

AN INTERVIEW WITH...

Saher Sabri, MD

Dr. Sabri discusses advocacy priorities for the interventional radiology field, the importance of global collaboration, pulmonary embolism trials, best practices for managing gastric varices, and more.



As President-Elect of the Society of Interventional Radiology (SIR), what do you think should be the top advocacy priorities for the society over the next few years to support the growth of the field?

Longitudinal comprehensive care is an integral part of the success of the interventional radiologist. We need to continue to advocate for our members in the interventional radiology (IR) community who practice comprehensive clinical IR to be recognized for the value they provide to the health care system. In the inpatient space, this means showing the value of the decreased length of stay and enhanced overall outcomes, and in the outpatient space (whether in the hospital, office-based lab, or ambulatory surgery center) showing the value of high-quality outpatient care that improves patient outcomes, cost-effectiveness, and sustained innovation. We in SIR will continue to collaborate with other organizations to advocate for increased residency spots to address the specialist physician shortage, as well as to advocate for improving patient access to high-level care.

How have you seen the VIVA organization, which you're involved in as a board member, evolve in recent years? And, what can be expected in the years ahead?

The VIVA Foundation has always been a multidisciplinary organization that advances vascular care through education, advocacy, and research. Over the last several years, several new board members have joined the organization and injected new energy and ideas to enhance the mission of the organization. The annual meeting continues to grow and attract impactful late-breaking clinical trials and high-end education. In addition, the Vascular Leaders Forum is being held

more frequently to address hot topics in the vascular field, such as the controversies surrounding drug-eluting devices, venous stenting, and access to care for chronic limb-threatening ischemia (CLTI) patients.

VIVA Foundation has also been supporting of several clinical trials by providing gap funding, as well as continuing to support collaborative research through several grants with American Heart Association and recently a collaborate grant with SIR Foundation and industry partners.

Last year, you and colleagues published the 2024 American College of Cardiology/American Heart Association guidelines for the management of lower extremity peripheral artery disease (PAD).¹ In what ways had the PAD landscape and evidence base shifted in the last decade to necessitate this update? As an interventional radiologist, what did you find to be the most important takeaways?

The guidelines needed to be updated to address the new development in the management of lower extremity arterial disease. The inclusion of algorithms for treatment has been a highlight of this new document for patients with claudication and CLTI. A particular emphasis was made on detailed guidance for preventative and conservative therapy before an intervention is considered. In addition, we reviewed follow-up therapy (including foot care) and a multidisciplinary approach for CLTI management. Medical management was also covered, especially postprocedure medical management, which is important for the interventionalist. There have been some updates on certain vascular beds, such as management of the common femoral and infrapopliteal, that were also included in the guidelines.

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As an early proponent for and educator about balloon-occluded retrograde transvenous obliteration (BRTO) for portal hypertension, what best practices should any first-time operator should know? What are your tips for minimizing complications?

BRTO is a procedure to treat gastric varices and also large portosystemic shunts causing hepatic encephalopathy. Patient selection is key. BRTO for gastric varices can be considered as a standalone therapy for isolated gastric varices, or it can be used as an adjunct to transjugular intrahepatic portosystemic shunt (TIPS) in patients with other complications of portal hypertension, such as esophageal varices and ascites. This procedure should be avoided in patients with portal vein thrombosis or diminutive portal vein without an accompanying TIPS.

Several technical tips have been described to help achieve technical success, such as choosing internal jugular versus femoral access based on the location of the shunt off the left vein. It is also important to size the occlusion balloon without overinflating it to avoid rupture, as well as to avoid over manipulation of the catheters within the shunt to avoid extravasation. In addition to occlusion balloons, use of vascular plugs or coils are all acceptable techniques. With a balloon, sclerosis can be done with a foam sclerosant such as sodium tetradecyl sulfate. However, with plugs and coils, a thick gelfoam should be used initially to achieve a seal, followed by a foam sclerosant.

The endpoint of embolization should be filling of the varices and minimal reflux into the afferent portal vein branch. Meticulous attention to detail and technique

and adherence to the proper indication helps with achieving best outcomes. In addition, having a follow-up program where the patient will receive routine endoscopy to avoid esophageal varices bleeding is recommended. Around 10% of patients may require a TIPS procedure down the road to treat portal hypertension complications if BRTO alone was performed.

You also work in the venous space, with involvement in PE-TRACT as well as trials investigating new technologies. What do you think we should be focusing on in the next phase of pulmonary embolism (PE) trials?

There have been a lot of advances in the PE management space, and several new technologies have recently been approved. I have had the benefit of being involved in some of the investigational device exemption trials to evaluate these newer devices. With each iteration, we are getting better tools to improve both clot removal and the safety profile. Our next focus should be on patient selection and establishing the stratification of patients: Who should receive an intervention, and who should be managed medically? We are currently awaiting several randomized controlled trials that are randomizing patients into catheter-directed therapy and anticoagulation. Some of these studies are focused on short- versus midterm outcomes. PE-TRACT looks at longer-term outcomes and specifically evaluates the functional outcomes and the need for intervention to avoid development of post-PE syndrome and chronic pulmonary hypertension. In addition, evaluation of the high-risk patient and their appropriate treatment strategy is being evaluated by several upcoming trials.

DR. SABRI'S LEADERSHIP LESSONS

01

You have to listen to be heard: Being a good listener gains you the respect of the team and allows you to be a more impactful leader.

02

Be fair but not reluctant to make the hard decision: You can't please everyone all the time.

03

Empathy is the key to a successful clinical practice: Clinical skills and medical knowledge can only get you so far.

04

Be truthful and up-front: It's not easy to get someone's trust back after losing it.

How can United States–based societies collaborate with and complement the work of regional/interventional groups, such as the Pan Arab Interventional Radiology Society (PAIRS), where you have the roles of Advisory Board member and journal Deputy Editor?

I had the pleasure of volunteering for several organizations, including the PAIRS, which has seen significant growth over the last several years. The PAIRS annual meeting is currently the third-largest IR meeting worldwide and the largest in the Middle East region. It provides an avenue for people in that region to collaborate and grow the field. The *Arab Journal of Interventional Radiology* has had great success in providing a way for researchers in the region to display their work. In addition to this volunteering, I am passionate about spreading IR and vascular education globally. One of my proudest efforts is conducting workshops and performing procedures in my home country of Jordan and in the Palestinian territories, with the goal of elevating the field of IR and educating people on its value.

SIR, as a leading global IR society has been collaborating with several of the IR and vascular organizations across the globe. The IR Global Summit, in conjunction with the Cardiovascular and Interventional Radiological Society of Europe and other IR organizations, is a success story in helping to advance education efforts and advocating for IR services to be available worldwide.

Over the course of your career, you’ve been invested in education of the next generation. What do you think are the biggest challenges facing today’s vascular trainees?

One of the main challenges facing the vascular field is the fact that we may not have enough physicians to treat vascular disease in the future. We have an aging workforce and not enough supply of trainees coming into the workforce across the main vascular specialties. We have an issue of concentration of specialists in urban areas and

insufficient distribution to rural areas, which form what we call “vascular deserts.” Collaboration between all societies about advocating for increased residency spots and creating work environments that improve access to care will be critical. For IR specifically, we need to maintain a high level of education in peripheral vascular disease and continue to advance education in longitudinal, comprehensive clinical care.

What motivates you in your day-to-day work?

Doing work that is meaningful and impactful makes each of us motivated to keep going. Also, diversifying one’s day-to-day work helps break the monotony. I split my time between clinical work, research, and administrative work. I try to keep a balance so one does not overcome the other. But without a doubt, I am the happiest when I’m with my patients doing clinical work. I would take a 4-hour-long complex procedure, working with trainees, over a 30-minute administrative meeting on finances! ■

1. Gornik HL, Aronow HD, Goodney PP, et al; Peer Review Committee Members. 2024 ACC/AHA/AACVPR/APMA/ABC/SCAI/SVM/SVN/SVS/SIR/VES guideline for the management of lower extremity peripheral artery disease: a report of the American College of Cardiology/American Heart Association joint committee on clinical practice guidelines. *Circulation*. 2024;149:e1313–e1410. Published correction appears in *Circulation*. 2025;151:e918. doi: 10.1161/CIR.0000000000001251

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