

related costs and ICU hospital stay in the traditional group was significantly less than compared to the ClotTriver group. However, the Inari patients' length of stay was overall less as compared to the traditional group which decreases the risk of a hospital-acquired infection. Moreover, our data show that referrer education is needed as most ClotTriver patients do not need to stay in hospital beyond 1–2 days from a DVT standpoint. As our ClotTriver patient volume increases over the next few months, we aim to present refined data with more volume.

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Outcomes of Endovascular Aneurysm Repair in Octogenarians and Nonagenarians: A Single-Center Study

Zara Sheikh, Sadasivam Selvakumar

*The Lister Hospital, East of England, United Kingdom.
E-mail: zarasheikh1992@gmail.com*

Objectives: Endovascular aneurysm repair (EVAR) has enabled the treatment of aneurysmal disease in those of significantly advanced age. Although there have been positive experiences documented in the literature, the feasibility of EVAR in octogenarians and nonagenarians as a demographic are still largely unknown. We report a single-center experience with EVAR in octogenarians and nonagenarians. **Methods:** Cases of EVAR in octogenarians and nonagenarians were identified retrospectively at our center over 5 years using a prospectively maintained database. **Results:** Seventeen patients undergoing EVAR at our institution were reviewed; this included 14 octogenarians and 3 nonagenarians. Of these, 94% were male, with a mean age of 86.6 (81–98) years and a mean aneurysm diameter of 7.6 cm. The average number of comorbidities in our cohort was 2.6. Perioperative morbidity was 35.3% and consisted of hospital-acquired pneumonia, ischemic bowel, and one return to theater for bleeding from the access site. 30-day mortality was 17.6% ($n = 3$), with 2 of these patients undergoing repair for a ruptured AAA. Mean survival in those surviving 30 days was 27.8 months (39 days–51 months). **Conclusion:** EVAR in octogenarians and nonagenarians is feasible with good technical outcomes and acceptable perioperative morbidity and mortality.

P520

Intervention of Acute Limb Ischemia

Anil Bansal

*Zulekha Hospital, Dubai, United Arab Emirates.
E-mail: abansal2002@yahoo.com*

Objectives: A 41-year-old smoker brought to the emergency room by ambulance complaining sudden-onset numbness of the right foot, followed by severe pain and weakness of the right lower limb while driving. **Methods:** Percutaneous transluminal angioplasty (PTA) and stenting to the right common iliac artery–right external iliac artery with 8 mm × 59 mm Omnilink elite stent. Post-PTA done with 9 mm × 60 mm admiral extreme balloon. **Results:** The patient had bounding pulse in the right femoral, popliteal, posterior tibial, and dorsalis pedis artery and complete resolution of pain, anesthesia, and motor dysfunction. **Conclusion:** Endovascular therapy remains the choice of therapy for limb salvage and the quickest method to revascularize acute limb ischemia.

P521

Successful Endovascular Repair of a Mycotic Thoracic Aortic Aneurysm via Subclavian Artery Approach: A Case Report

Asim Shah, Alaaeldin Ginawi

*Nottingham University Hospitals, Nottingham, United Kingdom.
E-mail: asimshah83@gmail.com*

Background: A mycotic aortic aneurysm is an aortic aneurysm due to infection. They most commonly develop through microbial inoculation of the diseased aortic endothelium during bacteremia. It is considered a serious and fatal complication of aortic aneurysms. They represent only 0.7%–2.6% of all aneurysms, of which 60% may present as ruptured. Here, we present a case of a 71-year-old man who developed a distal thoracic aortic penetrating ulcer and a mycotic aneurysm during treatment for prosthetic aortic valve infective endocarditis. The aneurysm was treated successfully via an endovascular left subclavian artery approach. **Results:** Thoracic endovascular aortic repair (TEVAR) is now considered as the standard alternative to open surgery for a variety of aortic pathologies due to the lower morbidity of this approach. Advances in endograft technology continue to broaden the applications of this technique. The standard access method for TEVAR is via the femoral/iliac arteries; these vessels require careful assessment before the insertion of the graft. In this case, the patient had a history of ischemic heart disease with recent coronary intervention, previous aortic valve repair, and diabetes. On assessment, the mycotic aneurysm measures approximately 5 cm. The iliac arteries were diseased and calcified bilaterally with a diameter of 5 mm, down to 3 mm in places. After careful multidisciplinary discussion, the decision was to proceed with endovascular repair via the left subclavian artery approach, although this is an off-label use for the available device. The device was inserted via the subclavian artery upside down with the uncovered sealing stent distal rather than proximal. Successful aneurysm exclusion was achieved on the angiogram and on a follow-up computed tomographic scan after 1 week. The patient was discharged home in stable condition. This novel approach, to our knowledge, has not been used in the UK before. **Conclusion:** The subclavian artery can be an alternative route for access in the treatment of thoracic aortic aneurysms for patients with diseased femoral/iliac arteries.

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Outcome of Endovascular Treatment in Acute Gastrointestinal Bleeding Referred to Rehman Medical Institute, Peshawar

Aman Nawaz Khan, Ummara Siddique Umer, Muhammad Abdullah, Shahjehan Alam, Hadia Abid

*Rehman Medical Institute, Peshawar, Pakistan.
E-mail: muhammad.abdullah1@rmi.edu.pk*

Objectives: The purpose of this study was to find the outcome of endovascular treatment in cases of acute gastrointestinal (GI) bleeding due to different etiologies. **Methods:** It is prospective evaluation of transarterial embolization done for acute GI hemorrhage at the Radiology Department of Rehman Medical Institute (RMI), Peshawar, from March 2016 to April 2019. A total of seven cases with GI bleed were included, four of which

were female and three were male, with a mean age of 50 years and median of 48. Five patients were with lower GI bleed and two had upper GI hemorrhage. For knowledge of vascular anatomy or the presence of any variants, computed tomographic angiography was performed in all cases. The patients were treated with superselective transarterial embolization under fluoroscopic guidance (Siemens ARTIS ZEE) at RMI angiography suite. Embolization materials used were coils, particles, gel foam, and amplatzer plugs. **Results:** All the seven patients were embolized, with five having lower GI causes and two with upper GI causes. Six patients had vascular causes of hemorrhage, i.e., Arteriovenous malformations, angiodysplasia, and dieulafoy. One patient had a tumoral bleed from duodenal mass. Six patients were embolized with curative intent, whereas one patient with bleeding duodenal mass was embolized preoperatively, just before the surgery. Coils of different sizes were used in all cases. Technical success, immediate clinical success, and late success on follow-up of 1 year were recorded in all cases. Technical success in arresting hemorrhage was achieved in all cases. 0% in-hospital mortality was recorded in all cases. **Conclusion:** We concluded from our results that endovascular embolization is a management of choice in cases with acute GI bleeding, after endoscopic attempts have failed/deemed inappropriate. Endovascular treatment is a safe and effective technique with a small associated risk of morbidity. Risk of further bleeding is small with vast majority of patients achieving resolution of symptoms.

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Angioseal-Assisted Closure of Arterial Pseudoaneurysm in Cases of Allergy to Thrombin and Uncorrectable Coagulation: A Case Report

Abdulmajeed Bin Dahmash, Abdul Rahman Al Qahtani¹, Shaker Alshehri¹

*College of Medicine, Imam Mohammad ibn Saud Islamic University,
²Department of Medical Imaging, Vascular and Interventional Radiology Unit, King Abdulaziz Medical City and King Abdullah Specialized Children's Hospital, Ministry of National Guard-Health Affairs, Riyadh, Saudi Arabia.
E-mail: BinDahmash.a@gmail.com*

There are very limited data on the use of angio-seal closure device to treat common femoral artery pseudoaneurysm. Here, we present a case of right groin pseudoaneurysm treated with a closure device. A 45-year-old male presented with a pseudoaneurysm at the right groin. The patient has an abnormal uncorrected coagulation and underwent a thrombin injection before 1 week. Given that the patient underwent a thrombin injection 1-week prior, the potential risk of developing an anaphylactic reaction was unpredictable. Therefore, ultrasound-guided compression was carried out for 30 min without success. Consequently, an autologous clot injection inside the pseudoaneurysm by stirring blood gathered from the perma-cath port was done after suspension for more than 10 min, and unfortunately, there was no evidence of clot formation and until the end for this procedure. Therefore, the plan was changed to place a closure device across the pseudoaneurysm neck. After puncturing the sac, the needle was advanced carefully through the narrowed-pseudoaneurysm neck to the common femoral artery under ultrasound guidance. After advancing the guidewire and removing the needle under fluoroscopic guidance, a 6-F angio-seal closure device was deployed across the pseudoaneurysm

neck under ultrasound guidance; homeostasis was achieved with no evidence of flow into the pseudoaneurysm by color Doppler. This technique seems to be safe and successful in treating pseudoaneurysm in cases of allergic to thrombin and uncorrectable coagulation.

P524

Embolized Venous Stent in the Right Ventricle, What to Do? A Case Report

Mohamed Omar Elfarak

*GOTHI General Organization for Teaching Hospitals and Institutes, Cairo, Egypt.
E-mail: helliopolis@gmail.com*

Background: Subclavian vein stenosis is not an uncommon condition in end-stage renal failure patient due to reaction to dialysis central catheters. **Methods:** This is a case report of a patient with right subclavian vein stenosis treated with venoplasty and a 12-mm self-expandable stent deployed which has embolized to the right ventricle. **Results:** A unique approach of using two snares from the cephalic vein and femoral vein has been used to retract the stent from the right ventricle to left common femoral vein. **Conclusion:** Foreign body inside the heart is a unique and rare situation, and multiple modalities have been used to deal with this situation; we present one way to dealing with this complication that can be helpful in future similar cases.

P525

Inferior Vena Cava Filters

Jalil Kalantari

*Loma Linda University, Loma Linda, United States.
E-mail: jalilka@gmail.com*

Objectives: Inferior vena cava (IVC) filters have been retrieved after prolonged dwell times; however, the rate of success decreases over time. Embedded or perforated filter components increase the risk of vascular injury and are common reasons for failed retrieval. Advanced techniques, including the use of endobronchial forceps, can be employed to remove tip-embedded filters and filters with prolonged dwell times; however, these removals are riskier than standard filter retrievals. IVC pseudoaneurysm is a form of vascular injury which has been rarely reported after IVC filter retrieval. This report describes the management of an IVC pseudoaneurysm following the endobronchial forceps retrieval of a 28-year-old Greenfield filter. **Methods:** A 71-year-old male with a history of traumatic brain injury and prophylactically placed titanium Greenfield IVC filter in 1990 presented for the consideration of IVC filter retrieval. A computed tomography (CT) scan revealed moderate caval stenosis, 40° of apical tilt, likely apex embedment, and perforation of two medial struts through the caval wall, abutting the aorta and lumbar artery. The patient complained of focal abdominal pain corresponding to the area of the filter, strongly desired filter retrieval, and had no ongoing indications for filtration. After a detailed discussion with the patient regarding the risk of retrieval, the decision was made to attempt filter retrieval to improve the patient's symptoms and decrease the risks of arterial injury from strut perforation and further caval stenosis or thrombosis. **Results:** Due to jugular vein occlusion, femoral access was initially