

OBL CORNER

Performing Embolization in the Office-Based Lab

An Interview With Christoph A. Binkert, MD, FSIR

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May 2025

ISSN 2152-4343

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VASCULAR DISEASE MANAGEMENT. 2025;22(5):E43-E44

At the 2025 SIR Annual Scientific Meeting in Nashville, Tennessee, *Vascular Disease Management* spoke with interventional radiologist Christoph A. Binkert, MD, FSIR, from Medizinisch Radiologisches Institut in Zurich, Switzerland, to discuss his presentation entitled “Embolization in the OBL.” Dr Binkert discussed why the office-based lab (OBL) is a good setting for embolization and the role of interventional radiology (IR) in the procedure.

What are the key advantages and potential challenges of performing embolization in an OBL compared to a hospital setting?

The big advantage of an OBL for the patient is the dedicated setup. I worked for many years in a hospital, and of course you can perform outpatient embolization in a hospital as well, but a hospital is geared toward severely injured patients who are usually comorbid, and there are emergencies coming in between. In the OBL, you can plan the procedure, and for embolotherapy in particular the vascular access is small, which requires only short recovery times of 2 to maximum 4 hours and then they can go home. The advantage of most embolization therapies is that there's not much pain afterwards. After prostate, hemorrhoid, or genicular artery embolization, there is only minimal pain after the procedure. The patient comes to you in a very scheduled setting, and the environment is geared to that particular patient population, including a short stay afterwards.

We have seen significant innovation in embolic agents over the last few years. From your perspective what has changed in terms of the tools we have and how is that changing the way you approach cases?

The embolic field is evolving, has evolved, and I am sure it will further evolve over the next few years. I think the main innovation, especially in musculoskeletal embolization, is the use of temporary agents, which helps to make this a very safe procedure. There are hardly any complications, and that helps a lot. The reabsorbable embolics are important. Another embolic that has really developed are the liquid embolics. Glue is becoming more and more popular. One advantage is that you can change the time to polymerization by adding more or less Lipiodol to make sure the penetration is as you want it.

Embolization has traditionally been the domain of IR, but we're seeing more overlap with other specialties. How do you see collaboration evolving across IR, vascular surgery, and interventional cardiology?

I see some overlapping of peripheral arterial disease (PAD) treatments. However, I really believe that embolotherapy is the core of IR because it is different, and compared to other cardiovascular diseases that cardiologists work with, the prostate has nothing to do with the heart or with vessels, so I think embolotherapy is really an IR procedure. It takes a lot of specific experience, so I don't see that much overlap; of course there are always some special settings, but in the big picture I think embolotherapy is an IR procedure. The same is true for cardiac intervention, which is mainly cardiology and open surgery, which is nearly exclusively vascular surgery. There are always some exceptions, but I think that in large majority embolotherapy is well placed in IR.

Is there anything else you wanted to add?

OBLs are quite common in the US; I started one in Switzerland where OBL aren't common at all as in the rest of Europe. I think OBLs are an interesting setup of interventional therapies and I hope the model of OBLs will become more common in Europe in the near future. ■