

thyroid nodules in the US images and faster convergence than other relevant methods. **Methods:** The purpose of this article is to introduce application and utilization of the CAD system in thyroid ultrasonography. After getting clear images of thyroid nodule along with longitudinal and traverse measurements, four parameters are calculated and displayed by the computer system automatically, which include microcalcifications, hypoechoic lesion, heterogeneity, and indistinct margin. **Results:** The results are displayed automatically with pointers in the semilunar figures. The necessity of FNAC depends on the size and numbers of positive findings along with percentage risk of malignancy. **Conclusion:** This CAD system is objective, reproducible, and easy to use. It can be easy to determine the necessity for FNAC, but what we must keep in mind is that this method can reduce the necessity of FNAC, not replace FNAC for the diagnosis of thyroid cancer. RFA of thyroid nodule is minimally invasive very good tool as mode of treatment.

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Reduce Confusion! Using Combined Contrast Ultrasound and Fusion Technique During Radiofrequency Ablation of Liver Space-occupying Lesions

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Background: Purpose of this prospective study conducted in small oncology hospital is to highlight using either contrast-enhanced ultrasound (CEUS) with or without computed tomography (CT) fusion imaging to treat liver lesions well seen on positron emission tomography (PET)/CT or magnetic resonance imaging (MRI), but inconspicuous on ultrasound during radiofrequency and alcohol ablation of liver space-occupying lesions. **Methods:** Nine consecutive liver lesions; of size ranging from 1.2 to 4.7 cm; four metastatic and five primary HCC were subjected for US-guided radiofrequency or alcohol ablation earlier detected on either PET/CT or MRI. Using additional tools of CEUS or fusion imaging the pre, intra, and immediate post-RFA response was correctly judged; later confirmed on CT or PET study. In two cases, additional alcohol ablation was used to avoid heat sink effect due to main portal vein proximity and difficult RFA approach. **Results:** Except in two cases, all other lesions were considered as completely ablated based on pre- and post-CEUS enhancement pattern conducted before the patient was allowed to go home. One metastatic lesion showed definite peripheral enhancement and was reablated in additional sitting within next 2 h. In other case, CEUS showed minimal doubtful enhancement which on follow-up PET imaging was reported as post-RFA inflammatory response showing reducing standardized uptake values on repeat PET with absent enhancement on CEUS after 3 months. **Conclusion:** US guidance is at times handicapped by lack of confident identification of a lesion during ablation or by deciding the end-point of ablation merely on B-mode US due to difficulty in carrying out of immediate postablation PET/CT. This confusion can be minimized using real-time contrast US and fusion imaging to achieve the end-point.

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Pictorial Review of Biliary and Enteric Stents: What a Radiologist Needs to Know

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Background: Enteric and biliary stents are important to recognize, however, these are commonly ignored and considered nonpathological in diagnostic imaging. Careful examination of the device is required to recognise common complications. Inexperience in the imaging appearances of such stents contributes to misinterpretation. **Methods:** A pictorial review of biliary and enteric stents demonstrating how careful examination of such devices is essential to recognize and manage common complications. **Results:** We present a comprehensive pictorial review of metallic, biodegradable stents in a wide range of modalities. We discuss imaging appearances of common complications of such stents including occlusion, migration, and fracture. **Conclusion:** A sound knowledge of the imaging appearances of enteric and biliary stents is essential to recognize common complications such as stent fracture and occlusion. Diagnostic radiologist needs to be aware of imaging appearance of a wide variety of stents in various modalities to facilitate prompt management when complications arise.

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Fluoroscopic-Guided Self-Expandable Retrievable Esophageal Stent Application in Management of Postbariatric Surgery Anastomotic Leaks

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Background: Anastomotic leakage is a major complication of bariatric surgeries that can lead to high mortality and morbidity. Depending on the clinical presentation, management options include conservative management with or without external drainage, stenting, or surgical reintervention which carries relatively high morbidity and mortality rates. **Methods:** Self-expanding silicon stents were inserted under fluoroscopic guidance in 9 patients with radiologically diagnosed anastomotic leakage, 7 of them postbariatric gastric bypass operation and 2 patient after laparoscopic sleeve. Patients were referred for stenting between 7 and 26 days (mean 14 days) after surgery. Balloon repositioning was needed twice in one patient distal migration. The stent was left for 8 weeks in all patients. The patients were following a strictly fluid diet to avoid stent migration. Stents were removed endoscopically. The 9 patients were followed till removal of the stents. **Results:** A 100% technical success was achieved defined as successful positioning of the stent bypassing the leakage. Distal migration occurred twice in the same patient with balloon repositioning. Persistence of the leakage after stent removal took place in 4 patients (all were referred late 20 days plus postsurgery), 3 of which had resurgery and 1 patient who had residual tubular cutaneous-anastomosis fistula had track coiling with cessation of leakage. **Conclusion:** Fluoroscopic-guided esophageal stenting might be effective in bypassing anastomotic