

localization of 42 pulmonary nodules (mean size, 7.3 mm; range, 4-18 mm). A 7 cm platinum micro coil was inserted into pulmonary nodules under CT guidance using a 21-gauge chiba needle. The technical details, surgical and pathologic findings associated with micro coil localizations were retrospectively evaluated. **Result(s):** All nodules were localized by CT guided micro coil with 100% technical success with mean time 13.4 minutes (range 8- 26 minutes). 6 patients developed Mild parenchyma lung hemorrhage along with needle tract and 7 patient developed mild pneumothorax all are asymptomatic and no intervention needed. 3 patients developed moderate pneumothorax for which needle aspiration was performed but not chest tube was inserted. No other complication occurred. All micro coils were identified during the surgery except one which was dislodged and attached to chest wall (41 out of 42 micro coils) 97.6 % clinical success and all nodule were surgically resected. Pathology revealed 28 metastatic pulmonary nodules, 1 primary adenocarcinoma-in-situ and 13 benign pulmonary nodules. Micro coils did not affect the histopathology examination. **Conclusion(s):** CT-guided micro coil localization is an effective and safe pre-operative localization procedure prior to VATS, enabling accurate resection and diagnosis of pulmonary nodules.

OC2.11

Re-Establishing Patency of Occluded Metallic Biliary Stents by Endobiliary-Radiofrequency Ablation Technique

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Background: Biliary drainage with the use of metallic biliary stents (MBS) is a well-accepted palliative therapy for patients with unresectable malignant hilar obstruction. These stents often lose their patency over a period of 6-9 months secondary to tumor ingrowth or overgrowth, epithelial hyperplasia. Occlusion caused by sludge deposition or clot or stone formation. Limited treatment options are available for such a condition. Endobiliary radiofrequency ablation (RFA) has been shown to be an effective modality in the treatment of malignant biliary obstruction Here we present our experience with endobiliary RFA technique for restoring the patency of occluded MBS. **Method(s):** Patients were taken with previously placed MBS for malignant aetiology, presented with rising serum bilirubin and signs of cholangitis secondary to occlusion of MBS. Percutaneous trans-hepatic biliary drainage was achieved in all cases. After negotiating guide-wire across the stent, biliary drainage was established. After treating cholangitis, endobiliary-RFA was performed. Post-procedure cholangiogram was performed to ascertain the patency. Periodic clinical follow-up was scheduled for 6-months or till their survival. **Result(s):** The patients were followed up clinically and with USG to a minimum of 6 months or till their survival. The presence of pneumobilia on USG along with normal LFT were considered as the signs of stent patency. All patients showed restoration of patency on cholangiography examination performed on the following day of RFA (restored diameter 6-8 mm). The mean duration of stent patency after the first session of RFA was 3.9 months (range 2-7 months) which was comparable to the primary patency of these stents (4.8 months). This extended period of stent patency ensured administration of additional cycles of chemotherapy in these patients coupled with objective

improvement in the quality of life. **Conclusion(s):** Our experience suggests that endobiliary-RFA with balloon-sweep maneuver can be a safe and useful technique for re-establishing the patency of occluded MBS. Reopened stent with good short term patency offers medical oncologist a chance of administering additional chemotherapy which may improve patient's survival.

OC3.1

Road to Interventional Radiology: Introducing Interventional Radiology to the Global Community

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Background: According to the WHO four billion people around the world lack access to medical imaging, and even more lack access to Interventional Radiology (IR). We performed an assessment of the largest tertiary referral center and teaching hospital in Tanzania, a nation of over 50 million people. This demonstrated that there is currently not a single interventional radiologist in the entire nation, but all relevant imaging modalities, including Ultrasound, CT, and fluoroscopy, are available. **Method(s):** To address the acute shortage of IR in Tanzania, we started training Tanzanian Radiology residents in IR. Over the course of three years (2018-2021), 30 IR teams, each consisting of an IR faculty member, a nurse, and a technologist, travel to Tanzania in two-week blocks with the goal of training three Tanzanian residents per year to be fully competent in general IR and basic neurointerventional procedures. **Result(s):** During the initial two trips in October and November 2018, a total of 37 interventions were performed on 31 patients. Technical success was achieved in 30/31 initial procedures (97%). There were no major complications. Specifically, the following procedures were performed: 15 Core needle biopsies, 6 nephrostomy tube placements, 6 drain checks/internationalizations/exchanges, 4 biliary drain placements, 3 abscess drain placements, 2 cyst aspirations, and a cholecystostomy placement. All procedures were logged via Google forms and follow-up phone calls are performed at one and three months post-procedure. Preliminary follow-up data demonstrates that >90% of patients report no subsequent complications and are satisfied with the procedure and related care. **Conclusion(s):** This early experience demonstrates that IR practices can be established in the resource limited setting. There is potential for expansion of this program to other sites where IR can add great value, in many cases decreasing morbidity and improving patient satisfaction.

OC3.2

Percutaneous Obliteration of Urinary Leakage after Partial Nephrectomy Using Coils and N-butyl-cyanoacrylate

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