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Educational Poster Background: Visceral artery aneurysm (VAA) and visceral artery pseudoaneurysm (VAPA) rupture can lead to catastrophic hemorrhage with high mortality. Diagnosis is with computed tomographic angiogram. Management is endovascular and aims to exclude the aneurysm from the circulation. We describe the treatment of three patients (mean age 74) with asymptomatic and ruptured VAA/VAPA presenting to a University Teaching Hospital. Patient A –30 mm gastroepiploic aneurysm: Angiogram confirmed a tortuous GA arising from the gastroduodenal artery (GDA). This aneurysm was excluded from the circulation by placement of embolization coils in front and back door arteries with angiographic success maintained during 2 years' imaging follow-up. Patient B – Ruptured 11 mm SMA branch pseudoaneurysm: DSA confirmed SMA branch pseudoaneurysm, tight coeliac axis (CA) stenosis, and right hepatic artery replacement to the GDA. The pseudoaneurysmal SMA branch also perfused the CA territory retrogradely via the GDA. Arterial inflow to the pseudoaneurysm was a tiny vessel with a high angle to the SMA branch. Covered stentgraft placement in the pseudoaneurysm neck was used to exclude it from the circulation while maintaining retrograde perfusion of the CA via the SMA. Patient C – 9 mm ruptured GDA branch aneurysm: DSA demonstrated CA occlusion and a pseudoaneurysm with a narrow neck supplied by a tortuous submillimeter GDA branch. CA occlusion and tortuosity prevented stent-graft placement. Embolization of the pseudoaneurysm feeding vessel would have compromised retrograde CA perfusion. The pseudoaneurysm neck was cannulated with 0.021" microcatheter and 0.014" wire and embolized using Histacryl glue and lipiodol (2:1 ratio). Angiogram showed exclusion of the pseudoaneurysm and maintained retrograde (via GDA) CA perfusion. **Conclusion:** In this educational poster, we show how our optimal treatment of these three patients presenting to our institution was determined by the clinical scenario and locoregional arterial anatomy.

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Imaging Pathway for the Diagnosis and Treatment for Pelvic Congestion Syndrome

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Educational Poster Background: Pelvic congestion syndrome (PCS) is a known (and underdiagnosed) cause of chronic pelvic pain in the female population. There is an increased incident in the postpartum cohort and in patients with recurrent lower limb varicose veins. Although the pathophysiology is poorly understood, pelvic venous incompetence is defined by the presence of pelvic varicoceles and reflux within the ovarian veins. The clinical presentation is often nonspecific; thus, the causes of pelvic pain such as pelvic inflammatory disease, endometriosis, adenomyosis, and uterine fibroids must be excluded before diagnosis. We describe the clinical aspects of PCS including the common presentations, examination findings, and etiology. Our imaging pathway for patients clinically suspected of PCS includes transabdominal/transvaginal ultrasound, duplex ultrasound, and magnetic resonance imaging pelvis features (with specific examples). The treatment options will be considered, with a specific focus on ovarian vein embolization (OVE). The technical considerations of OVE and the pearls and pitfalls with example cases from our tertiary center are also demonstrated. PCS can be a debilitating condition in the symptomatic patient population. The importance of correct diagnosis and treatment with OVE with a multidisciplinary approach can lead to good clinical outcomes in the vast majority of cases.

1. To demonstrate clinical presentation and imaging findings of pelvic congestion syndrome (PCS).
2. To demonstrate our local imaging pathways for patients with PCS.
3. To understand the treatment options available for PCS and specifically the work up for ovarian vein embolization, focusing on pearls and pitfalls.

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Selective Uterine Artery Embolization in Postpartum Hemorrhage; Updates on 5 Years' Single-Center Experience

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Objectives: Postpartum uterine hemorrhage is ~~one~~ of the most important causes of maternal mortality worldwide and as well in Egypt. Causes are variable, the most important of which are uterine atony and birth canal lacerations. Uterine artery embolization (UAE) is very effective if local measures failed to stop bleeding. **Methods:** In the period between January 2015 and December 2019, 200 women (mean age 26 years) with postpartum hemorrhage underwent embolization in Ain Shams University Hospitals after failure to achieve hemostasis after conservative treatments. Clinical success was defined as stabilization of vital data of the patient and obviation of hysterectomy. Gel foam hand-cut pledges were the embolic agents used. **Results:** Bleeder whether extravasation or pseudoaneurysm could be identified angiographically in 120 patients. In 80 patients, no definite bleeder or just diffuse hyperema could be identified, so bilateral UAE was done empirically. Clinical success rate was 85% (170 patients including 117 patients with angiographically identified bleeder). Hysterectomy was needed in 30 patients after rebleeding post-UAE. No major procedural-related complications were recorded. **Conclusion:** Transcatheter arterial embolization of the uterine artery is a feasible treatment option in management of postpartum bleeding with low rates of complications. Angiographic identification of the bleeding source was associated with higher clinical success rates decreasing the need for hysterectomies.