identify the name of the OEM.

Through the FDA Medical Device Reporting (MDR) system and the MedWatch reporting system, healthcare professionals submit voluntary reports. And, under the Medical Device User Fee and Modernization Act of 2002 (MDUFMA), the MedWatch report form was revised, adding a question to enhance the agency’s ability to identify and investigate reports of problems that are linked to reprocessed SUDs.

The FDA has implemented the following procedures to further ensure that SUDs are safe for public health: an addition of two new rules to ensure that reproprocessors submit cleaning, sterilization and functional performance data...
to show that their device is more than equivalent to the predicate device; established work groups to keep scientists abreast of evolving literature and new consensus standards relevant to the reprocessing of SUDs; submitted reprocessor inspection requests to the Office of Regulatory Affairs; provided regular updates to its ‘reuse web page’ to keep healthcare facilities and providers informed; updated guidances to industry and FDA reviewers on validation data requirements for reprocessed SUDs; updated lists of reprocessed SUDs subject to the additional pre-market requirements imposed by MDUFMA; conducted research to develop/establish “acceptable” SUD cleaning criteria and are collaborating with two healthcare facilities monitoring changes in the design of some SUDs and identifying new SUDs being reprocessed.

In a report before the Committee on Government Reform in September 2006, Daniel Schultz, MD, director of FDA’s Center for Devices and Radiological Health (CDRH), noted that as of September 2006, the FDA received nearly 200 pre-market notification 510(k) submissions for reprocessed SUDs for as many as several hundred device models. Of those submissions, the FDA cleared approximately 67 percent.

As of July 2007, FDA officials have identified 11 institutions that plan on marketing or are actively marketing more than 100 types of reprocessed SUDs in the US. They include everything from cardiovascular and orthopedic devices to general surgery accessories as well as opened but unused items.

The FDA found that many hospitals were thought to be reprocessing their own SUDs in 2000, but as in 2007, only one hospital was identified. And, while it is a fact that there are many hospitals that are using reprocessed SUDs in the U.S., including several military hospitals, the Department of Veterans Affairs – one of the nation’s largest health care systems – prohibits their use.

The “yeas”

SUD reprocessing has been evaluated for safety and cleaning efficacy by various groups within the healthcare industry and several have adapted Industry Position Statements on the issue. These statements include:

The American Hospital Association conclusion that “patient safety is the first and foremost concern of all hospitals and health systems, and appropriate reprocessing poses little or no risk to the public as evidenced by the findings of the GAO report, the FDA, CDC, infection control officials, risk management managers and quality consultants. It represents responsible waste management and appropriate use of scarce health care resources.”

The American Society for Healthcare Central Service Professionals (ASHCSP) believes: “A well-developed and managed program for the reuse, resterilization or reprocessing of single-use devices will include the decisions not to reuse, resterilize or reprocess some devices; internal reuse, resterilization or reprocessing of some devices; and the outsourcing of reuse, resterilization or reprocessing of some devices. For non-critical medical devices, all of the options may be selected, for critical medical devices only reprocessing may be an option. There are a number of resource materials published that allow health care facilities to make an informed decision on what specific steps are required for their facilities’ process. Reuse, resterilization and reprocessing of disposable or single-use medical device protocol must be developed to ensure no greater risk to patients exists than in the use of medical devices marked reusable.”

Ascent Healthcare Solutions, based in Phoenix, AZ, reported that in 2007, it worked with its partners to eliminate 1,684 tons of waste from local landfills, saving nearly $1 million. Ascent has developed an analytical tool that compares their database of cleared and approved devices by manufacturer, product model and number and description to the hospital’s purchase master. Arthur Goodrich, Vice
President of Business Development at Ascent says, “We are able to provide a facility with very specific reports of potential savings by product number and level of participation.” Ascent meets with its hospital partners on a quarterly basis to review projected savings and ensure that maximum savings are realized.

**AMDR positive corroboration**

Dan Vukelich, President of The Association of Medical Device Reprocessors (AMDR), Washington, DC, states that in 2007, the market for third-party reprocessed devices was $150 million. The overall single-use medical device market is approximately $31.5 billion a year. Currently only about $150 million of the $31.5 billion in single-use devices are recycled. “We believe about $2.6 billion of single-use devices are safe for reprocessing, which could save the healthcare industry $1.8 billion a year – our market potential.”

Vukelich believes that reprocessed devices are safer in some cases because they must be inspected before reuse, whereas original manufacturers test new devices in batches. He also debates that OEMs label many products as single-use merely to sell more new devices to hospitals and hinder competition. This contention is widely dismissed by the OEMs. “Enough is enough,” says Vukelich. “The SUD controversy over reprocessing is ‘old news’ – There is no controversy because after eight years of FDA data, the GAO has concluded that there is NO evidence that reprocessed single use devices create an elevated risk for patients.” Vukelich went on to say that the reuse of medical devices that are labeled for single-use only is a well established and safe practice regulated by the FDA and utilized by most of the top-ranked hospitals in the country.

The AMDR adds that the FDA’s adverse event reporting database, as documented by the Government Accountability Office (GAO), showed a rate of less than one tenth of one percent (or 65 reports out of 320,000) of all adverse events reported between 2003 and 2006 possibly involving a reprocessed device. In addition, Rep. Henry Waxman, D-California, reports that it is time to put the issue of reprocessed devices to rest and move on to making sure that FDA has the authority and resources it needs to safeguard medical devices. As chair of the Committee on Government Reform, Waxman, along with ranking minority member Rep. Thomas Davis, called for the GAO study in 2005.

**The “nays”**

The practice of reprocessing disposable, single-use medical devices has sent up red flags among many OEMs, patients’ rights groups and some hospitals. This contingent argues that these products are meant to be – as the label states – used only once. They stand firm in their belief that medical devices labeled “single-use only” are not designed to stand up to the harsh sterilization processes that include the use of stringent chemicals. They contend that even after the devices are sterilized, bodily fluids including blood and tissue can remain on porous surfaces and crevices allowing transmission of viral and bacterial infections.

Many OEMs are lobbying for legislation requiring healthcare providers to obtain “informed consent” from a patient before a reprocessed device is used for a procedure. Massachusetts has also introduced a bill that would require hospitals in that state to obtain permission from patients before using a refurbished single-use device on them. That bill is still in committee. Utah has approved liability protections for OEMs, and there are other state bills that include measures that would release OEMs from liability if a reprocessed device fails and causes injury or death.

Jacqueline Tamis-Holland, MD is site director at Roosevelt Hospital Cardiac Catheterization Laboratory, St. Luke’s Roosevelt Hospital Center, New York, NY. Some of the equipment the hospital uses to treat or diagnose a patient’s condition are single-use only devices. “I can tell you with certainty that it is our belief at St. Luke’s-Roosevelt that patient safety comes first,” says Dr. Tamis. “It is inappropriate to re-use such devices as the integrity and ‘sterility’ of devices may become compromised with repeated use. “All single-use devices in the cath laboratory, CCU and EP labs are discarded after single use as the manufacturer suggests. The hospital also does not use devices that are sterile and unused if they have exceeded their expiration dates; because, according to Dr. Tamis, “if they have exceeded their expiration date it is unclear whether they remain sterile or maintain their integrity once expired.” Dr. Tamis states that although she works in the Division of Cardiology, she is confident that this attitude is reflected by the entire Hospital Center.

Ethicon Endo-Surgery, a Johnson & Johnson company with main headquarters in Cincinnati, OH, focuses on innovation in the minimally invasive surgery arena. The company sells high quality, cost-effective SUDs designed and manufactured to be used on a single patient and then discarded. According to the Director of Public Relations, Wendy Dougherty, “Ethicon labels its SUDs as “single-use” because these devices have intricate parts that are difficult to clean thoroughly for use on multiple patients.”

Ethicon Endo-Surgery’s SUDs are made with high performance polymers and lubricants that may break down when the SUDs are reprocessed for use on multiple patients. Dougherty went on to say that Ethicon continues to develop solutions that address the
clinical, economical and environmental demands of all healthcare stakeholders. “Ethicon Endo-Surgery does not have sufficient data to suggest that using SUDs on multiple patients is a viable solution to meet these demands, while at the same time delivering the safety and efficacy that the company, its customers and their patients have come to expect.” Interestingly, in 2006, Ethicon Endo-Surgery filed suit against Ascent Healthcare Solutions for trademark infringement over reprocessing its single-use devices.

**DOTmed users take a stand**

Cindy Munoz, President of CVM Trading Solutions, Miami, FL, feels that it is not in the best interest of end users to be treated with recycled medical disposable products. Munoz understands that some individuals may opt to take a frugal approach and reprocess single-use devices. “However,” she says, “that would be compromising human life for money in my mind.”

CVM Trading Solutions offers disposable products including gloves, attire, IV sets, syringes, catheters, masks, thermometers, tongue depressors, dressings, sheets, oxygen masks, bandages, wipes and more. She added that group purchasing organizations (GPOs) do not affect her company because CVM sells to many different types of medical facilities and ships worldwide, therefore opening doors to many opportunities.

Phil Marotta, President of Sell It On eBay, Inc., Cooper City, FL has an interesting take on single-use medical devices. Because besides selling disposables on eBay, Marotta is a nurse. He worked at Mount Sinai Hospital in Miami Beach for several years and relates that that hospital tried to start a reprocessing program, but the physicians protested and it was quickly dissolved. “The doctors at Mount Sinai didn’t trust any single-use product that was reprocessed and wouldn’t have anything to do with trying to start up a reprocessing program,” says Marotta. “I worked with and knew medical personnel in the ER and OR, and they pretty much all felt the same way.”

As far as Marotta’s business goes, he stays away from reprocessed medical devices because end users don’t want to pay a decent price for them, and so there is no profit involved.

“When I was learning to drive in the UK, the golden rule for overtaking maneuvers was to always ask these questions – Is it safe? – Is it necessary?” Simon Harper, President of AZReam, Inc. in Phoenix, AZ, believes this golden rule also applies to single-use medical devices. He believes that all too often reprocessed SUDs are purchased is for entirely the wrong reason: simply because they are cheaper, without due regard to patient safety and environmental impact. Harper feels that there is a place for single-use devices, especially with infection control in mind and assuming that clinical waste procedures are in place and being adhered to. But he also feels that for many medical and surgical products single-use is not the best choice. “There are many products being manufactured and pre-packaged for single-use that simply don’t need to be used — particularly when more than adequate reprocessing facilities already exist. This certainly goes for the majority of surgical instruments,” states Harper. On the other hand, Harper points out that the medical community has now had to rethink many products that were previously not considered for disposability, but now are because of concerns over hospital and community acquired ‘super bugs’ like MRSA and C-difficle.

AZReam’s product range includes a “mixed bag” of products in many categories including blood pressure cuffs (Temp-Cuff disposable, Omni-Kuff reusable), scalpel blades and handles (Swann-Morton) and a range of safe patient moving and handling equipment.

Finally, there are those in the disposable business like Marian Larson, Sales and Marketing Group leader at Sonotech, Inc., Bellingham, WA and Kevin Munoz, President, HR Medical, Inc., Houston, TX, whose products are in that group of disposables that simply can not be reprocessed; therefore, the current discussion does not apply. Sonotech sells Cefar Image Singles disposable, unit dose packets of ultrasound scanning gel designed to eliminate the risk of cross contamination from reusable bottles of ultrasound scanning gel. Larson says that many institutions are recognizing the risk of patient cross-contamination from ultrasound scanning gel and bottles and have switched to Clear Image Singles to prevent a problem. Munoz’s business isn’t affected because of the same reason. The products he offers for single use – are literally only used once. However, he feels that from what he knows, there seems to be overwhelming evidence that reprocessed single use devices do not create any elevated health risk to patients. “I’m in favor of it because hospitals can use reprocessed, single-use medical devices to lower costs,” says Munoz.

**Online:** dotmed.com/dm6323
The most critical and expensive component of today’s CT scanners is the X-ray tube (glassware). Replacing one can cost, depending on the make and model, in excess of $150,000.

When a CT X-ray tube fails it needs to be replaced immediately to avoid downtime. The $64,000 dollar question — no pun intended — is how many times, if at all, will a healthcare facility need replacement tubes during the year? There are several factors to consider, such as the number of scans/month a machine performs and the number of machines a facility has in use. If replacement costs spike, it can cause financial headaches.

This is why several major X-ray tube manufacturers now offer what essentially are tube insurance programs. The goal is to help predictably manage glassware costs going forward for an annual “premium.”

Dunlee has a menu of options

Dunlee, a division of Philips Medical Systems, offers its Glassware Solutions program to help alleviate unpredictable and costly tube expenditures. The program is used by service providers, asset managers and in-house clinical engineers for hospitals and imaging centers.

“The idea behind Glassware Solutions is to pay a fixed monthly fee for as many tubes as needed for any particular system,” said Thomas T. Spees, Director of U.S. Sales for Dunlee. “We are matching the expense they would have to pay with the potential revenue they could receive from the CT system.”

The company would not provide specific pricing information, as it varies greatly by customer and product type. However, they explained the program’s customized pricing structure, including three types of contracts, typically 36-months in duration:

• Glassware Solutions Classic provides fixed pricing and no glassware risk.
• Glassware Solutions Risk Pool has stable monthly pricing, but at the end of each contract year, price adjustments are made to ensure the customer receives a 10 percent savings compared to the transactional value of the tubes consumed.
• Glassware Solutions by Design is a custom solution that can be developed with a customer’s specific glassware coverage needs in mind.

Each type of contract has three usage tiers. The tiers are based on the amount of scans consumed on the warranty:

• Low Use Tier: For customers consuming less than 30% of the scans seconds (a measure of single-slice scanner usage) or amp seconds (multi-slice usage) allowed under the tube’s warranty each year. An example of a typical low-volume application might be outpatient oncology.
• Medium Use Tier: 30 to 100% of scans seconds/amp seconds of the tube’s warranty used within one year.
• High Use Tier: Usage exceeds 100% of the tube’s warranty usage level within one year. High volume applications typically include emergency rooms.

For example, if the CT scanner’s tube warranty provides for 100,000 scans seconds in one year and that scanner was using only 25,000 scans seconds each year, it would be in the low-use pricing level. If the scanner was being used for 130,000 scans seconds per year, then it would be put at the high-use pricing level.

Glassware Insurance Programs

They can take the roller coaster ride out of your tube replacement costs – for a price

By Barbara Kram

Varian, the independent X-ray tube leader, likes the view from the sideline

Varian occupies a unique position in the world of X-ray tube OEMs. David Hurlock, International Marketing Manager, Varian Medical Systems/Interay, is well aware of what the other big three are doing, and stated Varian’s position this way: “Varian Medical Systems, the largest independent X-ray tube manufacturer in the world, distributes our replacement X-ray tubes through a network of independent distributors and service companies — these companies are our customers. Some of our customers offer an X-ray tube insurance program. We choose not to compete directly against our customers.”
“For as many sites as we can, we try to get the past usage history on the scanners; the scanners contain that information,” Spees explained. “This allows us to get a pretty good idea of where to slot each scanner...We fit the customer into the right usage level to guarantee they will save on their tube costs.”

Dunlee Glassware Solutions was launched in 2004 and currently has about 15-20 customers with nearly 300 scanners under contract. Some ISOs that use the program have more than 50 scanners on a contract.

**GE Healthcare has two major plans**

GE Healthcare also offers Full Service and shared risk glassware service coverage. GlassPro is their shared risk option, available for customers with a GE service agreement. The program is for GE equipment only, and is available not only for CT, but other GE X-ray modalities.

“With Full Service, the customer has the peace of mind of being able to spread out payments evenly and plan monthly payments over more than a year and know that all their equipment in service is covered,” says Kristin St. Martin, Diagnostic Imaging Services Marketing Manager, GE Healthcare, Waukesha, WI. “In this economy with reimbursement where it is, shared risk is a flexible option that allows [customers] to take on some risk and be rewarded with savings in service dollars.”

With GE’s GlassPro shared risk program you pay a monthly subscription fee and that entitles purchase of replacement tubes at a discounted price. Installation by GE engineers is included.

“With Full Service, you pay one annual fee over the life of your contract every year and the tube is included so you don’t have that additional outlay of cash. When the tube blows, you can spread that out over the life of the contract,” she says.

In either approach, the cost is tied to usage and the type of application. “Usage can vary dramatically. So to say you will replace a tube per year, you can’t make that generalization. It has to be tailored to the needs of the customer.”

St. Martin noted a trend toward Full Service contracts for glassware. “As equipment gets more complex and the interaction between the equipment and the imaging subsystem becomes even more tightly woven, that desire for Full Service coverage certainly is increasing.”

GE manufactures its own X-ray tubes around the world. “When you have a scanner down, timing is absolutely everything. It’s not just the expertise of the installer, but also having the right part available when you need it. And that’s where GE is well equipped no matter where you are located in the world to handle those needs in a very timely and efficient way.”

**Siemens takes an incremental approach**

Siemens also manufactures glassware and provides tube coverage for their CT systems. The company has more than a dozen CTs and types of tubes. Pricing depends on the system in question and on usage.

“We have an unlimited coverage plan...what I call an ‘all-you-can-eat’ plan,” said John Barbati, Service Product Manager for CT, Siemens Medical Solutions USA, Inc., Cary, NC. “If you’re our customer and you buy unlimited tube coverage, no matter how much you use it... if a tube goes bad we replace it.”

They also offer options for less than unlimited coverage at a variety of usage levels. This menu includes many incremental tiers so that customers pay only for their likely volume.

If a customer exceeds their intended volume, they simply move into the next tier of usage from extremely low use (25,000 scans seconds on some CTs) up to unlimited coverage. Customers get 5% overage without any additional charge.

“By offering a plan at a low level, you aren’t exposed financially paying for a lot of usage that you don’t need,” Barbati said.

The likely usage depends on patient volume, scanner type, medical specialty, and other factors. “In an oncology situation where they use a CT for simulation, the usage would be much lower. A typical radiation oncology facility that has a CT would typically buy 100,000 scans seconds per year,” he said. “In using the same type of CT in a radiology setting, they are more likely to buy 300,000 or unlimited because they’ll use it that much more.”

Installation is done by Siemens field engineers. Siemens also offers tube coverage for other modalities such as general X-ray and cath lab.

- Online: dotmed.com/dm6315
## With RSTI Training,

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A Dealer From Dallas Scores a Texas-Sized Payday — Thanks to a DOTmed Auction

It was formally known as DOTmed Auction #4175, specifically a GE Excite III MRI.

But for an imaging equipment dealer located right outside Dallas, Auction #4175 turned out to be a number that turned into huge winner.

The GE MRI first appeared on DOTmed as a Self-Managed Auction posted by the company — which has a reputation for integrity that’s attested to by its status as a DOTmed Certified company, and as a DOTmed 100 Company.

But the dealer had no luck initially selling the equipment under Self-Managed Auction guidelines.

There then followed conversations between DOTmed and the dealer which led the dealer to re-auction the second time as a DOTmed Full-Service Managed Auction.

After conducting some research on the unit, DOTmed’s Online Auction Specialists determined that the magnet for this particular MRI was a special one, and thus highly desirable in the marketplace. The new information was added to the Auction particulars, promoted, and sure enough, interest from potential bidders skyrocketed.

Because of DOTmed’s savvy and follow up, the GE Excite MRI fetched a winning bid of $300,000. And even for a dealer from Texas, that was a big deal and a significant return on investment — and another endorsement for DOTmed Full-Service Auctions.

Greater New York Hospitals Reap Continuing Rewards

DOTmed Auctions continue to help Greater New York Hospital Association (GNYHA) members sell equipment that has become redundant, or scheduled for replacement.

Examples of some recent successful auctions include three for Nassau University Medical Center, one which netted $6,000 for an ALARIS 7230 I/V Infusion Pump. Nassau also received $6,000 for a similar pump, an ALARIS 7130 model. And Nassau was also able to auction off an AMSCO 1080/2080 O/R Table, which also netting them $6,000 on the deal.

An upstate GNYHA member hospital, Vassar Brothers Hospital, in Auction #4925, was able to sell a SIEMENS Siremobil 2000 C-Arm. After 14 bids, it closed at $8000, and the hospital received more than it hoped for.

An Open Viva Scanner Goes from “For Sale” to “For Auction” — And Sells for Almost 4 Times As Much

Hillcrest Radiology Associates of Long Island, NY, recently purchased a new Siemens Espree MRI scanner, which replaced a 1990 Siemens Open that had been upgraded to an Open Viva in 1995. Dr. Kim Podolnick, the clinic director, decided to try and sell the Open Viva.

As happens quite frequently, Dr. Podolnich did a Google search and found DOTmed on his own, at which
point he decided to simply list his Open Viva for sale in a classified listing.

Not surprisingly, Dr. Podolnick quickly received a $10,000 offer from a local dealer, plus a number of other inquiries, including one from his DOTmed Project Manager David Blumenthal.

Blumenthal believed that the machine should sell for much more than $10,000. He suggested to Dr. Pololnick that the scanner be put up for Auction on DOTmed where the sale price could benefit from more views — as Auctions are the most visible listings on DOTmed. In addition, the DOTmed Auction Team would handle all of the negotiations and logistics.

After reviewing Blumenthal’s proposal with his partner, Dr. Podolnick decided to go the DOTmed Full-Service Auction route.

Blumenthal then sprang into action, visiting the imaging facility, taking pictures and a video of the system. Armed with all relevant details, Blumenthal set up the DOTmed Auction and waited for results.

The Open Viva was priced with a starting bid of $15,000, a reserve price of $30,000, and a “Purchase It Now” price of $35,000. This system turned out to be a most attractive item, getting a $16,000 bid right off the bat.

Ultimately, the auction produced a series of 25 escalating bids from four different buyers located in four different countries. The winning bid was for $37,000 from a buyer in Argentina.

After the sale was concluded, DOTmed worked with a local rigging company to arrange for the removal of the system in coordination with the center and the buyers’ engineer. And Dr. Pololnick became a happy believer in DOTmed Full-Service Auctions.

**DOTmed Managed Auctions Produce Results**

As the monthly success stories in Old Into Gold testify, there’s no better or easier way to sell your surplus equipment and idle assets than through a DOTmed Full-Service Managed Auction.

The beauty of DOTmed Managed Auctions is that they allow a hospital or clinic administrator to maximize profits with the minimum amount of time and effort.

DOTmed Online Auction Specialists handle virtually all aspects of the process. From setting the Auction, to managing it, and then successfully closing it, the DOTmed Online Specialist runs the show. In fact, DOTmed even collects the payment and pays you in advance.

Here’s one of the key factors that makes the DOTmed Managed Auctions such a winner: the bidding process means the equipment seeks and finds its true market value — so you never sell yourself short.

Moreover there are no set-up fees. DOTmed only gets paid after your equipment sells. And if a particular item does not find a buyer after its initial posting, DOTmed will re-auction until it does sell.

All in all, DOTmed Full-Service Managed Auctions are the best way to get the best price for your used equipment.
Digital is the way to go—the health care industry is well aware of the inevitable march of progress. Old technology will be phased out as a matter of course—people always want imaging equipment that is newer, faster, better, and as that equipment becomes affordable, version 1.0 becomes obsolete and a quaint artifact of yesteryear. Laser cameras (also known as laser printers or laser imagers) are one of those technologies on the cusp of extinction. Digital systems, such as PACS, have dazzled practitioners with speed and convenience, ensuring that the use of laser cameras is on the decline.

But we’re not writing the epitaph for the laser camera just yet. In the health care industry, nothing is as simple as predicted. For the next decade or so, the laser camera has a few niches remaining in manufacture and for preowned sales and service.

The three main factors that keep laser cameras from joining the junk pile along with 8-track cassette players and the rotary phone are: 1) economics—the affordability of lasers camera vs. the expense of a digital system infrastructure; 2) the international market—which offers laser cameras a steady and even growing sales base; and, 3) the personal preference of radiologists and physicians who refuse to go digital. OEMs are still manufacturing dry laser cameras (wet cameras are closest to truly being obsolete) and new products have even been developed in the last few years, such as Sony’s thermal imager and Carestream’s desktop imager.

Domestically declining, but laser cameras still have a role to play in the market

“Film was said to be ‘out’ ten years ago,” says Mr. Neal Thompson, President of JD Imaging in Mundelein, IL. “Laser camera usage is declining fast, but will still be around, because there are those who still want to have the hard copies.” Thompson refers to doctors who were trained on film and don’t want to bother with computers to view an image. These docs want to see the traditional hard-copy on the lightbox. Film will also still be important in an OR or ER, where a surgeon wants the one to one relationship with the film without searching for a computer. And, Thompson points out, mammography providers still must have a laser camera for American College of Radiology accreditation.

On the flip side, doctors and radiologists trained in digital won’t want to use film. “There are a lot of doctors who are techies,” says Mr. Ed Ruth, partner in Managed Medical Imaging, of Pembroke Pines, FL. These doctors and technologists are enthusiastic about the capabilities in digital. “A digital image is flexible, the technologist can play around with contrast until the right quality is achieved.”

“A laser camera will still be around in the future as a necessary back-up,” Thompson says. Thompson and JD Imaging offer parts and servicing for laser cameras, which are prone to mechanical problems from worn parts, causing film jams. Critical to refurbishment is making sure all rollers in the film path have been replaced, or are in very good condition.

Inevitably, though, most facilities will switch over as the time comes that laser cameras cannot be replaced; the parts won’t be available and the technology will be so obsolete that replacing the same device is unworkable.
Thompson points out that the original wet cameras became expensive and fell out of usage domestically because of the cost in base materials of silver and petroleum, in addition to the devices’ cumbersomeness and problems in chemical storage.

Ed Ruth, who has a variety of imaging clients in stand-alone facilities and hospitals, observes that cost is the biggest factor in moving to digital. “The industry is not going to move over completely to digital for at least four to five years,” Ruth says. The price of digital systems needs to drop at least 30 percent. Right now, facilities have to struggle with economic issues such as Medicare reimbursement. MMI caters to those facilities that need to rely upon the laser camera for the near future. The company sells and services Fuji, Kodak, and Agfa equipment. Ruth says MMI is one of the limited number of companies in Florida that offer service rates below the OEMs, and his staff is Fuji-trained in all the Fuji lines for such service problems as gear and roller damage.

Yet Ruth also has digital in his business plan. Customers will eventually be upgrading their equipment. Ruth says his company knows the systems, and can interchange motherboards. “We look at it in a positive sense, because we are offering digital for those that can upgrade.” In the meantime, Ruth also plans to move into international sales for laser cameras.

Mr. Kevin Fix, CEO of Ultimate Medical Services, Inc. of Lake Charles, LA, has also seen the ups and downs of laser cameras firsthand. “I saw laser imaging slow about two years ago.” At that point, servicing laser cameras made up 25 percent of Fix’s business. Now it’s four to five percent. Service calls dropped because the machines are built better and the replacement parts are superior. Five years ago, dry cameras were using rubber heat drums; now they use Teflon, which can enable a machine to go through around 200,000 sheets before needing replacements. There is also less chemical compound residue to remove. Laser cameras used to have a life cycle of three years, but now last longer before exhaustion. If a device is maintained well in an optimum environment, Fix says, it could last 10 to 15 years. Currently, Fix has no problem finding parts unless the system is very old—or wet. Very, very few facilities are using wet cameras. Ultimate Medical has not had calls for a wet laser in two years, “it’s just not a good solution for a facility’s needs anymore.”

Fix has factory-trained Konica service people and a long-time allegiance with Konica. However, Fix is solidly in the digital market as well, with Ultimate Medical’s own PACS system, offering customer service that is not outsourced, and real-time support.

**OEMS solutions: smaller devices for a dependable back-up**

For around $9000 Sony has a thermal dry film imager that has the unique capability of being installed either vertical or horizontal for space-saving capacity. Thermal imagers use thermal resistors, which activate the processing, as compared to laser heating. The Sony Filmstation offers 320 dpi thermal head technology and is compatible with CT, MR, X-ray, and ultrasound equipment.

Ms. Julie Holodak, manager for Sony radiology marketing in Park Ridge, NJ, says the Sony FilmStation has caught on nicely in the last few years, despite having been introduced in a mature market with other well-established film companies. Why a new device in the market when laser cameras are being pushed toward the exit sign? Holodak says there was a real opportunity for low-cost reliable devices that could be conveniently stored in a facility. Holodak says the FilmSta-
tion’s size and vertical mounting is a huge benefit for the mobile market as well.

Holodak offers the FilmStation as a good companion piece to a PACS system, when film is still needed for referrals and the practitioners who demand the hard copies. The FilmStation has a single-tray model under $10,000; a dual-tray model was added a year and a half ago, printing in 8 x 10 and 10 x 12, and resistant to smudging through a specially designed protective layer in the film. The imager uses a film specifically manufactured, a proprietary dry film providing the density and specs for diagnostics, with no jams.

For Sony, this is a growth sector in radiology. As facilities evaluate their costs and reimbursements, Holodak says people are getting savvy in their purchases. “The feedback on the FilmStation has been great, with recognition of the brand, engineering reliability and saving money on ownership cost.”

According to Ms. Roberta Buttino, Business Manager for Carestream Health in Rochester, NY around 50% of the U.S. healthcare industry has gone digital, varying by type of facility. Mammography is getting stronger in the digital market now (although FDA regulations still require a laser printer) while other modalities have been going digital over the last 10 to 15 years. Worldwide, digital is too costly for immediate conversion. In rural U.S. areas, digital is also too costly, Buttino has found. “To go digital you need to make usually a large investment.

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No mourning for the late, great laser camera era. Laser cameras will be to digital like typewriters are to a computer.

If you want to be filmless, you need to access those images, store those images, you need the infrastructure, and obviously the money.”

“Carestream (formally Kodak) has placed around 50,000 laser cameras globally for those customers not ready to convert,” Buttino says. What has changed in the laser camera industry is a need for a lower volume, smaller and more affordable device. The Kodak DryView 5800 is a tabletop imager that sells for less than $20,000. The size of a small computer printer, the 5800 can be easily stored. It prints in five film sizes and prints from CR, DR, CT, MR, US, NM, PACS, and digital fluoroscopy. For the future, Carestream recognizes both the current need remaining for dry laser cameras, and the encroaching tide of digital. Buttino says Carestream is ready to sell enhancements to existing products as well as DR, CR and PACS systems.

The international market—where laser cameras are a staple

Globally, new and preowned laser cameras sell at a good clip. Thompson says that in countries such as Mexico, dry and wet processors are still very much in use. Holodak has found a “tremendous” market for the Sony FilmStation in China and Latin America.

Ruth is also optimistic for international dry laser sales: “In the international market, I can see a lot of opportunities out there for the older systems to sell.” Carestream is also benefitting from a growth market in laser cameras worldwide, Buttino reports.

India is a key international market for medical equipment. Mr. Gautam Sehgal of Ads Diagnostic Limited in New Delhi, India, has a customer base solely in India. Sehgal says that 98 percent of his clientele facilities are still using laser cameras both dry and wet—although the dry cameras are slowly replacing the wet cameras. Right now in India, about two percent of all hospitals and radiology centers use PACS. According to Sehgal, healthcare costs are mostly paid out of pocket, so a hard copy of the film is a must. He sees the biggest challenge in PACS and DICOM conversion as being the cost and the connectivity of non-DICOM products. Still, Sehgal also predicts laser cameras being phased out in 10 to 15 years.

Because the market for laser cameras is very strong, Sehgal has no problem finding parts. The popular models in India are the Agfa Drystar 5500, the Kodak 8900, as well as Fuji and Konica lines. A preowned wet camera will run around $3000, and a preowned dry camera around $5000. Sehgal services the equipment as well, and finds the wet systems require more parts and the processor end is more cumbersome to repair.

Mr. Martin Sundararajan of V.M. Meditech Services, an ISO based in Chennai, India, also has an India client base with occa-
Sundararajan finds lasers cameras a mainstay. “Except in a very few corporate hospitals, most of the medical industry in India is using laser cameras for hard copy printing. We can count about 30 big corporate hospitals that have switched totally to PACS.”

Sundarajan says in his experience, a facility stays with laser cameras for economics, with the high comparative costs of PACS a hurdle to the facilities. In addition, film is preferred by physicians. Sundarajan sees the market for dry laser cameras continuing for at least another five years. He also has no problems in finding parts for his best-selling Kodak and Fuji models; however, in the course of time, laser cameras will be phased out due to the rising cost of the cameras’ film. Sundarajan also observes that the wet cameras still need plumbing for water and drainage, which makes the dry cameras much more eco-friendly.

Use caution or yield to digital? What to take into account

How do you know when to go digital—now or in the future when the costs decline? On the plus side, digital makes sense as a solution to physical storage problems. But in resolving one set of problems, an equal set of problems develop. Buttino says the decision involves considering the cost-effectiveness. A hospital needs efficiency, and the digital systems are efficient. But can you afford the changeover?

“Technology breeds technology,” Wayne Webster, Owner of Proactics, Melrose, MA, observes. Webster often acts as a consultant company for healthcare facilities considering a move to digital. Using PACS efficiently means that the facility must have the accompanying infrastructure, especially the bandwidth to ensure that a doctor or technologist does not wait forever to download or send a high-bit image. Upgrades may be necessary for the intranet or viewers. Staff training may be needed. All devices must be integrated and compatible with each other. Even more air conditioning is needed for the proper computer environment. Who takes charge of the images is also an infrastructure decision—is it the IT personnel or the radiologists? Then there is back-up: how will a facility handle an internal problem that takes down the digital system—the server or intranet, or if the offsite storage is destroyed? The stakes and responsibility are higher.

Industry insiders say the factors to consider include leaving technology razzle-dazzle out of the equation. A facility should look at the community it serves (including whether the patient base is rural, urban, Medicare, Workers Comp, etc.), what is needed to serve the community, and what is the reimbursement for the processes. Treat the medical business like any other; look at the business overhead. If a facility goes digital and gets rid of laser cameras, is it in a position to maintain and grow revenue, or will the digital system be an insurmountable expense at this time? This is especially applicable where digital currently makes little difference in the reporting and analysis of the images.

No mourning for the late, great laser camera era. Laser cameras will be to digital like typewriters are to a computer. Typewriters, once a standard in office industry, were supposed to go the way of the dinosaur when the personal computer caught on. Yet there is still a niche market for typewriters in applications a computer can’t handle, as well as an international market. The laser camera will occupy a similar role for mammography and as a backup to PACS—and not go gently into the good night.

• Online: dotmed.com/dm6251

DOTmed Registered Laser Camera Equipment Sales and Service Companies

For convenient links to these companies’ DOTmed Services Directory listings, go to www.dotmed.com and enter [DM 6251] Names in boldface are Premium Listings.

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**Nationwide Imaging Services Inc. Celebrates Its 15th Anniversary**

Nationwide Imaging Services, Inc. (NIS), of Brick, NJ, is celebrating its 15th year in business. The company specializes in buying, selling, servicing, installing and deinstalling high-quality, pre-owned imaging equipment, including CTs, MRIs, PETs, Ultrasounds, Gamma Cameras, C-arms, and more.

Reflecting on reaching this milestone, Robert Manetta, Co-founder and President of NIS, said, “the past 15 years have seen strong growth in the sale and use of all imaging modalities, and NIS has been one of the leading, independent companies at the forefront of this historic business expansion.”

Manetta, who is DOTmed Certified and DOTmed 100, added, “we stand behind every piece of equipment and part we sell. When someone calls, they can be confident they will get their money’s worth and a job well done.”

In conjunction with the anniversary, Manetta recently formed a new business subsidiary, Nationwide Funding LLC (NFC), that provides customized financing solutions so that clients can better meet their business goals.

Nationwide Funding Corp. (NFC) is focused on providing flexible options that enable its customers to make the investments necessary to support and allow their operations to grow in the fast-paced medical imaging business.

Lynne Timian heads Nationwide Funding Corp (NFC). He has over 15 years of experience in the equipment finance industry with areas of specialization in the information technology and health care.

**Online:** dotmed.com/dm6230

**Hologic to Buy Third Wave Technologies**

Hologic, Inc., Bedford, MA, has signed a definitive agreement to acquire Third Wave Technologies, Inc. The Boards of Directors of both companies unanimously approved the transaction.

Third Wave develops and markets molecular diagnostic reagents for a wide variety of DNA and RNA analysis applications based on its proprietary Invader® chemistry. The company’s current clinical diagnostic offerings consist of products for conditions such as Cystic Fibrosis, Hepatitis C, cardiovascular risk and other diseases. The company recently submitted pre-market approval (PMA) applications to the FDA for two human papillomavirus, or HPV, tests. There are currently 10 million HPV tests being performed in the United States annually, representing a $200 million market. Hologic believes the global market for HPV testing will increase to $800 million over the next few years.

Jack Cumming, Chairman and Chief Executive Officer of Hologic, said, “The combination of Hologic and Third Wave brings together two great companies that employ complementary technologies, but share a common mission: to help save the lives of women. This important transaction will broaden Hologic’s range of diagnostic product offerings, enhance revenue and earnings growth potential and, we believe, create long-term value for our shareholders,” he added.

**Online:** dotmed.com/dm6208

**Atlantis Worldwide is Company of Choice for OEC C-Arm Trade-ins**

Atlantis Worldwide, LLC, Yonkers, NY, has struck a deal with GE Healthcare’s Surgery business (OEC), which makes Atlantis Worldwide the preferred choice for OEC C-arm customers that need a seamless trade-in buyer.

“We applaud GE OEC’s ability to deliver their new OEC 9900 Elite GSP and ESP C-Arms,” says company President Jeff Weiss. “But Atlantis will be purchasing all trade-in systems as new systems are delivered, as well as trade-in systems from ongoing transactions.”

The new and exclusive arrangement enhances Atlantis Worldwide’s stature as the source for C-Arms, with a full inventory of C-Arms from economically priced systems to ones with the latest technology.

**Online:** dotmed.com/dm6143

**NIH’s Director of National Human Genome Research Institute Leaving**

Francis S. Collins, M.D., Ph.D., the Director of the National Human Genome Research Institute (NHGRI), and part of the National Institutes of Health (NIH), is leaving that position August 1st to explore other professional opportunities.

Dr. Collins, 58, a physician-geneticist, has served as NHGRI’s director since April 1993. He led the Human Genome Project (HGP) to its successful conclusion in 2003, and subsequently initiated and managed a wide range of projects that built upon the foundation laid by the sequencing of the hu-
man genome. Following the precedent set by the HGP under Dr. Collins, data from the projects have been freely available to the worldwide scientific community. Collectively, these projects and their data have transformed biomedical research and empowered researchers all around the world.

Online: dotmed/com/dm6115

Industry Veteran Andersson Joins Carestream Health

Thomas R. Andersson has joined Carestream Health, Inc., as General Manager, U.S. & Canada Medical Sales Region. He becomes a member of the company’s senior sales leadership team, reporting to Michael W. Jackman, President, Global Sales & Services, Medical Solutions, and Carestream Health.

In this role, based at the company’s headquarters in Rochester, NY, Andersson will manage and provide strategic direction for the company’s team of sales professionals that serves a broad range of unique healthcare providers across the U.S. and Canada.

Andersson has more than 20 years of experience and a proven track record in the medical imaging profession, combined with a strong background in sales at all levels.

Online: dotmed.com/dm6234

ARRS Names 2008 Residents in Radiology Award Winners

The American Roentgen Ray Society (ARRS) has named three Residents in Radiology Award winners. Those saluted include President’s Award winner Ethan A. Smith, M.D., the University of Michigan Health Systems, Ann Arbor. The Executive Council Award to Joanna N. Tewfik, DO of the University of Virginia in Charlottesville, and the Executive Council Award II to Sachit K. Verma, M.D., Thomas Jefferson University Hospital, Philadelphia, PA. The Residents in Radiology Awards are available to residents and fellows in radiology and radiological sciences and range from $1,000-$2,000.

Online: dotmed.com/dm6044

Philips Expanding Business in Emerging Markets

Philips Healthcare has reached an agreement to acquire Brazilian-based Dixtal Biomedica e Tecnologia, a leading maker of hospital patient monitoring systems, anesthesia and ventilation and ECG equipment. The Brazilian company also manufactures sensors for vital sign measurements.

Privately held, Dixtal will become part of Philips’ patient monitoring business unit. Philips says Dixtal will incorporate its financial results with its own in the third quarter of this year.
Terms of the deal were not disclosed.

Clearly staking out turf in emerging markets, Philips acquisition of Dixtal follows on the heels of earlier acquisitions of healthcare companies in China and Brazil.

- Online: dotmed.com/dm5999

Nastech Changes Name to MDRNA; Appoints J. Michael French CEO

Nastech Pharmaceutical Company, Inc. with shareholder approval in hand, has changed its name to MDRNA, Inc. MDRNA will leverage its scientific and intellectual property (IP) position surrounding the research, development and delivery of Dicer substrates and “Meroduplex” (mdRNA) RNA interference (RNAi) drug candidates. This will build an industry-leading position in the development and commercialization of RNAi-based therapeutics. The company will trade on NASDAQ under the symbol MRNA.

As part of its new corporate and scientific focus, MDRNA has named J. Michael French, formerly of Sirna Therapeutics, Inc., Chief Executive Officer, effective June 23, 2008. French succeeds Steven C. Quay, M.D., Ph.D., who has been appointed Chief Scientific Officer and Chairman of MDRNA’s Scientific Advisory Board and remains Chairman of the Board of Directors.

MDRNA is pursuing pre-clinical RNAi programs in influenza and rheumatoid arthritis, from which it will identify appropriate target candidates for partnering and clinical development.

- Online: dotmed.com/dm6228

Virtual Imaging Acquires Central Imaging of Tennessee

Virtual Imaging, Inc., a diagnostic imaging, manufacturing and service organization based in Deerfield Beach, FL, has completed its acquisition of Central Imaging, a remanufacturer of patient handling devices and imaging systems located in Greenbrier, TN.

Thirteen Central Imaging employees have been incorporated into Virtual Imaging to expand sales and service, continuing the Virtual Imaging customer service commitment philosophy.

“We will offer expanded services in high-end modalities such as CT and MRI, along with our full line of digital products,” says Tim Martinson, President and CEO of Virtual Imaging. “The rural hospitals surrounding Nashville need the cost saving benefits that VI offers.”

“We are very excited about the merger,” says Randy McMoran, former President and CEO of Central Imaging.

- Online: dotmed.com/dm6206

Medtronic Awarded $250 Million in Damages

A federal jury in Marshall, Texas has determined that Boston Scientific Corporation has infringed three patents owned by Medtronic, and awarded Medtronic with $250 million in damages.

In 2006, Medtronic sued Boston Scientific alleging that Boston’s Taxus Express2, Express2, Liberte, Maverick, Maverick2, and Quantum Maverick products infringed the Fitzmaurice and Anderson catheter patents owned by Medtronic.

The Fitzmaurice patents cover angioplasty catheters with narrowed distal ends, which improve the deliverability of angioplasty catheters. The Anderson patent covers semicompliant angioplasty balloons.

Boston Scientific has appealed the verdict and has said it will vigorously look to have the decision overturned.

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“It is a strategic alliance that will enable us to grow a strong service and sales business in the state of Tennessee.”
The Association for Healthcare Resource & Materials Management (AHRMM) will hold its 46th Annual Conference & Exhibition in San Antonio, Texas, July 20-23 at the Henry B. Gonzalez Convention Center. The AHRMM08 Conference features three full days of valuable educational programs and networking events so healthcare supply chain professionals can receive up-to-date information on the latest healthcare supply chain trends, issues, and best practices, and learn from national experts in the materials management field.

The Exhibition, held in conjunction with the AHRMM Annual Conference, is the number one place where attendees network with some of the most influential global leaders in the healthcare industry. The Exhibition showcases the latest products and services in today’s marketplace from over 200 exhibiting companies.

Exceptional Education
AHRMM08 includes 48 Learning Lab sessions broken into seven different educational tracks: distribution, finance, technology solutions, purchasing, strategic planning, clinical resource management, and professional development, as well as pre-conference sessions on Six Sigma, the Anatomy of Materials Management, Leadership, and more.

Joe Flower, CEO, Imagine What If, Inc. will open the meeting with the Keynote Address on Monday, July 21. And, the closing Keynote Address on the final day of the conference will feature senior instructor, ROTC Department at The John Hopkins University, Sergeant Matt Eversmann.

Everything’s Bigger and Better in Texas
The gift of history in San Antonio is its star attraction, aside from the Alamo of course. The River Walk, winding through the center of downtown, is the “cool” hot spot for all AHRMM members to relax after their meetings, take a stroll beside the river, and eat at one of the many appetizing restaurants.

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Which modalities will ultimately prove best at imaging the breast?

By Keith Loria
Mammography appears to be on the radar screen of every imaging modality today. While the traditional mammogram has helped lower breast cancer deaths by as much as 30 percent over the last two decades, as many as one in five cancers, nevertheless, are still overlooked. That is why all the other major imaging modalities are aggressively being assessed — both for their diagnostic and therapy-management capabilities.

“I think an important message is that we’ve really evolved tremendously from the old mammography that really started only 25 years ago. Today we’re using a whole compendium of different modalities that allow us to improve the detection of breast cancers and find them earlier and manage patients better,” says Dr. Ellen De Paredes, chair of the ACR Breast Imaging Communication Committee. “A lot of these other modalities are really aimed at trying to help manage the treatment and decide what’s the best surgery for patients. Is breast conservation the best thing, or are there other diseases, which means some other surgery would be better? We’ve really advanced a lot in the field of breast imaging, which I think is an exciting thing and it’s helped educate the public.”

According to Jim McGinty, President of Digitec Medical, a sales and service organization focusing on breast imaging equipment, there are a lot of exciting things going on in breast imaging in the first decade of the 21st century. “There is breast MRI and three dimensional imaging methods coming out with enhanced imaging,” he says. “They all hope to improve image quality and reduce patient dose. Then there are improvements in CAD where a computer looks at images and suggests where doctors should look.”

Every modality — from film and digital mammo, to MRI, CT, ultrasound, and nuclear medicine — has its advocates. Ask five different radiologists which is best, and you’re likely to get five different opinions as to where imaging is headed in the future.

“There is going to be a shakeup in breast imaging, and the reason you have 5 to 6 modalities to choose from is that no one has any real, conclusive data that any one is a better screening tool than the others,” says Dr. Bruce Schroeder, Director of Breast Imaging at Eastern Radiologists, Inc. “No one really knows which one is best or whether you need more than one.”

Digital vs. analog — the cost/benefit debate continues

For women who are 40 or older, a mammogram is recommended at least once a year — but for most women, it’s not necessarily that important whether it is an analog or digital image.

Until eight years ago, all mammograms were done with film. Then in 2000, GE pioneered digital mammography with the introduction of the first full field digital mammography unit, and the digital industry has exploded. Manufacturers such as Hologic and Siemens joined GE in creating a strong marketplace for digital mammography.

“Almost the entire industry has gone digital because it offers a lot of efficiency,” says Pat Hall, Director Product Communication and Professional Relations for Hologic, a leading OEM of digital mammography equipment. “What makes digital better is that you can see things much more clearly and more quickly. It also significantly reduces the recall rate in mammography. That’s a major advantage. Anytime a woman doesn’t have to go through the anxiety of thinking something is wrong, that’s a major advancement.”

As with film mammography, optimal positioning and compression are critical in identifying a suspicious lesion. Unlike an analog image, with digital mammograms the technologist is looking at the image within seconds. “They can see if the woman moved during imaging, or if the breast tissue was properly positioned, or whether they got the entire breast or not — with film it takes a few minutes,” Hall says. “It’s a much faster process, so there are patient advantages, doctor advantage, and workflow advantages. You don’t have chemicals, you don’t have film, and you don’t have film storage to worry about.”

On the other hand, you have a more expensive piece of equipment — digital imaging is about three times as expensive as analog units — and you’ll also need a PACS system in place to store and transmit the images.

“I think cost is an issue for many hospitals and many facilities because they have existing film equipment in good condition and it’s fine to use. But when it becomes time to replace that equipment, I think most people will move towards digital,” De Paredes says. “I do think digital is the wave of the future.”

Last year, 92 percent of mammography systems (of the 1,776 units) sold in the United States were digital, and it appears most people are convinced this is the way to go.

According to Karen Schmitt, Director of the Columbia University Breast Cancer Screening Partnership, the convenience far outweighs the cost. “Two radiologists could be looking at the same film at the same time from two different places on the planet. That’s really helpful, especially if you are going for a second opinion or you are in a rural area,” Schmitt says. “Plus, there aren’t a lot of large storage costs because you are storing everything on disk.”
The American College of Radiology Imaging Network (ACRIN) in 2005 released the results of one of the largest breast cancer screening studies ever performed, and it is referred to by most experts when discussing the differences between film and digital mammograms. “Digital was shown to be superior to film mammography in some subsets of women,” says De Paredes. “In my own practice I use digital exclusively. I think it’s the future of mammography as most of general radiology has become.”

The primary finding of the study was that, for the entire population of women studied (49,528 women), digital and film mammography had very similar screening accuracy. Where digital was deemed significantly better (28% better) was in women under 50, those with dense breasts, and those pre- or perimenopausal (defined as women who had a last menstrual period within 12 months of their mammograms).

“There are just a few new analog systems being placed today,” McGinty says. “For women under 50 with dense breasts, it has been found that digital is probably a better way to go because of its ability to differentiate the different shapes and structures in the dense tissue. Once you get above that, it’s a wash and it doesn’t make a whole lot of difference.”

The MRI option
MRI can be used along with mammograms for screening women who have a high risk of developing breast cancer, or it can be used to better examine suspicious areas found by mammograms. MRI is also used for women who have been diagnosed with breast cancer to better determine the actual size of the cancer and to look for any other cancers in the breast.

“I believe the breast MRI is really used once you establish there is a problem and you need to see the extent of that problem,” says Peggy Pust, Director of Imaging Services at Monongalia General Hospital. “Certain cancers will occur in the other breast. Many times the doctors won’t do the surgery until they are fully aware of all the cancer that is there.”

Recent studies conducted by the National Cancer Institute (NCI) found that MRI was not only more effective than mammography, but also better than ultrasound or other clinical breast exams in finding breast cancer in women who had the screening.

The study showed that MRIs were accurate in detecting breast cancer in 83 percent of the 54 women who participated. The MRI returned a false positive in 17 percent of its diagnoses. “You inject a contrast agent, and as it’s going through the body, there’s increased vascularity and the uptake of the solution is greater if a tumor is present. That shows up as a hotspot on an MRI, so you can make a more definitive diagnosis by looking at that,” says Hall. “You certainly would not think about doing an MRI for every single situation. It’s very expensive and not all that pleasant a procedure, and not required to do a basic screening. It’s typically used as a second-step diagnostic tool. If you find something on the mammogram that looks suspicious, this gives you new avenues to explore it.”

MRI has shown usefulness as a next-step imaging modality for difficult-to-diagnose cases, as well. Much like X-ray mammography, breast MRI relies on anatomical or structural information, but provides much more detailed images. It is limited, however, by its highly variable specificity, which can range from below 37% to 97%. Combined with its high sensitivity, MRI produces a high false positive rate. It also is sometimes difficult to schedule, and

“If money was no object and time was no object, I guess MRI would be the answer.”
may require multiple days to complete.

The major disadvantage of breast MRI is the cost, which is about 15 times that of a basic mammogram. The entire exam could run anywhere from $1,000 to $1,500.

“If money was no object and time was no object, I guess MRI would be the answer,” Schroeder says. “If you had an unlimited number of scanners and slots and people to read it, but that’s not going to happen, it’s not practical.”

Ultrasound has its own niche

Ultrasound has become a valuable tool to use with mammography because it is widely available and less expensive than other options. The use of ultrasound instead of mammograms, however, is not recommended.

“The current standard way [ultrasound is used] is generally after, or in conjunction with, mammography. The accepted path for a woman is: first, she is screened with traditional mammography. Some of these women have abnormalities on their mammograms that can be further defined by ultrasound, so they go on to have an ultrasound.” says Dr. Beverly Hashimoto, a radiologist at Virginia Mason Seattle Main Clinic. “The only exception to that is when a patient has something that can be felt, a lump, and they are very young, some of those patients will go to ultrasound early. But even women who have lumps who are over 40 will have both mammogram and ultrasound.”

Usually, breast ultrasound is used to target a specific area of concern found on the mammogram. Using ultrasound, physicians are able to determine that many areas of concern are due to normal tissue (such as fat lobules) or benign cysts. For most women 30 years of age and older, a mammogram will be used together with ultrasound. For women under age 30, ultrasound alone is often sufficient to determine whether an area of concern needs a biopsy or not.

“Basically when you see something on a mammogram, an ultrasound can clarify it,” Hashimoto says. “An ultrasound can show a lot of different things. It can distinguish fluid from solids and define solid objects much better.”

In some cases, ultrasound is not able to determine whether a mass is cancerous, and a biopsy will be recommended. Many calcifications seen on a mammogram cannot be seen with ultrasound. Some early breast cancers only show up as calcifications on mammography.

Ultrasounds also take longer to do. Many breast radiologists do the ultrasound imaging themselves (instead of using a technologist) so it takes more physician time.

“When we target a specific area it doesn’t take all that long, but if we need to scan the entirety of both breasts, it can take quite a while, especially with larger breasts,” Schroeder says. “I can easily read 5-10 mammograms in the time it takes to read one ultrasound. It’s time consuming and you get a ton of false positives. I don’t think that will be the answer.”

“Ask five different radiologists which is best, and you’re likely to get five different opinions as to where imaging is headed in the future.”

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Clinical trials are now looking at the benefits and risks of adding breast ultrasound screening to mammogram screening for women with dense breasts who are at a higher risk of breast cancer.

“There was research that came out [in early June of this year] indicating that women at higher risk — especially younger women who tend to have denser breast tissue — would benefit from mammography coupled with ultrasound screening. The study indicated that there was a three-times higher breast cancer detection rate when both tests were used, meaning that something that wasn’t seen on the mammogram was seen on the ultrasound,” Schmitt says. “There was a higher capture. That is not policy, but it was a huge study so it will have some impact on how screening will be done for higher risk women.”

Along with the higher cancer detection comes a lower specificity. “When we recommend biopsy for an
abnormality seen on a mammogram we find cancer in around 20-25 percent of women,” says Schroeder. “When we biopsy something seen in an ultrasound we find cancer less than 10 percent of the time.”

When you talk about high risk women, you are talking mainly about women who have first degree or multiple second degree family members with breast cancer. The other high risk category is the prior existence of breast cancer in one breast.

**CT is making a strong case for itself**

There are some who believe that using CT is the best modality when it comes to breast imaging for diagnostic purposes, and there are plenty of studies going on today that are trying to prove this theory.

A breast CT scanner takes images of virtual “slices” of the breast—about 300 images per breast. Computers then assemble these images into highly detailed, three-dimensional pictures that provide a more unobstructed view of breast tissues than can be seen on mammography.

Schroeder has invested in CT because he believes it takes a good modality and makes it better. “I’m looking at this and saying, X-rays work now, so a better X-ray seems to be the most logical next step,” he says. He admits, however, he has no way of knowing how popular CT mammo will become. “A breast CT with a contrast agent will provide at least as much information as MRI, if not more — but that’s not definitively known yet, because it has not yet been fully studied.”

De Paredes says there is some new research using high resolution CT that is promising, and that breast cancer screening using new CT imaging devices may be more accurate than standard mammograms, and much less painful.

Among those studies is the 2006 research of The Cone Beam Breast Computed Tomography scanner, which takes 360-degree views of breast anatomy, with no need to compress the breast between cold glass plates. It is a new kind of test to screen for breast cancer. “We have one case in which a cancer shows up phenomenally well using this new imaging system, whereas when you look at the same lesion on a mammogram, it is hard to detect,” said study leader Dr. Avice O’Connell, Director of Women’s Imaging at the Highland Breast Imaging Center, on release of the study.

Their new scan produces three-dimensional pictures, which are better at showing whether a spot on the X-ray is benign or malignant, the researchers at the University of Rochester in New York said. It can also provide pictures of tissue around the ribs and outer breast toward the armpit, where 50 percent of cancers are found, the researchers told a Radiological Society of North America meeting in Chicago.

**PET/PEM has a role both before and during treatment**

According to Jacqueline Brunetti, M.D., Associate Professor of Clinical Radiology, Columbia University, PET imaging is a clear advance in the approach to staging and monitoring breast cancer. Positron imaging offers better accuracy than conventional imaging in the identification of metastatic disease both in the initial staging of breast cancer and in follow-up.

In the future, further refinements in scanner technology and new radiopharmaceuticals will likely result in better identification of smaller lesions. Dedicated breast PET/CT or PET/Mammography units show promise in improved detection in primary breast cancer, while also providing a method for image guided biopsy.

Also known as PEM (Positron Emission Mammography), De Paredes says that it’s a technology somewhat similar to an MRI in that it’s used in a cancer patient to look at the extent of a tumor, but it hasn’t been studied by any means to the degree that MRI has.

PEM is believed to be of great value in the preoperative identification of non-invasive breast cancer called Ductal Carcinoma In Situ (DCIS), which is often difficult to quantify with mammography and MRI. PEM has been reported to have a 91% sensitivity for DCIS which far exceeds all other imaging modalities.

Another recent nuclear modality which has proven useful as a second step, if the initial mammogram is inconclusive, is Breast-Specific Gamma Imaging (BSGI). A small amount of the radiotracer Technicium Tc 99m, is delivered to a patient. Due to the higher metabolic activity of cancerous cells, those cells absorb a greater amount of the tracing agent and are revealed as “hot spots.” BSGI captures the cellular functioning of the breast tissue, and is particularly useful for patients with dense breasts.
CAD – the radiologist shortage is giving it a boost

Over the past two decades, computer-aided detection and diagnosis (CAD) has been developed to help radiologists detect suspicious changes on mammograms, and this has really taken off with the growth of digital mammography.

“CAD is a hot topic,” says Hall. “It’s the one reimbursable by most insurance companies. With a shortage of radiologists and most sites wanting two readings, if you don’t have enough doctors, the computer can help you look.”

Computers can help doctors identify abnormal areas on a mammogram by acting as a second set of “eyes.” For traditional mammograms, the film is fed into a machine, which converts the image into a digital signal that is then analyzed by the computer. Alternatively, the technology can be applied to an image captured with digital mammography. The computer then displays the image on a video screen, with markers pointing to areas that the radiologist should check closely.

A recent study, published in the April 2008 *American Journal of Roentgenology*, confirms that CAD is useful in screening mammography. The study compares a single reading with CAD to double readings of screening mammography studies. After considering more than 200,000 mammograms, researchers concluded that CAD, compared to double readings, results in lower recall rates, which was the point of contention. CAD enhances the performance of a single reader with only a small increase in recall rate. A previous *New England Journal of Medicine* study suggested that increased CAD false positives were evidence of inaccuracy, leading some insurers to consider dropping CAD reimbursement at least temporarily.

The study finds that, compared with a double reading, single-read CAD resulted in a slight increase in sensitivity at a lower recall rate. Double reading increased sensitivity as well as recall rate when compared to a single reading. (The North Carolina radiology group that conducted the study had switched from double reading to a single reading with CAD.)

The larger volume of film-based CAD studies in the newer research may suggest it supersedes the NEJM study. To read more about the AJR study as originally reported in DOTmed Online News, visit dotmed.com/dm5468.

*Schroeder has invested in CT because he believes it takes a good modality and makes it better. “I’m looking at this and saying, X-rays work now, so a better X-ray seems to be the most logical next step.”*

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**Mobile mammography**

Of the 1700-plus systems sold last year in the U.S., Hall says that less than 50 were for mobile units, but that doesn’t stop Hologic from offering a digital system designed for mobile transportation units, which help hospitals and facilities that may don’t have the money or the need for a system full-time.

The mobile digital mammography van operated by Woman’s Hospital in Baton Rouge, LA, for instance, performed 5,000 mammograms using Hologic’s technology.

In years past, the crew would drive a small van to a remote site, take the analog equipment out of the van, and set it up in the building that would host the screening. With digital, there’s no such portability.

Michael Dobbins, President of Mobile Conversions, Inc., which supplies four different mobile vans throughout the U.S. to universities and breast screening centers, saw the need to switch to digital two years ago, despite the challenges the mobile units faced.

“Digital is what is popular now and better diagnostic readings can be made by the doctors. Digital mammography equipment has much more stringent requirements than analog when it goes mobile,” Dobbins says. “It has to be environmentally maintained. The generator has to operate as you go down the road, air conditioning has to operate as you go down the road… more sensitive shock and vibration issues have to be figured out.”

Their mobile mammography equipment visits more than 6,000 locations each year. “We’re inspired by what we do,” Dobbins says. “We are doing the public some good.”

DMS Imaging, in partnership with rural hospitals throughout northeast North Dakota and Northwest Minnesota, is bringing full-field digital mammography to women across the region as well.

“The mission of DMS Imaging is to make a difference in the lives of our patients. We believe all people, no matter where you live, deserve access to cutting-edge health services,” says Paul Wilson, CEO of DMS Health Group, the parent company of DMS Imaging. “This gives rural facilities the ability to provide its patients with the highest quality care, without having to invest in the purchase of capital equipment. They likely don’t have the patient load to justify having the service available every day, but having the service one or two days a week means their patients don’t have to travel to a facility that has the technology available. It’s a win-win for the patient and the facility.”

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**Money matters**

On top of the different clinical capabilities of all this imaging equipment, the capital costs have to be taken into account. For instance, a new MRI will run around $2 million, a breast CT is $700,000, and a mammography system runs $100,000 for analog to around $300,000 for digital.

When it comes to Medicare reimbursements, the numbers look roughly like this: an analog mammogram is around $85, digital mammogram is $125, CAD is $15-$20, ultrasound is less than $100, and MRI is around $1,000.

**The refurbished market**

Since digital mammography is three times as expensive as film, there are a lot of hospitals and facilities that are looking to refurbished equipment to update their existing equipment. The same can be said for all imaging modalities.

“The refurbished market is good for us,” McGinty says. “People are looking for a lower cost entry point in digital and certainly the refurbished market is a way to do it. We probably get 50-60 percent of what the OEM got upfront. In the case of Digitec, you get a 12 month warranty with the system.”

Christopher Cone, CEO of Echoserve, a field service company and repair depot for ultrasound equipment and probes, as well as mammography equipment, says he sees a high demand for refurbished digital mammographic equipment. “It’s difficult to find equipment on the aftermarket,” he says. “I would guess that the vast majority of refurbished mammo equipment sold is still conventional analog.”

Krista Kotrla of Block Imaging International, Inc. says the company has seen their mammography sales increase dramatically in 2008. “A large part of our Women’s Health business in mammography is done overseas, or in Latin America where
the demand for analog is still very high,” she says. “Domestically the demand from end users has been digital and that is where the focus has shifted.”

**The overseas market**

Many countries outside of the U.S. are also switching to digital mammography, but some are taking a while to get there. South America and Latin America, for instance, are still using analog.

“The Netherlands and the Scandinavian countries were early adapters [of digital],” Hall says. “If you start looking at other countries in Europe, say at France, Germany, and the UK, because of the way their healthcare systems are set up, they have just gotten approval for buying digital for the whole country. But it will be a multi-year process before digital mammography is dominant in any of those places.”

McGinty says that in some countries, like Japan, they are going to computed radiography (CR), which is a step between analog and digital. “It’s not as high quality as DR, but it’s very good, and we find a lot of people using CR as an entry point.”

**The future of mammography**

In addition to the modalities already discussed, there are some other things that could be making some noise in breast diagnostics in the next 5-10 years.

“I think in terms of imaging the breast, the thing that is coming on the horizon is tomosynthesis, which potentially could become a significant screening tool,” De Paredes says. “It’s a form of mammography based off of digital mammography.”

Digital tomosynthesis takes multiple X-ray pictures of each breast from many angles. The breast is positioned the same way it is in a conventional mammogram, but only a little pressure is applied—just enough to keep the breast in a stable position during the procedure. The X-ray tube moves in an arc around the breast while 11 images are taken during a seven-second examination. Then the information is sent to a computer, where it is assembled to produce clear, highly focused three-dimensional images throughout the breast.

According to Schroeder, this is very similar to breast CT. “Both use X-ray to create a three-dimensional set of slices of the breast tissue. They are very similar in theory but each may have pros and cons versus the other,” he says. “Tomoynthesis is more similar to a conventional mammogram so the transition could be easier to integrate into current centers. However, tomosynthesis may have some challenges to overcome since it uses only a portion of the three dimensional information available to CT scanners. Both modalities will need to be developed with attention to limiting radiation doses.”

“GE has done much of the pioneering work in making digital mammography the new standard and is a leader in the race to bring tomosynthesis to market,” Schroeder says. “Even as digital mammography is ultimately replaced by a new tool, whatever that may be, it was a necessary step in the evolution of breast cancer screening.”

“I think tomosynthesis has a lot of potential,” De Paredes says. “There are a number of facilities testing it, but it is not FDA approved yet, so it’s still in the investigational stage.”

Researchers believe that this new breast imaging technique will make breast cancers easier to see in dense breast tissue, and will make breast screening more comfortable.

“What all these improvements in imaging really do is to refine image,” Schmitt says, “but once you see something, you’re already in trouble. In the ideal future, the goal will be to find it without imaging. What you want to do is find it before it turns into cancer. Whether that can be done through blood testing or some other type of testing, I don’t know. What you want to do is predict and interdict the cancer, to stop it before it starts, because once you can image it, it’s too late.”
DOTmed Registered Mammography Equipment Sales and Service Companies

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Anesthesia Machine:
529311 - DRAGER Narcomed GS
Anesthesia Machine $17,500 Multiple units available. Jerry Riley, Heartland Medical Sales and Services

Arthroscopy Shaver System:
529264 - DYONICS EP-1 Complete Arthroscopy Shaver System $1,600

Autoclave Tabletop:
529487 - MIDMARK m9 ultraclave Autoclave Tabletop $2,500

Autorefractor:
529179 - CANON R-10 Autorefractor $1,800
The Canon R-10 functions perfectly but the top covers have a small chip. Karen Forman, Long Island Ophthalmic Service

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470286 - HILL-ROM P1900 Total Care Beds Electric $5,000 beds available with and without air. Damon Dembkoski, Beta Medical, 786 506 1878

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Duodenscope:
515119 - OLYMPUS JF-130 Duodenscope This is an Olympus JF-130 Duodenscope recently taken out of hospital service. Sam Scrofani, Supplemedical

EKG:
499256 - SCHILLER AT-2 Light EKG $1,675 CardioTech 200, also known as Schiller AT-2 Light. Gordon Huckenstein, Cardiac Direct

EP Lab/X-Ray Room:
499733 - PRUCKA/GE Cardiolab 7000 EP Lab/X-Ray Room GE/Marquette, Cardiolab 7000 Electrophysiology, recording system, Maclab/Cardi, Phil Lonbeck, DB Medical Electronics, 909 861 3157

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452154 - UNKNOWN Lam Probe 4000 Electrolysis Machine $4,995 Lam Probe Model 4000 Brand New Machine - our favorite seller! Every client you have needs this machine and that generates revenue. Mark Lynch, Wholesale Medical and Spa Equipment

Endoscope:
511347 - OLYMPUS CF-Q140L Endoscope $2,500 Good condition; 90 day warranty; Ready to ship with newer case, valves, manual. Mike Solot, Kingsbridge Healthcare

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452828 - RITTER 75E Model 230-004 Exam Chair $6,000 With foot pedal and hand boards. Joseph Kroslak, Kroslak Enterprises

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529053 - V. MUELLER 89-8950 O/R Instruments in search for a fast clamp endoscopic clamping system or something similar. Seema Talati, Surgery Center of Santa Monica

O/R Light:
529096 - HERAEUS Hanaulux 2005 O/R Light $3,500 Set of Heraeus Hanaulux 2005 lights with Hanauport arms and Hanauvision Camera. Dwayne Carlyle, Ideal Medical LLC

O/R Microscope:
529178 - ZEISS O/R Microscope $9,000 Zeiss OPMI MDU XY Surgical Microscope S3 stand Otherwise this microscope looks good. John Ross Campbell, John Ross Campbell

O/R Table:
529192 - SKYTRON S001 Hand Control O/R Table S700 Re-conditioned Skytron 5001 Elite Hand Control, 30 day warranty. Crystal Leroy, Blue Horizon Medical

OB / GYN - Vascular Ultrasound:
459094 - GE Voluson 730 BT05 OB / GYN - Vascular Ultrasound GE Voluson 730 BT05 EXPERT 4D OB/GYN Ultrasound Machine with two volume probes. Abe Sokol, Absolute Medical Equipment, 800-436-4173

OB / GYN Ultrasound:
528739 - GE Logiq 200 OB / GYN Ultrasound $7,500 GE Logiq 200 Ultrasound used in excellent (Like-new) working and cosmetic condition. Kristopher Kaestner, Professional Medical Systems, Inc.

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529039 - OPTOS P200 Ophtalmoscope $17,500 Optos Panoramic 200 Non-Mydriatic Ophtalmoscope is an ultra widefield digital imaging device. David Bullington, Bullington Associates, Inc

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529214 - Pajama top & Bottom Other $20 new hospital pajama top and bottom. Jeffery Agyepong, Allied medical equipment company

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529563 - WELCH ALLYN 74710 Otoscope $255 Good working condition, have three available, complete. John Peate, 18th Street Medical

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218373 - NELLCOR n 395 Oximeter - Pulse $499 Used units in EXCELLENT CONDITION! inspected, tested, and ready for use! Abe Sokol, Absolute Medical Equipment

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463761 - GE AMX 4 Portable X-Ray $4,000 Year of manufacture 1990, in great working condition available for immediate shipment. Mudi Ramesh, Anamika Medical

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455982 - BENNETT 12000P Rad Room $25,000 Bennett Rad Room with 4-way float top elevating table w/bucky, chest stand, over-head tube crane, 3 phase high frequency generator. Gregg Jones, Accurad Medical Imaging

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450944 - OLYMPUS ENF-P4 Rhinolaryngoscope $4,000 Olympus ENF-P4 with 0 broken fibers. Jacob Glaser, Endoscopy Specialists, Inc.

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360311 - ZEISS G300Z Siltlamp $9,000 Specification Microscope: Type: Galilean magnification, 13 degree binocular tu. Zhang Annie, AuMed Group Corporation

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437528 - LEICA CM1850 Tissue Processor $255 Looking to purchase a Leica CM1850 Cryostat in working condition. Rob Rankin, Rankin Biomedical Corporation

Ultrasound Transducer Ultrasound:
512469 - SIEMENS VF10-5 Ultrasound Transducer Ultrasound $122,850 PROOWNED LIEBEL-FLARSEHIM HYDRA VISION PLUS DR UROLOGY ULTRASOUND with Hanauport arms and Hanauvision Camera. Wayne Horsman, Columbia Imaging Inc

Ventilator:
464428 - PULMONETIC SYSTEMS LTV 900 Ventilator $125,000 Patient ready with all paperwork and 90 day warranty - contact sales@e-inventorysolutions. John Wittenberg, Inventory Solutions, Inc.

Video Endoscopy:
516917 - STORZ Telecam 202121 20 Video Endoscopy $900 Telecam Camera Box only; Excellent condition. Mike Solot, Kingsbridge Healthcare

X-Ray Accessories:
529173 - X-RITE 820TR X-Ray Accessories $795 X-Rite 820TR densitometer. Dave Hill, A to Z Medical, Inc.

X-Ray Tube:
529293 - GE Performix X-Ray Tube $22,500 June 2001 Low Use CT Tube Warranted to work. Scott Anderson, CT Resources LLC

PARTS FOR SALE

C-Arm:
225482 - OEC C-Arm Part #00-879322-XX OEC 9800 C-Arm Interconnect Cables OEC p/n #00-879322-XX we service -01 / -02 / -03 / -04 / -05 and all custom lengths needed. Kenneth Saltnick, Engineering Services

CT Scanner:
515361 - GE CT Scanner Part #2253562 New part ordered from GE and never used. Richard Dishman, MPX Sales and Service, LLC

Rad Room:
179997 - PICKER Rad Room Part #3915 Used, guaranteed working MTX Control Console. Wayne Horsman, Columbia Imaging Inc

Viewbox Motorized:
302772 - AMERICAN MEDICAL SALES Viewbox Motorized Part #330-00-050 Hard to find parts for R2 ImageCheck motorized viewers. Daniel Giesberg, American Medical Sales

X-Ray Generator:
527940 - SIEMENS X-Ray Generator Part #4680047 $5125 Used, from working system. Wayne Horsman, Columbia Imaging Inc

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EMPLOYMENT OPPORTUNITIES

#528990 - Radiology Position - Georgia, USA - Board certified general radiologist to cover one hospital and three imaging centers.

#527895 - Physician Position - Virginia, USA - Private Practice for SALE or OP-TION -to-Buy, EQUITY Partnership! Call Janet Haley at 800-978-7633.

#475744 - Long-Term Care Administration – Wisconsin - Confidential Search for experienced Nursing Home Administrator in a large facility.

#528735 - Laboratory Service Engineer - Washington, USA - 50000 - 65000 + Over-time + Auto Opportunity to join an organization specializing in clinical instrumentation utilized in medical laboratories.

#475950 - MRI Service Engineer – Florida - Immediate opening for a qualified service engineer, 3-5 years service experience on Siemens CT and/or MRI systems. Contact Mike Ghazal, Zetta Medical Technologies, 847-550-9990

#517205 - Nursing Position - Montana, USA - $41,000 - $60,000 Full-time position for Long Term Care Registered Nurse in scenic, pristine rural western Montana. Please email resume to cambagis@cfvh.org

#517085 - MRI Service Engineer - Dallas, TX - MRI OEM looking for Customer Support Specialist. Duties include install of MRI system and ancillary hardware and software. Call Bill Kearns at 831.287.9001 x26

#516255 - Surgical Position - Connecticut, USA - Position is to identify, develop, and launch new products, as well as continued maintenance for existing products.

#527868 - Anesthesiology CRNA Position - S. Central PA - $140K Salary + Numerous benefits, CRNA needed for Salaried Position for a busy Outpatient Surgery Center. Call Janet Haley at 800-978-7633

#51481 - Dialysis Position – Germany - Client looking for experienced dialysis nurse fluent in English and German for Quality Management position

#499246 - Neonatal Position - California, USA - Rare NNP Opportunity for growing and developing NICU part of the 10th largest free-standing Children’s Hospital in the nation. Tim Mattis, ENSearch Management - 888-667-5627 x14

#477214 - Nursing Technician – Savannah, GA - Staff Registered Nurse (RN) provides direct and indirect patient care based on the nursing process. Laura Ellis, Memorial University Medical Center, 912-350-7206

#456531 - Cardiology Technician - New Hampshire - Our client in New England is looking for an Echo Tech for a Mon. to Fri. day position. Perm position and there is no call.

For more information on any of these listings, visit www.dotmed.com and enter the Listing # in any search box. You can post a free classified ad on DOTmed.com. Just visit our website and register.

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Recent equipment and parts auctions on DOTmed with actual for-sale prices.

### CT
**Picker CT Mobile PQ5000**
- Axial and Helical Capabilities: Helical - 1 second scan time 1.2,4,5,8,10 Slice Thickness 30 degree tilt range on gantry E Z EM
- Percu-Pump injector PAC's Capable - Kodak Dryview Laser Camera DAT Datas Tetps- Archive 1985
- E&W Trailer - Refurbished in 1994 Tube is 5 1/2 years old with 1.3+ million exposures CT is a 1994 with an upgraded PQ5000 gantry from 1996 System and trailer are in good condition CT was checked by Philips and was reported to be operating within specifications.
- Trailer is in good shape with some surface rust and normal wear. Auction 4783 - sold for dealer in Georgia, $9,000.00

**KKT Kraus CT Chiller KPC 108-L-US**
- This system is for outdoor use. This unit was pulled from an operating 4 slice CT system in April 2008. Auction 4930 - sold for dealer in New York, $3,500.00

### MRI
**Electro Impulse MRI Chiller 49660-480-UL** for Picker Outlook
- Specifications: Series RU Cooling Capacity 25 KW Primary Coolant Ethylene Glycol/ Water Primary Coolant Loop: Coolant Composition EGW Reservoir Capacity 5 Gal (Approx) Flow Rate (Nom) 8 GPM Supply Temp (Adjustable) 18C Supply Press (Nom) 95 psig Blocked Discharge Relief Press (Adjustable) 120 psig Pump Type Centrifugal Wetted Path Materials Brass, SS, Nickel Ptd Brass, Copper, Viton, Buna-N, Synthetic Elastomers Secondary Coolant Loop: Refrigerant R-22, Approx. 70lbs Compressor Type Hermetically Sealed Compressor Rating 10 hp, 3 Phase Condenser Type Air Cooled Condenser Fan Motors 3/4 hp, 1 Phase Miscellaneous: Ambient Temp -20 to +40C Voltage 480VAC, 3 Phase, 60Hz Current 30A Interlock AC Failure, Loss Of Power Low Coolant Flow Composer Fault Coolant Over Temp Low Cool Temp Level Electrical Box Door Controls & Indicators Circuit Breaker Indicator, Low Reservoir Level Indicator, Low Flow Indicator, Over Temp Indicator, Unit On Indicator, Main Power On Controls & Indicators Inside Electrical Box Switch, Compressor On/Off Fuses Switch, Remote On/Off Temperature Controller Electrical Box, Under-side AC Power Access Interlock Access Front Panel Supply Temperature Gauge Supply Pressure Gauge Reservoir Level Gauge Rear Panel Connections Coolant Supply, 1” NPT Female Coolant Return, 1” NPT Female Dimensions (Approximate) Weight: 850 lbs Height 38” Length 74” Width 26” Auction 3336 - sold for dealer in New York, $10,000.00

**Arctichill MRI Chiller MACH/PV/1003559**
- This chiller is stored in a Texas at a DOTmed Certified company's facility. Auction 4931 - sold for dealer in New York, $1,500.00

**Siemens MRI Scanner Open Viva** Installed 5/1995, upgraded to OPEN VIVA 4th quarter 1999. Software version VB33 is Included: Operating manuals Coils: Transmit coil integrated into magnet Receive coils: Quadrature head Volume coils: Body/Spine...four sizes...-30/55/39/48cm (diameter) Multi-purpose coils...3 sizes-- 11cm, 16cm and 45 cm (diameter) Misc. coil holders/reg bolster/OEM phantoms. Auction 4941 - sold for imaging center in New York, $37,000.00

**GE MRI Scanner Contour / Excite I / Excite II / Lx / Mri Parts Kit**. This auction includes the following parts:
- Auction 5039 - sold for dealer in Tennessee, $950.00

### C-Arm
**OEC C-Arm 9000**
- Unit shows battery error when powering on. Unit will not power on due to this battery error. Auction 4936 - sold for medical office in New Mexico, $4,000.00

### Monitors
**Ohmeda Box 3700 SA02 Pulse Oximeter**
- Features:
  - highly visible backlit display panel, oxygen saturation display, pulse rate display, alarm level (pulse rate and oxygen saturation), display Waveform and signal strength indicators, adjustable high and low alarms for both pulse rate and oxygen saturation, trends 20/60, displays either the last 20 or 60 minutes of oxygenation data, outputs real-time data digitally to either a printer or computer, outputs real-time analog information to chart recorder. Auction 4509 - sold for dealer in West Virginia, $149.99

### Ultrasound

### Homecare/Rehab
**Air Sep Corporation Oxygen Concentrator New Life** 5LPM 11,800 total operational hours, new filter. Auction 4877 - sold for dealer in Florida, $225.00

### Laboratory
**Abbott Labs Hematology Analyzer Cell Dyn 1700**
- This is a 3-part differential analyzer offers throughout suitable for the medium-volume lab. Throughput is 60 samples (CBCs and diffs) per hour, 18-parameter menu includes WBC, Hb, Hct, MCHC, P3t, RBC, RDW, MPV, MCV, MCH, G4, G%, Mid#, Mid%, lymph%, and lymph%. This instrument is an open system and the method of measurement is volume impedance. Stores up to 5000 results. Supports EIA standard RS-232C LIS interface format. Includes built-in computer with color monitor, hard drive, printer, and manuals. Dimensions are 33”x w x 20” x 18” (84 x 51 x 46cm) and it weighs 145 lbs (66 kilos). Auction 4844 - sold for medical office in Virginia, $2,990.00

### Pumps
**Alaris Pump IV Infusion 7130**
- This price is for ten (10) Alaris 7130 Infusion Pumps. Auction 4851 - sold for hospital in New York, $6,000.00

**Abbott Labs Pump IV Infusion PMP (Lot of 205)**
- 111 Pumps are in working condition, 94 Pumps have some damage or are not working, Auction 4952 - sold for hospital in New York, $8,000.00

### Imaging - Misc.
**Radionics Stereotactic Radiotherapy Head Ring, Clamping Plate, Collimators**
- You are bidding on a Lot of Stereotactic Equipment manufactured by Radionics and Northwest Medical Physics. Age - 5 years. Condition: Very good. The following Radionics items are included in this Auction: 1 releasable Head ring Relocatable Head Ring Radionics # GTC 1 ct clamping plate Clamp Plate for Medtech Couch. Radionics # CTC 1 ct localizer frame Radionics # BRW-LP 1 linac couch mount adapter Radionics # LCM1 1 localizer system Radionics # LATL-SYS 1 rectilinear linac phantom base Radionics # RLP. Auction 4859 - sold for hospital in Wisconsin, $6,000.00

### Defibrillators
**Cardiac Science Defibrillators 9300E-001 Power Heart AED G3 Automated External Defibrillator** Works 100%. Open case and the lights work with audible instructions. Comes with two sealed #9131 Electrode packets. Auction 4891 - sold for dealer in Pennsylvania, $249.99
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• Calibrates like the original

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New 80,000 scan warranty

For more information go online for a datasheet, or contact your preferred dealer.

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