AN INTERVIEW WITH...

Gerard O'Sullivan, MD

The Galway-based interventional radiologist shares highlights from the recent SIR meeting and makes predictions on the future of deep venous care.

What led you to focus much of your work on deep venous disease?

To be honest, I went to Stanford for my interventional radiology fellowship in (gulp!) 1998–1999. It was (and still is) a powerhouse institution. I learned from some awesome teachers—Drs. Mike Dake, Charlie Semba, Mahmood Razavi, Stephen Kee, Dan Sze, Suzanne Slonim, and Shaun Samuels. I realized that I just loved deep venous disease, and their pioneering work opened my eyes to the possibilities of what we could do.

How would you describe the differences in your ability to treat deep vein thrombosis now as compared to earlier in your career? How have patient outcomes changed over this time?

Catheter-directed thrombolysis was the name of the game at the start of my career, and in many places, it still is. I believe due to the particular circumstances of Galway (eg, lack of monitored beds to safely perform catheter-directed thrombolysis according to institutional protocol), we were pushed fairly early toward pharmacomechanical venous thrombolysis/thrombectomy (PMT). I strongly believe in single-session PMT followed by stenting. Patients' outcomes are better because there is a lower risk of bleeding, and they mobilize much faster. I think ATTRACT will bear this out.

What is one as-yet unavailable feature or ability you would like to see in a future thrombectomy device generation?

The ability to deal with acute-on-chronic thrombus. Acute is easy enough, and chronic is also fairly straightforward (albeit depending on inflow), but at the present time, I don't touch patients between 4 weeks and 6 months. That is a chore.

What are your predictions for the field of venous stenting over the next 5 years?

It will grow, and we will get better at predicting which stents are best suited to which indication. We will also start trials with covered stents, coated stents, branched stents, and intentional arteriovenous fistula devices. We are at a very early stage of development and knowledge, probably akin to 1992 in coronary artery stenting.

At the 2016 SIR annual meeting, you were inducted as a fellow of the society. What does this honor mean to you?

I was thrilled to bits to be honest, and I wish either of my parents had been alive to see me up on the stage. I join Dr. Michael Lee as the only two Ireland-based fellows of this society. To see the people who have gone before me, we have a lot to live up to.

What was the most interesting thing you learned about at SIR 2016, either in a session or in meetings with colleagues?

A fairly out of left field, at least for me, technique for ablation of the sphenopalatine ganglion. In the same incredible session, there was a presentation on the use of focused ultrasound to break up fibrotic bands—that got me thinking about all sorts of new possibilities.

In his 2016 Charles Dotter Lecture at SIR 2016, Scott Trerotola, MD, discussed the importance of subspecializing. If you were starting your post-graduate career today, but with the benefit of what you've learned in your career, in what area would you choose to subspecialize and why?

Unequivocally interventional radiology, and I would stick with deep veins. I am fortunate to be extremely happy in the area in which I subspecialize! I wouldn't mind learning how to do common femoral phlebectomy.

What is your perfect day outside the cath lab?

Golfing in Lahinch in County Clare, Ireland (look it up—it is utterly magnificent), followed by surfing with my son and dinner with my beautiful wife and my three daughters. ■

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