Under the patronage of

Her Royal Highness Princess Ghida Talal

Chairperson of the King Hussein Cancer Foundation and Center

14th Pan Arab Association of Radiological Societies (PAARS) International Congress

15th International Congress of the Jordanian Radiological Society

Breaking Borders in Radiology AI and Global Trends

October 22–24, 2026

IN COLLABORATION WITH

ESOR EUROPEAN SCHOOL OF RADIOLOGY

The European School of Radiology (ESOR)
& London Sheffield Radiology International Conference

PRE CONFERENCE ESOR CHEST IMAGING COURSE: **October 21, 2026**

THE ST. REGIS (Amman, Jordan)

Jordan Medical Council
6 CPD Accreditation

www.jrs-jo.org

WELCOME MESSAGE

Dear Esteemed Colleagues,
On behalf of the Scientific and Organizing Committees, it is our great pleasure to welcome you to the **14th PAARS International Congres**s, held in conjunction with the **15th International Congress of the Jordanian Radiological Society**, taking place from **21–24 October 2026** at **The St. Regis Amman, Jordan.**

This prestigious congress is recognized as one of the leading scientific events in the field of radiology in the Arab world. Jordan is proud to host it for the fourth time and, for the first time, in collaboration with the European School of Radiology (ESOR) and the London Sheffield Radiology International Conference. Over the coming days, distinguished radiologists, clinicians, academics, and healthcare professionals from across the region and beyond will come together for an exceptional exchange of knowledge and a close look at the latest scientific and technological advances in our specialty.

The scientific program covers a comprehensive range of topics, including diagnostic and interventional radiology, imaging technologies, artificial intelligence, oncology imaging, neuroradiology, musculoskeletal radiology, pediatric imaging, and more. Our multidisciplinary faculty represents radiology, nuclear medicine, oncology, and surgery, which brings a holistic and integrated approach to imaging and patient care.

We encourage you to take full advantage of the lectures, workshops, and discussions, and to connect with colleagues and our industry partners throughout the congress. We are grateful for your participation and hope you enjoy a rewarding scientific experience and a memorable stay in Amman.

Together, let us learn, collaborate, innovate, and shape the future of radiology.

Warm regards,

Prof. Waleed Mahafza
President of JRS
Congress President

Dr. Wesam Shamma
Chair, Scientific Committee

Prof. Tarek A. El-Diasty
Co-President
PAARS Congress

Chest Imaging

October 21, 2026

08:45–09:00	Welcome and Introduction
09:00–09:30	Systematic approach to Interstitial Lung Diseases Helmut Prosch
09:30–10:00	Management of pulmonary nodules Guillaume Chassagnon
10:00–10:30	Pulmonary manifestations of systemic diseases Cornelia Schaefer-Prokop
10:30–10:50	Coffee break
10:50–13:00	Workshops
13:00–14:00	Lunch Break
14:00–14:30	Lung cancer staging Helmut Prosch
14:30–15:00	Pulmonary embolism Guillaume Chassagnon
15:00–15:30	Pulmonary infections Cornelia Schaefer-Prokop
15:30–15:50	Coffee break
15:50–18:00	Workshops
18:00	Course Evaluation

Jordan Medical Council
3 CPD Accreditation

ESOR EUROPEAN SCHOOL OF RADIOLOGY
ESR EUROPEAN SOCIETY OF RADIOLOGY

if you liked this, you'll love...

Foundation Course
Musculoskeletal Radiology
November 4, 2026 | Online

Special Focus Series
Lung Cancer Screening 3rd Edition
January 18, 2027 | Online

Foundation Course
Cardiovascular Imaging
January 27, 2027 | Online

Enjoy Education

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VISITING PROFESSORSHIP PROGRAMME TO JORDAN

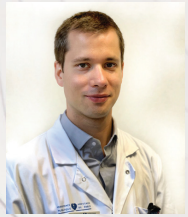
OCTOBER 21, 2026





Helmut Prosch, Vienna/Austria

Dr. Helmut Prosch, Associate Professor at the Medical University of Vienna, is Deputy Head of General and Paediatric Radiology and Section Chief of Thoracic Imaging. His research focuses on lung cancer diagnosis and deep learning in lung disease. He has published over 250 works and is President-Elect of ESTI.



Guillaume Chassagnon, Paris/France

Guillame Chassagnon is Professor of Radiology at Cochin Hospital, Paris. Specialized in thoracic imaging and AI, he holds a PhD in Mathematics/Computer Science. His research focuses on machine learning, interstitial lung diseases and bronchial diseases. He has authored 110+ papers and serves on several journal boards.



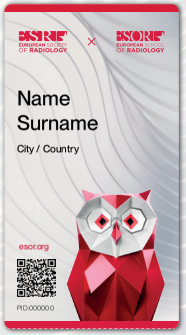
Cornelia Schaefer-Prokop, Amersfoort/The Netherlands

Cornelia Schaefer-Prokop is an internationally recognised chest radiologist and Professor at Hanover Medical School and Radboud UMC. Former President of ESTI and the Fleischner Society, she has published 200+ papers, lectures widely, and is renowned for her educational leadership in thoracic imaging.

Course Evaluation

1. Scan the QR code on your badge
2. Click the link
3. Fill out the survey and click 'submit'

NOTE: the evaluation requires your PID Number on your badge.



Receive your certificate

1. 7-10 working days after the course, log in at: https://portal.myesr.org/esr/membership/login
2. If you do not have a MyESR account, click 'forgot password' and create a new password
3. Don't forget to check that your email is correctly linked!
4. Once you have logged in, the certificate is available under 'documents' found in the right-side menu

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JORDAN26

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esor.org

ESOR EUROPEAN SCHOOL OF RADIOLOGY
ESR EUROPEAN SOCIETY OF RADIOLOGY

Pre-conference
European School of Radiology (ESOR)

Chest Imaging Course

Visiting Professorship Programme



Helmut Prosch
Coordinator



Tarek El-Diasty
Host



Waleed Mahafza
Host

Wednesday 21 October 2026	08:00 – 18:15	St. Regis Hotel Amman, Jordan	70 JOD

Topic: Chest Imaging

Thoracic imaging is developing quickly, with new diagnostic technologies and changing clinical guidelines, especially in lung cancer staging and the management of incidental lung nodules. However, interpreting complex findings remains challenging, particularly in interstitial lung diseases (ILD) and lung involvement in systemic diseases. This course aims to address these challenges by reviewing current imaging standards, evidence-based management strategies, and practical diagnostic tips.

Through expert lectures and workshops, participants will learn how to avoid common pitfalls in diagnosing pulmonary infections and embolism. The goal is to improve diagnostic accuracy and support better patient care in everyday clinical practice.

Learning Objectives

- To apply a systematic approach for the diagnostic differentiation of interstitial lung diseases and pulmonary infections.
- To utilize current TNM staging and evidence-based guidelines for the effective management of lung cancer and pulmonary nodules.
- To master the imaging criteria and clinical protocols required for the accurate diagnosis of pulmonary embolism.
- To identify the thoracic manifestations of systemic diseases to facilitate early diagnosis and multidisciplinary patient management.



WORKSHOPS

ESOR EUROPEAN SCHOOL OF RADIOLOGY

ESR EUROPEAN SOCIETY OF RADIOLOGY

08:00-08:45	**Registration**
08:45-09:00	**Welcome and introduction**
09:00-09:30	**Systematic approach to Interstitial Lung Diseases** **Helmut Prosch, Vienna/Austria** Medical University of Vienna
09:30-10:00	**Management of pulmonary nodules** **Guillaume Chassagnon, Paris/France** Hôpital Cochin
10:00-10:30	**Pulmonary manifestations of systemic diseases** **Cornelia Schaefer-Prokop, Amersfoort/Netherlands** Meander Medical Center
10:30-10:50	Coffee break
10:50-13:00	**Workshops**

	Helmut Prosch	Guillaume Chassagnon	Cornelia Schaefer-Prokop
10:50-11:30	Group 1	Group 2	Group 3
11:35-12:15	Group 2	Group 3	Group 1
12:20-13:00	Group 3	Group 1	Group 2

13:00-14:00	Lunch break
14:00-14:30	**Lung cancer staging** **Helmut Prosch, Vienna/Austria** Medical University of Vienna
14:30-15:00	**Pulmonary embolism** **Guillaume Chassagnon, Paris/France** Hôpital Cochin
15:00-15:30	**Pulmonary infections** **Cornelia Schaefer-Prokop, Amersfoort/Netherlands** Meander Medical Center
15:30-15:50	Coffee break
15:50-18:00	**Workshops**

	Helmut Prosch	Guillaume Chassagnon	Cornelia Schaefer-Prokop
15:50-16:30	Group 1	Group 2	Group 3
16:35-17:15	Group 2	Group 3	Group 1
17:20-18:00	Group 3	Group 1	Group 2

18:00	**Course Evaluation and End**

BOARD OF DIRECTORS

Jordanian Radiological Society



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President of Jordanian Radiological Society



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President of JRS - Congress President

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Chair, Scientific Committee

Prof. Tarek A. El-Diasty
Vice President, PAARS Congress

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ORMIS | Oman

Yaser Safi Ali
Syria

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Chairman of the Scientific Committee

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Dr. Jihad Fatafta

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تحت رعاية صاحبة السمو الملكي الأميرة غيداء طلال

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14th Pan Arab Association of Radiological Societies (PAARS) International Congress

In conjunction with The 15th International Congress of the Jordanian Radiological Society

In collaboration with the European School of Radiology (ESOR) & London Sheffield Radiology International Conference

Conference days: October 22-24, 2026

Pre conference ESOR Cardiothoracic course: October 21, 2026

The St. Regis (Amman, Jordan)

GUEST SPEAKERS


Abdullateef Ali


Alex Rovira Cañellas


Anas Khairi Awn


Ashwini Sharma


Asma Zidi


Assaad Mohanna


Ayman Ismail Amin Kamel


Bijan Bijan


Dinesh Chinchure


Emad Shenouda Naguib


Feras Awwad


Ioan Sporea


Jean-Pierre Tasu


Özgür Demirkılınç


Khaled M. Elsayes


Kshitij Mankad


Lamia Jamjoom


Mahmoud Alarini


Majida Alsultani


Mohamed Fawzi


Mousumi Bhaduri


Musturay Karcaaltincaba


Najat Cherif Idrissi El Ganouni


Robert Lambert


Tarek El Diasty


Walter Maksymowych

EUROPEAN SCHOOL OF RADIOLOGY (ESOR)


Helmut Prosch


Guillaume Chassagnon


Cornelia Schaefer-Prokop

LONDON SHEFFIELD RADIOLOGY INTERNATIONAL


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Saima Ajaz


Sameh Morcos


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Suha Alghoul

Tahani Khdair Ahmad

Wesam Shamma

14th Pan Arab Association of Radiological Societies (PAARS) International Congress

In conjunction with The 15th International Congress of the Jordanian Radiological Society



SPEAKER BIOGRAPHIES

INTERNATIONAL GUEST SPEAKERS

26 speakers, in alphabetical order by first name



Dr. Abdullateef Ali

Consultant Radiologist · Assistant Professor, College of Medicine, Mustansiriyah University, Baghdad | Iraq

MBChB · CABMS (Radiology) – Arab Board

Consultant radiologist and Assistant Professor at Mustansiriyah University College of Medicine, Baghdad. He is Program Director of Iraq's musculoskeletal radiology subspecialty and a regular teacher of MSK imaging at regional congresses.



Dr. Alex Rovira Cañellas

Head of the Neuroradiology Section, Vall d'Hebron University Hospital, Barcelona | Spain

MD · Past President, European Society of Neuroradiology (2016–2018)

Head of the Neuroradiology Section at Vall d›Hebron University Hospital, Barcelona, and Past President of the European Society of Neuroradiology. A leading authority on MRI in multiple sclerosis, stroke and neuro-oncology, with more than 500 published articles.



Dr. Anas Khairi Awn

Radiologist and Lecturer, University of Baghdad · Co-founder, One Stop Radiology | Iraq

MD

Radiologist and lecturer at the University of Baghdad and co-founder of One Stop Radiology, an online teaching platform that shares diagnostic imaging cases with radiologists, trainees and medical students.

MEET THE EXPERT



Dr. Ashwini Sharma

Consultant Radiologist (Breast Radiology), Western General Hospital, Edinburgh | United Kingdom

Medical degree, Bangalore Medical College · Diploma in Radio-diagnosis, KEM Hospital Mumbai · FRCR (Glasgow) · Chair, Scottish Breast Radiology Forum

Consultant Radiologist specializing in breast radiology at the Western General Hospital, Edinburgh, covering all aspects of screening and symptomatic imaging, with a keen interest in MRI and contrast-enhanced mammography. Chair of the Scottish Breast Radiology Forum and a clinical supervisor who teaches radiology trainees and film readers.



Prof. Asma Zidi

Professor of Radiology, Faculty of Medicine of Tunis · Head of Radiology, Institut Salah Azaiez | Tunisia

President-Elect, PAARS · Past President, Tunisian Radiological Society

Professor of Radiology at the Faculty of Medicine of Tunis and Head of the Radiology Service at Institut Salah Azaiez. President-Elect of PAARS and Past President of the Tunisian Radiological Society, with expertise in oncologic, breast and thoracic imaging.



Dr. Assaad Mohanna

Head of Medical Imaging, Bahman Hospital, Beirut · Assistant Professor, Lebanese University Faculty of Medical Sciences | Lebanon

Treasurer, PAARS

Head of the Medical Imaging Service at Bahman Hospital, Beirut, and Assistant Professor at the Lebanese University Faculty of Medical Sciences. Treasurer of PAARS, with clinical work in diagnostic and interventional imaging.

MEET THE EXPERT



Dr. Ayman Ismail Kamel

Head of Radiology and Chief Consultant Radiologist, Al Zahra Hospital Dubai | United Arab Emirates

MB BCh · MSc · MD (Cairo University) · FRCR (London)

Head of Radiology and Chief Consultant Radiologist at Al Zahra Hospital Dubai, with more than 25 years of experience. His practice combines advanced CT and MRI with vascular, neurovascular, and hepatobiliary interventional radiology.



Dr. Bijan Bijan

Radiologist and Nuclear Medicine Physician, Sutter Medical Group, Sacramento, California | USA

MD · Board certified in Radiology and in Nuclear Medicine (USA)

Radiologist and nuclear medicine physician with Sutter Medical Group in Sacramento, California. Board certified in both specialties, he focuses on oncologic MRI, PET and molecular imaging and is a frequent international lecturer.



Dr. Dinesh Chinchure

Senior Consultant, Department of Diagnostic Radiology, Khoo Teck Puat Hospital | Singapore

MBBS · FRCR (UK)

Senior Consultant in Diagnostic Radiology at Khoo Teck Puat Hospital, Singapore, and a teacher at Singapore›s medical schools. An invited speaker at AOCR 2026, with interests in emergency, chest and body imaging and AI in radiology.

MEET THE EXPERT



Dr. Emad S. Naguib

Consultant Radiologist · Secretary General, PAARS | Egypt

Secretary General, ESRNM and African Society of Radiology (ASR) · ISR Executive Committee Member

Consultant radiologist and Secretary General of PAARS, the Egyptian Society of Radiology and Nuclear Medicine and the African Society of Radiology. He represents Africa on the Executive Committee of the International Society of Radiology.



Feras Awwad

Modality General Manager – CT, GE HealthCare, Eurasian & African Growth Markets (EAGM) | United Arab Emirates

Modality General Manager for Computed Tomography at GE HealthCare, leading the CT imaging business across the Eurasian & African Growth Markets (EAGM) region.



Prof. Ioan Sporea

Professor of Gastroenterology, Victor Babeș University of Medicine and Pharmacy, Timișoara | Romania

MD, PhD · Past President, WFUMB · Honorary Member, EFSUMB

Professor of Gastroenterology at Victor Babeș University of Medicine and Pharmacy, Timișoara, and Past President of the World Federation for Ultrasound in Medicine and Biology. An international authority on liver elastography and contrast-enhanced ultrasound, and co-author of 17 international guidelines.

MEET THE EXPERT



Prof. Jean-Pierre Tasu

Professor of Radiology, Poitiers University Hospital (CHU de Poitiers) | France

MD, PhD · Executive Committee Member, International Society of Radiology (ISR)

Professor of Radiology at Poitiers University Hospital, France, specialising in abdominal and musculoskeletal imaging. An elected member of the Executive Committee of the International Society of Radiology, he works to make imaging and radiology education more accessible worldwide.



Özgür Demirkılınç

Clinical Team Leader, Magnetic Resonance, GE HealthCare Emerging Markets | Türkiye

Radiology diploma, Istanbul University-Cerrahpaşa · Master›s in Organization Management, Ahmet Yesevi University

Clinical Team Leader for MR at GE HealthCare Emerging Markets, leading the MR clinical team across the Middle East, Türkiye & Central Asia and Africa. With a foundation in clinical MR practice and more than 15 years at GE HealthCare, he focuses on clinical education, the adoption of new MR technologies and building local expertise.



Prof. Khaled M. Elsayes

Professor of Radiology, Department of Abdominal Imaging, MD Anderson Cancer Center, Houston | USA

MD (Cairo University) · American Board of Radiology · Fellowship, University of Michigan

Professor of Radiology in the Department of Abdominal Imaging at The University of Texas MD Anderson Cancer Center, Houston, where he directs faculty development and mentorship. An expert in CT and MRI of liver, biliary and adrenal tumours.

MEET THE EXPERT



Dr. Kshitij Mankad

Director of Radiology, Great Ormond Street Hospital, London · Hon. Associate Professor, University College London | United Kingdom

MD · MRCP · FRCR · PG Dip Hospital Management · Lean Six Sigma Black Belt · President Emeritus, Society of Pediatric Neuroimaging

Director of Radiology at Great Ormond Street Hospital, London, and Honorary Associate Professor at University College London. A consultant paediatric neuroradiologist and President Emeritus of the Society of Pediatric Neuroimaging, he is an internationally known educator in paediatric brain and spine imaging.



Dr. Lamia Jamjoom

Consultant Cardiothoracic Radiologist · Chairman, Radiology Department, King Abdulaziz University, Jeddah | Saudi Arabia

MD · DABR · Chair, RSNA Regional Committee for the Middle East and Africa · Executive Committee Member, ISR

Consultant cardiothoracic radiologist and Chairman of the Radiology Department at King Abdulaziz University. She chairs the RSNA Regional Committee for the Middle East and Africa and serves on the Executive Committee of the International Society of Radiology (ISR). She is Former President of the Pan Arab Association of Radiological Societies (PAARS) and of the Radiological Society of Saudi Arabia.



Dr. Mahmoud Alarini

Assistant Professor of Radiology · Former Director of Body MRI, UVA Health, University of Virginia | USA

MD (University of Jordan) · American Board of Radiology · FRCR

Assistant Professor of Radiology and former Director of Body MRI at UVA Health, University of Virginia. A University of Jordan graduate, he specialises in liver, biliary and prostate cancer imaging and image-guided procedures.

Dr. Majida Al Sultani



Diagnostic Radiologist, Baghdad Medical City Complex | Iraq

Diagnostic radiologist at the Baghdad Medical City Complex, Iraq, lecturing on musculoskeletal imaging. Invited speaker at the 4th Congress of the Iraqi Society of Radiologists and Medical Imaging (Baghdad, September 2026), where the talk was a practical guide to bone marrow oedema in MSK radiology.



Prof. Mohamed Fawzi
Radiology Advisor to the Minister of Health, Egypt | Egypt
MD · Head of Diagnostic and Interventional Radiology, NHTMRI, Cairo

Radiology Advisor to Egypt›s Minister of Health and Population. He also heads the Department of Diagnostic and Interventional Radiology at the National Hepatology and Tropical Medicine Research Institute, Cairo.



Dr. Mousumi Bhaduri
Associate Professor of Radiology, Western University, London | Canada
MBBS · DMRD · DNB · ABR · Director, Diagnostic Radiology Residency Program

Associate Professor of Radiology at the Schulich School of Medicine & Dentistry, Western University, and Citywide Obstetric Imaging Lead. An abdominal and women's imaging radiologist, her interests include pelvic imaging and high-risk obstetric ultrasound and MRI.

MEET THE EXPERT



Prof. Musturay Karcaaltincaba

Professor of Radiology, Hacettepe University Faculty of Medicine, Ankara | Türkiye

MD · Body Imaging Fellowship, Medical College of Wisconsin · ECR 2027 Subcommittee Chair, Abdominal Viscera

Professor of Radiology at Hacettepe University, Ankara, with more than 260 publications in abdominal and cardiac imaging, liver MRI and CT. He chairs the Abdominal Viscera scientific subcommittee for the European Congress of Radiology 2027.



Prof. Najat Cherif Idrissi El Ganouni

Professor of Radiology, Cadi Ayyad University · Head of Radiology, Arrazi Hospital, Mohammed VI University Hospital, Marrakech | Morocco

President, Moroccan Society of Radiology · Honorary Member, European Society of Radiology (2026)

Professor at the Faculty of Medicine and Pharmacy of Marrakech and Head of Radiology at Arrazi Hospital, Mohammed VI University Hospital. President of the Moroccan Society of Radiology and, in 2026, the first Moroccan radiologist named Honorary Member of the European Society of Radiology.



Prof. Robert Lambert

Professor of Radiology and Diagnostic Imaging, University of Alberta, Edmonton | Canada

MB BCh · FRCR · FRCPC

Professor of Radiology and Diagnostic Imaging at the University of Alberta, Edmonton, and former Department Chair (2002–2016). A pioneer of musculoskeletal MRI in Canada and an international authority on imaging of spondyloarthritis and arthritis.



Prof. Tarek A. El-Diasty
Emeritus Professor of Radiology, Urology and Nephrology Center, Mansoura University | Egypt
MD · President, PAARS · Secretary General, ISR · Honorary Member, RSNA and ESR

Emeritus Professor of Radiology at the Urology and Nephrology Center, Mansoura University, and a pioneer of uroradiology in Egypt. President of PAARS and of the Egyptian Society of Radiology and Nuclear Medicine, and Secretary General of the International Society of Radiology.



Prof. Walter P. Maksymowych
Professor of Medicine, Division of Rheumatology, University of Alberta · Chief Medical Officer, CARE Arthritis | Canada
MB ChB · FRCPC · FACP

Professor of Medicine in the Division of Rheumatology at the University of Alberta and Chief Medical Officer of CARE Arthritis. A rheumatologist with more than 300 publications, he developed widely used MRI scoring methods for spondyloarthritis.

INTERNATIONAL GUEST SPEAKERS

3 speakers, in alphabetical order by first name



Assoc. Prof. Helmut Prosch
Deputy Head of General and Paediatric Radiology · Section Chief of Thoracic Imaging, Medical University of Vienna | Austria
Associate Professor, Medical University of Vienna · President-Elect, European Society of Thoracic Imaging (ESTI)

Associate Professor at the Medical University of Vienna, Deputy Head of General and Paediatric Radiology and Section Chief of Thoracic Imaging. His research focuses on lung cancer diagnosis and deep learning in lung disease. He has published over 250 works and is President-Elect of ESTI.



Prof. Guillaume Chassagnon
Professor of Radiology, Cochin Hospital, Paris | France
PhD in Mathematics/Computer Science · Thoracic Imaging and AI

Professor of Radiology at Cochin Hospital, Paris, specialized in thoracic imaging and AI. His research focuses on machine learning, interstitial lung diseases and bronchial diseases. He has authored 110+ papers and serves on several journal boards.



Prof. Cornelia Schaefer-Prokop
Professor, Hannover Medical School and Radboud UMC | Netherlands
Former President, European Society of Thoracic Imaging (ESTI) and the Fleischner Society

Internationally recognised chest radiologist and Professor at Hannover Medical School and Radboud UMC. Former President of ESTI and the Fleischner Society, she has published 200+ papers, lectures widely, and is renowned for her educational leadership in thoracic imaging.

LONDON SHEFFIELD RADIOLOGY INTERNATIONAL FACULTY

7 speakers, in alphabetical order by first name



Dr. Hammad Siddiqi

Consultant Radiologist, Mid and South Essex NHS Foundation Trust | United Kingdom

FRCR

Consultant Radiologist at Mid and South Essex NHS Foundation Trust, United Kingdom. He specialises in cross-sectional imaging with a subspecialty interest in musculoskeletal imaging.



Dr. Mohanad Kareem Aftan

Consultant Musculoskeletal Radiologist, Manchester University NHS Foundation Trust | United Kingdom

FRCR · MSK Fellowship, Royal National Orthopaedic Hospital, London

Consultant Radiologist at Manchester University NHS Foundation Trust, specialising in musculoskeletal imaging and intervention. His work includes CT-guided ablation of bone tumours and image-guided pain procedures, and he is a core member of the sarcoma team.



Dr. Saima Ajaz

Hepatologist and Lifestyle Medicine Physician · Honorary Senior Clinical Lecturer, King's College London | United Kingdom

MBBS · MPhil · PhD · Dip IBLM/BSLM

Hepatologist and lifestyle medicine physician working in liver research at King's College Hospital, London, and Honorary Senior Clinical Lecturer at King's College London. Medical Director of Pro Lifestyle Wellness, with a focus on fatty liver disease (MASLD) and non-invasive biomarkers.



Prof. Sameh K. Morcos

Emeritus Professor of Diagnostic Imaging, University of Sheffield | United Kingdom

FRCS · FFRRCSI · FRCR · Past President, European Society of Urogenital Radiology (ESUR)

Emeritus Professor of Diagnostic Imaging at the University of Sheffield and former Consultant Radiologist at Sheffield Teaching Hospitals (1983–2011). An international authority on contrast media safety, with more than 200 publications in uroradiology and thoracic imaging. Founder and Honorary Chairman of the Sheffield/London Global Education Programme in Diagnostic Imaging.



Dr. Sujit Vaidya

Consultant Radiologist, Barts Health NHS Trust, London | United Kingdom

MBBS · MD

Consultant Radiologist at Barts Health NHS Trust, London. His specialist interests are musculoskeletal and spine imaging using MRI and CT.



Dr. Kalthoum Mourad (Suma Mourad)

British Radiologist · Member, Royal College of Radiologists | United Kingdom

M.B.B.Ch. (Cairo University) · D.M.R.D. (Cairo and London) · FRCR

A graduate of Cairo University, she earned her D.M.R.D. with distinction in Cairo, followed by a D.M.R.D. in London and Fellowship of the Royal College of Radiologists in 1979. She has been fully registered with the UK General Medical Council since 1980.

MEET THE EXPERT



Dr. Syed Babar
Consultant Radiologist, Imperial College Healthcare NHS Trust · Honorary Senior Lecturer, Imperial College London | United Kingdom
MBBS · MCPS · FCPS · DMRD · FRCR

Consultant Radiologist at Imperial College Healthcare NHS Trust and Honorary Senior Lecturer at Imperial College London. A sports and musculoskeletal imaging specialist who works with elite cricket, rugby and football teams, and President of the London Sheffield International Teaching Initiative.

JORDAN FACULTY

11 speakers, in alphabetical order by first name



Dr. Abdallah Jamil Nofal
Senior Consultant Radiologist · Chairman, Department of Diagnostic Radiology, King Hussein Cancer Center, Amman | Jordan
MB BCh · FRCR · Jordanian Board (Jordan Medical Council)

Chairman of the Department of Diagnostic Radiology and Senior Consultant Radiologist at King Hussein Cancer Center, Amman.



Dr. Adnan Zayadeen
Consultant Radiologist · Head, Diagnostic and Interventional Ultrasound Section, Jordanian Royal Medical Services | Jordan
MD (UJ) · JBR · JBUS · Examiner, Jordanian Radiology Board · Board Member, Jordanian Radiological Society

Consultant Radiologist and Head of the Diagnostic and Interventional Ultrasound Section at the Jordanian Royal Medical Services, with particular interest in Doppler, CEUS, shear-wave elastography, ultrasound-guided interventions, tumor ablation and liver transplantation imaging. A regular lecturer and workshop faculty member at national and international meetings.



Dr. Ala' Ibrahim
Associate Professor of Radiology and Assistant Dean, Faculty of Medicine, Yarmouk University · Radiology Division Coordinator | Jordan
Consultant Pediatric Radiologist & Pediatric Neuroradiologist

Associate Professor of Radiology, Assistant Dean and Radiology Division Coordinator at the Faculty of Medicine, Yarmouk University. Consultant pediatric radiologist and pediatric neuroradiologist.

MEET THE EXPERT



Dr. Jamil Shawaqfeh

Consultant Musculoskeletal Radiologist, Royal Medical Services · Head of MSK Team, RMS | Jordan

Jordanian Board in Radiology · Jordanian Board in MSK Radiology

Consultant musculoskeletal radiologist and Head of the MSK team at the Jordanian Royal Medical Services. Head of the Scientific Committee for Diagnostic Radiology at the Jordan Medical Council, JRS Board Member and member of the congress Scientific Committee.



Dr. Khaleel AlQararha

Consultant Interventional Radiologist · Program Director, Interventional Radiology Fellowship, King Hussein Cancer Center, Amman | Jordan

MBBS (JUST) · Jordanian Board in Diagnostic Radiology · Fellowships: Royal Marsden and King›s College Hospital, London

Consultant Interventional Radiologist and Program Director of the Interventional Radiology Fellowship at King Hussein Cancer Center, Amman. Fellowship-trained in oncologic, vascular and hepatobiliary intervention at the Royal Marsden and King›s College Hospital, London.



Prof. Mahasen Al-Najar

Professor of Radiology, University of Jordan School of Medicine · Consultant, Jordan University Hospital | Jordan

Professor of Radiology at the University of Jordan School of Medicine and consultant in women's and diagnostic imaging at Jordan University Hospital. Her clinical and research focus is breast imaging and breast cancer diagnosis.

MEET THE EXPERT



Prof. Mwafaq Elheis

Professor and Senior Consultant Radiologist, Jordan University of Science and Technology | Jordan

Professor and Senior Consultant in Radiology at King Abdullah University Hospital, Irbid, with clinical work in diagnostic and interventional radiology.



Dr. Naser Obeidat

Assistant Professor of Radiology, Jordan University of Science and Technology · Consultant Radiologist, King Abdullah University Hospital | Jordan

MBBS · Jordanian Board of Radiology · Fellowship, Royal Perth Hospital

Assistant Professor of Radiology at Jordan University of Science and Technology and Consultant Radiologist at King Abdullah University Hospital. He specialises in musculoskeletal and abdominal imaging and directs the MSK imaging fellowship programme at KAUH.



Dr. Suha Ghoul

Consultant Breast and Body Radiologist, King Hussein Cancer Center, Amman | Jordan

JRS Board Member · President, Jordan Disease Prevention and Control Society

Dr. Ghoul specializes in women's imaging and body MRI, and played a key role in establishing the breast imaging program at KHCC. She completed fellowships in Canada and is committed to radiology education and community outreach.



Prof. Tahani Khdair Ahmad
Pediatric Radiologist and Pediatric Neuroradiologist, The University of Jordan · Professor of Radiology, Dalhousie University, Canada | Jordan
American Board in Diagnostic Radiology · American Board in Pediatric Radiology · Canadian Subspecialty Affiliate in Pediatric Radiology · Fellowship, SickKids Hospital, Toronto

Pediatric radiologist and pediatric neuroradiologist at The University of Jordan and Professor of Radiology at Dalhousie University, Canada. Certified by the American Board in Diagnostic Radiology and in Pediatric Radiology, a Canadian Subspecialty Affiliate in Pediatric Radiology, with fellowship training at SickKids Hospital, Toronto.



Dr. Wesam Shamma
Consultant Radiologist, Islamic Hospital, Amman · Chairman, Scientific Committee – PAARS & JRS 2026 | Jordan
FRCR · EDiR

Consultant Radiologist at the Islamic Hospital, Amman, where he has also served as Head of the Radiology Department and Radiology Program Director. Active in radiology education, residency training and mentorship in Jordan and across the Arab region, he is Chairman of the Scientific Committee of the PAARS & JRS 2026 International Congress.

14th Pan Arab Association of Radiological Societies (PAARS) International Congress

In conjunction with

The 15th International Congress of the Jordanian Radiological Society



SCIENTIFIC PROGRAM

Session 1 — Hall A

08:00-08:30 Registration

Moderators
Prof. Waleed Mahafza, Dr. Abdullah Jamil, Dr. Tarek El Diasty (Egypt)

08:30–08:55	**Introduction to the London Sheffield Global Educational Program on Diagnostic Imaging** **Prof. Sam Morcos | UK**
08:55–09:20	**Medical Screening — Are They a Blessing?** **Dr. Suma Murad | UK**
09:20–09:45	**Cover Scan Uncovered: A New Era in Multi-Organ Diagnostics** **Dr. Saima Ajaz | UK**
09:45–10:10	**AI in Interstitial Lung Diseases** **Prof. Guillaume Chassagnon | France**
10:10–10:15	Discussion
10:15–10:35	**Coffee Break**

Session 2 **Hall A**

Moderators
Dr. Abdullah Omari, Dr. Emad Naguib (Egypt), Dr. William Maaiah

10:35–11:00	**The new ERS / ATS 2025 classification of interstitial pneumonia: what do we need to know?** **Dr. Cornelia Schaefer-Prokop | Netherlands**
11:00–11:25	**Acute chest pain: non-cardiac causes** **Prof. Guillaume Chassagnon | France**
11:25–11:50	**Pulmonary manifestations of collagen vascular diseases** **Dr. Cornelia Schaefer-Prokop | Netherlands**
11:50–12:15	**Diseases involving trachea** **Prof. Guillaume Chassagnon | France**
12:15–12:40	**Typical and atypical pulmonary findings in sarcoidosis** **Dr. Cornelia Schaefer-Prokop | Netherlands**
12:40–12:50	Discussion
13:00–14:00	**Lunch**

Session 3 **Hall A**

Moderators
Dr. Ahmad Abuain, Dr. Naser Obeidat, Dr. Emad Tarawneh

14:00–14:25	**Intervention in Sports-Related Injuries** **Dr. Syed Babar | UK**
14:25–14:50	**Marrow Fat: Diagnostic Friend or Foe?** **Dr. Mohanad Kareem Aftan | UK**
14:50–15:15	**Shoulder Imaging: Case Review** **Dr. Hammad Siddiqi | UK**
15:15–15:40	**Image Interpretation of the Spine — A Primer** **Dr. Sujit Vaidya | UK**
15:40–15:45	Discussion
15:45–16:10	**Coffee Break**

Session 4 **Hall A**

Moderators
Dr. Samih Al Khulaifat, Dr. Jehad Fataftah, Dr. Dhamen Alzinat

16:10–16:35 **Postoperative Knee- what the radiologists want to know.**
Dr. Mohanad Kareem Aftan | UK

16:35–16:50 **Finger Injuries**
Dr. Naser Obaidat | JO

16:50:17:25 **MRI Symposium**
Topic: MR Imaging in Neurodegenerative Disease – Clinical Applications, Current Advances, and the Role of AI.

CT Symposium
Topic: CT Spectral Technology in Oncology, with Particular Emphasis on Photon-Counting CT

Speaker: Dr. Ayman Ismail Amin Kamel | UAE

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17:25–17:30 Discussion

OPENING CEREMONY PROGRAM

18:30 – 20:00

National Anthem
Recitals from the Holy Quran

Address of the Scientific Chairman of the Conference
Dr. Wesam Shamma

Address of the President of the Conference and Society
Prof. Waleed Mahafza

Address of the President of the PAARS
Prof. Tarek El Diasty

Address of the President of Jordan Medical Association
Dr. Issa Khashashneh

Conference Patronage Address
HRH Princess Ghida Talal

Master of Ceremony
Dr. Suha Ghoul

Opening of the Medical Exhibition & Networking

Moderators
Dr. Asem Al Hiari, Dr. Jamil Shawaqfeh, Dr. Hamza Abbadi

08:30–08:55	**Clinical Applications of Artificial Intelligence in Liver Imaging** **Prof. Khaled Elsayes | USA**
08:55–09:20	**Seeing the unseen in liver Imaging** **Prof. Musturay Karcaaltincaba | Turkey**
09:20–09:45	**Multiparametric liver MRI** **Prof. Musturay Karcaaltincaba | Turkey**
09:45–10:10	**Case-Based LI-RADS: Fundamental, Nuts & Bolts, Advanced** **Dr. Bijan Bijan | USA**
10:10–10:35	**Pitfalls, Errors and Misdiagnoses in Oncologic Imaging of the Abdomen and Pelvis** **Prof. Khaled Elsayes | USA**
10:35–10:40	Discussion
10:40–10:55	**Coffee Break**

Moderators
Dr. Adnan Zayadeen, Dr. Qamar Malaabeh, Dr. Yazeed Bagain

10:55–11:20	**Multiparametric Ultrasound for Focal Liver Lesion** **Prof. Ioan Sporea | Romania**
11:20–11:45	**Clinical Cases on Small Gut Tumours** **Prof. Jean Pierre Tasu | France**
11:45–12:10	**Imaging Assessment of Adrenal Function** **Prof. Khaled Elsayes | USA**
12:10–12:35	**AI in Ultrasound** **Prof. Ioan Sporea | Romania**
12:35–12:40	Discussion
12:40–14:00	**Friday Prayer & Lunch**

Moderators
Dr. Omar Khries, Dr. Zeid Alaween, Dr. Nourah H. Almubarak (Kuwait)
Dr. Mohammad Abu Shattal

14:00–14:25	**Diagnostic Approach in Diagnosing Splenic Masses** **Prof. Khaled Elsayes | USA**
14:25–14:50	**Prostate MRI Cases You Have Never Seen.** **Prof. Musturay Karcaaltincaba | Turkey**
14:50–15:15	**Radiology Under Pressure: Tough Trauma and ED Cases** **Dr. Mahmoud Alarini | USA**
15:15–15:40	**AI Application in Emergency Imaging** **Dr. Bijan Bijan | USA**
15:40–16:05	**Neuroblastoma: imaging essentials** **Dr. Tahani Khdair Ahmad | Jordan**
16:05–16:10	Discussion
16:10–16:35	**Coffee Break**

Moderators
Dr. Laila Abu Tahoun, Dr. Nariman Alnsour, Dr. Asma Zidi (Tunisia)

16:35–17:00 **Gynaecological Oncologic Imaging: Comparison of MRI and PET**
Dr. Bijan Bijan | USA

17:00–17:25 **Contrast-Enhanced Mammography: Technique and Applications**
Dr. Ashwini Sharma l UK

17:25–17:50 **Women's Imaging Services Across Fragile Settings**
Dr. Suha Ghoul | JO

17:50–18:15 **MR Evaluation of Endometriosis: What and Where to Look For**
Dr. Mahasen Alnajjar | JO

Session 9 **Hall A**

Moderators
Dr. Mamoun Alomary, Dr. Rafiq Haddad, Dr. Lamia Jamjoom (KSA)
Dr. William Maaiah

08:00–08:25	**Imaging solid parenchymal renal masses** **Tarek Eldiasty I Egypt**
08:25–08:50	**How to assess cardiac amyloidosis by Cardiac MRI** **Asma Zidi I Tunisia**
08:50–09:15	**Clinical cases in thoracic imaging** **Najat Idrissi I Morocco**
09:15–09:40	**Reporting in Imaging: Current status and future trends** **Emad S. Naguib I Egypt**
09:40–10:00	**HIFU: Current implementations and future expectations** **Mohamed Fawzi I Egypt**
10:00–10:05	Discussion
10:05–10:15	**Coffee Break**

Session 10 — Hall A

Moderators
Dr. Maysoon Banihani, Dr. Ahmad Elayan, Dr. Issam Jaber

10:15–10:40	**Brain Imaging in Dementia** **Dr. Assad Mohanna | Lebanon**
10:40–11:05	**Carotid Dissection: Diagnosis and When to Interfere** **Dr. Mwafaq Elheis | JO**
11:05–11:30	**Essentials of Non-Vascular Blunt Thoracic Trauma** **Dr. Chinchure Dinesh | Singapore**
11:30–11:55	**NSCLC Loco-Regional Therapy: Widen the Application** **Dr. Khaleel Alqararha | JO**
11:55-12:00	Discussion
12:00–12:25	**Industrial Symposium**
12:25–13:00	**Enabling Precision medicine in CT.** **Feras Awwad, UAE** **MRI Beyond Today: A Snapshot of Innovations Shaping Clinica Practice.** **Kemal Ozgur Demirkilinc, Turkey**
13:00–14:00	**Lunch**

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Session 11 — Hall A

Moderators
Dr. Wesam Shamma, Dr. Anas Shehab, Dr. Ola Alemam

14:00–14:25	**White Matter Disorders: A Step-Wise Guide to Narrowing Differentials** **Dr. Kish Mankad | UK**
14:25–14:50	**A Good Radiology Report: Fundamentals to AI** **Dr. Chinchure Dinesh | Singapore**
14:50–15:15	**Childhood Epilepsy: Using Technology to Improve the Diagnostic Yield of Imaging** **Dr. Kish Mankad | UK**
15:15–15:40	**Errors in Reporting: Why Do We Make Them and How to Avoid?** **Dr. Chinchure Dinesh | Singapore**
15:40–16:05	**Stroke in Pediatrics** **Dr. Ala Ibrahim | JOR**
16:05-16:30	**Coffee Break**

Session 12 **Hall A**

Moderators
Dr. Nart Ebda, Dr. Ashraf Tamimi, Dr. Majed Dwaik (Palestine)

16:30-16:55	**Whole Body Blunt Trauma Imaging Strategies to Avoid Errors** **Dr. Chinchure Dinesh | Singapore**
16:55-17:20	**Real-World Impact of Neuroradiology in Paediatric Neuro-Oncology Practice** **Dr. Kish Mankad | UK**
17:20-17:45	**Imaging of Sellar and parasellar masses: what we need to know** **Dr. Abdullah Jamil I JOR**
17:45-18:10	**Neuroinflammation: An Update** **Dr. Kish Mankad | UK**
18:10-18:35	**Imaging of pediatric brain tumor** **Dr. Tahani Khdair Ahmad /Jor**
18:35	**Closing Remarks and Photo Session**

ORAL ABSTRACT PRESENTATIONS — Hall B

NO.	TIME	PRESENTATION TITLE	SPEAKER
B-01	09:00 – 09:10	Susceptibility-Weighted Imaging Versus CT in Differentiating Microhemorrhage and Calcification	**Dr. Safwan Alrawabdeh** Jordanian Royal Medical Services
B-02	09:10 – 09:20	Evaluating the Role of Skull X-ray and Computed Tomography in the Diagnosis of Craniosynostosis	**Dr. Mohammed Al Smadi** Senior Pediatric Radiologist
B-03	09:20 – 09:30	Multimodality Imaging of Renal Cell Carcinoma: CT and MRI Characterization of Subtypes and Diagnostic Pitfalls	**Dr. Mohamad Samarah**
B-04	09:30 – 09:40	Radiologic Evaluation of Parathyroid Nodules: Role of Imaging in Diagnosis and Localization	**Dr. Lubna Hasan Alheneiti** Department of Diagnostic Radiology, Royal Medical Services, Amman
B-05	09:40 – 09:50	Ultrasound-First Imaging Pathway in Pediatric Appendicitis	**Dr. Mohammed Bilal Numan** Jordanian Royal Medical Services
B-06	09:50 – 10:00	External Ear Diseases: A Radiological Approach Based on Clinical Presentation	**Dr. Omar S. Altamimi** Radiology Department, Jordanian Royal Medical Services, King Hussein Medical Center, Amman
B-07	10:00 – 10:10	Pneumatosis Intestinalis: Benign Versus Life-Threatening Causes	**Dr. Duha Alwreikat, MD** Radiologist
B-08	10:10 – 10:20	Comparing Diagnostic Accuracy of CT, MRI, and Nuclear Medicine Studies in Adrenal Pheochromocytoma	**Dr. Raad Youssef Al Tahat** Radiology Department, KHMC, JRMS, Amman

ORAL ABSTRACT PRESENTATIONS — Hall B

NO.	TIME	PRESENTATION TITLE	SPEAKER
B-09	10:20 – 10:30	Acute Appendicitis Presenting as Intestinal Obstruction: A Review of the Literature	**Dr. Weam Mohammad Edaibat** Diagnostic Radiology Specialist, Royal Medical Services
B-10	10:30 – 10:40	Imaging of Central Airway Diseases	**Dr. Audai Ahmad Shyyab**
B-11	10:40 – 10:50	Benign Bone Tumours by X-ray	**Dr. Basil Odeh Abdallah Albtoosh**
B-12	10:50 – 11:00	Ultrasound Assessment of Psoriatic Arthritis: Diagnostic Value and Follow-Up Utility	**Dr. Ahmad Abdelkarim Matalqah** Radiology Department, KHMC, JRMS, Amman
B-13	11:00 – 11:10	How Artificial Intelligence Will Improve Breast Cancer Detection by Radiologists	**Dr. Renad Aldurgham, MD**
B-14	11:10 – 11:20	Comparative Effectiveness of Mammography, Ultrasound, and MRI in the Detection of Breast Carcinoma in Dense Breast Tissue	**Dr. Zain Abu Abeileh, MD, JBR, ABR**
B-15	11:20 – 11:30	Determinants of Diagnostic Confidence in Coronary CT Angiography	**Dr. Suzan M. AlWaked, MD** Department of Diagnostic Radiology, Royal Medical Services, Amman
B-16	11:30 – 11:40	Central Venous Access: Interventional Radiology Point of View	**Dr. Nemer Alshakhshir** Diagnostic & Interventional Radiologist, Jordanian Royal Medical Services

ORAL ABSTRACT PRESENTATIONS — Hall B

NO.	TIME	PRESENTATION TITLE	SPEAKER
B-17	11:40 – 11:50	Incidental Adrenal Lesions on CT and MRI: A Practical Imaging Algorithm for Characterization	**Dr. Mohammad Isam Ali Bany Doumi**
B-18	11:50 – 12:00	Diagnostic Pitfall of Left-Sided Acute Appendicitis in the Setting of Intestinal Malrotation: A Case Report	**Dr. Shatha Essam Dmour** Diagnostic Radiology Specialist, Royal Medical Services
B-19	12:00 – 12:10	Role of Skull X-ray in the Diagnosis of Craniosynostosis	**Dr. Ayat Aziz Al Alwan**
B-20	12:10 – 12:20	Radiological Manifestations of Gastrointestinal Involvement in Familial Mediterranean Fever: A Pictorial Review	**Dr. Sajeda Ibrahim Ali Al-Owdat, MD**
B-21	12:20 – 12:30	Osteomyelitis: Imaging Diagnosis and Complications	**Dr. Samer Falah Alqudah**
B-22	12:30 – 12:40	Pelvic MRI Evaluation of Treatment Response in Rectal Cancer: Experience from JRMS	**Dr. Ahmad Salem Kreishan, MD** Radiology Department, Jordanian Royal Medical Services, King Hussein Medical Center, Amman
B-23	12:40 – 12:50	The Role of Magnetic Resonance Imaging in the Diagnosis and Management of Rotator Cuff Tears	**Dr. Amr Al-Damen** Radiology Specialist
B-24	12:50 – 13:00	Greater Trochanteric Pain Syndrome: Incidence and Clinical Importance	**Dr. Mohammed A. Elbes, MD** MSK Radiologist, Royal Medical Services

ORAL ABSTRACT PRESENTATIONS — Hall B

NO.	TIME	PRESENTATION TITLE	SPEAKER
B-25	13:00 – 13:10	Evaluating the Role of Ultrasound in the Diagnosis of Pediatric Intussusception	**Dr. Zaid A. Al-Hayajneh**
B-26	13:10 – 13:20	Contrast Extravasation on Contrast-Enhanced CT as a Reliable Imaging Sign of Hemorrhagic Severity and Need for Treatment in Pelvic Fractures	**Dr. Maies Nayel Al-Jbour** Radiology Specialist, Royal Medical Services
B-27	13:20 – 13:30	Imaging Evaluation of Breast Calcifications Detected on Mammography	**Dr. Shaden Alrawashdeh, MD** Department of Diagnostic Radiology, Royal Medical Services, Amman
B-28	13:30 – 13:40	Localisation of Parathyroid Adenoma: An Overview	**Dr. Mohammad Hyari, MBBS, JBR, FRCR**
B-29	13:40 – 13:50	Imaging Spectrum of Male Breast Diseases: Differentiating Benign and Malignant Lesions	**Dr. Amal A. Al-Hosban** Radiology Department, Jordanian Royal Medical Services, King Hussein Medical Center, Amman
B-30	13:50 – 14:00	Mammography and Its Practical Impact on Breast Cancer Surgery: A Review	**Dr. Noor Abdullah Al Kayed** Radiology Specialist, Royal Medical Services
B-31	14:00 – 14:10	Imaging Evaluation of Acute Ischemic Stroke in the Era of Advanced Neuroimaging	**Dr. Moad Falah Albdairat, MD** Radiologist
B-32	14:10 – 14:20	Non-Traumatic Acute Abdomen on CT: Common Pitfalls and How to Avoid Them	**Dr. Ara Mohammad Bani Melhem**

ORAL ABSTRACT PRESENTATIONS — Hall B

NO.	TIME	PRESENTATION TITLE	SPEAKER
B-33	14:20 – 14:30	Role of MRI in Evaluating Laryngeal Masses	**Dr. Khaldoon Ahmad Hadidi, MD** Radiologist
B-34	14:30 – 14:40	The Role of Artificial Intelligence in Detecting Lung Nodules on Computed Tomography	**Dr. Saja Mohammad Kofahi, MD** Radiologist
B-35	14:40 – 14:50	The Role of MRI in Diagnosing Prostate Cancer	**Dr. Montaser M. Sha'ban** Jordanian Royal Medical Services
B-36	14:50 – 15:00	Imaging of Splenosis	**Dr. Hajem AbuDalou, MD, JRMS**
B-37	15:00 – 15:10	Imaging of Small Bowel Lymphoma	**Dr. Hala Al-Salman, MD**
B-38	15:10 – 15:20	MRI Features of Neuro-Behçet's Disease	**Dr. Muna Alshubeilat, MD, JBR, FRCR**
B-39	15:20 – 15:30	Osteochondral Lesions of the Knee: Differentiating Osteochondritis Dissecans from Avascular Necrosis	**Dr. Ibrahim Al Okour**
B-40	15:30 – 15:40	Role of Penile Doppler Ultrasound in Vasculogenic Erectile Dysfunction	**Dr.Omar Ahmad AL-abbadi**
B-41	15:40 – 15:50	Late Surgical Site Hemorrhage as a Possible Radiologic Indicator of Early Tumor Recurrence in Grossly Totally Resected High-Grade Meningioma: A Case Report	**Dr. Alaa G. Al-Maaitah, MD** Department of Diagnostic Radiology and Imaging, King Hussein Medical Center

ORAL ABSTRACT PRESENTATIONS — Hall B

NO.	TIME	PRESENTATION TITLE	SPEAKER
B-42	15:50 – 16:00	Impact of Below-Knee Angioplasty on Lower Limb Amputation Rates	**Dr. Mohammad Nasr Muqbel Ahmad** Head of IR Unit, Princess Basma Teaching Hospital, Jordan Ministry of Health
B-43	16:00 – 16:10	Pattern of Uveitis in a Tertiary Hospital in North Jordan and the Impact of Behçet's Disease	**Dr. Fatemah Kamel Ababneh**



Day 2 **Friday, October 23, 2026**

ORAL ABSTRACT PRESENTATIONS — Hall B

TIME	PRESENTATION TITLE	SPEAKER
16:00 – 16:10	Vocal Cord Sign: A Potential New CTA Imaging Sign for Early Detection of Lateral Medullary Syndrome	**Dr. Bushra Tahan** Department of Radiology, Rashid Hospital, Dubai Health Authority, Dubai, UAE
16:10 – 16:20	Invasive Ductal Carcinoma Developing within a Longstanding Breast Fibroadenoma	**Dr. Bushra Tahan** Department of Radiology, Rashid Hospital, Dubai Health Authority, Dubai, UAE
16:20 – 16:30	The Effect of Medical Image Presentation on the Detection of Subtle Abnormalities in Mammography and Chest Radiography	**Prof. Mohammad Rawashdeh** Gulf Medical University, Ajman, UAE
16:30 – 16:40	Environmental Sustainability in Radiography: A Global Survey of Radiographers' Perceptions, Practices, and Barriers	**Prof. Mohammad Rawashdeh** Gulf Medical University, Ajman, UAE
16:40 – 16:50	Tumor-Cyst Segmentation Errors Can Inflate Renal Tumor Diameter and Cause Apparent T-Category Escalation: A KiTS23 Reference Label and AI Validation Study	**Mr. Mohammad Jaradat** Faculty of Medicine, Jordan University of Science and Technology, Irbid, Jordan
16:50 – 17:00	Artificial Intelligence-Driven Smart Protocols for Contrast Media Optimization in Computed Tomography	**Mr. Wesam AbuAlshaikh** Radiology Department, Sheikh Tahnoon Bin Mohammed Medical City (SEHA), Al Ain, UAE
17:00 – 17:10	Consultant Adjudication of Radiologist Feedback on AI Chest Radiograph Triage: A Six-Month Trust-Wide Evaluation	**Dr. Senan Alsanjari** Frimley Health NHS Foundation Trust, United Kingdom
17:10 – 17:20	Artificial Intelligence in Hematology and Oncology: A Comparative Evaluation of Factual Knowledge and Clinical Reasoning in Pharmacology and Pharmacotherapy Across Large Language Models	**Mr. Ghaith K. Mansour** College of Pharmacy, Alfaisal University, Riyadh, Saudi Arabia

NO.	CATEGORY	POSTER TITLE	PRESENTING AUTHOR
P01	Breast Imaging	Mimicking Malignancy: Pilomatrixoma of the Male Breast Presenting as a Calcified Breast Mass	**Dr. Rowaa Isam Eldin Mohamed** Hamad Medical Corporation, Doha, Qatar
P02	Breast Imaging	Breast Implant–Associated Anaplastic Large Cell Lymphoma: A Case Report	**Dr. Tala Ayman Jalamneh** Dunya Women's Cancer Center, Ramallah, Palestine
P03	Chest Imaging	The Invisible Gorilla Strikes Again and Again: Inattentional Blindness in Jordan, a Multicenter Cross-Sectional Study	**Dr. Mus'ab Theeb Mustafa** Faculty of Medicine, The Hashemite University, Zarqa, Jordan
P04	Gastro-Intestinal & Body Imaging	Rare Case of Left Epididymo-Orchitis Complicated by Pampiniform Plexus Thrombosis: A Case Report	**Dr. Hasan N. Al-Haidari** Radiology Department, Jordanian Royal Medical Services, King Hussein Medical Center, Amman, Jordan
P05	Gastro-Intestinal & Body Imaging	Embryonal Paratesticular Rhabdomyosarcoma in a Child Diagnosed Incidentally After Scrotal Trauma: A Case Report	**Dr. Raad Y. Al Tahat** Radiology Department, Jordanian Royal Medical Services, King Hussein Medical Center, Amman, Jordan
P06	Head & Neck and ENT Imaging	Two Rare Vertebral Artery Pathologies in One Case: Incidental Left Vertebral Artery Agenesis in a Young Patient with Right Vertebral Artery Dissection. A Case Report	**Dr. Raad Y. Al Tahat** Radiology Department, Jordanian Royal Medical Services, King Hussein Medical Center, Amman, Jordan
P07	Head & Neck and ENT Imaging	When Benign Mimics Malignancy: Parapharyngeal Oncocytoma in a Patient with Marginal Zone Lymphoma	**Dr. Mohammad Zaki Al-Qaisi** Radiology Department, Hamad Medical Corporation, Doha, Qatar

POSTER PRESENTATIONS

Hall B

NO.	CATEGORY	POSTER TITLE	PRESENTING AUTHOR
P08	MSK Imaging	Ultrasound Diagnosis of Rhabdomyolysis of Rectus Abdominis: Fortunate Unexpected Finding? A Case Report	**Dr. Dareen Jiad** Jordan Hospital, Amman, Jordan
P09	Oncology Imaging	Whole-Body MRI in Staging High-Risk Prostate Cancer: Where Does It Sit Alongside Conventional Imaging and PSMA PET/CT?	**Dr. Aws Alsboul** Department of Radiology, Specialty Hospital, Amman, Jordan
P10	Pediatric Imaging	Gastric Duplication Cyst Mimicking Adrenal Haemorrhage in an Infant: A Rare Case Report and Literature Review	**Dr. Bushra Tahan** Rashid Hospital, Dubai Health Authority, Dubai, UAE
P11	Pediatric Imaging	Neonatal Invasive Candidiasis: A Multimodality Imaging Perspective and a Case Report	**Dr. Lama Tamim** Saint Joseph University / Hôtel-Dieu de France Hospital, Beirut, Lebanon

14th Pan Arab Association of Radiological Societies (PAARS) International Congress

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WORKSHOPS

Note: Workshop schedule is to be announced unless otherwise indicated below.

WORKSHOPS

Musculoskeletal Hands-On Ultrasound Imaging Workshop


Dr. SYED BABAR AJAZ


Dr. Hammad Siddiqi


Dr. Mohanad Aftan

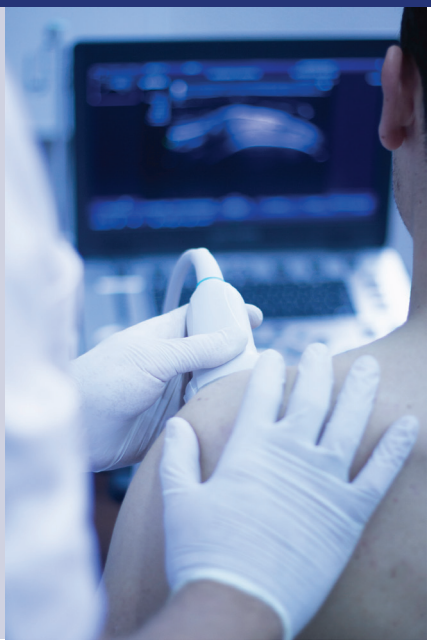
2 CPD



Thursday 22 October 2026	10:00–12:00	St. Regis Hotel Amman, Jordan	JOD 50 Per Doctor

Learning Objectives

Demonstrate the basic technique of dedicated ultrasound of the shoulder (upper limb) and foot and ankle (lower limb). Normal anatomy and ultrasound technique will be taught, followed by hands-on ultrasound. By the end of the workshop, participants will identify important landmarks and understand the normal ultrasound anatomy of the tendons, muscles, joints, and ligaments of the shoulder and ankle.



Program

Divided into two sections: Upper Limb and Lower Limb. A short 15-minute introductory talk on shoulder and ankle anatomy and technique opens the session. Participants are then divided into 5 groups and proceed to individual stations for hands-on practice.

Target Audience

Radiologists, radiology residents and fellows, musculoskeletal radiologists, orthopedic surgeons, sports medicine physicians, rheumatologists, rehabilitation and physical medicine physicians, and other healthcare professionals interested in **musculoskeletal ultrasound imaging**.

Pelvic Floor Ultrasound Hands-On Workshop



Asst. Prof. Dr. Abdullateef Ali, MD



Dr. Majida Al-Sultani, MD

2 CPD Accreditation



Thursday 22 October 2026	14:00–16:00	St. Regis Hotel Amman, Jordan	JOD 50 Per Doctor

Workshop Overview

This hands-on workshop provides a structured, practical, and clinically focused approach to pelvic floor ultrasound, including advanced transperineal pelvic floor imaging. Special emphasis is placed on probe selection, 3D/4D ultrasound applications, and smart pelvic floor software.

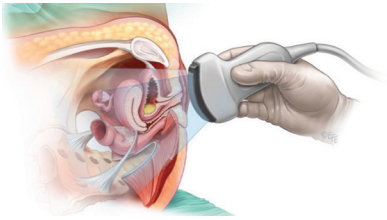
Duration: 2 hours (1 hour theory & interactive discussion; 1 hour hands-on practical session)

Learning Objectives

- Understand the basic physics and image optimization principles of pelvic floor ultrasound
- Select the appropriate probe for pelvic floor imaging
- Perform a systematic pelvic floor ultrasound examination
- Recognize normal pelvic anatomy on 2D, 3D, and 4D ultrasound
- Understand the principles and clinical applications of 4D pelvic floor ultrasound
- Utilize smart pelvic floor software for standardized assessment
- Identify common pelvic and pelvic floor pathologies
- Correlate imaging findings with clinical symptoms and management implications

Workshop Structure

1. Theory & Interactive Session (1 hour): female pelvic floor anatomy; probe selection; standard scanning protocols; introduction to 3D/4D ultrasound; smart pelvic floor software (acquisition, measurement/analysis, clinical applications); common pitfalls and reporting tips; case-based discussion.
2. Hands-On Practical Session (1 hour): live scanning; transperineal pelvic floor scanning; 4D acquisition techniques; hands-on use of pelvic floor software; real-time anatomy identification; faculty-guided feedback.



Target Audience

Radiologists, radiology residents and fellows, urogynecologists, obstetricians and gynecologists, urologists, colorectal surgeons, pelvic floor specialists, and other healthcare professionals interested in **pelvic floor ultrasound imaging, functional assessment, and related clinical applications.**

WORKSHOPS

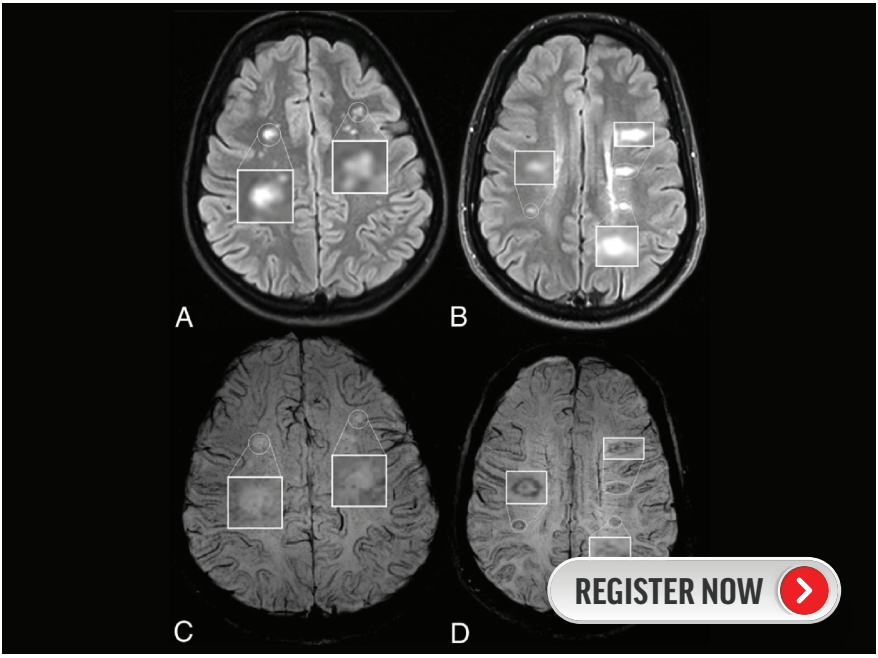
MS MRI in Daily Practice: McDonald 2024, Lesion Assessment, and Key Mimics



Prof. Alex Rovira

Sponsored by NOVARTIS

2 CPD Accreditation



Friday	3:00–4:00 PM	Hybrid	JOD 50
23 October 2026	(Jordan Time)		Per Doctor

McDonald 2024 Criteria and Practical Reporting Approach
Includes: dissemination in space/time; typical lesion distribution; new radiological biomarkers; suggested structured reporting wording

MRI Sequences and Protocol: A Reading Checklist
Includes: essential sequences; pitfalls; baseline vs. follow-up considerations

Standardized Lesion Assessment and Follow-Up Comparison
Includes: lesion identification/counting; measuring lesion size; documenting pre/post treatment scans

MS Mimics Session: Pattern-Based Differential Diagnosis
Includes: common mimics; red flags for atypical MS; practical reporting phrases

Interactive Case Discussion
Mixed cases covering typical MS, borderline criteria, and mimics; structured report template walkthrough

Wrap-Up and Key Take-Home Checklist

Target Audience

Radiologists, neuroradiologists, neurologists, radiology and neurology residents and fellows, and other healthcare professionals involved in the **MRI evaluation, diagnosis, and follow-up of multiple sclerosis.**

Liver Elastography Hands-On Ultrasound Workshop

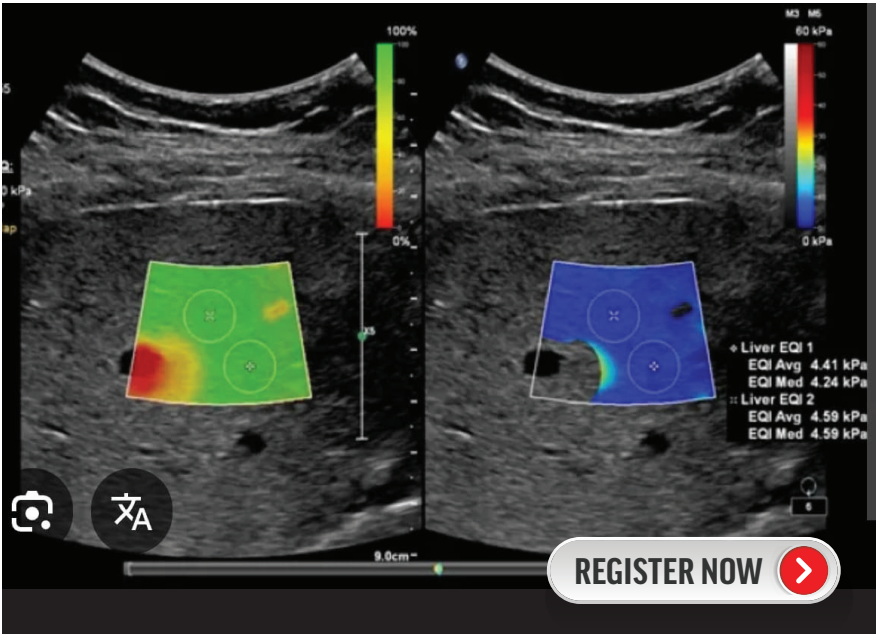


Prof. Ioan Sporia, MD, PhD



Dr. Adnan Zayadeen, MD

2 CPD



Friday | 14:00–16:00 | St. Regis Hotel | JOD 50

Focus Area
- Liver Elastography — ultrasound-based elastography
- Shear Wave Elastography (VCTE, pSWE, 2D-SWE)
- Strain Elastography
- Assessment of liver fibrosis and liver steatosis

Learning Objectives
Demonstrate the basic principles and practical techniques of ultrasound-based liver elastography, covering patient preparation, scanning protocols, probe positioning, image acquisition, and interpretation. Normal liver anatomy, common pitfalls, and quality control measures will be discussed, followed by hands-on practice.

By the end of the workshop, participants will be able to:
- Understand the principles of ultrasound-based liver elastography and fatty liver quantification
- Perform proper liver elastography examinations and fatty quantification
- Identify normal and abnormal liver stiffness values
- Recognize technical errors and limitations
- Correlate elastography findings with common liver diseases

Program
Theory Session (20-minute introductory lecture): liver anatomy relevant to elastography and fatty quantification; elastography techniques and protocols; interpretation of stiffness measurements and fatty infiltration.
Hands-On Session: participants divided into 5 groups, rotating through stations with faculty-guided scanning, real-time feedback, and practical tips for improving accuracy and reproducibility.

Target Audience
Radiologists, hepatologists, gastroenterologists, radiology residents and fellows, internal medicine physicians, and other healthcare professionals involved in the **ultrasound assessment of chronic liver disease, liver fibrosis, and steatosis using elastography techniques.**

WORKSHOPS

Interpreting Peripheral Arterial Doppler Ultrasound with Confidence Hands-On Workshop


Asst. Prof. Dr. Abdullateef Ali, MD


Dr. Majida Al-Sultani, MD


Dr. Anas Khairi Awn, MD

2 CPD



Friday	10:00–12:00	St. Regis Hotel	JOD 50
23 October 2026		Amman, Jordan	Per Doctor

Workshop Overview

This hands-on workshop provides a structured, practical approach to peripheral arterial Doppler ultrasound, emphasizing waveform interpretation, hemodynamic principles, and confident clinical application. It combines focused theoretical teaching with supervised hands-on scanning.

Duration: 2 hours (1 hour theory & interactive discussion; 1 hour hands-on practical session)

Learning Objectives

- Understand the basic physics and hemodynamic principles of arterial Doppler ultrasound
- Perform a systematic peripheral arterial Doppler examination
- Identify normal and abnormal arterial waveforms
- Confidently interpret triphasic, biphasic, monophasic, and dampened waveforms
- Recognize Doppler findings in common peripheral arterial pathologies
- Correlate waveform changes with site and severity of arterial disease

Workshop Structure

1. Theory & Interactive Session (1 hour): peripheral arterial anatomy; Doppler physics; scanning technique and protocol; pulse-wave and color Doppler optimization; waveform interpretation; common pitfalls; case-based discussion.
2. Hands-On Practical Session (1 hour): live scanning on models; supervised arterial mapping of the limbs; real-time waveform acquisition and interpretation; faculty-guided correction and feedback.

Target Audience

Radiologists, vascular surgeons, cardiologists, radiology residents and fellows, vascular technologists, and other healthcare professionals involved in the Doppler ultrasound assessment of peripheral arterial disease, waveform interpretation, stenosis evaluation, and vascular imaging in daily clinical practice.

WORKSHOPS

Thyroid Ultrasound and Fine Needle Aspiration (FNA) Hands-On Workshop



Adnan Zayadeen, MD

Dr. Mutaz Halasah

Dr. Razan Abudalo

2 CPD



Saturday 24 October 2026	10:00–12:00	Hybrid	JOD 50 Per Doctor

Focus Area
Thyroid ultrasound and TI-RADS; FNA

Duration
Two hours

Learning Objectives
Demonstrate the basic principles and practical techniques of thyroid ultrasound and ultrasound-guided fine needle aspiration (FNA), covering patient preparation, scanning protocols, probe selection and positioning, standardized image acquisition, thyroid and cervical lymph node assessment, and indications/technique of US-guided FNA. Normal thyroid anatomy, sonographic patterns, TI-RADS classification, common pitfalls, and quality control will be discussed, followed by hands-on practice.
By the end of the workshop, participants will be able to perform a systematic thyroid ultrasound examination, accurately characterize thyroid nodules, safely perform US-guided thyroid FNA, recognize technical errors and limitations, and correlate ultrasound findings with common thyroid pathologies.



Program
1) Theory Session: introductory lecture covering thyroid anatomy and TI-RADS.
2) Hands-On Session: participants divided into groups, rotating through stations with faculty-guided scanning, real-time feedback, and practical tips for improving accuracy and reproducibility.

Target Audience
Radiologists, endocrinologists, head and neck surgeons, ENT specialists, pathologists, radiology residents and fellows, and other healthcare professionals involved in thyroid ultrasound, **thyroid nodule assessment, risk stratification, and ultrasound-guided fine needle aspiration (FNA).**

WORKSHOPS

Diagnostic Imaging Tournaments for Residents


Dr. Wesam Shamma


Dr. Jamil Shawagfeh

2 CPD



Friday 23 October 2026	14:00–16:00	St. Regis Hotel Amman, Jordan	Free



Overview

The Radiology Residents Tournament is an educational and competitive academic activity incorporated into the conference scientific program, designed to enhance diagnostic competence and promote excellence in radiology training. It brings together radiology residents from different institutions and levels of training to participate in a structured, case-based competition within a professional academic environment.

The tournament consists of multiple questions evaluating participants' skills in image interpretation, pattern recognition, and clinical decision-making across major radiology subspecialties — including neuroradiology, musculoskeletal imaging, thoracic imaging, abdominal imaging, and emergency radiology. Imaging cases are selected to reflect real-life clinical scenarios commonly encountered in routine practice.

Participants compete individually according to standardised rules, with answers assessed by a panel of experienced radiology faculty members.

Learning Objectives

- Improve accuracy and confidence in radiologic image interpretation across core subspecialties
- Apply systematic and time-efficient approaches to evaluating common and critical imaging findings
- Integrate clinical information with imaging features to formulate appropriate differential diagnoses
- Recognize imaging pitfalls and common diagnostic errors in daily radiology practice

The Radiology Residents Tournament provides an interactive platform for academic engagement, professional collaboration, and recognition of excellence in radiology education. Certificates and awards are presented to acknowledge outstanding



Saturday 24 October 2026	9:00AM–1:00PM	St. Regis Hotel Amman, Jordan	JOD 50 Per Doctor

WORKSHOPS

BREAST IMAGING and ADVANCED INTERVENTION

WORKSHOP OVERVIEW
This workshop introduces participants into updates on breast imaging and intervention. Preoperative localization of non-palpable breast lesions using SCOUT®, a wireless, radar-based localization of non-palpable breast and axillary lesions.

SESSION I: 9:00 to 10:00 am
Moderators: Jamileh Sarayreh MD / Hanan Mansour, MD

9:00- 9:15	**Introduction into Breast Intervention**
	Dr. Suha Ghoul
9:15- 9:40	**Preoperative localization of non-palpable breast lesions using SCOUT®**
	Ashwini Sharma, MD
9: 40-10:00	Discussion

SESSION II: 10:00 to 11:00 am
Hands-On Workshop Advanced Breast Intervention
Moderators: Dr. Sura Fayez, Dr. Jamileh Sarayreh , Dr. Dima Oleimat

Participants will rotate through ultrasound units, ensuring adequate hands-on exposure.
Hands-On Practical Session

Maximum Number of Participants: 25

TARGET AUDIENCE
Radiology, pathology, surgical and gynecology residents and specialists



ORADs DEMYSTIFIED: AN INTERACTIVE SESSION.

WORKSHOP OVERVIEW
This workshop is a brief recap of imaging features in ovaries and algorithmic approach to O-RADS™ (O-RADS™ is a clinical support system for the standardized description and classification of ovarian/adnexal lesions).

Both O-RADS US and O-RADS MRI lexicon terminology will be explored through an interactive session reviewing imaging cases of adnexal lesions.

Moderators: Dr. Dima Oleimat, Dr. Tasnim AL-Muzayen

11:00- 11:15	Introduction
	Dr. Mousumi Bhaduri.
11 15-12:30	**ORADs DEMYSTIFIED: AN INTERACTIVE SESSION.**
	Dr. Mousumi Bhaduri
12:30-13: 00	Hands-On Pelvic Ultrasound

Axial Spondylopathy Workshop


Prof. Walter Maksymovich


Dr. Robert Lambert

Sponsored by NOVARTIS



Friday	4:00–6:00 PM	Hybrid	JOD 50
23 October 2026	(Jordan Time)		Per Doctor

Axial spondylopathy

16:00–16:20	**An Introduction to the International MRI Course in SpA** (All Content Case-Based) To become familiar with normal MRI appearances of the sacroiliac joint and spine, appropriate MRI protocols, and the standardized approach to routine evaluation, including DICOM imaging principles.
16:20–16:35	**Early SpA** To understand the evolution of early disease and the contribution of different MRI sequences; recognizing typical abnormalities seen in early SpA.
16:35–16:55	**Spectrum of SpA** To understand the spectrum of SpA lesions, pathological vs. physiological fat in the SIJ, sensitive/specific spinal lesions, and the influence of treatment on MRI appearance.
16:55–17:30	**Differential Diagnosis — Sacroiliac Joint** To recognize abnormalities that cause difficulty discriminating SpA from normal variation, osteitis condensans ilii, degenerative disease, sepsis, fracture, and malignancy.
17:30–17:50	**Differential Diagnosis — Spine** To recognize abnormalities causing difficulty discriminating SpA from degenerative disorders, DISH, SAPHO, sepsis, and malignancy in the spine.
17:50–18:00	**"You Make the Diagnosis"** Rapid-fire diagnostic evaluation of a series of real-world MRI scans where MRI evaluation proved critical in changing patient management.

Target Audience

Radiologists, rheumatologists, musculoskeletal imaging specialists, orthopedic physicians, radiology and rheumatology residents and fellows, and other healthcare professionals involved in the **diagnosis, imaging assessment, and follow-up of axial spondyloarthritis,** including the interpretation of **sacroiliac joint and spinal imaging findings.**

WORKSHOPS

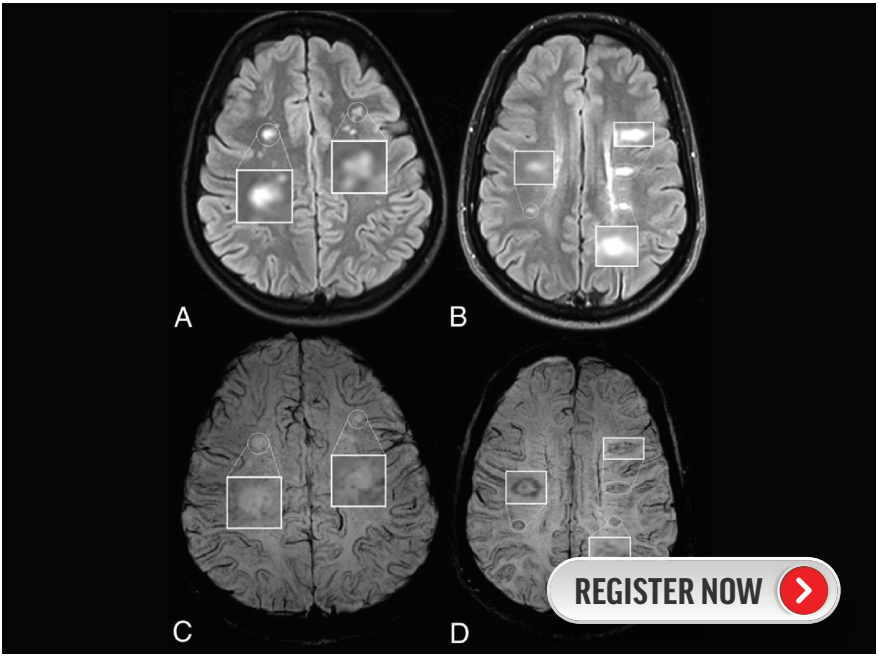
MS MRI in Daily Practice: McDonald 2024, Lesion Assessment, and Key Mimics



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2 CPD Accreditation



Friday	3:00–4:00 PM	Hybrid	JOD 50
23 October 2026	(Jordan Time)		Per Doctor

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Mixed cases covering typical MS, borderline criteria, and mimics; structured report template walkthrough

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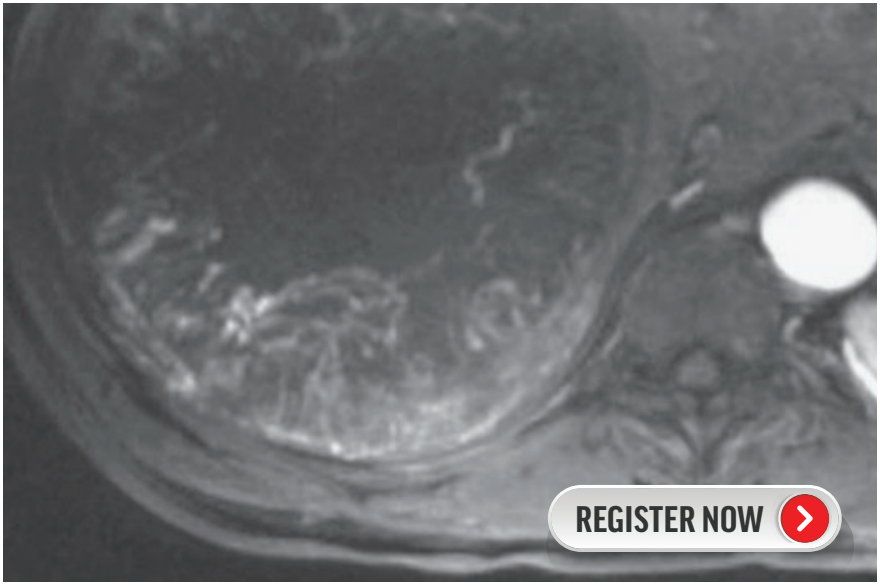
Target Audience

Radiologists, neuroradiologists, neurologists, radiology and neurology residents and fellows, and other healthcare professionals involved in the **MRI evaluation, diagnosis, and follow-up of multiple sclerosis.**

BijanRadTeaching Case-Based Radiology Residents Review Session GI & GU Radiology



Bijan Bijan



Friday
October 23, 2026

11:00 AM – 12:00 PM

St. Regis Hotel
Amman, Jordan

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14th Pan Arab Association of Radiological Societies (PAARS) International Congress

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ABSTRACTS

Abstracts appear in the order of the Hall B scientific program

B-01

Susceptibility-Weighted Imaging Versus CT in Differentiating Microhemorrhage and Calcification

Dr. Safwan Alrawabdeh
Jordanian Royal Medical Services

Background: Differentiating intracranial microhemorrhage from calcification is a frequent diagnostic challenge in neuroradiology, particularly in small lesions where imaging findings may overlap.
Methods: This conference abstract summarizes institutional imaging experience with patients who underwent brain MRI including susceptibility-weighted imaging (SWI) and non-contrast computed tomography (CT). Lesions demonstrating susceptibility effects were reviewed, with emphasis on imaging appearance, diagnostic confidence, and common interpretative pitfalls.
Results: SWI demonstrated high concordance with CT in characterizing susceptibility-related lesions. Most discrepancies occurred in lesions adjacent to the skull base, venous structures, or areas of mixed composition.
Conclusion: SWI is a reliable technique for differentiating microhemorrhage from calcification in most intracranial lesions, although CT remains valuable in selected equivocal cases.
Keywords: Susceptibility-weighted imaging; Computed tomography; Intracranial calcification; Microhemorrhage; Neuroimaging

B-02

Evaluating the Role of Skull X-ray and Computed Tomography in the Diagnosis of Craniosynostosis

Dr. Mohammed Al Smadi
Senior Pediatric Radiologist

Background: Craniosynostosis is a congenital condition characterized by premature fusion of one or more cranial sutures, leading to abnormal skull shape and potential neurodevelopmental complications. Early and accurate diagnosis is essential for appropriate surgical planning and prevention of raised intracranial pressure. Imaging plays a pivotal role in diagnosis, with computed tomography (CT) considered the gold standard for detailed assessment of cranial sutures and skull morphology. This study aimed to evaluate the diagnostic value of CT imaging in suspected cases of craniosynostosis.

Methods: This retrospective cross-sectional study included 72 pediatric patients referred for imaging evaluation of suspected craniosynostosis over a four-year period starting January 2019. Patient ages ranged from 1 month to 24 months. All patients underwent non-contrast low-dose CT of the skull with three-dimensional reconstruction. CT findings were correlated with clinical assessment and surgical outcomes, which served as the reference standard.

Skull X-ray imaging was available for a subset of patients prior to CT evaluation. Plain radiographs demonstrated indirect signs of craniosynostosis in some cases, including suture sclerosis, loss of suture lucency, and abnormal skull contours. However, the diagnostic confidence of skull X-ray was limited, particularly in younger infants and in cases of early or partial suture fusion.

When compared with CT findings, skull X-ray correctly suggested craniosynostosis in 24 of the 39 confirmed cases. In the remaining cases, radiographic findings were either inconclusive or appeared normal despite confirmed suture fusion on CT. Skull X-ray was less effective in accurately identifying the specific sutures involved and did not reliably demonstrate complex or multi-suture synostosis.

In contrast, CT imaging provided direct visualization of suture fusion, associated bony ridging, and compensatory skull changes, with three-dimensional reconstructions offering superior spatial assessment. Overall, CT demonstrated significantly higher sensitivity and anatomical accuracy than skull X-ray, reinforcing its role as the preferred

imaging modality for definitive diagnosis and surgical planning in craniosynostosis.
Results: Craniosynostosis was confirmed in 39 patients. CT accurately identified the involved sutures in 36 cases, demonstrating features such as suture fusion, bony ridging, skull asymmetry, and compensatory calvarial changes. Three cases showed equivocal findings due to early or partial suture fusion. Three-dimensional CT reconstructions significantly aided in surgical planning by clearly delineating cranial morphology and the extent of suture involvement.
Conclusion: Computed tomography is a highly effective imaging modality for the diagnosis and characterization of craniosynostosis. Its ability to provide precise anatomical detail and three-dimensional visualization makes it indispensable for diagnosis and preoperative planning. When performed using low-dose protocols, CT offers high diagnostic accuracy while minimizing radiation exposure in pediatric patients.

B-03

Multimodality Imaging of Renal Cell Carcinoma: CT and MRI Characterization of Subtypes and Diagnostic Pitfalls

Dr. Mohamad Samarah

Renal cell carcinoma (RCC) accounts for most malignant renal neoplasms, with clear cell, papillary, and chromophobe subtypes showing enhancement patterns on cross-sectional imaging that inform preoperative risk stratification. Multiphase contrast-enhanced CT remains the primary tool for renal mass characterization, using enhancement thresholds across corticomedullary, nephrographic, and excretory phases to separate RCC from benign mimics such as oncocytoma and fat-poor angiomyolipoma. Clear cell RCC typically shows avid, heterogeneous enhancement in the corticomedullary phase with delayed washout, reflecting its hypervascular stroma, while papillary RCC tends to appear homogeneous and hypoenhancing, which can make it difficult to distinguish from benign lesions. MRI adds value through chemical-shift imaging, diffusion-weighted sequences, and superior soft-tissue contrast, particularly for patients unable to receive iodinated contrast or for indeterminate cystic lesions assessed under the Bosniak classification. Signal dropout on opposed-phase sequences suggests intracellular lipid, more common in clear cell tumors, while restricted diffusion correlates inconsistently with nuclear grade across the literature. Diagnostic pitfalls remain common, including papillary RCC mistaken for a hemorrhagic cyst and fat-poor angiomyolipoma mimicking solid RCC on unenhanced imaging alone. Chromophobe RCC, which is less common, typically presents with homogeneous, mildly progressive enhancement and a central scar that can be mistaken for oncocytoma on either modality, underscoring the limits of enhancement pattern alone as a diagnostic criterion. Combining CT and MRI findings, alongside emerging radiomics and texture-analysis techniques, may improve subtype prediction and reduce dependence on percutaneous biopsy in select patients. Further standardization of reporting frameworks is needed to reduce interobserver variability when evaluating indeterminate renal masses.

Keywords: renal cell carcinoma; computed tomography; magnetic resonance imaging; clear cell RCC; papillary RCC; chromophobe RCC; renal mass; Bosniak classification; radiomics.

B-04

Radiologic Evaluation of Parathyroid Nodules: Role of Imaging in Diagnosis and Localization

Dr. Lubna Hasan Alheneiti
Department of Diagnostic Radiology, Royal Medical Services, Amman

Parathyroid nodules, most commonly representing parathyroid adenomas, are a major cause of primary hyperparathyroidism. Accurate preoperative localization is essential to guide minimally invasive surgical management. Radiologic imaging plays a pivotal role in the detection, characterization, and localization of parathyroid lesions. Highresolution neck ultrasound is often the first-line modality due to its availability, lack of radiation, and ability to assess concomitant thyroid pathology. Typical ultrasound features include a hypoechoic, well-defined nodule located posterior or inferior to the thyroid gland, often with a polar feeding vessel on Doppler imaging. Technetium-99m sestamibi scintigraphy complements ultrasound by providing functional information and is particularly useful in ectopic glands. Cross-sectional imaging, including contrast-enhanced CT (4D-CT) and MRI, is valuable in cases of negative or inconclusive first-line studies, recurrent disease, or ectopic parathyroid nodules. Advanced imaging techniques improve diagnostic accuracy and surgical planning. This review highlights the radiologic features of parathyroid nodules across different imaging modalities and emphasizes the importance of a multimodality approach for optimal patient management.

B-05

Ultrasound-First Imaging Pathway in Pediatric Appendicitis

Dr. Mohammed Bilal Numan
Jordanian Royal Medical Services

Background: Radiation avoidance is a major consideration in pediatric imaging, particularly in children presenting with suspected acute appendicitis. Ultrasound is widely recommended as the initial imaging modality; however, variability in diagnostic confidence and operator dependence remain challenges in daily practice.
Methods: This conference abstract summarizes institutional experience with an ultrasound-first imaging approach in pediatric patients evaluated for suspected appendicitis. Imaging findings were reviewed with emphasis on diagnostic confidence, need for additional imaging, and correlation with clinical and surgical outcomes.
Results: The ultrasound-first strategy demonstrated high diagnostic confidence in the majority of cases and significantly reduced reliance on computed tomography. Additional CT imaging was reserved for equivocal ultrasound examinations, without negative impact on clinical outcomes or delay in management.
Conclusion: An ultrasound-first imaging pathway is an effective and radiation-sparing strategy for evaluating suspected pediatric appendicitis and should remain the preferred initial imaging approach in children.
Keywords: Pediatric appendicitis; Ultrasound; Computed tomography; Radiation reduction; Imaging pathway.

B-06

External Ear Diseases: A Radiological Approach Based on Clinical Presentation

Dr. Omar S. Altamimi
Radiology Department, Jordanian Royal Medical Services, King Hussein Medical Center, Amman

Background: Although the external ear is readily accessible to clinical examination, imaging plays an important role in selected conditions, particularly congenital external auditory canal (EAC) atresia, necrotizing external otitis, EAC exostoses, medial canal fibrosis, and EAC squamous cell carcinoma.

Objective: To review the characteristic clinical and radiological features of common external ear diseases and emphasize the role of high-resolution computed tomography (HRCT) and magnetic resonance imaging (MRI) in diagnosis, assessment of disease extent, and treatment planning.

Discussion: EAC atresia is a congenital abnormality commonly associated with auricular malformation and conductive hearing loss. HRCT of the temporal bone is the imaging modality of choice for evaluating the external and middle ear anatomy and for preoperative assessment. The Jahrsdorfer scoring system evaluates key anatomical structures and provides a maximum score of 10, helping identify suitable surgical candidates. Necrotizing external otitis is a potentially serious infection, particularly in patients with diabetes or immunocompromised states. CT is useful for demonstrating bony involvement and determining the extent of disease, whereas MRI is valuable for detecting intracranial and soft tissue extension. EAC exostoses appear as bilateral benign bony overgrowths, commonly associated with prolonged cold water exposure. HRCT accurately demonstrates their location and degree of canal narrowing. Medial canal fibrosis represents post inflammatory EAC atresia and typically appears as homogenous soft tissue adjacent to the tympanic membrane without associated bony changes. EAC squamous cell carcinoma is an aggressive neoplasm that may present with otalgia, otorrhea, hearing loss, or bleeding. HRCT is particularly useful for assessing osseous destruction, while contrast enhanced MRI evaluates soft tissue, intracranial, and perineural extension.

Conclusion: A systematic radiological approach to external ear disease is essential for accurate diagnosis and appropriate management. HRCT provides detailed assessment of osseous anatomy and bony destruction, while MRI complements CT by defining soft tissue, intracranial, and perineural involvement. Correlation of imaging findings with clinical presentation facilitates disease differentiation, surgical planning, and assessment of aggressive disease.

B-07

Pneumatosis Intestinalis: Benign Versus Life-Threatening Causes

Dr. Duha Alwreikat, MD
Radiologist

Background: Pneumatosis intestinalis (PI) refers to the presence of gas within the bowel wall and represents an imaging finding rather than a disease itself. Although it may be an incidental and benign finding, PI can also be associated with bowel ischemia, necrosis, and other serious intra-abdominal conditions. For radiologists, the main challenge is therefore not simply recognizing PI, but determining whether it represents a benign process or an underlying bowel compromise.
Objective: To review the CT features of pneumatosis intestinalis and highlight the imaging findings that may help differentiate benign pneumatosis from cases associated with bowel ischemia or other life-threatening pathology.
Methods: A review of the CT appearances and reported causes of pneumatosis intestinalis was performed. Particular attention was given to the pattern and distribution of intramural gas, bowel wall thickness and enhancement, bowel dilatation, mesenteric changes, vascular patency, and associated findings, including portal or mesenteric venous gas, free fluid, and pneumoperitoneum. These imaging findings were considered together with the clinical presentation and laboratory results to assess their significance.
Results: The CT appearance of PI can provide important clues to its underlying cause. Findings that raise concern for bowel ischemia include decreased or absent bowel wall enhancement, bowel wall thickening, bowel dilatation, mesenteric edema, vascular occlusion, and associated portal or mesenteric venous gas. The presence of multiple concerning findings is particularly suggestive of an ischemic process. In contrast, PI may occur in benign settings, including chronic pulmonary disease, medication-related conditions, and increased intraluminal pressure. Cystic or linear intramural gas in the absence of abnormal bowel wall enhancement or other concerning findings may favor a benign etiology. However, the imaging appearance alone cannot reliably determine the clinical significance of PI.
Conclusion: Pneumatosis intestinalis is an imaging sign with a broad spectrum of clinical significance. Careful assessment of the accompanying CT findings is essential. Integrating the imaging features with the patient's clinical presentation and laboratory results can help identify patients who require urgent management while reducing unnecessary intervention in benign cases.

B-08

Comparing Diagnostic Accuracy of CT, MRI, and Nuclear Medicine Studies in Adrenal Pheochromocytoma

Dr. Raad Youssef Al Tahat
Radiology Department, KHMC, JRMS, Amman

Objective: Comparing diagnostic accuracy of magnetic resonance imaging (MRI), computed tomography (CT), as well as nuclear medicine studies in discovering and characterizing adrenal pheochromocytoma.
Discussion: CT and MRI are the main imaging techniques used for evaluating and detecting adrenal pheochromocytomas after biochemical laboratory confirmation. CT scan shows high sensitivity for lesion detection, especially for lesions larger than 1 cm, which have typical findings such as well-circumscribed, highly vascular lesions with heterogeneous enhancement on post contrast study. Nevertheless, the specificity is limited due to overlapping features with other adrenal pathology. MRI shows better soft-tissue contrast and enhanced tissue characterization. Adrenal pheochromocytomas usually exhibit very high signal intensity on T2-weighted sequences and vivid post-contrast enhancement, contributing to the higher specificity compared to CT scan. Nuclear medicine studies, including 123I-metaiodobenzylguanidine (MIBG) scintigraphy and positron emission tomography (PET) using several radiotracers, provide functional evaluation of catecholamine-producing lesions. These studies display high specificity and are important in detecting extra adrenal lesions, multiple lesions, tumor recurrence, or metastatic process, which improves the overall diagnostic accuracy.
Conclusion: CT and MRI provide high sensitivity for the diagnosis of adrenal pheochromocytoma, with MRI displaying better lesion characterization. Nuclear medicine studies improve diagnostic specificity and allow whole body evaluation. A multimodality imaging approach can improve diagnostic accuracy and plays a crucial role in the comprehensive evaluation and management of adrenal pheochromocytoma.
Keywords: Adrenal Pheochromocytoma, computed tomography (CT), magnetic resonance imaging (MRI), Nuclear medicine studies, positron emission tomography (PET), 123I-metaiodobenzylguanidine (MIBG) scintigraphy.

B-09

Acute Appendicitis Presenting as Intestinal Obstruction: A Review of the Literature

Dr. Weam Mohammad Edaibat
Diagnostic Radiology Specialist, Royal Medical Services

Background: Acute appendicitis is one of the most common surgical emergencies worldwide. While the classical presentation is well recognized, intestinal obstruction as a primary manifestation is uncommon and may lead to delayed diagnosis and increased morbidity.
Methods: A comprehensive literature review was conducted using major medical databases, including PubMed, Scopus, and Google Scholar. Articles reporting appendicitis presenting as mechanical or functional intestinal obstruction were included. Case reports, case series, and observational studies were analyzed to evaluate pathophysiology, diagnostic approaches, management strategies, and outcomes.
Results: Appendicitis-related intestinal obstruction occurs through several mechanisms, including inflammatory adhesions, abscess formation, appendiceal mass, and rarely volvulus or internal herniation. Clinical presentation often mimics primary small bowel obstruction, with abdominal pain, distension, vomiting, and constipation. Radiological findings may demonstrate dilated bowel loops without a clear cause. Surgical exploration frequently reveals complicated appendicitis as the underlying etiology. Early operative management, typically appendectomy with adhesiolysis, results in favorable outcomes when performed promptly.
Conclusion: Although rare, acute appendicitis should be considered in the differential diagnosis of intestinal obstruction, particularly in patients without prior abdominal surgery. Increased awareness among surgeons may reduce diagnostic delay and improve patient outcomes.

B-10

Imaging of Central Airway Diseases

Dr. Audai Ahmad Shyyab

[Opening of abstract missing in the submitted file — please obtain from author] … trachea and major bronchi, with clinical appearances that are nonspecific and share symptoms with other respiratory diseases. Main complaints comprise dyspnoea, cough and wheezing, haemoptysis or frequent lower respiratory tract infection, which can delay diagnosis. Computed tomography is the main imaging tool used to assess central airway disease; it allows accurate assessment of airway lumen patency, wall thickness, and length of involvement. In addition, associated mediastinal or lung abnormalities should not be overlooked. Distinctive CT findings include focal or diffuse airway narrowing, intraluminal masses, wall thickening, calcification, external compression and dynamic airway changes. These primary steps are necessary to narrow down the differential diagnosis. By linking imaging findings to underlying pathological processes such as neoplastic infiltration, inflammatory thickening, fibrosis, or destruction of cartilage, radiologic–pathologic correlation enhances diagnostic accuracy. CT-based virtual bronchoscopy allows non-invasive endoluminal visualization of airway lesions for accurate assessment of the degree of bronchial obstruction and aids in planning, especially for patients not suitable for conventional bronchoscopy. An integrated approach to early diagnosis in central airway pathology, combining clinical presentation, CT imaging, pathological correlation, and virtual endoscopy, is critical for effective management and better outcomes.
Keywords: […incomplete in submitted file] …disease; Virtual bronchoscopy; Radiologic–pathologic correlation

B-11

Benign Bone Tumours by X-ray

Dr. Basil Odeh Abdallah Albtoosh

Benign bone tumors are non-cancerous growths in the bone that, although they can cause local tissue destruction, do not metastasize to other parts of the body. These tumors are often detected incidentally on X-rays when patients are evaluated for unrelated issues or during the investigation of localized pain or swelling. While benign, they require proper diagnosis and management to prevent complications.

Types of Benign Bone Tumors

Several types of benign bone tumors are identifiable through X-ray imaging. Some of the most common include:

1. Osteochondroma: The most common benign bone tumor, which often occurs in children and adolescents. X-ray findings typically show a bony outgrowth, or exostosis, that arises from the surface of a long bone, especially around the knee or shoulder joints.
2. Osteoid Osteoma: A small, benign but painful tumor often seen in young adults. The hallmark X-ray appearance is a radiolucent nidus (a small, less dense area) within a sclerotic (dense) cortical bone, often surrounded by reactive bone formation.
3. Enchondroma: This tumor is composed of cartilage and typically presents within the medullary cavity of bones, often the small bones of the hands and feet. On X-ray, enchondromas appear as lytic lesions with scattered calcifications.
4. Giant Cell Tumor (GCT): Although typically classified as a benign tumor, GCTs have aggressive tendencies. These lesions occur near the end of long bones, most commonly around the knee. Xrays reveal a lytic lesion that is well-defined but lacks a sclerotic rim, often expanding into the surrounding bone.
5. Fibrous Dysplasia: This tumor arises from the replacement of normal bone with fibrous tissue. The «ground-glass» appearance of the affected bone on X-ray is characteristic of fibrous dysplasia.

X-ray Features of Benign Bone Tumors

X-ray is a crucial tool in identifying and characterizing bone tumors. When interpreting X-rays of suspected benign bone tumors, several features are evaluated, including:

- Location: Certain tumors have predilections for specific bones or regions within bones (e.g., diaphyseal, metaphyseal, or epiphyseal).
- Margins: Benign tumors typically show well-defined, non-aggressive margins, often surrounded by a thin rim of sclerotic bone.
- Matrix Mineralization: Some benign tumors, like enchondromas, exhibit characteristic patterns of calcification.
- Periosteal Reaction: Benign tumors often show minimal periosteal reaction unless there is an associated fracture or significant growth.
- Bone Destruction: Benign tumors typically cause less aggressive bone destruction compared to malignant tumors. They may expand the bone but generally do not breach the cortex early.

Differentiating Benign from Malignant

One of the key challenges in interpreting X-rays is distinguishing benign bone tumors from malignant ones. Benign tumors typically grow slowly, have a well-defined edge, and display a less aggressive pattern of bone destruction. In contrast, malignant tumors often present with rapid, uncontrolled growth, poorly defined margins, and significant soft tissue involvement. However, some benign tumors, like giant cell tumors, can display aggressive characteristics, making clinical correlation and further imaging (e.g., CT, MRI) necessary for a definitive diagnosis.

Keywords: Benign bone tumour, x-ray, osteochondroma, osteoid osteoma, enchondroma, fibrous dysplasia, giant cell tumour, non-aggressive margins, calcification, bony growth, bone destruction

B-12

Ultrasound Assessment of Psoriatic Arthritis: Diagnostic Value and Follow-Up Utility

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Introduction: Psoriatic arthritis (PsA) is a chronic inflammatory musculoskeletal disease associated with psoriasis, often presenting with variable and overlapping clinical features. Early detection of inflammatory changes and accurate assessment of disease activity are essential to prevent joint damage and functional disability. Ultrasound has increasingly been incorporated into the diagnostic and follow-up pathways of PsA.
Methods: Musculoskeletal ultrasound, including grayscale and power Doppler techniques, is used to assess peripheral joints, tendons, and entheses in patients with suspected or established PsA. Grayscale ultrasound evaluates synovial hypertrophy, joint effusion, tenosynovitis, enthesitis, and structural damage, while power Doppler assesses active inflammatory vascularity. Ultrasound findings are correlated with clinical assessment and laboratory markers during diagnosis and follow-up.
Results: Ultrasound demonstrates high sensitivity in detecting both clinical and subclinical inflammatory changes in PsA. Power Doppler signal correlates with active disease and provides objective evidence of ongoing inflammation, even in clinically silent joints or entheses. During follow-up, reduction in synovial thickness and Doppler activity reflects therapeutic response, while persistent Doppler signal may indicate residual disease activity despite clinical remission.
Discussion: Ultrasound offers a non-invasive, radiation-free, and readily available imaging modality that complements clinical evaluation in PsA. Its ability to detect early and subclinical disease, guide treatment decisions, and monitor response to therapy supports its role in routine clinical practice.
Conclusion: Ultrasound is a valuable tool for the diagnosis and longitudinal assessment of psoriatic arthritis, improving disease detection and facilitating optimized patient management.

B-13

How Artificial Intelligence Will Improve Breast Cancer Detection by Radiologists

Dr. Renad Aldurgham, MD

Objectives: To understand how artificial intelligence (AI) will help breast radiologists detect breast cancer more accurately and at an earlier stage.
Methods: AI can analyze mammograms quickly and identify suspicious areas that may be difficult for the human eye to see. It can highlight abnormal masses, calcifications and other signs of breast cancer such as skin thickening, and point out potentially suspicious areas to the radiologist. It can reduce the chance of missing small or subtle tumors during image interpretation and help reduce false-positive results by providing additional information to the radiologist. By comparing prior and current mammograms, AI can identify changes in breast tissue over time; it can also prioritize high-risk mammograms, helping radiologists review urgent cases more quickly. AI algorithms can analyze mammograms, breast ultrasound images and even MRI scans to identify suspicious findings, eventually supporting radiologists in making more consistent and informed diagnostic decisions with improved sensitivity.
Conclusion: AI is a very useful diagnostic and screening support tool that can enhance breast cancer detection while keeping the radiologist responsible for the final diagnosis. The combination of AI technology and radiologist experience can improve the overall breast cancer detection process.

B-14

Comparative Effectiveness of Mammography, Ultrasound, and MRI in the Detection of Breast Carcinoma in Dense Breast Tissue

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Aim: This paper aimed to critically assess the effectiveness of mammography, ultrasound, and magnetic resonance imaging (MRI) in the detection of breast carcinoma within dense breast tissue.
Discussion: An exhaustive search of contemporary literature was undertaken, focusing on the diagnostic accuracy, false positive and negative rates, and clinical implications of the aforementioned imaging modalities. Each modality was assessed in isolation and side by side against the others to draw comparative inferences. While mammography remains a foundational imaging modality, its effectiveness waned within the context of dense breast tissue. Ultrasound demonstrated a strong differentiation prowess, especially among specific demographic cohorts. MRI, despite its exceptional precision and differentiation capabilities, exhibited a tendency for slightly elevated false positive rates. No single modality emerged as singularly superior for all cases. Instead, an integrated approach, combining the strengths of each modality based on individual patient profiles and clinical scenarios, is recommended. This tailored approach ensures optimized detection rates and minimizes diagnostic ambiguities, underscoring the significance of individualized patient care in the field of diagnostic radiology.
Conclusion: A single imaging modality's dominance is not established; rather, the findings support a strategic combination of modalities, tailored to each patient›s unique profile, breast density, and specific clinical context. This holistic approach aims to enhance detection rates while reducing diagnostic ambiguities, emphasizing the primary goal of patient well-being. Thus, this review significantly contributes to the field of breast imaging research, advocating for a patient-centered imaging strategy in the continuously evolving landscape of diagnostic radiology. The ultimate beneficiary is the patient, who gains from the combined expertise and technological advancements in the field.
Keywords: breast carcinoma detection, dense breast tissue, diagnostic imaging modalities, mammography

B-15

Determinants of Diagnostic Confidence in Coronary CT Angiography

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Coronary CT angiography (CCTA) is an established noninvasive imaging modality for the assessment of coronary artery disease and is increasingly used in routine clinical practice. The level of diagnostic confidence during image interpretation may vary and can influence reporting accuracy and clinical decision-making.

The key determinants that impact radiologists' diagnostic confidence in coronary CT angiography throughout the imaging process involve patient-related physiological factors such as heart rate variability, arrhythmias, body habitus, coronary calcification burden and patient compliance during imaging. Technical factors include choosing the appropriate acquisition protocol and contrast timing, temporal resolution and spatial detail, along with reconstruction techniques. Interpretative factors include image post-processing, use of multiplanar reconstruction algorithms, the radiologist's level of experience and awareness of normal variants and artifacts.

Optimization of these factors was found to significantly improve image quality and outcomes in CCTA interpretation. Understanding these determinants and applying practical approaches—among them manual adjustment of patient-related parameters—can enhance the diagnostic value of coronary CT angiography in daily practice.

B-16

Central Venous Access: Interventional Radiology Point of View

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Background: Central venous access in adult and pediatric patients is of great importance especially for long term hospitalized patients and providing excellent venous access in emergency cases.

Interventional radiologist provides fast, safe, and reliable image guided venous access with negligible complications compared to other specialties.

The use of interventional radiology for central venous access has increased in the recent years due to their ability to navigate difficult venous anatomy and perform diagnostic and therapeutic venous accesses and procedures under ultrasound and fluoroscopy guidance with minimal complications especially for patient with bleeding tendencies, uncorrected coagulopathy and difficult access.

Central venous access catheters and lines are readily available with variable diameter and length related to their intended way of usage.

- Establish the correct access sites for different patients depending on their anatomy, coagulation profile, age and patency of the access site.
- Differentiate between catheter and lines intended for short term versus long term use.
- Determine the preferred device for the requested function and duration of therapy.
- Emphasis on procedural efficiency and safety and maintaining high standards of patient care in interventional radiology suites.

Conclusion: Central venous access is a critical component of the interventional radiology practice.

An image-guided approach paired with appropriate device selection results in high technical success and reduced complications.

Central venous access with line insertion is a mainstay of interventional radiology practice especially in coagulation disorders, bleeding tendencies, multi-access failure and pediatric patients.

B-17

Incidental Adrenal Lesions on CT and MRI: A Practical Imaging Algorithm for Characterization

Dr. Mohammad Isam Ali Bany Doumi

Background: Incidental adrenal lesions are increasingly found on cross-sectional imaging. Most of these are benign adenomas, but some can be serious conditions such as metastasis, pheochromocytoma, and adrenocortical carcinoma. Proper radiologic characterization is crucial to guide treatment and prevent unnecessary follow-up or procedures.

Purpose: To provide a practical algorithm for the imaging evaluation of adrenal incidentalomas using CT and MRI.

Methods: This structured approach combines non-contrast CT attenuation, contrast washout (when applicable), chemical shift MRI (in-phase and opposed-phase), lesion shape, and clinical context. Important features include unenhanced attenuation (≤10 HU for lipid-rich adenoma), signal loss on opposed-phase imaging indicating intracellular lipid, and washout thresholds (absolute ≥60% or relative ≥40%) that support adenoma in indeterminate (>10 HU) lesions. Worrisome morphological signs include size increase, irregular edges, heterogeneity, necrosis or hemorrhage, and invasive characteristics.

Results: Non-contrast CT attenuation ≤10 HU and/or opposed-phase signal loss allows a confident diagnosis of most adenomas. Washout techniques can further categorize many lipid-poor adenomas; however, there can be overlap, especially with pheochromocytoma, which may look like adenoma on washout. Additionally, MRI T2 signal can vary. Therefore, imaging findings need to be assessed together with morphology and clinical or biochemical evaluations when suitable.

Conclusion: An algorithm that combines CT attenuation, MRI chemical shift imaging, and selective washout assessment increases diagnostic confidence for adrenal incidentalomas while highlighting important pitfalls that affect patient management.

B-18

Diagnostic Pitfall of Left-Sided Acute Appendicitis in the Setting of Intestinal Malrotation: A Case Report

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Background: Intestinal malrotation persisting into adulthood is rare and may result in atypical presentations of common surgical emergencies. Left-sided acute appendicitis in the setting of malrotation represents an important diagnostic pitfall that can delay management.
Purpose: To highlight the key CT imaging features of adult intestinal malrotation presenting with left-sided acute appendicitis and to emphasize the role of imaging in accurate diagnosis and surgical planning.
Methods / Case Description: We present a 28-year-old woman with no significant past medical history who presented with a three-day history of progressive left iliac fossa pain and leukocytosis. Contrast-enhanced CT scan of the abdomen and pelvis was performed.
Results / Imaging Findings: CT demonstrated intestinal malrotation characterized by right sided small bowel, left sided colon, abnormal location of the duodenojejunal junction and reversed superior mesenteric artery–superior mesenteric vein relationship. The appendix was identified in the left iliac fossa, appeared inflamed with thickened wall and mild surrounding fat stranding and free fluid. The solid abdominal organs were unremarkable. Laparoscopic exploration confirmed a left-sided inflamed appendix. Laparoscopic appendectomy was performed without Ladd's procedure. Histopathology confirmed inflamed appendix.
Conclusion: Adult intestinal malrotation is associated with atypical presentation of many surgical emergencies, delaying the diagnosis and posing a significant diagnostic challenge. Recognition of the characteristic CT findings is essential to avoid misdiagnosis and treatment delay.

B-19

Role of Skull X-ray in the Diagnosis of Craniosynostosis

Dr. Ayat Aziz Al Alwan

Background: Craniosynostosis is defined as the premature closure of skull sutures, that is important for brain development and enlargement as the children grow, so it›s important to diagnose craniosynostosis early to allow the proper development of brain size without pressure.
Knowing that every suture has specific time to be closed normally, skull x-ray is the primary modality to diagnose craniosynostosis which then confirmed by 3D reconstruction images brain CT scan.
Method: 65 children between age of 1 month to 6 months who came with abnormal shape of head to our hospital Queen Rania hospital for children were analyzed retrospectively between January 2025 till January 2026, skull x-ray was done in pediatric radiology department then confirmed by 3D reconstruction images brain CT scan to have craniosynostosis.
49 patients (75.4%) were males and 16 patients (24.6%) were females.
42 of patients (64.6%) have sagittal suture craniosynostosis and 23 of patients(35.4%) have other sutures craniosynostosis.
Exclusion criteria: patients with syndromes.
Results: Regarding the 42 patients who have sagittal suture craniosynostosis 38 patients (90.5%) were diagnosed correctly to have craniosynostosis by x-ray and four patients (9.5%) were not diagnosed by x-ray alone.
Regarding the 23 patient who have other sutures craniosynostosis 13 patients (56.5%) were diagnosed correctly by X-ray and 10 patients (43.5%) were not diagnosed by x-ray alone.
Conclusion: Skull x-ray is valuable initial diagnostic modality for diagnosis craniosynostosis however 3D brain CT scan still the modality of choice to diagnose craniosynostosis and the treatment planning.
Keywords: Craniosynostosis, x-ray, 3D brain CT scan.

B-20

Radiological Manifestations of Gastrointestinal Involvement in Familial Mediterranean Fever: A Pictorial Review

Dr. Sajeda Ibrahim Ali Al-Owdat, MD

Background/Purpose: Familial Mediterranean Fever (FMF) is an autosomal recessive autoinflammatory disorder characterized by recurrent self-limited episodes of fever and serositis, with gastrointestinal (GI) manifestations being among the most common presenting features. Because these episodes can clinically mimic surgical emergencies such as acute appendicitis or bowel obstruction, imaging plays a central role in avoiding unnecessary intervention. This review aims to describe the spectrum of radiological findings of GI involvement in FMF, discuss their differential diagnosis, and outline the role of imaging in detecting disease complications.
Materials and Methods: A narrative review of the literature was performed, supplemented by illustrative imaging examples, focusing on the CT, ultrasound, and MRI findings of GI involvement during acute FMF attacks and in chronic disease. Results/Discussion: During acute attacks, contrast-enhanced CT most frequently demonstrates segmental bowel wall thickening with mucosal hyperenhancement and submucosal edema, predominantly affecting the terminal ileum and colon. Associated findings include mesenteric fat stranding, reactive mesenteric lymphadenopathy, and free or loculated ascites with peritoneal enhancement, reflecting sterile serositis. These changes are typically transient, resolving between attacks without residual bowel damage. Ultrasound is particularly useful in pediatric patients, demonstrating bowel wall edema, hyperemia, and free peritoneal fluid without radiation exposure, while MRI provides a valuable radiation-free alternative for characterizing inflammatory changes and monitoring disease activity or complications in both children and adults. Chronic or recurrent inflammation may lead to fibrous adhesions and intermittent bowel obstruction, while long-standing disease—particularly in inadequately treated or colchicine-resistant patients—carries a risk of secondary (AA) amyloidosis, which manifests radiologically as diffuse, symmetric bowel wall thickening with altered motility and malabsorption. The nonspecific nature of these findings creates substantial overlap with inflammatory bowel disease, infectious enterocolitis, and acute appendicitis, underscoring the necessity of correlating imaging with clinical history, attack pattern, and genetic testing (MEFV mutation analysis).

Conclusion: Imaging findings of GI involvement in FMF are variable, transient, and largely nonspecific, but recognition of the characteristic pattern of self-resolving bowel wall thickening and sterile peritonitis is critical for excluding alternative diagnoses, guiding conservative management, and identifying chronic complications such as amyloidosis. Familiarity with this imaging spectrum, combined with clinical and genetic correlation, reduces the risk of unnecessary surgical or invasive interventions in this patient population.

Keywords: Familial Mediterranean Fever; Gastrointestinal Involvement; Computed Tomography; Magnetic Resonance Imaging; Ultrasound; Amyloidosis; Autoinflammatory Disease

B-21

Osteomyelitis: Imaging Diagnosis and Complications

Dr. Samer Falah Alqudah

- Osteomyelitis: infection of bone marrow.
- Osteitis: infection of cortex.
- Periostitis: infection of periosteum.
- Osteomyelitis is an infection in a bone or more precisely infection of bone marrow.
- Spreads:
- Hematogenous (commonest).
- Direct penetration.
- Direct invasion.
- Acute: Days.
- Subacute: Days – 6 wks (Brodie's abscess).
- Chronic: > 6 wks.

Infants up to 12 months

- Some of metaphyseal vessels penetrate physis and anastomose with the epiphyseal vessels.
- Infection involve metaphysis, epiphysis and may joints.
- Osteonecrosis, SCFE and growth deformity.

Toddlers and older children (1-16 yrs)

- Vessels don't cross the physis.
- Metaphyseal vessels terminate in loops.
- Metaphysis is the most common site.
- Epiphyseal and joint involvement are less common but do occur.

Adults > 16 yrs

- Terminal epiphyseal vessels anastomose with the epiphyseal vessels.
- Metaphyseal and joint involvement are more common.
- Spine and small bone involvement are common than children.

Location

- Frequency by location, in descending order:
- lower limb (most common)
- vertebrae: lumbar > thoracic > cervical
- radial styloid

- sacroiliac joint

Diagnosis acute osteomyelitis

- Osseous changes are highly aggressive in acute stage and difficult to differentiate from aggressive neoplasm.
- Bone marrow edema due to infiltrative disease and trauma can mimic osteomyelitis.
- Clinical, laboratory evaluation and time course of the disease is important to differentiate.

Plain radiograph

- Swelling and loss or blurring of normal fat planes; osteopenia.
- Permeative pattern, indistinctness of cortex, endosteal scalloping, cortical destruction, new bone formation and sclerosis.
- Osteomyelitis must extend at least 1 cm and compromise ~40% of bone mineral content to produce noticeable changes on plain radiographs.
- 5 to 7 days from the onset in children and 10 to 14 days in adults.

MRI

- Gold standard.
- Combination of T1WI, fluid sensitive sequences (STIR/T2 FS)
- Post contrast images are very important in diagnosis the presence and extent of osteomyelitis.
- Contrast important in detection of abscess, sinus tract and devitalized soft tissue.
- Bone marrow edema is the first sign to appear. It appears as a low (dark) signal in the T1 sequence and a high (bright) signal in the T2 and STIR sequences .
- Confluent Pattern Marker: A complete replacement of the normal lipid signal in the bone marrow with a low signal in T1, which distinguishes true inflammation from mere reactive edema.
- Intraosseous Abscess: It appears as a void containing pus (high T2 signal) with rim enhancement when contrast, and this is known as the Penumbra Sign .
- Fat globules: The presence of fatty deposits within the medulla or under the periosteum is a strong indicator of inflammation.

Chronic Osteomyelitis

- Infection more than 6 wks.
- Untreated acute osteomyelitis.
- May remain silent for years then reactivate.
- Reactivation from sequestrum (nidus of reactivation).
- Sequestrum is necrotic infected bone.
- Bone scan (tagged RBC) is important in detecting sequestrum.

- Sequestrum: A piece of dead (infected) bone that appears dark (low signal) in all sequences because it lacks blood supply and is not enhanced by contrast.
- Involucrum: New bone that forms around the dead bone, appearing as a thick crust around the area of inflammation.
- Cloaca: A hole in the bone cortex that allows pus to drain from the marrow into the soft tissues.
- Sinus Tract: A channel that connects the injured bone to the skin surface, showing a high signal in T2 with enhanced contrast of its walls.
- Chronic osteomyelitis of tibia and femur often associated with chronic sinus tract.
- If drainage occurs over many years/decades the tract may develop squamous cell carcinoma.

Brodie's abscess

- (subacute/chronic infection).
- Usually metaphysis.
- Could be in the epiphysis (ddx chondroblastoma and eosinophilic granuloma).
- Patient may not have fever of high ESR.

X-rays (Plain Radiograph)

- Lytic Lesion: A translucent (lucency) area, usually oval in shape, aligned with the longitudinal axis of the bone.
- Sclerotic Rim: The transparent area is surrounded by a thick, dense wall of sclerotic bone (Reactive sclerosis).
- Periosteal Reaction: A periosteal reaction (formation of new bone) that may be present in chronic cases.

Magnetic Resonance Imaging (MRI)

- Penumbra sign: Rim of vascularized granulation tissue surrounding an intraosseous abscess cavity, with a higher T1 signal intensity than the cavity itself. (specific 98 %).
- Target Appearance: It consists of 4 layers: a fluid center, an inner ring (granulation tissue), an outer ring (osteosclerosis), and a peripheral halo (bone marrow edema).
- Contrast Enhancement: A clear and peripheral enhancement of the granulation tissue is observed after injection of gadolinium contrast.

B-22

Pelvic MRI Evaluation of Treatment Response in Rectal Cancer: Experience from JRMS

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Aim: Evaluation of treatment response is a key component in the management of patients with locally advanced rectal cancer, as the degree of tumor regression can influence subsequent treatment decisions. Depending on the response, patients may be considered for total mesorectal excision, organ-preserving approaches, or a watch-and-wait strategy. Pelvic MRI has an established role in post-treatment assessment and provides standardized imaging parameters for evaluating tumor regression. The purpose of this talk is to present our experience at Jordan Royal Medical Services (JRMS) in applying standardized pelvic MRI criteria for the assessment of treatment response in rectal cancer.

Discussion: At JRMS, patients undergo both initial staging and post-treatment pelvic MRI using a dedicated 3T scanner. Restaging examinations are generally performed approximately eight weeks following completion of treatment. Our imaging protocol incorporates high-resolution, small-field-of-view T2-weighted sequences together with diffusion-weighted imaging and ADC mapping.

Treatment response is evaluated through a combination of morphological and functional MRI findings. These include changes in the primary tumor and T stage, the degree of lymph node regression, alterations in DWI and ADC characteristics, the status of the mesorectal fascia and circumferential resection margin (MRF/CRM), changes in extramural venous invasion (EMVI), and the MRI tumor regression grade (mrTRG).

The mrTRG system provides a practical means of stratifying patients according to their response, with patients classified as good, intermediate, or poor responders. The MRI appearance also demonstrates a useful relationship between the regression grade and the relative presence of post-treatment fibrosis versus residual tumor, particularly on T2-weighted and diffusion-weighted images.

Conclusion: Our experience indicates that a dedicated pelvic MRI protocol combined with a standardized set of post-treatment imaging criteria can provide a reliable assessment of treatment response in rectal cancer. This information may assist the multidisciplinary team in selecting an appropriate, individualized management strategy for patients following neoadjuvant treatment at JRMS.

Keywords: Rectal cancer, pelvic MRI, neoadjuvant chemoradiotherapy, MRI tumor regression grade, diffusion-weighted imaging.

B-23

The Role of Magnetic Resonance Imaging in the Diagnosis and Management of Rotator Cuff Tears

Dr. Amr Al-Damen
Radiology Specialist

Rotator cuff tears are a common cause of shoulder pain, weakness, and functional impairment. Following clinical history and physical examination, magnetic resonance imaging (MRI) is the principal imaging modality for confirming and grading rotator cuff pathology, as well as assisting in treatment planning. MRI provides a detailed assessment of the supraspinatus, infraspinatus, subscapularis, and teres minor tendons. It differentiates tendinosis from partial- and full-thickness tears and determines the tear›s location, depth, width, configuration, and degree of tendon retraction. MR arthrography may provide greater sensitivity for detecting small, articular-sided, partial-thickness tears and associated intra-articular abnormalities. In addition to detecting a tear, MRI identifies important factors that affect prognosis and surgical reparability. These include the number of tendons involved, tendon quality, degree of tendon retraction, muscle atrophy, fatty infiltration, superior migration of the humeral head, and associated abnormalities of the long head of the biceps tendon, labrum, acromion, and glenohumeral joint. MRI findings play an essential role in treatment selection when interpreted alongside the patient›s age, symptoms, functional demands, physical examination findings, traumatic or degenerative onset, and response to conservative treatment. Small or low-grade partial-thickness tears without major tendon retraction or muscle degeneration are generally managed initially with activity modification, physiotherapy, analgesia, and selective corticosteroid injections. Persistent, symptomatic, high-grade partial-thickness tears and repairable full-thickness tears may require arthroscopic repair. Marked tendon retraction, advanced muscle atrophy, or fatty infiltration may direct treatment toward partial repair, tendon transfer, superior capsular reconstruction, or other salvage procedures. In elderly patients, MRI findings such as massive irreparable tears, cuff-tear arthropathy, and muscle atrophy may support consideration of reverse shoulder arthroplasty.

Conclusion: MRI is essential not only for detecting and characterizing rotator cuff tears but also for estimating tear chronicity, prognosis, and surgical reparability. By providing detailed information about tear morphology, degree of tendon retraction, muscle condition, and other associated shoulder abnormalities, MRI plays an essential role in guiding the choice between conservative management, tendon repair, reconstructive procedures, and shoulder arthroplasty.

B-24

Greater Trochanteric Pain Syndrome: Incidence and Clinical Importance

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Objective: To evaluate the incidence of greater trochanteric pain syndrome among patients presented for hip MRI as a case of hip pain at KHMC
Methods: 300 hip MRI studies were evaluated between November 2023 and November 2024, for patients presented as cases of hip pain at KHMC were reviewed.
All studies were done on Siemens Skyra 3 Tesla MRI machine with standard protocol axial and coronal T1WI and coronal T1, PD and STIR, sagittal PDFS.
The studies were reviewed for the diagnosis of greater trochanteric pain syndrome due to variable causes.
Results: 70 out of 300 had positive MRI findings, accounting for about 23%.
15 of them found to have greater trochanteric bursitis.
30 of them found to have gluteal tendinopathy (gluteus minimus or gluteus medius).
25 of them had non-specific T2FS hyperintense signal in the peritrochanteric regions.
Conclusion: Greater trochanteric pain syndrome is a general term that should be considered in diagnosing patients with hip pain and tenderness due to variable causes.
Keywords: Greater trochanteric pain syndrome,trochanteric bursitis, gluteal tendinopathy, hip MRI.

B-25

Evaluating the Role of Ultrasound in the Diagnosis of Pediatric Intussusception

Dr. Zaid A. Al-Hayajneh

Background: Intussusception is one of the most common causes of acute intestinal obstruction in infants and young children and represents a medical emergency requiring prompt diagnosis. Clinical presentation is often variable and nonspecific, frequently mimicking other causes of acute abdomen. Ultrasound has become the primary imaging modality for diagnosis due to its high sensitivity, lack of ionizing radiation, and widespread availability. This study aimed to evaluate the diagnostic performance of ultrasound in suspected cases of pediatric intussusception.
Methods: This retrospective cross-sectional study included 85 pediatric patients who were clinically suspected of having intussusception over a four-year period starting January 2019. Patient ages ranged from 3 months to 4 years. All patients underwent abdominal ultrasound examinations performed by experienced radiologists. Imaging findings were correlated with clinical outcomes, therapeutic enema reduction results, or surgical findings, which served as the reference standard.
Results: Intussusception was confirmed in 38 patients. Ultrasound demonstrated characteristic imaging features in 35 of these cases, including the target sign, pseudokidney sign, and identification of mesenteric fat and vessels within the intussuscepted bowel. Three cases showed equivocal findings and were later confirmed surgically. Ultrasound showed high sensitivity in detecting ileocolic intussusception and provided additional information regarding bowel viability and the presence of pathological lead points.
Conclusion: Ultrasound is a highly effective first-line imaging modality for diagnosing pediatric intussusception, offering excellent diagnostic accuracy while avoiding radiation exposure. Its ability to provide real-time assessment and guide management decisions makes it indispensable in emergency pediatric imaging. Early and accurate ultrasound diagnosis contributes significantly to improved clinical outcomes.

B-26

Contrast Extravasation on Contrast-Enhanced CT as a Reliable Imaging Sign of Hemorrhagic Severity and Need for Treatment in Pelvic Fractures

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Background: Pelvic fractures caused by high-energy trauma are serious injuries often linked to blood vessel damage and heavy internal bleeding. Spotting ongoing arterial bleeding early is key to saving lives. Detecting contrast extravasation on contrast-enhanced CT scans shows direct signs of active blood vessel leaks and can help guide urgent care decisions.
Objective: This study aimed to check if contrast extravasation on multiphasic contrast-enhanced CT can predict worsened blood pressure, need for blood transfusions, use of endovascular embolization, and risk of death in people with recent pelvic fractures.
Methods: A review of medical records was done on trauma patients with confirmed pelvic fractures who had multiphasic contrast-enhanced CT scans. Contrast extravasation was noted as a buildup of contrast outside regular blood vessels that lasted or worsened in delayed phase images. Clinical factors checked included blood pressure, signs of shock, transfusion needs, use of angiographic embolization, and patient outcomes. A multivariable regression model was used to see if contrast extravasation could independently predict the need for treatment and risk of death.
Results: Contrast extravasation was mostly seen in people with unstable pelvic fractures. Its presence was linked to signs of poor blood flow, higher transfusion needs, and a stronger chance of needing urgent embolization. Importantly, contrast extravasation remained a strong predictor of both treatment and death, regardless of the fracture pattern. Findings seen in the arterial phase were most strongly connected to major bleeding that needed embolization.
Conclusion: Finding contrast extravasation on multiphasic CT scans is a strong and reliable sign of serious internal bleeding in pelvic trauma. Recognizing this sign should lead to quick team efforts and early planning for endovascular treatment. Using contrast extravasation in trauma evaluation tools could improve risk assessment and help improve patient outcomes.
Keywords: Pelvic trauma, Contrast extravasation, Active bleeding, CT angiography, Hemodynamic instability, Endovascular embolization, Emergency radiolog

B-27

Imaging Evaluation of Breast Calcifications Detected on Mammography

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Background: Breast calcifications constitute up to 85% of screening mammograms and are a major source of patient anxiety. Although majority are benign, calcifications may represent the only initial sign of ductal carcinoma in situ (DCIS) or malignancy. Mammogram calcifications may impact a woman›s life-from the time of detection through prospect of possible biopsy and thereafter. Radiologists' role should extend beyond image interpretation to providing appropriate reassurance as well as ensuring timely intervention when necessary.
Methods: This focused review sheds light on the BI-RADS criteria for evaluation of calcifications, their morphology, distribution patterns, and their correlation with patient outcomes. We discuss clinical decision-making with emphasis on clear patient communication during the evaluation process. The discussion includes modern technologies like digital breast tomosynthesis and their influence on reducing patient anxiety and concerns.
Results: Benign calcifications including vascular, coarse «popcorn-like,» round, and rim patterns (BI-RADS 2) warrant reassurance for patients. Suspicious calcification patterns require more careful evaluation including amorphous calcifications pose 20-30% malignancy risk and fine pleomorphic patterns carry 30-60% risk. On the other hand, fine linear-branching calcifications carry 60-90% malignancy probability. Calcification distribution patterns matter significantly as linear and segmental patterns may suggest ductal involvement with higher cancer risk; on the other hand, grouped patterns may represent benign etiology. Digital breast tomosynthesis has improved the accuracy and precision to characterize calcifications, reducing unnecessary diagnostics by 15% while preserving reasonable sensitivity for cancer detection.
Patient Impact and Communication: Breast calcifications may represent a source of anxiety for patients. Clear and empathetic communication is pivotal while explaining that most calcifications are normal aging changes but with acknowledging the importance of careful evaluation. When additional imaging or biopsy is recommended, patients benefit from understanding the rationale and expectations, with emphasis on the high likelihood of benign outcomes even with suspicious findings.

Clinical Significance: Accurate assessment of breast calcification impacts patient wellbeing. Appropriate reassurance for benign findings prevents unnecessary anxiety and unnecessary diagnostic test and procedures, while timely evaluation of suspicious patterns enforces early cancer detection when treatment is most effective. Radiologists' interpretations influence not just medical outcomes but also patients› emotional journey throughout breast cancer screening.

Conclusion: Evaluation of breast calcifications necessitates both technical expertise and human compassion. Behind every mammogram is a woman seeking peace of mind and reassurance. Through combining evidence-based interpretation with clear, empathic communication, radiologists are able to provide accurate diagnosis while supporting patients throughout the evaluation process. Advanced imaging technologies continue to improve the diagnostic accuracy, ultimately serving the ultimate goal of providing the best outcomes for women's health.

B-28

Localisation of Parathyroid Adenoma: An Overview

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Precise localisation of parathyroid adenoma is essential for the surgical management of primary hyperparathyroidism, particularly with the widespread adoption of minimally invasive parathyroidectomy.

Diagnosis is established biochemically, while imaging is performed exclusively for preoperative localisation. Neck ultrasonography is commonly used as a first-line modality due to its availability and absence of ionising radiation, though its sensitivity is operator dependent and limited for ectopic glands. Technetium-99m sestamibi scintigraphy, especially when combined with SPECT or SPECT/CT, provides functional localisation with high sensitivity for solitary adenomas.

When initial imaging is inconclusive, advanced techniques such as four-dimensional computed tomography and magnetic resonance imaging improve detection, particularly in ectopic or reoperative cases.

In selected complex cases, selective venous sampling for parathyroid hormone may be required. A multimodality imaging strategy tailored to the clinical scenario enhances localisation accuracy and supports optimal surgical outcomes.

B-29

Imaging Spectrum of Male Breast Diseases: Differentiating Benign and Malignant Lesions

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Background: Male breast diseases are uncommon but clinically significant conditions that often present with nonspecific symptoms such as palpable masses, pain, or breast enlargement. Although most lesions are benign, accurate differentiation from malignancy is essential to avoid delayed diagnosis of male breast cancer.
Purpose: To review the imaging spectrum of male breast disease and highlight key mammographic and ultrasound features that aid in distinguishing benign from malignant entities.
Method: A structured review of male breast pathology was conducted, focusing on the clinical presentation, imaging findings, and histopathological correlation of common benign and malignant conditions.
Results: Gynecomastia is the most common male breast condition and typically presents as a subareolar flame shaped or nodular density on mammography with corresponding hypoechoic tissue on ultrasound. Pseudogynecomastia demonstrates fatty tissue without glandular proliferation. Other benign lesions include lipoma, epidermal inclusion cysts, fat necrosis and rare tumors such as angiolipoma, each with characteristic imaging features. Male breast cancer is rare (approximately 0.7% of all breast cancer) and most commonly represents invasive ductal carcinoma. It typically appears as irregular, spiculated or microlobulated subareolar mass, often eccentric to the nipple and may be associated with skin thickening, nipple retraction, and axillary lymphadenopathy.
Conclusion: Mammography is the first-line imaging modality in male breast evaluation, with ultrasound serving as complementary tool. Recognition of characteristic imaging patterns is crucial for differentiating benign conditions from malignancy and guiding appropriate biopsy and management.
Keywords: Male breast, gynecomastia, mammography, ultrasound, breast cancer

B-30

Mammography and Its Practical Impact on Breast Cancer Surgery: A Review

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Mammography is widely recognized as a cornerstone of breast cancer screening, but its clinical value extends well beyond early detection. Within the surgical pathway, mammographic imaging plays a central role in preoperative assessment, lesion localization, surgical planning, and postoperative surveillance. This review examines the practical contribution of mammography to breast cancer surgery, with particular emphasis on its influence on operative decision-making, management of non-palpable lesions, and follow-up after treatment.

A focused review of the available literature was conducted using major medical databases, including PubMed, Scopus, and Google Scholar. The search concentrated on studies evaluating the role of mammography in surgical planning, localization of clinically occult breast lesions, assessment of disease extent, and postoperative imaging surveillance.

The available evidence demonstrates that mammography is highly valuable in identifying and characterizing suspicious calcifications, breast masses, and architectural distortion. These imaging findings provide critical information regarding the location and extent of disease and may directly influence the choice and scope of surgery. Accurate assessment of lesion size, multifocality, and distribution can support decisions between breast-conserving surgery and more extensive surgical management.

Mammography is particularly important in the management of non-palpable lesions, where imaging-guided localization enables accurate surgical targeting and helps minimize unnecessary removal of healthy breast tissue. In addition, specimen mammography can be used intraoperatively to confirm that the radiographic abnormality has been successfully excised.

Its value also continues after surgery. Post-treatment mammography remains an essential component of surveillance following breast-conserving therapy. Although postoperative changes such as scarring, architectural distortion, and fat necrosis can complicate interpretation, serial mammographic assessment helps distinguish

expected postoperative findings from suspicious changes that may indicate residual or recurrent disease.

In conclusion, mammography remains an integral component of breast cancer surgical care. Its ability to define lesion location and extent, guide the management of non-palpable abnormalities, support operative planning, and facilitate postoperative surveillance makes it essential throughout the surgical pathway. Effective integration of mammographic findings into multidisciplinary decision-making can improve surgical precision, support appropriate treatment selection, and contribute to better patient outcomes.

B-31

Imaging Evaluation of Acute Ischemic Stroke in the Era of Advanced Neuroimaging

Dr. Moad Falah Albdairat, MD
Radiologist

Acute ischemic stroke remains a leading cause of mortality and long-term disability worldwide. Rapid and accurate neuroimaging assessment is essential for diagnosis, therapeutic decision-making, and prognostication. Non-contrast computed tomography (NCCT) continues to serve as the first-line imaging modality for excluding intracranial hemorrhage and detecting early ischemic changes, including loss of gray–white differentiation and hyperdense vessel signs. However, multimodal imaging has significantly expanded the diagnostic capabilities of modern neuroradiology.

Computed tomography angiography (CTA) enables rapid identification of large vessel occlusion and assessment of collateral circulation, while computed tomography perfusion (CTP) facilitates differentiation between irreversibly infarcted core tissue and potentially salvageable ischemic penumbra. Magnetic resonance imaging (MRI), particularly diffusion-weighted imaging (DWI), demonstrates high sensitivity for early cytotoxic edema within minutes of symptom onset. The combination of DWI with fluid-attenuated inversion recovery (FLAIR) imaging allows estimation of stroke timing, particularly in wake-up strokes. Perfusion-weighted imaging (PWI) further refines tissue viability assessment through mismatch analysis.

Advanced imaging biomarkers have become central to patient selection for intravenous thrombolysis and endovascular thrombectomy beyond traditional time windows. Landmark clinical trials such as the DAWN and DEFUSE 3 trials demonstrated the benefit of imaging-based selection in extended therapeutic windows. These paradigm-shifting studies emphasized the transition from a purely time-based to a tissue-based treatment approach.

In addition to guiding acute therapy, neuroimaging plays a critical role in identifying stroke etiology, evaluating complications such as hemorrhagic transformation, and predicting functional outcomes. Emerging techniques—including arterial spin labeling, vessel wall imaging, and artificial intelligence–assisted image analysis—are further enhancing diagnostic precision and workflow efficiency.

In conclusion, comprehensive multimodal neuroimaging has become indispensable

in the management of acute ischemic stroke, enabling personalized treatment strategies and significantly improving clinical outcomes.

Keywords: Neuroradiology; Acute Ischemic Stroke; Diffusion-Weighted Imaging; Perfusion Imaging; CT Angiography; Large Vessel Occlusion; Mechanical Thrombectomy; Imaging Biomarkers

B-32

Non-Traumatic Acute Abdomen on CT: Common Pitfalls and How to Avoid Them

Dr. Ara Mohammad Bani Melhem

Introduction: Computed tomography (CT) is the primary imaging modality for evaluating patients with non-traumatic acute abdominal pain. Despite high diagnostic accuracy, interpretation pitfalls may lead to delayed or incorrect diagnosis, directly impacting patient outcomes. Awareness of common errors and their imaging mimics is essential for accurate reporting and timely management.

Aim: To highlight common diagnostic pitfalls encountered in CT evaluation of the non-traumatic acute abdomen and to provide practical strategies to avoid misinterpretation.

CT Protocol Considerations

- Contrast-enhanced CT is essential in most cases
- Multiphase imaging when vascular pathology is suspected
- Thin-section axial images with multiplanar reconstructions (MPRs)
- Correlation with clinical presentation and laboratory findings

Common Pitfalls and Imaging Pearls

1. Early Appendicitis

Pitfall: Normal-caliber appendix with subtle periappendiceal fat stranding.

Avoidance Tip: Look for wall hyperenhancement, mild fat stranding, and correlate with focal tenderness. Always trace the appendix in multiple planes.

2. Closed-Loop Small Bowel Obstruction

Pitfall: Mistaking it for simple obstruction.

Avoidance Tip: Identify C-shaped or U-shaped loops, mesenteric swirl, and radial distribution. Assess for ischemic signs such as reduced enhancement and mesenteric edema.

3. Mesenteric Ischemia

Pitfall: Normal bowel wall thickness in early stages.

Avoidance Tip: Carefully assess mesenteric vessels. Look for subtle findings, including pneumatosis, portal venous gas, and decreased mural enhancement. Use arterial phase imaging when suspicion is high.

4. Perforated Hollow Viscus

Pitfall: Missing small amounts of free intraperitoneal air.
Avoidance Tip: Use lung window settings and search for indirect signs such as focal fat stranding, localized fluid, or a bowel wall defect.
5. Epiploic Appendagitis vs Diverticulitis
Pitfall: Overdiagnosing diverticulitis.
Avoidance Tip: Epiploic appendagitis typically presents as a fat-density oval lesion with a hyperattenuating rim and minimal bowel wall thickening.
6. Omental Infarction
Pitfall: Confusion with appendicitis or diverticulitis.
Avoidance Tip: Identify a larger heterogeneous fat-density lesion, usually located away from the bowel wall.
7. Gynecological Mimics
Pitfall: Missing ovarian torsion or ruptured ovarian cyst.
Avoidance Tip: Always review pelvic organs, particularly in women of reproductive age. Look for an enlarged ovary, twisted pedicle, or hemoperitoneum.
Role of Structured Reporting
Structured reporting reduces omission of critical findings, improves communication with referring clinicians, and promotes a systematic evaluation of bowel, mesentery, vessels, and solid organs.
Learning Points

- CT pitfalls in acute abdomen are common but avoidable
- Subtle imaging signs are critical in early disease
- Multiplanar review and clinical correlation are essential
- Structured reporting enhances diagnostic accuracy

Conclusion: Accurate interpretation of CT in non-traumatic acute abdomen requires systematic analysis and awareness of common pitfalls. Recognition of subtle imaging features and common mimics significantly improves diagnostic confidence and patient outcomes. Radiologists play a central role in guiding timely and appropriate management.

B-33

Role of MRI in Evaluating Laryngeal Masses

Dr. Khaldoon Ahmad Hadidi, MD
Radiologist

Magnetic resonance imaging (MRI) plays a crucial role in the evaluation of laryngeal masses by providing superior soft-tissue contrast and multiplanar imaging capabilities. It allows accurate assessment of tumor extent, submucosal spread, cartilage invasion, and involvement of adjacent spaces, which are often difficult to evaluate with clinical examination or other imaging modalities. MRI is particularly valuable in differentiating benign from malignant lesions based on signal characteristics and enhancement patterns, as well as in staging laryngeal carcinoma. Advanced MRI techniques, including diffusion-weighted imaging, further improve lesion characterization and treatment planning. Additionally, MRI is useful in post-treatment follow-up by distinguishing recurrent disease from post-therapeutic changes such as fibrosis or edema. Overall, MRI serves as an essential imaging tool in the diagnosis, staging, and management of laryngeal masses, contributing significantly to optimal patient care.

B-34

The Role of Artificial Intelligence in Detecting Lung Nodules on Computed Tomography

Dr. Saja Mohammad Kofahi, MD
Radiologist

Artificial intelligence is increasingly being introduced into computed tomography to support the detection of lung nodules. This study looks at the role of AI-based systems in helping identify pulmonary nodules on CT scans and in assisting radiologists during image interpretation. By analyzing large volumes of imaging data, these tools were able to highlight small or subtle nodules that may be difficult to notice on routine review. In addition, the use of artificial intelligence helped streamline the reading process and improved consistency between interpretations. Overall, the findings suggest that artificial intelligence can serve as a useful supportive tool in lung nodule detection, working alongside radiologists to enhance diagnostic confidence and contribute to earlier identification of clinically significant findings.

B-35

The Role of MRI in Diagnosing Prostate Cancer

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Background: Magnetic resonance imaging (MRI) has become the principal imaging modality for the detection, localization, and local staging of prostate cancer. The development of multiparametric MRI (mpMRI) and standardized reporting systems has improved identification of clinically significant disease and guided targeted management strategies.

Methods/Overview: mpMRI combines high-resolution T2-weighted imaging, diffusion-weighted imaging (DWI) with apparent diffusion coefficient (ADC) mapping, and dynamic contrast-enhanced (DCE) imaging to characterize prostatic lesions. Interpretation is standardized using the Prostate Imaging Reporting and Data System (PI-RADS), which stratifies lesions from category 1 (very low likelihood) to category 5 (very high likelihood) of clinically significant cancer.

MRI Findings: In the peripheral zone, prostate cancer typically appears as a focal hypointense lesion on T2-weighted images with marked diffusion restriction and low ADC values, often accompanied by early focal enhancement on DCE sequences. Transition-zone tumours commonly present as ill-defined, lenticular, or non-encapsulated hypointense lesions with heterogeneous signal and diffusion restriction, distinguishing them from benign prostatic hyperplasia nodules. MRI also enables assessment of extracapsular extension, seminal vesicle invasion, neurovascular bundle involvement, and regional lymphadenopathy.

Conclusion: mpMRI with PI-RADS assessment provides critical morphologic and functional information for accurate detection and local staging of prostate cancer, guiding biopsy, treatment planning, and risk-adapted patient management.

B-36

Imaging of Splenosis

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Background: Splenosis is an acquired condition caused by autotransplantation of splenic tissue following splenic trauma or splenectomy. Ectopic splenic implants may occur in various intra-abdominal or extra-abdominal locations and frequently mimic neoplastic lesions on imaging, leading to diagnostic uncertainty.
Objective: To demonstrate the imaging characteristics of splenosis using different radiologic modalities and to emphasize key features that facilitate accurate diagnosis and avoid unnecessary invasive procedures.
Conclusion: Splenosis should be considered in the differential diagnosis of unexplained soft-tissue nodules, particularly in patients with a history of splenic injury or splenectomy. Familiarity with its imaging appearances across modalities is essential for correct identification. Nuclear medicine techniques, especially technetium-99m–labeled heat-damaged red blood cell scintigraphy, remain the most specific diagnostic tools. Accurate radiologic recognition of splenosis can prevent misdiagnosis, inappropriate biopsies, and unwarranted surgical intervention.
Keywords: Splenosis; Ectopic spleen; Post-splenectomy; Diagnostic imaging; Nuclear medicine

B-37

Imaging of Small Bowel Lymphoma

Dr. Hala Al-Salman, MD

Background: Small bowel lymphoma is an uncommon but important gastrointestinal malignancy with variable clinical presentation and diverse imaging appearances. It may involve the duodenum, jejunum, or ileum and is often associated with delayed diagnosis due to nonspecific symptoms. Imaging plays a crucial role in detection, characterization, staging, and assessment of complications.
Objective: To review the imaging features of small bowel lymphoma across different imaging modalities and to emphasize key radiologic findings that aid in diagnosis and differentiation from other small bowel pathologies.
Conclusion: Small bowel lymphoma demonstrates characteristic imaging patterns, including segmental or diffuse bowel wall thickening, aneurysmal dilatation, bulky lymphadenopathy, and minimal desmoplastic reaction. Cross-sectional imaging with contrast-enhanced CT and MRI enterography is essential for accurate assessment of disease extent and extraluminal involvement. Awareness of these imaging features facilitates early diagnosis, appropriate staging, and optimal patient management.
Keywords: Small bowel lymphoma; Gastrointestinal lymphoma; CT enterography; MRI enterography; Abdominal imaging

B-38

MRI Features of Neuro-Behçet's Disease

Dr. Muna Alshubeilat, MD, JBR, FRCR

Behçet's disease is a multisystem inflammatory vasculitis of unknown etiology that can involve the central nervous system, termed neuro-Behçet's disease (NBD). MRI is the imaging modality of choice for diagnosis, monitoring and follow-up.

Neuro-Behçet's disease is classified into parenchymal and non-parenchymal forms. The parenchymal type most commonly affects the brainstem, particularly the mesodiencephalic junction (the characteristic cascade sign), pons, the basal ganglia. Less commonly the subcortical white matter and the spinal cord are affected too. Lesions typically appear hyperintense on T2-weighted and FLAIR images and may show contrast enhancement and diffusion restriction in the acute phase. The disease could be reversible if acute but in chronic disease it may result in brainstem atrophy and gliosis.

The non-parenchymal (vascular) form commonly presents as cerebral venous sinus thrombosis, best detected with contrast MR venography.

It is essential to recognize these MRI characteristic patterns for early diagnosis and differentiation from other diseases as inflammatory and demyelinating conditions, enabling rapid appropriate immunosuppressive treatment and improved outcomes.

B-39

Osteochondral Lesions of the Knee: Differentiating Osteochondritis Dissecans from Avascular Necrosis

Dr. Ibrahim Al Okour

Background: Osteochondral lesions of the knee represent a common diagnostic challenge in musculoskeletal imaging, especially in distinguishing osteochondritis dissecans (OCD) from avascular necrosis (AVN). Although there is overlap between the two, accurate distinction is crucial as management and prognosis differ significantly. Magnetic resonance imaging (MRI) plays a central role in early diagnosis and characterization.

Purpose: To underscore the salient imaging features with which to distinguish OCD from AVN of the knee. Emphasis is placed on lesion location, morphology, marrow signal characteristics, and stability assessment on MRI to ensure reliable differentiation.

Materials and Methods: A retrospective analysis of knee MRI scans conducted in patients with osteochondral lesions was performed. Cases exhibiting imaging features suggestive of OCD or AVN were analyzed. MRI examination assessed lesion topography, subchondral bone involvement, presence of a sclerotic rim, bone marrow edema pattern, cartilage integrity, and associated secondary signs. Imaging features were correlated with clinical data and follow-up findings when available.

Results: OCD lesions most often involved the lateral aspect of the medial femoral condyle and showed distinct subchondral defects, variable degrees of bone marrow edema, and features of lesion instability in advanced stages. By contrast, AVN lesions demonstrated a more geographic pattern of subchondral signal alteration, serpiginous margins, and relatively preserved overlying cartilage in early stages. Bone marrow edema was more diffuse and reactive in OCD, while AVN showed characteristic low signal intensity lines on T1-weighted images consistent with necrotic bone.

Conclusion: MRI offers critical diagnostic cues that facilitate confident differentiation between knee OCD and AVN. Identification of lesion location, morphology, and marrow signal patterns is vital to prevent misdiagnosis and guide appropriate clinical management. A structured MRI approach can significantly improve diagnostic accuracy in patients with osteochondral knee lesions.

B-40

Role of Penile Doppler Ultrasound in Vasculogenic Erectile Dysfunction

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Aim: The goal of this study is to show how penile Doppler ultrasonography helps in the evaluation of arterial and venous impairment in patients with vasculogenic erectile dysfunction (ED). The study focuses on peak systolic velocity (PSV), end-diastolic velocity (EDV) and resistive index (RI).

Background: Erectile dysfunction is a common sexual disorder that greatly affects quality of life, particularly in men over 40. It can result from multiple causes, including vascular abnormalities, neurogenic and endocrine disorders, drugs, psychogenic factors or morphological penile abnormalities. Vascular causes result from inadequate arterial supply or failure of the veno-occlusive mechanism with subsequent impaired smooth-muscle relaxation. Penile Doppler ultrasonography, especially when performed after pharmacological stimulation, provides a minimally invasive and dynamic examination of penile vascular hemodynamics and allows differentiation between arterial and venous insufficiency. It has therefore become an important diagnostic tool in the evaluation of patients with suspected vasculogenic ED.

Technique: A high-frequency transducer (7.5–9.0 MHz) is used for penile Doppler examination. The patient is placed in the supine position with the penis along the anterior abdominal wall in anatomical position. The cavernosal arteries are examined before and after administration of a pharmacological agent. Pre-injection measurements include the inner diameter of the cavernosal artery (normally 0.3–0.5 mm) and baseline peak systolic and end-diastolic velocities. Papaverine or prostaglandin is injected intracavernosally using an insulin syringe under ultrasound guidance. Post-injection measurements (at 5, 10, 15 and 20 minutes) include the inner diameter of the cavernosal artery (normally 0.6–1.0 mm), peak systolic and end-diastolic velocities, and visual tumescence. Measurements are taken during the different phases of erection. The peak systolic velocity reflects arterial inflow, while the end-diastolic velocity reflects the adequacy of corporal veno-occlusion. The examination continues until maximum erection is obtained and the blood-flow response is at its best. Both Doppler findings and penile tumescence are used for interpretation.

Findings: Penile Doppler ultrasonography provides real-time assessment. PSV is the most accurate Doppler indicator of arterial disease (arteriogenic impotence). Arterial insufficiency is diagnosed when the PSV is less than 25 cm/sec, with 92% accuracy. An increase of less than 60% in cavernosal artery diameter after pharmacological injection is another indicator of an arterial cause of ED. High end-diastolic velocity and a low resistive index with normal arterial peak systolic velocity suggest veno-occlusive dysfunction (venous leak). Veno-occlusive ED is diagnosed when the end-diastolic velocity remains above 5 cm/sec during all phases, with visible flow in the deep dorsal vein during the full-erection phase.
Conclusion: Although penile Doppler ultrasonography is very helpful, it requires correct technique and correlation with the patient's clinical situation. Blood-flow parameters can be affected by the type and dose of the pharmacological agent, the time of measurement, the degree of penile rigidity and the patient's response. For example, elevated EDV should not be interpreted as definite venous insufficiency when pharmacological stimulation is inadequate or complete smooth-muscle relaxation has not been achieved. Similarly, borderline PSV values may require repeat assessment after sufficient stimulation. Standardization of examination protocols and careful documentation of the erectile response are therefore very important.
Keywords: Erectile dysfunction, Doppler ultrasound, Peak systolic velocity, End-diastolic velocity

B-41

Late Surgical Site Hemorrhage as a Possible Radiologic Indicator of Early Tumor Recurrence in Grossly Totally Resected High-Grade Meningioma: A Case Report

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Rhabdoid meningioma is a rare high-grade tumor that tends to recur, with the potential for extracranial metastasis. The primary treatment is surgery, if feasible, with adjuvant radiotherapy. We present the case of a 27-year-old male patient who presented with symptoms of increased intracranial pressure. Imaging revealed a large heterogeneously enhancing mass in the right frontal lobe surrounded by moderate vasogenic edema, causing significant midline shift. The patient underwent gross total resection with uneventful postoperative recovery. Histopathology confirmed rhabdoid meningioma, classified as World Health Organization grade III. The patient received adjuvant radiotherapy with no significant adverse events.

Six months after surgery, he started to complain of headache. Brain magnetic resonance imaging showed an extra-axial hematoma at the surgical site with no associated enhancing soft-tissue component, which progressively increased in size on subsequent scans, along with intraparenchymal extension into the right frontal lobe, without midline shift or brain herniation. The hematoma was not explained by trauma or any medical cause. In addition, lung and bone metastases were evident 8 months post-surgery. Unfortunately, this rapid deterioration led to the patient's death.

Despite the emphasis on gross total resection as the most important factor for tumor control, high-grade meningiomas pose a therapeutic challenge due to their aggressive nature. Late intracranial bleeding (>3 months) in the absence of possible contributing factors should raise suspicion of tumor recurrence, as early detection can improve the patient's prognosis. Moreover, frequent close follow-up and molecular testing should be further investigated to improve patient outcomes, especially in the younger age group.

B-42

Impact of Below-Knee Angioplasty on Lower Limb Amputation Rates

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Background: Peripheral artery disease (PAD) is a common vascular condition characterized by narrowing of the peripheral arteries, predominantly in the legs. PAD can progress to critical limb ischemia (CLI), increasing the risk of severe complications such as lower limb amputation. Previous research on PAD interventions has focused on various endovascular and surgical treatments, including balloon angioplasty, stenting and bypass surgery, but few studies have addressed the effect of below-knee angioplasty on amputation rates.
Aim: To evaluate the effectiveness of below-knee angioplasty in reducing lower limb amputation rates in patients with advanced PAD, and to identify the demographic and clinical factors that influence its outcomes.
Methods: A retrospective cohort study was conducted using the electronic health records of 100 patients with advanced PAD who underwent below-knee angioplasty at King Abdullah University Hospital (KAUH) during 2021–2022. Data collected included age, smoking status, comorbidities (diabetes mellitus and hypertension), HbA1c level, procedural details and post-procedural outcomes. The primary outcome measure was the incidence of lower limb amputation following angioplasty.
Results: The overall amputation rate was 23% (23 of 100 patients). Patients aged 60 years or older had a higher amputation rate than younger patients (27.9% vs. 12.5%; $p = 0.03$). Patients with two or more comorbidities had a higher amputation rate (25.3%) than those with one comorbidity (12.5%) or none (0%) ($p = 0.03$). Patients with both diabetes and hypertension had the highest rate among comorbidity groups (26.5%), although this was not statistically significant ($p = 0.347$). Ex-smokers had the highest amputation rate (43.5%) compared with current smokers (16.7%) and non-smokers (17.2%) ($p = 0.029$). There was no significant difference between patients with HbA1c ≤ 6.5% and > 6.5% (23.5% vs. 21.7%; $p = 0.639$).
Conclusion: Below-knee angioplasty is an effective procedure in reducing lower limb amputation rates in patients with PAD. Age, comorbidities and smoking status are significant factors affecting amputation outcomes, and focus on managing comorbidities and smoking cessation should be part of improving PAD treatment outcomes.
Keywords: Peripheral artery disease, Critical limb ischemia, Below-knee angioplasty, Amputation, Endovascular intervention

B-43

Pattern of Uveitis in a Tertiary Hospital in North Jordan and the Impact of Behçet's Disease

Dr. Fatemah Kamel Ababneh

Aim: The purpose of this study is to assess the prevalence of autoimmune-mediated uveitis in relation to other diseases and to describe the clinical patterns of uveitis in a single tertiary hospital in north Jordan.
Methods: A cross-sectional retrospective review was performed. We included all patients diagnosed with uveitis in the King Abdullah University Hospital (KAUH) ophthalmology clinic and/or patients referred to KAUH rheumatology clinics for evaluation of suspected autoimmune-mediated uveitis or for difficult-to-treat uveitis. This included patients from January 2015 to January 2019. Data collected on patients› age, sex, anatomical location of the disease, etiology, treatment, complications, and outcomes on vision loss were analyzed.
Results: A total of 221 patients were included in our study. The mean (±SD) age was 36 (±16) years. A total of 111 patients were female and 110 were male, with a ratio of 1:1. Noninfectious uveitis was found to be more common than infectious uveitis (95% vs. 5%, respectively). Autoimmune-mediated uveitis accounted for 40% of the total cases. The most common causes of autoimmune-mediated uveitis included Behçet›s disease (n = 41, 19%) and seronegative spondyloarthropathy (n = 29, 13%). The majority of patients (n = 207, 94%) were treated with ophthalmic eye drops, cDMARDs (n = 101, 46%), biologics (n = 33, 15%), and colchicine (n = 30, 14%).
Conclusion: Autoimmune-mediated uveitis, most commonly associated with Behçet›s disease and seronegative spondyloarthropathy, represents a high percentage of uveitis in our area. This implies the need for a high index of suspicion at the time of evaluation.

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