P430**Uterine Artery Embolisation for Giant Fibroids: Does Size Matter?****Neeral Patel, Dermot Mallon, Alison Amoah, Ailing Fagan, Mohamad Hamady***Imperial College Healthcare NHS Trust, London, UK.
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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.

P431**Type II Congenital Portosystemic Shunt: Consideration for Endovascular Closure****Shadi Saleem***Oklahoma University Health Sciences Center, Oklahoma City, USA.
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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 branches. 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.

P432**Endovascular Management of Venous Complications Following Liver Transplantation****Mohammad Arabi, Omar Bashir, Refaat Salman, Shahbaz Qazi, Mohammad Almoaiqel***King Abdulaziz Medical City, Riyadh, Saudi Arabia.
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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.

P433**An Audit of Ultrasound Surveillance Following Deployment of Arterial Stents in the Lower Limb****Yasser Al-Obudi, Muhammad Zamir***West Hertfordshire Hospitals NHS Trust, London, UK.
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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

stent surveillance programmes should be managed by a dedicated member of the team with regular auditing.

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Hepatic Artery Stenosis in Liver Transplant Recipient's Angioplasty and Stenting a Single Center Experience

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Background: Significant hepatic artery stenosis after liver transplantation can lead to thrombosis with associated high morbidity and mortality. The aim of our study is to evaluate our technical success rate, clinical outcomes and complications. **Method(s):** It's a retrospective study in 13 patients who underwent liver transplantation between 2010 and 2018. Recipients demographics, type of liver transplant, clinical presentations methods of diagnosing hepatic artery stenosis, types of anastomosis, approached for intervention, hepatic artery stenosis grading, primary angioplasty and in some cases assisted stenting were evaluated. All patients were assessed after intervention by clinical outcomes, Doppler examination. **Result(s):** Out of 13 patients, 5 patients after angioplasty were assisted by stenting, 11 patients have good flow (84%), in 1 patient no change in flow and 1 have poor flow, 1 patient complicated by non flow limiting dissection, 1 underwent for surgical redo, 10 patients are still alive. **Conclusion(s):** Our results suggest hepatic artery angioplasty and stenting in liver recipients are minimally and safe procedures good alternative option to open surgeries.

P435

Varicocele Embolization after Surgical Failure

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Background: Varicocele is a common condition affecting up to 15 % of young adult males. It is associated with chronic scrotal pain and it can found in up to 81 % of infertile males. Surgery is the classic treatment for varicocele, however failure rates may reach up to 15 %. We aim to describe post-surgical angiographic patterns and assess both safety and efficacy of embolization for treatment of varicocele after surgical failure (residual or recurrent). **Method(s):** Inclusion criteria were symptomatic varicocele (pain or infertility) diagnosed by scrotal ultrasonography, presenting more than 3 months after previous surgical treatment. All patients underwent endovascular transcatheter retrograde varicocele embolization, under local anesthesia via right femoral vein or right internal jugular vein. We had no restrictions regarding embolization method/material. Peri-operative complications; procedure time; radiation dose; pre/post-embolization (3 months): pain score, scrotal ultrasonography and semen analysis were recorded. **Result(s):** Ten consecutive patients

were recruited. Seven suffered from chronic scrotal pain and four from infertility; eight patients had left varicocele and only two patients had bilateral varicoceles. Eight procedures were done via femoral approach and two were jugular. In nine procedures n-butyl cyanoacrylate was used and only one procedure was done using sodium tetradecyl sulphate 3 % foam. No serious perioperative complications were encountered; only one patient developed hydrocele one week after operation that subsided with conservative management. Pain score, scrotal ultrasonography and semen analysis significantly improved in nine patients. Angiographic patterns of post-surgical varicoceles are described through original images. **Conclusion(s):** Varicocele embolization after surgical failure is safe and effective, however larger sample size is needed to consolidate the conclusion.

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Pelvic Vein Embolisation of Gonadal and Internal Iliac Veins Can be Performed Safely and with Good Technical Results in an Ambulatory Vein Clinic, Under Local Anaesthetic Alone: Results from Two Years' Experience

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Background: Pelvic vein embolisation is increasing in venous practice for the treatment of conditions associated with pelvic venous reflux. In July 2014, we introduced a local anaesthetic "walk-in walk-out" pelvic vein embolisation service situated in a vein clinic, remote from a hospital. **Method(s):** Prospective audit of all patients undergoing pelvic vein embolisation for pelvic venous reflux. All patients had serum urea and electrolytes tested before procedure. A combination of coil embolisation and sclerosant were used in all patients. We noted (1) complications during or post-procedure (2) successful abolition of pelvic venous reflux on transvaginal duplex scanning (3) number of veins (territories) treated and number of coils used. **Result(s):** In 24 months, 121 patients underwent pelvic vein embolisation. Three males were excluded as transvaginal duplex scanning was impossible and six females excluded due to lack of complete data. None of these nine had any complications. Of 112 females analysed, mean age 45 years (24-71), 104 were for leg varicities, 48 vulval varicities and 20 for pelvic congestion syndrome (some had more than one indication). There were no deaths/serious complications at 30 days. Two procedures were abandoned, one completed subsequently and one was technically successful on review. One more had transient bradycardia and one had a coil removed by snare during the procedure. The mean number of venous territories treated was 2.9 and a mean of 3.3 coils was used per territory. **Conclusion(s):** Pelvic vein embolisation under local anaesthetic is safe and technically effective in a remote out-patient facility outside of a hospital.