# The Top 10 Things I Learned on Clinical Interventional Radiology Rounds

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At the end of their fellowship, I asked my fellows to give me the Top 10 things they learned while rounding on patients this year. I'd like to share these with you.

—Brian Funaki, *Editor in Chief*

1. *Ambiguity in responsibility*. Our (interventional radiology's) consult to the clinical service should be unambiguous. The few instances of mismanagement I can recall occurred when an issue fell between the cracks because services were unclear who was managing the issue. We manage our own catheters far better than any clinical service can and need to do so to avoid problems. Services need to understand to contact us if they want to manipulate catheters.
2. *Communication after procedures*. Chronically ill and/or recently sedated patients are often fairly confused, and I'm not sure how many of the postprocedural instructions given to patients are understood. Several of the inpatients on the floor and even outpatients I had the chance to speak with on the phone to their homes had a poor concept of what was done and why. Patient sophistication is variable. Frankly, any detailed postprocedural discussion should be performed after the patient has fully recovered, not immediately after the procedure. Rounding is a perfect time to accomplish this task. Additionally, including discharge instructions in the transcribed report and improving either nursing/fellow instruction in the postprocedural area and performing follow-up phone calls to patients greatly improve patient satisfaction and communication.
3. *Follow-up imaging*. Short lesson . . . following the postprocedural computed tomographies of patients in whom drains were placed greatly expedites a return appointment for removing the drain, upsizing, or repositioning. Falling tube output was sometimes assumed to be the resolution of the problem by the service even in the face of continued symptoms (i.e., fever, pain). We are unique compared with other clinical services because we have a facile understanding of the role of imaging in management. We look good when we can discuss the imaging with the clinical service on the floor. Our recommendations on further imaging (what kind and when) can be discussed with an interventional radiologist attending prior to rounding on the patient. This can be noted in the chart, saving time (i.e., skips the step of discussing with the interventional radiologist attending after seeing the patient and then having to again contact the clinical service).
4. *Unhappy patients*. Rounding on dissatisfied or surly patients could take the edge off a difficult procedure. Rounding for the sheer sake of postprocedural communication and a hello to the patient I think has inherent worth and might decrease patient grievances about not being heard. It gives them the opportunity to vent frustrations and ask pointed questions. This in turn can sometimes preclude later discussions with attorneys.
5. *Raising the profile of vascular and interventional radiology*. Not that we need additional business currently given our case load, but rounding increases the visibility of the interventional radiology staff. This invariably leads to more business for the section. On countless occasions, physicians who we encounter on the floor would refer additional patients.

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6. *Conspicuity of chart notes*. Colored stickers make our notes visible in a sea of black ink. Dedicated, color-coded "consult" sheets are also helpful. Notes that are merely written in black ink tend to get swallowed in the chart between everything else.
7. *Communication with primary service*. Rounding in conjunction with a call to the service *greatly* improves communication, meaning not just a chart note but a page, too. Even a text page! Writing interventional radiology notes in the chart doesn't guarantee communication with the clinical services. They may or may not read them. If a recommendation needs to really be pushed, paging the service and direct discussion can save a lot of time.
8. *Documentation and follow-up*. Rounding improves our charting of risk occurrences, such as line infections. Knowledge of these events that is as detailed as that of an irritated clinical service increases our ability to assess our own practices and argue *against* unfair assertions about our participation in care should they arise. Rounding also ensures that our interventional radiology orders are followed (e.g., gastrostomy tube orders in regards to the timing of feeding). Occasionally, orders are disregarded or missed. This can lead to serious complications.
9. *Early recognition of problems*. Rounding picks up a few instances of catheters that need repositioning or other unrecognized problems. Few services would have the ability to recognize and manipulate poorly positioned tubes. Intervention can be done while still early in the day instead of getting the 5 P.M. "emergent add-on tube check." Sometimes when a drainage catheter has stopped draining, a quick saline flush on the floor can save the patient and interventional radiology staff from late-day procedures. Carrying basic supplies can save a lot of time on the floors if maintenance is needed (i.e., gauze, tape, suture, saline flushes, needle driver, and so on).
10. *Follow-up*. Rounding fosters not only the reality but also the impression of follow-up on our part. This defuses the possible primary clinical service's notion that we're in the patient's pathway of care only for the procedure's duration. It also, by extension, changes the viewpoint of radiology from a nonclinical specialty into a clinically oriented and relevant one.