Article published online: 2021-05-11

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Uterine Artery Embolisation for Giant Fibroids: Does Size Matter?

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Background: Studies have suggested UAE in the case of giant fibroids (defined as fibroids ≥10 cm) increases post-procedural risk levels in comparison with smaller fibroids. The aim of this study is to determine the suitability of UAE in cases of giant fibroids and to assess the procedural outcomes and complications. **Method(s):** Retrospective data was collected for UAEs conducted over a five-year period at a tertiary centre. Patients with pre- and post-procedure MRI studies as well as giant fibroids were included. Alterations in the volume of the uterus and size of the dominant giant fibroid were calculated pre- and post-UAE. Post-UAE complications and surgical interventions were also documented. Patient satisfaction was assessed using the 40-point uterine fibroid symptom quality of life (UFS-QoL) questionnaire. **Result(s):** Between 2013-2018, 281 female patients underwent UAE. Of these, 24 (8.5%) patients were found to have giant fibroids (mean age 50.8±3.8 years; range: 40-55). The mean pre-UAE uterine volume was 1511.6±517.9 CC, while mean post-UAE uterine volume was 961.4±483.6 CC ($p<0.05$). The mean giant fibroid size pre-UAE was 13.5±2.6 cm, and post-UAE was 10.3±3.6 cm ($p<0.05$). 92% of fibroids were effectively devascularised. 16.7% of patients experienced post-UAE pelvic infection. 18.2% patients underwent further surgical intervention. **Conclusion(s):** UAE is a safe and efficacious treatment option for giant fibroids. The percentage of patients developing post-UAE infection is perhaps higher than quoted average of 2%, given the greater burden of necrotic tissue after giant fibroid embolisation.

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Type II Congenital Portosystemic Shunt: Consideration for Endovascular Closure

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Background: Congenital portosystemic shunts with preserved portal flow (type II) have variable anatomy and thus variable clinical manifestations and differing methods of treatment. Review of the literature shows shunts arising from a portal branch should be considered for endovascular closure as first-line treatment. **Method(s):** Following ultrasound-guided access via the right IJ, venography and portogram were performed via hand injection to look for additional abnormalities. The distal left portal vein of the shunt was coiled with 2 detachable Azur coils (3 mm x 2 cm, 4 mm x 5 cm). **Result(s):** Postembolization venogram showed successful closure. A total of 3.15cc of contrast was used with a total radiation dose of 127 mGy. Follow-up 2-week ultrasound showed no residual shunt. The patient's hypoglycemia resolved and ammonia levels improved. **Conclusion(s):** While no specific guidelines exist regarding endovascular versus surgical treatment, the literature favors endovascular therapy as first-line treatment in type II shunts involving portal barnches. In the pediatric population, there is hesitation given the radiation exposure and use of contrast. However, endovascular intervention can be relatively safe with care to keep the radiation and contrast dose to a minimum.

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Endovascular Management of Venous Complications Following Liver Transplantation

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Background: Venous complications following liver transplantations are rare but can lead to significant morbidity or graft loss. These complications may involve the portal vein, hepatic veins or the inferior vena cava. The underlying etiology could be related to thrombosis, anastomotic stenosis or vascular kink and may manifest early during the post-operative period or as a late complication. **Method(s):** This poster will illustrate and review. (1) The vascular anatomy of venous anastomosis in liver transplant. (2) The incidence of venous complications after liver transplant. (3) The role of endovascular management. (4) Presentation of illustrative cases.

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An Audit of Ultrasound Surveillance Following Deployment of Arterial Stents in the Lower Limb

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Background: There has been an increase in the number of stents deployed in the iliac, femoral and popliteal arteries following endovascular management of peripheral arterial disease. Excessive neointimal hyperplasia can lead to the development of in-stent stenoses following insertion and so most endovascular surgeons advocate the use of a formal stent surveillance program to identify clinically quiescent stenoses which can then undergo re-intervention to maintain stent patency. This audit aims to assess the number of patients who are undergoing stent surveillance as well as the timeframes related to the scans. **Method(s):** Retrospective audit of all patients who have had deployment of iliac, femoral and popliteal stents in the past five years and documentation of commencement onto the stent surveillance programme. A 100% enrolment was set as the standard. **Result(s):** Lower limb arterial stents were deployed in 106 patients. The average age was 71 years with an overwhelming male predominance (75%). Approximately half of the stents were inserted for category two and three patients (Rutherford classification for peripheral arterial disease) whilst 34% were inserted for category four and five patients. Only 69% of patients had been enrolled onto the stent surveillance programme with a median time of 85 days for the initial post-procedural duplex. **Conclusion(s):** A formal, consistent stent surveillance programme is essential to identify subclinical in-stent stenoses. Early recognition allows for speedy re-intervention in those patients who are deemed clinically appropriate ultimately leading to stent patency. Enrolment onto