



IAMERS Newsletter

Editor – Diana Upton

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November 19, 2007

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Letter from the President

As many of you may have read recently, Congressman Charles Rangel is working towards cutting Medicare reimbursements. Congressman Rangel is the Chairman of the House Ways and Means Committee. As with all legislative issues, we do our best to keep our voice heard in Washington. We will be working on this issue as well, in hopes of keeping these cuts away from imaging procedures.

Our efforts with the FDA and Department of Commerce are on-going; and it will always be that way. We can never allow ourselves to get comfortable and assume that all is well.

At the next IAMERS Board meeting, we will finalize our position on labeling and send it on to the FDA. We welcome all of your input.

On other IAMERS matters, we are doing well. Our membership is up. We are working on the Annual Meeting in Charleston. Just after we wrap up this year's RSNA, we will finalize plans on the IAMERS reception at the ECR in Vienna. All members attending the ECR are, of course, welcome to the reception. We encourage you to bring a non-member to the ECR party – ideally someone who might consider joining the association.

This year's IAMERS reception during RSNA is shaping up to be the largest attendance we've had in a long time. We are expecting about 300 people. Wow!

Have a wonderful Thanksgiving and a safe trip to Chicago. I look forward to seeing everyone at the InterContinental Hotel on Monday night.

Cheers,

Diana Upton

**IAMERS 2007 RSNA Reception
6:30 PM – 10 PM**

**InterContinental Hotel
505 N. Michigan Ave**



Pre-registration is mandatory

Non-member charge is \$250

IAMERS Welcomes 2 New Members

GE HEALTHCARE CLINICAL SERVICES
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GE Healthcare Clinical Systems has a variety of quality certified and pre-owned products from Lunar Bone Density Systems, Gold Seal Ultrasound products, to multi vendor refurbished ultrasound equipment from Ambassador Medical.

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FAST CHANGING TECHNOLOGY & SLOW CHANGING BUSINESS PRACTICES

Wayne Webster

As I contemplated the subject for this month's newsletter, I thought about providing a review of the technology to be exhibited at the RSNA. I don't know about you, but I've been inundated with electronic and printed articles by others doing just the same thing. I've seen reviews on CT, displays, ultrasound, PACS/RIS, mammography and every other technology imaginable. After reading a few I realized I was outdone by these fine overviews of the RSNA exhibits. So relax, you're spared from the feelings of guilt for not reading my review of the wonders on display in the exhibit halls at the RSNA.

A review of what's new at RSNA is interesting. But, what about our customers? What will they be doing in 2008 with the RSNA information? Since we all sell pre-owned instrumentation I wonder about the value of all the new and different? How do we help our customers deal with all of the changes that have happened and are about to happen?

This has been a difficult year for everyone in diagnostic imaging. I suspect the vendors at the RSNA won't have solutions for the cuts which are a result of the Deficit Reduction Act (DRA).

How can we as a group do a better job for our customers? It's my observation that most sellers of used equipment follow the same business model. A potential customer contacts the company. He describes what he wants, make and model, and what he's willing to pay. The company then looks for the device. This business model is straight forward and well known across a number of markets. I think it's like being a retail clerk in the Men's Wear Department at Macy's. I need a white oxford shirt and the clerk can lead me to the display. As the clinical markets slow, and the rules change in this business model, what is best for our customers and us? What will we do tomorrow to help our customers make clinically sound choices that will be profitable for the buyer and the seller?

I was presented with just such a problem last week. While coming home on the train I made a return call to a doctor seeking used imaging equipment for his practice. I think the conversation is an example of how we can use our business, technology and clinical applications knowledge to ensure that the buyer is getting what he needs for success; and we are getting what we need for profit.

At the beginning of the call we discussed the usual. Where are you? What do you want to do? When do you want to do it? What do you want to spend? Sound familiar?

As the discussion progressed he told me he was a cardiologist and was seeking a pre-owned GE PET/CT Discovery with eight or sixteen slices for one of his offices. Well, that seemed pretty easy. Go to the list of possible scanners, find out what he's willing to pay and bingo, we're done. Unfortunately we weren't talking about a \$50 white oxford shirt. This was going to take time and patience to get it right for us both.

I needed to understand more about the doctor's imaging requirement. As we spoke I began to realize that there was more to this discussion than simply finding what he said he wanted. Nothing is ever simple, is it?

I knew that there were not many PET/CT's with eight or sixteen slices available for resale. I asked what the doctor knew about the availability of these devices. It was clear he didn't know that they are in short supply. Although the sale would have been substantial, approaching a million dollars, I wondered about the practicality of finding such a device and selling it to a person in private practice. And again I thought, why only this device?

Rather than disagree with the doctor we looked deeper into his practice and discussed the GE PET/CT model. He told me that he had three offices and many patients. He was currently doing SPECT cardiac perfusion and wanted to switch to PET/CT.

This was interesting but considering the reimbursement differences, the substantial capital outlay as compared to SPECT and the additional technical complexity, I wasn't clear on why the GE PET/CT or PET/CT in general was an answer. More questions.

Why the GE PET/CT? The reason was evident when he explained that he'd spoken with an expert in PET cardiac perfusion. When asked which PET/CT was the best for cardiac PET perfusion the answer from the expert was GE. It happens that PET/CT is not the best way to perform cardiac PET perfusion but this didn't come out in their discussion.

When using PET/CT for cardiac perfusion with Rubidium-82 there is a problem introduced by the use of the CT for attenuation. The CT takes only a few seconds to collect the attenuation data for the heart. The emission scan for rest and stress can take up to forty-five minutes. The test requires that the two scans, attenuation and emission, be registered or overlaid. The CT is done with a breath hold in just seconds. During the 45-minute emission the patient breathes, the chest goes up and down and the heart moves 3 cm's in all directions while it beats. Registering these two images is difficult. When you use CT as the attenuation source it's almost impossible.

GE has implemented a program developed with the expert to improve the registration of the CT attenuation with the emission scan. In the case of cardiac perfusion the CT attenuation component is not as useful as it is in oncology. In non-cardiac imaging the CT makes the imaging time faster because it reduces the attenuation scan time from minutes to seconds. Although a positive outcome for non-cardiac imaging, in PET/CT cardiac perfusion the CT attenuation is detrimental to image quality. GE, working with the expert provides a solution with a two minute CT attenuation. This extended CT attenuation technique lessens the problem when conducting cardiac perfusion with a PET/CT, but the attenuation technique lengthens imaging time. Understanding that this solution was driving the doctor to PET/CT, I was prompted to ask more questions.

Was he making the change from SPECT to PET/CT for a clinical improvement? He was not. He saw little difference between the information provided from either technology. He thought there was an improvement for obese patients, but that was not the reason for PET/CT.

Was it the new reimbursement numbers projected for 2008 for cardiac PET perfusion that had him interested in PET/CT? He didn't know there was a change about to happen. I explained that Medicare was proposing to increase Medicare A to \$2,700 including the dose. This is up from about \$1,200. He told me most of his patients weren't Medicare A. We both understood that as an Independent Diagnostic Testing Facility (IDTF) he wouldn't qualify for the new rate. Although it would be easy to simply agree with him and seek a PET/CT, I no longer believed he needed PET/CT. He hadn't asked the expert enough questions.

He didn't see a clinical advantage to switching from SPECT to PET/CT. He was not doing it for the reimbursement. He understood that the projected increase in reimbursement did not apply because he was operating an IDTF. What was driving his decision? I asked if he had a budget for the equipment acquisition and if he understood what the Rb-82 generator would cost each year? In general he knew the answers to both of these questions. Like most of us contemplating a large purchase, we aren't always fully informed about the cost. This doctor was no different. We discussed the cost of the PET/CT. Although more than he expected, he accepted it. We reviewed the Rb-82 generator annual cost and the strict terms demanded by Bracco, the only supplier. He didn't like the terms, but he understood them.

This fact finding led to one more question. If you don't see a substantial clinical difference between SPECT and PET/CT, and if the costs of acquiring and operating PET/CT are significantly higher, you must be doing this because you have to replace your SPECT scanners. He said no, there was no need to replace the SPECT devices.

Then why acquire PET/CT? He explained that he had a large practice. He did many SPECT's each month. And he lost money on almost every perfusion SPECT he ordered. Why was PET/CT, with higher overhead, going to solve this problem?

This doctor is in a large metropolitan area. Most of his patients are on public assistance (Medicaid). He wants to provide the best clinical diagnostic solution. Therefore he orders SPECT scans. But, Medicaid reimburses SPECT at about 25% of what it reimburses PET. Finally, as we say here in the Boston area, "Light dawns over Marblehead".

When it became obvious that the reasoning for PET/CT was based upon clinical need and financial survival, we dug into the details. The room requirements, shielding for the CT, installation issues and finally the cost of choosing PET/CT were now all on the table for discussion. I asked if PET/CT was chosen for throughput issues. The answer was an educated no. He understood that perfusion with Rb-82 using PET or PET/CT was similar in time. We then compared the costs of acquisition for PET/CT and PET only.

It became evident to me that when the doctor asked the expert which PET/CT to buy for PET cardiac perfusion he was told the one that had implemented a solution for the image registration problem created by PET/CT. He never asked the expert whether he should do dedicated PET or PET/CT. Once I understood the narrowness of the question, and the answer, we were able to discuss PET versus PET/CT and compare the acquisition cost difference and overall operating cost benefit for cardiac perfusion when using dedicated PET

The doctor immediately understood that his cost to acquire dedicated PET was less, his installation and operation costs were less and the clinical result was in the worst case the same as PET/CT. My opinion is that most often dedicated PET will be better than PET/CT because the same energy isotope is being used to provide the attenuation scan.

With some discussion, a lot of listening and some understanding of what the doctor was trying to accomplish, we were able to take a slightly different path toward an affordable solution. Soon after the installer visited the doctor and we are now speaking about the reasonableness of using dedicated PET for cardiac PET perfusion rather than PET/CT.

This decision, if implemented, will save his practice several hundred thousand dollars at the time of purchase and install. This is the gift that keeps on giving. The practice will continue to save because the service expense for dedicated PET is about half that of PET/CT. Anyone trying to compete with this doctor using a PET/CT will have a difficult time surpassing the quality of his clinical output and beating the cost effectiveness of his program.

Yes, the doctor saves money, no question. The company selling the equipment also makes money. Our medical system is under great pressure and we must act differently to make it possible for buyers to reach their clinical requirements. If we can't make the stretch and be part of the solution, we won't be able to sustain our growth in the coming years.

There is great value in pre-owned medical diagnostic imaging equipment. The value is for:

- The owner of the equipment when he sells. He gets cash for his next purchase.
- The new buyer when he installs and uses. He gets affordable technology.
- The company that buys and sells the equipment profits from the sale.

I like being part of the solution and contributing to clinical usefulness and everyone's profitability. How about you?



Chicago is known for its ribs. In the opinion of your humble scribe, an ex-Chicagoan, this is the best city for ribs north of the Mason-Dixon Line. There are great ribs all over Chicago. However, do you know where to go that's good AND nearby where you'll be staying??

Twin Anchors Restaurant & Tavern @ 1655 North Sedgwick in the Old Town section of Chicago, is one of the oldest restaurants in the city of Chicago. Since its founding in 1932, Twin Anchors has always been known for great, tender, barbequed baby-back ribs that can be enjoyed in a quaint neighborhood tavern. A favorite of Frank Sinatra's in the 1950's, to Conan O'Brien more currently.

Located in a historic Old Town building that dates back to 1881, and once a Prohibition speakeasy, this low-ceilinged, dimly lit space nearly always has a wait. The dining room seats 60, while the bar squeezes in another 15 around curved leather booths. Baby back ribs are the main attraction, served with extra sauce--zesty or mild. Other entrees include broiled tiger shrimp, burgers, pulled pork and a half-chicken that's fried then quickly broiled and basted with barbecue sauce.

Great Cheap Eats in Chicago
Twin Anchors for terrific Chicago ribs



Free Time in Chicago

Most of us go to Chicago with one thought in mind – business. The business might include some great meals and fun with colleagues, but it rarely includes anything else. We never think of ourselves as tourists in Chicago; and that's too bad. Chicago is a great city with wonderful museums, fantastic architecture and world-class dining.

The Art Institute of Chicago is one of the foremost museums in the US. Their collection is interesting and diverse. A unique exhibit at the Art Institute is the Thorne Rooms.

Narcissa Niblack Thorne was an Indiana native who married into a wealthy Chicago family, becoming the wife of one of the heirs to the Montgomery Ward catalog and department store fortune. As Mrs. James Ward Thorne, during the first half of the 20th century, she created close to 100 room boxes to showcase her extensive collection of dollhouse miniatures.

Currently 68 Thorne Rooms are displayed at the Art Institute of Chicago. Another 20 Thorne Rooms are in the collection of the Phoenix Art Museum. Nine are at the Knoxville Museum of Art, and the Indianapolis Children's Museum and the Kaye Miniature Museum in Los Angeles have one Thorne Room each. During her lifetime Mrs. Thorne (1882 – 1966) also created a room which depicted a library at Windsor Castle as a gift for England's King Edward VIII. When the king abdicated, that Thorne room went into the collection of the Victoria and Albert Museum in London.

The 68 Thorne Miniature Rooms at the Art Institute enable one to glimpse elements of European interiors from the late 13th century to the 1930s and American furnishings from the 17th century to the 1930s. Painstakingly constructed on a scale of one inch to one foot, these fascinating models were conceived by Mrs. James Ward Thorne of Chicago and constructed between 1932 and 1940 by master craftsmen according to her specifications. They are of the same materials and quality workmanship as would have been used in the original furniture which they are modeled after.

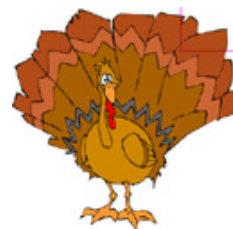


Virginia Drawing Room circa 1754

IAMERS Members at RSNA

For those of you who want to visit the booths of your fellow members, here's where you can find them at this year's RSNA.

	<u>Booth #</u>
Atlas Medical Technologies	3114
Barrington Medical Imaging	5537
Blue Ridge Medical Imaging	3973
C & G Technologies	6762
CIT Healthcare	7608
Digitec Medical Service	5836
DOTmed.com	8101
Dunlee	2703
GE Healthcare	1729
& East Bldg	HOW6
G F Mann Insurance	2203
Huestis Medical	3700
JD Imaging	3190
MEDX	8300
Metropolis International	5352
Mobile X-Ray Solutions	3947
NCD Medical	6409
Radiology OneSource	6462
ReMedPar	3155
RSTI	1032
Shared Imaging	4300
Tomovation	1972
Don't forget to visit IAMERS	1503



Working the IAMERS Booth

If you are working the IAMERS booth at the RSNA, please accept our sincere thanks for your time.

This year's IAMERS booth configuration has no extra storage space. Please check your coat, and any other items you have with you, before you come to the booth. We have no room to hang, or even hide, coats or other stuff. Sometimes it takes a while to check things at RSNA. Therefore, plan ahead, so that you will be on time for your scheduled booth duty.

If you have any questions regarding booth duty, please contact Bob Feldman.

Thanks again, for your participation.

Health Savings Accounts and Your Retirement

Health savings accounts are looking more attractive – but they still may not be powerful enough to cover all of your health-care costs in retirement. The accounts, which were created in 2003, are getting a lot of attention these days, even though they're still used by relatively few people. Some employers see them as a way to save on health-care costs. More banks are offering them, and, President Bush has signed into law a bill that sweetens their potential as savings vehicles.

The accounts allow consumers with high-deductible insurance plans – either from an employer or purchased on their own – to avoid taxes on contributions, investment growth and withdrawals as long as the money is used for qualified medical expenses. Still, crunching the numbers shows that it would be quite difficult to use an HSA to foot your entire health-care bill in retirement. But with some planning, you could use it to pay for a significant chunk of it.

Most people don't realize how much money they could need to fund their retirement health-care costs. Despite the fact that Medicare pays for many health costs for seniors, someone who retires today at 65 and lives 20 more years could need \$84,000 to \$164,000 to pay for uncovered medical expenses, according to a report by the nonprofit Employee Benefit Research Institute released earlier this year. And that's not counting long-term care costs.

How much you'll need depends heavily on how high your out-of-pocket drug costs will be. (That \$164,000 figure assumes high drug costs.) The money will go toward paying premiums for Medicare Part B, which covers physician and outpatient care, premiums for a standard Medicare prescription-drug plan, out-of-pocket prescription-drug costs not covered by that plan and a supplemental insurance plan for other uncovered expenses. Bear in mind that today's \$164,000 estimated costs will likely rise substantially for future retirees, according to the EBRI.

Beginning next year, you must have a qualified health-insurance plan with a deductible of at least \$1,100 for an individual, or \$2,200 for families to open an HSA. An individual will be allowed to contribute up to \$2,850 a year to the account; for families, the limit is \$5,650. Before Congress passed its changes this month, your contributions couldn't exceed the amount of your deductible.

Even with that adjustment, the contribution limits can be a snag. Here's why: Suppose the government increases the \$2,850 limit by 2.5 percent annually, and the money in your HSA realizes a 5 percent return each year. To amass around \$164,000 before you turn 65, you couldn't be older than 41 or 42 this year, based on an analysis using EBRI formulas, and even then that amount might not be enough because health-care inflation could well drive the goal figure much higher. This analysis assumes the HSA holder has a qualified insurance plan every year and contributes the maximum amount annually. This person also doesn't spend any of the money before age 65. The EBRI says today's 55-year-olds who retire 10 years from now and have high drug costs could actually need about \$298,000 from age 65 on, factoring in health-care inflation.

Yet an HSA, when used properly, has a big advantage over a 401(k), in which funds are taxed when they're withdrawn. Depending on your tax bracket, you could have to accumulate some \$252,000 in a 401(k) for those funds to be equivalent to \$164,000 in non-taxable funds for health costs in an HSA.

Once you're 65, you can also use HSA savings for non-health expenses without penalty. Those withdrawals are simply taxed as income, much like a 401(k).

To maximize your HSA, start young. Contributing regularly will get you a lot further if there are decades to do it. And, even though you're allowed to spend your HSA on health expenses before retirement, try to cover those costs with other funds.

By leaving the money in your HSA, you can accumulate interest and investment returns that will not be taxed later, assuming you ultimately spend the money on health expenses. If, instead, you spent your HSA money on present-day health expenses and saved after-tax dollars, the growth of those savings would in many cases be taxed, reducing their overall value.

The temptation to spend the money now, though, can be tough to resist. The high-deductible insurance plans that are paired with HSAs can expose consumers to significant costs before coverage kicks in. It probably doesn't make sense to go into credit-card debt, for instance, for the sake of leaving money in your HSA. But consider a 41-year-old who could build up that \$164,000 by saving the maximum amount each year. If that same person took \$1,000 a year out of her HSA, she would wind up with only about \$125,000, according to an analysis using EBRI formulas.

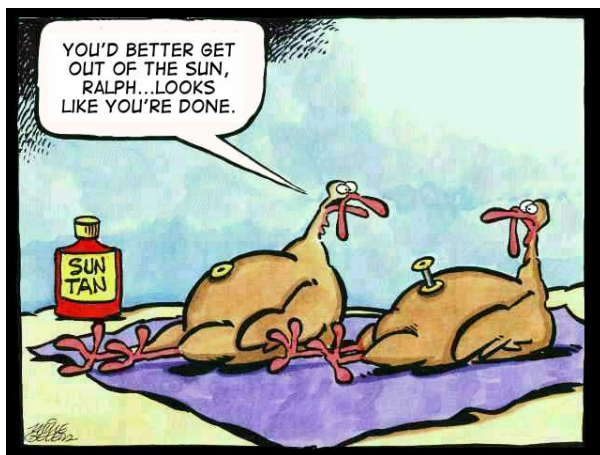
Source: Sarah Rubenstein, The Wall Street Journal

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 planning on coming to the IAMERS RSNA Reception, and haven't already registered, please contact Bob Feldman asap.
- 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 2008 Annual Dues must be paid before the end of 2007.
- 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
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2007/2008 IAMERS Board of Directors

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

Important Dates November 2007 – October 2008

RSNA
November 25th – 29th
McCormick Place – Chicago
IAMERS booth # 1503

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

ECR 08 (European Congress of Radiology)
March 7th – 11th Vienna

Arab Health 2008
January 28th – 31st
Dubai

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

AIUM 08 (Assn for Medical Ultrasound)
March 12th – 15th
San Diego

IAMERS 2008 Annual Meeting
May 1st – 3rd 2008
Francis Marion Hotel – Charleston, SC

AAMI 2008
May 31st – June 2nd
Mc Enery Convention Ctr – San Jose, CA
IAMERS Booth # 212

SNM 2008
June 14th – 18th
New Orleans
IAMERS Booth # TBD

CARS (Computer Assisted Radiology & Surgery)
June 25th – 28th
Barcelona

2008 IAMERS European Meeting
September 11th – 13th

EANM 2008
(European Congress of Nuclear Medicine)
October 11th – 15th
Munich

Greetings IAMERS Members,

This was me in August. I was out for a stroll at our summer home in La Croix Valmer. I wish I could persuade the Queen to establish a "winter home". I hate winter - at least here in Alpine, New Jersey. Like most dogs, I love to hang outside. Unfortunately, for me, the Queen is too embroiled in her social life, and all the gala events that surround the holidays. So I am stuck here in Alpine for the winter. The King and the Queen, of course, take a few short winter vacations; but they rarely take me.

Other than to attend a speaking engagement, I stick close to the manse in the winter. Harry visits, I terrorize the Queen's feline stronzi, I read, I write, and I watch TV. You know, the same old stuff - just more of it.

Two additional topics, which will brighten my otherwise dull winter, are the race for the next US Prez; and the Queen's (and her similar friends') quest for the fountain of youth.

Countless times I have tried to tell the Queen that people her age are invisible. All this cosmetic surgery is a big waste of time. She, and her circle of friends - let's call them "ladies that lunch", are obsessed with their appearance. Personally, I think for a bunch of broads in their late 50s and early 60s they look pretty good. However, it's never enough for this crowd. They're all in search of the next youth-enhancing procedure, and all have money to burn.

Most of you know what a face-lift and liposuction are; but how about "LipoSelection"? It's a new patented technology with advanced surgical techniques to break up and remove fatty tissue. Unwanted fat can be efficiently removed from abs, arms, back, hips, knees, love handles, neck and chin, saddlebags, thighs - any place you've developed a little "extra cushioning." It uses ultrasound energy to break up and emulsify fat, leaving surrounding tissue - such as nerves, blood vessels and connective tissue - relatively intact.

Tired of the frequency of your Botox injections? How about a fat transfer? Take the fat from your gut and reinject it into those sagging facial areas. And how about the latest in breast lifts? Noted Israeli plastic surgeon Eyal Gur said in August that he expects approval next year for his revolutionary breast-lift procedure ("an internal bra") in which an actual thin titanium bra-like frame is implanted just under the skin with silicone cups to hold the breasts up. Dr. Gur said the procedure will be quicker (40 minutes long), less invasive (local anesthesia only) and less expensive (no hospital stay) than today's breast lifts. So if your tits point to the ground, your worries are over.

When the "ladies that lunch" cease to amuse me, I'll turn to the US race for Prez. I suspect that even humies find this a barrel of laughs from time to time. I am especially fond of the way politicians manage to dance around no-win subjects; such as gay marriage. The prize, as of recent, should surely go to Fred Thompson. While campaigning in New Hampshire recently, Senator Thompson was asked a question by Edward Paul, an employee of the Delta Dental Plans Association. Apparently Senator Thompson had trouble hearing the question, which was, "I'm proud to say that in January 2008 New Hampshire has passed a law facilitating civil unions here. . . . What is your belief for federal civil unions to be passed?" Paul asked. "Soviet Union?" Thompson responded. "No, civil unions," Paul said. "Oh. No, I would not be in support of that," Thompson said. Paul said he wasn't surprised, or impressed. "I think he needs to do more homework on whatever state he's in and I don't think he did on that question," said Paul.

I would like to say here that I am in support of gay humies, just as I am in support of gay dogs. However, Mr. Paul is sadly mistaken if he thinks Senator Thompson, or for that matter, any of the other candidates running for Prez, gives a rat's buttocks for gay marriage. Candidates for Prez cannot make points on this subject. Therefore, it's just a dance. They are all hoping the press will stop talking about it. PLEASE, I beg all gay-rights groups, PACs, and candidates: don't sue the King and the Queen. These are not their opinions. They are mine and I am just a dog; a very smart dog - smarter than the average humie, but a dog none the less. I'm really looking out for gays. I mean someone has to tell them the truth.

I'm looking forward to seeing you IAMERS humies in Chicago at the Monday night RSNA reception. I'll be wearing a white evening gown; and my tits will be pointing to the ground.



Mud out 