

About Our Practice

Over 150 Years of Combined Experience in GI Radiology

The Pioneering:

In 1971, the Society of Gastrointestinal Radiologists was founded in part by Dr. Richard Marshak, a Manhattan based Radiologist at Mount Sinai Hospital, for the purpose of reviewing research and new developments in this engineering field. Dr. Marshak had already established himself as one of the industry's leaders when he introduced the idea of barium pills for studying esophageal structures. He would also go on to define what everyone in the industry uses today as the anatomic and physiologic norms for the radiologic appearance of the gastrointestinal tract.

Dr. Marshak later joined the GI practice of Dr. Burrill Crohn, where he teamed up with Dr. Daniel Makdansky, also of Mount Sinai Hospital. It was here that Dr. Marshak and Dr. Makdansky helped define and disseminate not only the findings of "Crohn's disease, but a gamut of gastric, intestinal, and colonic disorders. Through the exhaustive clinical-pathological correlation of thousands of patients' findings, tireless lecturing, and numerous scientific publications, Drs. Marshak and Makdansky, were later joined by Dr. Jerold Kurzban. Drs. Marshak, Makdansky, and Kurzban ushered in the coming-of-age of GI Radiology.

Makdansky & Kurzban at 1075 Park Ave:

Throughout the 1980's, continuing the work of their partner and mentor, Dr. Marshak, Drs. Daniel Makdansky and Jerold Kurzban collaborated in the clinical care of thousands of gastro-enterology patients, all while conducting research and teaching residents at the Mount Sinai Hospital, and building a first class outpatient radiology practice at 1075 Park Avenue, adding ultrasound to fluoroscopy and x-ray. In 1987, in partnership with

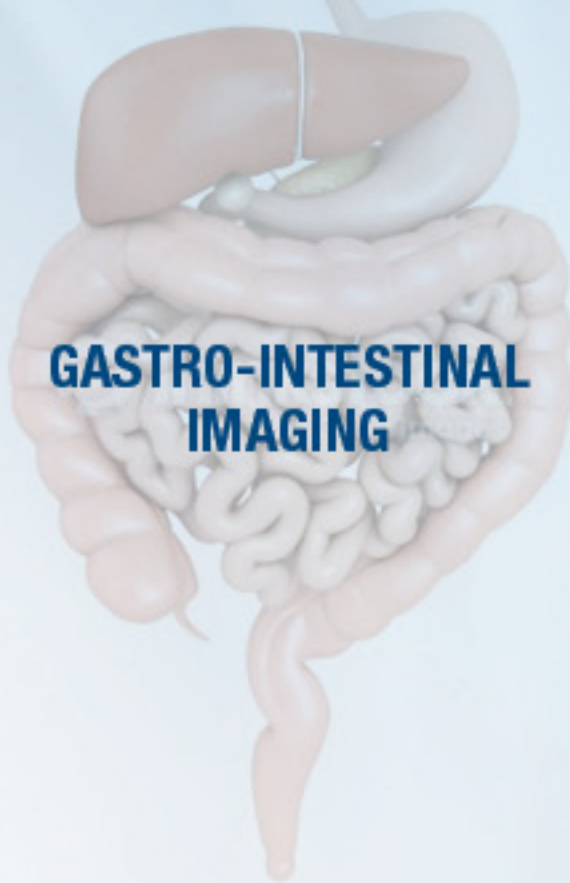
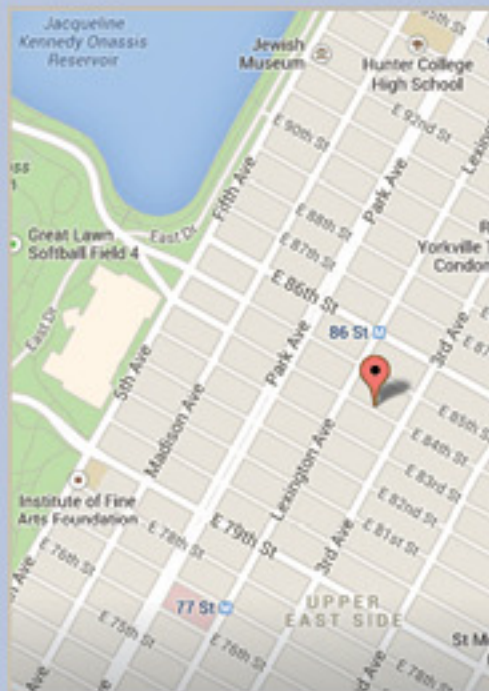
Dr. Burton Cohen, who was already renowned for his work in abdominal radiology at Mount Sinai Hospital, the group introduced its first CT scanner, heralding a new era in gastro-intestinal and pancreatic-biliary diagnosis. "Makimaging", as the group became known, resulted from the merger of Drs. Makdansky and Kurzban with Drs. Gunther and Stoll on East 82nd St. The merger considerably upgraded and expanded the practices' ability to care for patients throughout the community and well beyond. Together, the Makimaging power-house of experience, ability and compassion went on to inaugurate Open-MRI scanning, allowing even the largest and most claustrophobic patients to undergo detailed imaging of the abdomino-pelvic organs, further building on the unique, cross-sectional imaging techniques first developed by Dr. Cohen in CT., and the seminal achievements of Drs. Marshak, Makdansky, and Kurzban in GI fluoroscopy.

NYMI at 165 East 84th Street:

In 2005, after many years of dedicated service and a growing number of patients, NYMI Associates relocated to a larger space at 165 East 84th Street. A new high-field MRI and helical high-speed CT allowed for the immediate synergistic effect of blending old-fashioned hands on doctoring with the state-of-the-art technology in scanning, digital processing, and internet communication, NYMI Associates' GI Division has led the way through every advance in GI, be it low dose CT, dynamic MR or 3D Sonography, while continuously improving patients' access-elective, as well as urgent-to safe customized, and compassionate radiology care.



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GASTRO-INTESTINAL IMAGING

Visit our website at www.nymiassociates.com and take advantage of these online resources:

- About Your Visit
- Patient Forms
- Patient Portal
- Exam Preparations
- Insurance Participation
- Pay Your Bill Online
- Helpful Links
- FAQ's



OUR SPECIALTIES

Ileitis and Colitis

What began as GI and Small Bowel Fluoroscopy for the diagnosis and follow-up of Crohn's disease and ulcerative colitis has evolved into a cross-sectional imaging array of tools for the evaluation of the alimentary tract, including early and late complications of inflammatory bowel disease, pre-surgical mapping and post-operative evaluations of resections, -ostomies, and reconstructive pouches. Using the lowest x-ray doses available, we combine 64 detector CT, oral and intravenous contrast and judicious combinations of air and contrast per rectum, with careful monitoring of each examination to focus in on the clinical issue at hand, while keeping an eye out for any and all incidental findings of import.

Dysmotility

From video-fluoroscopic evaluation of swallowing and esophageal motility, to scintigraphic studies of gastric and gallbladder emptying and small bowel transit, to x-ray enteric marker studies, and finally, to MR Defecography for rectal prolapse (in a comfortable, non-radiation setting); we utilize a full complement of physiologic studies to visualize alimentary function.

Abdomino-Pelvic Pain

By correlating historical and physical findings, we design dynamic CT and MR protocols appropriate to the diagnosis and evaluation of all matters of hernia, perineal fistula, abdominal vascular pain syndromes (image), post operative adhesions/obstruction, athletic pubalgia, epiploic appendagitis, as well as every day and atypical presentation of diverticulitis and appendicitis.

GI and Liver Malignancy

CT Colonography is performed electively for primary polyp-screening in selected patients, as well as an adjunct to incomplete optical colonoscopy. Colorectal cancer staging and surveillance requires combinations of diagnostic contrast enhanced CT (or MR) and PET/CT. Our many years of experience span the spectrum of GI tumors, from GIST to pseudomyxoma, to carcinoid neoplasm (for which Octriatide-scan with CT correlation has been very useful), for liver and solid organ masses, we combine all necessary modalities to characterize lesions non-invasively.

Pancreas/Biliary

MR of the abdomen with MRCP cholangio-pancreatography has augured in a new era of invaluable non-invasive, non x-ray mapping and surveillance of ductal disease, be it sclerosing cholangitis, particularly in young patients with inflammatory bowel disease, or IPMT in older patients in whom pancreatic exploration/resection could be contra-indicated.

IMAGING ADVANCES

Low Dose CT (ASIR)

Using Advance Staistical Iterative Image Reconstruction algorithms, our GE 64 Multi-Detector CT provides excellent "freeze-motion" high-resolution, while reducing radiation doses up to 40% as compared to conventional scanners.

Typically, dose reduction causes an increase in noise and image artifacts. But ASIR solves this by subtracting noise, not merely masking it. As a result, ASIR delivers enhanced image quality by improving low contrast detectability while preserving anatomical detail.

3D Sonography

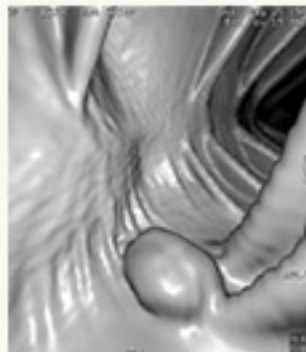
State-of-the-art ultrasound with 3D reconstruction complements color Doppler interrogation for "Interface"-rich structures such as the gallbladder. This adds depth to our sonographic evaluation of gallbladder contents and wall abnormalities, such as non-calcified stones, polyps, and masses (with a higher contrast resolution than CT and higher spatial resolution than MR). A series of 2D longitudinal or transverse images acquired simultaneously through a sweep of the transducer are then processed into any number of 3D "views". As an added benefit, images can be reconstructed on the third, non-scanned, plane (coronal plane) to evaluate complex spatial relationships.

MR Enterography

MR Enterography in selected ileitis patients (image). Using multiplanar ultrafast gradient echo (high-field) MR sequences, small bowel loops containing air or fluid can be "snap-shot" to reveal areas of wall thickening, narrowing, or dilation. Moreover, diseased loops show increased signal



and abnormal contrast enhancement, compared to the normal bowel. The procedure can be applied to the surveillance of patients with iodine-contrast allergy, or in patients whom even the lowest CT radiation doses are not advisable.



CT Colonography

CT "Virtual" Colonography can be performed as a primary screening procedure for the detection of polyps in patients in whom optical colonoscopy is relatively contra-indicated or deferred by

choice (image). For the patient's comfort, a "diagnostic" optical colonoscopy can be performed immediately after the CT, in the event that a colon lesion is detected. This would avoid having to re-prep the colon.

MR Defecography

Normal defecation occurs with distention of the rectum by colonic transit, which triggers:

1. A synergistic relaxation of the pelvic sling that angles the rectum and anus 90 degrees,
2. Relaxation of the internal sphincter,
3. Peristaltic contractions of the rectum.

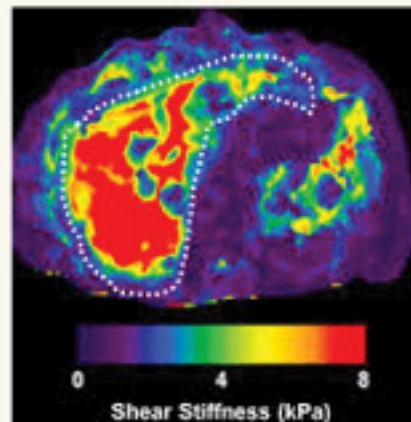
Abnormalities preventing normal defecation can occur anywhere along this pathway:

- Colonic and Rectal Atony
- Anismus or Dyssynergy
- Obstructive Defecation

MR Defecography primarily demonstrates and quantifies "obstructive defecation", most often due to abnormal laxity of the pelvic floor with excessive descent of organs with rectocele, enterocele, cystocele, or combinations thereof (image). Less common is sigmoid or intra-rectal intussusception.

Mucosal rectal prolapsed is protrusion of the inner layers of the lower rectum +/- hemorrhoids. (The latter diagnosis is usually made on physical exam)

MR Defecography is a short and comfortable procedure that requires no patient preparation.



MR Liver Elastography

MR Liver Elastography provides a safe, non-invasive alternative to liver biopsy for assessing diffuse fibrosis that leads to cirrhosis. The elastography portion of the MR scan measures liver tissue stiffness by analyzing the micro-movement of the liver tissue after stimulation by 60 Hz sound waves administered through a plastic tube and drum placed over the abdomen. The propagation of this "shear" wave is quantified and displayed as a color coded elastogram map (image). Slower wave movement correlates with higher stiffness, infiltration by fibrous tissue.

ONLINE RESOURCES

www.rymiaassociates.com

