How to Start a UAE Practice

Mary Costantino, MD, shares her advice for what to do (and not do) to build a successful uterine artery embolization practice in your local community.

What are the key elements of a dedicated uterine artery embolization (UAE) practice?

The key elements of a dedicated UAE practice are complex catheter skills, a strong clinical presence, a passion for women's health, and ample time for patient care. UAE patients require a complete consult that includes not only a detailed discussion of the procedure and expectations regarding pre- and postprocedural care, but also a full discussion of the alternatives. An interventionalist who performs UAE should be well versed and up to date with the gynecologic literature and should have a strong interest in women's health.

What level of proficiency is ideal for a practitioner looking to start a UAE practice? Which skills are necessary, and how are these best obtained?

UAE requires advanced catheter work. Uterine arteries are all different, and due to their small size and tortuosity, advanced catheter skills are necessary to keep procedure and fluoroscopy times within acceptable limits. A fellowship with a strong embolization program (not necessarily limited to the uterus) should be required before striking out on one's own. End-organ embolization should not be taken lightly; UAE patients are young, healthy, and usually highly informed. Complications and treatment failures are not well tolerated by this patient population.

Who are the nonphysician team members? What should their training and backgrounds include?

In my practice, I have two desk staff and a medical assistant. I do all of my own consults, phone calls, and office visits. I personally review MRI results and manage every patient. My patients have my cell phone number and are instructed to call anytime. Due to the nature of this procedure and the lack of familiarity with it in the community, I believe that it is irresponsible to have others outside of the team attempt to manage any postprocedural issues. This will lead to unnecessary admissions, unnecessary post-UAE hysterectomies, or, even worse, missed diagnoses when there is an actual complication such as an expulsing fibroid.

What complications might occur, and how can a practice be prepared to handle them?

The single best thing a practice can do is have the interventional radiologist available to take calls 24/7, as this avoids self-referrals to the emergency department, which may lead to an unnecessary post-UAE hysterectomy (and a distaste for the procedure in the community). No one likes to manage others' postprocedure patients, and it is our responsibility to keep patients out of the emergency department and gynecologists' offices because they don't have access to the interventional radiologist. Having managed these patients for years now, the biggest mistake an interventional radiologist could make is to not be involved in post-UAE care. With the proper training, a physician assistant or nurse practitioner could fill this role; however, I believe this would require at least a year of comanagement. All patients respond to UAE differently, both physically and mentally. This is an involved patient population, and it takes experience to know when to reassure them versus when to be concerned about a true complication.

The possible complications I discuss with my patients are embolization failure, nontarget embolization, procedure-induced menopause, vaginal discharge, radial artery occlusion, and fibroid passage. A long discussion should be had regarding post-UAE pain. Patients should be well aware of the potential intensity of the pain, and the interventional radiologist should be prepared to manage it. Nausea, fatigue, low-grade fevers, and constipation are common post-UAE management issues.

The most feared delayed complication is fibroid passage, which can occur months after the UAE procedure. Patients need to be informed of the symptoms and advised to call the interventional radiologist if they occur. If the cervix is open during this fibroid passage, there is potential for sepsis. If the patient presents to another doctor's office or urgent care center, it is possible that fibroid passage will not be considered, placing the patient at unnecessary risk.

What are the current best practices for follow-up evaluation?

I see patients at 2 weeks and 3 months postprocedure.

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I also ensure that they have continuity of care with routine gynecologic follow-up either via a gynecologist or a primary care physician.

What challenges should be expected in gaining referrals?

Over the last 10 years, I haven't seen the territorial issues that others have. All politics are local, and I'd say that in my own community, gynecologists have been open to UAE. However, they want an interventional radiologist who cares about women's health and is involved in patient follow-up. They do not want an interventional radiologist to do a UAE and then leave the rest to them.

Personally, I don't know how one builds a fibroid program without a particular passion for women's health, given the need to understand multiple disease processes of the uterus. A skilled UAE practitioner will be versed in conditions such as adenomyosis, endometriosis, endometrial hypertrophy, dysfunctional uterine bleeding, and uterine polyps, as well as have a basic understanding of the hormonal treatments for menorrhagia. I don't treat or manage hormones, but touching on hormonal treatment, ablation, intrauterine device placement, and herbal treatments such as Slow Flow (Vitanica) are all part of a list of alternative treatments that should be included in informed consent.

Where I see doctors go wrong is when there's a sensed lack of interest or depth of knowledge. Again, this may be local, but the average UAE patient that I see will research her options. These patients are well informed and proactive. They want to know more rather than less and are seeking to partner with their doctor.

What are some successful strategies for developing a referral base? Which tactics are less likely to work and thus should be avoided?

To be successful, you must practice great medicine. Success remains very regional, but there's not a lot of room for error. The first three patients are the most critical, then the next five. Referring providers will be skeptical of UAE, and it takes good work to build a track record for the practice to develop and become successful. Regionally, I have seen different methods work and fail, including bus ads, radio ads, TV appearances, and print ads.

What resources are available for those seeking more information and training?

An interventional radiology fellowship is sufficient for training in basic and complex embolization. With the technical skill set already developed, visiting active fibroid practices is helpful. Of course, having a low threshold to dialogue with colleagues on unusual cases is a must. The Society of Interventional Radiology is a great source for educational opportunities, particularly the women's health track at the annual meeting. ■

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Disclosures: None.