

Barcelona, Spain
September 7-11
CIRSE 2019

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Online Publication Number:
10.1007/s00270-019-02282-x

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PART 1

**Abstracts of
Controversy Sessions
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sorted by presentation
numbers**

P-388**Gastrointestinal bleeding from Dieulafoy's lesion: endovascular management with gelfoam and coil**

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Clinical History/Pre-treatment Imaging: A 56-year-old man was admitted to our hospital for some day of asthenia. He reported aspirin intake for a month. His past medical history included splenectomy for trauma. Laboratory tests showed hemoglobin of 9.1 g/dL and digital rectal examination revealed melena. Esophagogastroduodenoscopy showed, in proximal gastric body, active arterial spurting from two close minute mucosal defect. These lesions were successfully treated with combined mechanical hemostasis and injection therapy. However, a following laboratory test revealed hemoglobin drop.

Treatment Options/Results: Patient performed endovascular angiography but no active source of gastrointestinal (GI) bleeding were found. After celiac trunk catheterization, images revealed distal left gastric artery branches maintaining constant arterial caliber and tortuous appearance (Fig.1), finding suspected of Dieulafoy's lesion. To minimize risk of premature rebleeding, embolization with gelfoam and coil was performed demonstrating reduce flow towards the proximal stomach (Fig.2).

Discussion: Although often misdiagnosed, Dieulafoy's lesion represents an important etiology of acute, life-threatening and recurrent GI bleeding. Hemostasis with angiographic embolization has been reported in sporadic case reports. To minimize the risk of bowel infarction, the super-selective catheterization technique and a temporary agent such as gelfoam slurry is mandatory. In our patient, despite active bleeding was no seen, we have decided to release also a proximal single coil. To our knowledge, it allows to reduce recurrent bleeding risk decreasing perfusion pressure but to maintain sufficient tissue blood flow avoiding ischemia.

Take-home points: The embolization strategy is essential in the endovascular management of Dieulafoy's lesion to balance the risk of rebleeding and the risk of bowel ischemia.

P-389**126/5000 embolisation of a lesion of dieulafoy of the stomach blender already subject to hemoclipping endoscopic: a case report**

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Clinical History/Pre-treatment Imaging: Man 38 years old, with hematemesis and melena, was diagnosed with one hemorrhage from the upper GI tract; an EGDS examination allowed to identify a lesion of Dieulafoy on the gastric bottom and to proceed with the hemostatic treatment through clipping. This procedure was found to be inefficient due to acute re-bleeding with values of HB7g/dl.

Treatment Options/Results: On the second access, the man was postponed to an angiographic examination after the selective catheterization of the celiac tripod which, while not allowing to identify the source of bleeding in a left gastric site it was decided however to proceed to the embolization with metal spirals, in the dysplastic peripheral superselective seat, of the metal clips previously implanted by EGDS. The patient after 7 days was discharged in good general condition in the absence of symptoms of haemorrhage and with an increase in hemoglobin value of 9.9 g / dl, without resorting to transfusion therapy.

Discussion: Haemorrhages of the upper gastrointestinal tract pose complex situations in which the endoscopic examination appears an irreplaceable diagnostic stage. The lesion of Dieulafoy represents a condition in which hemostasis through the same endoscopy can be ineffective, but in which embolization represents a therapeutic choice practicable and certainly resolute.

Take-home points: Emphasize the possibility of attenuating a embolizing treatment in lesions of Dieulafoy. The endoscopic examination is a diagnostic evaluation and an intervention therapeutic hemostatic; frequent problems that endoscopic therapy fails or does not result feasible, conditions under which angiographic examination is; data embolization the most diagnostic-therapeutic efficacy.

P-390**Endovascular treatment of acute hemobilia following laparoscopic cholecystectomy**

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Clinical History/Pre-treatment Imaging: An 18-year-old girl underwent laparoscopic cholecystectomy for biliary sludge. During surgery, a coledocic duct injury occurred; decision was taken to convert to open surgery with subsequent positioning of an endoscopic endoprosthesis for biliary tree.

Three months after surgery, the biliary endoprosthesis was removed but after twenty minutes the patient showed signs of hypovolemic shock. Patient underwent computed tomography angiography (CTA) showing a possible arterial lesion, just adjacent to surgical clip, with coledocic luminal hyperdensity as for hemobilia (Fig.1-arrows). Patient underwent angiographic examination (DSA) with catheterization of proper hepatic artery. DSA confirmed a 7mm pseudoaneurysm arising from cystic artery, likely draining in the biliary tree (Fig.2-arrows).

Treatment Options/Results: Using "sandwich" technique, the pseudoaneurysm was excluded performing super-selective catheterization of parent vessel and subsequent coil embolization (Fig.2-arrows). Selective arteriography of common hepatic artery, superior mesenteric artery confirmed exclusion of the lesion. The girl was discharged after two months in good health.

Discussion: Hemobilia is a rare, life-threatening complication after cholecystectomy. CTA represents a fundamental technique, able to highlight the high-attenuation clots in the biliary duct on non-enhanced scans and the presence of an arterial lesion; in the latter case, DSA should immediately follow CTA.

Take-home points: Transarterial embolization has become the first choice in the management of hemobilia sustained by an arterial injury. In these cases, coil embolization of parent vessel with sandwich technique is recommended to avoid possible reperfusion of the pseudoaneurysm from collateral circulation; packing of the lesion with coils is not advisable due to relatively high risks of rupture and reperfusion.

P-391**Embolization of aneurysm of the hepatic artery and dissection of the celiac tripod with splenic artery originating from the false lumen**

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Clinical History/Pre-treatment Imaging: Patient with common hepatic artery aneurysm diagnosed with US-CD. An aneurysm of the common hepatic artery and an associated dissection of the celiac tripod with a splenic artery that originated from the false lumen is shown in the Angio CT.