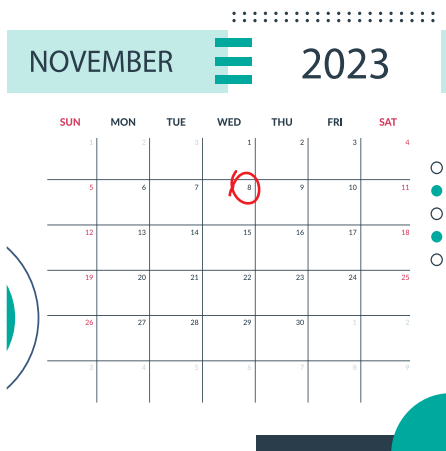




# International Day of Radiology November 8, 2023



The International Day of Radiology is a yearly event celebrated every November 8th, the anniversary of the discovery of x-rays, and promotes radiology's role in healthcare.

The European Society of Radiology (E.S.R.), the Radiological Society of North America, and the American College of Radiology (A.C.R.) jointly launched it in 2012. Nearly 200 national sub-specialty and allied organizations around the world recognize and celebrate the International Day of Radiology. Every year, a theme is chosen that focuses on various radiology specialties. To commemorate this day, we have taken a day in the life of a radiologist, a radiotherapy patient, and a radiographer from the E.S.R. website.

Enjoy the reading!

## A DAY IN THE LIFE OF A RADIOLOGIST

**Call me Giovanni** – A few minutes ago – never mind how long precisely – my alarm clock rang. It is about 6:30am and I have to go to work. I live downtown, not too far from the hospital. I am a radiologist working at the Emergency Department and I have to be there at 8 o'clock to start my morning shift. Today, I will have to take care of all patients sent for a computed tomography (CT) scan, another colleague will deal with plain film x-rays, and we will have to share the workload in ultrasound (US). Emergency radiology is a job I like: you have to deal with acute (suddenly arising) cases, you can, hopefully, provide a great contribution to solving their problems and you feel you are important for these patients. Furthermore, all radiologists in the emergency department have been able to create a good feeling with our colleagues specialising in other areas of medicine. Emergency physicians respect our opinion and rely, maybe too much, on our diagnostic skills. It is stressful (too many patients, always in a hurry), but it is a satisfying profession.

As always, traffic jams are a problem in the morning, but I have been able

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to arrive on time. There are already four patients on the list today. They arrived at the hospital during the night and were not emergencies, so they were able to wait until my arrival. Taking a look at the request forms, there is a patient with a bad fracture of the knee; the orthopaedic surgeon requests a CT examination to plan his operation. One is an old lady with a very swollen abdomen due to a suspected intestinal obstruction. Another patient has renal colic (abdominal pain originating from the kidneys) and is obese. The last patient is a 17-year-old girl with suspected acute appendicitis; I will first do an ultrasound examination on this patient and then decide whether to proceed with a CT scan or not. There are no neurological cases (patients with a problem relating to the nervous system) for me, since in my hospital neuroradiologists have their own patients; their CT area

is just 50 metres from here. Let's start. I call the technician and the nurse and ask them to let the first patient come in. My reading space – the area where I study the images resulting from the examination – is just behind the control room of the CT scanner. I work quite closely together with the technician who operates the equipment and the nurse who takes care of the patient. I know there are different ways of working, but I like this continuous contact with my co-workers: we are a team. I make a quick check of the patient's chart and decide on the scanning technique. Some patients require an injection of a substance called 'contrast medium', which helps to make certain things more clearly visible in the image, but this isn't necessary for my first patient. I will have to prepare some 'nice' 3D images for the orthopaedic surgeon; they say they are quite useful in planning their



This is rare, and difficult to diagnose without imaging. No wonder they did not spot it when she came in tonight.

surgical approach. The CT image shows it's a bad fracture. He will have to work hard to put all the fragments back together; good luck to both surgeon and patient! I see they plan to operate on him tomorrow, so I can postpone my report to the end of the day. The second patient is the old lady; she needs a contrast enhanced examination, which means using contrast medium. She's old and may have other medical conditions in addition to the current complaint.

an obturator hernia! This is rare, and difficult to diagnose without imaging. No wonder they did not spot it when she came in tonight. I must write down the report immediately and make a phone call to the doctor who referred the patient to me; they have to call surgery and operate on her soon. The hernia is causing dilatation of the loops of the small bowel, but their walls do not show signs of permanent damage. The prognosis does not look bad.

stones pass spontaneously in a couple of days, but patients have pain, and they want to know the reason why. Urologists prefer to decide immediately which cases they have to admit, and which can be sent home. It is always a battle. This was an obese patient, and it would have been difficult to examine him with ultrasound, but I usually prefer to start with an ultrasound study in cases of suspected renal colic. For more than 50% of these patients, we can often work out the problem while avoiding any radiation exposure. A phone call informs me that the girl has arrived in the US examination room. It is time to go. She is already on the examination table: a quick "good-morning",



The function of her kidneys has already been checked with a blood test, and from the chart it looks ok, so I can proceed with the contrast injection; but first I have to talk with her and get her informed consent for the injection. In my country, this is a duty of the radiologist, and we have to keep the signed informed consent form with the patient's charts. I decide on the scanning technique and let her in. The nurse has some problems in finding a suitable vein for the injection, but she is an expert, and she manages. The scan is finished in a few minutes and the images arrive at my workstation. Wow! The cause of the intestinal obstruction is

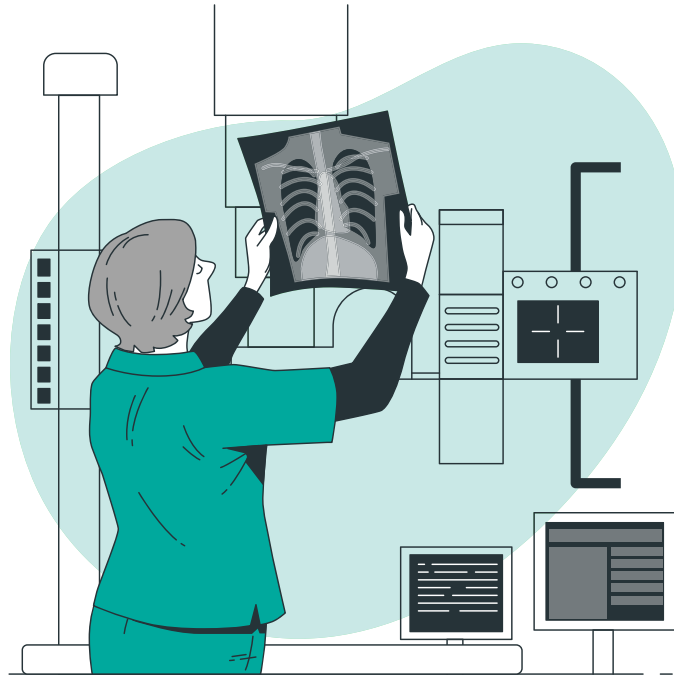
While I am writing the report, the technician and the nurse have already finished scanning the patient with the kidney-based pain; the technician knows exactly which low-radiation procedure to use in this kind of study, there was no need to tailor the examination for this specific patient. A quick scan has shown a 7mm stone at the middle third of the right ureter, which is the tube that leads out of the kidney to the bladder. Diagnosis done. But I always wonder if all these stone studies are really necessary. Most, if not all these patients, need a 'standard' therapy: analgesics, fluids, and anti-inflammatory drugs. Most

"where does it hurt?", "don't worry, I won't harm you, I will just need to put some gel on your belly", and the examination starts. She is a lean girl, easy to study. The inflamed appendix is easily visible. The report is ready in a few minutes. At this time, two additional patients are waiting outside the examination room, and a phone call invites me to come back to the CT station: two more patients have arrived. The two rooms are next to each other, so I can manage. I ask the nurse to let in one patient who is here for a US examination, and I go to the CT. These are two follow-up examinations from the oncologic clinic (we have to take care of some of their





requests during our daily work). Both patients were already here a few months ago. I remember one of them. The technician knows the examination procedures to be used in these cases; I let him and the nurse work with them and go back to US. The first patient has come due to upper abdominal pain; I see a stone pressing against the neck of the gall-bladder but the walls are not thickened and there is no tenderness at the base. And there are no other anomalies within the abdomen. The second patient is more of a concern: he has been admitted early this morning with jaundice. There is a mass at the head of the pancreas and the bile ducts are dilated. This is a serious problem; it looks like a pancreatic tumour. I can see the lesion completely surrounds a major vein; this is bad finding, as the lesion does not seem surgically removable. In the report, however, I suggest a CT exam to provide accurate and complete analysis; it will be probably done in the late morning or this afternoon, before sending the patient from the emergency department to a ward for palliative treatment. In the CT waiting room, two new patients have already arrived from the emergency room. A check of their charts, a chat for their consent to contrast injections ... but, while the first is ready to enter the examination room, there is a phone call informing me that an emergency patient has just arrived. The emergency physician informs us that he will arrive within 15 minutes. If I hurry, there is just enough time to examine one of the waiting patients! As soon as we are finished, the emergency is at our door. The patient is on a stretcher, is receiving breathing assistance, and is covered in life-support devices. We have to examine him from head to toe. He fell from a ladder while at work. A head injury is suspected, plus there are signs of chest and pelvis injuries and an exposed fracture of the right leg. We do the examination. I send the head images to the neuroradiologist and start looking at the body. There are fractures at the shoulder and a few ribs, some bruising to the lung, bad fractures of the pelvic bones, with blood infiltration within the pelvic muscles, and there is fluid in the abdomen. Stop! Don't take him out of the scanner! I need to do



another scan. Fluid in a patient with pelvic fractures can be urine from a ruptured urinary bladder. We need a late scan to see if the contrast medium we have injected passes into the peritoneum (which is the lining that covers most of the abdominal organs). In the late images I see the fluid shows the typical signs of urine, which must be from a ruptured bladder. This means the patient has to be assessed by a multidisciplinary team including the urologic surgeon. I need to make a note of this study and keep the images for teaching the trainees. The neuroradiologist says the patient is ok for her: no head or spinal cord injury. He has enough trouble already without neurological ones! Back to ultrasound: there is a young man with renal colic, and I can see a stone at the junction of the tube leading from the kidney into the bladder. The outlook for this patient is good. There is also a case of a painful lump in the neck that developed during the night: it is a thyroid cyst. The patient can go back to her family doctor; there was no need to come to emergency. It is almost noon. I get a coffee from the automatic machine and go back to CT. Three other patients: an old lady with a suspected blockage in the artery that transports blood to the lungs and a sudden onset of shortness of breath; a patient with an aneurysm of the

abdominal aorta who needs to be checked before surgery (it seems they sent him to emergency radiology because they think we have no waiting list!); and a patient with blood in his urine, in whom my colleague has seen a mass in the kidney during a US examination. It is probably a tumour. The patient needs a 'staging' examination, to precisely determine the extent of the mass before surgery. Two more US exams and my morning has gone! Another case of appendicitis; easily visible, no need for CT. The last patient is a young lady with acute and strong pelvic pain: she has a mass on the right side with both solid and liquid components, and a small amount of loose fluid. But her pain is on the left side. Could it be a cyst that has become twisted? Quite often a twisted mass may move from its normal position. I must suggest the diagnosis and talk with the gynaecologist: if it is confirmed at his visit they need to operate on her quickly. It is 2pm. The radiologist on duty this afternoon has arrived. I still have to spend some more time at my workstation; I need to finish and sign all the reports that are still open, make a few phone calls and go to prepare my lesson for the radiology trainees tomorrow; the first in a series on emergency radiology, called Roles and responsibilities of the radiologist in emergency care. There is quite a lot to say.

# A DAY IN THE LIFE OF A RADIOTHERAPY PATIENT



**Call me Heather** – I am in the middle of a six-week stay in London, where I am having fractionated stereotactic radiotherapy for a low grade non-malignant brain tumour. I say 'non-malignant' as I refuse to use the word benign because mine has certainly not been benign in effect. It's cost me a thirty-two-year career in nursing and has left me with a constant sensation of vertigo, fatigue, occasional disorientation, facial pain (as it is compressing one of the facial or 'trigeminal' nerves a bit), and occasional petit mal and absence seizures. My day starts at about 8:30am. I am staying at a friend's apartment in Ladbroke Grove, which is about 40 minutes to an hour away from the Royal Marsden Hospital in Chelsea, where I am having my radiotherapy as an out-patient. I come from Penzance in Cornwall, about 400km away. The hardest part of this is having to live away from my home and my husband for so long. Getting up is not too much of a problem, but with fatigue as one of my symptoms

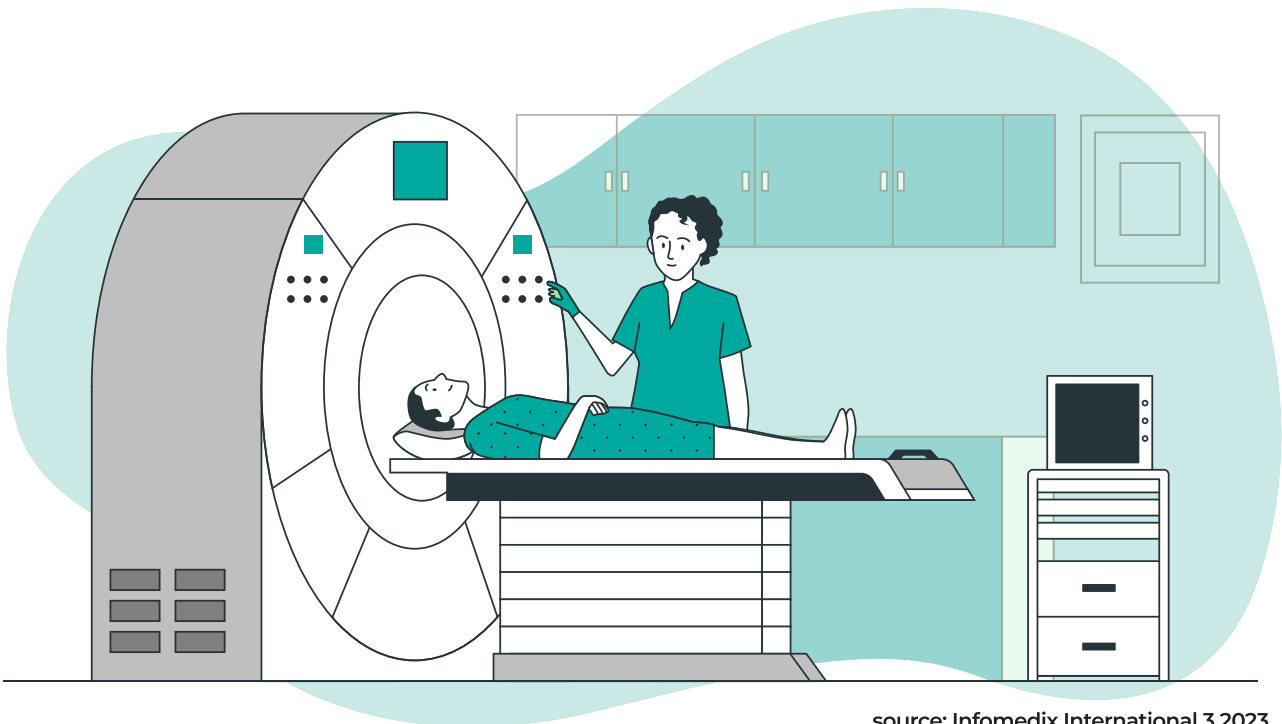
sometimes I really have to drive myself out from under the bed covers. I have managed to set up a daily routine, and, so far, have really enjoyed my time in London and am making the most of it as I do not know how the radiotherapy will affect me over time. Certainly, there will be side effects and there is already a stabbing pain at the top of my head, and the prickling, numbing and sometimes sharp sensation of pain I started to get down the right side of my face, as a symptom of my tumour, has intensified. As a result, I have recently been prescribed a drug specifically for nerve or 'neuralgic' pain.

My brain tumour is called 'Algernon' or Algy for short. I first became aware of him back in 2010, when I collapsed at work, ironically on a medical ward at the local hospital where I worked as a Registered Nurse in the town where I live. I had begun to suffer from dizzy spells for about three weeks beforehand and had not been terribly well over the previous winter. Looking back, I remember

the number of times I had falls, usually from tripping over something or just seeming to lose my balance, over the years. There was something else I was occasionally getting which was suddenly feeling faint or if waking up from a doze, the sensation of not being able to move and my blood pressure dropping through my boots. After a consultation with an ear, nose, and throat (ENT) clinic, a problem with my core balance was identified and so I was referred for a CT (Computed Tomography) scan. This was done at the hospital where I was working at the time, and I knew the radiology staff there. The procedure was explained clearly, including any risks, because although different to standard x-rays, it is still a radiological procedure that uses x-rays with computer technology. After explanations, I was assisted on to the scanner table; a cushion was placed under my knees to keep me comfortable as the table moved under the scanner, taking not very long. If I remember correctly, it took about ten minutes, something like that. Afterwards, the staff kindly helped me up on to my feet. The results at the time would be sent to my ENT consultant after review. What the CT picked up was a 'mass' impacting on the right side of the pons, which is part of the brainstem. As a result, I was referred for an urgent MRI (Magnetic



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Resonance Imaging) scan at RCH Tre-liske Hospital in Truro and also for a neurology appointment at Derriford Hospital in Plymouth. The MRI scan experience was different to the CT scan. Beforehand, I was sent information about the appointment and also a request to see my family doctor for a blood test to see if my kidneys were ok, as I will need to be injected with contrast medium, which needs to be excreted. On arriving at the department, I was given a questionnaire to fill out about whether I had had any recent surgery, metal implants and so on, in case there was anything that could be affected by the magnet in the scanner. The scan itself involved being placed in a much narrower and longer 'tube', which I found very claustrophobic. Also, because the scanner at Tre-liske is second-hand, it is very loud as the magnet spins, well deserving of the name 'Old Clunker'! I was given a set of headphones and a choice of music, or I could bring in my own music, which I did, but not even my loudest heavy rock music could drown out or lessen the intensity of the noise! Also, my head was encased in a frame which for some might add to the discomfort, so it is important to speak to the staff beforehand about any difficulties you may have. There is a microphone inside the machine and the staff can speak to you, and will stop the scan at the slightest hint of trouble. An MRI scan is important as a 3D image can be taken of the tumour, which can provide more detail if needed. I also needed a liquid 'contrast medium' injected into a vein in my arm, which highlights certain areas and the tumour itself. This wasn't always an easy process, as my veins tend to be reluctant to have a cannula pushed into them, and the experience varied over five sessions in three different hospitals. You have a scan first then the contrast is injected halfway through, then the scan repeated. After that, the cannula, which is the tube through which the medium is injected, is removed. From my own nursing experience, it is very important to take your time placing the cannula, by making the patient more comfortable, preferably sitting with their arm resting on a pillow or support. Some hospitals have special chairs for this. In my case, this didn't always happen, and on one occasion the cannulation was very painful. At the Royal Marsden there

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was more up-to-date equipment and more experience. As their sole specialty is in dealing with cancers, the staff are much more used to damaged or small veins, so cannulation was much more comfortable. The MRI scanner was not quite so claustrophobic and a little quieter, and there was maybe a little more space in the 'tunnel' as well. The scan, which could take anywhere from thirty to forty minutes at Tre-liske in Truro and Derriford in Plymouth, took not even twenty-five minutes to complete, even with contrast. In all three hospitals, I was treated with courtesy by the radiology staff, there were no problems with answering questions and all tried their very best to make sure I was as comfortable as possible during the procedures.

Getting back to the diagnosis. Of course, after Algy was found, it became clear that the 'fainting spells' were nothing to do with having blood pressure problems but actually petit mal seizures where the tumour was impacting on the brain's temporal lobe from underneath. The hardest part about receiving my diagnosis wasn't even the fact I have a tumour in my head, but the consequence of the eventual loss of my job, career, and financial independence. Having to go through the rigours of applying for financial support and a pension, as well as everything else, was very frightening, especially while also feeling unwell. Initially, I was

placed on 'watch and wait' surveillance for two years to see if Algy would progress. Even when the symptoms became more obvious, I felt there was a reluctance to start treatment due to the potential long-term effects that can result from radiotherapy. Eventually the tumour had become large enough to cause the symptoms to intensify, including neuralgic pain, and the number of seizures – although not as intense, as I had started medication – certainly were becoming more frequent. Cutting a very long story short, I was eventually offered radiotherapy, which I could have had done at Derriford Hospital in Plymouth, but I would have had to wait, due to installation of new equipment. As a result, I was offered a referral to the Royal Marsden in London, and knowing the wonderful reputation they have, jumped at the chance.

So here I find myself now. I am sitting in a small café across from the hospital (Café Roma if anyone is interested) where I have a cup of hot chocolate and one of their wonderful sandwiches. When done, I head over to the hospital and down to the radiotherapy department for my session. The team there are very friendly and reassuring, willing to have a little chat when setting you up for your treatment. Let me explain a little about the treatment I am having. Algy is considered inoperable because of his location, so radio-





therapy has been offered, the intent of which is to prevent the tumour from getting any bigger and hope that also there could be some shrinkage. I had an initial consultation earlier in the year and it was determined that I should have the longer and more traditional radiotherapy treatment, or 'fractionated stereotactic radiotherapy' where a dose of radiation is prescribed, the dose divided and given over a number of sessions. There are various options, and you may have heard the terms 'Gamma Knife', 'radiosurgery', stereotactic etc. These terms refer to the type of machine used, the intensity of radiation delivered and delivery time. In my case, because of where Algy is in relation to some very sensitive areas of the brain, it was decided to deliver the dose of radiation prescribed over thirty sessions, which is not so intense and less likely to have an impact on the areas surrounding the tumour. For this I have had to be fitted with a mask before I started treatment, to keep my head completely still during the session,

which is vital since the beams are targeted very precisely at the tumour and it would not do for the target to then suddenly move! This, for me, was the worst part, not because of any pain but because the mask itself can be claustrophobic to wear as it encompasses the whole head. Fitting the mask was very quick and painless. It is made from a plastic-type material which is heated in hot water, applied over the area to be treated – in this case over the front of my head and moulded around my face. A hole was quickly opened for my mouth and nostrils to enable breathing. Clips were then fixed on the edges of the mask as it is clipped on to the table to secure you. I was hoping that the Royal Marsden would allow me to take pictures of the stages of fitting but sadly their policy is not to allow any, so I can only go on other people's accounts of the actual session, as I could not see it! Now I have got used to the routine of going in, lying down, and having the mask clamped to the table, I can feel quite relaxed as there is the

option of having music played during the session, as with the MRI scans earlier. The session ends quite quickly, and the mask is then removed, plus I am helped to sit up as I need to regain my balance before getting off the table. After a quick goodbye, I leave the hospital and depending on how I am feeling at the time, might go for a walk and some lunch, or head back to where I am staying if I am feeling very tired, which does happen. In all, my experiences with radiotherapy have not been unpleasant so far, but everyone will have a different experience, depending on the type of radiotherapy offered and where. For me the worst will probably come later as the side effects become more noticeable and to that end, my husband will be joining me in London during the last week of my treatment as I have been warned that the fatigue and the disorientation could intensify for a while. I just hope this works and that Algy will no longer be trying to occupy more skull space in the future.



## A DAY IN THE LIFE OF A RADIOGRAPHER

**Call me Clizia** – I am a radiographer working at the radiology department of the county hospital where I live. Today I am doing the morning shift, so I need to be at my department by 7am. My radiographer colleagues and I always start the day with a cup of coffee while we are debriefed by the radiographer who did the night shift. This morning he told us that there were several emergency CT examinations which he had to perform on patients from the accident and emergency (A&E) department. All went well and the patients have gone back to the wards; he has tidied up the CT equipment and refilled all supplies so we can start the morning shift as planned. Today I will be performing general x-rays, however as there are several radiographers on vacation, I will most likely also help out in CT as they have quite a few examinations booked for today. The phone rings and it is from the intensive care unit (ICU). They need an urgent chest x-ray for a patient in a critical situation. I quickly gather up a few x-ray cassettes and take them up with me to the ICU to use with the



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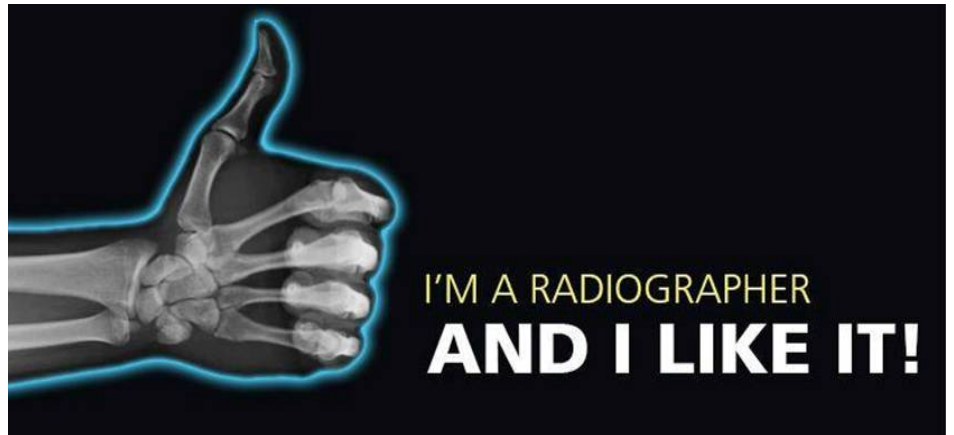
mobile digital x-ray unit. Arriving at the ICU, I consult with the ICU staff to ask for the x-ray referral and for some information on the patient needing the x-ray. While preparing the mobile x-ray unit for the examination I notice that there is another patient close by who is not mobile enough to be taken away while I perform the x-ray. I place a lead apron on this patient to try to minimise the scattered x-ray radiation that she would be exposed to while I perform the x-ray on the other patient. The ICU nurses help position the x-ray cassette underneath the chest of the patient and do their best to prevent various medical instruments and wires from overlapping the area being examined. After making the chest x-ray, I

quickly consult with the ICU physician to confirm whether the x-ray image is suitable for his requirements. Making chest x-rays on patients lying in a bed is not ideal. We need to find ways of maintaining good image quality on patients who are unable to cooperate, cannot hold their breath, or have lots of medical instruments around them and lots of wires or cables across them. I enjoy doing x-rays in the ICU as the staff are very helpful and do their best to help me and my work; I am glad that I can contribute to the care of patients in the ICU.

Going back to the radiology department, I realise that there are several patients waiting to have x-ray examinations. Reading through the



referrals, I see that one has come for a chest x-ray, another one for an ankle x-ray and another one for an abdomen x-ray. I ask the assistant to check with the patients to prioritise their needs. While she talks with the patients, I double check to make sure that all the referrals are signed by the clinician. I also check to see whether the patient consent forms have been filled out and signed by the patients themselves. I start with the chest x-ray. This time the conditions are ideal. After the patient has taken his shirt off, I position him standing in front of the cassette. This time I use a routine setting on my digital x-ray system. Having a look at the image on my screen, I am pleased to see that it is exactly what is needed. I finalise and save the image through the picture archiving and communication system (PACS). This is a great tool as it allows the referring clinician as well as the reading radiologist to view the x-ray image straight away, in their office or on the ward. I have heard that there are some places where the clinicians get the images sent straight to their smartphones. Wow! This is one of the reasons why I love my profession; the technology supporting radiology is changing dynamically with the latest innovative IT features always being integrated into our systems to improve the quality of patient care we provide. Next, I call in the patient coming for an ankle x-ray. I ask the patient to remove his shoes and to lie down on the x-ray table. I first cover his lap with a lead apron, again to minimise unnecessary radiation dose, and position the cassette. This time I have to make two images from two different angles. This is the routine in the case of an ankle x-ray. After checking the images and disinfecting the table, I call in the other patient who is here for an abdominal x-ray. I quickly ask whether the patient has had anything to eat that morning. Not surprisingly, she says that she had breakfast. I explain to her that I will need to consult with the radiologist to double check whether it is possible to take an x ray now or maybe it would be better if she comes back at a later time with an empty stomach. We wouldn't want her to be x-rayed twice, especially if it is not an urgent case. I quickly



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cross the department to the radiologist who is already making reports based on the previous x-rays I have done. After I explain the situation, he decides to postpone the examination until he has consulted the referring clinician. Even though this is the standard procedure at our department, I am happy to experience once again that the team in the radiology department do their best to prevent people from receiving unnecessary radiation.

Seeing as there are no more patients waiting for x-rays, I decide to go over to the CT area to see whether I can help them. I get there just in time, as a team from the A&E department, together with the neurosurgeon, rush in with a head trauma patient who needs an urgent CT scan of the head. I quickly ask the assistant to notify the radiologist on duty while I rush in to help. Positioning the patient is not easy because of his accident. This time we need to fasten the patient to the table to prevent further accidents from occurring. The CT scan of the brain is ready by the time the radiologist arrives. It shows a severe epidural haematoma, which is a build-up of blood between the skull and the outer membrane of the brain. We quickly save the images to the PACS system so the neurosurgeon can have easy access to them in the operating theatre. Once again,

I am proud that I can work with an excellent team in the radiology department, supported by the latest technology which not only allows for fast and precise imaging of patients, but caters for patient safety at the highest level. Next there is a 10-year-old boy, suffering from acute abdominal pain, who is waiting with his parents. Quite understandably, they are all very worried. The surgeon has asked for an abdominal CT as he suspects appendicitis in the young boy. We decide to consult the radiologist as he might prefer to have a talk with the surgeon and start by doing an ultrasound exam instead of CT, to avoid unnecessary exposure to ionising radiation. Luckily both clinicians decide it is best to start with an ultrasound. I have a word with the parents to calm them down and to say that the radiologist will be there soon to explain why another examination will be performed instead. I phone my colleague at the ultrasound station so she can prepare for this extra examination besides the pre-booked examinations. Then the assistant comes into CT to say that we are needed in the operating theatre where there is a hip operation in progress. I quickly head up to the operating theatre and change my clothes. I see that the assistant has already prepared the mobile C-arm, which is a special C-shaped piece of



equipment that is used to connect the x-ray source and x-ray detector to one another, with the patient in the gap of the 'C'. Looking around the operating room, I noticed that the anaesthesiologist and the nurse are not wearing lead aprons. I provide them with lead aprons and ask all others to leave the room while I make the x-ray. I understand that it could be uncomfortable to wear such heavy aprons, but safety comes first, and I have an obligation to maintain safety for staff and patients. I take some x-ray images for the orthopaedic surgeon so he can confirm that the implanted screw is really in the correct position. After cleaning up and disinfecting the C-arm, I return to the radiology department. The radiologist is just leaving the department for lunch. He tells me that the ultrasound showed no evidence of appendicitis in the 10-year-old boy and thanks me for taking the action of calling him. I am thankful that, in the end, we have avoided exposing the child to unnecessary ionising radiation. Back in the radiology department, I hear that two trauma patients have arrived at the A&E department following a car accident. One has multiple traumatic injuries (known as polytrauma) with several fractures. The nurses are already cleaning the blood from the wound and removing bits of glass that probably came from a broken car window. I go over to the CT area to help the radiographers prepare for the patients. We put on disposable aprons and gloves prior to receiving the patients. We are aware of the hazards associated with blood

” I go over to the CT area to help the radiographers prepare for the patients. We put on disposable aprons and gloves prior to receiving the patients.

contamination and it is our obligation to do all that we can, not only for patient safety, but for our own safety. The first patient brought to CT has breathing difficulties, so an urgent chest CT is requested by the emergency team. The patient is taken to the CT scanner where I see that not only are his sternum and four ribs fractured, but he has a perforated lung. The chest surgeon is called to have a quick look at the images and after consulting with the radiologist, he asks us to help organise the transfer of the patient to the operating theatre. Our assistant is glad to help and offers to help take the patient away. We quickly clean the CT table and get ready for the next patient. Luckily, the next patient has only suffered minor trauma with no apparent fractures. Nonetheless, a CT scan with a low dose of radiation and an injection of contrast medium (a substance which helps to make certain things more clearly visible in the image) is needed to rule out any internal injuries. My colleague goes over the consent form with the patient and discusses safety aspects and potential hazards before asking for the patient's signature. It is always very important to document all aspects of patient care as these may be sig-

nificant in the future. In the meantime, I prepare the contrast medium injector and after positioning the patient, I connect the injector with the tube placed in the patient's right arm. Everything goes well during the examination. We are glad to see that the patient doesn't have any further injuries. After the patient is taken away, I help clean up the CT area for the afternoon shift. As my morning shift comes to an end, I go off to have a coffee in our lounge with some of the radiographers and radiologists. We talk of how colourful our work is, no matter whether we do routine shifts or weekend shifts, so many incredible things happen, and we are always ready to contribute to patient care by helping other clinicians and staff members at the hospital. We all believe that the radiographers and radiologists make a perfect team here! It is now 2pm; my radiographer colleagues have arrived for the afternoon shift. It has been an intense day, but at the end I feel happy because I have had the opportunity to achieve the best of this profession: to help others in need. I'm proud to be a radiographer!

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