



# IAMERS Newsletter

Editor – Diana Upton

Technical Editor – Wayne Webster



October 25, 2007

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*Chicago's beautiful skyline*

## Letter from the President

Since the RSNA is near, it's a perfect opportunity for IAMERS members to see and socialize with one another. Most of you attending the RSNA will come to the IAMERS Reception on Monday night. Many of you will stop by the booth. Some of you will work the booth.

Recently, some of you have expressed a desire to help the association by volunteering for a committee. Some of you have also offered to help with our labeling project. As noted on Page 5 of this Newsletter, you can still get involved.

As most of us will be in Chicago for the RSNA anyway, I'd like to give anyone who wishes to express their ideas an opportunity. Therefore, on Sunday afternoon, we will have an informal meeting. All members are invited – maximum of two people per member company.

Of course we're interested in any committee help you might give, or any labeling suggestions you might have. We also want to give members the opportunity to ask any questions they may have or to express any concerns.

Since I do not know how many of you will attend, I don't have a specific place in mind as of this writing. The start time will be 5 PM. Please let me know by November 5<sup>th</sup>, if you would like to attend. Once I have a final count, I'll get back to those of you planning to attend with the specific location.

The Board of IAMERS always meets Tuesday morning during the RSNA. By attending the informal meeting on Sunday afternoon, the Board has a better idea of your concerns and ideas for IAMERS. The more you participate in the association, the more you are able to help shape it. Sometimes I feel as if we do what we do in a vacuum. We need your ideas.

If you're not coming to the RSNA, or can't make the 5 PM informal meeting on Sunday, I'd still like to hear your ideas about IAMERS.

Cheers,

*Diana Upton*

## IAMERS Welcomes New Member

LCD EQUIPMENT SERVICES INC.  
Michael Lumkes  
558 Plate Drive, Unit 9  
East Dundee, IL 60118  
Phone: 847-783-4200  
Fax: 847-783-6502  
Email: [lcdequipment@msn.com](mailto:lcdequipment@msn.com)

Refurbishment of CT scanners

IAMERS 2007 RSNA Reception  
will be held at a new location.

InterContinental Hotel  
505 North Michigan Avenue

6:30 PM – 10 PM

Pre-registration is mandatory

Non-member charge is \$250



## Virtual Colonoscopy • CT-C • *Ready or Not You Decide* Wayne Webster

Several weeks ago I visited our family physician for my annual (every three-year) physical. He is the same guy who is the head of the Gastroenterology at our community hospital. While he was poking and prodding and asking a plethora of questions, I asked him about virtual colonoscopy. He said he thought it was a great idea but he just couldn't convince himself that it was ready for his use.

I don't know about you, but from the very beginning I thought virtual colonoscopy was a winner and would be proven and accepted very quickly. Well, it appears that my speculation was less than accurate. We are making strides but there is more distance to travel.

I've been collecting articles and abstracts on CT-C. *What did you expect? If Virtual angiography with CT is going to be called CT-A then colonoscopy with CT has to be called CT-C.* The articles and reviews of articles seem to be saying that CT-C is here and quite comparable to optical colonoscopy performed with an endoscope. If this is so, what's the hold up?

Unlike the vessels in the heart the colon is large and twists every which way. CT's and other imaging devices have a difficult time imaging through these layers of overlaid tissue. Some argue that the heart is moving and that adds some complexity. It's true but with speed we can freeze the movement. In addition when you view the heart we are looking, at small vessels that are reasonably straight unlike the colon where we are looking at a large organ that is all packed together. It's unusual to see a heart artery, at least the ones we're interested in viewing, all twisted on itself.

The colon brings some special problems to the CT-C application. These problems have demanded the development of special protocols and 3-D software so that the lesions of interest in the colon can be identified with an acceptable sensitivity and specificity. The ultimate goal is to make CT-C a reasonable tool replacing optical colonoscopy for screening. Interestingly enough when I was speaking to my physician I didn't get the sense that he was worried about losing revenue to CT-C. He honestly cannot justify the use of another technique that he sees as less effective. I thought his comments were significant for he is representative of the segment of physicians who are performing the bulk of the optical colonoscopies.

Publications and Review Articles as you review the articles and news stories; it seems that the proof is there for the justification of CT-C. Here are some of the results. *Diagnostic Imaging Online* in October 2006, reviewed a publication that was to appear in *Radiology* in November. In this article by Perry J. Pickhardt et. al. *DI Online* reviewed the results of a one-year study at the University of Wisconsin<sup>1</sup>. The article, Screening for Colorectal Neoplasia with CT Colonography: Initial Experience from the 1st Year of Coverage by Third-Party Payers, included

<sup>1</sup> *Radiology* 2006;241:417-425

about 1,100 patients. The University's program was one of the first in the nation to receive reimbursement from third party payers.

The researchers reported that new 3-D software helped improve their performance and speed over earlier studies. The positive predictive values for lesions was broken out by lesion size. For example for lesions 6 mm or larger the positive predictive value for CT-C was 94% which was up considerably from an earlier trial. The earlier trial had a value of 54%. The new software was accompanied by changes in protocol which were noted as helping to improve the outcomes.

Those patients who exhibited significantly large or suspicious polyps with CT-C were sent on to optical colonoscopy the same day. This is being proposed as the preferred procedure when CT-C becomes the standard for screening.

Interestingly of the 1,100 people studied about 10% required optical colonoscopy after CT-C. The authors made some interesting observation from the year long study. The positive predictive values were directly attributable to methods being used by experienced professionals. They also noted that without soliciting additional patients the number of patients requesting CT-C rose during the study.

They went on to say that CT-C will not completely replace optical colonoscopy. This will still be needed to treat those who have been identified as having polyps on the virtual study.

In another article from *Diagnostic Imaging On-line* in October 2006, Mary Roddie, MD, provided a review of the CT-C technology. The article called, CT colonography tools advance in clinical use<sup>2</sup>, was an interesting look at the requirements for making CT-C mainstream. In reviewing studies she points out that some researchers found CT-C comparable to optical colonoscopy while others found it less effective.

Dr. Roddie says that interpretation of the CT-C images "entails a meticulous evaluation of the complete luminal surface of the colonic wall, making the interpretation a time-consuming and tiring task." I thought this an interesting choice of words. I also expect that this is why methodology, experience and 3-D software are so important to success with this application. In this case she points to the need for training and the establishment of "high-quality standards" as a way of eliminating the interobserver accuracy variability.

In her review she asks if CAD, or computer aided detection, is a way to increase accuracy. These programs are written to assist the radiologist by detecting polyp candidates and bringing these to the attention of the reader. At the time of this article there were two pieces of software available for this application that had been cleared by the FDA.

Interestingly for CAD software to be effective, i.e., increase sensitivity, it must allow a certain number of false positives to ensure that the positives are included. This brings the issue of experience and training up again. She speculates that more experienced users will perform better with CAD as they are able to dismiss false positives easily. Inexperienced users might require a presentation with fewer false positives included in order to perform better. Experience is emerging as a critical component with the CT-C application.

Dr. Roddie makes an interesting point as she considers who will be controlling the CT-C application. It appears unlike other applications that have been removed from radiology and gone to specialists this one may rely on a close association between the radiologist and the gastroenterologist. Remember that patients found to have polyps requiring treatment need to go on to optical colonoscopy and preferably the same day. She speculates that radiologists are not equipped to handle mass screenings for colon cancer. And the gastroenterologist may not be the proper person for reading the CT-C quickly and accurately. But, the teaming of the two specialists for handling the screening and required same day optical colonoscopy may be critical to establishing an effective program.

Dr. Roddie also notes that CAD is focused on detecting polyps and not on finding and identifying invasive cancers. She states that a CAD program with high sensitivity for cancer detection will be very important for the general radiologist.

In September at the ACRIN meeting, the American College of Radiology Imaging Network, a screening trial was presented. The study had 90% sensitivity and 86% specificity for adenomas 1 cm or larger. In smaller polyps the performance characteristics remained high at 86-89% across all relevant lesion sizes. This was according to Dr. C. Daniel Johnson, the principal investigator.

According to an overview of the presentation provided by *Diagnostic Imaging Online*, on September 28, 2007, the ACRIN trial involved 15 centers and over 2,500 asymptomatic patients over age 50. Insufflation with CO<sub>2</sub>, stool tagging and fluid tagging were used by the researchers. Several different multi-slice scanners were employed but 16-detector rows was the minimum accepted. Fifteen radiologists were randomly assigned to perform primary reads with 2-D or 3-D software from a range of vendors. In most cases optical colonoscopy was performed immediately after the CT-C.

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<sup>2</sup> <http://www.diagnosticimaging.com/showArticle.jhtml?articleID=193104556>

Dr. Johnson reported that most patients undergoing CT-C would not require optical colonoscopy after the CT-C. The study found that the type of scanner or software did not influence outcomes. In this study they found that there was no difference between the uses of 3-D or 2-D software in the primary reads and the 2-D was faster to read, saving about six minutes.

This study echoed the remarks found in several other papers. In particular that experience and training are critical to success with CT-C. Participating radiologists in this trial had to read 500 studies or take 1.5 days of training, with 50-cases included to qualify. They also had to pass a certifying exam. More than half of the readers didn't pass and needed additional training before they could become certified.

As in other studies and comparisons to optical colonoscopy, Dr. Johnson said, "We think quality and competency standards need to be addressed soon." He went on to say that he thought other factors for success were, "...the use of stool and fluid tagging, mechanical insufflation, modern imaging techniques and a very compliant patient group."

Dr. Johnson also focused on the importance of multidisciplinary cooperation (radiologists, primary-care physicians and colonoscopists) within an institution if one wishes to ensure that CTC will progress successfully.

In Boston in October the International Symposium on Virtual Colonoscopy met. Eric Barnes of *AuntMinnie* wrote about it in his 10/16/2007 posting<sup>3</sup>. The group attending the meeting was excited about the two trials mentioned here. In addition they were pleased with news from Europe where multi-center trials, from Italy and Germany demonstrated sensitivity of 91% and 100% respectively for clinically significant lesions. Unfortunately even with this good news the CT-C advocates didn't get what they'd hope for. They wanted to learn but didn't that the long awaited consensus for colorectal cancer screening guidelines was ready and thus would permit the use of CT-C as a colorectal cancer screening option.

The guidelines are still being worked on and Dr. Joseph Ferrucci, professor of radiology at Boston University School of Medicine explained why. He described the issues as many and complex. Cost efficacy, the progression of polyp growth and change, the interaction of radiologists and gastroenterologists and maybe the most important the public message are all part of the dynamic that must be addressed before CT-C can be included as a cancer screening test.

The Symposium attendees discussed various technologies, hardware and software, and their effect on outcomes. The types of participants in the studies and the size of the trials were also discussed as to how they affected outcomes. The variables from the different mix of high and low risk patients and the software employed for primary reads resulted in variable results.

Among many comments made by Robert Smith, PhD, director of cancer screening for the Atlanta-based American Cancer Society, this one caught my eye and speaks to the issue of training and experience. "The sensitivity of whole-colon structured exams, including virtual and conventional colonoscopy, can also vary considerably, and test sensitivity seems to drop most significantly in low-volume and low-experience settings."

#### Potential for the Future

- Colorectal cancer is the third most common cancer among men and women.
- It appears that sufficient data is becoming available that will result in CT-C being included as a cancer screening method within the next year or years.
- Experience, training and patient volume are the benchmarks of a successful program.
- CT-C will not replace optical colonoscopy for it is still needed for patient therapy when polyps are discovered.
- For this application to work properly cooperation among specialists will be required.
- Who will ultimately control the CT-C scanner is still up in the air.
- When approved, centers meeting the criteria for inclusion in CT-C screening are going to need 16-row or better CT scanners. This may result in a new area for expansion with pre-owned medical devices.

It's estimated that only about 40% of people who could benefit from colorectal screening actually have a procedure done. The result of inadequate screening is unnecessarily high mortality rates for a preventable cancer. CT-C could provide the public relations vehicle that will stimulate those needing the test to seek it. Increased utilization may have a positive impact on mortality rates.

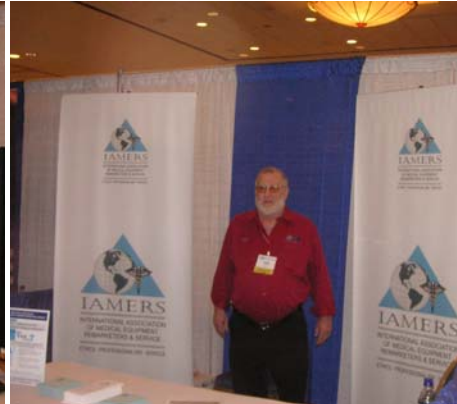
<sup>3</sup> <http://www.auntminnie.com/index.asp?Sec=sup&Sub=vco&Pag=dis&ItemId=77927>

## IAMERS Exhibits at MD Expo

It was a pleasure to meet up with so many IAMERS members at the MD Expo in Stone Mountain, Georgia. Compliments are in order for John Krieg, who ran an outstanding meeting. This wonderful event was capped off by a paddle boat ride at Stone Mountain. Regrettably we have no photos of that evening. Next years MD Expo will be in Orlando.



*Dave Trask from Blue Ridge Medical Imaging and Mike Helms from Troff Medical Services*



*Bob poses at the IAMERS Booth*



*Maggie and Joe from Mobile X-Ray Solutions*



## Labeling Equipment

As you know, IAMERS has had an ongoing dialog with the FDA, with regard to labeling, for several years. In the past, and in addition to IAMERS, AAMI has also pursued the subject of labeling equipment. We are in the final stages of presenting the FDA with our suggested labeling program.

The goal of IAMERS is to have a suggested program, which the members can adapt if necessary, with regard to labeling equipment which we buy and sell. Our suggested program will be very simple. You should also know that the program, as we will be presenting it to the FDA, is completely voluntary. Some of you already label your equipment. Some also have remanufacturing licenses. In order to comply with the necessary paperwork for a remanufacturing license, you are likely already submitting more stringent documentation than IAMERS' suggested labeling.

The IAMERS Board of Directors will meet at the RSNA on Tuesday. During that meeting, we will finalize our suggested labels; and the required documentation for IAMERS to issue a label on behalf of a member.

The labels that IAMERS will issue will fall into 1 of 4 categories as noted below.

- As is, where is
- Cosmetically enhanced
- Refurbished
- Remanufactured – as stated above, those of you who have remanufacturing licenses will already be generating labels and documentation, in conjunction with your remanufacturing license. This category, therefore, may be redundant.

If there is anyone who would like to participate in this discussion prior to the Board Meeting, please let me know. This meeting will take place on Sunday afternoon in Chicago – the first day of RSNA. A specific time and place will be determined when we have an accurate count of who would like to attend. Please let me know your intention to attend before November 5<sup>th</sup>. If you cannot attend, but would like to give us your ideas, we welcome them. Please call or email either: Ed Gibbs at 440.243.6189 or [ncmegibbs@cs.com](mailto:ncmegibbs@cs.com); or me at 201.833.2203 or [dupton@optonline.net](mailto:dupton@optonline.net).

## **RSNA 2007 Presentations**

### **What's the Latest Talk in Technology?**

While many of us are walking around making deals and seeing new equipment, what are the scientists getting out of the RSNA? What about the presentations they'll be hearing?

Major advances in multislice CT, MRI, minimally invasive therapy and molecular imaging are some of the innovative topics that researchers from around the world will present at RSNA 2007.

**BREAST IMAGING** Subcommittee Chair Jennifer A. Harvey, M.D., cited ultrasound and MR imaging in adjunct screening for women at high risk for breast cancer as an important trend this year.

With submissions nearly doubling during the last four years and a 20% jump in submissions from last year, **CARDIAC RADIOLOGY** continues to gain attention. Paul R. Julsrud, M.D., subcommittee chair, identified in-stent stenosis via CT angiography, extra-cardiac findings at coronary CT angiography and cardiac MR imaging of left ventricular remodeling as important topics this year.

H. Page McAdams, M.D., Subcommittee Chair for **CHEST RADIOLOGY**, noted that CT venography versus ultrasound, digital tomosynthesis, imaging pulmonary embolism in pregnancy and CT pulmonary angiography (CTPA) utilization are among this year's significant topics. Dr. McAdams added that CT measurement with computer-aided diagnosis and matching software remains a strong topic as well.

**GASTROINTESTINAL RADIOLOGY** Subcommittee Chair, Erik K. Paulson, M.D., said that attendees can anticipate presentations on increased utilization of CT colonography for polyp detection, with emphasis on standardized reporting as well as computer-aided detection and innovative approaches to small bowel imaging with multidetector CT and MR. 3T imaging of the abdomen and pelvis is also a popular topic.

In **GENITOURINARY RADIOLOGY** the focus remains sharp on the connection between nephrogenic systemic fibrosis (NSF) and contrast agent administration in patients with moderate to severe kidney disease, said Marcia C. Javitt, M.D., subcommittee chair. She added that attendees can expect to see more molecular imaging and diffusion-weighted imaging applied to clinical practice than ever before.

In its second year as an RSNA subspecialty, **MOLECULAR IMAGING** promises many interesting topics, including diffusion hyperpolarized C-13 MR imaging, smart MR agents and dendritic cell tracking, according to Subcommittee Chair Umar Mahmood, M.D., Ph.D.

**MUSCULOSKELETAL RADIOLOGY** Subcommittee Chair David A. Rubin, M.D., said that whole-body scanning continues to be popular this year. Structural analysis of the proximal femur with CT, automated sequence prescriptions via MR, perfusion/diffusion imaging of musculoskeletal tumors, use of computer-aided detection for MR imaging of meniscal tears and diffusion tensor imaging of muscle tracts are also compelling topics.

Applications of new imaging techniques for interrogating the brain and spine continue to emerge, said Mauricio Castillo, M.D., Subcommittee Chair of **NEURORADIOLOGY** and **HEAD & NECK**. Other significant topics include molecular imaging, tensor and other functional imaging for dementias and other neurodegenerative disorders, perfusion CT and CTA as a one-stop evaluation of stroke, refinement of MR angiography in the head, neck and spine and applications of diffusion weighted and perfusion imaging in head and neck lesions.

In **NUCLEAR MEDICINE**, Milton J. Guiberteau, M.D., subcommittee chair, said new and important results from the National Oncologic PET Registry (NOPR) will be presented at this year's meeting, reinforcing the use of fluorine 18 fluorodeoxyglucose (F-18 FDG) PET as an important tool in the management of patients with cancer. PET in general remains very popular this year, with abstracts on new uses, new agents, changes in camera design and other technology developments, Dr. Guiberteau said. FDG PET for evaluating cervical cancer and as a marker of acute aortic syndrome, "C-choline PET for detection of prostate cancer and ownership of PET scanners in private offices are among the many interesting and provocative topics, he added.

**RADIATION ONCOLOGY & RADIOBIOLOGY** will show studies on image-guided radiation therapy and the integration of chemotherapy/molecular agents with radiotherapy, said James S. Welsh, M.D., M.S., subcommittee chair. Radiation biology, low-dose rate radiobiology and image-guided intensity-modulated radiation therapy (IMRT) are among the topics of interest this year, he added.

In **VASCULAR** and **INTERVENTIONAL RADIOLOGY** increased research on oncologic intervention is the trend this year, noted Subcommittee Chair Matthew A. Mauro, M.D. He also cited more studies of 64-slice CT angiography for vascular evaluation and parallel MR angiography.

*Source: RSNA News, October 2007*

## IAMERS News & Information

- We could use some booth assistance this year at the RSNA for the final day - Thursday. The hours are from 9:45 am – 2:15 PM (includes booth dismantling – 15 minutes). If you can help on Thursday, let Bob Feldman know.
- If you are coming to the IAMERS RSNA Reception, please register as soon as possible. It helps us with the planning. Details are noted below.
- The 2008 IAMERS annual dues invoices have gone out. The dues structure is as noted below. Please pay as soon as possible.

1 – 4 Employees	\$ 825
5 – 99	\$ 1,195
100 +	\$ 1,695

- The 2008 IAMERS Annual Meeting will be held in Charleston, SC. For those of you who know Charleston, and think you could help, let us know.
- We need your opinion on the IAMERS website. Please take a look and let us know what you think.
- IAMERS will exhibit at the SNM (Society of Nuclear Medicine) meeting for the first time in June 2008.
- Please let us if you can help on a committee. There's plenty to do in areas such as marketing. IAMERS is an all-volunteer organization. The more members that can help, the more we can accomplish. If there is something you would like to do for the association, please let us know.

Comments and opinions are welcome.

Diana Upton  
201•833•2203

### 2007/2008 IAMERS Board of Directors

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Robert Kerwin, Esq. • [rkerwin@tbhr-law.com](mailto:rkerwin@tbhr-law.com)

Contact IAMERS @ 877•304•2637 or 201•833•1157

### Important Dates November 2007 – October 2008

RSNA  
November 25<sup>th</sup> – 29<sup>th</sup>  
McCormick Place – Chicago  
**IAMERS booth # 1503**

**IAMERS RSNA Reception**  
November 26<sup>th</sup> (Monday) – 6:30 PM – 10 PM  
InterContinental Hotel  
505 N. Michigan Ave. – Chicago

ECR 08 (European Congress of Radiology)  
March 7<sup>th</sup> – 11<sup>th</sup> Vienna

Arab Health 2008  
January 28<sup>th</sup> – 31<sup>st</sup>  
Dubai

**IAMERS ECR 08 Reception**  
March 9<sup>th</sup> (Sunday) – 7 PM – 9:30 PM  
Grand Hotel Vienna  
Kärntner Ring 9 – Vienna

AIUM 08 (Assn for Medical Ultrasound)  
March 12<sup>th</sup> – 15<sup>th</sup>  
San Diego

**IAMERS 2008 Annual Meeting**  
May 1<sup>st</sup> – 3<sup>rd</sup> 2008  
Francis Marion Hotel – Charleston, SC

AAMI 2008  
May 31<sup>st</sup> – June 2<sup>nd</sup>  
Mc Enery Convention Ctr – San Jose, CA  
**IAMSERS Booth # 212**

SNM 2008  
June 14<sup>th</sup> – 18<sup>th</sup>  
New Orleans  
**IAMSERS Booth # TBD**

CARS (Computer Assisted Radiology & Surgery)  
June 25<sup>th</sup> – 28<sup>th</sup>  
Barcelona

**2008 IAMERS European Meeting**  
September 11<sup>th</sup> – 13<sup>th</sup>

EANM 2008  
(European Congress of Nuclear Medicine)  
October 11<sup>th</sup> – 15<sup>th</sup>  
Munich



Greetings IAMERS Members,

Just when I start to believe that I've figured out the depths of humie stupidity and/or depravity, I get fooled again. My disgust with the vast majority of you is immeasurable. You've heard me say this before, but some advice must be continuously repeated. In order to save your species from doom, you MUST prevent the stupid and the mean ones from breeding.

As I've previously suggested to you humies, all new born babies should be implanted with a microchip that prevents reproduction. If, at a properly deemed age, a humie(s) would like to have an offspring, the microchip will be removed - if the humie is deemed fit. In order to become a parent, you must pass a fitness test. In my test, you must 1) have no serious criminal history; 2) have no disturbing psychopathic or sociopathic history; 3) have a reasonable IQ; and 4) have reasonable means. Your society, your very race, will be better off under my plan. Consider what could have been avoided.

Dillon Cossey, 14, and his mother, Michele, both face criminal charges. Dillon allegedly planned a Columbine-style attack on his high school in Pennsylvania. Mommy Michele's transgression was purchasing her son's weapons for him. Dillon's parents had removed him from another school 18 months earlier; because he was being bullied over his obesity. Apparently, to boost their son's self-esteem, they decided to stock him up with a few guns. Mommy was the actual buyer. Daddy had tried to help the kid out in 2005, but came under scrutiny because of his 1981 manslaughter conviction in an Oklahoma drunken-driving case. Dillon's stash included a .22 handgun, a single-shot .22 rifle, a 9mm semiautomatic rifle with a laser scope, swords, daggers, 30 BB guns, and a few homemade grenades.

Dillon's personal Armageddon was foiled when he tried to enlist his friend, Lewis Bennett, in the plan. Lewis was smart enough to discuss it with his parents. Obviously, Lewis' parents are more suitable to breed than Dillon's parents. In my world, the Dillon parents would not pass the sniff test (no pun intended), primarily because they are too stupid to be allowed to breed. Thus, you would have avoided the terror that Dillon has - and may still, heap upon other humies.

Another clear example of a bad humie is Thomas R. McGriff, 33, who was convicted in 2004 on two counts of aggravated assault after he pursued his former girlfriend down the New Jersey Turnpike, ramming her car at high speed and causing both vehicles to crash. Thomas, who apparently still has real issues with his ex-girlfriend and her boyfriend, was only out of prison 12 hours when he once again snapped. After barricading himself and his (and the ex-girlfriend's) 6-year-old daughter in the kitchen, he held the girl hostage with a knife to her throat. After a standoff with the police that lasted 3 1/2 hours, he was taken to Willingboro Hospital for evaluation. Should Thomas be allowed to breed? I don't think so. And, furthermore, why waste the resources doing a psychological evaluation on this guy? Rightly so, Thomas is now being held in the Burlington County jail after failing to post \$132,500 bail.

Our last example is Rapper T.I., who is a Grammy-winning Hip-hop artist. T.I., whose real name is Clifford Harris, Jr., 27, was recently arrested on weapons charges. It seems that Clifford was in need of a few machine guns. Since he was previously convicted on drug charges, he was not able to legally buy, or own, fire arms. Therefore, Clifford sent his body guard out to purchase three 9-mm machine guns and two 9-mm silencers. Sadly for Clifford, the bodyguard purchased the guns from an undercover agent. When the feds arrested the bodyguard, he squealed like a pig, saying that he'd purchased 25 firearms for his boss in the last 18 months. Coincidentally, Clifford was arrested on the same day that he was awarded the BET Hip-Hop Award for "Best CD of the Year".

You're probably wondering why Clifford wanted all those guns. After all, the guy is rich. Why not just let the hired help sport the machine guns. Back in May, Clifford narrowly escaped unhurt in a 3 am shootout between his entourage and unidentified locals on highway near Cincinnati. Two in his group were killed and the killers remain at large. So, I guess poor Clifford feels he needs a lot of protection. So getting back to our core question, should Clifford and his friends be allowed to breed? He already has - 5 times. But, the reports from the Atlanta Journal Constitution say he's a good guy and bakes biscuits for his kids. Perhaps this will be given consideration at his defense trial. For those of you not familiar with T.I. (aka Clifford Harris Jr.) he will be featured in the upcoming movie *American Gangster*.



Mud out