The interventional radiologist is armed with unparalleled percutaneous access to pain generators in the body. Integration of that skill set, sophisticated ablative technologies, and advanced image-guidance techniques to the management of pain has resulted in a distinct service line under the heading “Advanced Interventional Pain Management.”

The interventional radiologist provides a set of unique procedures defined by the use of advanced imaging guidance and/or ablation technology that can be broadly divided into groups of patients who present with cancer-related pain (subsequently subdivided to those lesions that involve the spine and those that do not) and noncancer-related pain (subsequently subdivided to those generators that involve the spine and those that do not).1

This issue of Techniques has been similarly organized, and guest expert authors invited to describe procedures that fall broadly into each of these four subdivisions. The approaches and techniques described in each article are often unique to interventional radiology (computed tomography-guided cryoablations, vertebral body radiofrequency ablations, etc) but may also represent procedures that can be performed outside of radiology (genicular nerve ablations, epidural injections, etc). Managing the nuances of practice growth and sustainability require operator balance of these procedures in order to offer a full-service practice to every patient if necessary, while simultaneously co-existing and collaborating with our colleagues in anesthesia, physical medicine and rehabilitation, and palliative care.

Superimposed on the evolution described above has been a worldwide opioid crisis, which has translated to millions of patients seeking and/or requiring procedural treatment alternatives.2 At the same time, healthcare costs and the burden of fiscal responsibility on healthcare providers has reached a critical point, resulting in an additional independent force supporting procedures that impact pain in lieu of long, expensive hospital stays.3 Finally, during unprecedented times our institutions faced a global viral pandemic that threatened to exceed hospital bed capacities, a situation which served as yet another source of appeal to proceduralists who may be able to shorten length of stay in order to maintain bed availability.

Despite our clear positioning related to these variables, the primary challenge that remains for interventional radiologists who hope to manage appropriate patients in pain, impact healthcare costs, and/or innovate and problem solve in this space remains our ability to market services. There are challenging clinical scenarios into which our procedures fit as collaborative solutions (the patient admitted for painful metastatic disease in the spine with associated fracture and pain, for example). It remains our outstanding task to inform our clinical colleagues of the evidence supporting these procedures, the role of interventional radiology in multidisciplinary pain management, and the availability of comprehensive clinical care services.

This issue embodies articles written by world experts and pioneers in advanced interventional pain, describing patient selection, procedural technique, peri-procedural care, reimbursement mechanisms, and current outcome evidence for long-standing procedures and current innovations. Translating these themes to individual mothers, fathers, brothers, sisters, and friends who have been patients in pain has been the greatest gift of my professional life. I want to personally thank these authors, the editors of Techniques in Vascular and Interventional Radiology, and all who have spent time caring for patients, innovating, and working to bring advanced interventional pain techniques to the front lines of patient care.

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