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**Filter design successfully retrieved at 300 days.
Binkert et. al. JVIR. 2009; 20: 1449-1453.

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features

COVER STORY
14 RE-ELECTION ECONOMICS
With President Obama’s re-election, the Affordable Care Act is moving forward. How will ACA impact your practice?

ARE YOU DRAWN TO ATTRACT?
Suresh Vedantham, MD, FSIR, explains why participating in the ATTRACT Study is smart for you—and for your patients.

FUTURE PERFECT
The SIR Executive Council has approved the Society’s new Strategic Plan. Find out what the next five years will bring for SIR members.

INTERVIEW: UPDATES IN IR
IR Quarterly discusses the Updates in Interventional Radiology series with Editors Charles E. Ray Jr., MD, PhD, FSIR, and Brian Funaki, MD, FSIR.

columns

04 PRESIDENT’S COLUMN
Marshall Hicks, MD, FSIR

06 EXECUTIVE DIRECTOR’S COLUMN
Susan E. Sedory Holzer, MA, CAE

18 CODING Q&A
Aaron Shiloh, MD

20 SIR FOUNDATION RESEARCH EDUCATION DIVISION UPDATE
Laura Findeiss, MD, FSIR

24 JVIR COLUMN
Ziv J. Haskal, MD, FSIR

26 ANNUAL SCIENTIFIC MEETING CHAIR COLUMN
Gary P. Siskin, MD, FSIR

28 TRAINEES COLUMN
Patrick Mulligan

departments

07 IR UP FRONT
• What Is IR Quarterly?
• SIR Celebrates 40 Years
• Resources From the International Atomic Energy Agency
• SIR Welcomes Cheryl Sadowski
• New PRESERVE Study Takes Shape With SIR Lead
• SIR Holds Fourth CLOTS Course
• Executive Council Meeting Highlights
• SIR Foundation Announces Award Winners
• SIR Foundation Board of Directors Meeting Highlights
• Standards Division Update

13 CALENDAR

27 CORPORATE CORNER
A Vision, a Plan and You

“We’re a small society, but—with your help—we’ll make a big footprint on modern medicine.”

SIR and SIR Foundation have a clear vision—that interventional radiology becomes the first choice for image-guided therapy—for health care professionals, consumers, legislators, reporters, regulators, private and federal funding sources and insurers.

Your Society leaders envision a transformed world in the years to come—a world where:

- IR is appropriately used and understood as a significant contributor to high-quality patient care worldwide
- Every patient seeks and has immediate access to interventional radiologists
- Disease-specific subspecialization is common, yet this strengthens the single identity of IR
- The rigors of hard science are incorporated into our innovative techniques
- Interventional radiologists play a central leadership role in international, national and local health care policy

I predict that the demand for—and complexity of—image-guided interventions will continue to increase every year. SIR is well-positioned to seize this transformation opportunity—especially since the approval of the dual primary certificate in IR/DR by the American Board of Medical Specialties.

With this in mind, members of the Executive Council recently finalized and adopted a wide-ranging strategic plan that addresses a number of critical issues: clinical care, outcomes data, revenue growth, awareness and innovation.

The plan charts the course for strategically building on our history and strengths, setting clear priorities and making a bold investment in our members. Our goals are to ensure that: 1) every interventional radiologist provides longitudinal care; 2) we develop a standardized outcomes data infrastructure; 3) the Society achieves a net revenue to provide the resources necessary to fund defined goals; 4) key decision makers understand what IR is, does and achieves; and 5) interventional radiologists lead the medical profession in innovation.

With our history of innovation, robust patient care delivery, and engaged and supportive membership, the promise of our collective planning has never been brighter. This year, SIR is celebrating 40 years of service to our nearly 5,000 members—having expanded our mission from that of being a forum for investigators in a new medical specialty to a vital professional society of innovators who seek to improve patient care through image-guided therapy. We will continue to fulfill our mission through targeted objectives, including promoting our members as longitudinal care practitioners with key stakeholders; supporting implementation of the IR/DR dual certificate in residency programs; highlighting and improving the value of IR using data; providing global competency-based learning; and increasing awareness of the profession’s role in medical innovation and clinical trials.

You were an integral part of our strategic planning effort, providing us with ideas and directions as we prepared to set the Society’s course. This April, let’s reconnect and re-energize our professional selves and practices at our Annual Scientific Meeting in New Orleans, as we participate in “IR Reaching Out.” Please plan to attend and to talk with your SIR leaders, learn about the latest techniques and trends in IR, share ideas with friends and colleagues, and participate in our committee and other activities.

It’s been an honor to represent you this past year and to assist in setting a new long-term direction for SIR, along with the dedicated volunteer members who collaborated on this project. Our best days are ahead as we become the specialty associated with value in medicine. With our strategic plan, we stand resolute on bringing the transformation value of IR to health care. Together, we can effect change.

Interventional radiology: First choice, first resource.

More on SIR’s strategic plan can be found on p. 25 (“Future Perfect”).
Osteoporosis is invasive enough.

Vertebral compression fracture treatment shouldn’t be.

The AVAmax Advanced Vertebral Augmentation system includes the smallest cannula on the market, providing the most minimally invasive kyphoplasty system available today. The system also features the unique AVAflex curved needle. Both allow you to treat vertebral compression fractures that you may not have been able to successfully treat in the past—enabling the right approach at the point of care.

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IR: First and Foremost

2013 may well be a year of “firsts” for SIR and SIR Foundation. With the recent adoption of a new strategic plan, we are committed to making interventional radiology the first choice for image-guided therapy—and to positioning SIR and the Foundation as indispensable resources in the fulfillment of that ultimate goal.

This bold new vision won’t be achieved overnight, which is why we will be addressing a range of critical issues—including clinical care, outcomes data, revenue growth, awareness and innovation—over a five-year period. (See “A Vision, a Plan and You,” p. 4, and “Future Perfect,” p. 25.) Already we have taken some important, tangible first steps, as with this inaugural edition of IR Quarterly—SIR’s new magazine and information source on vascular and interventional radiology.

Four times a year IRQ will deliver robust feature content, personal profiles and news on developments in the field, as well as updates on SIR courses, publications, advocacy and research—all in a fresh and contemporary format. It will also incorporate familiar columns from its predecessor, IR News, which will be discontinued in place of the magazine. IRQ will be indispensable to IR practitioners and trainees, clinical associates and scientists; it will reflect the strength and breadth of our community and the vision of the Society.

Here, within the debut issue, you will find “Re-election Economics,” an IR’s view of the Affordable Care Act and its impact on practices. Bonus features include “Are You Drawn to ATTRACT?” providing information on how trial participation is smart for you and your patients, and “Future Perfect,” which opens the window to what can be expected over the next several years at SIR. Future articles will focus on how IRs can partner with hospitals and equipment manufacturers to improve radiation safety, how to remain compliant with HIPAA, Stark and other regulations; and how to recognize—and avoid—publishing misconduct.

IRQ remains a no-cost benefit to SIR members; however, it will be made available to nonmembers on a subscription basis to increase awareness of IR among the broader radiological and medical communities. (Learn more about IRQ: http://members.sirweb.org/members/IRQ.cfm.)

In another first, you’ll soon hear about two new publications from SIR Press to be released this year and next: Updates in Interventional Radiology 2013 and Portal Hypertension. (See the interview with Updates in Interventional Radiology editors Charles E. Ray Jr., MD, PhD, FSIR, and Brian Funaki, MD, FSIR, on p. 29.)

Finally, I hope to see you at our Annual Scientific Meeting, April 13–18 in New Orleans, La.—the Society’s first trip back to the Big Easy since Hurricane Katrina. This year’s theme of “IR Reaching Out” emphasizes our intention to give everyone with a stake in IR representation within the program. And, in a departure from previous formal events, the SIR Foundation Gala guests will laissez les bons temps rouler at Mardi Gras World, while investing in the future of the specialty. Purchase tickets to the gala online at www.SIRFoundation.org/gala. (See “Annual Scientific Meeting Update” on p. 26.)

As always, your feedback is important. Please let me know what you think about IRQ’s format and content—or what you’d like to see covered.

Need the reader? ➤ www.gettag.mobi
What Is IR Quarterly?

For 25 years, IR News (formerly SCVIR News) routinely brought critical updates and information supporting the practice of IR to Society members. In 2013, as the Society celebrates its 40th year, SIR is discontinuing IR News and introducing IR Quarterly, a new magazine that will continue to communicate the updates so critical to the practice of IR, augmented with stories, interviews and analyses that will add tremendous value to each 32-plus-page issue.

Published in January, April, July and October, IR Quarterly will remain a no-cost benefit to SIR members. Readers may now also choose to take advantage of a convenient electronic version. If you are interested in receiving IR Quarterly electronically instead of in print, please contact the Society office at bhaefs@SIRweb.org.

SIR has also begun accepting advertising from manufacturers and other Society partners in industry, introducing readers to a wide range of their products and services. Those interested in taking advantage of the range of SIR media advertising opportunities should contact Beth Allgaier, SIR director of corporate relations, at (703) 460-5564 or ballgaier@SIRweb.org.

We look forward to hearing what you like about the new format and what new elements or feature articles you’d like to see. Suggestions? Comments? Contact us at bhaefs@SIRweb.org.

SIR Celebrates 40 Years

Four decades ago, in 1973, a group of disparate physicians came together united by a common desire—to treat their patients in a minimally invasive way that would have a maximum impact in reducing their recovery time and improving their prospects and their lives.

In the earliest days of this emerging field, these pioneering physicians were willing to take whatever personal risks necessary to advance the field for the sake of their patients. Year after year, decade after decade, the group steadily grew—in terms of number of members, in terms of its Annual Scientific Meeting and in terms of the range of areas of anatomy that these physicians could treat with tremendous efficacy. Respect for and recognition of the skill sets of these physicians continues to grow, as ABMS formally approved the Dual Certificate in Interventional Radiology and Diagnostic Radiology just last year.

The Society and its members have come a long way since 1973—and the successes and developments that SIR is celebrating this year are certainly its members’ own. Throughout 2013, SIR will explore its past, highlighting the pictures and stories that make up its history. If you have historic pictures related to SIR or interventional radiology, stories of innovative solutions from the early pioneering days of IR, examples of IRs who followed their parents into the field or other elements of IR or SIR history you would like to share, please contact Debbie Katsarelis at dkatsarelis@SIRweb.org.

We look forward to hearing what you like about the new format and what new elements or feature articles you’d like to see. Suggestions? Comments? Contact us at bhaefs@SIRweb.org.

IR Quarterly will be distributed four times per year, but the Society’s electronic member newsletter SIR E-News recently doubled its frequency to twice a month. Not receiving E-News? Contact the Society office at ssingletary@SIRweb.org to ensure that we have your current email address.

Stay in the loop!
Resources From the International Atomic Energy Agency

By Stephen Balter, PhD, and Robert G. Dixon, MD

The International Atomic Energy Agency (IAEA) deals with much more than nuclear weapons. The IAEA is a component of the United Nations and thus has worldwide responsibility for all aspects of radiation safety. While many interventionalists would not think of the IAEA as a go-to resource, the IAEA Radiological Protection of Patients Web site (https://rpop.iaea.org) provides a wide variety of valuable, free information for the interventional radiology community. These resources include materials appropriate for the public, patients and health care professionals. Downloadable materials include a great variety of publications, international standards, physics training resources and safety posters. This information is particularly useful for those involved in training medical students, residents and fellows, especially in this era of increased scrutiny on the use of radiation in imaging.

A brief sampling of this cornucopia includes: questions and answers about patient radiation risk in IR; a technical document on “Patient Dose Optimization in Fluoroscopically Guided Interventional Procedures”; a set of 23 physics and radiation safety PowerPoint lectures on diagnostic and interventional radiology; and posters on patient and staff radiation protection in fluoroscopy. Similar sets of materials are available for radiotherapy, nuclear medicine, digital and pediatric radiology, doctors using fluoroscopy outside of radiology and others. The main IAEA Web site (www.iaea.org) provides access to similar material on many other aspects of nuclear and radiologic technology and safety. Available materials on these Web sites range from very simple to extremely complex. With a bit of browsing, any IR should be able to find materials on many topics of interest written at the desired level of complexity. SIR members should avail themselves of this opportunity.

SIR Welcomes Cheryl Sadowski

SIR is pleased to welcome Cheryl Sadowski as the new SIR senior director of communications, marketing and publications. Cheryl holds a bachelor’s in journalism and advertising from the University of Wisconsin.

As vice president of communications at the Newspaper Association of America she directed the development and implementation of internal and external communications strategies, and supervised the communications department and external PR agency, she had overall responsibility for media and public relations, Web and social media strategy, content and operations, organizational branding and public awareness, and digital and print member communications.

Cheryl brings a strong history of advancing brand identity, organizational narratives and public policy perspectives across multiple platforms. She will be working to fulfill SIR’s branding, awareness and strategic positioning goals. In her free time, Cheryl enjoys ethnic cooking, wine, history and travel.

New PRESERVE Study Takes Shape With SIR Lead

Representatives from SIR, the Society for Vascular Surgery (SVS) and the U.S. Food and Drug Administration (FDA) have been collaborating to launch PRESERVE, a new large-scale, multispecialty prospective study to evaluate inferior vena cava (IVC) filter use and follow-up protocols to improve patient care. The effort is a direct result of an August 2010 FDA medical alert detailing the possibility that retrievable IVC filters could move or break, perhaps causing significant health risks for patients. SIR and SVS are in the process of forming a joint foundation to oversee the PREdicting the Safety and Efficacy of Inferior Vena Cava Filters Study.

With the goal of obtaining a functional view of all filters placed in the United States, the study will evaluate the overall safety and efficacy of filters placed by vascular specialists and intends to enroll about 2,500 patients at approximately 50 centers in the United States. The specifics of the study must first be approved by FDA through an investigational device exemption (IDE) study with HIPAA compliance. The societies are also in the process of making a final decision for a contract research organization (CRO). Filter manufacturers are participating in study discussions. SIR will announce more information about the study’s start as details become available.

For more information, please contact Carolyn Strain, SIR Foundation executive director, via email at csstrain@SIRweb.org or by phone at (703) 460-5567.

For more information, please contact Carolyn Strain, SIR Foundation executive director, via email at csstrain@SIRweb.org or by phone at (703) 460-5567.
SIR Holds Fourth CLOTS Course

The fourth SIR Catheter Lysis of Thromboembolic Stroke (CLOTS) course, which was held in October 2012, was extremely well received by all attendees. Using a multidisciplinary approach, the course offered participants a series of didactic presentations as well as case review, training in clinical neurological exams, NIH Stroke Scale certification, hands-on personal training using CT perfusion workstations and vascular simulators, as well as hands-on full-scale training on vascular flow models utilizing real sheaths, guide catheters, microcatheters and clot retrievers from groin to brain.

The evening dinner symposium featured speakers that further highlighted the capabilities of the technology. SIR’s Twitter and Facebook posts featured daily photos and updates from the CLOTS meeting.

SIR Foundation Announces Award Winners

SIR Foundation is pleased to announce that Barry T. Katzen, MD, FSIR, has been named the 2013 Leaders in Innovation Award winner and that Anne C. Roberts, MD, FSIR, has been named the 2013 Frederick S. Keller, MD, Philanthropist of the Year. SIR and the Foundation congratulate Dr. Katzen and Dr. Roberts on these awards.

Executive Council Meeting Highlights

The SIR Executive Council held its fall meeting in November to discuss the Society’s proposed strategic plan and other developments that will impact SIR’s future. The Executive Council approved adoption of the strategic plan, which will prioritize the Society’s efforts for the next five years (read more on p. 25).

Other meeting highlights include:
- Approval of a change in medical student dues to complimentary (excludes online or print Journal of Vascular and Interventional Radiology)
- Approvals of Nominating Committee appointees
- Approval of the SIR 2013 budget

SIR Foundation Board of Directors Meeting Highlights

The SIR Foundation board of directors approved the Discovery Campaign corporate deadline, which will occur at the SIR Annual Scientific Meeting in New Orleans, April 15-18, 2013. A few remaining corporate partners are being encouraged to participate by the deadline so that they can be appropriately recognized as Discovery campaign donors at the Annual Scientific Meeting.

The Foundation is building a thriving culture of giving, which includes increased focus on annual giving, expanding volunteer participation on the gala and auction, and developing a more robust planned/legacy giving program. If you’re interested in volunteering on any of these efforts, please contact Julie Wolfe, SIR Foundation development director, at jwolfe@SIRweb.org or (703) 460-5591.

On April 14, SIR Foundation will host its third annual fundraising gala, themed “A Taste of New Orleans,” at one of New Orleans’ most unique venues: Blaine Kern’s Mardi Gras World East. This year’s gala promises to give attendees a true New Orleans experience: world-renowned cuisine served via an array of tasting stations, insight into the city’s culture and history, the soulful sounds of local jazz and blues artists, cooking demos from an award-winning local chef and several contests that will put the “fun” in fundraising for advances in IR research. With all this in one place, in one night, why go anywhere else? Visit www.SIRFoundation.org/gala for tickets and details.

More details on the gala can be found on p. 21.
Standards Division Update

The Society recognizes the New Standards Division committee chairs and members for their hard work and significant accomplishments:

- **Wael E. Saad**, MD, FSIR, Standards of Practice Committee chair
- **Sean R. Dariushnia**, MD, Revisions/Endorsement Subcommittee chair
- **Richard B. Towbin**, MD, FSIR, and **Mark J. Hogan**, MD, Pediatric Subcommittee chairs
- **Steven C. Rose**, MD, FSIR, Technology Assessment Committee chair
- **Michael D. Kuo**, MD, FSIR, Position Statement Subcommittee chair
- **Joseph R. Steele**, MD, and **Jeremy C. Durack**, MD, Quality Improvement/Informatics Committee chairs
- **Robert G. Dixon**, MD, and **James E. Silberzweig**, MD, FSIR, Safety and Health Committee chairs

Documents Produced in 2012

- **January**: Quality Improvement Guidelines for Recording Patient Radiation Dose in the Medical Record for Fluoroscopically Guided Procedures.
- **January**: Radiation Management for Interventions Using Fluoroscopic or Computed Tomographic Guidance During Pregnancy: A Joint Guideline of the Society of Interventional Radiology and the Cardiovascular and Interventional Radiological society of Europe with Endorsement by the Canadian Interventional Radiology Association
- **February**: Society of Interventional Radiology Position Statement: Mini Training Courses in Interventional Radiology Techniques
- **March**: Quality Improvement Guidelines for Transhepatic Arterial Chemoembolization, Embolization and Chemotherapeutic Infusion for Hepatic Malignancy
- **April**: Review Article: Quality Improvement in Interventional Radiology: An Opportunity to Demonstrate Value and Improve Patient-centered Care
- **June**: Consensus Guidelines for Periprocedural Management of Coagulation Status and Hemostasis Risk in Percutaneous Image-guided Interventions
- **August**: Guidelines for the Prevention of Intravascular Catheter-related Infections: Recommendations Relevant to Interventional Radiology for Venous Catheter Placement and Maintenance
- **November**: Quality Improvement Guidelines for Pediatric Abscess and Fluid Drainage
- **December**: Joint Practice Guidelines for Sterile Technique During Vascular and Interventional Radiology Procedures: From the Society of Interventional Radiology, Association of periOperative Registered Nurses, and Association for Radiologic and Imaging Nursing and endorsed by the Cardiovascular and Interventional Radiological Society of Europe and Canadian Interventional Radiology Association

Pending Publication in early 2013

- Research Reporting Standards for Interventional Radiology Treatment of Renal and Pancreatic Transplant Complications
- Injection Safety: Improper Use of Single-Dose/Single-Use Vials
- Quality Improvement Guidelines for Percutaneous Management of Acute Lower Extremity Ischemia

Pending Final approval in early 2013

- Research Reporting Standards for Angioplasty in Chronic Cerebrospinal Venous Insufficiency and Multiple Sclerosis
- Occupational exposure to bloodborne pathogens in Interventional Radiology: Risks, Prevention and Recommendations

Members interested in volunteering for standards should contact Debbie Katsarelis at Debbie@SIRweb.org.
REGISTER TODAY!
Advance Registration Deadline: March 8, 2013

SEE YOU IN NEW ORLEANS!
For more information, contact SIR:

AnnualMeeting@SIRweb.org  (703) 691-1805  Scan the QR Code

WWW.SIRMEETING.ORG
SIR Call for 2014 Gold Medal Nominations

Nominations are due May 1, 2013

PURPOSE:
The SIR Gold Medal was established in 1996 and is the highest honor that can be achieved in the field of interventional radiology. This honor is bestowed for excellence and lifetime achievement in interventional radiology to those individuals who have rendered exceptional service to the field. Gold Medal recipients exemplify those individuals who have dedicated their past and present talents to advancing the quality of patient care through the practice of interventional radiology and who, by their outstanding achievements, also help to ensure the future of the field.

ELIGIBILITY CRITERIA:
The SIR Executive Council can award the Gold Medal to an individual for distinguished and extraordinary service to SIR or to the discipline of interventional radiology. Service to interventional radiology can be in teaching, basic research, clinical investigation or in other areas, such as outstanding contributions in work with the SIR, other medical organizations, governmental agencies or related groups.

PROCESS:
The SIR Gold Medal Awards Committee selects the medalists. The committee’s recommendation(s) are sent to the SIR Executive Council for approval. Immediately following approval, the president calls the honorees to announce that they have been chosen for the honor.

The Gold Medal Awards Committee consists of the president as chair, the immediate past president, president-elect and the chair of the Fellows’ Affairs Committee. The president may appoint two additional at-large individuals.

The committee will consider all candidates nominated by members and fellows of SIR. The committee may also submit internal nominations. The committee will submit no more than three names for endorsement by the Executive Council.

Nominations received in previous years are reactivated the following year unless withdrawn by the nominator. Members of the SIR Executive Council and the chair of the Fellows’ Affairs Committee may not act as primary nominators or sponsors and are ineligible to be nominated for or to receive the Gold Medal during their term of office.

HOW TO SUBMIT A NOMINATION:
Submissions should describe the nominee’s qualifications for the award and should include a detailed curriculum vitae. The primary nominator is responsible for initiating the submission of at least two letters of support from other SIR members.

SEND YOUR NOMINATIONS BY MAY 1, 2013, TO:
Chair, SIR Gold Medal Committee c/o Debbie Katsarelis
SIR  |  3975 Fair Ridge Drive  |  Suite 400 North  |  Fairfax, VA 22033
Phone: (703) 691-1805  |  Fax: (703) 691-1855  |  Debbie@SIRweb.org

SIR Congratulates the 2013 Gold Medalists!

Wilfrido R. Castañeda-Zuniga, MD, FSIR
Wilfrido R. Castañeda-Zuniga, MD, FSIR, a long-time educator and pioneer in interventional radiology, has worked tirelessly to advance the specialty around the world. According to Michael D. Darcy, MD, FSIR, “Few people have had as great an impact on our specialty… I have to say that my years as a fellow underneath Dr. Castañeda have been some of the most exciting of my career.”

David A. Kumpe, MD, FSIR
One of the greatest strengths of David A. Kumpe, MD, FSIR, as an interventionalist is his ability to build collaboration while exploring new areas. As Thomas A. Sos, MD, FSIR, says, “Not only has he been a pioneer in both peripheral and neuro intervention, but he has sought all along to be a uniter and teacher in radiology and other specialties.”

Kenneth R. Thomson, MD, FSIR
According to Alan H. Matsuzumo, MD, FSIR, Kenneth R. Thomson, MD, FSIR, is the “most prominent interventional radiologist in Australia and New Zealand and has made a significant impact on the development and spread of interventional radiology procedures in the Asian/Pacific arena, inclusive of Australia and New Zealand.” He concludes, “In many ways, he is considered the father of interventional radiology in Australia.”
2013 Calendar

January 1
SIR Office Closed

January 11
HHMI Medical Research Fellows Program
application deadline, 2 p.m. ET

January 16
Y-90 early bird registration and hotel deadline

January 18
SIR 2013 early-bird registration deadline

January 18–19
SIR Endorsed: 2013 CIO

January 19–23
SIR Endorsed: 2013 ISET

February 1
Radiology Resident Research Grant applications due

February 1
Student Research Grant applications due

February 7–8
Y-90: The Advanced Course, Coronado, Calif.

February 18
SIR Office Closed

March 8
SIR 2013 advanced registration deadline

April 13–18
SIR 38th Annual Scientific Meeting, New Orleans, La.

May 1
SIR 2014 Gold Medal nominations due

www.SIRmeeting.org: Details on the SIR Annual Scientific Meeting
www.SIRweb.org: Details on other SIR educational opportunities
www.SIRFoundation.org: Details on SIR Foundation grants and awards
Re-election Economics

What four more years will mean to your bottom line

BY GEORGE A. FUEREDI, MD, FSIR

As we settle into a new congressional session, we are reminded that sometimes the more things change, the more they stay the same. With the recent presidential and congressional election behind us, we shift our focus to the implications of President Obama’s re-election for the society and its members.
As you know, there was very little shake-up or change in our country’s leadership. President Obama and his administration are in power in the executive branch for another four years and the makeup of Congress also remains the same. Yet, despite preservation of the status quo, the future of health care policy has never been more in flux than it is now.

What’s Certain
The 800-pound gorilla hanging above the heads of those in policy circles prior to the most recent election was whether the possibility of a new administration meant the end of Obamacare as we know it. Any changes or a repeal of the Affordable Care Act (ACA) could have meant drastic changes as well to the practice of IR. The ACA contains a multitude of provisions that directly or indirectly affect your practice, such as the misvalued code provision, the provision on the multiple-procedure payment reduction (MPPR), the independent payment advisory board (IPAB) provision and a provision relating to self-referral laws. As it stands, all of these provisions remain in place, with most going into effect by 2014. How this will affect you and your practice will need to be determined on a case-by-case basis.

Immediate Economic Impact of the ACA Breakdown:

- **Increased Taxes:** For individuals making $200,000 per year or families making $250,000, there will be an increase in the Medicare payroll tax of 0.9 percent and an increase in investment income tax of 3.8 percent.

- **PQRS:** The ACA extends the current Physician Quality Reporting Initiative (PQRI) program through 2014. Incentive payments for 2011 equaled 1 percent, while payments for 2012–14 equal 0.5 percent. Eligible professionals who do not report quality data measures will be penalized 1.5 percent for 2015 and 2 percent for 2016. In light of these changes, the program is now known as the Physician Quality Reporting System (PQRS).

- **Equipment utilization rate:** The 2011 Physician Fee Schedule (PFS) rule implemented section 3135 of the ACA, which set the equipment utilization rate assumption for expensive diagnostic imaging equipment (equipment priced at over $1 million; e.g., computed tomography [CT] and magnetic resonance imaging [MRI] scanners) at 75 percent beginning Jan. 1, 2011, and exempted the provision from the budget neutrality limitation. CMS did not propose to extend the application of the 75 percent utilization rate to procedures beyond those using CT and MRI scanners. The 2011 PFS rule also applied the 75 percent utilization rate to 24 additional codes—predominantly diagnostic computed tomographic angiography (CTA) and magnetic resonance angiography (MRA)—because they include expensive diagnostic imaging equipment in their practice expense inputs.

- **Multiple-procedure payment reduction:** The 2011 PFS implemented section 3135(b) of the ACA, which increased the multiple-procedure payment reduction (MPPR) for the technical component (TC) of certain single-session imaging services to consecutive body areas to 50 percent, effective July 1, 2010, and exempted this change from the budget-neutrality provision. Previously, a 25 percent MPPR was applied to the TC of the second and subsequent imaging services when more than one service in one of 11 imaging families (defined by imaging modality and contiguous body area) was furnished in a single session. As of July 1, 2010, payment is made at 50 percent of the TC for each additional procedure.
What’s Uncertain

While the ACA remains the law of the land, there is still some uncertainty as we move forward with the 113th Congress:

- Physicians are still faced with uncertainty over the SGR despite the recent one-year fix.
- There are constant concerns about medical malpractice reform and whether we are any closer to a resolution now that we still have a divided Congress.
- We still face the continued crisis of the drug shortages.

Perhaps no other issue loomed larger than the proverbial “fiscal cliff” facing Congress at the end of 2012. The fiscal cliff referred to a combination of the expiration of the Bush tax cuts and the $1.2 trillion in spending cuts as a result of sequestration. As you recall, in 2011 Congress faced a crisis on whether to raise the debt ceiling. Republicans were in favor of raising the debt ceiling but did not want to pay for it by raising taxes. Democrats were considering raising taxes but insisted that entitlements not be part of the equation.

The Balanced Budget Act of 2011 was developed as part of a compromise between the two parties. This act called for an immediate spending cut of $1.2 trillion followed by another spending cut of $1.2 trillion divided evenly between discretionary and nondiscretionary spending. If Congress failed to come up with the additional $1.2 trillion in spending cuts by the November deadline, an automatic across-the-board cut would take place known as “sequestration.” Congress failed to reach a compromise and we are currently faced with sequestration.

The direct result of sequestration is a 2 percent across-the-board cut of physician Medicare payment once the deadline expires, but the bigger concern is the potential fallout from the fiscal cliff in general. Although politicians managed to avert going over the fiscal cliff and delayed sequestration for two months, there are still many uncertainties that remain. Congress addressed the expiring tax cuts and provided a temporary patch to the SGR fix but failed to address the looming debt ceiling and spending cuts, which are still part of the equation. As Congress looks for ways to cut spending, every government program is fair game and on the table. It should come to no one’s surprise that health care cuts are very much a part of this discussion. As is always the case, patient benefits will likely remain safe, but provider cuts are certainly in play.

The administration and many in Congress still feel that the best way to reduce health care costs is by practicing preventative medicine. They also believe that the way to enhance the practice of preventative medicine is to provide a financial boost to primary medicine, often at the expense of specialty medicine. Moving forward, physician specialty groups are being forced to play a game of turf battle as these new policies take shape. There has been much talk that Congress will eventually do away with the physician fee-for-service system and replace it with a system that rewards quality.

This is a critical factor and may actually work to the advantage of interventional radiologists because it will force Congress to discount utilization rates as a measurement of value and concentrate on clinical outcomes or efficiency. SIR projects such as the “IR value project” are geared around this fact and will hopefully provide the evidence-based data necessary to present to policymakers as they attempt to create delivery system reform.

The biggest challenge during the next few months will be to prove to policymakers the value of IR. It is our responsibility in these changing times to demonstrate to these key decision makers that the practice of IR provides quality, is efficient and, when applicable, can provide health care savings. The SIR leadership has developed an aggressive advocacy campaign to be implemented over the next six months that will address these concerns. The face of health care reform continues to evolve, but SIR will just as certainly continue to be a part of that process.

The ACA contains a multitude of provisions that directly or indirectly affect your practice, such as the misvalued code provision, the provision on the multiple-procedure payment reduction (MPPR), the independent payment advisory board (IPAB) provision and a provision relating to self-referral laws.

The spring 2013 issue of IR Quarterly will feature follow-up information describing the outcomes of the 113th Congress. If you have any questions about this article or would like to volunteer to support the Society’s grassroots advocacy efforts, contact Doug Huynh, SIR director of government and policy affairs, at dhuynh@SIRweb.org.
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**MICROWAVE ABLATION VS. RADIOFREQUENCY ABLATION**

**What are the appropriate codes to use when microwave ablation is the energy source used for liver, lung or renal lesions?**

**Answer:** The existing Current Procedural Terminology (CPT) codes for tumor ablation are defined for radiofrequency ablation. This definition has led to some confusion, resulting in the use of unlisted procedure codes for microwave ablation. SIR does not recommend the use of unlisted procedure codes for microwave ablation of kidney, lung or liver tumors.

Microwave is part of the radiofrequency spectrum and simply uses a different part of the radiofrequency spectrum to generate heat energy to destroy abnormal soft tissue. Microwave ablation equipment is substantially comparable to operate in practice, which is also reflected in the U.S. Food and Drug Administration (FDA) approval of microwave devices under the 510(k) clearance process as equivalent to radiofrequency.

As such, SIR recommends that CPT codes 47382, 32998 and 50592 be used for both microwave and radiofrequency ablation in their respective anatomic locations, in conjunction with the appropriate imaging guidance code:

47382  
*Ablation, one or more liver tumor(s), percutaneous, radiofrequency; with appropriate image guidance code: 77013 (CT), 76940 (US), 77022 (MRI)*

32998  
*Ablation therapy for reduction or eradication of one or more pulmonary tumor(s) including pleura or chest wall when involved by tumor extension, percutaneous, radiofrequency, unilateral; with appropriate image guidance code: 77013 (CT), 76940 (US), 77022 (MRI)*

50592  
*Ablation, one or more renal tumor(s), percutaneous, unilateral, radiofrequency; with appropriate image guidance code: 77013 (CT), 76940 (US), 77022 (MRI)*

**NEPHROSTOMY TUBE EXCHANGE**

**When is it appropriate to code for a nephrostogram during a tube change?**

**Answer:** There is much confusion about the use of CPT codes 50398 and 50394:

50398  
*Change of nephrostomy or pyelostomy tube*

50394  
*Injection procedure for pyelography— as nephrostogram, pyelogram, antegrade pyelouretrograms—through nephrostomy or pyelostomy tube or indwelling ureteral catheter*

The position of SIR is that contrast injection used for basic anatomy during nephrostomy tube exchange is part of the procedure, is therefore included in CPT code 50398, and should NOT also be coded as a diagnostic nephrostogram.

Coding for both under this circumstance is an area of potential misuse of the codes. There are occasions when a diagnostic study is performed at the same time as a tube change. Under that circumstance, it is appropriate to include CPT code 50394 with the -59 modifier. The use of modifier -59 with CPT code 50394 indicates that a true diagnostic study was performed. CMS does allow the use of National Correct Coding Initiative (NCCI)-associated modifiers for clinical scenarios where the patient having a tube change also presents with new symptoms related to the tube.

For example:

- A patient presents with pain and leakage in the area surrounding his nephrostomy tube.
- Contrast is injected, a diagnostic nephrostogram is performed, and it is determined, on the basis of the diagnostic study, that the tube must be changed.
- Codes 50398 and 50394-59 are reported.

Disclaimer: SIR assumes no liability, legal, financial or otherwise for physicians or other entities who utilize this information in a manner inconsistent with the coverage and payment policies of any payers or Medicare contractors to which the physician or other entity has submitted claims for the reimbursement of services performed by the physician. CPT codes and their descriptors are copyright 2012 by the American Medical Association.
Valuable SIR Resource Coming Soon With New Information!

2013 Interventional Radiology Coding Update features include:

- Overview of Payment and the CPT/RUC Process/E&M Coding—appropriately reporting services for IR
- New and revised 2013 interventional radiology codes
- Frequently asked questions
- Individual coverage request sample letters
- Re-formatted sample 2013 charge sheets

Available soon as an online download from the IR Store:

http://directory.SIRweb.org/store

SIR members: FREE
Nonmembers: $249

Bundle with the 2012 update and save (Nonmembers bundle price: $399)!
Research Education Division Update

An important goal of SIR Foundation is to promote and facilitate interventional radiology research to improve patient care through innovation and to strengthen the field through scientific evidence of the benefits of the IR procedures. One challenge we face is the relative lack of robust scientific data for many of the procedures we offer.

We are also challenged in our attempts to produce the data given the relative lack of clinical and basic researchers in our ranks. To strengthen our position as a specialty, the SIR Foundation Research Education Division is tapping into its resources to develop educational programs and opportunities, both for SIR members and the broader interventional radiology community, including future IRs.

Educational content produced by division volunteers includes Web-based education on research topics, which can be accessed on the SIR Learning Center (http://learn.SIRweb.org). The first is “Literature Review, Evidence-based Interventional Radiology (EBIR) and Comparative Effectiveness,” by James B. Spies, MD, MPH, FSIR. The Web-based activity is free to SIR members, and provides 1.25 AMA PRA Category 1 Credits on completion. The second opportunity (which will be available soon) is “Getting Started in Clinical Trials, IR, Research and You,” by Matthew S. Johnson, MD, FSIR, and Francis E. Marshalleck, MD. These and other Web presentations will continue to provide opportunities for SIR members to learn or review the basics of research, to help them to establish their own research programs at their institutions.

This summer, the Foundation’s research education division piloted an “embedded research intern” program for medical students to expose interested medical students to advanced concepts in IR research. Two medical student participants were selected through a competitive open application process. Two internship sites were selected—one with an IR research mentor and one in a corporate research and development environment. Both mentors and students gave the program excellent reviews at its completion, and the Foundation is pleased to expand the program to additional sites for its second year in summer 2013. Jeff H. Geschwind, MD, FSIR, and Bard Peripheral Vascular will continue as the internship sponsors, and the Foundation will be accepting applications for an additional IR research mentor and an additional corporate site. We hope this program will grow to include trainees at many levels to encourage the development of a robust network of clinical and basic science investigators in IR. For information on how to apply as a mentor or sponsor, please contact Kathleen Mercure, SIR Foundation clinical research and education manager, at kmercure@SIRweb.org.

The future of IR as a specialty will increasingly depend on our ability to produce evidence of our value, to patients and to the entire health care system. The many facets of research, from basic science to clinical innovation to comparative effectiveness, are all relevant to securing that future.

The SIR Foundation Research Education Division provides members with tools to move forward with innovation and create the necessary metrics and data.
INVEST IN THE SPECIALTY AND CELEBRATE AT THE 2013 SIR FOUNDATION GALA

The 2013 Gala will give you the true New Orleans experience—world-renowned cuisine, insight into the city’s culture and history, and the soulful sounds of local jazz and blues artists. With all this in one place, in one night, why go anywhere else?

Gala revelers will be fascinated by Blaine Kern’s Mardi Gras World, an extensive setting offering a river-front plaza for mingling, a festive ballroom where guests will taste the world-famous flavors of the Crescent City, and an indoor antebellum mansion replica (fit for Scarlett O’Hara) surrounded by moss-draped oaks, a starry night sky and a winding waterway.

This year’s Gala will also give attendees the opportunity to tour the Mardi Gras World Float Den, the manufacturing site of the magnificent Mardi Gras floats, sculptures and props and to learn the history behind one of the world’s largest cultural celebrations. Tickets are available at www.SIRFoundation.org/Gala.

Reserve your place at this highly anticipated event; we anticipate another sold-out event!

“The last two Gala events have been exceptional. Everything from the venue, to the auction items, to the dinners have been first class. Perhaps my favorite aspect of the event is in seeing all types of individuals there—SIR members, international attendees, staff and our corporate colleagues—enjoying themselves equally and together. The Gala has provided a real sense of esprit and camaraderie that is unique and quite special.”

— CHARLES E. RAY JR., MD, PHD, FSIR —

SUNDAY, APRIL 14, 2013, MARDI GRAS WORLD
Are You Drawn to ATTRACT?

FOR THE BEST DVT CARE, JOIN THE ATTRACT STUDY!

BY SURESH VEDANTHAM, MD, FSIR

The Acute Venous Thrombosis: Thrombus Removal with Adjunctive Catheter-directed Thrombolysis (ATTRACT) Study is an ongoing, pivotal, National Institutes of Health- (NIH-) sponsored, multicenter randomized controlled trial (RCT) that seeks to determine if the routine use of pharmacomechanical catheter-directed thrombolysis (PCDT) in patients with acute proximal deep vein thrombosis (DVT) reduces a patient’s risk of developing post-thrombotic syndrome (PTS). Key clinical outcomes being assessed include:

- Two-year PTS rates
- Quality of life
- Relief of pain and swelling
- Safety
- Cost-effectiveness

ATTRACT, which is being conducted in 50 U.S. hospitals and is coordinated at Washington University’s Mallinckrodt Institute of Radiology, is fortunate to collaborate with SIR Foundation and to carry the public endorsement of the U.S. surgeon general.

As of Dec. 27, 2012, the ATTRACT Study had enrolled 387 patients, which is more than halfway to its accrual target of 692 patients. The rate of monthly accrual improved substantially in 2012. Notwithstanding this success, it has been vexing to find the enrollment of a few hundred patients to be so difficult during a period in which 1 to 2 million DVT diagnoses will be made in the United States. The study investigators have tried hard to encourage community IRs to refer their patients to ATTRACT sites instead of just lysing them locally but with very limited success.

At present, clinical practice guidelines of health professional organizations are split on whether CDT/PCDT should be routinely utilized for DVT. Guidelines of SIR1 and the American Heart Association2 suggest catheter-based intervention for selected patients, but the influential guidelines of the American College of Chest Physicians3 recommend against it.

There is no question that the evidence in favor of CDT/PCDT has been gradually improving in both quantity and quality. In particular, the recently published CAVENT Study, a multicenter RCT performed in southern Norway, found the use of drug-only CDT to reduce the risk of PTS in patients with proximal DVT4.

Informed by this data and a generally proprocedure mindset, you may ask, “Is participation in ATTRACT, which implies a 50 percent chance of being randomized to the no-lysis control arm, really the best thing for my DVT patient?”

The answer is “Absolutely yes!” Why?

First, step back and view the big picture of DVT treatment. Two things become clear: 1) many IRs greatly overestimate the strength of the evidence supporting the use of CDT and PCDT relative to historical treatment approaches and 2) many IRs greatly underestimate the value of study participation to a DVT patient.

Regarding strength of evidence, consider first the record of anticoagulant therapy (AC) alone. This form of DVT therapy has been evaluated in many well-constructed clinical trials totaling more than 20,000 patients enrolled over a 50-year period. The findings—that AC prevents pulmonary embolism and recurrent DVT—have been consistent across many studies. The risk of...
major nonfatal bleeding for initial AC using low-molecular-weight heparin (LMWH) in all participants (including high-risk patients who could never be included in a thrombolytic study) is about 1.5 percent; fatal bleeding is exceedingly rare. Moreover, AC drugs are given orally or by parenteral injection in a uniform way, increasing the likelihood that clinical trial results truly represent the therapy as delivered in actual clinical practice. Hence, while AC may have limitations in terms of PTS prevention, it is very safe, it prevents PE and we can be quite certain that we actually understand its risk–benefit profile when we provide it to our patients.

In contrast, consider the body of literature in support of CDT and PCDT. Most studies have major methodological flaws, including nonrandomized study design, small sample size, lack of blinding and lack of use of validated outcome measures. There has been only one rigorously performed RCT (CAVENT). But CAVENT reported outcomes in just 189 patients, of whom only 90 patients received CDT. CDT was delivered in a manner in keeping with U.S. practice—15–20 years ago: 1-to 4-day infusions of thrombolytic drug through a multisidehole catheter, without use of thrombectomy devices and with very limited use of stents. As such, the ability to generalize its results to U.S. practice is highly questionable. Furthermore, the results of CAVENT were somewhat underwhelming—a 28 percent reduction in the risk of PTS at two years, at a price of a 3 percent additional risk of major bleeding. But no venous ulcers occurred in either treatment arm, so it is not clear if CDT simply prevented mild PTS as opposed to clinically important moderate-to-severe PTS.

Two additional RCTs have been reported in the literature, but neither evaluated follow-up beyond six months post-treatment and both had major methodological flaws. But even combined with CAVENT, there are fewer than 200 patients who have received endovascular lytic therapy in RCTs. Hence, there is tremendous statistical uncertainty around these estimates. When you consider the great heterogeneity in the way PCDT is performed in modern practice, with current evidence we cannot be remotely confident that our estimates of efficacy and safety really represent the use of modern PCDT in real-world clinical practice.

Patients entering the ATTRACT Study receive all evidence-based DVT treatments that are currently known to work: AC and compression therapy. Study patients are monitored closely and receive several “freebies”—compression stockings, follow-up visits, an ultrasound exam and the thrombolytic drug. They have the confidence that the treatment protocols being used on them have been endorsed by national DVT experts and the NIH. Because a motivated research nurse coordinator is assigned to monitor their care, they can more easily access the health care system for help and information (including questions about their DVT).

Studies have shown that in DVT patients receiving warfarin, patients who are enrolled in a clinical trial are much more likely to have internal normalized ratio (INR) values that are within the therapeutic range than patients treated in clinical practice. Hence, enrolling in ATTRACT is likely to enhance the quality of care given to your patient. 50 percent of study patients do not receive PCDT, but it should be recognized that that element of care has not been validated to improve any patient outcome and is almost certainly associated with some degree of increased bleeding risk and up-front cost.

In conclusion, participation in the ATTRACT Study is a terrific way for your patient to receive an outstanding level of DVT care while also helping other patients with DVT. I urge every IR reading this article to reconsider the feasibility of referring patients to ATTRACT sites (yes, it can be done!). If you have a patient, please page (314) 360-5565 and our clinical coordinating center staff will assist you in quickly finding a nearby ATTRACT site.

REFERENCES


Suresh Vedantham, MD, FSIR, principal investigator of the ATTRACT Study, is an SIR councilor-at-large and chair of the SIR Service Line Division.
Get the *JVIR* iPad® App Fast—It’s at Your Fingertips!

Most of you may already know that the Journal of Vascular and Interventional Radiology (*JVIR*) iPad app was released in August. If you don’t already have it, I suggest that you get it to enjoy all the benefits of a tool that literally places most recent IR research published in *JVIR* at your fingertips.

Offered to our large audience of tech-savvy tablet owners, the *JVIR* app is a medium for the direct and rapid spread of IR science around the globe. Whether you are on the road, on the run, between consults or procedures, or simply forgot your *JVIR* copy at home, you are certain to appreciate all the added benefits that our iPad version has to offer. If you want to keep abreast of the latest in IR literature and share it with colleagues—in no time—get it fast ... get it now!

Here are some of the app’s valuable features and functions:

- Read new issues and articles immediately upon release
- Conveniently browse *JVIR* content wherever and whenever you wish
- Save articles on your device
- Bookmark key articles
- Take notes for later follow-up
- Email useful images or articles
- Play in-article podcasts
- Post useful articles on your Facebook or Twitter accounts
- Search your locally stored content

We believe the app will serve you as well as the journal and Society’s global mission—to make the highest-quality interventional radiologic science available to practitioners around the world.

Last but not least, this iPad app is **free for *JVIR* subscribers.** If you haven’t already registered at the *JVIR* Web site, [www.jvir.org](http://www.jvir.org), just complete the quick registration form at [www.jvir.org/claim/activate](http://www.jvir.org/claim/activate). Once you register, you can download the app at the iTunes® App Store and access it through the Newsstand* interface—whenever and wherever you want.

The app is also available for **nonsubscribers at a discounted price** at iTunes® App Store.

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**Registration Tips**

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- On the Login or Register a New Account page, enter your email address.
- If you already have an account on *jvir.org*, go to Log in to an existing account.
- If you don’t have an account on *jvir.org*, go to Register an account.

**For those who need to set up their online access:**

- *JVIR* subscribers who are not SIR members will need their subscription number from their mailing label* to set up an account.
- SIR member subscribers need to use their SIR membership ID; the SIR login name will not work on *jvir.org*.

On the Claim Your Online Access page, select the applicable option from the following three alternatives:

- I have purchased a personal subscription
- I receive my subscription through a society membership
- I received a special promotional offer

Once the registration process is complete, the View Your Claim Confirmation box on the top becomes active, and you can download the app by searching *JVIR* in iTunes or the App Store on your device.

*Note: You will need your subscription number from your mailing label to set up your account on the first visit only.
Fast forward to 2023 and enter a world transformed. Changes in IR training and the elevation of the specialty have transitioned IRs to a more comprehensive level of expertise with the requisite combination of clinical, procedural and interpretive skills for the safe and competent practice of IR. Patient outcomes have been improved by these changes—and students are choosing IR over other specialties.

IR has demonstrated the safety and efficacy of existing procedures and technologies. The specialty now receives ample multinational, federal and industry funding to encourage continuous innovation and provide the evidence to support emerging new minimally invasive procedures and the role of IR in delivering high-quality longitudinal patient care. IRs serve as leaders in research, registries and trials. Evidence-based standards of practice form the foundation for safe medical care and appropriate quality standards. But IR is no longer defined by its technology or procedures; every IR has a robust admitting service and mature office practice.

All health care providers routinely and directly rely on and value the expertise of IRs and IR teams from assessment to longitudinal care as the primary experts, leaders and providers of image-guided therapy. Interventional radiology is considered a critical component of every hospital and IRs play an integral part as leaders in hospital decision-making at all levels.

SIR has ensured that IRs play a central leadership role in international, national and local health care policy.

IRs are regularly sought out as the leaders and experts in image-guided therapy by regulators, Congress, insurers, industry, national and international medical organizations, consumer advocacy groups and others.

As the models for health care delivery and reimbursement evolve to keep pace with innovation, IR’s value has grown, yielding even more efficient treatment options and improved patient outcomes. IR is recognized for decreasing the number of unnecessary procedures and a major pooling of RVUs is providing incentives for better patient care. Insurers recognize and value established image-guided therapies as the standard of care.

IRs are driving the next paradigm shift in medical care through innovation. SIR is valued for encouraging and fostering that innovation and meeting the needs of a diverse specialty. The community of professionals has expanded globally and is actively engaged in the work of the Society. Today, the profession is appropriately utilized and understood as a significant contributor to high-quality patient care worldwide.

In 2023, IR is the first choice for image-guided therapy.

Future IR Quarterly articles will explore how these goals will impact the future of the specialty and the practice of IR.
Annual Scientific Meeting Update

For those of you keeping track, there are just three more months until our 2013 Annual Scientific Meeting in Orleans, La. (April 13–18, 2013; www.SIRmeeting.org). That means SIR is in full gear to make this an exciting and worthwhile meeting to attend. If you think you know what to expect, think again—we’re working especially hard to make this a different experience for all attendees as well.

The format of the SIR 2013 Annual Scientific Meeting has evolved from the traditional SIR meeting format. One example is the “in-the-trenches” symposium. This four-day, meeting-long symposium will emphasize the issues facing community-based providers of IR care. It will offer updates in commonly performed procedures, marketing strategies for new areas of practice, and strategies for managing the stressful political and economic challenges facing today’s IR practice.

An alternative option for attendees who have recently entered academic practice is “Introduction to Academic IR Practice,” on Sunday, April 14, and Tuesday, April 16. During these sessions, many of the individuals who have succeeded in a university practice setting will share their wisdom with the newest members of the academic IR community. These sessions will provide important tips on how to succeed with the teaching and research expectations inherent to these positions.

Another session will be devoted to mentorship, where SIR hopes to provide insight into becoming a mentor while at the same time developing your own contacts in the field and finding a mentor.

On Monday, April 15, SIR will hold an international symposium highlighting the contributions of Latin American IRs to our field—certainly a must-attend session, considering how much of the work in prostate embolization is coming from Brazil.

Attendees should also watch for the Industry Interactives on Sunday, April 14, and Monday, April 15. These sessions give you additional opportunities to interact with SIR’s industry partners in the convention center and explore the technical advances in our equipment that make IR unique.

In the new small-group “Meet the Professor” sessions, attendees will hear opinions regarding IR’s future in such areas as peripheral arterial disease, interventional oncology, venous disease and reproductive embolization and will interact directly with the panel of experts. Register quickly because only a limited number of seats will be available in these sessions.

Even with all of these new sessions and opportunities, our traditional events such as the Dotter Lecture, the Debate Session and the Film Panel will hold a prominent place in this meeting. In addition, we have worked to minimize overlap and redundancy between symposia, categorical courses and workshops. Finally, our abstract submission numbers were once again extremely high this year, providing additional evidence that this meeting is the destination for the important scientific advances in our field.

We’ve been doing our planning for the Annual Scientific Meeting, so now it’s time for you to do your part of the planning. As 2013 calendars become set, make sure you reserve April 13–18 to spend time in New Orleans, La., with your colleagues in IR at SIR 2013. This is where you will hear what you need to know to move your practice forward. We look forward to seeing you there and hearing what you think about the changes in this year’s meeting.
Why Visit the SIR 2013 Technical Exhibit Hall?

The practice of IR is shaped by the technological advances our industry provides. Visit the Technical Exhibit Hall at SIR 2013 and see the latest in devices, imaging and other technologies.

The Technical Exhibit Hall will be convenient to meeting sessions, the New Product Showcase™ and the registration area, providing you with access to the hall during your scheduled breaks and lunches. The hall is open to registered attendees and guests who present a badge. Children under the age of 16 will not be permitted in the Technical Exhibit Hall.

The SIR 2013 Annual Scientific Meeting mobile app makes it easy to find what you’re looking for as you navigate through the hall using its product category feature.

The SIR 2013 Passport Program gives you the opportunity to meet as many exhibitors as you can during Technical Exhibit Hall hours. Collect 20 passport stamps from exhibitors for a chance to win a valuable gift.

There are also interactive education opportunities in the Technical Exhibit Hall:

- Participating exhibitors will provide an in-booth learning opportunity that is interactive and/or hands-on in nature. Look for the hands-on designation icon in exhibitor listings in the on-site guide and on the SIR 2013 mobile app.
- Select booths will feature Eat and Be Educated sessions with thought leaders on the latest innovations in interventional medicine. Look for a list of the sessions in the on-site guide and on www.SIRmeeting.org.

Technical Exhibits.

On Tuesday, April 16, 9:30–10 a.m., just before the Film Panel plenary session, meet and greet the exhibitors in the Technical Exhibit Hall while enjoying a warm beignet, a sip of coffee or a refreshing mimosa at a social networking reception.

Finally, SIR will host coffee break stations and complimentary lunch every day the Technical Exhibit Hall is open.

Social events and break times are subject to change. Refer to the SIR 2013 on-site guide for the final schedule.

Corporate support is vital to the success of the SIR Annual Scientific Meeting. Please thank our exhibitors as you spend time in the Technical Exhibit Hall at SIR 2013.

Technical Exhibit Hall Hours

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<th>Sunday, April 14</th>
<th>Monday, April 15</th>
<th>Tuesday, April 16</th>
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A Model Medical Student Symposium

The continuing success of interventional radiology demands recruitment of smart, motivated students to the field. This process begins with exposing students to interventional radiology and ensuring they realize the full scope of the field and the amazing opportunities it holds.

On Nov. 3, medical students at Emory held an interventional radiology symposium with the Emory IR Director and current APDIR President Hyun S. Kim, MD, FSIR, 14 Emory IR attendings and eight Emory IR fellows. The six-hour event began with an opening talk by past SIR Gold Medalist William J. Casarella, MD, FSIR, followed by several talks designed to teach medical students about the diseases IRs treat and the therapies they perform, including overview of state-of-the-art interventional oncology by Dr. Kim. The lectures concluded with a talk by SIR Past President Curtis Lewis, MD, MBA, JD, FSIR, regarding the impact of IR on health care. The IR faculty members and fellows also held a practical session where students received hands-on exposure to IR devices and practice with procedures such as ultrasound-guided vessel access. A total of 45 students attended, including 10 students from other medical schools in the Southeast and three physician assistant students.

To measure its success, pre- and post-symposium surveys were conducted to gauge students’ knowledge of IR, their interest in the field and interest in pursuing research and/or clinical opportunities within interventional radiology. Initial analysis suggests that the symposium was successful in increasing medical student awareness of and interest in interventional radiology, with several students already planning research projects with IR faculty. Furthermore, the event motivated several students to form an interventional radiology interest group with plans to hold several lectures throughout the year and to continue the symposium on an annual basis.

Planning is already underway for next year’s medical student IR symposium. The goal is to continue the symposium as a medical-student-led event tailored to the knowledge level and interests of students. In addition, we hope to expand the symposium to other medical students so that it will eventually become the southeastern and/or national medical student IR symposium. The survey will also continue to be an integral part of the symposium to study the effectiveness of the symposium and ways to improve. Furthermore, we plan to track the numbers of students actively pursuing IR research, participating in an IR elective rotation, and applying to radiology residency, and will compare the findings to the years prior to the symposium.

Students traditionally receive little exposure to the field of IR and, therefore, few students understand the scope of disease interventional radiologists treat and the breadth of procedures they perform. Furthermore, exposure to interventional radiology is vital to attracting the best and brightest students and ensuring that the field continues to grow with the next generation of physicians. Our experience suggests that the symposium format is an effective method to enhance medical student understanding and interest in interventional radiology. The Emory medical student IR symposium provides a successful and easily reproducible model for other medical schools to implement, thus increasing the number of students interested in interventional radiology across the country.

A Growing Trend

With the recent approval of the Dual Certificate, SIR recognizes the importance of introducing IR to trainees at the medical school level. At the October 2012 APDIR meeting, program directors encouraged each other to host IR medical student symposia to showcase IR as a specialty option for medical students. In October 2011, Northwestern Memorial Hospital held the Northwestern Interventional Oncology Training Symposium. More than 101 trainees participated in this one-day IO session, which included hands-on workshops.

In December 2012, the Warren Alpert School of Medicine at Brown University hosted its first Vascular and Interventional Radiology Symposium. This symposium provided medical students with a broad overview of interventional radiology, offering sessions on interventional oncology, the clinical practice of IR, PAD, women’s health, neurointerventional radiology. The symposium also included time for medical students to use simulators.

SIR applauds these efforts and encourages other institutions to provide medical student symposia as well.

Medical students who are interested in becoming an SIR member should contact Shaun Singletary, SIR member services associate, at ssingletary@SIRweb.org.
In 2012, SIR Press published the first in the *Updates in Interventional Radiology* series. Edited by Charles E. Ray Jr., MD, PhD, FSIR, and Brian Funaki, MD, FSIR, this series combines summaries of noteworthy literature with expert opinions on their applicability to the practice of IR. We sat down with Drs. Ray and Funaki to discuss the series and 2013 edition.

IRQ: What led to the *Updates in Interventional Radiology* series in the first place?

**Funaki:** We all want to stay current. There’s an ever-expanding body of literature affecting IR—but so little time to review it all.

**Ray:** It’s nearly impossible for IRs—or any practicing physician, really—to keep up with the wealth of information that comes out on a monthly basis. *Updates* offers a solution to this problem by providing one source for the most influential literature in the diverse fields of interventional radiology.

IRQ: You said in an interview last year that *Updates in Interventional Radiology* is unique—that there aren’t any other resources quite like it on the market. Why do you think that is?

**Funaki:** For one thing, reviewing current literature can be a bit tedious—and it’s always labor intensive. If it’s difficult to stay on top of all the literature for your own interests, you can imagine how much more difficult it would be to cull through all the literature for the most noteworthy research, organizing it all into a cohesive unit, etc.

**Ray:** Other fields actually do have similar resources, though, like the *Yearbook in Medicine* series. This is the first one we’ve had for IR.

IRQ: So why hasn’t there been one on IR until now?

**Ray:** Personally, I think it’s a matter of timing. IR has grown to the point where it affects nearly every other specialty in medicine. That means that these days there are IR-pertinent articles in nearly every specialty journal out there. Couple that explosion in literature with a record number of manuscripts submitted to our own journals and it seems an idea whose time has come.

**Funaki:** I agree. And once we’d completed our selections, it could be challenging to “unify” the disparate thoughts and views of the various authors to address the 10 topics in a cohesive way.

**IRQ:** Dr. Funaki alluded a moment ago to how labor intensive literature reviews can be. What have been your biggest obstacles in developing these books?

**Ray:** It’s actually been a far easier task than either of us imagined—thanks in large part to the volunteers, authors and staff who worked so hard to keep everything running smoothly. The biggest challenge probably came in determining which 10 or so articles have been the most influential in each topic covered. There’s a lot of good literature out there!

**Funaki:** I agree. And once we’d completed our selections, it could be challenging to “unify” the disparate thoughts and views of the various authors to address the 10 topics in a cohesive way.

It’s nearly impossible for IRs—or any practicing physician, really—to keep up with the wealth of information that comes out on a monthly basis. *Updates* offers a solution to this problem by providing one source for the most influential literature in the diverse fields of interventional radiology.

CHARLES E. RAY JR., MD, PHD, FSIR

*Updates in Radiology 2013* will be available for purchase in Spring 2013, exclusively through the IR Store on www.SIRweb.org. For information on pre-orders or other SIR Press resources, please contact publications@SIRweb.org.
IRA: The 2013 edition definitely covers a lot of ground: aortic aneurysms, portal hypertension, women’s health…nine topics in all. How did you decide what to include?

RAY: It was actually tempting to cover more topics, but ultimately we limited content to areas that seemed to be growing most quickly in the field and, by extension, those with the most influential literature.

FUNAKI: Right. All of the topics are in areas that have both relevance and relevant literature for the practicing interventional radiologist.

IRA: Do you think the selection of topics in itself gives the reader a sense of where the field is headed?

FUNAKI: It might be more accurate to say that it gives the reader a sense of where the field is right now. It’s always difficult to predict the future.

RAY: …but giving readers a sense of where we’re headed is certainly one of our hopes.

IRA: What was the toughest decision in the development of this book?

RAY: Deciding not to release an electronic platform for this edition...yet. We definitely plan to and we’re excited by the prospect and possibilities, but we want to make sure we do it right—so we decided to release it in print only for now.

IRA: What did you learn from the development of the first book in the series that you applied to the 2013 edition?

FUNAKI: We found that we needed to develop unifying principles that could be adopted and utilized by each author of each chapter. Chuck did these.

RAY: We really wanted to use reproducible methodology with the second iteration of the book, so the reader had some sense of the decision-making process behind choosing the articles presented.

IRA: What else has changed since the first edition?

FUNAKI: We now have a far more rigorous process for finding and vetting current literature rather than simply following an expert’s opinion of what may be important.

IRA: Most of the papers covered will be more than a year old when the book comes out. What about these papers makes them timely today?

FUNAKI: Given how rapidly medicine advances, that could certainly be seen as a drawback by some.

RAY: Many of these papers are the seminal articles in the literature, though, and should impact the practice of IR for many years to come.

FUNAKI: That’s what it’s all about, really—impact on practice. We believe readers will be able to evaluate the manuscripts presented and incorporate relevant information into their own practices.

RAY: We also were careful to avoid brand-new technical innovations and the like—we wanted to allow those kinds of breaking ideas that come out each month in the literature to mature somewhat.

IRA: So when those innovations mature they may find their way into a future volume?

RAY: Yes, I imagine that would be likely with many of these important articles.

IRA: You’ve referred to impact on readers’ practices. Did you find yourself learning practical lessons from the expert opinions included in each chapter? Did you ever say “Hey—I need to try that myself?”

FUNAKI: Absolutely. Particularly in academic medicine, we often have our own niches and don’t cover the gamut of therapy the field provides. This was as much a learning process for me as anything else I’ve participated in.

RAY: Me too—it’s always interesting to read how the leaders in the field have changed their practices over the past year. I actually think that is the greatest addition by the book—to have those unique perspectives presented to the reader in such an open format.

IRA: Would you say this book would appeal to non-IRs as well? How so?

RAY: Yes—particularly non-IRs who do minimally invasive image-guided therapies. The goal was really to have a source with practical applications on how the literature would change daily practice.

FUNAKI: There’s a broad gamut of information in this volume. Most of the material it covers has applications to every specialty of medicine and well-informed physicians will undoubtedly find at least portions of it important to their own practices.

BRIAN FUNAKI, MD, FSIR
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