



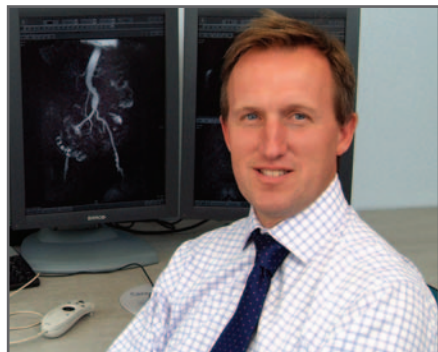
British Society of
Interventional
Radiology

BSIR

newsletter

ISSUE 24 Autumn 2008

editor's column



Welcome to the Autumn 2008 BSIR newsletter. A lot seems to have happened over what are usually the quieter summer months. The Olympics were a PR and sporting triumph. It would seem that sometimes being an autocracy has distinct advantages, when trying to get a head and producing the desired end result! It will be interesting to see what effect the political correctness and inclusiveness within the UK will have on the delivery of 2012 London Olympics. Similar states of forestalling and stand-off have taken place with regards many issues concerning IR development.

There continues to be much vying for position with regards the development of vascular IR between BSIR and the Vascular Society. The desire exists among both groups to produce a workable solution to the training and delivery of endovascular services, but progress is slow.

Within education many strands of sometimes quite disparate thoughts are continuing to vex both council and the sub-committee. There is a wholesale change to the education landscape that has been created by PMETB (Post Graduate Medical Education and Training Board). These involve all aspects of education delivery from standards of curricula and assessments to examinations and quality assurance, as well as looking at the running and roles of deaneries and schools. This has meant and continues to mean that there will be a great deal of work for all those involved. I would hasten to add, all is not bad news as there is a real opportunity within the deadlines of 2010, to make a real and lasting difference to how well we teach the next generation. A legacy worth fighting for!

In other areas where we are in control of our own destiny, results are being achieved. As you will see from the reports of the A&R group, we continue to be productive and are developing an evidence base in relation to our practice of the highest standard.

I include in this newsletter one of the winning scholarship essays as judged by the membership and rules committee. As you will read, the content of this work would not be out of place in a Harvard MBA dissertation. Undoubtedly, this is the world we now live in – justification and

business planning is as much a part of our working lives as our day to day workload. I am sure the next generation of clinicians will need to have good business acumen and talk the talk if IR is to compete in the modern world of healthcare delivery. It is good to see there are trainees already engaging in and thinking about the wider issues of IR delivery.

As a great reality check and for those to young to know the history of IR, John Dyet, a genuine pioneer and founder member of the society, says his goodbyes. John may have hung up his catheters and wires, but should be safe in the knowledge that he will have touched the lives of many interventional radiologists and has left a legacy within Hull and the wider IR community, of which he can be very proud. I thank him for agreeing to give us a glimpse of how IR developed throughout his professional life, where he feels things are heading and why providing a comprehensive IR service is vital to our future.

On a personal note, this pending a volunteer coming forward will be my last newsletter. My decision to hang-up on the editor's role is due to increasing personal commitments within the RCR and BSIR. I would like to thank all members for their support over the past three years. These are critical times for our specialty, your involvement is vital – please step up to the plate!

See you all in Manchester

Dr Ian Francis
Brighton and Sussex University Hospitals

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president's column



This will be my last Presidents note for the Newsletter whilst it has been under the stewardship of Ian Francis.

As ever he has done a magnificent job and we all wish him well with his future ventures. This leaves the BSIR with a gap that needs filling.

We urgently need a volunteer to undertake the important job of directing and producing the Newsletter – an important organ for the BSIR. Anyone interested should contact Lavinia Gittens.

We are fast approaching the Annual Scientific Congress in Manchester. The programme is fantastic and I am sure many of you will be eagerly looking forward to the educational feast. A side dish, but never-the-less very important is the AGM. Through discussion with your elected officers we feel it is important to move Interventional Radiology forward within these isles. We are constrained by many external forces and I am tired of reacting rather than being pro-active. In order that we develop as a speciality and achieve the gravitas that our speciality deserves, we wish to encourage the Royal College of Radiology to recognise Interventional Radiology as a sub-speciality within

the College (there are reasons why we cannot go for full specialty status). Some of you may think that we currently are recognised as such but your qualification is as a radiologist and there is no official recognition of your IR specialisation. Such recognition would open many doors and facilitate our development. To be very clear – such recognition of IR as a sub-speciality would not stop the majority of our members from undertaking both diagnostic and interventional work. On the contrary it will enable us all to move forward in a very positive way. I would be grateful therefore if you could attend the AGM to carry this motion.

The British Society of Interventional Radiology has had an eventful and productive year since the last Annual Scientific Congress. This is largely down to the very hard work of your chosen representatives on the BSIR Committees. Allow me to enlarge upon exactly what they have achieved.

The Registries and Audit Committee under the guidance of Raman Uberoi have been particularly active. We are aware that most interventional radiologists do not have the time to add data to all the registries. I asked this group to rationalise the registries and properly order their output. We have agreed a list of registries that should continue, registries that have come to the end of their valued life, and reports to compile. We are to focus upon the index procedures of which BIAS is our most worthy. The BIAS III report is now prepared and will soon be coming your way. An index procedure allows us to compare our outcomes. To facilitate this you will soon be able to download upon request your own funnel plots which will accurately demonstrate you are safe to practise. Such information will be vital for your appraisal, and vital for your future re-certification. I have asked this same Committee to develop similar index procedures for the non-vascular work. Work has also been undertaken to develop a dictionary of terms so that we can accurately define the outcomes of BIAS. Such work will be shared with CIRSE and SIR and will be extended to the other registries. Then we will be in a better position to ensure the data in is robust and our reports out are accurate. Iain Robertson is our liaison with other clinical specialist

societies. We are clear that future registries should follow patient clinical pathways and not simply document outcomes from a single device. To achieve this we will have to closely collaborate with other clinicians and their societies. As a starter Iain, Steve Thomas and Sumaira Macdonald are already working on two national collaborative data collection looking at the management of carotid disease and abdominal aortic aneurysms.

Alan Odurny has led a very busy Education Committee. He has taken over the lead from David Kessel in representing our interests through the RCR regarding the joint training initiative with the Vascular Society. This is a slow process, understandable given the unbelievably slow rumblings of PMETB and the sensitivities of the groups involved. More of this at the Congress. In addition this group has further developed the research and education bursaries available to our members and are developing a number of new initiatives, particularly making available some brief management pathways and patient information leaflets from our web-site.

Tired of the old web-site? So are we. The financial arrangements for a brand new website with the developers have now been agreed. David West has some sound and wacky ideas and I am certain the new site will be both stimulating and helpful. At the end of the day this site is yours so please contribute.

Tarun Sabharwal has led a very successful team to develop an extremely exciting Annual Scientific Congress in Manchester. Just to keep the group busy I have asked that that some time is also spent looking at delivering some focussed educational meetings throughout the year.

The Membership and Rules Committee have developed new strategy for attracting new members and registrar scholarships are available to support trainees attending the Annual Conference. The junior section had a very fruitful and enjoyable exchange with the junior section of the Vascular Society (Rouleaux Club)

I look forward to seeing everyone at the Congress. Have fun.

Prof Peter Gaines
President BSIR



BSIR 2008 5th Nov - 7th Nov
Manchester Central, UK

British Society of Interventional Radiology

Registered Charity No: 1084852

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BSIR Junior Section

It is encouraging to see that new radiology trainees continue to have strong interest in intervention and that this year many trusts across the UK have been and are looking to fill consultant interventional radiology posts. This reflects the increasing utilisation of IR services, including the rise in on call demands from clinicians.

The newer 3+2 year schemes will help train the current generation of trainees with additional training available through fellowship posts, both traditional (more of which have been advertised than in the previous year) and some of the newer Department of Health funded 'post CCT' fellowship posts. These post CCT fellowships of which there were four for radiology trainees, were designed to train vascular clinical and surgical skills. With MMC and more streamlined career progression than in the past, the learning of clinical skills will become more important, as will the need for interventionalists to run clinics. If you have done a fellowship, please post a report on the junior on line forum on the BSIR website. I would encourage also those in new post CCT fellowships to use the forum to discuss how clinical/surgical training is going and to 'compare notes'.

This July, the inaugural BSIR Junior Section Summer Meeting joint with the Rouleaux Club (Vascular Surgical Trainee forum) took place and was a success. There were good numbers of trainees from both sides attending and were privileged to listen to great lectures delivered by both Vascular Surgeons and Radiologists. It is important to meet with trainees from other disciplines who share similar interests and training requirements and it was good to get a feel for what vascular surgical trainees are looking for in terms

of endovascular training. The atmosphere and spirit at the meeting was warm and The Belfry was a great location for both those who managed to fit a round of golf in and also for those who appreciated the fine meal and generous bar tab. Rouleaux club members overwhelmingly voted to allow BSIR junior members the right to enrol with them and have access to their benefits including sponsorships. We will be aiming to continue this summer joint meeting format next year.

A great example of the support the BSIR are giving juniors is the fulfilment of a Junior Section idea on establishing free scholarships to the Annual Meeting. I have to thank Richard McWilliams and his membership and rules committee in getting the funding and organising these for this year and also Council in their approval. Next year, there should be vastly increased numbers of scholarships available.

I encourage all junior members and consultants in their first 2 years (who are still honorary members) to come to the Junior Section AGM being held on Thursday 6th November 1pm-2pm at the Annual Meeting in the Charter 3 room. This is your opportunity to find out about the latest on training in IR and have your opinion on this heard and debate other junior issues. This will be what the committee will take forward for the next year. Elections for committee positions will also be held. So please don't forget to come – there will be a free lunch! See you there.

Chris Dey, *Chair, Junior Section BSIR*

education committee report

Since the last newsletter the Education Committee has continued its work on a diverse range of topics ranging from patient information leaflets to restructuring the whole of interventional radiology training.

The committee continues to meet as a group although, with all our lives becoming increasingly busy, thought has been given to introducing tele-/video conferencing. I am not convinced that the work of the EC lends itself to this form of communication but future committees, perhaps with a greater input from the Nintendo Wii © generation, will decide on this.

The issues of joint training with the vascular surgeons continue to dominate most meetings. I have regularly attended the Education and Training meetings of the Vascular Society and this topic tends to monopolise discussion. There seems no doubt that the desire for comprehensive change is considerably stronger in the Vascular Society than in the BSIR, especially amongst the junior membership. I am very aware of the concerns of many BSIR members over these developments and a significant challenge remains for the various officers and committee members of the BSIR to convince its membership of the benefits to them of the proposed changes.

Further development of the joint vascular training scheme and its associated curriculum has been delayed during its review by PMETB. The introduction of the vascular training pilots that I mentioned in the last newsletter is proceeding slowly. Expression of interest has been received from 9 centres and progress towards appointing has been made by some of these. The EC is offering support and guidance to interested

centres but the appointment process and post content does need to be organised by the local departments and training schemes.

Some of the impetus for introducing these developments has undoubtedly been reduced by the creation of dedicated endovascular fellowships by BSET and the Post CCT posts created by PMETB/DOH. The BSET posts commence shortly. Appointment of the surgical Post CCT fellowships is well advanced. The radiological posts are lagging behind somewhat. These posts are supposedly an interim arrangement although it is rumoured that they may become a permanent development. Their introduction increases the requirement to introduce a recognised curriculum and training qualification for Interventional Radiology; assisting in the development of this remains a priority for the EC.

The committee met in the early summer to produce a further series of Multiple Choice/Single Best Answer questions for future FRCR examinations. This was a productive meeting led by Derek Gould and we hope that our offerings will be favourably received by the RCR Examination Board.

In May the committee reviewed a total of 6 applications for either Research or Educational bursaries. Successful applicants for this year's awards have all been notified. Despite the extension to the submission date one late application was received which was not accepted. Start planning for next year now!

Whilst the quality of submissions for research bursaries was high we were again disappointed with quality of applications for educational awards. This is despite the excellent, comprehensive guidelines produced by Derek Gould and David Kessel that were published in the Autumn 2007 Newsletter. The future of the

educational bursaries is being debated and a change to the format of these awards may be introduced next year.

The EC is producing a series of Clinical Management Algorithms in a standard format. These will be placed on the BSIR website as an educational aid for members to access. Thanks to those of you that have provided information.

The committee has also reviewed and submitted recommendations on behalf of the BSIR on a document from the DOH; "Competencies for Recognising and responding to acutely ill Patients in Hospital" and has also suggested revisions to the "Structured Training Curriculum for Clinical radiology" to the RCR. The EC has maintained its support and input into the development of simulation-based training into Interventional Radiology.

The final meeting of the current EC will be at the BSIR conference in Manchester. The new committee will then take over and the chair will pass into the very capable hands of Ian Francis.

I started this year with high hopes of significant progress being made with the joint training initiative and aimed to try and bring some clarity to BSIR members on the state of the negotiations. It is disappointing and frustrating that relatively little progress seems to have been made and much uncertainty remains. But as John Locke said in his Essay on the Human Understanding, "New opinions are always suspected, and usually opposed, without any other reason but because they are not already common."

Allan Odurny *BSIR Education Committee Chair*

The BSIR Education Committee

Chair; Allan Odurny. Elected members; Ian Francis, Ian McCafferty. Ex-officio members; David Kessel, Jai Patel. Co-opted members; Derek Gould, David Scullion. Junior representative; Chris Dey.

audit and registries committee

Audit and Registries

BSIR is committed to providing and supporting national registries of interventional radiology procedures. Some of these are funded and managed directly by the BSIR. Others are collaborations with other specialist societies, reflecting the multi-disciplinary nature of our work. These registries provide the opportunity to gather and analyse a large volume of data to better to inform our practice. This also provides confidential comparative data so that individuals and departments can compare their performance and also comply with local and national requirements for appraisal and be ready for revalidation.

Current Registries

The BSIR audit and registries committee has been working hard over the last 12 months to have a strategy for all our current registries for the long term. An audit has been performed on all our current registries and plans finalized for producing report on all of these to be rolled out over the next 12-18 months. The first of these will be the third BIAS report which should be available for the BSIR annual meeting in November. Over 2,200 patients were entered into this registry over the last 43 months, over 4000 in total since the launch of BIAS in 2000. Members will receive an individual copy of this report and an electronic version will also be available as a PDF download from the BSIR website.

The Fibroid registry has close to 12 month follow up and an interim report is planned

towards the end of the year. This has been a highly successful registry with over 1500 patients in total with over 500 patients with at least 12 month of follow up. This will provide useful clinical data over on the success of this technique.

Over 600 patients have been recruited to the Biliary drainage and stenting registry. This registry has performed exceptionally well and it is hoped we will be able to produce an early report on this registry at the beginning of 2009.

The complete list of active registries is available on the BSIR website.

All consultants carrying out these interventional procedures are encouraged to contribute to these registries as this is vital in developing and maintaining standards.

Contributing your data to the national registry will enable you to fulfil your commitment to clinical governance.

Index Procedures

BIAS has now also been identified by the society as its first index procedure and an important part of this has been the development of an outliers policy. This has been put on the BSIR website and will also be included in the appendix of the final BIAS report. It is clear from early analysis that there remains confusions regarding some of the terminology utilized in our registries. A dictionary of terms has been developed for BIAS to make sure we are all talking about the same things. This will be expanded to encompass all our current registries.

It is also proposed to develop other index procedures, particularly non vascular procedures and the Biliary registry has been identified as a potential candidate .

Future Developments

- Regular updates on all the registries are planned with email reminder for data completion, patient recruitment as well as regular funnel plots for individual contributors to gauge their own performance. This has been commissioned from Dendrite and is hoped to be available at the end of the year.
 - The BSIR is looking for more collaborative development and help with the running of registries in particular with other specialist societies such as the Vascular Society. There are advanced plans for development of a carotid intervention collaborative registry with external funding from the department of health.
 - It is planned to convert the remaining paper based aortic registries into an electronic registry for online access.
- Please contact members of the committee if you have any comments, suggestions or would like the committee to look at any specific areas for development of future registries.

Committee Members

Raman Uberoi, *chair*; Steve Thomas, *committee member*; Suresh Babu, *committee member*; Elizabeth O'Grady, *ex officio*

scientific programme committee

Dear All,

I guess everyone is eagerly awaiting the BSIR annual meeting (21st) that will be held at the Manchester Central (formerly known as GMex) from November 5 -7 2008.

Registration is open and so please pre-register early to save yourselves and the trusts some money. Also by registering early you can get your first choice hotel accommodation.

For Consultants (including Professors) we encourage you all to bring along your juniors, team nurses and radiographers as the meeting is designed for all to gain and share knowledge plus gossip.

Each year, BSIR offers participants a unique opportunity to meet with peers from the UK and around the world to exchange information about clinical practice and innovative research. It allows for easy access to meet with the companies operating in IR and discuss and review many of their products.

We have endeavoured to provide a programme that will stimulate, entertain and educate across the entire remit of Interventional Radiology.

This year we have the great pleasure to learn from some great IR leaders - Prof Barry Katzen (Carotid Intervention), Prof Andy Adam (Wattie

Flecture Lecture – 'Is Interventional Radiology on the crest of a wave or at the edge of a precipice?'), Prof J Lammer (Ruptured aneurysms) and Prof J Reekers (Looking for the black tulip).

State of the Art Lectures: including lectures on Thoracic Stenting, Embolization, Advances in Spinal Interventions, Paediatric Interventions and a talk on research in IR.

Plenary Sessions: Infrainguinal disease management, GI intervention and Oncological Interventions

Categorical Courses: featuring Thrombolysis, Aortic stent case selection and devices, Embolisation and Case series covering both vascular and nonvascular intervention.

Special Session: On Education and Service in IR.

Scientific sessions and posters: these form the core of every meeting and sessions will be held on the first two days of the conference. There will be prizes for grabs in several categories as below and I encourage all to compete.

1) Best overall presentation – a trip to the annual Phoenix endovascular meeting paid and presented very kindly by GORE.

- 2) Best presentation by a trainee – a trip to CIRSE. This is supported by BSIR.
- 3) Best scientific poster – registration fee paid for BSIR 2009. This is supported by BSIR.
- 4) Best educational poster – book token. This is supported by BSIR.

Technological Workshops: these workshops are organized by our industry partners and provide a varied and popular resource.

Scientific Workshops: Oncological IR, Trauma, Abscess management, Sedation, Venous insufficiency treatment and Pancreatitis.

We may also have a surprise addition on Wednesday evening of a special extraordinary symposium from 1800-1840 on the MIMMOC trial presented by the team led by Prof Roger Greenhalgh. This special event is just being finalised shortly.

We hope that you will be able to join us for our 21st BSIR annual meeting, see you in Manchester.

Dr. Tarun Sabharwal

Chair Scientific Programme Committee

Programme Committee members:

Dr Iain Robertson, Dr. Phil Haslam and Jane Phillips Hughes. **Meeting Organiser:** Ruth Moss.

an interventional radiologist's journey 1967 to 2007

I qualified in medicine in 1965 and following house jobs I became an SHO in general surgery. I soon became aware that the prospects in surgery were not brilliant and that even after many years of study there was no guarantee of a consultant post [the primary fellowship was also a nightmare!]. I therefore decided that a career in radiology was something I should look into.

In 1967 I therefore went to see the head of radiology in Glasgow Western Infirmary Dr. Scot-Park to enquire about a career in radiology. Dr Scot-Park was a venerable radiologist immaculately turned out in a starched white coat, bow tie and white gloves [someone you would never dream of calling anything else but Sir!]. He looked me up and down and said "I hear you would like to be a radiologist—good, when can you start? [I am sure to-days registrars would love an interview like that.] Thus I was instantly persuaded to be a radiologist.

In those days Radiology consisted mainly of plain film reporting, barium studies and IIVUs with the odd tomograms, myelograms and air cephalograms for light relief. In my early days all screening examinations were done using fluoroscopy only—ie no image intensifiers. My introduction to barium meals was with an elderly consultant who's philosophy was that you could not see anything on the fluoroscopy screen so why bother trying. He had ten patients on his morning list all who came at 9.00am.

They were all sat in chairs outside the barium room and a nurse appeared at 9.15 with ten mugs of barium. The patients all drank the barium at the one time and then one by one entered the barium screening room. They were stood behind the fluoroscopy screen and the consultant palpated there abdomen with his hand in a lead glove and took a single radiograph. The list was finished by 9.45. Needless to say the pick up rate was low.

In those days you started as an SHO, becoming a registrar when you passed Part One of the DMRD and a senior registrar when you passed Part Two. The Fellowship was not mandatory for a consultant post. In the Fellowship there were papers and vivas in

Medicine, Surgery, Pathology and Radiology. The Radiology papers consisted of 2 three hour papers containing three essay questions per paper. All three questions had to be answered on each paper. At my first attempt the first and second questions on the first paper were:

- 1) Discuss the plain film findings in bronchiectasis
- 2) Write what you know about the radiology of cystic medial necrosis of arteries.

Remember there was no CT, MRI or Ultrasound in those days. I remember finishing the paper in about 50 minutes- I did not pass. The percentage pass rate in those days was about 20% - hence the fact that many consultants were appointed without the fellowship.

We were lucky at The Western Infirmary to get the first Image Intensifier in Scotland made by Marconi. This was added onto an existing screening

table not designed for it. I well remember an early barium session where all was well until it came to laying the patient supine. Due to the weight of the intensifier, the table was unbalanced and took on a life of its own. Instead of stopping at the horizontal it continued into its 60% Trendelenburg position. At about 45% the patient slid off the table and landed on his head on the floor. In true stoical Glasgow fashion he got up, shook his head and then turned to the Consultant and said "Is that me finished then? "

In 1971 at the tender age of 29 years I was appointed to the post of Consultant Cardiovascular Radiologist to the Hull and East Yorkshire Group of Hospitals. This was a new post to develop Cardiac and Vascular services. I was very lucky as both a dynamic Cardiologist and Vascular surgeon had been recently appointed. In cardiology I undertook right and left heart catheters and also transeptal punctures. There was no echocardiography so we used barium fluoroscopy to identify cardiac chamber enlargement. In vascular radiology the work consisted of angiography with the translumbar aortogram being the method for peripheral arteriography. I started with a disaster. On my second day I was asked to do a TLA on a patient with a suspected saddle embolus. Under G A I advanced the needle and distinctly felt it suddenly give as it entered the aorta. I withdrew the stylet and got a slow drip-drip of blue blood. Somewhat bemused I withdrew the needle and punctured again with the same result. Was this a situs inversus and I was in the IVC? I turned to the anaesthetist who was reading the Times at the top of the table and asked him if the patient' BP was alright. He reluctantly put down his paper and turned to the patient and then exclaimed "My god she's dead!". After that things could only get better and it was soon possible with a slick anaesthetist to do up to 10 TLAs in a morning.

There were no commercially available catheters in those days so I had to make my own by cutting off a length of Kifa tubing, drawing a tip out over a Bunsen burner and creating a flanged end. Our needles were all reusable but had to be regularly sharpened. We injected using a Talley Pump which was fired by compressed air. You had no idea what the injection rate was and burst catheters were a common occurrence.

In the late 1970s the Cardiologist and I journeyed to the Hammersmith Hospital to learn Coronary Angiography from Professor Robert Steiner and then set up a local service. In 1979 I went to Sheffield to watch David Cumberland perform peripheral transluminal angioplasty - and then in the fine tradition of "see one, do one, teach one." a service was established in Hull. We were very lucky because our two overworked vascular surgeons took the attitude that anything the radiologist could do to relieve their workload was fine by them. The original balloon dilatation catheters were 9F and had a very thick and rigid balloon. Even pre-wrapped they needed a 12F sheath and then often would not come out through the sheath as the balloon tended to wing on deflation. This meant that the whole assembly had to be pulled out leaving a diamond shaped whole in the artery, a rapidly developing haematoma, an anxious radiologist and a gleeful surgeon who took much pleasure in bailing out the radiologist's "error". Thus proving to the surgeons' satisfaction that they remained the top players.

The early days of interventional radiology were very exciting; the equipment companies quickly improved the design of the balloons making them lower profile and better tracking. A lot of effort by radiologists and manufactures went into developing new devices to help cross occlusions and improve results by debulking lesions. We had drills, lasers, cutters and atherectomy devices. Europe and the UK were the prime sites for trying out these devices as we had no FDA to worry about, and patients were keen to avoid operations if possible. The fact that none of these devices stood the test of time does not mean that they were ineffective- just that they were largely superseded by better ones. The Terumo Wire became the tool of choice for crossing occlusions. We also found that the more damage you do to the arterial intima the more likely you are to get intimal hyperplasia and restenosis. Plain old balloon angioplasty was best. In the 1980s I was joined by Bill Hartley one of our neuroradiologists who volunteered to help with the vascular and cardiac workloads. Alan Cook made up the threesome. Having colleagues made a great difference and we were able to offer a comprehensive on call service.

Stents came along in the early 1990s, initially the balloon expandable Palmaz followed by the self expanding Wallstent. Alan Cook went back to Scotland and was replaced by Tony Nicholson, followed by Duncan Ettles. As a group we put stents into every artery we could reach [including the coronaries] with much enthusiasm until we were instructed to desist as the budget was overspent. Sense prevailed as it became apparent that stents worked best in iliac arteries. The Palmaz stent did not do well in the popliteal particularly if the patient knelt and crushed it. Putting ten overlapping nitinol stents into an SFA occlusion was a "lulu".

It was a wonderful time to be an interventional radiologist with the technical boundaries been advanced almost monthly. Throughout most of my career I learnt by trial and error, sharing the triumphs and disasters with colleagues in the newly founded BSIR. These days are gone as there is now much tighter regulation regarding innovation and cutting edge technology. Nevertheless I see Interventional Vascular Radiology going from strength to strength in the future. EVAR is already the treatment of choice for AAA and more durable and complex devices will expand the application. We are only just beginning to develop Oncological Vascular Interventions and I think this has a great future. Provided we can keep Interventional Radiology as a Radiologist driven service I think the future is bright. One note of caution, if the Radiologists are not prepared to offer a comprehensive on call service and go in at night and weekends to deal with emergencies then don't complain when the vascular surgeons do and go on to claim the in hours work as well.

I hope you all have as much fulfilment out of a career in vascular interventional radiology as I have over the last 40 years.

I would like to take the opportunity of paying tribute to my colleague of many years, Bill Hartley, who died recently. He was a perfect foil to my over enthusiasm and did much to further the development of Hull's Interventional Vascular Unit..

Dr. John Dyet, Retired Consultant
Cardiovascular Radiologist



membership and rules committee

A new venture for BSIR this year has been the provision of registrar scholarships for the Annual Meeting in Manchester. Three scholarships will be funded on this occasion by the society and for 2009 we have already secured industry funding for ten and expect to secure sponsorship for more.

The provision of scholarships was at the request of junior BSIR who have been admirably led by Chris Dey. Chris has enthusiastically represented the needs of our junior members and we have tried hard to meet these. The applicants for this year's funds were asked to write an essay entitled – "The role of Interventional Radiology in a modern hospital". This was a hastily thought up task and I anticipated a minimal response. I was filled with a sense of foreboding when Ruth Moss handed me a bundle of 18 CVs and essays at CIRSE in Copenhagen. Sumaira and I agreed to read and score the essays and we nobly accepted that we would write off a full night of our lives for the greater good of our fellow man. Despite expecting the exercise to be rather tedious, I found that it was really quite an uplifting one. Our IR trainees are very accomplished people. They have strong visions of the future, are accomplishing great things in the present and have done

so in the past. I would think hard before any established consultants challenge their trainees to a sporting or other contest as there are quite a number of international athletes, football and racket sport players in our midst. I would be even more careful about giving out dog's abuse for minor errors such as a biopsy of the wrong organ as the martial arts are very well represented.

We are really very fortunate that we can attract such high calibre junior doctors into Interventional Radiology and it left me with a keen sense of responsibility that we look after them. The Membership and Rules Committee will continue to work with junior BSIR next year when Maria Sheridan will be chairman. I shall use the remaining space allocated to share with you one of the essays, written by Dr Eleanor Soo who was awarded one of four scholarships this year. The original plan was for three scholarships but Sumaira and I were so impressed by the standard that we successfully negotiated with our treasurer, unkindly called the "grumpy bean counter" by our president, for a fourth.

Richard McWilliams *On behalf of the Membership and Rules Committee*
 Committee Members: Maria Sheridan, Sumaira McDonald

the role of interventional radiology in a modern hospital

Interventional radiology (IR) offers rewards spanning clinical, research and financial measures. This essay addresses why the role of IR in a modern hospital should be strategically aligned.

Developing strategy for IR

21st century medicine is increasingly competitive secondary to greater patient demands and government led market structure changes. This environment fuelled by technological advances provides clinicians with further management options for an ever-increasing variety of conditions. IR is a prime example of a speciality at the forefront of this changing environment, which has ramifications for determining its role in a modern hospital.

Providing an effective 24 hour IR service is currently constrained by a lack of financial and manpower resources. Nevertheless, there are good reasons why strategic planning of IRs role should be considered.

Firstly, from a market-based perspective (organisational positioning within profitable niches), a modern hospital should endorse IR as a central service, in light of increasing clinical demand, evidence based benefits and industry growth. Secondly, hospitals often provide IR resources within fragmented frameworks and as an adjunct to diagnostic services. However, from a resource-based perspective, strategic development of core IR capabilities would act as a primary service differentiator and optimise returns on IRs high-fixed costs.

Integrating these perspectives through strategically aligning resources, capabilities and

competencies with IRs future prospects would facilitate overcoming constraints and create a service with a sustainable competitive advantage. Achieving this 'holy grail' of strategy would result in a lucrative, value-added, patient-focused service, hindering competitor imitation and substitution; the latter being particularly important in the era of patient choice.

Figure 1 outlines how strategic alignment can achieve an IR service with sustainable competitive advantage; crucially it requires a cross-disciplinary collaborative approach.

Conclusion

IR is a prime growth speciality in modern medicine, thus a 24 hour service has a central role within a modern hospital. The strategic alignment model (Heracleous) describes multi-factorial issues to create an IR service with a sustainable competitive advantage that can achieve the multiple benefits actively sought in today's medical environment.

Reference: Heracleous L, Wirtz J, Pangakar N, 2006 'Flying High in a Competitive Industry' McGraw-Hill

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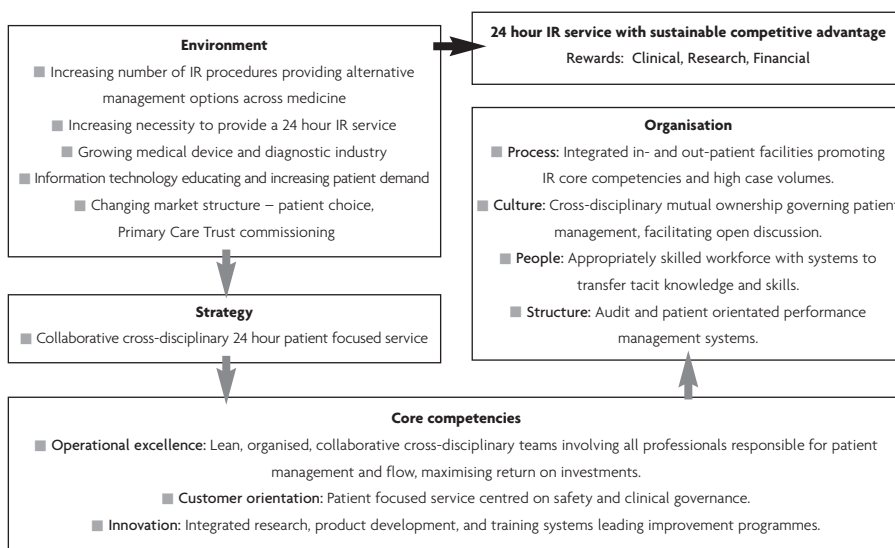


Figure 1: IR Strategic Alignment Model

notes from the BSIR office

Lavinia Gittins, for the BSIR

annual general meeting 2008 The 2008 Annual General Meeting of the British Society of Interventional Radiology will be held on Friday 7th November 2008 at 11.45 am at Manchester Central conference centre, in conjunction with the BSIR Annual Conference.

junior members When Junior members obtain a consultant or academic post they should advise BSIR office, and they will be transferred to Full membership at the beginning of the next subscription year.