Prof. Anna-Maria Belli, MBBS, FRCR, EBIR

The Past President of CIRSE shares her expert insights on UAE, traumatic hemorrhage, and the most important role of interventional radiology societies.

As a former president of the British Society of Interventional Radiology (BSIR) and CIRSE, how do you think the goals and demands of interventional radiology societies have evolved in recent years?

Interventional radiology (IR) has always been a very innovative subspecialty. With new procedures constantly being introduced into clinical practice, societies such as the BSIR and CIRSE need to provide guidance to their members regarding best practice and current trends and offer a commercially unbiased perspective.

There is also a need for IR societies to liaise with each other in the provision of education and research—a strong research network of experts providing good quality evidence can make a difference to medical developments and, ultimately, patient care. These societies also play an important role in setting standards.

CIRSE has always focused on providing safe patient care, and it is important to persuade other stakeholders of the need to support high-level clinical care with appropriate financial, infrastructural, and human resources. Past events have shown us that societies such as the BSIR or CIRSE can be hugely influential in discussions with regulators, reimbursement authorities, other clinical specialties, or the medical device industry, to name a few.

As many health care discussions or directives are now emanating from the European Commission, it is important that medical practitioners have an adequate platform to facilitate cross-national communication, and medical societies can play an invaluable role here. Advocacy at a European level—for both our patients and our specialty—has become a key concern of IR societies like CIRSE, and this is a trend that looks set to continue.

CIRSE published Standard of Practice guidelines for uterine artery embolization (UAE) in July. What was the most significant takeaway of these guidelines, and how do you foresee them affecting everyday practice?

The main take-home point is that there is no difference in quality of life or major complications between surgery and UAE at 5 years, so it is valid that every woman with symptomatic fibroids should be offered UAE as an alternative treatment to hysterectomy or myomectomy.

Women should be informed of all these options, and then they can decide for themselves which treatment they prefer. If all women were informed in an unbiased way, many more would opt for a minimally invasive procedure. Correct information, however, is the key, and this would mean that they should see both gynecologists and interventional radiologists to have a clear understanding of what each procedure involves. That means negotiating more time to see all these women in our clinics.

What do you think it will take to gain greater acceptance of UAE both in and out of the interventional community?

I believe there is acceptance within the interventional community. The problem is that outside this community, many clinicians have entrenched ideas based on a misunderstanding of the UAE procedure and its effects on the uterine arteries. There is also a fear of losing patients to interventionists. This is unfounded, and most institutes where collaboration occurs between specialties have found their practice base increasing because more patients are referred due to the knowledge that all expertise is available and will be offered. However, it is the women themselves who are driving greater acceptance of UAE and similar procedures. They are clamoring for access to minimally invasive

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procedures and ensuring that these are made available for those who prefer to avoid surgical intervention.

What data on the management of uterine fibroids are you most looking forward to seeing?

Uterine-preserving therapies suffer from the problem of fibroid recurrence. I am currently involved in a trial comparing outcomes between myomectomy and embolization, the FEMME trial. This will provide evidence of whether there is a difference in recurrence rates between the two therapies. The effect of myomectomy and embolization on fertility is another area where more information is needed. Myomectomy is currently accepted as the first-line option in women actively seeking fertility, but we know that UAE does not impair fertility in women who have this procedure for postpartum hemorrhage. The FEMME trial is looking at markers of ovarian reserve to see whether there is any difference between myomectomy and UAE. I want to know categorically whether the fact that UAE shrinks but does not remove the fibroids adversely affects fertility. FEMME is not powered to answer that question, and I am not sure that we will ever have this information.

Where are currently available treatment options for traumatic hemorrhage falling short?

I don't believe that the treatment options are falling short, but rather the problem is the lack of 24/7 availability of teams trained in these procedures. Centers skilled in these interventions need to treat high volumes, and this is the rationale for trauma centers. This provides an opportunity for a large number of interventionists to be available in one site and yet maintain competence with a wide variety of elective procedures. This means that such teams need to work in large hospitals with a wide variety of elective and urgent interventions performed on a daily basis.

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What are your current research interests?

I am particularly interested in the management and prevention of postpartum hemorrhage. Postpartum hemorrhage is a catastrophe for an otherwise young, healthy woman in the prime of her life and her family. The physical and psychological effects of an emergency peripartum hysterectomy are devastating for a woman, potentially turning a happy event into a life-changing tragedy. In an ideal world, we should be able to identify women at high risk antenatally and minimize or prevent hemorrhage, hysterectomy, and their consequences. I work very closely with my obstetric colleagues, and we have developed a multidisciplinary team that works together to achieve the best outcomes for women with placenta percreta. This is an area where there is a great deal of interest but it is still early days, and more research is needed. I am pleased, however, that since our new technique has been developed, no peripartum hysterectomies have been performed in our institution.

My other research interests are UAE for symptomatic fibroids, as mentioned, and the management of patients who have vascular malformations. The latter is a challenging group of patients with a range of conditions of varying severity. Once again, this is a very multidisciplinary group of clinicians working together for the benefit of patient safety and care and hence is very rewarding. ■

Prof. Anna-Maria Belli, MBBS, FRCR, EBIR, is Professor of Interventional Radiology and Consultant Radiologist with the radiology department of St. George's University Hospitals in London, United Kingdom. She has disclosed that she is on the advisory board for Boston Scientific Corporation. Prof. Belli may be reached at anna.belli@stgeorges.nhs.uk.