We ensure referrals by providing excellent service and being responsive to incoming requests.
Gaining the confidence of colleagues initially meant being available to do emergency procedures, and going the extra mile to help with such cases as postpartum haemorrhages. So they understood that we weren't interested in stealing from their practice, but in adding to it. We have excellent collaboration with our colleagues in other departments. Optimally we will create a formal collaboration, if not already done, to ensure a lasting good working relationship. We also have joint rounds with our vascular surgeons and other colleagues, which help us all communicate better.

To spread awareness, I also spoke to a woman's physician group. Among women in the age group who seek treatment for infertility or fibroid embolisation, the most trusted source is still their family physician, who is overwhelmingly a female primary care physician. And so speaking to the woman's physician group was probably the most cost-effective thing that I did to spread the word and raise interest.
***Dr. Lindsay Machan**, University of British Columbia Hospital Vancouver/Canada*

Worldview

To collaborate, or not to collaborate – that was never the question…

Leading interventional radiologists told IQ how and why they joined forces with their colleagues from other disciplines, and the advantages this approach has on the patients.

Refer to page 16 for more insights from the experts.

***Prof. Ricardo Garcia-Monaco,** Hospital Italiano, University of Buenos Aires, Buenos Aires/Argentina*
Nowadays in my hospital if a patient asks their gynaecologist, 'is there any alternative to hysterectomy?' The response is usually, 'yes – interventional radiology.'
I performed my first cases in 2000 via self-referral, and when I had treated around 50 patients, I approached our gynaecologists with the results. They were so impressed that they started supporting IR. To show I intended on working with, rather than against gynaecologists, I assured them that I would not treat a patient until they had seen her, and that all my patients would be hospitalised in the gynaecology ward. So little by little we built up trust and a good relationship. The treatment of symptomatic fibroids in Argentina is covered by social security. However, both awareness and supply still need to be improved – there are very few groups in Argentina that are experienced in performing embolisation. So the main goals of our educational activities are to ensure eligible patients are referred to a reputable clinic, as well as broadening the network of practitioners to cater for those outside the biggest cities.

***Dr. Paul Lohle**, St. Elisabeth Hospital, Tilburg/Netherlands*
There is a very close collaboration between radiologists and gynaecologists in our hospital, which is the reason we are so well known.
Our hospital administration is very supportive. Nursing care is provided in collaboration with the gynaecology ward and it works well. I check patients on the gynaecology ward before and after the embolisation procedure, and they come to our department to do a check-up MRI. We are by far the largest of around 10 hospitals that offer fibroid embolisation in Holland – we do more than 200 cases a year, with the next largest hospital doing 20 to 30. So that's not enough, I still think there are a lot of hysterectomies performed unnecessarily.
Currently a Dutch think-tank of radiologists and gynaecologists meets on a regular basis to draw up guidelines that will offer all women with bleeding problems the best type of treatment – in which interventional radiology undoubtedly plays a significant role.

I only treat patients who have also consulted with my colleagues in gynaecology.

We enjoy very good cooperation with the Obstetrics and Gynaecology department. We always help them with emergency cases of postpartum haemorrhage or uterine bleeding, day or night, and so they welcome us as allies. They know we are both available and able to help, as we succeed in helping the patient in 90% of cases, and our gynaecologists are keen to preserve the uterus wherever possible.

I believe it's better to share the patients. They should always come first, and for uterus problems, the gynaecologist is the main doctor, who can then decide on the best treatment, which may ultimately be provided by us. We're lucky to have a system that allows this cooperation. I don't have to think in terms of 'my' patient – they are *our* patients that need *our* help.

***Dr. Keigo Osuga**, Osaka University Graduate School of Medicine, Osaka/Japan*

***Dr. Adel Ahmed,** Kuwait University Faculty of Medicine Nuzha/Kuwait*

Our hospital administration recognises that we can reduce costs by performing many procedures on an outpatient basis, and is supportive of our work.

IR in the field of gynaecology is well established in Kuwait. We have been performing uterine fibroid embolisation since 1997 with a high success rate, and have circumvented surgery in more than 800 Obstetrics and Gynaecology patients in the last 10 years. We have 9 dedicated interventional radiology nurses and radiology technologists, as well as a dedicated anaesthetist to assist with all patients. Regular interdepartmental meetings help us communicate well with our surgical and medical colleagues. Most gynaecologists are aware of this service. However, many of our patients are not aware of the exact meaning and role of the interventional radiologist. We need to educate the public in Kuwait and the Middle East generally regarding the vital role of IR in modern medical practice.

***Dr. Donald Robertson,** Geelong Hospital Geelong/Australia*

Gynaecologists who are positively disposed to UFE see it as an adjunct to their suite of offerings for symptomatic fibroids, and they don't see it as competitive.

Women are becoming much more aware of their own bodies and their right to ask for what they want. I supported this by raising awareness of the minimally invasive options available to women in the local press. Frequently these women will then take that information to their GP and request a referral to a gynaecologist, and then take that same information to their gynaecologist and ask for a referral to an IR. So it's driven by the patients.

A gentle option such as uterine artery embolisation may encourage women to seek medical advice, even if it results in another procedure. After a 6- and 12-month follow-up, I usually don't see the patient anymore, and they go back to their gynaecologist, who will send me updates. So I think there's a real role for that collaborative side.