

Barcelona, Spain
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PART 1

**Abstracts of
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sorted by presentation
numbers**

the pancreatic duct with balloon dilatation (4 mm) and stent placement (7F x 7 cm). Postoperatively, the patient did well and had no pancreatitis.

Discussion: Percutaneous access to the pancreatic duct for antegrade pancreatic duct stent placement represents an alternative approach to patients with altered anatomy or challenging retrograde endoscopic access.

Take-home points: Antegrade pancreatic stent placement represents a feasible and safe alternative.

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Initial experience with PHIL liquid embolic agent for gastrointestinal bleeding embolization and occlusion of enteric fistula using n-BCA glue

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Clinical History/Pre-treatment Imaging: 71 y.o. female underwent Whipple resection for duodenal papillary adenocarcinoma. 7 weeks after surgery was readmitted with upper GI bleeding and enteric fistula. On CT-angiography no evidence of active bleeding. Direct fistulography demonstrated parapancreatic fluid collection with fistula into the bowel loop. In order to control the bleeding and close the fistula two sequential interventions were performed: empirical embolization and occlusion of fistula at the same session.

Treatment Options/Results: Celiac trunk was catheterized using C2 4F catheter. Gastroduodenal artery (GDA) appeared notably suspicious as a source of bleeding source of the enteric anastomosis. On SMA angiography we observed branches to GDA without evidence of bleeding. GDA was embolized with IDC microcoil (BSCI) and PHIL 25% (Microvention) via 1.7 F Headway (Microvention) microcatheter until complete occlusion. Fistulography was performed using Mach C2 (BSCI) Guiding catheter was introduced via surgical incision to anastomosis. Enteric fistula in the area of anastomosis zone was observed. Microcatheter was advanced into the fistula and an anastomotic leak was observed. Jejunal fistula was occluded using n-BCA Trufill system. Fistulography on day 5 following intervention without evidence of pathology. Further follow up was uneventful.

Discussion: PHIL liquid embolic agent can be used for termination of peripheral bleeding, whereas n-BCA Trufill system can be used for enteric fistula closure.

Take-home points: Intelligent matching of different liquid embolic agents to specific indications is effective in vascular and non-vascular interventions.

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Utilizing methylene blue prior to embolization in a patient with upper gastrointestinal bleeding

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Clinical History/Pre-treatment Imaging: Patient is a 26 year-old female, status post aortic valve replacement, tricuspid valve repair, with her ICU course complicated by hematemesis. Endoscopy showed multiple gastric ulcers, which were not able to be treated. After several days, she became unresponsive, hypotensive, with coffee ground emesis and IR was consulted for immediate embolization.

Treatment Options/Results: A diagnostic celiac arteriogram showed no active extravasation of contrast and the left gastric artery was empirically embolized with gelfoam. Minimal mucosal staining was also seen at the right gastroepiploic artery along the greater curvature of the stomach and selective arteriogram of this artery showed no active extravasation

of contrast (Figure 1). Due to large territory vascular compromise, determination of vasospasm versus gastric mucosal ischemia/necrosis was needed. 10 ml of methylene blue was injected under endoscopic visualization which showed extravasation of methylene blue dye into the gastric lumen at the ulcers (Figure 2), excluding gastric necrosis. Gelfoam embolization was subsequently performed at the right gastroepiploic artery and the bleeding ceased.

Discussion: Review articles and case reports have described the use of methylene blue to identify sources of bleeding from AVMs in the small and large bowel. However, the use of methylene blue to identify a source of gastric bleeding concomitantly with angiography and endoscopy has not yet been described in the literature.

Take-home points: Empirical embolization of the left gastric artery may be performed with ulcers present at the gastric fundus.

Methylene blue was used to exclude gastric mucosal ischemia/necrosis in the setting of vasospasm.

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Massive rectal bleeding treated with transcatheter artery embolization: an unusual presentation of the solitary rectal ulcer syndrome

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Clinical History/Pre-treatment Imaging: A 35-year-old paraplegic man because of a thoracic spinal cord injury and, history of constipation and self-digitation maneuver to evacuate, complained rectal bleeding and maroon-colored stools from some days. Laboratory findings revealed hemoglobin of 8.3 g/dL and a hematocrit of 25% requiring the transfusion of 3 units of packed blood cells. Esophagogastroscope was negative and colonoscopy was inconclusive showing blood and clots. Abdominal contrast enhanced CT showed endorectal active contrast extravasation from left superior hemorrhoidal artery (SHA). Endovascular angiography and embolization was performed for controlling acute bleeding.

Treatment Options/Results: Selective catheter angiography at the inferior mesenteric artery demonstrated active extravasation from a peripheral posterior branch of the left SHA (Fig.1). It was subsequently super-selective embolized with coils. Post-embolization images demonstrated resolved bleeding (Fig.2). Two days later endoscopy revealed a single shallow longitudinal ulcerating lesion covered by white slough on a hyperemic surrounding mucosa. Combination of symptomatology, patient history and endoscopy prompted the diagnosis of Solitary Rectal Ulcer Syndrome (SRUS).

Discussion: SRUS is a rare benign disorder supposed to be secondary to straining, self-induced trauma, paradoxical contraction of puborectal muscle, rectal prolapse and intussusception. Although rectal bleeding is one of the most common clinical features, massive hemorrhage is extremely rare. Patients with a massively bleeding rectal ulcer that does not stabilize with endoscopic or supportive therapy must be considered for operative treatment, including endovascular embolization.

Take-home points: -SRUS is an extremely rare cause of massive lower gastrointestinal bleeding.

-Embolization is a safe and effective alternative to endoscopic treatment and surgery for the rapid clinical stabilization.