

The BEAM

Winter 2017

Mississippi Society of Radiologic Technologists *Affiliated with the American Society of Radiologic Technologists*

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MSRT Members,

I am truly honored and grateful for the opportunity to serve as President of the Mississippi Society of Radiologic Technologists for the upcoming year. It is a blessing to be part of such an outstanding organization. Because of the dedication and hard work of the MSRT's Board of Directors and its members, our society is strong and continues to grow. I look forward to working with the Board of Directors to ensure our tradition of strong leadership continues.

I want to thank everyone who worked tirelessly behind the scenes to make sure the MSRT's 76th annual conference was such a success. I would also like to thank the speakers, technologists, and students who participated in the multitude of events throughout the three days of conference. Congratulations to those who presented papers, submitted exhibits, or competed in the student prep bowl.

I want to strongly encourage all members to become involved in the MSRT as well as the ASRT. Being a member is important; however, membership is only the beginning. There are numerous volunteer opportunities in both societies. As President, I am actively looking to expand the leadership of our society and create opportunities for all members willing to serve. If you are interested in volunteering and would like more information, please contact any member of the MSRT Board of Directors. Also, consider attending our next Board of Directors meeting on January 20, 2018. This will offer you an inside look at the way the MSRT operates, and it is a perfect time to discuss leadership opportunities.

Again, I want to thank everyone for their support. I am proud to be a member of the MSRT and I look forward to a productive and exciting year serving as President.

Sincerely,

Lee Brown, MHIIM, R.T. (R)(N), CNMT, RHIA

MSRT President

TECHNOLOGIST OF THE YEAR!!



John "Ron Jon" Melvin



REPORT FROM THE NORTH DISTRICT

NEW OFFICERS (PICTURED)



PRESIDENT
LEIGH MOSER



VICE-PRESIDENT
JESSICA REID



SECRETARY
SHERRY CRAIG



TREASURER
KATHY STEGALL



REPORTER
RITA FRASER

On Thursday, February 1, 2018, the North District held a meeting to elect officers for this New Year. This year's elected officers are Leigh Moser (President), Jessica Reid (Vice President), Sherry Craig (Secretary), Kathy Stegall (Treasurer), and Rita Fraser (Reporter). Chuck Busby and his wife, Shirley, attended to assist in starting the planning of the annual conference scheduled for Tupelo October 2018.

Respectfully submitted by Rita Fraser.



Mississippi Society of Radiologic Technologists

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The **MSRT Business Meeting** for the 76th Annual Conference was held at The Hard Rock Hotel and Casino in Biloxi, MS, on October 24, 2017. Dr. Kristi Moore, President of the MSRT, welcomed those present and thanked everyone for attending conference.

A quorum was established and the meeting was called to order by the MSRT President, Dr. Kristi Moore, at approximately 5:00 p.m.

The minutes from Conference 2016 were accepted as published in the BEAM.

The following reports were given:

1. Treasurer:
 - a. Please refer to Appendix A for Annual Financial Report that was presented at the business meeting.
2. Vice President: Nothing to report.
3. Secretary: Nothing to report.
4. Editor of The Beam:
 - a. The Summer 2017 Beam has been published.
 - b. The Editor requested that pictures for the winter edition be emailed as soon as possible.
5. Executive Secretary/Website Administrator:
 - a. Refer to Appendix C for the Executive Secretary/Website Administrator Report.
 - b. Membership is down a little from this time last year.
 - Active Members (RTs)- 117
 - Associate Members- 1
 - Honorary Members- 2
 - Life Members- 10

6. ASRT Affiliate Delegates: Lee Brown and John Melvin represented the MSRT as ASRT Affiliate Delegates at the June 2017 ASRT House of Delegates Meeting in Orlando, FL.

a. The report can be found in the summer 2017 issue of The BEAM at www.msrt.biz.

7. Operating budget:

a. John Melvin, Chairman of the Board, presented the proposed operating budget for 2017-2018 that was approved by the board. (See Appendix B)

8. President:

a. There were about 41 scientific manuscripts submitted this year.

b. She attended the 2017 ASRT Annual Governance and House of Delegates Meeting in Orlando, FL.

-The meeting was good. She enjoyed the networking and opportunity to learn about the society.

9. Conference Coordinator/Conference Chair:

i. The cost is up on the sound equipment for conference.

ii. Donations given and booth space rental totaled \$2,400.00.

10. Nominations

a. President- Lee Brown and Leigh Moser

b. Vice President- Asher Beam

c. Secretary- Mandy Pearson

d. ASRT Affiliate Delegate- Shazowee Edgerton and John Melvin

i) Election held for President and ASRT Affiliate Delegate.

- Lee Brown was elected President.

- Shazowee Edgerton was elected as ASRT Affiliate Delegate.

11. Education

a. Prep Bowl Rules

i). Presented by Dr. Kristi Moore. Please refer to Appendix F to review the rules and regulations.

- The competition consists of four (4) rounds of categorical questions weighted in approximate proportion to the current ARRT Registry content for each category.

- The participating students will now hold up one card per team when time is called to submit their answer choice.

ii. The presented rules and regulations were approved by the board.

12. Training Session Coordinator

a. Refer to Appendix E for the report from the Training Session Coordinator.

b. A session is scheduled for the weekend after conference in Picayune.

With no further business to be discussed, the meeting adjourned at approximately 5:30 p.m.

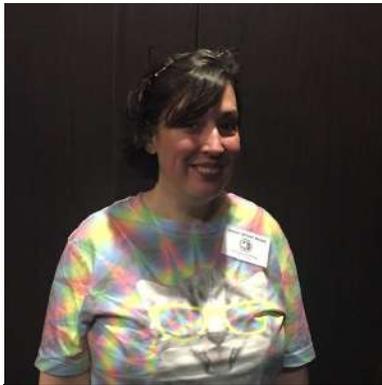
Respectfully submitted,



Mandy Pearson, M.H.S., R. T. (R)

MSRT Conference Speakers

2017



Asher Street Beam



Patricia Brewer



Catherine Cooper



Richard "Fuge" Fucillo



Melissa Jackowski



Jordan Johnson



Mike Ketchum



Susan Reyes



Deborah Shell

Donna Cleveland (Not Pictured)

Student Papers were mailed to three (3) out-of-state judges for the student manuscript competition. Pictured below are the six students whose papers were selected for manuscript competition.

- **"Radiology as a Battlefield Modality" by Amber Chandler**
- **"The Nervous Killer" by Christian Chirinos**
Received 3rd Place
- **"Pediatric Rhabdomyosarcoma" by Toni Leverette**
Received 1st Place
- **"The Butterfly-Shaped Gland and its Function in the Body"**
by Kathleen Lott
- **"Rock Hard" by Hayden Sistrunk**
- **"A Burning Candle without a Fire: Melorheostosis"**
by Brittany Walters
Received 1st Place



Left to Right - Christian Chirinos, Toni Leverette, Brittany Walters, Kathleen Lott, Amber Chandler, Hayden Sistrunk

Student Manuscript: 1st Place Recipient Toni Leverette (UMMC)

Abstract

From a young age, the only thing some children have ever known is being stuck with needles, given strong drugs that make them weak, and being told to sit through long unexplained exams. No child should have to endure the hardships that cancer brings. Rhabdomyosarcoma (RMS) is a common form of soft tissue cancer that invades the muscles; it can be benign or, as the worst case scenario, spread very quickly. RMS can affect any age group, mostly pediatrics, and it can occur abruptly. Many modalities can detect this disease while it is in its early stages and treat it accordingly. The long term effects of rhabdomyosarcoma are life changing and from which are hard for children to recover. In most cases, recovery is not an option. As sad as it may be, the chance of survival for these children depends on how hard they fight; but honestly, as a child, fighting for one's life should not be a daily reality.

Pediatric Rhabdomyosarcoma

Rhabdomyosarcoma (RMS) is a specific form of cancer that invades the soft tissues and muscles of pediatric patients. RMS affects the voluntary muscles, also known as the skeletal muscles. Because this particular group of muscles can be found all over the body, rhabdomyosarcoma can be found anywhere in the body (Wexler, 2004). According to St. Jude Children's Research Hospital, RMS is more common in Caucasians than African Americans. There are two specific types of rhabdomyosarcoma, which include embryonal and alveolar. The embryonal type occurs in children under five years of age, typically invading the neck, bladder, and head, but can sometimes affect the vaginal area and testicles. Embryonal tumors encompass 2/3 of all RMS and have stroma-rich spindle cell histology (Balaji, Kumar, Garg, & Das, 2017). The alveolar type can be present at any age, from pediatrics through adulthood, and is the most aggressive form. Alveolar RMS resembles microscopic lung alveoli, but is solid in appearance (Egas-Bejar & Huh, 2014). Overall, RMS worsens with age, but within the proper time frame can be corrected with treatment (Cavalli, Hanson, & Kaye, 2004).

Pediatric rhabdomyosarcoma is the most common type of soft tissue cancer averaging between 7.0% and 8.0% of childhood cancers (St. Jude Children's Research Hospital, n.d.). About 350 pediatric cases have been identified in the United States and around four children per every million healthy children under 5 years of age develop RMS each year (Wexler, 2004). Males are more susceptible to RMS than females, and 2/3 of the patients diagnosed are younger than 10 years of age. A few symptoms that accompany RMS include: constipation, headaches, earaches, bulging eyes, epistaxis (nose bleeds), edema (swelling), and diarrhea. Many of these symptoms are a direct result of rhabdomyosarcoma but go unnoticed because of their resemblance to general, everyday aches and pains (St. Jude, n.d.). Rhabdomyosarcoma that

occurs in the bones, lungs, and lymph nodes can be easily mistaken for other types of cancer, such as acute leukemia and lymphoma (Esmaeili & Azimpouran, 2016).

Pathologists typically sample the patient's blood as a way of determining if RMS is present, and if so, which type. Under the microscope, RMS visually resembles the cell structure of striated muscle. Rhabdomyosarcoma cultured stains contain special antibodies (proteins) that are not present in any type of cancer cell (American Cancer Society, 2014). Most of the time, a blood test is not very thorough in determining the exact type of RMS, so the physician will order a complete blood count to tally the number of white blood cells, red blood cells, and platelets. If the summation of those numbers comes back abnormal, this indicates that most likely the tumor has entered into the bone marrow, restricting the growth and development of blood cells and platelets (American Cancer Society, 2014).

Patients who have RMS invading their extremities, normally have a narrow survival rate (Esmaeili & Azimpouran, 2016). "When discussing cancer survival statistics, doctors often use a number called the 5-year survival rate. The 5-year survival rate refers to the percentage of patients who live at least 5 years after their cancer is diagnosed" (American Cancer Society, 2014, para. 2). There are three categories embedded into the 5 year survival rate: low risk, intermediate risk, and high risk. Overall, 90% of patients in the low risk group are usually cured and are given a greater possibility of living a longer lifespan. Most patients who are categorized within the intermediate risk group are 60%-80% more likely to survive, depending on the locality and severity of the tumor. The high risk group accounts for 20% to 40% of patient survival, which ultimately depends on the following three factors: the location of the tumor, age of the patient, and stage of cancer in which it was diagnosed (American Cancer Society, 2014). The prognosis for a cure in the high risk group is extremely low (Wexler, 2004).

Rhabdomyosarcoma can be evaluated in numerous ways with the aid of radiology. The first test that physicians perform involves a thorough history and physical examination (Wexler, 2004). An open biopsy of a suspected mass is often used to confirm the diagnosis of rhabdomyosarcoma (Egas-Bejar & Huh, 2014). Chest x-rays can assist radiologists in ruling out the spread of cancer into the lung field. The lungs are the first target area; however, bone and bone marrow can also be affected (Cavalli et al., 2004). Computed tomography (CT) scans can also assist by providing detailed cross sections of soft tissue, along with detecting the size and location of the tumor. Magnetic resonance imaging (MRI) is by far the best modality to rule out primary tumors. MRI uses radio waves to evaluate the head and neck as a means of ensuring that the tumor has not invaded the spinal canal or brain. Sometimes, MRI involves the injection of a contrast called gadolinium into the veins, which will provide better details of the cancerous tumor (American Cancer Society, 2014). Positron emission tomography (PET) is a nuclear medicine test given, as a means of capturing an image of the entire body to clarify the findings discovered through both CT and MRI (Wexler, 2004).

Surgery should not be the initial plan for treatment because the treatment is location dependent. There are two main ways to treat and shrink RMS cancer cells: chemotherapy (chemo) and radiotherapy (Khosla, Sapkota, Kapoor, Kumar & Sharma, 2015). Chemotherapy refers to a chemical or drug that is given by the oncologist using an intravenous method. Chemo is given within 6-12 month intervals, and within 2-10 day “pulses” which result in various side effects that are drug specific. Radiotherapy refers to the process of administering highly ionizing radiation to target a specific area of the body as a means of destroying and ultimately killing cancerous tumors. Embryonal RMS patients are required to take the maximum radiation dose of treatment to increase their survival rate. Radiotherapy is given within 4-5 day “pulses” after

chemo; it can also be taken at the same time as chemo (Wexler, 2004). “The recommended dose for microscopic residual diseases is between 36- 41.4 Gy and for those who are diagnosed with gross residual tumor, the dosage is 50.4 Gy” (Khosla et al., 2015, para. 15). The necessary treatment plan can be implemented after the cancer stage has been determined.

The prognosis of RMS is related to several different biological factors: age, site of origin, and biological characteristics. Infants tend to react poorly to treatment due to their bone marrow being the most radiosensitive to chemotherapy. This results in them being under dosed, causing their tumors to be readily destroyed (Wexler, 2004). Adolescents, on the other hand, can recover better and more rapidly than an infant due to their body’s ability to endure higher dose of radiation. More patients survive with soft tissue tumors, located on the mouth or eye versus tumors that are embedded within the abdomen or extremities. Tumor locations can be favorable such as: orbit, head and neck; non favorable tumor locations include the bladder, extremities, and abdomen (Wexler, 2004). The site of the tumor is the most important factor into determining survival. The biological characteristic factor simply refers to how well the tumor will react to radiation in terms of radiosensitive versus radio resistant (National Cancer Institute, 2016). The spread of rhabdomyosarcoma is further characterized in three categories: local, regional, and distant. RMS spreads locally when it invades the immediate tissues in the vicinity of its origin. When the cancer travels through the lymph nodes, it is said to be regional. Distant RMS is diagnosed when the tumor has entered the bloodstream, in turn reaching the bone marrow and bones (Wexler, 2004). Most of the distant metastasis of RMS travels within the blood to reach the lungs (Khosla, et al., 2015). Many complications that accompany RMS can be categorized as short term, intermediate, or long term. There are a few delayed, long term effects that are typical for RMS and develop months to years after treatment. Infertility and sex

hormone deficiency are the main two effects and are more prevalent in males than females (Wexler, 2004). Various bladder dysfunctions are very common with embryonal rhabdomyosarcoma, resulting in dribbling and enuresis (involuntary urination, especially at night with children). Radiation damage to the head and neck region is extremely dangerous, yet it is inevitable due to direct therapy. Secondary cancer, such as leukemia, is almost always present in years following treatment. Generally, 95% of all patients have had a recurrence within 3 years (Wexler, 2004).

Rhabdomyosarcoma is not a very complicated form of cancer; its genetic makeup is what makes it tough to locate at times because it can travel very fast to numerous places in the body. The tumors that appear in various locations (favorable and unfavorable), tend to behave differently to treatments. Pediatric RMS differs from adult RMS mainly because pediatric, treatment protocols are more standard and are kept at a tolerable dose. Knowing that RMS is so rare, biologists and physicians should work hard to discover a simpler and less damaging way to treat this disease. Patients need to maintain long term care and pay special attention to ensure that more serious conditions do not arise in the future.

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Radiologic technologists have the opportunity to participate in the RT category of both scientific manuscript and exhibit competitions at the MSRT Conference each year. Technologist papers were mailed to three (3) out-of-state judges for the radiologic technologist manuscript competition. Pictured below are the six technologists whose papers were selected for manuscript competition.

- "MRI Guided Radiation Therapy" by Ikia Celestine, B.S., R.T.(R)
- "The Mystery of Multiple Sclerosis" by Zack Gray, B.S., R.T.(R)

Received 2nd Place

- "Post-Traumatic Stress Disorder" by Zack Gray, B.S., R.T.(R)
- "What's the DISH?" by Layna Phillips, B.S., R.T.(R)
- "High Field MRI" by Chris Scoles, B.S., R.T.(R)

Received 3rd Place

- "Chronic Traumatic Encephalopathy in Professional Athletes" by Audrey Wilson, B.S., R.T.(R)

Received 1st Place



Front (L-R) Layna Phillips, Ikia Celestine, Audrey Wilson
Back (L-R) Zack Gray, Chris Scoles, Tyler Patrick

Technologist Manuscript: 1st Place Recipient - Audrey Wilson, B.S., R.T.(R)

"Chronic Traumatic Encephalopathy in Professional Athletes"

Chronic Traumatic Encephalopathy in Professional Athletes

Here in the south, football is a way of life. Being part of the South Eastern Conference (SEC) is a privilege southerners hold close to their hearts. During the fall season, fans of every generation countdown the minutes until kickoff, each high on adrenaline and in anticipation of how the next 60 minutes will unfold. To grow up in a football loving family, it is very common for a young boy to start playing Pee Wee football as young as seven years old and play through high school. Many young men continue playing at the college level, while only a handful of talented athletes eventually go on to play in the National Football League (NFL).

Over the last decade, discussion on Chronic Traumatic Encephalopathy (CTE) in professional athletes has sky rocketed as a result of research that was released in 2005 by Dr. Bennet Omalu (Riley, 2016). The study published in *Neurosurgery* presents autopsy results of a former NFL player that displayed neuropathological changes during the end of his life. The behavioral changes exhibited by the former athlete coincided with symptoms of multiple mild traumatic brain injuries (MTBI). After completing the autopsy and having the player's brain dissected and stained in 2002, Omalu knew he had discovered something unlike anything else. It was at that time the doctor introduced Chronic Traumatic Encephalopathy (Omalu et al., 2005).

Chronic Traumatic Encephalopathy is defined as a progressive degenerative condition of the brain caused by repetitive head trauma such as concussions (Perrine, Helcer, Tsiouris, Pisapia, & Stieg, 2017). Concussions are the most common sports related mild traumatic brain injury (The Lancet Neurology, 2014). These concussive and subconcussive hits directly to the head are believed to be the reason why several deceased NFL players developed CTE after retirement (Perrine et al., 2017). In light of the recent research by Dr. Omalu and his team, there has been increasing debate concerning the long term effects of mild traumatic brain injury in athletes. Short term symptoms of a concussion may include weeks or months of ongoing headaches and dizziness. The long term consequences include

dementia many years after trauma to the brain, which is synonymous with the symptoms of CTE (The Lancet Neurology, 2014).

Ironically, a study recognizing similar symptoms was first published in the *Journal of the American Medical Association* in 1928. The author coined the phrase “punch drunk syndrome,” which originated from the Latin term “dementia pugilistica.” This expression referred to boxers who suffered from deteriorating mental capabilities, confusion, and slowing of speech as a result of multiple concussions (Brain Injury Research Institute, 2017).

Chronic Traumatic Encephalopathy has two major components: the symptomology that the affected person exhibits during the latter part of his life, and the pathophysiology that is identified in the brain during a postmortem examination. The symptomatic characteristics of CTE may include depression, mood swings, confusion, dementia, personality changes, aggression, impulse control problems, substance abuse, paranoia, memory loss, and suicidality (Gaetz, 2017). The pathophysiology aspect of CTE that is found only during an autopsy is representative by tangles of tau protein in the brain. Tau is vital in supporting and sustaining certain structures inside brain cells, such as the cell’s internal transport system. Repetitive head trauma may cause tau protein in the brain to misfold and change shape. The mutated tau then moves into the cell, which starts a chain of events that causes the protein to cluster together. These tangles of protein begin deep in the sulci of the cortical folds around the blood vessels. As CTE progresses, the tau bundles disperse to other regions of the brain and eventually take over the entire organ in the late stage of the disease (Concussion Legacy Foundation, n.d.). A few gross pathological indications of an infected brain consist of enlarged lateral and third ventricles, as well as atrophy of the frontal, temporal, and parietal lobes (Yi, Padalino, Chin, Montenegro, & Cantu, 2013). It was described by Dr. Bennet Omalu as, “..like pouring wet concrete down kitchen pipes. As it hardens, it chokes the brain, leaving him unrecognizable, even to himself” (Schaefer et al., 2015).

In recent years, experts have discovered that certain magnetic resonance imaging (MRI) sequences and tools could be of value in spotting CTE. Specifically, functional MRI (fMRI) and magnetic resonance spectroscopy (MRS) have become a significant part of this process. These specialized imaging procedures are able to distinguish between neurodegenerative diseases such as Alzheimer's, Lewy body dementia, and frontotemporal dementia (FTD). Therefore, MR may be able to differentiate between chronic traumatic encephalopathy and other neurodegenerative conditions (Yi et al., 2013). Functional magnetic resonance imaging is a safe and noninvasive imaging technique that measures and maps brain activity (University of California San Diego, 2017). Magnetic resonance spectroscopy is valuable in providing information about cellular metabolic activity in the brain (National Cancer Institute, 2017). In conjunction with MRI, these particular methods could be the key to detecting CTE before death (Yi et al., 2013).

The most important way to prevent and respond to the development of CTE is to educate athletes and the public on the devastating effects of mild traumatic brain injuries. Ongoing research will be vital in providing current information relating to both short term and long term effects of repetitive head trauma (The Lancet Neurology, 2014). The continued implementation of stricter rules and more specialized protective athletic equipment can also play a role in reducing the number of fatal head injuries received. Likewise, following strict sideline protocols after an athlete is injured can help authorities make smarter decisions on whether the player should return to the game or not (Yi et al., 2013). It is essential to remember that symptoms of a concussion do not automatically indicate brain injury. In turn, the actual neurological damage is not always accompanied by immediate signs and symptoms (The Lancet Neurology, 2014).

As of now, there is no precise imaging modality or absolute biochemical marker that can certainly and reproducibly identify the existence of early mild traumatic brain injury or the development of CTE. However, there may be ways to determine the relationship between what is seen on a diagnostic image and the severity of a concussion. This correlation may help in the long term management of athletes who have suffered from MTBI. While CTE symptoms may be treated, there is currently no treatment to stop the disease from progressing. It is the hope of all athletes, families, and fans that with further research, a treatment may be discovered (Yi et al., 2013).

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doi:10.1249/JSR.0b013e31827ec9e3

Student Exhibits



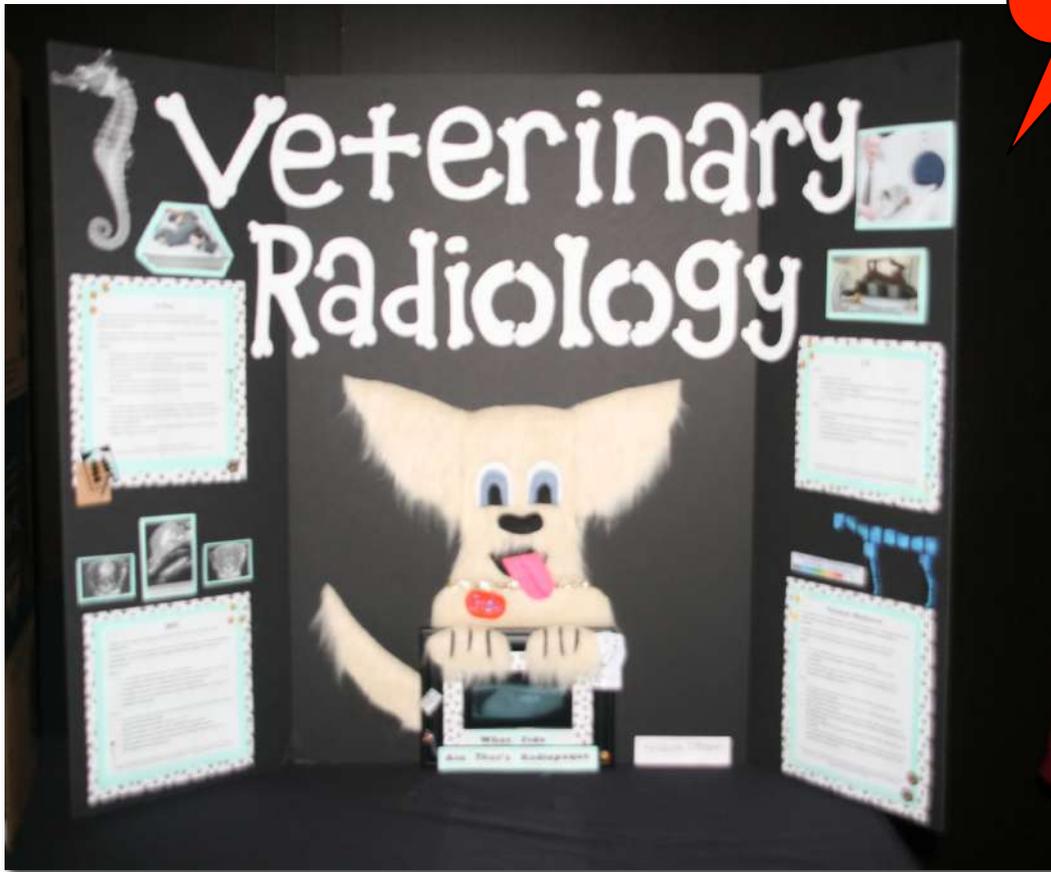
"Conjoined Twins"

1st Place

**Students: Alex Wilcher & Amy Valenciano
(UMMC)**

Student Exhibits

People's
Choice
Winner!!



"Veterinarian Radiology"

2nd Place & People's Choice

**Students: Natalie Eakes & Andrea Sims
(Co-Lin Community College)**

Student Exhibits

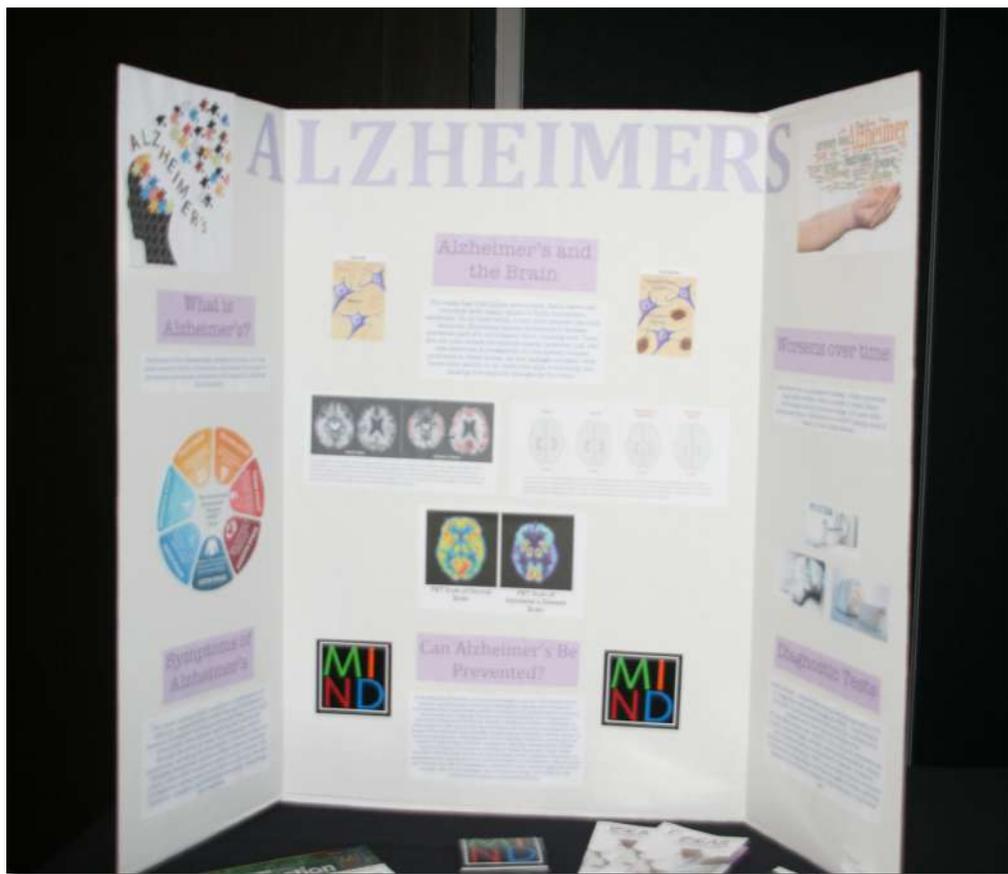


"Electromagnetic Radiation"

3rd Place

Student: Shelby Wilkerson
(UMMC)

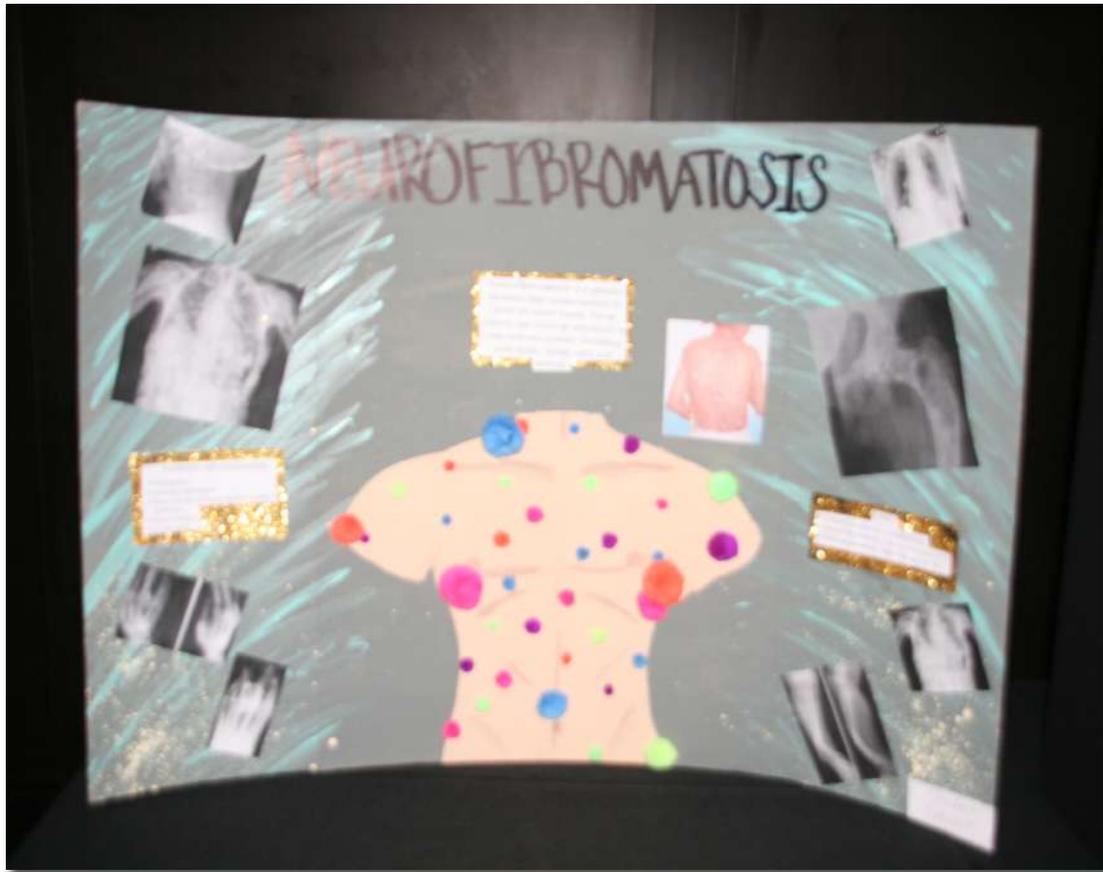
Student Exhibits



"Alzheimer's"

Student: Madison Burford
(UMMC)

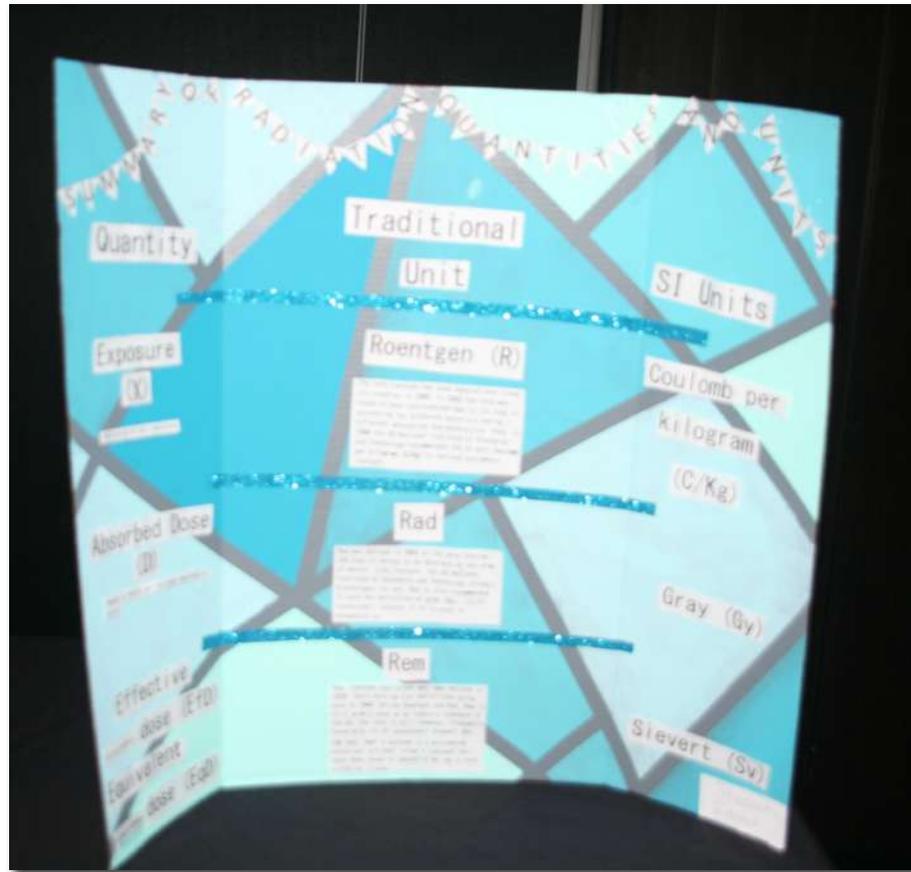
Student Exhibits



"Neurofibromatosis"

Students: Shari Russell, Carmen G, Toni Leverette, Reuben G
(UMMC)

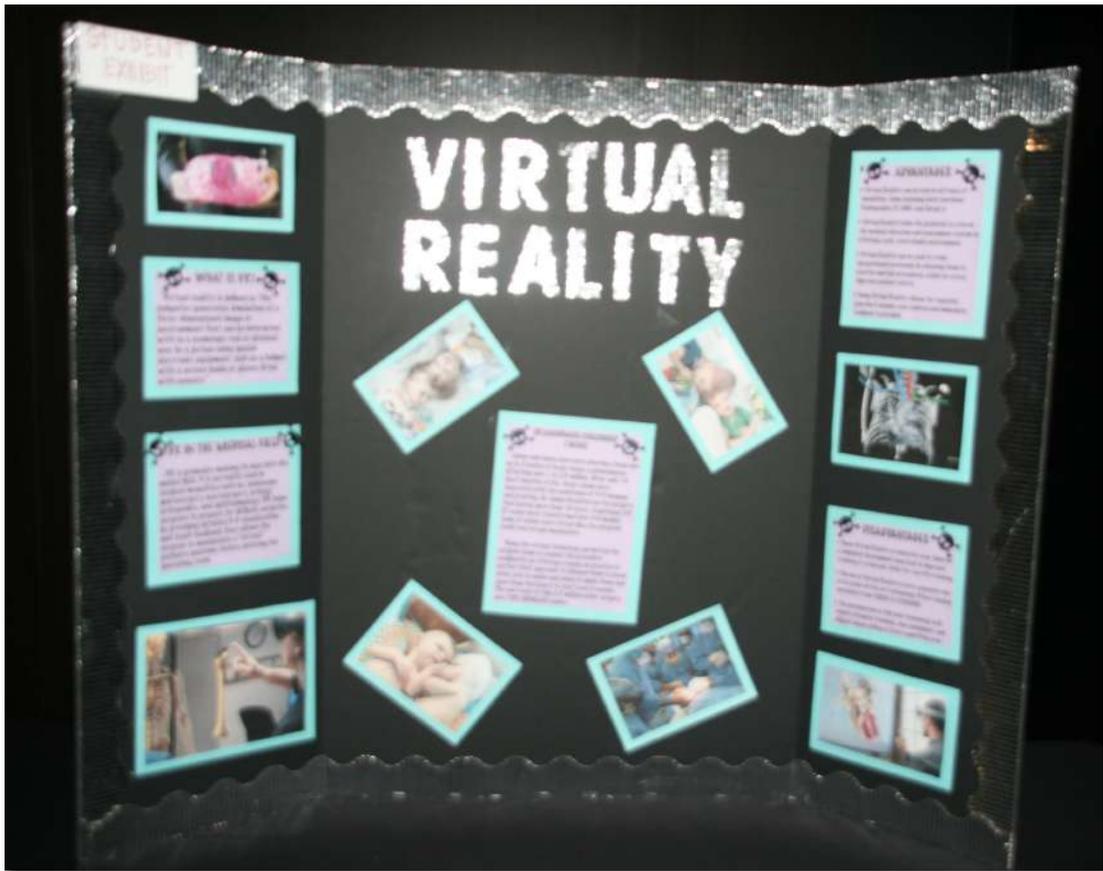
Student Exhibits



"Summary of Radiation Quantities & Units"

Students: Kelsie Luke, Tiffany Eakins, Samantha Mirandy
(UMMC)

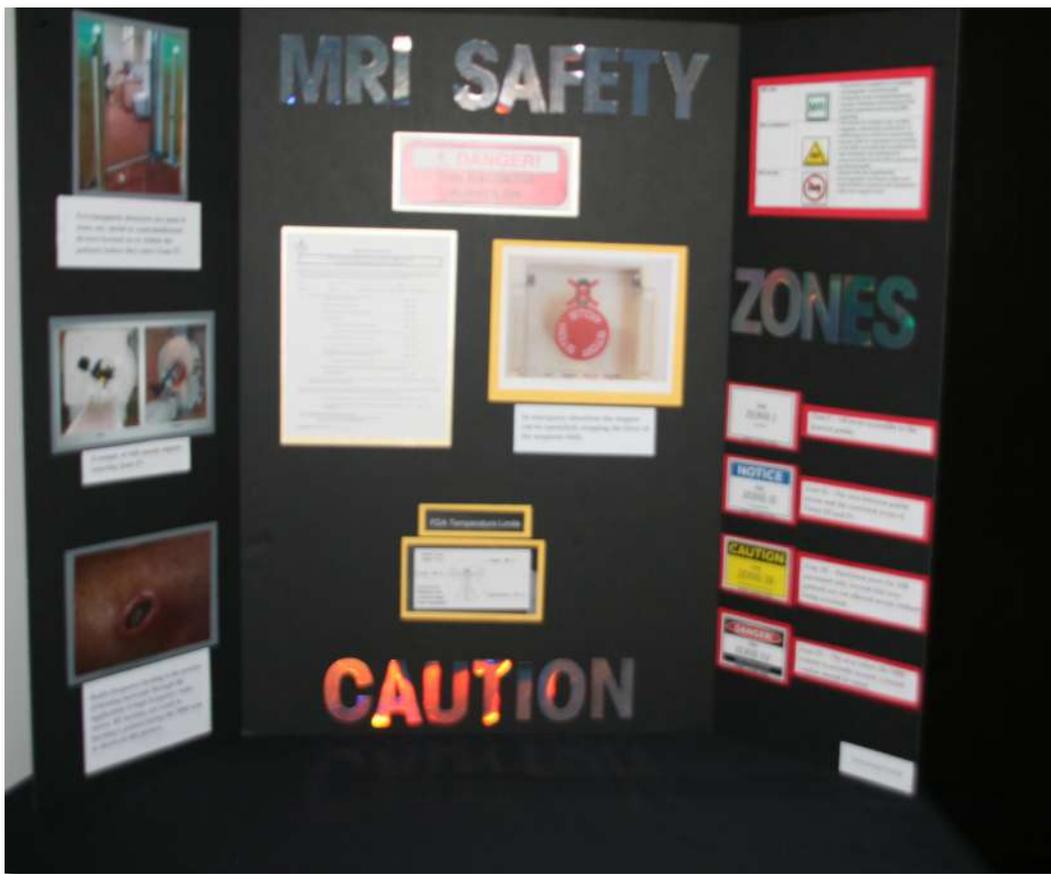
Student Exhibits



"Virtual Reality"

Students: Zack Gray & Gunnar Boleen
(UMMC)

Technologist Exhibit



"MRI Safety"

1st Place

Technologists: Layna Philips B.S., R.T.(R) & Zack Gray, B.S., R.T.(R)

Technologist Exhibit

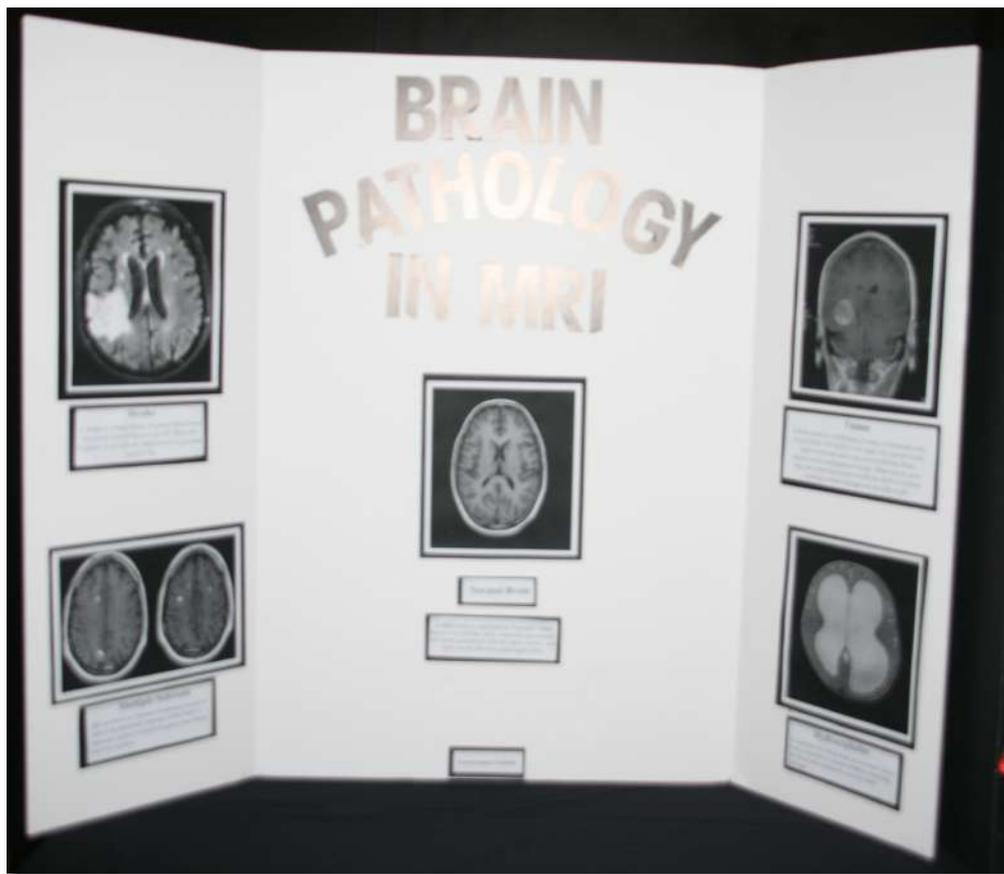


"What's Happening?"

2nd Place

Technologists: Ikia Celestine, B.S., R.T.(R) & Chris Scoles, B.S., R.T.(R)

Technologist Exhibit



"Brain Pathology in MRI"

3rd Place

Technologists: Tyler Patrick, B.S., R.T.(R) & Audrey Wilson, B.S., R.T.(R)

Congratulations!!



1st Place Technologist Exhibit "MRI Safety"

(L-R) Zach Gray, Kristi Moore - MSRT President & Layna Phillips



1st Place Student Exhibit "Conjoined Twins"

(L-R) Alex Wilcher, Kristi Moore - MSRT President, & Amy Valenciano



(Left) MSRT Elected Officers: (L-R) Asher Beam, MSRT Vice President; Mandy Pearson, MSRT Secretary; Lee Brown, MSRT President; Melissa Jackowski, ASRT President - Elect

(Below) Past President's Plaque presented to Kristi Moore by John Melvin

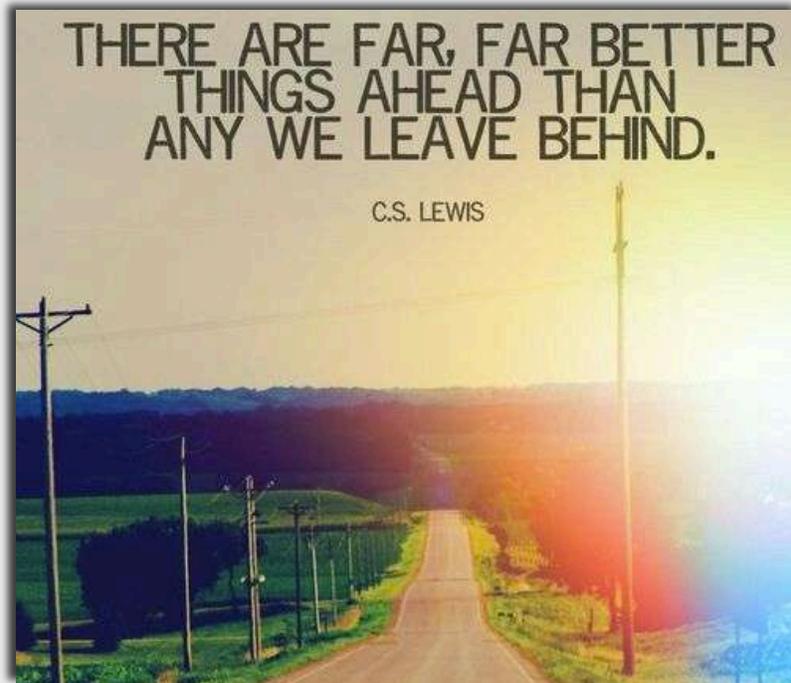
Congratulations!!



Student Delegates (L-R)- Hannah Ross (Newly elected -UMMC), Adrian Brewer (Newly elected - Co-Lin), Christian Chirinos (UMMC), Summer Hutchinson (Jones County JC)



MSRT Scholarship Recipients



Each of these students has demonstrated outstanding academic and clinical performance throughout their education. We salute them and wish them well in their future endeavors.

MSRT Board of Directors

Congratulations!!



Ashley Dunaway
Co-Lin Community College



Elizabeth McCullar
Itawamba Community College



Jade Holifield
Jones County Junior College



Sierra Hinson Maxwell
Meridian Community College



Carlie Johnson
MS Delta Community College



Angelina Smith
Pearl River Community College



Toni Leverette
University MS Medical Center

Student Prep Bowl Competition



1st Place - University of MS Medical Center

(Front L-R) Toni Levertte, Hannah Anderson, Brittany Walters

(Back L-R) Micah Harthcock & Shari Russell

Student Prep Bowl Competition



2nd Place - Itawamba Community College

(L-R) Elizabeth McCullar, Tanner Deaton, Amber Carter,
Katelyn Hughes, & Rebekah Anzuini

Student Prep Bowl Competition



3rd Place - Copenh-Lincoln Community College

Front (L-R) Natalie Eakes, Jourdon Cummings, Markie Case,
Ashley Dunaway & Brittnee Blakney

Student Prep Bowl Competition



Prep Bowl Participants - Jones County Junior College

(Front L-R) Summer Hutchinson, Nathan Lewis, Jade Holifield

(Back L-R) Carrie Welborn & Jeri Singley

Student Prep Bowl Competition



Prep Bowl Participants - Mississippi Delta Community College

Front (L-R) Carlie Johnson, Sydney Street, Dory Goss
Back (L-R) Mary Holly Flemming & Cathryn Kilgore

A Visit from Ben Riley



Pictured front and center is Ben Riley among all of the students after the Awards Ceremony.

A message from Ben Riley:

I am truly thankful for being able to attend the conference in Biloxi. I am not sure if I will be able to attend many more because of my health. The good Lord willing, I will be at the next conference in Tupelo. It is really great to see young people getting so involved in our profession and all of you are doing a wonderful job. Keep up the good work. Thank you from the bottom of my heart. You don't know how much it means to me.

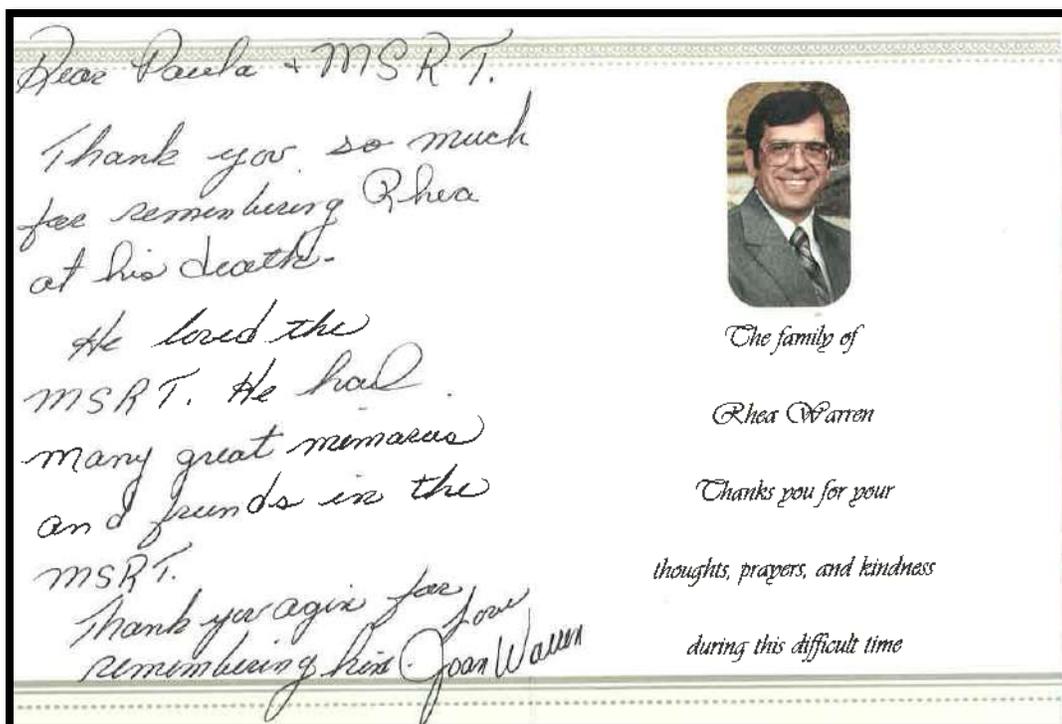
(Paraphrased from a phone call to Leigh Moser)

Remembering Rhea Warren

Rhea Warren passed away September 19, 2017 at North Mississippi Medical Center in Tupelo, MS. Rhea served in the U. S. Army from 1969 until 1972 in Shape, Belgium at the NATO Headquarters Hospital as a Staff Tech.

Rhea held various positions in the Radiology department at the North Mississippi Medical Center, including Technical Director. Two years before his retirement, Rhea would come to work early to greet and hold the back door open for hospital staff. He continued this tradition after his retirement. He retired after 42 years. Rhea was very proud of the work he did for the Mississippi Society of Radiologic Technologist (MSRT) where he served as President of the society in 1986. He also won the Technologist of the Year award in 1986. Rhea also served on the Itawamba Community College Board for selecting incoming students in the Radiology Program.

Joan Warren, Rhea's wife, asked that we publish a thank you note in this edition of The BEAM.

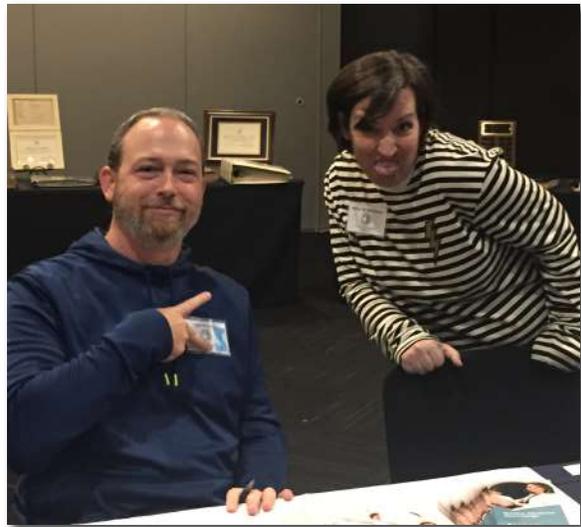




Out and About



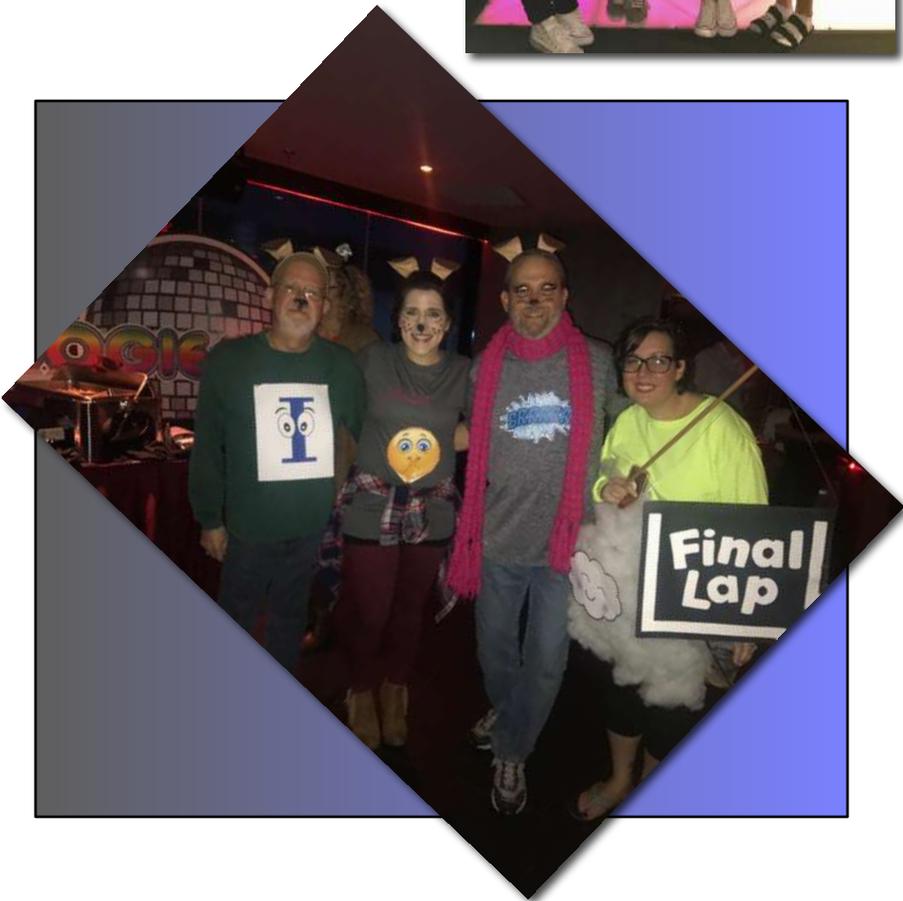




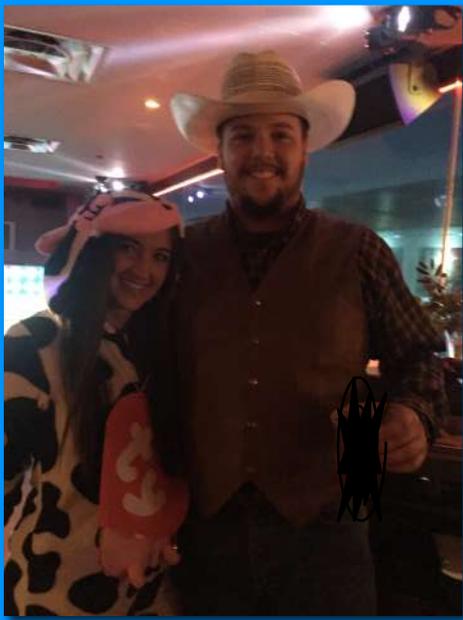


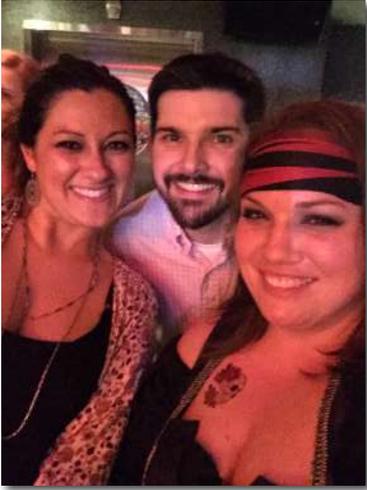
















Letter from the Editor

I would like to take this opportunity to thank everyone for helping make the 76th MSRT Conference another great annual meeting. The Hard Rock Casio and Hotel in Biloxi was such a fun venue. There is so much that goes on behind the scenes from planning and arranging schedules of speakers and meetings, to taking pictures and setting up all of the tables/displays. Now is the time to volunteer to be on a conference committee and/or on the MSRT board. In the light of current events in our profession, we need to come together as a united front to make sure our profession thrives. I am so excited for this new year and I challenge you to help make a difference for OUR profession. Remember that our board meetings are open and anyone is invited to come. Our next meeting is scheduled for July 14, 2018 at noon. It will be held in Tupelo with the meeting place to be determined at a later date. Remember to like our Facebook page, "MSRT-Mississippi Society of Radiologic Technologists". Announcements about future events and meetings will be posted on the page. Get connected!! I can't wait to see everyone October 2018 in Tupelo, MS!!

- Leigh Moser, R.T.(R)