

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.

#### P436

### 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.