

obtained to provide a target for fluoroscopic access into a retroclavicular collateral from above, facilitating large sheath insertion and endobronchial forceps retrieval of the filter, which required surprisingly little force. Following retrieval, contained extravasation was observed at the previous site of the filter struts. Despite balloon-tamponade and an attempt at flow diversion using a bare-metal stent, the pseudoaneurysm continued to fill. A catheter was advanced through the stent interstices into the pseudoaneurysm, which was treated with balloon-controlled thrombin administration. After 5 min, repeat Intra vascular Ultrasound (IVUS) showed pseudoaneurysm thrombosis. The final venogram revealed no further contrast extravasation and a patent IVC. The patient was discharged on postoperative day 2. At the 5-month postoperative follow-up visit, the patient reported resolution of previous abdominal pain and CT scan re-demonstrated patent IVC. **Conclusion:** Extended dwell times and penetrating IVC filters increase the risk of retrieval complications. While conservative treatment options should be considered first, physicians performing high-risk retrievals should understand and be prepared for rare complications.

## P526

### Fibrin Sheath Removal from Port-A-Cath by Exteriorization of the Catheter by Snaring Through a Shortened Vascular Sheath: A Novel Technique

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**Objectives:** Port-a-caths are commonly placed central venous access devices in children. Fibrin sheath formation is a common complication, leading to port malfunction. Unlike other tunneled central line, port-a-caths cannot easily be exchanged over a wire. Treatment of fibrin sheath formation includes fibrinolytic therapy, fibrin sheath stripping via transfemoral route or replacement. We describe an alternative minimally invasive technique of fibrin sheath removal. **Methods:** This novel technique was performed on four patients with port-a-cath who had failed fibrinolytic therapy and presence of fibrin sheath confirmed on contrast injection. The port was accessed under aseptic precautions. Ultrasound-guided right internal jugular vein access was performed just cranial to previous catheter insertion site, and shortened vascular sheath, which was one and half times larger French size relative to the size of the port catheter, was inserted. Catheter tip was successfully snared under fluoroscopic guidance using a 30 mm Goose Neck snare. Catheter was then exteriorized through the sheath. Catheter was then cleaned with a wet Telfa gauze to clear any fibrin sheath. A 0.018" Nitrex wire was also passed through the catheter to clear intracatheter clot or debris. Catheter was reinserted back through the vascular sheath into right atrium with the help of snare. **Results:** Port-a-cath function was restored in all four patients with satisfactory flushing and aspiration. Contrast venogram was performed to confirm function and no residual fibrin sheath was demonstrated. No complications were encountered. **Conclusion:** Fibrin sheath removal by exteriorization of port catheter by snaring through shortened vascular sheath is

an attractive alternative which is minimally invasive and highly effective, compared to traditional stripping or replacement with new port.

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### Transarterial Embolization of the Renal Arteries for the Management of Iatrogenic Renal Vascular Injuries: Two Centers Experience in 150+ Patients

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**Objectives:** Nephrourologic percutaneous interventions namely percutaneous nephrolithotomy (PCNL), percutaneous nephrostomy (PCN), and renal biopsy are common minimally invasive procedures; however, they can be associated with massive life-threatening hemorrhage. Conventional surgical management in the form of partial and total nephrectomy is usually associated with marked comorbidity and massive renal parenchymal loss. This study aims to retrospectively assess the technique and short-term hemostasis of transarterial renal artery embolization in iatrogenic vascular injuries in two centers. **Methods:** A total of 154 patients (90 males and 64 females) with suspected renal vascular trauma (107 post-PCNL, 46 postrenal biopsy, and 1 post-PCN) either presenting with hematuria (120 patients) or increasing perinephric hematoma by ultrasonography (34 patients) were referred to both institutes for the possibility of embolization. Embolization was done with variable-sized vascular coils in 133 patients, hand-cut gel foam pledgets in 13 cases, and NBCA in three patients with marked hemodynamic instability. Five patients had negative angiographic findings, so embolization was not done. **Results:** The bleeding artery could be identified and embolized in 149 patients; in patients with negative angiography, no further intervention was done. A total of 146 patients showed clinical improvement in the form of stoppage of hematuria and stabilized vital data. Rebleeding occurred in three patients (all embolized by gel foam) who were treated by another session of embolization with combined gel foam and NBCA. None of the treated patients needed any further surgical treatment. No major complications occurred. **Conclusion:** In this large-volume series, transarterial renal artery embolization has shown to be an effective option in the management of iatrogenic renal vascular injuries with high hemostasis as well as low complication rates.

## P528

### Anaphylaxis Following Angioplasty of the Superficial Femoral Artery with Paclitaxel-Coated Balloon: A Case Report

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