EDITORIAL

How to better valorise interventional radiology (IR)

While the number of interventional radiology (IR) procedures increases every year, regardless of the guiding method (X-rays, ultrasound, CT scan, MRI) and the fact that these activities are an important attractive factor towards our specialty for medical students from the national placement examination, IR is still faced with a lack of valorisation despite its innovative and mini-invasive character that allows a significant reduction in hospital stays, and allows to offer, regardless of our method of exercise, to all of our patients throughout the country, a range of homogeneous and quality treatments.

The significant loss of technical lump sums that the establishment could have received for activities carried out under CT scan or MRI, the absence of reimbursement of costly sterile medical devices (SMD) for complex procedures such as microcatheters in embolisation or cryotherapy and radiofrequency needles for percutaneous tumour destruction and the absence of pricing for procedures proposed regularly in oncology multidisciplinary collaboration meetings (DTP) are a few situations that are emblematic of our difficulties.

IR procedures are very diverse, covering all the organ specialties of radiology, and this multiplicity of procedures results in a lack of readability by the authorities. The classification featuring IR procedures on three levels is based on the nature of the procedures and the necessary infrastructure as well as on the territorial and regional organisation of IR centres proposed in the “Interventional Techniques guided by Imaging” section of the Regional Health Plan—Regional Diagram for Health Organisation (PRS-SROS) in each regional health agency (RHA), is a step that is absolutely necessary.

The certification of radiologists practicing level 2 and three IR, validated by a College from the radiology specialty and the accreditation of the centres based on criteria that include those defined in the interventional radiology activity decree would make definitive recognition of our practices possible. This organisation can appear restrictive at first glance, but the various prerequisites are already met in almost all of the centres that carry out level 2 and 3 IR:

- initial training of radiologists allowing for expertise in imaging and radio-protection, expertise in percutaneous guiding in endovascular navigation and clinical expertise for the evaluation and diagnostic and therapeutic treatment of patients;
- additional training via the obtaining of a diagnostic and interventional imaging inter-university diploma (DIU) in most of the organ specialties;
- practical internship (during the diploma of specialized studies and the assistance period in radiology) in departments with IR expertise;
- organisation of our interventional radiology rooms as per the regulatory constraints of a surgical room;
- diversified technical imaging platforms with CT scan machines and possibly MRI machines accessible 24/7;
- quality process that meets the regulatory obligations.
The two major changes that must be associated are the declaration of activities in a national database (EPIFRI, which is being validated by the National commission for computer files and liberties [CNIL], could be our reference tool) and, for level 3 procedures, the organisation at the territorial and if necessary regional level of treatment permanence in healthcare establishments (PDSES). This organisation would make it possible for young radiologists trained in interventional radiology to join technical platforms that are already structured.

At the same time, French radiology must, via the intermediary of a task force centred on valorisation, propose to the CNAMTS (National health insurance fund) of the new homogeneous hospital stay group (GHS) specific to our "heavy" procedures of percutaneous IR, prioritizing the qualitative aspect and innovation, taking into account the area being explored, the condition of the patient, the treatment modalities by an IR technique, the monitoring and the duration of hospitalization, and if necessary, the combination with an additional procedure based on the recent guide of interventional radiology practices by the French Radiology Society (SFR). The potential savings related to the replacement of other therapeutic procedures will be an essential aspect of the argument, as well as the therapeutic benefit, of course. This work axis, in combination with a certification of interventional radiologists and an accreditation of the structures in which they work, should make it possible to ensure recognition of our activities of radiology physicians bringing together the diagnosis, the decision, the collaboration, the therapeutic procedure and the monitoring of the patient with a suitable valorisation.

Disclosure of interest

The author declares that he has no conflicts of interest concerning this article.

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