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International

Thermology 2012 - literature survey

Thermal Changes after IUD Insertion

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Viscero-cutaneous reflexes in relation to abdominal and pelvic pain. A study from 1982 in females with IUD insertions

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SUMMARY

OBJECTIVES: The aim of this study was to establish whether there is a relationship between a specific area of the abdominal wall and the uterus as the accompanying organ.

The null hypothesis in this study was: the uterus has no specific area of skin which relates to viscero-cutaneous reactivity. The study had to take place in a G.P.'s practice, and had to comply with strict medical ethics requirements (a medical ethics review board did not exist at that time), particularly the study must not constitute any risk or cause any discomfort to the participants.

STUDY DESIGN: The target group consisted of 31 healthy women between 20 and 45 years of age who wanted an IUD inserted or replaced. The study took place in a G.P.'s practice where IUDs had already been inserted over a period of many years.

INTERVENTION: The IUD-insertion procedure was not changed during the study. After oral consent had been obtained from the patient, infrared thermographic images were recorded of the abdominal wall immediately before and after IUD insertion.

STATISTICS: The average temperatures of four areas were measured and analysed in 1982 and 2012 with the Wilcoxon Signed Rank test.

RESULTS: There is one specific area where the skin temperature changes significantly more than elsewhere ($p<0.001$). This area is the same area as the one in which temperature changes have been measured in a study with pregnant women.

CONCLUSIONS: The null hypothesis must be rejected. This study shows the potential of mapping 'referred zones' with infrared thermography. The findings also question abdominal wall pain as an independent disease entity. Changes of inner organs should be considered as cause of abdominal wall pain.

KEYWORDS: Chronic pain, infrared thermography, abdominal wall pain, pelvic pain.

DIE RELATION VIZZERO-KUTANERS REFLEXES ZU ABDOMINALEN UND BECKENSCHMERZEN. EINE STUDIE IM JAHRE 1982 MIT IUD-VERSORGten FRAUEN

ZIEL: Ziel der Studie war es zu zeigen, ob ein reflektorischer Zusammenhang zwischen einem bestimmten Gebiet der Bauchwand und der Gebärmutter besteht.

Die Nullhypothese in dieser Studie war, dass die Gebärmutter in keinem speziellen Bereich der Haut viszerokutane Reaktivität entwickelt. Die Studie musste in der Praxis eines Allgemeinmediziners durchführbar sein und strenge Anforderungen der medizinischen Ethik erfüllen, da eine medizinischen Ethikkommission zu dieser Zeit (1982) nicht existierte. Insbesondere durfte die Studie weder ein Gesundheitsrisiko noch ein Unbehagen bei den Teilnehmern verursachen.

STUDIEN-DESIGN: Die Zielgruppe bestand aus 31 gesunden Frauen zwischen 20 und 45 Lebensjahren, die eine erstmalige Versorgung mit oder den Ersatz einer vorhandenen IUD (Spirale) wünschten. Die Studie fand in Praxis eines Allgemeinmediziners statt, in der Frauen bereits seit vielen Jahren mit IUD versorgt worden waren.

INTERVENTION: Das Verfahren zur Versorgung mit einer intrauterinen Spirale wurde während der Studie nicht verändert. Nach Erklärung des mündlichen Einverständnisses zur Teilnahme an der Studie, wurden vor und unmittelbar nach der Versorgung mit einer IUD Infrarot-Wärmebilder der Bauchdecke aufgenommen.

STATISTIK: Die Durchschnittstemperatur wurde in vier Bereichen der Bauchdecke gemessen und die Daten in den Jahren 1982 und 2012 mittels Wilcoxon Rang Test analysiert.

ERGEBNISSE: Es fand sich eine spezifische Region, in der die Hauttemperatur signifikant deutlicher variierte als irgendwo sonst ($p<0.001$). Dieses Hautareal ist dasselbe, in der auch in der Studie mit schwangeren Frauen Temperaturänderungen beobachtet worden waren.

SCHLUSSFOLGERUNG: Die Null Hypothese musste abgelehnt werden. Diese Studie zeigt das Potenzial der Infrarot-Thermografie zur Darstellung von "Reflex-Zonen" auf der Haut. Die Ergebnisse stellen auch den "Bauchdeckenschmerz" als eigenständiges Krankheitsbild in Frage. An Veränderungen von inneren Organen sollte als Ursache von Bauchdeckenschmerzen gedacht werden.

SCHLÜSSELWÖRTER: Chronischer Schmerz, Infrarot-Thermographie, Bauchdeckenschmerz, Beckenschmerz

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Introduction

When abdominal pain symptoms are present, first of all causes are sought in the abdomen itself; although there is increasing interest in the abdominal wall as an independent source of myofascial or other pain. Looked at from the point of view of segmental embryonic development, that can only be part of the truth.

Segments

As early as 1886, Head [1] described areas of skin with increased sensitivity on non-damaging stimulation. This sensitivity was redefined in 1979 [2]. Head demonstrated the segmental nature of these areas, which was confirmed by others [3,4]. A segment is the total area, innervated by a spinal nerve [5]. Head postulated that there is a relationship between these areas and internal diseases. This explains 'referred pain.' In the same way, visceral changes can trigger vascular activity in the skin. In view of this, a correlation between 'referred pain' and local skin temperature was presumed and even between skin temperature and internal disease [6].

Skin temperature

In 1954, the results of studies with contact thermometry were described [7,8]. Skin temperature in segmental zones, related to pain, was almost always lower in their study groups than in other skin areas. Contact thermometry was also used later in the diagnosis of different medical situations [9,10].

Contact-free infrared thermography does, however, have the advantage of the skin temperature not being affected by the measuring instrument. [11]. Furthermore, it offers the possibility of carrying out observations on different large areas of skin at the same time [11,12]. Nerve root irritation [13] and sympathetic dysfunction [14] are accepted as the cause of a change in skin temperature.

The scope of the study

The question here is whether visceral changes can be established by a change in the skin temperature of the accompanying segmental zone. If these changes can be found, the question can be asked whether they can be explained by temperature conduction or radiation, instead of by segmental, neural connections.

Another question, not answered here, is whether a relationship between visceral and referred pain and visceral changes can be established by means of thermography. It is true that pain is also experienced by the skin in visceral conditions, and such pain is different from visceral pain. However, it remains unclear whether this pain is actually generated in the skin or only experienced in it.

Development of diagnostics and therapy in abdominal pain symptoms (1962-2012)

In 1962, a text book was published which brought together the knowledge on this subject collected at that time [4]. Over the years, the interest in the myofascial aspect of metamericism in particular has increased [15,16,17,18,19]. It is an established fact that the costs of abdominal pain syndrome are high [20,21], on the one hand due to the frequent occurrence of the condition, and on the other due to its

multidisciplinary nature and the difficult diagnostics and the costs of abdominal procedures (22,23).

The main problem was and is the difficulty of establishing a causal relationship between pain and the condition found. That asks for a simplified way of diagnosing and treating the condition. Carnett's sign (24,25,26,27) and the reduction of pain after local anaesthesia (28) are increasingly being seen as proof of the absence of visceral processes. Abdominal pain is then seen as an independent myofascial entity. Theoretically - supported by extensive literature - (4) and later research (29), that cannot be correct. The viscera are connected via reflex pathways with the central nervous system, the muscles, the skeleton and, not to be forgotten, the skin. Vice versa these organ systems influence each other. Until 1981, this viscero-cutaneous and cutaneous-visceral activity had never been established experimentally *in vivo* in man. The proof relied on animal studies and indirect verification.

A study carried out in pregnant women (30) indicates the existence of viscero-cutaneous skin reactions in human pregnancy. After 1995, very little research has been carried out into pain transfer via viscero-cutaneous reflex pathways.

Aim of the study

This study describes an experimental hypothesis-testing study in man *in vivo* into the existence of viscero-cutaneous reflex pathways. The study was carried out in 1982 and has not been published before. The aim was to investigate whether, in spite of the literature against it, abdominal wall pain could indeed be an independent entity.

The null hypothesis in this study was: the uterus has no specific area of skin which relates to viscero-cutaneous reactivity.

Study Conduction

In 1925, cutaneous-visceral activity was demonstrated in glass eels by stimulating the skin (31). The blood flow in the viscera changed. Therefore, conversely, the blood flow in the skin was selected as the parameter for viscero-cutaneous activity. Since the sixties, it has been possible to measure the blood flow of the skin with non-contractile infrared thermography with an absolute accuracy of 0.1 °C. For the study a sufficient number of volunteers from general practice were needed.

Ethics

For ethical reasons a study or treatment should only be carried out if it is commonly used in general practice, should involve no extra discomfort or risk for the volunteer and would not require any recruitment to be carried out. The solution was found in the group of women who wanted to use an intrauterine device (IUD) as a method of contraception. They were found in a general practice where IUDs had been inserted for years and there was therefore ample experience of inserting them. The IUD-insertion procedure was not changed by the study. Infrared thermography was added after this had been explained orally to the patients and their consent had been obtained.

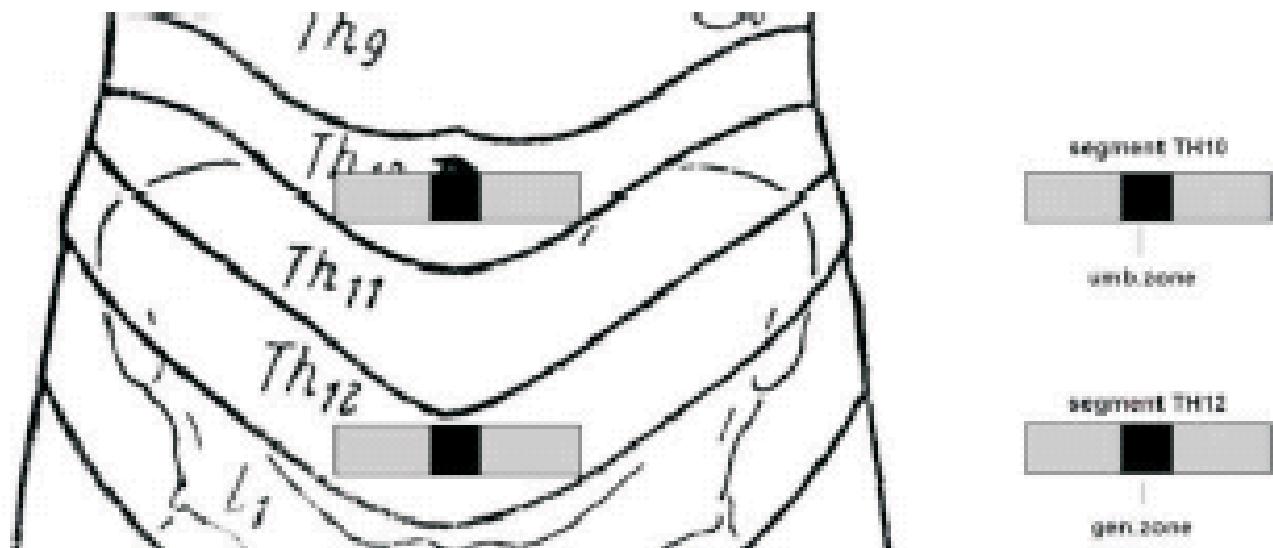


Figure 1

The entire rectangle is the area measured 'segment Th10'. The 'Umb. zone,' referred to as the navel zone in the text, is the black part. The same applies for segment Th 12 and the 'gen. zone' (genital zone). These zones are the same as those used in the literature.

Then the average temperature of four areas of the abdominal wall was measured immediately before and after IUD insertion. In 10 women (Phase I) thermistors were attached to the abdominal wall. Then continuous measurement was carried out for 15 minutes. The participants were informed about this orally and in writing. Written informed consents did not exist at that time, nor did medical ethics committees. The Declaration of Helsinki was followed.

Method

There were three phases in the total study.

Phase I: Control at the correct measurement sites
The control group consisted of 10 healthy volunteers who wanted an IUD inserted (N=5) or replaced (N=5). They were between 20 and 45 years of age. The skin temperature was measured at the standard areas for up to 15 minutes after IUD insertion. The data were collected with 4 contact thermistors with a 1.5 second interval. Via an interface they were connected to an 800 XL Atari PC. YSI [Yellow Springs Instruments] specifications were used. (YSI 43 TD). A KIPP plotter was connected for the results. The sensitivity of the system was 0.1 °C.

Phase II: insertion of IUDs

Phase III: Control on conduction/radiation

14 experiments with a healthy volunteer, whose skin in the region above the stomach was measured after she had consumed hot drinks or ice-cream. The temperature variation was in the range of +50 °C to -18 °C. The genital zone, the gall bladder region and the forehead were used as reference points. An infrared thermometer (Heiman KT 41, 1 channel) was used in 3 experiments for continuous measurement; intermittent 4-channel recording in 11 experiments. Control experiments without taking in fluid were also carried out.

Population

The Phase II study group consisted of 31 healthy women aged between 20 and 45. 15 of them had not had an IUD



Figure 2
Philips Thermo graph, 1980 modification

previously. In 16 of them the IUD was being replaced. In all cases a 'Copper T' was inserted.

Technique of infrared imaging

The measurements were carried out with a Philips Thermo graph, 1980 modification (Fig. 2), on 4 sites on the skin of the abdomen (Fig. 1.) The measurements were recorded from the display screen in real time on diapositive film (18 DIN) immediately before and immediately after IUD insertion. There were no facilities for electronic data storage.

An area of 5 x 5 cm was used as the core measuring area, in the middle of the lower abdomen, directly above the pubic hairline. This is the area in which pain is often reported in gynaecological conditions. It is known in the literature as the 'genital zone' (4). It was compared with an area of the same size and the upper limit of which was the navel, further referred to as the 'navel zone,' a larger area 25 x 5 cm above the pubic hairline of the same dermatome, further

referred to as 'segment Th12' and a comparable area with the navel as the upper limit, referred to as 'segment Th10.' It was accepted that the outcomes of segment TH12 were influenced by those of the 'genital zone.'

Measuring was always carried out in the same room under standard conditions with a standard room temperature: 21° C, standard humidity and active air-conditioning (32). The humidity was monitored with a Thies Clima Hygrothermograph 01777; accuracy 0.5 °C. Targeted dynamic air-conditioning was used for 30 seconds with a wall ventilator at a distance of 2 metres, followed by three minutes of adaptation.

Statistics

Statistical analysis was performed with the software R-2.13.2. The Wilcoxon Rank test was used because the conditions of the normality of the differences (for example between Δt gen and Δt Th12) were not always complied with and the number of observations was small.

Results

Phase I

The temperature graph showed a maximum effect 5-10 minutes after starting the IUD procedure. No further increase was seen. (Fig.3)

Phase II

Before IUD insertion.

In the case of first-time insertion: no significant differences between the skin areas to be measured. In the case of replacement: very weak significance of the genital zone compared with the navel zone. ($P<0.03$) Otherwise, no significant differences.

For the temperature differences (Δt) before and after insertion, the two groups were therefore added together.

After insertion the navel zone ($P=0.03$) and segment Th10 ($P=0.02$) also rose in temperature.

Wilcoxon-Test

The average change in temperature as a result of the insertion of the IUD was significantly greater in the genital zone than in the navel zone (0.47 degrees Celsius, 99% CI 0.21 to 0.73, $p<0.001$).

The average change in temperature as a result of the insertion of the IUD was significantly greater in segment Th12 than in segment Th10 (0.3 degrees Celsius, 99% CI 0.09-0.52).

Although all the areas of skin measured rose in temperature on insertion of an IUD, the temperature of the genital zone increased significantly more ($P<0.001$).

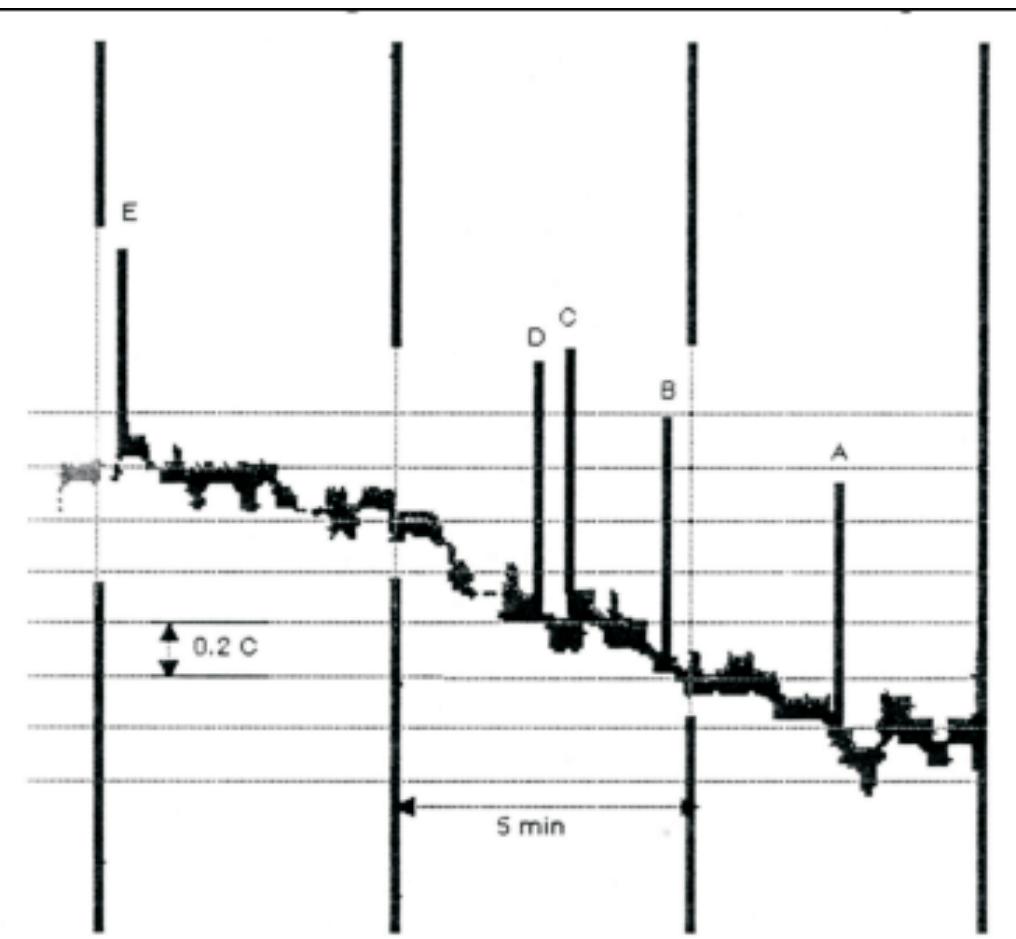


Figure 3

A. Start of the insertion procedure, B. Clamping of the uterus, C. Insertion of the IUD, D. Removal of the cervical clamp E. End of the procedure

Table 1
Temperatures measured before and immedeately after IUD insertion

Gem A (Gem Δt - gen)	0.73	Gem A (Gem Δt - gen)	0.73
Gem B (Gem Δt - Th12)	0.46	Gem C (Gem Δt -umb)	0.26
n= number of observations	31	n= number of observations	31
Gem A - Gem B	0.27	Gem A - Gem C	0.47
Std dev Gem A -Gem B	0.28	Std dev Gem A -Gem C	0.53
Confidence interval	0.06-0.34	Confidence interval	0.21-0.73
P-value (Wilcoxon)	<0.001	P-value (Wilcoxon)	<0.001
Gem C (Gem Δt - umb)	0.26	Gem B (Gem Δt - Th12)	0.46
Gem D (Gem Δt - Th10)	0.16	Gem D (Gem Δt - Th10)	0.16
n= number of observations	28	n= number of observations	28
Gem C - Gem D	-0.1	Gem B - Gem D	0.30
Std dev Gem C -Gem D	0.229	Std dev Gem B -Gem D	0.40
Confidence interval	-0.11-0.13	Confidence interval	0.09-0.52
P-value (Wilcoxon)	0.464	P-value (Wilcoxon)	<0.001

Gem A is short for Gem. delta t genital zone; Gem B idem for Gem. delta t segment Th12;
Gem Cidem for Gem. delta t umb zone; Gem D idem for Gem. delta t segment Th 10. [Gem = average]

“n=number of observations” is the maximum number of observations which could be included in the calculation.

There was a significant difference in temperature between the genital zone and segment TH12 (0.2 0 Celsius, 99% CI 0.06-0.34, P<0.001), , but not between the navel zone and segment TH10. (0.01 0 Celsius, 99% CI -0.11 to 0.13, p=0.464).

Phase III:

There was a slight reaction in the area of the stomach but no reaction in the reference areas. After ice-cream there was a slight rise in the skin temperature (0.3-0.4 °C).

After hot drinks there was no reaction or a slight drop in temperature. A slight drop was sometimes found in the control experiments.

Discussion

Small rises in skin temperature were found in almost all IUD experiments, particularly in the genital zone. These occurred a maximum of 10 minutes after the start of the procedure. The results of the intermittent 4-channel recording therefore also justify the measurement just before and just after the insertion procedure. The temperature increase is difficult to explain by conduction, convection or an induced change in the temperature of the uterus. Anatomically the uterus does not lie against the abdominal wall. The medium for this is not isotropic and homogeneous, there is a question of flow and the temperature differences are very small. Nor do the phase III experiments give any indication in this direction.

The relationship between the area of the uterus and the genital zone may therefore be causal in nature. Whether this effect is the result of manipulation or local nociception or both still needs to be clarified.

Skin temperature cannot only be influenced by central pain mechanisms in relation to nociception. Stress and emo-

tions also do this. The central mechanisms, involved in acute pain, may be responsible as far as the part of the total body temperature change is concerned.

The drop in temperature in some volunteers may be the result of total and local skin reactions possibly mediated by prostaglandins.

In previous study [30] the relationship between the skin temperature of the genital zone and a pregnancy was established. In this study it was the relationship between the uterus and the genital zone. From this it can be deduced that the functional condition of the uterus can be visualized with infrared thermography by measuring the temperature of the accompanying skin segment, probably via viscero-cutaneous reflex pathways.

Pain transfer can also take place via this route, even if that has not been established in this study. The experience of pain in the skin is not by definition the same as the generation of pain in the skin. Later studies [33] confirm the outcomes described. But these studies too do not give a full explanation of the transfer of pain via these reflexes. The transfer of pain to 'referred zones' is assumed by the pattern of pain experienced: sharp and circumscribed instead of vague and diffuse. The same happens when clamping the cervix: a sharp, circumscribed pain in the genital zone instead of a diffuse, vague pain. Pain generation was not investigated.

Closer investigation with elimination of the cutaneous element by means of local anaesthesia of the dermatome should be able to remove this uncertainty.

Conclusions

The null hypothesis of this study should be rejected. There is a relationship between the uterus and the genital zone.

A change in skin temperature can be found in an accompanying segmental zone in IUD insertion. Viscero-cutaneous reflexes may be (also) responsible for this.

Central pain-related mechanisms can influence the local temperature reaction. Conduction does not play a role in this.

The area found here, linked to the uterus segmentally, is the same as the area in which in a pregnancy too a significant rise in temperature occurs.

That means that abdominal wall pain may possibly have something to do with a process taking place in the abdomen. Carnett's test method and the elimination of an abdominal wall nerve are therefore not valid tests for ruling out problems with the abdominal contents.

The existence of organ-related skin areas, to be established by infrared thermography, in theory offers the opportunity for 'mapping' the abdominal organs.

That should be able to contribute towards cheaper, faster and less invasive diagnostics in the case of abdominal pain symptoms.

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Thermology 2012 - a computer-assisted literature survey

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SUMMARY

The literature survey 2012 is based on 1426 papers found in the databases MEDLINE and EMBASE with the keywords "thermography" or "thermometry" "temperature measurement" or "thermotherapy" or 'skin temperature' or 'core temperature' and restricted to "human" and "included in the databases between 01.01 and 31.12. 2012". 37.9 percent of papers of this review are originated from Europe and 95.3 percent of all papers are written in English. 238 controlled studies using some kind of temperature measurement were included in this survey. Pharmacology, Internal Medicine, Internal Medicine, Cancer and Neurology & Psychiatry were the predominant fields of applications of temperature measurement in medicine. As in previous years, therapeutic hypothermia and hyperthermia treatment was the topic of many papers. Fever attracted also a high number of publications. Although the term "breast cancer" appeared in 77 publications, only minority of those were related to breast thermography. Some articles were found for the complex regional pain syndrome and Raynaud's phenomenon.

KEY WORDS: Thermography, literature search, temperature measurement

THERMOLOGIE 2012 – EINE COMPUTER-GESTÜTZTE LITERATURSUCHE

Die Literatursuche für 2012 basiert auf 1426 Arbeiten, die unter den Schlüsselwörtern "Thermographie" oder "Thermometrie" oder "Temperaturmessung" oder "Thermotherapie" oder "Hauttemperatur" oder "Kerntemperatur" und den Einschränkungen "Mensch" und "zwischen 1. Jänner und 31. Dezember 2012 erfasst" in den Datenbanken MEDLINE und EMBASE gefunden wurden. Die Autoren thermologischer Publikationen kommen in 37,9 Prozent aus Europa, und 95,3 Prozent aller Arbeiten wurden in Englisch publiziert. 238 kontrollierte Studien, die irgendeine Form von Temperaturmessung einsetzen, wurden in diese Übersicht aufgenommen. Pharmakologie, Innere Medizin, Krebserkrankungen und Neurologie & Psychiatrie waren die vorherrschenden Anwendungsbereiche für Temperaturmessung in der Medizin. Wie in früheren Literaturübersichten, war die therapeutische Hypothermie und die Behandlung mit Hyperthermie das Thema vieler Veröffentlichungen. Auch Fieber erzielte eine große Zahl von Publikationen. Obwohl der Begriff "Brust" in 77 Publikationen erwähnt wurde, berichtete nur eine Minorität davon über Brustthermographie. Einige Publikationen wurden zum komplexen regionalen Schmerrzsyndrom (CRPS) und über das Raynaud-Phänomen gefunden und neue Anwendungen der medizinischen Thermographie wurden berichtet..

SCHLÜSSELWÖRTER: Thermographie, Literatursuche, Temperaturmessung

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Introduction

This year's annual survey is the 25th in a series that started in 1989. The aim of this regular annual publication is to survey the publications of 2012 related to thermography and temperature measurements in medicine.

Methods

A search in EMBASE and MEDLINE with the terms "thermology" or "thermography" or "thermometry" or "temperature measurement" or "thermotherapy" or "skin temperature" or "core temperature" and "year 2012" yielded 2835 hits. Table 1 shows the contribution of each search term to the results. Exchanging "year 2012" with "included between 01-01-2012 and 31-12-2012" reduced the number of hits to 2371. Further restriction with the term "human" yielded a further reduction to 1426 hits.

All 1426 hits will appear in the section "References" of this survey. However, the full list of 2371 references will be included in the reference collection of "Published papers on THERMOLOGY or TEMPERATURE MEASUREMENT between 2011 and 2012". This will become volume 4 of a collection of references related to thermology spanning the period from 1989 to 2012. They will be available from the webpage of Thermology international at "www.uhlen.at/

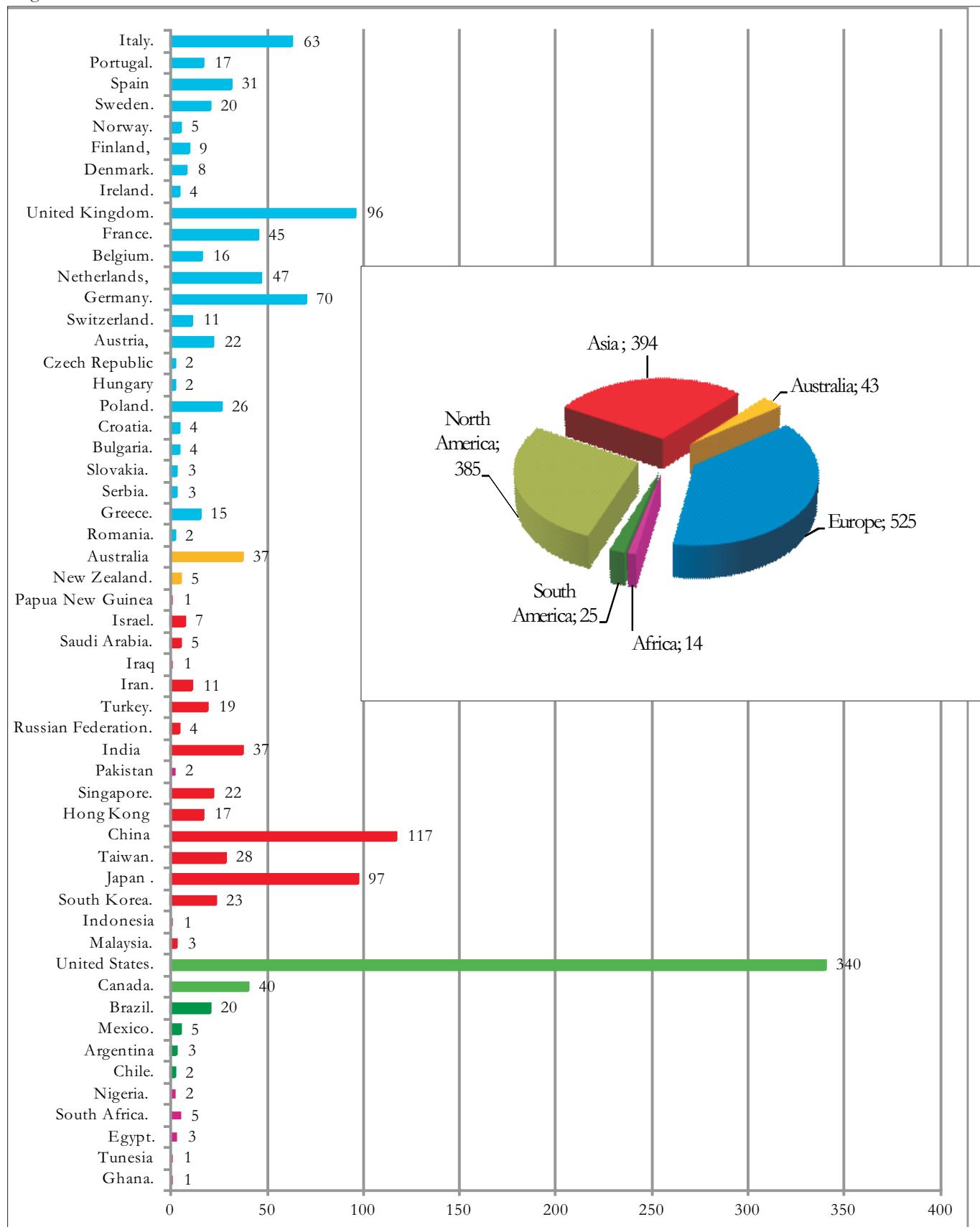
Table 1
Search terms and results

Combination of search terms	Hits
Thermology AND "year 2012"]	101
thermology OR thermography AND "year 2012"	403
thermology OR thermography OR thermometry AND "year2012"	414
thermology OR thermography OR thermometry OR "temperature measurement" AND "year 2012"	1419
thermology OR thermography OR thermometry OR "temperature measurement" OR thermotherapy AND "year 2012"	2116
thermology OR thermography OR thermometry OR "temperature measurement" OR thermotherapy OR "skin temperature" AND "year 2012"	2456
thermology OR thermography OR thermometry OR "temperature measurement" OR thermotherapy OR "skin temperature" OR "core temperature" AND "year-2012"	2835
thermology OR thermography OR thermometry OR "temperature measurement" OR thermotherapy OR "skin temperature" OR "core temperature" AND "included between 1-1-2012 and 31-12-2012"	2371
thermology OR thermography OR thermometry OR "temperature measurement" OR thermotherapy OR "skin temperature" OR "core temperature" AND "included between 1-1-2012 and 31-12-2012" AND "restricted to humans"	1426

Thermology international/ Publications on thermology and temperature measurement/ Volume 4". Volumes 1-3 of this reference collection can be accessed free of charge "www.uhlen.at/ Thermology international/Archives.

The papers were analysed to show the origin of authors, the language, and the journal and issue number of publication. For further classification, the Citation Report Database at Thompson Institute for Scientific Information

Figure 1
Origin of authors: countries and continents



(ISI) was searched to obtain the most recent Impact Factor for journals publishing papers related to the search profile in 2012. If a journal was not listed in ISI, the two years citation index, published by Scimago, was used instead.

Papers were allocated with respect to the topic of the publication. The filter option of EMBASE was used to differentiate the papers by focus of paper, disease, publication type and study type

Results

2374 publications were obtained with the search profile. Restriction to humans yielded 1426 hits of which 1326 publications were located in EMBASE and 102 in MEDLINE. 672 papers were listed in both databases.

Language of publication

All but 67 papers of this database were published in English (95.31%). 26 publications appeared in Chinese (1.82%), 15 papers were published in German (1.05%) and 10 in Spanish (0.70%). 6 papers each were written in French (0.42%) or Turkish (0.42%). The language in 4 papers each was Japanese (0.28%) or Russian (0.28%). 2 papers were written in Polish (0.14%), Portuguese (0.14%) or Croatian (0.14%). Bulgarian, Dutch, Serbian, Slovak, Swedish and Thai were the publication language in 1 paper (0.07% each).

16 publications appeared in two languages, English plus Chinese (2 papers) Croatian (1 paper), French (1 paper), Polish (1 paper), Portuguese (2 papers), Serbian (1 paper) Slovak (1 paper), Spanish (1 paper), Thai (1 paper) and Turkish (5 papers).

201 publications did not provide a summary. All of the remaining 1227 papers showed an abstract of the article in English. 31 articles were published with an additional summary in Chinese, 21 papers with an additional abstract in German. Abstracts in Spanish were provided in 10 papers and in French in 9 articles. 6 papers appeared with a summary in Turkish. 2 papers each published abstracts in Italian, Japanese, Polish or Thai. Bulgarian, Croatian, Serbian or Slovak was the language of the additional abstract of 1 paper each.

Authors

In total, 5892 authors appeared in 1426 publications. Prof Dr Joaquim Gabriel from the University of Porto, Faculty of Engineering appeared as co-author in 12 papers [1-12]. Liang P was found 11 times as corresponding author or co-author [13-23]. Han Z-Y 9 times as co-author [13-15, 17-21, 24]. Both latter authors work in the Department of Interventional Ultrasound, Chinese People's Liberation Army General Hospital in Beijing, China. P. H. Sugarmaker was author or co-author in 9 publications. X Li, E.F.J. Ring and A.A. Silva published each 8 papers, Z.-G. Cheng, E.A. Levine, J.S. Petrofsky and J.Yu authored each 7 papers. and K. Ammer, X. Liu, R. Vardasca, L. Wang, X. Wang and X.L. Yu appeared as authors of 6 publications. J. Allen, L. Berk, M.D. Fischer, J. Li, P. Piso, E. Schmutzhard, M. Sillero-Quintana, J. Wang, S. Wang and X. Yu authored each 5 papers. The names of 30 authors appeared in 4 papers and of 87 authors in 3 papers.

Research was performed in 1475 institutions located in 54 countries. 27.78% of these were situated in North America, the majority, i. e. 340, in the United States, 40 in Canada and 5 in Mexico. 37.88% of authors came from European countries, 96 of these work in the United Kingdom, 70 in Germany, 63 in Italy and 45 in France. 28.43% of authors are from Asia, 117 of these live in China (figure 1).

Journals

In total, 751 journals published papers related to the search profile. 16 journals published 80 to 8 papers related to topic of this survey. 80 publications were found in "Thermology international". Next in rank were "PLOS One" and the "International Journal of Hyperthermia" with 23 papers each. Table 2 lists the journal name, the number of papers of interest and the impact factor 2012. A mean impact factors of 2,620 was calculated for the 16 journals listed. The mean impact was derived from the cumulated impact factor of all 16 journals.

Type of publication

726 papers were classified as articles, 13 as article in press and 233 as review. 6 short surveys, 327 conference abstracts and 11 full length conference papers have been published. The remaining papers were classified as 60 letters, 24 notes, 21 editorials and 3 conference reviews.

Type of study

All 1426 papers have been related to humans. 117 reported findings in normal humans and 71 human experiments. 63 investigations conducted research on human cells and 44 on human tissue. 141 clinical articles and 131 case reports

Table 2

Journals that published more than 8 articles related to thermology in 2012

Journal	papers	Impact factor
Journal of Urology	8	3,696
Radiology	8	6,339
International Journal of Nanomedicine	10	3,463
Journal of Surgical Oncology	10	2,664
CardioVascular and Interventional Radiology	11	2,138
Journal of Thermal Biology	11	1,376
Surgical Oncology Clinics of North America	12	1,222
British Journal of Anaesthesia	13	4,237
HPB	13	1,939
Journal of Vascular and Interventional Radiology	14	2,002
Journal of Sleep Research	16	3,043
Critical Care	18	4,718
FASEB Journal	19	5,704
International Journal of Hyperthermia	24	2,591
PLoS ONE	24	3,730
Thermology international	80	0,818*

* Scimago two years citation index 2011

have been published. 66 randomized controlled trials and 151 major clinical studies have been reported. A controlled study was the theme in 283 papers, 60 prospective studies and 48 retrospective studies have been published.

128 papers were classified as non human studies, 101 publications reported models, 33 of these investigated animal models. 51 in vitro studies and 30 in vivo studies have been published.

Table 3
Papers allocated to medical fields

Medical field	Reference	Total number of allocated papers
Biochemistry	25-143	119
Cancer	13,14, 17,20-24, 144-394	300
Dermatology and Venerology	395-449	72
Genetics	450-453	16
Geriatrics and Gerontology	454-459	9
Internal medicine	460-622	341
Immunology and Haematology	623-652	70
Microbiology	653-667	42
Medical instrumentation	668-720	133
Neurology and Psychiatry	721-830	176
Obstetrics and Gynecology	831-850	56
Ophthalmology	851-863	39
Otorhinolaryngology	864-866	20
Paediatrics	867-888	85
Pathology and Forensic Science	889-900	51
Pharmacology and Pharmacy	901-929	488
Physiology and Endocrinology	18, 930-964	84
Public Health	965-980	143
Radiology and Nuclear Medicine	981-984	144
Rehabilitation	985-987	27
Surgery	988-993	136
Toxicology and Drug Dependence	994-996	12
Papers not allocated to a field	1-12,15, 16., 997-1426	445
Fever	13, 17, 20, 27, 34, 71, 101, 176, 207, 223, 244, 247, 270, 271, 284, 301, 301, 346, 365, 370, 403, 421, 455, 459, 463, 470, 471, 471, 499, 503, 504, 516, 556, 557, 564, 569, 578, 597, 606, 620, 627, 637, 640, 656, 658, 660, 663, 727, 734, 777, 809, 817, 822, 843, 850, 871, 880, 892, 895, 900, 924, 995, 997, 1021, 1042, 1043, 1047, 1068, 1112, 1118, 1126, 1133, 1165, 1183, 1187, 1207, 1245, 1248, 1253, 1255, 1264, 1304, 1305, 1306, 1313, 1329, 1335, 1350, 1354, 1368	91
Hypothermia, local & general	1,32,119,475,478,500,507,512,519,523,583,592,643,645,647,667,690,702,706,731,741,821,835,848,875,905,907,910,911,962,966,993,989,935,1006,1007,1042,1067,1092,1095,1115,1116,1188,1192,1194,1196,1201,1227,1245,1279,1280,1281,1292,1293,1295,1311,1327,1329,1330,1350,1365,1378,1379,1393,1406,1407,1427,1428,1429	84
Hyperthermia; local & general	27, 159, 193, 202, 211, 233, 244, 301, 311, 390, 446, 481, 667, 677, 713, 730, 777, 785, 793, 794, 806, 897, 903, 916, 932, 946, 962, 994, 997, 1043, 1050, 1062, 1083, 1092, 1112, 1114, 1144, 1184, 1201, 1215, 1225, 1228, 1264, 1287, 1307, 1329, 1364, 1394, 1417	49
Breast or Breast Cancer	37,115,139, 155, 226, 268,324,353,1172,145,202, 216,245,248, 256, 264,320, 1016,1202,1251,1426	77
Complex regional pain syndrome (CRPS)	27, 126,397,625,641,728, 729, 783, 786,787,823, 1052,1072, 1205, 1265, 1304, 1307, 1371	19
Raynaud's phenomenon	425,428,469, 480, 549, 612, 639,893, 1005, 1009, 1150, 1304, 1312, 139	16

Medical publications

The citations in MEDLINE and EMBASE are allocated to distinct fields of medicine. Usually, allocations to more than just one field are made. Table 3 shows in column 3 the total of references allocated to one field, whilst column 2 lists the reference numbers remained after exclusion of multiple allocations. Table 3 shows the allocations to fields of medicine. Pharmacology and Pharmacy was the most

frequent allocated speciality of medicine. Internal Medicine, Cancer and Neurology & Psychiatry were the next in frequency of allocation, followed Radiology & Nuclear Medicine, Public Health, Surgery, Medical instrumentation and Biochemistry. 445 paper publications were not allocated to a field. Some papers were found for Breast Disease, Complex Regional Pain Syndrome and Raynaud's Phenomenon.

The EMBASE filter "disease" obtained the following distributions (number of papers in brackets): fever (91), hypothermia (84), pain (66), hyperthermia (49), inflammation (48), bleeding (47), breast cancer (47), cancer recurrence (46), liver cell carcinoma (46), side effect (46), injury (44), colorectal cancer (42), neoplasm (42), heart arrest (40), postoperative complication (38), infection (35), diseases (33), metastasis (33), ovary cancer (33), shivering (33), advanced cancer (32), liver metastasis (29), carcinomatous peritonitis (27), hypertension (27) and nausea (27).

CRPS

Complex regional pain syndrome (CRPS) was the topic or keyword of 18 papers, 5 conference abstracts [1052, 1072, 1205, 1265, 1307], two case reports [397, 1371], two observational studies [728, 787], one note [783] one editorial [729], two clinical articles [786, 823] and five reviews [27, 126, 625, 641, 1304].

A clinical article from Germany stated, that "a classification by the initial skin temperature (primary warm or primary cold CRPS) seems more appropriate than the classification as type I or II, depending on the absence or presence of a nerve lesion" [786]. Based on the data from a multicenter study from South Korea, which was presented at the 6th World Congress of the World Institute of Pain in Miami Beach, FL, United States, the course of skin temperature varies a lot over time, for example the affected limb stayed hot for 12 months in approximately 10% of investigated patients [1265]. A note in the journal "Pain" expressed the need of objective measurements of physiological signs related to CRPS and proposed techniques of thermometry for the assessment of vasomotor abnormalities.

A prospective observational study, conducted in the Netherlands correlated response to sympathetic blockade in complex regional pain syndrome type 1 with skin temperature and sensory changes. The response rate was not different in patient groups with cold or warm type CRPS-1 or in those with more or less than 1.5°C differential increase in skin temperature after sympathetic blockade [728]. A series of patients with CRPS I, located on the upper extremity, responded in an uncontrolled observational study favourably to treatment with anti-inflammatory drugs and selected physical therapy modalities resulting in complete recovery in 32 out of 36 patients [787]. A case of an 8 years old haemophilic boy with CRPS located in the left ankle region, reported complete recovery to normal activities of daily life after 6 weeks of treatment with physical therapy [1371]. A paper reviewing effective medical and psychological treatment approaches and current trends in rehabilitation for patients with CRPS, mentioned that thermography has low specificity for diagnosis and prognosis [126].

A case report of a patient after herpes zoster infection based their diagnosis of CRPS I of the nasal area on a hypothermic area detected by thermography [397, 1205]. A presentation at the 12th European Conference of Thermology reported four indices derived from functional infrared imaging which support the identification of the actual stage of CRPS [1072]. Another conference abstract stated that thermography is a useful tool for assisting the diagnosis and monitoring treatment of CRPS patients [1307].

A review on the temperature of the human knee included data from patients with CRPS of the knee [625]. A paper from Germany reviewed the impact of elevated pro-inflammatory cytokines, increased neurogenic inflammation and auto-antibodies in the pathophysiology CRPS [641]. Last year's annual literature report on published papers on thermology and temperature measurement showed also a section on CRPS [27].

Raynaud's phenomenon

16 papers were found with the key word "Raynaud's phenomenon" 1 review [401] and 1 case report [403] were not relevant for the search profile.

1 review from Poland discussed the mode of action of physical therapy in angiopathies such as Raynaud's phenomenon [469], and another from Bulgaria the value of thermography in rheumatic diseases in which Raynaud's phenomenon was included [639]. A review on pathogenesis, diagnosis and treatment of Raynaud phenomenon mentioned thermal imaging as a technique that helps to differentiate primary Raynaud phenomenon from Systemic Sclerosis-related disease [893]. A highly accessed review, published in "Physiological Measurement", classified the detection of Raynaud's phenomenon with infrared thermal imaging as established method for vasospastic disease of finger arteries [1304].

A case report described the use of thermal imaging to monitor the effect of thoracic sympathectomy [480]. A study investigating blood pressure electrocardiographic parameters such as QT-QTc intervals during stellate ganglion block in patients with primary Raynaud's phenomenon monitored skin temperatures of both middle fingers with thermistors, but did not report any temperature measurements [612]. Three conference abstracts from the 12th European Conference of Thermology were related to Raynaud's phenomenon [1005, 1150, 1396]. 1 abstract reported the development of a clinical vascular optics measurement facility, where Connective Tissue Disease and Raynaud's phenomenon assessments, Specialist, Limb studies (i.e. amputation level, muscle compartment perfusion and venous physiology), Neurovascular Assessment and Burn Depth Assessment were performed [1005]. Another conference abstract investigated the application of a portable, low cost thermal imager for the assessment of finger temperature after hand cold challenge and found the device feasible in differentiation of vasospastic from non-vasospastic subjects, as long as standard procedures are strictly followed [1150]. An abstract from Japan evaluated the sympathetic blocking effect of phototherapy near the neck stellate ganglion, a potential treatment for Raynaud's phenomenon, by means of thermography [1396]. A paper,

presented at the 16th Conference of the Polish Association of Thermology, reported the daily variation of the longitudinal temperature gradient from the dorsal hand to the fingertip for a period of two to three weeks in 2 male and 1 female subjects. The author showed a large range of temperature variation from one day to the next, which may also vary at different time points of the same day [1009].

In a randomised controlled study, the average time to recover 50% and 70% of pre-challenge skin temperature was used as outcome measure for evaluates the efficacy of fasudil, a RhoA/Rho kinase inhibitor, to reverse cold-induced vasospasm in patients with Raynaud's phenomenon secondary to systemic sclerosis [549]. A systematic review from Bath, UK, reported the use of infrared thermography as an endpoint in therapeutic trials of Raynaud's phenomenon and systemic sclerosis. Thirty-two studies evaluating 654 patients with RP were assessed. Thermographic parameters showed agreement with clinical endpoints in therapeutic trials. [428]. Single oral dosages of 50 mg or 100 mg sildenafil increased resting skin temperature and resting skin blood flux in patients with primary Raynaud's phenomenon. Sildenafil at 100 mg, but not 50 mg, significantly reduced the 15°C local cooling induced decrease in skin blood flux compared to control [425, 1312].

Breast cancer

Out of 77 hits labelled with the key words "breast" or "breast cancer", only 21 papes were dedicated to either thermal imaging [145,202, 216, 245,248, 256, 264,320, 1016,1202,1251,1426] or thermotherapy [37,115,139, 155, 226, 268,324,353,1172].

A sequence of 300 thermal images recorded immediately after cooling a t the frame rate of 2 frames per second from cancerous and unaffected breast for 15 seconds, obtained longer temperature recovery times to baseline readings over cancerous tissue than in normal, unaffected tissue. These unexpected findings of high time constants must be confirmed in a large sample of breast cancer patients [256]. Chinese authors combined ultrasound imaging with thermal imaging for breast cancer detection and reported a diagnostic sensitivity of 95.35% and a diagnostic accuracy of 86.84% for the combined technique [264]. A study from Singapore used texture features from thermal images to generate an automatic system to diagnose breast cancer. A diagnostic sensitivity of 85.7% and specificity of 90.5% was achieved [145]. One extended abstract reviewed the role of infrared thermal imaging in breast reconstruction, particularly its use for detecting perforating blood vessels appropriate to nourish the tissue flaps used for breast reconstruction [1251]. A conference abstract reported a pilot study in which digital infrared thermal imaging was applied for the detection of axillary lymph node metastases [1016].

A systematic review from New Zealand did not find sufficient evidence to support the use of thermography in breast cancer screening or that thermography provides benefit to patients as an adjunctive tool to mammography or to suspicious clinical findings in diagnosing breast cancer [1202]. This review, accompanied with an editorial

[320], triggered a letter discussion between a retired general practitioner, who obviously believes in medical experience based on anecdotal cases [216] and the authors [202]. Another controversial discussion was conducted in the journal "Clinical Radiology". Authors from Zagreb, Croatia, criticized the conclusions drawn in British study on the value of breast thermography [245], which was included in the list of references of last year's literature review [27]. In their response the authors argued against the criticism of poor methodology that they have strictly followed the protocol of the manufacturer and pointed to difference between a clinical investigation and an animal study [248].

Japanese authors reported the case of 66 years old woman with local recurrence of breast cancer which was resistant to local radiotherapy plus chemotherapy. After adding hyperthermic treatment, a favourable outcome was achieved [139]. In another case report of 70 years old woman with skin metastasis due to breast cancer, cryo- surgery combined with hyperthermia resulted in reduction of the metastatic tumour. A group from the US showed that heat induced radiosensitisation is maximised if hyperthermia and radiotherapy are given simultaneously, with the radiation fraction delivered midway through a hyperthermia session. In 57 patients with locally advanced breast cancer, who received between four and eight sessions of simultaneous thermo-radiotherapy, two local and two nodal recurrences were observed within an average follow-up of 79 months [353]. A Dutch study reported high tolerance and clinical effectiveness of re-irradiation and hyperthermia in breast cancer patients with reconstructions [368]. A systematic review on radiation induced sarcoma of the breast mentioned hyperthermic treatment for this kind of tumour [324].

Ferromagnetic nanoparticles incorporated in human breast cancer cells (MCF-7) showed a higher heating efficiency than the superparamagnetic nanoparticles when exposed to an external magnetic field and death of cancer cells with high nanoparticle content was achieved [155]. Hyperthermic treatment based on gold-nanoparticles heated with near-infrared showed a deleterious effect on cancer cells in tissue cultures and animal experiments [115]. A study from US clearly demonstrated on cell cultures and animal experiments, that so-called breast cancer stem cells -which are assumed to initiate and promote tumour growth - are resistant against conventional hyperthermic treatment and become enriched in the surviving cell population cells following treatment. In contrast, these cells are sensitive to nanoparticle-mediated thermal treatment and lose their long-term proliferative capacity after nanoparticle-mediated thermal therapy [37]. A conference abstract reported the extent of thermal ablation of breast cancer tissue ex vivo induced by the use of laser-fibers at different power levels and exposure time [1172].

Hypothermia

An animal experiment supported the hypothesis that the transient receptor potential vanilloid 1 (TRPV1) ion channel has a role in hypoxia induced fall of core temperature [962]. Sarcoleptin, a newly identified regulator of the sarcoplasmic reticulum Ca^{2+} -ATPase (Serca) pump, is necessary for muscle-based thermogenesis under cold

conditions. Sarcolepin deficient mice have been unable to maintain their core temperature and died of hypothermia when exposed to a room temperature of 4°C for 10 hours [32].

Contractility of human colonic circular muscle strips increased in mean contractile amplitude by 20 and 19% at 36°C and 35 °C respectively, compared to 37 °C mean percentage of contraction. Response to acetylcholine was 40% at 36°C and 46% at 35°C compared to baseline response. After resetting the temperature to baseline value (37°C), the mean percentage of contraction and Acetylcholine response remained higher during the entire 30-min period of observation [1006, 1007].

In a swine model of brain injury, reflex hyperthermia occurred during the re-warming phase following prolonged hypothermia. In the recovery phase, maximum core temperature was $39.75 \pm 0.54^\circ\text{C}$ in previous hypothermic animals, which was significantly higher than $38.21 \pm 0.38^\circ\text{C}$ in normothermic control animals [1201]. An animal study in mice showed that tail temperature decreased but nose temperature did not decrease significantly during ketamine anaesthesia anaesthesia [1]. In a piglet experiment, intravenous doses of melatonin $>5 \text{ mg/kg}$ lead to hypotension following a hypoxic-ischaemic insult when combined with hypothermia [1188]. Induction of brief mild hypothermia increased but did not significantly prolong survival in a resuscitated rat model of large scald burns [1365].

Cooling of head and neck with a device kept at 4°C for 120 minutes, resulted in different changes of temperature at the forehead, tympanum and rectum (Table 4). Systolic and diastolic blood pressure increased immediately on cooling onset and rose by $15.3 \pm 20.8 \text{ mm Hg}$ and $16.5 \pm 13.4 \text{ mm Hg}$ after 120 minutes. Skin blood flow decreased significantly during cooling [519].

In a boating accident all 15 persons fell overboard and were immersed in 2 °C salt water, 1 man drowned, 5 male, and 2 female adolescents developed cardiac arrest due to hypothermia (mean core temperature: 18.4, range 15.5 to 20.2°C). 7 people - 1 male adolescent, 5 female adolescents, 1 young female adult - showed spontaneous circulation with a mean core temperature of 28.0 (range: 23.0-37.5)°C. The victims that survived the accident without circulatory arrest were predominantly females and had a higher body mass index [512]. Respiratory failure and spontaneous hypoglycemia during noninvasive re-warming from 24.7°C core body

temperature after prolonged avalanche burial was reported in 42 old, previously healthy male backcountry skier [119]. Infrared Thermography was found useful for the detection of hypothermia in subjects at high altitude [1379]. A review published in the New England Journal of Medicine provided information on patient's presentation, diagnosis, pre-hospital treatment, transport, rescue collapse and after-drop, in hospital treatment, modified versus standard advanced life support, serum potassium, outcome and accidental hypothermia in special situations such as trauma, avalanche burial without vital signs or drowning without vital signs [1428].

Hypothermia was prevented in sports students who wore gloves, a T-shirt and shorts and walked at 70% VO₂max for 1 hour in a climate chamber at 0°C ambient temperature and wind speed of 10 km/h. If the walking speed was reduced to 30% VO₂max additional clothing such as a cap, a windbreaker jacket and pants were necessary to prevent hypothermia [935]. Divers who suffer from spinal cord injury are in danger of hypothermia. A tetraplegic diver reduced his core temperature after 1 hour in pool water of 27.7°C by 3.0°C while the decrease of deep body temperature of a non impaired diver with similar body habitus was approximately 0.8°C [1116]. A conference abstract reported a study from Germany investigating the effects of different water temperatures (33°C, 36°C, and 39°C) on peripheral and core body temperature [1092]. Local hypothermia of the feet was detected by infrared thermography in an athlete whose feet were exposed to low environmental temperature during running [966].

Pre-hospital hypothermia was diagnosed in 44.6% of 21023 patients included between 2005 and 2009 into the Los Angeles County Trauma System Database. Hypothermic patients with increased transfusion and fluid requirement had subsequently worse outcomes [478]. Treatment with recombinant factor VIIa lead to survival in 31% of 45 trauma patients presented with the "triad of death" i.e. Coagulopathy, acidosis and hypothermia. Core temperature prior to factor VIIa therapy was $33.8 \pm 0.7^\circ\text{C}$ in survivors and $33.3 \pm 0.9^\circ\text{C}$ in non survivors [645]. A prognostic study from San Francisco, California confirmed that acidosis, hypothermia, coagulopathy or relative thrombocytopenia predicts hyperfibrinolysis with 100% sensitivity and 55.4% specificity [643]. At 32°C core temperature, mean platelet aggregation was mildly reduced to $93 \pm 25\%$ of baseline function at 37°C. Reduction of body core temperature to

Table 4
Temperature at the forehead, tympanum and rectum during head and neck cooling [519]

	forehead skin temperature	tympanic temperature	rectal temperature
Baseline	$37.3 \pm 0.3^\circ\text{C}$	$36.6 \pm 0.7^\circ\text{C}$	$36.7 \pm 0.4^\circ\text{C}$
immediately after cooling onset	$31.8 \pm 2.2^\circ\text{C}$	$34.9 \pm 1.2^\circ\text{C}$	
20 minutes	$24.9 \pm 3.2^\circ\text{C}$		
40 minutes		$31.8 \pm 1.2^\circ\text{C}$	
60 minutes	$28.5 \pm 3.5^\circ\text{C}$	$32.1 \pm 1.1^\circ\text{C}$	$36.5 \pm 0.3^\circ\text{C}$
120 minutes	$34.1 \pm 2.4^\circ\text{C}$	$33.3 \pm 1.0^\circ\text{C}$	$36.4 \pm 0.3^\circ\text{C}$

28°C or below resulted in a decline of platelet aggregation as low as 23 ± 12%. Impaired platelet function to 75 ± 28% aggregation was detected immediately after blood re-warming to 36°C [1280]. Ventricular fibrillations in a patient with infero-lateral early depolarization syndrome have been suspected to be caused by repeated episodes of hypothermia [1245].

186 out of 573 patients admitted to the intensive care unit at Southampton University Hospital, United Kingdom, had at least one incident of inadvertent hypothermia during a 6 month period [1406]. A study from Chile reported that the incidence of hypothermia was 2,7% in a cohort of 73 patients who underwent hip arthroscopy [647]. The latter paper started a small discussion about methods to avoid hypothermia during hip arthroscopy [989,1427]. A study from Brazil reported that obese female patients have higher peri-operative core temperature and a lower incidence of hypothermia compared with non-obese female patients during abdominal surgery with active forced-air warming [907]. A drop in core temperature was reported in preterm infants undergoing laparotomy for necrotizing enterocolitis Mean postoperative core temperature was 34.9°C [range:31.5-37.0] compared to 37.0°C (range: 35.8-38.0) prior to surgery [592].

A study from India reported no significant difference in the decrease of core temperature caused by the use of propofol or sevoflurane for general anaesthesia in patients undergoing transsphenoidal pituitary surgery [731]. Under sub-arachnoid anaesthesia, deflation of a pneumatic lower limb tourniquet did not result in a decrease of core temperature [1067] which was reported after tourniquet release under general or epidural anaesthesia. In contrary to these results, a study from South Korea reported decrease of body core temperature after deflation of the tourniquet in knee surgery. The reduction of body temperature was closely related to the duration of tourniquet inflation[905].

A review article on monitoring the postoperative period addressed hypothermia as one of the related challenges [507]. Another paper stated that hypothermia is a major cause of perinatal mortality [875]. A poster presentation at the Annual Congress 2012 of Royal College of Anaesthetists showed that adding temperature control to the World Health Organization surgical checklist 3 reduced the occurrence of postoperative hypothermia better than sole staff training [1279]. A CME (continuous medical education)- article reviewed publications on available methods for reduction of maternal and neonatal hypothermia during cesarean delivery [848]. Some papers were related to the prevention of hypothermia during surgery including pre-operative warming [911], covering children with cotton blankets and a warm forced-air blanket set at 43°C [1406], using either warmed intravenous fluid or forced air-warming prior to cesarean section under spinal anesthesia [835]. A systematic review reported the effectiveness of different active cutaneous warming systems to prevent intra-operative hypothermia [1295]. Intraperitoneal nebulization of ropivacaine prevented body core temperature reduction during laparoscopic surgery [1227]. The combination of good thermal insulation and conductive war-

ming prevented effectively peri-operative hypothermia during head and neck surgery [706]. Local insufflations of warm fully humidified CO₂ in an open surgical wound cavity increased the temperature of the surgical wound and prevented hypothermia better than conventional preventative techniques of peri-operative heat loss [475]. An American plastic surgeon criticized a publication of poor methodology [993]. The criticized authors compared the effect of warming methods during plastic surgery on patients comfort and complication rates to a historical control group, but as core temperatures were not measured in either group [1429].

Abnormal core temperature (hypothermia <36°C or hyperthermia >38,5°C) is one of two mandatory findings of the systemic inflammatory response syndrome and body temperature can be used to screen for sepsis of children in developing countries [667]. "ThermoSpots" are adhesive 12 mm stickers with liquid crystal compound embedded in the upper surface. These technology was used to detect successfully hypothermia in children with severe acute malnutrition, who were treated at the malnutrition ward of Queen Elizabeth Central Hospital, Blantyre, Malawi [702].

In newborn infants, therapeutic hypothermia reduced peripheral microcirculation which resolved totally after re-establishing normal core temperature [1095]. Hypothermia may occur as complication of cerebral magnetic resonance imaging in preterm infants at gestational age term-equivalent to 30 weeks [741].

In patients after cardiac arrest treated with mild therapeutic hypothermia, in-hospital mortality was significantly lower than in a historic control group without hypothermic treatment [1293]. Japanese authors reported potential benefits of hypothermia in comatose survivors of out-of-hospital cardiac arrest due to aneurysmal subarachnoid haemorrhage[1192]. 55 (64.7%) out of 85 initially comatose patients treated with therapeutic-induced mild hypothermia due to out-of-hospital cardiac arrest were either working full-time and independent of any social welfare or were unemployed, but able to work 1 year after the cardiovascular accident [1196].

German surgeons reported retrospectively the results of aortic arch reconstruction under mild hypothermia and antegrade cerebral perfusion in 426 patients [500]. Mild hypothermia achieved by intravascular cooling as compared to surface cooling resulted in a more rapid induction (100 vs 436 minutes) of target core temperature [1407]. Age, initial heart rhythm, duration of hospitalization and hypothermia associated complications were identified as the most important predictors of good clinical outcome in a group of 274 hypothermia-treated patients after survived cardiac arrest [1292]. A Dutch study reported that persistent abnormalities in sublingual micro-circulation and peripheral tissue perfusion were associated with organ failure and death in a group of 25 patients after out-of-hospital cardiac arrest treated with therapeutic hypothermia [523]. A conference abstract failed to demonstrate any significant short-term or long-term benefit for rectal cooling during robotic-assisted radical prostatectomy [1393]. Mild hypothermia decreased intracranial pressure and increased

cerebral perfusion pressure regardless to the type of brain injury. Therapeutic hypothermia did not able to improve the clinical outcome in patients with primary brain lesions, but significantly improved the outcome in patients with extracerebral haematomas [1115]. Possible limitations in performance of humidifiers was addressed in a review paper [583].

In newborn infants with hypoxic-ischemic encephalopathy target temperature of 33.5°C for therapeutic hypothermia was easily achieved by cooling with gel-pack and servo-controlled with a radiant warmer [690]. Therapeutic hypothermia is predominately monitored by oesophageal temperature probes. A study from Korea investigated the success rates and procedure time of different methods of insertion of the temperature device. The authors reported higher success rates on the first attempt and shorter procedure time with a novel procedure than with the conventional method [1281]. A letter reported two patients under therapeutic hypothermia in whom heat transfer from warmed tracheal tubes to oesophageal temperature probes resulted in overestimation of core temperature [821]. A study from Germany investigated the correlation, accuracy, precision and practicability of peri-operative measurement of sublingual temperature in comparison with tympanic membrane temperature in awake and anaesthetised patients. Sublingual temperatures were higher than tympanic temperatures by 0.1-0.2°C. The 95% limits of agreement between the two temperature measurements were in the range of -0.63 to 0.32 preoperatively, -0.51 to 0.32 intra-operatively and -0.55 to 0.37 postoperatively [910].

The open access journal "Critical Care" published a supplement with extended abstracts of a conference on "Update on Therapeutic Temperature Management". Various contributions were related to different aspects of hypothermia [1042, 1194, 1311, 1327, 1329, 1330, 1350, 1378].

Hyperthermia

Some papers reported physiological alterations caused by hyperthermia. Cutaneous vascular conductance defined as laser-Doppler velocimetry output in arbitrary perfusion units divided by mean arterial pressure and expressed as percentage of maximum, was altered only under high heat stress by postexercise ischemia and concurrent application of lower body positive pressure or lower body negative pressure challenges. The sustained elevations in sweat rate typically associated with postexercise ischemia under moderate or high heat stress were not affected by concurrent application of lower body pressure. The authors concluded from these findings that cardiopulmonary and arterial baroreflex activity influences the metabo-reflex modulation of cutaneous vascular conductance, but not sweat rate, during heat stress [932]. A study conducted at the San Diego State University, California, suggested that reflex sweating in the heat during isometric handgrip exercise is primarily due to a priming effect in the sweat glands and not caused by an increase in skin temperature [446].

A useful overview discussed actions of hyperthermia on the autonomic nervous system. The authors reported that the detrimental effect of hyperthermia on central nerves

and the hyperthermia induced damage to the enteric nerves are long lasting, but the reduced contractility of cardiac muscle and gastrointestinal smooth muscle when exposed to hyperthermia is short-lived. Inadequate calcium handling is the accepted mechanism of heat damage to cardiac and skeletal muscle [785]. Brain temperature which depends on the general body core and arterial blood temperature response, seems to be a major factor affecting motor performance during sustained contractions and most probably also during prolonged dynamic exercise [806].

Multiple animal experiments have artificially evoked hyperthermia induced seizures to determine how fever seizures are generated [1430]. Animal models of hyperthermia induced seizures was topic in 4 conference abstracts [997, 083, 1112, 1144].

A paper from Taiwan reviewed therapeutic applications of heat in cancer therapy including nanotechnology based hyperthermia. The authors discussed mathematical and numerical models for calculating temperature distribution and addressed the importance of understanding the heat transfer for optimal treatment results [233]. Many cancer-targeting nanosystems have been synthesized that can mediate hyperthermia, including carbon nanotubes and gold- and magnetic-based nanocarriers [211]. The use of nanoparticles for the induction of hyperthermia was reported in animal experiments [390, 1184].

An article from Germany reviewed the current knowledge about the anaesthesiological and intensive care management of patients undergoing hyperthermic intraperitoneal chemotherapy. Based on alterations of hemodynamic, hematopoietic, and fluid haemostasis occurring under this treatment, strategies for the perioperative monitoring are proposed [311]. Another review paper identified bone marrow suppression, renal failure and anastomotic leakage or perforation as the most frequent complications following hyperthermic intraperitoneal chemotherapy [193].

Fever

Fever appeared in most papers as symptom of infection [34, 223, 346, 459, 463, 499, 504, 516, 564, 578, 597, 606, 627, 659, 660, 663] or inflammatory disease [71, 101, 207, 470, 569, 637]. Treatment of fever with antipyretic drugs [880, 900, 1207], antibiotics [658] or cooling [471, 663, 1165] was reported. Three presentations at the conference "Clinical Temperature Measurement" were related to fever detection [1118, 1305, 1354].

A letter related to a comment that was included in last years literature survey [27] addressed the beneficial effects of fever as a component of host defenses against infection [620]. A cross-sectional study conducted in Turkey, investigated the knowledge, attitudes and misconceptions regarding fever in children. The study involved all primary care physicians working in a province with a population of 600 000. 10% of the physicians knew that a body temperature of above 37.2°C according to an auxiliary measurement is defined as fever and only 26.2% of the physicians took signs and symptoms other than fever in consideration to prescribe antipyretics [809]. Another study from Turkey investigated the accuracy of fever diagnosis based on pa-

tients's perception or on temperature estimation based on touching the patients by nurses or physicians of different levels of training. Diagnostic accuracy of patients perception was 71%, was 89% for nurses, 88% for specialists, 87% for resident doctors and 85% for interns [817].

A comparison of rectal and axillary temperature measurements in infants less than 1 year of age found higher values at the rectum than at the axilla and only moderate concordance of findings in febrile patients. Age of the infants and the time of day when temperature have been measured, had a variable influence on the temperature measurements [1349]. Temporal artery temperature and rectal temperature were determined in 47 pediatric patients between 3 and 36 months of age. No significant difference in either febrile or non febrile children were found between the two measurements, but mean values of differences between temporal artery and rectal temperature have not been reported [1021]. Temperature of the forehead either measured with an infrared thermometer or an contact thermometer were compared to rectal temperatures in 434 children, aged 1 to 48 months. The mean difference between the rectal temperature and the contact thermometer was $-0.2 \pm 0.28^\circ\text{C}$ and the mean difference between the non-contact infrared thermometer and rectal temperature was $0.029 \pm 0.01^\circ\text{C}$ [1368]. In 60 children, aged between 1 and 48 months, temperatures were measured at the axilla, over the temporal artery and at the naso-pharynx during anaesthesia for elective lower abdomen surgery. The authors reported almost identical mean values of nasopharyngeal and temporal temperatures with acceptable 95% limits of agreement (mean difference : 0.02°C , -0.46 to 0.51°C). Mean axillary temperature was 0.69 to 0.71°C lower than the temperature taken at the two other sites and 95% limits of agreement were wide (-1.5 or 1.45 to 0.08°C) [701].

Low agreement between non-contact, tympanic, and axillary body temperature measurements was also reported in an adult emergency department population. Mean temperature difference between axillary and tympanic measurement was $0.5 \pm 0.63^\circ\text{C}$, $0.2 \pm 0.71^\circ\text{C}$ between axillary and non contact thermometer, and $0.31 \pm 0.61^\circ\text{C}$ for the comparison of tympanic with non contact measurement. The limits of agreement were in the range of 2.4 to 2.8 degrees C[114].

An updated guideline on "Management of Fever in Children" recommended axillary temperature measurement using a digital thermometer in children younger than 4 weeks. In children older than 4 weeks, either axillary temperature measurement using a digital or infrared thermometer (tympanic or with or without skin contact) is recommended [871].

Thermography

The use of infrared thermography in CRPS, Raynaud's phenomenon and breast cancer was already mentioned. Differential scanning calorimetry was reported in 3 biochemistry [97,122,130] and 2 pharmaceutical papers [870, 904]. An editorial discussed methods for the detection of vulnerable plaques and mentioned also thermography [67]. A case of gustatory sweating that developed after neck dissection was evaluated by infrared thermography [378]. An

excellent intra-observer reproducibility of ocular surface measurements with a novel thermographic device was reported [695]. The sleep stage was successfully estimated by using thermographically obtained environmental, forehead and nasal skin temperatures with a support vector machine [763].

The thermal distribution patterns of the surface of the entire head in 12 healthy bald headed male subjects was reported in a stud from Norway. The authors stated that the thermal patterns in general followed the anatomical location of the main superficial arteries and veins of the head as described in anatomy books, but some variations, especially with regard to the forehead and the superior aspect of the head were detected [689]. Reliability of thermal readings of the skin surface over the anterior deltoid was investigated during intermittent, overhead tapping tasks. The results suggested that thermal imaging is a reliable method for assessing work task demand effects on the musculoskeletal system and may be useful in assessing risk for upper extremity work related musculoskeletal disorders [971].

Thermography was used to investigate the relationship between body mass and decrease of skin temperature at the lower extremities after whole body cryotherapy [422]. A review paper reported the use and effectiveness of thermal imaging for the assessment of skin temperature following the application of cryotherapy [631]. Infrared thermography was also used to record skin temperatures following cooling of rheumatoid arthritic hands with vaporizing nitrogen or cold air [469].

An article recommended the application of thermography in clinical care for the diabetic foot [444]. A review on the temperature of the human knee reported differences in temperatures recorded with contact or non-contact devices [625]. 3 days after total knee replacement, the temperature of the operated knee was $3.4 \pm 0.7^\circ\text{C}$ higher than contra-lateral non operated knee. 90 days after surgery the knee temperature returned to baseline readings in patients with uncomplicated surgery, but in patients with complications the mean side-to-side difference of knee temperature was $1.6 \pm 0.6^\circ\text{C}$ [709]. A large retrospective study related thermographic imaging with musculo-skeletal ultrasound findings of the knee [632,633]. Subclinical inflammation was detected in a patient with tophaceous gout [651]. A publication from Brazil reported no difference in temperature over the upper trapezius muscle between patients with mild neck pain and healthy controls [545]. Fractures at the extremities of children can be identified by infrared thermography. In 51 children presented in a pediatric emergency department following limb trauma, the warmest area on digital thermal imaging matched the pain site in 36 of 49 patients and coincided with the fracture side in 7 of 11 children [713].

Skin temperature of the lower extremities determined with infrared thermal imaging was used as secondary outcome measure in a pilot study in which the safety and efficacy of multiple intramuscular injections of adipose tissue-derived mesenchymal stem cells was investigated in 15 patients suffering from critical limb ischemia [532]. Thermal imaging was found to be a non responsive outcome measure in a pi-

lot trial of laser treatment for systemic sclerosis related telangiectasies [404].

Change of body surface temperature was recorded with infrared thermography during laser needle acupuncture in premature infants [413]. A thermogram and Doppler flowmetry were used as anecdotal proof for the effectiveness of warming following qigong therapy by hovering both hand palms over the head of the patient [668]. A Chinese study speculated about the existence of meridians based on the results of treatment of facial paralysis with moxibustion applied at the Hegu (LI4) acupuncture point. Due to poor and insufficient methodology these results lack plausibility [887]. Another study claimed that thermography can detect meridians in children suffering of autism and that these meridians change infrared emission after drinking a solution of “stable water clusters with double helix configuration” [816]. If applying thermography or other techniques for detection of meridians, Litscher’s statement that “from a scientific point of view, nobody could reproduce, demonstrate or visualize meridians” is correct [754]. However, thermography was described as a useful technique to record blood flow related skin temperature changes during acupuncture treatment [986].

Authors from India used skin temperature measurements recorded with thermography to diagnose diabetes type II [495]. A thermographic system reliably acquired time aligned nasal airflow and thoraco-abdominal motion estimates without relying on attached sensor performance and detected asynchronous breathing in pediatric patients [560]. A provocative test of allergy against peanuts was evaluated with thermography, which successfully differentiated the effects of the allergen or placebo [630]. A review paper on the technique and interpretation of diagnostic oral food challenges mentioned as thermography as possible alternative to full oral challenge [497]. A study from Croatia proposed an diagnostic algorithm for varicocele based on patterns of skin temperature distributions at the scrotum. In a small evaluation study with 12 patients the thermographic examination confirmed the diagnosis based on physical examination in all subjects [572].

A biography of the American neuroradiologist Ernest Harvey Wood who pioneered the application of thermography for the diagnosis of occlusive carotid artery disease [827]. A historical perspective on the relationship between physics and medicine [913] mentioned Hippocrates as the inventor of an early form of a thermographic image.

Discussion

The search profile of this year’s survey is identical to that of the literature review for the year 2011 (27). However, the survey might be not comprehensive due to the source of publications used. Fever, accidental and therapeutic hypothermia and hyperthermic treatment were the main fields of application of thermometry. Methods and techniques for controlling and modifying core temperature were discussed in many papers. The awareness of unintended hypothermia is still growing and a number of procedures have been reported to prevent the drop of core temperature during surgery. Beneficial and harmful effects of hyperthermia are

now better understood and the physiological mechanisms behind these effects become clearer.

Half of the publications related to infrared thermography were dedicated to assist diagnosis in wide range of diseases. There is an ongoing debate whether meridians can be imaged with thermography. Novel approaches to diagnose endocrine and metabolic disorders with thermography need to be supported by further, high quality studies.

English continues to be the predominant language for medical publication. Only 4.3 percent of the papers reviewed in this article were not published in English, and 39% of these papers appeared in Chinese. About 1% of publications appeared bilingual, presenting the paper in an English version combined with a version in the national language. Turkish was the language most often combined with English in bilingual publications.

An average impact factor of 2620 points was calculated for the 16 journals, which published in 2012 more than 8 papers on temperature measurement. This is a decrease by 1.0 points compared to last year. These might be caused by the contribution of last year’s publications in “Circulation” which boosted the average impact factor of 2011 similar as the papers published in “Nature.” increased the mean impact factors in 2010.

37.9% of authors of papers came from Europe, 27.8 % originated from North America and 28.4 % from Asia. 117 authors (29.7%) from Asia live and work in China, 97 researcher (24.6%) come from Japan and 37 authors (9.4%) originated from India. Publications from countries in Africa or South America are still rare and comprise together less than 3% of all articles included.

Like last year, this years’ literature survey was focused on temperature measurements with impact on clinical medicine. Pharmacology and Pharmacy, internal medicine and cancer were frequently identified fields of temperature measurement in medicine. Monitoring of thermotherapy with change of the core temperature in either direction was another important application of medical thermometry. Established and novel applications of diagnostic infrared thermal imaging have been reported.

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Meetings

September 10 - 13, 2013, Turin

AITA 2013 - 12th International Workshop on Advanced Infrared Technology and Applications

Venue: Castello del Valentino , Politecnico di Torino, Viale Mattioli, 39 - 10125 Turin

PRELIMINARY PROGRAMME

Wednesday, September 11

Opening Session

09.00 Institutional Greetings from: Prof. Marco Gilli -Rector of the Politecnico di Torino
 Welcome from AITA Chair, Co-chair and Organizers: L. Abbozzo Ronchi, P. Bison, C. Corsi, I. Pippi, O. Salvetti, M. Strojnik, M. Volinia

09.30 *C. Corsi (invited lecture)* New frontiers for infrared

Session: Advanced Sensors

10.00 *D. De Sousa Meneses, M. Eckes, B. Bouvy, L. del Campo, P. Egebekut*: High temperature Infrared spectrometer

10.20 *M. Alyoruk, Y. Ergun, M. Hostut* AlSb Layer Thickness Effect on HH-LH Splitting and Band Gap Energies in InAs/AlSb/GaSb Type-II Superlattices

10.40 *A. Ordóñez Müller, A. Kroll*: Effects of beam divergence in hand-held TDLAS sensors on long distance gas concentration measurements

11.00 Coffee Break

Session: Advanced Technologies and Materials - Part I

11.20 *F. D'Amato, A. Montori, M. De Pas, M. Giuntini, M. Siciliani de Cumis, S. Viciani*: A constant intensity technique to improve the performances of devices based on direct absorption spectroscopy

11.40 *A. Mazioud, L. Ibos, J. Dumoulin*: Detection of buried thin geometrical structure in a plaster layer by active infrared thermography

12.00 *Abd El-Naser A. Mohamed, Imbaba I. Mahmoud, Ahmed Nabib Zaki Rashed, Mohamed S. El Tokhy, Osama H. Elgar*: Radiation induced thermal effects and effects of bending on power attenuations in deformed polymer optical fibers

12.20 *Abdulrazak A.S. Mohammed, Safaa M. Hameed*: A new formula to evaluate the band width of an image for a digital camera

12.40 *Imbaba I. Mahmoud, Abd El-Naser A. Mohamed, Ahmed Nabib Zaki Rashed, Mohamed S. El Tokhy, Osama H. Elgar*: Modeling of radiation induced attenuation and its recovery in optical fibers

13.00 *Herchang Ay, Bing-Yan Wu*: A Study of enhanced heat transfer for a plate-fin heat sink by operating two piezoelectric fans

13.20 Lunch

Session: Nanotechnologies

14.20 *P. Gori, L. Matthes, O. Pulci, F. Bechstedt* Infrared absorbance of graphene, silicene and germanene

14.40 *M. D'Acunto, A. Benassi, A. Criventi, M. Luce D. Moroni, O. Salvetti*: NIR response of gold nanoparticles for biological detection

15.00 *P.A. Hobson, P. Andrew, B.T. Hallam, C.R. Lawrence* Infrared resonant absorption by coupled surface plasmon modes in an ultra-thin nanostructured microcavity

15.20 E. Kennedy, R. Al-Majmaie, M. Al-Rubeai, D. Zerulla, J. H. Rice Infrared nanoscopy of cells for nanoscale therapeutic agent localization

15.40 *D. Chauhan, N. Singhvi, R. Singh* Role of nanolayer and aggregation of dispersed metal oxide particles in enhancement of effective thermal conductivity of nanofluids

16.00 *F. Vitali, V. Foglietti, D. Lorenzetti, E. Cianci, F. Ghinassi, A. Harutyunyan, C. Riverol, L. Riverol, S. Antoniucci* Nanotechnology applied to silicon grism, for high-resolution infrared spectroscopy in astronomy

16.20 Coffee Break

Session: Cultural Heritage

16.40 *A. Bendada, S. Sfarra, C. Ibarra-Castanedo, M. Akboufi, J.-P. Caumes, C. Pradere, J.C. Batsale, D. Paoletti, X. Maldague* Subsurface imaging for panel paintings inspection, passing through the ultraviolet, the visible, the infrared and the terahertz spectra

17.00 *G. Cadelano, P. Bison, A. Bortolin, G. Ferrarini, M. Girocco, F. Peron, M. Volinia* Conservation of historical frescoes by timed infrared imaging analysis

17.20 *S. Sfarra, C. Ibarra-Castanedo, E. Marcucci, A. Bendada, D. Ambrosini, D. Paoletti, X. Maldague* From the laboratory to the in situ inspection: active and hybrid infrared thermography approaches as aid for the consolidation of mosaics

17.40 *A. Tarukcuoglu, E.N. Caner-Saltik* Quantitative infrared thermography and ultrasonic testing for in-situ assessment of Nemrut Dag stone statues

Session: Remote sensing

18.00 *P. Coppo* : Fire detection simulation with infrared payloads from geostationary platform

18.20 *S. Lagiela, L. Díaz-Vilarino, D. Roca, J. Armesto* Aerial thermography from low-cost UAV for the generation of thermographic digital terrain models

18.40 *M.R. Mugbal, L.M. Reyneri, D. Del Corso* Free space and glass fibre based infrared communication system on-board Aramis satellite

19.00 *S. Sadovnychiy, J. M. López, A. Sadovnychiy, M. A. Hernandez* Applying of the infrared system for oil and gas pipeline right of way aerial inspection

Thursday, September 12

09.00 *X. Maldague, F. López, C. Ibarra-Castanedo (invited lecture)* Enhanced image processing for IR-NDT

Session: Buildings and Infrastructures

09.30 *L. Belussi, L. Danza, I. Meroni* Energy performance assessment with empirical methods: application of energy signature

09.50 *A. Bortolin, G. Cadelano, G. Ferrarini, P. Bison* Thermal performance measurement of the building envelope by infrared thermography

10.10 *P. Bison, A. Bortolin, G. Cadelano, G. Ferrarini, P. Gasparetto* : Infrared thermography for on-site inspection of photovoltaic systems: a brief review

10.30 *E. Robison, C. Estrada* The Application of Infrared Thermography to Conditions Assessments of Guastavino Vaulting

10.50 *G. Ferrarini, P. Bison, A. Bortolin, G. Cadelano, M. Girocco, U. Mazzali, F. Peron, M. Volinia* Energy survey of a historical building by infrared thermography

11.10 Coffee Break

Session: Nondestructive evaluation

11.30 *L. Vega, P. Venegas, J. Guerendiaga* : Validation of a novel NDT technique with infrared thermography

11.50 *A. Elbassnaoui, S. Sabnoun, S. Belattar* : Nondestructive testing by determining the thermal effusivity of the geometry defects

12.10 *P. Venegas, L. Vega, J. Guerendiaga* : Instrumentation technology based on infrared thermography for the control of aeronautical composite components subjected to certification load tests

12.30 *K. Li, G. Yun Tian* : State Detection of Bond Wires in Power Electronics Devices using Eddy Current Pulsed Thermography

12.50 *U. Galletti, D. Palumbo, R. De Finis, F. Ancona* : Evaluation of defects in composite materials by means microwave thermography

13.10 *L. Vega, P. Venegas, J. Guerendiaga* Study of the capabilities of the processing techniques applied to defects detection in active thermography

13.30 Lunch

14.30 *Workshop sponsors* News, Trends and Opportunities

Session: Industrial applications

15.10 *M.M. Dugand* Automotive applications of IR thermography at CRF

15.30 *A. Khalifa, M. Marchetti, L. Ibos, V. Feuillet, J. Dumoulin, M. Buès, L. Bouilloud* Monitoring of traffic incidence on pavement surface temperature

15.50 *F. Bozzoli, L. Cattani, G. Pagliarini, S. Rainieri* Infrared imaging of the convective heat transfer coefficient distribution in coiled tubes

16.10 *D. Shiozawa, K. Inaba, A. Akai, T. Sakagami* Experimental study of relationship between energy dissipation and fatigue damage initiation based on observation of slip band by atomic force microscope

16.30 Coffee Break

Session: Bio-applications - Part I

16.50 *B. Jalil, O. Salvetti, L. Potì, M. Marinelli, V. Hartwig, A. L'Abbate* Heterogeneity of hand skin microcirculation assessed by near infrared 2D imaging

17.10 *D. Al-Ramamneh, M. Gerken, A. Riek* Effect of shearing on water turnover and thermobiological variables in German Blackhead mutton sheep

17.30 *S. Riyahi-Alam, V. Agostini, F. Molinari, M. Knaflitz* Evaluation of time-series registration methods in dynamic area telethermometry for breast cancer detection

17.50 *I. Benkő* Histogramic method as a tool of thermal image processing

18.10 *E. Rokita, T. Rok, G. Taton*: Evaluation of allergic response using dynamic thermography

18.30 *R. Lampe, S. Kavelke, J. Mitternacht, V. Turova, T. Blumenstein* Thermographic study of upper extremities in patients with cerebral palsies

Social Dinner

Friday, September 13

09.00 *M. Strojnik, G. Paez, M. K. Scholl (invited lecture)* Oximetry Wavelength Selection based on Functional Oxygen Saturation

Session: Bio-applications - Part II

09.30 *H. Trabelsi, E. Sediki* Detection of abnormalities under skin tissue by thermography: a numerical study

09.50 *G. Paez, M. Strojnik, L. F. Corral* Feasibility of non-contact oximetry: Monte-Carlo simulation

10.10 *V. Redaelli, G. Pizzamiglio, P. Selleri, N. Di Girolamo, P.A. Martino, F. Luzzi* : Environmental assessment of terrarium in the main species of reptiles through the thermography technique: preliminary results

10.30 *V. Veikutis, J. Petrauskaitė, E. Tubelyte, A. Bogusevicius* Infrared thermography in breast cancer screening

10.50 *A. Ichiki, H. Sakamoto, Y. Ohbuchi* Development and verification of living body information monitoring system

11.10 Coffee Break

Session: Systems, Images and Data Analysis

11.30 *E. O'Keefe, E. Liggins* Materials for infrared remote identification & differentiation

11.50 *K.O. Petrosyants, I.A. Kharitonov, P.A. Kozynko, A.A. Popov* : Electronic components thermal regimes investigation by IR thermography

12.10 *W. Allasia, P. Prinetto, A. Riva* : EAGLE, a compact vision system with two simultaneous field of view

12.30 *S. Soldan, A. Kroll*: Towards automated gas leak detection using IR gas imaging cameras

12.50 *W. Swiderski, D. Nesteruk, V. Vavilov* Data fusion in IR thermographic detection of landmines

13.10 *A.G. Jara Chavez, F.O. Torres Vicencio* Acceleration algorithm for constant-statistics method applied to the nonuniformity correction of infrared sequences

13.30 Lunch

Session: Advanced Technologies and Materials - Part II

14.30 *A. Libbra, A. Muscio* Reverse use of an infrared emissometer for measurement of thermal conductivity

14.50 *E.A. Pieczyska, M. Staszcak, L. Urbanski* Infrared imaging of ferromagnetic NiFeGaCo SMA single crystal subjected to subsequent compression cycles

15.10 *O. Plekhan, A. Fedorova* Evaluation of fatigue limit of submicrocrystalline metals based on infrared thermography

15.30 *R. Singh, S. Kumar* Effective thermal conductivity of composite materials with spherical

15.50 *W. Swiderski, V. Vavilov*: Ultrasonic IR thermographic inspection of graphite epoxy composites: a comparative study of piezoelectric and magnetostrictive stimulation

16.10 *W. Di, X. Wu, L. Liu, X. Zhao, H. Luo*: Pyroelectric performances of relaxor-based ferroelectric single crystals and infrared detectors

16.30 Coffee Break

16.50 *S. Trabelsi, H. Trabelsi, E. Sediki*: Infrared active gas properties and effects on thermal fluid dynamics

17.10 *M. Ždářský, J. Valach, D. Kyjčík, M. Šperl, T. Fíla*: Sensitivity study of resonance cyclic loading of carbon fibre PPS matrix composite specimen by hi-speed recording thermocamera

17.30 *U. Galiotti, D. Palumbo, R. De Finis, F. Ancona*: Fatigue damage evaluation with new thermal methods

17.50 *M.N. Litvinova, V.V. Krishtop, N.M. Kireeva*: Conversion of incoherent IR-radiation into visible radiation in nonlinear crystals

Closing session and Greetings

5th -6th October 2013, Amsterdam

Seminar: Human and Veterinary Thermography

More information: www.cursus-thermografie.eu

Last date of registration: September 1st 2013

PROGRAMME:

Saturday, October 5th 2013

9:00 AM - 9:30 AM Registration (with coffee and tea)

9:30 AM - 9:45 AM Word of Welcome
Prof. Dr. Ram Purohit

9:45 AM - 10:30 AM The benefits and applications of thermography in zoo animals.
Daphe van Dongen - Valk

10:30 AM - 11.15 AM A study into the use of Thermography for Functional Evaluation of Stallion Scrotum and Testes.
Janet Lloyd-Jones

11:15 AM - 12:00 PM Thermal imaging in the sled dog.
Dr. Kimberly Henneman, DVM

12:00 PM - 1:30 PM Lunch

1:30 PM - 2:15 PM New Aspects of Medical Thermography: Advances in Practice
Prof. Dr. med. Marcos Brioschi

2:15 PM - 3:00 PM Thermography for evaluation of dermatome patterns in horses as it relates to neck and back injuries.
Prof. Dr. Ram Purohit DVM

3:00 PM - 3:30 PM Break

3:30 PM - ± 5:00 PM A Review of Thermographic Evidence to Substantiate Acupuncture Meridians.
A look at how thermography has been used in an endeavour to validate Acupuncture and its Meridians. To be followed by a practical replication of one or two studies - incorporating an open discussion on 'best practice' whilst imaging.
Janet Lloyd-Jones

6:00 PM Dinner

Sunday, October 6th 2013

9:00 AM - 9:15 AM Welcome with coffee and tea

9:15 AM - 10:00 AM Similarities and dissimilarities of the technique of infrared Imaging in humans and in horses. -
Prof. Dr. med. Kurt Ammer PhD

10:00 AM - 10:45 AM Injury Prevention by Biomechanical Thermography Analysis - Prof. Dr. med. Marcos Brioschi

10:45 AM - 11:15 AM Break

11:15 AM - 12:00 PM Thermal evaluation of the head and neck in the horse. Including the hyoid, TMJ and upper cervicals.
Dr. Kimberly Henneman, DVM

12:00 PM - 1:30 PM Lunch

1:30 PM - 2:15 PM Thermographic evaluation of back pain in humans or in horses.
Prof. Dr. med. Kurt Ammer PhD

2:15 PM - 3:00 PM Thermographic Evaluation of Scrotal and Testes as it relates to various testicular diseases. -
Prof. Dr. Ram Purohit DVM

3:00 PM - 3:30 PM Break

3:30 PM - 4:15 PM Causations from praxis and relations.
Relations with anatomy, vertebra, physiological systems, dental, emotions, meridians, muscular skeletal and deeper causations of diseases.
Martin Möhrke

25th-27th October 2013,

American Academy of Thermology, Annual Meeting in Greenville, South Carolina

AAT welcomes you to our 2013 Medical Thermal Imaging Scientific Session in beautiful downtown Greenville, South Carolina!

This activity has been planned and implemented in accordance with the Essential Areas and Policies of the South Carolina Medical Association (SCMA) through the joint sponsorship of Bon Secours St. Francis Health System, Inc. and the American Academy of Thermology. Bon Secours St. Francis Health System, Inc. is accredited by the SCMA to provide continuing medical education for physicians.

Bon Secours St. Francis Health System, Inc. designates this "live activity" for a maximum of 6.75 AMA PRA Category 1 Credit(s). Physicians should only claim credit commensurate with the extent of their participation in the activity.

To be compliant with the AMA's **"Physician's Recognition Award and Credit System, we require physicians to attest to the amount of time they are claiming credit – which should be commensurate with the extent of time they participate in a CME activity.**

The AAT Annual Meeting will be held at the Bon Secours St. Francis Hospital campus.

Pre-Meeting Physician Member Certification Course: Friday, October 25, 2013

Take the next step toward AAT Membership status elevation! Take an AAT Member Certification Course

Saturday, October 26, 2013

General Sessions

08:00am - Registration

08:30am Welcoming Remarks

Jeffrey Lefko, Greenville, SC, Executive Director, American Academy of Thermology

08:45am - Session 1:

Basic Science, Clinical Conditions, AAT Guidelines & Indications

Thermographic Imaging - What, Why, When?

Dr. Robert Schwartz, MD,
Greenville, SC, President of American Academy of Thermology:

Dr. Philip Getson, DO,
Marlton, NJ, Vice President, American Academy of Thermology:

The Predictive Value of Neuromuscular Thermography in CRPS

Dr. Tracy Turner, DVM,
Elk River, MN, Board Member, American Academy of Thermology:

Thermographic Imaging Uses in Animal Physiology and Anatomy,
Veterinarian Thermography Guidelines

10:30am - Break

10:45am - Session 2:

Panel Discussion: Thermography Office Practices and Business Models - *Moderator: Dr. Robert Schwartz, MD:*

Compliance Issues in a Breast Thermography Practice

Dr. John Pittman, MD, Raleigh, NC:
Chair, AAT Website subcommittee

Use of Thermography as a Business Model in Building New Practices

Dr. Bruce Rind, MD, Washington, DC:

Thermography Camera Palettes in a Thermography Imaging Practice

Dr. Tashof Bernton, MD,
Denver, CO: Co-Editor, AAT Newsletter

Thermal Stability in an Imaging Lab

JaneCrawford, RN,
Rockford, Illinois: Chair, AAT Technicians Subcommittee
Monitoring

12:15pm - Lunch (provided)

1:30pm - Session 3:

Panel Discussion: FDA Review and Monitoring Process of Thermographic Cameras and Technical Specifications
Moderator: Andrzej Zielke, MD Allison Park, PA Chair, AAT Devices and Equipment Subcommittee

Infraimaging Camera Specifications Study

Terry Clausing, PE,
 Drysdale and Associates, Cincinnati, Ohio: AAT Consultant,

Understanding the Role of the FDA in Thermography

Carol Chandler, DOM,
 Lakeland, FL, Member, AAT Devices and Equipment Subcommittee

3:30pm - Break

3:45pm - Session 4:

Panel Discussion: Thermography Licensing, Regulation, and Research Issues and Challenges

Recent State Licensing Boards Activities on Thermography and Thermographers

John Gilbert, Ph.D,
 Professional Licensing Consultant, Asheville, NC:

Canadian Thermography Regulations and Licensing Issues

Dr. Alexander Mostovoy, HD, DHMS,
 Toronto, Ontario: Member, AAT Membership Committee

The Current Thermography Status in Australia

Dr. Philip Getson, DO,
 Marlton, NJ: Vice President, AAT

Medical Research and Publishing:

The Duke Clinical Research Institute Experience

James Melton, MHA,
 Cary, NC: Member, AAT Board of Directors

5:00pm – Annual Scientific Session Wrap Up and Remarks

5:30pm – Session Ends

6:30pm to 7:30pm – Meet and Mingle with the Leadership at the Hilton Hotel

Presentation of the AAT 2013 Achievement Award

Sunday October 27, 2013

Committee Meetings:

07:30am – Shuttle from Hilton Hotel

08:00am – Committee Meetings (Committee members and other attendees):

Membership Committee including:

- •Sub Committee on Complimentary Alternative Medicine (CAM) and Allied Health
- •Sub Committee on Technicians/Technologists.
- •Devices and Equipment Committee
- •Journal/Newsletter
- •Website Committee
- •Education Committee
- •Advocacy Committee

09:15am – General Session (all in attendance)

10:15am – General Session Ends

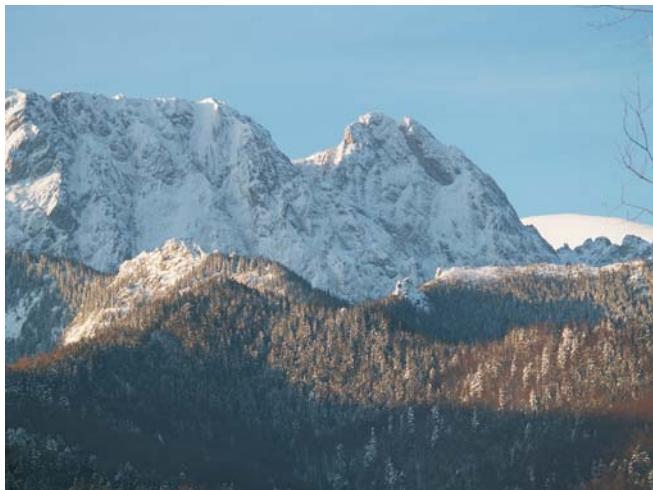
10:30am – Shuttle returns to Hilton Hotel

10:15am - Board of Directors Meeting (board members only)
 1pm - Board of Directors Meeting Ends

Further information

Dr Robert G. Schwartz
 500 Duvall Drive, Greenville, S.C., 29607 USA
 email: contact@aathermology.org

Website: aathermology.org



I



XVIII NATIONAL CONGRESS OF THE POLISH ASSOCIATION OF THERMOLOGY

ZAKOPANE 4th-6th April 2014

GENERAL INFORMATION

REGISTRATION FEE: 250.- €

ABSTRACT DEADLINE February 15th 2014

ajung@wim.mil.pl or a.jung@spencer.com.pl

Abstract form will be published in Thermology International and in Acta Bio-Optica et Informatica Medica and registration on line

Professor Jung and the Organizing Committee invite you to this annual conference in the beautiful mountain resort of Zakopane in South Poland, which is 2hours journey by bus from Krakow International airport and the city of Krakow. The conference is in HYRNY Hotel with its wonderful views of the Tatra mountains, and short walk from the town centre.

Local Organizing Committee

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Agnieszka Rustecka

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ProfAdriana Nica MD,PhD (Romania)

Registration fee for non Polish participants will be paid in cash on arrival at the conference.

Registration by e-mail is required before March 1st to ensure hotel reservation.

After registration number is issued, delegates are committed to payment of the fee.

Registration includes welcome dinner Friday 15th

Lunch and accomodation.

Extra night + breakfast + 70 €

Accompaning person – 200 €



QIRT 2014

7-11 July Bordeaux

The 12th International Conference on Quantitative InfraRed Thermography

Call for Papers

Since 1992, the Quantitative InfraRed Thermography (QIRT) conference is a biannual international forum which brings together specialists from industry and academia, who share an active interest in the latest developments of science, experimental practices and instrumentation, related to IR thermography.

Following conferences in Paris (1992), Sorrento (1994), Stuttgart (1996), Lodz (1998), Reims (2000), Dubrovnik (2002), Brussels (2004), Padova (2006), Krakow (2008), Québec City (2010) and Naples (2012), the 12th Quantitative InfraRed Thermography Conference, QIRT 2014, will take place on July 7-11, 2014, at the Mechanics & Engineering Institute of Bordeaux.

QIRT 2014 will cover, but will not be limited to, the following topics:

- State of the art and evolution in the field of IR scanners and imaging systems allowing quantitative measurements and related data acquisition and processing.
- Integration of thermographic systems and multispectral analysis. Related problems like: calibration and characterization of IR cameras, emissivity determination, absorption in media, spurious radiations, 3D measurements, certification and standardization.
- Thermal effects induced e.g. by electromagnetic fields, elastic waves or mechanical stresses.
- Application of IR thermography to radiometry, thermometry and physical parameters identification in all fields such as: industrial processes, material sciences, thermo-fluid dynamics, energetics, non-destructive evaluation, cultural heritage, environment, medicine, bio-medical science, food production...

Important dates

- Abstract submission deadline: November 20, 2013
- Acceptance notification: January 31, 2014
- Paper submission deadline: April 30, 2014

Abstract and Paper Submission

The participants are invited to submit to the QIRT 2014 Web Site by November 20, 2013 an **extended abstract** of 2 pages (letter size A4 format), either for oral or poster presentation, including key figures and main results. A book of abstracts will be distributed at the conference.

Following acceptance notification, **camera ready, full paper** of 6-10 pages including color figures should be submitted to the QIRT 2014 web site by April 30th, 2014. All submissions for oral or poster presentation will be handled electronically via the conference website

QIRT2014.scientificevent.

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A Word template to be used for both abstracts and full papers is downloadable at the website. Authors are requested to propose the thematic section in which the paper should be included.

Abstract submission

Web-Based Proceedings and possible publication in QIRT Journal

Presented papers (oral and posters) will be published online in the QIRT Open-Archives, which can be found at the website: www.qirt.org. A USB flash drive with all conference papers will be also distributed to the conference participants.

After the conference, the Scientific Committee will carry out a pre-selection of the most prominent presented papers for a possible publication in Quantitative InfraRed Thermography Journal after a subsequent review by two experts.

Tutorials, Technical Visit and Workshop

QIRT short courses

In addition to the main technical program, the conference will include one-day short courses (Monday, July 7). The program and the related fees will be defined soon and presented in the conference website. It will include a general introduction to thermography in the morning and specialized courses on various application fields given in parallel during the afternoon (non-destructive evaluation, thermo-fluid-dynamics, building, thermomechanics...).

Summer course on thermomechanics

A summer-course (given in French) on thermography and thermomechanics of materials will take place from June 30 to July 4. The website will be opened and related to the QIRT conference site in October 2013.

Technical Visits

A lot of research teams are using IR thermography on the Bordeaux University Campus and will be opened for visits.

Student Award

Striving to stimulate young researchers, the organizing committee will award the best conference contribution presented and authored only by students.

Conference fees (VAT included)

Regular participants

- Early rate (deadline: May 20, 2014): (550 €)
- Late rate (deadline: June 27, 2014): (650 €)
- Desk registration rate: (800 €)

Students

- Early rate (deadline: May 20, 2014): (350€)
- Late rate (deadline: June 27, 2014): (450 €)

Fee covers: Book of abstracts, Conference USB Proceedings, Welcome reception, Conference dinner, 3 lunches and coffee breaks. Accommodation is not included.

For regular participants only, fee includes also a subscription to QIRT Journal for 2 years (standard personal subscription rate 100 €/year).

Accompanying persons

- Rate (deadline: June 27, 2014): (120€)

This amount includes the Welcome reception and Conference dinner.

Venue

QIRT 2014 will be held at the Ecole Nationale des Arts et Métiers located in the campus of the Bordeaux University, at 20 min by tram from the historic center of the City. Bordeaux is listed to the UNESCO world heritage. The city is exemplary thanks to the unity of its classical and neoclassical architecture (see www.bordeaux-tourisme.com).

A list of hotels will be given in the conference website. Booking of hotel is not assumed by the conference organization. For students only, low cost accommodations can be booked on the Bordeaux University campus.

Conference website

For further information please visit the site:
QIRT2014.scientific-event.com

or contact the organizing committee at:
QIRT2014@scientific-event.com



European Association of Thermology



Physical Activiy and Sports Faculty
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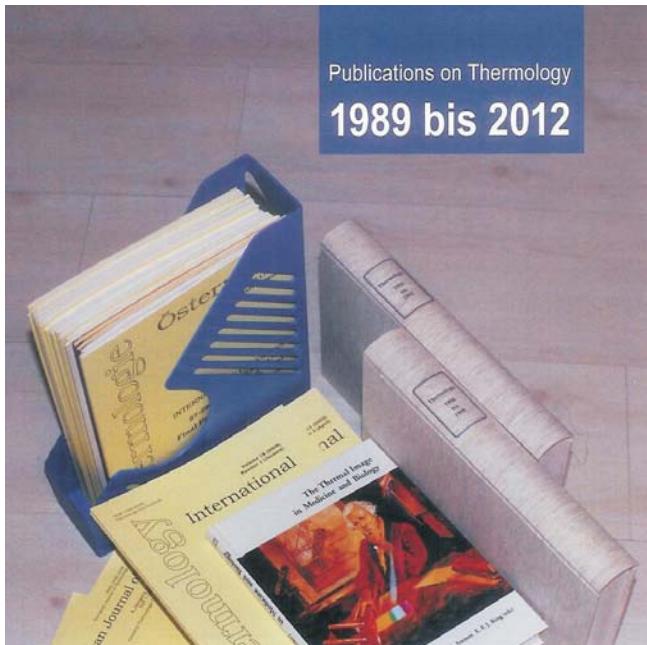
XIII European Association of Thermology Congress



FIRST ANNOUNCEMENT

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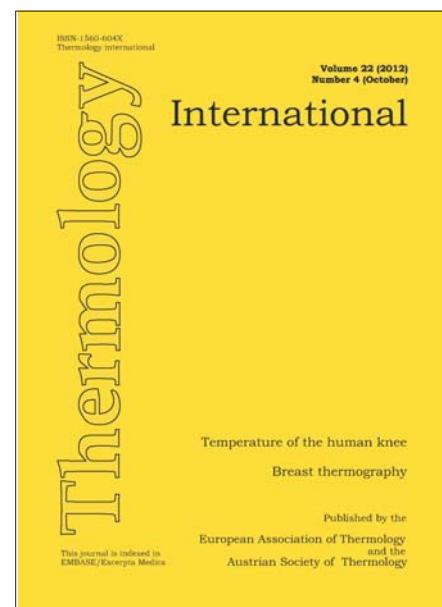
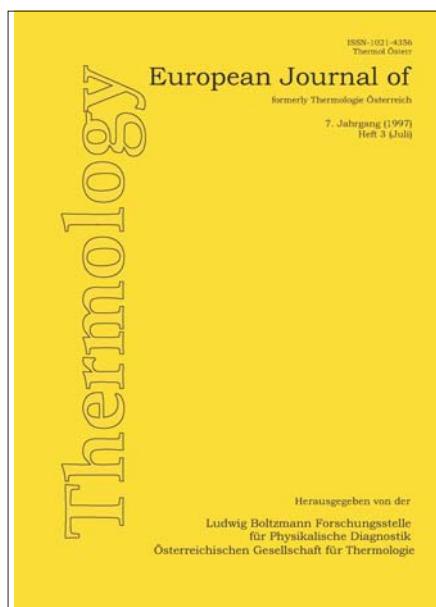
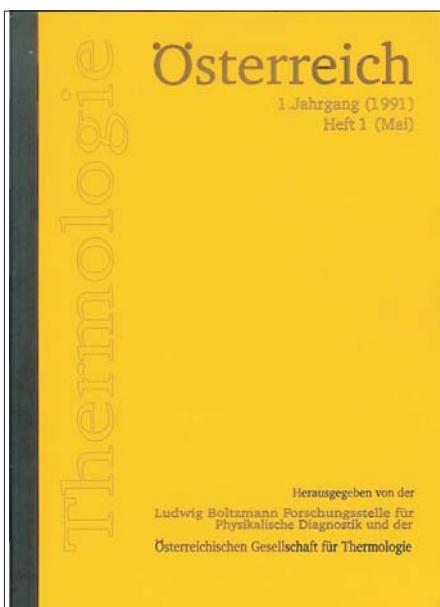
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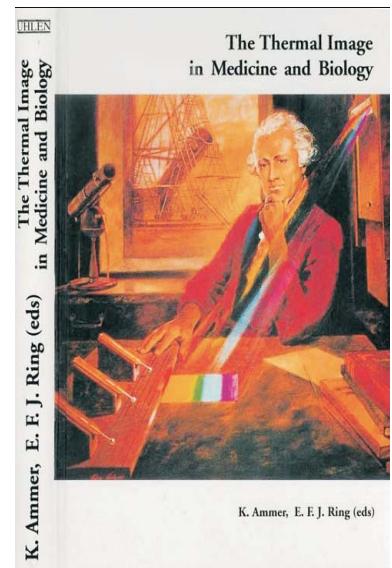
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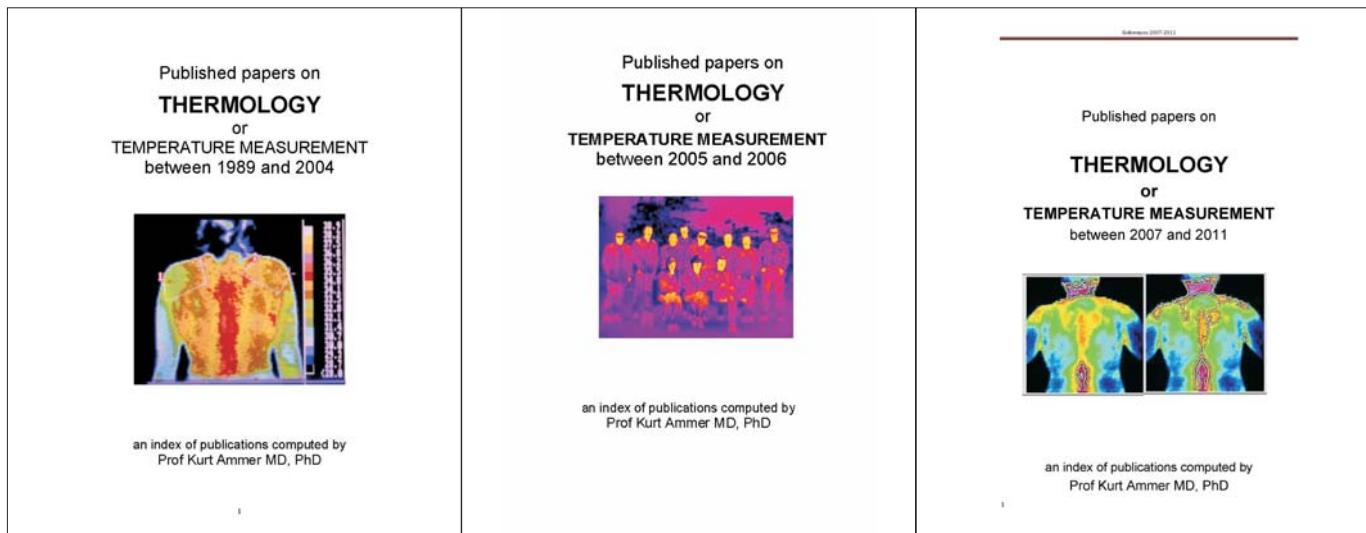
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Plus

The Thermal Image in Medicine and Biology
edited by K. Ammer and E. F. J. Ring
Uhlen Verlag, Wien (1995)





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Published Papers on Thermology and Temperature Measurement

Volume 1: 1989 to 2004

Volume 2: 2005 to 2006

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Proceedings of the First Thermological Symposium of the Austrian Society of Thermology

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