Diagnostic Radiology for Interventional Radiologists

As interventional radiology continues its clinical evolution, more and more time is spent evaluating and managing patients. These activities do not generate substantial revenue, particularly when compared with the interpretation of diagnostic studies. Diagnostic radiologists who are focused on the bottom line may find it difficult to support such endeavors. I've heard of many instances of tension developing within radiology groups between IRs and diagnostic radiologists when IRs assume clinical responsibilities. Despite a white paper from the American College of Radiologists (ACR) on the subject, the value of clinical activities comes into question, and, fairly or unfairly, investments such as a clinic are seen as "money losers" or, worse yet, a waste of time.

At the last SIR meeting, I presented an abstract on our experience with inpatient rounding at the University of Chicago. This session also included several other abstracts that dealt with the clinical activities of interventional radiology and specifically the impact of these activities on radiology departments as a whole. Two of the abstracts were intended to show the value of an IR clinic as it relates to overall diagnostic radiology referrals. Both demonstrated that an IR clinic generates significant revenue for diagnostic radiology in follow-up referrals for both vascular and nonvascular interventions. This was termed the "halo" effect of an IR clinic. The conclusion of these studies was that an IR clinic is valuable not merely because it is the "right thing to do" but also because it helps produce significant income for the radiology group as a whole.

One of the moderators of the session raised the problem with this line of reasoning. Specifically, he noted that even though interventional radiologists were sending many patients for diagnostic imaging studies, they couldn't receive credit for this income any more

than any other clinician in the hospital could. Physicians who are top referrers to diagnostic radiology do not receive credit for their clinic activities and neither should IR. I found this discussion interesting because in my own situation, I can and do take credit for these examinations for one simple reason. I read them. Often, when other IRs find out that I still interpret CT, US, and MRI, they look at me like I've lost my mind. Currently, in academic radiology, an interventional radiologist who actually interprets diagnostic studies appears to be the exception rather than the rule. But honestly, I am more comfortable reading films than I am admitting and managing patients (although I do that also). Furthermore, who on earth is better qualified to interpret studies on IR interventions than an interventional radiologist?

The other day I saw a patient in our clinic with an aortic stent graft who had undergone embolization of a type II endoleak several months earlier. He lived in the far northern suburbs of Chicago and had follow-up imaging done near his home. He brought the report and computed digital radiography (CDR) report from this outside hospital, which stated that the "endoleak was still present despite embolization." I found this discouraging because it was a particularly complex case and I was happy with the immediate angiographic result. The patient was also an attorney. Interestingly, when I reviewed the study myself, I discovered that what the outside radiologist was calling an endoleak was, in fact, the glue and Ethiodol mixture I'd used to embolize the leak. Apparently, he had not noticed the same finding on pre-enhanced images and didn't notice the density discrepancy between the intravenous contrast and the glue cast. In any case, this is not the only example I've seen of an abdominal imager misinterpreting the results of an IR intervention. My diagnostic colleagues commonly forward post-IR therapy cases to me. It saves them the

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trouble of trying to figure out what we did and the embarrassment and frustration of misinterpreting these studies. Similarly, some of my IR colleagues who interpret noninvasive vascular studies commonly ask me to peruse the nonvascular structures or ask me the significance of a nonvascular finding.

Most clinicians use a portion of their clinic time to review diagnostic imaging studies. IRs should not be an exception. At the recent American Roentgen Ray Society meeting, Dr. Gary Siskin presented his experience with an outpatient clinic. Among other things, I recall he used part of his clinic time to perform and interpret follow-up imaging. This is a practical, efficient, and fiscally smart practice. I have found that my own diagnostic activities go a long way toward keeping the peace with diagnostic colleagues and improve the overall cohesion of our department, which is otherwise nearly completely subspecialized currently.

Some interventional radiologists avoid diagnostic imaging due to the "jack-of-all trades, master-of-none" argument. They believe that interventional radiologists

who continue to behave like diagnostic radiologists undermine the perception that interventional radiology is a true clinical specialty. Those who pursue these activities are not true clinicians, dedicated to the specialty. I agree that this is certainly a pitfall of this approach, but I would argue there are plenty of cardiologists who perform imaging and many vascular surgeons who run vascular laboratories. Neither specialty is "threatened" by their imaging activities, and in the case of cardiology, the specialty is attempting aggressively to increase its diagnostic imaging expertise. So here is a radical concept. In our efforts to provide comprehensive care, in addition to providing consultation, periprocedural care, and longitudinal follow-up, maybe interventional radiologists should interpret the follow-up imaging studies on IR patients. Or after 4 years of training, a written board examination, and a trip to Louisville, maybe we're not qualified?

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