CIRREF Launches FIBROID Registry

CIRREF and SCVIR, in cooperation with the Duke Clinical Research Institute (DCRI) launched the Uterine Artery Embolization (UAE) Fibroid Registry for Outcomes Data (FIBROID) on October 14, in conjunction with SCVIR’s Emerging Interventional Therapies Weekend: UAE Conference in Washington, DC. The Registry brings together a tremendous depth of scientific and technical resources through the collaborative efforts and support of a professional medical society, academic research organization, the Food and Drug Administration (FDA), industry and consumers.

Uterine fibroids are very common in women. From 20 to 40 percent of women age 35 and older have uterine fibroids of significant size. African-American women are at higher risk for fibroids: as many as 50 percent have fibroids of a significant size. Estimates are that between 177,000 and 366,000 hysterectomies and approximately 35,000 myomectomies are performed each year as a surgical solution for this problem. In addition, many women receive medical treatment for fibroids and many others suffer symptoms but never undergo treatment. Hence, UAE has the potential to provide hundreds of thousands of women a dramatic non-surgical, uterus-sparing alternative for the treatment of uterine fibroids each year.

The purpose of the FIBROID Registry is to generate sufficient data to demonstrate the safety and efficacy of UAE for the treatment of fibroids and to assess the procedure’s durability, impact on fertility and quality-of-life. This goal will be achieved by capturing a concise set of baseline, short and long term functional and clinical outcome data for patients undergoing UAE. Secondary objectives of this study include: measuring the volume of patients undergoing UAE; assessing and benchmarking clinical practice patterns (patient selection, technique, use of procedure across country); and collecting and quantifying resource utilization of patients undergoing UAE.

The Registry is open to all SCVIR members performing UAE who have Internet access. It is estimated that the Registry will collect baseline data on approximately 4000 patients per year with longitudinal follow-up on 900 patients per year. Consecutive patients undergoing UAE for uterine fibroids at participating sites will be approached for consent for inclusion by the treating interventional radiologist into the registry. Patient characteristics, procedural data, in-hospital events and post-discharge events (to 30-days) will be collected on all patients. Data will be entered by site personnel onto Web-based data forms and submitted to the registry blinded as to patient identifying information.

In order to maximize resources, longitudinal data greater than 30 days will be collected from 20 core sites. A random sample of patients from the core sites will be selected for follow-up. These participants will receive a follow-up survey at 6 months, 12 months and 24 months following the procedure for assessment of clinical outcomes, quality-of-life (QOL) and patient satisfaction. Surveys will be mailed by DCRI, the data

(See Fibroid page 7)

Legs For Life® 2000

The 2000 edition of the Legs For Life National Screening Program for PVD Leg Pain was a tremendous success. In its second full year, the program has achieved a level of unprecedented prominence, attracting the active participation of Surgeon General David Satcher, as well as the proclamations from 20 states and a letter of commendation from the White House. The inaugural Congressional screening program was a great success as was the press conference that followed on Capitol Hill. In addition, a AAA pilot screening was launched, the program’s family of national sponsors grew and a new public survey was conducted. See pages 12-15 for highlights from Legs For Life 2000.
SCVIR Announces www.practiceguidelines.org

To better facilitate members and others in finding the SCVIR’s practice guidelines, SCVIR has created www.practiceguidelines.org All SCVIR guidelines can be directly and easily accessed via that address, which takes you right to the Society’s clinical practice guidelines page. The following documents are available:

Introduction

Introduction and Definitions

Quality Improvement Documents
2. Guidelines for Percutaneous Transluminal Angioplasty (1990)
3. Angioplasty Standards of Practice (1992)
4. Diagnostic Arteriography in Adults (1993)
11. Quality Improvement for Diagnostic Neuroangiography and Other Procedures—JVIR and AJNR, January 2000

Consensus Documents
2. Trans Atlantic Inter-Society Consensus Document on the Management of PAOD—JVS, January 2000—coming soon to the SCVIR Web site

Credentialing Documents

Policy and Position Statements

Technology Assessment Documents
5. Recommended Reporting Standards for Vena Cava Filter Placement and Patient Follow-up—(JVIR and JVS, September 1999)

Documents from Outside Organizations
1. Training Standards for Physicians Performing Peripheral Angioplasty and Other Percutaneous Peripheral Vascular Interventions (1992)*
2. Clinical Practice Guideline—Smoking Cessation (1996)*
   *Endorsed by the SCVIR Executive Council in 1997.

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What’s in a Name, Logo, Plan?

by Terence A.S. Matalon, MD

At various times over the last decade, the issue of changing our name has been raised by many of our leaders and members. The name of an organization should be a tool to convey information. Particularly for interventional radiologists, the issue of communicating to both the medical and public sectors the varied skills we have to offer has been hampered by an acronym that has been (quite rightly) rejected by our leadership. Additionally, our name should accurately describe who and what we are. Many have lobbied for a shortening and more descriptive name. More recently advocates for severing the traditional relationships with diagnostic radiology are increasingly heard.

One problem is that if you have met one interventional radiologist, you have met one interventional radiologist. The diversity, scope, types, clinical breadth and consultative vs. referral practices make a single name or logo difficult to not exclude a significant portion of our membership. Two-thirds (2/3) of our members do not exclusively practice interventional radiology. Yet many of our thought leaders are actually in private practice performing procedures during only a portion of their professional activities.

Our logo is now more than 25 years old. It needs to be simplified to better serve the current and future needs of the Society. Dr. Robert Vogelzang has agreed to chair a task force whose charge is to revise our logo as a first step in revitalizing the image of our Society.

A gaping hole in our daily and yearly activities has been the existence of a usable strategic plan. Our last strategic plan, completed about five years ago produced a document that has not been used effectively as a tool to guide and administer the activities of the Society. In an effort to temporarily address this, a short-term strategic planning session was conducted last year to help us for the short term.

Clearly the need of a strategic plan (particularly to guide the key decisions regarding identity, logo and priorities of the Society) is critical to our continued growth and prosperity.

Clearly the need of a strategic plan (particularly to guide the key decisions regarding identity, logo and priorities of the Society) is critical to our continued growth and prosperity.

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CODING & BILLING

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PROCEDURES ON EXISTING TIPS

- TIPS venogram
- TIPS revision, balloon
- TIPS revision, stent
- Embolization (No C.A.)
- Embolization (CNS)
- Embolization (non-CNS) Head of Neck
- F/U Angio post Embo
- Endovas four more information contact
  Society of Cardiovascular & Interventional Radiology
  at (703) 691-1805, (800) 488-7284 or by fax at (703) 691-1855

Abdominal Aorta Aneurysm
See Carr?
**Coding Q & A**

A number of questions have been posed recently regarding coding issues with abdominal aortography and femoral arteriography. While these exams are not new, coding can be confusing and this column will address some of those concerns.

**Q.** I have a new digital subtraction unit that allows rotational angiography. Is there a specific code to use for the rotational imaging?

**A.** There is no additional code to designate rotational angiography. The radiologic S&I codes for angiography include all views of that body part necessary to make the diagnosis. Rotational angiography simply gives you many views with one run. That is included in the S&I code for the angiogram done (e.g., 75625 if a rotational abdominal aortogram is done.)

**Q.** Occasionally I must do a lateral aortogram to visualize the SMA origin. This is over and above my usual AP view of the aorta. Is there an additional code I can use for this extra work?

**A.** No. As with rotational angiography, all views required to fully evaluate the body part are included with the S&I code for that part. In this case, 75625 would be the appropriate code to use, despite the addition of a lateral view.

**Q.** CPT code 76350 is designated for “Subtraction in conjunction with contrast studies”. Should we use this for digital subtraction angiography?

**A.** No. This code is used for cut-film angiography where subtraction films must be hand-developed in the darkroom. It is not intended for use with DSA.

**Q.** I do a flush run-off imaging both legs but need additional detail of the distal vessels in one leg, so I move the catheter and select the contralateral external iliac artery and do magnified views of the distal leg. How do I code for that work?

**A.** Instead of coding 36200 for the non-selective positioning of the catheter in the aorta, 36246, second order selective catheterization, is used for the catheter positioned into the contralateral external iliac artery. 75774, S&I code for each additional vessel after basic, may also be coded IF the extra work was done for added diagnostic detail. If the extra work was done because of a technically inadequate study with the flush injection, 75774 would not be coded in addition to 75716. 75774 would also NOT be used if additional imaging was done with magnification views of a part of the leg from a second flush aortic injection.

**Q.** I need to do a selective renal arteriogram to look for small vessel detail, but despite a long struggle to catheterize the renal artery, it is not possible to selectively catheterize the renal artery. I therefore place the pigtail catheter right at the renal artery origin and do multiple detail views of the renal artery and its branches. Should I code this as a selective renal angiogram (75722) since so much work was done and extra detail images were taken?

**A.** In this case, the CPT descriptor for 75722 specifies that a selective catheterization was done. We would recommend coding this 75625, non-selective aortogram, since a selective catheterization was not done.

**Q.** I use 75625 + 75716 to code for an aortogram and bilateral femoral run-off exam, but my carrier often changes these codes to 75630. Which is correct?

**A.** The use of these codes depends on how the study was performed. 75630 is used with a catheter is positioned in the upper aorta and a single injection is done, visualizing the aorta and the run-off vessels. With this technique, detailed imaging of the abdominal aorta and of the lower extremities is less than if a dedicated injection of each body part is done. If the catheter is placed in the upper abdominal aorta and injection is done with full and complete imaging of the abdominal aorta, and then the catheter is repositioned using fluoroscopic guidance into the lower aorta for a dedicated bilateral lower extremity angiogram, 75625 would be used for the full and complete abdominal aortogram, and 75716 would be used for the bilateral lower extremity angiogram. Use of both codes also necessitates documenting in the dictated report the additional work to reposition the catheter and to do separate runs. The dictated report should also describe the full and complete findings of the aortogram and of the lower extremity run-off.

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**E-Commerce Now Available on SCVIR Web Site**

Purchase SCVIR products and materials on-line. The full 2000 SCVIR product catalog can now be accessed through SCVIR’s Web site www.scvir.org. Simply click on the products button found on the left side of the home page.

As always, SCVIR members receive a member discount when ordering products. Additionally, to ensure the privacy of your credit card information, a secure transaction server is in place for this on-line service. The on-line catalog will be updated throughout the year so that you can order materials and products, as they become available.
NPs and PAs are Letting IRs Emphasize Clinical Aspects of Practice

Editor’s Note: This is the final segment of the three-part series on NPs and PAs in IR.

Nurse practitioners and physician assistants have long been an integral part of many primary care practices. But now, while seeking to optimize their physician resources, a small but growing percentage of interventional radiology practices are expanding their use of NPs and PAs, and finding that the move can give a boost to their efforts to provide more clinical services.

In some cases, the assistants are already employed by the group but have begun to take on more and more tasks traditionally performed by the interventionalists. “We probably had 1.5 FTEs of nurse practitioners when I got here, but they did not function the same way as now,” said James L. Swischuk, MD, co-director of interventional radiology at OSF St. Francis Medical Center in Peoria, IL, the main teaching hospital for the University of Illinois College of Medicine. “They basically just did pre-procedure notes. We decided to expand their role mainly because we wanted to start providing many more clinical services and to be able to take patients directly from referring physicians’ offices and admit them to the hospital.”

Now the practice employs one PA, two nurse practitioners and one certified nurse specialist, who have taken on much of the routine work using a very standardized process the group has in place. “On every single patient they do some sort of history and physical. In addition, for roughly 700 patients per year we see for follow-up visits in the clinic, they gather all the data and actually write all the notes,” Dr. Swischuk explained. “PAs and NPs come with that training. They know the format, so oftentimes I’ve found they do more extensive visits than what we code for using the E & M guidelines.”

“As an interventional radiologist, you oftentimes get a phone call from a physician and you see the patient for the first time shortly before a procedure. So you don’t have a lot of time to shore up the clinical data and get to know the patient,” he pointed out. But NPs and PAs can perform those tasks, and he believes the referring physicians appreciate the difference. The ability to admit patients on their own service is an important benefit for IRs who are emphasizing clinical services. “When we admit the patient, the referring doctor knows that every ounce of the care provided is attributable to us,” Dr. Swischuk said.

“The other day we had a patient with an ischemic leg that needed possible thrombolyis. There was no surgery scheduled and he would have a two-day stay. But the patient was referred by a doctor outside the region who would not be treating the patient here. Because we could see the patient and admit him under our service, it made it very easy for the doctor to send the patient and have the problem taken care of.”

His private practice group, which has four CAQ-certified interventionalists and one neuro-interventionalist, has seen several gains from using NPs and PAs. “If we offered the same clinical services without them we would probably have to hire 1.5 more IRs, easily, plus the patients with less complicated procedures just wouldn’t get the workup. We’d go back to the way we used to do it.”

But that would make the practice less competitive, he contends. “In the good old days, interventionalists had a fluoroscopic machine no one else could get their hands on, and procedures no one else knew how to do. You could come in and do procedures all day and you didn’t do that much clinical management. But now, you’re competing with cardiologists and vascular surgeons who have that machine, and these are people who are used to giving that clinical service.”

Having to switch from doing lucrative procedures all day to E & M services, which are not that lucrative, makes the use of NPs and PAs a natural fit, he adds. In addition, the group can bill for E & M services under the NP’s or PA’s identification number, which can offset the overhead expenses of such employees.”

At Massachusetts General Hospital in Boston, use of a nurse practitioner by the IR group is a “work in progress,” says Arthur Waltman, MD, director of vascular and interventional radiology. His 10 interventionalists includes a nonvascular and a vascular group which together perform 7,000-8,000 procedures per year. They hired a nurse practitioner, formerly working for a cardiologist, about eight months ago. “She came on board when we were sort of at the end of the year, and her primary assignment was to learn and become competent in venous access procedures. She became proficient at that before our new fellows or trainees arrived, so that facilitated her acceptance,” he said. “She was taking on a role in an area that has become burdensome for us; it’s a very large part of our repertoire.”

The nurse practitioner is also starting to help with another high resource utilizer: communication and follow-up with patients with uterine

(See NPs and PAs page 21)
CIRREF Announces Newest Grant Recipients

CIRREF is pleased to announce the newest recipients of the CIRREF Pilot Research Grant Program. The purpose of this program is to fund research in areas identified by CIRREF as important to the advancement of cardiovascular and interventional radiology and patient care. The next deadline for submission of grant applications is February 1, 2001. Applications are available on the CIRREF Web site at www.cirref.org. For more information, please contact Wendy Landow at the SCVIR Office at (800) 488–7284.

Pilot Research Grant Program Award Recipients (July 2000):

Chieh-Min Fan, MD, Harvard Medical School
Use of Polyethylene Glycol for Branch Vessel and Sac Ablation during Stent Graft Repair of Abdominal Aortic Aneurysms in a Sheep Model

Andrew Forauer, MD, University of Michigan Medical Center
Analysis of Catheter Associated Fibrin Sheaths: Histology and Development

Sanjay Misra, MD, Mayo Medical School
Investigation of Tissue Level Expression and Secretion of Matrix Metalloproteinase 2 and 9 (gelatinases) in a Porcine Polytetrafluoroethylene Graft Model of Venous Stenoses

Fibroid ...
(Continued from page 1)

A Registry steering committee has been appointed and is chaired by SCVIR Immediate Past President, Matthew A. Mauro, MD. The committee is responsible for defining and prioritizing the objectives and goals of the Registry and providing input into the project processes, as well as overseeing access to and publication of Registry data. The committee has been working to finalize the protocol including the case report form and follow-up. The committee has defined site selection criteria and identified potential core sites for longitudinal follow-up. In addition to Dr. Mauro, members of the steering committee include Robert Worthington-Kirsch, MD, Scott Goodwin, MD, James Spies, MD, Anne Roberts, MD, Gaylene Pron, PhD, principal investigator of the Ontario Multi-Center UFE Trial and Diane Mitchell, MD, an obstetrician/gynecologist from the FDA, as well as investigators from DCRI. An Industry Advisory Board, comprised of representatives of project sponsors, has been formed to represent industry needs and concerns.

Funding has been secured in the amount of $575,000 from the major embolic manufacturers to help support the Registry over three years. Additional funding will be solicited from industry, government and other societies.

"We believe that the support of this project is essential in an effort to provide information to the public about a safe alternative for women with this condition," said John Dean, Director of Tumor Management for Boston Scientific/MEDI-TECH, which is providing lead funding for the registry. Additional funding is being provided by: Cordis, a Johnson & Johnson Company, Biosphere Medical and Cook Diagnostic and Radiology. In addition, CIRREF has received direct donations from UAE patients for the Registry.

For additional information about the FIBROID Registry, please go to www.cirref.org or contact Wendy Landow at (800) 488–7284.
INTERNATIONAL FOCUS

Millennium Congress Set for New Delhi

The Indian Society of Vascular and Interventional Radiology is hosting the Millennium Congress of Vascular and Interventional Radiology to be held December 9–12 at the Grand Hyatt Hotel in New Delhi, India. The Congress is co-sponsored by SCVIR, Cardiovascular and Interventional Radiological Society of Europe (CIRSE), Asian-Pacific Congress of Cardiovascular and Interventional Radiology (APSCVIR) and Interventional Radiology Society of Australia (IRSA). The Congress incorporates the 3rd Annual Conference of ISVIR.

The Congress will feature all aspects of vascular and interventional radiology, with special emphasis on recent advances and innovations in technology and techniques, including their relevance to the regional perspective. The list of faculty includes eminent specialists from all parts of the world who will join hands to provide comprehensive state-of-the-art information on various procedures.

A comprehensive technical exhibition will be held concurrently with the Congress and will be an integral part of its proceedings.

Registration is US$ 250 for interventional radiologists, interventional cardiologists and vascular surgeons, US$ 150 for residents and PG students. For more information, contact Conference Secretariat Sanjiv Sharma, MD at Sanjivap@medinst.ernet.in or via fax (from the US) at 011 91 11 6862663.

International Workshop Features Cutting Edge Tele-Education

A record number of Eastern European interventional radiologists attended the 6th International Workshop on Interventional Radiology, June 15–17, 2000 in Prague, Czech Republic. More than 150 of these registrants received grants that enabled them to attend the meeting. The Dotter Interventional Institute sponsored a large number of these grants. The meeting was organized by the Dotter Interventional Institute and the Institute for Clinical and Experimental Medicine in Prague. Frederick Keller, MD and Jan Peregrin, MD served as meeting chairs. A total of 320 individuals from 28 countries attended the meeting, including 123 from the Czech Republic, 31 from Slovakia, 28 from Hungary and 19 from the US.

Along with an update on the rapidly developing field of interventional radiology the meeting featured cutting edge technology that enabled attendees access via live transmission to cases from six hospitals around the world, including hospitals in the Czech Republic, Austria, the United Kingdom and the US. A special presentation detailed the technical tele-education process used for the live case transmissions and described how advances in technology over the past several years have lowered the costs involved with offering live cases and allowed for an increase in the number and variety of state of the art transmissions.

New technology and devices were another popular feature of the meeting and focused on carotid stenting, mechanical thrombectomy, fragmentation catheter, vertebroplasty, stent grafts for AAA and esophageal stent with anti-reflux valve. Plenary sessions included vascular surgery and interventional radiology, stent grafts for AAA, TIPS stent grafts, intra-arterial thrombolysis for acute stroke, intracranial aneurysms: endovascular versus surgical approach and specific economic aspects, among other topics. Tim Goldfarb, Director of the Oregon Health System spoke on OHSU and the competitive environment in his presentation on the “Importance of Interventional Radiology for the Academic Medical Center.” Curt Bakal, MD gave an overview on standards and guidelines for interventional radiology.

A variety of workshops gave attendees hands-on experience, focusing on topics such as thrombolysis, neurointerventions, aortic stent grafts, venous interventions and renal artery interventions.

Friedrich Olbert, MD of Vienna received a lifetime achievement award from the Czech Radiological Society. Dr. Olbert stated that he was “deeply impressed and very proud at receiving this distinction.”

Mark your calendars for the 7th International Workshop on Interventional Radiology June 7–9, 2001.

Feedback …

In your patient education section on treating and preventing stroke, diagnosis section, page 1, there is a picture of an angiogram labeled as a patient having a CT.

Thank you for this patient section, I printed it for a friend. It is a great resource, significantly better than any patient info packets I’ve seen. My friend found it very easy to read and understand.

Thank you.

John Mikalajczyk, MD
Director, Radiology
St. Francis Hospital
Wilmington, DE
(received via email)
**The Interventional Clinician:**

How One IR Translated the Lessons He Taught in Academics to a Successful Clinical Practice

His name is big. Up there with Amplatz and Waltman. Dr. Floyd Osterman was the force that drove Johns Hopkins Interventional Radiology program for over 10 years. During that time over 35 fellows trained and many continued on to develop training programs modeled after the comprehensive clinical interventional program at Hopkins.

Many others entered into private practice positions, practicing their specialty skill part time and devoting the rest to diagnostic radiology. According to Dr. Osterman “it seemed like such a waste. After two years of training the key skills we taught in patient management were never used. Our trainees seemed to be missing the basic point—that the core skills are clinical judgment and patient management, not procedures. Techniques come and go. They can be mastered by anyone with reasonable coordination. The challenge lies in the decision making process and patient interaction."

“The unique combination of high technology and patient care opportunity is what attracted many of us to this subspecialty, but the private practice paradigm seems to prevent our trainees from achieving their potential.”

Can we achieve the same level of clinical excellence in a private practice environment?

Dr. Osterman was fairly uniquely qualified to address this question, having begun his career in private practice. So in 1998 he elected to return to his home state of Florida, recruited by Reuven Porges, MD for a 100 percent interventional radiology practice and staffing the 400 bed Adventura Hospital and Medical Center.

“On arrival I felt as if I had found the black hole of interventional radiology” he notes. “They did a minimal number of basic procedures between reading films. I began with the typical approach, planning on figuring things out over time, getting to know the medical staff and offering a few lectures and relying on a well deserved reputation.” It failed.

After six months, it was time for a new approach. He viewed his hospital from the perspective of opportunity. One clear area of weakness was in vascular care. No one was offering exclusive diagnostic and management services for vascular disease on the Hospital Campus. He opened a clinic. Not in the corner of the recovery area or in his office, but in a separate Medical Office building shared with a non-competitive pulmonary and intensive care physician.

“Time sharing is a great approach. I gained a professional space with secretarial and nursing support. It is a common way to begin a professional practice.”

He sent a letter out to the medical staff describing his clinical interests, his past experience and availability.

Initially things were slow, with one to three patients weekly. But it began to pick up with patients arriving for office follow-up visits (nephrostomy and biliary drainage) and new patients requesting (See Clinical Practice page 20)

### IR Procedure Volume Time Line

<table>
<thead>
<tr>
<th>Year</th>
<th>Volume</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td>4,750 Projected Volume IR Procedures</td>
</tr>
<tr>
<td>1999</td>
<td>2,564 IR Procedures</td>
</tr>
<tr>
<td>April 1999</td>
<td>Office Opened</td>
</tr>
<tr>
<td>September 1998</td>
<td>Begin practice with Florida United Radiology</td>
</tr>
<tr>
<td>1998</td>
<td>2,006 IR Procedures</td>
</tr>
<tr>
<td>1997</td>
<td>2,128 IR Procedures</td>
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</table>

<table>
<thead>
<tr>
<th>Requirement to Meet IR Volume Increase:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Nurse practitioner or PA</td>
</tr>
<tr>
<td>2. 1/2 FTE Interventional Radiologist</td>
</tr>
<tr>
<td>3. Second room</td>
</tr>
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</table>
Discussion: Pulmonary artery injury is a known complication of Swan-Ganz catheter placement, as was likely the cause in this case. Less likely, it may have resulted from the patient’s initial trauma, as the abnormality was not present on the initial admission chest CT. There have been several case reports regarding pulmonary artery pseudoaneurysms caused by Swan-Ganz catheters, as well as coil embolization, as well as coil embolization as a primary treatment option (1, 2, 3).

Pulmonary artery injuries due to Swan-Ganz catheter placement frequently result in rapidly fatal hemoptysis. However, in patients who remain stable enough to undergo pulmonary arteriography, transcatheter embolization often represents the best treatment option (1, 2, 3). Pulmonary artery injuries due to Swan-Ganz catheter placement frequently result in rapidly fatal hemoptysis. However, in patients who remain stable enough to undergo pulmonary arteriography, transcatheter embolization often represents the best treatment option. Additionally, this case demonstrates the usefulness of rotational angiography, to immediately identify the correct selective pathway for successful and prompt embolization.

This case is submitted as an example with good correlative imaging, rotational angiography, and selective coil embolization.

References

Fig. 2. Chest CT. An atypical contrast collection (see arrow) is seen representing focal dilation of the pulmonary artery just proximal to the basal segment branches, adjacent to the Swan-Ganz catheter tip.

Fig. 3, as seen on the SCVIR Case Club™ Web page, is a video file.

Fig. 4. Angiogram. Single image again demonstrating the pseudoaneurysm arising from the proximal lateral basal pulmonary artery.

Fig. 5. Post Embolization Angiogram. Image demonstrates selective placement of 5mm coil x 4, and 3mm coils x 3, with complete occlusion of the pseudoaneurysm.
Summary of Case Commentary

Several respondents indicated that they had performed coil embolization of iatrogenic pulmonary artery pseudoaneurysms caused by balloon catheters. Some wondered about the natural history of these lesions when left alone. One respondent reported his experience with a case in which the hemoptysis had stopped by the time the patient reached the angiography suite. Although a small pseudo-aneurysm was identified angiographically, the referring service would not allow embolization because the patient was now clinically stable and believed the lesion would resolve spontaneously. Unfortunately this was not the case as the patient rebled in the ICU and expired. The histories of vasculitis and steroid use were thought to predispose to this injury. The respondents agreed that the rotational angiog run was helpful in displaying the optimal angle for subselective catheterization.

ON THE WEB

Professional Organizations On-line

By Robert T. Andrews, MD

By now, readers of this newsletter are familiar with our Society’s outstanding Web site at www.scvir.org (if you are not, make a point of visiting today). The SCVIR site is, by design, focused upon issues facing interventional radiologists in the United States, and is a tremendous resource for information on those issues. Nonetheless, since our members are also impacted by developments within the broader field of radiology and medical practice in general, other professional, specialty-related sites are also useful from time to time.

The URLs tabulated below (in alphabetical order by organization name) are a sampling of professional Web sites that relate to general and interventional radiology practice in the United States and interventional practice in Europe. The sites differ from each other in organization and content, but generally have extensive information for physicians and patients alike. Most feature meeting announcements with on-line registration, instructions for authors and links to related publications. Some also contain member-only subsections with case files or advertisements for employment, equipment and other items. Keep these sites handy by clipping and posting the table or by placing the URLs into a folder named “professional organizations” in your bookmark (Netscape) or favorites (Microsoft Internet Explorer) files. You will likely visit one or all in the future.

American Board of Radiology
www.theabr.org

American College of Radiology
www.acr.org

American Medical Association
www.ama-assn.org

American Roentgen Ray Society
www.arrs.org

American Society of Interventional and Therapeutic Neuroradiology
www.asitn.org

Cardiovascular and Interventional Radiology Research and Education Foundation
www.cirref.org

Cardiovascular and Interventional Radiological Society of Europe
www.cirse.org

SCVIR E-commerce Site Expands Beyond Society Publications

SCVIR and Lippincott Williams & Wilkins (LWW) have entered into an exciting new e-commerce partnership. LWW currently markets the SCVIR Syllabus Series on their online bookstore and provides exposure for the books at various meetings worldwide. Now SCVIR is offering selected LWW titles through the Society’s e-commerce site. For each LWW book or CD-ROM purchased thought the SCVIR Web site, the Society receives a substantial commission. This is a painless way to contribute to your Society. When you are bolstering your personal or institutional library, please make your purchases through the SCVIR Web site.

To encourage visits to the e-commerce site, we will be offering an introductory 10 percent discount on all LWW titles purchased through the SCVIR Web site. Don’t miss out on this great opportunity to expand your library, save money, and support your Society at www.scvir.org.

CIRREF Web Site

CIRREF continues to update it’s Web site—www.cirref.org.

Check out the site for grant guidelines, updates on CIRREF grant recipients and information on other research-related activities.
Healthy lifestyle choices, such as giving up smoking, eating low-fat foods and exercising regularly can prevent peripheral vascular disease or ease its symptoms. In many cases, positive lifestyle changes, medications, or medical procedures that open up the clogged arteries can greatly improve the condition.

If you suspect that you might have peripheral vascular disease, you should get tested. September is National Peripheral Vascular Disease Month and hundreds of hospitals across the United States will offer free Legs For Life® screening and testing programs the week of Sept. 17–23. (www.legsforlife.org has a list of the free screening sites)

To set the stage for the screening week, a number of legislators will participate in a Capitol Hill screening Sept. 7 in Washington, DC. Their goal is to call attention to PVD and encourage people to sign up for the free screenings.

Our health is our responsibility. The more we do to prevent illness, the longer we will live. The more aggressive we are in detecting disease in its earliest stage, the more effectively it can be treated. A free opportunity to check whether the pain in your legs is being caused by PVD should not be ignored. Catch it early and the remedy might be simpler than you think. It’s worth the effort.

David Satcher, MD, PhD, is the US Surgeon General and the Assistant Secretary for Health.

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**Legs For Life® Welcomes Otsuka as Newest Sponsor**

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CVIR and CIRREF are proud to announce that Otsuka America Pharmaceutical, Inc. (OAPI) and Pharmacia Corporate have joined the Legs For Life program as a Platinum level sponsor (a three-year commitment of $500,000). Their commitment as a national sponsor will assist in underwriting the cost to: produce Legs For Life instructional, patient, physician and media materials; provide ongoing technical assistance to sites; maintain the Legs For Life Web site and toll-free information line for patients; and perform research to evaluate program outcomes. OAPI and Pharmacia join diamond sponsors Boston Scientific/MEDI-TECH and Guidant Foundation, and silver sponsors Genentech and Angiodynamics, Inc. as national program sponsors.

OAPI is recognized as an innovative discoverer, developer, and provider of unique pharmaceutical products that address unmet medical needs. Their purpose is to improve the quality of human life by developing innovative products as rapidly as possible through ethical and creative ways. Pharmacia Corporation (NYSE:PHA) is a leading global pharmaceutical company created through the merger of Pharmacia & Upjohn with Monsanto Company and its G.D. Searle unit. Pharmacia has a broad product portfolio, a robust pipeline of new medicines, and an annual investment of more than $2 billion in pharmaceutical research and development.

OAPI manufactures the product PLETAL®, PLETAL® was approved by the FDA in 1999 to help intermittent claudication patients walk farther without pain.

"Peripheral vascular disease has a higher mortality rate than breast cancer. Our companies support the Legs For Life program because it helps to raise the awareness of this serious disease and the leg pain that is often the first symptom of PVD," says Lauren Coyle, product manager for OAPI. An estimated four million Americans ages 55 and older experience this leg pain due to a debilitating circulatory condition called intermittent claudication. This can make walking even one block a struggle. Seventy-five percent of sufferers go undiagnosed. They think that the pain is part of aging. It isn’t. Legs for Life serves as a conduit to tell patients that they don’t have to take leg pain sitting down.”
Survey Shows Americans Unaware of Gravity of PVD

While nearly two out of three Americans have heard of peripheral vascular disease (PVD), a major cause of leg pain, more than two-thirds are unaware of how serious the condition can be, according to a national survey conducted in August 2000 and commissioned by SCVIR. The survey was conducted by Opinion Research Corporation International. Further, nearly half can't name even one symptom of PVD that would lead them to seek help.

Only 21 percent of those surveyed realized how prevalent PVD is, affecting one in 20 people, and fewer than one in three (28 percent) were aware the condition can be life-threatening. Nearly nine in 10 (89 percent) did not know that men age 50 and older were at highest risk for PVD.

Few surveyed knew the most common symptoms, including leg pain that occurs during walking or exercise (6 percent), numbness (5 percent) and skin discoloration (2 percent).

While nearly two-thirds of people surveyed (63 percent) said they were aware of PVD, most (86 percent) knew of it as hardening of the arteries, an old description that incorrectly describes the condition. Fewer than one in 10 (9 percent) knew that plaque or fat build up in the arteries or veins causes PVD.

Nearly half (48 percent) were unaware of how PVD is treated. Depending on severity of the disease, PVD can be treated with lifestyle changes (including exercise and cessation of smoking), medication, angioplasty, stent placement or surgery.

While nearly one in three (35 percent) said they didn't know how PVD can be prevented, some correctly said a low-fat diet (44 percent) and regular exercise (33 percent) can help. However, fewer than one in 10 (8 percent) said “do not smoke,” which is a major risk factor for PVD.

Pilot AAA Screening Launched During Legs For Life®

A new component of the Legs For Life® Screening Program for abdominal aortic aneurysm (AAA) was piloted in 13 sites in conjunction with Legs For Life 2000. Five of the sites offered ultrasound (US) and the others used a screening questionnaire. Letters were sent to participants’ primary care physicians suggesting follow-up for those with positive US results or who were deemed to be at high risk based on the questionnaire.

“We were thrilled with the turnout,” said SCVIR member Katharine Krol, MD of St. Vincent’s Hospital, Indianapolis, who screened nearly 900 people for PVD over two days and performed more than 200 US exams for AAA. Nine aneurysms were found, two of which were previously known. Of the seven newly diagnosed cases, two were greater than 50 mm in size and were referred for treatment; the others will be followed.

Other SCVIR members who offered US screening were Curtis Bakal, MD, St. Lukes-Roosevelt Hospital Center, NY; George Fueredi, MD, Sinai Samaritan Medical Center, Milwaukee; Barry Katzen, MD, Miami Cardiac and Vascular Institute; and Matthew Mauro, MD, University of North Carolina Hospitals, Chapel Hill. Members administering the AAA screening questionnaire were Robert Beres, MD, St. Luke's Hospital, Milwaukee; Kyran Dowling, MD, Albany Medical Center, NY; Francis Fernandez, Jr., MD, Florida Hospital, Orlando; Colleen Harker, MD, LDS Hospital, Salt Lake City; Jeffrey Leef, MD, University of Chicago; E. Bruce McIff, MD, Utah Valley Regional Medical Center, Salt Lake City; Rodney Raabe, MD, Sacred Heart Medical Center, Spokane; and Harvey Weiner, MD, Phoenix Baptist Hospital.

A special thanks to Sonosite, Inc. for their donation of hand-held ultrasound machines for the pilot sites doing ultrasound screenings.

The AAA screening will be launched nationally with the 2001 Legs For Life Screening Program.

Legs For Life Direct Public Interest

| Web: 228,266 visits to Legs For Life Web site |
| Phone: 39,332 calls recorded to patient infoline |
| Emails: 1,560 |
| Total: 269,158 direct public impressions Through October 1, 2000 |
On Capitol Hill …

On September 7, as the kick-off to the inaugural National Peripheral Vascular Disease Awareness Month, SCVIR held a PVD screening and press conference on Capitol Hill.

I have just seen the TV segment concerning the disease PVD. I was unaware of this disease until I viewed the health segment on the noontime news. I think my husband suffers from this disease. The screening dates have past. Will there be any more set up? … Thank you so much for this PVD awareness educational program.

Source: Patient Email
Across the Country ...  
Legs For Life 2000 produced nearly 600 screenings within 47 states and the District of Columbia.

Those screened for PVD within the Legs For Life program received great attention from medical staff.

St. Vincent Hospital’s Richard Isaacson, DPM consults with patient.

Phoenix: Angiotechnician Jim Akridge administers the ABI.

San Francisco Bay: David H. Chin, MD (c) works with his PVD screening staff during Legs For Life 2000.

Indianapolis: A crowded Legs For Life waiting area.

The Leesburg Regional Medical Center’s welcoming committee.

Our Orlando Market exceeded all expectations and broke record numbers! A grand total of 1235 patients were screened. We detected 196 patients with a Moderate Risk for PVD and 37 patients with High Risk for PVD.

Orlando: The Legs For Life team at Orlando Regional Vascular Center.
The 2001 Annual Scientific Meeting will be held in San Antonio March 3-8. The Annual Meeting Committee has been hard at work preparing what promises to be yet another great meeting. With superlatives like “best meeting ever” used to describe prior meetings, the bar is set very high. Nonetheless, we think SCVIR members will “Remember the SCVIR” long after they leave San Antonio. To start with, the city itself has so much to offer, from the famed Alamo to the eclectic Riverwalk. The Henry B. Gonzalez Convention Center is newly renovated and the hotels are all very close by.

The revised meeting format introduced last year was a tremendous hit, not surprising as it allowed members to participate in even more educational programs during the day. The format will remain the same this year, with three afternoon timeslots for an “Interventional Odyssey” worth remembering.

This year, two full-day symposia are planned, from 8 a.m. until 5 p.m. on Saturday, March 3. Dave Hunter, MD and Rich Shlansky-Goldberg, MD are coordinating Medications for Interventional Radiology: Pharmacology and Practice, and Anne Roberts, MD is coordinating the Hemodialysis Symposium. These topics were chosen based on exit evaluations from the 2000 meeting as well as the educational importance of these subjects to the daily practice of IR.

The plenary sessions will highlight a variety of topics including a morning-long mini-symposium on renovascular intervention; peripheral vascular intervention; nonvascular intervention; aortic stent-grafts; venous interventions; neurointerventions and vascular imaging. In addition, at the request of many members, a special session on cardiac imaging will be held Tuesday morning, March 6. Several plenary talks will highlight pediatric interventions as well. Featured speakers will include William Hendee, MD, Dean of the Graduate School for Biomedical Sciences, Medical College of Wisconsin, who will discuss medical errors, and Marsha Angell, MD, former editor of the New England Journal of Medicine, who will discuss conflict of interest in clinical trials. This year’s Dotter Lecture will be delivered by Julio Palmaz, MD, a fitting tribute for the 10th anniversary of the Palmaz Stent.

The highly popular live cases will return again in 2001. This year, the father-son duo of Mark and Michael Wholey will present live carotid and renal stent cases respectively. As in 2000, these cases will be part of plenary sessions relevant to the case. Just as popular as the live cases is the Interventional Film Panel, the brainchild of J. J. Van LaBerge, MD that has become an integral part of the Annual Meeting in just a few short years. This year’s moderator will be Fred Keller, MD and the panelists will be Gordon McLean, MD, Stuart Geller, MD, Gary Becker, MD and Vicki Marx, MD. If only there were Academy Awards for Film Panels … don’t miss this one! Don’t forget to log on to the SCVIR Web site www.scvir.org before the meeting to review the cases. As always, they will also be posted at the meeting and published in JVIR before the meeting so you can submit your diagnoses before the session.

Watch the newsletter for updates on other programming highlights for the 2001 meeting. Scientific Program Chair Al Nemcek, MD and Workshop Chair Alan Matsumoto, MD are preparing outstanding programs. The fluoro lab stent-graft and vertebroplasty workshops will return this year, and online submission of abstracts for the scientific program is now an integral part of the meeting. Dr. Nemcek has also prepared an outstanding list of categorical courses; stay tuned to SCVIR News for details!

Watch for the registration brochure or log-on to the SCVIR Web site for online registration. The registration process has begun. Register on-line to get first pick of the most popular workshops, which tend to fill up very early.

Don’t miss the “Interventional Odyssey” in San Antonio. Mark your calendars now!
Spotlight San Antonio

By Ernie Loeffler

This is part two of a two-part series spotlighting San Antonio, host of SCVIR 2001, March 3-8.

San Antonio For Kids

San Antonio provides the picture-perfect setting for great family vacations, beginning with the San Antonio children's museum, where kids are encouraged to explore a miniature version of the city. Children of all ages will experience the excitement of the big top at the Hertzberg Circus Museum, while The Magik Theatre provides family, professional theater, in the heart of downtown.

The Downtown All-Around Playground at Hemisfair Park and the newly renovated Milam Park (across from Market Square) provide excellent stops for kids to burn off excess energy. And don't forget the Tower of the Americas, which offers a spectacular view of San Antonio from 579 feet above the ground.

The Plaza Theatre of Wax houses more than 225 life-like characters in four themed sections—Hollywood, Horror, History and Religion. Ripley's Believe It Or Nott has more than 500 unique curiosities from around the world. Another popular stop is the Cowboy Museum on Alamo Plaza.

Brackenridge Park, a 433-acre refuge in the heart of the city, offers a full day of family fun. The San Antonio Zoo, with a collection of more than 3,000 animals, is ranked as one of the best in the country.

The Witte Museum's philosophy is hands-on learning, with exhibits exploring Texas history and science. The Japanese Tea Garden, the Brackenridge Eagle Miniature Train, Brackenridge Stables, the carousel, the skyride and Kiddie Park will round out a day of fun and education.

Van Gogh, Mozart and Trevino

San Antonio has two impressive art museums. The McNay Art Museum is set in a Mediterranean-style mansion and has wide-ranging collections, including post-impressionist and modern art, theater art, Medieval art, Native American art and more.

San Antonio Museum of Art (SAMA) is housed in the castle-like former headquarters of the Lone Star Brewery. This museum is noted for its antiquities collections, Mexican folk art, modern art, pre-Columbian art and Spanish colonial art.

Hotbeds of contemporary artistic expression include the Blue Star Art Space in Southtown, ArtPlace on Main Avenue and the Southwest School of Art and Craft, a lovely complex built by French nuns in 1848 which served as the first girls' school in the city. Galleries abound and offer the serious collector a wide range of styles and topics from Texas landscapes to Latin American folk art to western and Native American to contemporary.

The Guadalupe Cultural Arts Center provides a venue for Hispanic artistic endeavors—literary, dance, music and drama. Signature events of the center include the San Antonio CineFestival, a celebration of conjunto music, a South Texas original.

The Carver Community Cultural Center mounts a stellar season each year, with performing groups from around the world, with an accent on African-American artists. The Carver Jazz Festival is famous for presenting the hottest new stars and the masters of American Jazz each year.

The opulent Majestic Theatre downtown, built in 1929, is a memorable setting for touring Broadway shows and concerts and is also the permanent home of the San Antonio Symphony, now in its 54th season.

The Spurs, Golf and Hill Country Adventure

With over 300 days of sunshine annually and an average temperature of 68.8 degrees Fahrenheit, visitors to San Antonio will find an abundance of outdoor sports and recreation to challenge them.
HCFA Updates Devices Eligible for HOPPS “Pass Through” Payment

Effective October 1, 2000, the Health Care Financing Administration (HCFA) will make separate “new technology” payments for over 30 drugs and devices that met HCFA’s new technology criteria. Included in the October 1 list are VasoSeal’s vascular closure device, the PALMAZ balloon expandable biliary stent, the Wallstent transhepatic biliary endoprosthesis, the OptiPlast XT 5F PTA catheter and the Synchomed vascular catheter model 8700A, 8700V. HCFA also created 11 APCs applicable only to new technology. For more information, see HCFA Transmittal A-00-61 at www.hcfa.gov/pubforms/transmit/A0061.pdf

FDA Issues Single-Use Device Reprocessing Guidance

On August 14, 2000, the Food and Drug Administration (FDA) issued a guidance document entitled “Enforcement Priorities for Single-Use Devices Reprocessed by Third Parties and Hospitals.” This document provides guidance to third party and hospital reprocessors about their responsibility in reprocessing of single-use devices. The agency believes that the risk posed by reprocessing a device is related to its classification. Accordingly, from the date of the guidance document, FDA plans to enforce premarket submission requirements within six months for class II devices, 12 months for class II devices and 18 months for class III devices.

SCVIR to Co-Sponsor Embolotherapy Workshop with FDA

SCVIR will co-sponsor Embolotherapy: Bench to Bedside, An Interdisciplinary Workshop (Academic, Clinical, Industrial and Regulatory Perspectives) on December 11–12, 2000. The workshop will take place at the FDA’s Animal Lab Research Facility in Laurel, MD (just outside of Washington, DC). Other workshop co-sponsors are: FDA’s Center for Device Evaluation and Radiological Health (CDRH), the International Society of Cardiovascular Medicine and Science and the American Society of Interventional and Therapeutic Neuroradiology (ASITN).

The objectives of the meeting are to foster communication between the professional, manufacturing and regulatory community and to generate a preclinical/clinical update that summarizes the research, development and application of embolotherapy.

The workshop co-chairs are Patricia E. Cole, MD, PhD, of Yale University; Jafar Vossoughi, PhD, Biomed Research Foundation; Nicholas Kipshidze, MD, PhD; John Karianian, PhD, FDA.

To register, and for additional information, contact Jafar Vossoughi, Biomed Research Foundation, 4401-A Connecticut Ave., NW, PMB327, Washington, DC 20008–2322; telephone and fax: (301) 847–0526; email: vossoughi@classic.msn.com. He registration fee is $150 and space is limited to 60 participants.

The full text of the presentations will be published in a book entitled: “Embolotherapy: Bench to Bedside” shortly after the workshop.

Legislative Update

Imaging Institute Bill Passes US House; Heads for Senate

On September 28, a bill that would establish an Institute of Biomedical Imaging and Bioengineering at the US National Institutes of Health was passed in the House of Representatives. H.R. 1795 now proceeds to the Senate in the form of S. 1110, where it will most likely be voted upon before the close of the current legislative session in two weeks. There is strong support of the legislation in the Senate, with the majority leader, Trent Lott, (R-MS), committed to getting the bill passed.

Norwood and Dingell to Revise “Bipartisan Consensus Managed Care Improvement Act”

Representatives Charlie Norwood (R-GA) and John Dingell (D-MI), authors of the Bipartisan Consensus Managed Care Improvement Act (H.R. 2723) that passed the US House of Representatives, but failed before the US Senate, are working on legislation that will bring both Houses together on the Patient Bill of Rights issue. Under the revised legislation, states with existing patient protections may seek certification that their provisions are substantially equivalent to the federal law. The revised legislation also caps punitive damages up to a maximum of $5 million and would have to be proven that the defendant had engaged in “willful and wanton conduct by clear and convincing evidence.”

Bill Mandating Technologist Standards Introduced in House

The Consumer Assurance of Radiologic Excellence (CARE) Act, a bill requiring states to set up licensing procedures for radiologic technologists, was introduced into the House of Representatives on September 25. Also known as H.R. 5274, the bill calls for federally established educational and credentialing standards for personnel who provide radiation therapy and perform all types of medical imaging procedures, with the exception of ultrasound.
Wayne Yakes, MD (m) with John Doppman, MD and Mrs. Doppman.

From the Colorado Rockies …
Wayne Yakes, MD continues his ground-breaking work with vascular malformations. He notes with great respect and sadness the passing of the legendary Dr. Doppman, a founding member of SCVIR, and a pioneer in the field of embolization therapy. While not busy performing 15–20 embolization procedures every week, lecturing, writing or researching, Dr. Yakes finds time for his wife Nona and their two children, Alexis (age 9) and Eric (age 7). Dr. Yakes wants Society members to know that his door is always open for questions about vascular malformations or tutorials at their facility in Englewood, Colorado. He can be reached at wayne.yakes@swedmc.com.

Hoosier … Kathy Krol, MD (St. Vincent’s Hospital, Indianapolis) reports … My practice is now limited to vascular and vascular interventional radiology. It’s a very active practice with a large volume of endovascular AAA repairs, diagnostics, PTA/stenting, renovascular intervention, dialysis access intervention and clinical research, including ongoing AAA trials and carotid stent trials. … The SCVIR Economics Committee Chair and Government Affairs Committee Co-Chair, Dr. Krol has been married to John E. Krol, MD (family practitioner), for 22 years. Her daughter Julia is a senior at Brown University and her son John is a freshman at University of Kentucky with a career goal of singing at the Met. Look out Pavarotti. She and her husband have recently acquired a lake condo and boat with the hopes of taking up a new hobby—fishing! Hoosier turned “Quaker” … Scott Trerotola, MD has accepted a position as the section head of vascular and interventional radiology at the University of Pennsylvania. Dr. Trerotola is currently at Indiana University Hospital in Indianapolis. He is also the program chair for the 2001 SCVIR Annual Scientific Meeting. From the Heartland … University of Cincinnati Hospital’s Jonathan Alspaugh, MD reports: We’re finally adding another interventionalist, Darryl Zuckerman MD, to our group. Darryl will be the section chief and we look forward to adding his experience from MGH, Mallinckrodt, and Wash U to ours. We have a very busy hepatobiliary, transplant and trauma practice. The vascular surgeons and cardiologists still haven’t realized that we could be valuable allies, and the turf war continues. Unfortunately, we’re in a state of siege, but it’s often the patients who suffer most. Hopefully, some of the high profile joint ventures will be so successful that even the most reactionary of the real doctors will take notice. However, that leads me to reiterate my favorite quotation from Samuel Clemmons (a.k.a. Mr. Twain): “When the end of the world happens, I want to be in Cincinnati… because it won’t happen for another 20 years!” From Opryland … Michael Edwards, MD and his wife Nancy recently celebrated 20 years together. (Some of them longer than others, according to Nancy.) Dr. Edwards presently performs IR procedures about half time for a large radiology group in Nashville (TN) at the hospital at the center of the HCA System (it was Senator Bill Frist’s first facility). He currently chairs both the SCVIR Government Affairs Committee and the Economics Committee “with one of my best professional friends, Kathy Krol.” From the Big Apple … Catherine Tuite, MD was interviewed live about peripheral vascular disease on CBS Saturday Morning October 28. Editor Flies South … SCVIR News Editor Brian Stainken, MD has accepted a position leading the division of Vascular and Interventional Radiology at the University of Maryland in Baltimore. He begins his new adventure in January 2001. He leaves Albany Medical College where he has practiced for the last six years.

Our hope is that you will provide the material about comings and goings, births, retirements, philosophy, questions, photos, etc. … We will be glad to run what you send or post on www.scvir.org as long as it is legal, true or funny. The Society Page … let’s talk.
Clinical Practice ...

(Continued from page 9)

consultative service prior to interventions. Now, a year and a half later, he is seeing nearly 8 to 10 patients one day per week in the office. Procedural volume has increased significantly in the hospital.

But, nothing is free.

"Operating a clinical service requires a commitment. Patients call you with their problems. I use an answering service but always return patient calls. We can not rely on others to care for our patients."

With his vascular volume growing, Dr. Osterman began to focus on practice expansion by offering new services like choledochoscopy and local tumor therapy. He is also working on expanding his model to the radiology group's other sites.

In Memoriam

John Doppman, MD
Founding SCVIR Fellow

John L. Doppman, a founding SCVIR Fellow and the 1983–84 SCVIR president, died of cancer on August 21, he was 72 years old.

Dr. Doppman, a diagnostic and interventional radiologist, served 36 years on the staff at NIH, serving as chief of the National Institutes of Health Clinical Center Diagnostic Radiology Department for 26 of those years. He retired there earlier this year.

Over the course of his career, he developed, refined and performed numerous interventional procedures, including angiography. He conducted research on vascular malformations of the spinal cord and developed ways to both visualize and treat them. This research resulted in the publication in 1969 of the first text on this subject. He later concentrated on endocrinology research, for which he developed techniques for locating ectopic or elusive glandular tumors.

The 1997 recipient of the SCVIR Gold Medal Award, Dr. Doppman's other honors included: the Gold Medal of the American Roentgen Ray Society, the Copeland Award from the M.D. Anderson Cancer Center and the Public Health Service Distinguished Service Medal, which is the highest award of the Public Health Service. Earlier this year, Dr. Doppman was awarded scientist emeritus status at NIH.

He was author of 516 articles in scientific journals and 38 textbook chapters.

Survivors include his wife of 34 years, Anne-Marie Doppman of Potomac; two children, Corinna Olishiraz of Petersburg, WV, and John Christopher Doppman of Washington; his stepmother; a sister; and a granddaughter.

Dr. Doppman's family has established a memorial fund to provide for a named lecture at the NIH in John Doppman's memory. The fund will be managed by the Foundation for Advanced Education in the Sciences (FAES), a charitable organization which supports NIH-related activities. The point of contact at FAES is Ms. Lois Kochanski, who may be reached at (301) 496–7975. All contributions are tax deductible.

Checks should be made out to: FAES John L. Doppman Memorial Fund, and sent to: FAES, 1 Cloister Court, Bethesda, MD 20814

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Clinical Practice ...

(Continued from page 9)

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Office as a Patient Management Tool

1. Scheduling of all outpatients
2. Pre and post procedure office visits
3. Patient data base
4. Follow-up surveillance
5. Pre procedure insurance authorization
6. Handling of patient phone calls and emergencies
7. Billing and coding
8. E&M coding and documentation
9. Admission and discharge planning
10. Correspondence

"The key to developing a strong interventional service is to build a good clinical practice. Within existing groups this may require that the interventional radiologists work together within the group to demonstrate the potential opportunity to their partners, or perhaps they need to ... put their money where their mouth is ... and share the financial risk with the group. The first step is to define your sub practice with a separate budget."

Whatever the path, it is clear. The type of clinical practice we enjoyed at Hopkins can be achieved in the private arena. You can have the best of both worlds. Ask Floyd.

Dr. Osterman can be contacted at faoldo@bellsouth.net
NPs and PAs ...  
(Continued from page 6) 

fibroid embolization. “Everyone’s very happy to have her do this,” Dr. Waltman noted. The group is now structuring an added role for her: helping with data acquisition in the clinic by doing longitudinal follow-up with patients on all of the group’s procedures. 

But reorganizing to use assistants has not been without difficulties, he said. One major problem: finding the space and an environment in which the physicians and the nurse practitioner can see patients. “Radiology departments are not structured for examinations and clinical discussions with patients,” he pointed out. “We’re really having to push to get the space we need.” In addition, there has been some conflict over the role of another nurse practitioner who works in the department performing pain management in musculo-skeletal cases, and drainage procedures in non-vascular therapeutic care. “Nurse practitioners can’t take call independently, and they’re not fully versed in everything we do,” he said, “and we’ve had a lot of conflict between the physicians in those areas over what her role is.” 

Jeffrey Pollak, MD, co-chief of the section of vascular and interventional radiology at Yale-New Haven Hospital and associate professor at the Yale University School of Medicine, says his group of 5.5 interventionalists had the services of a nurse for many years, who has recently advanced to a nurse practitioner. Her primary clinical role is to help with the specialized IR practice. The nurse practitioner doesn’t get too involved with routinely referred patients unless they need long-term care related to our interventions. She is much more involved with patients who are referred directly to us.” 

In addition to helping the group’s secretary organize the clinic, the nurse practitioner sees patients, answers questions over the phone, helps handle admissions, and makes follow-up calls. She is able to write basic prescriptions, and will soon secure privileges from the hospitals to be able to write narcotics prescriptions as well, said Dr. Pollak, who has submitted an abstract for the SCVIR Annual Scientific Meeting on changing practice patterns for IR clinics. 

At Yale, Dr. Pollak’s group is having talks with the department chairman about expanding support staff, and has found he is quite receptive despite the limitations on resources. “In the long run we’ll need another nurse or nurse practitioner because our clinic visits have grown so much. In 1996 we saw about 16 patients in the clinic. In 1999 we had 128 visits, and in 2000 [as of early October], it’s already over 160.” Using NPs may not always translate into a net monetary savings, but the payback is fairly easy to show. “We haven’t done an economic analysis on this,” Dr. Pollak said. “But there’s certainly a savings in physicians’ time.” 

At this stage, probably no more than five percent of IR practices have opted to use NPs and PAs, Dr. Swischuk estimates. But it’s clear that physician extenders have moved well beyond primary care, and many other physicians have already realized the benefits they can bring, says Dr. Pollak, who frequently sees cardiac surgeons walking down the hospital hallway with a nurse or physician assistant. “If we’re going to provide greater clinical care of our patients, that will entail using PAs and nurse practitioners to help us,” he maintains. “This is the way interventionalists need to move.”

Guidant Supports CME for AAA 

Legs For Life® Diamond Sponsor 
Guidant Corporation has announced its support for a continuing medical education (CME) program on abdominal aortic aneurysms (AAA). The program AAA: Screening for a Silent Threat, is available exclusively at www.medscape.com, and is designed to raise awareness of AAA among primary care and family physicians, and underscore the importance of early diagnosis. This CME program is supported via an unrestricted educational grant from Guidant. 

“As a company dedicated to saving and improving lives through innovation, we are very pleased to sponsor this important CME program,” said Jay Watkins, President, Cardiac & Vascular Surgery Group, Guidant Corporation. “We would hope that all family and primary care physicians become aware of how to diagnose AAA before the condition becomes a life-threatening emergency.” 

On completion of the CME program, primary care and family physicians will be able to recognize patients who are at risk for AAA, screen patients appropriately for AAA in the primary care setting, learn the latest research supporting thresholds for intervention and outline recent advances in surgical techniques for AAA. (See related Legs For Life® AAA article on page 13.)
Interventional America 2000 Supporters

On behalf of the Cardiovascular and Interventional Radiology Research and Education Foundation, we would like to extend our appreciation to the following companies, interventional radiology practices, organizations, angio clubs and individuals who support Interventional America 2000.

**Donors as of October 1, 2000**

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FUTURE MEETINGS

Practical Training in Interventional Radiology
November 6–10, 2000
Liege, Belgium
Web site: www.mdacc.tmc.edu/angio/ditraining.html

Current Issues and New Techniques in Interventional Radiology
November 14–17, 2000
New York Marriott Marquis
New York, NY
Phone: (718) 920–6674
Email: cme@montefiore.org
Web site: www.mecme.org

Millennium Congress of Vascular & Interventional Radiology
December 9–12, 2000
Grand Hyatt Hotel
New Delhi, India
Sponsored by: Indian Society of Vascular & Interventional Radiology
Contact: Dr. Sanjiv Sharma
Email: Sanjivap@medinst.ernet.in

13th Annual International Symposium on Endovascular Therapy (ISET)
January 21–25, 2001
Fontainebleau Hilton Resort & Towers
Miami Beach, FL
Sponsored by Miami Cardiac & Vascular Institute
Phone: (305) 279–2263
Email: ccm@pobox.com
Web site: www.ISET.org

Fourth Annual Interventional Radiology Practicum
February 6–9, 2001
Snowmass Village Resort
Snowmass, CO
Sponsored by: Miami Cardiac & Vascular Institute
Contact: Hollie Altman
Phone: (305) 279–2263
Email: ccm@pobox.com

Fifth Annual Hemodialysis and Venous Intervention Symposium
February 7–10, 2001
Keystone Resort
Keystone, CO
Sponsored by: Indiana University School of Medicine, Department of Radiology
Contact: Dona Larson
Phone: (317) 274–8354 or (800) 622–4989

Innovative Solutions for Prostate Cancer Care:
Minimally Invasive Diagnosis & Treatment
February 9–11, 2001
Coronado Marriott Resort
San Diego, CA
Web site: www.amainc.com/prostate_cancer.html

International Course on Carotid Angioplasty and Other Cerebrovascular Interventions with Live Case Demonstrations
March 1–3, 2001
Busing Palais Offenbach Arabella Sheraton
Frankfurt/Offenbach, Germany
Contact: KelCon-Keller Congress Organization
Email: j.keller@kelcon.de
Web site: www.carotid-angioplasty.ccb.de

2001 Research Initiatives in Vascular Disease Conference
March 2–3, 2001
Hyatt Regency Hotel
Bethesda, MD
Phone: (978) 526-8330
Email: lifeline@prri.com

SCVIR 26th Annual Scientific Meeting
March 3–8, 2001
Henry B. Gonzalez Convention Center
San Antonio, TX
Contact: Hilary Bikowski
Phone: (800) 488-7284 or (703) 691-1805
Fax: (703) 691-1855
Email: Bikowski@scvir.org
Web site: www.scvir.org

The information reported in “Future Meetings” is supplied by the individuals/sponsoring organizations noted. These meeting listings do not constitute a recommendation or endorsement by SCVIR. Further investigation by interested individuals is suggested.
SCVIR Membership Continues to Grow

As the 2000–2001 membership renewal cycle comes to an end, SCVIR is pleased with the overall growth of the Society over the last year. At this time there are over 3,600 active members in the Society, an increase from 3,360 last year. The number of members joining the Society totals 275 so far this year, compared to 230 new members at this time last year.

In addition, the membership renewal rate has improved from 77 percent last year to 83 percent this year. (See chart for comparison.) Members have commented positively about the new dues invoice style, and many have taken advantage of the opportunity to renew their AHA memberships in conjunction with their SCVIR memberships.

The newest membership category, Clinical Associate, is drawing interest from physician assistants, nurse practitioners and radiology technicians working in IR, and SCVIR expects to see significant growth in this category by the end of the fiscal year. The category was voted on and added into the bylaws at the 2000 SCVIR Annual Meeting in March, and was promoted at the American Academy of Physician Assistants meeting in May. The newly restructured Associate category is also enjoying a surge of interest from non-IR physicians who are interested in the field of IR. SCVIR members can do their part by encouraging their colleagues’ staff who qualify for these membership categories to join the Society.

Membership applications are available on the Web site, at www.scvir.org, or by contacting the Membership Department at (800) 488-7284.

Important Member Information

To help us keep you updated, please remember:
- Notify us if you have a new address, phone, fax number or email address.
- Military discount on membership dues are available to those who provide us with a military address.

The SCVIR Membership Department can be reached at: (800) 488-7284 or (703) 691-1805 or by email at info@scvir.org.

SCVIR News—July/August 2000
SCVIR PUBLICATIONS AND MATERIALS

INFORMATION REQUEST FORM

Please send me information and an order form for the items checked below:

___ SCVIR Logo Pin
___ Annual Meeting Program—2000
___ Annual Meeting Plenary and Scientific Session Audiotapes—2000
___ Interventional Radiology As A Career Brochure—FREE
___ Interventional Radiology Coding Users’ Guide—Fifth Edition
___ Journal of Vascular and Interventional Radiology 10 issues per year
___ Log Books (Great for IR Fellows and Residents!)
   ___ Patient Information Brochures: (Check titles below if you would like a sample.)
      ___ Angiography __ Intervventional Radiology __ TIPS
      ___ Spanish version ___ Needle Biopsy (updated) ___ Treating Peripheral Vascular
      ___ Angioplasty ___ Nephrostomy Catheter Care ___ Disease
      ___ Spanish version ___ Nephrostomy Drainage ___ Uterine Fibroid Embolization—
      ___ Biliary Catheter Care ___ Pediatric Interventional Radiology NEW!
      ___ Biliary Drainage ___ Smoking OR Health—Your Choice ___ What You Should Know
      ___ Central Venous Access ___ Stent Placement About Peripheral Vascular
      ___ Gastrostomy Disease—NEW!

___ Patient Care in Interventional Radiology in Print Syllabus Format—NEW!
___ SCVIR News—bi-monthly subscription
___ SCVIR HI-IQ™ System Quality Assurance and Inventory Management Software Program
___ Vascular and Interventional Radiology Curriculum
___ Vena Cava Filters: A Roundtable Discussion
___ Videodisc #1: Peripheral Vascular Disease (Available on MAC or IBM)
___ Videodisc #2: Portal Hypertension (Available on MAC or IBM)
   ___ Portal Hypertension in Print Syllabus Format
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   ___ Biliary Interventions in Print Syllabus Format
   ___ Peripheral Vascular Interventions in Print Syllabus Format
   ___ Venous Interventions in Print Syllabus Format
___ Thoracic and Visceral Vascular Interventions in Print Syllabus Format
___ Videodisc #7: Thoracic and Visceral Nonvascular Interventions (Available on MAC or IBM)
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Attention Members!

Membership in one or more of the American Heart Association (AHA) councils gives interventional radiologists the opportunity to play a major role in this influential organization. “The AHA is a neutral ground for interaction with cardiology, cardiac and vascular surgeons and other specialists who diagnose and treat cardiovascular disease,” states John Kaufman, MD, program chair for the AHA Cardiovascular Radiology Council.

You are encouraged to join one or both of these councils today:

- **AHA Cardiovascular Radiology Council**
  (dues are $40 per year)
- **AHA Stroke Council**
  (dues are $35 per year)

To join contact the American Heart Association at (800) 787-87984, or check the AHA Web site for a membership form at the following address: www.americanheart.org/scientific/council/mem-how.html.

### Clinical Training Pathway Update

by John A. Kaufman, MD
Councilor, Education Division

A survey of program directors was recently conducted regarding the new American Board of Radiology (ABR) clinical pathway for vascular and interventional radiology training. Of the 55 directors who responded, 75 percent were aware of the pathway, 43 percent had discussed it with their radiology chairman, but only 5 percent had plans to implement the pathway.

This pathway has been approved by the ABR, meaning that in the eyes of the ABR residents who complete the pathway are eligible to sit for the oral boards in radiology and the Certificate of Added Qualifications in Vascular and Interventional Radiology (see July/August issue of SCVIR News). The exact text of the pathway is available on-line at www.scvir.org/feldir/. Implementation of the pathway is now matter of organization at the local level. Negotiations with the radiology residency program director may be necessary to acquire a position for the pathway, as rotations in general radiology are reduced. Entry into the pathway indicates a commitment on the part of the resident to complete training in vascular and interventional radiology, and upon the program to ensure that the resident has the opportunity to do this.

This is an important opportunity for our specialty. Let’s make the most of it.

### Travel Scholarship Announcement

Applications are being accepted on an ongoing basis for the CIRREF Travel Scholarship Award in the amount of $1000. This new grant program is designed to provide residents and fellows an opportunity to attend specialized research meetings related to their research in cardiovascular and interventional radiology. Applicants must submit a completed Travel Scholarship Award application form at least two months prior to the meeting for which the applicant wishes to attend. For additional information, please log on to the CIRREF Web site at www.cirref.org.