AN INTERVIEW WITH…

Raghu Lakshminarayan, FRCR, EBIR

Dr. Lakshminarayan reflects on his priorities as President of the British Society of Interventional Radiology, efforts to advance IR as a specialty, and evolving approaches to drug delivery, calcium assessment, and IVUS use in PAD interventions.



Last year the British Society of Interventional Radiology (BSIR) outlined a long-term strategy for interventional radiology (IR) in the United Kingdom (UK) focused on patient care and safety, workforce development, education/training, research, and strengthening the Society.[1] As President of the BSIR, what are some initiatives the society has underway to translate these pillars into action?

It is a privilege and an honor to be President of such a vibrant community of interventional radiologists as the BSIR. Our long-term strategy was developed by the leadership team in consultation with the membership and our special interest groups, and over the past year we have launched initiatives that advance every one of these five pillars.

On patient care and safety, we have fed into the National Health Service New Hospitals Programme to make sure IR is properly designed into future facilities. We have also worked with the All-Party Parliamentary Group on Vascular and Venous Disease, with a strong focus on patient engagement. Alongside this, a working group has developed guidance on the clinical aspects of job planning for interventional radiologists, which is now being considered for publication.

In education and training, we successfully delivered the BSIR Industry Scholarship for trainees and have developed an advanced vascular IR fellowship that will be rolled out early next year. We have also established a new visiting professorship, through which interventional radiologists visit medical schools to inspire students to consider IR as a career.

To develop the workforce, we brought together IR training program directors for a dedicated meeting on training delivery, and its findings are being fed back to the Royal College of Radiologists. We have introduced a visiting professorship for IR nurses and radiographers as well to strengthen our allied health professional workforce. Work is underway on the next edition of *Provision of Interventional Radiology Services*, which is scheduled for release in the fourth quarter of 2027.

Research is essential to the development of any specialty. Our research committee has been very active and has been working on putting in plans for grant writing workshops and PPIEPs (Patient and Public Involvement, Engagement, and Participation in health and social care research).

At the end of your term, what impact do you want your leadership to have had on the society and the broader IR community?

I hope to leave the UK IR community in a better place. Through the initiatives I've described, the BSIR aims to complete the transition of IR into a well-established clinical specialty that takes ownership of its own future. I hope I will have helped bring us a step closer to that goal.

I would be proud for my presidency to be remembered for establishing the visiting professorships, one for medical schools and one for IR radiographers and nurses (our allied health professionals), alongside our work on research and patient engagement. I am proud to have helped create a new special interest group for anaesthetists in IR and facilitating the vascular anomalies group to have a face-to-face meeting in 2027.

As IR looks to strengthen its workforce, you recently examined female representation among faculty at BSIR meetings over the past decade.[2] What has driven the progress you observed, and how is meaningful progress measured?

When we looked back over the past decade of BSIR meetings, female representation among faculty had risen from 5.9% in 2013 to around 30% in 2022.[2] That progress hasn't happened by chance. It reflects deliberate decisions by the BSIR and the hard work of many colleagues. I am glad to say that female members made up 36% of faculty at the 2026 BSIR annual meeting in Birmingham.

The biggest driver has been intentional program planning. Our meeting organizers now actively look to build diverse faculty and panels, rather than relying on the same familiar names. As more women have taken on prominent roles as speakers, session chairs, and

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committee members, they have become role models who encourage others to step forward. This has been supported by growing networks and mentorship for women in IR and by a gradual increase in the number of women entering IR training.

You've dedicated much of your career to training and mentoring the next generation of interventional radiologists. When trainees ask what a career in IR is really like, what do you tell them about both the rewards and the challenges of the specialty?

I have enjoyed every bit of my career in IR. It is a relatively young specialty, but its growth has been exponential, and it offers an ideal mix of minimally invasive treatment, innovation, and the chance to deliver care in the best possible way for patients. IR is, by its nature, a disruptive specialty that repeatedly challenges established ways of treating disease and replaces them with less invasive alternatives. It is also uniquely cross-cutting, working across almost every area of medicine and surgery, from vascular disease and cancer to trauma, obstetric hemorrhage, and renal care. Any young person considering a career in IR should be in no doubt that they will be part of tremendous innovation and will make a real difference by offering patients safe, less invasive treatments, which patients increasingly prefer. With an aging population, the need for IR procedures will only grow.

Success brings its own challenges. As IR increasingly replaces procedures that were once the standard of care, particularly in surgery, it inevitably creates tension over who should treat which patients. The way through this is collaboration. Modern treatment is multidisciplinary, with specialists working together around the patient. At the same time, we must keep innovating and bringing new technology through quickly, so that IR stays ahead of the curve in every area of management.

The rapid rise in minimally invasive techniques also brings a need for a larger workforce and greater training capacity. Together with the rising cost of devices, this will require new models of care delivery, such as IR day-case units and community-based services, to keep costs under control.

You have been participating in the Cardiovascular and Interventional Radiological Society of Europe (CIRSE) European IR Leadership meetings.[3] Can you expand on the changes that such meetings can bring about?

The CIRSE European IR Leadership meeting has become a valuable forum for national societies. I was privileged to present the BSIR strategy at the very first meeting, and it has been encouraging to see how the forum has grown since then. This year's meeting in Valencia, Spain, the third, brought together 58 representatives from 24 national societies alongside the CIRSE Executive Committee. The strength of this meeting lies in moving beyond discussion to practical exchange and sharing what has worked in our own countries, identifying the barriers we have in common, and agreeing on how to tackle them together.

Many of the challenges we face in the UK are shared across Europe. As a member of one of the subgroups of CIRSE's Therapies and Treatment task force, I have had the privilege of working with IRs from other parts of Europe in expanding the vision of IR being a standalone clinical specialty.

The strongest message from the meeting was visibility. IR needs to be visible not just to fellow doctors but also to patients, students, hospital managers, and policymakers, and that visibility comes from clinical responsibility: IRs who assess, treat, and follow up their own patients. That is exactly the direction we are taking in the UK. Meetings like this give national societies a shared voice and the evidence to make that case at home.

You have taken a particular interest in drug elution for femoropopliteal intervention. What factors are most important to achieving effective and safe drug delivery, and where do you see the greatest opportunities to improve current technologies?

Drug elution in peripheral artery disease (PAD) has had many more twists and turns than in the coronary circulation. The drive to develop drug-coated technologies came from the rapid growth in treating complex femoropopliteal disease and from the need to make those treatments durable by reducing restenosis and reocclusion in challenging lesions. The journey has been marked by repeated questions about both safety and effectiveness, most notably the paclitaxel mortality signal, which was subsequently not borne out in larger patient-level analyses but did shape the field for several years.

Effective drug delivery depends on getting the right drug into the vessel wall at the right dose and keeping it there long enough to act. That means considering the drug itself and its therapeutic window, the coating and excipient that carry it, how efficiently it transfers to the tissue, and how long it is retained. Vessel preparation matters just as much, particularly in heavily calcified lesions where calcium can act as a barrier to drug uptake. On the safety side, we need to minimize loss of drug downstream and particulate embolization and use the lowest effective dose.

If you ask me to look into the future, and I am always somewhat skeptical when it comes to the future of devic-

es, I lean toward the limus family. However, we still have a long way to go to build the evidence base, particularly regarding the long-term effectiveness of this technology.

In a recent publication, you and colleagues found variable agreement among current methods for grading calcium severity.[4] What are the implications for how we define and assess calcification in clinical trials and practice going forward?

Calcification increases with age, and we are treating an increasingly elderly population with more extensive calcific disease. We also know that in calcified vessels, adequate vessel preparation is essential if we are to achieve effective drug delivery into the vessel wall. Yet, at present, we lack the ability to measure the amount and extent of calcification accurately.

Our work showed that the various methods used to grade calcification on CT are not consistently reproducible in everyday clinical practice. This matters for patient care and for clinical trials. We are now developing artificial intelligence–based techniques to provide accurate calcium scoring, together with a visual representation of the severity and distribution of calcification.

In a recent meta-analysis, you and colleagues found improved outcomes associated with intravascular ultrasound (IVUS)- versus angiography-guided intervention for PAD.[5] What do we still need to establish before IVUS becomes a routine part of PAD intervention? Which patient populations or lesion subsets might benefit most from IVUS guidance?

IVUS has proved to be an extremely valuable problem-solving tool, but its use remains limited. Questions remain about the additional time and cost involved, and how far these are offset by better outcomes. What we still need to establish is whether routine IVUS use leads to durable clinical benefits that justify that investment.

I believe it is important to have a technology that ensures treatment is performed adequately, with appropriate lumen gain and, when stenting is needed, coverage from normal vessel above the lesion to normal vessel below it. I expect IVUS use to grow over time and for it to become an important adjunct for improving both immediate and long-term outcomes.

The patients most likely to benefit are those with complex disease, such as long or heavily calcified femoropopliteal lesions, chronic total occlusions, in-stent restenosis, and dissections posttreatment. IVUS is also valuable in patients with renal impairment, where it can reduce contrast use, and it is already well established in iliofemoral venous stenting.

What activities do you prioritize outside of medicine, and how does that influence the way you approach your work?

I enjoy walking and have completed several treks with my trekking group. I also love music and reading, both of which help me relax. More recently, my wife and I have started working on our allotment, growing our own vegetables. There is something about such a simple, basic activity that helps enormously to clear my head.

These pursuits give me balance and perspective. I return to work refreshed, and I think they make me a calmer and more thoughtful clinician and colleague. ■

1. Morgan R, Hamady M, Wah TM, et al. Interventional radiology in the United Kingdom–a long-term strategic plan. Clin Radiol. 2025;91:107094. doi: 10.1016/j.crad.2025.107094
2. Zhen S, Ng HH, Sayeed S, et al. "Breaking barriers": a decade of women's representation at the British Society of Interventional Radiology Meetings in the UK (2013–2022). Clin Radiol. 2026;93:107201. doi: 10.1016/j.crad.2025.107201
3. Cardiovascular and Interventional Radiological Society of Europe. European IR leaders unite around access, visibility, and the future of patient-centred care. July 20, 2026. Accessed October 27, 2026. https://www.cirse.org/publications/cirse-insider/ir-leadership-meeting-2026/
4. Ogawa K, Tan MT, Asif A, Lakshminarayan R. Evaluation of contemporary calcium scoring methods in peripheral artery disease. J Vasc Soc G B Irel. 2026;5:164–169. http://doi.org/10.54522/jvsgbi.2026.237
5. Agarwal G, Kamal R, Saeed D, et al. Should Interventional radiologists incorporate intravascular ultrasound (IVUS) into their daily practice? a systematic review and meta-analysis of IVUS in peripheral arterial endovascular interventions. Cardiovasc Intervent Radiol. 2026;49:1441–1451. doi: 10.1007/s00270-026-04509-0

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