Diagnostic Radiology Resident IR Call Coverage

Reference Guide

General Workflow for All Requests

IT IS ALWAYS OK TO CALL THE ON-CALL IR ATTENDING IF:

- **YOU CANNOT FIND AN ANSWER IN THIS DOCUMENT**
- **YOU GET PUSHBACK FROM THE REFERRING SERVICE**
- **YOU ARE UNSURE HOW TO PROCEED**
- **YOU ARE NOT COMFORTABLE WITH THE CASE REQUEST**

1. Obtain thorough history and clarify *specifically* what procedure is requested.
    a. Patient name and MRN.
    b. What is the urgency? Does the service think it can wait until the morning?
    c. Which service is managing?
    d. Who is the person to contact and their pager/cell/Voalte number?
2. Review relevant imaging and labs.
    a. For anticoagulation/antiplatelet questions, defer to SIR Guidelines app
3. Ensure correct IR order is placed by the service
    a. Service can also place appropriate specimen orders when applicable (LP, abscess drain, chest tube, etc)
4. Verify anesthesia or sedation plan
    a. If urgent/emergent case is requested and patient is not NPO-appropriate (see below), have referring service confirm if anesthesia is willing to take the patient emergently.
        i. If YES – call IR attending immediately
        ii. If NO – OK to call IR attending 1 hour prior to anticipated case start time based on NPO status after discussion with anesthesia coordinator
        iii. If UNSURE – **ALWAYS** OK to call IR attending to discuss the case
5. Ensure that appropriate NPO status is in place.
    a. Clears – 1 hour
    b. Breastmilk – 4 hours
    c. Infant formula – 6 hours
    d. Solids, tube feeds – 8 hours
6. Clarify consenting party
    a. Does the parent/guardian need to be called for consent or are they available at bedside?
    b. Does that person speak English or is a translator needed?
7. Communicate appropriate emergent/urgent overnight cases to the ***correct*** attending on-call
    a. For all neurointerventional cases -> page neuro IR
    b. For all body interventional cases -> page body IR
8. For all non-urgent/routine cases and "FYI" pages, e-mail detailed report to on-call attending by 7am.

Body IR Case Specific Guidance

1. GJ malfunction/dislodgement
    a. For all GJ related concerns, follow the GJ Tube Decision Tree.
2. PICC, Tunneled/Non-tunneled central venous catheters
    a. Placement
        i. Assess for emergent/urgent reason for request (eg. critically ill with insufficient access, dialysis)
        ii. Does the patient have evidence of an active infection (fever, leukocytosis)?
            1. Need negative blood cultures x 48 hours prior to central catheter placement
        iii. Does that patient have CKD?
            1. Tunneled CVC preferred over PICC
    b. Malfunctioning Catheter/Request for Exchange

i. Who placed the line?
    1. If malfunctioning line is surgically placed, refer service to pediatric surgery for further management.

ii. If catheter tip is malpositioned:
    1. If line is "too deep" on CXR
        a. VAT can retract and re-secure line, so it can be used until IR is available for non-emergent line exchange (or further discussion).
        b. Also OK to leave in place and continue using if not causing ectopy/arrhythmia.
    2. If line is flipped into contralateral brachiocephalic vein or ipsilateral jugular vein
        a. Have they tried power flushing? Call VAT if not.
        b. If power flush fails, but line is working, OK to continue using until IR is available for non-emergent exchange. There is some risk of thrombosis/phlebitis associated with using a line positioned in the IJV, so there should be a discussion with the referring service.
        c. "Flipped" lines will often spontaneously return to appropriate position within 24 hours, so NPO after midnight with repeat morning CXR may be appropriate.

iii. If catheter is occluded:
    1. Have they tried tPA?

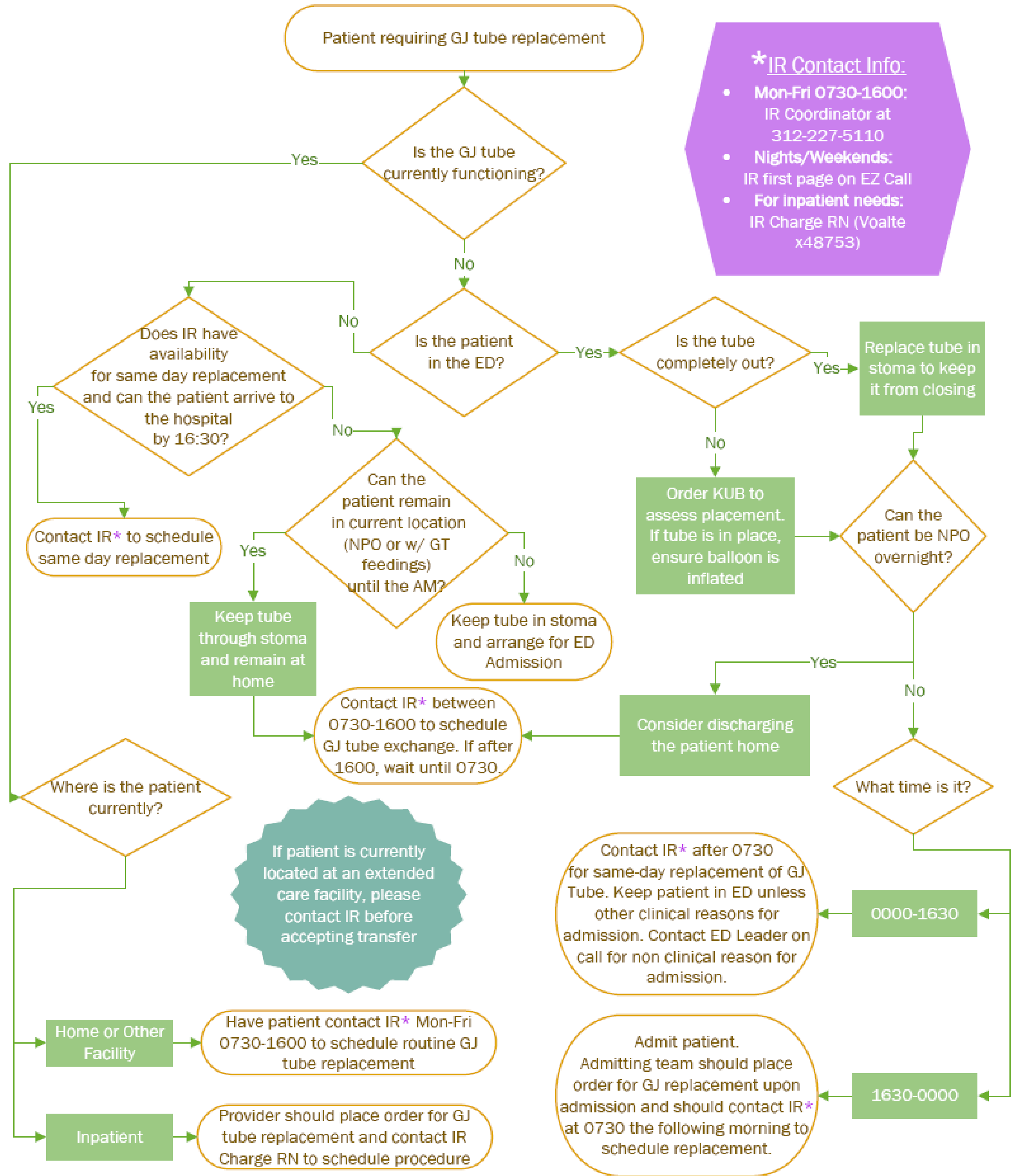
c. No line removals will be performed overnight.
    i. Weekend removals will be on a case-by-case basis, but can be discussed during normal business hours.

d.

3. Arterial Line Requests
    a. Ensure that the ICU and/or anesthesia has attempted first prior to paging IR
4. Chest Tube
    a. Are there clinical signs of tension pneumothorax or tension phenomenon with large pleural effusion?
        i. If so, emergent surgical or ICU chest tube may be more appropriate
    b. If patient is stable, this procedure can usually wait until the following day
        i. Patient should be made NPO in anticipation of next-day procedure
5. Abscess Drain
    a. Assess for sepsis or hemodynamic instability
        i. Majority of requests can wait until the next day
            1. Patient should be made NPO in anticipation of next-day procedure
6. Lumbar Puncture
    a. We usually ask that a "capable provider" (ED, ICU, Neurology) attempt LP first
    b. Infant
        i. US guided, typically done by body IR
        ii. Majority can wait until the next day
        iii. Usually do NOT require anesthesia
        iv. If patient has had prior attempts on the floor/ICU, it may be helpful to obtain spine US to assess for epidural/intrathecal hematoma and presence of adequate CSF volume
        v. Patient should be well-hydrated
    c. Child
        i. Usually fluoro guided, may be done by neuro IR or body IR
        ii. Majority can wait until next day
        iii. Determine whether patient needs anesthesia/sedation, or local anesthetic only
            1. If anesthesia/sedation is necessary, patient should be made NPO in anticipation of next-day procedure
7. Nephrostomy tube placement
    a. Assess for an emergent/urgent reason for placement (sepsis, acute renal failure)
    b. If outpatient PCN patient presents to ER with dislodgement, IR should ideally replace within 6 hours. Page IR attending to discuss.
8. Trauma
    a. Is there active extravasation on CTA? If so, where?
    b. Is the patient hemodynamically unstable?

c. How many units of pRBCs has the patient received?
d. Has pediatric surgery been consulted? If so, are they recommending an IR consult/procedure?
    i. Endovascular evaluation +/- intervention is *often* not indicated in pediatric trauma even if there is active extravasation identified on CTA, particularly in hemodynamically stable patients

Gastrojejunostomy (GJ) Tube Decision Tree



IR team to do all GJ replacements within 24hrs. There is same day availability if the patient is able to be in IR between 0730-1630.

To see which Interventional Radiologist is on call, please refer to the Enterprise on-call schedule: Enterprise On Call Schedule - EZCall

Body IR Attending Contact Information
Shankar Rajeswaran – P: 70125
Jebb Baker – P: 73602, C: (505) 715-7477
Darshan Variyam – P: 97360
Joseph Ness – P: 96159

Neuro IR Attending Pager Contact Information
Ali Shaibani – P: 53711
Ramez Abdalla – P: 74251
Donald Cantrell – P: 96151
Sameer Ansari – P: 96153