INDIAN ASSOCIATION OF CARDIAC IMAGING(IACI)

NEWSLETTER APRIL 2026

As we move further into the year, we hope 2026 is unfolding well for each of you—professionally and personally. Since our last note in January, it has been encouraging to see the continued enthusiasm and engagement within our cardiac imaging community.

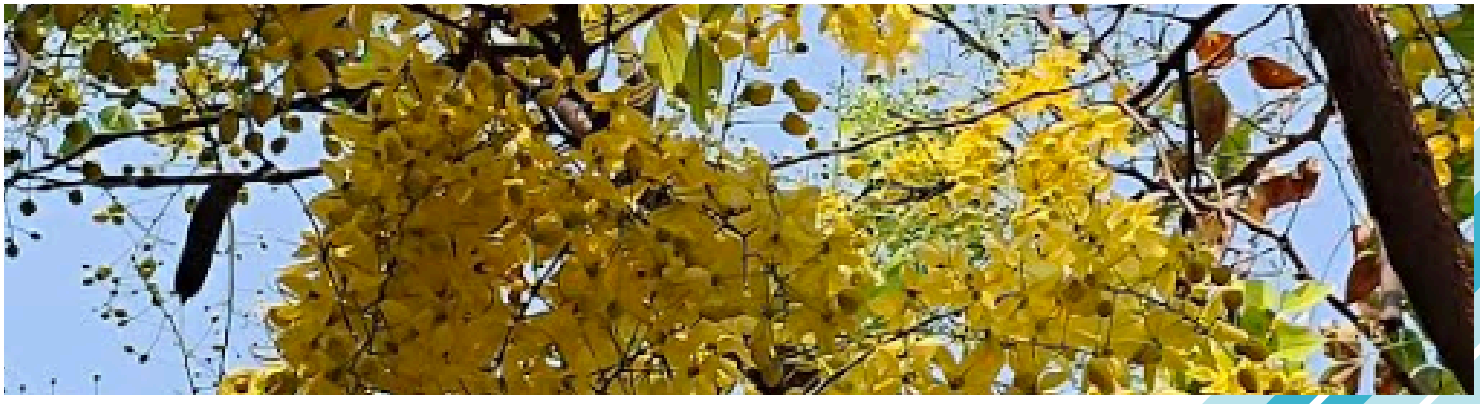
IACI remains committed to advancing education, collaboration, and excellence in cardiac imaging. Through our ongoing academic activities and collaborative efforts, we continue to build on a strong foundation.

We hope you will like a new feature on "Doyens of Cardiac Imaging" that we are introducing from this issue.

We invite IACI members for suggestions and contributions to the IACI newsletter and use it as a platform to share and showcase their achievements, research, interesting and challenging cases etc.

Wishing you all continued growth, inspiration, and success in the months ahead.

-Editorial team (Amol, Parul and Aparna)



DOYENS OF CARDIAC IMAGING

DR. OMPRAKASH TAVRI

Dr Omprakash Tavri is an internationally respected **expert in cardiovascular imaging**, with a distinguished career spanning over **four decades in clinical practice**, research, and medical education.
He holds an M.B.B.S. and M.D. in Radiology, and has pursued advanced training in cardiac CT and MRI at leading global institutions.

Dr. Tavri has been affiliated with several prestigious institutions. He is Professor Emeritus of Radiology at D. Y. Patil School of Medicine, Navi Mumbai, and serves as a Senior Consultant in Cardiac CT/MRI at Asian Heart Institute, Mumbai. His academic journey includes training and fellowships at globally renowned centers such as the University of California, San Francisco (UCSF), Massachusetts General Hospital (MGH), Boston, New York-Presbyterian Hospital/Weill Cornell Medical Center, and the Cleveland Clinic Foundation. He has also been associated with L.T.M.M. Medical College (Sion, Mumbai) as a Professor of Radiology.

A pioneer in the field, Dr. Tavri was **part of the team that established one of the first MRI facilities in India and has played a key role in advancing cardiovascular imaging in the country.** His leadership contributions include serving as President of the Indian Radiological and Imaging Association and as Editor of the Indian Journal of Radiology and Imaging.

His excellence has been recognized with numerous honors, including the **2026 Education Award from the Society for Cardiovascular Magnetic Resonance and the Lifetime Achievement Award from IRIA (2025).** He is widely regarded for his commitment to mentoring and training clinicians, significantly shaping the next generation of radiologists.

Dr. Tavri's vision is centered on advancing cardiovascular imaging through innovation, global collaboration, and accessible, high-quality education. He continues to advocate for the integration of emerging technologies to enhance diagnostic precision and improve patient outcomes.

ACTIVITIES

IACI MID TERM CME

ON CONGENITAL HEART DISEASE

Sir Ganga Ram Hospital, New Delhi

14th 15 February, 2026

Exclusive CME on imaging of Congenital Heart Disease with Interactive case discussions and panel discussions was a grand sucess and was attended by more than 100 doctors.

ACTIVITIES

ADVANCED CARDIAC MRI COURSE, MUMBAI

APRIL 2026

The Advanced Cardiac Magnetic Resonance (CMR) course was successfully conducted in April 2026 at Jupiter Hospital. Organized in association with the Society for Cardiovascular Magnetic Resonance, the program brought together leading experts in the field. International faculty included Dr Vanessa Ferreira and Dr Ron Jacob, who shared valuable insights and practical expertise. Dr Chiara Bucciarelli-Ducci also joined virtually, providing guidance and enriching the learning experience. .

The national faculty comprised distinguished members from the Indian Association of Cardiovascular Imaging, all recognized stalwarts in cardiac imaging. This four-day intensive course focused on hands-on training, offering participants extensive experience on dedicated workstations and practical exposure to advanced CMR techniques

IACI

CT CORNER

HIGH RISK PLAQUE ON CCTA: WHAT DO YOU DO WITH IT?

WHY THIS MATTERS

With growing emphasis on plaque characterization, radiologists are increasingly identifying "high-risk" plaque features on coronary CT angiography (CCTA). However, a key gap remains: how should these findings influence reporting and clinical decision-making?

While stenosis severity still guides revascularization, many acute coronary syndromes arise from non-obstructive but vulnerable plaques. This places the radiologist in a pivotal role—not just detecting disease, but flagging risk that may alter preventive strategies.

1. When Should You Call a Plaque "High-Risk"?

Not every non-calcified plaque warrants alarm. Overcalling can dilute clinical impact.

Consider labeling a plaque as "high-risk" when:

- ⩾2 high-risk features are present (e.g., low attenuation + positive remodeling)
- There is clear low-attenuation component (<30 HU) with supportive morphology
- Typical appearance of napkin-ring sign

Practical tip:

If only a single subtle feature is present, it is often better to describe rather than label.

Why it matters:

The term "high-risk plaque" carries management implications—use it selectively and confidently.

2. Suggested Reporting Language:

Be Clear, Not Vague

Ambiguous phrases like "soft plaque noted" are often ignored clinically. Aim for structured, decisive wording, like:

- "Non-obstructive plaque in proximal LAD demonstrating high-risk features (low attenuation and positive remodeling)."
- "Findings suggest plaque vulnerability despite absence of significant luminal stenosis."
- "Overall imaging features indicate increased risk phenotype; clinical correlation advised."

Avoid:

- Over alarm (eg. impending rupture")
- Overly passive descriptions without interpretation

Goal: Strike a balance between clarity and clinical usefulness.

3. Does This Change Management?

(Yes—but Indirectly)

CCTA does not directly dictate treatment, but your report can influence downstream decisions.

High-risk plaque findings may prompt:

- Intensification of medical therapy (e.g., statins, lifestyle modification)
- Closer clinical follow-up
- Consideration of functional assessment in selected cases

Important distinction:

- Stenosis → revascularization decisions
- Plaque vulnerability → preventive strategies

4.When Should You Recommend Further Testing?

- HRP in symptomatic patient with borderline stenosis
- Discordance between symptoms & stenosis
- Multivessel non-obstructive disease with HRP

Possible next steps (depending on clinical context):

- Functional assessment (e.g., stress imaging, CT-FFR)
- Clinical cardiology consultation

Avoid reflex recommendations—context matters.

5. The Bigger Picture:

Integrate, Don't Isolate

A single plaque should not be interpreted in isolation.

Always integrate:

- Overall disease burden
- Distribution (proximal vs distal disease)
- Patient profile (age, symptoms, risk factors)

Example:

A solitary high-risk plaque in an otherwise normal study carries a different implication than diffuse multivessel vulnerable plaque phenotype.

6.Common Pitfalls to Avoid:

- Overcalling due to artifacts (especially low attenuation in noisy scans)
- Ignoring technical factors affecting HU measurements
- Labeling all non-calcified plaque as high-risk
- Failing to mention high-risk features altogether

When in doubt, describe objectively rather than overinterpret.

.

Take-Home Messages

- **High-risk plaque detection adds prognostic value beyond stenosis**
- **Use the term "high-risk plaque" judiciously and with defined criteria**
- **Clear, structured reporting can influence preventive cardiology decisions**
- **Always interpret findings in the context of overall disease burden and clinical scenario**

NO LGE: DOES IT MEAN A NORMAL CMR?

CMR INSIGHT

Late gadolinium enhancement (LGE) is central to CMR—but absence of LGE is not absence of disease. Many clinically significant conditions show no scar yet carry important diagnostic and management implications. Stopping at "no LGE" risks under-calling disease.

What does "no LGE" actually tell you?

- No focal replacement fibrosis or scar detectable by LGE
- Does not exclude:
  - Diffuse interstitial disease
  - Acute injury without necrosis
  - Functional cardiomyopathies
  - Early-stage pathology

LGE is excellent for scar, not for everything else.

IMPORTANT CONDITIONS WITH NO LGE

1. Totsubo cardiomyopathy
Typical apical/mid-ventricular ballooning on cine
Myocardial edema on T2 imaging
No LGE (key differentiator from infarction)
Clinical impact: Avoid unnecessary revascularization

2. Early or mild myocarditis
Edema may be present before fibrosis develops
LGE can be absent in early stages
Use updated Lake Louise approach:
T2 (edema) + T1 (injury) mapping

3. Diffuse interstitial fibrosis
- Seen in hypertension, diabetes, early DCM
- Fibrosis is too diffuse for LGE detection

Mapping is key:
- Elevated native T1
- Increased extracellular volume (ECV)

4. Anderson-Fabry disease (early stage)
- May have no LGE initially
- Characteristic low native T1

Don't miss the window for early treatment

5. Arrhythmogenic cardiomyopathy (early)
- Structural changes may be subtle
- LGE can be absent or minimal

Look for:
- Regional wall motion abnormalities

RV involvement

6. Microvascular ischemia / INOCA
- No infarction → no LGE
- Symptoms persist
- Stress perfusion CMR becomes crucial

How to approach a no LGE study?

1. Don't stop at LGE; Review cine images for ventricular volumes, function, wall motion
2. Use mapping routinely
   - T1 / ECV → fibrosis, infiltration
   - T2 → edema/inflammation
3. Integrate stress imaging (if done)
   - Perfusion defects without LGE → ischemia without infarction
4. Correlate clinically
   - Chest pain + normal coronaries → think Takotsubo CMY
   - Systemic disease → consider diffuse fibrosis

What should we report?
Instead of: "No LGE seen." Add value with-
- Ventricular size and function
- Presence/absence of edema
- Mapping values (T1, T2, ECV)
- Perfusion findings (if available)
- Most likely diagnosis or differential

Common pitfalls
- Equating "no LGE" with "normal study"
- Skipping mapping interpretation
- Missing subtle wall motion abnormalities
- Not suggesting further evaluation when needed

Take-Home Messages
- **"No LGE" is not the end of the report—it's the beginning of interpretation.**
- **If there is no scar, ask: is there edema, dysfunction, or diffuse disease?**
- **CMR without LGE can still be diagnostic—and sometimes more revealing.**

ARTICLE IN FOCUS

PATIENT-SPECIFIC REGISTRATION OF SEGMENTAL JEOPARDY &VIABILITY

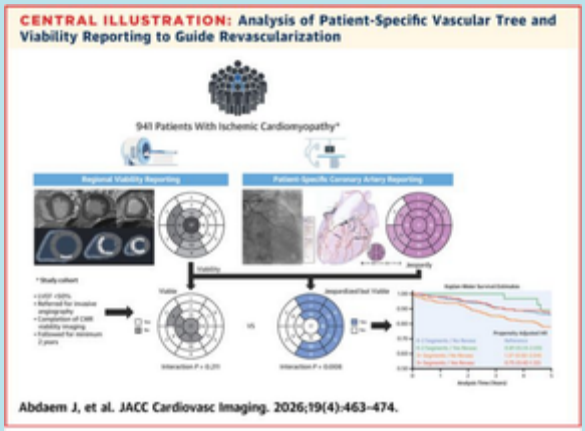
JACC: Cardiovascular Imaging
Volume 19, Issue 4, April 2026, Pages 463-474

J. Abdaem et al.[Patient-specific registration of segmental jeopardy and viability: novel method to guide revascularization in ischemic cardiomyopathy](https://www.sciencedirect.com/science/article/pii/S1936878X25006552)

Background
The role of myocardial viability in guiding revascularization for ischemic cardiomyopathy (ICM) remains controversial. Prior trials using global or territory-based viability assessments failed to show clear survival benefit.

What's New?
This study introduces a patient-specific approach that integrates:
- Segmental viability (via LGE-CMR)
- Patient-specific coronary anatomy and lesion severity (via angiographic modeling)

This allows identification of "jeopardized but viable myocardium"—segments that are both significantly ischemic and salvageable.



Study Design
- 941 patients with ICM (LVEF <50%)
- Underwent both CMR and invasive angiography
- Follow-up ~4.8 years
- Outcome: all-cause mortality

Key Findings
* Viability alone did NOT predict benefit from revascularization
* Anatomical disease burden alone also failed to predict benefit
Critical insight:
o Patients with ⩾3 jeopardized but viable segments had significantly lower mortality with early revascularization (HR ~0.55)
o No benefit seen when ⩽2 such segments were present

Why It Matters
This study reframes viability assessment:
It's not just "Is the myocardium viable?"
It's "Is the viable myocardium actually at risk from a treatable lesion?"
By aligning coronary anatomy with tissue viability, this method identifies patients who truly benefit from revascularization—potentially resolving inconsistencies from trials like STICH and REVIVED.

Clinical Takeaway
Move beyond global viability metrics
Focus on patient-specific, segmental matching of ischemia and viability
Consider revascularization strongly when ⩾3 jeopardized viable segments are present

Bottom Line
A precision-imaging approach combining CMR and patient-specific coronary anatomy may finally unlock the true value of viability imaging in ICM.

UPCOMING EVENTS

IACI

UPCOMING EVENTS

* Cardiac MRI workshop with workstations
* Cardiac CT workshop with workstations
* Advanced Cardiac workshop
* Echo workshop
* Two days Conference

September 25th, 26th & 27th, 2026
Hotel Green Park, Vadapalani Chennai

Register Now!

https://registration.iaciind.org/

COMMITTEES

IACI

IACI committees for 2026

PRESIDENT: DR. (MAJ) VIMAL RAJ.
GENERAL SECRETARY: DR. NILAY S. NIMBALKAR

COMMUNICATION COMMITTEE

Mentor: Vijay Bhaskar Nori
Chairperson: Dr. Ashita Barthur
Secretaries: Dr. Vishnu Ravilla

Members:

Social media:
Dr.Ashita Barthur
Dr Vineeta Ojha
Dr Suraj Gowda

News letter:
Dr Aparna Irodi
Dr Parul Garde
Dr Amol Kulkarni

Website:
Dr Vishnu Ravilla
DrYashpal Rana

EDUCATION COMMITTEE

Mentor: Dr. Rajesh Kannan
Chairperson: Dr. Priya Chudgar

IACI academy:
Secretaries:
Dr Ritu Agarwal
Dr Salil Bhargava
Members:
Dr Parang Sanghavi
Dr.Tosha desai
Dr Preeti Neve
Dr Minal Seth
Dr Vishnu Ravilla
Dr Shuchi Singh
Dr Suman Singhal

Certification:
Secretaries:
Dr Subhajit Das
Dr Zeeshan Lakhani.
Members:
Dr Suraj Gowda
Dr Shruti Kalyan
Dr Pranav Gupta
Dr Pudhiavan
Dr Ashita Barthur

COMMITTEES

IACI committees for 2026

PRESIDENT: DR. (MAJ) VIMAL RAJ.
GENERAL SECRETARY: DR. NILAY S. NIMBALKAR

CLINICAL PRACTICE AND GUIDELINE COMMITTEE

Mentor: Dr Bhavin Jankharia
Chairperson: Dr Richa Kothari
Secretaries: Dr Vineeta Ojha

Members:
Dr Priya Jagia
Dr Johann Christopher
Dr Nitin Burkule
Dr Parul Garde
Dr Preeti Neeve
Dr Mary Varunya
Dr Parang Sanghvi
Dr Tosha Desai
Dr Aparna Irodi
Dr Preeti Neve
Dr Onkar Auti

CONFERENCE AND MEMBERSHIP COMMITTEE

Mentor: Dr Hemant Telkar
Chairperson: Dr Babu Peter
Secretaries:
Dr Megha Sheth,
Dr Suraj Gowda

Members:
Dr Mary Varunya
Dr Pranav Gupta
Dr Rajesh Kanan
Dr Abhilash Kumar

GLOBAL COLLABORATION COUNCIL

Mentor: Dr Elizabeth Joseph
Chairperson: Dr Suman Singhal
Secretaries: Dr Bhavana Reddy

Members:
Dr Vineeta Ojha
Dr Elizabeth
Dr Vijayabhaskar Noori

TECHNOLOGIST COMMITTEE

Mentor: Dr Sanjaya Viswamitra
Chairperson: Dr Pudhiavan
Secretaries: Dr Onkar Auti

Members:
Dr Abhilash Kumar
Dr Amaresh
Dr Shuchi Singh
Dr Anirudha Patil

INTERSTING CASES

Visit the IACI website for interesting cases -

Don’t miss -

Feb 2026 case of “Tale of 2 cities- Navigating bilateral cardiac masses”

Mar 2026 case of Cardiac MRI solving “lesion” seen on echo in a renal failure patient

Apr 2026 case of “ Dilated CMY in a young adult - clue beyond the heart”

https://www.iaciind.org/case-in-point

LEARNING / EDUCATION

Visit the IACI website for educational content like the CMR learner series

https://www.iaciind.org/cmr-learnings

EMAIL
info@iaciind.org

CALL US ON
+91 7738648444