James F. Benenati, MD

At the forefront of peripheral vascular therapy, Dr. Benenati discusses fellows training at Baptist Cardiac and Vascular Institute (BCVI), women's health treatments, and what sets ISET 2008 apart.

Where did you get your start, and what brought you to BCVI? After receiving my undergraduate degree from Notre Dame in 1978, I went to medical school at the University of South Florida, in Tampa, and then did my radiology training at Indiana University. The interventional radiology department at IU in the mid-1980s was a very well-known and influential section. This is where I developed my desire to enter the interventional radiology field. Following my residency, I went to Johns Hopkins for a fellowship. Shortly after finishing my fellowship, an opportunity to work at BCVI arose. At that time, BCVI was a small program. I was able to join Barry Katzen, MD, and at the same time that I joined, Gary Becker, MD, came to Miami and along with Gerry Zemel, MD, who was the first fellow here, we were able to develop and grow the practice over the years. Now we have eight interventionists, and we just merged with five vascular surgeons, allowing us to practice high-quality vascular medicine in a collaborative environment. Merging with our new surgical partners will enhance our level of practice even more. Collaboration is intellectually stimulating and is great for the patient, the hospital, and the community. This is a really fun place to work—it is dynamic and evolving.

What sets your practice apart from others? Our practice comprises dedicated interventionists who are committed to high-quality, cutting-edge innovation. Additionally, we have a great training program that is part of our practice. This is one of the most competitive fellowships in the country. Knowing that our training program is internationally respected is one of the things I am most proud of at BCVI. This is also one of the most rewarding aspects of our practice. I am the director of the training program and have committed a tremendous amount of time and resources to make this a unique environment and to give our trainees a special experience. All our fellows are board certified when they arrive to do this extra year of training. Our fellowship is unique because not only are our fellows exposed to a high number of cases, but in a peripheral vascular world, we have access to a vast majority of the latest and greatest tools. We participate in more than 30 clinical trials. We consider ourselves leaders in procedures such as carotid artery stenting, endovascular aneurysm repair, superficial femoral artery (SFA) intervention, and critical limb ischemia treatment, and we can expose our fellows to a high volume of those cases plus the newest technology. In addition, the major focus of our practice is the clinical management of patients. We focus not only on procedures, but also on diagnosis and patient care. When something should not be done is every bit as important as when something should be done.

Our noninvasive lab does more than 20,000 studies a year, and our fellows read a majority of those studies. Our fellows learn not just how to open an iliac vessel or an SFA but also how to work up the patient, assess the noninvasive testing, look at the imaging and noninvasive tests to synthesize a plan with the patient, and then ultimately go on to treat the patient. We train them to be excellent clinical physicians as well as very good interventionists.

Can you describe your practice's approach to women's health? In addition to dealing with peripheral vascular disease and cancer therapy, we have built up a large practice dealing with women's health initiatives. Uterine fibroid embolization is a large part of our practice at this time. This is something we have been involved with since the inception of that procedure 10 years ago.

What advances do you anticipate occurring in women's health in the next few years? Fibroid therapy took a long time to get moving because it is a procedure that is not done by the gynecologist. It took a lot of marketing and public awareness campaigns to educate women of their choices. Now, as we go forward, continued refinements with the procedure make it more tolerable for patients. There are some new treatments that we are studying that may make fibroid treatment even easier than the embolization treatment. We will participate in some trials to study new procedures that employ a combination of MRI and ultrasound to ablate the fibroids. Ultimately, our mission is to explore every possible intervention in order to provide less-invasive, safe, and durable treatments that give patients a choice. Not every woman who presents with fibroids is a candidate

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for fibroid embolization, but many women for years had no choice but to have a hysterectomy. Now, we provide women with a choice that works well, is durable, and provides high patient satisfaction.

In what ways do noninvasive imaging and diagnostics techniques facilitate the treatment of patients with arterial disease? In arterial disease, I believe firmly that we should always start off with a noninvasive, physiologic exam. That test includes pressure measurements and waveform evaluations and is the least expensive, most reproducible exam that you can do while obtaining a tremendous amount of information. We use treadmill testing, which allows us to reproduce the patient's symptoms so that we can confirm that the symptoms are really caused by blood vessel abnormalities. If that test were abnormal, in the past, we went right to an angiogram, which is invasive, and then to some sort of treatment. Now, we use MRA or CTA to provide a noninvasive roadmap of the arterial system and assemble that information with the noninvasive physiologic test. The waveforms allow us to determine whether the patient's symptoms are from arterial disease, and the pictures provide a roadmap. The noninvasive test provides the physiologic information, and the imaging tests provide the anatomic information. In addition, those tests help save on procedure time, which helps to reduce complication rates. Gathering that information before we intervene allows the patient to understand the expected outcomes. During follow-up, we use a physiologic noninvasive test to determine the patency of our intervention. It is always easier to reintervene on a patient before things close down completely, so we maintain a good surveillance program using noninvasive testing.

What is your current role with the Society of Interventional Radiology (SIR)? I am the Communications Division Counselor for the executive committee of the SIR, which means that I am in charge of all of our public relations, our outreach to our membership and other specialties, and all bits of communication that go on between different divisions within the Society. That responsibility includes disseminating information to members about new initiatives and educating them on new procedures as well as the political and economic changes within the Society. I also help create relationships and collaboration with other societies, such as the American Heart Association, the Radiologic Society of North America, the American College of Radiology, the Society of Vascular Surgery, and the American College of Cardiology.

Previously, I was the SIR's Annual Meeting Chairman and served on the Annual Meeting Committee for 4 years. That experience and my 18-year ISET experience have taught me a lot about running meetings and doing CME work. There has been a great working relationship between ISET and the SIR: ISET has always supported SIR initiatives, and the SIR has been very receptive to ISET and what it does for interventional radiologists. We are proud of this relationship and want to keep it going in the future.

2007 marks the 20th anniversary of ISET. What can you tell us about the meeting's growth, and the live cases and controversies it will feature? ISET has grown to be one of the largest peripheral interventional meetings in the country and is considered a global interventional meeting. We have more than 120 international and national faculty members attending ISET, along with many international registrants. One of the significant changes during the past 20 years is our inclusion of interventional cardiology, vascular medicine, and vascular surgery specialists. We have sought to include content relevant to those specialties in the meeting.

Our live cases and debates set us apart. Each year, we strive to emphasize learning points in all the live case demonstrations. These cases are not situations where we show off what we can do. Tackling very complicated cases is always challenging in front of a very large audience, but we make the commitment because it is a great learning vehicle. We try to demonstrate that sometimes things work well and sometimes they do not. This year, we will feature a series of debates and presentations concerning controversial topics. We will take a look at newer procedures and their indications and some of the economic impacts that those procedures have on the medical community. It is our chance to inform our colleagues about issues that affect them, such as new regulatory guidelines that now prohibit or restrict things that we have been doing for years, new reimbursement guidelines, and trial results. We want to provoke our audience to think and maybe respond either on a local or national level when the meeting is over.

ISET involves a great deal of audience participation. How does a multidisciplinary audience factor in with the live cases? We strive to keep the audience involved through a computerized polling system that we use during the live cases and presentations. We can track the type of therapy an audience member might choose during the live cases, which helps us understand trends and competitive forces that are occurring inside and outside of interventional radiology and create great learning experiences for the faculty and registrants, as well as the organizers. ■