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previous attempts of hepatic vein recanalization and IVC stenting, retrospectively. All patients underwent ultrasound and fluoroscopy guided percutaneous direct intrahepatic porto systemic shunt creation extending from the right portal vein to IVC. One patient had IVC recanalization along with shunt creation. **Results:** All procedures were technically successful with no procedure related complications. One patient required shunt revision 3 days later with portal stent extension due to shunt thrombosis. All shunts remain patent at mean follow up time of 205 days with resolution of ascites in 3 patients. One patient had decreased frequency of drainage due to associated nephrotic syndrome and hypo albuminemia. All patients required life-long anticoagulation with warfarin. **Conclusions:** Percutaneous direct intrahepatic porto systemic shunt creation in chronic Budd Chiari is technically feasible and safe with good short term outcomes.

## P509

## Microwave Ablation of Hepatocellular Carcinoma Using a New Percutaneous Device and Results of Combination Therapy: Preliminary Results

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**Background:** Thermal ablative techniques have gained increasing popularity as safe and effective options for patients with unresectable solid malignancies. Microwave ablation has emerged as a relatively new technique with the promise of larger and faster ablation areas without some of the limitations of radiofrequency thermal ablation. **Methods:** Under ultrasound and CT guidance 30 HCCs in 22 patients were treated through a percutaneous approach. The median diameter of lesions was 2.3 cm (range = 2.0-8.0 cm); 14 lesions had a diameter greater than 30 mm. We used a microwave generator (ECO for Microwave Ablation) connected to a 14- or 16-gauge coaxial antenna. Contrast-enhanced computed tomography scan was carried out one month after treatment, and then every three months to assess efficacy. **Results:** Complete ablation was achieved in 84.3% of the lesions after a mean of 1.03 percutaneous sessions. For small HCCs (diameter <3 cm) complete necrosis was obtained in 100%. Local tumor progressions were found in 3 treated lesions (15.1%) a median of 10.5 months after ablation. Minor complications occurred in 5.1% procedures. No deaths, or other major complications occurred. **Conclusions:** In our experience, the new device for microwave ablation proved to provide an effective and safe percutaneous ablative method, capable of producing large areas of necrosis. Combination therapy with microwave ablation followed by TACE is very good tool for large sized tumours.

## P510

## Laser Sheath Assisted Removal of Optease Filters with Long Dwelling Time

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**Background:** To evaluate the feasibility and safety of laser sheath assisted removal of IVC filters with long dwelling times. **Methods:** Between December 2015 and December 2016, three patients underwent laser sheath assisted filter removal. All patients had prophylactic filter placement following trauma and prior to orthopedic surgery. Filters were infra renal Optease with mean dwelling time was 510 days (210-720 days). All patients had failed previous retrieval attempts using standard techniques, and were prescribed prophylactic anticoagulation therapy. Glidelight laser sheath was used (12 or 14 Fr) to disengage the filter from the IVC wall. The sheath was operated at 60 mjoule/mm with pulse repetition rate between 60-80 Hz. Two filters were removed via femoral access and one was removed from jugular access as the hook was embedded in the occluded right iliac vein. **Results:** Laser sheath assisted filter removal was technically successful in all patients. The mean fluoroscopy time was 55 minutes (4-118 minutes) and the mean total DAP was 101410 mGyCm2. Two patients had IVC stenosis following retrieval and responded adequately to balloon dilatation. No major complications were encountered. Patients were prescribed prophylactic enoxaparin for 10 days post procedure. Abdominal CT scan at 1 month was done in two patients, showed patent IVC with no stenosis or thrombosis. All patients discontinued the pre-procedure anticoagulation therapy. **Conclusions:** Laser sheath assisted filter removal of Optease filters with long dwelling time is feasible. Safety of this technique is yet to be proven in a larger patient cohort.

## P511

## Peritoneal Decompression Devices: Introduction to IR Nurses

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This educational poster introduces peritoneal decompression devices to IR nurses and briefly discusses how to maintain them in patients with malignant ascites. Malignant ascites (MA) is the cancer-associated accumulation of fluids in the peritoneal cavity. The most gastrointestinal tract tumors that are frequently associated with MA include pancreatobiliary, gastric, esophageal and colorectal cancers. MA associates with significant morbidity and poor prognosis with median overall survival of 1-6 months. Symptomatic MA is a significant clinical challenge due to considerable reduction in the quality of life (QoL) with no generally accepted guidelines for the management of MA. The main goal of the peritoneal decompression is to palliate the symptoms of elevated intra-abdominal pressure (discomfort, dyspnea, nausea, and vomiting) and improve QoL. Paracentesis is indicated for symptomatic ascites which can be relieved by draining up to 5 L of fluid. Peritoneal decompression devices (PDDs) help in maximizing time spent out of hospital. They include external drainage catheter devices and peritoneovenous shunts. These devices are placed under strict aseptic techniques, imaging guidance and sometimes-moderate sedation on outpatient or one-day surgery basis at the interventional radiology suites. However, to date, none of these different devices has been subjected to evidence-based clinical trials.