

Conclusions: Significant improvement in physical and mental health related quality of life was observed in patients suffering from hepatocellular carcinoma undergoing TACE.

OC 2.4

Five-year Experience of Percutaneous Cryoablation of Symptomatic Venous Vascular Malformations as Second-Line Therapeutic Option

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Background: To report the mid-term outcomes of percutaneous cryoablation (PCA) performed as second-line therapeutic option of venous vascular malformations (VVM). **Methods:** From 2011 to 2015, PCA was offered in 24 patients (mean age: 31 years, range: 12-64) as second-line treatment for recurrences of symptoms after sclerotherapy and when resection was not possible (due to lesion location or previous failure) or refused by the patient. Adverse effects were recorded, disease-free survival (DFS) and local tissue control (LTC) rates were calculated based on symptoms and volume evolution. **Results:** Mean follow-up was 18.7 months (6-48). Nine (37.5%, 9/24) adverse effects occurred but only three (12.5%, 3/24) were severe. Mean pain assessed by visual analogic scale (VAS) was 41.7 mm (0-80) before treatment and 20.3 mm (0-80) ($P = 0.01$) after. Mean volume decreased significantly after treatment from 22.4 cm³ (0.9-146) to 8.35 cm³ (0-81.3) ($P < 0.001$). Pain recurred in nine patients and size of one lesion increased. The DFS and LTC rates were 54% [95% CI: 22.94-77.27] and 93.33% [61.26-99.03] at 24 months, respectively. Only VVM volume >10 cm³ was associated with a higher risk of local recurrence ($P = 0.05$). **Conclusions:** PCA as second-line treatment appears to be safe and effective for local control of VVM according to mid-term results.

OC 2.5

Bedside Intravascular Ultrasound-guided Inferior Vena Cava Filter Placement in Critically-Ill Patients

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Background: Pulmonary Embolism (PE) is a potentially life-threatening complication of critical illness. Prophylactic inferior vena cava filter (IVC) placement offers a protection rate of 99% against fatal PE. **Methods:** Bedside IVC filter insertion guided by IVUS in 37 consecutive critically-ill patients. All patients had clinical indications for IVC interruption; including prophylaxis in high risk patient in the absence of DVT or PE ($n = 27$). The other indication was that patients were suffering from PE and/or DVT with a contraindication to anticoagulation, or ineffective anticoagulation. Transportation to angiography suite was risky or not feasible. **Results:** 37 patients, 13 patients were female and 24 were male with age ranged from 18 to 80 years with an

average age of 44 years old. The filters were placed correctly in 35 of 37 patients (95%). filter was inserted at iliac vein in 2 patients that were retrieved and IVC filter was inserted guided by Fluoroscopy via transjugular approach. Placement timing was 5 days at average for surgical ICU patient compared to 17 days for medical ICU patients. infrarenal IVC diameter was 21.8 mm. There were no filter-related complications such as migration penetration or Filter-related thrombosis. There was no recorded incident of PE after IVC filter deployment. Only one filter was retrieved 20 days after placement. **Conclusions:** Bedside IVUS guided IVC filter placement for critically ill patient in the intensive care unit is a radiation free, contrast free and it is not limited by patient's obesity or recent abdominal surgeries or orthopedic hardware which could be limiting factor for trans abdominal duplex Doppler guided technique.

OC 2.6 (First place oral presentation prize winner)

Day Case Endovascular Aneurysm Repair – Our Experience after 250 Patients

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Background: With more than 1000 EVAR patients experience in our centre, the advancement of ultra-low profile EVAR devices and percutaneous access, discharging uncomplicated EVARs in less than 24 hours is becoming more common. **Methods:** Single centre retrospective analysis of prospectively gathered data on 250 consecutive elective day-case EVAR cases (dEVAR). Patients for dEVAR are selected following joint radiology, surgical and anaesthetic team meeting using UK day-case surgery and locally agreed guidance. Patients deemed suitable are put on a special dEVAR pathway to be admitted on day of surgery and discharged in less than 24 hours. **Results:** 220 patients were followed-up after dEVAR. 98% were successfully discharged in less than 24 hrs post-operatively. One patient (0.45%) with access vessel complications required additional procedures and had to be hospitalised for two days. One patients (0.45%) with non-cardiac chest pain was hospitalised for two days. Two patients (1%) failed to be discharged within 24 hours but no clear cause documented in the notes. None of the dEVAR patients had a re-admission to hospital within 30 days with no 30-day mortality. Cost comparison showed dEVAR led to reduced overall average cost when compared to standard EVAR from ≤13,705 (CI = ±685) to ≤ 9,330 (CI = ±735). **Conclusions:** dEVAR is not for every patient but can be performed safely under appropriate criteria. In this series morbidity was minimal with significant cost saving.

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Interventional Radiology: Giving Cosmetic Medicine a Makeover

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Background: The global cosmetic market has been on the rise with a recent surge in minimally invasive procedures. Cosmetic