TECHNOLOGY REFRESHER COURSE

The development of the imaging camera.... CRT to Laser

The laser imager

1987 saw the advent of the laser imager with 3M introducing an infra red system to the American market. Today there are seven major manufacturers of laser imagers, namely Agfa, DuPont, Fuji, Kodak, Konica, 3M and Polaroid.

The output, that is the film, of the laser imager may look very much like that of a CRT multiformat camera, but that is where the similarity ends.

Input

Although provision can be made on most systems for a video input, laser imagers almost exclusively use a digital interface to the imaging modality. This has far reaching implications with regard to increased departmental productivity where different modalities can be connected to the same imager. Much research and development is underway developing Local Area Networks (LAN), Image Gateways, Picture Achiving and Communications Systems (PACS) to fully utilise the potential of laser imagers.



Figure 2: Principles of laser

therefore, that the monitor is set for a

maximum sharpness / brightness

compromise with exposure time

There are various problems

determining blackness of the image.

associated with an optical system:

Vignetting - a loss of brightness at

the edges of the image. This is reduced

by using a CRT screen that is larger than

Optical system

the image field

• Spherical aberration - this manifests itself as geometric distortion. This is overcome by the use of in-line optics and a flat screen monitor

• Density uniformity - a falling off of brightness at the edges of the screen due to variations in electron density on the phosphor. This is compensated for electronically by altering the brightness profile across the screen

Basic principles

The following is a description of the operation of a Helium Neon (HeNe) laser: (Figure 2)

The data from the imaging modality is inputted via the interface electronics and an image buffer which acts as a storage device. The data are then split into x-axis; y-axis and intensity information.

The multiformat camera

Whilst very few multiformat cameras, based on cathode ray tube (CRT) technology, are purchased these days, it is important to review that technology in order to assess both the impact and potential of laser imagers.

Early imaging cameras bolted directly onto the diagnostic monitor (Figure 1) had special lenses to



Figure 1: The imaging camera is bolted directly on to the diagnostic monitor. compensate for spherical aberration because of the curved screen. The applications of these cameras were in the fields of ultrasound and first generation CT scanners.

Next came the dedicated multiformat camera, so called because multiple exposures could be made on the same film. These cameras are video based, that is they require a video signal in order to work. Such a camera featured a flat screen CRT tube, in-line optics and electronic control. The various challenges faced with this type of camera are as follows:

Stability

The image on the CRT is built up from the electronic beam crossing the tube at least 625 times from top to bottom. Each sweep constitutes a line (a raster line) with a set of 625 lines constituting a frame. A frame is built up 25 times a second. With conventional film an exposure of about 10 frames will be necessary to form an image. It follows, therefore, that each line on each frame must be in exactly the same position on the screen in order to produce maximum sharpness in the image. Any instability will result in the raster lines being blurred with a resultant loss in image quality.

Exposure

As stated above, 25 frames a second are produced on the monitor screen. The minimum exposure time is thus 1/25th of a second. On later multiformat cameras a method of determining exposure by number of frames (or fields) was developed.

An additional issue in determining exposure is the monitor brightness. A change in exposure time causes a sensitometric change in the film's characteristic curve similar to the effect caused by increasing monitor brightness. Additionally, an increase in monitor brightness can cause a deterioration in image sharpness due to phosphor flare. It will be appreciated,

32 SA JOURNAL OF RADIOLOGY • March 1996

to page 33

from page 32

The intensity of the laser beam is varied by means of an Acoustic Optical Modulator. This is a very stable system which delivers 4096 grey levels (compared to 200 on the CRT). The beam is then swept to and fro across the film by a system of lenses and a rotating or galvanometric mirror (x-axis). At the same time the film is transported in the longitudinal direction by a precise mechanical drive system (y-axis). The image is thus "painted" on the film from top to bottom in sequential lines by a very fine laser beam which achieves a pixel size of 80µm. By this means problems of geometric and density distortion common to CRT imagers are avoided.

Exposure

The one main disadvantage of the laser imager against the CRT imager is exposure time. On the CRT it is approximately 40 ms. The laser imager takes anything from 17 to 45 seconds per film. Because of its digital architecture, however, the data for an image can be stored in a queue to maximise throughput. In addition multiple copies can be made independently of the imaging system (CTScanner, MRI, etc.).

Resolution

The resolution of a laser imager is in the region of 6300 X 7650 pixels. This applies to the whole film. With a CRT camera the resolution of 1250 lines applies to each image. With 12 exposures on a 35 X 43 cm film the resolution of each system is comparable. With less than 12 exposures on a film, the laser imager is superior. This is the first in the series "Technology Refresher Course". We would welcome feedback as to whether the subject material is correct, whether the information should be more in-depth, and suggestions about what subjects should be covered in future issues.

The author wishes to thank Agfa, DuPont and Konica for the information they provided towards this article.

Roger Short Publisher

Instructions to authors

Authors are requested to adhere closely to these instructions. Failure to comply will lead to delay in publication.

Manuscripts

Original articles, technical reports, book reviews and case reports are invited and should be sent to the Editor, SA Journal of Radiology c/o Cannon Communications (Pty) Ltd, PO Box 2433, Randburg, 2125, Republic of South Africa both in hard copy and on diskette, or e-mailed to cannon@solo.pipex.co.za

Manuscripts must be submitted exclusively to the Journal on the understanding that they have not and will not be published elsewhere (refer to document: Conditions of Submission). Each author should have participated sufficiently in any submission to take responsibility for its contents and a letter to this effect, signed by all the authors, should accompany the manuscript. Papers based on work submitted for examination purposes to a tertiary institution should be accompanied by written permission authorising publication of the material in its original form or part thereof.

Papers accepted for publication become the copyright of the Journal. The Editor retains the right to modify the style and length of the submitted manuscript (major changes being agreed with the corresponding author) and to decide the time of publication. The Journal publishes all material on the understanding that the design of the work has been approved by a relevant ethics committee and/or it conforms to the professional standards and legislation currently applied in the country of origin (refer to document: Conditions of Submission).

Two copies of each manuscript should be submitted and, if applicable, accompanied by two sets of tables, graphs, and illustrations. Authors are advised to retain a copy of all material submitted in case of loss as the Editor cannot accept responsibility for loss or damage. It is essential that manuscripts be clearly presented with adequate space for editorial comment. The manuscripts should be typed with double spacing on one side of A4 paper (297 x 212 mm), with 3cm margins; all pages should be numbered consecutively, including those of acknowledgements, references, tables and figure legends. Block paragraphing should not be used. Headings should be in lower case and not be underlined. Manuscripts that do not conform to these requirements will be returned for retyping. Papers must be in English and spelling should conform to the Concise Oxford Dictionary of Current English. Authors are urged to keep their manuscripts as short as possible and to write them in simple precise English.

Original papers

Each typescript component should begin on a new page in the following order: title page, abstract and key words, main text, acknowledgements, references, tables, figure legends.

The title page should include title, authors' names (with initials and departmental addresses), authors' qualifications, a short title of not more than 45 characters for the running headlines, and the name, address, telephone and fax numbers (and if available the e-mail address) of the corresponding author to whom proofs and offprint requests should be directed.

The abstract, comprising a summary of not more than 250 words, should highlight the design and objective of the investigation/research, results and conclusions. The abstract should be followed by a list of not more than five Key Words which should not appear in the main title. The introduction should succinctly state the purpose of the article. The main body of the text will usually be divided into sections headed Methods, Results, and Discussion. Avoid repeating all the detail in the tables, and avoid repetition of data in the Results and Discussion sections. The Discussion should emphasise new and important aspects of the study and conclusions that follow from them.

When quoting specific materials or drugs, authors should give their approved names, with if necessary, proprietary names in parentheses with the name of the manufacturer.

Case reports

Case reports should consist of title page as above, a short abstract and key words, the case report and a brief discussion of the pertinent literature. They should not exceed 1000 words with not more than ten (10) references. Case reports should not have more than three authors.

Abbreviations

Abbreviations should be unambiguous and only used where appropriate. Their meaning should be clearly explained where they are first introduced e.g. anterior-posterior (AP); computed tomography (CT).

Units and symbols

Measurements of height, length, mass (weight) and volume should be