CAIR EXPRESS

Inside this issue: Fall 2019

Dr. Amol Mujoomdar

President's Blog: Dr. Mujoomdar

I am happy to report that the CAIR Initiative Platform has recently been endorsed by the Canadian Association of Radiologists (CAR). The CAR Board adds its voice to ours to raise awareness about the benefits of Interventional Radiology (IR) for our patients to bridge the huge gap that separates Canada from other countries with respect to access to minimally invasive, patient friendly IR treatments.

As we continue to grow the CAIR Initiative, we're excited to share our main messages on social media to reach an even wider audience. I hope CAIR members will circulate supportive messages on social media by using the hashtag **#ISupportIR.** I encourage you to use the shareables you will find by clicking here .

The new section of the CAIR website on Uterine Fibroid Embolization (UFE) is attracting more and more attention. This was made possible, at least in part, by the advertising campaign, targeting women between the age of 35-50, we recently conducted through social media and digital posters in approximately 30 clinics in Ontario and Québec. A number of UFE resources are listed on the CAIR website. If you wish to add your resource to the list, please contact the CAIR head office.

The CAIR Initiative Platform is available on the CAIR website .

I look forward to reading your messages online.

Amol Mujoomdar
CAIR President

Catching up with... Dr. Drew Schemmer

Dr. Schemmer is a well-known interventional radiologist from Barrie, Ontario with vast experience in endovascular (EV) treatment of peripheral artery disease, EV treatment of Aortic aneurysms (EVAR / pEVAR), and Interventional Oncological procedures. He is a co-investigator in the CORAL and KAVIAR trials.

Dr. Drew Schemmer

CAIR Interview Question & Answers

1. Your group has built a successful 'one-of-a-kind' busy VIR practice in Canada. Please tell us more about your practice.

Our VIRs provide the full scope of procedures, save EVT. We have 5 VIRs whose skills and services are borne from both interest and necessity, and we now have a progressive VIR practice that has evolved over many years. Recently our group has been exposed to some negative political influences and turf conflict, but it has been very helpful to have a supportive group of general partners that share our vision and support our work. VIR is a clinical specialty, and our group is openly collaborative when we consult with other physicians, discuss cases and direct patient care. Taking the lead in clinical management is nothing new for VIR, but now we have more of a presence on the "front line" so to speak, as we take direct referrals, including the Emergency department, and sort out patient's conditions directly and help them to navigate their options. We don't 'own' patients like some specialties but the importance of being an MD who accepts direct referrals, takes ownership of providing unparalleled care when helping patients cannot be overstated.

2. What went into building a clinic based practice where you see your own patients and do your own work up?

I think having 2 or 3 confident veteran VIRs with broad experience is very important. A supportive general partnership with clerical and technical support staff is paramount. In my experience, many of our staff members enjoy the challenge of being part of a larger collaborative 'clinical' model. We also found that having a very competent and efficient Clinical Navigator to maintain our clinical patient results, follow-up imaging and patient care appointments is key to our success.

I was our group's Office/clinic lead for 6 years and slowly made sure that we had US technologists with Vascular RVT proficiency, that our office PACS system had a functional electronic handshake between our regional hospitals and referring MDs. Also, we developed a much needed element of 'branding'. I dovetailed our office branding with the future VIR work, and our group decided on "Vascular and Interventional Therapies" (VIT) as our provisional name. We provided informative mail to the larger hospitalist and Family MD

" ... Having a very competent and efficient Clinical Navigator to maintain our clinical patient results, follow-up imaging and patient care appointments is key to our success."

groups in town, and made site visits to referring office clerks. We further added our requisitions to their EMR order entry programs, or left requisition pads for them. Word of mouth contributions cannot be underestimated.

We also ensured that our annual Radiology hospital credentialing included admitting privileges - easily attainable for all VIRs. There is no reason that a VIR would be denied admitting privileges, and our recent sub-specialization status with the FRCP confirms this. In Ontario, the CPSO fully supports our clinical status.

3. How did the local medical community feel about a radiology service operating as you do and not completely depending on specialist referrals?

Our 'new' clinical VIT program was well received. Referring MD's also enjoyed the efficient and improved access to our clinical service and the shorter wait-times. It was encouraging for us to feel as though we were part of a program that decreased wait times often complicated by unnecessary appointments and secondary referrals. For example, patients do not need to see a surgeon prior to our clinical exams as we have been assessing and treating patients for decades, and, 90% of PAD states are remedied by out-patient EV therapies. Patients' give us feedback like, "I cannot believe that you actually spoke to me for more than a minute and listen to our concerns." Essentially, we aimed to provide an "all-in-one" service of clinical appointment and consultation, diagnosis and treatment plan of either clinical follow-up with surveillance imaging or EV treatment. Since we support full informed consent, when appropriate we refer to other services for alternate care. Lastly, I feel that VIRs do not appreciate their all-encompassing education, cross-sectional knowledge and dexterous catheter skills. We have diagnostic and therapeutic talents that are unmatched in most instances.

4. Would you be able to speak to the financial considerations you may have had in building such a practice?

As first our VIT clinical consult space was within our Radiology department with a dedicated consult room, and easy access to imaging, we could show patients their imaging and plan their care. In the mean time we were getting our preferred clinical site ready and used the existing Radiology clinic to craft an even better location and delivery care model for patients. This started as one day a month, and it quickly grew to two days a month in the hospital. Since moving our VIT program out into our office clinics we currently see patients 6-8 days a month with plans of making 2-3 VIR dates each week. In isolation, a day in a VIR clinic is less remunerative that other assignments. With this in mind, our VIR group has accepted that we need to contribute to our Radiology group by reading assigned work to contribute equally. I think it is appropriate to maintain such an efficient and growing VIR practice. It works out quite nicely.

5. Do you incorporate teaching and research into your practice and how do you do so?

We are genuinely pro-Radiology, and so we want all VIRs in Ontario, and Canada for that matter, to embrace our clinical specialty and the services that they have been providing patients for over 40 years. We are clinicians, full stop. We align clinical cases with product specialists and we provide 'Clinical VIR education days' whereby VIRs from other sites come to watch Various Thermal ablation (RFA, MicroW, Cryo), atherectomy, difficult arterial re-entry, venous thrombolysis and thrombectomy cases. We also teach Family Medical residents each month.

6. Could you describe any novel and exciting work you do or patients you see?

We have a broad and rich VIR

" We provided informative mail to the larger hospitalist and Family MD groups in town, and made site visits to referring office clerks."

"VIRs from other sites come to watch Various Thermal ablation (RFA, MicroW, Cryo), atherectomy, difficult arterial re-entry, venous thrombolysis and thrombectomy cases. "

practice that has recently performed 2 pEVAR cases in our suite with controlled sedation. One day we hope to provide EVT lead by Dr. Christ Guest.

7. What are the future plans for your practice and how do you see yourselves evolving?

The future of VIR is to provide a full clinical package to best serve people. Embracing our inherent clinical status only adds power to each Radiology group in Canada, and should be supported by our general partners. As increasing turf issues and financial and bureaucratic strain arise, they will be met with our robust clinical specialty that puts patients first. In the near future, I hope to see VIR Radiologists supporting CAIR, becoming more politically involved, educating administrators, program developers and politicians to strengthen our specialty and ultimately provide the least morbid, out-patient care for patients. At our site, we hope to provide acute EVT stroke care, continue with pEVAR and Carotid stenting cases.

Drew Schemmer, MD

Hot Off the Press : ICEfx System in Review

Cryoablative therapies are evolving into first-line treatment strategies for a wide variety of conditions from oncologic applications to vascular malformations. We connected with Ryanne Kosick from BTG—Boston Scientific, to discuss the newly approved ICEfx cryoablation system.

1. Could you enumerate the indications the ICEfx system has been approved for?

Cryoablation is an established, proven therapy and the Visual ICE™ system is a well-established, leading technology in kidney cryoablation. Visual ICE™ is indicated for use as a cryosurgical tool in the fields of general surgery, dermatology, neurology (including cryoanalgesia), thoracic surgery (except for cardiac tissue), ENT, gynecology, oncology, proctology and urology.

2. Could you highlight some relevant data and evidence available for the ICEfx system in different disease conditions?

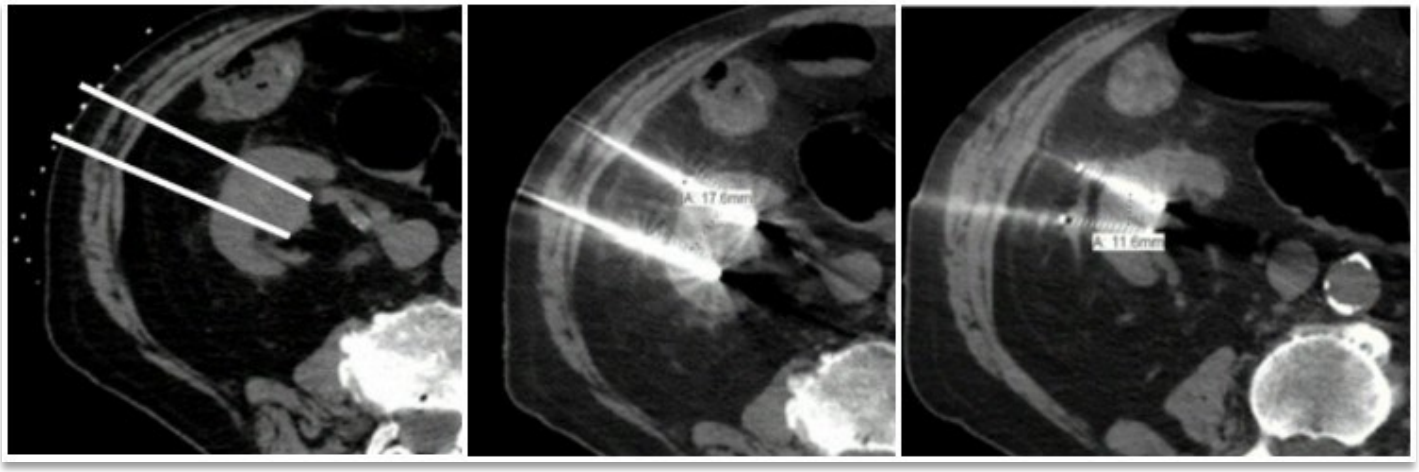
Cryoablation is a proven and established therapy for patients with certain types of cancer. For example, the Canadian Urology Guidelines list cryoablation as an option to treat selected patients with small renal mass, usually patients with clinical T1a RCC (renal cell carcinoma). Oncologic outcomes of image-guided renal cryoablation for RCC are competitive with those of partial nephrectomy and are associated with a low complication rate. Other advantages include shorter hospital stays and a faster recovery time.

Cryoablation and cryoanalgesia are indicated in a variety of diseases:

<u>Renal Cell Carcinoma (RCC)</u>

* Comparable outcomes to partial nephrectomy with less complications and decreased hospital stay [Thompson et al, Breen et al].
* Cryoablation results in fewer retreatments, improved local tumour control and may be associated with a higher rate of Metastases-free survival compared to RFA [Thompson et al, Kunkle et al]

<u>Prostate cancer</u>



* Preservation of erectile function and decreased rates of incontinence and fistulas compared to prostatectomy and brachytherapy [Woodrum et al, Shah et al]

Lung cancer

* Comparable outcomes to lobectomy with increased parenchyma sparing and preservation of lung function [de Baere et al, Moore et al]

Breast cancer and breast fibroadenomas

* Preservation of tissue structure and reduced scarring compared to surgical excision [Littrup et al, Sheth et al]

Musculoskeletal tumours and cryoanalgesia (desmoid, osteoid osteoma, venous malformations, Morton's neuroma, pudendal neuralgia)

* Local tumour control, significantly decreased pain and with low rate of complications [Kurup et al, Kujak et al, Coupal et al]

3. How is ICEFx different from other cryoablation systems?

The launch of the ICEfx™ Cryoablation System builds on our current platform, Visual ICE™, which is the market leader in Cryoablation. The ICEfx™ system offers the same powerful freezing performance as the larger Visual ICE™ system. It is a more compact unit (44lbs vs 220lbs), has an intuitive user interface, is an easy to use system that can be used in indications that require 8 needles or less.

Both the Visual-ICE™ and ICEfx™ systems offer:

- Flexibility of needle options to tailor treatment
- Precise control allows sculpting of the optimal ablation zone
- Progressive cryoablation software platform simplifies procedure

Both devices also employ helium-free thawing, a difference to some other cryoablation systems, allowing for accelerated thaw-time, reduced logistic demands and eliminating the cost of helium. The device also has a proprietary cautery function that allows for the needle to cauterise the needle track.

4. Are there any specific technical considerations while using the ICEfx system?

We're always learning from the physicians who use our products and we've taken advantage of those insights to create a new platform that is extremely usable by physicians and their supporting staff. While, the principal of the technology has been around for a while, we were able to leverage modern components and design philosophy to make the technology more robust and easier to manage.

5. What are common problems IRs face while starting to utilize this technology?

Canadian customers we've spoken to see real value in the ease of use and other improvements we've made. They see the potential for this device to improve how they conduct procedures.

6. What is in the pipeline in the evolution of this technology and where do you see the utilization of cryoablation headed?

We have previously announced the development of a new microwave heat ablation system, which we anticipate will continue to be developed. It's too soon to reveal any further detail about that.

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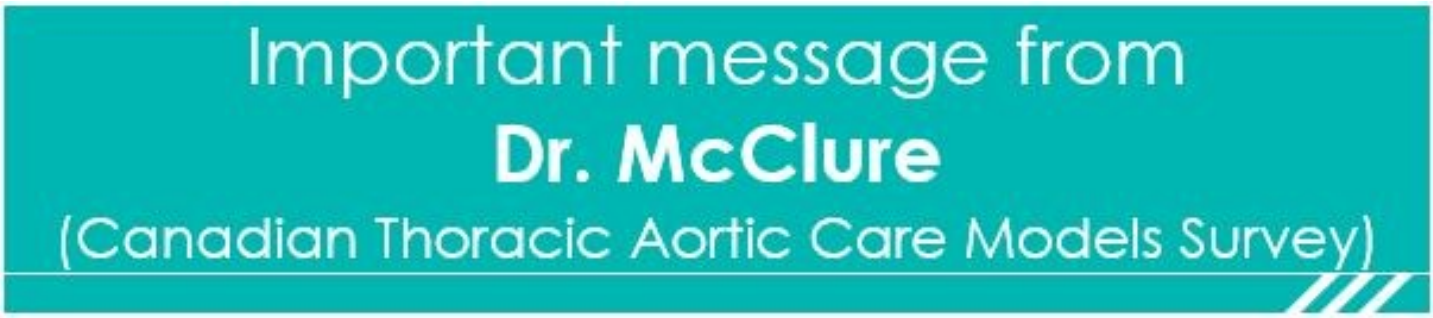
Latest news: Survey for Physicians

You may click this image only to answer the survey.

For physicians only.



RE: Nationwide Survey – Contemporary Care Models for Thoracic Aortic Disease

Dear colleagues in Cardiac Surgery, Cardiology, Interventional Radiology, and Vascular Surgery:

This email is a request for your participation in a nationwide multidisciplinary survey to define contemporary care models to treat thoracic aortic disease in Canada. We are requesting that you complete this online survey to characterize **how you AND your institution** deal with thoracic aortic disease.

If you have no involvement in the management of the thoracic aorta, the survey will take less than 3 minutes (8 questions). If you are actively involved in thoracic aortic care, the survey is 20 minutes with 32 – 39 questions, depending on your specialty.

Regardless of your involvement with thoracic aortic care, your participation in this survey is of equal importance. Please participate even if you never deal with thoracic aortic disease. Participation is voluntary. Responses remain 100% anonymous.

The survey can be accessed by the following link:

https://www.research.net/r/Canadian_Thoracic_Aortic_Survey

Upcoming Event : REGISTRATION OPEN!

GUEST SPEAKER

DANIEL Y. SZE, MD, PHD

PROFESSOR, INTERVENTIONAL RADIOLOGY

STANFORD UNIVERSITY MEDICAL CENTER

Dr. Sze is a Professor of Interventional Radiology at Stanford University. He double-majored in biochemistry and studio arts and design at Harvard University. After working as a graphic designer and medical illustrator, he went on to complete an MD and PhD in Biophysics at Stanford, internship at California Pacific Medical Center, and residency and chief residency in Radiology at UCSF. He returned to Stanford for fellowship in Interventional Radiology and joined the faculty in 1997. His clinical and research interests include image-guided treatment of cancers using oncolytic viruses, radioembolization, chemoembolization, and immunotherapy. Other interests include management of portal hypertension and cirrhosis, and treatment of aortic disease and venous thromboembolic disease. He received the Becker Young Investigator Award from the Society of Interventional Radiology in 2002. He has authored over 400 papers, books, and abstracts, and has been an investigator in over 60 clinical trials. He has helped to train over 80 fellows, nearly half of whom have pursued academic careers. He serves as an advisory board member or consultant to a multitude of device and pharmaceutical companies, including start-ups in his neighborhood of Silicon Valley.

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