



Interventional Radiology Curriculum for Medical Students

Second Edition

A brief overview
of the most
common clinical
conditions
handled by IRs

CIRSE

May 2019

Editorial Board

Editor in Chief

Christoph Binkert

Editors

Roberto Cazzato

Jan Jaap Janssen

Gregory Makris

Arash Najafi

Fatemeh Sakhinia

CIRSE Central Office

Neutorgasse 9/6

1010 Vienna

Austria

Phone: +43 1 904 2003

Fax: +43 1 904 2003 30

E-mail: info@cirse.org

www.cirse.org

© All rights reserved by the
Cardiovascular and Interventional
Radiological Society of Europe / 2019



Table of Contents

Introduction	2
1 Vascular IR	3
1.1 Peripheral Vascular Disease	3
1.2 Aneurysms	4
1.3 Venous Disease	5
1.3.1 Venous Thromboembolic Disease	5
1.3.2 Chronic Venous Obstruction	5
1.4 Embolisation for Benign Conditions	6
1.4.1 Uterine Fibroid Embolisation	6
1.4.2 Prostate Artery Embolisation	6
1.4.3 Gastrointestinal Bleeding	7
1.4.4 Gonadal Vein Embolisation	7
1.5 Access	8
1.5.1 Central Venous Access	8
1.5.2 Dialysis Shunt	8
2 Non-Vascular IR	9
2.1 Biopsies and Drainages	9
2.2 Biliary Procedures	9
2.3 Genitourinary Interventions	10
3 Interventional Oncology	11
3.1 Ablative Therapies	11
3.1.1 Liver Tumour Ablation	11
3.1.2 Renal Tumour Ablation	11
3.1.3 Lung Tumour Ablation	12
3.2 Liver Malignancy Embolisation	13
4 Musculoskeletal Interventions	14
4.1 Vertebral Compression Fractures and Vertebral Augmentation	14
4.2 Lower Back Pain	15
References	16
CIRSE and Interventional Radiology	18
Supporting IR's Next Generation	19

Introduction

In order to make medical students aware of the ever-increasing role of IR in hospital medicine and to provide guidance on the learning outcomes required to prepare medical students for their role during residency years, CIRSE published the first edition of the Interventional Radiology Curriculum for Medical Students in 2012. In recognition of the rapid growth that IR has experienced since then, CIRSE founded a Task Force chaired by Prof. Binkert to revise this document and develop an updated version.

This revised curriculum highlights the main areas of IR and outlines a variety of the most common clinical conditions routinely handled by interventional radiologists. It aims to support medical students planning on pursuing a career in IR and those who may participate in a multidisciplinary approach to patient care in the future.

In order to get a structured overview, each topic is examined under the following headings:

- Clinical presentation
- Imaging before the procedure
- IR treatment options
- Clinical care and follow-up

For a comprehensive overview of IR, students are encouraged to view the CIRSE European Curriculum and Syllabus for Interventional Radiology.

Interventional Radiology – A career fit for the future

1 Vascular IR

1.1 Peripheral Vascular Disease

Clinical presentation including classification:

- Peripheral vascular disease (PVD) is a disease of the arteries which affects the extremities, usually the lower limbs. The most common cause is atherosclerotic disease with risk factors such as cigarette smoking, hypertension, hypercholesterolaemia and diabetes mellitus. It can present with or without concomitant coronary artery disease or cerebrovascular disease.
- PVD is classified based on the presentation of intermittent claudication (IC), which is pain usually found in the calves, buttocks or thighs when walking. It progresses to disabling claudication and eventually to critical limb ischaemia (CLI). CLI represents an advanced stage of the disease with pain that cannot be relieved by standard analgesia. It presents with pain when at rest for 2 weeks or more. It can appear with or without the presence of tissue loss, this includes ulceration and/or gangrene. Untreated CLI often leads to limb loss from amputation.
- PVD can also be classified based on the ankle brachial pressure index (ABPI). The normal ABPI ranges from 0.9-1.1. An ABPI of <0.8 represents PVD with a reduction in ABPI with IC [1–2]. CLI is also defined with an ABPI of <0.3 or an absolute pressure of <50 mmHg at the ankle or a toe systolic pressure of <30 mmHg in a person with diabetes [3].
- Fontaine classification system categorises PVD based on clinical symptoms [4].

Fontaine Classification

Grade	Symptoms
Stage I	Asymptomatic, incomplete blood vessel obstruction
Stage II	Mild claudication pain in limb
Stage IIA	Claudication at a distance >200 m
Stage IIB	Claudication at a distance <200 m
Stage III	Rest pain, mostly in the feet
Stage IV	Necrosis and/or gangrene of the limb

- The Rutherford classification categorises PVD into acute and chronic limb ischaemia and highlights the different treatment algorithms for each presentation [5].

Rutherford Classification

Grade	Category	Clinical description
0	0	Asymptomatic
I	1	Mild claudication
I	2	Moderate claudication
I	3	Severe claudication
II	4	Ischaemic rest pain
III	5	Minor tissue loss – nonhealing ulcer, focal gangrene with diffuse pedal ischaemia
III	6	Major tissue loss – extending above trans metatarsal level, frank gangrene

Imaging findings before intervention:

- Duplex ultrasound is often the first modality of imaging.
- CT or magnetic resonance angiography (MRA) are the next modalities of imaging. Digital subtraction angiography (DSA) is preferred for treatment with concomitant balloon angioplasty and/or stenting of narrowed or blocked blood vessels.

IR treatment options:

- Endovascular procedures are performed through a small access in the groin. If needed, after recanalisation of the stenotic or occluded segment, the artery is dilated with a balloon followed by a stent. Newer developments include drug-coated balloons to improve patency and atherectomy to debulk calcifications.

Clinical care and/or follow-up:

- Follow up is conducted in a clinic to review symptoms, check medication (typically an antiplatelet drug and a statin), examine the leg perfusion and control the angioplasty result with Duplex ultrasound.

1.2 Aneurysms

Clinical presentation including classification:

- Aneurysms are defined as the dilatation of a blood vessel, usually greater than 50% of the normal diameter [6].
- Aneurysms can be classified based upon location, such as in the aorta, iliac artery or popliteal artery. There is also a distinction made between true aneurysms which involve all 3 layers of the blood vessel, and false/pseudo aneurysms which arise due to trauma or infection.
- Abdominal aortic aneurysms (AAA) are the most common aneurysms. They are seen more frequently in men than women (4:1) and typically affect older patients [6]. These are thought to be atherosclerotic in nature with cigarette smoking as a common risk factor.

Imaging findings before intervention:

- Aneurysms are often asymptomatic and are detected incidentally on ultrasound (US) or CT scanning. To accurately determine the size of the aneurysm and plan treatment, the gold standard for imaging is multi-sliced CT angiography (CTA).
- On CTA, aneurysm anatomy and morphology are studied to assess suitability for endovascular repair (EVAR) and device selection.
- Aneurysms can also first present once they rupture. Ruptured aneurysms carry a high mortality rate of between 80-90% [6]. In the United States of America, screening with US for men between the ages of 65-75 who have smoked is offered, whereas in the United Kingdom and Sweden, all men at the age of 65 are offered AAA screening [7-8].

IR treatment options:

- EVAR is an alternative to open surgery. Suitable anatomy is important to exclude the aneurysm. Special devices such as fenestrated or branched stent grafts can be used in difficult anatomy.

Clinical care and/or follow-up:

- Follow-up after EVAR is important to detect possible leaks into the aneurysm which will need to be fixed. The most common modality is CTA at 1 month, 6 months and then yearly.

1.3 Venous Disease

1.3.1 Venous Thromboembolic Disease

Clinical presentation including classification:

- Sluggish blood flow, intimal injury and hypercoagulability can lead to a venous blood clot (thrombus). If the thrombus dislocates and travels in the blood it is called an embolus. The most common thrombus sites are the legs and the pelvis. Patients usually experience pain and swelling in the affected leg, or dyspnoea and haemodynamic instability if there is a thrombus dislocation to the pulmonary arteries.

Imaging findings before intervention:

- Imaging modalities include US for peripheral and abdominal veins and CTA for pulmonary embolism. Sonographic features of acute thrombosis include dilatation and non-compressibility of the vein, hyperechoic endoluminal matter and a lack of Doppler signal. On CTA there is a partial or total filling defect of the vessel lumen.

IR treatment options:

- The standard treatment is anticoagulation.
- For extended venous thrombosis, the thrombus can be dissolved either mechanically or pharmacologically, or using a combination of both to minimize the risk of post-thrombotic syndrome [9].
- If anticoagulation is contraindicated, the blood can be filtered to prevent a pulmonary embolism using a vena cava filter.

Clinical care and/or follow-up:

- Anticoagulation is generally needed even after successful thrombolysis. Clinical and Duplex ultrasound are performed at 2 weeks and 3 months.

1.3.2 Chronic Venous Obstruction

Clinical presentation including classification:

- Clinical symptoms and presentations vary depending on the location of the obstruction or occlusion. Chronic venous obstruction may occur after venous thrombosis with insufficient recanalisation. This can be due to anatomical venous variants or mechanic/external compression of the vein (e.g. tumour, May-Thurner Syndrome) [10]. The extremity before the obstruction is typically swollen and painful.

Imaging findings before intervention:

- Imaging modalities commonly include US for peripheral veins and CT venography for the inferior vena cava. Sonographic features of chronic thrombosis include obliteration and fibrosis of a vein which has a lack of Doppler signal. On CT venography, the occluded veins are small with strongly developed collaterals.

IR treatment options:

- Recanalisation of the occluded vein with percutaneous transluminal angioplasty (PTA) and stenting is needed in nearly all cases to avoid recoil [11].

Clinical care and/or follow-up:

- Medical anticoagulation for several weeks. Clinical follow-up including Duplex ultrasound after 3 months.

1.4 Embolisation for Benign Conditions

1.4.1 Uterine Fibroid Embolisation

Clinical presentation including classification:

- Fibroids are common and treatment is only necessary if they cause symptoms. Symptoms include heavy menstrual bleeding or bulk symptoms (i.e. sensation of pressure in the pelvis or urinary frequency).

Imaging findings before intervention:

- Fibroids are solid masses within the uterine wall, they can be submucosal or subserosal. The fibroids can show areas of cystic degeneration/necrosis or calcifications. Magnetic resonance imaging (MRI) is the preferred imaging modality for determining size, vascularity and location. MRA can assess potential collaterals mainly in the ovarian arteries.

IR treatment options:

- Embolisation of both uterine arteries with particles (efficacy ~ 80%) [12].

Clinical care and/or follow-up:

- Patients experience some pain for 1-2 weeks after the procedure. Thereafter, they are usually pain free with symptoms resolving within 3 months. Clinical outpatient visits are typically scheduled at 2 weeks and again at 3 months or 6 months.

1.4.2 Prostate Artery Embolisation

Clinical presentation including classification:

- Men with benign prostate hyperplasia (BPH) present with lower urinary tract symptoms (LUTS) consisting of storage symptoms (i.e. frequency, urgency, nocturia, urinary incontinence) or voiding symptoms (i.e. slow or intermittent urinary stream, hesitancy, terminal dribbling). The severity of the symptoms is assessed using the international prostate symptom score (IPSS) [13].

Imaging findings before intervention:

- Imaging modalities include US and MRI to determine gland size and lack of malignant features. MRA or CTA helps to assess the variable prostatic vessel anatomy before the procedure.

IR treatment options:

- Selective embolisation of the prostatic arteries with small particles (efficacy ~ 80%) [14].

Clinical care and/or follow-up:

- Prostate artery embolisation (PAE) is typically performed as an outpatient procedure. The symptoms improve within several months. Clinical outpatient visits are usually scheduled at 3 months, 6 months and 12 months.

1.4.3 Gastrointestinal Bleeding

Clinical presentation including classification:

- Depending on the vessel location, patients with gastrointestinal (GI) bleeding experience haematemesis and melena (usually indicates a bleed in the upper GI, proximal to ligament of Treitz) or haematochezia (indicates a bleed in the lower GI, distal to ligament of Treitz).

Imaging findings before intervention:

- CTA can detect the active bleeding site if the bleeding rate exceeds 0.3 ml/min [15]. It is visible as focal hyperdense spots on the arterial phase or pooling of contrast agent on the portal venous phase. For intermittent bleeding, a scintigraphy with labelled red blood cells can be performed.

IR treatment options:

- Embolisation of bleeding site by blocking the bleeding artery. Depending on the location, the embolic agent can be temporary (e.g. gelatine sponge) or permanent (e.g. coils or glue).

Clinical care and/or follow-up:

- Bleeding should stop immediately after embolisation. Short term follow-up with lab tests and clinical visits. If necessary, the embolisation can be repeated.

1.4.4 Gonadal Vein Embolisation

Clinical presentation including classification:

- Insufficiency of the gonadal veins can lead to testicular varicosities with subsequent pain and infertility in men, or vulvovaginal varicosities and pelvic congestion syndrome (i.e. pain, dysmenorrhea, deep dyspareunia and urinary urgency) in women.

Imaging findings before intervention:

- A testicular varicocele can be diagnosed sufficiently by US. Salient findings are serpentine dilatation of the pampiniform plexus >2-3 mm and flow reversal on Doppler sonography with Valsalva manoeuvre [16]. Sarteschi classification grades testicular varicoceles [17].
- Ovarian varicosities are best visualised on contrast-enhanced MRI. Sonography is only performed for assessment of lower extremity vein insufficiencies.

IR treatment options:

- Embolisation of gonadal veins with sclerosants, coils and/or plugs (efficacy ~ 95%) [18].

Clinical care and/or follow-up:

- Gonadal vein embolisation is usually performed as an outpatient procedure. If sclerosants are used there can be some pain in following days.
- An outpatient visit should be scheduled several weeks after the procedure.

1.5 Access

1.5.1 Central Venous Access

Clinical presentation including classification:

- Common indications for central venous access include, the administration of noxious medications (e.g. chemotherapy or parenteral nutrition), haemodialysis, inadequate peripheral venous access, etc.

Imaging findings before intervention:

- Usually no imaging is needed beforehand. Vein puncture is typically performed under US-guidance. Handling of the wire and catheter is performed under fluoroscopy.

IR treatment options:

- Central venous access consists of tunnelled catheters or ports. In the latter, a reservoir is implanted subcutaneously. Another variant is peripherally inserted central lines (PICC) which are typically inserted through a superficial upper extremity vein.

Clinical care and/or follow-up:

- Outpatient or bed-side visit the next day. Patients should be seen again if the access malfunctions.

1.5.2 Dialysis Shunt

Clinical presentation:

- Haemodialysis is one of the most common forms of dialysis for end stage renal disease.
- Arteriovenous fistulas (AVFs) are created preferably between the radial artery and the cephalic vein.

Imaging findings before intervention:

- US is used initially to determine the most suitable vein and afterwards to assess malfunctioning fistulas.

IR treatment options:

- PTA of the stenosis can be performed with or without a drug-eluting balloon (efficacy 80-90%) [19]. Occasionally stent grafts are used.
- Recently endovascular creation of AVFs has been introduced.

Clinical care and/or follow-up:

- Patients on dialysis are generally seen 3 times per week during which the AVF or shunts are observed.

2 Non-Vascular IR

2.1 Biopsies and Drainages

Clinical presentation:

- Biopsy: patients in which tissue sampling is necessary for determining the aetiology of a lesion before treatment.
- Drainages: patients with infected fluid collections causing sepsis (e.g. abscess or empyema), or mechanical complaints (e.g. pleural effusion or ascites).

Imaging findings before intervention:

- US, CT or MRI can show the extent of the lesions or fluid collections and also determine the best access for puncture.

IR treatment options:

- Image-guided access using US, CT or fluoroscopy can be used to: ascertain the cytology or histology for sampling the solid lesions, and enable the aspiration or drainage for sampling and/or evacuation of fluid collections. They can also be used to place the drainage catheter in a one-step procedure or using the Seldinger technique.

Clinical care and/or follow-up:

- Patients should be monitored post-procedure for several hours.
- Further imaging is performed before drain removal and if the drain is not working.

2.2 Biliary Procedures

Clinical presentation including classification:

- Patients with biliary obstruction (e.g. due to benign/malignant stenosis or biliary stone disease) can present with jaundice and/or sepsis.

Imaging findings before intervention:

- Magnetic resonance cholangiopancreatography (MRCP) is the best modality to assess biliary anatomy.
- The cause of obstruction and potential abscesses can be evaluated using MRI, CT or US.

IR treatment options:

- The biliary system is accessed under US and fluoroscopic guidance.
- Initially a catheter with multiple side holes is inserted with the tip in the duodenum to allow the most effective drainage.
- Benign lesions are treated with a balloon and long-term drainage.
- Malignant lesions are typically stented with a metal stent.
- Removal of biliary stones can be done through the percutaneous access.

Clinical care and/or follow-up:

- Patients should be observed overnight after the initial biliary drainage placement.
- The biliary drainage catheter should be changed every 2-3 months because of the high viscosity of the bile.

2.3 Genitourinary Interventions

Clinical presentation:

- Ureteral obstruction (e.g. due to; kidney stones, tumours or fibrosis) can lead to hydronephrosis, impaired renal function and even rupture of the renal collection system.
- Urinary tract leakage can occur after abdominal trauma or iatrogenic injury.

Imaging findings before intervention:

- US and non-contrast-enhanced computed tomography (NECT) are useful to identify renal stones.
- CT urography shows the collecting systems, ureters and bladder. This helps determine the cause of the obstruction (e.g. tumour, stricture, etc.).

IR treatment options:

- An US-guided puncture is used for access to the pelvicalyceal system. Under fluoroscopic guidance, a nephrostomy catheter for external drainage can be placed, or a ureter stent can be advanced into the bladder.

Clinical care and/or follow-up:

- Patients should be observed overnight after the initial nephrostomy catheter placement.
- The nephrostomy catheter should be changed at least every 6 months or if it malfunctions.

3 Interventional Oncology

3.1 Ablative Therapies

3.1.1 Liver Tumour Ablation

Clinical presentation including classification:

- Primary or secondary liver lesions are usually found during staging CT scans or US.
- Lesions can be classified according to the Barcelona Clinic Liver Cancer (BCLC) staging system and treatment strategy [20].

Imaging findings before intervention:

- Cross sectional images (e.g. CT, MRI) are necessary to determine the size and location of the tumours.
- CT and MRI also help to plan access and ablation of these lesions.

IR treatment options:

- The most common ablation modalities are radiofrequency (RF) or microwave (MW).
- For RF and MW a needle has to be placed into the lesion using image-guidance such as US or CT, or a combination of both.
- After thermal ablation, the success is documented typically using contrast CT.

Clinical care and/or follow-up:

- CT control with a clinical visit to determine the outcome and recognise the potential complications such as abscesses, biloma or bile leaks.

3.1.2 Renal Tumour Ablation

Clinical presentation:

- Renal masses are usually asymptomatic. Occasionally, they can cause back pain or macroscopic or microscopic haematuria.

Imaging findings before intervention:

- Renal tumours are commonly incidental findings during routine imaging. US and multiphase CT are the most common imaging modalities to determine whether a renal mass is malignant.

IR treatment options:

- Small renal tumours or poor surgical candidates can be treated with image-guided ablation [21].
- Besides heat (i.e. RF or MW), cold (i.e. cryotherapy) can be used. The latter has the advantage that the ice ball can be seen in CT or MRI.

Clinical care and/or follow-up:

- A post-ablation CT is usually recommended to ensure that the targeted lesion has been treated and that no complications such as bleeding or urinary leak have occurred.

3.1.3 Lung Tumour Ablation

Clinical presentation:

- Primary lung cancer and metastatic lung disease are usually asymptomatic but can occasionally manifest with haemoptysis, especially in advanced cases.

Imaging findings before intervention:

- The chest radiograph is the main screening tool. However, CT is increasingly used for screening/staging.
- The main imaging features on CT are nodules within the lung parenchyma, with or without hilar lymphadenopathy.

IR treatment options:

- Thermal ablation of the lungs can be used to treat both primary and secondary thoracic malignancies when they are small ≤ 3 cm and few < 5 [22].
- Good results have been reported in several studies [22].

Clinical care and/or follow-up:

- A post-ablation CT is performed within a few days to ensure adequate ablation of the targeted lesions and to ensure that no complications such as pneumothorax, pleural effusion, lung haemorrhage or the formation of a lung abscess have occurred.

3.2 Liver Malignancy Embolisation

Clinical presentation including classification:

- Primary or secondary liver lesions are usually an imaging finding during staging CT scans or US. However, there are occasions when they manifest as abnormal liver blood markers or with jaundice if there is a central lesion obstructing the common bile duct.

Imaging findings before intervention:

- Solitary or multiple lesions involving various components of the liver. They typically show early enhancement of contrast and a contrast wash out during later phases.

IR treatment options:

- The BCLC staging system and treatment strategy outlines the treatment algorithm for liver lesions [20]. The main types of transcatheter arterial embolisation are:
 - Transcatheter arterial embolisation (TAE): The branches of the artery supplying the liver tumour/s are selectively cannulated and then occluded using microparticles. The main aim is to cut the blood supply to the tumour.
 - Transcatheter arterial chemoembolisation (TACE): This procedure is similar to TAE but is completed with chemotherapy loaded particles. The combination of ischemia and chemotherapy increases the effect.
 - Transarterial radioembolisation (TARE): This procedure is similar to TAE but completed with radioactive particles (Yttrium-90). The treatment involves injecting tiny microspheres of radioactive material into the arteries that supply the tumour so the spheres lodge in the small vessels of the tumour. As this treatment combines radiotherapy with embolisation, it is also called radioembolisation. Yttrium-90 is the radionuclide used.
 - Portal vein embolisation (PVE) prior to therapeutic hepatectomy: PVE is performed if the remaining liver volume after resection is not large enough. Typically, this is the case after right-sided hepatectomy. By blocking the portal vein branches on the side of the resection in order to force the blood supply of the liver to move to the smaller side, the so-called future liver remnant can be increased in size.

Clinical care and/or follow-up:

- There is typically some pain management needed after TAE or TACE. TARE and PVE are often outpatient procedures with few side effects. However, after TARE there is often some fatigue.
- Follow-up is done with cross-sectional imaging (e.g. CT or MRI) to assess efficiency and to rule out complications such as abscess formation.

4 Musculoskeletal Interventions

4.1 Vertebral Compression Fractures and Vertebral Augmentation

Clinical presentation including classification:

- Benign osteoporotic fractures result from bone weakness due to substantial loss of mineral density. This condition can be physiologic (e.g. in post-menopausal women), or iatrogenic (e.g. caused by: steroid use, chemotherapy, hormonal treatments for cancers, fractures subsequent to thermal ablation or radiation therapy, etc.). The weakened vertebral body collapses due to minimal compressive stress, resulting in a vertebral compression fracture (VCF). This causes the vertebral body to lose part or all of its height.
- Chronic unhealed VCFs result in a necrotic cavity filled with fluids and gases inside the vertebral body. This condition is known as Kummel's disease and is generally painful.
- A VCF may also occur as a result of high-energy trauma in healthy people, in such a case the Magerl's classification is used [23]. This classification distinguishes VCFs in 3 main groups according to the type of traumatic stress.
- Malignant vertebral body fractures are the consequence of bone destruction (including multiple myeloma).

Imaging findings before intervention:

- X-ray is typically used to obtain an overview; however, before intervention, an MRI is commonly needed to assess the activity of a fracture. Healed fractures should not be treated.
- If MRI is contraindicated, single photon emission computed tomography (SPECT-CT) should be used.
- Pre-operative imaging should rule out the main contraindications to vertebral augmentation, including vertebral instability, spondylodiscitis and spondylarthrosis.

IR treatment options:

- Initially conservative treatment with analgesics can be used, but intervention should be considered if pain persists or if the vertebral body collapses further.
- Standard vertebroplasty is performed by injecting an acrylic cement (i.e. polymethyl methacrylate (PMMA)) through uni- or bi-pedicular needles in the vertebral body.
- Vertebroplasty can be combined with radiation therapy in malignant fractures.
- Height restoration can be achieved through the use of balloons (i.e. kyphoplasty), or with stents (i.e. stentoplasty). The fracture should not be consolidated if height restoration is intended.

Clinical care and/or follow-up:

- Following vertebroplasty, patients are instructed to have bed-rest for 4-6 hours. Thereafter, they may move without any significant restrictions.
- A follow-up X-ray in an upright position, as well as a clinical assessment is typically performed after 2-3 weeks. Additional fractures due to the fragile bones are common so additional vertebroplasties may be needed.

4.2 Lower Back Pain

Clinical presentation including classification:

- Lower back pain is very common and presents as acute or chronic pain of the lumbar region, with or without irradiation to the lower limbs.
- Lower back pain has many causes including, disc tears in the annulus, disc herniation, degenerative or inflammatory changes of facet joints and spinal canal stenosis.

Imaging findings before intervention:

- Unenhanced lumbar MRI is the preferred imaging modality used to postulate the possible cause of pain.
- MRI findings should be combined with the patient's history and a physical examination.

IR treatment options:

- Initially, conservative treatment with analgesics and physiotherapy is preferred.
- If conservative therapy is not successful, spinal injections can be performed under image-guidance (e.g. fluoroscopy or CT) to deliver anaesthetics and/or long-lasting anti-inflammatory steroids in the area where the pain is supposed to originate.
- If back pain originates from the facet joints and recurs after the injection, a focal thermocoagulation can be considered.

Clinical care and/or follow-up:

- A pain questionnaire (e.g. a visual analogue scale) is typically filled out 30 minutes after the injection in order to assess the immediate effect.
- If the pain reoccurs, the injection can be repeated. If the pain free interval is short, surgical therapy can be considered, the response to the injection should reveal the source of pain.

References

- [1] F. Fowkes, E. Housley, E. Cawood, C. Mac Intyre, C. Ryckley and R. Prescott, "Edinburgh Artery Study: Prevalence of Asymptomatic and Symptomatic Peripheral Arterial Disease in the General Population", *International Journal of Epidemiology*, vol. 20, no. 2, pp. 384-392, 1991.
- [2] A. Hirsch, M. H. Criqui, D. Treat-Jacobson, J. G. Regensteiner, M. A. Creager, J. W. Olin, S. H. Krook, D. B. Hunninghake, A. J. Comerota, M. E. Walsh, M. M. McDermott and W. R. Hiatt "Peripheral Arterial Disease Detection, Awareness, and Treatment in Primary Care", *JAMA*, vol. 286, no. 11, pp. 1317-1324, 2001.
- [3] "Second European Consensus Document on Chronic Critical Limb Ischaemia", *European Journal of Vascular Surgery*, vol. 6 (Supplement A), pp. 1-32, 1992.
- [4] R. Fontaine, M. Kim and R. Kieny, "Surgical treatment of peripheral circulation disorders [in German]", *Helvetica Chirurgica Acta*, vol. 21, no. 5-6, pp. 499-533, 1954.
- [5] L. Norgren, W. Hiatt, J. Dormandy, M. Nehler, K. Harris and F. Fowkes, "Inter-Society Consensus for the Management of Peripheral Arterial Disease (TASC II)", *Journal of Vascular Surgery*, vol. 45, no. 1, pp. S5-S67, 2007.
- [6] K. Kent, "Abdominal Aortic Aneurysms", *New England Journal of Medicine*, vol. 371, no. 22, pp. 2101-2108, 2014.
- [7] M. L. LeFevre and the U.S. Preventive Services Task Force, "Screening for Abdominal Aortic Aneurysm: U.S. Preventive Services Task Force Recommendation Statement", *Annals of Internal Medicine*, vol. 161, no. 4, pp. 281-290, 2014.
- [8] S. Svensjö, M. Björck and A. Wanhainen, "Update on screening for abdominal aortic aneurysm: a topical review". *European Journal of Vascular and Endovascular Surgery*, vol. 48, no. 6, pp. 659-667, 2014.
- [9] A. J. ten Cate-Hoek, "Prevention and treatment of the post-thrombotic syndrome", *Research and Practice in Thrombosis and Haemostasis*, vol. 2, no. 2, pp. 209-219, 2018.
- [10] S. Khalid, A. Khalid, T. Meridores and H. Daw, "May-Thurner Syndrome: A Rare Cause of Deep Venous Thrombosis", *Cureus*, vol. 10, no. 5, p. e2700, 2018.
- [11] O. Ahmed, J. Ng, M. Patel, T. J. Ward, D. S. Wang, R. Shah and L. V. Hofmann, "Endovascular Stent Placement for May–Thurner Syndrome in the Absence of Acute Deep Vein Thrombosis", *Journal of Vascular and Interventional Radiology*, vol. 27, no. 2, pp. 167-173, 2016.
- [12] A.M. deBruijn, W.M. Ankum, J.A. Reekers, E. Birnie, S.M. van der Kooij, N.A. Volkers and W.J. Hehenkamp, "Uterine artery embolization vs hysterectomy in the treatment of symptomatic uterine fibroids: 10-year outcomes from the randomized EMMY trial", *American Journal of Obstetrics & Gynecology*, vol. 27, no.2, pp167-173, 2016.
- [13] M. J. Barry, F. J. Jr. Fowler, M. P. O'Leary, R. C. Bruskewitz, H. L. Holtgrewe, W. K. Mebust and A. T. Cockett, "The American Urological Association Symptom Index for Benign Prostatic Hyperplasia", *Journal of Urology*, vol. 148, no. 51, pp. 1549-1557, 1992.

- [14] J. M. Pisco, T. Bilhim, L. C. Pinheiro, L. Fernandes, J. Pereira, N. V. Costa, M. Duarte and A. G. Oliveira, "Medium- and Long-Term Outcome of Prostate Artery Embolization for Patients with Benign Prostatic Hyperplasia: Results in 630 Patients", *Journal of Vascular and Interventional Radiology*, vol. 27, no. 8, pp. 1115-1122, 2016.
- [15] W. Kuhle and R. Sheiman, "Detection of Active Colonic Hemorrhage with Use of Helical CT: Findings in a Swine Model", *Radiology*, vol. 228, no. 3, pp. 743-752, 2003.
- [16] G. Liguori, C. Trombetta, G. Garaffa, S. Bucci, I. Gattuccio, L. Salame and E. Belgrano, "Color Doppler ultrasound investigation of varicocele", *World Journal of Urology*, vol. 22, no. 5, pp. 378-381, 2004.
- [17] M. Valentino, M. Bertolotto, L. Derchi and P. Pavlica, "Children and adults varicocele: diagnostic issues and therapeutical strategies", *Journal of Ultrasound*, vol. 17, no. 3, pp. 185-193, 2014.
- [18] C. Brown, M. Rizer, R. Alexander, E. Sharpe and J. Rochon, "Pelvic Congestion Syndrome: Systematic Review of Treatment Success", *Seminars in Interventional Radiology*, vol. 35, no. 01, pp. 35-40, 2018.
- [19] G. Maleux, W. Vander Mijnsbrugge, D. Henroteaux, A. Laenen, S. Cornelissen, K. Claes, I. Fourneau and N. Verbeeck, "Multicenter, Randomized Trial of Conventional Balloon Angioplasty versus Paclitaxel-Coated Balloon Angioplasty for the Treatment of Dysfunctional Autologous Dialysis Fistulae", *Journal of Vascular and Interventional Radiology*, vol. 29, no. 4, pp. 470-475.e3, 2018.
- [20] European Association for the Study of the Liver, et al., "EASL-EORTC Clinical Practice Guidelines: Management of hepatocellular carcinoma", *Journal of Hepatology*, vol. 56, no. 4, pp. 908-943, 2012.
- [21] H. D. Patel, P. M. Pierorazio, M. H. Johnson, R. Sharma, E. Iyoha, M. E. Allaf, E. B. Bass and S. M. Sozio, "Renal Functional Outcomes after Surgery, Ablation, and Active Surveillance of Localized Renal Tumors: A Systematic Review and Meta-Analysis", *Clinical Journal of the American Society of Nephrology*, vol. 12, no. 7, pp. 1057-1069, 2017.
- [22] R. Lencioni, L. Crocetti, R. Cioni, R. Suh, D. Glenn, D. Regge, T. Helmberger, A. R. Gillams, A. Frilling, M. Ambrogi, C. Bartolozzi and A. Mussi, "Response to radiofrequency ablation of pulmonary tumours: a prospective, intention-to-treat, multicentre clinical trial (the RAPTURE study)", *The Lancet Oncology*, vol. 9, no. 7, pp. 621-628, 2008.
- [23] F. Magerl, M. Aebi, S. Gertzbein, J. Harms and S. Nazarian, "A comprehensive classification of thoracic and lumbar injuries", *European Spine Journal*, vol. 3, no. 4, pp. 184-201, 1994.

CIRSE and Interventional Radiology



Students at CIRSE 2018, Lisbon, Portugal

What is CIRSE?

The Cardiovascular and Interventional Radiological Society of Europe (CIRSE) is a non-profit making, educational and scientific association aiming to improve patient care through the support of teaching, science, research and clinical practice in the field of cardiovascular and interventional radiology.

What is interventional radiology?

Interventional radiology (IR) is a growing discipline at the forefront of modern medicine. Dynamic and innovative in nature, this minimally-invasive alternative to conventional practices attracts physicians who possess expertise in high-end imaging technology and clinical involvement with patients.

Interventional radiologists (IRs) are doctors trained in radiology and in minimally-invasive procedures. Experts in both imaging technology and clinical involvement, IRs take care of their patients, while also cooperating closely with specialists from other medical fields. Their expertise in imaging techniques such as X-ray, ultrasound and CT enables them to perform many minimally-invasive procedures which can treat a vast range of medical conditions.

For more information about CIRSE and IR please visit www.cirse.org

Supporting IR's Next Generation



Student Programme at CIRSE 2018, Lisbon, Portugal

CIRSE Student Membership

All medical students who started their first university degree no more than eight years ago and are still enrolled in a university programme are eligible to become CIRSE Student Members. As a member of CIRSE, students are able to enjoy all the benefits, such as free access to CVIR online, streaming videos from past CIRSE congresses on the CIRSE Library and the opportunity to purchase CME-accredited online courses through the CIRSE Academy at a significantly reduced fee. Freshly graduated students will be offered CIRSE Junior Membership which will allow them to actively participate in CIRSE's European Trainee Forum activities.

Get more information about CIRSE Student Membership at www.cirse.org/society/membership/

CIRSE's Student Programme – Be inspIReD

CIRSE invites all undergraduate medical students to attend CIRSE Annual Meetings for free in order to enjoy educational, engaging and fun IR-related onsite sessions and events. The Student Programme enables students to learn about IR and its applications by attending recommended scientific sessions, taking part in hands-on device trainings and simulation sessions and joining learning centres workshops, which are coordinated by CIRSE's industry partners.

To learn more about CIRSE's student initiatives, please visit the CIRSE website at www.cirse.org/students

A series of horizontal dashed lines for writing notes.

