AN INTERVIEW WITH...

Christoph A. Binkert, MD, MBA

Prof. Binkert discusses the 2017 GEST and CIRSE meetings, as a member of the scientific program committees, as well as current areas of interest in embolization and arterial access techniques.

You are serving on the scientific program committees of both GEST and CIRSE this year and chairing the latter. How do you decide which lectures should be included?

For both meetings, CIRSE and GEST, a scientific program committee is in place that develops the scientific content. I believe it is important that different physicians can bring in their ideas to put together an interesting and balanced program. As long as there is honest science behind an idea or a concept, no topic is excluded from the meeting. Even early stage reports can be interesting for participants.

What do you believe were the highlights at GEST this year?

GEST covers all aspects of embolotherapy including rare disorders or clinical presentations. This provides the participant with a broad overview of the indications and techniques that can be applied with embolotherapy. It was interesting to observe that prostate artery embolization is gaining scientific evidence as an alternative therapy for benign prostate hyperplasia. In addition, the technique of hemorrhoid embolization is also definitely evolving.

With CIRSE just around the corner, what can we expect from this large and diverse congress?

The CIRSE meeting in Copenhagen covers all aspects of interventional radiology for all levels of experience. The overall schedule will be similar to previous years. My focus is to increase the discussion and interaction between the speakers and audience. Therefore, we will continue the interactive formats, such as expert roundtables and case discussions, which allow more interaction not only with the audience but also among panelists from different specialties in order to learn about the key elements for decision making. There will also be a new format called "news on stage" where the latest studies or early innovations are shared with participants in an informal setting during lunchtime.

What are your goals for the IDEAS portion of the CIRSE meeting?

IDEAS is a track within the CIRSE program. The third edition of IDEAS will again focus on treatment of challenging aortic diseases with close interdisciplinary cooperation. Interventional radiologists (IRs) and vascular surgeons working together is a fruitful experience and likely benefits the outcome of patients.

What is the most exciting or interesting application of embolization that you've seen recently? Are you participating in any research on these techniques, and if not, for which applications are you most anticipating clinical trial data?

Hemorrhoid embolization is a new and very promising therapy option for treating symptomatic hemorrhoids. At our institution, we were able to gain experience in selected cases with good clinical outcomes. We are currently planning a randomized clinical trial to compare embolotherapy to the standard therapy of surgery and gastroenterology.

A few years ago, you wrote an article in *Endovascular Today* that described a direct ultrasound-guided approach to superficial femoral artery (SFA) access. Do you still think

this is the best first-line option for antegrade arterial interventions? Do you think this practice should be adopted more broadly?

Our group has published several articles about this topic, including data from two randomized clinical trials that studied access location and entry needle. Ultrasound-guided access to the proximal SFA is our preferred access for all antegrade access to the lower limb because it is fast and safe. I do believe that many IRs, especially in Europe, have adopted this approach.

As a radial access enthusiast, how would you summarize the benefits of this approach, as well as its limitations? Which procedures in your regular case load are radial-first, and which are either not ideal or not possible radially?

The main advantage of the radial approach is that the patient can ambulate immediately after the procedure. Other than patient comfort, it can also help to decrease the recovery time and potentially offer cost savings. The main drawback of a radial approach is the lack of suitable dedicated tools for peripheral interventions, especially the lengths of catheters and balloons.

In my practice, I use a radial-first approach for most visceral interventions, specifically transarterial chemoembolization and transarterial radioembolization procedures. For peripheral artery disease treatment in the lower extremities, I still prefer an antegrade femoral access.

What do you think the role should be for IRs in patient pain management and sedation?

Comfort during and after an interventional procedure is important for the well-being of our patients. IRs should place similar effort in sedation and pain management as they do in the interventional techniques. In our institution, sedation is provided by dedicated nurses using propofol more and more frequently. Postprocedural pain management is enhanced by regional blocks, such as the superior hypogastric nerve block after uterine fibroid embolization, and standardized pain medication tailored to each procedure. ■

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