British Society of Interventional Radiology

BSIR newsletter

ISSUE 26 Spring 2009

www.bsir.org

registered charity no. 1084852

editor's column

Welcome to the spring edition of the BSIR newsletter. Ian Francis has moved on to pastures greener and I have inherited the wonderful challenge (heavy sarcasm) of editing the newsletter.

If I was feeling philosophical I would reflect on how the ying and yang of life means that the task of editing the newsletter brings happiness and unexpected opportunities but also the balance of eye watering hassle. The pleasure of e-mailing old and now far flung colleagues to ask for contributions versus the pain of them largely and sensibly ignoring the emails. Instead I merely feel aggravated.

In this edition of the newsletter Professor Gaines writes in his penultimate newsletter as president. We also have updates from the coalface of the Society committees. Steve Thomas brings us up to speed on the Dendrite registries, with a plea to continue to contribute and update these, David West appraises us of the future direction of the website and Ian Francis lets us know about the work of the education committee in his new guise as Chair.

Finally despite sustaining a fractured head of humerus Phil Haslam has produced a nice summary of the arrangements for the next BSIR annual meeting in Brighton. I wish him good luck for his recovery and compliment him on his ability to answer emails from his hospital bed.

Lavinia explains why BSIR membership now costs more and how to get e-access to CVIR.

Huge thanks to those who contributed general articles, at short notice for the newsletter. Ramita Dey for a piece on being vascular fellow in Sheffield. She describes it in glowing terms, which I find difficult to credit given that she had to both work in Sheffield and with the president of the BSIR. Jon Willat also provides a very dry and funny piece from the states. Space issues prevented publication of Abdul Razack's piece describing the difficulties of setting up a new IR service and Kurian Mylanakals piece on the Surgical endovascular fellowship. They will appear in the Autumn edition of the newsletter.

Lastly, thanks also, to Professor Jon Moss from Glasgow who has written succinctly but cogently on what we don't know about fibroid embolisation and why we should push for further RCT's in this area.

Two things to finish. Cycling seems to exert an almost mesmeric hold on interventional radiologists. Something my wife, garage and children all recognize. So isn't time we had a sponsored cycle sportive at BSIR? Interested parties email me at *paul.scott@hey.nhs.uk* and I'll see if we could muster support or sponsorship for an event next year.

Finally TLA's (three letter acronyms) are one of the curses of modern life. The change locally from Radiology Executive Meeting (REG) to Bussiness Unit Meeting may give as a clue to the direction that NHS management is taking us in.

All the best for Summer. May it be long and hot.

Paul Scott
Hull Royal Infirmary

Contents

1 editor's column
2 president's column
2 communications committee update
3 registries and audit committee update: what's happening with the registries?
4 life in IR in the US
5 if it was a drug
5 on being a radiology endovascular fellow
6 notes from the BSIR office
6 scientific programme committee

send all contributions to

Dr Paul Scott
Department of Radiology
Hull Royal Infirmary
Anlaby Road
Hull
HU3 2JZ
Phone: 01273 627013
E-mail: paul.scott@hey.nhs.uk

president's column

Holidays are ideal for contemplation, reflection, and getting blathered. So here's a little contemplation from the Caribean. The England cricket team are a bunch of ne'er-do-wells who show little pride for their nation. They should have citizenship removed and banished to a primordial civilisation – Dundee perhaps. Secondly, Paul Scott, new Newsletter editor (many thanks from us all), is pesky. Official.

Thanks to him my sojourn has crumbled into reviewing the latest BSIR activities. I place this as a warning for all members who look to take up the Presidents post – it is more hard work and intrusive than ever I thought. The Society may have to address this in future when hopefully my aspirations for the society will have come to fruition. Principally I believe that the BSIR should be more pro-active, functioning less in response to events around us. We should be the originators of change and progress so that we can take charge of our own future.

To achieve this requires activity on a number of fronts; we must be able to review and change our current practice by constructing and using robust national registries, we must engage in dialogue with those placed within the NHS to help us, and we should have a stable platform from which to work. A stable platform was the focus of a letter recently dispatched on behalf of the BSIR to senior members of the NHS. We underlined the need for (a) stable financial structure and the need for members to be able to identify income to trusts through the PbR process, (b) adequate consultant numbers and (c) public, managerial and political awareness of the crucial role of IR within the health service.

Payment by Results is the mechanism whereby Trusts are reimbursed for our activity and as such its efficient working is essential for a healthy specialty. Some of you may have read the article that I wrote for the College Newsletter on the state of Interventional Radiology in the current PbR process. Whilst that report was gloomy sunshine has now broken through. The PbR team has agreed to continue the development of separate IR HRGs within its own chapter and to allow Interventional Radiologists to be integral to that process. All part of the aspirations detailed above.

We continue to consolidate our registries – a part of this society that I feel passionate about. Our registries will allow us to review and justify our practice, both at a local and a national level. Contributing members can now download their funnel plots from BIAS that are so very useful for local performance review and are likely to play a significant part in recertification. It is likely that the Biliary Registry will act as the index procedure for non-vascular work and the data from that is currently being reviewed. Sound data and outcomes from the registries will now allow us to develop 'Standards of Practise' for Interventional Radiology that are based upon evidence from our own UK practice.

For all of this to make sense does require that members continue to contribute their data. I know that this can add burden to a busy practice. We are trying to ease this by making access to the registries easier through the new website and rationalising the number of active registries that we as you to contribute to. Some of these registries have consolidated their multi-disciplinary approach. The Carotid Registry has now joined with the national vascular database (see over for details). All units undertaking carotid stenting should now be submitting data to this – for access contact Lavinia Gittens or via *ceaaudit@rcplondon.ac.uk*. RETA – the long-standing EVAR registry will soon be part of the National Aneurysm Audit developed collaboratively with the Vascular Society.

Finally on the subject of registries, I would encourage members to actively submit all their data to the IVC Filter Registry. I am becoming more aware of the complications associated with removable filters, particularly when they are left long term. Only 30-50% of such filters are ever retrieved and it is time that we were able to collect and analyse data on these devices for which we are largely responsible for implanting.

I am pleased to announce that we have developed what I hope will be a fruitful collaboration with our industrial partners. Device companies are strong players in Interventional Radiology practice and working closely with them can only be of benefit to both partners. This group is being led by Iain Robertson on our behalf and will initially focus upon (a) developing a platform that we can all use to support local business cases, (b) enabling better communication with primary care and PCTs, and (c) working towards a functioning supportive patient group. If anyone is in doubt about the importance of the latter I suggest that you go and read about Patient Reported Outcome Measures (PROMs).

Your registrars can be financially supported to attend this year's Annual Scientific Congress through the £4000 worth of grants that we have put aside for them. They simply have to apply through an essay competition – details can be found on the website or from Lavinia. We are delighted with this years awards at the Congress. Tim Buckenham has been awarded Honorary Fellowship and has agreed to deliver a number of illuminating (yeah right) lectures. Andy Platts has been a beacon within the BSIR for many years, successfully combining both neuro and non neuro intervention. Both funnier and better looking than Buckenham he has been asked to deliver this year's Wattie Fletcher Lecture. Derrick Martin has placed UK biliary intervention on a worldwide stage, particularly through endoscopic work and has worked tirelessly for the BSIR. He has been awarded the Gold Medal. Grumpy old man comes good.

Finally, for the BSIR to function we need members to play an active role. Please all consider nominations for the posts available and please all take time to vote. No complaints afterwards please, if you couldn't be bothered to do either. I look forward to seeing everyone at this years annual Scientific Congress after which maybe I will be able to chill in the sunshine.

Prof Peter Gaines
President BSIR

Communications committee Update

The communications committee has been concentrating efforts on just one project, the new website.

Progress on the project is going well but this is a complex website involving, among other innovative features, sophisticated software to enable WIKI type online realtime content management by all members to keep the site up-to-date and fit for purpose into the future. There is nothing as yet for members to see which is frustrating but the design and build are on schedule with completion of a fully functional live site planned well in advance of the 2009 annual meeting. Much of our efforts will be expended testing the prototypes to destruction to limit teething problems in advance of going live.

David West

registries and audit committee update: what's happening with the registries?

As I settle myself into the "Chair" of the Registries and Audit committee I would first like to thank Raman Uberoi for his leadership and advice as the outgoing Chair of the committee, and he should be congratulated on all that was achieved in the last year. As ever it has been a busy time for us on the committee, and here I would like to reflect and update you on some of what is happening with our BSIR registries.

All BSIR members should have received the update on our registries produced by Dendrite earlier this year, if not this is available from the BSIR website. This confirmed the continued growth of the active datasets. All the datasets managed by Dendrite should allow easy data entry, preferably by a common login for each BSIR member. If you have separate logins for each dataset then contact Dendrite (*registration@e-dendrite.com*) via the links on the hosting webpages, and it should be possible to synchronise them all.

Our youngest dataset, the IVC filter registry has just produced an interim report, following analysis of the submitted data by Dendrite on our behalf. This report has been provided by Dendrite to the sponsors of the Registry, Cook, Bard, Cordis and Pyramed, as well as to contributors. I have also asked Lavinia to circulate this to the whole membership of the BSIR, so I hope you have had a chance to look at this. Entry of cases has really picked up in the last few months and if you haven't started adding cases already, can I ask you to do so. At present the amount of follow up data is relatively small, and the value of the data would be much improved if contributors could add as much follow up data as possible. Thanks must go to Dendrite for co-ordinating the data and producing this interim report with Nick Chalmers, and in particular to Chloe Ibrahim at Dendrite for her efforts in raising the profile of the Registry, she can be contacted (*chloe.ibrahim@e-dendrite.com*) if you have any problems with entering data to the IVC registry.

The BIAS III report was available at the Annual meeting, and all BSIR members should have received this. This is our vascular index procedure, and as such provides an insight into the quality of the service provided to patients by this commonly performed procedure- Iliac artery intervention. Registered users can now access real time funnel plots from the BIAS registry pages, following login to the database. This provides users with an ability to compare their practice with those across the country, useful for self-audit and appraisal and ultimately revalidation. The governance of any outlier operators identified on these funnel plots has been outlined in the BSIR outlier policy, a copy of which can be found as an appendix in the BIAS III report.

The Biliary registry should report for the annual meeting in November, data entry will continue, but it is imperative that the data is as clean, and complete as possible. So please if you can, take to time to review the cases you have submitted, as well as ensure that all your registered cases are up to date. Once the data has been analysed, review of the results should allow an assessment as to the suitability of this registry to act as a non-vascular index procedure.

The Oesophageal stent registry (ROST) should also report this year, and again I would ask that you ensure that your entered cases are complete and up to date.

The other main development is the move to add an EVAR dataset to the National Vascular Database in collaboration with the Vascular Society. This will basically incorporate the data submitted to RETA, with some modification. This will allow web-based data entry, and will tie cases into the AAA National Screening Programme as this gets underway. As the EVAR dataset on the NVD becomes available in the next few months, BSIR members will be informed of the mechanism to get registered to use this dataset, and this will essentially replace the paper version of RETA that has been the mainstay of EVAR audit for BSIR members. A final report of cases on the RETA registry will be available prior to the move to the NVD. Once data input to the NVD of EVAR data for BSIR members is initiated, funnel plots, similar to those now available for data submitted to BIAS, will become available for individual contributors and centres. The website for the NVD is www.nvdonline.org.uk. Further information on obtaining a log in for the NVD can be obtained from Sara Baker (*Sara.Baker@rbch.nhs.uk*)

The Carotid Intervention Audit is also now the place to register carotid stenting interventions, this is the second iteration of this audit into treatment of carotid disease and stroke, and as the carotid stenting data has now been incorporated, this allows web-based data entry. The data entry is hosted on-line within the National Vascular Database (*www.nvdonline.org.uk*) and passwords and relevant information are available from *ceaaudit@rcplondon.ac.uk*.

The data submitted to the Uterine Fibroid Registry is being analysed at present and once completed later this year the report will be circulated to all BSIR members. The committee would like to thank all those who submitted their cases and follow up data to the registry, and the results should be very informative.

To encourage continued input to the datasets generally and to keep contributors up to date with their submitted cases, regular e-mail reminders will soon be sent to BSIR members contributing to the Dendrite registries. This will detail the number of cases submitted, with cases flagged that are incomplete, or requiring follow up.

Hopefully much of the information that many of you need with regard to getting cases into the Registries will be improved once the new BSIR website is in place later this year. We are aiming to make it possible to have direct access to datasets following login to the BSIR website, and where this is not feasible, to provide appropriate links to relevant websites to make data entry more streamlined and easier. This will be the main resource for getting information about all the Registries, including contacts and previous registry reports.

The Registries and the R&A committee depend on the input and support of the BSIR membership. The Registries can only continue to be useful tools with the help of all the membership as contributors of cases, but also with the help and enthusiasm of the committee members past, present and also in the future. With this in mind I would like to encourage those who feel they can contribute to the work of our committee to put themselves forward to be considered at the up-coming elections to the BSIR committees.

Steve Thomas (Chairman)

On behalf of the BSIR R&A committee: Graham Munneke, Suresh Babu and Raman Uberoi

<

Registry	Format	Form	Website/link	Final report	Interim report	Contact	Email	BSIR lead
Biliary	Web			Due 1/03/2010		Dr. Raman Uberoi	Raman.Uberoi@orh.nhs.uk	Dr. Raman Uberoi
RETA Abdominal Aortic Aneurysms	Paper					Dr S. Thomas	S.M.Thomas@sheffield.ac.uk	Dr S. Thomas
RETTaD Thoracic Aneurysm and Dissection	Paper					Dr S. Thomas	S.M.Thomas@sheffield.ac.uk	Dr S. Thomas
Endovascular Carotid	Paper					Dr S. Thomas	S.M.Thomas@sheffield.ac.uk	Professor P Gaines
Uterine Fibroid	Web/Paper			Due 1/02/2009		Dr Elizabeth O´ Grady	elizabeth.ogrady@aintree.nhs.uk	Dr Elizabeth O´ Grady
ROST Oesophageal Stent	Web			Due 1/03/2009		Dr H-U Laasch	Hans-Ulrich.Laasch@christie-tr.nwest.nhs.uk	Dr H-U Laasch
BIAS III	Web			Due 1/10/2008		Dr. J. Moss	j.moss@clinmed.gla.ac.uk	Dr. J. Moss
Caval filter Registry	Web			Due 1/10/2010		Dr N Chalmers	Nicholas.Chalmers@CMMC.nhs.uk	Dr N Chalmers
Please note the colon stenting registry is funded and monitored by the society of coloproctologists who own and maintain the data and is not a BSIR registry. A link is provided below for the convenience of members.								
Colonic Stenting	Web			Due 1/02/2010		Mr Mike Parker	mikeparker@doctors.org.uk	

life in IR in the US

I can only speak for one institution: a large academic centre in the Midwest, where the brightest come, and then move on to the larger cities on the West or East coast. America has an obscene number of hospitals, grossly out of proportion with its populations, in comparison with any country in Europe. This bears witness not only to the appalling state of health of the most powerful country in the world, but also to its obsession with healthcare. If you can't find something wrong with you in this country, then a doctor sure as well will.

The tales of over-investigation and of excessive treatment are generally true, which of course helps people like me because not only are there many studies, but they are in many different modalities which enables me to compare and contrast the values of CT, MRI, angio, nuclear medicine, ultrasound and more.

Do I sound cynical enough yet…? Ok, I will carry on, but first, let me tell you why it is worthwhile being here. First, from a training point of view, I can't dispute that it is extremely good. Institutions like this recruit from all over the world. Training is very seriously taken, and each institution competes with others for the best medical students. So the residents and fellows in radiology get a huge amount of teaching. The results of exams are published by institution to make sure they keep striving for improvement. Although there is a surfeit of supervision, this does mean that you don't develop bad habits and carry them through until completion. There is no see one, do one, teach one here. More do a whole load with someone else peering over your shoulder, so that when you do stand on your own two feet for the first time, it is a little unnerving. The litiginous society contributes to all this anxiety to avoid mistakes, of course, but I cannot help thinking that we do benefit from the need to get things right. I should add that I miss the world of early exposure to responsibility. They were carefree days.

Fellows are paid poorly here in comparison to the UK. About half as much in fact. And there is no working time directive to speak of. However, the rewards come quickly, and will be good even after the new administration has knocked some sensible restraint into the system.

Let me conclude by saying that I feel pleased with some of the procedures I have done. High tech equipment, endless support staff, and a wide referral base have enabled me to do some complex IR procedures. The teaching has been good, if a little antiquated. It is a good place to learn, and then return from and get back to some sensible pragmatic medicine. Here is the worst encounter. Not a blink or a raised eyebrow at this one. A 35 year old man of middle eastern origin presents with erectile dysfunction. He has every reason to have problems, having been through a short lived, unconsummated marriage with a woman he describes in unendearing terms. Prior to this there were no problems. Since the marriage he has been given almighty stick by his family who tell him he needs to get married and produce some offspring to be proud of. He feels a little cowed, and this is one of the manifestations.

His urologist carries out multiple tests and refers him to us for angiography of the penile arteries. He gets what he asks for, and intra-coporeal papaverine injections for good measure. My undying memory is of his face as he looked down while a spear was introduced to his shaft. I wonder if his psychosocial problems will ever resolve now. I doubt it. Only in America.

There are plenty of opportunities over here. USMLE is pretty much a must for IR, but that is not as big a deal as one might think. Once the fellowship is complete, the recruiters chase in packs. America is a big country with all types of work and geography.

Jon Willatt, Ann Arbor
University Of Michigan Medical Center

<

if it was a drug ?

We all recognise that uterine fibroid embolisation (UFE) is now an established procedure and should be offered to women as a treatment option for symptomatic fibroids. But there is still so much to learn and we must not become complacent. Let's look at what we do know. There have been 4 published randomised controlled trials and these have all reported broadly similar results. When compared with hysterectomy, UFE offers similar outcomes as measured by the generic quality of life (SF36) instruments. Complication rates are similar but differ in type and temporal profile, for example complications after surgery usually arise in the first 30 days whereas UFE complications usually appear beyond this time period and up to 12 months post embolisation . Recovery times and return to work (so important in a young population) are significantly faster with UFE. More importantly UFE appears more cost effective when compared with surgery at least in the short term, and you keep your uterus.

The Achilles heel lies with the re-intervention rate. Further invasive treatment is required in 10 – 30 % for either persistent or recurrent symptoms. This usually results in a hysterectomy, the very procedure the patient was trying to avoid. A familiar bell should ring in the heads of interventional radiologists, think of EVAR, of angioplasty and stenting, less invasive yes, more rapid recovery yes, but a significant need for further intervention over the long term.

So what is it with UFE, why the need for re-intervention in up to a third of patients? Incomplete fibroid infarction in a nutshell. Katsumori recently showed a cumulative need for further intervention of only 3% at 5 years provided infarction was complete, this rose to 20 % where infarction was incomplete. Factors governing fibroid infarction are clearly multifactorial (collateral supply, technique, end points and embolic agent) and not all are within our control. The embolic agent itself is becoming of increasing importance however and something we can study and influence. Spherical PVA for example in spite of being promoted actively as an ideal agent for UFE turned out not so good in two small RCT`s when compared with Embospheres. More recently colourful language from an eminent Interventionalist has suggested Embozene may be the ideal agent. Has Embozene been tested through the rigours of a RCT – no it has not. Has gelfoam been compared with other agents or Beadblock – no they have not. Yet these agents are all available in the European market. Do we know whether there is any difference between these agents regarding ovarian or endometrial function – no we do not. In women wishing to preserve fertility who ask us "UFE or myomectomy?" another question we cannot answer.

The way ahead is obvious we need more RCT`s and these should be appropriately funded and powered with clear questions and achievable answers. Ah you may say Interventional Radiologists have not been good at trials and that is true but it's changing. Proper trials are a concerted team effort involving the skills of many, epidemiologists, health economists, trial units, statisticians and for UFE gynaecologists and radiologists. Anything is achievable if you want to do it and you have the right tools.

Fanciful talk? no anything but. A grant application sits with the HTA as we talk and another is in the pipeline. These will hopefully address some of the unknowns in UFE and will require your cooperation as an individual to see them through to fruition so watch this space.

Back to my first question "if it was a drug?" – well there is little doubt that UFE would probably have struggled for approval in this much tighter regulatory environment. But it's not a drug and we all know that UFE has saved countless hysterectomies and improved the quality of life of hundreds of thousands of women. We just need to make it even better and safer, can Interventional Radiology do that? YES WE CAN

Professor Jon Moss

<

on being a radiology endovascular fellow

I have spent the last year as an endovascular fellow at the Sheffield Vascular Institute, consolidating and advancing skills learnt during my basic 5 year Radiology training in Hull. The populations are quite similar, with poor lifestyle, a high smoking incidence and, in addition, a large Asian population with high prevalence of diabetes, creating a large cohort of vascular patients locally, supplemented by national and international referrals.

The team of 5 consultant radiologists works closely with 8 vascular surgeons across 2 sites – the Northern General and the Hallamshire – and liase with various other specialties, including neurology, diabetology, renal medicine, cardiothoracic surgery, cardiology, urology and Obs&Gyn. The working week consisted of up to 10 elective angiography sessions, with additional emergency lists thrice a week.

The majority of elective patients were day cases, accommodated in a high throughput 4-bedded day ward. However, with Radiology 'beds' on the vascular wards and weekly combined ward rounds, patient care did not stop once groin haemostasis was achieved, and I was encouraged to regularly review patients on the ward. Patient care actually started in the weekly out patient clinics – a novelty in radiology circles!

It was fantastic, being in a dedicated vascular radiology clinic, being able to assess patients myself, stratify their management and investigations, monitor various aspects of disease modification, consent and list them, and during follow-up, the satisfaction of seeing patients I had treated myself, describe how it felt 'like having a new set of legs', or the heart-sink of the occasional treatment failure.

The rest of the week was mostly spent in the angio suites, where I was given free rein, doing as much as I wanted. While I had done straightforward angioplasties and stents before, I now started dealing with more complex cases – long SFA recanalisations, iliac occlusions, crural interventions, upper limb interventions, consequently my skills repertoire expanded rapidly.

Add to this specialist interest skills such as the treatment of the failing dialysis fistula, uterine fibroid embolisation, pelvic congestion treatment and managing various vascular malformations, supplemented by CT and MR experience, and I was learning new procedures almost every week. My logbook numbers were exploding.

Sheffield has been at the forefront of EVAR for a while and I too was soon actively involved in aortic stent grafting, mostly below but a few above the diaphragm as well (not forgetting the spinal drain!). I even learnt to do part of the procedures percutaneously and look forward to the day when EVARs are done entirely without surgical cutdowns. Of course I also had to learn how to plan the EVARs, order the grafts and provide the "before and after" service – embolise internal iliacs and treat endoleaks.

Sheffield probably leads the country in carotid stenting and this meant discovering a new world of monorail technique, protection devices and reverse-flow systems (wear wellies when using them!). Cases were discussed at weekly carotid MDTs, and patients recruited for the ICSS trial. The weekly vascular MDT was always a lively forum and with everyone presenting their own cases, I had to be ready for both the usual brickbats and the rare plaudits.

The other aspect of working in Sheffield was getting to know the technology. Various company reps were forever traipsing through the door and offering groundbreaking technology and equipment allegedly before most of the world had heard about it, and whether it be new generation stent grafts, new stents and balloons, detachable coils, occlusion plugs – it felt at times like I used them all.

Apart from me there were other trainees at various stages – ranging from course attendees, visiting consultants brushing up their skills, other senior fellows, some fellows doing short term attachments, trainees from the Sheffield rotation coming to grips with their first angio to medical students stuttering over aortic anatomy – and I was encouraged to get involved in their training as well.

I did a 1 in 6 on call with one of the consultants covering, and that week could be a very mixed bag, from a minor phone consult with a neighbouring hospital to adrenaline surging middle-of-the-night embolisations – including the occasional stabbing or shotgun blast.

While I had developed basic wire skills before coming to Sheffield, the past year has equipped me to deal with vascular patients as a whole. Not only have I picked up advanced technical skills, but I now feel confident making clinical decisions, and can deal with a greater range of vascular problems. It has been an invaluable learning experience, and a thoroughly enjoyable one and I thank Professor Gaines and Dr Cleveland for giving me the opportunity. I've worked with a great bunch of colleagues and made new friends – and it has been an experience that I can wholeheartedly and without reserve, recommend to anyone wanting to expand their endovascular experience.

Ramita Dey
Endovascular Fellow
Sheffield Teaching Hospitals

BSIR 2009
4th-6th November
Brighton, UK
Meeting Announcement
BSIR Conference Organiser (Ruth Moss)
PO Box 2769, Bearsden, Glasgow, G61 4WR, UK
Tel: +44 (0)141 942 8104 **Fax:** +44 (0)141 942 8278
Email: meeting@bsir.org or ruth.moss@ntlworld.com
Website: www.bsir.org
British Society of Interventional Radiology
Registered Charity No: 1084852

notes from the BSIR office

BSIR Administrator

subscription payment reminder

BSIR subscriptions for 2009 have been increased, to £180.00 for Full members and £80.00 for Junior members, and this was with effect from 1st January 2009. All members were advised of this change by letter from the BSIR Treasurer.

Members were asked to set up new standing orders to take account of this new subscription rate. However a substantial number of members did not take action to do this in time for the payment to be made in January, and as a result we received many payments at the previous subscription rate of £140,00. I will be contacting members to ask them to pay these arrears and also to ask them to set up new standing orders for the new subscription rate. If you do receive one of these letters it would be appreciated if you could deal with the matter promptly, to avoid the need for further correspondence about subscriptions.

problems with CVIR

During 2008 several members reported problems with delivery of the CVIR Journal.

We have been in contact with both CIRSE and the journal publishers (Springer) about this, and we hope that the situation is improved as a result. However if anyone does not receive their due issues please contact me and I will follow this up directly with CIRSE.

CVIR online

If anyone would like the instructions to access CVIR online please contact me on *office@bsir.org*

scientific programme committee

Brush up your surfing skills as this years BSIR annual scientific meeting is being held in sunny Brighton. The programme committee have been working hard and we hope that we have put together a varied and stimulating programme covering many areas of both vascular and non vascular IR.

The meeting provides us with the opportunity meet up with our peers (possibly over some beers), learn from our invited speakers, present our own scientific research and find out what's new on the cutting edge of IR.

This year's trade exhibition is one of our largest and provides a great opportunity for delegates to meet up with our industry partners and see what new equipment is out there. Some of this year's sponsors will also host technological workshops demonstrating equipment use in specific clinical scenarios.

We have great pleasure this year in learning from some of the leading figures in IR – **Andy Platts** (Wattie Fletcher Lecture), **Jose Bilbao** (Radio embolisation), **Tim Buckenham** (Thoracic EVAR) and **Mick Lee** (Evidence for optional IVC filters).

State of the art lectures: including radio embolisation, intervention in pancreatitis, imaging and IR in acute GI haemorrhage, fenestrated/ hybrid EVAR and vascular malformations.

Plenary sessions: including aorto iliac disease, head and neck IR, joint session with the Vascular Society and thoracic intervention.

Categorical courses: Drugs in intervention, venous intervention, non vascular and vascular case series.

Special session: Debates 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 excellent prizes for grabs in several categories as below and I encourage all to compete.

1) Best overall presentation. Prize to be confirmed
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.

Abstract submission will be open from 15th April until 20th June.

Scientific workshops: These include, biliary intervention, GI stenting, abscess management and musculoskeletal intervention.

We will also be holding a new special workshop this year 'What IR can do for you'. This is an attempt to raise the profile of IR and we hope to involve local clinicians, medical students and patient representative groups along with the local press.

We hope that this years meeting will be a great success for you and the BSIR.

Dr. Phil Haslam
Chair BSIR Scientific Programme Committee 2009

Programme Committee members:
Dr. Tarun Sabharwal, Dr. Jane Phillips Hughes and Dr Raman Uberoi

The BSIR newsletter has been designed and published by foundation design consultants specialising in healthcare communications.

While every effort is made by the publishers to see that no inaccurate or misleading data, opinions or statements appear in this newsletter, they wish to make it clear that the material contained in the publication represents a summary of the independent evaluations and opinions of the authors and contributors. As a consequence, the publisher cannot accept responsibility for the consequences of any misleading data or statements. Neither do they endorse the contents of the publication or the use of any drug or device in a way that lies outside its current licensed application in any territory.

For detailed information on any drugs or device discussed in this publication, readers are advised to consult the Physicians Circular issued by the manufacturer.

foundation design consultants
Grove Park Studios, 188-192 Sutton Court Road, Chiswick, London W4 3HR
tel: 020 8994 3443 fax: 020 8995 6195
email: info@foundationdesign.co.uk web: www.foundationdesign.co.uk