The Stall Grid Contest

Sir,

We wish to share a managerial technique that we newly incorporated during the recent radiology conference organized by the Department of Radiology, Christian Medical College, Vellore, India, namely, the Stall Grid Contest. This was carried out first at the 66th Tamil Nadu and Pondicherry Annual Indian Radiological and Imaging Association (IRIA) Conference in December 2013, and subsequently at the XIIth Annual Conference of Indian Society of Paediatric Radiology (ISPR) in September 2014. “Stall” represents medical exhibition stalls and “grid,” a term familiar to radiologists, indicates the arrangement of stalls. The aim of the contest was to improve interaction between the delegates and the personnel manning the stalls. Such interaction helps each party to get to know the other and gives a window of opportunity to get to know medical companies and their products.

Each registered candidate of the conference was given a sheet [Figure 1] along with the registration kit. A notice was displayed near the registration desk as well as mentioned in the conference website with a sample format. One side of the A4 size sheet contained the contact details of the candidate and a grid containing multiple squares, each filled with a stall number and the emblem of the company. The rules of the contest were simple: The candidate had to collect an acknowledgement (a seal or stamp) from the respective stalls. The other side of the sheet contained the arrangement of stalls, which also served as a map. The grids with the maximum number of seals/stamps were included in a lucky draw with a prize (which was an iPad Mini on both events), sponsored by the organizing committee.

When this was conducted for the first time (66th Tamil Nadu and Pondicherry Annual IRIA Conference, December 2013), nearly 130 of the total 400 delegates had completed the entire grid; which meant that they had visited all 26 stalls. There were nearly 200 partially filled forms where the candidates had visited more than 15 stalls. The winner received an iPad mini during the valedictory program. The feedback from our trade partners who had set up the stalls was very positive. They acknowledged that the attendance was the highest at the stalls for a State conference, and

![Figure 1: Front and back pages of the stall grid contest conducted during the 66th Tamil Nadu and Pondicherry Annual IRIA Conference in 2013](image-url)
in fact, their representatives needed to be available in the stalls throughout the conference. Our trade partners very much wanted a similar contest to be held at the second event (ISPR 2014) too. After this, we noticed stall grid contests being organized in other conferences.[3,4]

We believe this initiative to be a “win-win” opportunity for delegates and companies alike. The oft-heard complaint of delegates not visiting the stalls can be easily overcome by introducing such methods of participation. Increased interaction would encourage delegates and trade partners in participating in future events.

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Multidetector CT angiography in evaluation of prospective renal donors

Sir,

We read with interest the article by Ghonge et al.[1] alluding to the importance of multidetector computed tomography (MDCT) imaging in the era of laparoscopic donor nephrectomy (LDN). We congratulate the authors for this excellent review. Studies in the past have shown that the sensitivity and specificity of MDCT angiography for the detection of accessory renal arteries, prehilar renal artery branching, and renal venous anomalies were 88% and 98%, 100% and 97%, and 100% and 97%, respectively. Computed tomography (CT) findings agreed with the surgical findings for accessory renal arteries, prehilar renal artery branching, and renal venous anomalies in 94%, 93%, and 98% of patients, respectively.[2]

Ghonge et al., in addition to the above facts, add an important point of “clinical correlation” in this regard.

We have a few comments to add.

First, “Primum non nocere,” that is, “first, do no harm” to the donor is the principle that appropriately describes the procedure of LDN. We feel that MDCT helps in providing a road map as far as vascular anatomy is considered. Apart from the information about the length, width, and the number of arteries and veins, the surgeon is immensely benefited if he/she knows the exact location of the artery and vein in relation to each other. For instance, if the surgeon is informed that the artery is posterior and cranial to the vein with two large lumbar vein branches just close to it, he can plan his lower pole and hilar dissection accordingly and avoid potential challenges in the procedure. Such information can be gained if there is close communication between the radiologist and the operating urologist. This information can be easily gained on the CT workstation, with the axial and coronal images viewed simultaneously.

Second, the authors rightly describe the importance of prehilar branching of the vascular structures. This is important as newer methods such as the use of staplers and clips to secure the renal vasculature compromise a significant amount of vein and artery in comparison to the traditional way of tying two knots. The length of the stump is measured from the aortic ostium to the first segmental branch. This length should be clearly mentioned on the CT report as this has a bearing with regard to which side of the renal unit is to be harvested. A renal arterial stump length less than 6 mm would inevitably lead to a double artery in cases with early dividing arteries requiring bench surgery. So information on the length of the common stump would help in deciding the side and planning the surgical strategy.

Last but not the least, we completely agree with the authors that case-based interactive sessions between the radiologist and the urologist are of paramount importance. Toward this end, CT workstation analysis and/or reviewing the cuts on compact discs (CDs) help more than plain film analysis.