Why RP? A Q&A with Dr. Syam Reddy, Body and Breast Radiologist

Dr. Syam Reddy, National Subspecialty Lead for Body Imaging at Radiology Partners (RP), discusses RP's focus on delivering quality care and enhancing patient and client experiences while leading innovation in AI and technology.

Dr. Syam Reddy is the National Subspecialty Lead (NSL) for Body Imaging at RP. A body and breast radiologist and practice president at RP Chicago, he and his practice joined RP in 2014. He is the clinical chair at UChicago Medicine Ingalls Memorial and a member of several physician support boards, as well as a facilitator for coaching circles. He holds memberships in the Chicago Radiologic Society, Breast Imaging American College of Radiology (ACR) Data Science Institute, ACR CT colonoscopy committee, the ACR HR Commission, Society of Cardiovascular CT (SCCT) and Society of Cardiovascular MR (SCMR). Outside of work, Dr. Reddy enjoys spending time with family – traveling, playing tennis with his kids, and learning the cello.

We talked to Dr. Reddy about his role with RP's Clinical Value Team as NSL for Body Imaging, RP's commitment to quality and innovation, the role of collaboration and AI in advancing subspecialty practice, and his excitement about leveraging imaging technology like MosaicOS™.

What inspired you to be a radiologist?

The biggest reason is my mom was a radiologist. Towards the end of her career, teleradiology was becoming more common. She had this monstrous screen she would have to bring home, and I saw her read these head CTs that took forever to load. That inspired me to see the mix of computers and

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medicine and how they meld together to help the patient. The more I learned about it, I was drawn to the fact that it's almost like looking at artwork, trying to decipher what's going on and putting all the pieces together – you're a little bit of a detective, too. I also like my hands in a little bit of everything, and I found radiology to be a field that really covers all the specialties to a great extent.

What drew you to body imaging as a subspecialty?

I like body imaging because it's so integrated with everything – from ER to developing subspecialties. I also got involved with breast imaging quite a bit, so those are the two areas I focused on. I really enjoy learning, and in radiology, there are always new updates, information and trials.

Talk about your decision to join RP.

Our group was one of the earliest groups to join RP, way back in 2014. At the time, we were a fairly large group, with about 100 radiologists across four or five states. Our group landed with RP because of their focus on quality. RP's mission to transform radiology includes improving quality, patient experience and client-side experience, which drew our attention. That's exactly what we wanted. Being a physician who can be integrated and involved with that process is really meaningful.

Talk about the change and growth you've seen within RP since you joined in 2014.

Looking back, I think RP has positioned itself as a practice that's ahead of the curve in several ways. We're the ones helping the rural areas that can't get help. We're working with reimbursement issues to ensure physicians are getting reimbursed properly to maintain their practices. And we're the practice that's ahead of the curve when it comes to AI and technology. I see a lot of vendors coming out, but I don't know how many are radiology-driven with the input that we have and the speed at which we are progressing. All of those really speak volumes about what we are doing, what we have done and where we're going.

What was your path to serving on our Clinical Value Team as the National Subspecialty Lead (NSL) for Body Imaging?

I started out being on the subspecialty advisory board. After a couple years, our previous NSL decided to explore other opportunities and asked me if I wanted to get involved. I thought it was a good way to get further into the subspecialty. I was nervous at first, but it was fun to jump in and meet everybody in the body imaging group. I've really enjoyed meeting other people in the practice and seeing all the things that we've developed over the years. I think there's so much more potential – just the vastness of radiology really needs guidance for all these subspecialty exams that we do. There's so much information out there.

What has been the most rewarding aspect of your NSL work?

I think sometimes we can get somewhat siloed, even within our own groups. When we come together in our advisory boards and discuss topics like trauma, we're all on the same page. Those conversations give us the chance to say, "We do that too," "This is how we do it," "This is a great idea," or "Maybe we can tweak it this way." That sharing of ideas is so powerful. It's great knowing there are so many resources out there and different ways to connect with people. And then there's the challenge of pulling information together in a concise way. There are so many books and articles, so you have to dig through information. We need to get to a point where everything is very concise and easy to access, because that's the way of the future.

Talk about the "Rad to Rad" peer learning program. What is it and what's the goal of it?

When we think of our residents and fellows, a lot of information today is short-form – quick snippets like a one- or two-minute video on YouTube or a one-pager. With that in mind, we created the "Rad to Rad" peer learning program. It's simple: share a couple of images from an important case and highlight the most valuable points. It's super easy, super quick and very high yield. That's the kind of content people are seeing on social media when it comes to radiology cases. Our hope is that it draws the attention of residents and fellows – and also keeps all of us engaged. We're all busy, but if we can take a minute or two to see a case that boosts our confidence or helps avoid a mistake, it's worth it.

How do you and the Clinical Value Team come together to create "Rad to Rad" learnings?

All of us are exposed to different cases in our practice, and some of them stand out. For example, maybe it was a miss, or maybe it was a great catch. I think most of us have a process where we document that, whether it's a teaching case or something else, and we're all very passionate about our desire to showcase our subspecialty. Those are the kind of cases we present to each other in our board meeting when we're working on this. It's kind of a working meeting; we'll share the case, and then people will bring up some pointers, verify if it looks accurate, etc. Being able to create that is rewarding by itself.

Why is a team like the Clinical Value Team so integral to the rapid technology changes?

We're all racing to get our work done, but we need someone to pause and make sure we're running in the right direction. Sometimes speed without guardrails or guidance can lead to chaos pretty quickly. RP's Clinical Value Team provides a forum that allows us to still move fast, but in the right direction, and ensure we're doing it safely for our patients and the radiologists. That is so important. Our radiology societies play a similar role by ensuring new information and literature reach radiologists, so the quality of practice is always improving. Medicine is changing so quickly, and so is technology.

How would you define a successful future?

It seems like there's this ever-growing gap between the volumes of work and the supply of radiologists. One of the things we're focusing on is AI and how we can integrate it with radiologists to improve the whole process. To me, success would be all of that coming to fruition: leveraging AI while maintaining our quality and improving patient care. If we're able to see all those things happen, that's true success – no question.

You are an early user of Mosaic Clinical Technologies™. What has your experience been so far?

My background is in biomedical engineering, and the biggest decision I had to make was whether to go into computers or medicine. The reason I didn't go into computers is that I tend to obsess about trying to get things right. That's why I enjoy working with MosaicOS™ – I like creating and understanding. It's very early, but the concept of telling AI to handle tasks like calculating volumes or percent changes is just incredible. I used to do all of that manually with a calculator. What I really want to know is how far I can push the envelope. There are people who know more than I do, and I'm excited to learn from them. I think we're headed in the right direction, and it's going to be pretty amazing.

How would you like AI to help support your specialty?

I've always felt the purpose of RP's Clinical Value Team is to make it easier to practice in our subspecialty: being faster, more efficient and with high-quality content. As we become more subspecialized, our subspecialized referrers expect very specific content. If we can increase everyone's skill set in that way, then I think we're successful. There's a shortage of body imaging radiologists and breast imaging radiologists; how do we use AI and the clinical value we provide to decrease the gap while increasing the number of people who are able to perform?

Dr. Syam Reddy earned his medical degree from the University of Illinois Medical Center in Chicago; completed his residency at Sparrow Health System; and completed his fellowship in body MRI imaging at Baylor College of Medicine in Houston.

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Rad to Rad Learning: Male Breast Cancer

The Radiology Partners (RP) Breast Imaging National Subspecialty Division (NSD) presents our newest Rad to Rad Learning case.

Peer Learning Opportunity

While male breast cancer is rare, it is often diagnosed at a later stage with poorer outcomes.

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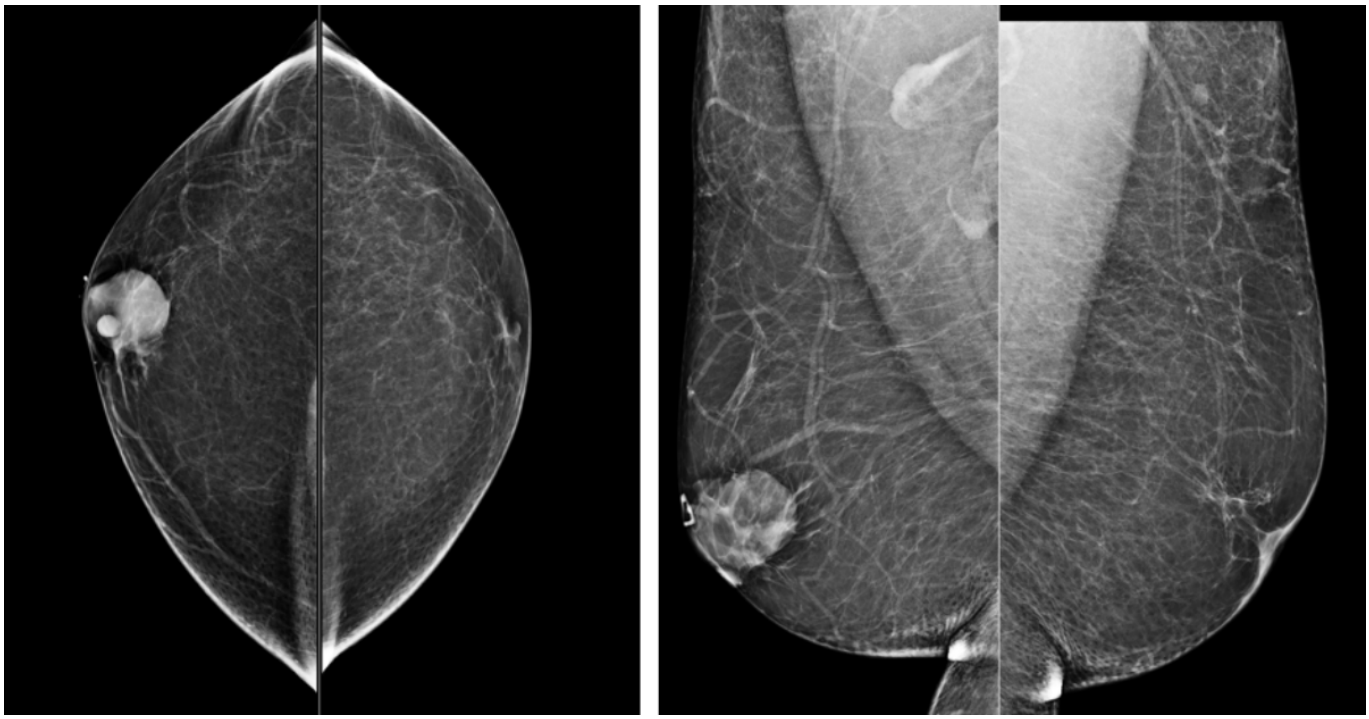

Male Breast Cancer

Most commonly found in the subareolar region, frequently with secondary signs including nipple retraction or thickening.

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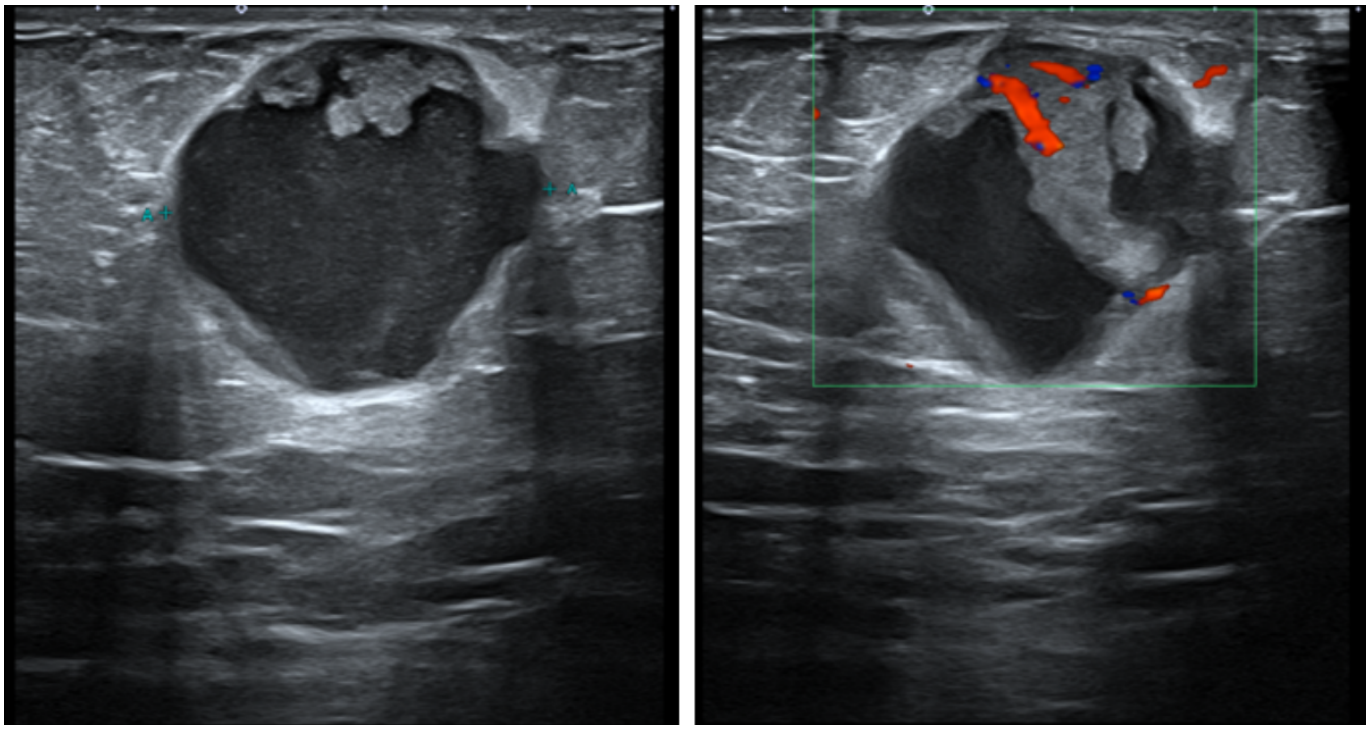

Shared to improve patient safety and healthcare delivery in the provision of radiology services. The circumstances and facts are changed, altered, or deidentified to preserve confidentiality. Privileges have not been waived.

Practical Insights

- **Gynecomastia often presents as a retroareolar, flame-shaped density that gradually blends into the surrounding fat.**
- **Can present with classic malignant features like spiculation or indistinct margins, but also as more benign-appearing oval or round shapes.**
- **Any calcification should be considered suspicious.**

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US typically shows a hypoechoic solid mass with variable posterior acoustic properties and often increased vascularity on Doppler.

Always suspect malignancy if there is an irregular or spiculated retroareolar mass.

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Rad to Rad Learning
Focused tips from our experts

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Rad to Rad Learning: Hyperechoic Breast Lesions

The Radiology Partners (RP) Breast Imaging National Subspecialty Division (NSD) presents our newest Rad to Rad Learning case.

Peer Learning Opportunity

Hyperechogenicity is typically associated with benign breast lesions, including hamartoma, lipoma, angiolipoma, hemangioma, hematoma, fat necrosis, fibrosis, and galactocele. However, some rare malignant lesions may also appear hyperechoic.

Presents with palpable mass

Presents with new bruise

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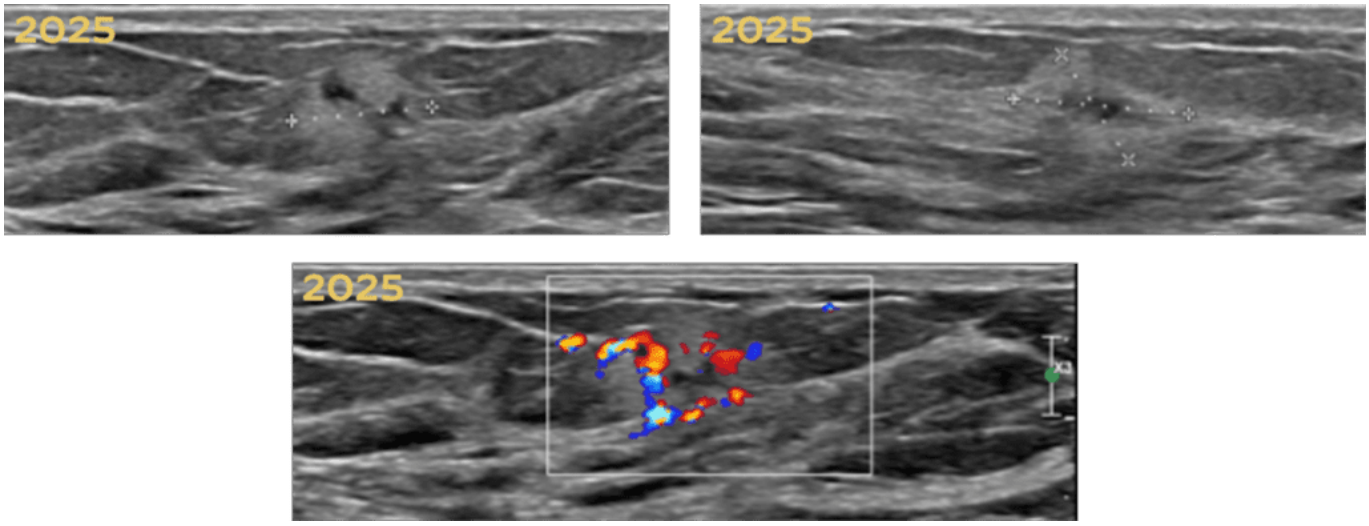
Hyperechoic Breast Lesions

Presents with persistent palpable concern

Biopsy-proven Invasive Lobular Carcinoma



Watch for subtle, suspicious features like irregular shape, non-circumscribed margins, non-parallel orientation, or posterior acoustic shadow.

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Practical Insights

- **Don’t dismiss a lesion simply because it is hyperechoic. Correlate US findings with other modalities and the patient’s clinical history.**

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Consider specific histologies, not only invasive ductal or lobular carcinomas.

- **Rare cancers like angiosarcoma, lymphoma, and metastases can also present.**
- **Don’t hesitate to recommend a biopsy for suspicious lesions. Do not rely solely on the hyperechoic appearance to rule out malignancy.**
- **Contrast-enhanced mammography is a promising alternative for dense breasts.**

Hyperechoic breast lesions are not always benign.

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Why RP? A Q&A with Dr. Jean Weigert, Breast Radiologist

In honor of Breast Cancer Awareness Month, we spoke with Dr. Jean Weigert about the path that led her to become a breast radiologist, advocate for dense breast legislation and champion patient-centered care through decades of innovation.

Dr. Jean Weigert is a breast radiologist and breast imaging section chief at Jefferson Radiology, a Radiology Partners (RP)-affiliated practice. A Fellow of the American College of Radiology (FACR) and the Society of Breast Imaging (FSBI), she joined RP in 2017. Outside of work, Dr. Weigert's passions include singing and ballroom dancing.

We talked to Dr. Weigert about her experience in the continually transforming field of breast imaging, her part in passing legislature in her home state of Connecticut and how the role of women has changed drastically in medicine.

What inspired you to be a radiologist?

I went to medical school in the late 1970s, when medicine still had quotas for women. Only about 20%

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of the class could be female. Most of us assumed we'd go into fields like pediatrics, OB-GYN or internal medicine. We didn't think about surgery or what was then the "esoteric" field of radiology. I originally planned to pursue OB-GYN and took several electives, including one in radiology. During that rotation, I realized I could see anatomy in three dimensions. Not everyone can do that. The radiologists would show us images, and I could immediately recognize the structures. Everyone else was asking, "What are you seeing?"

Looking back, I think a lot of that came from my upbringing. I was raised in a very artistic home. My father was a physician who also painted, and we spent a lot of time in art museums. To me, the human body is beautiful, inside and out. Radiology let me appreciate it in a truly unique way. Unlike most people at the time, I went directly into radiology. I did a rotating internship and was fortunate to be accepted to some of the top residencies. I chose Columbia, and it was the right fit; their radiology department was excellent, and the experience shaped the rest of my career.

How did you become a breast radiologist?

Back when I trained, "breast imaging" didn't really exist. But during my abdominal imaging fellowship, I started spending more time in gynecologic imaging and with early mammography, which was still developing in the early 1980s. At that time, mammograms were done on standard X-ray machines, often for women who already had a suspicious lump, as there was no screening yet.

After my training, I moved to Connecticut for my husband's job. It was very hard to find a radiology position, especially as a woman. Ironically, I was hired by a group opening a mammography center, mainly because I was a woman and they thought it would be good for public relations. Reverse discrimination? Maybe. But I took the opportunity and ran with it, and that's how I carved out a niche in breast imaging. I started teaching residents at the University of Connecticut once a month, hauling in my mammograms in a bag. They called me the "bag lady." Over time, I built a reputation as a women's imager, doing research, lecturing and growing the practice in ways no one else was really doing.

What was mammography like for women in the 1980s?

It was a very different world. Women typically came in because they felt a lump. Cancers were larger and often already metastatic. We didn't have minimally invasive biopsies; surgeons would remove large pieces of tissue. If the pathology came back as cancer, the woman would often wake up having had a mastectomy. Lumpectomies weren't a thing yet. We've come a long way, but even today, we still see too many advanced cancers. We all hoped we'd catch every cancer early – under 1 cm – but that's not always the case. Still, with the tools we have now, we can detect more cancers earlier than ever before.

What do you wish more women knew about breast health today?

That they have power and control over their health. I say this to patients all the time: “You know your body better than anyone. If something doesn’t feel right, don’t ignore it.” Even if it turns out to be nothing, that’s still a win. We’re also seeing a troubling trend, with more aggressive breast cancers in younger women. I’ve seen women in their 20s with invasive disease. Since screening usually starts at 40, these cancers are often only found because the patient noticed a lump. That’s why self-awareness and risk-based screening are so important.

Speaking of guideline, what should women understand beyond “get a mammogram at 40”?

Guidelines are just that – guidelines. If you have a first-degree relative with breast cancer, you should start screening 10 years earlier than their age at diagnosis. And now we have genetic risk models and tools to assess a woman’s lifetime risk. But I also remind patients: “Don’t say you’re not at risk just because you have no family history. If you have breasts, you’re at risk.”

What innovations have transformed breast imaging during your career?

When I started, mammograms were done on film and developed in dark rooms. Fast-forward to today, and we have:

- Digital mammography, which allows real-time manipulation of images.
- Tomosynthesis (3D mammography), which gives us millimeter-thin slices of breast tissue—like a CT scan of the breast.
- Advanced ultrasound, which can evaluate vascularity and tissue characteristics.
- MRI, now a powerful tool for high-risk women, with sequences that reveal solid vs. cystic lesions and vascular kinetics.
- Contrast-enhanced mammography and molecular imaging, which give us insight into metabolic activity—cancers are often hypermetabolic.
- AI, which helps us assess density, flag subtle findings and improve accuracy.

We’ve gone from “how did we even find cancers back then?” to having an array of incredible tools today. The challenge now is interpreting all that data responsibly and minimizing unnecessary biopsies while still catching early, aggressive cancers.

You played a role in passing Connecticut’s dense breast legislation. Can you tell us more about that?

In 2005, Connecticut passed a little-known law allowing ultrasounds for women with dense breasts, but no one was using it. Then a close colleague of mine was diagnosed with Stage III breast cancer shortly after receiving a “normal” mammogram. Her breasts were dense, and the mammogram had missed it. She became a tireless advocate. Together with the Connecticut Radiology Society, we

lobbied to make breast density reporting and supplemental screening the standard. In 2009, Governor Rell, herself a survivor, signed the first dense breast law in the U.S.

I also led some of the earliest studies on screening ultrasound, publishing papers that showed we could detect an additional 3–4 cancers per 1,000 women. That's huge. Now, 38 states have laws, and as of September 2024, every woman in the U.S. must be notified of her breast density on her mammogram results.

What's been the most meaningful part of working with patients?

It's the human part of radiology. When I can tell a woman, "This looks totally fine," and she hugs me in relief—it's amazing. When I have to tell a patient we need a biopsy, I'm honest and compassionate. I say, "I've been doing this long enough to know that when I don't know what something is, I need to find out." Then I lay out the plan. Patients appreciate that clarity.

You're now part of Jefferson Radiology and RP. How has that experience been?

What drew me to Jefferson Radiology was their subspecialty model, where I could focus on what I do best. The volume, the team and the technology elevated my skills. Honestly, it felt like a mini fellowship. I learned so much from my colleagues. Radiology has changed drastically over my career and so has the role of women in medicine.

As part of RP, I've gotten to participate in exciting national projects, like research on breast calcifications. That level of collaboration didn't happen in my smaller group before. I also appreciate RP's openness to innovation and the fact that they've created a platform for clinical voices like mine to be heard.

What honors have shaped your career?

In 2008, I became a Fellow of the American College of Radiology (FACR) an honor given to only 10% of radiologists, and even fewer women at the time. I was also appointed chair of the ACR Accreditation Committee for Mammography and continue to serve as a senior reviewer for MQSA.

In 2020, I was honored to become a Fellow of the Society of Breast Imaging (FSBI). Most SBI fellows are academics with dozens of publications. I've always been a clinician, a "closet academic." They actually adjusted the criteria to allow recognition of clinical excellence—and I was the first to be awarded through that path.

How do you spend your time outside of medicine?

I have five daughters—two of my own and three stepdaughters—and seven grandchildren. I'm not the

“babysitting grandma,” but I’m very involved. Some of my daughters now get mammograms, and I’m proud they take their health seriously—even if they sometimes forget to tell me!

Outside of family, I have two big passions: singing and competitive ballroom dancing. I’ve been dancing for 30 years. It’s great for my body and my brain and it forces me to let someone else lead, which isn’t easy for me! I also love history and genealogy. I come from a long line of scientists and physicians, including a Nobel Prize winner, in some ways, this path was always part of my DNA.

Dr. Jean Weigert earned her medical degree from State University of New York Upstate Medical Center, and she completed both her fellowship in abdominal imaging and residency in diagnostic radiology at Columbia-Presbyterian Medical Center.

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Rad to Rad Learning: False Negative in Dense Breast

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The Radiology Partners (RP) Breast Imaging National Subspecialty Division (NSD) presents our newest Rad to Rad Learning case.

Peer Learning Opportunity

Mammographic sensitivity can drop to as low as 50% in extremely dense breasts (Category D), compared to nearly 90% in fatty breasts (Category A).

Top: Screening 2021, Bottom: Screening 2024

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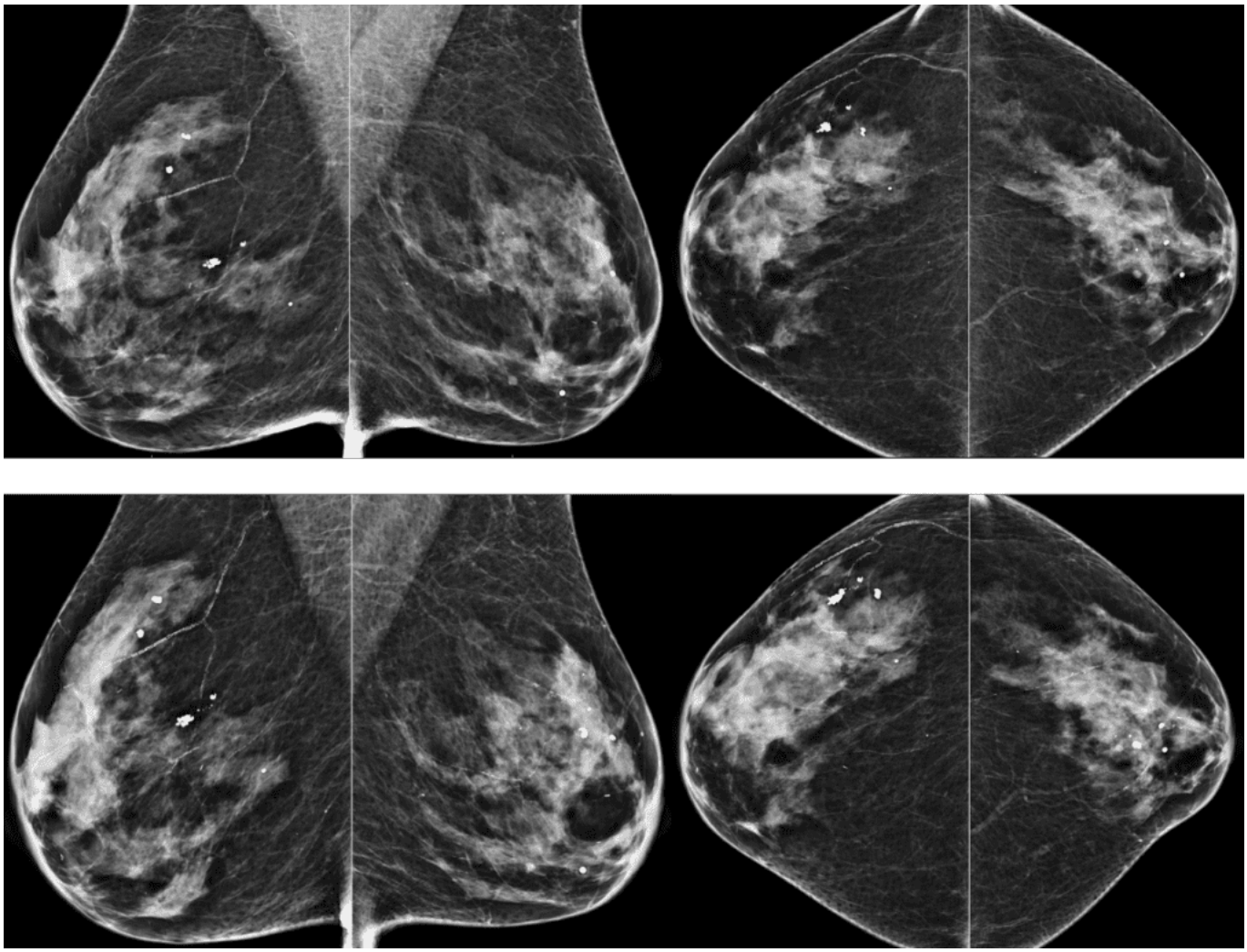

False Negative in Dense Breast

Cancers detected by supplemental screening whole-breast ultrasound are often invasive, however small and node negative, indicating they are found at an early, more treatable stage.

Post-biopsy reflector. Right breast, 7:00.

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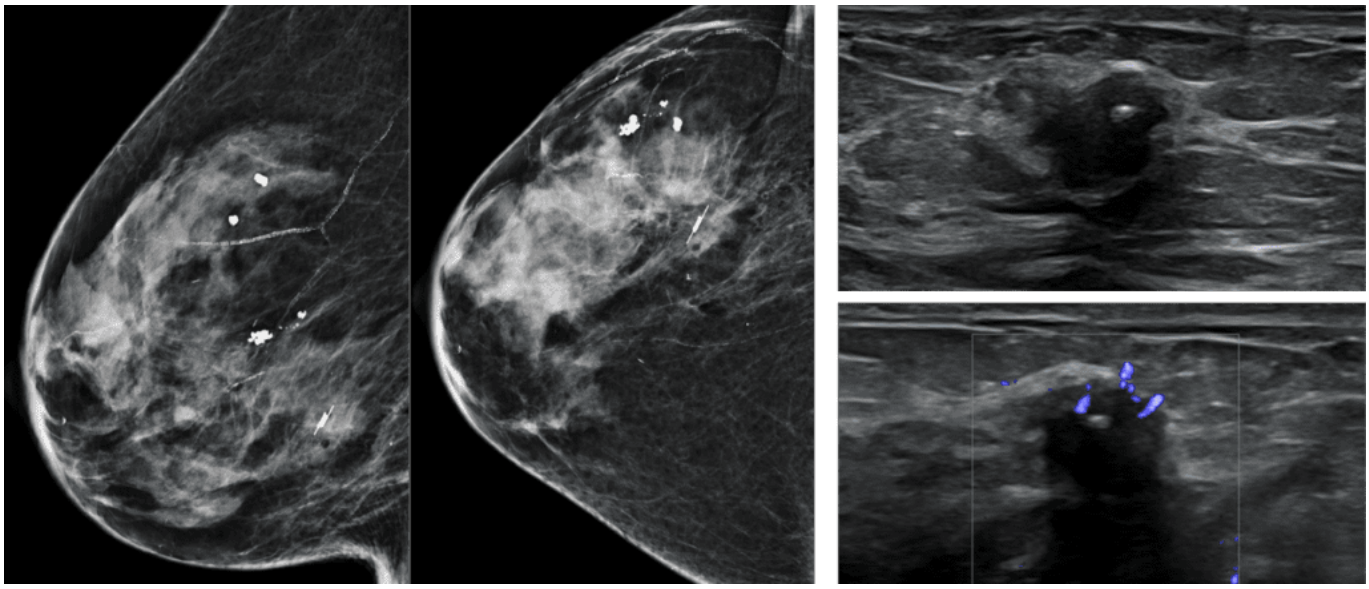

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Practical Insights

- **Breast density is an interdependent risk factor for breast cancer.**
- **Supplemental breast ultrasound can detect an additional 2-4 cancers per 1,000 women screened with dense breasts.**
- **Ultrasounds have a high false positive rate. The positive predictive value is 5-10% (compared to 25-40% for mammography).**
- **Women with dense breasts and other risk factors (e.g., strong family history, genetic mutations) may benefit most from supplemental MRI.**

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- **Contrast-enhanced mammography is a promising alternative for dense breasts.**

In dense breasts, US can find additional clinically significant cancers.

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Rad to Rad Learning: Carotid Cavernous Fistula

The Radiology Partners (RP) Neuroradiology National Subspecialty Division (NSD) presents our newest Rad to Rad Learning case.

Peer Learning Opportunity

Permanent vision loss is seen in 10-20% of untreated cases. Intracranial hemorrhages or venous infarctions are seen in 5-10% of cases.

Carotid Cavernous Fistula

- **Asymmetric enhancement of left cavernous sinus and dilated left superior and**

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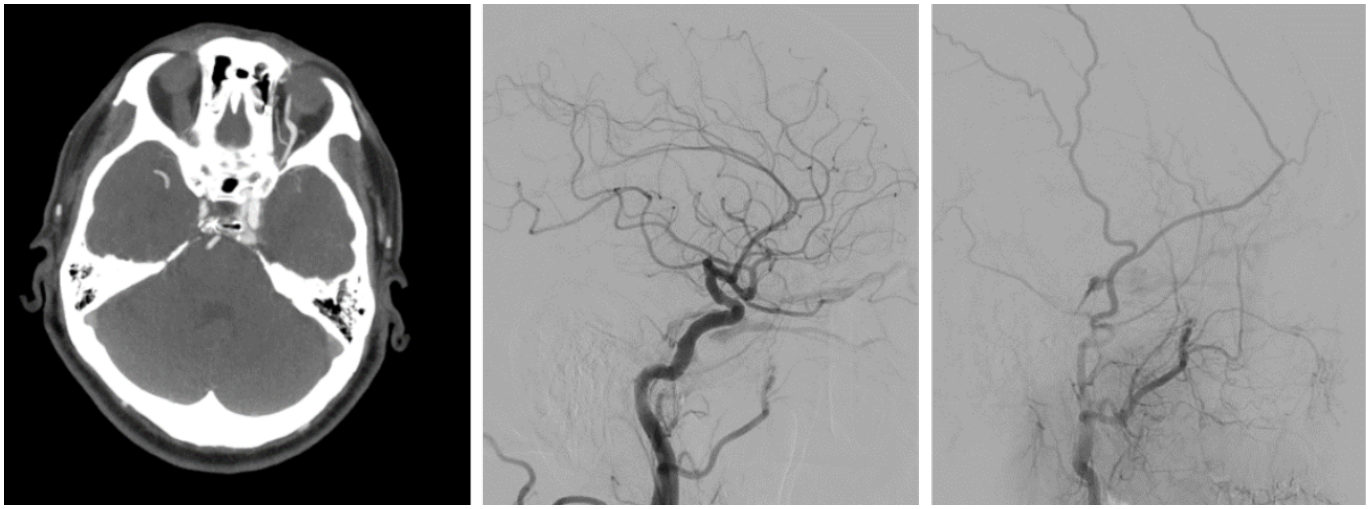
inferior ophthalmic veins in arterial phase.

- **Type D Fistula is supplied from branches of external carotid arteries**



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Practical Insights

- **Classic clinical triad of pulsatile proptosis, orbital bruit and conjunctival chemosis is often incomplete.**
- **Cortical venous reflux indicates high risk of hemorrhage.**
- **High-flow (Type A) CCF are often traumatic, develop abruptly and have worse**

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prognosis.

- **Up to 70% of low-flow (Types B, C, D) may resolve spontaneously.**
- **Cranial Nerva palsies II, IV, and VI are often reported.**

Dynamic MRA or CTA initially, DSA for confirmation and treatment planning.

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Rad to Rad Learning
Focused tips from our experts

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Rad to Rad Learning: Post-Bariatric Surgery Complications

The Radiology Partners (RP) National Quality and Safety Committee presents our newest Rad to Rad Learning case.

Peer Learning Opportunity

Bariatric surgeries have a high incidence of varied complications, such as staple line dehiscence, perforation, obstruction, vascular occlusion and postoperative volvulus.

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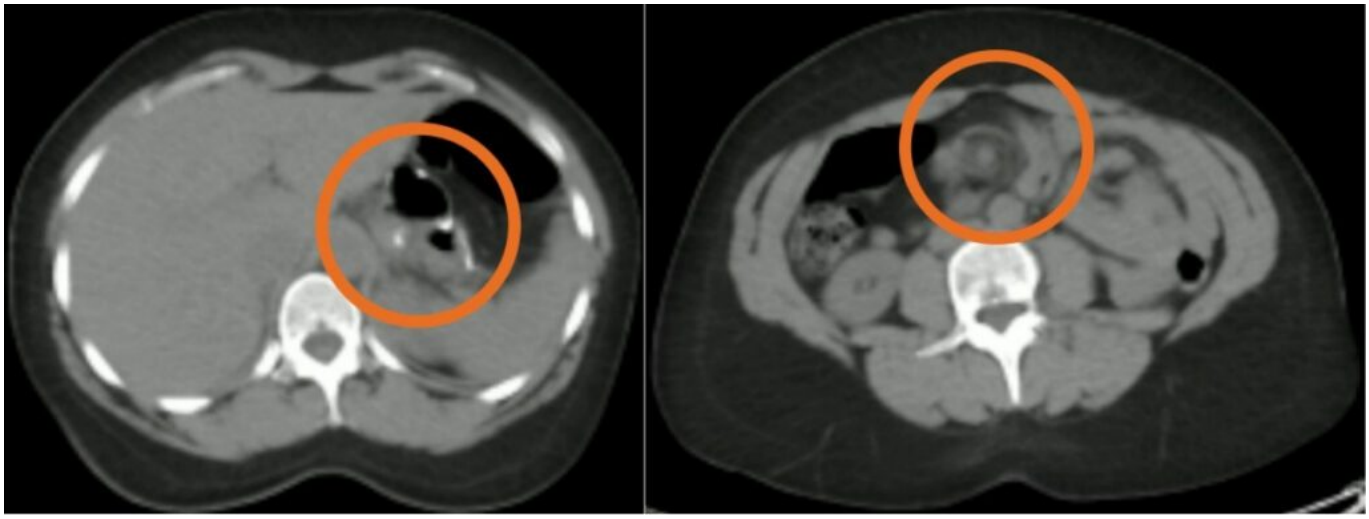
Post-Bariatric Surgery Complications

Distinctive mesenteric vessel “swirl” visible with postoperative volvulus.



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Practical Insights

- **Particular attention should be paid to the integrity of the staple line, condition of the bowel and patency of mesenteric vessels.**
- **Knowledge of typical post-operative anatomy is essential for accurate interpretation.**

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These studies should be performed with oral and intravenous contrast unless contraindicated.

Recommend oral and intravenous contrast on bariatric surgery patients.

The National Quality and Safety Committee is part of RP's Clinical Value Team, which works to elevate patient care and enhance value through innovation, collaboration and education. To advance this goal, our radiologists and advanced practice providers are committed to sharing peer learning as valuable reminders and insights about what we encounter in our day-to-day practice. Check back here and on X, LinkedIn and Instagram to see these common cases and our findings.

Visit the Clinical Resources page for more cases and to see what we've developed to enhance best practice recommendations, elevate image quality and patient care and update current standards throughout RP's network of practices, all to deliver excellent radiology services to patients, referring clinicians and client partners.

Radiology Partners, through its owned and affiliated practices, is a leading physician-led and physician-owned technology-enabled radiology practice in the U.S. For the latest news from RP, follow us on X, LinkedIn, Instagram, YouTube and the blog.

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Rad to Rad Learning: Implant Obscured Mass

The Radiology Partners (RP) Breast Imaging National Subspecialty Division (NSD) presents our newest Rad to Rad Learning case.

The Breast Imaging NSD is part of RP's Clinical Value Team, which works to elevate patient care and enhance value through innovation, collaboration and education. To advance this goal, our radiologists and advanced practice providers are committed to sharing peer learning as valuable reminders and insights about what we encounter in our day-to-day practice.

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Clinical Pathway: Dementia Imaging

Radiology Partners recently created a Dementia Imaging Clinical Pathway.

Drawing on their extensive expertise, RP's national subspecialty division (NSD) advisory boards for both neuroradiology and nuclear medicine and molecular imaging (NMMI) collected practical guidance for dementia imaging, interpretation and reporting. This reference material is geared to serve practicing radiologists when establishing dementia programs at their institutions.

Dr. Igor Mikityansky serves as RP's national subspecialty lead (NSL) for neuroradiology, and Dr. Nathan Gee serves as NSL for NMMI. Both NSLs partner with advisory boards made up of practicing radiologists in their subspecialties to spearhead the development and implementation of programs with a mission to enhance clinical value and quality in imaging across RP. They focus on refining best

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practice recommendations, advancing image quality and aligning with the latest industry standards, all to deliver innovation and excellence in radiology services for patients, referring clinicians and client partners, and they share resources, like this clinical pathway, broadly so that all practices can deliver high-quality subspecialty care to patients in their communities.

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Clinical Pathway: RP's Clinical Value Team presents best practices for breast biopsy clips

Radiology Partners (RP) recently created a Breast Biopsy Clip Clinical Pathway.

Drawing on their extensive expertise, the practicing radiologists of RP's national subspecialty division (NSD) for breast radiology developed practical guidance for breast biopsy clips. This resource includes

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guidelines for breast biopsy clip documentation, a breast clip education handout for patients and clip shape resources.

See a summary one-pager on the breast clip lifecycle and breast biopsy clip placement patient handout.

Dr. Dana Bonaminio leads RP's NSD for breast radiology. In partnership with an advisory board of practicing breast radiologists, she spearheads the development and implementation of programs with a mission to enhance clinical value and quality in breast imaging across RP. The Breast Imaging NSD focuses on refining best practice recommendations, advancing image quality and aligning with the latest industry standards, all to deliver innovation and excellence in radiology services for patients, referring clinicians and client partners. They share resources, like this clinical pathway, broadly so that all practices can deliver high-quality subspecialty care to patients in their communities.

"Actively participating in patient care and contributing to the early detection of breast cancer and other breast-related issues is a great honor," said Dr. Bonaminio. "Encouraging patients to take an active role in their breast health is empowering. I thoroughly enjoy working collaboratively to ensure the overall best outcome for each patient."

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