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Endovascular Management of Traumatic Thoracic Aorta Injury

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Background: Acute traumatic rupture of the descending thoracic aorta is a life-threatening situation. Endovascular technique offers a minimal invasive alternative compared to open surgical repair, thereby reducing morbidity and mortality. The aim of this study is to evaluate the early outcomes of patients undergoing thoracic endovascular aortic repair for blunt aortic isthmus injury. **Method(s):** Between January 2009 and October 2018, 52 patients with acute traumatic rupture of the descending thoracic aorta were treated with a stent-graft. Preoperative workup included body computed tomography scan for all patients. The endovascular management was selected because of associated polytrauma. The injuries were classified into categories (grades I-IV) based on severity: intimal tear, intramural hematoma, pseudo aneurysm, or rupture. **Result(s):** Ninety-two percent (23/2) of patients were male with mean age of 38.4 (range 16-78) years. Thoracic stent grafts were implanted within a median of 5 days following injury (range 01-15 days). Seventy-two percent of aortic injuries were grade III. Mean injury severity score was 29 (range 16-61). The left subclavian artery was completely covered in 70% of patients. One patients underwent staged procedure: left carotid artery and subclavian artery revascularization then endograft procedure ; due to a retrograde dissection involving the origin of the left carotid artery. The median procedure time was 50 minutes, and median hospital stay was 8.9 days. There was 100% successful device delivery and deployment. The postoperative course was uneventful, especially no upper limb ischemia or neurologic complication. No procedure-related deaths have occurred and no cardiac or peripheral vascular complications were observed within the 12 months (range 6-16 months) follow-up. Computed tomography at one month showed in one patient a complete coverage of the left carotid artery by the stent graft without any clinical consequence, and in one patient endoleak type 3. **Conclusion(s):** Thoracic endovascular aortic repair in treatment of blunt thoracic aortic injuries showed a good early outcome. It is considered the new gold standard treatment. Dealing with young patient represents the big challenge.

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Vena Cava Filter Deployment Prior to Percutaneous Endovenous Therapy for Proximal Lower Limb Deep Venous Thrombosis: Should we Routinely Practice?

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Background: Anticoagulant therapy remains the prevalent treatment for venous thromboembolism (VTE). In the new era of percutaneous endovenous intervention, there is a progressive raise in the use of percutaneous endoluminal clot dissolution techniques

as catheter directed thrombolysis (CDT) and mechanical aspiration thrombectomy (MAT) devices due to its established shortterm benefits. Prophylactic Deployment of inferior vena cava (IVC) filter during percutaneous endovenous therapy for lower extremities deep venous thrombosis (DVT) is still debatable issue. **Method(s):** Percutaneous endoluminal clot dissolution using either CDT or MAT for proximal lower extremity DVT was performed on 64 limbs in 58 patients of 148 patients diagnosed with proximal acute / subacute DVT in vascular surgery department of study hospitals. IVC filter was deployed in 31 patients prior or during the procedure. **Result(s):** From 58 patients were treated for proximal DVT with clot debulking procedures, IVC filter was prophylactically deployed in 30 patients (51.7%). Trapped thrombus in the deployed filters as revealed on venocavography was observed in 8/30 (26.7%) filters deployed prophylactically with overall rate of thrombus embolization during percutaneous endovenous thrombus dissolution techniques was 11/58 patients (18.9%). **Conclusion(s):** Catheter directed thrombolysis could be done safely and effectively without routine prophylactic IVC filter placement in treating acute DVT. Selective filter placement may be considered in patients undergoing mechanical thrombectomy or patients with more proximal thrombus pattern with multiple risk factors.

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Preoperative Embolization of Renal cell Carcinoma Femoral Mets with Pathological Fracture: Case Series

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Background: Renal cell carcinoma (RCC) accounts for 3% of all cancers, with peak incidence between 60 and 70 years of age. RCC is very aggressive tumour and almost 20-30% of patients have metastatic disease at time of presentation. Most common metastasis in RCC occurs to lung, followed by bone, lymph nodes, liver, adrenal gland and brain. Skeletal metastasis may present with pain, impending fractures, nerve compressions, hyperkalemia and even pathological fracture which may require surgical interventions. As RCC is normally a hypervascular tumor, seen in 65%–75% of patients that bleed profusely even after a simple biopsy. We present here two cases of Renal cell carcinoma metastasized to femur with pathological fractures and were pre-operatively embolized and then underwent operation fixation with minimal blood loss. **Method(s):** Angiography and embolization was done using state of art, digital subtraction angiography unit (Siemens artis zee floor mounted), under local anesthesia by a single interventional radiologist with experience of more than 10 years. Transfemoral route was used in both cases. Access was gained through 5-6 Fr catheter and combination of gelfoam particles and tornado coils were used for embolization. No immediate post operative complications observed. **Result(s):** At our institution, embolization of femoral metastasis showed high technical success and reduced intraoperative blood loss. **Conclusion(s):** At our institution, embolization of femoral metastasis showed high technical success and reduced